



Phoebe Putney Memorial Hospital 2016 Community Health Needs Assessment

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Introduction

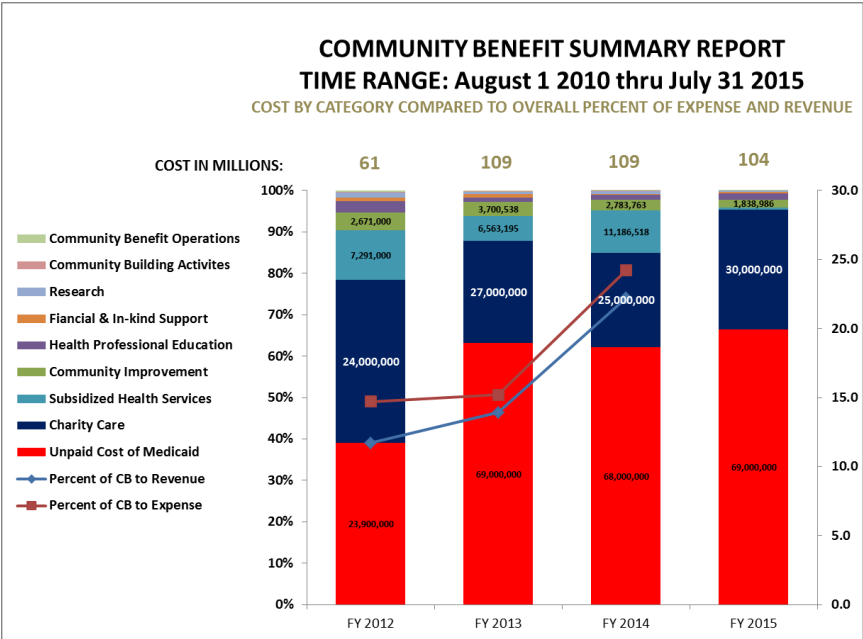
Phoebe Putney Memorial Hospital (PPMH) opened its doors in 1911 with a founding mission to embrace all who come to her doors. More than 100 years later, that mission is unchanged, providing care and healing to all, regardless of personal circumstances or ability to pay. PPMH has a long and documented history of providing care and services to the most vulnerable among us, and the hospital works in partnership with the community to address health needs and develop plans that will improve and sustain the health of the community. PPMH has relied on a broad-ranging partnership model to create community actions that translate into better access for all citizens in Southwest Georgia. These strategic partnerships have resulted in health improvement initiatives that are most often hospital-led and community-owned, reaching out across diverse needs, and ultimately becoming the ties that bind people, resources and organizations together with a common focus on improving community health for the long term.

PPMH conducted a Community Health Needs Assessment in compliance with the provisions of the Patient Protection and Affordable Care Act (ACA), which requires all non-profit hospitals in the United States to conduct a community health needs assessment to identify health priorities and adopt an implementation strategy to meet the identified community health needs. The assessment process requires hospitals to take into account input from individuals who represent a broad interest of the community served, including those with special knowledge or expertise in public health.

This work resulted in identifying three priorities: Behavioral Health and Addictive Disease, Birth Outcomes and Reproductive Responsibility, and Chronic Disease Based Coalitions.

Community Benefits are programs or activities that provide treatment and/or promote health and healing as a response to identified community needs. They are not provided for marketing purposes and are guided by these four principles:

1. Improves access to health care services.
2. Enhances health of the community.
3. Advances medical or health knowledge.
4. Relieves or reduces the burden of government or other community efforts.

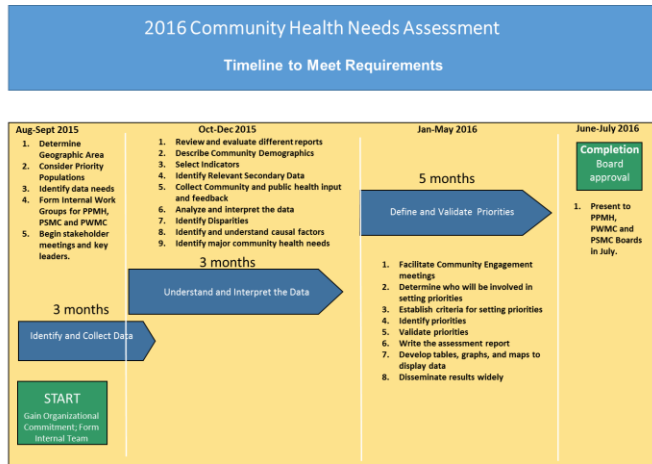


In the past four fiscal years beginning in 2012, [see chart on the left] Phoebe-Albany’s total estimated community benefit expense to its primary service area was nearly 400 million dollars, increasing by 70% since FY2012. Albany, the hub of Southwest Georgia, was hit hard by the recession. Reeling from Merck Chemical and Bobs Candies plant closing in 2005, the 2008 recession hit Albany again with Cooper Tire closing its doors and the 1,300 jobs that went with it. As job losses mounted and job constriction continued, Phoebe-Albany’s community benefit expense continued to rise with all the increase due to charity, indigent and unreimbursed Medicaid, more than doubling from FY2012 level. The legislature’s decision to opt-out of the Medicaid expansion program further exacerbated those two fold increases.

SECTION I: Planning and Preparing for Assessment

The **Internal Assessment Team** was a blend of hospital staff, hospital board members and strategic community partners located in Phoebe-Albany's defined five county primary service area. The project Team Lead was Mark Miller, Strategy Analyst with oversight from Lori Jenkins, Director of Strategy and Planning, and Darrell Sabbs, Community Benefit Coordinator. Early on, hospital leadership made the decision to use the Multiple Organization Partnership Model as the approach to **Determine How the Community Health Needs Assessment Will Be Conducted**. This approach engages multiple organizations, provides a broader focus, and allows greater input in need identification and determining appropriate strategy for action.

Community Health Needs Assessment Timeline



Source: Assessment & Addressing Community Health Needs, Catholic Health Association, June 2013

Phoebe-Albany Community Benefit Board Subcommittee

Dr. Kimberly Fields, Phoebe Subcommittee Chair
 Dr. John Culbreath, Phoebe Board Member
 Tim Dill, Phoebe Board Member
 Mary Helen Dykes, Phoebe Board Member

Internal Assessment Team Members

Judith Rosenbaum, Research Coordinator, Albany State University
 Joyce Johnson, Dean, Albany State University
 Kimberly Fields, Albany State University
 Jere Brands, National Alliance of Mental Illness*
 Lisa Dylinski, Worth County Family Connection*
 Tina Halverson, Phoebe Physician Group
 Denise Ballard, Cancer Coalition of South Georgia*
 Jim Franklin, Phoebe Putney, Quality
 Amanda Clements, Phoebe Putney, Marketing
 Christie Czerw, Phoebe Behavioral Health
 Pamela Amos, Darton State College
 Sean Hendley, Phoebe Putney
 Angie Barber, Phoebe Network of Trust*
 Sandy Bamford, Family Literacy Connection*
 Clif Buell, Phoebe Cancer Center
 Bruce Trickel, Albany Internal Medicine
 Kathy Brinson, Phoebe Putney
 Linda Johnson, National Alliance of Mental Illness*
 Mindy Spencer, Perinatal Outreach
 Rob Collins, Lee County Family Connection
 Heather Combs, Albany Area Primary Health Care*
 Dr. Willie Adams, Retired-Ob/Gyn
 Remy Hutchins, Dougherty County Health Department*
 Torrey Knight, District Public Health*
 Jackie Jenkins, District Public Health*
 Ryan Graham, Phoebe Physician Group
 Tracy Morgan, Phoebe-Putney, Women and Children
 Tosha Dean, National Alliance of Mental Illness*

*** Represents Low Income, Medically Underserved & Minority Populations**

SECTION II: Defining Community and Key Demographic Data

The Internal Work Team [defined the community](#) as Phoebe-Albany's Primary Service Area comprised of Dougherty, Lee, Mitchell, Terrell and Worth counties. However, the implementation plan will target the most vulnerable populations in some of the poorest areas in the country. According to Forbes Magazine, Albany was ranked as the fourth poorest city in America.

The five county area [see map on right] expects very little growth 2010-2020. The Georgia Office of Planning and Budget expects a very modest growth rate of 7.2% with a projected population of 190,329 with gains in Dougherty and Lee County. However, the rate of growth shows a net loss between the ages of 15-64 and the greatest gains from age 65&Up which impacts the tax base as wage-earners and their skill set relocate to find better opportunity. Current 2014 Estimated Population for the region is 174,441 making the 2020 population projection very optimistic. Current population is 52.6% AA/Black, 44.7% White and 2.7% all others.

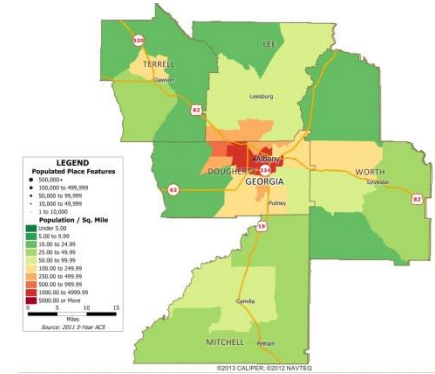
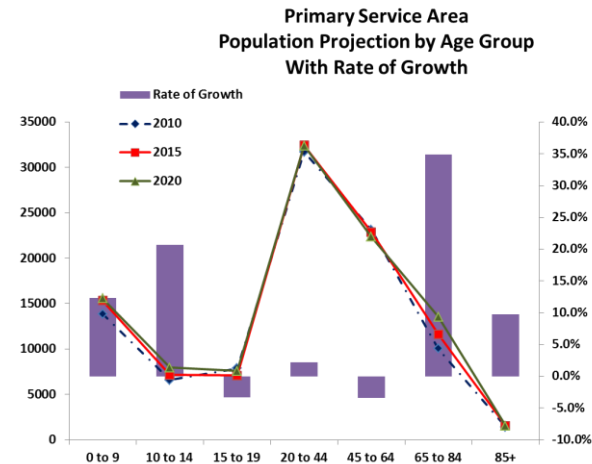
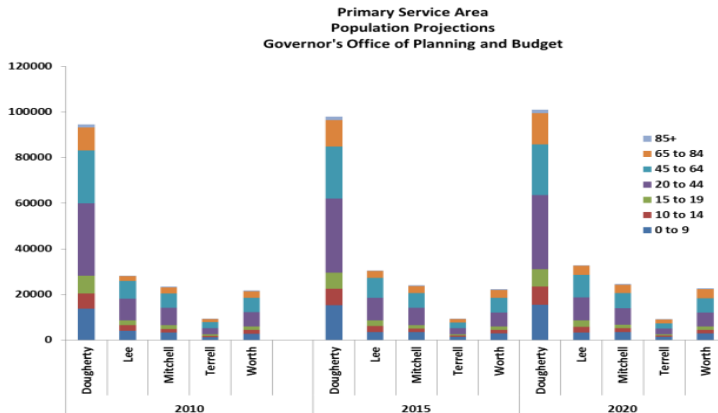


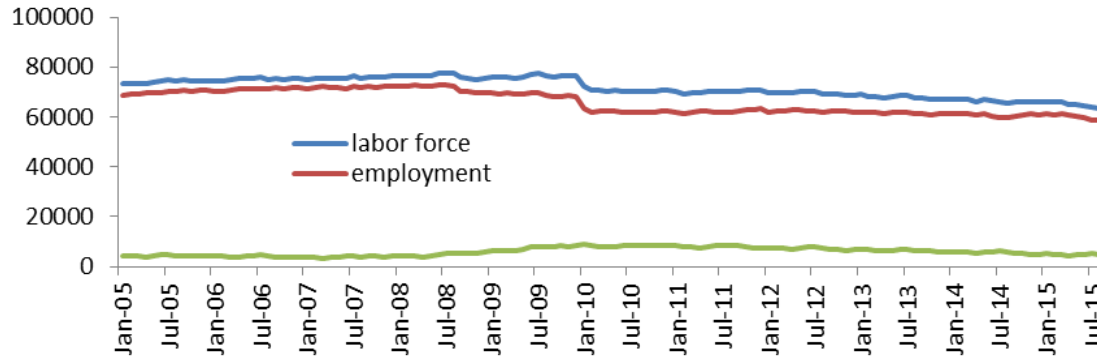
Figure 1: This is a population density map showing the number of people per square mile by census tract within the Primary Service Area. The darker the color the greater the density. North Central, North West and the bottom third corridor of Lee County have the most dense population per square mile. The densest located in north central Albany is the poorest and has the **worst health outcomes** in the area.



Albany, GA
Metropolitan Statistical Area



Historical trends since 2005 show a relatively flat labor and unemployment rate with the notable exception of the 2008-2009 recession [see line graph below]. The most recent statistics are no different and are consistent with decade long trend line[see chart bottom of the page]. Current unemployment sits at 5.3% with a civilian labor force of 65,773.



ALBANY MSA	Employment Status	Preliminary	Revised	Revised
		MAR 2016	FEB 2016	MAR 2015
	Civilian labor Force	66,565	66,239	65,773
	Employed	62,251	61,889	61,230
	Unemployed	4,314	4,350	4,543
	Rate	4.9	5.1	5.3

**Top Ten
Employers**

- Albany State University
- Darton State College
- Integra Business Alternatives, LLC
- Lear Siegler Services, Inc
- MillerCoors, LLC
- Phoebe Physician Group
- Phoebe Putney Memorial Hospital
- Teleperformance USA
- Proctor and Gamble Paper Products
- Walmart

Nationally, the median percent of people in poverty hovers at 15.9. Southwest Georgia experiences widespread poverty with just a few tracts at or above the US 50th percentile [see figure 4] mainly in Northwest and West Albany, the Putney area and a majority of Lee County. Research shows that a high poverty rate indicates local employment opportunities are scarce and not sufficient to provide for the local community. A decreased buying power and tax base adversely impacts quality schools and business survival. To the right and below [see figure 5] is the SocioNeeds Index created by Community Health Solutions, a community health enterprise recently purchased by Xerox. The index uses social determinants of health including poverty and ranks each zip code from a scale of 1 to 5. The scale links social determinants of health to health outcomes. A rank of 1 reflects the best health outcomes and a 5 the poorest health outcomes. Illustrated in the map below, it shows much of Southwest Georgia facing poor health outcomes due to the deleterious affects of poverty, inadequate housing, lack of insurance for some, food insecurity and income equality when measuring the income spread between the top 80% and the bottom 20%.

Figure 4: PERCENT OF PEOPLE IN POVERTY BY CENSUS TRACT

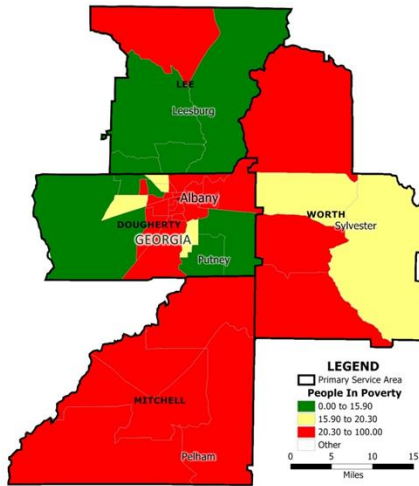
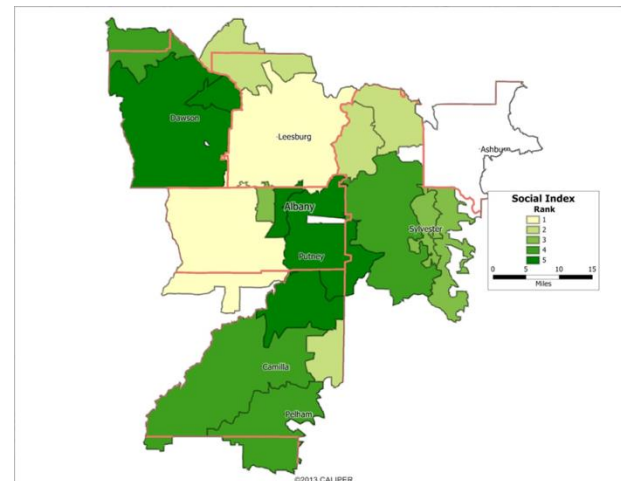
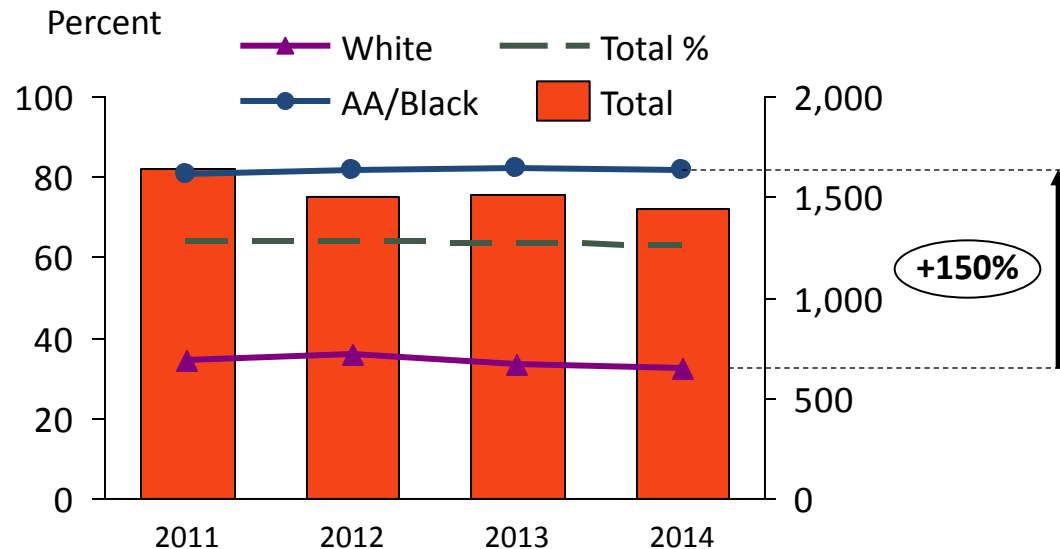
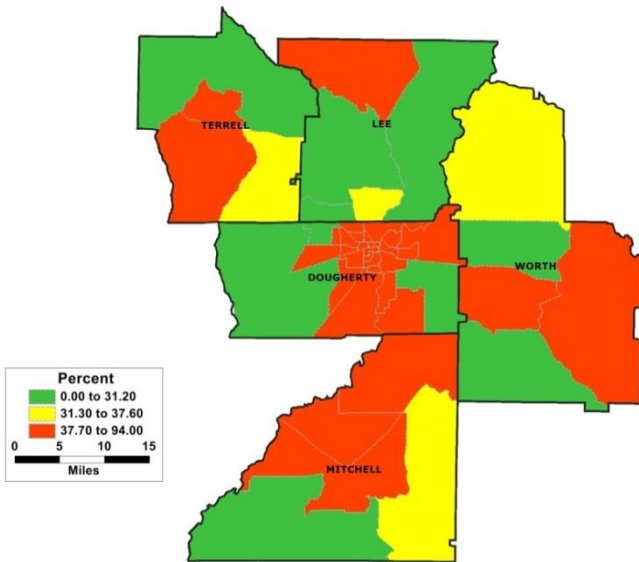


Figure 5: SOCIONEEDS INDEX



Children growing up in single-parent families typically do not have the same economic or human resources available as those growing up in two-parent families. Compared with children in married-couple families, children raised in single-parent households are more likely to drop out of school, to have or cause a teen pregnancy and to experience a divorce in adulthood. In Southwest Georgia, the percentage of single parent households only Lee County is below the US 50%. And among unwed mother who give birth, AA/Black are three times as likely than whites. Since 2011, the percentage of unwed mothers among blacks and whites has not fluctuated and remained static.

In a recent study published by the Brookings Institute, *Marriage and Child Wellbeing Revisited, Volume 25, Number 2 Fall 2015*, found that 73% of all pregnancies to females below the age of 30 were unintended. The result is that a growing proportion of children are born to unmarried parents-roughly 40 percent in recent years and over 50 percent for children born to women under 30. According to the published report, almost all the gains in non-marital childbearing during the past two decades have occurred to cohabitating rather than single mothers. However, cohabitating relationships are unstable and are defined as “fragile families.” The thematic below shows single parent households by census tract. The red shows areas where the single parent households are very high and places them in the bottom quartile when compared against all other US census tracts. The chart on the bottom right shows that the number of Southwest Georgia children born to unwed mothers is a third higher than the national average[40.3%].



EDUCATION SCORECARD: This scorecard highlights core test scores for the Phoebe-Albany 5-county Service Area. Those scores highlighted in Red are below the State Average and those in Green are at or above the State Average. Compared to other counties in the region, Lee has the highest achieving schools followed by Mitchell and Worth. Dougherty and Terrell have the least achieving schools.

Metric	Georgia	Dougherty	Lee	Mitchell	Terrell	Worth
Early Childhood						
Children Ages 3 to 4 not attending preschool 2009-2013	50.2%	40.5%	52.6%	51.3%	74.9%	43.4%
Children Enrolled in Pre-K Program	58.0%	56.5%	82.0%	64.0%	63.0%	53.0%
Children from Low income Families Enrolled in the Georgia Pre-K Program	55.0%	67.4%	38.0%	69.0%	91.0%	47.0%
School Age						
Children Absent More Than 15 Days From School	8.2%	9.7%	5.3%	5.1%	12.1%	12.8%
Students Who Graduate From High School on Time	72.5%	59.1%	76.8%	80.3%	85.1%	80.4%
Teens Who Are High School Dropouts, Ages 16-19	6.6%	9.4%	4.7%	8.4%	8.6%	8.7%
Teens Ages 16-19 Not in School and Not Working	10.9%	10.4%	8.3%	18.9%	8.6%	16.6%
Test Scores						
3rd Grade Students Exceeding State Standards on CRCT Promotional Test In Reading	46.0%	23.0%	52.0%	27.0%	23.0%	38.0%
3rd Grade Students Meeting or Exceeding State Standards on CRCT Promotional Test In Reading	95.0%	89.0%	99.0%	94.0%	92.0%	97.0%
5th Grade Students Exceeding State Standards on CRCT Promotional Test In Reading	42.0%	23.0%	46.0%	27.0%	19.0%	30.0%
5th Grade Students Meeting or Exceeding State Standards on CRCT Promotional Test In Reading	98.0%	97.0%	100.0%	98.0%	92.0%	99.0%
5th Grade Students Exceeding State Standards on CRCT Promotional Test In Math	44.0%	30.0%	58.0%	30.0%	32.0%	29.0%
5th Grade Students Meeting or Exceeding State Standards on CRCT Promotional Test In Math	93.0%	92.0%	98.0%	96.0%	90.0%	92.0%
8th Grade Students Exceeding State Standards on CRCT Promotional Test In Reading	53.0%	37.0%	56.0%	37.0%	28.0%	39.0%
8th Grade Students Meeting or Exceeding State Standards on CRCT Promotional Test In Reading	98.0%	95.0%	99.0%	99.0%		98.0%
8th Grade Students Exceeding State Standards on CRCT Promotional Test In Math	34.0%	19.0%	31.0%	32.0%	20.0%	27.0%
8th Grade Students Meeting or Exceeding State Standards on CRCT Promotional Test In Math	87.0%	80.0%	93.0%	96.0%	80.0%	86.0%

SECTION III: Indicators and Types of Data

Indicator selection was determined by reviewing the Leading Cause of Death for each county, hospital ER discharge data, previous Community Health Needs Assessment, Inpatient discharge data, the hospital's Community Health Dashboard, input from key leader interviews and community sessions, and indicators which can be accurately measured over time. *There were no comments from the previous assessment received; otherwise, they would have been included as findings.* The assessment process included **qualitative and quantitative data** from both primary and secondary sources. Qualitative data was primarily sourced using key leader interviews [see survey], County Level Community Forums, and input sessions to identify potential gaps in service and priority identification. Careful attention to assure that people and/or organizations representing the broad interest of the community and medically underserved, low income and minority were specifically targeted to participate in the key leader interview process and the community input sessions [see appendix for the complete list]. Selection process for the Key Leader Interviews was generated by a list from the core support in Strategy and Planning. The interviews were conducted by Darrell Sabbs and Mark Miller. The Community Input Sessions were

coordinated by Darrell Sabbs [see complete list in appendix]. Quantitative Data was both primary and secondary sourced. Hospital-related data such as utilization rates came directly from Decision Support team—other metrics, primarily community health [population health] where sourced mainly from the Community Health Dashboard, County Health Rankings, and the Department of Public Health OASIS web-based data sets. Each targeted indicator is sourced for verification.

TOP TEN Low Level Severity EC VISITS July 1 2015 thru June 30 2015	
Diagnosis	TOT
Otitis Media & URI	4118
Medical Back Problem	2658
Minor Skin Disorders	2553
Dental and Oral Diseases	1866
Cellulitis	1352
Musculoskeletal & Tissue	1498
Gastro/Esophagitis	1768
Trauma to the skin	1203
Headaches	1236
Other Ear Nose Throat Diag.	742

Data Source: Phoebe Putney Decision Support

Leading Cause of Death Phoebe Primary Service Area 2010-2014	
Diagnosis	TOT
Ischemic Heart and Vas	573
Lung Cancer	532
Primary Hypertension and Renal	463
All COPD except Asthma	435
Cardiovascular Disease	416
Mental/Behavior Disorder	385
Diabetes Mellitus	365
Alzheimer's Disease	307
Nephritis	131
Septiciemia	102

Data Source: OASIS-Community Health Needs Assessment Dashboard

Top Inpatient Discharges

Phoebe-Albany

Time Range: 10/1/2014 to 9/30/2015

According to an inpatient report extracted from GHA's discharge data warehouse, psychoses is the top discharge when excluding normal newborns and vaginal deliveries with joint replacement surgery a distance second. Heart failure and shock, esophagitis, and red blood diseases such as sickle cell anemia which has high discharge rates due to severe pain associated with the disorder. Diabetes and complications from diabetes leads to other co-morbid conditions such as renal failure, heart disease, lower limb amputation, stroke and neuropathy to name a few. Chronic Obstructive Pulmonary Disease when combining with and without complications was one of the top IP discharges in our region.

795 - NORMAL NEWBORN	1,678
775 - VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	1,148
885 - PSYCHOSES	918
470 - MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	566
766 - CESAREAN SECTION W/O CC/MCC	532
765 - CESAREAN SECTION W CC/MCC	365
292 - HEART FAILURE & SHOCK W CC	359
945 - REHABILITATION W CC/MCC	348
392 - ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	337
812 - RED BLOOD CELL DISORDERS W/O MCC	331
871 - SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	314
690 - KIDNEY & URINARY TRACT INFECTIONS W/O MCC	277
683 - RENAL FAILURE W CC	265
065 - INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS	264
794 - NEONATE W OTHER SIGNIFICANT PROBLEMS	259
603 - CELLULITIS W/O MCC	251
194 - SIMPLE PNEUMONIA & PLEURISY W CC	243
247 - PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	242
190 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	219
682 - RENAL FAILURE W MCC	218
790 - EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	210
378 - G.I. HEMORRHAGE W CC	207
641 - MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W/O MCC	207
638 - DIABETES W CC	199
191 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	197
291 - HEART FAILURE & SHOCK W MCC	194
792 - PREMATURITY W/O MAJOR PROBLEMS	186
767 - VAGINAL DELIVERY W STERILIZATION &/OR D&C	180
312 - SYNCOPE & COLLAPSE	173
192 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W/O CC/MCC	172

Prevention Quality Indicators (PQIs) are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for “ambulatory care sensitive conditions”. These conditions are potentially avoidable with timely outpatient care. Data pulled by Phoebe’s quality team showed that compared to all other hospitals of our type in the State of Georgia, Phoebe was either at the top or 2nd in number of cases. Generally, across the matrix, given the diagnosis, Phoebe’s length of stay and readmit rate was higher than the peer group. Readmit rates were higher than expected for hypertension, asthma in younger adults, long and short-term diabetes, urinary track infections and dehydration. However, the complication rate was high for hypertension, asthma COPD, short-term diabetes and dehydration. Complications are associated with those patients that have multiple diseases.

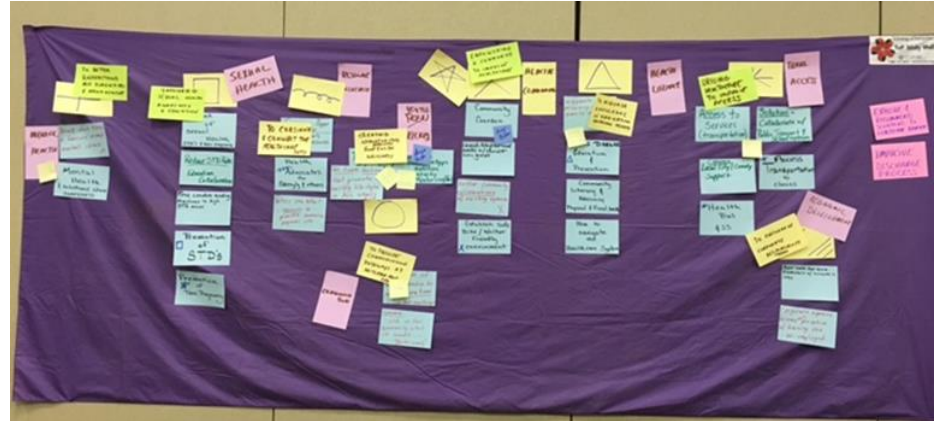
PREVENTION QUALITY INDICATORS					
Discharges from Phoebe					
Date Range: August 1 2014 to July 31 2015					
			INDEX		
Diagnosis	Volume	LOS Variance	Mortality	Complication	Readmit
Hypertension	111	0.7	0.00	3.34	1.21
Asthma/COPD	604	1.4	1.92	2.51	1.00
Asthma Younger Adults	27	1.1	0.00	0.00	1.31
Long-Term Diabetes	210	0.0	1.26	0.68	1.22
Short-Term Diabetes	211	1.2	1.84	4.12	2.01
Uncontrolled Diabetes	26	0.4	0.00	0.00	0.57
LE Amputations					
Diabetic Patients	131	-1.19	1.75	0.56	1.00
UTI	315	1.6	1.11	0.94	1.28
Dehydration	1936	2.1	0.86	1.39	1.16

Section IV: Community Engagement & Priority Identification

Meeting Agenda for Input Sessions

- Review Area and Local Data
- Facilitate a Consensus Workshop Method
 - Identify the Focus Question
 - Individually make a list
 - Discuss the list in a small group setting
 - Each group will develop 8 to 10 ideas
 - Whole group will pair then cluster the Ideas
 - Whole group will title the clusters.
 - Assign importance using dots.
- Next Steps and Closing

The Community Input Sessions



Priority Recommendations:

- *Improve Maternal, Infant, Child Health and Reproductive Responsibility*
- *Empowering Residents to Build a Healthy Community*
- *Driving Healthcare to Improve Access*
- *Collaboration and Networking among healthcare providers*
- *Increase Mental Health options*
- *To provide Health Education and Patient Advocacy*
- *To remediate and train unskilled labor*

Methodology

The participant list was drafted by the staff support team of Darrell Sabbs, Mark Miller and Lori Jenkins . Thirty people participated in one of the two Input Sessions held on February 17 and March 5. The event was hosted by Phoebe-Albany and observed and assisted by the support team. The Input Sessions were facilitated by Mark Miller, Phoebe Putney-Strategy Analyst, using the ToP Consensus Workshop Method with sticky wall (see photo above). The focus question, “What Must Be Done to Improve Health and Well-Being in our community?,” was brainstormed then clustered in pairs and groups and then titled. It’s referred to as “Storming, Forming, and Norming”. After all the ideas were placed on the sticky wall and titled, each participant received two dots to place on one or more health issues facing our community [see appendix for participant list and complete results].

PRIORITY SETTING

Priority Rating VS. Performance

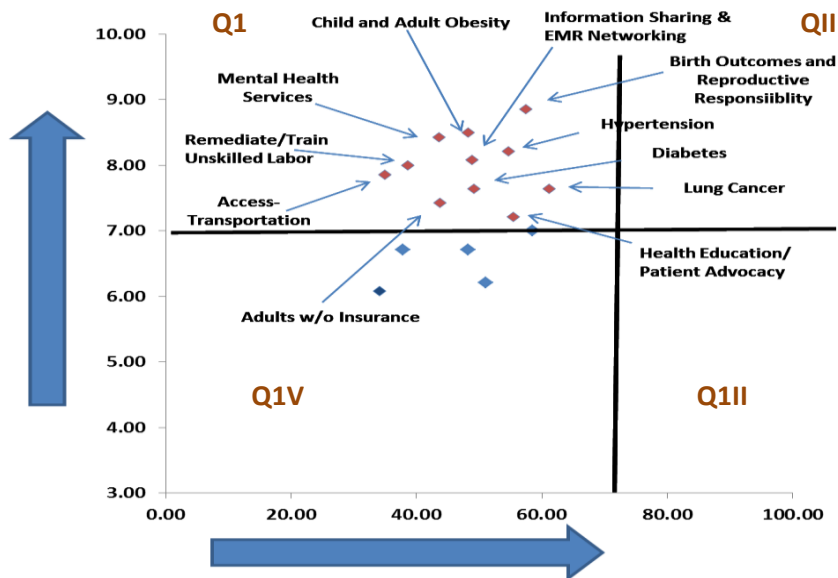
Quadrant I	May need increased attention	Perceived Priority (1-10)	High	I High Priority Low Performance	II High Priority High Performance
Quadrant II	May be important to maintain efforts			IV Low Priority Low Performance	III Low Priority High Performance
Quadrant III	May shift or reduce some resources or attention to focus on higher priority activities		Low	Low	High
Quadrant IV	May need little or no attention at this time		Current Level of Performance (1-100)		

Priority Selecting-Meeting I

Using the National Public Health Performance Standard Program model for prioritizing need, a score sheet was developed that measured “How important is the Need” and “the Healthcare System and it’s partners” addressing the need to optimize performance. Those that scored in **Quadrant I** reflect the highest priority.

TOP Priorities:

- ✓ Child and Adult Obesity
- ✓ Mental Health Services
- ✓ Train Unskilled Labor
- ✓ Access to Care-Transportation
- ✓ Adults without Health Insurance
- ✓ Information Sharing and EMR Networking
- ✓ Birth Outcomes and Reproductive Responsibility
- ✓ Hypertension
- ✓ Diabetes
- ✓ Lung Cancer
- ✓ Health Education/Patient Advocacy



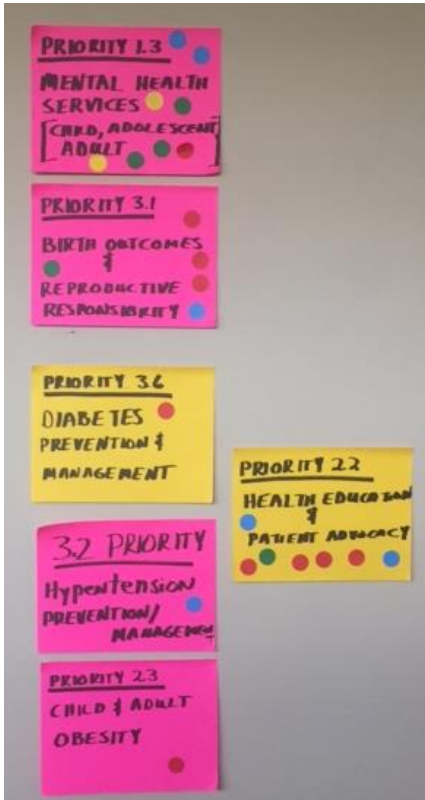
Priority Attendees:

- Clif Buell, Phoebe Oncology
- Remy Hutchins, Public Health*
- Torrey Knight, District Public Health*
- Linda Johnson, National Alliance of Mental Illness*
- Tosha Dean, National Alliance of Mental Illness*
- Jim Franklin, Phoebe Quality Analyst
- Judith Rosenbaum, Albany State University
- Tracy Morgan, Phoebe-Albany
- Ryan Graham, PPG
- Amanda Clements, Phoebe-Albany
- Heather Combs, AAPHC*
- Joyce Johnson, Albany State University
- Angie Barber, Network of Trust*
- Jackie Jenkins, District Public Health*

*Represents Low Income, Medically Underserved, and Minority Populations

Section V: Priority Selection

Priority Selecting-Meeting II



CATHOLIC HEALTH ASSOCIATION RECOMMENDATION SELECTION FILTERS

Magnitude. The magnitude of the problem including the number of people impacted by the problem.

Severity. The severity of the problem includes the risk of morbidity and mortality associated with the problem.

Historical Trends.

Alignment of the problem with the organization's strengths and priorities.

Impact of the Problem on Vulnerable Populations.

Importance of the problem to the community.

Existing Resources Addressing the Problem.

Relationship of the Problem to other Community Issues.

Feasibility of change, availability of tested approaches.

Value of Immediate Intervention vs. any delay, especially for long-term or complex threats.

The Priority Committee reconvened and reviewed the eleven priorities that scored in Quadrant I [High Priority-Low Performance]. The data for each priority was reviewed and the participants were given three dots to choose their 3 most important health issues. The priorities were ranked according to number of dots and further vetted using elements of the criteria shown in the box. The selection committee choose these two with discussion:

1. *Behavioral and Addictive Disease for Adults and Adolescents*
2. *Birth Outcomes and Reproductive Responsibility*

Health Education & Patient Advocacy was third one selected but required additional discussion. The committee decided this would be an initiative tied to chronic disease management such as Diabetes , Hypertension and identified risk factors such as obesity.

3. *To prevent and manage chronic diseases.*

Selection Committee: Dawn Benson, Senior VP/General Counsel; Thomas Chambless, Senior VP Government Relations; Brian Church, Chief Financial Officer; Dr. Steven Kitchen, Chief Medical Officer; Dr. Keisha Callins, Ob/Gyn*; Evelyn Olenick, Chief Nursing Officer, Phoebe-Albany; Bruce Trickle, Albany Internal Medicine; Judith Rosenbaum, Albany State University*; Melissa Gosdin, Albany State University*; Kimberly Fields, EdD, Albany State University, Phoebe-Albany Board Subcommittee Chair*

* Represents Low Income, Medically Underserved, and Minority Populations

Priority I: Behavioral Health/AD Key Fact Sheet

- In Georgia, over 2.3 million face the challenge of living with mental illness; 1 in 3 will receive treatment.
- U.S. death rate by suicide happens every 16 minutes.
- In Georgia, suicide is the 11th leading cause of death.
- 41% of Georgians with addictive diseases report needing treatment but are not receiving it.
- 111,000 children in Georgia live with serious mental illness.
- Individuals with Serious Mental Illness average age of death is 53.
- And those with co-occurring mental illness and substance abuse disorders average age of death is 45.
- Region 4 [Phoebe-Albany PSA] shows the estimated Unmet Need which is significant. In Albany, GA—a federally qualified health clinic began offering psychiatry and counseling services to patients age 8 & up.
- Excluding Well Newborns and Vaginal deliveries, Psychoses has the highest number of discharges from Phoebe-Albany.

Category	REGION 6			REGION 4
	Estimated Number of Needing Services	Number Served	Unmet Need	Unmet Need
Adult Serious and Persistent Mental Illness	3426	2101	38.7%	45.1
C&A Serious Emotional Disturbance	950	370	61.1%	63.5
Adult Addictive Disorder/Substance Abuse	3046	494	83.8%	91.2
Adolescent Addictive Disorder/Substance Abuse	680	6	99.1%	96.8

CHALLENGES

- *People with Mental Health and Substance Abuse problems have historically had high rates of being uninsured.*
- *Multiple Transportation Issues*
- *Homelessness*
- *Stigma*
- *Criminal Justice Involvement*
- *Lack of Employment Opportunities*
- *Lack of Providers in some areas-particularly rural-make it more difficult to seek treatment if wanted.*
- *Impact of bullies and victims in primary and secondary schools increase the risk of depression, anxiety and low self-esteem.*

Priority I: The Provision of Behavioral Health and Addictive Disease Prevention and Treatment Services

Aspire provides comprehensive Mental Health, Addictive Disease & Development Disability Services for adults and Adolescents in Dougherty, Baker, Calhoun, Early, Lee, Miller, Terrell, and Worth counties. Services include:

- Crisis Intervention
- Assessment
- Individual and Group Counseling
- Day Services
- Community Support Services
- Medication Management
- Recovery
- Residential and Community Services

Albany Area Primary Health Care, a federally qualified health clinic, recently opened an Outpatient Behavioral Health program staffed by a licensed Psychiatrist and supported with LCSW staff. They provide medication management, supportive therapy, crisis intervention and counseling sessions. Services are offered at the AAPHC Behavioral Wellness Center and satellite locations in Lee County, South Albany Medical Center and Terrell County.

Phoebe Behavioral Health provides a Structured Outpatient Program (SOP) for individuals who present with a psychiatric diagnosis and an Inpatient Behavioral Care Unit treating geriatric and adult populations for those that have been diagnosed with an acute psychiatric illness and need immediate intervention. The Behavioral Health triage area located adjacent to Phoebe's Emergency Center is for patients who present to the facility as a direct admission or as an emergency referral. Scope of Services include:

- Outpatient Services
- Inpatient Services
- Mobile Assessment Program
- Postpartum Depression

Phoebe's School Nurse Program provides teen mother mentoring program after giving birth and partner with **NAMI** on bullying and suicide prevention.

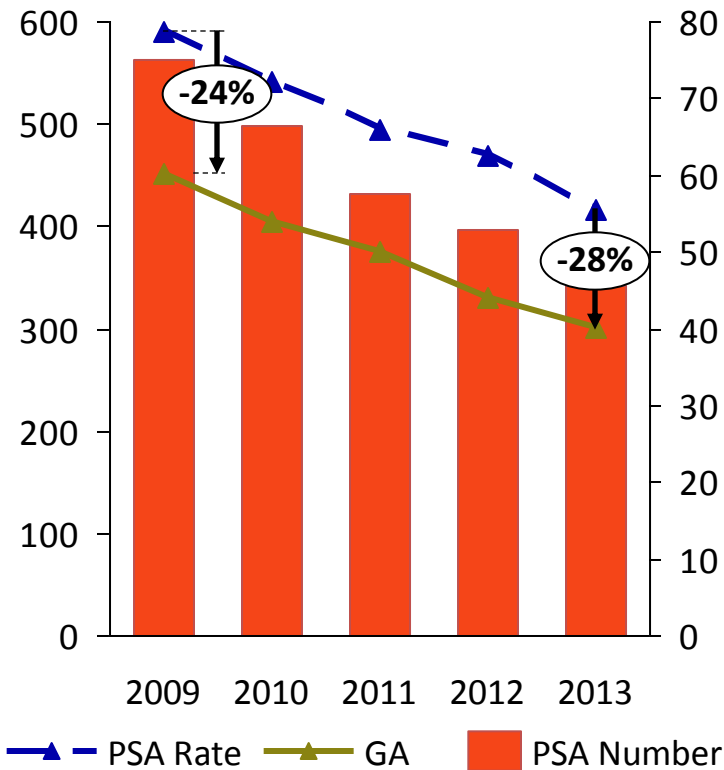
Counseling Resources:

Andy Martin, LPC; Aspire Child & Adolescent Program, Biblical Counseling Center, Elaine Gurley, LCSW; Family Life Counseling Center, Insight Psychotherapy & Assessment Services; Lynda Hammond and Ann Priddy, LCSW; Renaissance Center, South GA Neuropsychological Associates, Team EAP Inc., TWI Counseling, Vision Foundation Counseling

Priority II: Birth Outcomes and Reproductive Responsibility

Teen Pregnancy and childbearing have substantial social and economic impacts for communities. Teen pregnancy, births and Sexually Transmitted Diseases are substantially higher in the United States than other industrialized nations. Since 2009, the teen pregnancy rate decreased in the PSA decreased by 30%, slightly lower than the State Average. While the percentages dropped, the gap between the PSA rate and Georgia slightly increased. The teen pregnancy rate is approximately twice as high among AA/Black compared to white teens.

Comparison of Pregnant Teens Aged 15-19 by Race and County of Residence and Within Race Compared to State Mean from 2010 to 2013



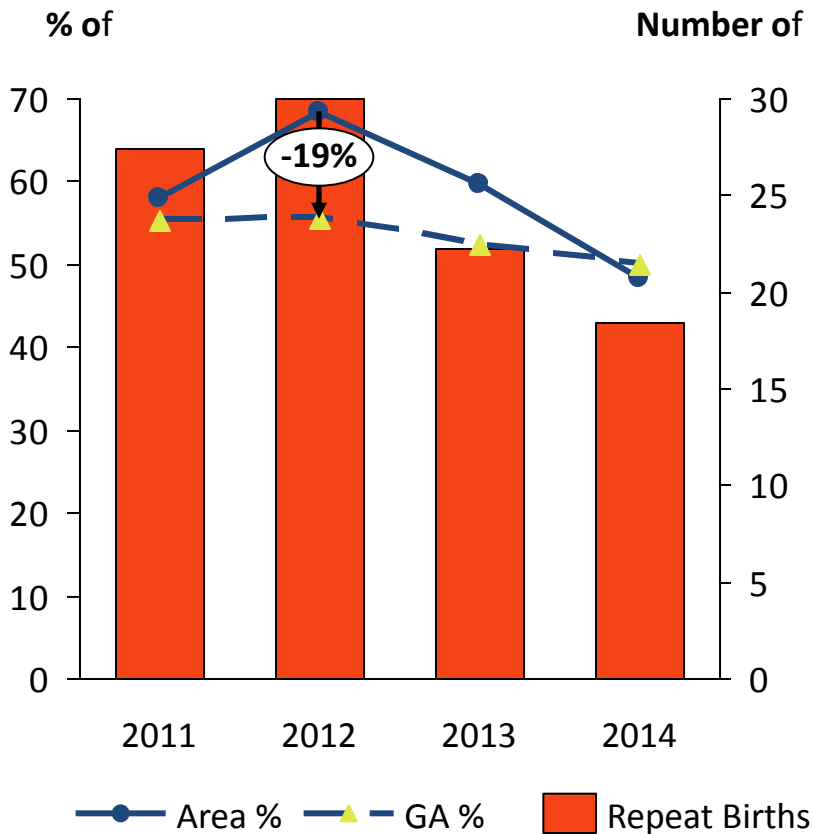
	2010						2011					
	White		AA/Black		Other		White		AA/Black		Other	
	N	Rate	N	Rate	N	Rate	N	Rate	N	Rate	N	Rate
Dougherty	34	47.9	275	89.0	9	85.7	33	51.2	246	83.9	3	*
Lee	29	35.0	9	83.7	3	*	22	28.2	11	48.7	1	*
Mitchell	17	54.8	39	105.9	2	*	13	46.3	18	47.7	5	294.1
Terrell	3	*	35	142.9	0	0.0	5	63.3	18	82.9	2	*
Worth	20	40.9	23	75.5	0	0.0	31	65.3	21	65.4	2	*
Summary	103	42.6	410	92.4	14	81.4	104	46.0	314	77.1	13	66.7
GA		34.7		76.5		130.8		32.3		64.3		122.5
	2012						2013					
	White		AA/Black		Other		White		AA/Black		Other	
	N	Rate	N	Rate	N	Rate	N	Rate	N	Rate	N	Rate
Dougherty	27	42.4	212	73.3	15	138.9	20	33.7	191	66.5	8	81.6
Lee	24	31.7	14	61.1	0	0.0	16	21.7	9	37.5	3	*
Mitchell	9	31.4	25	75.5	6	400.0	15	52.3	30	90.6	2	*
Terrell	1	*	23	127.8	1	*	0	0.0	17	88.5	2	*
Worth	22	46.7	18	57.5	0	0.0	18	44.0	11	42.6	0	*
Summary	83	30.2	292	74.0	22	113.4	69	33.1	258	66.2	15	79.8
GA		37.5		56.9		92.1		27.1		52.1		81.3

■ Above State Mean
■ Below State Mean

Data Source: Department of Public Health, Oasis, 2016

Priority II: Birth Outcomes and Reproductive Responsibility

Comparison of Repeat Births Age 18-19 by Race and County of Residence and Within Race Compared to State Mean from 2011 to 2014. Repeat births have dramatically decreased since 2012 and the percentage of repeat births is slightly below the 2014 State percent. The significant decrease in repeat births among black teens was the principal driver in the 2012 19% gap completely disappearing by 2014. This is in concert with the declining Teen Pregnancy Rate.

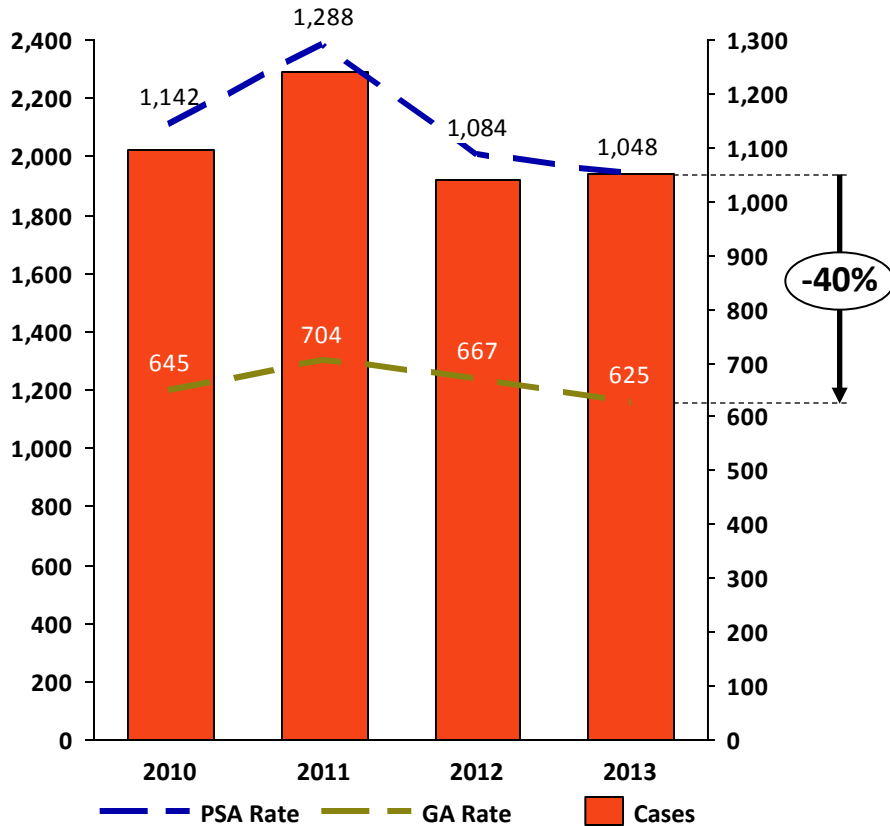


	White				Total	
	2011	2012	2013	2014	N	% of
Dougherty	3	4	5	3	15	21.7
Lee	2	1	0	1	4	
Mitchell	2	0	0	0	2	
Terrell	0	0	0	0	0	0.0
Worth	3	2	0	1	6	10.0
Summary	10	7	5	5	27	12.1
GA						19.4
	AA/Black				Total	
	2011	2012	2013	2014	N	% of
Dougherty	41	47	32	28	148	30.8
Lee	2	2	2	0	6	20.7
Mitchell	4	4	1	4	13	23.6
Terrell	4	6	5	0	15	37.5
Worth	2	1	3	3	9	18.0
Summary	53	60	43	35	191	29.2
GA						25.3

Data Source: Department of Public Health, Oasis, 2016

Priority II: Birth Outcomes and Reproductive Responsibility

Southwest Georgia and Dougherty County in particular continue to be hit hard with high STD cases. In fact, district public health recently called a task force to address the high rate.



Data Source: Department of Public Health, Oasis, 2016

Sexually Transmitted Diseases (STD) can be asymptomatic but easy to treat with antibiotics.

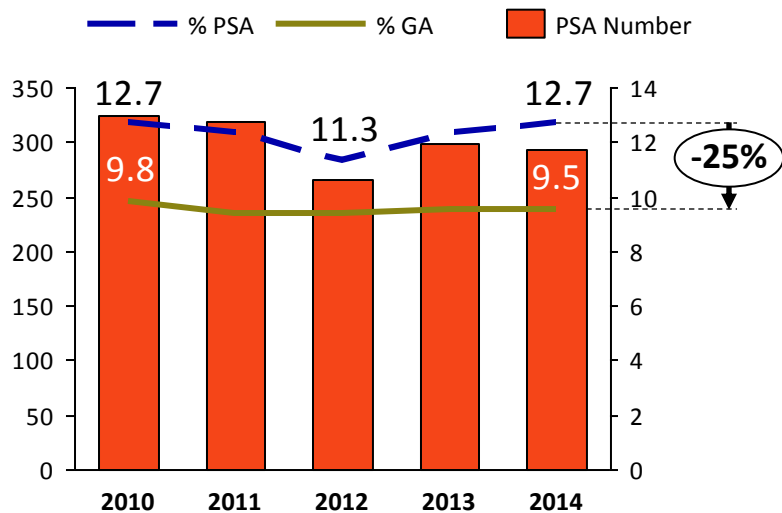
Left untreated, STD can lead to infertility, pelvic inflammatory disease particularly in women and cause permanent health problems in both men and women. There is a 40% gap between the area rate and the Georgia Rate. To compare within Race Rates to the State of Georgia, see the table on the right. Those in Red are above the State Rate and those in Green are below. The AA/Black rate is ten-fold higher than whites.

STD RATE BY COUNTY AND RACE
Primary Service Area
Time range: 2010 through 2013

County	Race	Cases	Rate	Age 15-19	Rate
Dougherty	White	162	143.4	32	600.2
	Black	3498	1375.2	1199	5171.7
Lee	White	86	98.2	28	442.3
	Black	143	630.8	47	2502.7
Mitchell	White	56	120.3	23	897.0
	Black	530	1186.9	181	5574.4
Terrell	White	10	73.1	1	*
	Black	297	1332.3	111	6183.8
Worth	White	71	118.2	22	581.2
	Black	199	1264.9	52	2394.1
PSA Total	White	385	120.0	106	570.4
	Black	4667	1264.9	1590	4926.3
GA Total	White		120.9		502.4
	Black		1086.6		3867.4

Priority II: Birth Outcomes and Reproductive Responsibility

Low Birth Weight in Southwest Georgia remains problematic. After a short dip in 2012, the percentage rose for two consecutive years and shows no change since 2010. AA/Black mothers are almost twice as likely to give birth to a Low Birth Weight infant than a White mother. There is a 25% gap between the GA and County Summary LBW percentages.



Date Source: Georgia Department of Public Health, Oasis, 2016

- The percentage of births that are Low Birth Weight [LBW] is one of the most widely used indicators of population-level health around the globe, and reducing LBW is a common public health policy objective.
- Is associated with worse health outcomes over the entire life course.
- LBW infants are more likely to suffer from chronic conditions such as asthma, high blood pressure and compromised cognitive development.
- The disadvantage from LBW persists into adulthood, with lower weight individuals scoring lower on IQ tests at age 18, attaining less education, and earning less income than their peers.
- It is estimated that raising the birth weight of a LBW infant by even a half pound saves an average of more than \$28,000 in first year medical expenses alone.
- The average cost of Medicaid Services for the first four years of life of a very low birth weight infant is \$62,000 compared to \$7,000 for a normal weight infant.

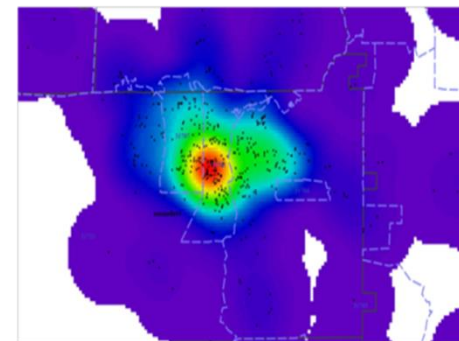
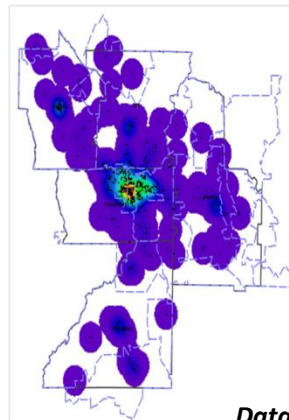
	White				Total	
	2011 N	2012 N	2013 N	2014 N	N	% Of
Dougherty	31	19	27	11	88	8.4
Lee	18	13	15	21	67	6.2
Mitchell	9	5	6	11	31	7.3
Terrell	3	1	3	4	11	8.9
Worth	13	12	14	12	51	8.3
Summary	74	50	65	59	248	7.5
GA						7.2

	Black/AA				Total	
	2011 N	2012 N	2013 N	2014 N	N	% Of
Dougherty	173	137	156	163	629	15.0
Lee	18	6	12	8	44	13.9
Mitchell	23	24	14	24	85	14.0
Terrell	11	14	13	10	48	13.3
Worth	10	22	22	19	73	17.9
Summary	235	203	217	224	879	14.3
GA						13.7

	Other				Total	
	2011 N	2012 N	2013 N	2014 N	N	% Of
Dougherty	4	8	11	5	28	10.5
Lee	3	1	2	4	10	10.6
Mitchell	2	4	1	0	7	9.1
Terrell	0	0	2	0	2	
Worth	0	0	0	1	1	
Summary	9	13	16	10	48	9.9
GA						7.6

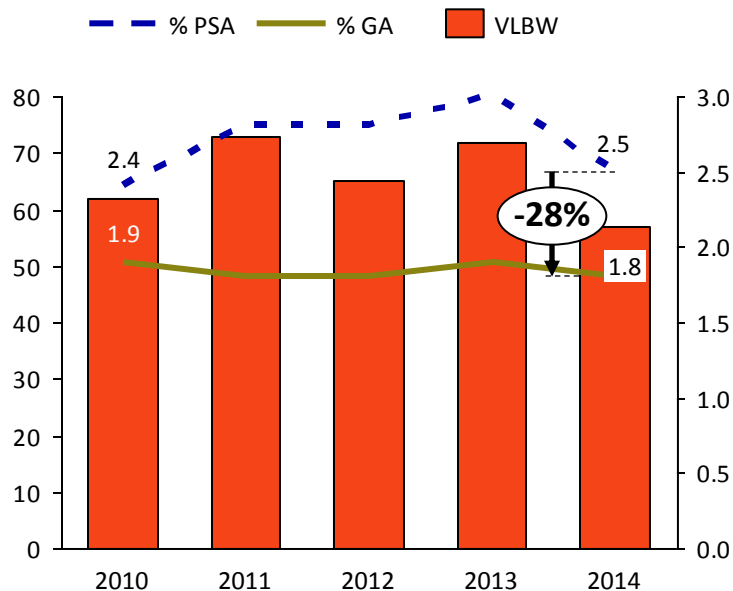
Priority II: Birth Outcomes and Reproductive Responsibility

The percentage of Very Low Birth Weight (VLBW) infants hasn't moved downward over the five year reporting period. You are more than twice as likely to have VLBW infant if you are AA/Black compared to White mothers. Within race comparison to the State Averages [see table] shows most counties within race percentages exceed the State Average. To the right, the first map shows the five county view of all low birth weight infants in the five county area. The second map zooms to the hot spot which located primarily in zip code 31701 and conforms to the SocioNeeds Index of Low Health Outcomes.



Data Source: PPMH Hospital Data, 2009-2011, Map Produced by Mark Miller

Percent of Very Low Birth Weight <1500 Grams



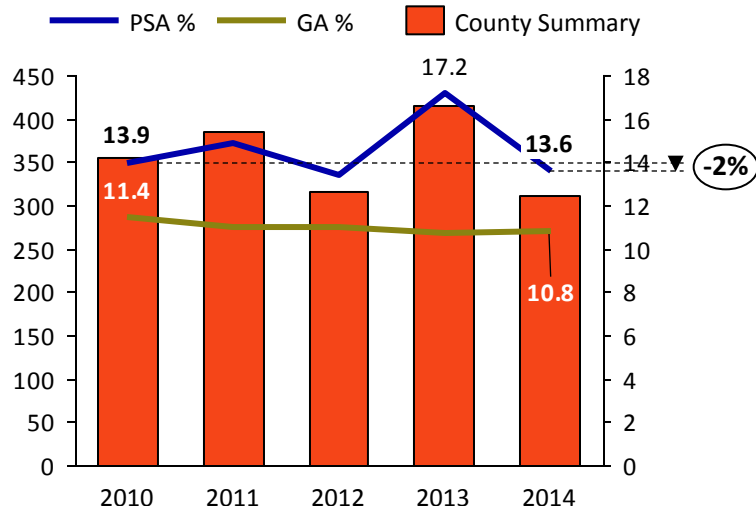
Date Source: Georgia Department of Public Health, Oasis, 2016

	White				Total	
	2011 N	2012 N	2013 N	2014 N	N	% Of
Dougherty	5	6	6	2	19	1.8
Lee	6	4	2	1	13	1.2
Mitchell	1	1	2	4	8	1.9
Terrell	0	1	0	0	1	8.9
Worth	3	3	1	4	11	1.8
Summary	15	15	11	11	52	1.6
GA						1.2
	Black/AA				Total	
	2011 N	2012 N	2013 N	2014 N	N	% Of
Dougherty	40	38	35	32	145	3.5
Lee	8	2	5	0	15	4.7
Mitchell	6	3	6	9	24	4.0
Terrell	2	1	3	1	7	1.9
Worth	2	5	8	4	19	4.7
Summary	58	49	57	46	210	3.6
GA						3.1
	Other				Total	
	2011 N	2012 N	2013 N	2014 N	N	% Of
Dougherty	0	0	4	0	4	
Lee	0	0	0	0	0	0.0
Mitchell	0	1	0	0	1	
Terrell	0	0	0	0	0	0.0
Worth	0	0	0	0	0	0.0
Summary	0	1	4	0	5	1.0
GA						1.3

Priority II: Birth Outcomes and Reproductive Responsibility

This table shows Low Birth Weight data from Albany Area Primary Health Care's (AAPHC) Obstetrics and Gynecology Group. AAPHC provides OB/GYN services to those most at risk to giving birth to a LBW infant. Many of these mothers giving birth are head of household—single parents, face extreme poverty, and experience difficult pregnancies. When compared to other Federal Qualified Health Centers, AAPHC's percentage of low birth weight infants is more than twice that of other national health centers. Infants born premature often require specialized medical care including intensive care nurses. Risk factors for prematurity include lack of pre-conception health, lack of prenatal vitamins, smoking, alcohol or drug use and birth spacing. The total number of premature births has decreased by 44 cases since 2010 with a very slight decrease in percentage. According to data from the State Public Health data system. Black/AA are 50% more likely to give birth to a premature infant than whites.

Pre-Mature Births <37 Weeks Gestation



Measure	Statistic Group	2012	2013	2014	2013-2014		2012-2014	
					Change	%	Change	%
Low Birth Weight (Live births <2500 grams)	National Health Centers	7.14%	7.29%	7.29%	0.00%	-0.06%	0.15%	2.10%
	Georgia Health Centers	9.57	9.96	9.65	-0.31%	-3.13%	0.07%	0.76%
	AAPHC	18.69%	15.77%	16.07%	1.92%	3.44%	-3.10%	-5.10%

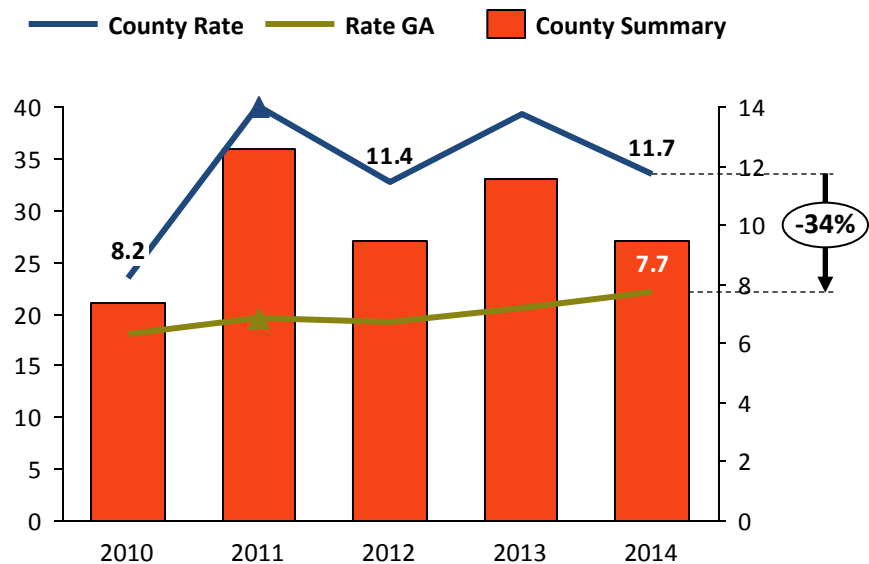
Data Source: AAPHC, Heather Combs, 2016

	White				Total	
	2011 N	2012 N	2013 N	2014 N	N	% Of
Dougherty	35	21	35	20	111	10.6
Lee	32	26	22	33	113	10.5
Mitchell	11	8	11	13	43	10.1
Terrell	3	4	4	7	18	14.6
Worth	13	14	19	16	62	10.1
Summary	94	73	91	89	347	10.6
GA	9.5					
	Black/AA				Total	
	2011 N	2012 N	2013 N	2014 N	N	% Of
Dougherty	185	152	157	150	644	15.4
Lee	16	7	11	5	39	12.3
Mitchell	23	20	17	21	81	13.4
Terrell	15	20	16	10	61	16.9
Worth	15	20	23	18	76	18.7
Summary	254	219	224	204	901	15.3
GA	13.8					
	Other				Total	
	2011 N	2012 N	2013 N	2014 N	N	% Of
Dougherty	7	6	9	13	35	13.2
Lee	5	0	3	4	12	12.8
Mitchell	2	5	1	2	10	13.0
Terrell	0	0	2	0	2	
Worth	1	1	0	0	2	
Summary	15	12	15	19	61	12.6
GA	9.1					

■ Above State Mean
■ Below State Mean

Priority II: Birth Outcomes and Reproductive Responsibility

The Infant Mortality Rate has risen since 2010 consistent with State trends. In fact, the County Summary rate has grown by 43% since 2010 while the gap between the State average and County Summary average widens. As with other birth data, AA/Black children are twice as likely to die in infancy than their white counterparts. The leading causes of death among infants are birth defects, pre-term delivery, low birth weight, Sudden Infant Death Syndrome (SIDS), and maternal complications during pregnancy. The Healthy People 2020 national health target is to reduce the infant mortality rate to 6 deaths per 1,000 live births. In 2014, the Primary Service Area had an 11.7 infant mortality rate - a third-higher than the GA rate.



Date Source: Georgia Department of Public Health, Oasis, 2016

County	Race	Cases	Rate
Dougherty	White	10	7.4
	Black	89	16.7
Lee	White	11	8.3
	Black	6	15.6
Mitchell	White	5	9.1
	Black	8	10.2
Terrell	White	0	0
	Black	6	13.0
Worth	White	3	*
	Black	4	*
PSA Total	White	22	7.0
	Black	93	15.2
GA Total	White		5.7
	Black		11.4

Priority II: Birth Outcomes and Reproductive Responsibility

[Phoebe Putney Memorial Hospital](#) provides a full service labor and delivery unit and includes: (1) 10 Suites for routine delivery (2) High risk pregnancy monitoring, 2 ante-partum suites, 2 caesarian birthing suites, Mother/baby Unit, Neonatal Intensive Care Unit, Network of Trust, and a Neonatal Outreach and Maternal Outreach Education program. PPMH is also designated as a Regional Perinatal Center by the State of Georgia.

[Albany Area Primary Health Care](#) offers birthing classes quarterly to provide information for expectant parents on the child birth process, breastfeeding, newborn care, and pediatrics.

[District Public Health](#) offers Centering , a group model of prenatal care with sessions located at the Dougherty County Health Department. Studies show that group prenatal care reduces premature birth, results in higher birth-weight babies and increased breastfeeding. The Women, Infants and Children (WIC) program services women who are pregnant, non-lactating up to six month postpartum, and lactating up to twelve months postpartum, and children up to five years of age who are at nutritional risk. Family Planning services are designed to support families in planning and spacing their children to improve the health of women so that with pregnancy the potential for a healthy outcome for the mother and child is improved. Perinatal Case Management connects low-income pregnant women to health care providers for prenatal care, assists the expectant mother with obtaining the services of a pediatrician in preparation for delivery and follows an established plan with periodic reassessment to identify support services needed throughout the pregnancy. Their Acute, Chronic and Infectious Disease Program provides HIV/AIDS counseling, testing and referral services and oversees testing, treatment and management of common STD's as well as prevention education.

[The Alpha Pregnancy Center](#) provides free counseling, pregnancy testing, ultrasound and support and personalized education including healthy pregnancy and parenting. The Center provides support to women of all ages and from all walks of life who may be pregnant and are possibly facing difficult decisions.

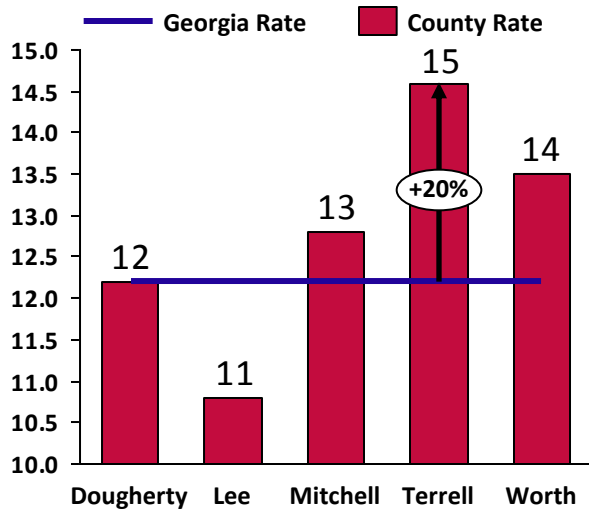
[The Boy's and Girl's Club of Albany, GA](#) uses Smart Moves which is a prevention based program that addresses the tough issues of drug and alcohol use and premature sexual activity. The program is designed to promote abstinence from substance abuse and adolescent sexual involvement.

[Girls Inc. Preventing Adolescent Pregnancy](#) is a knowledge and skills based program designed to teach girls how to take charge of and make informed decisions about their sexual health.

Priority III: Prevention and Management of Chronic Diseases

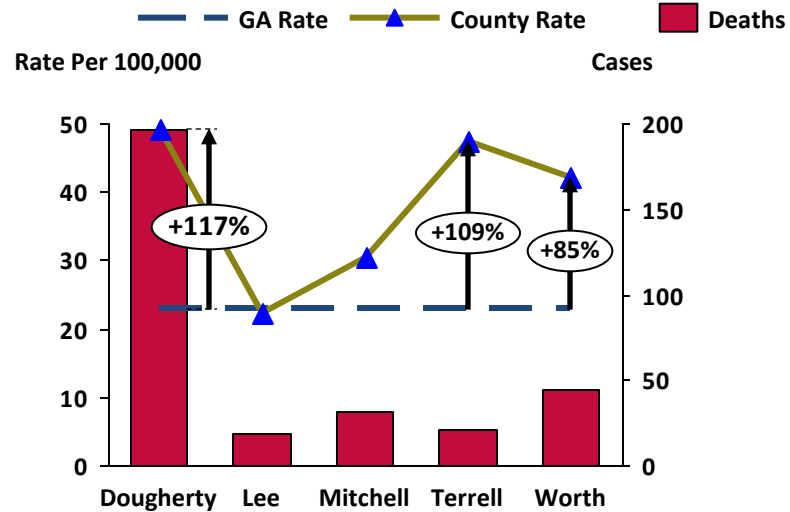
Compared to State Average, Terrell County has the highest diabetes Prevalence rate, exceeding the state average by 20% followed by Worth and Mitchell. Other than Lee County, age adjusted death rates due to diabetes were more than twice the State average for Dougherty and Terrell and almost double in Worth County.

Prevalence of Diabetes Among Adults Age 20 or older-2012



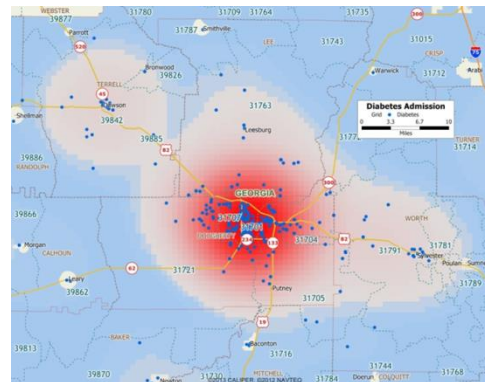
Data Source: Centers for Disease Control and Prevention

Age Adjusted Death Rate due to Diabetes 2014

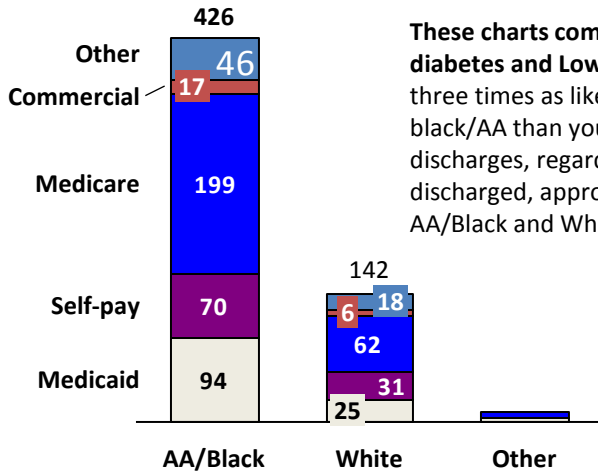


Date Source: Georgia Department of Public Health, Oasis, 2016

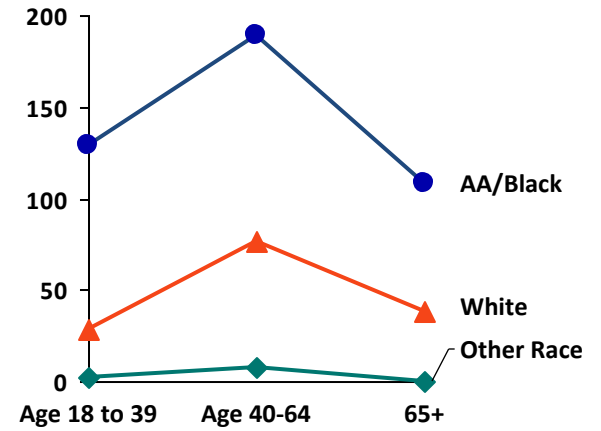
The heat map to the right shows all Phoebe-Albany Inpatient Discharges from diabetes including Lower Extremity Amputations due to diabetes for fiscal Year 2015. The Hotspot follows the same pattern as Low Birth Weight Infants with concentration in zip codes 31701 and 31705. The same Zip Codes have the worst SocioNeeds Index that correlates with low health outcomes.



Priority III: To build Chronic Based Coalitions

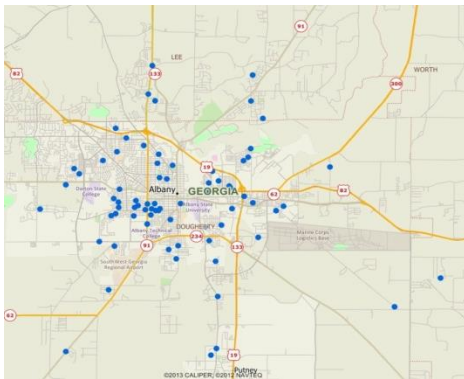


These charts combine short and long term diabetes, uncontrolled diabetes and Lower Extremity Amputation due to diabetes. You are three times as likely to be discharged from the hospital if you are black/AA than your white counterpart. The highest number of discharges, regardless of race, is the age 40-64 cohort. Of those discharged, approximately 40% were either poor or uninsured among AA/Black and White.

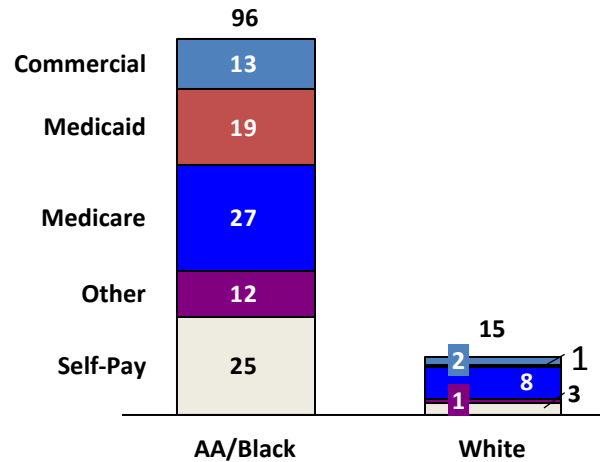


Of all identified PQI-hypertension cases, 86% were AA/black illustrating a significant disparity with slightly half of these either on Medicaid or uninsured [see chart on the right]. The dot density map shows the largest cluster in some of the poorest neighborhoods in the United States.

DOT DENSITY MAP OF HYPERTENSION

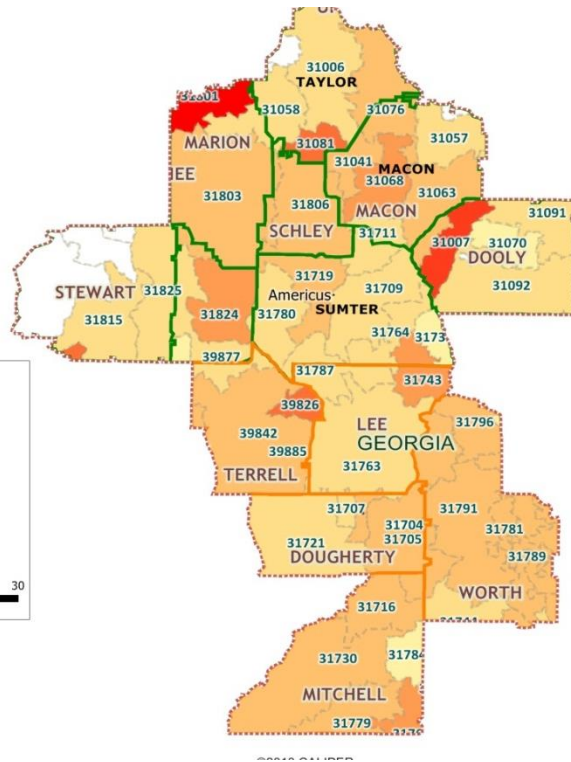


Data Source: Jim Franklin, PPMH Quality Improvement

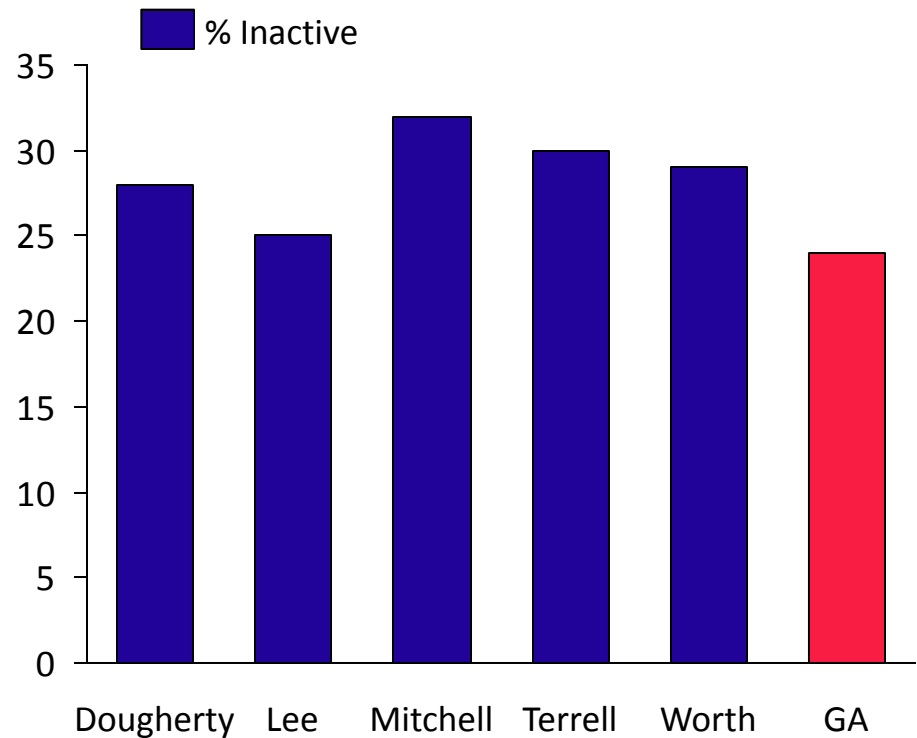


Priority III: Prevention and Management of Chronic Diseases

However, internal data from Athena from all Phoebe Physician Group locations, shows adult obesity percentages closer to 48% of the patients that come to one of its facilities. Compared to the Georgia Average, all counties had a higher inactivity percentage as measured by County Rankings. Obesity in adults increases the risk of many diseases and health conditions including heart disease, Type 2 diabetes, cancer, hypertension, stroke, liver and gallbladder disease, respiratory problems, and osteoarthritis.



Percentage of Physical Inactivity



Data Source: Ryan Graham, PPMH, Ambulatory Applications, 2015

County Rankings, 2015

Priority III: To build Chronic Based Coalitions

Dr. Kile is an [endocrinologist](#) at the Veranda and has a staff of two Nurse Practitioners.

[The Dougherty County Extension Office](#) offers healthy eating and cooking classes on Diabetes.

The [Samaritan Clinic](#), a free clinic for indigent patients, provides diabetes management supplies and educational sessions.

[YMCA of Albany, GA](#), hosts a diabetes management program and previously partnered with Phoebe for a Diabetes Management Camp for Kids.

[Phoebe Diabetes Resource Center](#) provides comprehensive diabetes education, gestational diabetes education, insulin instruction, insulin pump management, nutrition counseling, carbohydrate counting instruction and continuous glucose sensor monitoring.

[Phoebe's School Nurse Program](#) provides diabetes management in partnership with Medical College of Georgia partners and the Phoebe Diabetes Center.

CURRENT IMPLEMENTATION PLAN

EVALUATION

Phoebe Putney Memorial Hospital 2013-2016 Implementation Plan

NEED IDENTIFIED:	To Improve Maternal, Infant, and Child Health and Reproductive Responsibility																										
Objective:	To improve the birth outcomes to include low and very low birth weight, infant mortality, pre-term births, and teen pregnancy																										
Initiative/Program/Service Population Target	Timeline	Action Steps/Responsible Party	Target Completion Date & Metrics-status																								
Initiatives: (1) Develop Partnerships and Support Collaboration Population Target: At-risk Teens, Single Moms, At-risk Mothers-particularly living in Census Tract 8, low socio-economic status, Pregnant Women and High-risk neonates	2013-2016 <i>On-going</i>	1. Continue relationship with Family Connection and the Teen Maze Event	<p style="text-align: center;">Premature Births-PSA</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">2011</th> <th style="text-align: center;">2012</th> <th style="text-align: center;">2013</th> </tr> </thead> <tbody> <tr> <td>Percent</td> <td style="text-align: center;">14.9</td> <td style="text-align: center;">13.4</td> <td style="text-align: center;">17.2</td> </tr> <tr> <td>Number</td> <td style="text-align: center;">385</td> <td style="text-align: center;">317</td> <td style="text-align: center;">416</td> </tr> </tbody> </table> <p>Healthy People 2020 Goal: 11.4%</p> <p style="text-align: center;">TEEN BIRTH RATE-PSA</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">2011</th> <th style="text-align: center;">2012</th> <th style="text-align: center;">2013</th> </tr> </thead> <tbody> <tr> <td>Percent</td> <td style="text-align: center;">57.1</td> <td style="text-align: center;">54.2</td> <td style="text-align: center;">46.9</td> </tr> <tr> <td>Number</td> <td style="text-align: center;">373</td> <td style="text-align: center;">344</td> <td style="text-align: center;">289</td> </tr> </tbody> </table> <p>Health People 2020 Goal: 21.7%</p> <p style="text-align: center;">Low Birth Weight Infants-PSA</p>		2011	2012	2013	Percent	14.9	13.4	17.2	Number	385	317	416		2011	2012	2013	Percent	57.1	54.2	46.9	Number	373	344	289
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	Number	385		317	416																						
		2011		2012	2013																						
Percent	57.1	54.2	46.9																								
Number	373	344	289																								
<i>Not Started</i>	2. Partner with Albany State University to conduct focus groups of women who gave birth to low birth weight children, targeting inner city Albany and, in particular census tract 8.																										
<i>In Process</i>	3. Form or re-energize a taskforce with the goal to improve birth outcomes and to reduce teen pregnancy.																										
<i>On-going</i>	a) Initial discussions with Phoebe's Women and Children Division to create a workgroup.																										
<i>On-going</i> <i>Not-Started</i>	4. Phoebe and NOT will support Teen Breastfeeding Initiative.																										
	a) Phoebe is seeking <u>Baby Friendly</u> designation and has received a grant. Launch date is 9/9/2015. The goal is to encourage breastfeeding, non-separation and mother-baby dyad.																										
<i>On-going</i>	5. Support and Facilitate expansion of centering pregnancy program – The Southwest District Health plans to seek permission from PPMH's Institutional Review Board to conduct a research study with a control group to determine the impact of the centering program on low birth																										

<p>(3) Early Elective Deliveries Target Population: Women and Infants</p> <p>(4) Education Target Population: health care providers</p> <p>(5) Marketing Target Population: Children and Families</p>	<p>Not Started</p>	<p>a.1.5. Expand NICU bed capacity through the CON process and repurposing of facility space. (a)NICU expansion continues to be a priority and once a comprehensive facility plan is complete, NICU bed capacity will go through the CON process</p> <p>a.1.6. PPMH is expanding access to the current cadre of pediatric subspecialty physicians with Georgia Regents University Responsible: Network of Trust, Women's and Children's, Strategy and Planning,</p> <p>1. Work with physicians to reduce the number of induced births. Person Responsible: Women's and Children's</p> <p>a) There have been no Early Elective deliveries in the past two years.</p> <p>1. Baby Friendly Education and Awareness program –Neonatal Outreach coordinator at PPMH will continue to provide community-based services as a part of the perinatal outreach program Responsible: Perinatal Outreach</p> <p>(1) Coordinate a campaign with city, county and state entities addressing reproductive responsibility.</p>	<p>Teen Pregnancy Rate</p> <table border="1"> <thead> <tr> <th></th> <th>2010</th> <th>2011</th> <th>2012</th> </tr> </thead> <tbody> <tr> <td>Dougherty</td> <td>59.0</td> <td>53.5</td> <td>49.7</td> </tr> <tr> <td>Lee</td> <td>12.8</td> <td>11.6</td> <td>11.8</td> </tr> <tr> <td>Mitchell</td> <td>25.9</td> <td>20.2</td> <td>34.4</td> </tr> <tr> <td>Terrell</td> <td>51.3</td> <td>42.6</td> <td>58.4</td> </tr> <tr> <td>Worth</td> <td>20.0</td> <td>33.9</td> <td>18.2</td> </tr> </tbody> </table> <p>Healthy People 2020 Tracker: 36.2</p> <p>Infant Mortality Rate</p> <p>PSA</p> <table border="1"> <thead> <tr> <th>Number</th> <th>2011</th> <th>2012</th> <th>2013</th> </tr> </thead> <tbody> <tr> <td>Dougherty</td> <td>26</td> <td>20</td> <td>23</td> </tr> <tr> <td>Lee</td> <td>6</td> <td>0</td> <td>2</td> </tr> <tr> <td>Mitchell</td> <td>3</td> <td>4</td> <td>2</td> </tr> <tr> <td>Terrell</td> <td>1</td> <td>1</td> <td>2</td> </tr> <tr> <td>Worth</td> <td>0</td> <td>2</td> <td>2</td> </tr> </tbody> </table> <p>Composite Rate: 11.8 Georgia: 7.2</p>		2010	2011	2012	Dougherty	59.0	53.5	49.7	Lee	12.8	11.6	11.8	Mitchell	25.9	20.2	34.4	Terrell	51.3	42.6	58.4	Worth	20.0	33.9	18.2	Number	2011	2012	2013	Dougherty	26	20	23	Lee	6	0	2	Mitchell	3	4	2	Terrell	1	1	2	Worth	0	2	2
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NEED IDENTIFIED:	Behavioral Health		
Objective:	To Facilitate a sustainable community mental health continuum of care model with an emphasis on addressing identified gaps in service.		
Initiative/Program/Service Population Target	Timeline	Action Steps/Responsible Party	Target Completion Date & Metrics-status
<p>Initiatives:</p> <p>(1) Taskforce/Workgroup Target Population: Mental Health Providers and Advocates</p> <p>(2) Anti-bullying Target Population: School-age children and Teachers</p> <p>(3) Funding Target Population: Private non-profit providers</p>	<p>On-going</p> <p>Defunded</p> <p>2013-2016</p> <p>2014</p> <p>On-going</p>	<p>1. PPMH will convene a community collaborative of stakeholders and professionals in mental and behavioral health to examine resources define gaps and craft solutions for improved stabilization of patients.</p> <p>a) Phoebe host a community collaborative every quarter and includes agencies such as Aspire, NAMI, Suicide Prevention, Phoebe Behavioral Health, Mobile Crisis Team, AHEC, Alzheimer's Outreach, ASU, Albany Tech, AAPHC and representation from DBHDD-Region 4. They main focus centers on getting programmatic updates from each provider that attends.</p> <p>1. Continue to provide and support anti-bullying measures in the schools through the funding of <u>HealthTeachers</u> and <u>Awesome Upstander!</u> <u>curricula</u>. (a) <u>HealthTeacher</u> was defunded due to budgetary constraints</p> <p>1. PPMH will continue to fund through Community Visions grants program not-for-profit organizations that address mental health issues with evidence-based, measurable programming aligned to this health needs priority</p> <p>2. PPMH has funded a local non-profit initiative by the Albany 100 Black Men called Youth Mental Health Alliance that will be operated in local schools targeting elementary and middle school</p>	<p>Completed</p>

<p>(4) Advocacy and Support Target Population: Children who grieve from a loss</p>		<p>students from fatherless homes Responsible: Community Works</p> <p>(1) PPMH will continue to provide various behavioral health support groups and camps such as Camp Good Grief Responsible: Hospice</p>	
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NEED IDENTIFIED:		Healthy Lifestyles to Reduce Chronic Disease	
Objective:		To promote healthy living lifestyles that reduces obesity and related acute and chronic diseases.	
Initiative/Program/Service Population Target	Timeline	Action Steps/Responsible Party	Target Completion Date & Metrics-status
<p>Initiative: (1) Support Services Target Population: Underinsured and Uninsured</p>	2013-2016	<ol style="list-style-type: none"> 1. PPMH is planning the implementation of a congestive heart failure clinic to address the significant incidence in the community 2. PPMH will continue to operate the Southwest Georgia Family Medicine Residency program <ol style="list-style-type: none"> a) Residency program graduated 7 this year. 3. PPMH is developing and implementing a lung cancer screening program to provide better access with a goal of earlier diagnosis and treatment. <ol style="list-style-type: none"> A) The lung program has completed 613 lung screens since January 2014 with 18 confirmed cases. 4. PPMH will continue to support Albany Area Primary Health Care's chronic disease management program and continue primary care initiatives in its Phoebe Physician Group practices. 5. PPMH will continue to support and fund South 	



NEED IDENTIFIED:	Health Literacy		
Objective:	To Promote health literacy, education, awareness and access to care		
Initiative/Program/Service Population Target	Timeline	Action Steps/Responsible Party	Target Completion Date & Metrics-status
<p>Initiatives:</p> <p>1. Education and Awareness Target Population: Community at large, Uninsured, school-age children</p>	July 2016	<ol style="list-style-type: none">1. Increase awareness for cancer trial participation.2. Share and show Phoebe's Community Health Dashboard tool to the public.3. Provide Community information and assistance for selecting and enrolling in insurance exchanges to promote better access to care and eliminate. PPMH will partner with other providers and community organizations to achieve this. A) Completed- Phoebe Putney in partnership with AAPHC provided education and support to understand the enrollment process for the health exchanges4. Network of Trust will employ a full-time outreach coordinator to implement a health futures Program in schools that is aimed to increasing school persistence and teaching skill sets for career development Responsible: Network of Trust, Strategy and Planning, Community Benefit Coordinator A) Plans withdrawn due to budget cuts.	

FINANCIAL ASSISTANCE POLICY

Approved by: PPHS Board of Directors

Review Period: Annually

Contact Information: VP Revenue Cycle

Review Date:

Revised Date:

Approval Date:

Effective Date:

SCOPE: This Policy applies to Phoebe Putney Health System (PPHS) hospital facilities and Phoebe Physician Group (PPG) providers providing care within PPHS facilities.

PURPOSE: PPHS as a not-for-profit charitable corporation is committed to fulfilling its charitable mission of each hospital by providing high quality medical care to all patients in their service areas, regardless of their financial situation.

POLICY: PPHS hospitals and PPG physicians shall provide financial assistance according to the PPHS Financial Assistance Program (FAP) policy for persons who have healthcare needs and are uninsured or under-insured, ineligible for government program, and otherwise unable to pay for medically necessary care based on their individual financial situation. Based on financial need, either reduced payments or free care may be available. The Financial Assistance Program is administered by the Revenue Cycle of each PPHS hospital and PPG, with authority and approval from the PPHS Board of Directors

DEFINITIONS

Amounts Generally Billed (AGB) means the amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care, determined in accordance with § 1.501(r)-5(b). AGB is determined by dividing the sum of claims paid the previous fiscal year by Medicare fee-for-service and all private health insurance, including payments received from beneficiaries and insured patients, by the sum of the associated gross charges for those claims.

Applicant: Applicant may include the patient, the guarantor of a patient's financial account, or a designated patient's representative such as a legal guardian.

Assets: Assets include but are not limited to: bank accounts; investments including 401k and 403b accounts; real property; businesses whether or not incorporated; personal property including vehicles, boats, airplanes, and other such items. Assets shall be reported on the FAP application as a source of revenue.

Catastrophic Status: Applicants whose balance owed exceeds 25% of the patient's annual income, resulting in excessive hardship.

Financial Assistance Program (FAP): PPHS program that provides financial assistance to persons who have emergent and/or medically necessary healthcare needs and are uninsured or under-insured, ineligible

and Active Labor Act (EMTALA). This policy prohibits any action that would discourage individuals from seeking emergency medical care (EMC) including but not limited to demanding pay before treatment for emergency medical conditions or by permitting debt collection activities that interfere with the provision, without discrimination, of EMC.

Financial Assistance

PPHS Hospital Facilities will extend free or discounted care to eligible individuals for all other medically necessary services. The FAP applies to medically necessary services that are not elective in nature.

Who may apply for financial assistance?

Patients, or the person legally responsible for their bill, may request financial assistance in regards to their obligation at any time before or during the billing process. Patients, or the person legally responsible for their bill, may meet guidelines for full or partial assistance.

Who is eligible for financial assistance?

You may be eligible for financial assistance if you:

Have limited or no health insurance

Are not eligible for a Federal or State health care program that would cover the specific services, or a specified episode or plan of care, for which you are making this application

Can show that you have financial need

You are a legal resident of a county within the PPHS service area

You have less than \$175,000 in assets

The PPHS service area encompasses the following counties (see map in Exhibit 3):

PPMH and PSMC: Baker, Calhoun, Dooly, Dougherty, Lee, Macon, Marion, Mitchell, Randolph, Schley, Stewart, Sumter, Terrell, Webster, and Worth

PWMC: Dougherty and Worth

Georgia residents who are existing patients of PPG physicians will be deemed to have met the residency requirement regardless of which county in Georgia they currently reside.

You are not eligible for financial assistance if you:

- Refuse to apply for a State or Federal health care program.
- Refuse to apply for an individual or a group market health plan when legally entitled to do so
- Not a legal resident of a county within the PPHS service area
- Not a US resident
- Your plan of care is covered under liability or worker's compensation with no proof of denial of coverage
- Your plan of care is covered under liability still in litigation or where the payment went to the subscriber

A. What services are eligible for financial assistance?

Financial assistance is available for eligible patients who require:

- Emergency medical services
- Other non-elective and medically necessary services

Financial assistance is not available for the following:

- Elective plastic surgery
- Services that are not medically necessary
- Services covered by State or Federal agencies such as, but not limited to, Cancer State Aid, Disability Adjudication

A. When do you have to apply for financial assistance?

- For non-emergent services, patients who expect to need assistance must apply for a financial assistance determination prior to obtaining care.
- Patients may also request financial assistance at any time during pre-registration, registration, inpatient stay, or throughout the course of the billing and collections cycle by requesting and completing an application for financial assistance.
- The time limit to apply for financial assistance twelve is (12) months from the time the patient became responsible for the account balance, unless the patient initiated a payment plan. There is no time limit to apply for the FAP when the patient was participating in a payment plan but has a change in financial circumstances.

How does an eligible person apply for financial assistance?

1. *Download or request the FAP Application*

The FAP application, along with a complete list of any required documentation that you may be required to submit, is available in English and Spanish at <http://www.phoebe.com>. To request an application for financial assistance, a copy of the detailed financial assistance policy, or if you have any questions about the process please contact the Financial Counseling team.

Note: PPHS may use a propensity-to-pay or presumptive charity scores to determine a patient's financial status and a patient's ability to pay for bills already incurred. These scores are obtained by using a data analytics model that helps us identify patients that qualify for financial assistance but may not have specifically requested it.

Complete the FAP Application.

Complete the FAP application and submit it, along with the documentation listed in the FAP application, directly to the Financial Counseling team or by mailing it to the PPHS Facility of application. Financial Assistance will not be denied based solely upon an incomplete application initially submitted. A PPHS representative will contact patients or financial guarantors via mail to notify of additional documentation requirements. Patients will have fourteen (14) business days to return additional information.

The Financial Counseling team will review your application and notify you of their decision

PPHS will review all FAP applications in a timely fashion. PPHS employees may require an interview with the applicant. If an interview is required, the FAP application may be completed at that time if all required documents have been provided. Once a completed application is reviewed, a decision will be made and the patient/applicant will be notified in writing of the decision. Patients who do not qualify for financial assistance will be billed in accordance with PPHS policy as a means of making arrangements for payments or obtaining payment in full.

You may appeal the decision

Applicants who receive a letter of denial may appeal the denial. The appeal must be made within thirty (30) days of the date of the letter of denial.

What financial assistance is available?

Level 1 Status: Household incomes at or below 125% of the FPG are eligible for free care as provided in the FAP.

Level 2 Status: Household incomes between 126% and 200% of FPG qualify for discounted charges for care (see Exhibit 1).

Catastrophic Status: Applicants, including applicants whose incomes exceed 200% of FPL, whose balance owed exceeds 25% of their annual income, resulting in excessive hardship, qualify for discounted charges for care on a sliding scale basis ranging from 89% to 60% based on income and number of dependents. Applicants that qualify for both Catastrophic Status and Level 2 Status will receive whichever discount is greater. Additionally, PPHS hospitals and physicians provide financial assistance to indigent patients for services needed that a physician deems necessary for post-discharge care, in accordance with PPHS policies and procedures

Billing and Collection

PPHS makes reasonable efforts to ensure that patients are billed for their services accurately and timely. PPHS will attempt to work with all patients to establish suitable payment arrangements if full payment cannot be made at the time of service or upon delivery of the first patient statement.

PPHS maintains a separate billing and collections policy which describes in detail the actions PPHS hospital facilities and PPG may take in the event of non-payment. Copies of the PPHS Billing and Collections Policy are available to members of the community for no charge at <http://www.phoebeputney.com> and also upon request to the Financial Counseling Department.

Communication of the Financial Assistance Program

PPHS shall take the following measures to widely publicize its FAP:

Notice of the PPHS FAP is posted in areas where patients may present for registration prior to receiving medical services at any of the PPHS hospital facilities, or where any patients/patient representatives may make inquiries regarding their hospital bills. Information is available in English and Spanish.

All patients of PPHS hospitals will be offered a plain language summary of the FAP and upon request, receive a FAP Application prior to being discharged from a PPHS hospital.

The FAP Policy, FAP Application, and a plain language summary are available on the PPHS website in English and Spanish at <http://www.phoebeputney.com>. A plain language summary is also in the PPHS Patient Handbook, in the “Guide to Understanding Your Hospital Bill”, and is referenced in patient statements and letters.

The FAP Policy, FAP Application, and plain language summary are available without charge upon request and by mail. In-person requests may be made to any registration area of any PPHS hospital, the Financial Counseling Department, and the Patient Accounting Department. Written requests can be submitted to addresses set forth in Exhibit 2 to this Policy.

The FAP plain language summary will also be made available at community health centers, Financial Counselors are available to discuss the Financial Assistance Program and to accept and assist with applications. Hours of operations are set forth in Exhibit 2 to this Policy.

REFERENCES:

Federal Poverty Guidelines

Patient Protection and Affordable Care Act, Public Law 111-148 (124 Stat. 119 (2010))

Internal Revenue Service Regulations s. 1.501(r)-1 through s. 1.501(r)-7

APPENDIX I

OTHER SELECTED INDICATORS AND METRICS

Social Determinants of Health: County Rankings 2016

	Dougherty	Lee	Mitchell	Terrell	Worth
Length of Life	145	38	84	129	52
Quality of Life	151	14	133	155	120
Health Behaviors	153	27	145	144	88
Clinical Care	19	18	51	81	122
Social and Economic Factors	151	16	90	100	77
Physical Environment	25	16	4	49	30
Health Outcome Ranking	154	18	112	153	78
Health Factor Ranking	135	10	88	115	84

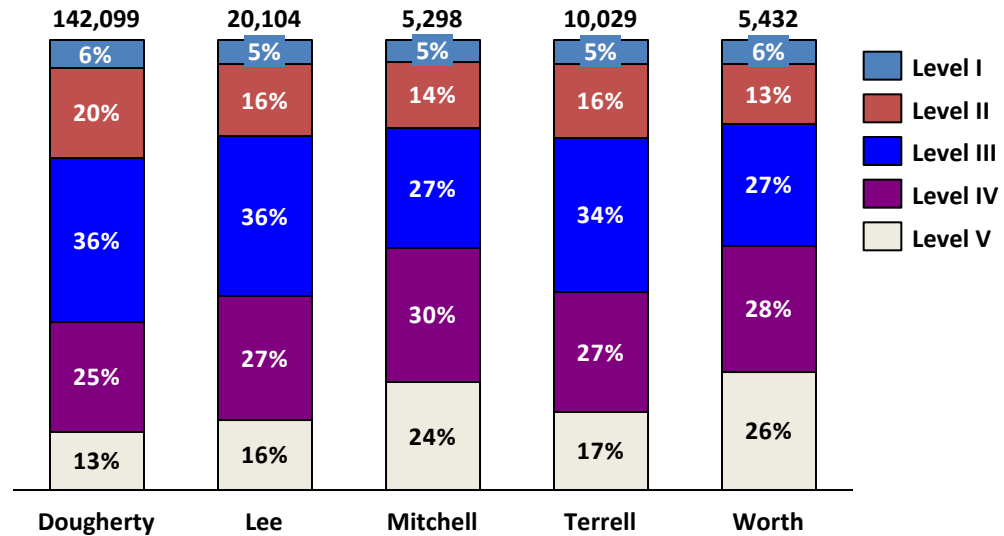
2013 Behavior Risk Surveillance Survey (BRFSS) Health District 8 Unit 2

Selected Indicator	%	M	F	White	AA/Black	Georgia	M	F	White	AA/Black
Binge Drinking	10.6	15.9	5.6	13.5	7.8	13.1	17.3	9.2	15.1	9.4
Heavy Drinking	3.8	5.2	2.6	6.2	1.0	4.7	5.6	3.8	5.4	3.6
Med Appt Due to \$	17.4	13.0	21.3	15.1	20.2	19.8	16.1	23.2	16.2	24.5
Poor Health	18.8	16.4	21.0	17.2	20.9	19.0	17.5	20.5	16.4	21.4
Smokeless Tobacco	5.6	9.4	2.2	6.5	4.4	5.0	8.4	1.8	6.0	4.0
Smoking	20.2	17.3	22.9	27.5	14.0	18.8	22.5	15.4	20.6	16.0
Doc Visit Past Year	70.8	64.3	76.3	70.7	75.1	72.9	69.0	76.4	72.9	78.1
Mammography	78.4			76.6	82.1	81.7			80.2	85.6
Seat Belt Use	80.7	70.1	89.4	74.8	88.8	87.4	83.3	91.6	87.1	86.4

Potentially Avoidable EC Visits

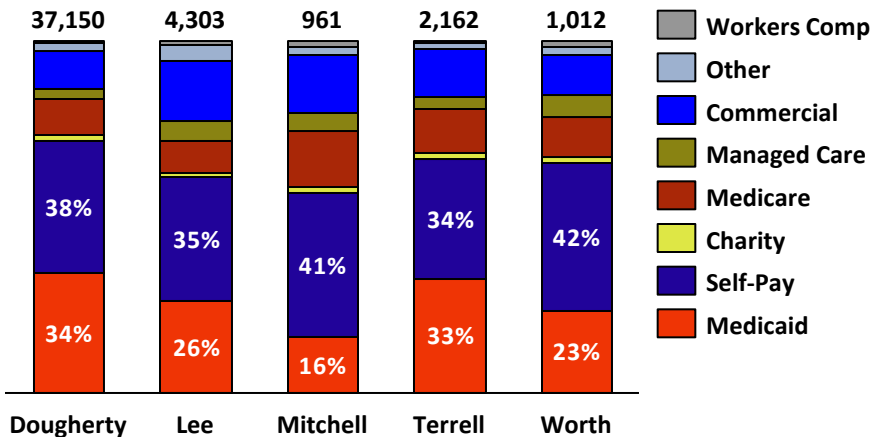
There were almost 185,000 visits over a two period in the Primary Service Area. According to Victor Garcia, regional Vice President of Phoebe Putney Emergency Services, those visits whose Severity Index is a level 1 or Level II are considered Potentially Avoidable.

Of the Potentially Preventable EC Visits, approximately two-thirds were those on Medicaid, uninsured or underinsured suggesting a myriad of underlying contradictions and blocks to care access.



N=45,654

Date Range: 08/01/2013 to July 31, 2015



What is a Potentially Preventable Event?

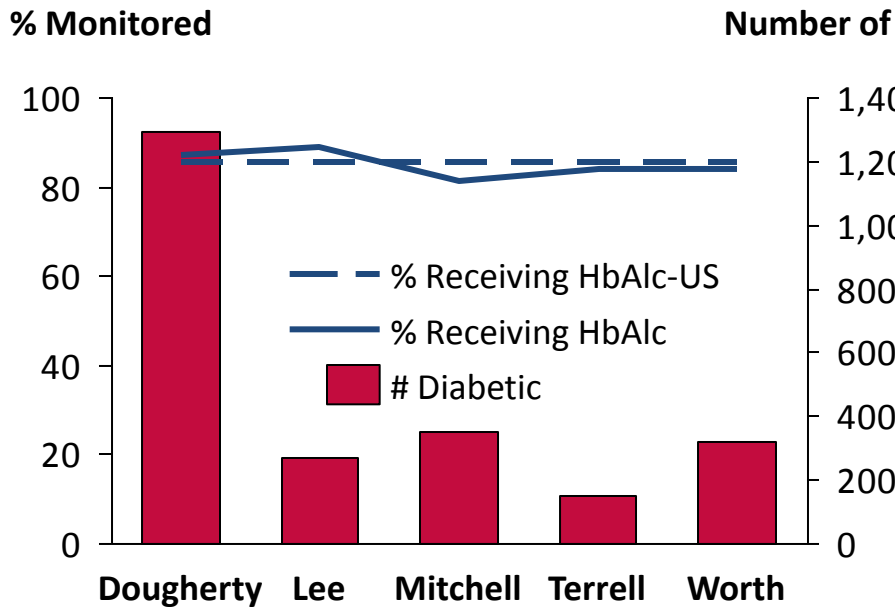
An event that could have been prevented with the right circumstances, such as:

- Timely access to high quality care in an outpatient setting;
- Improved medication management;
- Greater health and health system literacy; and
- Better coordination of care among providers across the system of care delivery and between patients, their families and health care providers.

Data Source: Anna Wade, PPMH Decision Support

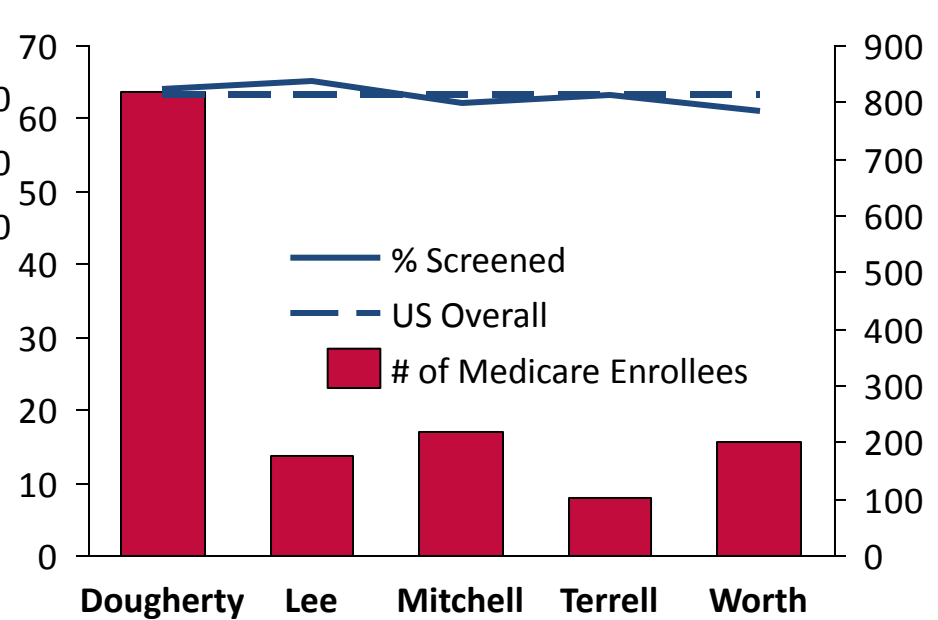
Diabetic Monitoring

Diabetes is the 7th leading cause of death in the United States and an estimated 23.6 million people have diabetes. Regular HbA1c screening among patients tells us how well the disease is being managed. There are an estimated 2,400 Medicare enrollees age 66-75 with diabetes.



Mammography Screening-Medicare Population

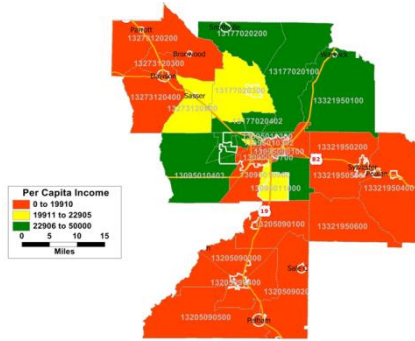
Annual mammography increase early detection of breast cancer leading to higher survival rates. Among Medicare women aged 67-69, mammography screening percentages close to or above the US Overall Screening percentage.



Data source: County Rankings, 2015

Per Capita Income by Census Tract

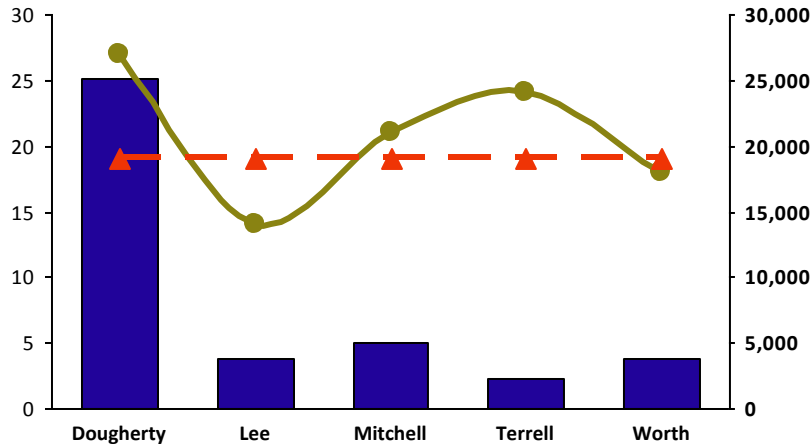
The average census tract per capita income is \$19,073 or 78% of the national average. Of the 46 census tracts shown here, 13 were at or above the national average. Contiguous tracts running from Western Albany through Lee County and Northern Worth County are relatively well-off while Dawson, Camilla, Sylvester and a swath running from Northeast Albany through South Central are some of the poorest in the nation.



Data Source: American Community Survey, 2015

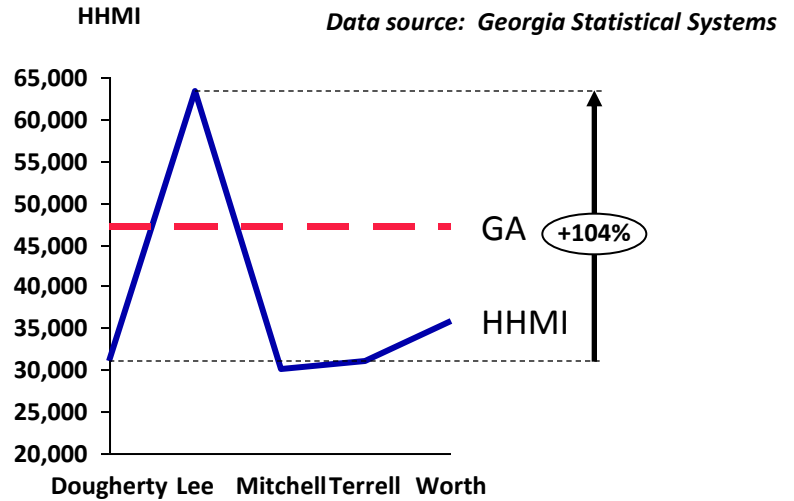
Food insecurity is an economic and social indicator of the health of a community. The USDA defines food insecurity as limited or uncertain ability to acquire these foods in socially acceptable ways. Poverty and unemployment are frequently predictors of food insecurity in the United States.

Data source: Feeding America, 2015

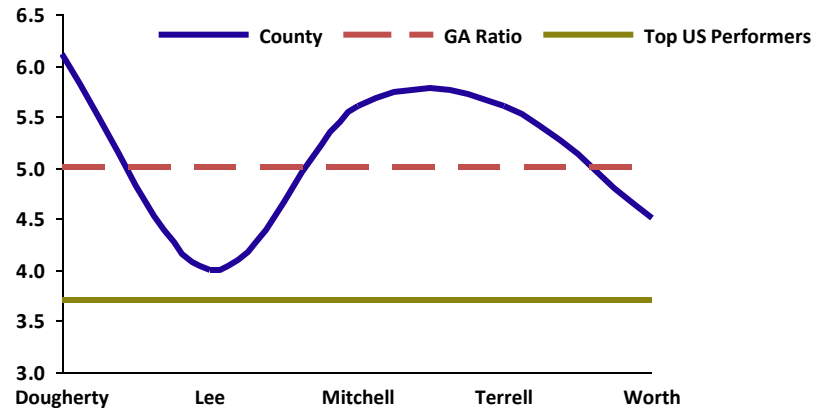


Household Median Income 2012 Model Based Estimate

With the exception of Lee County, all other counties were well below the Georgia average. In fact, Lee County's HHMI is slightly more than twice the largest county in the Primary Service Area, Dougherty.



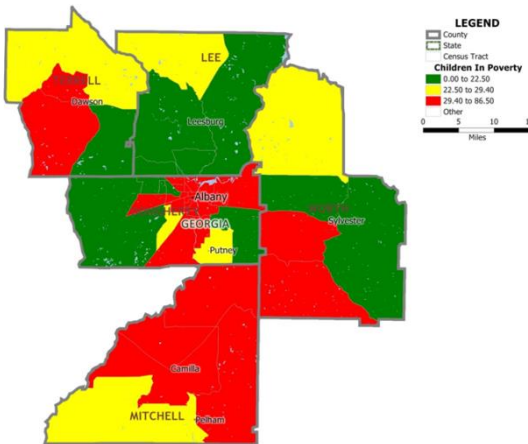
Income Inequality is the ratio of household income at the 80th percentile to that at the 20th percentile. The higher the ratio the greater the division between the top and bottom ends of the income spectrum.



Poverty and Home Ownership

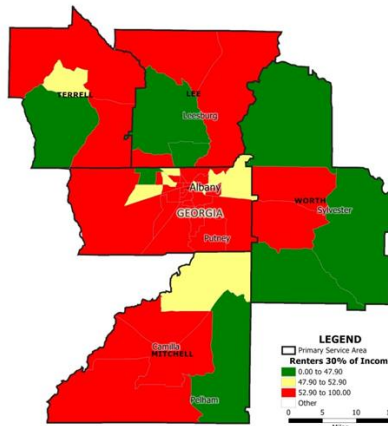
Children In Poverty are more likely to have physical health problems like low birth weight and more likely to have social and emotional problems and perform less well in school. This map shows poverty by Census Tract with 61% of the 47 tracts in the bottom quartile compared to all tracts in the United States. Another 13% placed in the 3rd Quartile and approximately 26% are at or above the US Median of 22.5%.

Data source: US Census Bureau, ASC Survey, 2010-2013



The average percentage renters pay toward occupancy is 57% of income with a range between 26.4 and 84.3 by census tract. 18% of those tracts (shown in green) are at or above the US Median.

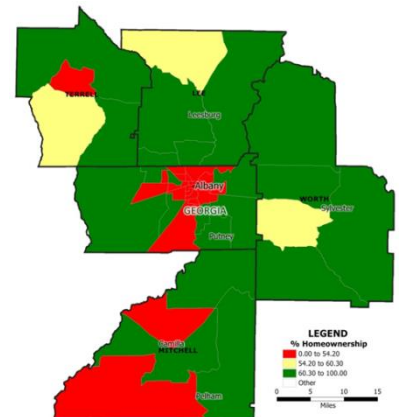
Data source: US Census Bureau, ASC Survey, 2010-2013



Renters spending 30% or More on Rent per Month by Census Tract

Homeownership has benefits for the individual and the community. Homeowners are more likely to be active in civic organizations, neighborhood associations, improve their homes and enlarge the tax base. To the right, home ownership averages 50% with almost half the tracts at or above the US Median for Home Ownership. Spending a high percentage of household income on rent can create financial hardships, especially for low-income renters. Paying a higher rent makes it difficult to purchase healthy foods, transportation or pay for medical expenses.

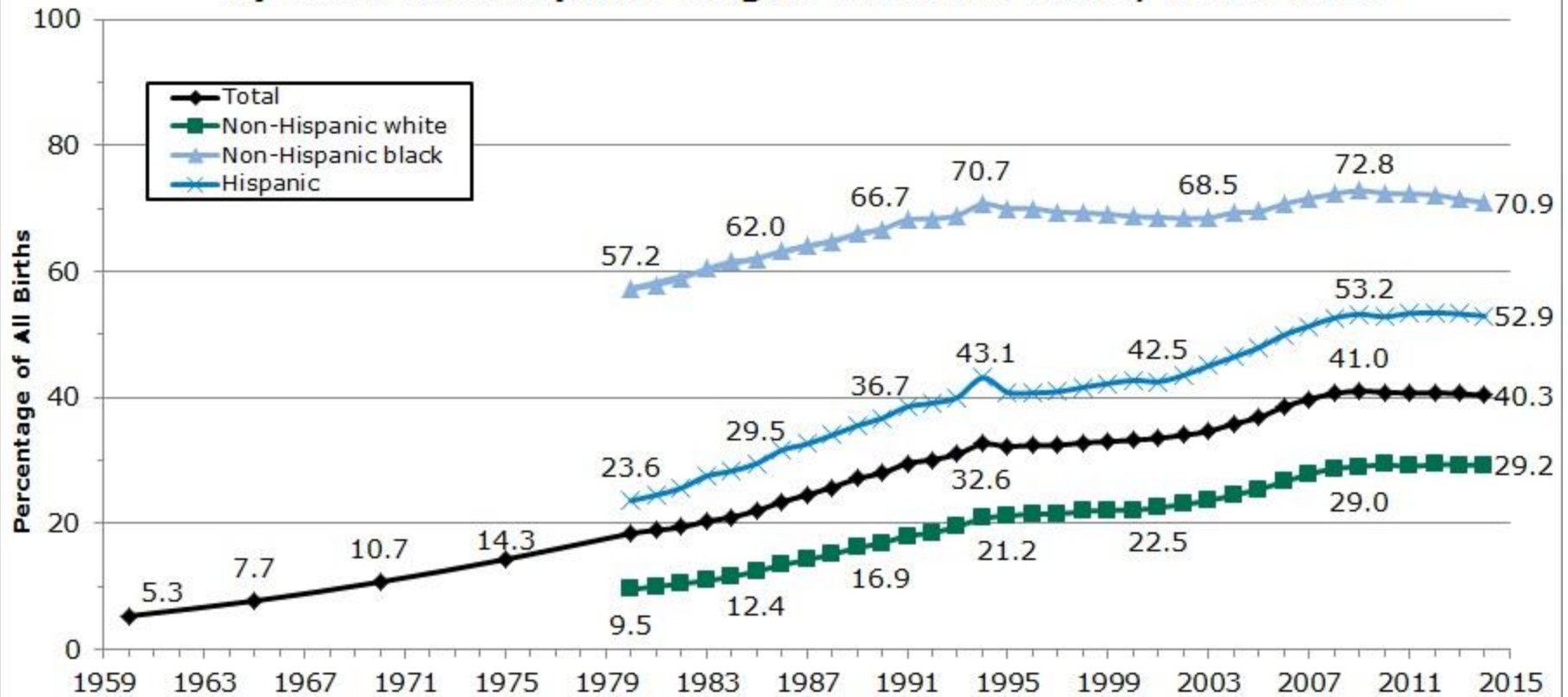
Data source: US Census Bureau, ASC Survey, 2010-2013



% of Housing Units That Are Occupied by homeowners

Figure 1

Percentage of All Births that Were to Unmarried Women, by Race and Hispanic Origin: Selected Years, 1960-2014



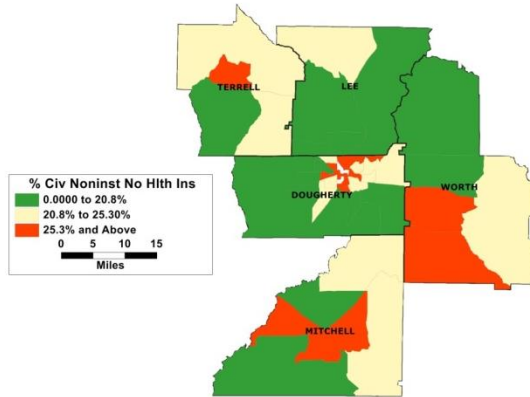
Data for 1960-1975: Ventura, S.J., Bachrach, C.A. (2000) Nonmarital childbearing in the United States, 1940-1999. *National Vital Statistics Reports*, 48(16). Hyattsville, Maryland: National Center for Health Statistics. Table 4. http://www.cdc.gov/nchs/data/nvsr/nvsr48/nvs48_16.pdf.
 Data for 1980-1989: National Center for Health Statistics. (2014) Health, United States, 2013. Hyattsville, Maryland. Table 5. Available at: <http://www.cdc.gov/nchs/hus/previous.htm#tables>.
 Data for 2011-2013: National Center for Health Statistics, CDC WONDER online tool. <http://wonder.cdc.gov/nativity-current.html>.
 Data for 1990-2010 and 2014: Centers National Center for Health Statistics, National Vital Statistics System. *VitalStats*. Demographic characteristics of mother. Available at <http://205.207.175.93/VitalStats/ReportFolders/ReportFolders.aspx>.



HEALTH AND HEALTH CARE

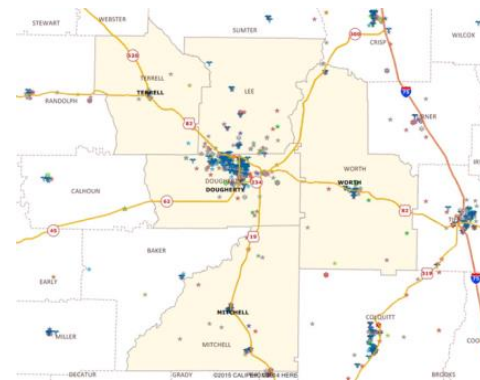
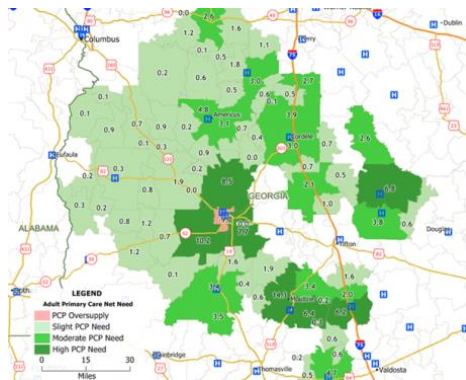
Adults without Health Insurance

Adults without insurance are less likely to seek preventative care including routine screenings and often wait until the condition worsens and becomes more difficult to treat making it more expensive. In the Primary Service Area, approximately 40% of the census tracts are at or about the US Median with 25% at the bottom quartile.

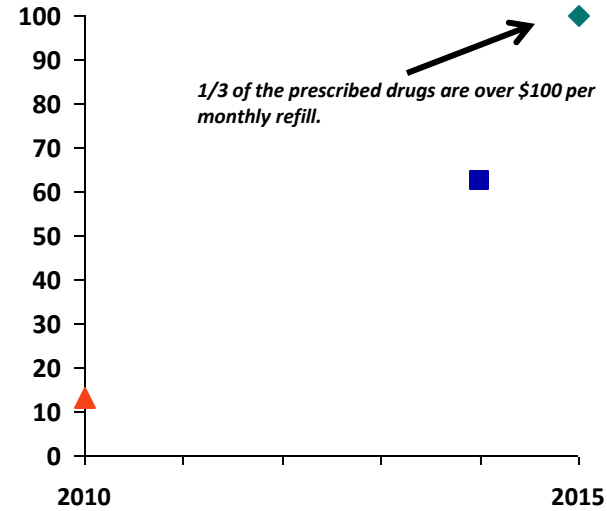


Data Source: US Census Bureau, Small Area Health Insurance Estimates for Counties and states, 2016

This thematic map shows projected **Primary Care Need according to Healthcare Strategy Group**. The darker the green the greater the need. The non-Primary Care Need is proximate to the Phoebe Putney Healthcare Complex. And bottom center, this dot density map shows all providers regardless of speciality.

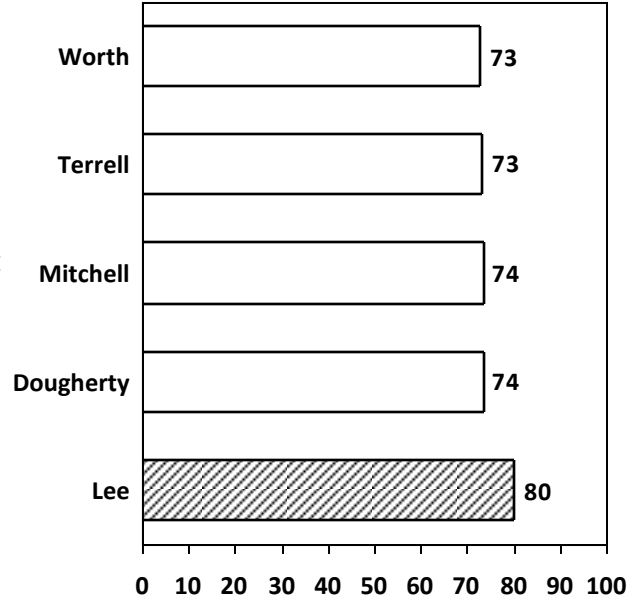
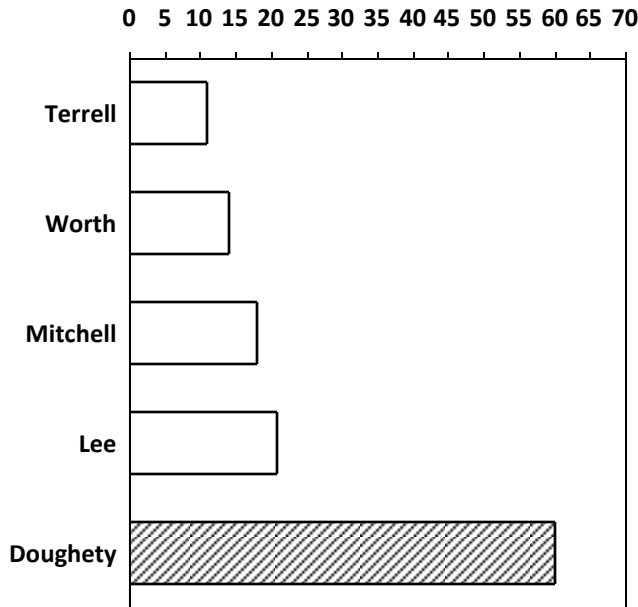


Average Monthly Cost of the 50 Most Prescribed Generic Drugs. According to Catamaran, a pharmaceutical benefit company, the average cost of the 50 most commonly generic drugs has sky-rocketed since 2010 creating another class of people unable to afford prescription drugs.

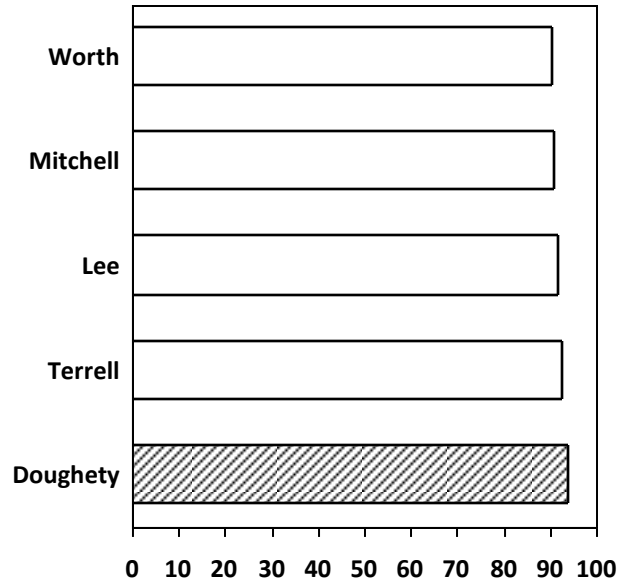


Dentist Rate Per 100,000

Nearly one-third of all adults in the United States have untreated tooth decay, or tooth cavities, and one in seven adults ages 35 to 44 years old has periodontal disease. Tooth decay is the most prevalent chronic infectious disease affecting children in the U.S., and impacts more than a quarter of children ages 2 to 5 and more than half of the children ages 12 to 15. In the bar chart below, Dougherty is the only county with an adequate supply of Dentists per 100,000 population.



Adults with Insurance
 Medical costs in the United States are extremely high, so people without health insurance may not be able to afford medical care or prescription drugs, which have skyrocketed since 2010. Many small business are unable to provide health insurance due to rising premiums. Lee is the only county whose adult insured rate is at or above the US Median for all counties.



Children with Insurance
 Health Insurance for children is vitally important. Having regular vision, dental, hearing and health checkups lays the foundation for a healthy adolescent. Children with insurance are more likely to be immunized, experience less sick days from school and prevent serious illness later on. Dougherty is the only county in the Primary Service Area that meets or exceeds the US Median.

Health and Health Care

ADULT LITERACY

It is estimated that college graduates earn approximately \$1 million per lifetime more than non-graduate peers. Southwest Georgia counties are well below the Georgia Average. In addition, southwest Georgia has a high illiteracy rate ranging from 13 to 27% of the population which negatively impacts the their heath status.

Metric	Georgia	Dougherty	Lee	Mitchell	Terrell	Worth
Early Childhood						
Adult Educational Attainment High School Graduate or Higher(2009-2013)	84.7%	79.9%	83.9%	72.3%	65.6%	71.4%
Bachelor's Degree Or Higher(2009-2013)	28.0%	17.8%	20.5%	9.6%	8.7%	8.1%

National Center for Education Statistics

Indirect estimate of percent lacking *Basic* prose literacy skills and corresponding credible intervals : Georgia 2003

Location	FIPS code ⁰	Population size ¹	Percent lacking <i>basic</i> prose literacy skills ²	95% credible interval ³	
				Lower bound	Upper bound
Dougherty County	13095	68,104	20	10.3	34.6
Lee County	13177	20,839	13	6.2	22.0
Mitchell County	13205	16,531	25	13.0	40.3
Terrell County	13273	8,025	27	14.0	42.9
Worth County	13321	16,372	20	10.2	33.5

⁰ The state and county Federal Information processing Standards (FIPS) codes are standardized unique state and county identifiers. The first two positions identify the state, and the last three positions identify the county. For more information, see <http://www.census.gov/geo/www/fips/fips.html>

¹ Estimated population size of persons 18 years and older in households in 2003.

² Those lacking *Basic* prose literacy skills include those who scored *Below Basic* in prose and those who could not be tested due to language barriers.

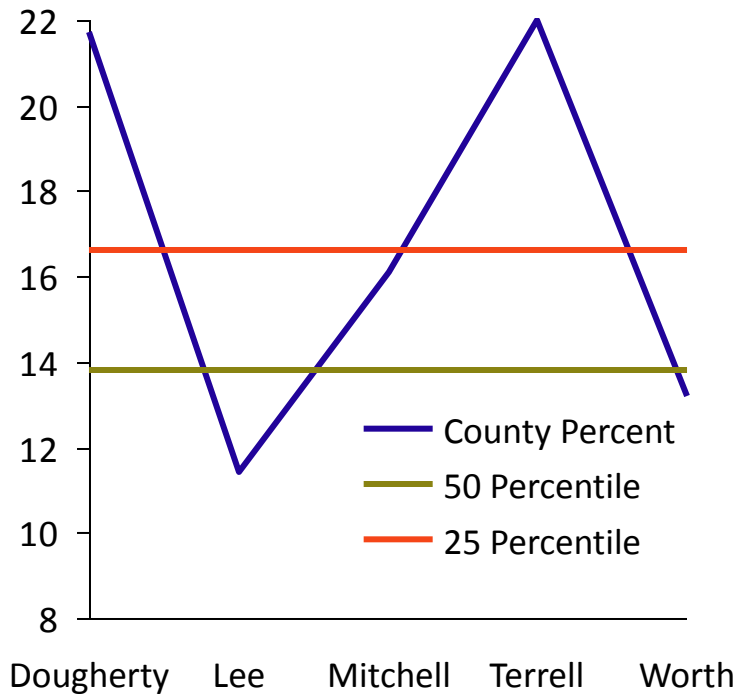
³ The estimated percent lacking *Basic* prose literacy skills has a margin of error as measured by the associated credible interval. There is a 95% chance that the value of the percent lacking *Basic* prose literacy skills is contained between the lower and upper bound.

SOURCE: U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics, 2003 National Assessment of Adult Literacy

Severe Housing Problems

Safe and affordable housing is an essential component of healthy communities. Substandard and crowded housing residents are at risk of food insecurity. These living conditions, particularly for children, increase the risk of infection, pest infestation, mold, and mildew. The higher the rank the more severe the housing problem.

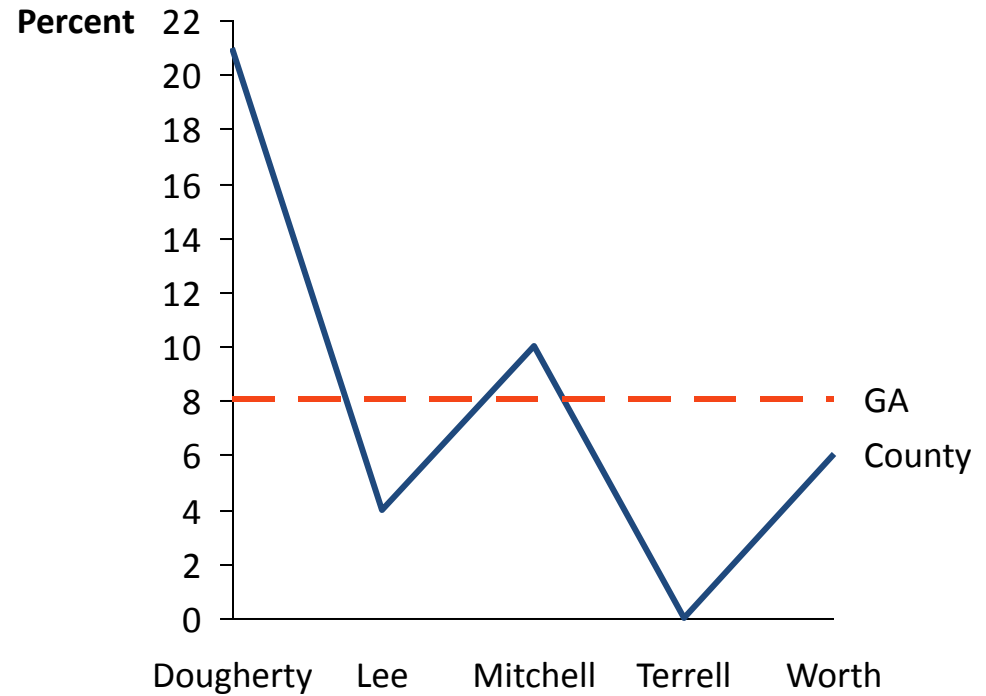
Data source: County Health Rankings, 2015



Limited Access to Healthy Foods

For far too many people, especially those living in low-income communities and minority communities, healthy food is simply out of reach. Finding quality fresh food means traveling significant distances or paying exorbitant prices for overripe fruit. Dougherty is three times the State Average with Lee, Terrell and Worth performing better than the State.

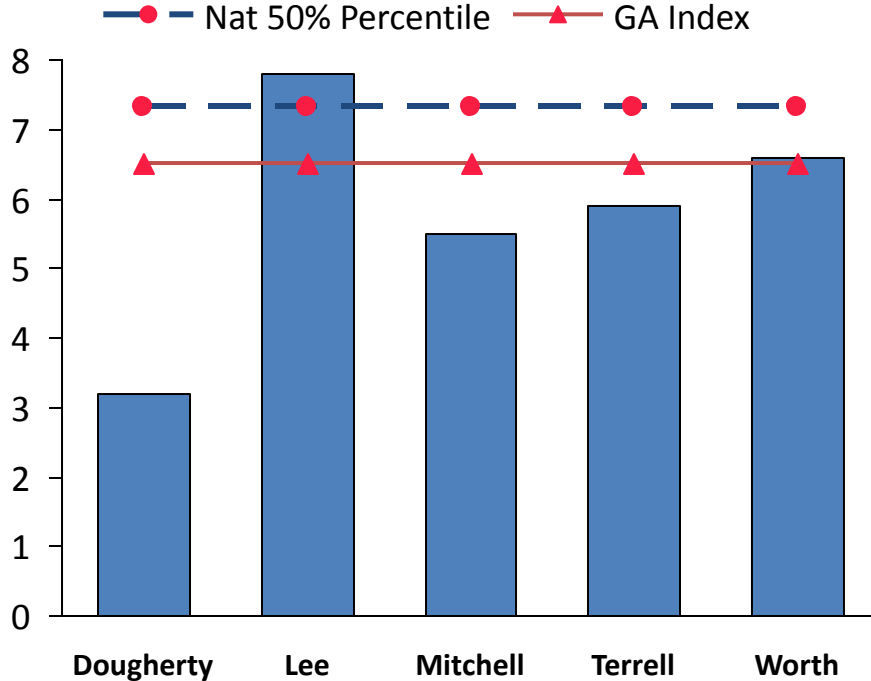
Data source: County Health Rankings, 2015



Food Environment Index

The Food Environment Index uses two measures of food access: low income and low access to grocery store with food insecurity. Lower scores are associated with chronic health problems including diabetes, heart disease, high blood pressure, hyperlipidemia, obesity and mental health issues including major depression. Lee County exceeds the National Index and Worth meets the GA Index threshold.

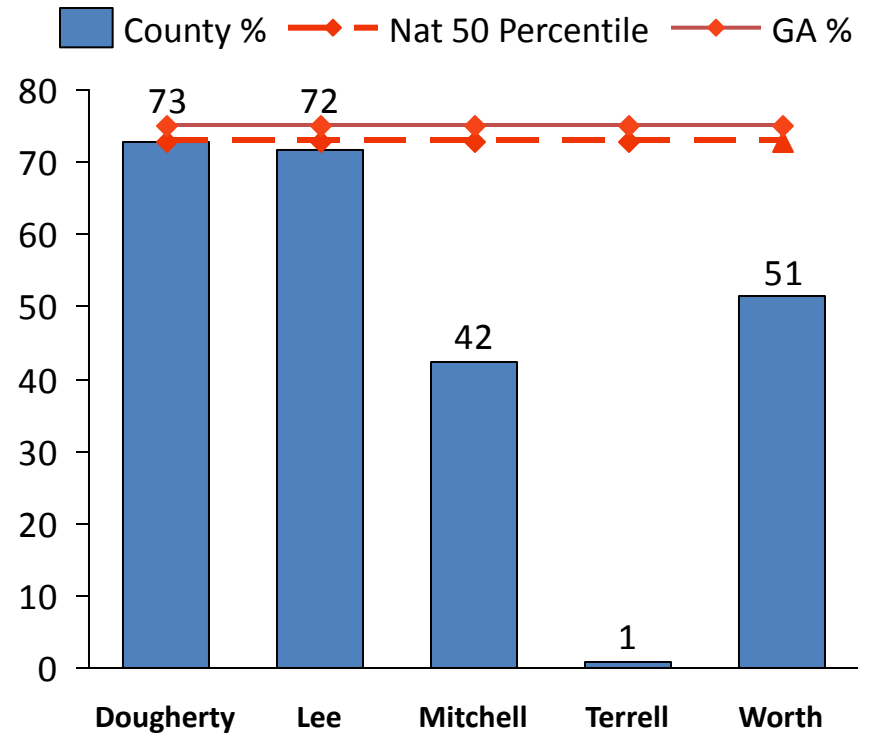
Data source: County Health Rankings, 2015



Access to Exercise Opportunities

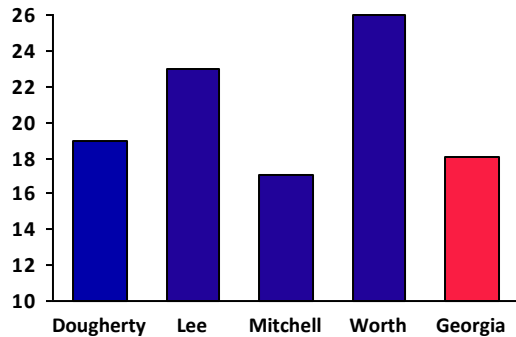
This indicator measures the percentage of individuals who live reasonable close to a park or recreational facility. The closer you are to an exercise facility the more likely you will use it. Dougherty and Lee Counties are at the National 50 Percentile rank while Terrell County score is almost 0.

Data source: County Health Rankings, 2015

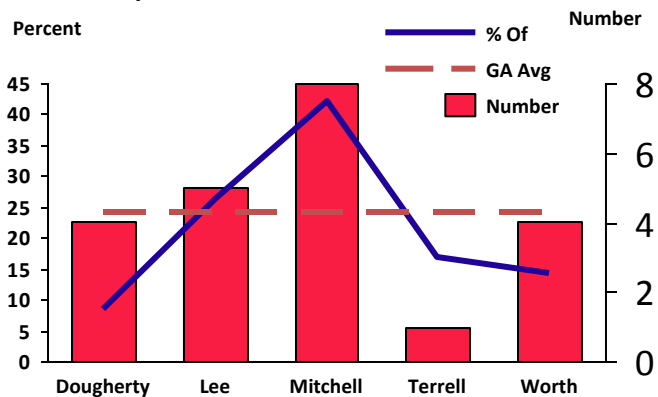


ADULTS WHO SMOKE

Tobacco is responsible for the most preventable illnesses and death in America today. Almost a third of smokers will die prematurely due to tobacco dependence. Worth County has the highest percent of adults who smoke and 44% higher than the Georgia average. (County Health Rankings 2013)

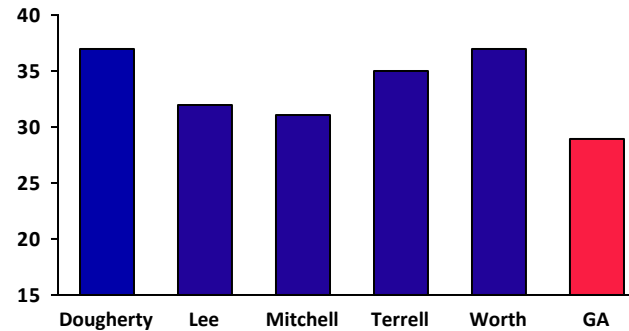


In 2013, approximately 4.7% of the total population in Georgia were identified as heavy drinkers. Whites were more likely to drink heavily than AA/Blacks and males more likely than females. Those making at least \$75,000 and a college graduate are the most likely group to drink excessively. According to the latest report released by the Georgia Department of Public Health, Mitchell County exceeds the State Average while all others are just at or below.



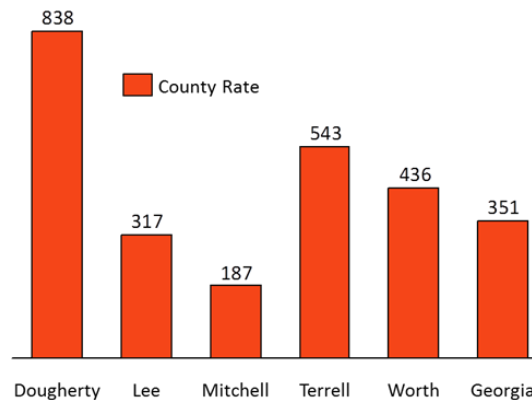
ADULT OBESITY

Obesity is a benchmark indicator of the overall health and lifestyle of a community. Obesity increases the risk of a host of chronic diseases from hypertension and diabetes to osteoarthritis. Dougherty and Worth have the highest obesity percentage and the only above the Georgia average. (County Health Rankings 2016)

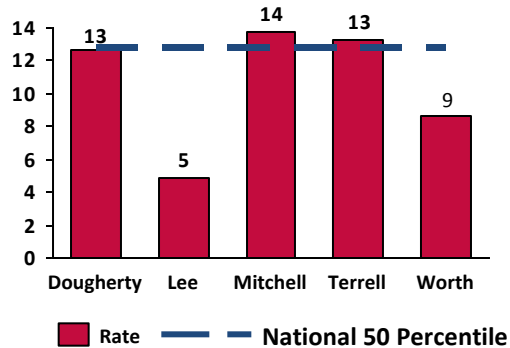


Violent crime includes murder, rape, robbery, and aggravated assault. Violence negatively impacts communities by reducing productivity, making it more costly for businesses to locate or stay there, and decreasing property values. The Dougherty County Crime Rate is more than twice the Georgia rate while Terrell is approximately 50% higher.

Data source: Georgia Statistical System



Social Associations measures the number of membership associations per 10,000 population. Associations include business, labor, political, professional, athletic, civic, volunteer, and religious organizations.



Social Associations and community engagement, along with a person’s social support network, enhances perceptions of social trust. People who are fully integrated into the community and who have strong support network experience better health outcomes compared to individuals who lack support.

Data Source: County Health Rankings, 2015

Percentage of Register Voters who voted in the last General Election, 2012

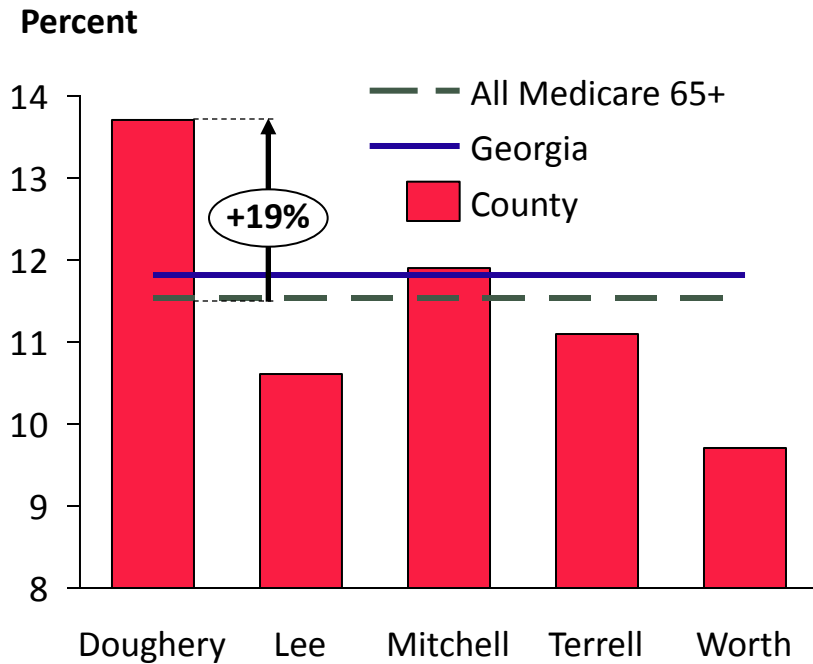
County	Percent Voted
Dougherty	70.2
Lee	73.6
Mitchell	71.9
Terrell	74.3
Worth	74.3
GA	73.1

As a fundamental right in a free society, citizens have an opportunity to affect how tax dollars are being used and influence policies. High voter turnout suggests an involved citizenry.

Data Source: Georgia Statistical System, 2016

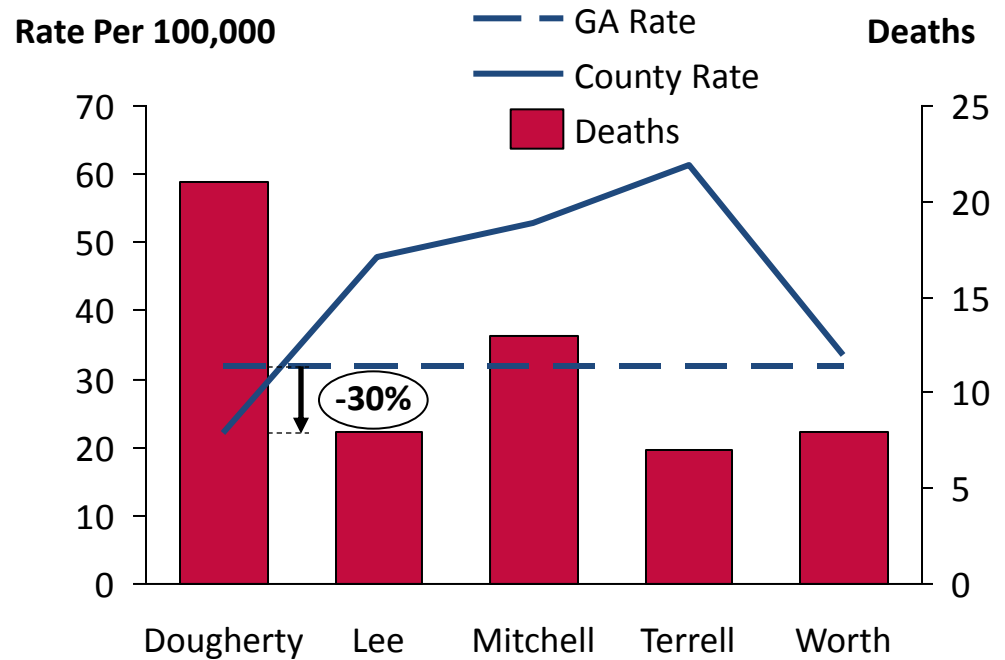
Prevalence of Alzheimer's Among Medicare Beneficiaries-Age 65+ 2014

The Alzheimer's Association estimates that 7.1 million people age 65 and over will have the disease by 2025. Currently, Alzheimer's and other dementias is estimated to cost \$107 billion dollars. The prevalence of Alzheimer's is 19% higher in Dougherty County than the National average. However, the Age Adjusted Death Rate due to Alzheimer's is 30% below the State Average in Dougherty County.



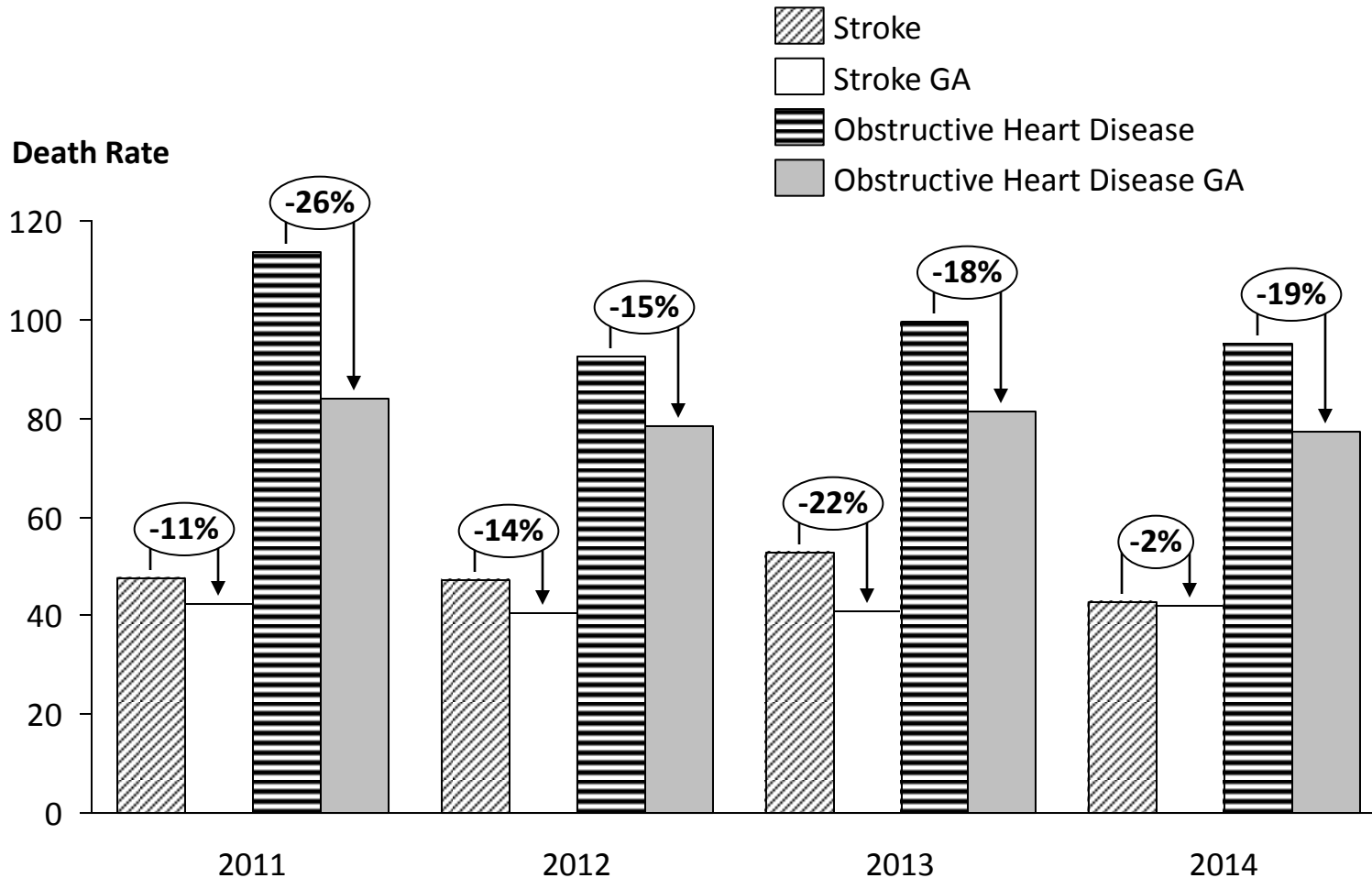
Data Source: Centers for Medicare & Medicaid Services, 2016

Deaths and Age-Adjusted Death Rate, Alzheimer's 2014



Data Source: GA Department of Public Health, Oasis, 2016

Comparing Age Adjusted Death Rates due to Stroke and Obstructive Heart Disease including Heart Attack in Primary Service Area. Compared to state average, death Rates due to stroke were higher in the Primary Service Area with the gap closing to 2% in 2014. Obstructive heart disease exceeded the state average since 2011 with a 19% gap as of 2014.



Data Source: Georgia Department of Public Health, 2016

APPENDIX II

QUALITATIVE RESEARCH AND INPUT SESSIONS

COMMUNITY INPUT SESSIONS



Two community input sessions were held in Albany on February 17th and March 2nd 2016 and a final input session hosted by Mitchell County Children and Youth Family Connection Partnership in Camilla, GA on April 27th. The sessions pulled participants from an array of organizations such as the YMCA, religious and educational institutions, media, healthcare non-profits to name a few. The Albany priorities generated from each input session were synthesized with renamed themes[priorities] without affecting the separate work of each group. The Mitchell County Input Sessions stand alone.

Albany Participants:

Clif Buell, Phoebe Cancer Center
Bruce A Trickel, Albany Internal Medicine
Kathy Brinson, Phoebe Putney
Jim Franklin, Quality Care Analyst, Phoebe Putney
Linda Johnson, NAMI *
Mindy Spencer, Phoebe Perinatal Research
Tina Halverson, Phoebe Physician Group
Sean Hendley, Phoebe Putney
Heather Combs, AAPHC*
Rod Collins, Lee County Family Connection-Board Member
Dr. Willie Adams, Retired OB/GYN
Ken Boler, General Sales Manager, The Albany Herald
Marvin Laster, Executive Director, Boys and Girls Club*
Angie Barber, Director, Project Network of Trust*
Sandra Parker, Lee County Schools
Joyce Johnson, Dean of Health and Sciences, Albany State Univ.
Dan Gillian, Executive Director, YMCA
Tyshiba Maxie, Dougherty County School System*
Cecillia Morris
Delvin Hawkins, Albany Housing Authority*
Torrey Knight, District Public Health*
Patsy Shirley, Lee County School System
Linda M Johnson, Albany State University
Judith Rosenbaum, ASU, Research Coordinator
Dr. Kimberly Fields, Community Benefit subcommittee chair
* Represents Medically Underserved, Minority or Vulnerable Pop

Meeting Agenda for Input Sessions

- Review Area and Local Data
- Facilitate a Consensus Workshop Method
 - Identify the Focus Question
 - Individually Make a List
 - Discuss the List in a Small Group Setting
 - Each Group will develop 8 to 10 ideas
 - Whole group Will Pair then Cluster the Ideas
 - Whole group will title the Clusters.
 - Assign Importance Using Dots.
- Next Steps and Closing

Key Leader Interviews Phoebe Putney Community Health Needs Assessment December 2015

Purpose

To gather information, input and feedback from selected key leaders Phoebe's Primary Service Area [Dougherty, Lee, Mitchell, Terrell, Worth] to identify health care needs for the 2016-2019 Community Health Needs Assessment.

Number of Interviews (20)

Jackie Jenkins, District Public Health, Epidemiologist *
Shelley Spires, CEO, AAPHC*
Dr. James A Hotz, Clinical Services Director*
Debbie Blanton, Council on Aging*
Lakiesha Bryant, Executive Director, United Way of Southwest Georgia*
Marvin Laster, Executive Director, Boys and Girls Club*
Kiesa Callins, Ob/Gyn, Marian Worthy*
Remy Hutchins, Director, Dougherty County Health Department*
Justin Strickland, CEO, Economic Development Commission
Barbara Rivera-Holmes, Vice-President, Economic Development Commission
Greg Rowe, Director, Dougherty County EMS
Charlene Glover, Minister, Trumpet of God Ministries
Dorothy Hubbard, Mayor, City of Albany
John Hayes, District 4 County Commissioner, Dougherty County
Jessica Jennings, Director, Mitchell County Children and Youth*
Major English, Executive Director, Salvation Army*
Pam Reynolds, Executive Director, AHEC
Michael Satchell, Family Practice Physician, Albany
Donna Edmond-King, Pediatrician, AAPHC*
Nedra Fortson, Executive Director, Samaritan Clinic*

Key Leader Interviews Conducted by:

Darrell Sabbs, Community Benefit Coordinator
Mark Miller, Strategy Analyst

Findings Compiled by.

Mark Miller, Strategy Data Analyst

Report Written by.

Mark Miller, Strategy Data Analyst
Phoebe Putney Memorial Hospital

I. Introduction

Purpose/Objectives of Research

The purpose of the Key Leader Interviews was to gather information, gain knowledge and receive input regarding health issues facing the Phoebe Albany service area as part of the 2016-2019 Community Health Needs Assessment (CHNA).

Methodology

Darrell Sabbs (Community Benefit Coordinator), Lori Jenkins (director of Strategy of Planning) and Mark Miller (Strategy Analyst) met to discuss and select CHNA interviewees that comply with requirements outlined in the IRS code 990. Twenty participants received face to face interviews and represented religious, business, political, public health, the elderly, physicians and afterschool programs. Interview length was between 30 to 45 minutes and conducted between September and December of 2015. Christine Whitaker, Administrative Assistant, transcribe the notes for further analysis into an Excel qualitative coding workbook.

Statement of Limitation

In qualitative research, the key leader interview approach seeks to develop insight and direction rather than quantitatively precise or absolute measures. Because of the limited number of respondents and the limitation of recruitment, this research must be considered in a qualitative frame of reference.

The reader may find some information that seems inconsistent in character on first reading this report. When such data appears in the context of findings, it should be considered as valid data from the participant point of view. That is, the participant may be misinformed or simply wrong in his/her judgment, and the reader should interpret that as useful information.

This study cannot be considered reliable in the statistical sense since the recruiting of participants was self-selected and not randomized. The information gained can only be added to the body of knowledge on this topic. This type of research is intended to provide a first step in determining knowledge, awareness, attitudes and opinions about services, concepts or products.

The reader is reminded that this report is intended to clarify cloudy issues and to point the direction for further research, and that the findings presented here cannot confidently be statistically projected to a universe of similar respondents without quantitative support. However, the strength of qualitative research lies in its ability to provide insights and flush out data that can be used to help decision-makers make more informed decisions.

I. Executive Summary: Key Findings

Our Community: Strengths, Weakness, Opportunities and Threats:

- **While it's popular to say "There are two Georgia's, Metro Atlanta and everyone else," when the participants were asked to define their community, it struck the same note.** There is a large divide between employment and economic status, a shrinking middle class and making an unexciting place to live-particularly for young professionals.
 - Northwest Albany is perceived as the place to live. It has all the amenities with plenty of opportunity and much of the resources; and
 - These neighborhoods are viewed as a good place to raise your family, relatively free from crime and a safe place for children to live and play-but
 - Due to the ever shrinking middle-class, some neighborhoods are slowly transitioning from home ownership to investors.
 - Job losses over the decades (Naval Air Station, Delco-Remy, Bob's Candies, Firestone then Cooper) have severely diminished the middle class leading to significant income inequality among those with no options to leave in pursuit of other employment.
 - Intransigent poverty has led to homelessness even among the teenagers who often live couch to couch from day to day. With the culling of the middle class jobs, it's becoming difficult to find a job with healthcare benefits.
 - As one respondent summed it up, "I haven't seen a place like this anywhere else." However, the deep wounds allow for opportunity.
 - We still have big employers with potential to expand such as MillerCoors, Proctor and Gamble and the Marine Corps Logistics Base.
 - Albany, the hub of Southwest Georgia, has potential but we need visionary leadership that is less managerial but more innovative. And,
 - We have the educational infrastructure (colleges and universities) but residents need to take advantage of these. Education was cited as strength, weakness, opportunity, threat and a challenge to children and families for various reasons. The K-12 education system has its challenges to be sure, but there is general agreement that the just approved new charter school is a big plus and will attract students from multiple counties.

- **The strengths of our community consisted of its business climate, the strong non-profit community, the energy generating from downtown, healthcare infrastructure and local amenities. However, there are some embedded blocks and underlying contradictions that must be negotiated.**
 - As the capital of Southwest Georgia, Albany and surrounding areas have interstate quality roads, excellent infrastructure such as water, gas, fiber optics and a one-stop shop permitting process making for a low cost of doing business.
 - But, the most cited reason for a business not to locate here is proximity to Atlanta, lack of Interstate and distance to end user.
 - Simply put, we need more jobs and many healthcare providers leave because their spouse can't find suitable employment.
 - Albany has amenities underappreciated by those who reside here. It is home to the River Aquarium, Chehaw, plentiful natural resources and affordable housing, a healthcare system with ample subspecialty care. While housing is affordable, property taxes are disproportionately high.
 - Somewhat under the radar, there is some excitement regarding the direction of Albany and downtown in particular. With a new city manager and other leadership, a fresh look and bold vision is being painted. Investors and developers are taking a second look at downtown and plans are underway to capitalize on this energy.
 - Albany has a large non-profit sector. While sometimes crowding each other out or working in silos, Public Health and Phoebe Putney pull people together to coordinate services. If you need a resource, you have an excellent chance of finding it here.
 - The healthcare complex rivals any system south of Macon. For a community its size, there are few services that can't be offered locally. However, gaps and access remain an issue for some.
 - It's difficult to access a Primary Care Provider if you don't have insurance.
 - For those with insurance, high deductible plans are creating a new class of underinsured.
 - Mental Health crisis care for adolescence; and
 - Limited capacity for Mentally Ill residents

- **“I’m the mayor of Albany and I want to see it thrive.”** Community leaders identify three areas of opportunity to do just that.
 - Improve education- For community this size, we have all the options a larger city affords. However, we need people to take advantage of the resources. Albany State University recent announced consolidation with Darton College will create a 9,000 to 10,000 student body.
 - K-12 shows promise to improve graduation rates with new tablets being rolled out in the schools and expanded dual enrollment so high school students can earn college credit.
 - The local board of education recently approved a college and career academy.
 - Community Development
 - We need to map our assets and leverage them just like Thomasville GA. Are we a retirement destination or not? What is our brand?
 - Further strengthen downtown redevelopment. One proposal is to build loft apartments with retail space on the first floor of a former hotel located downtown.
 - Unused, abandon rail system can be repurpose to a rails to trails whose trail head will start at River Park end in Sasser, Georgia approximately 15 miles from the starting point.
 - Respondents linked a Healthy Population to a vibrant one.
 - Non-Profit Sector
 - With a deep non-profit sector presence in Southwest Georgia, there is an opportunity to develop even stronger collaborations like the one with Phoebe Putney and the Cancer Coalition with Public Health Involvement.
 - Boys and Girls Club, Inc. has embarked on wide reaching 3 to 5 year strategic planning process to map out action steps to reach even more children.

- Threats to our practical vision include complacency and entrenchment, social economic disparities and health outcomes.
 - Complacency and Entrenchment
 - Some local political leaders resist change and feel threatened by it. It leads to competing agenda, bickering and grudge holding. This entrenchment crosses racial lines making it more difficult to engage and educate people. And,
 - Further affirms the negative image of our community.
 - These factors make it very difficult to recruit local leaders with good hearts to contribute to the business led ecosystem.
 - “We aren’t clear on who we are.”

- Social Economic Disparities
 - We need more jobs that pay well. There is a lack of employment opportunities.
 - Poverty negatively correlates with educational achievement further reducing job opportunities for many of our citizens. As one said, “That poverty thing is real.” And, it’s generational poverty.
- Health Outcomes
 - Driven by race and endemic poverty, the poor and minority community experience a diminished health status compared to whites and Asians. They are more likely to become obese leading to stroke, diabetes and hypertension.

Challenges Facing Women, Children and Families:

- Extreme Poverty
 - Extreme poverty leads to homeless families with infants and school age children in tow. It’s not uncommon for pediatricians observing children in tattered clothing, in need of diapers, and already at such a young age cognitively behind their peers.
 - Fractured families with limited incomes have difficulty in securing Quality Child Care due to cost or not having reliable transportation.
 - Much of this according to the respondents, centers on the fractured family structure leading to too many fatherless households, siblings with different fathers, leaving children without a positive role model.
 - Children need positive role models to make good choices for eating healthy to not becoming pregnant.
 - Many children are left living with grandparents in a very crowded and dilapidated housing. These conditions give rise to Asthma, allergies and other respiratory infections.
 - Infants face whatever their mother faces and far too many remain trapped in poverty.
- Access to Care
 - In Mitchell County, there is no OB/Gyn practice and those with transportation find it difficult to make or keep appointments due to travel distance.
 - The lack of Medicaid expansion leaves some without insurance.
- The Education system isn’t inclusive enough. There is a lack of diversity.

What's Blocking Access?

(1) High Healthcare Cost limit healthcare options creating new disparities

- Limited roles of advanced practice RNS
- Political Climate
- Insurance Plan trending to high deductibles
- Fee for Service Model-incentivizes volume vs outcomes
- Corporate Structure and approval Process
- Healthcare Consolidation
- Federal and State Regulations

(2) Socio-economics repels qualified providers

- Diversified Medical School Students
- Attraction to area for providers and Spouses

(3) Social Determinants of Health Prevents healthy Life styles

- Patient compliance adherence- responsibility
- Apathy
- Cognitive thinking Skills
- Information usually in written form
- Stigma- Particularly Behavioral Health
- Financial Resources (Patients)
- Health Knowledge and Diagnosis
- Lifestyles
- Low Literacy Rate
- Resource Knowledge

(4) Travel time impedes access to health services and employment opportunities

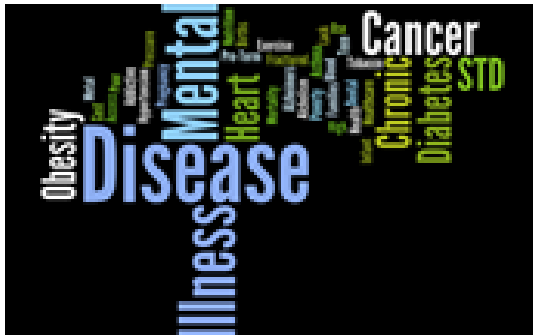
- Doctors' Office Hours
- Livable Wages
- Expansive rural region (travel time, distance)
- Inability to effectively coordinate transportation
- High Unemployment Rate
- Hours and Reach of public transportation

(5) Silo of Information Impedes Care Coordination

- Patient Access to Technology (portal, email)
- No Health Information Exchange Strategy (Population Health)
- Physician Communication

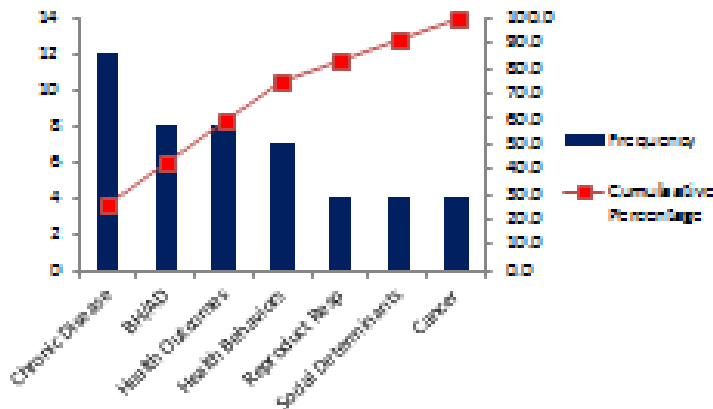
Key Leader Interviews

4 Major Health Issues Facing Our Community Today?



4 Major Health Issues

Among Key Leader participants, Mental Illness or Mental Health to include Addictive Disease was the single most mentioned Health Issue facing our community today. While Behavioral Health was the largest by type, chronic diseases was the largest by group [Diabetes, hypertension, heart disease] with Obesity viewed as a major driver of chronic disease and health outcomes. With a need of additional adolescent services, Albany Area AAPHC offers psychiatric and counseling services to patients age 8 and up. Bullying at school and a non-stable family structure make poor and minority children more likely to need behavioral health services.

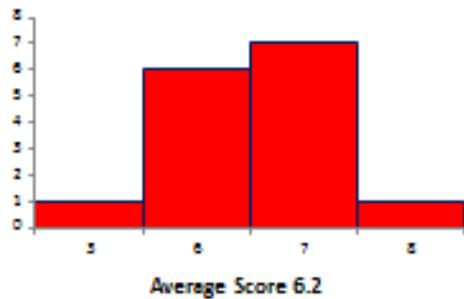


Key Leader Feedback to Rating the Healthcare system?

KEY LEADER INTERVIEWS

Rate the Healthcare System on
A Scale of 1 to 9

Histogram



What would it take to bump it up a notch?

- Pediatric Subspecialties in Neurology and Endocrinology. Traveling to Macon or Tallahassee make transportation difficult for those on Medicaid or Uninsured.
- Additional Internist that take Medicaid are needed in our region will help address access.
- Ramp-up Community Engagement with citizens targeting customer service, image, and reputation.

What would it take to bump it up a notch?



Community Health Needs Assessment INPUT SESSION Consolidated Results

Enter "Systemness," Collaboration & Networking

- Create an Area-Wide Safety Council
- Better Community Collaboration with Existing Agencies
- Disease Specific Coalitions
- Better Community Planning for Superbug or Infectious Disease
- Primary Care is GATEKEEPER
- How to Navigate the Healthcare System?
- Connect Community Support Groups to Resources

Providing a Competitive Employee Package

- More Community Education
- Education of Younger Generation
- Tobacco Education in Elementary Schools
- Sexual Health for All Ages
- Teen Wellness Education and Mentoring

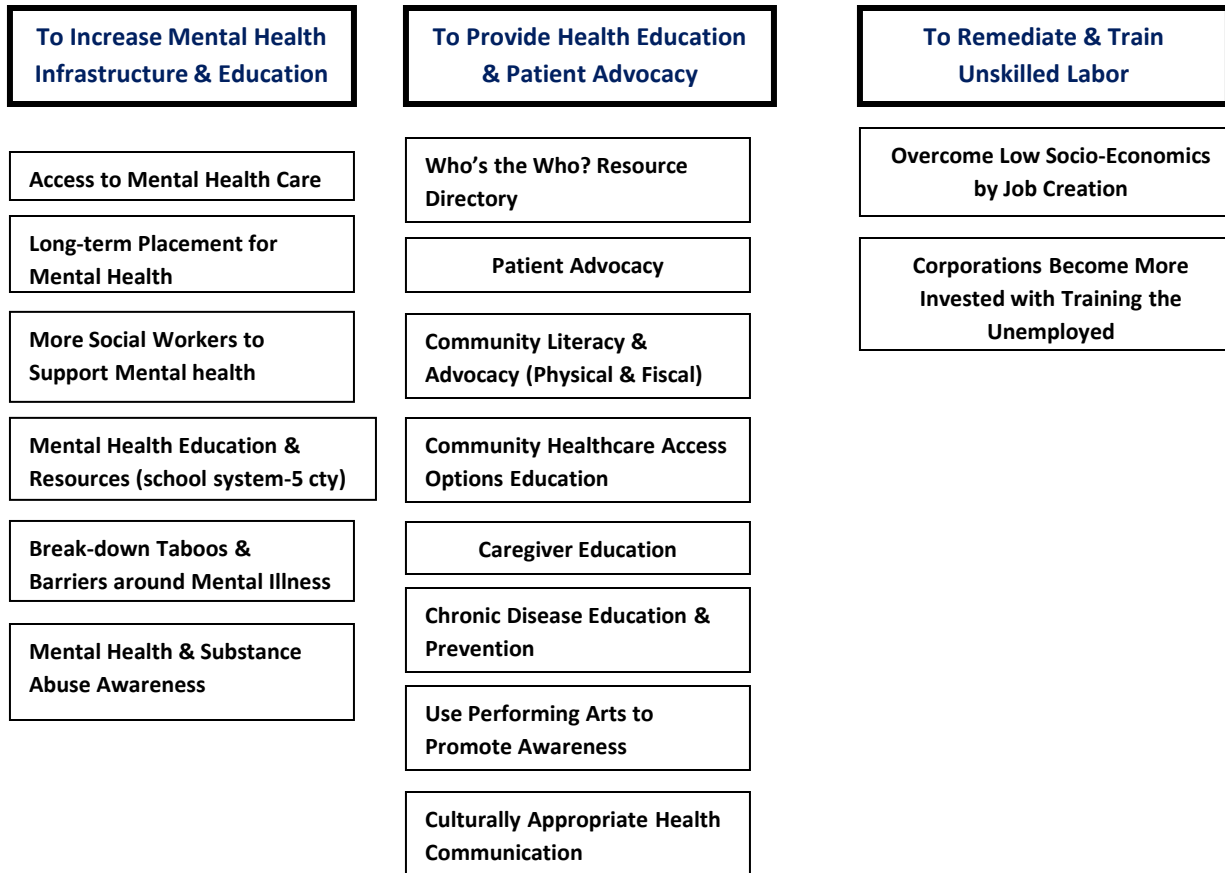
Empowering Residents to Build a Healthy Community

- Community Involvement
- Solicit and Implement Community Feedback
- Community Garden
- Eliminate Food Deserts
- Walking City
- Establish Safe Bike/Walker Friendly Environment
- Faith-Based Health Programs
- Launch Neighborhood Walks with/Church Civic Groups
- Ban Smoking in Public Areas
- Plan to Investigate the Cost of Targeted (new) drugs (script)
- Use Social Media to Reach Generations, ie; Town Hall

Driving Healthcare to Improve Access

- Elicit Local city/county support
- Telemedicine
- Improve Telemedicine Access Points in Community.
- Transportation
- Access to Services (Transportation)
- Coordination of Regional Transportation
- Collaborate w/Public Transport & School System
- Investigate Medicaid Transportation Rules
- Access Transportation to Clinics
- Health Bus \$0.25
- Driving Doctors

Community Health Needs Assessment INPUT SESSION Consolidated Results



**COMMUNITY HEALTH NEEDS ASSESSMENT
 INPUT SESSION –Mitchell County(Camilla, GA)
 April 27, 2016**

Plan Strategically to Improve Results

Increase and Advertise Community Resources

Identify Issue-Related Stakeholders

Educate Residents on Available Resources

Promote Free GED Program

Provide Support Groups for Disease Specific Issues

Work collaboratively to Provide Resources

Lack of Community Education

Local DOL Services

Promote Prevention and Awareness of Risky Behavior

Promote Prevention: ATOD TP Bullying and Family Violence

Adolescent Risky Behavior

Buy-in For Use of Safety Equipment

A Guide To Healthy Living

Promote Free Health Screenings

Implement Community Health Fairs

Provide Affordable Adult Fitness Opportunities

Require Nutrition Training for Medical Professionals

Educate on Meds/Health Lit/Mental Health

Accessibility to Health & Well-being Services

Access to Walk-In Clinics

Affordable Medications

Free Mobile Dental Clinic

Transportation to Provider Services

Access to Mental Health Services

Access to Specialists

Affordable Health Insurance

Promote Proper Nutrition

Provide Healthy Eating Alternatives

Farmers Market

Input Participants:

- Fredrick Wrenn, Dept of Juvenile Justice
- Mollie Pollock, Dept of Juvenile Justice
- Jordyn Murphy, Mitchell County Children and Youth*
- Andy Collins, Recreational Dept
- Merrie Johnson, Sheriff's Dept.
- Shirley Daniels, Boys and Girls Club*
- Tosha Keaton, Mitchell County Schools*
- Jessica Jennings, Family Connection*
- Jenny Bostick, City of Camilla
- Jamie Sullivan, Fire Department
- LaDonna Delk, SRT College, Adult Ed
- Tarocdra Hodge, Cancer Coalition
- Christine Landstrom, GA Pines *
- Wanda Atkins, Star Island
- Lavonne Clayton SBZ Services