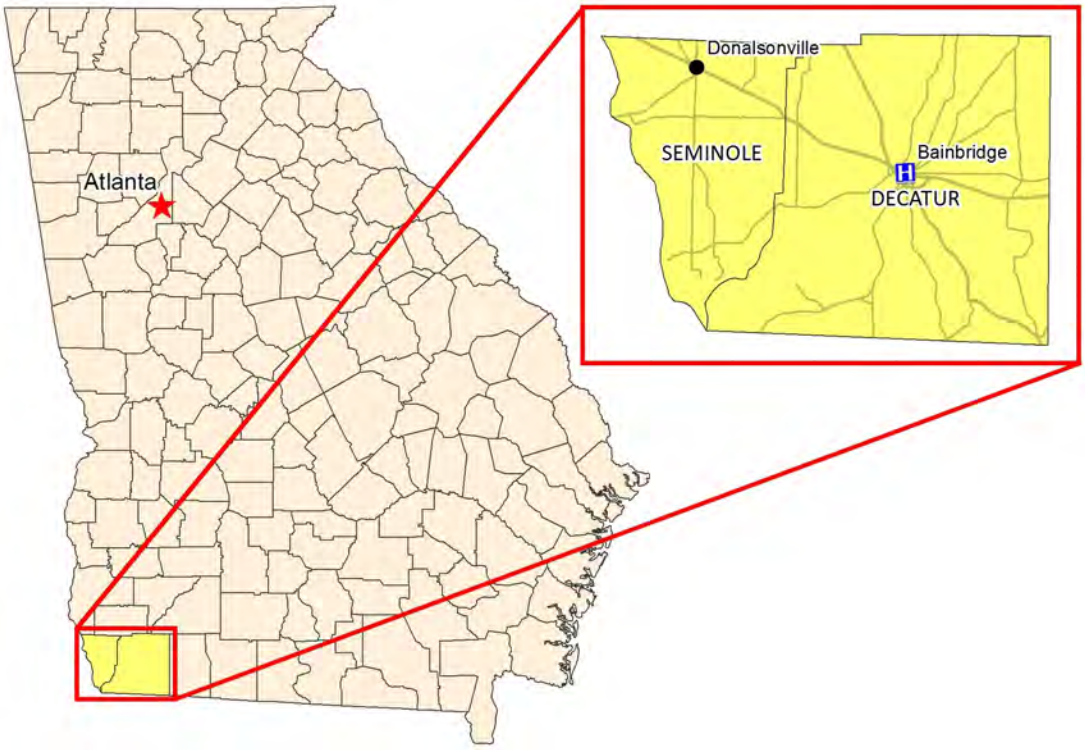
Memorial Hospital & Manor
Community Health Needs Assessment



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ABOUT THE PROJECT TEAM

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

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

Marie Denis-Luque, MSPH, MPH serves as the Research Manager for this project. Mrs. Denis-Luque emigrated from Haiti to the U.S. in 1991. She lived in Florida until January 2010 when she joined her spouse, Dr. John Luque, a Georgia Southern University faculty member in Statesboro, Georgia. Mrs. Denis-Luque holds two Master's degrees in Public Health from the University of South Florida (USF): Epidemiology and Community & Family Health, and she has

extensive national and international experience in Public Health. In 2003, while still in graduate school, she founded Caring for Haitian Orphans with AIDS, Inc., a nonprofit organization that provides care to HIV-positive abandoned children in Haiti. After her graduate studies she worked as an Associate in Research for five years at the USF Chiles Center for Healthy Mothers and Babies, where she sharpened her skills as a qualitative researcher using qualitative data analysis software such as MAXQDA and NVIVO. She later worked as an ethnographer and qualitative data analyst for SmartRevenue, a market research firm. Before taking on her current role at the Jiann-Ping Hsu College of Public Health, she worked as a Project Director on a federal grant assisting HIV-positive women in 15 rural Georgia counties access services, at Georgia Regents University, formerly known as Medical College of Georgia. As the Research Manager in the Community Health Needs Assessment project, she manages and oversees the daily activities; develops and implements a tailored stepwise framework; develops project protocols, procedures and instruments; analyzes the data; and produces quarterly reports.

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

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

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EXECUTIVE SUMMARY

Purpose

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

Service (target) Area

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

- ✓ The specific target area for Memorial Hospital & Manor was Decatur and Seminole Counties.

Community Advisory Committee Membership

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

Site Visits

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

Data Collection Approaches

- ✓ The secondary data reports were generated using data collected from multiple online sources including the Georgia Department of Public Health's Online Analytical Statistical Information System (OASIS), County Health Rankings, the U.S. Census Bureau, and the Georgia Board for Physician Workforce's 2008 Physician Workforce Profile.

- ✓ Primary data were collected using a pilot tested community-based survey. Through the assistance of the CAC, a minimum of 400 surveys were distributed to a cross-section of the defined target area.

- ✓ Primary data were collected using 3 focus groups (6 to 8 members each) in each community. One group consisted of CAC, the persons recruited by each hospital to actively participate in the needs assessment. The other two groups were recruited by CAC members and referrals.

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

Prioritization Strategy

- ✓ A two-stage process was used to complete the prioritization of issues in each community. The first stage involved using a "multi-voting" technique designed to facilitate discussion of the relative importance of each issue presented during the third site visit. The second stage involved, the Hanlon Method to obtain the final prioritization of issues.

Results: Secondary Data Analysis

- ✓ The majority of the population is white (Decatur County – 56%, Seminole County – 65%), while African-Americans constitute the largest minority (Decatur County - 42%; Seminole County – 33%).

- ✓ Diabetic and mammography screenings below the state averages.

- ✓ In 2008, the service area had a total of 58 physicians, mostly Family Practice.

Morbidity

- ✓ Cardiovascular diseases are a significant cause of morbidity, which resemble state averages. Males, especially African-Americans, have the highest rates of cardiovascular diseases.

- ✓ In the service area, African Americans have higher rates of stroke. However, their rates are below the state averages.

- ✓ Obstructive Heart Disease (OHD) is lower among white residents in the service area.

- ✓ The rates of respiratory diseases are considerably higher than the state average for each race and gender classification. Rates are highest among African-American males.

- ✓ Although, African Americans females have the highest rates of asthma, all race and gender classifications are higher than the state averages.

- ✓ The cancer morbidity rate is lower than the state average.

- ✓ Hospital discharge rates for diabetes among African Americans are three times higher than that of white residents.

- ✓ African Americans have the highest rates of HIV/AIDS.

- ✓ The rate of sexually transmitted infections is higher than the state average among African Americans.

Mortality

- ✓ Rates of cardiovascular disease mortality in the service area are higher than the state of Georgia average, particularly among males.

- ✓ Total stroke mortality rate is higher than the state average for all groups except African American females.

- ✓ Rates of obstructive heart failure are lower than the state average.

- ✓ The mortality rates for respiratory disease were higher than the state average among white males.

- ✓ The total age-adjusted cancer mortality rate was similar to the state average, but noticeably higher among white males.

- ✓ The age-adjusted diabetes mortality rate is similar to the state average in all groups except African American males. The rate is considerably higher than the state average.

Maternal and Child Health

- ✓ The percentage of births receiving less than five prenatal care visits is higher in the African American community, but these rates are lower than those observed for the state.

- ✓ The infant mortality rate for whites is higher than the observed rate for African Americans.

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

- ✓ The percentage of low birth weight births for teen mothers is higher among African-Americans than in whites.

Results: Community-Based Survey

- ✓ A total of 324 surveys were completed and returned to Georgia Southern University for analysis.

- ✓ Considerably more females (74.2%) completed this survey than males (25.8%).

- ✓ Most respondents were either white (61.7%) or African American (34.2%).

- ✓ Nearly 51% of all participants were between the ages of 25 and 54 years old.

- ✓ Approximately 35% of respondents reported having some college education and 29.7% of respondents reported having a high school diploma or the equivalent.
- ✓ Most survey participants (44.7%) indicated they worked full-time while only 9.0% reported part-time work. Approximately 11% of participants reported they were unemployed.
- ✓ Nearly 33% of participants reported household incomes of less than $25,000 per year.
- ✓ A considerable proportion of the respondents reported having access to transportation (92%).
- ✓ Overall, quality of life in the community is high. Respondents characterized the community as safe, good place to live and raise children. Moreover, most participants agreed the community had a strong educational system and health care system. However, the economic viability of the community was a concern.
- ✓ Approximately 50.3% of respondents perceived their health status as "good," and 29.2% perceived their health status as "very good."
- ✓ A majority of respondents reported either exercising occasionally exercising (39.7%) or not at all (17.5%).
- ✓ 58.8% of the female respondents reported completing a self-breast examination.
- ✓ Most respondents (82.8%) reported not using tobacco.
- ✓ Nearly 90% of respondents reported never consuming alcohol (51.9%) or only consuming it occasionally (38.4%).
- ✓ Most respondents reported always (73.8%) or mostly (15.7%) using seatbelts.
- ✓ Prayer (55.9%) was the most commonly reported strategy for controlling stress. However, talking to friends (36.8%), exercise (36.2%), and hobbies/sports (26.7%) were also commonly reported.
- ✓ The majority of survey respondents (76.2%) indicated they received physicals on a regular basis.
- ✓ Most (84.4%) respondents reported having a regular doctor.
- ✓ Nearly 57% of all respondents indicated having private insurance to pay for health care services. Approximately 26.0% reported being Medicare beneficiaries and 7.8% reported being on Medicaid.
- ✓ Over 65.6% of respondents indicated having a regular dentist.

- ✓ 79.7% of respondents reported seeking health care from a private practice. The emergency room (20.4%) and the health department (1.9%) were additional sites for receiving health care services.

- ✓ 74.7% percent of respondents indicated that cost was not a barrier to receiving health care services.

- ✓ Nearly 73.9% of respondents indicated that cost was not a barrier to filling a prescription medication.

- ✓ Trauma (71.6%) was the most commonly reported ambulatory care condition reported by participants reporting admission to the emergency room (ER). Ear/nose/throat infections (65.5%), hypertension (46.9%), kidney infection (54.5%), asthma (44.2%), and dehydration (44.9%) were also commonly reported conditions for emergency room admissions.

- ✓ Among respondents surveyed, 71.5% used hospital services in the last 24 months. Those reporting using hospital services, 90.2% indicated using services at Memorial Hospital & Manor.

- ✓ Most participants reported using Taylor Regional Hospital because of convenience (70.2%). However, 21.9% reported being referred by a physician.

- ✓ Radiologic services (48.9%) and laboratory services (45.4%) were the most commonly reported services used by survey respondents. The emergency room was used by 40.6% of those surveyed.

- ✓ Over 81% of those surveyed indicated being satisfied with services while only 13.5% indicated dissatisfaction. The primary reasons for reporting dissatisfaction involved long ER wait times and hospital personnel interaction.

- ✓ Approximately 87% of those surveyed indicated using a primary care physician.

Results: Focus Group Analysis Themes

- ✓ Community: Safe and friendly; agriculture driven economy; 'small town effect;' school nutrition programs for children and other standard feeding programs for the elderly; other programs with available scholarships; current economic downturn as barrier to healthy lifestyle; too many fast food restaurants; and access to adequate health care

- ✓ Community Issues: Lack of employment opportunities, public transportation and entertainment; increase number of uninsured; lack of mental health professionals; chronic health conditions in adults and children; and illegal immigrants.

- ✓ Hospital: Family Feel, Good Services, Referrals when necessary.

- ✓ Hospital Problems: Expand Services, increase morale and administrative issues.

- ✓ Recommendations: Improve nursing home staff; collaborate with churches; expand upon health fairs; and reduced ER wait times.

- ✓ Community Vision: Availability of more doctors, mental health services, and programs directed at reducing obesity.

Community Assets

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

Prioritization

- ✓ **The following issues emerged from the data**: Community Health Education (Exercise, Diet, Tobacco), Community Image of the Hospital (Morale, Turnover, Wait-time), Mental Health, Economic Development (Unemployment, Poverty), Cancer, Heart Disease, Access to Healthcare (Transportation, Cost, Issues Affecting elderly), Issues Involving Youth (Teen Pregnancy, Lack of Recreational Activities), Diabetes, Respiratory Disease/Asthma, Dental Care

- ✓ **Following the prioritization exercise the rank order of community issues included**: Community Image of the Hospital ranked first. This issue was closely followed by Community Health Education.

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INTRODUCTION

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

The Patient Protection and Affordable Care Act

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

IRS Compliance

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

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

Timing:

- ✓ The implementation strategy must be adopted by the end of the same taxable year in which the CHNA was conducted

- ✓ The CHNA is considered to be conducted in the taxable year that the written report of its findings is made widely available to the public

- ✓ The implementation strategy is considered to be adopted when it is approved by the governing body of the hospital

Requirements of the CHNA:

- ✓ Description of the community served and the community was defined.

- ✓ Description of the processes and methods used to conduct the CHNA.

- ✓ Description of the sources and dates of the data and other information used in the CHNA.

- ✓ Description of the analytical methods applied to the CHNA.

- ✓ Identification of any information gaps that impact the ability to assess the community's health.

- ✓ A list of all collaborating organizations in conducting the CHNA.

- ✓ Identification of third parties with which the hospital contracted to assist in conducting CHNA, along with qualifications of such third parties.

- ✓ Description of how input from parties representing broad interests of community served were solicited.
- ✓ Description of community interaction.

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

Phases of a Needs Assessment

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

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

Step 1: Engaging the Community

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

Step 2: Defining the Issues

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

Step 3: Establishing Community Priorities

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

Step 4: Designing a Strategy for Intervention

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

Step 5: Evaluating the Impact

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

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

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

Project Purpose

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

1. *To organize core steering groups to provide assessment support and guidance in all 18 target communities by June 30, 2013*

2. *To complete community health assessments (needs identification and assets inventory) of all 18 target communities by June 30, 2013*

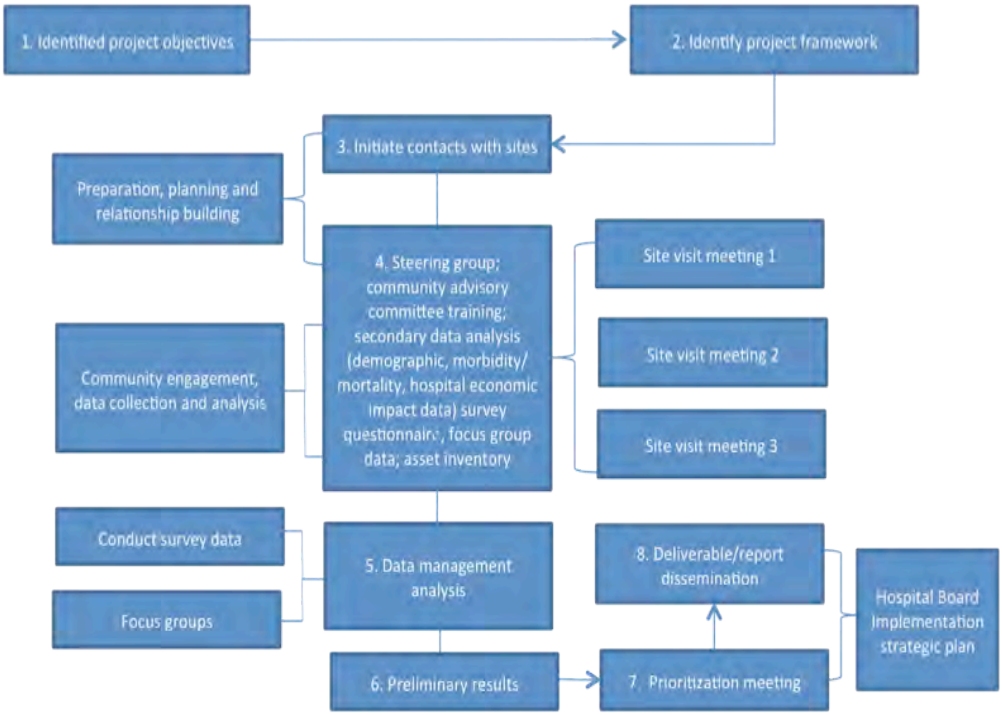
3. *To prioritize identified community health issues in all 18 target communities by June 30, 2013*

4. *To educate core steering group members and community members in all 18 target communities about the principles and practices of health promotion program planning and evaluation by June 30, 2013.*

Project Overview

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

Community Health Assessment: A Conceptual Framework©



METHODOLOGY

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

Overview of the Communication Process

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

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

Data Templates and Instruction Guides

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

Data Template

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

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

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

Initiating and Sustaining Community Contact

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

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

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

For Memorial Hospital and Manor, a 30-minute conference call with the site leader, Mrs. Jan Godwin took place on June 14, 2012.

Steering Group Membership

Each hospital was responsible for forming a Steering Group. The Steering Group consisted of 5-7 members from the hospital. However, hospitals were given the latitude to include other key stakeholders from the community. For Memorial Hospital and Manor, Steering Group members were recruited within the hospital and included Billy Walker (CEO), Lee Harris (Assistant Administrator for Support Services), Cynthia Vickers (Assistant Administrator), Angel Sykes (HR Manager/ Chief of Culture and People), Karen Faircloth (Chief Financial Officer), Jan Bennett (Director of Physician Relations and Quality/Risk Management), Dolores Eidson (Registered Nurse), and Jan Godwin (Director of Public Relations and Patient Representative) (*Appendix E*).

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

Medical Service Area Definition and Confirmation

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

For Memorial Hospital & Manor, zip code data were reviewed and forwarded to Georgia Southern University. Based on these data, the medical service area for the CHNA was defined as Decatur. However, it was determined that Seminole County should be included in the target area as well. The Steering Group members later confirmed this decision. The table below illustrates the proportional distribution of zip code data and the assigned designation.

Counties Served in 2011

County	Zip Code	Number of Patients Served	Percentage	Designation
Decatur	39819 39817 39818	47,085	88%	Primary
Seminole	39845	2840	5.2%	Secondary
Miller	39837	1773	3.3%	Secondary
Grady	39827 39828	1352	2.5%	Secondary
Mitchell	31730	553	1%	Secondary

Community Advisory Committee Membership

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

The CAC was composed of 15-25 members representing a cross-section of the defined community (target area). Hospitals, in particular the Steering Groups, were specifically

instructed to recruit people, or agencies, representing traditionally underserved and minority populations within the target area. In addition, hospitals were encouraged to seek diversity with respect to race, ethnicity, social, economic, and education backgrounds. For Memorial Hospital & Manor, CAC members were recruited by selecting members from various socio-economic groups in the geographic locations within the county. These included elected officials, business owners, hospital volunteers and community volunteers (*Appendix H*).

Site Visits

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

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

Specific tasks to be completed following the first meeting included formation of the Steering Group, beginning the process of recruiting CAC members, aggregating zip code data, defining the target area, discussing a community responsive data collection strategy, developing a project timeline, formalizing the community-based survey, and pilot testing the community-based survey. In an effort of getting a cross-section of the community represented in the CAC, each member of the Memorial Hospital and Manor Steering Group was charged to provide the site leader with a list of five names of persons in the community they thought would be willing to become members. Twenty five potential members were contacted; however, 20 became members of the CAC.

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

Meeting 2: The purpose of the second meeting was to meet with Community Advisory Committee (CAC) members to provide an overview of project activities and initiate data collection. The specifics of data collection will be discussed later in this section. Similar to the first meeting, the second meeting relied on a standard PowerPoint presentation. The presentation content included an overview of community demographics and key health related indicators, an overview of the project, and instructions for collecting data. Data collection efforts were first

initiated by surveying CAC members using the community-based survey. In general, this took approximately 10 to 15 minutes. CAC members were also given instructions for distributing the survey to the community. In addition to survey completion and instructions for distribution, CAC members were asked to volunteer to participate in one of three focus groups to be conducted in the community. These members were also asked to assist the hospital in recruiting potential community members to participate in the remaining two focus groups. Meeting 2 ended with a general and open discussion about the perceived issues in the community. The data gathered from this open discussion were used as preliminary data in preparation for Meeting 3. A copy of the Meeting 2 presentation can be found in the *Appendix J*.

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

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

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

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

Data Collection Approaches

Secondary Data Collection and Analysis

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

order to reduce variability of all point estimates, reported rates are based on ten-year aggregates (2001-2010).

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

Primary Data Collection: Survey Development and Distribution

As mentioned previously, a draft community-based survey was provided during the first site visit (community meeting). The steering committee was instructed to make necessary adjustments to the survey and to provide feedback to Georgia Southern University. Upon receiving the survey feedback from each site, the next step in the process was to make the requested changes so that the survey could be pilot tested. Instructions for the pilot test consisted of having 5-7 persons in the community who were representative of the service area take the survey. The instructions for pilot testing (*Appendix O*) were emailed to the site leader with the revised survey, and each site was given one week to complete this activity. Once pilot testing was completed, the site leader was asked to return the results to Georgia Southern University either by email or postal mail. After changes based on pilot test results, were incorporated, a finalized survey was developed (*Appendix P*). Memorial Hospital and Manor requested minor changes to the survey, but chose not to pilot test the instrument.

Prior to Meeting 2, 400 copies of the survey were made and taken to the meeting. These surveys were numbered sequentially and distributed at the conclusion of Meeting 2. CAC members were asked to take the surveys and distribute them to their personal network. The decision to distribute a specific number of surveys was left to each CAC member. Therefore, the number distributed by each CAC member varied according to the size of their personal network and their overall willingness to participate in this project. Because the surveys were numbered, the hospital was able to track individual CAC members and the number of surveys they intended on distributing. In some instances, CAC members opted to only take one survey and use their own resources to make additional copies. In this case, the CAC member was asked to keep track of numbers of copies made and distributed. It was the responsibility of the site leader at the hospital to track this information, and total numbers of surveys in the community were known. Although some variability existed among all sites, most communities agreed that the CAC members would be responsible for getting completed surveys to the hospital. In most instances, CAC members would return the surveys to site leaders, front desk receptionists, or strategically placed drop boxes in the hospital. Each site was given approximately 6 to 8 weeks to forward the completed surveys to Georgia Southern University. Theoretically, it was possible to estimate the total number of surveys distributed in a given community, and all hospitals were strongly encouraged to attempt at least an 80% response rate. Each hospital received a weekly reminder email message requesting an update on the survey distribution process. Specific information included the following: 1) the number of surveys received from CAC members; 2) the number of additional copies of the survey made; 3) (any) changes made to the original data collection

strategy; and 4) (any) more time needed to reach the required 80% response rate. All surveys were manually entered into SPSS for Windows. Only descriptive statistics were used for this report.

For Memorial Hospital & Manor, survey completion relied on the efforts of CAC members and a Hospital led community health fair on October 24, 2012. According to some of the CAC members who assisted with the data collection, the only major challenge they faced in the survey data collection is that more than a few participants refused to reveal their financial information on the survey.

Primary Data Collection: Focus Groups

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

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

All three focus groups for Memorial Hospital & Manor were scheduled on September 10, 2012 and were conducted on October 11-12, 2012. All participants completed a demographic form (*Appendix S*) and the informed consent (*Appendix T*), and each focus group lasted an average 75-90 minutes. A list of focus group participants can be found in *Appendix U*.

Community-Based Assets

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

Prioritization Strategy

As mentioned previously, a two-stage process was used to complete the prioritization of issues in each community. The first stage involved using a "multi-voting" technique developed by the University of Kentucky. To complete this exercise, community members were presented with the list of issues placed on large Post-it notes taped to the wall. These issues emerged from the secondary and primary data (surveys and focus groups). Prior to the prioritization of issues, participants were asked to briefly discuss these issues and validate that the list indeed reflected the community. After initial validation, participants were given five colored dots and were asked to place the dots next to the top five issues they perceived to be the most important or that could be most easily modified. After participants completed this part of the exercise, the project team counted the results and presented a rank ordered list based on the number of dots each issue received. The participants were then asked to discuss this list. Specifically, they were asked if issues needed to be consolidated or if new issues should be added. After discussion, the Hanlon Method was used for the final prioritization of issues. The Hanlon Method calculates a Basic Priority Rating (BPR) for each problem identified in the assessment process. This prioritization scheme considers four dimensions of each problem and includes the size of the problem (measured by incidence, prevalence or percentage of the population affected) ranked on a scale from 0 to 10 (denoted as A). The seriousness of the problem (measured by economic loss, impact of other populations, or overall severity as indicated by mortality/morbidity) is ranked on a scaled from 0 to 20 (denoted as B), and the effectiveness of interventions (measured by how well previous interventions have worked) is ranked on a scale from 0 to 10 (denoted as C). Finally, a measure known as the PEARL (Propriety, Economics, Acceptability, Resources, and Liability) is ranked on a scale of either 1 or 2 (denoted as D). This last measure (PEARL) assesses issues of ethics, legality, and economics in addressing a given problem. The formula for calculating the BPR is as follows:

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

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

RESULTS: SECONDARY DATA ANALYSIS

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

Demographics

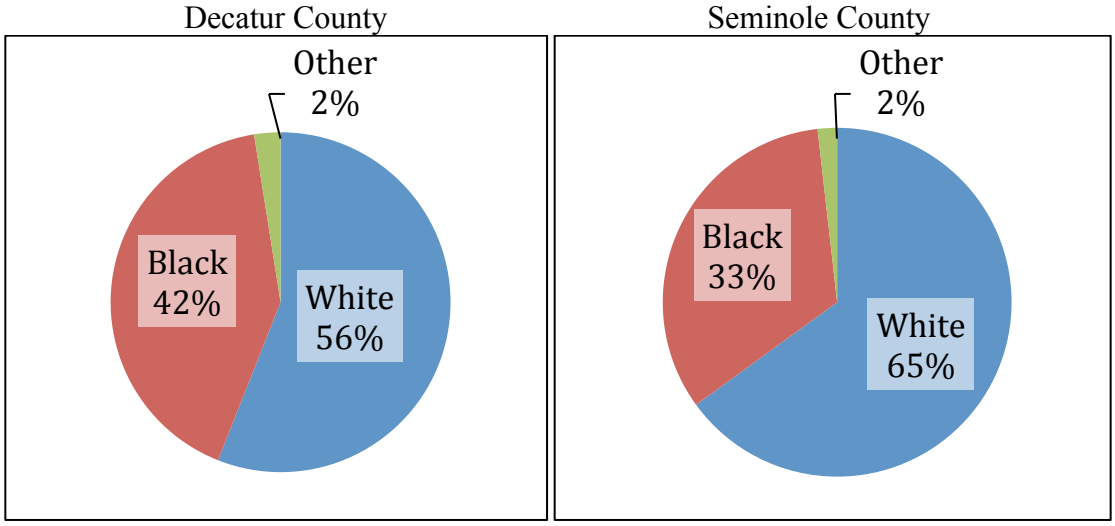
Demographic Characteristics 2010 Census

	Decatur County	Seminole County	Georgia
Population†	27,842	8,729	9,815,210
Persons under 5 years†	6.9%	5.7%	7.1%
Persons under 18 years†	25.5%	23.0%	25.6%
Person 65 years and over†	14.3%	19.5%	10.7%
Male†	51.0%	52.2%	48.8%
Female†	49.0%	47.8%	51.2%
White persons†	56.0%	65.0%	59.7%
Black persons†	41.5%	33.2%	30.5%
Median Household income (2006-2010)†	$33,297	$32,666	$49,347
Homeownership rate (2006-2010)†	65.9%	78.5%	67.2%
High school graduates†	75.6%	77.0%	83.5%
Bachelor's degree or higher†	12.5%	10.3%	27.2%
Percent Uninsured‡	24%	22%	21%

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

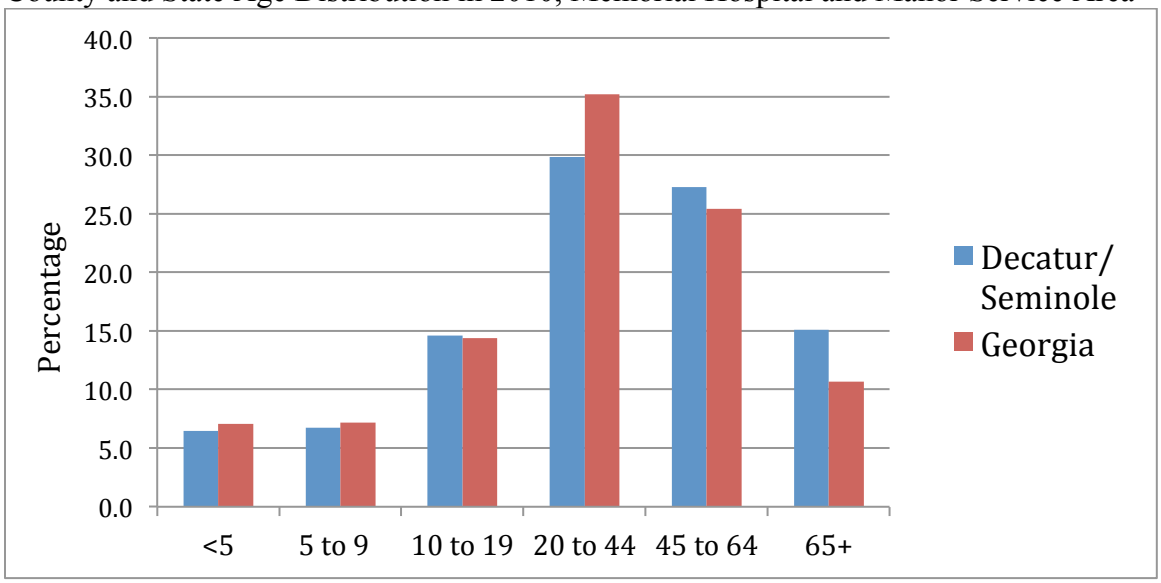
Service Area Demographics: Memorial Hospital & Manor's service area is a rural community. The majority of the population is white, though African Americans constitute the largest minority. The median household income, proportion of residents with at least a high school diploma, and percentage of people without insurance lag behind the state averages.

Proportion of Races



U.S. Census Bureau: State & County QuickFacts

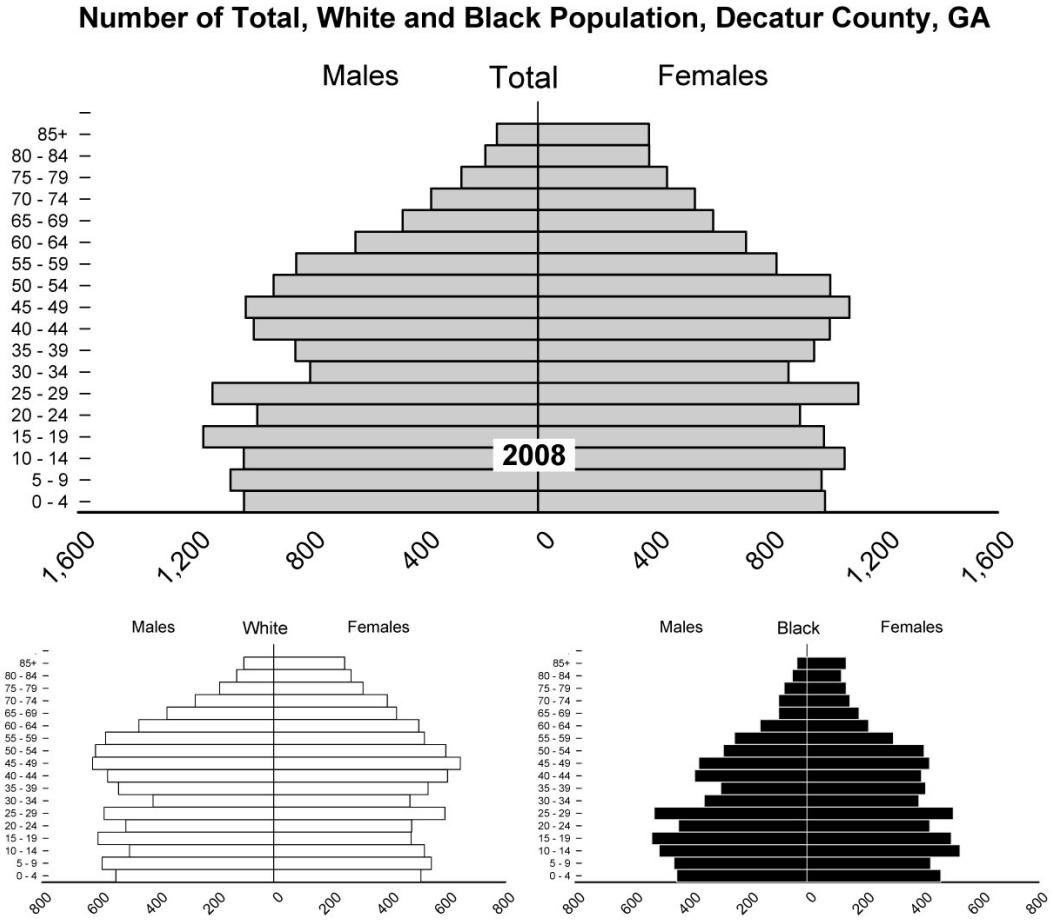
County and State Age Distribution in 2010, Memorial Hospital and Manor Service Area



U.S. Census Bureau: American Fact Finder

Age Distribution: Memorial Hospital & Manor's service area resembles Georgia's age distribution. Compared to the state average, the service has fewer residents aged 20 to 44 and has a higher proportion of its residents above the age of 65 years old.

Population Pyramids 2008, Decatur County



OASIS: Georgia Department of Public Health

Health and Socio-Economic Indicators

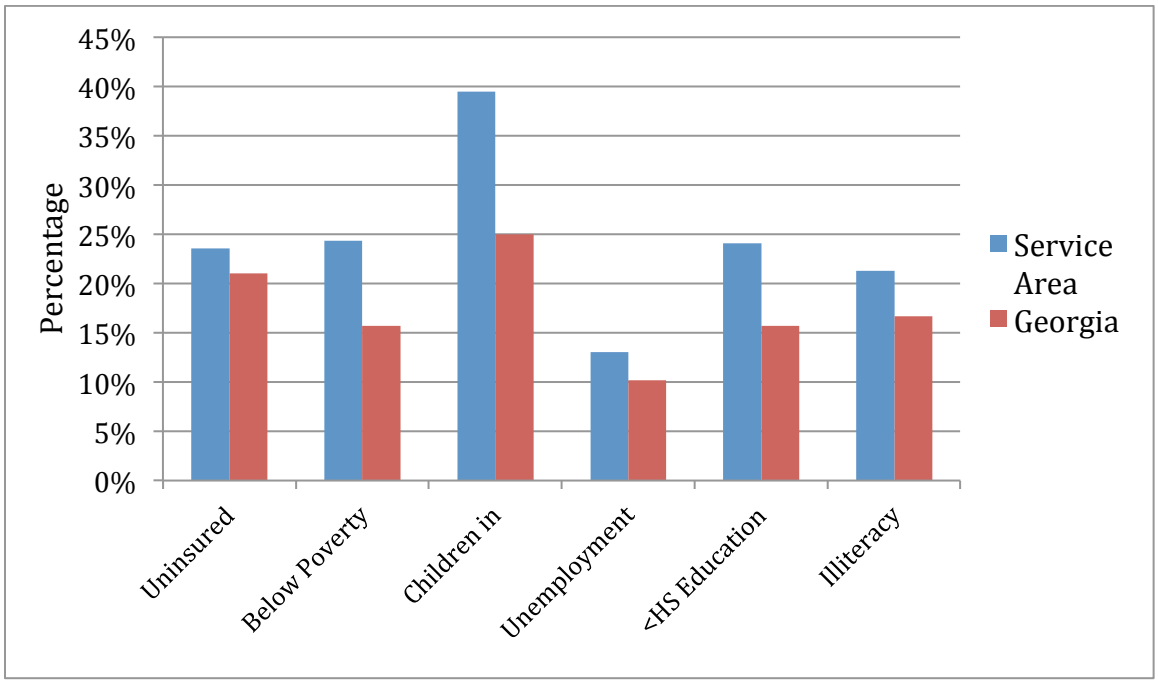
Health Behaviors

	Decatur County	Seminole County	Georgia
Adult Smoking	24%	12%	19%
Adult Obesity	34%	33%	28%
Physical Inactivity	33%	27%	24%
Excessive drinking	10%	5%	14%

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

Health outcomes in the community are best understood in the context socio-economic factors and health behaviors because they are powerful influences on a population's health. Figure 4 indicates that residents in the service area face higher rates of poverty, and have lower graduation and literacy rates. The health behavior indictors in Table 3 indicate that while similar to the state averages, the rates of risk-taking behaviors are still problematic in the service area.

Socio-Economic Indicators



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

Preventive Care Services

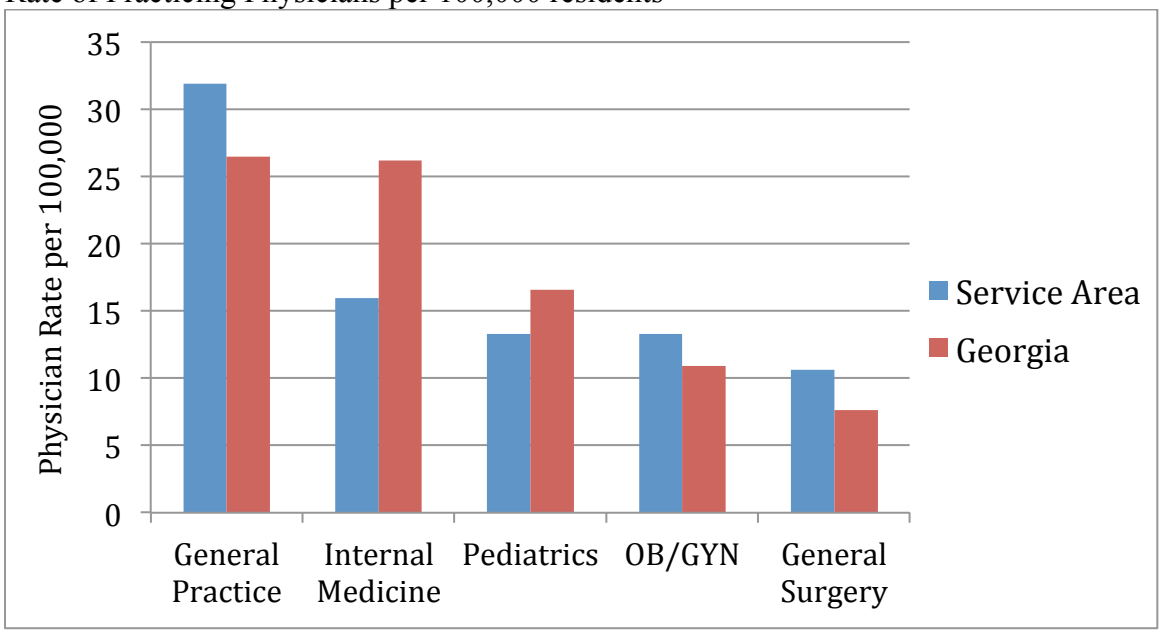
Screening Behaviors

	Decatur County	Seminole County	Georgia
Diabetic screening	72%	73%	83%
Mammography screening	56%	62%	66%
Preventable hospital stays	86	132	68

County Health Rankings: University of Wisconsin Population Health Institute and Robert Wood Johnson Foundation Health and Socio-Economic Indicators

Physician Workforce Summary

Rate of Practicing Physicians per 100,000 residents



Georgia Board for Physician Workforce Report 2011

Physician workforce: In 2008, the service area had 58 practicing physicians. The proportion of internal medicine doctors is lower than the state average.

Total Number of Practicing Physicians in 2008

	Family Practice	Internal Medicine	Pediatric	OB/GYN	General Surgery	Total
Decatur	10	4	3	3	2	47
Seminole	2	2	2	2	2	11
Total	12	6	5	5	4	58

Georgia Board for Physician Workforce Report 2011

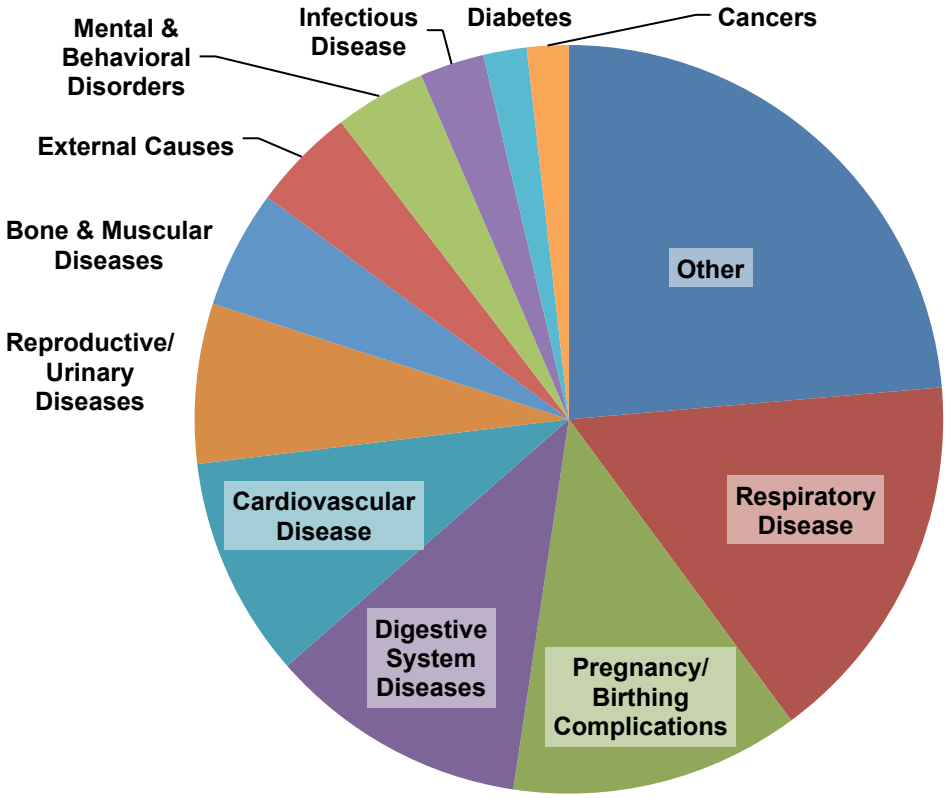
Overview of Morbidity Rates (2001-2010)

Deduplicated Discharge Rates and Proportion of Births at Low Birth Weight

Cause of Morbidity	Service Area	Georgia
All Causes†	12,156.6	9,389.3
Major Cardiovascular Disease†	1,159.5	1,389.0
Cancers†	219.1	274.1
Respiratory Disease†	1,973.9	944.1
Infectious Disease†	338.2	305.9
Diabetes†	227.4	138
Low Birth Weight‡	10.8%	9.3%

†Age-adjusted, Deduplicated Discharge Rate per 100,000
‡ Proportion of live births with weight below 2,500 g
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Proportion of Deduplicated Discharges by Leading Causes of Morbidity



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

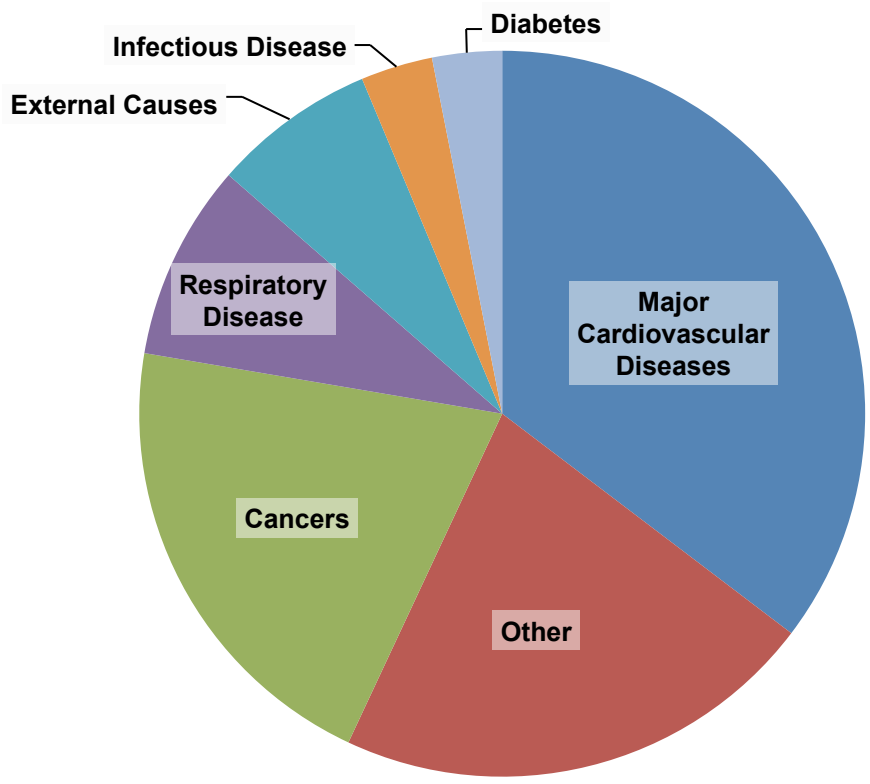
Overview of Mortality Rates (2001-2010)

Age-Adjusted Death Rates for Leading Causes of Death

Cause of Death	Service Area	Georgia
All Causes†	985.7	883.8
Major Cardiovascular Disease†	348.3	302.2
Cancers†	204.1	185.6
Respiratory Disease†	86.2	88.7
Infectious Disease†	31.6	30.5
Diabetes†	30.6	21.5
Infant Mortality Rate‡	8.2	8.1

†Age-adjusted Death Rate per 100,000
‡ Deaths per 1,000 live births
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Proportion of Deaths by Leading Causes of Mortality



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

Trends in Morbidity

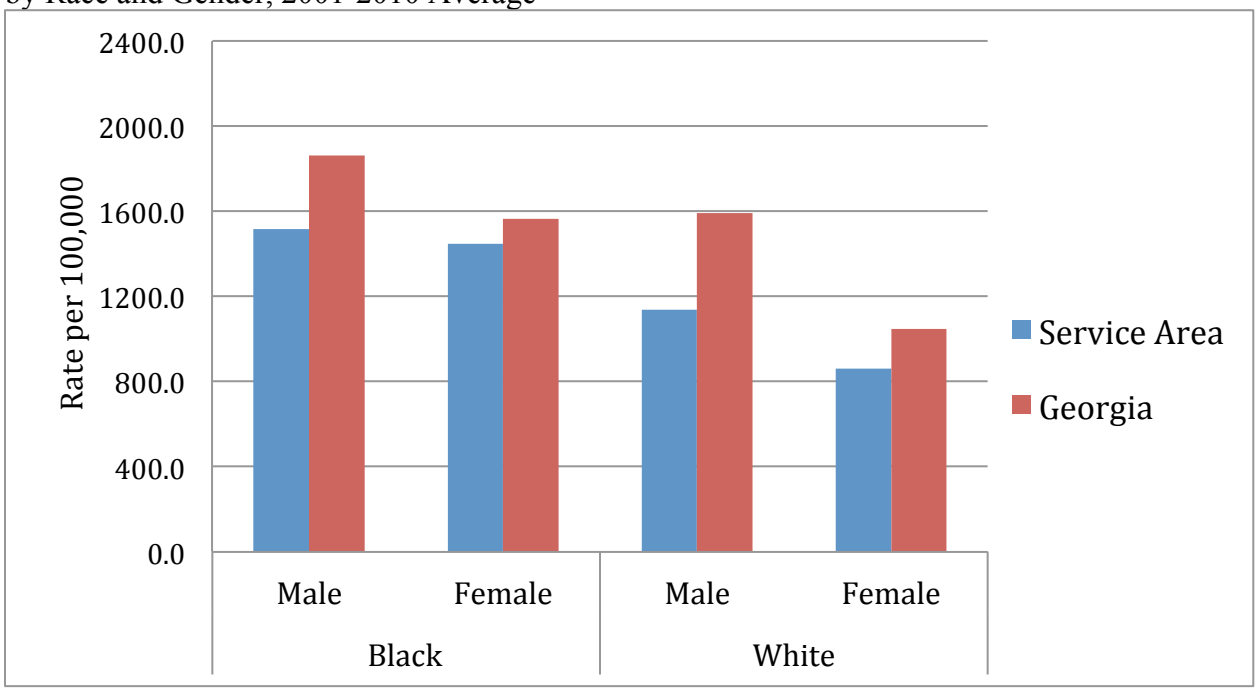
All Major Cardiovascular Diseases: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	184	1481.7	1695.4
White	282	1000.4	1297.5
Other	3	758.4	1334.9
Total	469	1152.3	1521.2

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

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

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



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

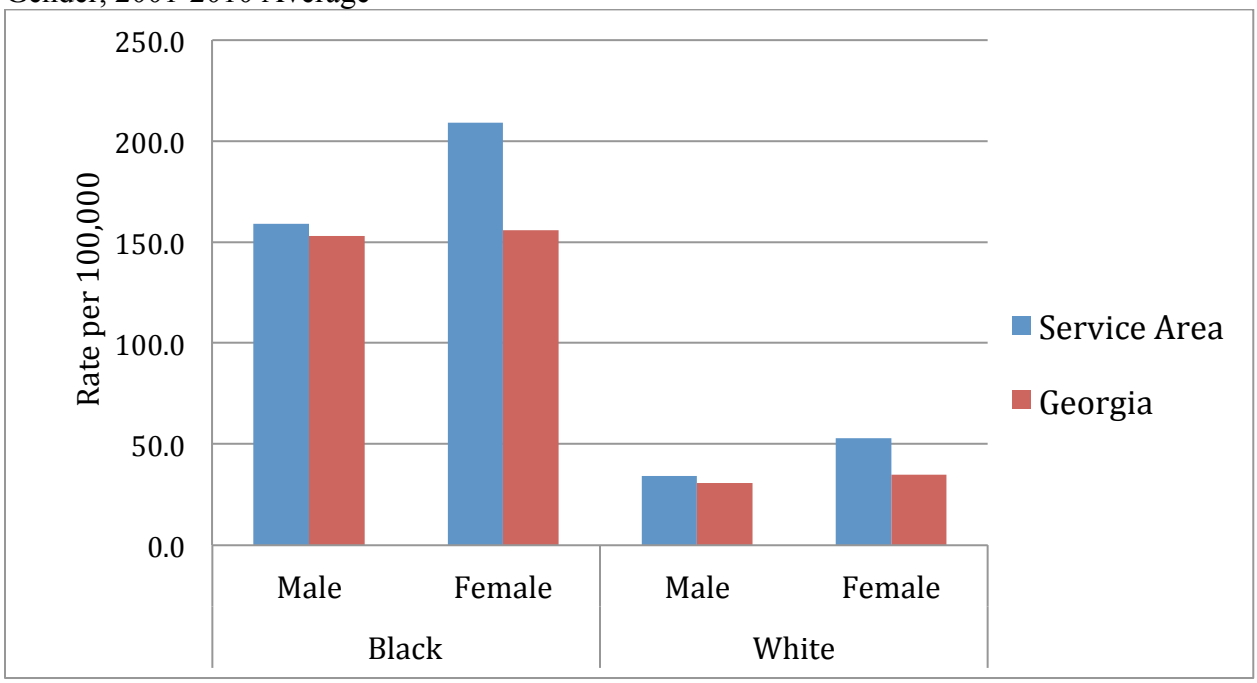
High Blood Pressure: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	24	185.9	155.9
White	12	45.6	33.3
Other	< 1	*	53.4
Total	36	92.6	68.7

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
* Insufficient number of discharges to calculate a rate

Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us
As consistent with the state averages, African Americans in the service area have much higher rates of hypertension.

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



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

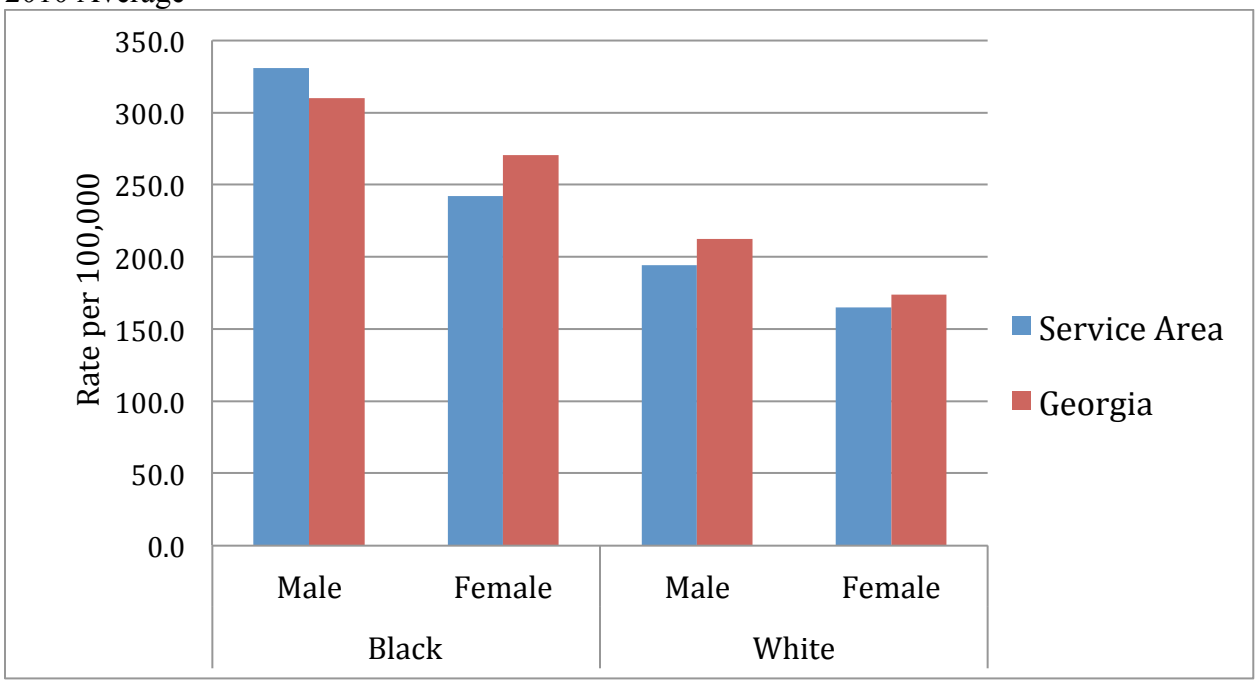
Stroke: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	34	279.5	288.4
White	52	180.6	191.5
Other	1	132.8	226.5
Total	87	209.3	224.0

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Males and African Americans have higher rates of stroke than their female and white counterparts.

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



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

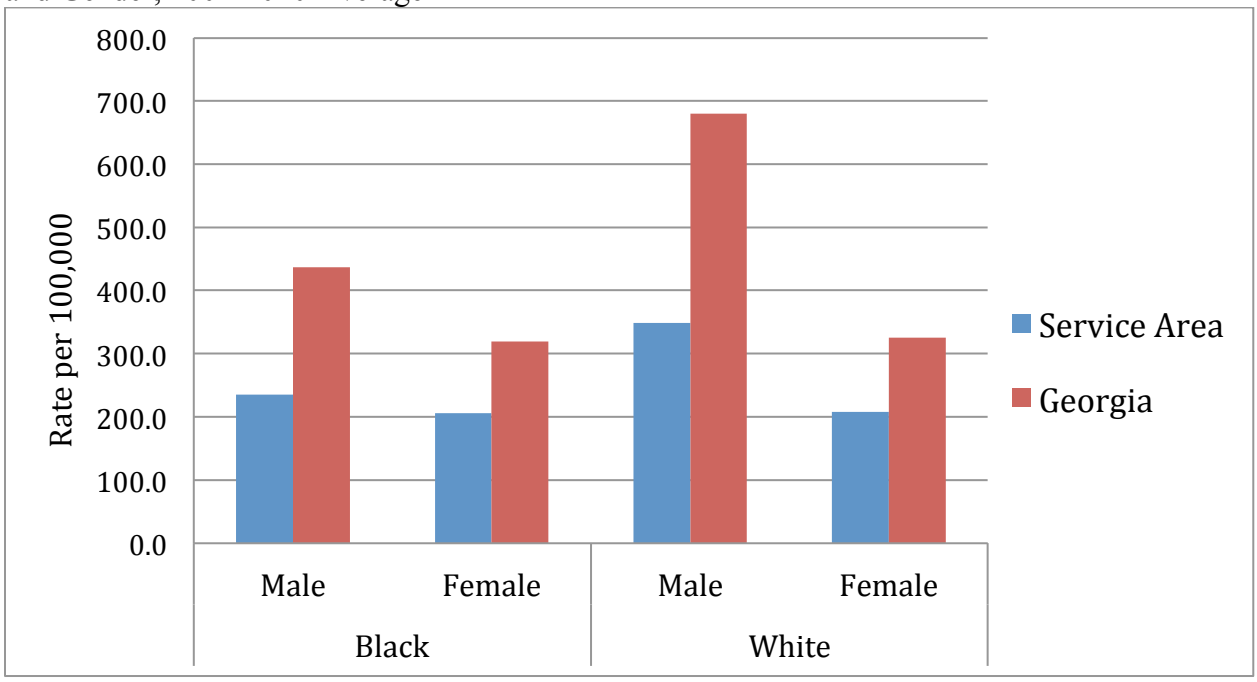
Obstructive Heart Disease: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	28	221.3	370.3
White	78	277.3	489.8
Other	< 1	*	511.4
Total	106	258.1	504.5

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
* Insufficient number of discharges to calculate a rate
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Obstructive heart disease (OHD) includes heart attacks. The rates of OHD are lower than the state averages for each race and gender classification.

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



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

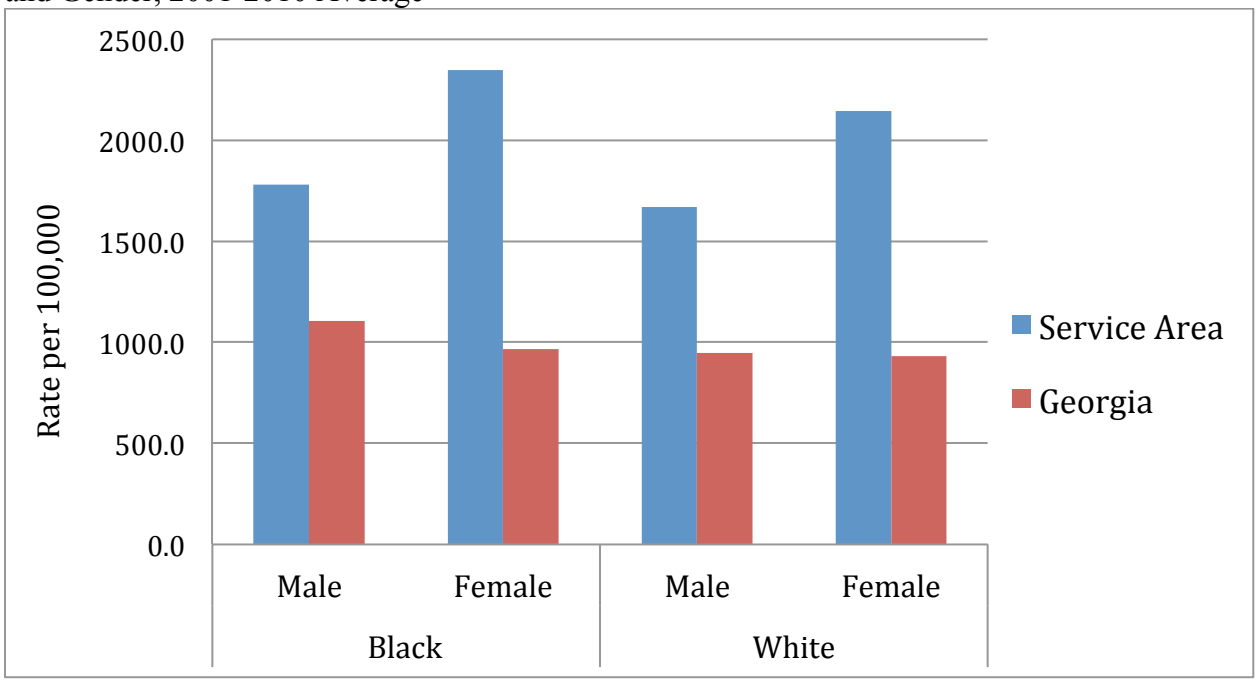
All Respiratory Diseases: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	288	2098.7	1018.1
White	484	1906.0	930.6
Other	8	1621.8	692.3
Total	780	1995.9	1003.3

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The service area hospital discharge rate for respiratory diseases is twice the state average. The rates of respiratory diseases are higher than the state average for each race and gender classification.

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



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

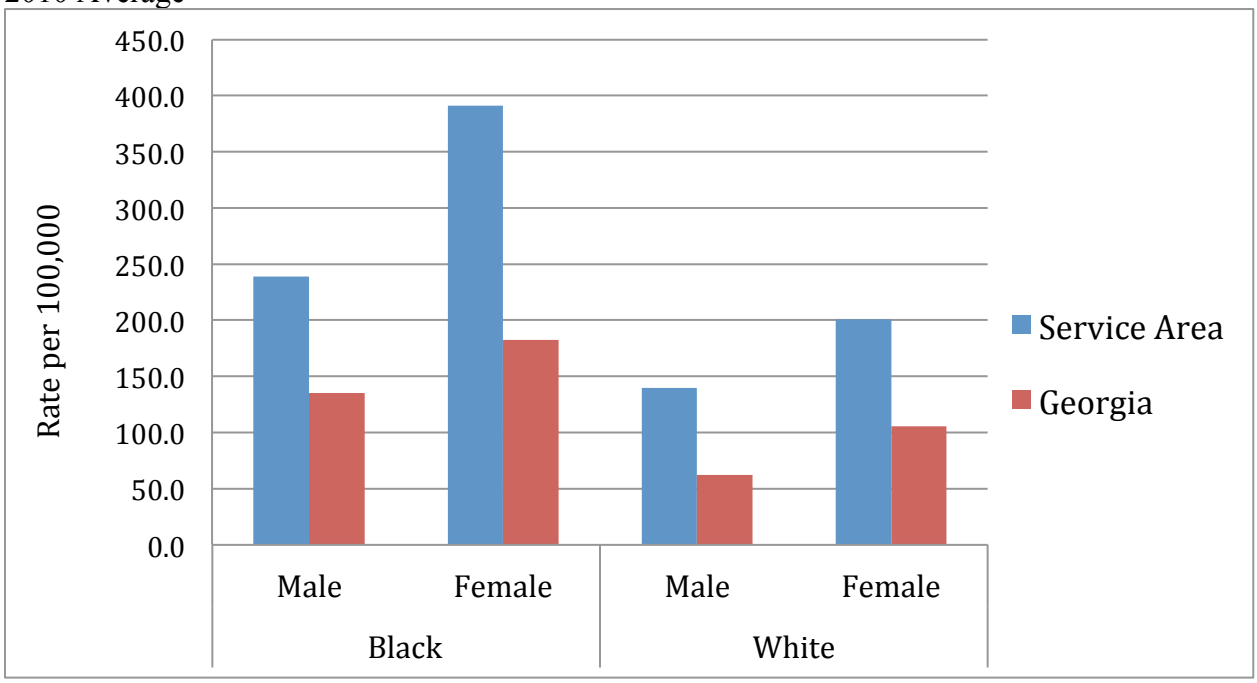
Asthma: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	48	329.6	164.1
White	39	171.4	85.2
Other	2	228.9	75.2
Total	88	233.4	122.8

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

As consistent with all respiratory illnesses, the service area has rates of asthma approximately twice the state average. African-Americans females have the highest rates of asthma.

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



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

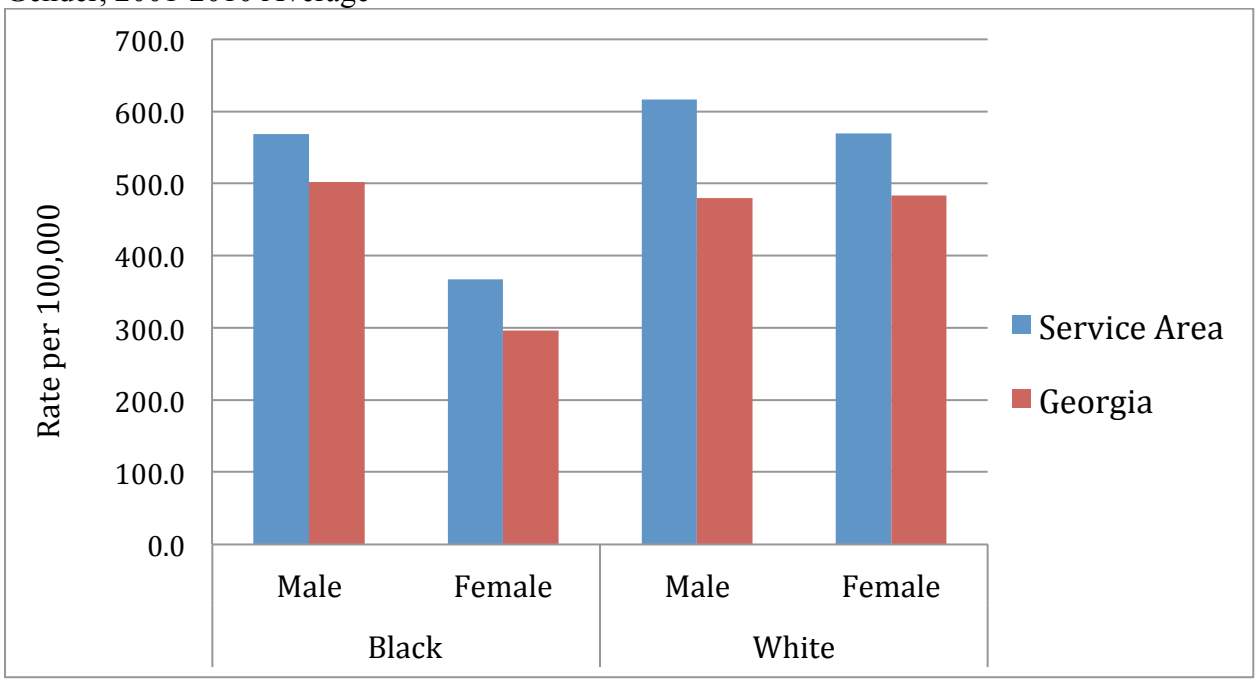
External Causes: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	62	464.1	395.7
White	147	611.7	496.5
Other	1	270.3	493.7
Total	210	555.4	446.9

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

External causes of hospital visits include injuries from any type of accident, including both intentional and unintentional causes. The rates of hospital visits are higher for white residents in the service area. African-American females have the lowest injury rate.

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



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

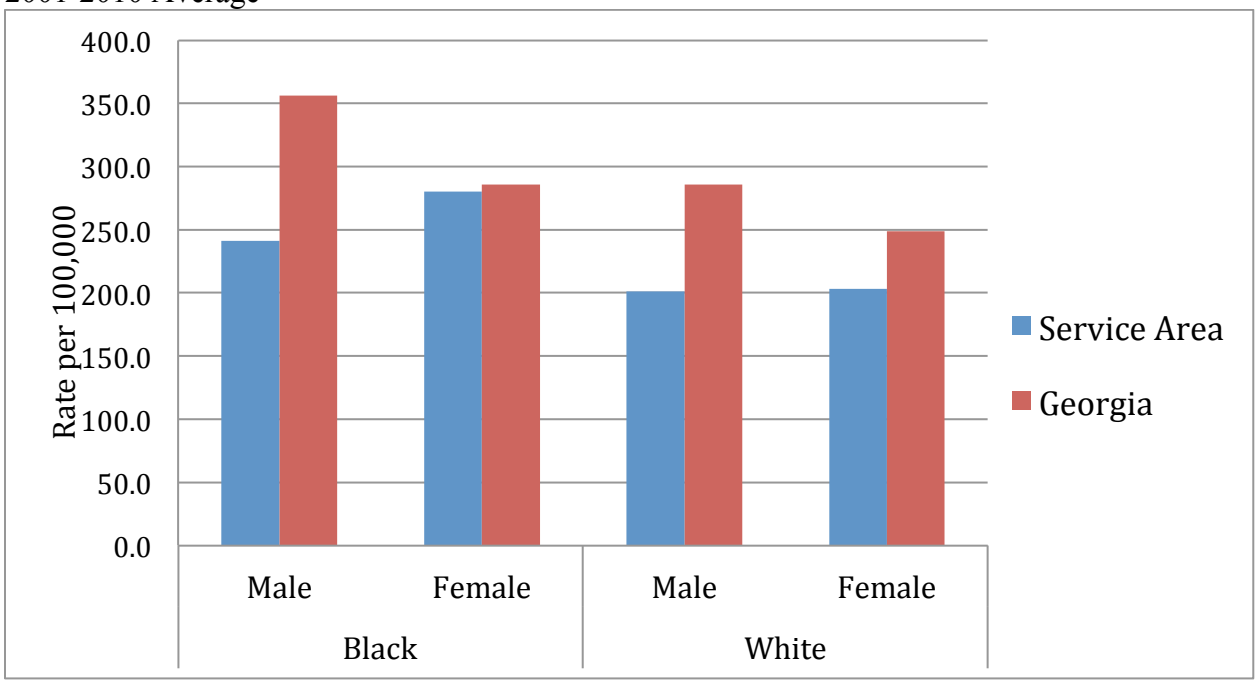
All Cancers: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	33	261.4	311.1
White	56	198.9	262.7
Other	1	149.4	295.8
Total	89	217.1	304.8

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The cancer rate is lower than the state average. Cancer rates are lower for each race and gender classification.

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



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

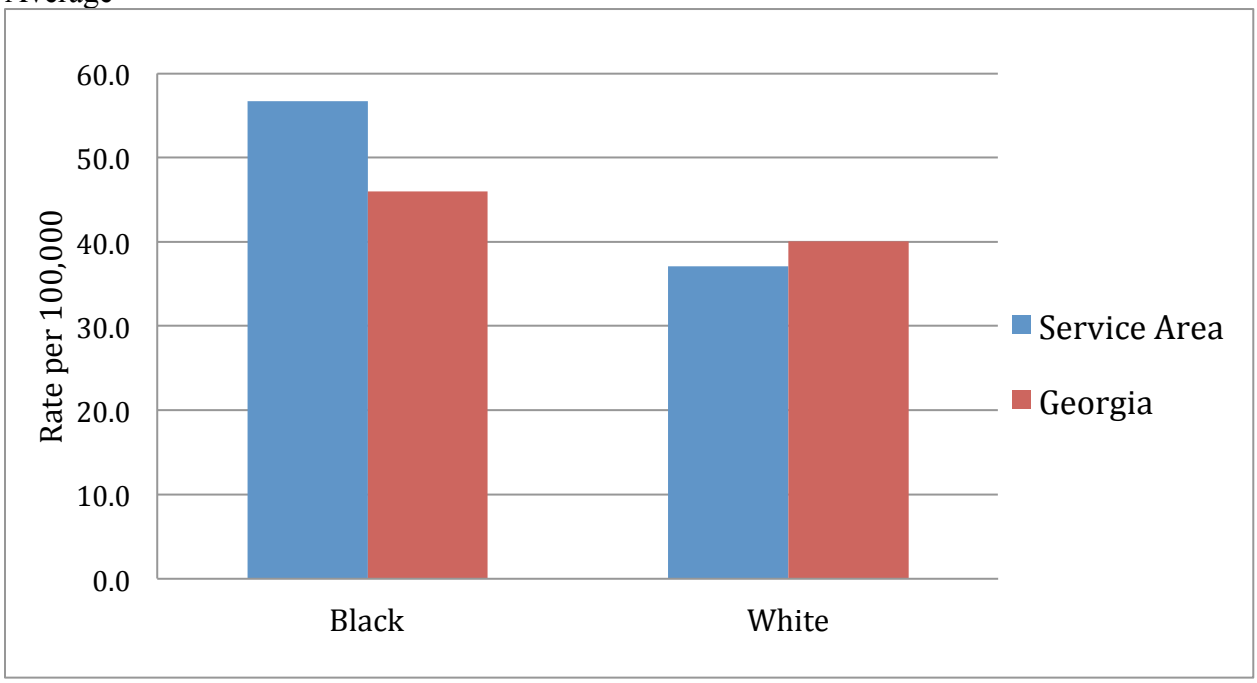
Breast Cancer: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000 Females

	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	4	56.7	46.0
White	6	37.1	40.1
Other	0	0.0	31.6
Total	10	43.1	43.2

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The breast cancer hospital visitation rate is similar to the state average.

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



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

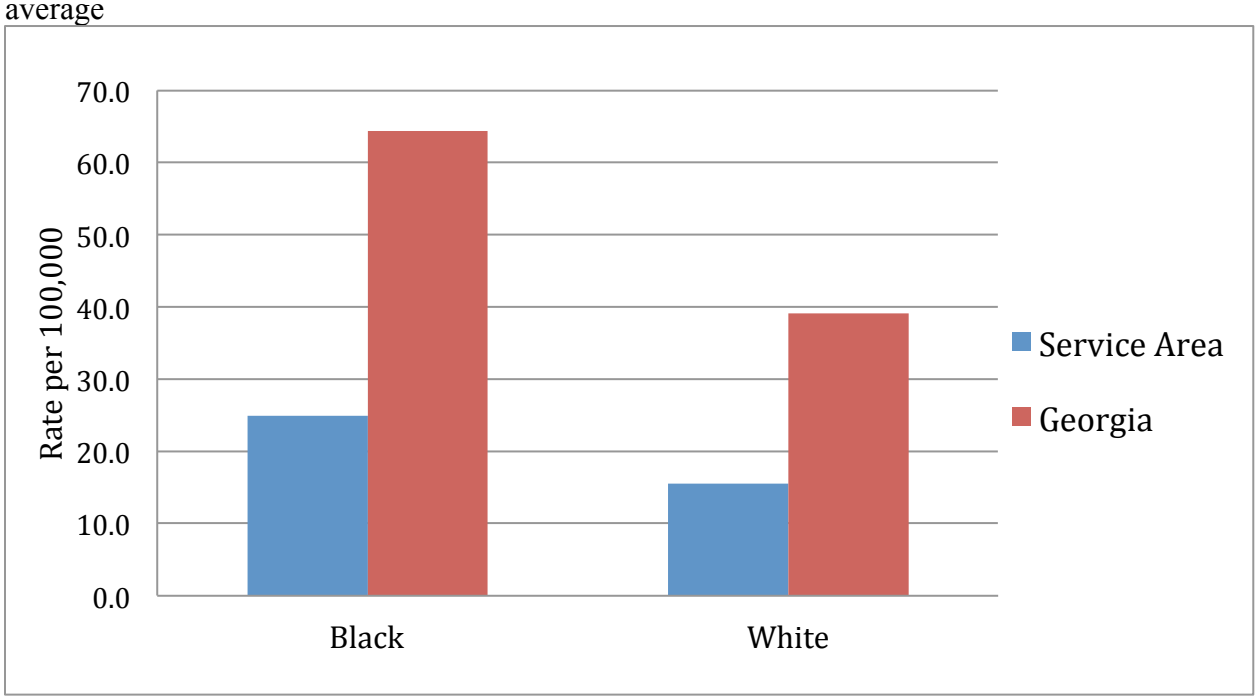
Prostate Cancer: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000 Males

	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	1	24.9	64.4
White	2	15.5	39.1
Other	0	0.0	39.1
Total	3	17.7	40.0

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The rates of prostate cancer were 50% lower than the state average.

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



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

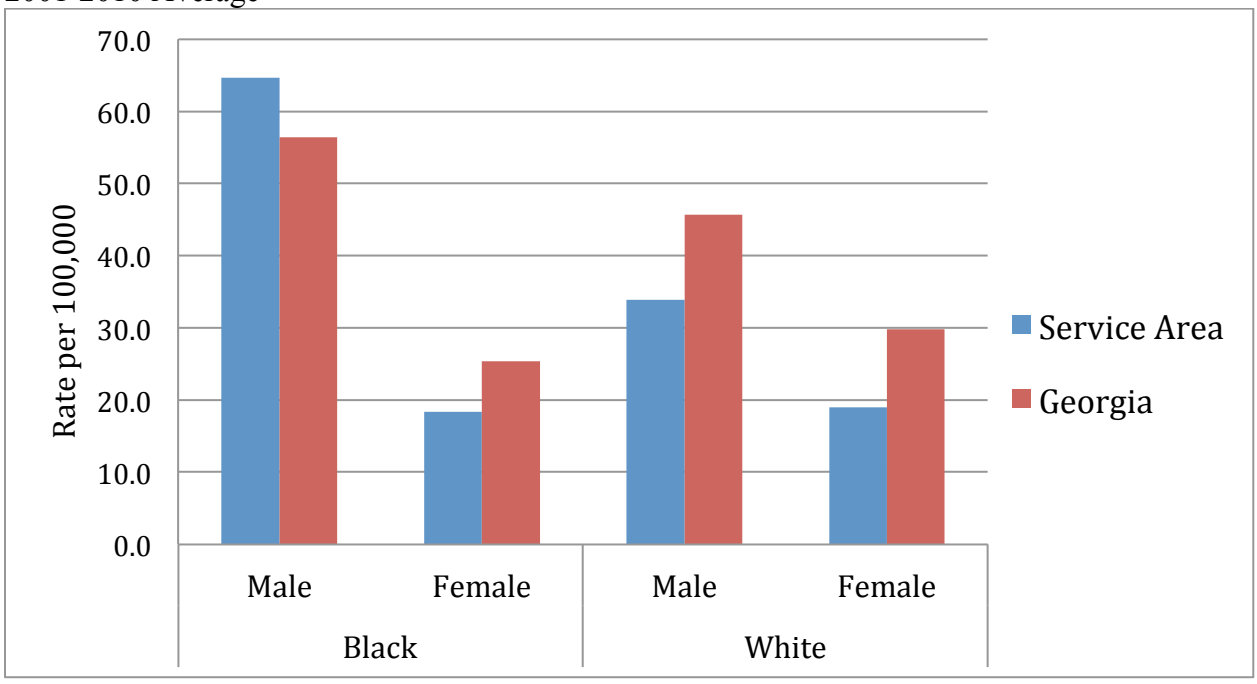
Lung Cancer: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	4	36.2	37.3
White	8	24.6	36.6
Other	< 1	*	26.7
Total	12	27.9	41.4

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: -people are counted only once if readmitted for the same chronic condition during a calendar year.
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
* Insufficient number of discharges to calculate a rate
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

As consistent with the state averages, males have higher rates of lung cancer.

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



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

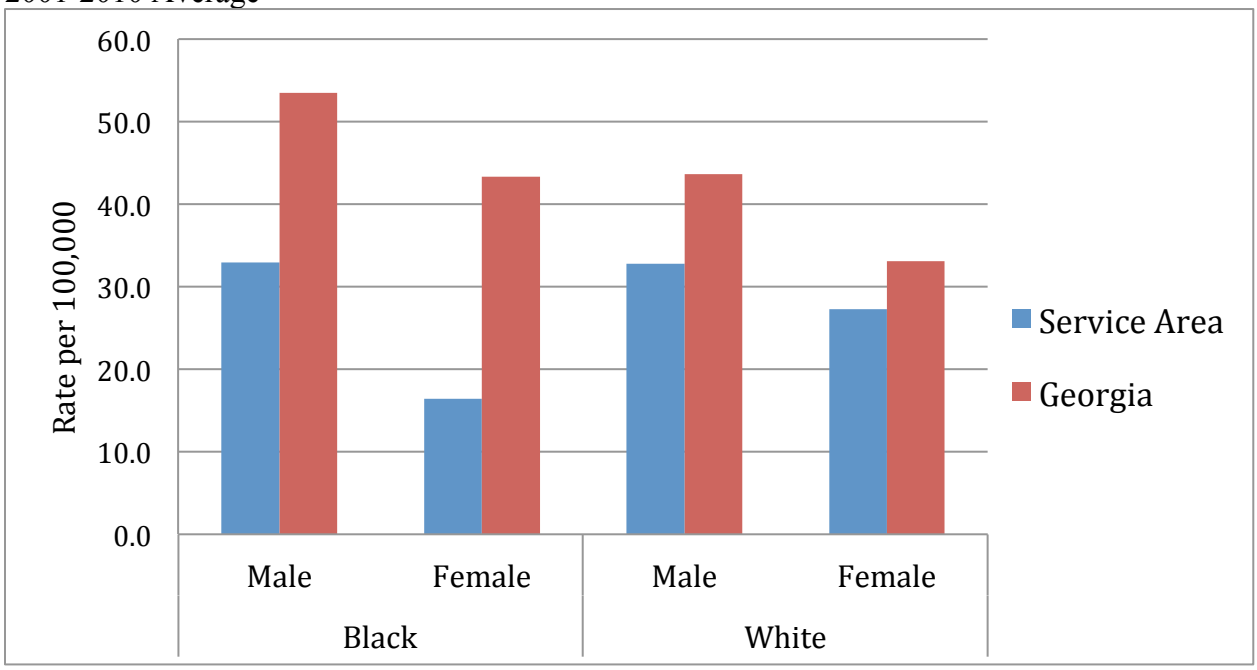
Colon Cancer: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	3	23.4	47.3
White	9	29.9	37.7
Other	0	0.0	44.5
Total	12	27.9	40.1

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The service area's rates of colon cancer are lower than the state average.

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



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

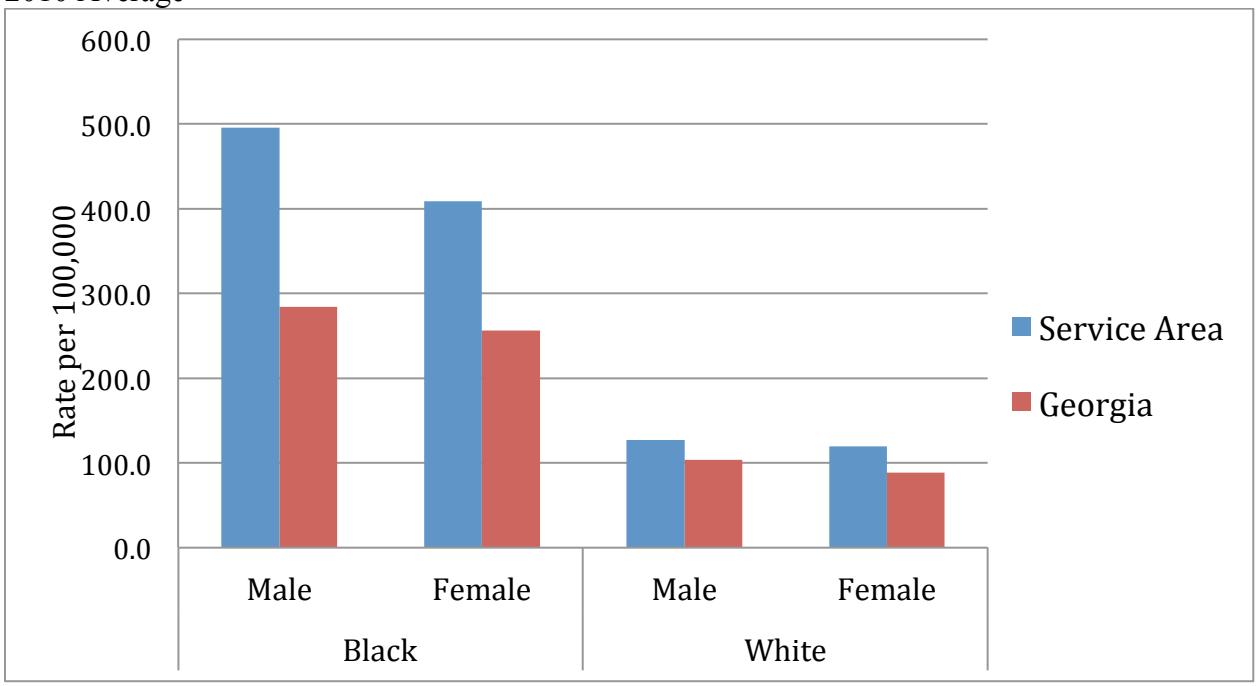
Diabetes: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	56	446.3	269.7
White	33	123.1	95.8
Other	< 1	*	106.5
Total	89	227.2	172.6

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
* Insufficient number of discharges to calculate a rate
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Hospital discharge rates for diabetes among African Americans are more than three times higher than the rates for white residents.

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



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

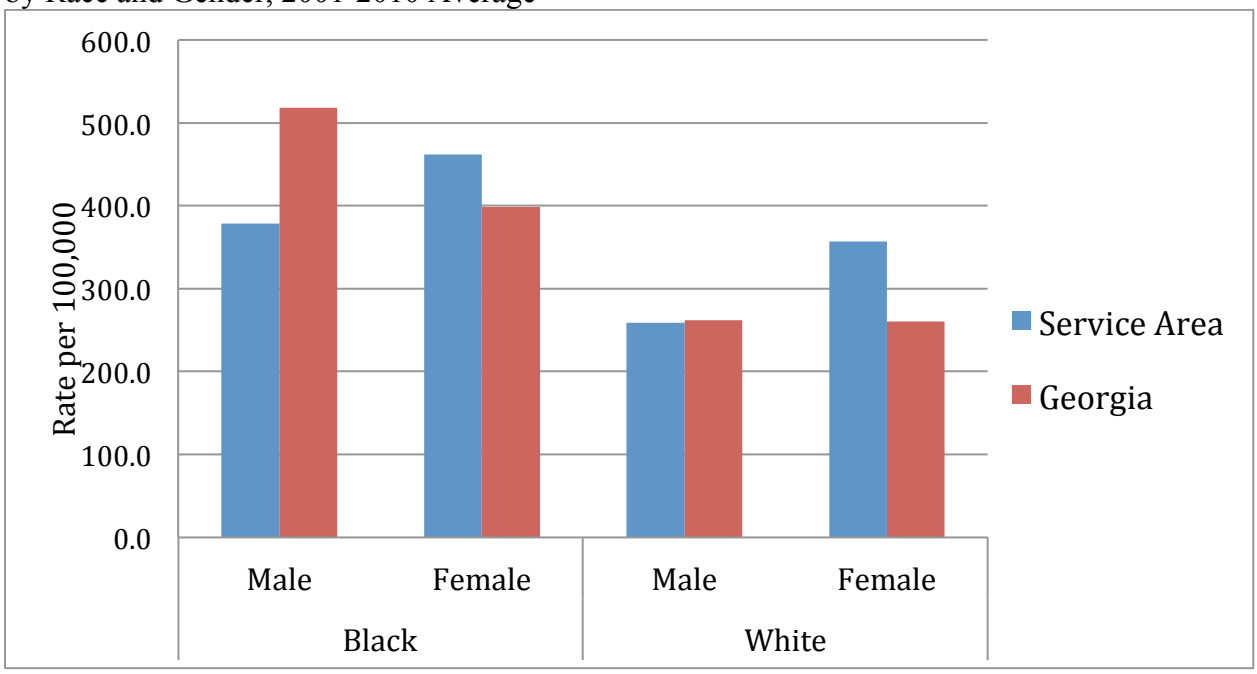
All Infectious and Parasitic Diseases: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	56	423.4	449.0
White	73	312.2	260.5
Other	1	135.7	279.7
Total	130	343.8	318.6

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The infectious disease rates were similar between the service area and the state. The service area averaged about 130 unique cases per year.

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



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

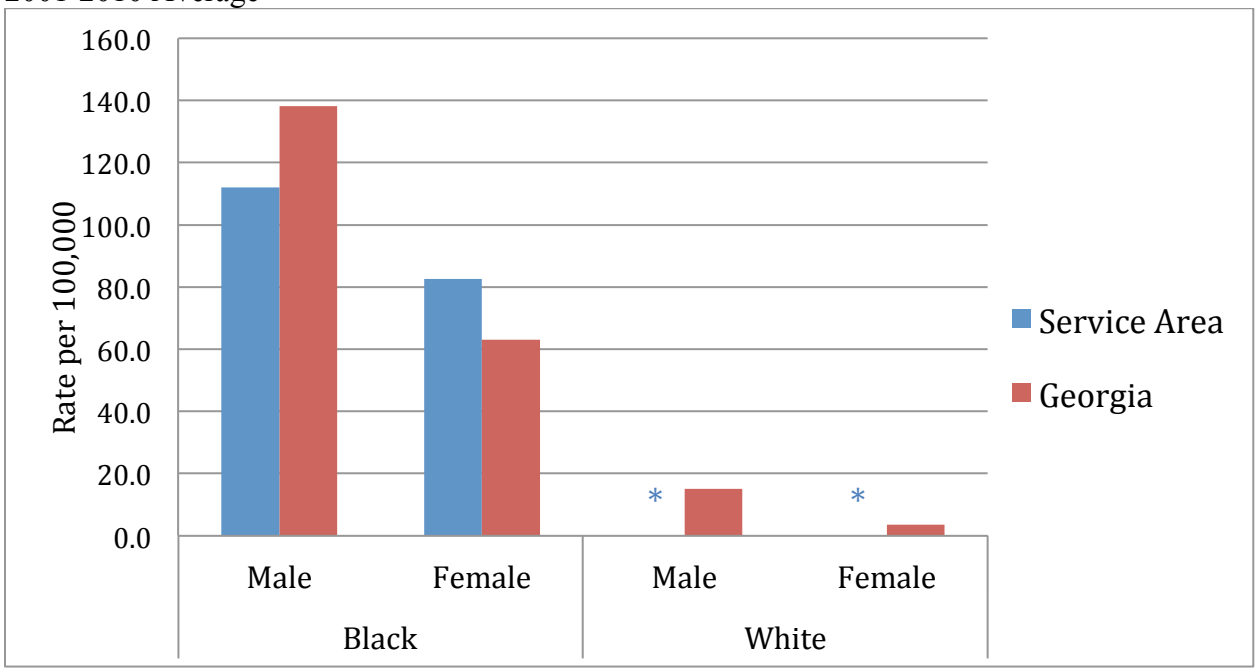
HIV/AIDS: Deduplicated Discharges & Age-Adjusted, Deduplicated Discharge Rates per 100,000

	Service Area (Discharges) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	12	95.8	97.2
White	< 1	*	9.3
Other	0	0.0	19.7
Total	12	36.2	38.7

†Average number of unique persons that sought care at a hospital during a calendar year. Deduplicated discharge: people are counted only once if readmitted for the same chronic condition during a calendar year.
‡ Ten year average age-adjusted, deduplicated discharge rate from 2001-2010
* Insufficient number of discharges to calculate a rate
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

As is consistent with the state averages, African Americans in the service area have the highest rates of HIV/AIDS. The rates for white males and white females could not be calculated because there was insufficient number of hospital visits.

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



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

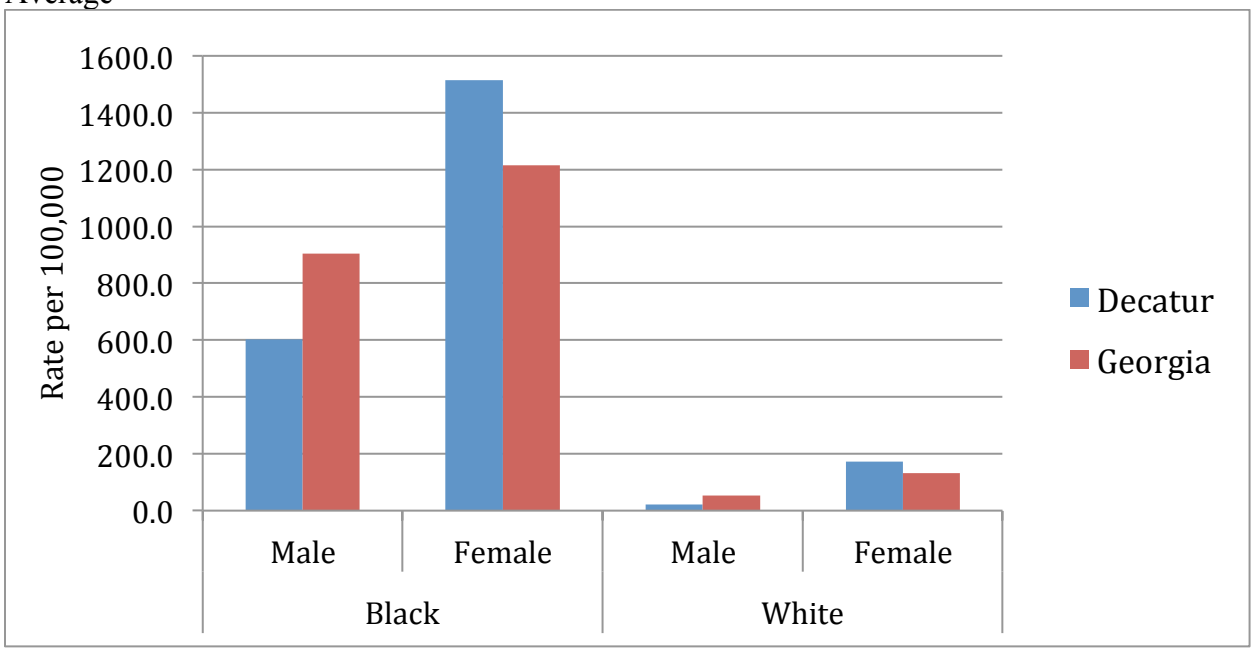
Sexually Transmitted Disease (STD) Rate: Total STD Cases and New STD Cases per 100,000

	Service Area (Cases) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	34	1,122.6	1062.6
White	6	100.1	87.9
Other	< 1	*	69.4
Total••	63	701.0	626.2

† Yearly average number of new STD cases per year between 2001-2010
‡ Average STD Incidence Rate between 2001-2010
* Insufficient number of discharges to calculate a rate
•• Total case number includes cases with unknown race
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

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

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



SOURCE: OASIS (www.oasis.state.ga.us)

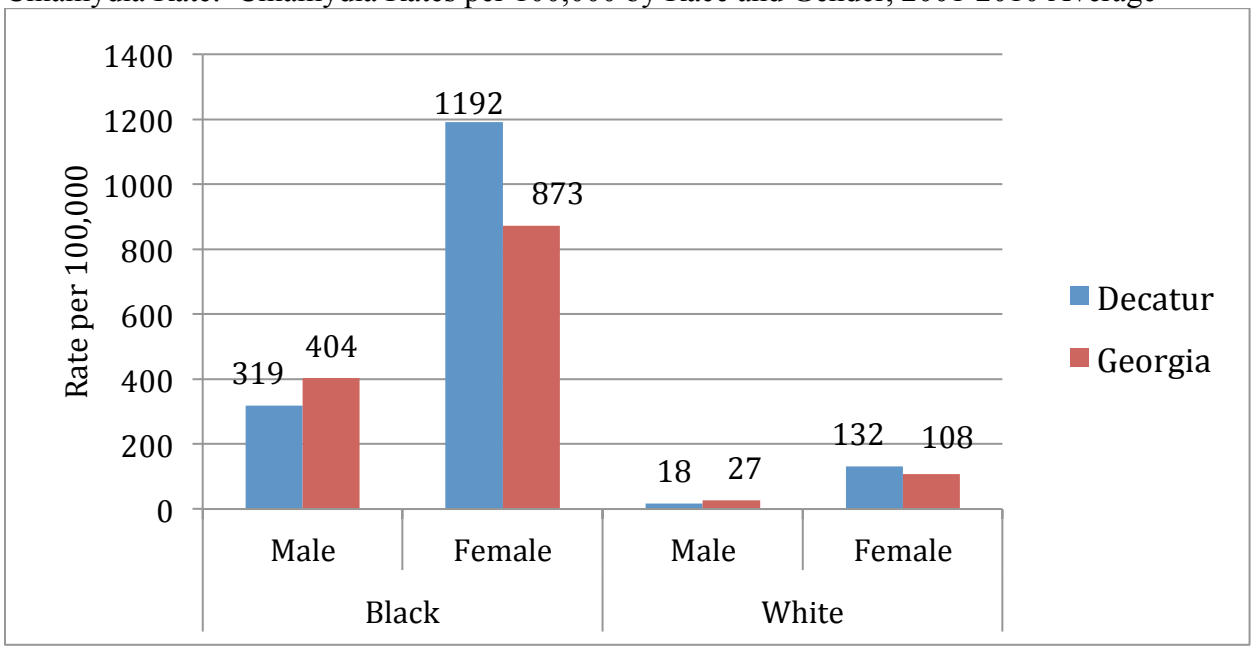
Chlamydia Rate: New Chlamydia Cases and Cases per 100,000 People

	Service Area (Cases) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	25	808.4	636.4
White	5	77.7	63.4
Other	< 1	*	46.4
Total❟	461	515.4	416.1

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

The chlamydia rate for the service area is higher than the state average. African Americans have higher rates of chlamydia than the other race classifications.

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



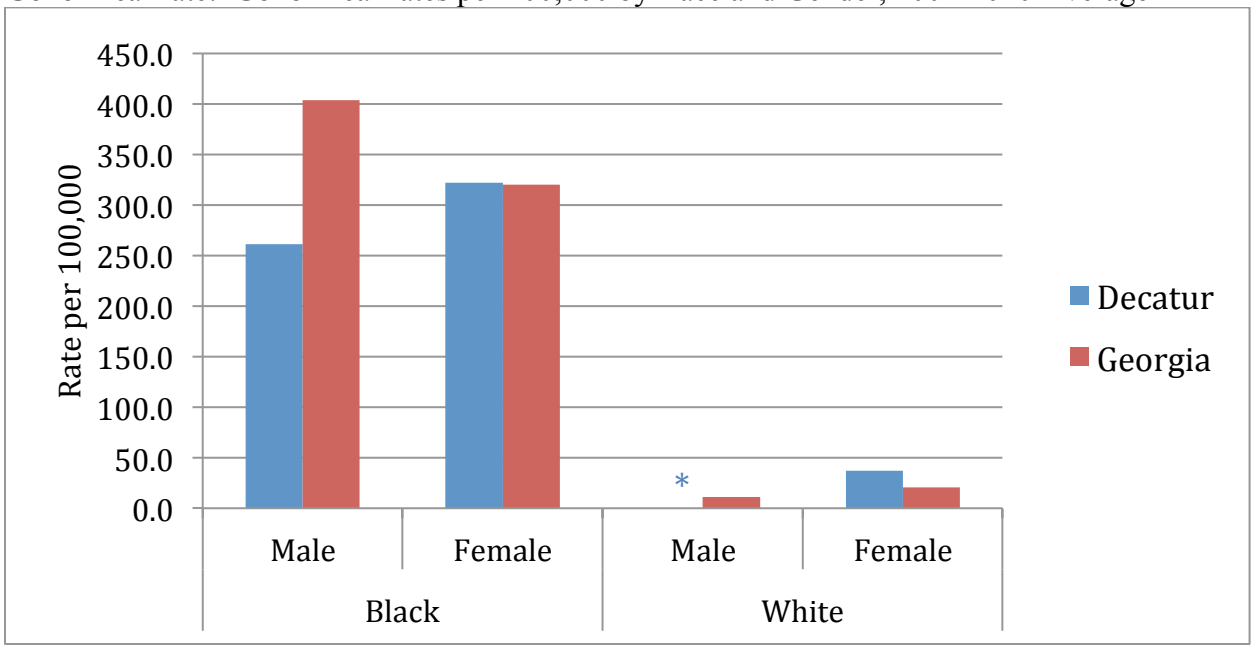
SOURCE: OASIS (www.oasis.state.ga.us)

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

	Service Area (Cases) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	9	304.4	368.5
White	1	20.7	16.1
Other	0	0.0	16.8
Total❟	16	181.1	186.0

† Average number of new STD cases per year between 2001-2010
‡ Average STD Incidence Rate between 2001-2010
❟ Total case number includes cases with unknown race
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us
The rates of gonorrhea are similar to the state average for whites and blacks. While still high, black males in the service area had a rate much lower than the state average.

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



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

Trends in Mortality

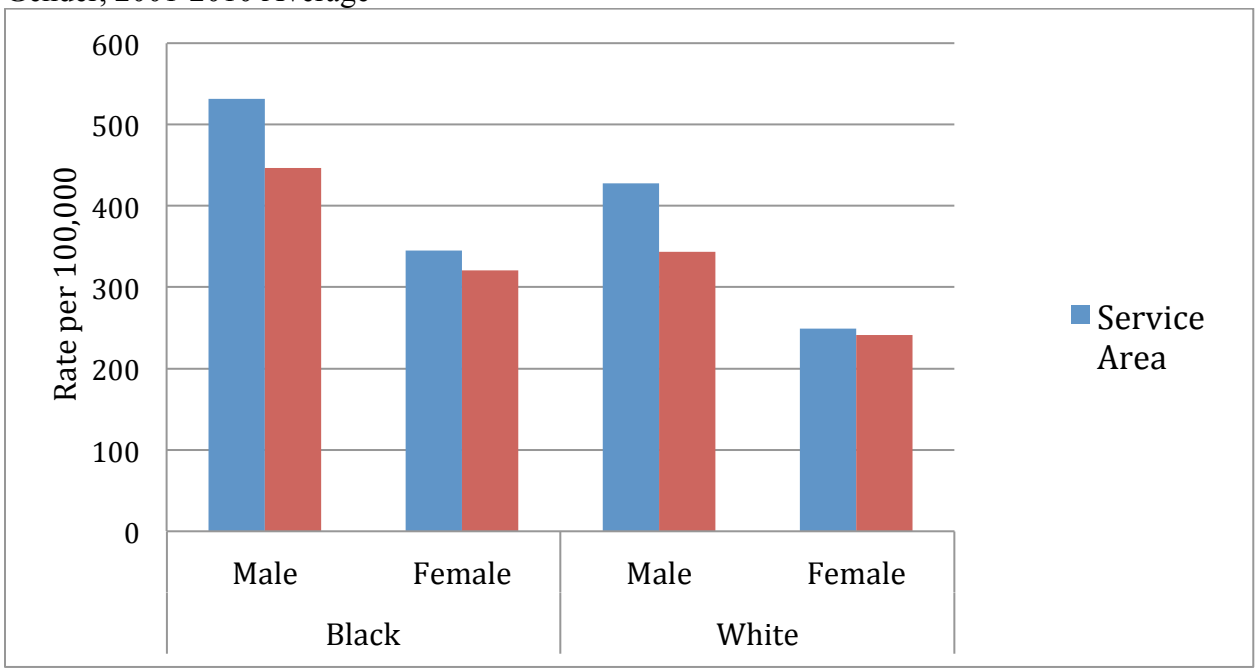
All Major Cardiovascular Diseases: Deaths & Age-Adjusted Mortality Rates per 100,000

	Service Area (Deaths) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	46	421.9	380
White	82	323.8	291.9
Other	< 1	*	100.0
Total	129	351.5	308.3

† Average number of deaths per year from 2001-2010
‡ Age-adjusted mortality rate from 2001-2010
* Insufficient number of deaths to calculate a rate
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

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

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



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

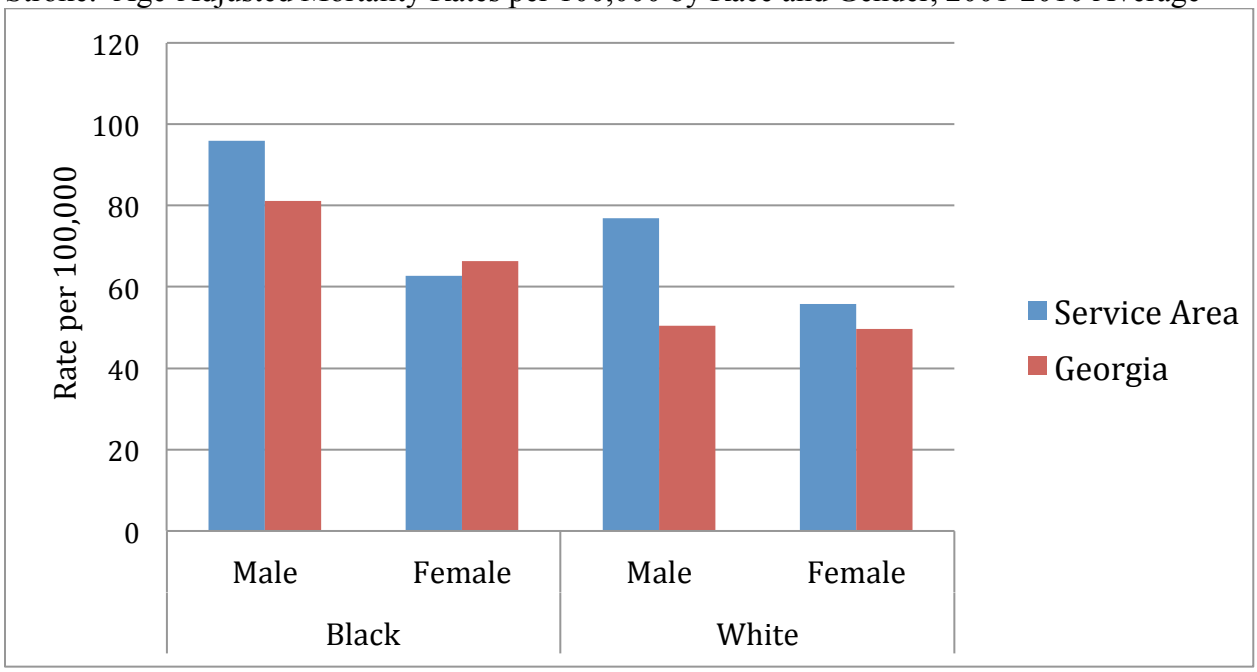
Stroke: Deaths & Age-Adjusted Mortality Rates per 100,000

	Service Area (Deaths) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	9	78.1	74.2
White	16	63.6	51.5
Other	0	0.0	24.0
Total	25	67.2	56.2

† Average number of deaths per year from 2001-2010
‡ Age-adjusted mortality rate from 2001-2010
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Total stroke mortality rate for the service area is higher than the state average.

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



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

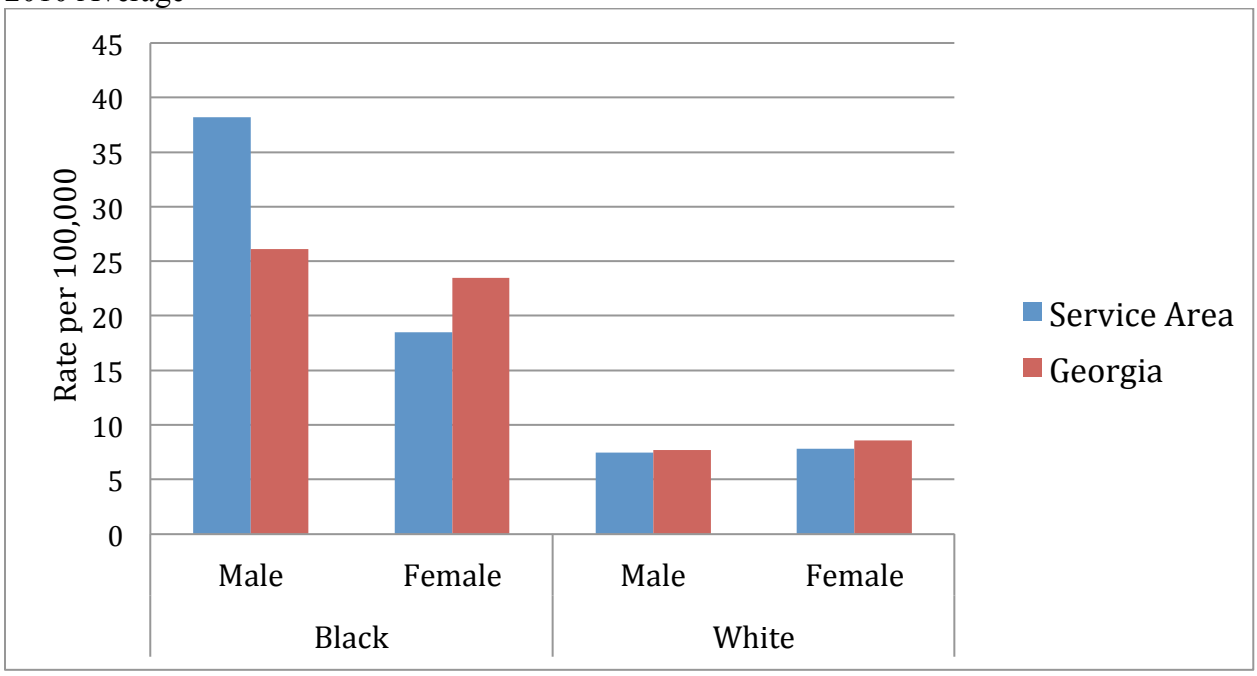
High Blood Pressure: Deaths & Age-Adjusted Mortality Rates per 100,000

	Service Area (Deaths) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	3	24.8	25.4
White	2	7.7	8.7
Other	0	0.0	3.8
Total	5	12.6	12.1

† Average number of deaths per year from 2001-2010
‡ Age-adjusted mortality rate from 2001-2010
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Mortality rates for blood pressure comprise a small proportion of deaths in comparison with other type of cardiovascular diseases. As with the morbidity data for high blood pressure, African Americans in the service area have higher rates than the counterparts in other races.

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



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

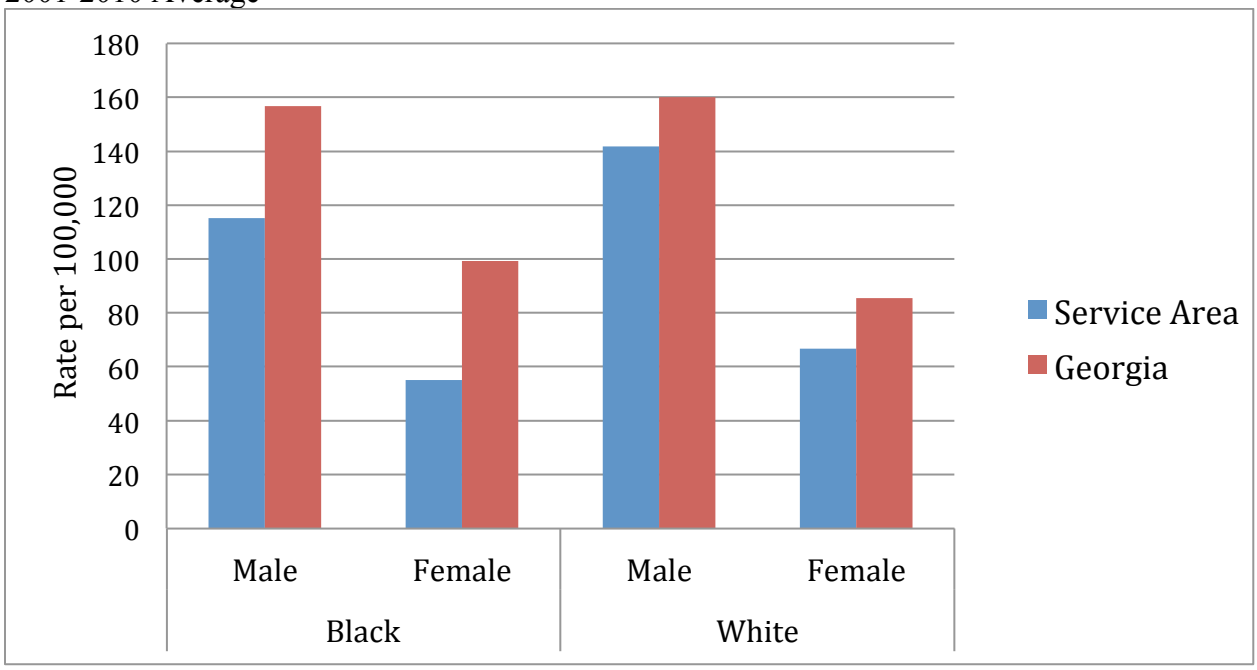
Obstructive Heart Failure: Deaths & Age-Adjusted Mortality Rates per 100,000

	Service Area (Deaths) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	9	79.9	124.7
White	25	98.4	119.3
Other	0	0.0	35.8
Total	34	92.3	119.0

† Average number of deaths per year from 2001-2010
‡ Age-adjusted mortality rate from 2001-2010
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Rates of obstructive heart failure were lower than the state average.

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



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

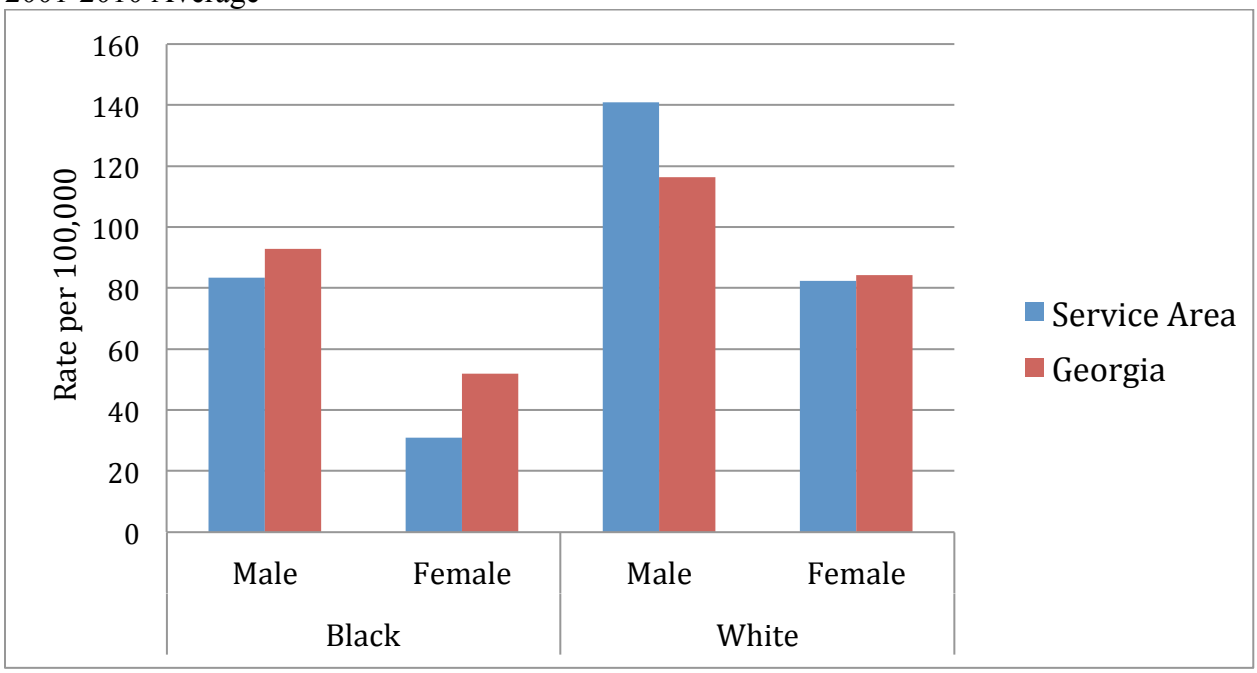
All Respiratory Diseases: Deaths & Age-Adjusted Mortality Rates per 100,000

	Service Area (Deaths) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	5	48.1	67.8
White	27	103.6	97.4
Other	0	0.0	22.9
Total	32	86.7	90.3

† Average number of deaths per year from 2001-2010
‡ Age-adjusted mortality rate from 2001-2010
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The total age-adjusted mortality rates for the service area were similar to the state average.

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



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

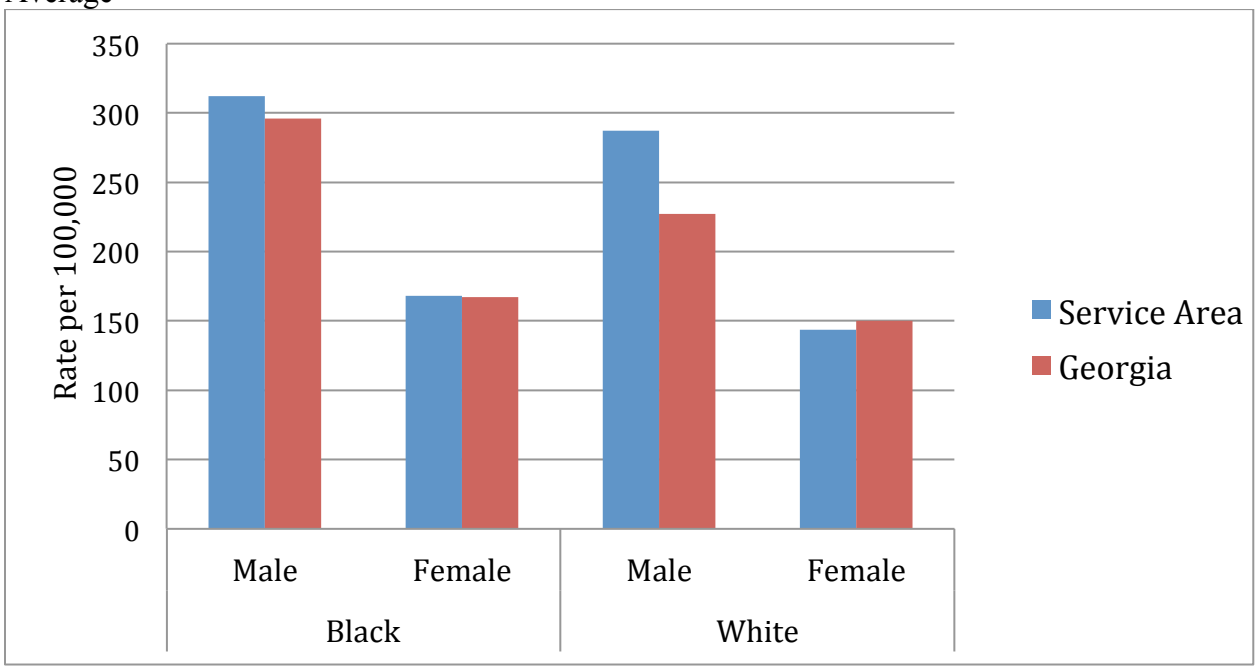
All Cancers: Deaths & Age-Adjusted Mortality Rates per 100,000

	Service Area (Deaths) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	23	214.5	213.8
White	51	199.2	182.2
Other	< 1	*	71.6
Total	75	202.8	186.8

† Average number of deaths per year from 2001-2010
‡ Age-adjusted mortality rate from 2001-2010
* Insufficient number of deaths to calculate a rate
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The total age-adjusted cancer mortality rate was similar to the state average.

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



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

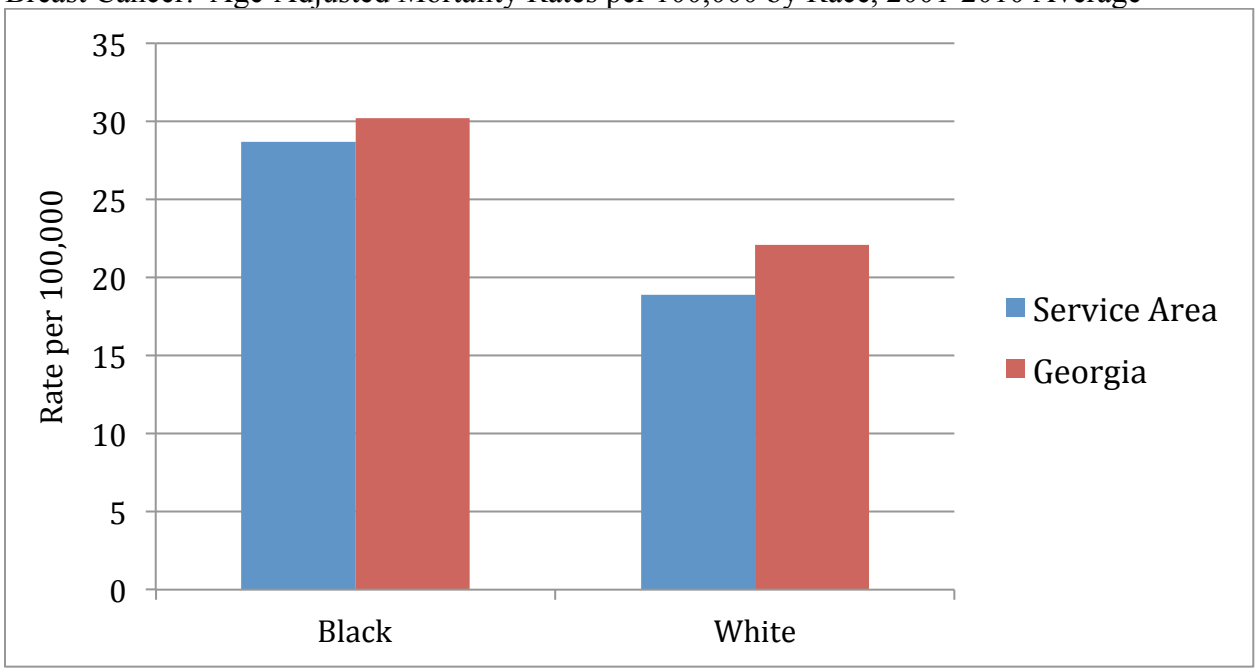
Breast Cancer: Deaths & Age-Adjusted Mortality Rates per 100,000 Females

	Service Area (Deaths) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	2	29.0	30.3
White	3	18.9	22.3
Other	0	0.0	7.6
Total	5	21.7	24.0

† Average number of deaths per year from 2001-2010
‡ Age-adjusted mortality rate from 2001-2010
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

Breast cancer mortality rates in the service area were similar to the state average.

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



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

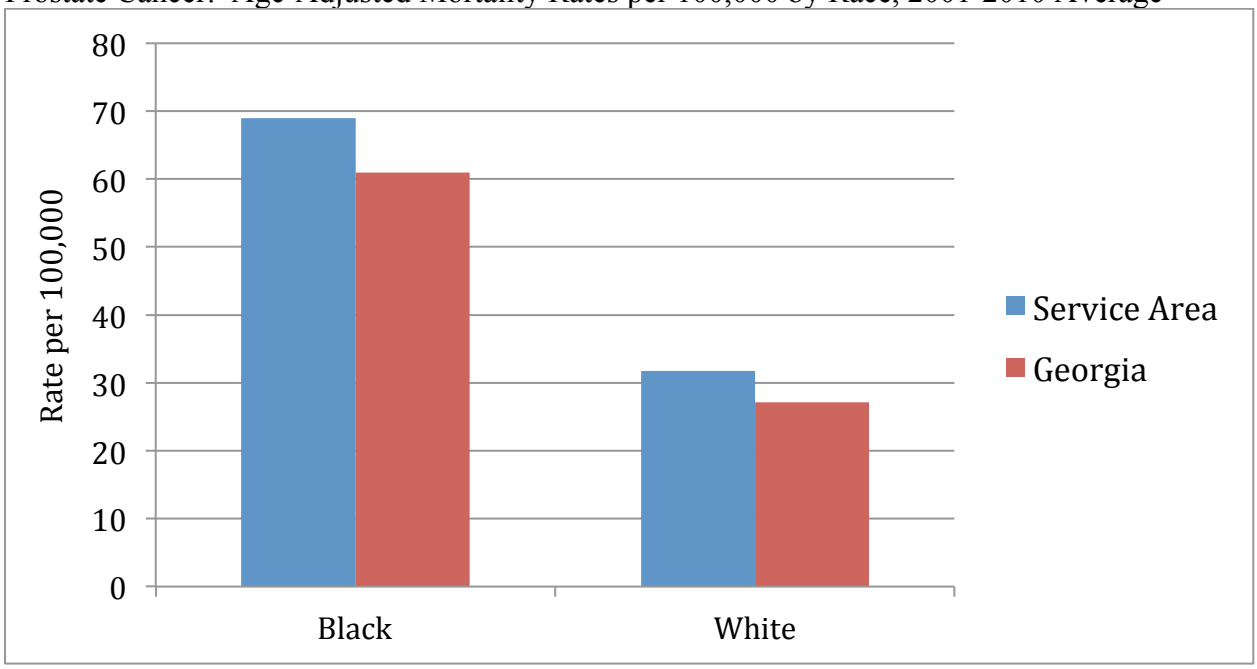
Prostate Cancer: Deaths & Age-Adjusted Mortality Rates per 100,000 Males

	Service Area (Deaths) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	2	68.8	63.8
White	3	31.2	22.2
Other	0	0.0	7.1
Total	5	41.7	29.3

† Average number of deaths per year from 2001-2010
‡ Age-adjusted mortality rate from 2001-2010
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The age-adjusted mortality rate for prostate cancer in the area was higher than the state average.

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



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

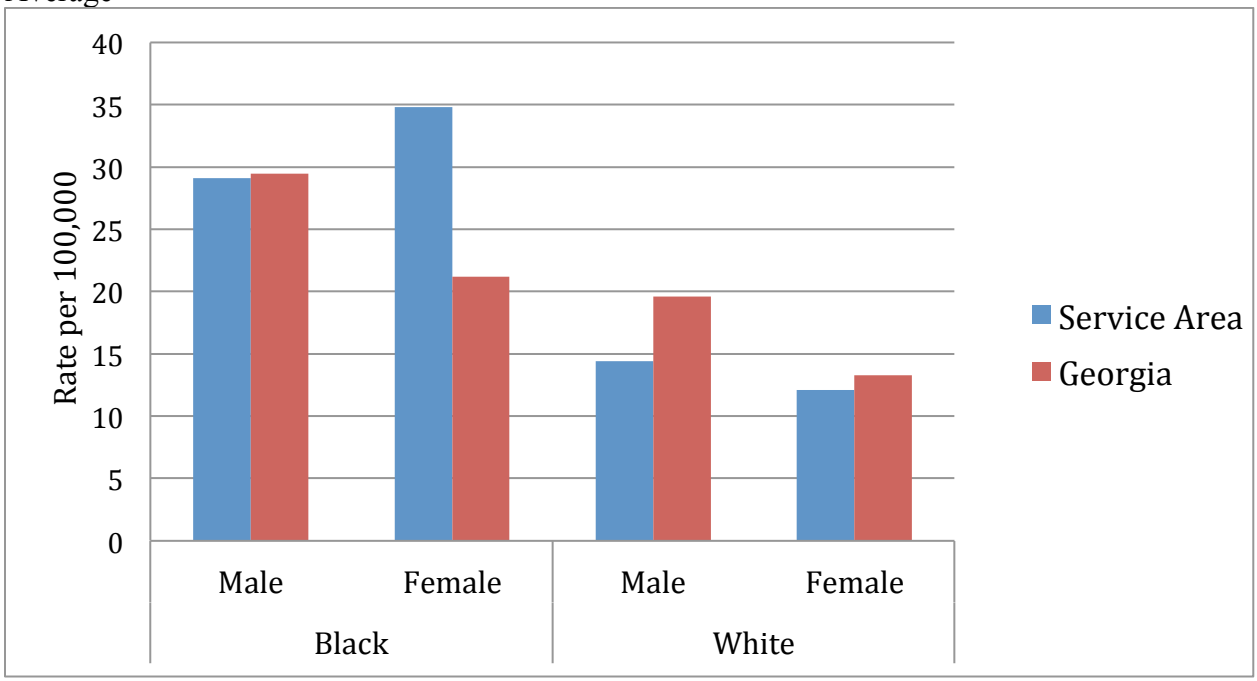
Colon Cancer: Deaths & Age-Adjusted Mortality Rates per 100,000

	Service Area (Deaths) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	2	18.2	24.4
White	4	15.5	16.1
Other	< 1	*	7.9
Total	6	16.3	17.7

† Average number of deaths per year from 2001-2010
‡ Age-adjusted mortality rate from 2001-2010
* Insufficient number of deaths to calculate a rate
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The age-adjusted death rate for colon cancer was approximately equal to the state average. African-American females had a rate significantly higher than the state average.

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



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

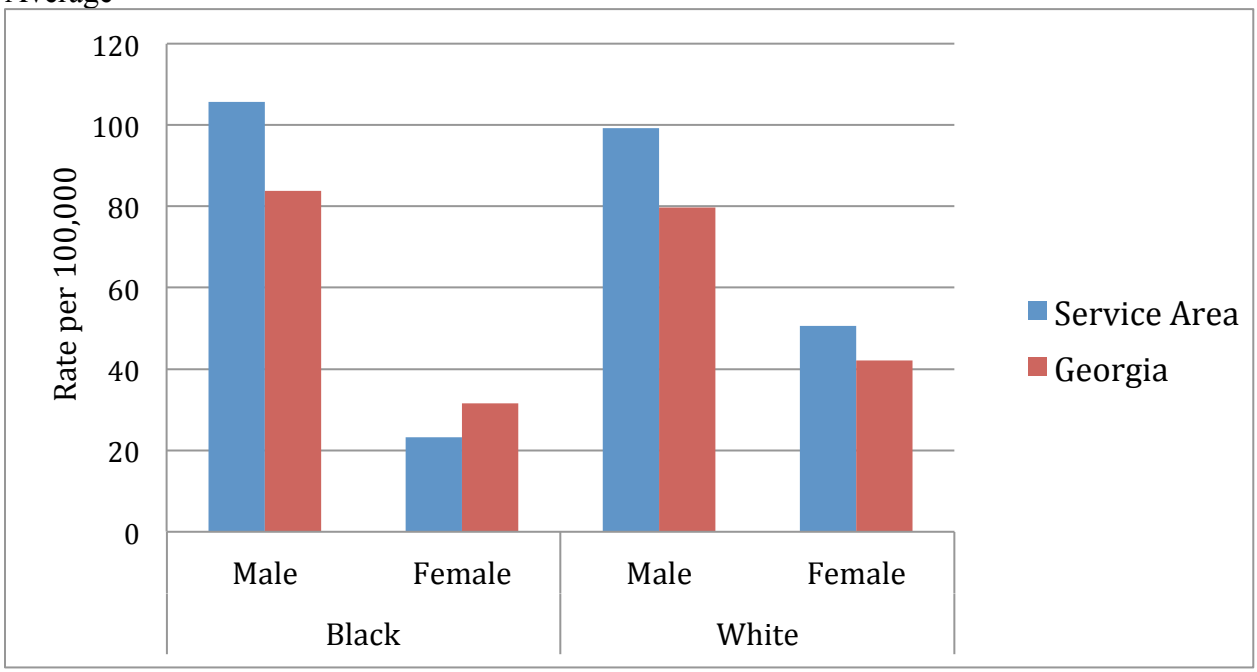
Lung Cancer: Deaths & Age-Adjusted Mortality Rates per 100,000

	Service Area (Deaths) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	6	51.9	51.3
White	19	70.2	58.1
Other	0	0.0	16.0
Total	24	64.2	55.7

† Average number of deaths per year from 2001-2010
‡ Age-adjusted mortality rate from 2001-2010
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The age-adjusted lung cancer death rate was similar than the state average. The rates for males are more than twice the rates for females. Health behaviors, such as smoking habits, could be the explanation for the difference.

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



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

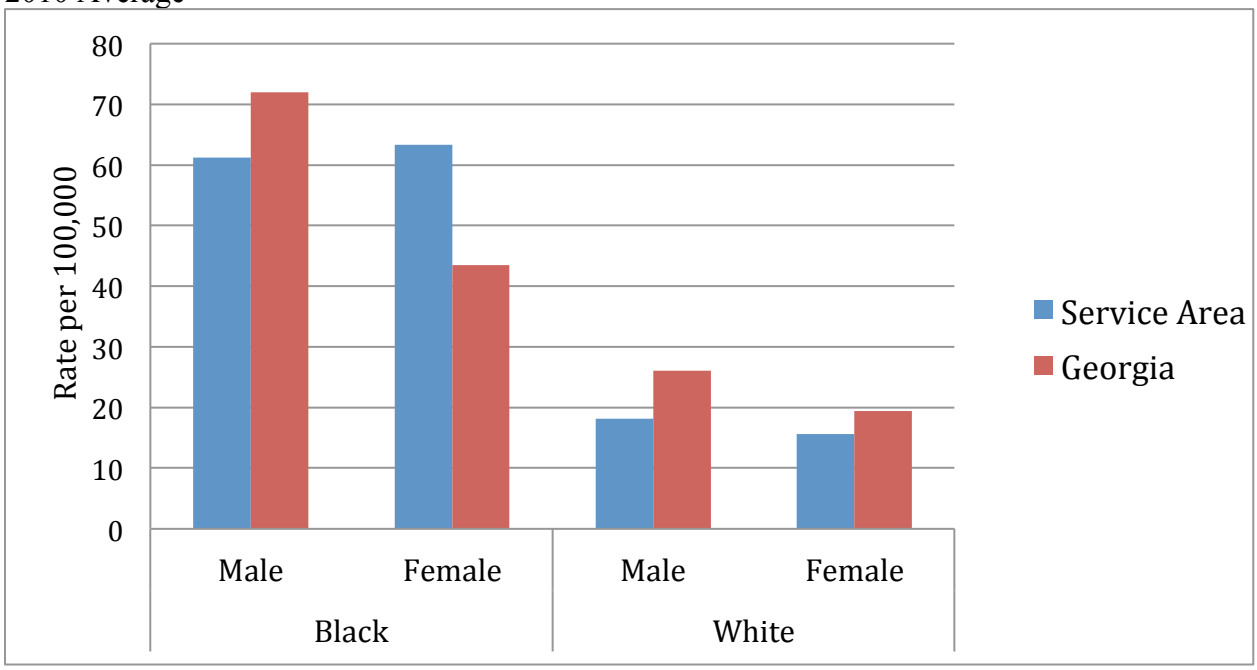
All Infectious Diseases: Deaths & Age-Adjusted Mortality Rates per 100,000

	Service Area (Deaths) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	7	61.1	56.1
White	4	17.6	22.9
Other	0	0.0	9.5
Total	11	31.8	30.9

† Average number of deaths per year from 2001-2010
‡ Age-adjusted mortality rate from 2001-2010
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The total age-adjusted mortality rates for all infectious diseases are approximately equal to the state average. Black males had the highest rates in the service area. Rates for African Americans were more than three times the rates of whites in the service area.

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



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

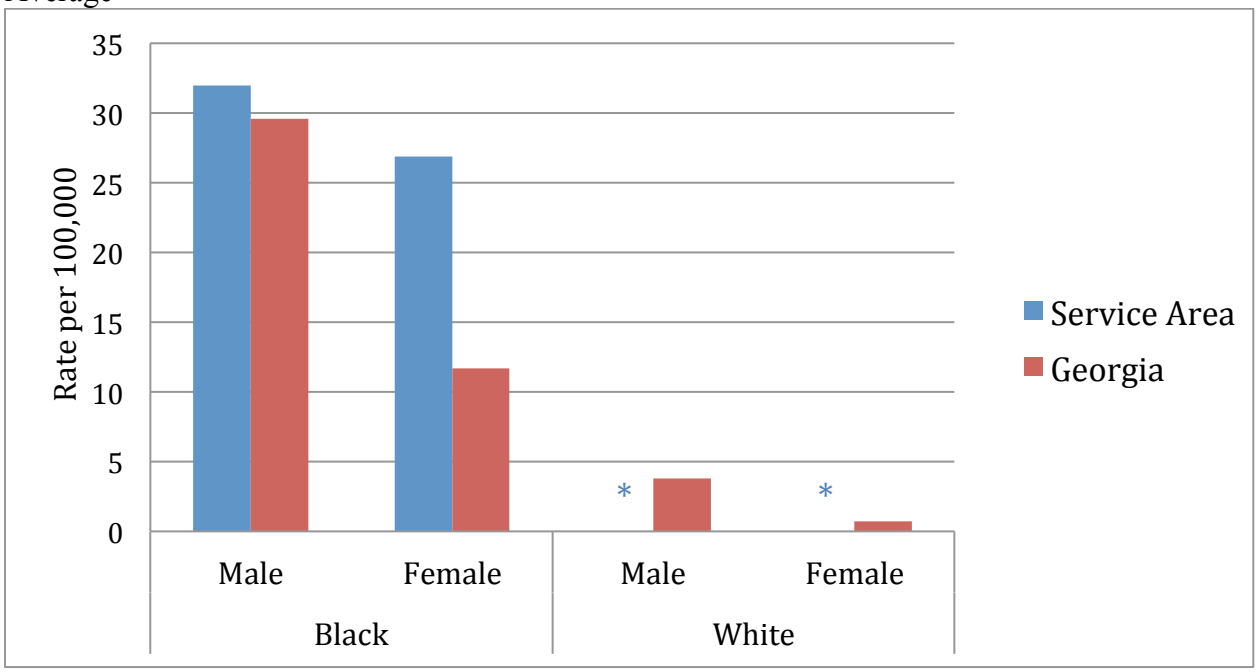
HIV/AIDS: Deaths & Age-Adjusted Mortality Rates per 100,000

	Service Area (Deaths) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	3	29.2	19.7
White	< 1	*	2.3
Other	0	0.0	0.7
Total	4	11.5	7.1

† Average number of deaths per year from 2001-2010
‡ Age-adjusted mortality rate from 2001-2010
* Insufficient number of deaths to calculate a rate
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

HIV/AIDS mortality rates are much higher in the African-American population. The HIV/ mortality rate for white males and white females in the service area could not be calculated because of an insufficient number of deaths.

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



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

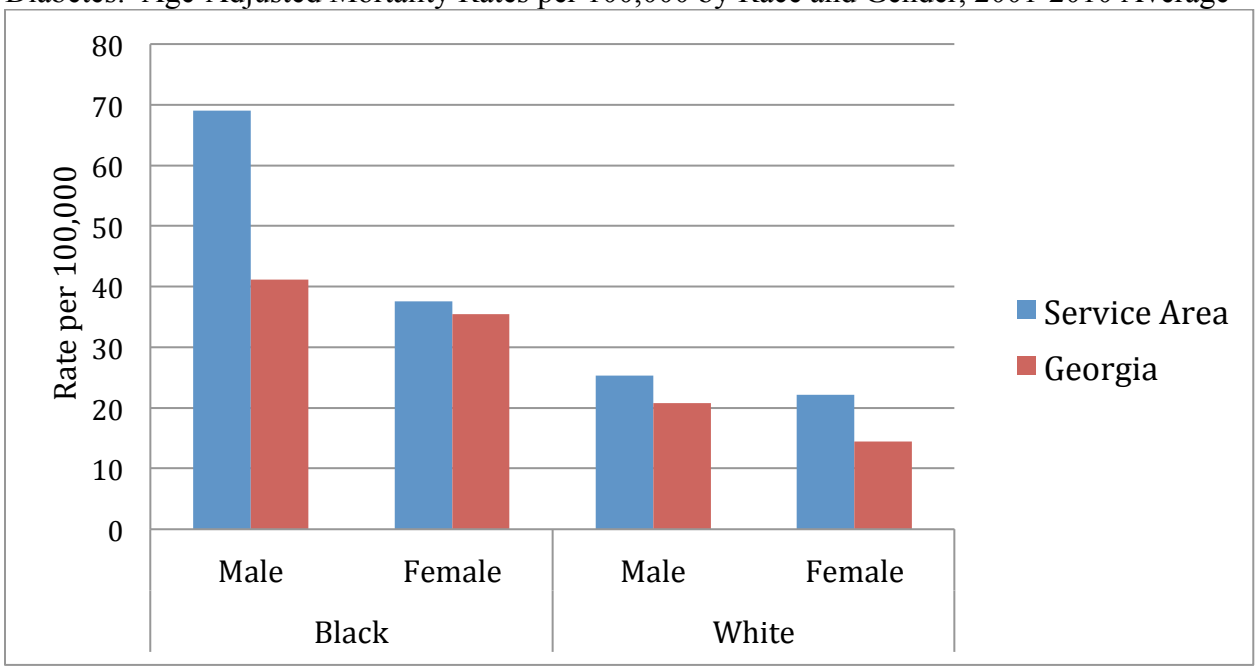
Diabetes: Deaths & Age-Adjusted Mortality Rates per 100,000

	Service Area (Deaths) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	5	46.9	38.4
White	6	24.0	17.4
Other	0	0.0	9.8
Total	11	30.6	21.7

† Average number of deaths per year from 2001-2010
‡ Age-adjusted mortality rate from 2001-2010
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The age-adjusted diabetes mortality rate is similar to the state average. The rates are higher in the African-American community.

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



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

Maternal and Child Health

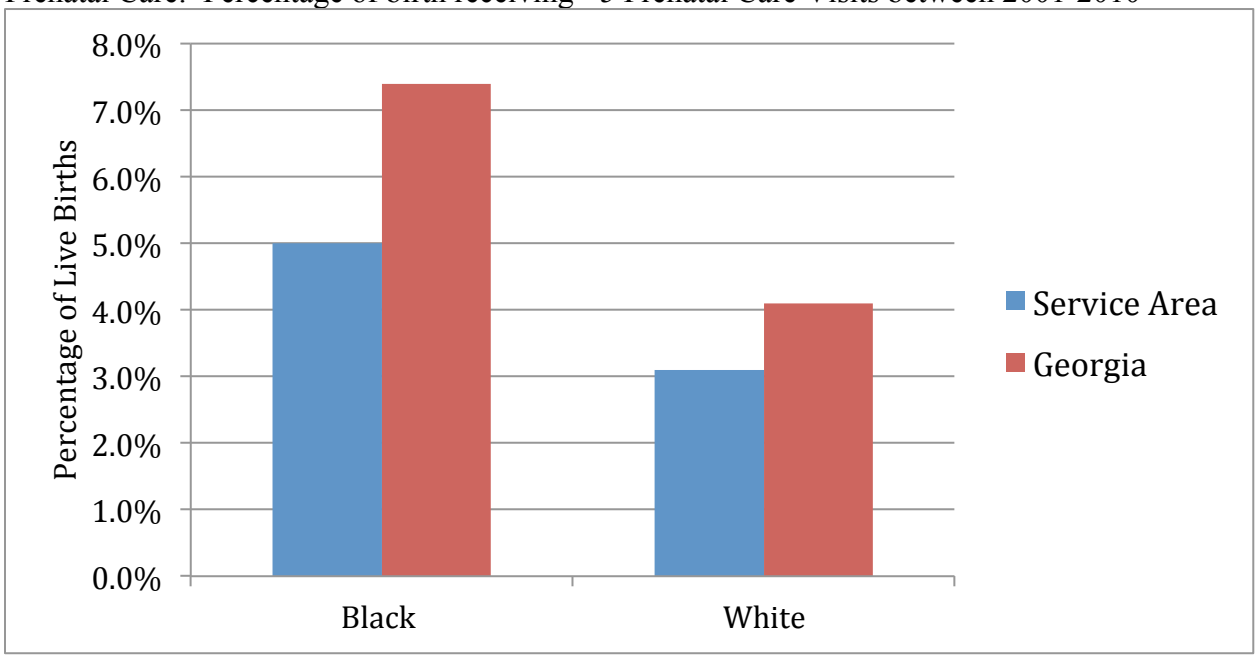
Prenatal care: Number and Proportion of Births Less Than 5 Prenatal Care Visits

	Service Area (Births) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	9	5.0%	7.4%
White	6	3.1%	4.1%
Other	< 1	*	4.0%
Total	15	4.0%	5.1%

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

The percentage of births receiving less than five prenatal care visits is higher among African-Americans in the service area. The rates are lower than the state averages.

Prenatal Care: Percentage of birth receiving <5 Prenatal Care Visits between 2001-2010



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

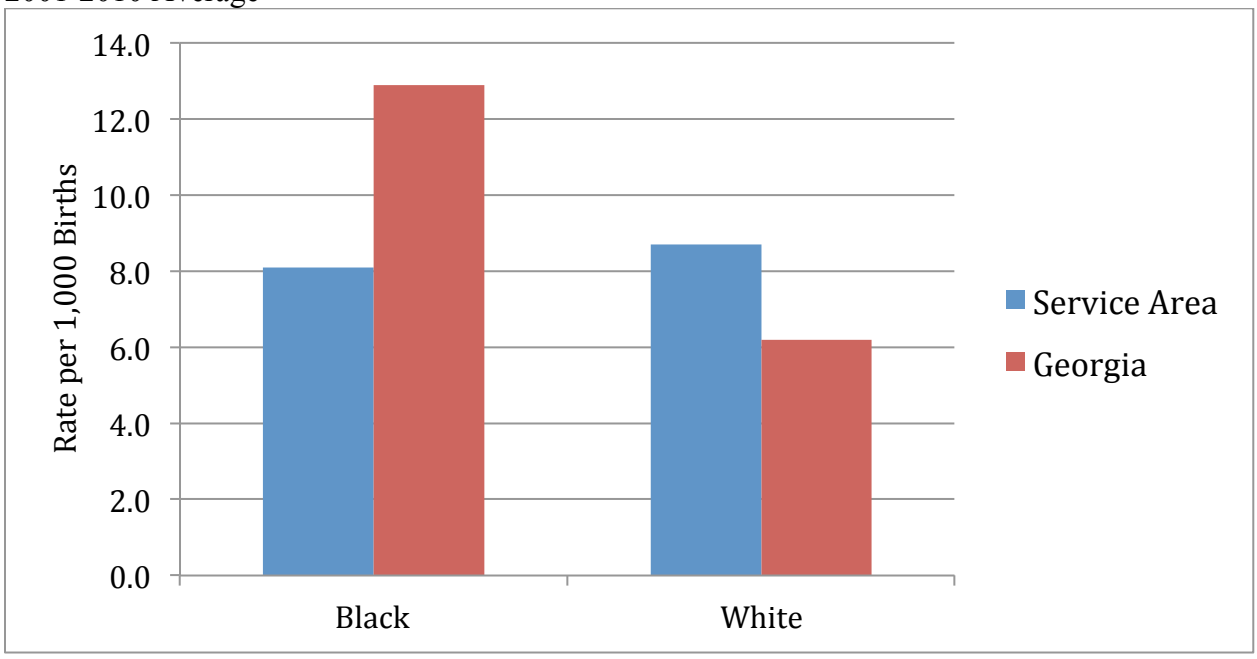
Infant Mortality Rate: Deaths & Mortality Rates per 1,000 Live Births

	Service Area (Deaths) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	2	8.1	12.9
White	2	8.7	6.2
Other	0	0.0	11.7
Total	4	8.2	8.1

† Average number of infant deaths (aged 0-11 months) per year from 2001-2010
‡ Average Infant Mortality Rate from 2001-2010
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The infant mortality rate in the service area is similar to the state average.

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



SOURCE: OASIS (www.oasis.state.ga.us)

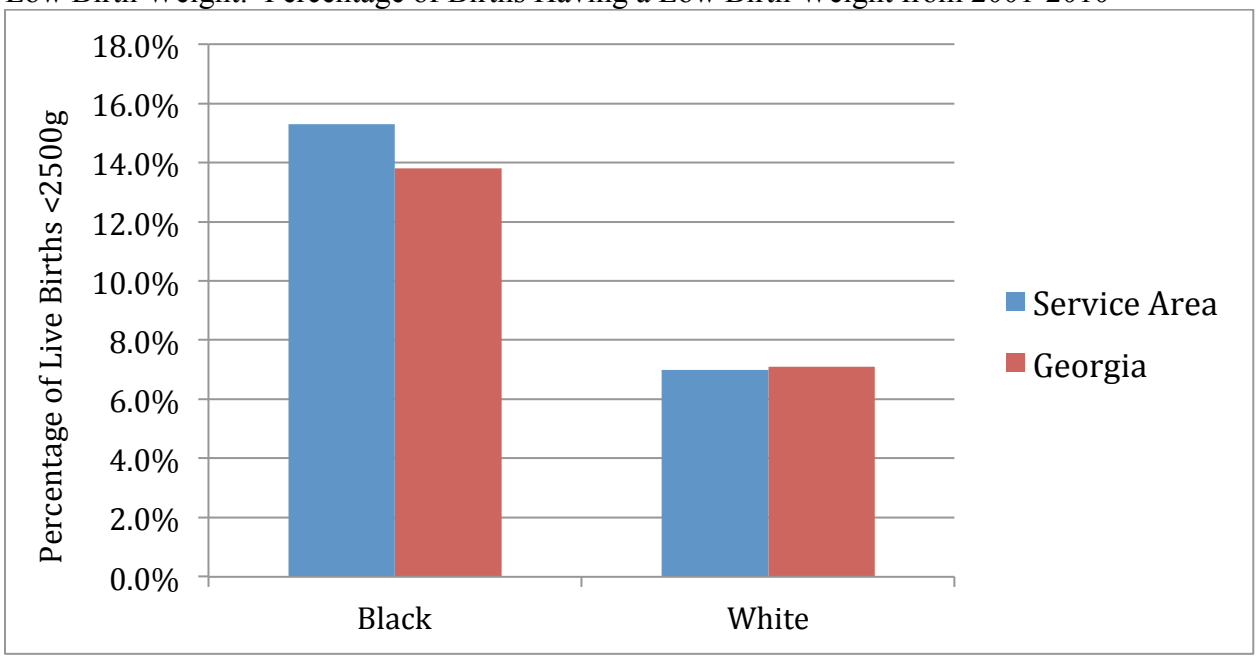
Low Birth Weight: Percentage of Births Less Than 2500g (5lbs 8oz.)

	Service Area (Births) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	38	15.3%	13.8%
White	19	7.0%	7.1%
Other	1	9.2%	8.4%
Total	57	10.8%	9.3%

†Average number of low birth births per year from 2001 to 2010
‡ Ten year average low birth weight rate from 2001-2010
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The percentage of low birth weight babies in the black population is twice as high as in the white population. The overall weight is higher than the state average.

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



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

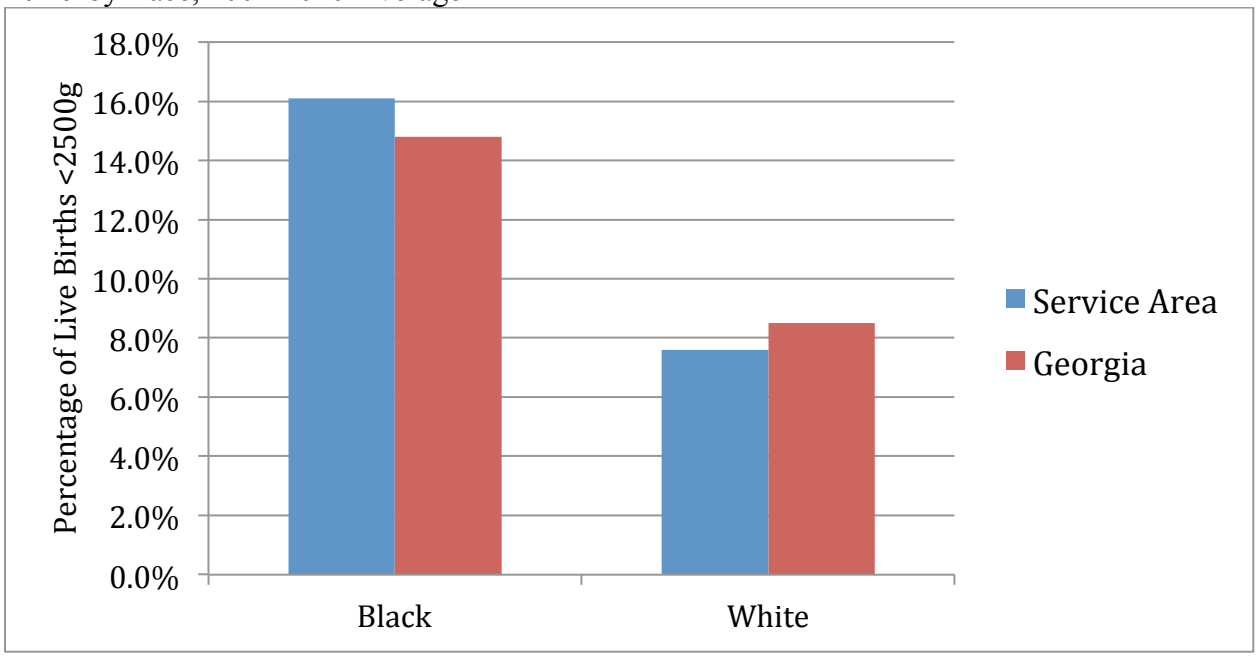
Low Birth Weight for Teen Births: Percentage of Births Less Than 2500g (5lbs 8oz.) for Mothers Aged 10-19

	Service Area (Births) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	11	16.1%	14.8%
White	3	7.6%	8.5%
Other	< 1	*	10.6%
Total	14	12.9%	11.4%

† Average number of low birth weight births from 2001-2010 for mothers aged 10-19
‡ Average Percentage of Birth below 2500g for mothers aged 10-19 from 2001-2010
* Insufficient number of births to calculate a rate
Georgia Department of Public Health OASIS. Retrieved from www.oasis.state.ga.us

The percentage of low birth weight births for teen mothers is higher than the low birth weight rate for the total population (as shown on the previous page). The rates are highest among African Americans in the service area.

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



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

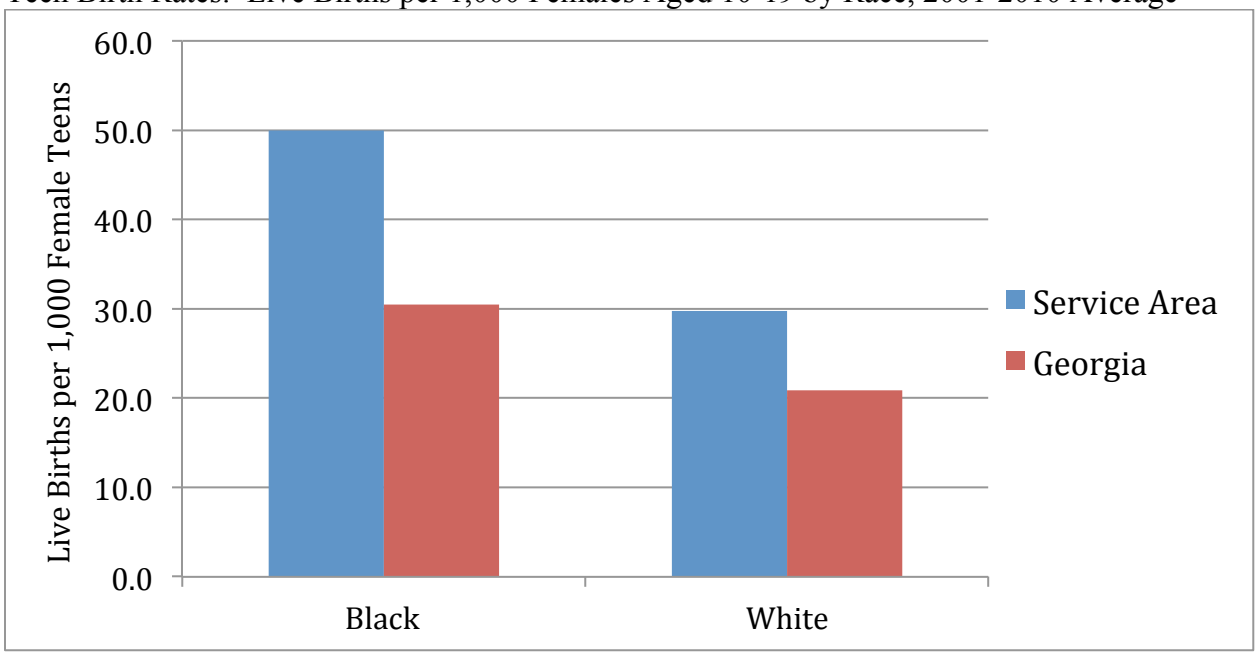
Teen Birth Rate: Live Births per 1,000 Females Aged 10-19

	Service Area (Births) †	Service Area (Rate) ‡	Georgia (Rate) ‡
Black	66	50.0	30.5
White	38	29.8	20.9
Other	1	33.8	31.8
Total	108	40.6	25.0

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

The teen birth rate in the service area is similar to the state average. The majority of births to teen mothers occur in the African-American population.

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



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

RESULTS: COMMUNITY-BASED SURVEY

A total of 324 surveys were completed and returned to Georgia Southern University for analysis. The distribution of surveys by zip code is displayed below. As indicated, seven participants failed to report zip code (2.2%). As is the case with most survey work, missing values are most likely noted with all assessed variables. However, the remaining variables outlined below will not include missing data and the analysis will be limited only to those participants addressing a specific survey question. Therefore, table values not equaling 324 indicate the presence of missing values.

Distribution of Participants by Zip Codes

Zip Code	Frequency	Valid Percent
31036	135	41.7
31014	98	30.2
31092	13	4.0
31001	4	1.2
31023	2	0.6
Other	65	20.1
Missing	7	2.2
Total	324	100.0

Demographic Characteristics

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

Distribution of Participants by Gender

Gender	Frequency	Valid Percent
Male	83	25.8
Female	239	74.2
Total	322	100.0

As is typical with community-based efforts, considerably more females (74.2%) completed this survey than males (25.8%).

Distribution of Participants by Race/Ethnicity

Ethnicity	Frequency	Valid Percent
White, Non-Hispanic	195	61.7
Black/African-American	108	34.2
Hispanic/Latino	2	0.6
Asian/ Pacific Islander	1	0.3

Other	10	3.2
Total	316	100.0

Most respondents were white (61.7%). However, a significant proportion of survey participants were African American (34.2%). This number is representative of the racial demographics observed for the service area.

Distribution of Participants by Age

Age	Frequency	Valid Percent
18-24	34	10.6
25-34	47	14.6
35-44	53	16.5
45-54	65	20.2
55-64	74	23.0
65 And Older	49	15.2
Total	322	100.0

Nearly 51.0% of all participants completing the community-based survey were between the ages of 25 and 54 years old. Only 10.6% of participants were 18 to 24 years old, and 23.0% of participants were between the ages of 55 and 64. Approximately 15.2% of all participants were 65 years old or older. Therefore, the age distribution suggests an adequate cross-section of participation.

Distribution of Participants by Marital Status

Marital Status	Frequency	Valid Percent
Single	71	22.0
Married	192	59.6
Separated	4	1.2
Living Together	2	0.6
Divorced	30	9.3
Widowed	21	6.5
Other	2	0.6
Total	322	100.0

Most participants (59.6%) were married while 22.0% of participants were single. The relative proportions of other categories were minimal.

Distribution of Participants by Educational Status

Level Of Education	Frequency	Valid Percent
Less Than High School	21	6.6
High School Or GED	95	29.7
Some College	111	34.7
Bachelor's Degree	52	16.3
Advanced Degree	29	9.1
Other	12	3.8
Total	320	100.0

Approximately 34.7% of respondents reported having some college education, and 29.7% of respondents reported having a high school diploma or the equivalent. Only 6.6% of respondents indicated they had less than a high school education.

Distribution of Participants by Employment Status

Employment Status	Frequency	Valid Percent
Student	23	7.1
Full-Time	144	44.7
Part-Time	29	9.0
Retired	28	8.7
Self-Employed	63	19.6
Unemployed	28	8.7
Not Seeking Employment	7	2.2
Total	322	100.0

Most survey participants (44.7%) indicated they worked full-time while only 9.0% reported part-time work. Approximately 8.7% of individuals completing the community-based survey reported being unemployed.

Distribution of Participants by Household Income

Household Income	Frequency	Valid Percent
Under $25,000	100	32.8
$25,000-$49,999	74	24.3
$50,000-$74,999	42	13.8
$75,000-$99,999	28	9.2
$100,000 Or More	44	14.4
Don't Know/Not Sure	17	5.6
Total	305	100.0

Nearly 32.8% of participants reported household incomes of less than $25,000 per year. Other income categories were fairly evenly distributed.

Distribution of Participants by Home Ownership Status

Home Ownership	Frequency	Valid Percent
Yes	203	63.6
No	116	36.4
Total	319	100.0

Most survey participants (63.6%) reported owning their home.

Distribution of Participants by Access to Transportation

Access To Transportation	Frequency	Valid Percent
Yes	295	91.9
No	26	8.1
Total	321	100.0

A considerable proportion of those surveyed reported having access to transportation (91.9%). However, it is important to note that this does not necessarily indicate they own transportation.

Distribution of Participants by Number of Dependents in the Household

Number Of Dependents	Frequency	Valid Percent
0	128	40.4
1	75	23.7
2	52	16.4
3 Or More	62	19.6
Total	317	100.0

Most respondents indicated no dependents were living in the household (40.4%), but over 19.6% of those surveyed reporting having 3 or more dependents.

Community Perception

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

Individual Perception of Quality of Life in the Community

My Community Is A:		
Good Place To Live	Frequency	Valid Percent
Strongly Agree	116	37.4
Agree	157	50.6
No Opinion	22	7.1
Disagree	13	4.2
Strongly Disagree	2	0.6
Total	310	100.0

Among those surveyed, 88.0% of participants either "agree" (50.6%) or "strongly agree" (37.4%) that their community is a good place to live.

Individual Perception of the Economy

My Community Has:		
Strong Economic Growth	Frequency	Valid Percent
Strongly Agree	16	5.1
Agree	67	21.5
No Opinion	61	19.6
Disagree	135	43.4
Strongly Disagree	32	10.3
Total	311	100.0

However, most participants feel that economic growth in the community is not optimal. Among those responding to this survey, 53.7% of participants either "disagree" (43.4%) or "strongly disagree" (10.3%) that economic growth is adequate in their community.

Individual Perception of the Health Care System

My Community Has A:		
Strong Health Care System	Frequency	Valid Percent
Strongly Agree	33	10.8
Agree	137	44.8
No Opinion	63	20.6
Disagree	68	22.2
Strongly Disagree	5	1.6

Total	306	100.0

Most participants "agree" (44.8%) or "strongly agree" (10.8%) the health care system is strong in their community.

Individual Perception of the Family Oriented Nature of the Community

My Community Is A:		
Good Place To Raise Children	Frequency	Valid Percent
Strongly Agree	86	27.8
Agree	171	55.3
No Opinion	34	11.0
Disagree	14	4.5
Strongly Disagree	4	1.3
Total	309	100.0

Among those responding to this survey, 83.1% of participants either "agree" (55.3%) or "strongly agree" (27.8%) that the community is a good place to raise children.

Individual Perception of Community Safety

My Community Is A:		
Safe Community	Frequency	Valid Percent
Strongly Agree	59	19.6
Agree	175	58.1
No Opinion	37	12.3
Disagree	28	9.3
Strongly Disagree	2	0.7
Total	301	100.0

Most participants agree that the community is a safe place to live. Approximately 77.7% of respondents either "agree" (58.1%) or "strongly agree" (19.6%) that the community is a safe place to live.

Individual Perception of the Educational System

My Community Has A:		
Strong Education System	Frequency	Valid Percent
Strongly Agree	66	21.4
Agree	151	48.9
No Opinion	57	18.4
Disagree	30	9.7

Strongly Disagree	5	1.6
Total	309	100.0

The educational system of the community ranked fairly high. Nearly 70.3% of those responding indicated that they either "agree" (48.9%) or "strongly agree" (21.4%) that the community has a solid educational system.

Behavioral Patterns

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

Perception of Individual Health Status

Perceived Health Status	Frequency	Valid Percent
Excellent	26	8.4
Very Good	90	29.2
Good	155	50.3
Fair	32	10.4
Poor	4	1.3
Don't Know/Not Sure	1	0.3
Total	308	100.0

Approximately 50.3% of respondents perceived their health status to be "good" and 29.2% perceived their health status to be "very good". Only 8.4% of participants stated their health status was "excellent".

Distribution of Patterns of Exercise

Frequency Of Exercise	Frequency	Valid Percent
Not At All	55	17.5
Occasionally	125	39.7
1-2 Times Each Week	69	21.9
3-4 Times Each Week	44	14.0
5 Or More Times Each Week	22	7.0
Total	315	100.0

Approximately 57.2 percent of respondents reported either not exercising (17.5%) or only occasionally exercising (39.7%). Only 7.0% of those participating in this survey reported exercising 5 or more times per week.

Distribution of Monthly Self-Breast Exam

Monthly Self Breast Exam	Frequency	Valid Percent
Yes	130	58.8
No	91	41.2
Total	221	100.0

Only female participants were asked to respond to the question concerning monthly self-breast examination. According to those surveyed, 58.8% of women reported completing a self-breast examination.

Distribution of Tobacco Use

Tobacco Use	Frequency	Valid Percent
Yes	55	17.2
No	264	82.8
Total	319	100.0

Most participants (82.8%) reported not using tobacco.

Distribution of Alcohol Use

Alcohol Use	Frequency	Valid Percent
Not At All	165	51.9
Occasionally	122	38.4
1-2 Times Each Week	13	4.1
3-4 Times Each Week	15	4.7
5 Or More Times Each Week	3	0.9
Total	318	100.0

Nearly 90.3% of participants reported never consuming alcohol (51.9%) or only consuming it occasionally (38.4%).

Distribution of Seat Belt Use

Seat Belt Use	Frequency	Valid Percent
Always	231	73.8
Mostly	49	15.7
Sometimes	30	9.6
Never	3	1.0

Total	313	100.0

The distribution of seatbelt use in the community is very high. Most participants reported always (73.8%) or mostly (15.7%) using seatbelts.

Distribution of the Perception of Diet

Diet	Frequency	Valid Percent
High In Fat	28	8.9
Medium In Fat	152	48.7
Low Fat	62	19.9
5 Daily Servings Of Fruits/Vegetables	26	8.3
2-4 Daily Servings Of Fruits/Vegetables	92	29.4
Rarely Eat Fruits/Vegetables	19	6.1

Participants were asked to indicate any all aspects of their personal diet that applied to daily life. Therefore, the data illustrated below represents multiple responses and percent totals do not equal 100%. Approximately 48.7% of respondents indicated their diet was medium in fat content. Slightly over 29.0% of those surveyed reported consuming 2 to 4 servings of vegetables each day.

Strategies for Controlling Stress

Controlling Stress	Frequency	Valid Percent
Exercise	114	36.2
Hobbies/Sports	84	26.7
Eating More Than Normal	52	16.5
Eating Less Than Normal	11	3.5
Smoking	28	8.9
Alcohol/Drugs	14	4.4
Medication	24	7.6
Talking To Friends	116	36.8
Talking To A Counselor	2	0.6
Direct It To Others	16	5.1
Prayer	176	55.9
Other	28	8.9

Participants were asked to indicate any all mechanisms of coping with stress that applied to daily life. Therefore, the data illustrated below represents multiple responses and percent totals do not equal 100%. Prayer (55.9%) was the most commonly reported strategy for controlling stress. However, talking to friends (36.8%), exercise (36.4%), and hobbies/sports (26.7%) were also commonly reported to control stress.

Healthcare Seeking Behavior

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

Distribution Reporting to Receive Regular Physicals

Receive Regular Physicals	Frequency	Valid Percent
Yes	234	76.2
No	73	23.8
Total	307	100.0

The majority of survey participants (76.2%) indicated they received physicals on a regular basis.

Distribution Reporting to Have a Regular Doctor

Have A Regular Doctor	Frequency	Valid Percent
Yes	259	84.4
No	48	15.6
Total	307	100.0

Most (84.4%) participants reported having a regular doctor.

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

Distribution of Insurance Type

Type Of Insurance	Frequency	Valid Percent
Uninsured	41	13.4
Pay Out Of Pocket	26	8.5
Medicaid	24	7.8
Medicare	63	20.5
Medicare Part D	17	5.5
Private Insurance	175	57.0

Approximately 57.0% of all respondents indicated having private insurance to pay for health care services. Medicare (20.5%) and Medicaid (7.8%) were reported by 28.3% of survey participants.

Distribution Reporting to Have a Regular Dentist

Regular Dentist	Frequency	Valid Percent
Yes	202	65.6
No	106	34.4
Total	308	100.0

Over 65.0% of respondents indicated having a regular dentist.

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

Distribution of Healthcare Service Location

Location Of Healthcare Services	Frequency	Valid Percent
Private Practice	247	79.7
Emergency Room	63	20.4
Health Department	6	1.9
Other	16	5.2

According to the data above, 79.7% of participants reported seeking health care from a private practice. The emergency room (20.4%) and the health department (1.9%) were additional sites for receiving health care services.

Distribution Reporting Cost as a Barrier to Healthcare

Cost As A Barrier To Healthcare	Frequency	Valid Percent
Yes	78	25.3
No	230	74.7
Total	308	100.0

Nearly 75.0% of respondents indicated that cost was not a barrier to receiving health care services.

Distribution Reporting Cost as a Barrier to Filling Prescription Medication

Cost As A Barrier To Prescription Medication	Frequency	Valid Percent
Yes	80	26.1
No	227	73.9
Total	307	100.0

Nearly 74.0% of respondents indicated that cost was not a barrier to filling a prescription medication.

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

Distribution Reporting Ambulatory Care Conditions

Ambulatory Care Conditions	Frequency	Valid Percent
Dehydration	22	44.9
Gastroenteritis	14	32.6
Kidney Infection	30	54.5
Bleeding/Perforated Ulcer	3	8.3
Pelvic Inflammatory Disease	3	8.6
Ear, Nose Throat Infections	36	65.5
Cellulitis	4	12.1
Dental Conditions	7	18.9
Diabetes	34	57.6
Asthma	19	44.2
Angina	4	11.1
Hypertension	23	46.9
Congestive Heart Failure	6	16.2
COPD	8	20.5
Trauma	58	71.6

Trauma (71.6%) was the most commonly reported ambulatory care condition reported by participants reporting admission to the emergency room. Ear/nose/throat infections (65,5%), hypertension (46.9%), kidney infection (54.5%), asthma (44.2%), diabetes (57.6%), and dehydration (44.9%) were also commonly reported conditions for emergency room admissions.

Local Hospital Services And Overall Satisfaction

Among participants surveyed, 71.5% used hospital services in the last 24 months.

Distribution of Health Care Utilization

Utilized Hospital Services	Frequency	Valid Percent
Memorial Hospital & Manor	221	90.2
Other	24	9.8
Total	245	100.0

Among those reporting using hospital services, 90.2% indicated using services at Memorial Hospital & Manor.

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

Reason for Healthcare Utilization

Reason For Service At Local Hospital	Frequency	Valid Percent
Physician Referral	82	35.8
Closer/More Convenient	126	55.0
Insurance	22	10.0
Quality Of Care	14	6.1
Availability Of Specialty Care	5	2.2
Other	14	6.1

Most participants reported using the local hospital because of convenience (55.0%). However, 35.8% reported being referred by a physician.

Distribution of Services Utilized

Specific Services Utilized	Frequency	Valid Percent
Radiologic Imaging	112	48.9
Laboratory	104	45.4
Other Outpatient Services	28	12.2
Inpatient Services	22	9.6
Emergency Room	93	40.6
Other	16	7.0

Respondents indicated using a variety services at the local hospital. Radiologic services (48.9%) and laboratory services (45.4%) were the most commonly reported services used by survey participants. The emergency room was used by 40.6% of those surveyed.

Level of Satisfaction of Services

Level Of Satisfaction With Service	Frequency	Valid Percent
Satisfied	182	81.6
Dissatisfied	30	13.5
Don't Know	11	4.9
Total	223	100.0

Over 81.0% of those surveyed indicated being satisfied with services while only 13.5% indicated dissatisfaction. The primary reasons for reporting dissatisfaction involved long wait times and hospital personnel interaction.

Distribution Reporting Utilizing a Primary Care Physician

Utilization Of A Primary Care Doctor	Frequency	Valid Percent
Yes	194	87.0
No	22	9.9
Don't Know	7	3.1
Total	223	100.0

Approximately 87.0% of those surveyed indicated using a primary care physician. Among those participants indicating to not use a primary care physician (9.9%), the table below illustrates the type of medical care provider utilized for routine healthcare.

Provider Location for Routine Care

Location Of Provider For Routine Care	Frequency	Valid Percent
Community Health Clinic	2	9.1
Rural Health Clinic	5	22.7
Hands Of Hope	10	45.5
Emergency Room	1	4.5
Specialist	4	18.2
Total	22	100.0

As indicated above, the Hands of Hope clinic was most often utilized in the absence of a primary care physician (45.5%).

Utilization of Primary Care at the Local Hospital

Utilization Of Primary Care At Local Hospital	Frequency	Valid Percent
Yes	181	81.2
No	35	15.7
Don't Know	7	3.1
Total	223	100.0

Nearly 81.2% of those surveyed reported using primary care services at the local hospital.

Level of Satisfaction with the Primary Care Provider

Level Of Satisfaction With The Primary Care Provider	Frequency	Valid Percent
Satisfied	163	86.7
Dissatisfied	13	6.9
Don't Know	12	6.4
Total	188	100.0

Among those using primary care providers at the hospital, the vast majority (86.7%) was satisfied with the services received.

Distribution Reporting Ease of Appointment with a Primary Care Provider

Ability To Get Appointment With A Primary Care Provider At The Local Hospital	Frequency	Valid Percent
Yes	163	84.5
No	22	11.4
Don't Know	8	4.1
Total	193	100.0

Most respondents (84.5%) indicated they were able to schedule an appointment with the primary care provider at the local hospital.

RESULTS: FOCUS GROUP ANALYSIS

Introduction: Participants' Characteristics

Memorial Hospital and Manor was encouraged to recruit three groups of 6-8 participants to take part in three focus groups. One group consisted of community advisory members (CAC), persons among the group of individuals the hospital recruited to actively participate in the needs assessment. The other two groups consisted of community members who were recruited by CAC members and referrals. Twenty-five participants took part in the three focus groups. All three focus groups took place at the Southwest Georgia Regional Library in Decatur County. Two focus groups were scheduled on the same day 1:30PM and 4:00PM, while the third group was conducted the next day at 3:00PM. The third group had fewer participants than the first two groups.

The three focus groups consisted of 25 participants: seven men and 18 women. Seventy-five percent of the sample was white (15) with 9 blacks, one participant did not report his/her race. All of the participants spoke English. Eighteen of the 20 participants lived in Bainbridge, three lived in Climax, with the other two participants lived in Attapulgus and Brinson. Participants' ages ranged from 25 years old to 81 years old, with a median age of 60. Participants education levels were as follows: six advanced degrees; six college degrees; five with some college; and eight completed high school. Participants' annual income levels included six with 100k or more; five persons with 75k – 100k; three with income levels 50k – 75k; seven person with 25k – 50k; two had income levels under 25k; and two participants provided no answer to that questions. The following sections divide the focus group discussions by common thread or topic.

Community

Theme: Safe and friendly; agriculture driven economy; 'small town effect;' school nutrition programs for children and other standard feeding programs for the elderly; other programs with available scholarships; current economic downturn as barrier to healthy lifestyle; too many fast food restaurants; and access to adequate health care

The majority of participants described Decatur County as a small rural town with an agriculture driven economy. Most participants said Decatur County is safe, but in recent years has experienced an increase in criminal activities. Participants also talked about Bainbridge being slow-paced, laid back, friendly environment and a place where 'everybody knows everybody'. One participant summed up the community by stating,

> *"It's a typical small, rural town. Farming. Agriculture's probably our number one industry here. Bainbridge. Is somewhat unique in the fact that where it's located that we have sometimes the potential for not a lot of economic growth in that we're like an hours from four major cities."*

Another participant said,

> *" So it's a balance in being a nice place to live where you got a nice small community that's fairly safe, clean, but yet there's a lot of our young people who would say, ' well, I just don't see much future living here.' There are not a lot of jobs."*

Participants recognized the down sides to everyone knowing everyone, since the familiarity of community members sometimes led to rumors. One participant said of a young person who expressed that

> *"Well I can tell something that a young person told me that left and went away. They said they'd never come back to Decatur County because everybody knew your business and I thought, yes. But it's true."*

Further, some of the participants talked about the school system in Decatur County to be progressive. When referred to the school system, they also included the local community college. More than a few of the participants talked about the natural resources in Bainbridge that bring tourism and other economically driven properties. They talked about a lake and river that bring certain events unique to the area – (i.e., bass tournament). A few of the participants saw people living in surrounding counties as an asset to Bainbridge.

Participants discussed several community programs to include Choice, a breakfast/lunch program through the schools that is available to students on a sliding scale. This same program has another extension called Backpack. Backpack provides school children food to take home for the weekend. A few participants talked about the availability of recreational areas that are not being used because of their locations and the lack of transportation for those who are likely to use them. One participant said,

> *"We have this great recreational area down toward the boat basin and we have all these baseball fields and now basketball courts and all that, but they're located way on the other side of town."*

Another participant agreed with the previous participant's statement by saying,

> *"If children's or kids…. if you don't have parents or somebody that can get you there… the kids are living over here and yet recreation is way over the other side of town. Because I know a lot of parents don't like kids riding bicycles and all, but it's way too far to walk and it's in a part of town that's kinda dangerous to ride a bicycle."*

Other community resources mentioned were Meal-on-Wheels for the elderly, homebound and shut-in, YMCA scholarships, the Friendship House Program, and a fee-based health program by the city. A few participants talked about a new clinic that the hospital was building in association with another project. Though other focus groups' participants just learned the new project during the session about, it is imperative that the hospital works in sharing its role in this endeavor with the community. One participant said,

> *"there's a clinic coming to town."*

Another participant, who also knew of this soon to be opened clinic, provided more information to the group by saying,

> *"It's supposed to be a group of doctors. Dr. {…} and I know two other women, a pediatrician and an internist are supposed to be where the old… office is… I'm thinking if we're gonna stay open till 7:00 at night, is that gonna be where everybody decides we need to run to the emergency room for those things."*

This same participant continues to say,

> *"Is that gonna meet the needs of the community? Is it gonna prevent some of these emergency room visits."*

Though they talked about available walking areas and the YMCA having some affordable programs and scholarships, they saw the economy as a barrier to maintaining a healthy lifestyle. The issue of eating healthy brought up the topic of the economy, jobs and healthy foods being much more expensive than the availability of cheap fast foods. Specifically, participants expressed there was too much fast food available in the community. One African American participant shared her observations when she talked about how the economy negatively affected the health of African Americans in Decatur County. The participant stated,

> *"With African Americans, which I'm a part of, it's at crisis level I would think because of things like the economy."*

This participant continued,

> *"It's a major part of the well-being of African American people and because they are doing the best that they can in feeding their families, but they might not be feeding them the correct things, the nutritious food and all of that. They don't have the money to buy it."*

A few participants thought access to adequate health insurance was a barrier to maintaining a healthy lifestyle, especially for the elderly. One participant shared her observation of the elderly in the community.

> *"It's just nothing too easy for the elderly people because some have to make choices whether I'm gonna eat today or buy medication."*

While two other participants concurred with her by saying,

> *"This is true, very true. I work with senior adults at our church and it's sad. It's really sad. It goes back to having adequate health insurance. Not being able to afford it."*

Moreover, participants were asked, what makes it hard to maintain a healthy lifestyle in Decatur County; they stated transportation as a barrier.

Community Issues

Theme: lack of employment opportunities, public transportation and entertainment; increase number of uninsured; lack of mental health professionals; chronic health conditions in adults and children; and illegal immigrants

Participants thought the lack of mental health professionals in Decatur County was a problem. One participant has an in-law, who requires mental health care, but travels out of town for services, as she said,

> *"I have a sister-in-law that requires mental health facilitation and as far as medication, she has to go to Thomasville to see a doctor. There's no doctor here that she can visit and see and that when she goes to Thomasville she has a set appointment. I believe it's about every three months."*

Participants also talked about the removal of certain programs, i.e., counseling in schools for young children because of lack of funding. Other health issues in this community include diabetes and obesity in both adults and children. A few participants talked about vitamin D deficiency and high rates of cancer (no specific type of cancer was mentioned.). One participant whose child has a vitamin D deficiency mentioned the family doctor shared with her that, people in Decatur County have a propensity to vitamin D deficiency because of too much time spent indoors and a lack of dairy in their diets. Participants discussed their way of eating in the south or 'southern diet.' In other words, a few of the participants said the way they learned to eat is cultural and that they are now being educated on healthy ways to eat by their grandchildren. As indicated by this participant,

> *"I think there's a cultural thing in the South, too, of how we were raised and it's hard to break the habits. I love fried chicken, fried fish, fried fat back, country ham, mashed potatoes. My wife says I'm a meat and bread man."*

In support of this participant's statement, another participant who has been observing her young grandchild's positive way of eating said,

> *"My grandchildren now are much more conscious about their lifestyle and what they eat than what I was at that age and still for that matter."*

Yet another issue that Decatur County faces is the issue of illegal immigrants who come to the area for seasonal agricultural work. This area of Georgia gets a lot of Haitians, Mexicans and other Hispanics who travel the country as seasonal workers. These seasonal workers (though many are believed to be illegal and live in fear of deportation) use the available services whether or not they can afford to pay for them.

Participants also talked about the disappearance of manufacturer and factories jobs in the area as in issue that the community faces, which leads to high unemployment and the possibly increase in crime. Criminal activities that were discussed include gang activities; illegal drugs, specifically – prescription, marijuana and cocaine; and substance abuse such as underage drinking. One participant said,

"Even in a small town there are some areas of town I won't go down to."

Less frequently mentioned but with conviction was the issue of teen pregnancy. A few participants talked about the federal government being responsible for this problem. These participants did not think the government being responsible for this problem was unique to Decatur County. They went on talking about government programs especially Medicaid is misused by a certain sect of the population, especially young people who may to want to stay in the 'system' long-term. These participants are convinced that these government programs are incomplete; therefore, that's the reason they are often misused. Participants also talked about the school system's limitation in providing any family planning resource as well as counseling to this at risk population. According to some of the participants many services including counseling to children in the school have been cut out of the schools' budgets because of the lack of funding. The only thing school nurses are allowed to do is dispensing medications and ensure children are properly immunized, but not provide counseling.

Although many thought Decatur County was a safe place to live, they also felt there was a lack of employment opportunities, lack of a transportation system, recreations and entertainment for young people in the county, because recreation centers are often located in areas of town where the youth would need transportation to access.

"Our recreation right now as far as our baseball and all these courts are being built on a far side of town that's almost impossible to get to by youth on their own."
"We're not getting any money into this town. It's either getting elderly or it's not coming into town, because they need to go somewhere else for a job, because they're not here."
"We don't have enough activities, which in a lot of ways cause problems because if you don't have those things in place, young people are gonna find things to do and it's not necessarily the positive things. So that is one shortcoming."

Among the other hindrances expressed about living in Bainbridge were employment opportunities for everyone, which many thought was driven by the current national economic crisis; insufficient public transportation; and an increased number of uninsured in the county, which they often attributed to lack of employment opportunities. As this participant confirmed by saying,

"We don't have available public transportation for some of our citizens."

Concerning the transportation issue county residents face, one participant said,

"It's a problem especially for some of the municipalities that are a good distance away from the hospital and other things in Bainbridge. They sometimes don't have transportation to be able to get to Bainbridge. I agree with you. That would be a very important aspect for our community."

Another talked about children walking and playing in the streets, because they don't have access to public transportation to get to the recreation center that is often located far from where they live. This participant said,

"When I look at the number of children that are just walking the street, playing in the street, playing basketball in the street just doing nothing – well it's good to them because that's all they have. How could we remedy that problem with transportation unless some serious responsibility is taken on the part of the parent or the city, which we don't look for the city to do that."

Some participants thought there were too many hoops or red tapes for patients to go through when they were in need of transportation to medical appointments. One participant indicated that

"This is what I think we need in Decatur County as far as medical, we need a bus, a medical bus that's got everything on it and you go where the patient is. That's a real need in Decatur County I think."

Community Summary

When it came to the challenges faced by Decatur County participants did not think theirs were unique from other small rural towns. Though they enjoyed living in a setting where everybody knows everybody, a safe and friendly environment to raise children, there are some society ills that cause stress – to include persistent unemployment, lack of public transportation and entertainment for the young. There are several resources available in the community, but many seem to not know about or be able to access them, because of they don't know or lack transportation. There is a number of people in the community who are in need of certain available services but do not use them because those services are traditionally advertised for the low income or marginalized in the community.

Hospital: Positive feedback

Theme: Family Feel, Good Services, Referrals when necessary

Participants were generally satisfied with the staff of the hospital, convenient location, advertising, and referrals. They felt, the hospital made significant improvements over time and understood that change was gradual.

Referring to the hospital's staff, one participant simply commented,

"Good People"

Another participant commented on the hospital's advertising,

"The hospital is proactive about getting the word out about new doctors, services, etc."

Another agreed with this comment and further explained the hospital's willingness to refer patients if necessary:

"And doctors will refer patients if they can't handle an issue"

One participant recognized that the hospital's services had greatly improved and explained her experience receiving a mammogram:

"*I feel like the hospital has turned around 110 percent. I was just out there earlier today getting a mammogram. I was in and out in 30 minutes, less than 30 minutes. Everyone was genuinely helpful and cheerful. My mother spent three days out there in August. Couldn't have asked for a better experience."*

Participants believed that the hospital was integral to the community and enjoyed receiving care from familiar faces:

"You couldn't have asked for better care in that you push a button and you're asking for some help, they were there to take care of you. It's kinda' comforting sometimes to know some of the faces that are in the hospital. It's like goin' back to the community. We know one another and sometimes we know too much about one another, but its comfort, too, that you recognize some of those faces of people taking care of you."

Participants also felt that hospital staff created a family environment:

"When we have situations, health situations in Decatur County, not only does the rural community come to help and assist and help care for, but also the family within the hospital."

Another participant agreed and further explained a positive experience with hospital staff:

"I almost bled to death 12 years after a surgery because of hemophilia. They didn't know that we had that at the moment and I had a nurse that moved in with me. She stayed in the room with these big computers and I thought, well I didn't realize I was bleedin' to death at that moment and I thought, boy, they sure do take good care of you here at this hospital, but they did take good care of me…the whole nursing staff."

The service that the hospital offers that seems to make the community the most proud are the health fairs. One participant stated:

"Their services are offered for health screenings, PSA tests, full blood work tests for about 10 percent of normal rates. For example, tests that would run normally $435.00 right now are available with this health fair for $30.00 or $20.00. They're severely discounted and you get the same test results that you would get if you went to the doctor and he ordered complete blood work done. So I think that's a great thing."

Participants were generally familiar with hospital services offered. When asked to name hospital services, they replied,

"X rays, Ultrasound, Mammography, Imaging Services, Blood Work, Life Flight, General Surgery, ENT, Small office for blood work, etc.., Physical therapy, Emergency care, Cardiologist, Urologist, Orthopedist, Gynecology, Oncology, and Team Lean weight loss challenge."

When asked if the community at-large is aware of these services, one participant replied,

> *"Community members know about services if the doctor has ordered them…not necessarily just because… But to me I'm not aware of these programs and I'm a citizen here. I'm not a real media savvy; I don't sit down and read the internet a lot. Probably a lot of my local news and interest come from reading Post Searchlight. I don't listen to a lot of radio programs. So I'm not hearing these things. So, there's got to be a better avenue or something to reach people like myself –Those who are sick and indigent know the hospital services well, but the general community member may not…"*

Participants agreed that lack of awareness may be an issue for some groups of community members, but one participant summarized the community's overall perception of the hospital by saying,

> *"We don't live in a perfect world and it's not perfect. But they do try."*

Hospital: Areas to be improved

Theme: Expand Services, increase morale and administrative issues

Although overall perceptions of the hospital were positive and there was a perception that the hospital is doing all it can within the financial constraints, participants felt, the hospital could be improved by expanding upon its current services, increasing staff morale, and addressing administrative issues.

Participants felt that the hospital could expand upon its already successful health fairs:

> *"Why couldn't you have a little children's health fair in the park and make it a fun thing and let the hospital get that together and let them do some little activities that's health related. I think that could be fun."*

Participants also felt that the hospital could improve the community by offering discounted medical services. This practice was observed at other hospitals and caused participants to sometimes travel great distances to receive the discounted services. Some participants also expressed a desire for the hospital to be more proactive:

> *"More preventative things in place, educational, preventative. If you're a diabetic is there a support group? Is there information out there? If I were to be told that I was a diabetic, what does that mean? What could happen to me in the future? What do I need to look forward to? What do I need to do to take care of myself? I really wouldn't know."*

Participants felt that service would be improved if the hospital brought in more physicians. Participants also experienced physicians referring them outside of the hospital. One participant relayed an experience as described by one of his fellow parishioners.

> *"There's a guy in our church said his doctor told him he had to have an MRI for something and his doctor told him, "You can have your MRI in Bainbridge, but I prefer*

that you go to Thomasville because it's gonna be a better MRI." Now do I understand that? No. I don't know what the difference is in the equipment. But when you got your own doctors in your own counties sayin' that…"

Participants also expressed problems with indigent care. They were concerned that those with insurance bear the financial burden of those who do not. They realized that this is a national problem. However, they would like to see a system implemented where those with insurance could receive help with hospital expenses as well. One participant explained the perceived burden indigent care places on those with insurance and the desire for the hospital's assistance:

"But also help the people who have insurance who's paying out of their pockets for the same service that a person that don't have any insurance. That's a problem at the hospital. 'Cause they would say I'm gonna garnish your wages and all this. And I went there one time and they said I'm gonna garnish your wages. It's no problem. I said yes, it is a problem, 'cause my wages have never garnisheed. I'm gonna find you this money and I'm gonna pay this money. Then I ask how do you help a person who don't have any insurance, who don't have any money? She said, well, we got this program and we just write them off."

The participants felt that although there has been a tremendous improvement in hospital services, hospital staff or "*front line employees,*" continue to have extremely poor morale. Accompanying this perception is the fact that some of the participants perceive that the hospital has new doctors/services versus older hospitals with more experience. Therefore, participants travel to friendlier, trusted facilities.

One participant explained that community members travel to other hospitals because of, *"sub-par experiences with hospital staff."* Participants also said that staff needed "*attitude adjustments*."

Participants expressed that recent changes in hospital administration caused issues such as lost jobs, retirement, etc. They believe that this has resulted in some employee dissatisfaction with being understaffed. The participants recommend that the administration place more emphasis on the front line employees such as the CNAs if they want to enhance the image of the hospital and increase patient/community satisfaction. One participant explained,

"*A lot of time big emphasis are spent or resources go to new technologies, new buildings, doctors who will hopefully generate pulling people in here to the hospital…but if your very basic care, if that level is lacking, then that's where your law suits and stuff come from because people get angry 'cause they feel like they haven't been taken care of.*"

Participants continued to address their dissatisfaction with hospitalists,

"Well I think we do have some problems with cooperation of doctors and the hospital. There are instances with some doctors. If you're a patient of a particular doctor, you need to go to the hospital, you may not have that doctor comin' around makin' rounds to make sure you're doin' fine. You're taken care of by other doctors, but if I have a family

doctor, I would like to have my particular family doctor doin' the rounds and makin' sure I'm okay."

Hospital administrators should also be aware of patients' concerns about the level of privacy at the hospital. One participant explained this discomfort:

"I do not like going into the lobby of the hospital to register for whatever screening I'm having done today or whatever testing I'm having done or for whatever purpose that I'm there. I agree with you. I've set back and anywhere in that lobby area and you can hear the entire conversation because of the way it's setup. There's nothing private about that."

Some of the participants also had a desire for visibility of the hospital administrator:

"I think that the hospital administrator should be out and about in that hospital. Now I know that the hospital administrator has some work that has to be done in an office, but I do know that he's in the cafeteria with the same people every day unless he goes to Rotary or somethin' like that. So he is seen in the cafeteria, but he's just not making himself visible throughout that hospital and I think that should be done."

Recommendations

Themes: Improve nursing home staff; collaborate with churches; expand upon health fairs; and reduced ER wait times

Participants recognized, the hospital was improving and that change could not take place over night. They were pleased with the services the hospital offers, but saw the need to enhance specialty care. They recommended changes in the dispositions of nursing home staff, particularly the CNAs, hospital parking and privacy, and desired some form of a walk-in clinic to reduce emergency room wait times. Participants recommended that the hospital partner with churches and further utilize the health fairs for the purposes of public relations. Furthermore, one participant expressed the Memorial Hospital and Manor could benefit from a merge with a bigger hospital system. The reason for this conclusion, the hospital does not have enough revenues, nor there was enough revenues coming in the county to stop the deterioration of the hospital.

Participants discussed desired hospital services, listing *primary care physicians, dermatology, neurologists, orthopedists, cardiologists, urologists, ultrasound, cancer treatment such as radiation and chemotherapy, and more preventative services*.

Participants expressed that even though these services were desired, it is essential to first improve staffing of CNAs at The Manor. One participant explained,

"I will say that I feel – I've also had someone at The Manor for several years. And I feel that the only weak link in The Manor is the CNA. I think the nurses are extremely dedicated. They work extremely hard. And I think that if I had to say two things that I

would like to see changed would be that they find a way to either hire people who are going to truly want to stay there, some way to screen them and train them, the CNAs."

Another participant explained the burden placed on the seniors when there is high CNA turnover or shift rotation:

"In The Manor, I think that for elderly people it is very difficult when there is so much rotation. I really feel that if they would let the CNAs and the nurses stay in the same wing day after day after day instead of moving them from place to place rotating that it would not be as confusing for the older people. They like the familiar faces. And, also, a lot of communication about that person's health is dropped when there's someone different in every day."

Participants were concerned with the nursing home staff attentiveness to its residents. One participant explained her concern about the amount of nourishment the seniors received throughout the day:

"One thing I would like to see as far as the nursing home is that they have somebody – if they had to hire extra staff to feed those people, to feed them, because some of 'em plate, I have stood up in the dining room and some of 'em plate just be right there in front of 'em. When they leave that plate might still be there. I would love to see a change in that, because I feel like that they are not getting their nourishment because they are not eating. It could be breakfast. It could be lunch. And it could be supper. And they might not have eaten anything, because they don't have nobody to feed them."

Participants also wanted increased health education, especially for seniors and agreed that the churches could collaborate with the hospital to improve community health education and outcomes. One participant explained her vision for this partnership:

"Public relations for education If you had public relations that could go to the senior center and talk to those folks down there or maybe to a Wednesday night supper at a church, you've got an eclectic group within a church body because you've got those from the higher end, you got those from the lower end and all in between. Or even through the schools."

Another participant explained how the church could assist the hospital and community in addressing issues with young people to educate youth about teenage pregnancy and its consequences among other issues:

"[The church could assist] in our young people lives as well. We go to church. They have church. We go home. And we really a lot of times don't consider our young people. We see things happening within our church with our young people and we ignore it. And the church has a big part that they should pay – all churches with different things."

Other topics discussed include for the Memorial Hospital and Manor to educate the community by tagging along with other health related programs in the community especially in local

churches. One participant suggested if there is a blood drive going on during Wednesday night Bible Study; the hospital can attach another health related program to what's already going on.one participant said,

> *"This is something that's going on in Climax through the Baptist Church and this is something you could do, other churches could do it to make people more are of health – when you see a blood mobile parked in the parking out of your church on Wednesday nights say like from 4:30 in the afternoon to 8:00 and anybody that comes and goes out of that church can give blood, you've got a chance to communicate with people."*

Participants also had recommendations that were specific to the hospital. Participants believed that the hospital would benefit from being bought by a larger hospital system. They also recommended that the hospital improve access to the facility by improving parking. Some participants explained that the hospital had fought its acquisition by another hospital. However, one participant explained that from a participant's viewpoint, it would increase health care access within the county:

> *"Allow a larger hospital to buy us. That would give us the opportunity to have better facilities and better doctors."*

One participant explained the parking situation at the hospital:

> *"Another thing that I would like to see is better parking at the hospital. They have improved over the years, but they have so much green space out front, I believe they could do a better job of adding more parking to make it a little bit more convenient because the nursing home is next door and sometimes if the nursing home is having programs, you just about can't get a parking place."*

Recommendations for the internal environment of the hospital were related to shorter ER wait times, the establishment of a walk-in clinic for non-emergent situations, and increased privacy. One participant who had previously surveyed the community concerning the hospital said,

> *"Well all my surveys, they said shorter time in the ER. Just about every one of them was fussin' about the amount of time they had to wait in the ER to be seen. I don't know what that's about or anything, but I did notice that was mentioned a few times."*

Another participant offered a solution to long ER wait times and discussion began among participants concerning swing beds or a walk-in clinic:

> *"I can think of one thing just from experience is in the rehab when they put you in a swing bed is what they call it, you go in there. You're not hospitalized. You're not nursing home. You're in between. Your expectations are to get out of there within a certain amount of time. That is setup instead of the tiny little bathrooms. It's made more along the lines for handicapped people. There are showers in the room. I know that they don't fill all the rooms in some of that wing with persons that are in rehab so they're just empty. So why not utilize some of those rooms and make private bathrooms that go along*

with these rooms. If I were to go back in this is what I would want. Just to make it more user friendly than there's one bathroom down the hall that you have to take your loved one to or you've got to find out a way to get down there to take a shower."

Participants agreed and expressed the need for a walk-in clinic to help reduce long ER wait times:

"Well if you have a walk-in clinic that's non-emergency that would alleviate that, a lot of that [long wait times]."

Participants believed that the hospital should capitalize on the already successful health fairs it holds. Community members recommended that a public relations designee be sent to the health fairs to enhance the image of the hospital and community health education.

"You know the little farmers market thing in the park and we have lunch in the park and -- what is it. The music in the park, the brown bag. Why couldn't you have a little children's health fair in the park and make it a fun thing and let the hospital get that together and let them do some little activities that's health related. I think that could be fun."

Another participant suggested that representatives from the hospital attend the health fairs:

"Well and when they have their health fair at the hospital, maybe they could have some representatives from the different departments present."

The expansion of the hospital's current parking lot. A participant noted,

"Another thing that I would like to see is better parking at the hospital. They have improved over the years, but they have so much green space out front, I believe they could do a better job of adding more parking to make it a little bit more convenient because the nursing home is next door and sometimes it's the nursing home is having programs, you just about can't get a parking place."

Finally, participants believed that if the hospital worked with the community to develop resources, relationships, and connections with physicians, they would remain in the area. One participant relayed a conversation he recently had with a local physician. The physician said,

"My wife and when we first came to town, we were so fortunate. We went to church and got in with a really neat group of people and said we are just really happy with our personal social life in this town." So see, I think because of that and it's been again the quality of life in this town"

Community Vision County

When participants were asked about improvements they would like to see in the community in the next five years, many said they would like to see more doctors, the availability of mental health care, and a decrease in obesity. Additionally, a few participants talked about removing the current label that may be seen as negative to certain programs. For instance, some people

perceive the available transportation program as one which serves the needy. This program and those who use it in the community are seeing as low income and stigmatized. The community would like have a transportation program for all to access without a specific label attached. One participant talked about a much needed medical bus to be available for everyone, but this bus cannot be associated with a certain sect of the community – especially the low income, one participant said,

> *"If we can her get it, it needs to be understood it is for everybody. It is not if you're poor because there's a stigma with older people. A lot of time they don't wanna use something if they think it's for the poor. We don't need to label these kinds of things."*

COMMUNITY ASSETS

Decatur County Assets

Name of the company	Phone number	Address	Services
Memorial Hospital & Manor	(229) 246-3500	1500 E Shotwell St, Bainbridge, GA 39819	Hospitals, Medical Clinics, Nursing Homes-Skilled Nursing Facility
John D Archbold Memorial Hosp	(229) 246-0492	700 Gordon Ave, Bainbridge, GA 39819	Hospitals
United Way	(229) 246-9288	Bainbridge County United, Bainbridge, GA 39817	Community Organizations
New Beginnings Community Outreach Program	(229) 246-9050	617 S West St, Bainbridge, GA 39819	Community Organizations
Decatur County Dialysis Facility	(229) 243-0280	700 Gordon Ave, Bainbridge, GA 39819	Clinics, Dialysis Services
Bainbridge Healthcare	(229) 243-0931	1155 W College St, Bainbridge, GA 39819	Medical Clinics, Nursing & Convalescent Homes, Nursing Homes-Skilled Nursing Facility
Bainbridge Specialty Clinic	(229) 246-6555	1323 E Shotwell St, Bainbridge, GA 39819	Medical Clinics, Physicians & Surgeons, Orthopedics
My Senior Care	(888) 258-9535	Bainbridge Area	Home Health Services, Alzheimer's Care & Services
Tristate Home Medical	(229) 243-0093	1420 E Evans St, Bainbridge, GA 39819	Home Health Services, Hospital Equipment & Supplies, Eldercare-Home Health Services

Samaratian Counseling Ctr	(229) 243-1633	410 S West St, Bainbridge, GA 39819	Counseling Services, Counselors-Licensed Professional, Marriage, Family, Child & Individual Counselors
Decatur County Senior Center	(229) 246-8672	402 W Water St, Bainbridge, GA 39817	Senior Citizen Counseling, Senior Citizens Services & Organizations

Seminole County Assets

Name of the company	Phone number	Address	Services
Donalsonville Hospital	(229) 524-5217	102 Hospital Cir, Donalsonville, GA 39845	Hospitals, Nursing Homes-Skilled Nursing Facility, Surgery Centers
Donalsonville Hospital Women	(229) 524-8378	900 N Wiley Ave, Donalsonville, GA 39845	Hospital
Waddell Andrea MD Dermatologists	(229) 524-2706	102 Hospital Cir, Donalsonville, GA 39845	Medical Clinics, Physicians & Surgeons, Dermatology, Physicians & Surgeons
Nunez Jessica MD Ob-Gyn	(229) 524-8489	102 Hospital Cir, Donalsonville, GA 39845	Medical Clinics, Physicians & Surgeons, Obstetrics And Gynecology, Physicians & Surgeons
Martin Dion MD Pediatrics	(229) 524-1307	102 Hospital Cir, Donalsonville, GA 39845	Medical Clinics, Physicians & Surgeons,

			Pediatrics, Physicians & Surgeons
Southwest Georgia Community Action Council	(229) 524-5494	1121 E 3rd St, Donalsonville, GA 39845	Community Organizations
Southwest Georgia Community Action Child Dev Center	(229) 524-6060	710 W Crawford St, Donalsonville, GA 39845	Community Organizations, Social Service Organizations

PRIORITIZATION

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

A. Community Health Education (Exercise, Diet, Tobacco)
B. Community Image of the Hospital (Morale, Turnover, Wait-time)
C. Mental Health
D. Economic Development (Unemployment, Poverty)
E. Cancer
F. Heart Disease
G. Access to Healthcare (Transportation, Cost, Issues Affecting elderly)
H. Issues Involving Youth (Teen Pregnancy, Lack of Recreational Activities)
I. Diabetes
J. Respiratory Disease/Asthma
K. Dental Care

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

Community Issue	# Ranking Issue	Size of Problem*	Seriousness of Problem*	Effectiveness of Possible Intervention*	Basic Priority Ranking
Community Image of the Hospital (Morale, Turnover, Wait-time)	16	7.4	11.9	9.0	57.9
Community Health Education (Exercise, Diet, Tobacco)	16	8.1	14.4	7.7	57.7
Economic Development (Unemployment, Poverty)	16	9.6	16.7	6.1	53.7
Access to Healthcare (Transportation, Cost, Issues Affecting elderly)	16	7.5	15.0	7.1	53.4
Heart Disease	16	7.3	15.1	6.8	50.7
Mental Health	16	6.6	14.4	6.9	48.1
Diabetes	16	7.1	14.6	6.3	45.8
Issues Involving Youth (Teen Pregnancy, Lack of Recreational Activities)	16	6.8	13.0	6.4	42.1
Cancer	16	7.3	12.9	5.6	38.0
Respiratory Disease/Asthma	16	6.2	11.6	5.7	33.8
Dental Care	16	4.0	7.9	3.9	15.3

*Represent average score of all participants ranking a particular issue

According to the results, “Community Image of the Hospital” ranked highest according to the calculated BPR score. This issue was followed closely by “Community Health Education.” “Economic Development”, “Access to Healthcare”, “Heart Disease”, “Mental Health”, “Diabetes”, “Issues Involving Youth”, and “Cancer” also ranked high.

HOSPITAL CHALLENGES

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

- Initially, the hospital administrator expressed reluctance to participate in the initiative. He expressed uncertainties that he would need our assistance in completing the CHNA.
- The logistics of scheduling CAC meetings and assignment of specific roles and responsibilities created a challenge for Memorial Hospital and Manor. In some instances, ambiguity reduced team cohesion in moving the initiative forward. This may have resulted in the failure to follow CHNA recommendations more closely and not reading specific instructions outlined in email correspondence.
- The timely receipt of requested documents was a challenge. This was due in large part to the need to balance current job responsibilities and roles with the demands of the CHNA initiative

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LIST OF APPENDICES

APPENDIX A

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

Health Department CEOs contact Information

Hospital	County Health Department (physical location)	CEO	Email Address	HD Phone #
Bacon Regional Hosital	101 N Wayne Street Alma, GA 31510	Cathy Taylor, BSN		912-632-4712
Chatuge Regional Hospital	1104 Jack Dayton Circle Young Harris , GA 30582	Roxanne Barrett, RN	rsbarrett@dhr.state.ga.us	706-896-2265
Clinch County Hospital	285 Sweat Street Homerville, GA 31634	Beth Jones, Nurse Manager	dbjones9@dhr.state.ga.us	912-487-2199
Evans Memorial Hospital	4 N Newton Street Claxton, GA 30417	Keisha Welch, Nurse Manager		912-739-2088
Jasper Memorial Hospital	336 E Greene Street Monticello, GA 31064	Lisa Kersey, General Operations Generalist	ltkersey3@dhr.state.ga.us	706-468-6850
Jeff Davis Hospital	30 E Sycamore Street Hazlehurst, GA 31539	Patty Ellis, Nurse Manager	paellis@dhr.state.ga.us	912-375-2425
Jefferson Hospital	2501 US 1 North Louisville, GA 30430			478-625-3716
Miller County Hospital	250 West Pine Street Colquitt, GA 39837	Suzanne Fetner, Director	ssfetner@dhr.state.ga.us	229-758-3344
Monroe County Hospital	106 Martin Luther King, Jr. Drive Forsyth, GA 31029	Janet Freeman, Nurse Manager	jjfreeman@dhr.state.ga.us	478-992-5082
Morgan Memorial Hospital	2005 South Main St. Suite 200 Madison, GA 30650	Mary Alice Gilbert, Nurse Manager	magilbert@dhr.state.ga.us	706-752-1266
Phoebe Worth Medical Center	1012 West Franklin Street Sylvester, GA 31791			229-777-2150
Taylor Regional Hospital	301 N Lumpkin Hawkinsville, GA 31036			478-783-1361
Union General Hospital	67 Chase St. Blairsville, GA 30512	Janice Lance, Nurse Manager		706-745-6292
Washington County Medical Center	201 Morningside Drive Sandersville, GA 31082	Deryl Scarboro, Nurse Manager	dhscarboro@dhr.state.ga.us	478-552-3210
Memorial Hospital & Manor	928 West Street Bainbridge, GA 39819	Sherry Hutchins, Director	slhutchins@dhr.state.ga.us	229-248-3055
Meadows Regional Medical Center	714 NW Broad Street Lyons, GA 30436	Tabitha Hutto, Nurse Manager		912-526-8108
Stephens County Hospital	64 Boulevard Suite 120 Toccoa, GA 30577			706-282-4507
Louis Smith Memorial Hospital	53 West Murrell Street Lakeland, GA 31635	Maggie King, Nurse Manager		229-482-3294

Updated: 7/5/12

APPENDIX B

Georgia Southern University
Office of Research Services & Sponsored Programs

Institutional Review Board (IRB)

Phone: 912-478-0843
Fax: 912-478-0719
IRB@GeorgiaSouthern.edu
Veazey Hall 2021
P.O. Box 8005
Statesboro, GA 30460

To:	Dr. Stuart Tedders Dr. Raymona Lawrence
CC:	Charles E. Patterson Vice President for Research and Dean of the Graduate College
From:	Office of Research Services and Sponsored Programs Administrative Support Office for Research Oversight Committees (IACUC/IBC/IRB)
Initial Approval Date:	08/14/12
Expiration Date:	06/30/13
Subject:	Status of Application for Approval to Utilize Human Subjects in Research

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

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

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

Sincerely,

Eleanor Haynes
Compliance Officer

APPENDIX C

Community Health Needs Assessment

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

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

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

Jiann-Ping Hsu College of Public Health Team Contact Information

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Stuart Tedders, PhD, MS
Principal Investigator
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Phone: (912) 478-1922

APPENDIX D

JIANN-PING HSU COLLEGE OF PUBLIC HEALTH 徐建萍公共卫生学院

Community Health Needs Assessment
Project Activity Outline

1. Steering committee is to consist of up to 7 members

2. Suggestions for steering committee membership
   a. Hospital administrator
   b. Hospital marketing personnel
   c. Health department representative
   d. Hospital governing board member
   e. Local government representative
   f. Social service agency representative
   g. Other community members to consider
      i. Patient representative
      ii. Community leader
      iii. Other relevant community representation

3. Steering committee roles/responsibilities
   a. Identify and designate Medical Service Area
   b. Identify community leaders to serve in on the Community Advisory Committee (CAC)
      i. A group of **15-25 members** which represents a cross-section of the medical service area
   c. Develop **press releases** to get the word out to the community
   d. Draft invitation letters to send to potential CAC members
   e. Select someone from the group to take meeting notes
   f. Develop and circulate meeting agendas
   g. Assist in data collect strategies and timeline development
   h. Participate in all site steering committee activities

4. Activities **prior** to Steering Committee **meeting 1** (Facilitator and steering committee)
   a. Identify and designate Medical Service Area
   b. Start to gather information on potential CAC members
   c. Overview of hospital services and community benefits
   d. Community input tool
      i. Survey questionnaire
      ii. Focus group

****Steering Committees may opt to have more meetings, but we would like to have <u>at least</u> three meetings.**

JIANN-PING HSU COLLEGE OF PUBLIC HEALTH 俊邦公共卫生学院

Community Health Needs Assessment
Project Activity Outline

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

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

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

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

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

****Steering Committees may opt to have more meetings, but we would like to have <u>at least</u> three meetings.**

10. Post-Meeting Activities **meeting 4**
    a. List and prioritize Community Health Needs
    b. Develop possible implementation and strategic/responsibilities
    c. Publish Community Health Needs
    d. Develop Action Plan
    e. Implement Action Plan with Partners

****Steering Committees may opt to have more meetings, but we would like to have <u>at least</u> three meetings.**

APPENDIX E

Memorial Hospital and Manor Steering Group Members					
Sectors	**Members**	**Title**	**E-mail**	**Phone Contact**	**Address**
Hospital	Billy Walker	CEO	billyw@mh-m.org	(229) 243-6109	
Hospital	Lee Harris	Assistant Administrator for Support Services	leeh@mh-m.org	(229) 243-6103	
Hospital	Cynthia Vickers	Assistant Administrator	cynthiav@mh-m.org	(229) 243-6111	
Hospital	Angel Sykes	HR Manager/ Chief of Culture and People	angels@mh-m.org	(229) 243-6100, Ext. 432	
Hospital	Karen Faircloth	Chief Financial Officer	karenf@mh-m.org	(229) 243-6100 ext. (495)	
Hospital	Jan Bennett	Director of Physician Relations and Quality/Risk Management	janb@mh-m.org	(229) 243-6267	
Hospital	Dolores Eidson	Registered Nurse	delorise@mh-m.org	(229) 243-6151	
Hospital	Jan Godwin	Director of Public Relations and Patient Representative	jang@mh-m.org	(229) 243-6187	

Memorial Hospital and Manor Steering Group Members Bio-sketches	
Name	
Billy Walker, CEO	A resident of Decatur County since 1992 and joined Memorial Hospital and Manor in November 2000. He is currently serving as the Chief Executive Officer, a position he has held since March 2011. Prior to being selected as the Chief Executive Officer, he served as the Chief Financial Officer. Billy grew up in Blackshear, Georgia, and graduated from Mercer University with a Bachelor of Business Administration degree and a major in Accounting. He is a licensed CPA and has work experience with a public accounting firm and the private industry. He is married to the former Rhonda Godwin of Bainbridge, Georgia. They have three children, Trey, Matthew, and Ansley.
Lee Harris	A native of North Carolina and has been a member of the management team at Memorial Hospital and Manor since 1989. He currently serves in the role of Assistant Administrator for Support Services. Lee grew up in Stone Mountain, Georgia and graduated from Emory University with a Bachelor of Science degree in Biology. He continued his education at Georgia State University, earning both a Master of Business Administration in Finance, as well as a Master of Health Administration degree. Lee is married to the former Julie Kyle of Atlanta, Georgia. They have three sons, Kyle, Chase and Caleb.
Cynthia Vickers	Cynthia Vickers hired at Memorial Hospital in September 1983, initially as ICU Nurse Supervisor. In February 1984, she became Director of Nursing of both Memorial Hospital and Memorial Manor. Her responsibilities now include Assistant Administrator over Nursing, Pharmacy, Rehab, Education, Infection Control, Willow Ridge Personal Care Home and Administrator of Memorial Manor Nursing Home. Cynthia graduated from Valdosta State College with a Bachelor of Science degree in Nursing. Cynthia resides in Whigham and is married to Shaw Vickers. They are the parents of two adult children.
Angel Sykes	A lifelong resident of Bainbridge. Angel Sykes is the new Chief Culture and People Officer at Memorial Hospital and Manor. Her work involves leading "BRIDGE to Excellence," a patient-centered excellence initiative, and maintaining the BRIDGE culture throughout the entire facility. She began working at Memorial Hospital and Manor in 1994, and transferred to the Human Resources Department in 1996. She

	served as the Human Resources Manager from 2001 until her change to the Chief Culture Officer in March 2013. Angel graduated from Georgia Southwestern University with the Bachelor of Arts degree in Business Administration. She has a 5-year old daughter, Isabella Marie.
Karen Faircloth	A lifelong resident of Decatur County. She has been an employee of Memorial Hospital and Manor for 37 years and has worked in the areas of Registration, Data Processing, Claims Specialist, Patient Relations and Finance. Karen currently serves in the role of Chief Financial Officer. She is an advanced member of Hospital Financial Management Association. Karen is married to her high school sweetheart, Leonard. They have two children, Roger and Katy, and two grandchildren, Ben and Valley. Karen is a volunteer with the American Red Cross and the American Cancer Society.
Jan Bennett	Jan Bennett has worked at Memorial Hospital and Manor for the past three years as Director of Physician Relations, Quality Management, and Risk Management. She has over 20 years' experience in the hospital's quality management and utilization review department. She graduated from Thomas University with a Master of Science degree in Nursing.
Delores Eidson	Delores Eidson has a BS in Education from Evangel College in Springfield, Missouri and an Associate Degree in Nursing from Darton College. She has worked as an RN at Memorial Hospital and Manor for 22 years and worked as a nursing assistant for 4 years before earning her ADN Degree. Delores has been a part time Instructor in Nursing Health at Bainbridge College for the last 20 years. She and her husband, Dane, have three sons and eight grandchildren.
Jan Godwin	Jan Godwin began working at Memorial Hospital and Manor in 1996 as Director of Public Relations and Patient Representative. In 2002, her position changed to Director of Public Relations and Volunteer Services, and in 2013 her position was reclassified to Marketing and Volunteer Services Coordinator. Jan graduated from Bainbridge College with Associate degrees in English and Secretarial Science. In 2005, she graduated cum laude from the Florida State University with a Bachelor of Arts degree in Communication with Public Relations Emphasis. She is a member of the Georgia Society of Healthcare Marketing and Public Relations. Jan is a lifelong resident of Decatur County and currently serves on the Decatur County Board of Commissioners. Jan has also worked for three years at Bainbridge College as a part-time instructor

	in the Health Occupations and Professional Services Division. She is the mother of two adult sons.

APPENDIX F

PROPOSED COMMUNITY ADVISORY COMMITTEE INVITATION LETTER

Dear (***County/Community***) Leader:

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

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

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

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

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

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

Sincerely,

APPENDIX G

Potential Community Advisory Committee Members

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

APPENDIX H

Memorial Hospital and Manor Community Advisory Committee Members					
Name	**Occupation**	**Business/Agency**	**County**	**Phone**	**Email**
Helen Sanders	Retired Juvenile Probation Officer	Volunteer, Memorial Hospital and Manor	Decatur	246-3628	
Josephine Biggles	Retired	Volunteer, Memorial Hospital and Manor	Decatur	246-0192	
Connie Snyder	Dean of Student Services	Bainbridge College	Decatur	248-2517	csnyder@bainbridge.edu
Roslyn Palmer	Councilwoman Retired Retailer	Bainbridge City Council	Decatur	246-2124	
Martin Bius	Ag Teacher Young Farmer Coordinator	Bainbridge High School	Decatur	254-3886	mbius@dcboe.com
Kim Jeter	Homemaker	Faceville Community	Decatur	220-2416	Can't attend first meeting.
Liv Warren	Certified Personal Trainer	Retired, YMCA	Decatur	220-4291	
Edward Reynolds	Mayor Pharmacist	Mayor, City of Bainbridge Bainbridge Pharmacy	Decatur	246-7200	edward@bainbridgepharmacy.com
Jay Leverett	Dentist	Jack Leverett, Jr., DMD	Decatur	246-1548	jleverettjr@gmail.com
Alan Davis	Farmer	Davis Farms	Decatur	400-1969	

David (Butch) Mosley	County Commissioner Retired School Supt.	Decatur County	Decatur	400-0911	
Matt Palmer	Insurance Agent	Palmer Insurance	Decatur	246-3873	rmattpalmer@gmail.com
Cassandra Bouie	Phlebotomist	Memorial Hospital and Manor	Decatur	465-3450	
David Conoly	Farm Manager	Tomato Grower	Decatur	246-6580	
Ruthie Giles	Retired, DFACS	Volunteer, Memorial Hospital and Manor	Decatur	515-3038	rmgiles@yahoo.com
Vivian Hill	Retired	Volunteer, Memorial Hospital and Manor	Decatur	246-4327	
Charles Tyson	Realtor Retired City Manager	DeHildren Realty Chairman, Hospital Authority	Decatur		
Ronnie Burke	LMSW	Family Connections	Decatur	309-9032	rcburke@windstream.net Can't attend first meeting.
Sherry Hutchins	Health Dept. Director	Decatur Co. Health Dept.	Decatur	248-3055, Ext. 210	slhutchins@dhr.state.ga.us
Janice Kell	Retired Teacher	Volunteer, Memorial Hospital and Manor	Decatur	246-0956	jkell@mchsi.com

APPENDIX I

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

Objectives

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

New IRS mandate

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

Project overview

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

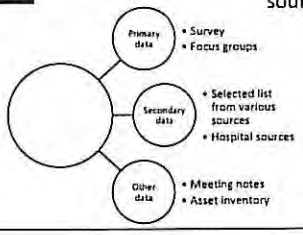
The contract

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

Participating Hospitals

Health District	Counties	Hospitals
North	Towns, Union, Stephens	Chatuge Regional; Union General; Stephens County
North Central	Jasper, Monroe, Washington	Jasper Memorial; Monroe County; Washington County Regional
Northeast	Morgan	Morgan Memorial
South Central	Pulaski	Taylor Regional
East Central	Jefferson	Jefferson Hospital
South	Lanier	Lanier Memorial
Southeast	Bacon, Evans, Jeff Davis, Clinch, Toombs	Bacon County; Evans Memorial; Jeff Davis; Clinch; Meadows Regional
Southwest	Miller, Decatur, Worth	Miller County Memorial Hospital & Manor; Phoebe Worth Medical

Data collection methodologies & sources



Next Steps

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

Proposed Timeline

	June – August	Sept-Dec	Jan-Mar (2013)	Apr-May 2013
Activities	Preparation and planning; community engagement; data collection	Data collection and analysis	Data collection and analysis	Deliverables and dissemination
	• Form steering group and CAC • Establish regular meetings with group. • Develop roles/duties of CAC • Determine medical service area • Provide feedback on survey • Develop data collection strategy (ies) for survey and focus group • Begin data collection	• Complete data collection (survey and focus groups) • Asset inventory • Data collection and analysis (1° & 2°)	• Data collection and analysis (1° & 2°) • Asset mapping data collection • Report write up	Report write up and data dissemination

Your thoughts and ideas

APPENDIX J

Community Health Needs Assessment

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

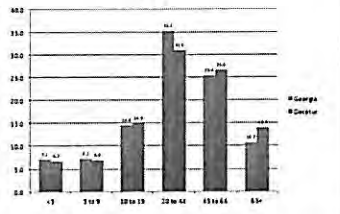
Objectives

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

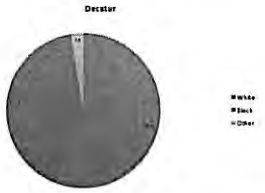
A Brief Snapshot of the Community

Decatur County

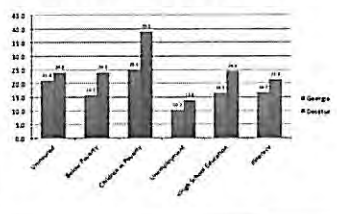
Age



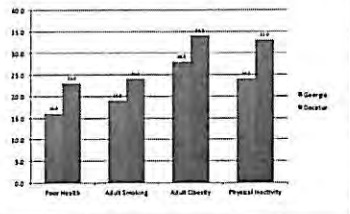
Race



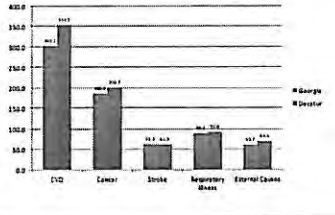
Socio-Economic Status Indicators



Health Status Indicators



Health Status Indicators



Why Are We Here?

The IRS Mandate

Project Overview

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

What is a Community Health Assessment?

The Process

Simply Defined

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

In a Nutshell …

Health Assessments Are the Starting Point for Solving Complex Community Problems

Three Phases of Completing a Community Health Assessment

Completing a Community Health Assessment

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

Focus Group 101

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

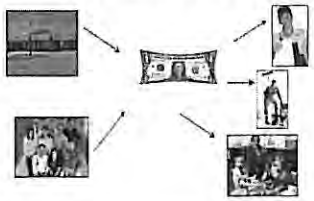
Why **You** Are So Important in Completing an Assessment of the Community?

Because **YOU ARE** the Community

Specifically, We Need ...

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

Economic Impact of the Hospital



Survey Completion

Community Advisory Committee

Survey Distribution/Focus Group Recruitment

Helpful Hints

Helpful Hints

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

HOWEVER ...

Make sure everyone knows that participation is ***VOLUNTARY***

Do not coerce participation

Actual Administration of Surveys

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

Next Steps

Conducting Focus Groups

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

It Is Time To Hear From You

Discussion of the Issues

For Additional Information

Please contact:

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

APPENDIX K

Community Health Assessment

Prioritization of Issues

Stuart H. Tedders, PhD, MS
Raymona Lawrence, DrPH, MPH
Maria Denis Luque, MSPH, MPH
James Wells, BS

Jiann-Ping Hsu College of Public Health
Georgia Southern University

Objectives

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

Purpose of the Project

Purpose

- To provide technical assistance to 18 nonprofit hospitals in completing the **Community Health Needs Assessment** as mandated IRS.
  - Service/Target Area:
    - Decatur County
    - Seminole County

Community Health Assessment (CHA)

A Review of the Process

Community Health Assessment

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

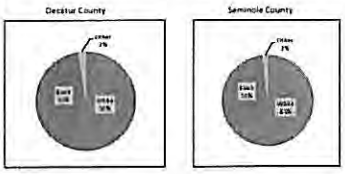
Phases of a CHA

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

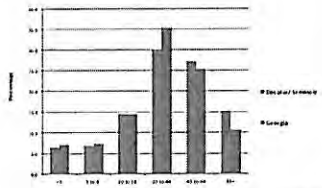
Secondary Data

Highlights

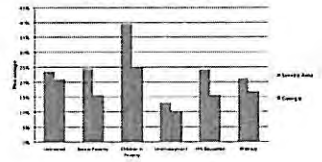
Race



Age



Social Indicators

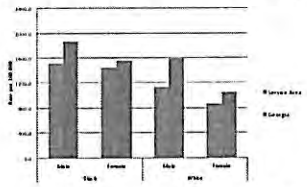


Leading Causes of Morbidity

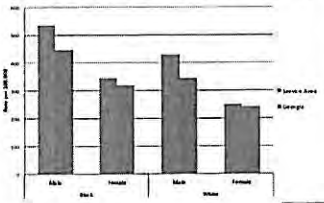
Leading Causes of Mortality

Select Trends in Morbidity & Mortality

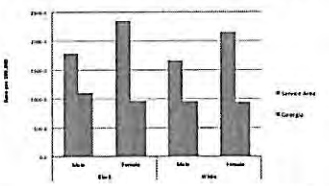
Cardiovascular Disease Morbidity



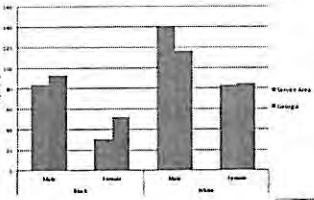
Cardiovascular Disease Mortality

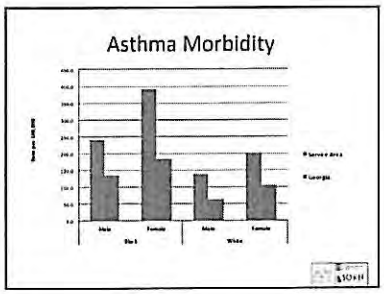


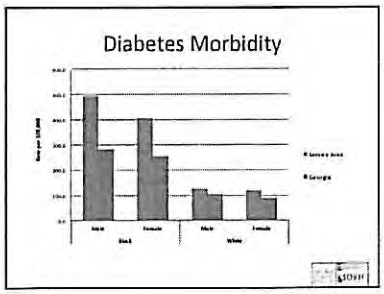
Respiratory Disease Morbidity

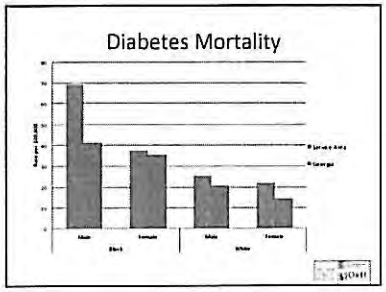


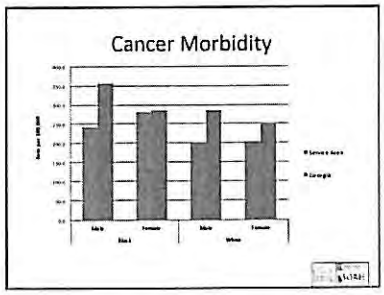
Respiratory Disease Mortality

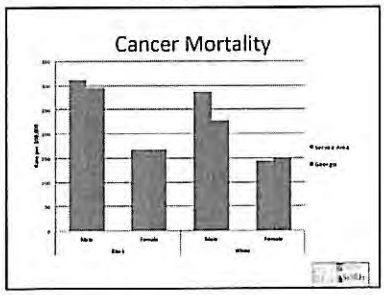


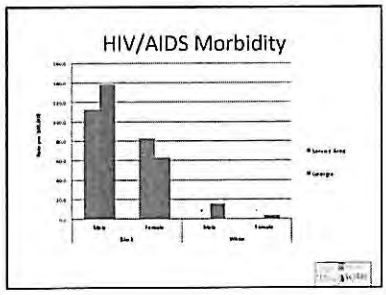

Asthma Morbidity

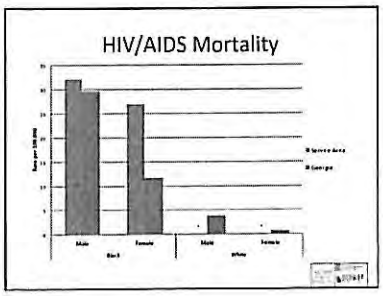

Diabetes Morbidity

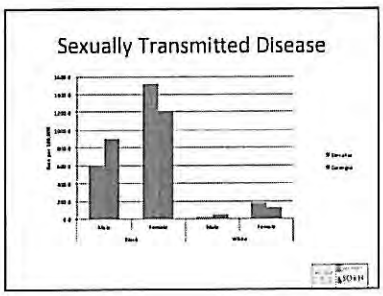

Diabetes Mortality

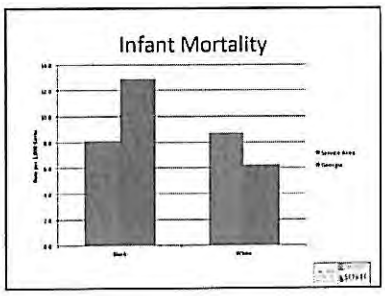

Cancer Morbidity


Cancer Mortality

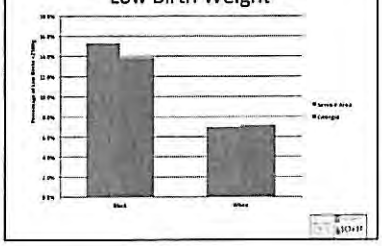

HIV/AIDS Morbidity


HIV/AIDS Mortality

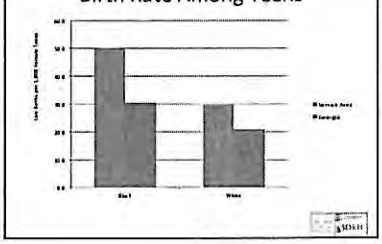

Sexually Transmitted Disease


Infant Mortality

Low Birth Weight



Birth Rate Among Teens



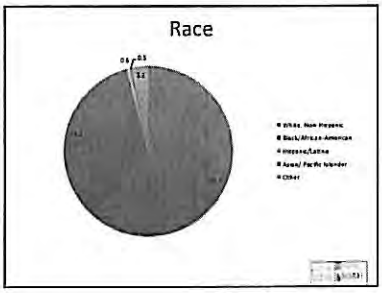
Primary Data: Community-Based Survey

Highlights

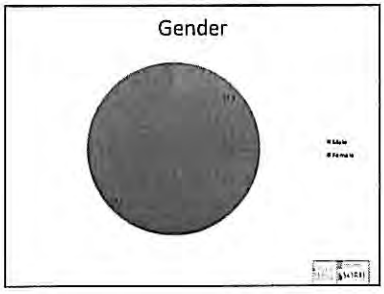
Community Based Survey

- Target Area
  - Decatur & Seminole Counties
- 324 of 400 surveys were returned to Georgia Southern University for analysis
  - 81% response rate
- 76.5% of participants used hospital services in the last 24 months
  - Among these participants, 90.2% of services were obtained at Memorial Hospital & Manor.

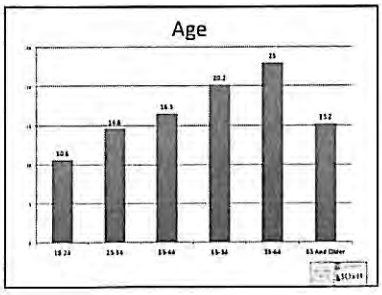
Race



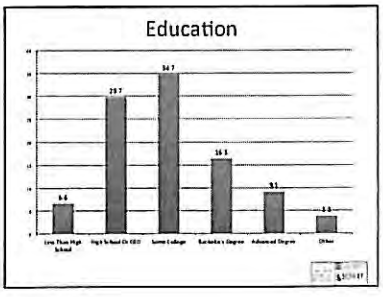
Gender



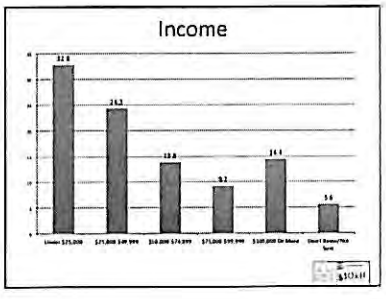
Age



Education



Income

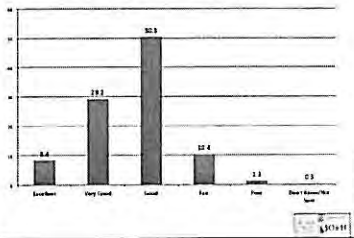


Access to Transportation

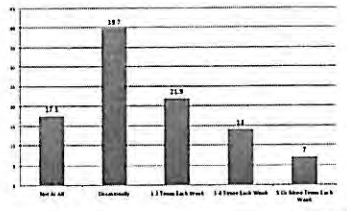
Community Perception

My Community:	"Agree" or "Strongly Agree"
Is a Good Place to Live	88.0%
Has Strong Economic Growth	26.6%
Has a Strong Health Care System	55.6%
Is a Good Place to Raise Children	83.1%
Is a Safe Community	77.7%
Has a Strong Education System	70.3%

Perceived Health Status

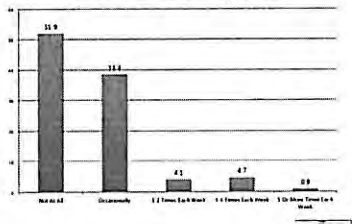


Frequency of Exercise

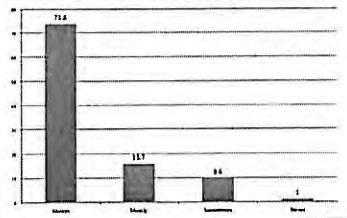


Tobacco Use

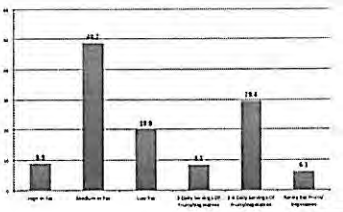
Alcohol Consumption



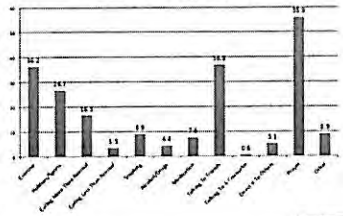
Seatbelt Use

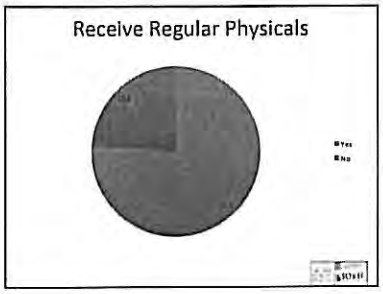


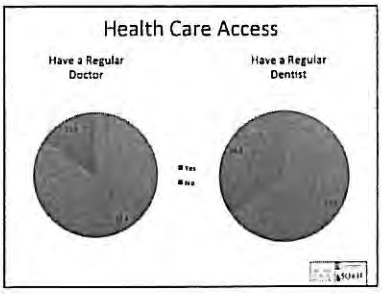
Diet

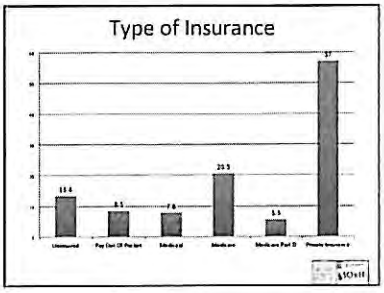


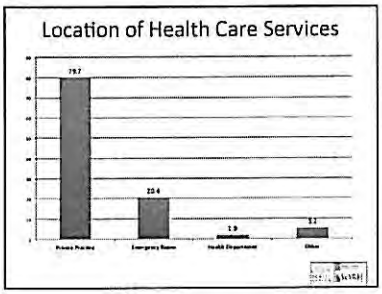
Controlling Stress

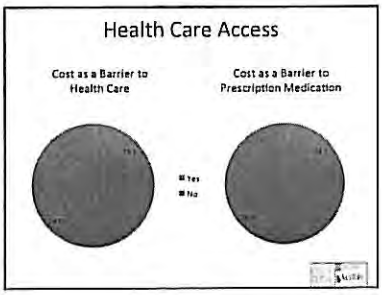


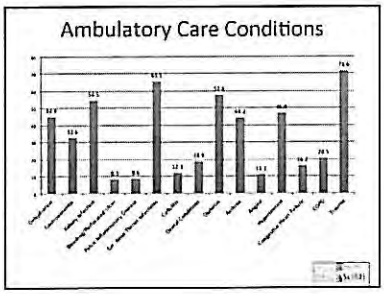

Receive Regular Physicals
Yes
No

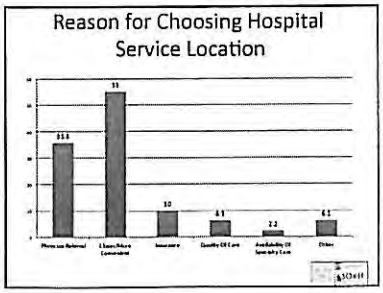

Health Care Access
Have a Regular Doctor
Have a Regular Dentist
Yes
No

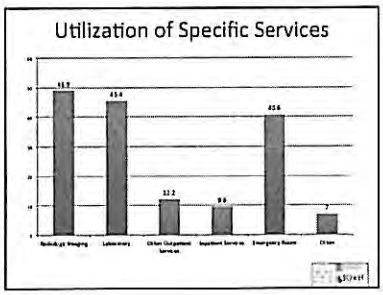

Type of Insurance

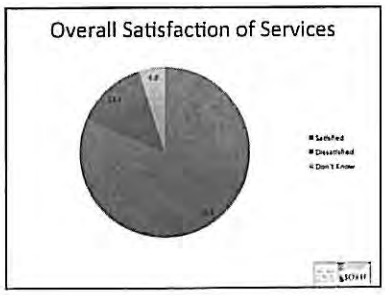

Location of Health Care Services


Health Care Access
Cost as a Barrier to Health Care
Cost as a Barrier to Prescription Medication
Yes
No


Ambulatory Care Conditions


Reason for Choosing Hospital Service Location


Utilization of Specific Services


Overall Satisfaction of Services
Satisfied
Dissatisfied
Don't Know

Primary Data: Focus Groups

Highlights

Methods

- **Focus Groups**
  - Three Focus Groups
    - One: Community Advisory Committee
    - Two: Community members
- **Participants**
  - 25 Participants
    - Men: 7 Women: 18
    - White: 15 Black: 9
- **Age Range**
  - 25-81

Results

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

Community

***Theme*: Safe and friendly; agriculture driven economy; 'small town effect;' school nutrition programs for children and other standard feeding programs for the elderly; other programs with available scholarships; current economic downturn as barrier to healthy lifestyle; too many fast food restaurants; and access to adequate health care**

"It's a typical small, rural town. Farming. Agriculture's probably our number one industry here, Bainbridge. Is somewhat unique in the fact that where it's located that we have sometimes the potential for not a lot of economic growth in that we're like an hours from four major cities."

"So it's a balance in being a nice place to live where you got a nice small community that's fairly safe, clean, but yet there's a lot of our young people who would say, 'well, I just don't see much future living here.' There are not a lot of jobs."

Community Issues

- ***Theme*: lack of employment opportunities, public transportation and entertainment; increase number of uninsured; lack of mental health professionals; chronic health conditions in adults and children; and illegal immigrants**
- *"We're not getting any money into this town. It's either getting elderly or it's not coming into town, because they need to go somewhere else for a job, because they're not here."*
- *"We don't have enough activities, which in a lot of ways cause problems because if you don't have those things in place, young people are gonna find things to do and it's not necessarily the positive things. So that is one shortcoming."*

Hospital

***Theme*: Family Feel, Good Services, Referrals when necessary**

"Good People"

"I feel like the hospital has turned around 110 percent. I was just out there earlier today getting a mammogram. I was in and out in 30 minutes, less than 30 minutes. Everyone was genuinely helpful and cheerful. My mother spent three days out there in August. Couldn't have asked for a better experience."

Hospital Problems

***Theme*: Expand Services, Increase morale and administrative issues**

"Why couldn't you have a little children's health fair in the park and make it a fun thing and let the hospital get that together and let them do some little activities that's health related. I think that could be fun."

"A lot of time big emphasis are spent on resources go to new technologies, new buildings, doctors who will hopefully generate pulling people in here to the hospital...but if your very basic care, if that level is lacking, then that's where your law suits and stuff come from because people get angry 'cause they feel like they haven't been taken care of."

"I think that the hospital administrator should be out and about in that hospital. Now I know that the hospital administrator has some work that has to be done in an office, but I do know that he's in the cafeteria with the same people every day unless he goes to Rotary or somethin' like that. So he is seen in the cafeteria, but he's just not making himself visible throughout that hospital and I think that should be done."

Recommendations

***Themes*: Improve nursing home staff; collaborate with churches; expand upon health fairs; and reduced ER wait times**

"I will say that I feel – I've also had someone at The Manor for several years. And I feel that the only weak link in The Manor is the CNA. I think the nurses are extremely dedicated. They work extremely hard. And I think that if I had to say two things that I would like to see changed would be that they find a way to either hire people who are going to truly want to stay there, some way to screen them and train them, the CNAs."

"[The church could assist] in our young people lives as well. We go to church. They have church. We go home. And we really a lot of times don't consider our young people. We see things happening within our church with our young people and we ignore it. And the church has a big part that they should play – all churches with different things."

"Well if you have a walk-in clinic that's non-emergency that would alleviate that, a lot of that [long wait times]."

Community Vision

- **Vision for the Community Includes:**
  - **More doctors**
  - **Availability of mental health care**
  - **Decrease in obesity**
  - **Removing the current label that may be seen as negative to certain programs**

"If we can get it, it needs to be understood it is for everybody. It is not if you're poor because there's a stigma with older people. A lot of time they don't wanna use something if they think it's for the poor. We don't need to label these kinds of things."

Emergent Community Issues

Emergent Community Issues

A. Heart Disease
B. Cancer
C. Respiratory Disease/Asthma
D. Diabetes
E. Economic Development (Unemployment, Poverty)
F. Access to Healthcare (Transportation, Cost)
G. Community Health Education (Exercise, Diet, Tobacco)
H. Community Image of the Hospital (Morale, Turnover, Wait-time)
I. Issues Involving Youth (Teen Pregnancy, Lack of Recreational Activities)
J. Dental Care
K. Mental Health

The First Step

- Multi-Voting Exercise
  - Before we begin prioritizing the issues, it is first important to generate discussion about the list.
  - All issues have been listed on the large Post-it wall posters
  - Identify the FIVE most important issues
  - Place a single "dot" next to each of the FIVE issues YOU feel are most important

Issues to be Prioritized

A. Community Health Education (Exercise, Diet, Tobacco)
B. Community Image of the Hospital (Morale, Turnover, Wait-time)
C. Mental Health
D. Economic Development (Unemployment, Poverty)
E. Cancer
F. Heart Disease
G. Access to Healthcare (Transportation, Cost, Issues Affecting elderly)
H. Issues Involving Youth (Teen Pregnancy, Lack of Recreational Activities)
I. Diabetes
J. Respiratory Disease/Asthma
K. Dental Care

Prioritization of the Issues

The Second Step

The Basics of Health Prioritization

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

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

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

Instructions for Prioritization

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

Issues to be Prioritized

A. Community Health Education (Exercise, Diet, Tobacco)
B. Community Image of the Hospital (Morale, Turnover, Wait-time)
C. Mental Health
D. Economic Development (Unemployment, Poverty)
E. Cancer
F. Heart Disease
G. Access to Healthcare (Transportation, Cost, Issues Affecting elderly)
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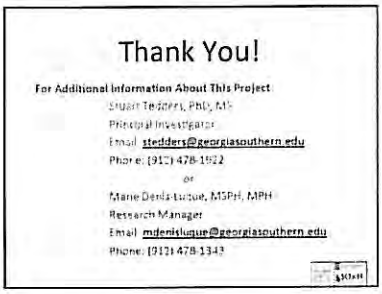
K. Dental Care


Thank You!
For Additional Information About This Project
Stuart Tedders, PhD, MS
Principal Investigator
Email: stedders@georgiasouthern.edu
Phone: (912) 478-1922
or
Marie Denis-Luque, MSPH, MPH
Research Manager
Email: mdenisluque@georgiasouthern.edu
Phone: (912) 478-1343

APPENDIX L

Meeting Agenda

Memorial Hospital & Manor

Tuesday, July 10, 2012

2PM-3:30PM

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

JIANN-PING HSU COLLEGE of PUBLIC HEALTH

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

SORH
GEORGIA STATE OFFICE OF RURAL HEALTH

Meeting Agenda

Memorial Hospital & Manor

Friday, September 7, 2012

2PM-4PM

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

Meeting Agenda

Memorial Hospital and Manor

Tuesday, February 5, 2013

2PM-4PM

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

APPENDIX M

Decatur County
Meeting 1

Members	E-mail	Phone Contact
Billy Walker	billyw@mh-m.org	(229) 243-6109
Lee Harris	leeh@mh-m.org	(229) 243-6103
Karen Faircloth	karenf@mh-m.org	(229) 243-6100 ext. (495)
Dolores Eidson	delorise@mh-m.org	(229) 243-6151
Jan Godwin	jang@mh-m.org	(229) 243-6187

Memorial Hospital and Manor Meeting 3 Attendance Sheet		
Member Name	**Phone Number**	**Email Address**
Jan Godwin	229-243-6187	jang@mh-m.org
Billy Walker	229-243-6109	billyw@mh-m.org
Lee Harris	229-243-6103	leeh@mh-m.org
Cynthia Vickers	229-243-6111	cynthiav@mh-m.org
Karen Faircloth	229-243-6100, Ext 495	karenf@mh-m.org
Delores Eidson	229-243-6150	delorese@mh-m.org
Josephine Biggles	229-246-0192	
Connie Snyder	229-248-2517	csynder@bainbridge.edu
Debbie McIntyre	229-248-2517	deborah.mcintyre@bainbridge.edu
Roslyn Palmer	229-246-2124	
Martin Bius	229-254-3886	mbius@dcboe.com
Kim Jeter	229-246-5080	
Liv Warren	229-220-4291	
Matt Palmer	229-246-3873	mattpalmer@gmail.com
Cassandra Bouie	229-465-3450	
Ruthie Giles	229-220-5992	
Vivian Hill	229-246-4327	
Charles Tyson	229-246-8568	
Sherry Hutchins	229-248-3055, Ext. 210	slhutchins@dhr.state.ga.us
Janice Kell	229-246-0956	jkell@mchsi.com

APPENDIX N

Georgia Hospital Association

MEMORANDUM

DATE: May 10, 2012

TO: Hospital and Health System CEOs

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

SUBJECT: Economic Impact Report

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

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

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

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

Georgia Hospitals - Vital Economic Engines for Georgia's Economy

Economic Impact Report

GHA
Georgia Hospital Association

Economic Impact Report
Executive Summary

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

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

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

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

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

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

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

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

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

Sources:

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

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

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

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

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

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

Memorial Hospital and Manor

Economic Impact on the Local and State Economy
Calendar Year 2010

SECTION I: Economic Impact of Hospital	
Total Direct Expenditure	$24,641,187
Georgia Output Multiplier [1]	2.3132
Total Output/Income Generated	**$56,999,994**
Hospital Payroll and Benefits	$21,273,817
Georgia Earnings Multiplier [2]	1.8585
Total Household Earnings Generated	**$39,537,388**
Number of Hospital Jobs (Full and Part Time)	458
Georgia Employment Multiplier[3]	2.15
Georgia Full Time Jobs Created[4]	**985**

SECTION II: Community Benefit These numbers represent the actual cost[5] incurred by the hospital	
Uncompensated Indigent Care Provided	$991,146
Uncompensated Charity Care Provided	$0
Uncompensated Bad Debt Incurred on Health Care Services Provided	$1,651,906
Other Free Uncompensated Care	$0
TOTAL:	**$2,643,052**

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

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

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

Center for Rural Health Hospitals

Economic Impact on the Local and State Economy
Calendar Year 2010

Georgia Hospital Association

SECTION I: Economic Impact of Hospital	
Total Direct Expenditure	$1,548,309,567
Georgia Output Multiplier [1]	2.3132
Total Output/Income Generated	**$3,581,549,690**
Hospital Payroll and Benefits	$971,307,700
Georgia Earnings Multiplier [2]	1.8585
Total Household Earnings Generated	**$1,805,175,360**
Number of Hospital Jobs (Full and Part Time)	28,013
Georgia Employment Multiplier[3]	2.15
Georgia Full Time Jobs Created[4]	**60,228**

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

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

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

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

Rural Hospitals

Economic Impact on the Local and State Economy
Calendar Year 2010

Georgia Hospital Association

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

SECTION II: Community Benefit These numbers represent the actual cost[5] incurred by the hospital	
Uncompensated Indigent Care Provided	$74,566,898
Uncompensated Charity Care Provided	$22,374,133.51
Uncompensated Bad Debt Incurred on Health Care Services Provided	$130,994,200
Other Free Uncompensated Care	$7,805,609
TOTAL:	**$235,740,841**

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

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

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

Congressional District 2,
Rep. Sanford Bishop

Economic Impact on the Local and State Economy
Calendar Year 2010

Georgia Hospital Association

SECTION I: Economic Impact of Hospital	
Total Direct Expenditure	$1,177,584,869
Georgia Output Multiplier [1]	2.3132
Total Output/Income Generated	**$2,723,989,319**
Hospital Payroll and Benefits	$620,231,780
Georgia Earnings Multiplier [2]	1.8585
Total Household Earnings Generated	**$1,152,700,763**
Number of Hospital Jobs (Full and Part Time)	11665
Georgia Employment Multiplier[3]	2.15
Georgia Full Time Jobs Created[4]	**25,080**

SECTION II: Community Benefit These numbers represent the actual cost[5] incurred by the hospital	
Uncompensated Indigent Care Provided	$43,043,866
Uncompensated Charity Care Provided	$12,692,944.73
Uncompensated Bad Debt Incurred on Health Care Services Provided	$64,680,002
Other Free Uncompensated Care	$7,136,576
TOTAL:	**$127,553,389**

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

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

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

State of Georgia

Economic Impact on the Local and State Economy
Calendar Year 2010

SECTION I: Economic Impact of Hospital	
Total Direct Expenditure	$16,435,716,117
Georgia Output Multiplier [1]	2.3132
Total Output/Income Generated	**$38,019,098,522**
Hospital Payroll and Benefits	$8,114,440,277
Georgia Earnings Multiplier [2]	1.8585
Total Household Earnings Generated	**$15,080,687,254**
Number of Hospital Jobs (Full and Part Time)	153,364
Georgia Employment Multiplier[3]	2.15
Georgia Full Time Jobs Created[4]	**329,733**

SECTION II: Community Benefit These numbers represent the actual cost[5] incurred by the hospital	
Uncompensated Indigent Care Provided	$524,433,651
Uncompensated Charity Care Provided	$218,478,004
Uncompensated Bad Debt Incurred on Health Care Services Provided	$665,704,510
Other Free Uncompensated Care	$95,291,552
TOTAL:	**$1,503,907,717**

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

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

APPENDIX O

Instrument Pilot Test Instructions

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

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

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

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

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

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

    a. How would you phrase this question in your own words?

    b. Did the answer choices allow you to answer as you intended?

    c. Is there anything you would change about the instrument?

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

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

APPENDIX P

JIANN-PING HSU
COLLEGE of PUBLIC HEALTH

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

SORH
GEORGIA STATE OFFICE OF RURAL HEALTH

County Health Assessment Survey

Thank you for taking time to give us your input.

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

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

Please select only one answer unless otherwise instructed.

Contact Information

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

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

Please return this survey to:

Memorial Hospital & Manor
ATTN: Jan Godwin
1500 E. Shotwell Street
Bainbridge, GA 39819

For Questions regarding the survey please call
Jan Godwin at (229) 243-6187

DEMOGRAPHIC

1. **What is your gender?**
   - Male
   - Female

2. **What is your ethnicity/race?**
   - White, Non-Hispanic
   - Black/African-American
   - Hispanic/Latino
   - Asian/Pacific Islander
   - Other: _____

3. **Which of the following age ranges best describes you?**
   - 18-24
   - 25-34
   - 35-44
   - 45-54
   - 55-64
   - 65 or older

4. **What is your marital status?**
   - Single
   - Married
   - Separated
   - Living Together
   - Separated
   - Divorced
   - Widowed
   - Other: _____

5. **What is your highest level of education?**
   - Less than High School
   - High School *or* GED
   - Some College
   - Bachelor's degree (BA, BS)
   - Advanced degree (MA, PhD)
   - Other: _____

ECONOMIC STATUS

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

7. **What is your household income?**
   - Under $25,000
   - $25,000 to $49,999
   - $50,000 to $74,999
   - $75,000 to $99,999
   - $100,000 or more
   - Don't know /not sure

8. **Do you own your home?**
   - Yes
   - No

9. **Do you have access to your own means of transportation?**
   - Yes
   - No

10. **What is your residential zip code?**
    - 31036
    - 31014
    - 31092
    - 31001
    - 31023
    - Other: _____

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

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

13. **How many of the people live with you who are dependent on you?**
    - None
    - 1
    - 2
    - 3 or more

HOSPITAL

14. **Have you or anyone in your household used the service of a hospital in the last 24 months?**
    - Yes
    - No *(Skip to Question #29)*
    - Don't know *(Skip to Question #29)*

15. **At which hospital were services received?**
    - **Memorial Hospital & Manor**
    - Some other hospital. List the city or cities where the hospital(s) was located _____ then *(Skip to Question #27)*

16. **You responded that you or someone in your household received services at Memorial Hospital & Manor, why did you or family member choose Memorial Hospital & Manor?**
    - Physician referral
    - Closer, more convenient
    - Insurance
    - Quality of care
    - Availability of Specialty Care
    - Other: _____

17. **What hospital services were used at Memorial Hospital & Manor?**
    - Radiological Imaging (X-rays, MRI, CT scan, ultrasound, mammogram)
    - Laboratory
    - Other Outpatient services
    - Rural health clinics
    - Inpatient services
    - Emergency room (ER)
    - Oncology
    - Other (*List*) _____

18. **How *satisfied* were you or someone else in your household with the services received at Memorial Hospital & Manor?**
    - Satisfied *(Skip to Question #20)*
    - Dissatisfied
    - Don't know *(Skip to Question #21)*

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

    Answer: _____

20. **Why were you *satisfied* with the services at Memorial Hospital & Manor?**

    Answer: _____

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

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

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

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

25. **Why were you *dissatisfied* with the *quality of* physician care at Memorial Hospital & Manor?**

    Answer: _____

    _____

    _____

26. **Why were you *satisfied* with the *quality of* physician care at Memorial Hospital & Manor?**

    Answer: _____

    _____

    _____

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

28. **What services would you like to see offered at Memorial Hospital & Manor?**

    Answer: _____

    _____

YOUR COMMUNITY

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

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

INDIVIDUAL BEHAVIORS & HABITS

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

***(If Male, Skip Question #31)*

31. **Do you do a *monthly* breast self-exam?**
    Yes
    No

32. **Do you use tobacco products?**
    Yes
    No

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

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

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

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

HEALTHCARE SEEKING BEHAVIOR & CONDITIONS

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

38. **Do you get regular physicals and/or healthcare?**
    - Yes
    - No

    If no, how do you get healthcare?

    _____

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

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

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

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

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

44. **Where do you usually go when you are sick or need health care?**
    (Check all that apply)
    - Private practice/family health care providers
    - Hospital Emergency Department
    - Health Department
    - Other (*Specify*): _____

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

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

<u>QUESTION 47</u>

GO TO NEXT PAGE

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

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

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

Answer: _____

Thank you again for completing the survey!

APPENDIX Q

Community Health Needs Assessment Project Focus group Preparation Logistics

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

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

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

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

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

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

APPENDIX R

COMMUNITY HEALTH NEEDS ASSESSMENT
FOCUS GROUP GUIDE

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

The first few questions are about <u>your community in general</u>:

1. Tell us a little bit about living in ***[insert community name].*** [**PROBE**: How does it feel to live in this community?]

    a. What do you like about living in ***[insert county name]***?

    b. What don't you like about living in ***[insert county name]***?

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

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

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

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

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

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

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

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

COMMUNITY VISION

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

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

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

APPENDIX S

JIANN-PING HSU COLLEGE of PUBLIC HEALTH

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

SORH
GEORGIA STATE OFFICE OF RURAL HEALTH

DEMOGRAPHIC QUESTIONS

1. Gender: _____

2. What year were you born? _____

3. What is your ethnicity/race?

_____

4. What languages do you speak?

_____

5. What is your occupation?

_____

a. Are you a manager? Yes / No

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

6. Name of Organization where you work:

_____

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

_____

8. How long have you worked there?

_____

9. What is your zip code? _____

10. What town do you live in?

_____

11. Children in the home
 # under 18: _____

 # over 18: _____

12. What is your level of education? (*Circle*)
☐ High School

☐ Some College, Technical School

☐ College Degree

☐ Advanced Degree

13. What is your household income?
☐ Under $25,000

☐ $25,000 to $49,999

☐ $50,000 to $74,999

☐ $75,000 to $99,999

☐ $100,000 or more

☐ Don't know /not sure

THANK YOU FOR YOUR PARTICIPATION

APPENDIX T

WHAT IS THE PROJECT ABOUT?
The purpose of this research project is to:

1) Help 18 rural nonprofit hospitals in addressing the Community Health Needs Assessment as mandated by the Internal Revenue Service (IRS) in accordance with the Patient Protection and Affordable Care Act.

2) Empower rural communities and underserved populations by providing a snapshot of overall community health status.

You are being asked to take part in the research project because you have valuable insight into your community.

WHAT WILL YOU BE ASKED TO DO?
If you want to take part, you will be asked to:

- Participate in a 60-90 minute discussion about the health status of your community.

WHAT WILL YOU GET OUT OF BEING IN THE PROJECT?

- Results from the focus groups will be used to determine the health status of your community and will assist in completing a community health assessment.
- This will assist your community hospital in completing IRS requirements for a community health assessment.

ARE THERE RISKS TO TAKING PART?
Taking part in this research study should not put you at risk. You may be uncomfortable sharing some health related information. However, you can be sure that none of the information from the focus group will be connected to you. It is confidential and will not be shared with anyone.

ARE THERE COSTS TO TAKING PART?
There are no costs to taking part in the study other than the time to participate in the discussion.

DO YOU HAVE TO TAKE PART?
You do not have to be part of the study if you do not want to. Taking part in the study is up to you. You can stop taking part at any time. If you decide to stop, no one will be angry or upset with you.

IS WHAT I SAY IN THE FOCUS GROUP PRIVATE?
Focus groups will be recorded. However, o protect your privacy, your name will not be included in the focus group data. This information will not be connected to you in any way. All data will be reported as a summary of information.

WHO ARE THE PEOPLE RUNNING THIS STUDY? CAN I CALL THEM?
The Principal Investigator for this research study is Dr. Stuart Tedders. His telephone number is (912) 478-1922. He is the Associate Dean of the Jiann Ping Hsu College of Public Health at Georgia Southern University. His address is PO Box 8015, Statesboro, GA 30460. His email address is stedders@georgiasouthern.edu

You may also contact:
Office of Research Services and Sponsored Programs
Georgia Southern University
P.O. Box 8005
Statesboro, GA 30460-8005
Phone: 912-478-5465
Fax: 912-478-0719
E-mail: research@georgiasouthern.edu

AGREEMENT STATEMENTS

Do you have any questions about the research study?

YES NO

Do you agree to take part in the research study?

YES NO

If you sign your name below, it means that you agree to take part in the research study.

_____

Signature of Participant

_____

Printed Name of Participant

_____

Date

The Community Health Needs Assessment Project

JIANN-PING HSU
COLLEGE of PUBLIC HEALTH

Principle Investigator
Stuart Tedders, PhD
P.O. Box 8015
Statesboro, GA 30460
(912) 478-1922

The Community Health Needs Assessment Project

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

SORH

GEORGIA STATE OFFICE OF RURAL HEALTH

JIANN-PING HSU
COLLEGE of PUBLIC HEALTH

APPENDIX U

Decatur County
Focus groups

Group 1: Thursday, October 11th @ 1:30PM

Name	Organization	Phone Number	Email Address
Ruthie Giles	CAC/Retired DFACS	(229) 220-5992	rmgiles56@yahoo.com
Janice Kell	CAC/Retired Teacher	(229) 246-0956	jkell@mchsi.com
Martin Bius	CAC/Ag Teacher	(229) 254-3886	mbius@dcboe.com
Vivian Hill	CAC/Retired State Hospital	(229) 246-4327	
Kim Jeter	CAC/Homemaker	(229) 220-2416	gjeter62@yahoo.com
David (Butch) Mosley	CAC/County Comm.	(229) 400-0911	dmosely1941@gmail.com
Josephine Biggles	CAC/Retired	(229) 246-0192	
Liv Warren	CAC/Cert. Pers. Trainer	(229) 220-4291	livwarren@hotmail.com

Decatur County
Focus groups

Group 2: Thursday, October 11th @ 4PM

Name	Organization	Phone Number	Email Address
Connie Jakes		(229) 246-5314	
Eva Pearl Evans		(229) 243-7751	
Gwen Belin		(229) 246-7646	belinc@bellsouth.net
Constance Hamilton		(229) 246-6105	cewhamilton@bellsouth.net
Gene Dunlap	Realtor	(229) 254-1976	gdunlap@dehidren.com
Brenda Thomas		(229) 254-6781	
Kevin Dowdy	Radio Station Owner	(229) 416-6021	
Laura Bridges	Retail Chain Owner	(229) 246-2929	lsbridges@bellsouth.net
Doris V. Cosby		(229) 243-0069	d.cosby@mchsi.com
Paul Mock		(229) 248-3055	pmmock@dhr.state.ga.us

Group 3: Friday, October 12th @ 3PM

Name	Organization	Phone Number	Email Address
Arky Long	Retired Post Office	(229) 220-2262	
Danna Sue Hadsock	Retired Teacher	(229) 248-5954	
Charles Hadsock	Retired	(229) 248-5954	
William Hand	Newspaper Ad Rep	(229) 726-8697	
Edna Bonner	Retired Teacher	(229) 246-3478	
Diane Strickland	Chamber of Commerce	(229) 246-4664	

APPENDIX V

Prioritization Exercise

Using the table provided, rate each issue identified in terms of:

- Size..... Rate from 1 – 10
- Seriousness..... Rate from 1 – 20
- Solutions..... Rate from 1 – 10

Simply write the number (on the scale) that seems to make sense to you

This is an exercise based on **WHAT YOU THINK!**

- **There are NO RIGHT or WRONG ANSWERS**

	Size of the Issue *How many people does the issue affect?*	Seriousness of the Issue *What are the consequences of **NOT** addressing the issue?*	Ability to Solve or Change the Issue *In the context of the community and it's resources, is this an issue that can solved or changed?*
Issue	Rate on a Scale from 1 – 10 You can use the same number more than once	Rate on a Scale from 1 – 20 You can use the same number more than once	Rate on a Scale from 1 – 10 You can use the same number more than once