ST. MARY'S
HEALTH CARE SYSTEM
A Member of Trinity Health

Community Health Needs Assessment 2022

St. Mary's Health Care System
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EXECUTIVE SUMMARY

Community Health Needs Assessments (CHNAs) use data and community input to measure the relative health and social well-being of a community. The community assets and needs identified through the CHNA will be used to develop an implementation strategy, which outlines the hospital's strategies for addressing the identified needs and expanding upon the assets. The findings should inspire collective action and ensure meaningful, effective allocation of resources, both within the hospital and in the community.

The Patient Protection and Affordable Care Act (ACA), enacted March of 2010, added Section 501(r) to the Internal Revenue Code, which effects charitable hospital organizations that are 501(c)(3) tax-exempt. Section 501(r)(3) of the Code requires each separately licensed hospital facility to conduct a CHNA at least once every three tax years, beginning in 2011, and to adopt an implementation strategy to meet the community health needs identified through the CHNA. A Notice of Final Rule was published December 2014 and provides the requirements for tax-exempt hospitals to conduct the CHNA and prepare Implementation Strategies, as well as the consequences for failing to comply with Section 501(r). Tax-exempt hospitals are required to report on the most recently conducted CHNA and implementation strategy on the annual IRS Form 990, Schedule H, which is made publicly available to regulators, press, community organizations and residents by the Trinity Health Tax Department.

This CHNA used a comprehensive mixed-methods approach with the latest available data on demographics of the community, healthcare access, economic stability, social support and community context, neighborhood and physical environment, and health outcomes and behaviors. The CHNA for St. Mary’s Health Care System, Athens, Georgia was adopted by St. Mary’s Health Care System Board of Directors on April 26, 2022.

Through further prioritization and identification of existing community resources and assets, St. Mary's Health Care System will focus on four priority community health needs. The significant community health needs are listed below, with the emergent and ongoing public health need of COVID-19.

1. Access to Healthcare
2. Addressing Social Needs
3. Behavioral and Mental Health
4. Chronic Disease Prevention and Management

INTRODUCTION

About St. Mary's Health Care System

St. Mary's Health Care System is proud to be a Regional Health Ministry in Trinity Health. Trinity Health is one of the nation's largest Catholic health care systems, serving people multiple states from coast to coast. Being a part of a large national system gives us access to resources and ideas across the broad spectrum of care, making it easier for us to advance clinical quality in significant ways at the local level and providing economies of scale that reduce our costs. It also allows us to contribute our knowledge and best practices to make care better where Trinity Health operates.

St. Mary's Health Care System, a member of Trinity Health, is a faith-based, not-for-profit health care ministry whose mission is to be a compassionate and transforming healing presence in the communities we serve. St. Mary's puts special focus on neurosciences, cardiac care, orthopedics, general medicine, general surgery, women's and children's health, and care for older adults. Our system includes hospitals in Athens, Lavonia and Greensboro, as well as a multi-practice medical group, a retirement community, outpatient care facilities, graduate medical education, and a region-wide home health care/hospice service. St. Mary's Hospital in Athens is a certified chest pain center, a gold-plus hospital for stroke care, and has been named Georgia's Large Hospital of the Year multiple times. For more information, visit St. Mary's website at www.stmaryshealthcaresystem.org.

Mission Statement

We, St. Mary's Health Care System and Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

Vision

As a mission-driven, innovative health organization, we will become the national leader in improving the health of our communities and each person we serve. We will be the most trusted health partner for life.

Values

- **Reverence.** We honor the sacredness and dignity of every person.
- **Commitment to Those Who Are Poor.** We stand with and serve those who are poor, especially those most vulnerable.
- **Safety.** We embrace a culture that prevents harm and nurtures a healing, safe environment for all.
- **Justice.** We foster right relationships to promote the common good, including the sustainability of Earth.
- **Stewardship.** We honor our heritage and hold ourselves accountable for the human, financial and natural resources entrusted to our care.
- **Integrity.** We are faithful to who we say we are.

Advisory Committee

The advisory committee consisted of both internal and external representatives. The internal stakeholders of the advisory committee consisted of the St. Mary's Health Care System Community Health and Well-being Team. The external stakeholders included community-based organizations and individuals representative of the community that St. Mary's Health Care System serves. This combined group provided feedback on the CHNA process, ensuring a collaborative and inclusive approach to conducting the CHNA. This committee was also informed of the regulatory standards to ensure that the CHNA and Implementation Strategy process and final written reports are compliant. The advisory committee participants can be found in Appendix A.

Review of the 2019 CHNA

In 2019, St. Mary's Health Care System completed a Community Health Needs Assessment (CHNA) that met the requirements of the Internal Revenue Service (IRS), Notice 2011-52. The document assessed population factors, health conditions, community priorities, and health behaviors in Athens-Clarke County and the surrounding counties in Northeast Georgia. Additionally, and as the IRS requirement suggests, the assessment was used to inform the hospital's community benefit strategy, including outreach services and resource development, for the following three years (2019-2022).

The St. Mary's Health Care System hospital service area was defined by examining data at the patient visit level. For the purposes of the CHNA, existing secondary and primary data were gathered from local, state, and federal data sources. The implementation strategy provided specific areas of focus with objectives and strategies to accomplish stated objectives for the three years following the 2019 CHNA. Through this process, the following needs were recognized as the most important issues to be addressed to improve the health and quality of life in our community: healthcare access; nutrition, physical activity, and obesity; and respiratory health.

Evaluation of 2019 Impact

In the prior CHNA, primary data was gathered through administration of a household survey in Athens-Clarke County and focus groups in surrounding counties to gain insight into the most pressing community health needs. Special focus was given to populations where health disparities were present, including those without health insurance and low-income families. The Community Advisory Committee assessed this data in order to prioritize the health conditions and risk factors for which the hospital could concentrate their efforts and improve community health. Following the identification and prioritization of health needs, the St. Mary's Health Care System staff worked with faculty from the University of Georgia's J.W. Fanning Institute for Leadership to construct an implementation plan to systematically address the health needs in the service area.

Through this process, the following needs were recognized as the most important issues to be addressed to improve the health and quality of life in our community: health care access; nutrition, diabetes, and obesity; and respiratory health.

Health Care Access

Goal: Increase access to health care within the St. Mary's Hospital service area, specifically Athens-Clarke and Oconee counties.

Nutrition, Obesity & Diabetes

Goal: Expand access to fresh fruits and vegetables, thereby reducing obesity and better managing diabetes.

Respiratory Health

Goal: Reduce prevalence of smoking in service area.

In March 2020, St. Mary's Health Care System began to implement strong measures to ensure an effective response to the historic COVID-19 global health crisis. Overall, the measures focused on safety, care delivery and stewardship. Like for many health systems, multiple surges of COVID-19 cases strained the capacity of our hospitals and outpatient clinics.

St. Mary's has worked diligently to expand resources and capacity, including:

- Identifying and supplying personal protective equipment to caregivers
- Increasing staffing, beds and ventilators in hospitals
- Expanding telehealth visits with physicians
- Expanding lab testing and turnaround

In response to COVID-19, St. Mary's mobilized infrastructure to assess the most urgent community needs, strengthened partnerships with community-based organizations, and collaborated with medical groups and clinically integrated networks providing direct patient care to ensure that patient social needs were met. St. Mary's Health Care System accelerated its response for social services by launching launched Social Care programs, and pivoted community education classes to online platforms and/or telephonic check-in. COVID-19 testing and non-COVID-19 medical services were provided for those who are homeless, uninsured, underinsured or with Medicaid, and/or lack the resources to obtain care.

Due to the COVID-19 pandemic response, some of the CHNA implementation strategies were paused and/or reprioritized based on the urgent and emergent community needs. Many community organizations followed CDC guidance and postponed meetings, and other community events. Hospital priorities shifted to focus community related efforts towards COVID education, testing, and vaccination. These efforts were done in collaboration with the local health department, community clinics, first responder organizations, and the neighboring hospitals and healthcare facilities. A summary of the 2019 CHNA impact can be found in the charts below.

CHNA Impact: Healthcare Access

Primary & Speciality Care	•Improved access to primary care visits and same day appointment for uninsured and underinsured. Community Internal Medicine of Athens (CIMA) expanded operations and resident physicians to provide full internal medicine care for adults, including routine wellness visits, treatment of minor acute illnesses and injuries, and management of certain chronic conditions such as high blood pressure, chronic obstructive pulmonary disease, and diabetes. Approximately 10 residents serve at CIMA each year. •Provided financial and clinical support to Federally Qualified Health Centers and community clinics including Mercy Health Center, Athens Neighborhood Health Center, and Innovative Healthcare Institute. •Implemented a Community Paramedicine Program partnership with National EMS to provide mobile health care program (Healthy@Home) to deliver preventative care to underserved community members. 30 participants were in the program. •Launched the St. Mary's Breast Health Center that offers prevention, high-risk counseling, medical, radiographic, and surgical treatment all in one center.
Medication and DME Assistance	•Collaborated with University of Georgia pharmacy students to enroll low income patients into pharmaceutical and medical assistance programs. •The St. Mary's Community Health Worker Program identifid local and regional organizations that provide free or low cost durable medical equipment. 10 resources have been identified.
Mental Health	•Collaborated with Advantage Behavioral Health Services and developed a formal Memorandum of Understanding to improve access and coordination of care for people with mental health conditions. •Collaborated with and financially supported Envision Athens (Healthy Athens workgroup) to support optimum health by providing substance use disorder prevention and awareness, and increasing coordination of and access to supportive services for people affected by substance use disorders and those searching for and living in recovery. •St. Mary's colleagues collaborated with Advantage Behavioral Health Services for a United Way Day of Service. Approximately 20 colleagues participated.
Special Populations	•People with Disabilities- Collaborated with and financially supported Extra Special People (ESP) to create transformative experiences for people of all abilities. •Veterans- Implemented St. Mary's Military and Veterans Health Program (MilVet) to provide military service members, veterans and their families with convenient access to high-quality, culturally sensitive, people-centered health care services that meet their specific needs. •Seniors- St. Mary's offers the Joint Support Group for those living with arthritis; Stroke Support Group for those who have survived stroke; and, Living with Memory Loss Group geared to the needs of family members most directly responsible for the health and safety of loved ones with memory loss. St. Mary's colleagues collaborated with Athens Community Council on Aging for a United Way Day of Service.
COVID-19	•Collaborated with community partners to offer education, mass testing events, and vaccination to the broad and underserved communities. •Collaborated with and financially supported community clinics to increase access and clinical capacity for COVID-19 efforts; Mercy Health Center, Athens Neighborhood Health Center, Innovative Healthcare Institute. •Targeted vaccinatation activities in vulnerable and underserved populations through partnerships with jails and community clinics, as well as in-house vaccination clinics for local first responders, teens, and the broader community.

CHNA Impact: Nutrition, Diabetes, Obesity

Nutrition	•St. Mary's Nutrition Department leds regular community based nutrition education, and during Nutrition Month held a special event called "Personalize your plate"; Education on nutritious recipes and special diets for those living with chronic diseases are on the St. Mary's blog and external webpage 4 times per year. •Breastfeeding classes- St. Mary's offers an introduction to the importance of breastfeeding and infant nutrition, and breastfeeding basics such as how to get started and how to prevent problems. This monthly class includes information to help parents maintain the breastfeeding relationship after a return to work or school.
Diabetes	•Prevention- Trained facilitators for the launch of the CDC Diabetes Prevention Program (DPP). This research-based program will focus on healthy eating and physical activity in a structured lifestyle change program aimed a reducing the risk of developing type 2 diabetes. Four colleagues were trained and three regional classes planned. •Support- St. Mary's Community Internal Medicine of Athens (CIMA) resident clinic provides a diabetes support group. Approximately 10 monthly participants. •Self-Management- St. Mary's Outpatient Diabetes Education Department is recognized by the American Diabetes Association and offers individual appointments and diabetes education classes covering all aspects of diabetes self-management from nutrition to reducing risk of diabetes-related complication.
Obesity	•St. Mary's Wellness Center is the region's only medical fitness center. The facility is a large, fully-equipped gym with a wide range of group fitness classes, personal training, massage therapy, and a medical wellness program. Free memberships are provided to low income patients of Mercy Health Center. •St. Mary's Community Health and Well-being Department and the Nutrition Department launched educational blogs and healthy recipes posted on the external website for patients, community members, and colleagues. Education on healthy eating and physical activity are also posted on the St. Mary's Wellness Center social media pages 4 times per year.
Access to Healthy Foods	•St. Mary's donated over 200 turkeys to the Food Bank of Northeast Georgia and the Greene County Food Pantry to give to families in need at Thanksgiving. •Collaborated with and financially supported Envision Athens (Abundance Athens workgroup) to increase access to healthy food and address food insecurity. •St. Mary's Farmers-to-Families Program collaborated with Metz Culinary Management and Sysco Atlanta to provide 1,250 food boxes to distribute to families in need of food. Every food box contained 30-40 pounds of fresh fruit, vegetables, dairy, meat and eggs. •St. Mary's colleagues collaborated with Athens Land Trust- Willams Farm for a United Way Day of Service. The Williams Farm Incubator Program provides access to land, training and resources to beginning farmers belonging to groups whose members have historically been subject to racial or ethnic, prejudice. The goal of the program is to help these farmers hone their skills and develop independent sustainable farm businesses. •St. Mary's collaborated with and financially supported the Athens Farmers Market and UGA SNAP Education Program for the Food As Real Medicine Rx Program (FARM Rx). This produce prescription program promotes healthy eating and reduces the burden of chronic disease by prescribing fruits and vegetables to patients with chronic, diet-related illnesses. Approximately 60 community members were served.

CHNA Impact: Respiratory Health

Smoking	•St. Mary's Freedom from Smoking Program is for tobacco users who are ready to quit. This American Lung Association program focuses almost exclusively on how to quit, not why to quit. This class has reached approximately 60 smokers.
Chronic Lung Disease	•St. Mary's Better Breathers Club is a welcoming support group for individuals with chronic lung disease and their caregivers. This American Lung Association approved group provides strategies to cope with conditions such as COPD, pulmonary fibrosis, and asthma while getting the support of others in similar situations. This class supports approximately 10 participants monthly.
Flu	•Donated 250 flu vaccine to community clinics that serve uninsured community members, including Mercy Health Center and Alliance Recovery Center.
COVID-19	•Collaborated with 3 community partners to offer education, mass testing events, and vaccination to the broad community as well as underserved communities. •Collaborated with and financially support community clinics to increase access and clinical capacity for COVID-19 efforts; Mercy Health Center, Athens Neighborhood Health Center, and Innovative Healthcare Institute are the 3 primary partners. •Targeted vaccinatation activities in vulnerable and underserved populations through partnerships with jails and community clinics, as well as in-house vaccination clinics for local first responders, teens, and the broader community

COMMUNITY SERVED

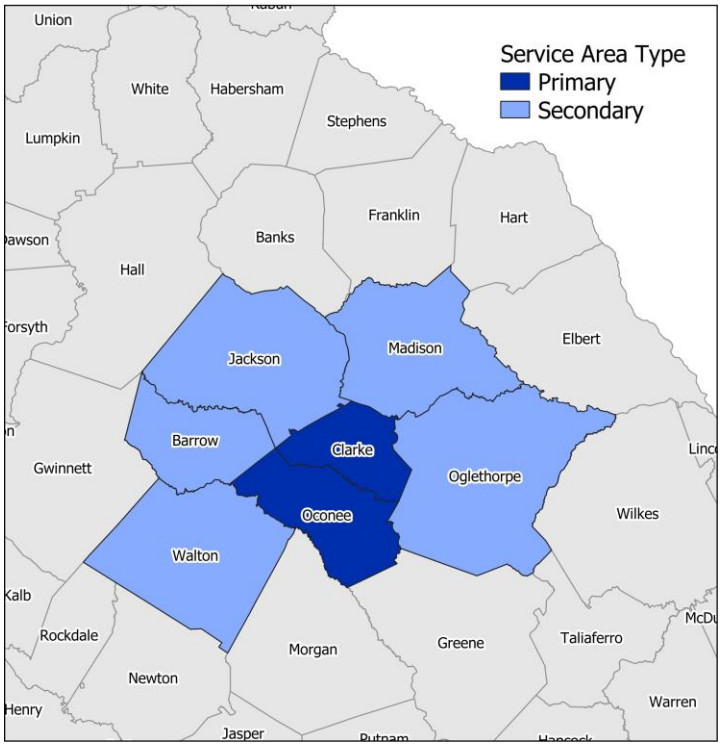
St. Mary's Health Care System Service Area

The geographic service area was defined at the county-level for the purposes of the 2022 Community Health Needs Assessment (CHNA). The service area was determined by counting the number of patient visits by county of residence. Seven counties are defined as the service area for St. Mary's Health Care System: Athens-Clarke, Barrow, Jackson, Madison, Oconee, Oglethorpe, and Walton. The counties with the most patient visits are the Primary Service Area. The counties with the next highest patient visits are the Secondary Service Area. See the below map of the service area.

The inpatient discharge data for the hospital was reviewed and zip codes reflecting the top inpatient discharges within the most recent year of data were included within the defined community. Demographic data by zip code was analyzed to ensure that medically underserved, low-income, or minority populations who live in the geographic areas from which the hospitals draw patients were not excluded from the defined community.

St. Mary's Health Care System service area zip codes: 30529, 30549, 30605, 30606, 30607, 30621, 30625, 30628, 30629, 30633, 30635, 30641, 30642, 30643, 30650, 30655, 30656, 30662, 30677, 30680, 31024.

St Mary's Service Area



Demographic Overview

The demographic overview is a snapshot of the St. Mary's service area and highlights the total population by age race, and ethnicity; demographics of special populations; and other relevant demographics that describe the community served. A comprehensive account of the service area demographics can be found in Appendix B.

Total Population by Age

Data Indicator	Indicator Variable	St. Mary's Service Area	State of Georgia
Population Age 0-4	Population Age 0-4	32,338	656,677
	Population Age 0-4, Percent	6.07%	6.31%
Population Age 5-17	Population Age 5-17	94,594	1,848,563
	Population Age 5-17, Percent	17.76%	17.77%
Population Age 18-64	Population Age 18-64	334,228	6,492,122
	Population Age 18-64, Percent	62.76%	62.40%
Population Age 65+	Population Age 65+	71,367	1,406,485
	Population Age 65+, Percent	13.40%	13.52%

Data Source: US Census Bureau, American Community Survey. 2015-19. Source geography: Tract

Population Age 18-64 by Race Alone

Report Area	White Age 18-64	Black or African American Age 18-64	Native American or Alaska Native Age 18-64	Asian Age 18-64	Native Hawaiian or Pacific Islander Age 18-64	Some Other Race Age 18-64	Multiple Race Age 18-64
St. Mary's Service Area	245,485	65,506	657	9,864	143	6,455	6,115
Georgia	3,759,078	2,113,473	24,138	286,554	3,981	180,760	124,138

Data Source: US Census Bureau, American Community Survey. 2015-19. Source geography: Tract

Population Age 18-64 by Ethnicity Alone

Report Area	Hispanic or Latino Age 18+	Not Hispanic or Latino Age 18+	Hispanic or Latino Age 18+, Percent	Not Hispanic or Latino Age 18+, Percent
St. Mary's Service Area	25,085.00	309,143.00	7.51%	92.49%
Georgia	590,793	5,901,329	9.10%	90.90%

Data Source: US Census Bureau, American Community Survey. 2015-19. Source geography: Tract

Special Populations

Data Indicator	Indicator Variable	St. Mary's Service Area	State of Georgia Data
Population with Any Disability	Total Population (For Whom Disability Status Is Determined)	529,182	10,213,659
	Population with a Disability	67,530	1,261,925
	Population with a Disability, Percent	12.76%	12.36%
Veteran Population	Total Population Age 18+	405,306	7,849,349
	Total Veterans	27,704	629,302
	Veterans, Percent of Total Population	6.84%	8.02%
Homeless Children and Youth	Total Students	88,755	1,741,375
	Districts Reporting	100.0%	93.7%
	Students in Reported Districts	100.0%	99.3%
	Homeless Students	1,534	36,678
	Homeless Students, Percent	1.7%	2.1%

Other Demographics

Data Indicator	Indicator Variable	St. Mary's Service Area	State of Georgia Data
Total Population	Total Population	532,526	10,403,847
	Total Land Area (Square Miles)	1,960.05	57,594.80
	Population Density (Per Square Mile)	272	181
Urban and Rural Population	Total Population	480,813	9,687,653
	Urban Population	313,275	7,272,151
	Rural Population	167,537	2,415,502
	Urban Population, Percent	65.16%	75.07%
	Rural Population, Percent	34.84%	24.93%

PROCESS AND METHODS

A mixed-methods approach, which is a combination of qualitative and quantitative data and analyses, was used to identify and prioritize community health needs. This approach allows for more confidence in the findings of the CHNA and ensures robustness in identification of health needs. The qualitative methods to solicit input from primary sources included focus groups and stakeholder discussions; the quantitative methods utilized secondary data sources such as the TrinityHealthDataHub.org for service area data and Emergency Department for hospital-specific data.

The primary data collected included input from persons who represented the broad interests of the community and those with special knowledge of or expertise in public health; federal, regional, state, or local health or other departments or agencies with current data or other information relevant to the health needs of the community served; leaders, representatives, or members of medically underserved, low-income, and minority populations with chronic disease needs in the community; and, input from other persons located in and/or serving the community. Information was gathered by conducting focus groups and stakeholder interviews with individuals representing community health and public service organizations, medical professionals, hospital administration, and other hospital staff members. Appendix A is a list of participants.

The secondary data sources were used to gather demographic and health indicator data. The data analysis generated by the Trinity Health Data Hub is based on each hospital service area and provided comprehensive reports on the following indicators: healthcare access, economic stability, education, social support and community context, neighborhood and physical environment, and health outcomes and behaviors. A number of indicators are calculated using areal weighted interpolation to estimate the values for each census tract which overlaps with the service areas, and the tract-level estimates are aggregated for the hospital regions. A rule has been implemented to ensure the total percentage of all selected hospital service areas does not exceed 100% for any census tract. Each hospital report includes data from the most updated and nationally

recognized sources such as the US Census Bureau, American Community Survey, and Behavioral Risk Factor Surveillance System.

Summary of Community Input

There were no written comments received on the prior CHNA and Implementation Strategy. Community input for this CHNA was obtained through focus groups and stakeholder discussions held between December 2021 and February 2022. The hospital engaged state, local, and regional health departments; representatives of those who are medically underserved, low-income, or in minority populations; and internal stakeholders to provide feedback on identifying and prioritizing significant needs. The list of stakeholders is on Appendix A of this report.

The focus group and stakeholder discussions were in response to the following prompts: (1) describe the community health needs, (2) identify the existing resources and assets, and (3) provide recommendations to address the needs identified. Members of the St. Mary's Community Health and Well-being team took notes separately during each meeting and compared them to each other to ensure consensus of qualitative themes.

Based on the primary data collected during focus groups and individual interviews, as well as available secondary data, the St. Mary's Community Health and Well-being team ranked the identified community needs based on priority and existing community assets. A written summary of the findings was developed and shared via e-mail to stakeholders for feedback. Feedback from internal and external stakeholders was addressed and incorporated into the final list of community health priorities.

SIGNIFICANT COMMUNITY HEALTH NEEDS

The overarching goals of the Community Health Needs Assessment process are to evaluate the impact of actions taken to address significant health needs identified in prior CHNA, identify new significant community health needs of the community, prioritize those community health needs, and identify resources and community assets available to address those health needs. This CHNA used a comprehensive mixed-methods approach that considered community input and the latest available secondary data on demographics of the community, healthcare access, economic stability, social support and community context, neighborhood and physical environment, and health outcomes and behaviors. Through the prioritization process described on page 16 of this report, St. Mary's Health Care System identified four priority community health needs. The significant community health needs are described below, in addition to the emergent and ongoing public health need of COVID-19.

1. Access to Healthcare
2. Addressing Social Needs
3. Behavioral and Mental Health
4. Chronic Disease Prevention and Management

Priority Need #1: Access to Healthcare

Access to healthcare continues to be a priority need within the service area. Community stakeholders cited limited preventive healthcare, specialty care services (e.g., dental, HIV/AIDS) and care coordination, lack of primary care for the uninsured, limited resources for immigrant and other underserved ethnic communities (including language services at providers), and lack of knowledge about existing services in the area. Access to care is also exacerbated by the fact that most major healthcare and social service providers in the service area are located within Clarke County (transportation was cited as a social need and is further detailed later in this report). Providers who participated in the assessment also identified ongoing shortage of clinical staff (in part due to burn-out from COVID-19 response since 2020) as detrimental to their ability to provide adequate services to the community.

Supporting Data: Access to Healthcare

- There are more than 65,000 residents of the service area who are uninsured, making up 12.33% of the total population (compared to 13.23% state-wide). This rate is highest within the 18-64-year-old age group (17.34%) in the service area.
- Compared to 77.3% of all adults in the state, only 75.61% of adults in the service area visited their primary care provider at least once in the last year.
- There are only 213 dentists serving the service area. This is a rate of 38.7 dentists per 100,000 population (compared to 52.4 state-wide). In fact, 77.39% of the service area population lives in a designated Health Professional Shortage Area (HPSA) of dental health professionals.
- Within the service area, 3.92% of people age 5+ have limited English proficiency (compared to 5.54% at state-level). This rate increases to 5.76% in Clarke County.
- Within the service area, 34.84% of the population lives in rural communities, compared to 24.93% state-wide.
- The local healthcare workforce and staffing shortage is exacerbated by the fact that the population 25+ in the service area is relatively low educated. Only 29.75% has earned a bachelor' degree or higher, and 12.9% does not have a school diploma (compared to 31.32% and 12.86% state-wide, respectively).

Priority Need #2: Addressing Social Needs

In addition to medical needs, community stakeholders highlighted that a number of social needs present access barriers to healthcare access and healthier communities. Specifically, they highlighted transportation, food insecurity, as well as housing insecurity.

Transportation

Access to safe and reliable transportation is critical to access healthcare, seek or keep work, obtain food and medications, and seeking recreation to decrease social isolation. Lack of public and/or private transportation is further exacerbated by community members' low-income living conditions, as well as the geographic nature of the service area. Stakeholders highlighted that while most area healthcare and social services are in the urban hub of Athens-Clarke County, they serve residents of the surrounding rural

counties. Unfortunately, public transportation, rideshare programs offered by CBOs, and even services like Uber and Lyft, can be expensive and do not always extend to the more rural areas.

Supporting Data: Transportation

- **Use of Public Transportation.** Only 1.31% of the entire service area's population regularly uses public transit to commute to work, compared to 2.10 state-wide. The low rate is likely due to the actual availability of transit. Of the 7 counties we service, only Clarke County boasts a system of low-cost and/or free bus lines and on-demand ride-shares. The more rural surrounding counties may—if at all—offer ride-shares within their county lines and sometimes to the service hub in Athens.
- **Private Motor Vehicles**. Only 94.8% of households in the service area has a motor vehicle (compared to 93.55% state-wide), limiting the ability of 9,768 households to access necessary healthcare and social services.

Food Insecurity

Food insecurity continues to be an expressed priority need by the stakeholders, mirroring findings from the 2019 CHNA. There is specific concern for individuals and families of the "working poor" who are not eligible to receive benefits like SNAP. At the same time, there is a sizeable gap between the number of households eligible for nutrition assistance (e.g., SNAP) and those who are actively enrolled. Stakeholders also highlighted the need for food distribution sites and complementary delivery services to support home-bound residents and those living in more rural communities.

Supporting Data: Food Insecurity

- **Food Insecurity Rates.** Thirteen percent of the total service area population, or 66,698 residents, face food insecurity (compared to 14.4% state-wide). Food insecurity is a more acute problem among children and youth under 18 years old. Almost 24,000 children (19.5% of people under 18 years old) face this challenge, compared to 14.7% state-wide. This indicator reports the estimated number of

people who had limited or uncertain access to adequate food at some point during the report year.

- **Assistance Eligibility.** Of the 666,698 residents of the service area who are food insecure, 70% meet eligibility requirements to receive Federal of State nutrition assistance programs like Supplemental Nutrition Assistance Program (SNAP), WIC, school meals, Commodity Supplemental Food Program (CSFP) and TEFAP. Additionally, 49.6% of students in the service area were eligible to receive reduced price or free lunches at their school due to their family's income at or below 185 percent of the Federal Poverty Threshold.
- **Assistance Utilization.** Among all households in the service area, 11.96% receive SNAP benefits compared to 12.8% state-wide.
- **Food Environment.** Within the service area, however, there are only 60 grocery stores and supermarkets servicing 480,808 residents. This is a rate of 12.48 per 100,000 population, compared to 17.46 state-wide. Additionally, 36.69% of the low-income population in the service area lives more than ½ mile from the nearest supermarket, supercenter or large grocery store (compared to 28.39% at the state-level). Grocery stores are defined as
  supermarkets and smaller grocery stores primarily engaged in retailing a general line of food, such as canned and frozen foods; fresh fruits and vegetables; and fresh and prepared meats, fish, and poultry. Delicatessen-type establishments are also included. Convenience stores and large general merchandise stores that also retail food, such as supercenters and warehouse club stores, are excluded.

Housing Insecurity

Access to safe and stable housing is a social influencer of whole-person health and wellbeing. Stakeholders who participated in focus groups and interviews also identified it as a high priority for the service area. There is particular concern about the availability of affordable housing for lower-income residents and students within the public school system. Stakeholders also highlighted the perceived prevalence of poor mental health among those who are experiencing homelessness.

Supporting Data: Housing Insecurity

- Almost 30% of all households in the service area (55,407 out of 187,411) spend more than 30% of their total household income on housing costs. Almost 55% of those cost-burdened households rent their home, which limits residents' inability to grow generational wealth.
- Out of 187,796 housing units in the service area, 56,470 (30.07%) have at least one substandard condition including: 1) lacking complete plumbing facilities, 2) lacking complete kitchen facilities, 3) with 1 or more occupants per room, 4) selected monthly owner costs as a percentage of household income greater than 30%, and 5) gross rent as a percentage of household income greater than 30%.
    - Homelessness is experienced by 2.5% of all K-12 students across the entire service area, a rate that jumps to 6.4% for students within Clarke County (compared to 2.3% state-wide).

Priority Need #3: Mental and Behavioral Health

All community focus groups and stakeholder conversations highlighted mental and behavioral health as primary community health needs. Two sub-themes were prevalent. First, the community clinical providers shared concern regarding deaths from opioids and that some behavioral health clients have substance abuse issues. Second, stakeholders shared the impact of behavioral health issues on children and families within the school system, as well as a perceived higher prevalence of anxiety, suicidal thoughts, depression, trauma in younger people.

Supporting Data: Mental and Behavioral Health

- **Poor mental health.** Almost 18% (17.87%) of all adults 18 and older within the service area self-reported poor mental health in the past month. This indicator reports the percentage of adults age 18 and older who report 14 or more days during the past 30 days during which their mental health was not good.
- **Deaths of despair.** Within the service area, there were 1,208 deaths of despair between 2016-2020. This indicator reports average rate of death due to intentional self-harm (suicide), alcohol-related disease, and drug overdose. The

age-adjusted despair death rate (per 100,000 population) in the service area is 44.1 compared to 38.1 state-wide.

- **Deaths by Drug Poisoning.** Of all the reported deaths of despair, 435 (or 36%) were due to drug poisoning. This represents an age-adjusted death rate (per 100,000 population) of 17.1, compared to 15.7 state-wide.
- **Deaths by Suicide.** Additionally, the service area saw 442 deaths by suicide within the same time period, representing 36.5% of all deaths of despair. This represents an age-adjusted death rate of 16.3 per every 100,000 people, compared to 14.0 state-wide.
- **Mental health providers.** There is a community perception of a lack of providers and care coordination for mental and behavioral services. However, there are 449 mental health providers with a CMS National Provider Identifier located within the service area. This represents 81.02 providers per 100,000 total population. This is a rate of more providers than the state at 62.86 providers per 100,000 population in service area.

Priority Need #4: Chronic Disease Prevention & Management

Stakeholders also identified the need to continue efforts to prevent and manage chronic diseases, including cardiovascular and respiratory health, nutrition-related disease like obesity and diabetes, and cancer.

Cardiovascular Disease

- 61.6% of Medicare population in the service area has high blood pressure (compared to 61.8% state-wide)
- 26.6% of Medicare population in the service area has heart disease (compared to 26.3% state-wide).
- 50.6% of Medicare population has hyperlipidemia (high cholesterol), compared to 50.1% state-wide.

Respiratory Disease

- The rate adjusted death rate by lung disease is 51.3 per 100,000 population in the service area (compared to 44.5 state-wide).

- There rate of current smokers in the service area is higher (20.12% of adults) compared to state-wide rate of 18.09%.
- Residents of the service area spend 1.81% of their household expenditures on cigarettes (compared to 1.68% state-wide).

Nutrition, Obesity and Diabetes

- 10.49% of adults in the service area have been diagnosed with diabetes at some point (compared to 12.64% state-wide).
- Half (50.6%) of Medicare beneficiaries in the service area have high cholesterol (compared to 50.1% state-wide).
- The rate of adult obesity (BMI >= 30.0kg/m2) in the service area is 33.06%, compared to 33.88% state-wide.

Cancer

- Within the report area, there were 2,616 new cases of cancer reported. This means there is a rate of 487.6 for every 100,000 population. This is higher than the state rate at 468.5 per 100,000.
- The breast cancer incidence rate in the service area is 131.8 per 100,000 population, compared to 128.4 state-wide.
- Colon and rectum cancer incident rates in the service area are also higher than state-wide rates (41.6 compared to 40.9 per 100,000 population)

Emergent Public Health Need: COVID-19

COVID-19 became an emergent global health priority in March 2020. Since then and as of March 31, 2022, there have been at least 113,272 confirmed cases of COVID-19. people in the service area and 1,352 have died as a result of the respiratory infection. St. Mary's Hospital treated a total of 1,498 inpatients for COVID-19 through March 2022. The global pandemic put unprecedented burden on local healthcare facilities and staff, necessitating the refocus of human and capital resources originally earmarked for 2019 CHNA priority needs. The service area—as highlighted by the stakeholder group behind this CHNA—continues to feel the impact of COVID-19, particularly with every surge of cases and hospitalizations. Stakeholders described the need to be better prepared for new surges of COVID-19 and other such public health emergencies.

Needs Not Being Addressed

St. Mary's Health Care System acknowledges the complex and wide number of health needs that emerged from the CHNA process. Stakeholders mentioned needs that specific communities face as daily barriers to health and quality of life. We prioritized to address those areas of collaboration and partnerships that can leverage impact and address systemic social determinants of health and chronic concerns, as well as emergent public health needs. For those three areas not being addressed – HIV/AIDS, dental health, and social needs for children - it was determined that addressing those needs were best served by others in the community who have the expertise, capacity, and adequate resources. Accordingly, St. Mary's will continue to support strong partners in the community to effectively address the needs of the community we serve.

COMMUNITY RESOURCES AND ASSETS

Community resources and assets were identified in the both the community focus groups and through the Community Resource Directory (https://communityresources.trinity-health.org). The Community Resource Directory is an online platform enables the hospital, community-based organizations, and community members to identify and refer community wide resources to address the social needs of the community we serve. With knowledge of the current assets, the hospital places greater emphasis on enhancing, expanding, and connecting existing resources to address the priority community needs. The Community Resource Directory has been an important tool in identifying specific free or reduced cost services such as medical care, food, job training, and more. Appendix C includes instructions on how to access the Community Resource Directory.

Assets that were considered critical to meet community needs include:

Human resources. Examples of local organizations, governing bodies, existing programs, and associations

Envision Athens (www.envisionathens.com)

- Envision Athens serves Athens-Clarke County as the catalyst, convener, and champion of progress in addressing our community's most pressing needs and optimizing our opportunities for collaborative community development.

Habitat for Humanity (www.athenshabitat.com)

- Habitat for Humanity partners with people in your community, and all over the world, to help them build or improve a place they can call home. Habitat homeowners help build their own homes alongside volunteers and pay an affordable mortgage.

United Way of Northeast GA (www.unitedwaynega.org)

- United Way improves lives by mobilizing the caring power of communities around the world to advance the common good.

Informational resources. Examples of associations and memberships, both formal and informal, available for networking, communication, and support.

Casa de Amistad (www.athensamistad.com)

- Casa de Amistad is an organization based in Athens, Georgia, that works to identify and address the needs of the under-served Hispanic community by offering direct service, education, advocacy and community involvement. Casa de Amistad works to create a just, harmonious, and multicultural community.

Rotary Club (www.athensgarotary.com)

- Rotary is a global network of 1.4 million neighbors, friends, leaders, and problem-solvers who see a world where people unite and take action to create lasting change – across the globe, in our communities, and in ourselves.

Athens Technical College (www.athenstech.edu)

- Athens Tech is a unit of the Technical College System of Georgia in Athens, Georgia

Family Connection-Communities in Schools (www.fc-cis.org)

- The mission of Family Connection-Communities in Schools is to surround students with a community of support, empowering them to stay in school and achieve in life.

Physical resources. Examples of public spaces that are available to community members for meeting space and recreation.

Nuçi's Space (www.nuci.org)

- Nuçi's Space maintains a health and resource center for musicians as a safe space to seek support and guidance, provides access to affordable, obstacle-free professional care, actively participates in treatment and educates about awareness, prevention and the risk factors of brain illnesses.

Heard Park (www.accgov.com/2761/Heard-Park-previously-E-Athens-Community)

- Heard Park is a public space that is equipped with a gymnasium, full-service kitchen, and a multi-purpose room on the main floor; a game room, fitness room, and dance room on the second floor; and a library, arts and crafts room, and another multi-purpose room on the third floor.

Athens Farmer's Market (www.athensfarmersmarket.net)

- The Athens Farmers Market exists to provide an economic, educational, and cultural connection between community members, farmers, and artisans.

Firefly Trail (www.fireflytrail.com)

- Firefly Trail, Inc., is a 501(c)(3) Georgia non-profit incorporated for the purpose of creating a multi-use trail from Athens to Union Point along the corridor of the historic Athens Branch of the Georgia Railroad.

Existing intervention resources. Examples of initiatives and programs that are currently provided within the community.

Advantage Behavioral Health Systems (www.advantagebhs.org)

- Advantage Behavioral Health systems provides person-centered treatment and recovery support to individuals and families experiencing behavioral health challenges, intellectual/developmental disabilities, and addictive diseases.

Athens Area Emergency Food Bank (www.athensfoodbank.org/main.html)

- The AAEFB's purpose is to meet the food needs for one week for families or individuals who live in Athens-Clarke County who are faced with emergencies upon referral by an approved agency.

Athens Community Council on Aging (www.accaging.org)

- ACCA's mission is to promote a lifetime of wellness through engagement, advocacy, education and support.

Athens YMCA (www.athensymca.org)

- The Y is the nation's leading nonprofit organization for youth development, healthy living and social responsibility.

Boys and Girls Club of Athens (www.greatfuturesathens.com)

- The Boys & Girls Clubs of Athens have provided a clean, healthy, and safe environment for youth ages 6 to 18 for over 50 years. Our after-school activities are designed to fully engage our members in skill-building exercises while encouraging them to have fun.

Political/governmental resources. Examples of public and private institutions that currently advocate for resources and policy change within the community.

Project Safe (www.project-safe.org)

- Project Safe is a 501c3 nonprofit organization working to end domestic violence through crisis intervention, ongoing supportive services, systems change advocacy, and prevention and education.

Athens Anti-Discrimination Movement (www.aadmovement.org)

- The Athens Anti-Discrimination Movement ("AADM") advocates for racial and social justice and strives to combat discrimination through education and activism. AADM offers various workshops, programs, and resources designed to help citizens protect their civil and human rights.

Juvenile Offenders Advocate (www.juvenileoffenderadvocateinc.org)

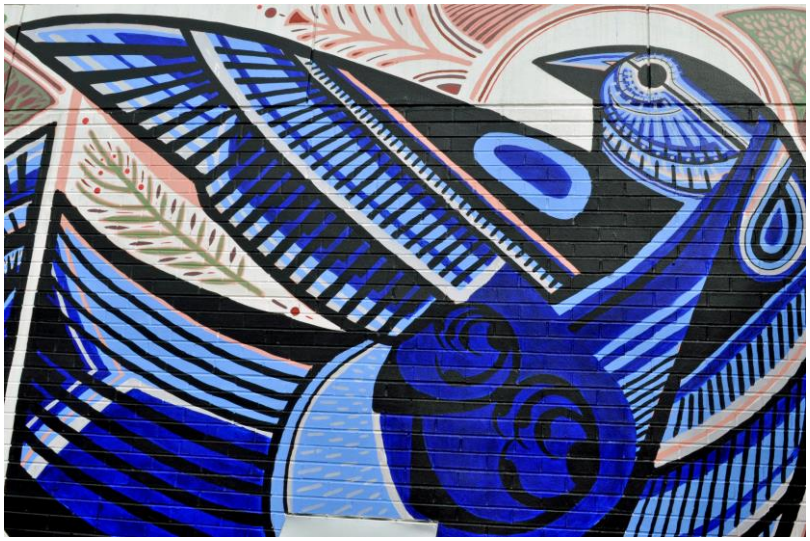
- Juvenile Offenders Advocate purpose is to reduce the recidivism rate and poverty level in the Athens-Clarke County community by holding all parties accountable while fostering positive relationships through community collaboration

CONCLUSION

In collaboration with key stakeholders, this comprehensive Community Health Needs Assessment (CHNA) identified access to healthcare, addressing social needs, behavioral and mental health, and chronic disease prevention and management as priority focus areas for residents of Barrow, Clarke, Jackson, Madison, Oconee, Oglethorpe, and Walton counties. The 2022-2025 CHNA process is part of ongoing efforts of St. Mary's Health Care System to best support health and well-being of the community it serves. An accompanying implementation strategy that outlines how we will address those areas will be developed and available in a separate document.

To receive a physical copy of this 2022 CHNA report and the implementation strategy, please contact St. Mary's Community Health and Well-being Department at 706-389-3424. Digital copies of the documents are also available to the public on the St. Mary's Health Care System website https://www.stmaryshealthcaresystem.org/about-us/community-benefit.

Members of the public are encouraged to provide comments on the 2022 CHNA by contacting St. Mary's Community Health and Well-being Department at 706-389-3424. We will consider all comments received as we plan to develop the next 2025 CHNA.



APPENDIX A. ADVISORY COMMITTEE AND KEY STAKEHOLDERS

Advantage Behavioral Health Systems
Tamara Conlin, CEO
Provides person-centered treatment and recovery support to individuals and families experiencing behavioral health challenges, intellectual/developmental disabilities, and addictive diseases.

Athens-Clarke County Commissioner (district 9) and community advocate
Ovita Thompson

Athens Community Council on Aging
Erin Beasley, VP and Director of Operations
Promotes a lifetime of wellness through engagement, advocacy, education and support.

Athens Neighborhood Health Center
Stalina Gowdie, Chief Medical Officer
Provides affordable, high quality healthcare to all individuals in Athens-Clarke County and surrounding areas.

Athens Nurses Clinic
Page Cummings, Executive Director
Provides free evaluation, treatment, and education for acute and chronic medical and dental conditions to uninsured low-and-no income residents of Athens-Clarke County and the surrounding communities.

Athens Wellbeing Project
Grace Bagwell Adams, Principal Investigator
Jacob Lambeck, Project Manager
Empowers the Athens community with meaningful [longitudinal] data that will lead to more informed decision-making, improvements in service delivery, and greater quality of life for our citizens.

Bethel Haven
Melinda Allen, Executive Director
Dedicated to serving the community through quality, professional therapeutic services that are affordable for all clients.

Clarke County School District
Linda Davis, Board Member (district 3)
Develops life-long learners and globally minded citizens by fostering the academic, creative, and social skills needed to achieve excellence in a multicultural environment.

Creature Comforts
Fenwick Broyard, VP of Culture
Under its corporate giving program, Get Comfortable, Creature Comforts channels the generosity of many toward the greatest local needs.

The Food Bank of Northeast Georgia
Erin Barger, CEO
Works to address hunger and end food insecurity by serving communities across our region, providing consistent access to nourishing food and relevant education.

Georgia Department of Public Health
Erika Lopez Gil, Chronic Disease & Health Promotion
Lead agency in preventing disease, injury and disability; promoting health and well-being; and preparing for and responding to disasters from a health perspective.

Innovative Healthcare Institute
Cshanyse Allen, Director
Provides quality education and prepare each student to meet the highest standards and qualifications necessary for a career and employment in the healthcare field.

Mercy Health Center
Susie Mobley, Development Director
Through a community of volunteers, Mercy provides quality, whole-person healthcare in a Christ-centered environment to our underserved neighbors.

Piedmont Athens Regional Medical Center
Elaine Cook, VP of Public & Gov. Affairs
A 360-bed non-profit hospital and regional referral center serving a 17-county service area in Athens and northeast Georgia.

St. Mary's Health Care System
Montez Carter, President and CEO
Ralph Johnson, Board Member
Dessa Morris, Board Member
Tamara Bourda, VP Community Health and Well-being
Ed Moore, Community Health and Well-being Coordinator
Alejandra Calva, Community Health and Well-being Coordinator
Lindsey Floyd, Community Health and Well-being Coordinator
Catherine Gurak, Community Health Worker

United Way of Northeast Georgia
Kay Keller, Executive Director
Motivates and mobilizes resources to meet the highest priority needs of individuals and families in Northeast Georgia.

APPENDIX B. OVERVIEW OF SERVICE AREA DEMOGRAPHICS

The following report was generated by the Trinity Health Data Hub on February 21, 2022, based on the hospital service area. A number of indicators are calculated using areal weighted interpolation to estimate the values for each census tract which overlaps with the service areas; the tract-level estimates are aggregated for the hospital regions. A rule has been implemented to ensure the total percentage of all selected hospital service areas does not exceed 100% for any census tract. The report includes data from the most updated and nationally recognized sources, including the US Census Bureau, American Community Survey, and Behavioral Risk Factor Surveillance System.

Demographics

Data Indicator	Indicator Variable	Location Summary	Georgia
Foreign-Born Population	Total Population	532,526	10,403,847
	Naturalized U.S. Citizens	18,665	459,275
	Population Without U.S. Citizenship	20,690	594,599
	Total Foreign-Birth Population	39,355	1,053,874
	Foreign-Birth Population, Percent of Total Population	7.39%	10.13%
Population Age 0-4	Total Population	532,527.00	10,403,847
	Population Age 0-4	32,338.00	656,677
	Percent Population Age 0-4	6.07%	6.31%
Population Age 18-64	Total Population	532,527.00	10,403,847
	Population Age 18-64	334,228.00	6,492,122
	Population Age 18-64, Percent	62.76%	62.40%
Population Age 5-17	Total Population	532,527.00	10,403,847
	Population Age 5-17	94,594.00	1,848,563
	Population Age 5-17, Percent	17.76%	17.77%
Population Age 65+	Total Population	532,527	10,403,847
	Population Age 65+	71,367	1,406,485
	Population Age 65+, Percent	13.40%	13.52%
Population Geographic Mobility	Total Population	526,555	10,277,909
	Population In-Migration	50,799	825,405
	Percent Population In-Migration	9.65%	8.03%
Population with Any Disability	Total Population (For Whom Disability Status Is Determined)	529,182	10,213,659
	Population with a Disability	67,530	1,261,925
	Population with a Disability, Percent	**12.76%**	**12.36%**
Population with Limited English Proficiency	Population Age 5+	500,189	9,747,170
	Population Age 5+ with Limited English Proficiency	19,604	539,739
	Population Age 5+ with Limited English Proficiency, Percent	**3.92%**	**5.54%**
Total Population	Total Population	532,526	10,403,847
	Total Land Area (Square Miles)	1,960.05	57,594.80
	Population Density (Per Square Mile)	272	181
Urban and Rural Population	Total Population	480,813	9,687,653
	Urban Population	313,275	7,272,151
	Rural Population	167,537	2,415,502
	Urban Population, Percent	65.16%	75.07%
	Rural Population, Percent	34.84%	24.93%
Veteran Population	Total Population Age 18+	405,306	7,849,349
	Total Veterans	27,704	629,302
	Veterans, Percent of Total Population	6.84%	8.02%

Healthcare Access

Data Indicator	Indicator Variable	Location Summary	Georgia
Access to Care - Addiction/Substance Abuse Providers	Total Population (2020)	No data	10,711,908
	Number of Facilities	No data	210
	Number of Providers	No data	529
	Providers, Rate per 100,000 Population	No data	4.94
Access to Care - Dentists	Estimated Population	549,471	21,112,656
	Number of Dentists	213	11,056
	Ratio of Dental Providers to Population (1 Provider per x Persons)	2,581.5	1,909.6
	Dentists, Rate (Per 100,000 Population)	38.7	52.4
Access to Care - Mental Health Providers	Total Population (2020)	554,590	10,711,908
	Number of Facilities	34	1,259
	Number of Providers	449	6,733
	Providers, Rate per 100,000 Population	81.02	62.86
Access to Care - Primary Care	Total Population (2020)	No data	10,711,908
	Number of Facilities	No data	3,276
	Number of Providers	No data	8,924
	Providers, Rate per 100,000 Population	No data	83.31
Federally Qualified Health Centers	Total Population (2020)	313,492	10,711,908
	Number of Federally Qualified Health Centers	7	287
	Rate of Federally Qualified Health Centers per 100,000 Population	2.26	2.68
Health Professional Shortage Areas	Primary Care Facilities	2	83
	Mental Health Care Facilities	2	73
	Dental Health Care Facilities	2	72
	Total HPSA Facility Designations	6	228
Health Professional Shortage Areas - Dental Care	Total Area Population	480,808	9,687,653
	Population Living in a HPSA	372,109.00	5,720,632
	Percentage of Population Living in a HPSA	77.39%	59.05%
Insurance - Population Receiving Medicaid	Total Population (For Whom Insurance Status is Determined)	529,183.00	10,213,659
	Population with Any Health Insurance	463,954.00	8,862,562
	Population Receiving Medicaid	87,296.00	1,787,277
	Percent of Insured Population Receiving Medicaid	18.82%	20.17%
Insurance - Uninsured Population	Total Population (For Whom Insurance Status is Determined)	529,183	10,213,659
	Uninsured Population	65,228	1,351,097
	Uninsured Population, Percent	12.33%	13.23%
Recent Primary Care Visit	Total Population (2019)	480,808	10,617,423
	Percentage of Adults with Routine Checkup in Past 1 Year	75.61%	77.33%

Economic Stability

Data Indicator	Indicator Variable	Location Summary	Georgia
Area Deprivation Index	Total Population	520,036	10,136,085
	State Percentile	43	No data
	National Percentile	53	56
Employment - Labor Force Participation Rate	Total Population Age 16+	419,925	8,187,263
	Labor Force	262,906	5,125,182
	Labor Force Participation Rate	62.61%	62.60%
Employment - Unemployment Rate	Labor Force	274,020	5,207,912
	Number Employed	268,351	5,084,054
	Number Unemployed	5,668	123,858
	Unemployment Rate	2.1%	2.4%
Food Insecurity Rate	Total Population	511,436.00	10,428,333
	Food Insecure Population, Total	66,698.00	1,501,680
	Food Insecurity Rate	13.00%	14.40%
Homeless Children and Youth	Total Students	88,755	1,741,375
	Districts Reporting	100.0%	93.7%
	Students in Reported Districts	100.0%	99.3%
	Homeless Students	1,534	36,678
	Homeless Students, Percent	1.7%	2.1%
Income - Income Inequality (GINI Index)	Total Households	187,796	3,758,798
	Gini Index Value	0.42	0.48
Income - Median Household Income	Total Households	187,796	3,758,798
	Average Household Income	$76,677	$82,406
	Median Household Income	No data	$58,700
Poverty - Children Below 200% FPL	Total Population Under Age 18	517,530.00	2,468,726
	Population Under Age 18 at or Below 200% FPL	176,919.00	1,106,903
	Percent Population Under Age 18 at or Below 200% FPL	34.19%	44.84%
Poverty - Children Eligible for Free/Reduced Price Lunch	Total Students	92,359	1,769,657
	Students Eligible for Free or Reduced Price Lunch	45,789	1,056,179
	Students Eligible for Free or Reduced Price Lunch, Percent	49.58%	59.68%
Poverty - Population Below 200% FPL	Total Population	517,530.00	10,130,335
	Population with Income at or Below 200% FPL	176,919.00	3,470,773
	Percent Population with Income at or Below 200% FPL	34.19%	34.26%
SNAP Benefits - Households Receiving SNAP	Total Households	187,796	3,758,798
	Households Receiving SNAP Benefits	22,454	481,103
	Percent Households Receiving SNAP Benefits	11.96%	12.80%

Education

Data Indicator	Indicator Variable	Location Summary	Georgia
Access - Head Start	Children Under Age 5	32,979	686,785
	Total Head Start Programs	11	469
	Head Start Programs, Rate (Per 10,000 Children)	3.20	6.83
Access - Preschool Enrollment (Children Age 3-4)	Population Age 3-4	13,442	273,912
	Population Age 3-4 Enrolled in School	6,665	137,655
	Population Age 3-4 Enrolled in School, Percent	49.58%	50.26%
Attainment - Bachelor's Degree or Higher	Total Population Age 25+	339,785	6,888,279
	Population Age 25+ with Bachelor's Degree or Higher	101,102	2,157,616
	Population Age 25+ with Bachelor's Degree or Higher, Percent	29.75%	31.32%
Attainment - No High School Diploma	Total Population Age 25+	339,784	6,888,279
	Population Age 25+ with No High School Diploma	43,825	885,498
	Population Age 25+ with No High School Diploma, Percent	12.90%	12.86%
Chronic Absenteeism	Student Cohort	86,531	1,753,047
	Number Chronically Absent	11,893	251,310
	Chronic Absence Rate	13.74%	14.34%
Proficiency - Student Reading Proficiency (4th Grade)	Students with Valid Test Scores	26,149	524,832
	Students Scoring 'Proficient' or Better, Percent	44.2%	39.2%
	Students Scoring 'Not Proficient' or Worse, Percent	55.9%	60.8%

Social Support & Community Context

Data Indicator	Indicator Variable	Location Summary	Georgia
Commuter Travel Patterns - Public Transportation	Total Population Employed Age 16+	244,324.00	4,781,201
	Population Using Public Transit for Commute to Work	3,189.00	100,374
	Percent Population Using Public Transit for Commute to Work	1.31%	2.10%
Households with No Motor Vehicle	Total Occupied Households	187,796	3,758,798
	Households with No Motor Vehicle	9,768	242,468
	Households with No Motor Vehicle, Percent	5.20%	6.45%
Incarceration Rate	Total Population (2010)	480,808	9,687,653
	Incarceration Rate	2.0%	2.1%
Opportunity Index	Total Population	519,493	10,304,763
	Opportunity Index Score	47.59	47.93
Social Vulnerability Index	Total Population	522,772	10,297,484
	Socioeconomic Theme Score	0.56	0.52
	Household Composition Theme Score	0.52	0.41
	Minority Status Theme Score	0.47	0.80
	Housing & Transportation Theme Score	0.41	0.53
	Social Vulnerability Index Score	0.48	0.57
Teen Births	Female Population Age 15-19	142,277	4,893,952
	Teen Births, Rate per 1,000 Female Population Age 15-19	17.8	24.2
Violent Crime	Total Population	529,368.00	10,527,735
	Violent Crimes, 3-year Total	5,002.00	117,844
	Violent Crimes, Annual Rate (Per 100,000 Pop.)	314.90	373.10
Young People Not in School and Not Working	Population Age 16-19	35,361	583,596
	Population Age 16-19 Not in School and Not Employed	1,930	45,857
	Population Age 16-19 Not in School and Not Employed, Percent	5.46%	7.86%

Neighborhood & Physical Environment

Data Indicator	Indicator Variable	Location Summary	Georgia
Air Quality - Particulate Matter 2.5	Total Population (2010)	480,812	9,687,653
	Average Daily Ambient Particulate Matter 2.5	8.10	9.85
	Days Exceeding Emissions Standards	2	1
	Days Exceeding Standards, Percent (Crude)	0.61	0.27
	Days Exceeding Standards, Percent (Weighted)	0.69%	0.39%
Built Environment - Broadband Access	Total Population (2020)	560,869	10,709,715
	Access to DL Speeds > 25MBPS (2020)	97.58%	96.02%
Built Environment - Park Access	Total Population, 2010 Census	657,772	9,687,653
	Population Within 1/2 Mile of a Park	57,103.00	1,687,537.00
	Percent Within 1/2 Mile of a Park	8.68%	17.42%
Built Environment - Recreation and Fitness Facility Access	Total Population (2010)	241,530	9,687,653
	Number of Establishments	52	1,107
	Establishments, Rate per 100,000 Population	21.53	11.43
Built Environment - Social Associations	Total Population (2010)	480,808	9,687,653
	Number of Establishments	404	9,623
	Establishment Rate per 100,000 Population	84.03	99.33
Drinking Water Safety	Estimated Total Population	140,308.00	5,629,816
	Presence of Health-Based Drinking Water Violation	Yes	Yes
Food Environment - Fast Food Restaurants	Total Population (2010)	480,808	9,687,653
	Number of Establishments	392	8,762
	Establishments, Rate per 100,000 Population	81.53	90.45
Food Environment - Grocery Stores and Supermarkets	Total Population (2010)	480,808	9,687,653
	Number of Establishments	60	1,691
	Establishments, Rate per 100,000 Population	12.48	17.46
Food Environment - Low Income & Low Food Access	Total Population	480,812	9,687,653
	Low Income Population	170,441	3,420,617
	Low Income Population with Low Food Access	62,528	971,069
	Percent Low Income Population with Low Food Access	36.69%	28.39%
Housing Costs - Cost Burden (30%)	Total Households	187,411	3,758,798
	Cost Burdened Households (Housing Costs Exceed 30% of Income)	55,407	1,110,770
	Cost Burdened Households, Percent	29.56%	29.55%
Housing Quality - Overcrowding	Total Occupied Housing Units	142,422	2,320,665
	Overcrowded Housing Units	3,505	83,669
	Percentage of Housing Units Overcrowded	2.46%	3.61%
Housing Quality - Substandard Housing	Total Occupied Housing Units	187,796	3,758,798
	Occupied Housing Units with One or More Substandard Conditions	56,470	1,131,218
	Occupied Housing Units with One or More Substandard Conditions, Percent	30.07%	30.10%
Tenure - Owner-Occupied Housing	Total Occupied Housing Units	187,796	3,758,798
	Owner-Occupied Housing Units	125,309	2,377,773
	Percent Owner-Occupied Housing Units	66.73%	63.26%
Tenure - Renter-Occupied Housing	Total Occupied Housing Units	187,796	3,758,798
	Renter-Occupied Housing Units	62,486	1,381,025
	Percent Renter-Occupied Housing Units	33.27%	36.74%

Health Outcomes & Behaviors

Data Indicator	Indicator Variable	Location Summary	Georgia
30-Day Hospital Readmissions	Medicare Part A and B Beneficiaries	87,201	1,680,680
	30-Day Hospital Readmissions	1,739	35,341
	30-Day Hospital Readmissions, Rate	17.6%	18.7%
Alcohol Expenditures	State Rank	No data	No data
	Z-Score (US)	No data	-0.08
	Z-Score (Within-State)	No data	No data
	Average Expenditures (USD)	$601.17	$759.52
	Percentage of Food-At-Home Expenditures	13.58%	13.75%
Breastfeeding - Any	Total Population (Age 0 - 5)	No data	734,500
	Number Ever Breastfed	No data	554,493
	Percent Ever Breastfed	No data	75.00%
Cancer Incidence - All Sites	Estimated Total Population	536,582	11,091,782
	New Cases (Annual Average)	2,616	51,965
	Cancer Incidence Rate (Per 100,000 Population)	487.6	468.5
Cancer Incidence - Breast	Estimated Total Population (Female)	287,469	5,968,847
	New Cases (Annual Average)	378	7,664
	Cancer Incidence Rate (Per 100,000 Population)	131.8	128.4
Cancer Incidence - Colon and Rectum	Estimated Total Population	525,196	11,000,000
	New Cases (Annual Average)	218	4,499
	Cancer Incidence Rate (Per 100,000 Population)	41.6	40.9
Chronic Conditions - Alzheimer's Disease (Medicare Population)	Total Medicare Fee-for-Service Beneficiaries	47,056	922,696
	Beneficiaries with Alzheimer's Disease	4,972	98,702
	Beneficiaries with Alzheimer's Disease, Percent	10.6%	10.7%
Chronic Conditions - Diabetes (Adult)	Total Population (2019)	480,808	10,617,423
	Adults Ever Diagnosed with Diabetes (Crude)	10.49%	12.64%
	Adults Ever Diagnosed with Diabetes (Age-Adjusted)	No data	12.01%
Chronic Conditions - Heart Disease (Medicare Population)	Total Medicare Fee-for-Service Beneficiaries	47,056	922,696
	Beneficiaries with Heart Disease	12,537	242,410
	Beneficiaries with Heart Disease, Percent	26.6%	26.3%
Chronic Conditions - High Blood Pressure (Medicare Population)	Total Medicare Fee-for-Service Beneficiaries	47,056	922,696
	Beneficiaries with High Blood Pressure	28,991	570,504
	Beneficiaries with High Blood Pressure, Percent	61.6%	61.8%
Chronic Conditions - High Cholesterol (Medicare Population)	Total Medicare Fee-for-Service Beneficiaries	47,056	922,696
	Beneficiaries with High Cholesterol	23,826	461,974
	Percent with High Cholesterol	50.6%	50.1%
Chronic Conditions - Obesity (Adult)	Total Population (2019)	480,808	10,617,423
	Adult Obesity (BMI ≥30.0 kg/m²) (Crude)	33.06%	33.88%
	Adult Obesity (BMI ≥30.0 kg/m²) (Age-Adjusted)	No data	33.86%
Diabetes Management (Hemoglobin A1c Test)	Medicare Enrollees with Diabetes	5,598	101,932
	Medicare Enrollees with Diabetes with Annual Exam	5,039	89,176
	Medicare Enrollees with Diabetes with Annual Exam, Percent	90.03%	87.49%

Health Outcomes & Behaviors (Ctd.)

Data Indicator	Indicator Variable	Location Summary	Georgia
Fruit/Vegetable Expenditures	State Rank	No data	No data
	Z-Score (US)	No data	-0.26
	Z-Score (Within-State)	No data	No data
	Average Expenditures (USD)	$551.29	$674.17
	Percentage of Food-At-Home Expenditures	12.45%	12.20%
HIV Prevalence	Population Age 13+	450,134.00	8,737,682
	Population with HIV / AIDS	1,211.00	54,600
	Population with HIV / AIDS, Rate per 100,000 Pop.	269.05	624.9
Hospitalizations - Preventable Conditions	Medicare Beneficiaries	84,135	1,633,421
	Preventable Hospitalizations, Rate per 100,000 Beneficiaries	3,311	3,503
Lack of Prenatal Care	Total Births	11,959	381,786
	Births with Late/No Care	775	32,275
	% of Births with Late/No Care	6.48%	8.45%
Life Expectancy (County)	Total Population	512,203	19,915,602
	Life Expectancy at Birth (2017-19)	78.1	78.0
Low Birth Weight	Total Live Births	44,304	1,801,717
	Low Birthweight Births	3,790	175,548
	Low Birthweight Births, Percentage	11.7%	9.7%
Mortality - Cancer	Total Population, 2016-2020 Average	539,672	10,517,333
	Five Year Total Deaths, 2016-2020 Total	4,464	87,299
	Crude Death Rate (Per 100,000 Population	165.4	166.0
	Age-Adjusted Death Rate (Per 100,000 Population)	158.0	153.1
Mortality - Coronary Heart Disease	Total Population, 2016-2020 Average	539,672	10,517,333
	Five Year Total Deaths, 2016-2020 Total	1,651	39,694
	Crude Death Rate (Per 100,000 Population)	61.2	75.5
	Age-Adjusted Death Rate (Per 100,000 Population)	61.5	72.4
Mortality - Deaths of Despair	Total Population, 2016-2020 Average	539,672	10,517,333
	Five Year Total Deaths, 2016-2020 Total	1,208	20,881
	Crude Death Rate (Per 100,000 Population)	44.8	39.7
	Age-Adjusted Death Rate (Per 100,000 Population)	44.1	38.1
Mortality - Drug Poisoning	Total Population, 2016-2020 Average	539,672	10,517,333
	Five Year Total Deaths, 2016-2020 Total	435	8,294
	Crude Death Rate (Per 100,000 Population)	16.1	15.8
	Age-Adjusted Death Rate (Per 100,000 Population)	17.1	15.7
Mortality - Homicide	Total Population, 2016-2020 Average	539,672	10,517,333
	Five Year Total Deaths, 2016-2020 Total	116	4,352
	Crude Death Rate (Per 100,000 Population)	6.0	8.3
	Age-Adjusted Death Rate (Per 100,000 Population)	5.9	8.4
Mortality - Infant Mortality	Number of Infant Deaths	247.00	12,283
	Deaths per 1,000 Live Births	6.4	7.3

Health Outcomes & Behaviors (Ctd.)

Data Indicator	Indicator Variable	Location Summary	Georgia
Mortality - Lung Disease	Total Population, 2016-2020 Average	539,672	10,517,333
	Five Year Total Deaths, 2016-2020 Total	1,349	24,234
	Crude Death Rate (Per 100,000 Population)	50.0	46.1
	Age-Adjusted Death Rate (Per 100,000 Population)	50.4	44.5
Mortality - Motor Vehicle Crash	Total Population, 2016-2020 Average	539,672	10,517,333
	Five Year Total Deaths, 2016-2020 Total	402	7,787
	Crude Death Rate (Per 100,000 Population)	14.9	14.8
	Age-Adjusted Death Rate (Per 100,000 Population)	14.9	14.5
Mortality - Premature Death	Premature Deaths, 2017-2019	6,454	265,864
	Years of Potential Life Lost, 2017-2019 Average	112,297	4,559,513
	Years of Potential Life Lost, Rate per 100,000 Population	7,308	7,637
Mortality - Suicide	Total Population, 2016-2020 Average	539,672	10,517,333
	Five Year Total Deaths, 2016-2020 Total	442	7,505
	Crude Death Rate (Per 100,000 Population)	16.4	14.3
	Age-Adjusted Death Rate (Per 100,000 Population)	16.3	14.0
Poor Mental Health	Total Population (2019)	480,808	10,617,423
	Adults with Poor Mental Health (Crude)	17.87%	16.05%
	Adults with Poor Mental Health (Age-Adjusted)	No data	16.15%
Poor or Fair Health	Population Age 18+	140,308	5,629,816
	Adults with Poor or Fair Health	26,766	1,049,611
	Percentage of Adults with Poor or Fair Health	19.1%	18.6%
Poor Physical Health Days	Total Population (2019)	480,808	10,617,423
	Adults with Poor Physical Health (Crude)	13.82%	14.0%
	Adults with Poor Physical Health (Age-Adjusted)	No data	13.7%
Soda Expenditures	State Rank	No data	No data
	Z-Score (US)	No data	0.21
	Z-Score (Within-State)	No data	No data
	Average Expenditures (USD)	$183.95	$231.07
	Percentage of Food-At-Home Expenditures	4.16%	4.18%
Tobacco - Current Smokers	Total Population (2019)	480,808	10,617,423
	Adult Current Smokers (Crude)	20.12%	18.09%
	Adult Current Smokers (Age-Adjusted)	No data	18.26%
Tobacco - Expenditures	State Rank	No data	No data
	Z-Score (US)	No data	-0.04
	Z-Score (Within-State)	No data	No data
	Average Expenditures (USD)	$712.60	$835.80
	Percentage of Food-At-Home Expenditures	1.81%	1.68%

APPENDIX C. COMMUNITY RESOURCE DIRECTORY

The Community Resource Directory is an online platform that enables the hospital, community-based organizations, and community members to identify and refer community wide resources to address the social needs of the community we serve*. The Directory is accessible in multiple languages and is fully WCAG 2AA compliant.

To access the Community Resource Directory, visit https://communityresources.trinity-health.org or use the QR code below. Follow the on-screen prompts to search for free and reduced-cost health resources and social services.

* Trinity Health is working with findhelp to provide this online tool. Findhelp is not an affiliate of Trinity Health. The Community Resource Directory uses the findhelp network of third-party resources and community-based resources available in a specific community that are free and/or low-cost. Trinity Health does not endorse third-party organizations and resources linked in the findhelp network, and some resources may not align with our Trinity Health Mission

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