2016 Community Health Needs Assessment

Kaiser Foundation Health Plan of Georgia
Approved by KFH Board of Directors
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To provide feedback about this Community Health Needs Assessment, email CHNA-communications@kp.org

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CHNA REPORT FOR KAISER FOUNDATION HEALTH PLAN OF GEORGIA

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I. EXECUTIVE SUMMARY

Community Health Needs Assessment (CHNA) Background

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain their tax exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement that all nonprofit hospitals must conduct a community health needs assessment (CHNA) and develop an implementation strategy (IS) every three years (http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf).

While Kaiser Permanente has conducted CHNAs for many years to identify needs and resources in our communities and to guide our Community Benefit plans, these new requirements have provided an opportunity to revisit our needs assessment and strategic planning processes with an eye toward enhancing compliance and transparency and leveraging emerging technologies. The CHNA process undertaken in 2016 and described in this report was conducted in compliance with current federal requirements.

Summary of Prioritized Needs

The Kaiser Permanente Georgia Region (KPGA) encompasses urban, rural, and suburban settings in a 32-county area in north central Georgia. The population in KPGA's service region has increased to approximately 5.8 million (up from 5.5 million in 2013). A health needs assessment was conducted between October 2015 and February 2016 and is intended to be an update of the 2013 effort. As a result of primary and secondary data reviews and analysis, the prioritized health needs for the KPGA region are:

1. **Obesity/ Healthy Eating and Active Living** - In the CHNA region, obesity is most prevalent among people of color and in low-income and rural communities. In the region, there is wide variation in diet quality and active living, but economically distressed areas fared worse in these measures. Obesity is inversely related to healthy eating and active living.
2. **Access to care** (primary, and mental) - The supply of primary and mental health care providers around the region is not proportionately dispersed by population and is low in many areas. Moderate lack of insurance exists throughout the service region with some minority populations having significantly less coverage rates than others.
3. **Cardiovascular conditions** - Hypertension, stroke and heart disease, are a predominant cause of morbidity and mortality. Diet, physical activity, and tobacco use are all risk factors for these conditions and African Americans are more adversely affected.
4. **Educational Attainment** - Educational attainment is one of the strongest predictors of life expectancy and lifetime health status. In the CHNA region, there is wide variation in educational attainment. School quality is not evenly distributed.
5. **Cancer** - In the CHNA region, breast and prostate cancer incidence rates are moderately high. In some parts of the region screening rates are low, contributing to late detection and increased mortality risk.

6. **HIV/AIDS/STD** - HIV prevalence is nearly five times higher for non-Hispanic Black residents of the region than for non-Hispanic White residents. Fulton and DeKalb counties have extremely high rates. Chlamydia infection rates are also relatively high in more dense and urban populations.
7. **Diabetes** - Type II Diabetes is another outcome resulting from poor diet quality, low levels of physical activity, and other risk factors including genetics. In the CHNA region, diabetes tends to trend with economic disadvantage, rural residency, and non-immigrant status.
8. **Poverty** - Poverty is a serious issue in the CHNA region. There are insufficient resources to help poor families get ahead. Poverty exists in concentrated clusters, resulting in extreme variation of resources among high-amenity communities and areas without access to amenities.
9. **Mental health conditions** - In the CHNA region, mental health needs are one of the leading causes of hospital and ER utilization. Self-harm/suicide is a challenge in some communities.
10. **Transportation** - Transportation is a key component to accessing the essentials of a healthy life. Throughout the CHNA region, there is very limited access to transportation to access daily essentials and a significant number of residents express challenges in getting to care.

Many of these health needs remain the same from the 2013 assessment, with some changes in priority. Obesity, healthy food access, and opportunities for increased physical activity continue to be top priorities for the region. Access to primary and mental health care was also raised by stakeholders across the region as an important issue to be addressed. Although insurance rates have increased in some counties, the regional rate remains about the same and there are several counties (e.g. Clayton) that now have higher rates of uninsured residents compared to the 2013 assessment. Georgia did not approve Medicaid expansion under the ACA. As a result, there is great need for affordable health care coverage for low-income adults who don't traditionally qualify for Medicaid.

This needs assessment highlighted other non-health priorities, including educational attainment, poverty, and access to public transportation. Disparities across health needs are evident by geographic location (for example, HIV/AIDS and STI rates in Fulton county are significantly higher than other counties) and race/ethnicity (i.e., Latino subpopulations are more adversely affected by disparate diabetes outcomes and African Americans are more adversely affected by hypertension and stroke).

Summary of Needs Assessment Methodology and Process

Community Health Needs Assessment Toolkits provided by the Kaiser Permanente Program Office guided the assessment methodology and process. Subtle modifications were made to the process, given that the region does not operate its own central hospital or group of hospital systems. The Georgia Region includes 26 medical facilities spread across a service area that encompasses 32 counties.

Stemming from KPGA's participation in the Atlanta Regional Collaborative for Health Improvement (ARCHI), this assessment was carried out in collaboration with Piedmont Health System, Mercy Care, Grady Health System and Wellstar Health System. Resources from these partnerships resulted in a robust CHNA with more than 70 interviews and 20 focus groups and listening sessions, conducted in various areas across in the service region.

Secondary data pulled from the KP CHNA Data Platform and a host of other sources, including Georgia-based datasets, are outlined in Appendix A. These data informed the designation of hotspots (where conditions, drivers and outcomes were relatively poor), and brightspots (where these factors performed better than the rest of the region). During interviews and focus groups, stakeholders ranked the health needs that they identified.

Prioritization tools were used to rationalize all the data and information. A shortlist of health needs was generated using a simple culling method that focused on the intersection of findings from secondary data and the information from the primary data. KPGA Community Benefit staff and internal partners participated in a review of the data and used criteria and a voting process that valued the ranked feedback from the community to further prioritize health needs. Organizational resources and assets related to health and community capacity were also captured and are expected to be used in the development of the implementation strategies arising from this assessment.

II. INTRODUCTION/BACKGROUND

About Kaiser Permanente (KP)

Founded in 1942 to serve employees of Kaiser Industries and opened to the public in 1945, Kaiser Permanente is recognized as one of America's leading health care providers and nonprofit health plans. Kaiser was created to meet the challenge of providing American workers with medical care during the Great Depression and World War II, when most people could not afford to go to a doctor. Since our beginnings, we have been committed to helping shape the future of health care. Some of the innovations Kaiser Permanente has brought to U.S. health care include:

- Prepaid health plans, which spread costs to make healthcare more affordable
- A focus on primary prevention as much as on caring for the sick
- An organized integrated system that puts as many services as possible under one roof—all connected by an electronic medical record

Kaiser Permanente is a coordinated health care delivery system comprised of Kaiser Foundation Hospitals (KFH), Kaiser Foundation Health Plan (KFHP), and physicians in the Permanente Medical Groups. Today we serve approximately 10.6 million members in eight states and the District of Columbia. Our mission is to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.

Care for members and patients is focused on their Total Health and guided by their personal physicians, specialists, and team of caregivers. Our expert and caring medical teams are empowered and supported by industry-leading technology advances and tools for health promotion, disease prevention, state-of-the-art care delivery, and world-class chronic disease management. Kaiser Permanente is dedicated to care innovations, clinical research, health education, and the support of community health.

About Kaiser Permanente Community Benefit

For more than 70 years, Kaiser Permanente has been dedicated to providing high-quality, affordable health care services and to improving the health of our members and the communities we serve. We believe good health is a fundamental right shared by all and we recognize that good health extends beyond the doctor's office and the hospital. It begins with healthy environments: fresh fruits and vegetables in neighborhood stores, successful schools, clean air, accessible parks, and safe playgrounds. These are the vital signs of healthy communities. Good health for the entire community, which we call Total Community Health, requires equity and social and economic well-being.

Like our approach to medicine, our work in the community takes a prevention-focused, evidence-based approach. We go beyond traditional corporate philanthropy or grantmaking to pair financial resources with medical research, physician expertise, and clinical practices. Historically, we've focused our investments in three areas—Health Access, Healthy Communities, and Health Knowledge—to address critical health issues in our communities.

For many years, we've worked side-by-side with other organizations to address serious public health issues such as obesity, access to care, and violence. We have conducted Community Health Needs Assessments to better understand each community's unique needs and resources. The CHNA process informs our community investments and helps us develop

strategies aimed at making long-term, sustainable change, and it allows us to deepen the relationships we have with other organizations that are working to improve community health.

Purpose of the Community Health Needs Assessment (CHNA) Report

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain their tax exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement that all nonprofit hospitals must conduct a community health needs assessment (CHNA) and develop an Implementation Strategy (IS) every three years (http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf). While this law did not apply to the GA region, the region decided to conduct both a CHNA and develop an IS in order to be transparent and accountable to the communities served by the region. Both the CHNA Report and the IS for each Kaiser Foundation Hospital facility are available publicly at kp.org/chna.

Kaiser Permanente's Approach to Community Health Needs Assessment

Kaiser Permanente has conducted CHNAs for many years, often as part of long standing community collaboratives. The new federal CHNA requirements have provided an opportunity to revisit our needs assessment and strategic planning processes with an eye toward enhanced compliance and transparency and leveraging emerging technologies. Our intention is to develop and implement a transparent, rigorous, and collaborative approach to understanding the needs and assets in our communities. From data collection and analysis to the identification of prioritized needs and the development of an Implementation Strategy, the intent was to develop a rigorous process that would yield meaningful results.

Kaiser Permanente's innovative approach to CHNAs include the development of a free, web-based CHNA data platform that is available to the public. The data platform provides access to a core set of approximately 150 publicly available indicators to understand health through a framework that includes social and economic factors, health behaviors, physical environment, clinical care, and health outcomes.

In addition to reviewing the secondary data available through the CHNA data platform, and in some cases other local sources, each KFH facility—individually or with a collaborative—collected primary data through key informant interviews, focus groups, and surveys. Primary data collection consisted of reaching out to local public health experts, community leaders, and residents to identify issues that most impacted the health of the community. The CHNA process also included an identification of existing community assets and resources to address the health needs.

Each hospital/collaborative developed a set of criteria to determine what constituted a health need in their community. Once all of the community health needs were identified, they were all prioritized, based on a set of pre-determined criteria. This process resulted in a complete list of prioritized community health needs. The process and the outcome of the CHNA are described in this report.

In addition to this report, Kaiser Foundation Health Plan of Georgia will develop an Implementation Strategy plan for the priority health needs that will be areas of focus in the 2017-2019 CHNA period. These strategies will build on Kaiser Permanente's assets and resources, as well as evidence-based strategies, wherever possible. The Implementation Strategy will be filed with the Internal Revenue Service using Form 990 Schedule H.

III. COMMUNITY SERVED

Kaiser Permanente's Definition of Community Served

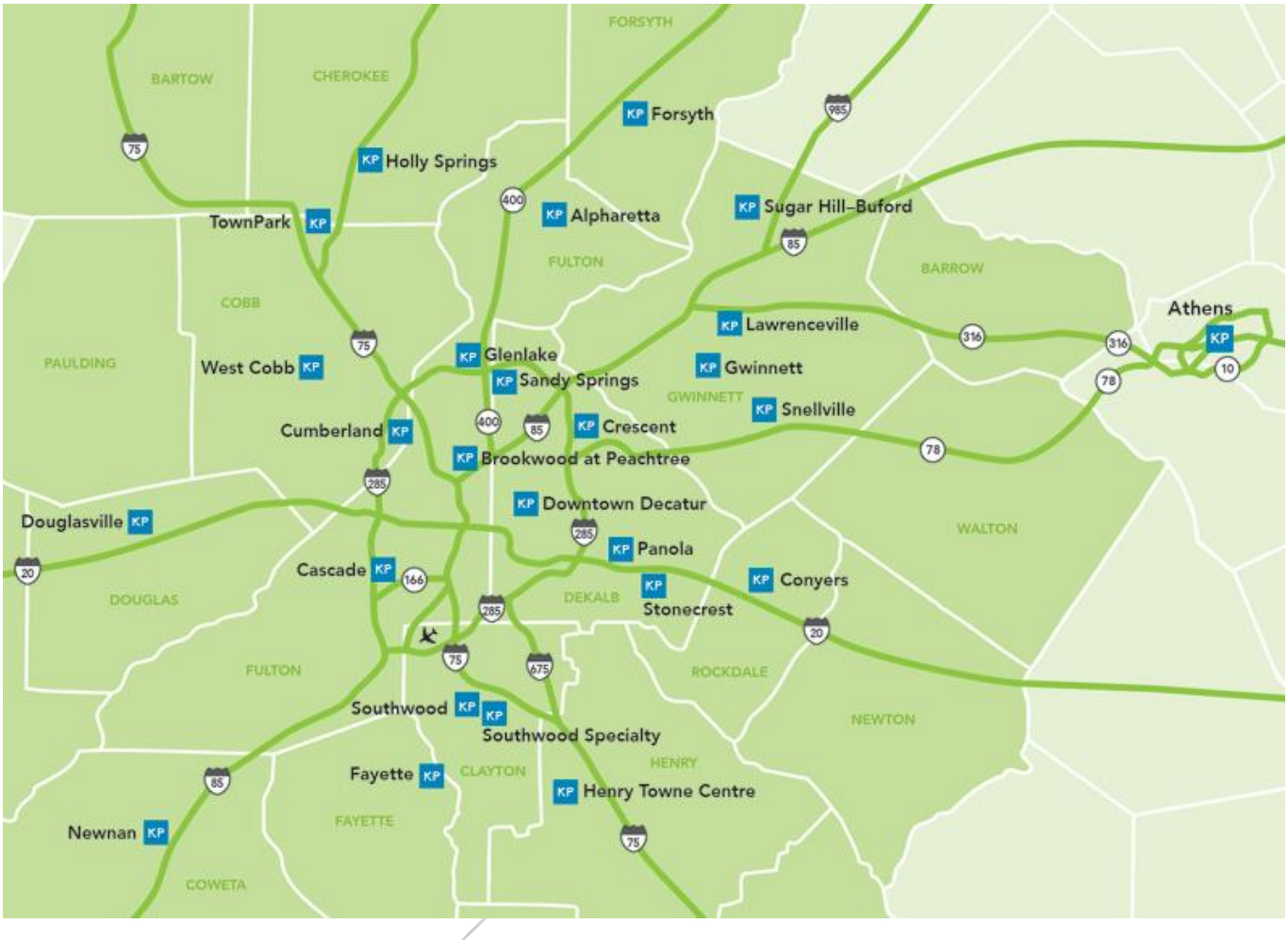
Kaiser Permanente defines the community served as those individuals residing within its service area. A service area includes all residents in a defined geographic area surrounding its medical facilities and does not exclude low-income or underserved populations.

The 32 county Georgia region does not operate a hospital, but there are 26 medical facilities throughout (see listing and map of facilities below).

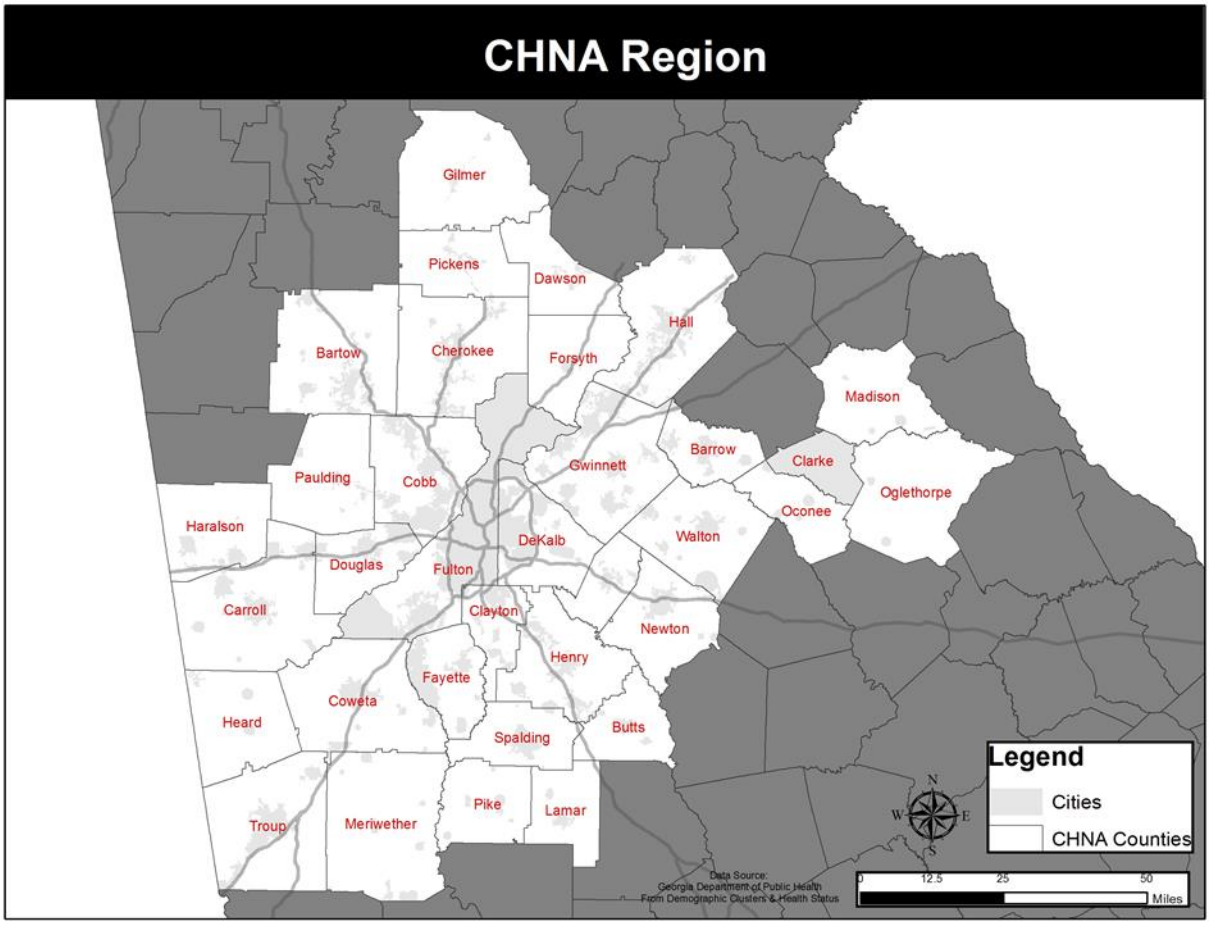
Table 1. Kaiser Permanente Georgia Region Medical Offices

County	Medical Center/Offices
Cherokee	Holly Springs Medical Office
Clarke	Athens Medical Office
Clayton	Southwood Comprehensive Medical Center
	Southwood Specialty Center
Cobb	Cumberland Medical Center
	Town Park Comprehensive Medical Center
	West Cobb Medical Office
Coweta	Newnan Medical Office
DeKalb	Crescent Medical Center
	Downtown Decatur Medical Office
	Panola Medical Center
	Stonecrest Medical Office
Douglas	Douglasville Medical Office
Fayette	Fayette Medical Office
Forsyth	Forsyth Medical Office
Fulton	Alpharetta Medical Center
	Brookwood at Peachtree Medical Office
	Cascade Medical Center
	Glenlake Comprehensive Specialty Center
	Sandy Springs Medical Office
Gwinnett	Gwinnett Comprehensive Medical Center
	Lawrenceville Medical Office
	Snellville Medical Office
	Sugar Hill - Buford Medical Center
Henry	Henry Towne Centre Medical Center
Rockdale	Conyers Medical Office

Map of KPGA Facilities



Map and Description of Community Served



Geographic description of the community served (towns, counties, and/or zip codes)

The KPGA service region is geographically comprised of 32 counties within an area of just under 9,400 square miles. The five principal counties that make up the metro-Atlanta area—DeKalb, Cobb, Clayton, Gwinnett and Fulton—are included in the service area and are the most densely populated counties in the state. Much of the service area is dissected by the primary interstate network (i.e. I-75, I-85 and I-20). The outer extent of the service region is generally more rural than the core of the region and some communities in the north/northeast sectors are part of the Appalachian foothills.

Table 2. KPGA Counties

Barrow	Coweta	Hall	Oconee
Bartow	Dawson	Haralson	Oglethorpe
Butts	DeKalb	Heard	Paulding
Carroll	Douglas	Henry	Pickens
Cherokee	Fayette	Lamar	Pike
Clarke	Forsyth	Madison	Rockdale
Clayton	Fulton	Meriwether	Spalding
Cobb	Gwinnett	Newton	Walton
Coweta	Hall	Newton	Walton

Demographic profile of community served

The population of the KPGA service region is diverse and relatively young (i.e., 1 in 4 are less than 18 years old). Nearly 6 million people live within the region and approximately one third identify as African American with a growing number of Latino residents (see Table 3). Because counties in the KPGA service regions are rather large, there is great variability within counties and many subpopulations are clustered by race and socioeconomic status. Residents typically live in communities where living conditions and health outcomes are more similar than those in nearby communities (defined by zip code and/or census tract) within the same county. Accordingly, county level data, especially in more urban and diverse counties, do not necessarily represent the nuanced picture of health for all county residents.

Table 3. Socio-demographic Highlights of the KPGA service Area

Demographic Data	*Regional Total*	*Regional %*	*Georgia Total*	*Georgia %*
Population	5,805,115	58.6%	9,907,756	100%
White	3,330,744	57.4%	5,989,234	60.5%
Black	1,839,034	31.7%	3,056,726	30.9%
Asian	290,813	5.0%	344,195	3.5%
Native American/ Alaskan Native	15,521	0.27%	25,137	0.25%
Pacific Islander/ Native Hawaiian	2,056	>0.1%	4,137	>0.1%
Some Other Race	202,420	3.5%	287,276	2.9%
Multiple Races	124,527	2.2%	200,871	2.0%
Hispanic/Latino	634,211	10.9%	896,717	9.1%
Socio-economic Data		*Regional %*		*Georgia %*
Living in Poverty (<200% FPL)		34.6%		38.7%
Children in Poverty		21.9%		25.3%
Unemployed		6.1%		6.4%
Uninsured		18.9%		19%
No High School Diploma		12.8%		15.3%

Regionally, a third of the population lives below 200% federal poverty level (FPL), with approximately one in five children living in poverty. In densely populated urban and rural communities across the region these rates are sometimes significantly higher. Since the passage of the ACA, the uninsured rate for the region has remained the same (just under 19%), though in a few counties the rate has increased since the time of the last assessment. Table 4 presents some of the counties in the region where the primary health drivers—population in poverty, uninsured rate and population without a high school diploma—are highest in the region.

Table 4. Socio-economic Determinants (Low Performing Counties in Service Region)

Report Area	Percent Population in Poverty	Percent Uninsured Population	Percent Population Age 25 with No High School Diploma
KPGA Service Area	15.81%	18.86%	12.66%
Barrow County, GA	13.7%	19.69%	17.85%
Bartow County, GA	17.14%	19.34%	19.59%
Butts County, GA	14.51%	19.19%	25.29%
Carroll County, GA	18.88%	18.58%	20.26%
Clayton County, GA	**24%**	**26.94%**	**18.32%**
DeKalb County, GA	18.99%	21.48%	11.63%
Hall County, GA	**18.72%**	**20.92%**	**21.24%**
Haralson County, GA	22.78%	16.89%	25.83%
Heard County, GA	**24.32%**	**19.75%**	**27.3%**
Lamar County, GA	**18.87%**	**19.35%**	**18.14%**
Meriwether County, GA	**21.13%**	**20.76%**	**26.99%**
Rockdale County, GA	14.72%	20.52%	13.77%
Spalding County, GA	21.46%	18.24%	23.36%
Georgia	18.2%	18.96%	15.26%
United States	15.37%	14.87%	13.98%

IV. WHO WAS INVOLVED IN THE ASSESSMENT

The 2016 Community Health Needs Assessment was a joint undertaking of KFHP and three other health systems in the metro Atlanta area that are part of the Atlanta Regional Collaborative for Health Improvement – Grady Health System, Piedmont Health System, and Mercy Care. Additionally, Wellstar Health System—which is not yet a part of the collaborative—contributed resources to conduct the assessment. This collaboration allowed for more in-depth primary data collection through additional interviews, focus groups, and listening sessions, especially in "hotspot" communities where health drivers and outcomes were particularly burdensome, and a few "brightspot" communities where some of these outcomes were the best in the state.

A number of state agencies contributed to the data and report, including: Georgia Department of Education, Georgia Department of Public Health, Georgia Department of Community Health, and the Georgia Department of Agriculture. Ten District Health Directors with responsibility for the region's counties participated in stakeholder interviews (detailed in the *Community Input* section of this report) as well as representatives from the Fulton County Department of Health and Wellness.

Non-profit organizations were engaged via key informant interviews, including leaders from the Atlanta Regional Commission, Center for Pan Asian Community Services, and the United Way of Metro Atlanta. Focus group recruitment was completed by the market research company Wilkins Research Services, LLC (WRS). Based in Chattanooga, Tennessee, the firm has been in business since 1971. WRS recruited focus group participants for nine groups who resided in select zip codes or census tracts in DeKalb, Fulton, Gwinnett, Hall, and Meriwether Counties. Also assisting with the focus group arrangements was Mrs. Daphne Renolds and Ms. Sacha Gayle who helped to secure locations, arrange catering, and complete recording and transcription of the groups' comments.

Finally, the Kaiser Permanente Community Benefit team in Georgia, internal KPGA partners, and the Advisory Board provided feedback and input into the CHNA.

Identity and qualifications of consultants used to conduct the assessment

The Georgia Health Policy Center (GHPC), established in 1995, is housed within Georgia State University's Andrew Young School of Policy Studies. GHPC provides evidence-based research, program development, and policy guidance locally, statewide, and nationally to improve communities' health status. The center focuses on solutions to difficult issues facing health care today, including: insurance coverage; children's health; sustainable rural and urban health systems; community-based health promotion; and social determinants of health and health equity.

Drawing on more than 15 years of combined learning from its experience with 100+ projects supported by 75 diverse funders, the Center's projects and studies span the layers of the socioecological model and include individual, multi-site, and meta-level assessments of communities, programmatic activities, and provision of technical assistance. The Center has guided a national expert team in the design of the Federal Office of Rural Health Policy's Network and Outreach Program evaluations; been commissioned by communities as external evaluators; and conducted multiple assessments, community engagements and strategic planning processes.

In 2009, the Georgia Health Policy Center was engaged by the Kaiser Foundation Health Plan of Georgia to conduct a Health Needs Assessment and Survey of Opportunities in the 32 metro Atlanta counties that made up the service region of Kaiser Permanente in Georgia at that time. This assessment examined the health status,

social determinants, resources and outcomes in the service region, and detailed best practices for improving health equity and disparity in vulnerable populations. Additionally, the Center developed the Community Health Needs Assessment and Implementation for Grady Health System, the largest public hospital system serving the metro Atlanta community.

GHPC has also collaborated with KFHP on the Healthy Belvedere community initiative. Healthy Belvedere is a partnership between Kaiser Foundation Health Plan for Georgia, The Community Foundation for Greater Atlanta, and the community of Belvedere in southwest DeKalb County/southeast Atlanta, Georgia. GHPC has provided facilitation and evaluation services to this Healthy Eating Active Living initiative for the last 5 years.

The KFHP CHNA team lead is Dr. Chris Parker, GHPC Associate Project Director, who has worked in a leadership capacity on a variety of projects that reflect his areas of expertise and interest. Dr. Parker has been the Principal Investigator on the two Kaiser Permanente projects mentioned above as well as facilitated strategic planning for a number of state health agencies and non-profit organizations. Chris is a graduate from the Rollins School of Public Health, Emory University, where he completed his MPH degree, focusing in Health Policy and Management in 2001. As a trained physician he brings a wealth of significant clinical experiences, having worked with underserved communities and faith-based organizations. Supporting Dr. Parker on this project are GHPC team members who have expertise in: health impact assessments, built environment analysis, health disparities, health system evaluation, obesity, physical activity and nutrition interventions, epidemiology and geographical information systems.

V. PROCESS AND METHODS USED TO CONDUCT THE CHNA

Secondary data

Sources and dates of secondary data used in the assessment

Kaiser Foundation Health Plan of Georgia used the Kaiser Permanente CHNA Data Platform (www.chna.org/kp) to review over 150 indicators from publically available data sources. Supplementary data was obtained from the Georgia Department of Public Health Online Analytical and Statistical Information System (OASIS), the County Health Rankings data platform (countyhealthrankings.org), the US Census Bureau American Community Survey 5-Year Dataset (census.gov), and the Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) atlas (www.cdc.gov/NCHHSTP/Atlas/). Data on gender and race/ethnicity breakdowns were analyzed when available. For details on specific sources and dates of the data used, please see **Appendix A**.

Methodology for collection, interpretation and analysis of secondary data

GHPC used the modified Mobilizing Action toward Community Health (MATCH) model, to gather and evaluate secondary data starting with the information on the KP CHNA Data Platform. Gaps in data or state-specific data sources were identified to determine the need for the secondary data sources. In addition to information from the Kaiser Permanente CHNA platform and those sources listed in Appendix A, the Georgia Department of Public Health Online Analytical Statistical Information System (OASIS) and a subset of 2011 Behavior Risk Factor Surveillance System data were used to inform the project. Information was also received from the Georgia Department of Education, specifically Georgia Student Health Survey data (in Acrobat reader files), a subset of FitnessGram results (body composition/body mass index only), and free and reduced lunch data. Data were synthesized using tabular formats and layered maps allowing researchers to gain insight about location specific health needs. Custom online layered maps were used in conjunction with Kaiser Permanente CHNA platform maps to overlay common indicators with secondary data. Finally, the Preliminary Health Needs Determination Tool assisted the team in helping to list those health needs for which the data demonstrated significant variance from the state benchmark.

Community Input

Description of the community input process

Community input was provided by a broad range of community members through the use of key informant interviews and focus groups. Individuals with the knowledge, information, and expertise relevant to the health needs of the community were consulted and their input captured as part of the process. These individuals included representatives from local public health departments as well as leaders, representatives, and members of medically underserved, low-income, and minority populations. Additionally, where applicable, other individuals with expertise of local health needs were consulted. For a complete list of individuals who provided input, see Appendix B.

Focus groups were held to gain input about the health of the communities within the Kaiser Permanente service area. A total of eleven focus groups were conducted throughout the 32 county service area. The objectives of the focus groups were to:

- Gather participants' perspectives of the health and health needs of their respective communities
- Solicit recommendations about how health needs could be addresses
- Get an understanding of what currently exists in communities to make positive change happen

The focus groups were held in ten counties within the KP service area. These counties were chosen because of the health status of communities within the counties. Some communities are "hot spots" where the health status and drivers of health status are poor and, some are "bright spots", where the health and socioeconomic status is moderate to good, because these communities can provide learning on how to improve health in areas that do not fare as well. Focus groups were held in the following counties:

- Bartow
- Cherokee
- Clarke
- Clayton
- Cobb
- DeKalb
- Douglas
- Fulton
- Meriwether
- Paulding

Additionally, nine community listening sessions—which were carried out in the Buford Highway corridor as part of the primary data collection process for the Mercy Care service area—were included as part of the input for this assessment given the collaborative nature of the effort among ARCHI partners. Listening sessions lasted approximately 2 hours, during which time participants were asked to respond to a variety of questions about the health of their community using audience response technology. Instantaneous results were offered to participants to encourage small and large group discussions about the collective responses. Listening sessions were conducted with Latinos, English speaking seniors and Korean immigrants. Analysis of the transcripts from these sessions yielded themes which were included as input to this assessment.

The targeted recruitment areas, with the exception of Cobb, Clayton, DeKalb, and Fulton Counties, were the whole county. The targeted recruitment areas in Cobb, Clayton, DeKalb, and Fulton Counties were based on specific ZIP Codes where the health and socioeconomic status was low. The focus group in Cobb was conducted with Spanish-speaking Latino residents. While there is not a large population of Latino residents in Cobb County, the health needs among these residents are great.

Key informant interviews (25) were conducted with leaders and public health practitioners spanning the entire service region. Additionally, as part of the more focused effort of the Piedmont Health System to hear from local stakeholders, an additional 40 interviews with stakeholders in Coweta, Fayette, Fulton, Henry, Newton and Pickens counties were included as part of the input to this assessment (See Appendix B: Community Input Tracking Form).

Methodology for collection, interpretation, and analysis of primary data

A third party recruitment agency, Wilkins Research Services (WRS), recruited participants for each of the focus groups which were conducted in "hotspots and brightspots" across the service area. Demographic profiles of these areas - (zip codes, communities and/ counties) were created to aid the recruitment process. The profile included racial make-up and age distribution. Participant recruitment targets were set to reflect the demographic profile of the county or targeted zip code (e.g. if a targeted area had 70% African American population and a 30% white population, WRS attempted to recruit a focus group participants reflecting that demographic profile). WRS utilized lists of land line phone numbers for the targeted zip codes in the focus counties and randomly called phone numbers to screen for participants for the focus groups.

All of the focus groups were held in a location central to the targeted area. Participants were provided a light meal and a stipend for their participation. They were provided a copy of an informed consent form approved by the Institutional Review Board of Georgia State University and asked to sign these consent forms prior to beginning the group discussion.

Focus groups lasted an average of 90 minutes. There was a facilitator and note taker present at each focus group. Each discussion was recorded and transcribed. Focus group participants were asked about their perceptions of their families' health and health in their communities, barriers to better health, and their suggestions for how to address key health concerns in their communities. This summary report reflects the main themes coming from the discussions recorded in the nine communities. Themes that are common across the focus groups are summarized and presented here. When appropriate, differences within and across focus groups are noted.

The majority of the key informant interviews were conducted by teleconference using a structured questionnaire aimed at understanding health challenges and opportunities/recommendations for community health improvement. The interviews lasted between 30-45 minutes and were recorded by handwritten/typed notes. Using an excel spreadsheet, responses were entered by questions in a tabular manner and common themes and outlier responses were noted and reported. Responses and recommendations will also be used in the implementation strategy development process.

Written comments

As of the time of this CHNA report development, Kaiser Foundation Health Plan of Georgia had not received written comments about previous CHNA Reports. Kaiser Permanente will continue to track any submitted written comments and ensure that relevant submissions will be considered and addressed by the appropriate Facility staff.

Data limitations and information gaps

The KP CHNA data platform includes approximately 150 secondary indicators that provide timely, comprehensive data to identify the broad health needs faced by a community. In coordination with our supplementary data sources, it provided an overview of many health needs and determinants. However, there are some limitations with regard to these data, as is true with any secondary data. Some data were only available at the county or state level, making an assessment of health needs at a smaller scale challenging. Data for smaller areas including counties with small populations were

sometimes suppressed due to small sample size or too few cases to ensure confidentiality in reporting. Some known data issues were present, such as hospital reporting errors or faulty data collection instances. Furthermore, disaggregated data around age, ethnicity, race, and gender are not available for many data indicators, which limited the ability to examine disparities of health within the community. Data are not always collected on a yearly basis and can take time to process, meaning that some data are several years old. Lastly, there are many important health indicators that are not being measured and reported to the extent necessary, due to systemic political and economic challenges.

VI. IDENTIFICATION AND PRIORITIZATION OF COMMUNITY'S HEALTH NEEDS

Definition of "health need"

For the purposes of the CHNA, Kaiser Permanente defines a "health need" as a health outcome and/or the related conditions that contribute to a defined health need. Health needs are identified by the comprehensive identification, interpretation, and analysis of a robust set of primary and secondary data.

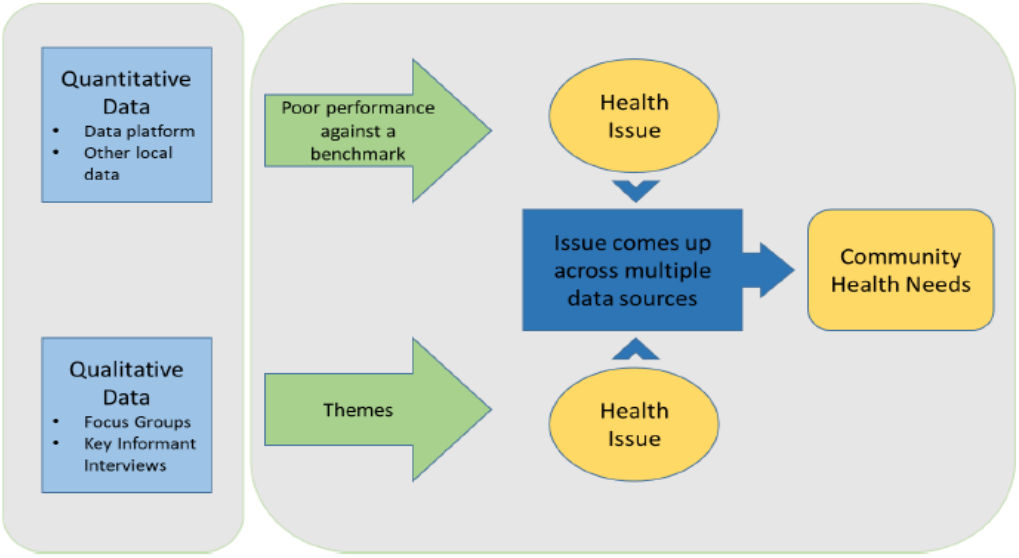
Criteria and analytical methods used to identify the community health needs

This assessment used the 2013 assessment methodology and results as a platform for the approach and interpretation of health need. Primary and secondary data were collected and analyzed using information from the KP CHNA Data Platform, Georgia-specific data sets, key informant interviews, focus groups, and community listening sessions.

The three indicators that are the most powerful predictors of population health and facilitate identifying communities with the most significant health needs are poverty rate, percent of population uninsured, and proportion of adults without a high school diploma *(Source: KP CHNA Data Platform).* Low-income, uninsured, and undereducated populations have been found to be most at risk for poor health status. These key conditions/drivers were once again used to identify areas likely to have the poorest outcomes and greatest health disparities. Focus group conversations were held in many of these communities to further understand the perception of facilitators and barriers to community health and wellbeing.

In addition to the three key health drivers, a comprehensive review of the data was undertaken by the GHPC team. The KP Community Benefit Programs toolkit titled *Community Health Needs Assessment Toolkit - Part I: Pre-Assessment & Data Collection* guided the methodology and process used to conduct the first step in the CHNA in the Georgia Region.

Developing Health Needs



A large secondary dataset was created using information from the KP CHNA Data Platform, Georgia data sources and other national data sets to examine critical areas of concern. The information was assigned to various GHPC staff members for review. Those working in the KP CHNA Data Platform ran profile reports and detailed where health indicators were worse than the region, Georgia, or U.S. averages or targets. Other team members used a similar process in examining data outside the Data Platform. Throughout the review, the team convened on several occasions to discuss the data and identify critical health needs impacting the region as a whole and specific "hot spots" within the service area. The team also used interview summaries and transcripts from focus groups and community listening sessions to develop themes about local health issues and formulate a list of ranked health needs. Careful review of all the data yielded a comprehensive list of key health concerns and issues that crossed both the secondary dataset and the primary input from stakeholders.

Process and criteria used for prioritization of the health needs

The primary criteria used to prioritize the list of needs that was generated from data and input were:

1. The issue fit the KP definition of a "health need"
2. The health need is confirmed by multiple data/information sources
3. Indicator(s) related to the health need perform(s) poorly against either the region/state as a benchmark
4. There are clear disparities/inequities across different sub-populations
5. The community perceives the issue to be important; as recorded by their ranking of issues during interviews and focus groups

The internal GHPC staff team used the preliminary health needs determination tool to aid (a) in the generation of a list of health needs based from secondary data and understanding; and (b) in prioritizing based on criteria 1-4. Using the information and rankings from key informants and focus group participants, the team completed created a prioritization matrix and narrowed the set of identified health needs in keeping with the criteria.

Health Needs - Preliminary Health Needs Determination Tool

- Obesity / HEAL
- Diabetes
- Violence
- Injury
- Mental health
- Cancer
- HIV
- Education
- Transportation
- Economic security
- Access to care

Health Needs - Stakeholder Input

- Access to care (coverage/primary and mental health workforce/linguistic and geographic barriers)
- Transportation
- Mental health conditions
  - Substance abuse (youth)
- Cardiovascular disorders
- Cancers
- Diabetes
- Obesity
  - Access to healthy foods and recreational spaces
- HIV and STDs
- Teen pregnancy
  - early sexual initiation
- Educational attainment
- Violence and safety
- Poverty and economic opportunities

Finally, working with KPGA Community Benefit representatives and their internal partners[1], GHPC facilitated one final step in the prioritization process by having the group vote to identify the health need priorities for the KPGA region. As a result of these efforts, 10 prioritized health needs are outlined below.

Prioritized description of all the community health needs identified through the CHNA

1. **Obesity/ Healthy Eating and Active Living** - In the region, there was wide variation in diet quality and active living. Wealthier areas generally had higher access to food retailers and places to exercise, and also demonstrated higher rates of fruit and vegetable consumption and physical activity; more economically distressed areas fared poorly in these measures. Obesity is closely related to healthy eating and active living. In the CHNA region, obesity is most prevalent in low-income and exurban/rural communities and people of color. Unfortunately, obesity is not well reported, especially in children. However, obesity and childhood obesity were concerns of the community.

[1] Internal partners were a diverse group represented by the following departments:
(Public Affairs) Beverly Thomas, Keisha Walker, Renata Hilson, Quinntez Gurndy, Gloria Kemp, Madelyn Adams, Cheryl Brown, Mary Schramm, Sharon Gettes
(Marketing & Communications) Leslie Blair, Chase Smallwood,
(Research) Marca Gurule
(MFA) Harry Thomas
(Worksite Wellness) Kathryn Harrison, Jill George
(ETP) Bett Potazek, Larry Davis, Ruth Thompson
(CHC - Bridge Program) Emily Marquette, Elizabeth Spinning, Kakia Prasad
(Georgia Health Policy Center) Chris Parker, Robyn Bussey

2. **Access to care** (primary, and mental) - The supply of primary care is not evenly dispersed around the region. It is above benchmark levels in wealthier areas while there is a shortage in areas with lower levels of employment, income, and insurance coverage. Health insurance status is another important factor, as well as the overall household budget. Mental health services are generally adequate but may be more cost prohibitive due to insurance restrictions. There are also barriers due to transportation and differential treatment.
3. **Cardiovascular conditions** (Hypertension, stroke and heart disease) - Obstructive heart and vascular diseases, including heart attack, congestive heart failure, and stroke, are a predominant cause of morbidity and mortality. High blood pressure and hypertensive heart diseases contribute to a lower rate of medical attention but are still prominent. Obstructive disorders tend to be more prevalent in White individuals, while hypertensive disorders are much more prevalent for Black individuals. They both have similar contributing factors, namely diet, physical activity, and tobacco use. Lower income, non-immigrant, older, lower-resourced, low population density, and geographically isolated areas tend to show higher rates.
4. **Educational Attainment** - Educational attainment is one of the strongest predictors of life expectancy and lifetime health status. In the CHNA region, there is wide variation in educational attainment. School quality is not evenly distributed. However, many of the educational outcome inequities are based in early childhood and extracurricular experiences due to economic instabilities that contribute to traumatic childhood experiences and barriers to parent involvement - for instance, parents who work multiple jobs, extremely long travel times to work, parents who are absent due to illness or violence, or loss of housing.
5. **Cancer** - Taken together, cancers are one of the leading causes of death. However, each type of cancer has somewhat different causes and risk factors. Additionally, some cancers are more conducive to prevention or screening. In the CHNA region, there is moderate variation in the total cancer mortality burden. Breast and prostate cancer incidence is moderately high. However, within key types of cancer, there are larger differences. In particular, where screening rates are low, prevalence can also be low but mortality rates are often higher. Tobacco use, diet, physical activity, vaccinations, and environmental exposures contribute to some variation as well.
6. **HIV/AIDS/STD** - There are enormous differences in the distribution of HIV prevalence by geography, age, sex, and racial/ethnic identity in the CHNA region. Most notably, HIV prevalence is nearly five times higher for non-Hispanic Black residents of the region than for non-Hispanic White residents. Chlamydia infection rates are also relatively high in more dense and urban populations.
7. **Diabetes** - Type II Diabetes is another outcome from diet quality and physical activity levels, as well as certain other risk factors including genetics, depression, and others. It can lead to severe complications, such as amputations, loss of eyesight, and organ damage or failure. Thus, there are disease management, disability, and mortality implications. In the CHNA region, diabetes tends to trend with economic disadvantage, rural residency, and non-immigrant status.
8. **Poverty** - Poverty refers to household income level relative to the household size, but can include many contributors, such as unemployment or underemployment, cost of living burdens, low wage employment options, lack of assets, and barriers to employment such as

spatial mismatch, inadequate transportation options, convictions or credit history, or low educational attainment. Neighborhoods with a very high percentage of poor households are likely to experience disinvestment by businesses, property owners, and community assets, leading to further distress and lack of opportunity. Poverty is a serious issue in the CHNA region. There are insufficient resources to help poor families get ahead. Additionally, poverty is not evenly distributed, which results in extreme variation between concentrated areas of well-resourced high-amenity communities and areas without access to amenities.

9. **Mental health conditions** - Mental wellbeing can be affected by biological, social/ emotional, sensory, and environmental factors. Stress, lack of social/emotional capacity, and exposure to contaminants can be greatly influenced by living conditions. Mental health is an important element that allows individuals to maintain their physical health and productivity. In the CHNA region, mental health needs are one of the leading causes of hospital and ER utilization. Self-harm/suicide is a challenge is some communities. Additionally, there are many risk factors present such as economic stressors, exposure to traumatic events, and social isolation that may contribute to poor mental health.
10. **Transportation-** Transportation is a key component to accessing the essentials of a healthy life, such as access to employment opportunities, social enrichment, green space, medical care, food and other daily needs, and much more. Private automobile travel is expensive, and also associated with reduced physical activity, reduced social interaction, and increased injuries and air pollution. In the CHNA region, there is very limited access to daily essentials without a private automobile. However, automobile ownership is expensive, imposing a major burden on lower income households in either cost or access. Additionally, there are long travel distances to amenities, associated with longer driving trips.

Community assets and resources available to respond to the identified health needs of the community

Access is a big part of achieving health. Several areas of the region have a high number of facilities to enhance access to care, i.e. Fulton and DeKalb, while other sections are medically underserved.

An estimated 3,162 primary care physicians (61 per every 100,000 people) are available in the region, predominantly in the large urban counties. Thirty-two (32) federally qualified health centers, 52 acute care hospitals, 10 long-term/rehabilitation hospitals and 12 behavioral health/psychiatric hospitals are located in the 34-county region. Fulton and DeKalb Counties have the most hospitals with 11 and 9 respectively. Table 6 details the hospitals providing acute care in the 34-county region.

Table 6. Acute Care Hospitals in KPGA Service Region

Hospital Name	City	County
Barrow Regional Medical Center	Winder	Barrow
Cartersville Medical Center	Cartersville	Bartow
Sylvan Grove Hospital	Jackson	Butts
Tanner Medical Center Carrollton	Carrollton	Carroll
Tanner Medical Center Villa Rica	Villa Rica	Carroll
Northside Hospital – Cherokee	Canton	Cherokee
Athens Regional Medical Center	Athens	Clarke

Table 6. Acute Care Hospitals in KPGA Service Region		
Hospital Name	**City**	**County**
St. Mary's Hospital	Athens	Clarke
Southern Regional Medical Center	Riverdale	Clayton
Emory Adventist Hospital	Smyrna	Cobb
WellStar Cobb Hospital	Austell	Cobb
WellStar Kennestone Hospital	Marietta	Cobb
WellStar Windy Hill Hospital	Marietta	Cobb
Piedmont Newnan Hospital	Newnan	Coweta
Children's Healthcare of Atlanta at Egleston	Atlanta	DeKalb
DeKalb Medical	Decatur	DeKalb
DeKalb Medical Hillandale	Lithonia	DeKalb
Emory University Hospital	Atlanta	DeKalb
Emory University Orthopedics and Spine Hospital	Tucker	DeKalb
Wesley Woods Geriatric Hospital of Emory University	Atlanta	DeKalb
WellStar Douglas Hospital	Douglasville	Douglas
Fayette Community Hospital	Fayetteville	Fayette
Piedmont Fayette Hospital	Fayetteville	Fayette
Northside Hospital Forsyth	Cumming	Forsyth
Atlanta Medical Center	Atlanta	Fulton
Children's Healthcare of Atlanta at Hughes Spalding	Atlanta	Fulton
Children's Healthcare of Atlanta at Scottish Rite	Atlanta	Fulton
Emory Johns Creek Hospital	Johns Creek	Fulton
Emory University Hospital Midtown	Atlanta	Fulton
Grady Memorial Hospital	Atlanta	Fulton
North Fulton Regional Hospital	Roswell	Fulton
Northside Hospital	Sandy Springs	Fulton
Piedmont Hospital	Atlanta	Fulton
Saint Joseph's Hospital of Atlanta	Atlanta	Fulton
South Fulton Medical Center	East Point	Fulton
Emory Eastside Medical Center	Snellville	Gwinnett
Emory John’s Creek Hospital	Duluth	Gwinnett
Gwinnett Medical Center Duluth	Duluth	Gwinnett
Gwinnett Medical Center	Lawrenceville	Gwinnett
Northeast Georgia Medical Center	Gainesville	Hall
River Place Braselton	Braselton	Hall
Higgins General Hospital	Bremen	Haralson
Piedmont Henry Hospital	Stockbridge	Henry
Warm Springs Medical Center	Warm Springs	Meriwether
Newton Medical Center	Covington	Newton
WellStar Paulding Hospital	Dallas	Paulding
Piedmont Mountainside Hospital	Jasper	Pickens
Rockdale Medical Center	Conyers	Rockdale

Table 6. Acute Care Hospitals in KPGA Service Region		
Hospital Name	**City**	**County**
Spalding Regional Medical Center	Griffin	Spalding
Clearview Regional Medical Center	Monroe	Walton

Other existing community resources

According to the Kaiser Permanente Community Health Needs Assessment Toolkit, community assets are people, places, and relationships that can conceivably be used in acting to bring about the most equitable functioning of a community. Community assets can include grocery stores, parks, schools, and hospitals. The KPGA region has a multitude of community and organizational assets ranging from local healthcare facilities to faith-based institutions and independent community groups. To analyze the community assets in the KPGA region, GHPC focused on those providing health and health related services, including faith-based institutions that provide health-related services to the community. Reviewing data from the National Center for Charitable Statistics, the Georgia Center for Nonprofits, and Community Commons, 91 county-specific organizations were documented within the region. Each of the region's counties has within its boundaries or is proximate to the basic community assets of schools, parks, and healthcare facilities.

Throughout the process of identifying community assets, focus was specifically placed on assets that were deemed to be operational and of notable value to the community. As a result, not all assets in each county have been included in this report. Assets were prioritized based on their scope and level of activity so far as could be determined. We have not listed organizations without a functioning website or food banks that do not distribute food or meals. A strong focus has been placed on representing organizations that provide services to vulnerable populations, as well as organizations that provide free or sliding scale services.

The organizations documented were broken out into three separate categories based on their primary focus: health care, community-focused, and education. Of the 91 county-specific assets, 9 focus on education, 34 have a healthcare or health related focus, and 56 are community focused. The highest concentration of assets is within Fulton, DeKalb, Gwinnett, and Cobb counties. These counties also have the greatest variability of assets. Several counties in the region have no county-specific community assets from which to draw. These include Haralson, Heard, Lamar, Meriwether, Paulding, and Pike. However, the KPGA region includes assets with a regional, and in some cases, a statewide reach. Counties with no unique assets are served by a number of larger organizations, such as the Georgia Family Connection and Georgia Head Start. A table has been provided showing in which counties larger organizations are operating. Since 2013, a number of non-profit organizations have started in underserved communities, such as Bartow and Coweta Counties.

VII. KAISER FOUNDATION HEALTH PLAN OF GEORGIA 2013 IMPLEMENTATION STRATEGY EVALUATION OF IMPACT

Purpose of 2013 Implementation Strategy evaluation of impact

The Kaiser Foundation Health Plan of Georgia 2013 Implementation Strategy Report was developed to identify activities to address health needs identified in the 2013 CHNA, including:

- Obesity
- Diabetes
- Heart Disease (including stroke and hypertension)
- Mental Health
- STIs/HIV/AIDS
- Cancer
- Teen Pregnancy
- Low Birth Weight Infants
- Asthma

These health needs were further prioritized by internal stakeholders. The stakeholder group applied a criteria-based decision making process to examine the list of health needs with regard to Kaiser Permanente's assets and resources, as well as the evidence-base where possible. The result was a list of prioritized health needs/drivers, which were included in the 2013 Implementation Strategy Report. This following sections of the CHNA Report describe and assess the impact of the following health priorities:

1. Access to health care to ensure better health outcomes the KPGA service region
2. Improved education and health literacy levels among residents in the KPGA service region
3. Overweight and obesity control among adults and children to prevent long term chronic disease in the KPGA service region
4. Diabetes prevention and management among adults in the KPGA service region
5. Prevention and management of heart disease, hypertension and stroke among adults in the KPGA service region

Kaiser Foundation Health Plan of Georgia is monitoring and evaluating progress to date on their 2013 Implementation Strategies for the purpose of tracking the implementation of those strategies as well as to document the impact of those strategies in addressing selected CHNA health needs. Tracking metrics for each prioritized health need include the number of grants made, the number of dollars spent, the number of people reached/served, collaborations and partnerships, and KFH in-kind resources. In addition, Kaiser Foundation Health Plan of Georgia tracks outcomes, including behavior and health outcomes, as appropriate and where available.

As of the documentation of this CHNA Report in March 2016, Kaiser Foundation Health Plan of Georgia had evaluation of impact information on activities from 2014 and 2015. While not reflected fully in this report, Kaiser Foundation Health Plan of Georgia will continue to monitor impact for strategies implemented in 2016.

A. 2013 Implementation Strategy Evaluation Of Impact Overview

In the 2013 IS process, all KFH hospital facilities planned for and drew on a broad array of resources and strategies to improve the health of our communities and vulnerable populations, such as grantmaking, in-kind resources, collaborations and partnerships, as well as several internal KFH programs including, charitable health coverage programs, future health professional training programs, and research. Based on years 2014 and 2015, an overall summary of these strategies is below, followed by tables highlighting a subset of activities used to address each prioritized health need.

- **KFH Programs:** From 2014-2015, KFH supported several health care and coverage, workforce training, and research programs to increase access to appropriate and effective health care services and address a wide range of specific community health needs, particularly impacting vulnerable populations. These programs included:

    - Medicaid: Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. KFH provided services for Medicaid beneficiaries, both members and non-members.

    - Medical Financial Assistance: The Medical Financial Assistance (MFA) program provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.

    - Charitable Health Coverage: Charitable Health Coverage (CHC) programs provide health care coverage to low-income individuals and families who have no access to public or private health coverage programs.

    - Workforce Training: Supporting a well-trained, culturally competent, and diverse health care workforce helps ensure access to high-quality care. This activity is also essential to making progress in the reduction of health care disparities that persist in most of our communities.

    - Research: Deploying a wide range of research methods contributes to building general knowledge for improving health and health care services, including clinical research, health care services research, and epidemiological and translational studies on health care that are generalizable and broadly shared. Conducting high-quality health research and disseminating its findings increases awareness of the changing health needs of diverse communities, addresses health disparities, and improves effective health care delivery and health outcomes

- **Grantmaking:** For 70 years, Kaiser Permanente has shown its commitment to improving Total Community Health through a variety of grants for charitable and community-based organizations. Successful grant applicants fit within funding priorities with work that examines social determinants of health and/or addresses the elimination of health disparities and inequities. In 2014-2015, Kaiser Foundation Health Plan of Georgia awarded 250 grants amounting to a total of $19,637,514.40 in service of 2013 health needs. Kaiser Foundation Health Plan of Georgia has funded significant contributions to the Community Foundation for

Greater Atlanta in the interest of funding effective long-term, strategic community benefit initiatives within our 34 county service area. During 2014-2015, a portion of money managed by this foundation was used to award 10 grants totaling $601,000 in service of 2013 health needs.

- **Collaborations and Partnerships:** Kaiser Permanente has a long legacy of sharing its most valuable resources: its knowledge and talented professionals. By working together with partners (including nonprofit organizations, government entities, and academic institutions), these collaborations and partnerships can make a difference in promoting thriving communities that produce healthier, happier, more productive people. From 2014-2015, Kaiser Foundation Health Plan of Georgia engaged in several partnerships and collaborations in service of 2013 Implementation Strategies and health needs, including the Atlanta Regional Collaborative for Health Improvement (ARCHI) and the Westside Health Collaborative.

B. 2013 Implementation Strategy Evaluation of Impact by Health Need

Kaiser Foundation Health Plan of Georgia Priority Health Need: Access to Care

Long Term Goal:

- Increase in access to health care and coverage for in the KPGA service region

Intermediate Goal:

- Increase in health care coverage rates for low income populations in the KP service region
- Increase in access to health care services for low income populations

Access to Care KFH Administered Program Highlights

KFH Program Name	KFH Program Description	Results to Date Include relevant Program metrics if available
Medicaid	Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. KFH provided services for Medicaid beneficiaries, both members and non-members.	Total Medicaid expenditure in 2014 was $7.3M. Approximately 19,077 patients covered under Medicaid were seen in Kaiser facilities within the Georgia service region, with an average of 947 office visits per month. Total Medicaid expenditure in 2015 was $9.9 million. Approximately 19,000 patients covered under Medicaid were seen in Kaiser facilities within the Georgia service region, with an average of 3,825 office visits per month. Between 2014 and 2015, the number of Medicaid patients served remained about the same, but expenditure increased by about 40%. This is perhaps explained by the great increase in the average number of office visits per month (from 947 to 3,825).
Medical Financial Assistance	The Medical Financial Assistance (MFA) program provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.	In 2014, total MFA expenditures totaled $7,151,191. In 2015, total MFA expenditure for 2015 was $10,661,463. Between 2014 and 2015, the number of unique patients served through MFA increased from 21,956 to 34,918.

Charitable Health Coverage	Charitable Health Coverage (CHC) programs provide health care coverage to low-income individuals and families who have no access to public or private health coverage programs.	In 2014, our Charitable Health Coverage program enrolled 1,173 members. The total CHC Expenditure was $8,119,608. In 2015, Charitable Health Coverage program enrollment and expenditure increased to 1,946 and $8,981,216, respectively. In 2015, the number of individuals receiving Charitable Health coverage increased by 773, compared to the previous year.

Access to Care Grantmaking Highlights				
Summary of Impact: During 2014-2015, there were 44 active grants in the Kaiser Foundation Health Plan of Georgia service area. Grantmaking contributions to Access to Care totaled $3,501,357.				
Grantee	**Grant Amount CY 2014**	**Grant Amount CY 2015**	**Project Description**	**Results to Date**
Partners for Equity in Child & Adolescent Health (Emory University, Department of Pediatrics)	**$95,000**	**-**	Improve the health and overall well-being of Georgia's underserved children by increasing access to quality healthcare, improving the academic achievement through reduced absenteeism, and reducing the cost of healthcare through school-based health centers (SBHCs).	<u>Access to care</u>: • To date 21% (169) of North Clayton High School students are enrolled in the SBHC. • 37% of students enrolled received health checks and all students were screened for psychosocial issues through the HEADSSS and PHQ – 9 surveys. Those positive for either screen were referred to a behavioral health provider for further assessment and counseling. <u>Absenteeism among students with behavioral health problems:</u> • To date, 57 students have been referred and treated by a behavioral health provider. A total of 153 encounters were documented. • 38 of the 57 students were from North Clayton High School and 10% of the students had a reduction in absenteeism after therapy was initiated. 20 of the 38 students were initially seen at the beginning of the school year and there were no records to compare pre- and post-intervention. <u>Reduced disciplinary referrals among students with behavioral health problems</u>: • 57 students were seen by a behavioral health provider. Top diagnoses were: Depression, Oppositional Defiant Disorder, and Attention Deficit Hyperactivity Disorder (ADHD).

				• 38 of the 57 students were from North Clayton High School and 10% of students had a decrease in disciplinary referrals after therapy was initiated. Most of the students (75%) received only 1-2 therapy sessions. (Data from school and SBHC records)
First Step Staffing	**$90,000**	**$95,000**	The project assists mentally ill homeless individuals with co-morbid chronic conditions/disabilities to enroll access care through enrollment with Medicaid and partnerships with providers in metro Atlanta. The project also provides case management and housing support services for clients.	On average, just under 300 applications for SSI/SSDI are filed each year with an approval rate of about 50%, resulting in access to care for nearly 150 vulnerable individuals. An additional 60% of participants are connected with confirmed housing.
United Way of Greater Atlanta	**$300,000**	**$500,000**	The Healthy Communities Initiative sought to increase access to care for populations in areas with high numbers of uninsured individuals. A multi-pronged approach - primary care access, family stability initiative, Veterans connection and school based health was used to increase clinical capacity in the community and strengthen place based efforts to connect individuals to care	<u>Primary Care Access Fund:</u> 1,758 patients have increased access to primary care and 1,304 were connected to a medical home. 894 improved their health status (as measured by self-report survey and measurement around chronic disease such as blood pressure, cholesterol, A1c levels). 679 patients have reduced unnecessary usage of the Emergency room. <u>Project Health Access-AmeriCorps:</u> The AmeriCorps program has increased access to care for 6,713 individuals across 10 sites. At year-end, 2,356 patients have maintained or improved their health status, 804 have been connected with a medical home, and 956 have been screened for SSDI. <u>Family Stability Initiative:</u> 35 families in Clarkston, GA (an area known to have a significantly high refugee population), have been provided with housing, health, and educational supports. 21 families have identified a

				medical home. These 35 families include 218 children. <u>Vets Connect:</u> 53 Veterans were provided with Care Coordination services. 42 patients have been placed in permanent housing.

Access to Care Collaboration/Partnership Highlights		
Organization/ Collaborative Name	**Collaborative/ Partnership Goal**	**Results to Date** .
Atlanta Regional Collaborative for Health Improvement (ARCHI)	This is a multi-sectorial, public-private coalition created to improve the health of metropolitan Atlanta by aligning the region's health and economic interests, investments and incentives. ARCHI's vision is to align interests, incentives and investments in order to generate and sustain a healthy population and a vibrant economy. Its mission is to engage public, private, and community partners to improve healthcare and foster health-promoting social, economic, and educational environments. The basis of ARCHI's common agenda is the Atlanta Transformation Scenario, a set of priorities selected by the over 80 organizations that make up the ARCHI collaborative. The priorities that comprise the Atlanta Transformation Scenario are: ***encouraging healthy behaviors, care coordination, pathways to advantage for students and families, expanding access to health insurance, capture and reinvest savings, contingent global payment, and the innovation fund.***	Kaiser Permanente is a founding member of the Atlanta Regional Collaborative for Health Improvement (ARCHI). Kaiser Permanente and other partners engaged ARCHI to conduct their Community Health Needs Assessments. By working with ARCHI, regional health care providers aligned their intervention strategies with the Atlanta Transformation Scenario. Kaiser's work in the area of Access to Care directly supports ARCHI's priorities of ***care coordination*** and ***expanding access to health insurance*** by aligning its investments and care coordination activities in a community in South Fulton County where ARCHI is testing the implementation of its priorities on the ground. There are no tangible health outcomes to date, but great success has been demonstrated in the fact that a diverse group of organizations is engaged and partnerships are being strengthened.

Kaiser Foundation Health Plan of Georgia Priority Health Need: (Educational Attainment)

Long Term Goal:

- Increase the levels educational attainment and health literacy of the KPGA service region

Intermediate Goal:

- Increase in educational attainment for children and youth in elementary and middle school
- Increase in the knowledge and use of health information in the community

Educational Attainment Grantmaking Highlights

Summary of Impact: During 2014-2015, there were 15 active KFH grants, totaling $654,500, addressing Educational Attainment in the Kaiser Foundation Health Plan of Georgia service area.

Grantee	Grant Amount CY 2014	Grant Amount CY 2015	Project Description	Results to Date
Junior Achievement	**$15,000**	**$15,000**	This effort takes students in Title 1 schools through in-class Core programs aimed at promoting the financial literacy and the importance of education and graduation while preparing and equipping them for success.	A total of 544 middle school students from Clayton County schools attended the JA Discovery Center in Atlanta, which provided 13,600 program contact hours to the students. Program success was achieved as determine by: • 95% of volunteers reporting that the JA Finance Park experience strengthened students' financial capacity • 93% of students understand the connection between the choices they make today and the real-life choices they will have to make in the future. • 93% of students agreed that after participating in the program, they now see why school and education are important to the lifestyles they want to live • 93% of students report being better prepared to manage their money because of what they learned in the program. •
Sheltering Arms	**$25,000**	**$50,000**	This early childhood education organization seeks to improve access to early childhood by awarding scholarships for children from	<u>Scholarships:</u> 75 separate $1,000 scholarships were assigned as of February 2015. Nine children withdrew from the

			low-income families to support 1 year of tuition. Sheltering Arms also oversees Operation Storybook, which is an early literacy program aimed to improve reading and literacy skills and engage families.	center, but their scholarships were reassigned. These scholarships benefited 71 families, whose parents received comprehensive support services. <u>School readiness:</u> The 75 scholarship recipients met 96% of their learning objectives as measured by the Teaching Strategies Gold and Work Sampling assessment tools. <u>Parent Support:</u> Based on the annual Parent Survey: • 97% of parents communicated regularly with teachers • 93% attended parent-teacher conferences • 96% attended and/or contributed to classroom and center events. The average indicator of parent support is 95%.

Educational Attainment Collaboration/Partnership Highlights		
Organization/ Collaborative Name	**Collaborative/ Partnership Goal**	**Results to Date**
Atlanta Regional Collaborative for Health Improvement (ARCHI)	This is a multi-sectorial, public-private coalition created to improve the health of metropolitan Atlanta by aligning the region's health and economic interests, investments and incentives. ARCHI's vision is to align interests, incentives and investments in order to generate and sustain a healthy population and a vibrant economy. Its mission is to engage public, private, and community partners to improve healthcare and foster health-promoting social, economic, and educational environments. The basis of ARCHI's common agenda is the Atlanta Transformation Scenario, a set of priorities selected by the over 80 organizations that make up the ARCHI collaborative. The priorities that comprise the Atlanta Transformation Scenario are: ***encouraging healthy***	Kaiser Permanente is a founding member of the Atlanta Regional Collaborative for Health Improvement (ARCHI). Kaiser Permanente and other partners engaged ARCHI to conduct their Community Health Needs Assessments. By working with ARCHI, regional health care providers aligned their intervention strategies with the Atlanta Transformation Scenario. Kaiser's work in the area of Educational Attainment directly supports ARCHI's ***pathways to advantage for students and families*** priority by aligning its investments

	behaviors, care coordination, pathways to advantage for students and families, expanding access to health insurance, capture and reinvest savings, contingent global payment, and the innovation fund.	and educational attainment activities in a community in South Fulton county. In this community, ARCHI is testing the implementation of its priorities on the ground. There are no tangible health outcomes to date, but great success has been demonstrated in the fact that a diverse group of organizations is engaged and partnerships are being strengthened.

Impact of Regional Initiatives Addressing Educational Attainment
In 2014-2015, KPGA supported educational attainment for students pursuing health profession training at post-secondary institutions. In 2014, nine institutions (six schools of nursing, two pharmacy schools, and one medical school) received funds and awarded 14 student scholarships. Several Nursing Schools also supported Nursing faculty's pursuit of additional education and training. In addition, KFHP of Georgia contributions enabled three universities (Clayton State, Georgia State and Kennesaw State Universities) to award scholarships to students pursuing undergraduate Health Profession careers. In 2015, Community Benefit supported the training of 34 medical students (24 in Pediatrics, 8 in Ambulatory medicine, and 2 in Obstetrics/Gynecology)

Kaiser Foundation Health Plan of Georgia Priority Health Need: Overweight and Obesity

Long Term Goal:

- Reduce the percentage of children & youth in the KPGA service region who are overweight and obese

Intermediate Goal:

- Increase intake of fruits, vegetables and whole grains by youth in the region
- Increase moderate-to-vigorous physical activity (PA) in children & youth

Overweight and Obesity Grantmaking Highlights

Summary of Impact: During 2014-2015, there were 33 active KFH grants, totaling $4,548,628, addressing Overweight and Obesity in the Kaiser Foundation Health Plan of Georgia service area.

Grantee	Grant Amount CY 2014	Grant Amount CY 2015	Project Description .	Results to Date
Atlanta Beltline Partnership, Inc.	**$2.5M**	**-**	The Atlanta BeltLine project aims to improve quality of life for Atlanta residents through the creation of trails and transportation pathways that connect communities. The Project encourages health and economic prosperity as well as active engagement and support of communities and neighborhoods along the BeltLine.	In 2014, Kaiser Permanente Georgia contributed $2.5M toward the Atlanta BeltLine ($2M for the construction of the West Side trail hardscape and $500,000 for programming to improve health among residents in the 12 surrounding neighborhoods). In addition to this substantial grant, Kaiser is playing a hands-on role in strategic planning for the programmatic aspects of this project. The Atlanta BeltLine is a flagship investment for KPGA. Because of its potential impact on health and physical activity in the low-income neighborhoods surrounding the West Side trail, we have begun to help shape an evaluation plan and related outcome measures so that impact can be demonstrated over time (results forthcoming). Planned outcome measures include: • Improved health outcomes (e.g. decrease the prevalence of the chronic disease) • Improved health behaviors (e.g. increase in physical activity and use of the BeltLine trail) • Improved built environment (e.g. Improve physical access to BeltLine trails) • Improved perceptions of the BeltLine (e.g. safety, access, walkability, etc.)

				Baseline values and a more formal evaluation plan are forthcoming.
Children's Museum of Atlanta	**-**	**$85,000**	The Museum's growing Healthy Kids project addresses obesity, lack of physical activity and unhealthy lifestyles in children through health, nutrition and fitness education to young children and their adult caregivers. Programs include Eat a Georgia Rainbow and Let's Read, Let's Move.	185,000 individuals (children and parents) were served between 2013 and 2014. Nearly 200 participated in the Eat a Georgia Rainbow program and 350 children and caregiver participated in cooking classes. 80% of surveyed participants agreed or strongly agreed that program participation improved the healthiness of their lifestyles.
Georgia Organics	**-**	**$90,000**	The primary aims of this project are to: (a) increase the amount of fresh and local foods served in Georgia schools; (b) increase the number of edible gardens at schools and (c) education through the Farm to School program	The project served nearly 2,500 individuals in 16 counties during the 2014-2015 period. 30 school districts were honored for their participation in the Farm to School program. Over 300 school nutrition staff, educators, parents, farmers and community members were trained and the Georgia Department of Education (facilitated by Georgia Organics) hosted 150 school nutrition directors at a Farm to School procurement workshop.

Overweight and Obesity Collaboration/Partnership Highlights		
Organization/ Collaborative Name	**Collaborative/ Partnership Goal**	**Results to Date**
Atlanta Regional Collaborative for Health Improvement (ARCHI)	This is a multi-sectorial, public-private coalition created to improve the health of metropolitan Atlanta by aligning the region's health and economic interests, investments and incentives. ARCHI's vision is to align interests, incentives and investments in order to generate and sustain a healthy population and a vibrant economy. Its mission is to engage public, private, and community partners to improve healthcare and foster health-promoting social, economic, and educational environments. The basis of ARCHI's common agenda is the Atlanta Transformation Scenario, a set of priorities selected by the over 80 organizations that make up the ARCHI collaborative.	Kaiser Permanente is a founding member of the Atlanta Regional Collaborative for Health Improvement (ARCHI). Kaiser Permanente and other partners engaged ARCHI to conduct their Community Health Needs Assessments. By working with ARCHI, regional health care providers aligned their intervention strategies with the Atlanta Transformation Scenario. Kaiser's work in the area of overweight and obesity supports ARCHI's priority of ***healthy behaviors*** by aligning its investments and activities related to healthy behaviors in a community in South Fulton County. In this community, ARCHI is testing the implementation of its

	The priorities that comprise the Atlanta Transformation Scenario are: ***encouraging healthy behaviors, care coordination, pathways to advantage for students and families, expanding access to health insurance, capture and reinvest savings, contingent global payment, and the innovation fund.***	priorities on the ground. There are no tangible health outcomes to date, but great success has been demonstrated in the fact that a diverse group of organizations is engaged and partnerships are being strengthened.
Atlanta BeltLine Partnership, Inc.	The Atlanta BeltLine project aims to improve quality of life for Atlanta residents through the creation of trails and transportation pathways that connect communities. The Project encourages health and economic prosperity as well as active engagement and support of communities and neighborhoods along the BeltLine.	In 2014, Kaiser Permanente Georgia contributed $2.5M toward the Atlanta BeltLine ($2M for the construction of the West Side trail hardscape and $500,000 for programming to improve health among residents in the 12 surrounding neighborhoods). In addition to this substantial grant, Kaiser is playing a hands-on role in strategic planning for the programmatic aspects of this project. The Atlanta BeltLine is a flagship investment for KPGA. Because of its potential impact on health and physical activity in the low-income neighborhoods surrounding the West Side trail, we have begun to help shape an evaluation plan and related outcome measures so that impact can be demonstrated over time. Planned outcome measures include: • Improved health outcomes (e.g. decrease the prevalence of the chronic disease) • Improved health behaviors (e.g. increase in physical activity and use of the BeltLine trail) • Improved built environment (e.g. Improve physical access to BeltLine trails) • Improved perceptions of the BeltLine (e.g. safety, access, walkability, etc.) Baseline values and a more formal evaluation plan are forthcoming.

Kaiser Foundation Health Plan of Georgia Priority Health Need: Diabetes Prevention and Management

Long Term Goal:

- Reduce the prevalence rate of diabetes in the KPGA service region

Intermediate Goal:

- Increase percentage of residents achieving glycemic control in the region

Diabetes Prevention and Management Grantmaking Highlights

Summary of Impact: During 2014-2015, there were 18 active KFH grants, totaling $847,175.90, addressing Diabetes Prevention and Management in the Kaiser Foundation Health Plan of Georgia service area.

Grantee	Grant Amount CY 2014	Grant Amount CY 2015	Project Description	Results to Date .
Bethesda Community Clinic	**$16,500**	**-**	The Life Coach project focuses on one-on-one education and nutrition classes for diabetic and pre diabetic individuals in 5 northwestern counties. The program also includes prescription assistance, case management and HbA1C monitoring.	96 residents participated in the program. Just over 15% of participants lost more than 5pounds for the period. 30% decreased their HbA1C values and 20% did so by more than 2 points. More than half received prescription assistance benefit.
Diabetes Association of Atlanta	**$50,000**		The Diabetes Prevention and Control program attempts to address barriers to health care and reduce the burden of the disease on low income, uninsured and vulnerable populations at risk of developing diabetes and/or its complications. The program uses evidence based self-management education, medical assistance and early detection and screening and the core of its approach**.**	Most recent available evaluation show that 1330 individuals benefited from at least one element of the program. There was a 90% success rate of connecting individuals without a regular provider to medical homes. More than 200 people received training and education on diabetes self-management. 55% of individuals with elevated HbA1Cs (i.e. >8%) were able to lower their values by at least 1%over the period.
Hands of Hope Clinic	**$36,325**	**$39,492**	The Spalding Health Initiative is led by the clinic through a partnership with the McIntosh Trail Community Service Board in Spalding county, a county with poor health outcomes and high diabetes burden. The project will outreach uninsured clients and provide education, care coordination and referral services.	In the first phase of the effort the program served 313 residents. 62% of them reported improvement in their health condition at the end of the project period. More than half were evaluated as being at high risk and more than two-thirds were provided with diabetes education. In the next phase, the emphasis will be on increasing self-care management to reduce complications in more than 100 residents.
Tanner Medical Center	**-**	**$50,000**	The Diabetes Care Management Program seeks to empower underserved clients in Haralson,	Just over 200 individuals participated in the program with 88% reporting progress toward

			Heard and Carroll counties toward self-management, and care coordination through training, peer support and self-management education.	improved self-care. 70% of participants achieved ABC targets set (A1C, Blood pressure and cholesterol).

Diabetes Prevention and Management Collaboration/Partnership Highlights		
Organization/ Collaborative Name	**Collaborative/ Partnership Goal**	**Results to Date**
Atlanta Regional Collaborative for Health Improvement (ARCHI)	This is a multi-sectorial, public-private coalition created to improve the health of metropolitan Atlanta by aligning the region's health and economic interests, investments and incentives. ARCHI's vision is to align interests, incentives and investments in order to generate and sustain a healthy population and a vibrant economy. Its mission is to engage public, private, and community partners to improve healthcare and foster health-promoting social, economic, and educational environments. The basis of ARCHI's common agenda is the Atlanta Transformation Scenario, a set of priorities selected by the over 80 organizations that make up the ARCHI collaborative. The priorities that comprise the Atlanta Transformation Scenario are: ***encouraging healthy behaviors, care coordination, pathways to advantage for students and families, expanding access to health insurance, capture and reinvest savings, contingent global payment, and the innovation fund.***	Kaiser Permanente is a founding member of the Atlanta Regional Collaborative for Health Improvement (ARCHI). Kaiser Permanente and other partners engaged ARCHI to conduct their Community Health Needs Assessments. By working with ARCHI, regional health care providers aligned their intervention strategies with the Atlanta Transformation Scenario. Kaiser's work in the area of diabetes prevention and management supports ARCHI's priority of ***healthy behaviors*** by aligning its investments and activities related to healthy behaviors in a community in South Fulton County. In this community, ARCHI is testing the implementation of its priorities on the ground. There are no tangible health outcomes to date, but great success has been demonstrated in the fact that a diverse group of organizations is engaged and partnerships are being strengthened.

Kaiser Foundation Health Plan of Georgia Priority Health Need: Cardiovascular Health

Long Term Goal: Reduce mortality due to heart attack and stroke in KPGA service region

Intermediate Goal: Increase the percentage of residents with normal blood pressure and cholesterol in the region

Cardiovascular Health Grantmaking Highlights

Summary of Impact: During 2014-2015, there were 10 active KFH grants, totaling $454,906 addressing Cardiovascular Health in the Kaiser Foundation Health Plan of Georgia service area.

Grantee Highlight 3-5 grants with greatest impact to date.	**Grant Amount CY 2014**	**Grant Amount CY 2015**	**Project Description** Include project name, and brief description (one or two sentences) of the work supported by the grant.	**Results to Date** Include recent progress of grant including reach and actual or expected outcomes. One to four sentences.
American Heart Association (AHA)	**-**	**$50,000**	The AHA (Georgia branch) hosted a fundraiser event aimed at getting donations for research and educational programming to impact cardiovascular disease prevention and management/treatment	The event raised $1.05 M for research and programs. Four hundred individuals attended, made contributions to the cause and were provided with educational materials and messaging to support control of heart disease, hypertension and stroke.
Center for Black Women's Wellness (CBWW)	**$65,000**	**-**	The CBWW's cardiovascular prevention initiative aims to prevent or delay the onset of cardiovascular events by improving the health of individuals with risk factors. The program targets low income, uninsured and black populations in metro Atlanta. Services include lifestyle classes, care plan follow-up, intensive nurse case management and clinical care enhancements	The program expects to serve 250 individuals in 10 counties. At last report 80-100% of participants surveyed strongly agreed that the program added health value and they were more inclined to modify behaviors to improve their cardiovascular health. Care plans were complete for 10% of the participants at the time and just about the same percentage was reporting an 80% or better compliance with meds and care plan.
Good Samaritan Health Center of Cobb County	**$65,000**	**-**	The Primary Care Acute and Chronic Disease Program focuses on providing access to prevention and treatment of chronic disorders for low income uninsured residents. Program elements in part, address, hypertension, hyperlipidemia and diabetes through medication compliance, regular blood pressure checks, lab exams and disease management	1113 individuals with hypertension were seen over the grant period. Nearly 20% of these individuals were newly diagnosed. Of that number more than half were controlled during the period. Blood pressures were controlled in 80% of the enrolled clients.

Cardiovascular Health Collaboration/Partnership Highlights		
Organization/ Collaborative Name	**Collaborative/ Partnership Goal**	**Results to Date**
Atlanta Regional Collaborative for Health Improvement (ARCHI)	This is a multi-sectorial, public-private coalition created to improve the health of metropolitan Atlanta by aligning the region's health and economic interests, investments and incentives. ARCHI's vision is to align interests, incentives and investments in order to generate and sustain a healthy population and a vibrant economy. Its mission is to engage public, private, and community partners to improve healthcare and foster health-promoting social, economic, and educational environments. The basis of ARCHI's common agenda is the Atlanta Transformation Scenario, a set of priorities selected by the over 80 organizations that make up the ARCHI collaborative. The priorities that comprise the Atlanta Transformation Scenario are: ***encouraging healthy behaviors, care coordination, pathways to advantage for students and families, expanding access to health insurance, capture and reinvest savings, contingent global payment, and the innovation fund.***	Kaiser Permanente is a founding member of the Atlanta Regional Collaborative for Health Improvement (ARCHI). Kaiser Permanente and other partners engaged ARCHI to conduct their Community Health Needs Assessments. By working with ARCHI, regional health care providers aligned their intervention strategies with the Atlanta Transformation Scenario. Kaiser's work in the area of cardiovascular health supports ARCHI's priority of ***healthy behaviors*** by aligning its investments and activities related to healthy behaviors in a community in South Fulton County. In this community, ARCHI is testing the implementation of its priorities on the ground. There are no tangible health outcomes to date, but great success has been demonstrated in the fact that a diverse group of organizations is engaged and partnerships are being strengthened.

Kaiser Foundation Health Plan of Georgia Priority Health Need: Research

KFH Research Highlights

Long Term Goal:

- To increase awareness of the changing health needs of diverse communities

Intermediate Goal:

- Increase access to, and the availability of, relevant public health and clinical care data and research

Summary of Impact:

During 2014-2015, KPGA Community Benefit $720,082.05 for research at the Center for Clinical and Outcomes Research (CCOR). This research includes a variety of studies that are aligned to the region's strategic objectives.

In 2014, top research areas included: behavioral health and aging, cancer, cardiovascular and metabolic conditions, infectious disease, vaccine safety and effectiveness, and maternal and child health. Below are examples of studies funded by KPGA Community Benefit in 2014:

1. Helping Live Health Georgia to Thrive Extension (Access to Care)

(Lead Investigator/Contact: Melissa Butler)

The Helping Live Health Georgia to Thrive extension was a follow-up to the initial project started in fall of 2012. In preparation for the expansion of health insurance coverage as part of the Affordable Care Act, uninsured low-income patients of an Atlanta safety net clinic were offered one-year access to a self-directed wellness program. The purpose of the study was to evaluate the effectiveness of the distribution methods, communications strategy and patient's utilization of the wellness program.

Lessons learned

a. Initial communication should be face-to-face when launching services to this population of patients

b. Mailings should be distinguishable so people will read them and not toss them.

c. Frequent contact for follow-up may be needed.

d. Organize group meetings to provide an opportunity for social interaction to discuss how people were doing in the program. Such meetings could take place at an employer or union. The employers/unions would provide the education and information around a wellness programs. The information may even be shared at the worksite versus by mail. Thus, there is a connection between the vendor and the group member.

e. Further research is needed to understand if these patients will use the Internet to access wellness tools and resources that can help them improve or maintain their health.

2. PAWS (Mental Health)

(Lead Investigator/Contact: Ashli Owen-Smith)

The PAWS project was a mixed methods observational pilot to document the effects service dogs have on veterans diagnosed with PTSD and other mental health conditions. A subset of 5 caregivers of veterans who received dogs as part of the study were also interviewed to enhance the understanding of the role such dogs play in veterans' lives and those with whom they regularly interact.

In partnership with two non-profit organizations (paws4people and Canine Assistants) a total of 19 veterans consented to participate in the study. Data collection involved 30 to 60 minute in-depth interviews in-person or by telephone and paper-and-pencil questionnaires that assessed participants mental health and community integration, PTSD and other mental health symptoms, and military and other risk factors such as combat experiences. Seven of the veteran participants were paired with service dogs prior to the start of the study and 12 were new veteran-dog pairings. Data collection for the 12 new pairs was completed to document the processes and effects of service dogs on these veteran's lives. Primary measures will be statistically compared to national norms for veterans with mental health diagnoses and veterans with PTSD.

3.Eat Out with KP (Healthy Eating, Active Living)

(Lead Investigator/Contact: Kristina Lewis Description:)

"Eat Out with KP" was a follow-up pilot study building on the "KP Personal Shopper", conducted in summer 2013. In the original study, the hypothesis tested if grocery store-based visits with a registered dietitian would be more effective than clinic-based visits on nutrition education and weight management, and found that they were. In the Eat Out study, the purpose was to expand the nutrition education intervention to include entire families rather than just one individual from a household, and to find a way to engage the whole family in a visit that would be easier for all to attend. To accomplish this, family visits with the dietitian in a local restaurant during mealtime were compared to those held in the clinic. A curriculum was created based on a pediatric weight management program "Operation Zero", and condensed into 3 visits. Enrolled families had at least one child and one parent who were obese. The families were randomized to either receive their visits in the clinic or the restaurant. Thirty-one families (94 individuals) were enrolled. The majority of whom remained enrolled for the duration of the study. Nearly 80% of participants self-identified as African American. The mean body mass index (BMI) of adult participants was 38 kg/m^2, putting most of them in the severely obese category. Three-quarters of participant families reported an annual household income <$100k. The participants were surveyed before and after the study about their nutritional knowledge, dietary habits and confidence in their ability to achieve healthful behavior changes. The data is currently being analyzed to see if their knowledge, behaviors or confidence levels changed with the intervention, and to test whether or not there are differences between the groups. The findings will be published in a peer-reviewed journal during 2015.

In 2015, regional research continued to support priority health needs, but contributions from KPGA Community Benefit focused on Cancer Clinical Trials. With Community Benefit funding, the following activities resulted in laying the foundation for an Oncology Clinical Trials Program at KPGA:

1. In April of 2015, KPGA signed the Kaiser Permanente Inter-regional Statement of Work and Agreement in order to join the Kaiser

Permanente National Community Oncology Research Program (NCORP), which is affiliated under the National Cancer Institute (NCI).

2. Dr. Bindu Lingam presented the following NCI trials to the KPGA Research Committee, which were approved on 5/6/15:
   A. C80702-A Phase III trial of 6 vs 12 treatments of FOLFOX plus celecoxib or placebo for patients with resected Stage III colon cancer
   B. S1202- A randomized placebo-controlled Phase III study of duloxetine for treatment of aromatase inhibitor-induced musculoskeletal symptoms in patients with early stage breast cancer
   C. NSABP B52-A randomized Phase III trial evaluating pathologic complete response in patients with hormone receptor positive, her2 positive breast cancer in large operable and locally advanced breast cancer treated with neoadjuvant chemotherapy with docetaxol, Herceptin, perjeta, carboplatin(TCHP) with or without estrogen deprivation.

In June 2015, the application for enrolling patients into NCI trials was approved by the Central IRB. Six medical oncologists/hematologists were approved as Principal Investigators. Dr. Lingam attended both the Spring (in San Francisco) and Fall (in Chicago) National SWOG conferences where potential trials for enrollment were discussed and collaborations with the other KP researchers/oncologists were fostered.

Kia Stokes (clinical trials manager) and Dr. Lingam participated in monthly national KP NCORP PI teleconferences. CCOR has also had approximately monthly internal KPGA clinical trials preparatory meetings with members of research, nursing, pharmacy, and the oncology department, and have connected with pathology and radiology as well. Currently, CCOR is reviewing KPGA staffing requirements based on current and projected clinical trial volumes. KPGA is in the process of developing an Oncology Clinical Trials Site Management Plan based on the KP Northern California Site Management Plan (provided by the KP Northern California Oncology Clinical Trials team). We are also preparing for a site visit by KP Northern California planned for January 2016. The goal of this visit is to assess our readiness to start an Oncology Clinical Trials program here at KPGA.

VIII. APPENDIX

A. **Secondary Data Sources and Dates**
B. **Community Input Tracking Form**
C. **Community Assets**
D. **Health Need Profiles**

APPENDIX A: Secondary Data Sources and Dates

1. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2006-2010.
2. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2006-2012.
3. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2011-2012.
4. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. US Department of Health & Human Services, Health Indicators Warehouse. 2005-2009.
5. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. US Department of Health & Human Services, Health Indicators Warehouse. 2006-2012.
6. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.
7. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. US Department of Health & Human Services, Health Indicators Warehouse. 2010.
8. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. US Department of Health & Human Services, Health Indicators Warehouse. 2012.
9. Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2008.
10. Centers for Disease Control and Prevention, National Vital Statistics System. Centers for Disease Control and Prevention, Wide Ranging Online Data for Epidemiologic Research. 2006-2010.
11. Centers for Disease Control and Prevention, National Vital Statistics System. Centers for Disease Control and Prevention, Wide Ranging Online Data for Epidemiologic Research. 2007-2010.
12. Centers for Disease Control and Prevention, National Vital Statistics System. Centers for Disease Control and Prevention, Wide Ranging Online Data for Epidemiologic Research. 2007-2011.
13. Centers for Disease Control and Prevention, National Vital Statistics System. University of Wisconsin Population Health Institute, County Health Rankings. 2008-2010.
14. Centers for Disease Control and Prevention, National Vital Statistics System. US Department of Health & Human Services, Health Indicators Warehouse. 2006-2012.
15. Centers for Medicare and Medicaid Services. 2012.
16. Child and Adolescent Health Measurement Initiative, National Survey of Children's Health. 2011-2012.
17. Dartmouth College Institute for Health Policy & Clinical Practice. Dartmouth Atlas of Health Care. 2012.
18. Environmental Protection Agency, EPA Smart Location Database. 2011.
19. Federal Bureau of Investigation, FBI Uniform Crime Reports. 2010-2012.
20. Feeding America. 2012.
21. Multi-Resolution Land Characteristics Consortium, National Land Cover Database. 2011.
22. National Center for Education Statistics, NCES – Common Core of Data. 2012-2013.
23. National Oceanic and Atmospheric Administration, North America Land Data Assimilation System (NLDAS). 2014.
24. New America Foundation, Federal Education Budget Project. 2011.
25. Nielsen, Nielsen Site Reports. 2014.
26. State Cancer Profiles. National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. 2007-2011.
27. University of California Center for Health Policy Research, California Health Interview Survey. 2009.
28. University of California Center for Health Policy Research, California Health Interview Survey. 2012.
29. University of Wisconsin Population Health Institute, County Health Rankings. 2012-2013.
30. University of Wisconsin Population Health Institute, County Health Rankings. 2014.
31. US Census Bureau, American Community Survey. 2009-2013.
32. US Census Bureau, American Housing Survey. 2011, 2013.
33. US Census Bureau, County Business Patterns. 2011.
34. US Census Bureau, County Business Patterns. 2012.
35. US Census Bureau, County Business Patterns. 2013.

36. US Census Bureau, Decennial Census. 2000-2010.
37. US Census Bureau, Decennial Census, ESRI Map Gallery. 2010.
38. US Census Bureau, Small Area Income & Poverty Estimates. 2010.
39. US Department of Agriculture, Economic Research Service, USDA – Food Access Research Atlas. 2010.
40. US Department of Agriculture, Economic Research Service, USDA – Food Environment Atlas. 2011.
41. US Department of Agriculture, Economic Research Service, USDA – Child Nutrition Program. 2013.
42. US Department of Education, EDFacts. 2011-2012.
43. US Department of Health & Human Services, Administration for Children and Families. 2014.
44. US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. June 2014.
45. US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2012.
46. US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2013.
47. US Department of Health & Human Services, Health Resources and Services Administration, Health Professional Shortage Areas. March 2015.
48. US Department of Housing and Urban Development. 2013.
49. US Department of Labor, Bureau of Labor Statistics. June 2015.
50. US Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System. 2011-2013.
51. US Drought Monitor. 2012-2014
52. US Census Bureau, American Community Survey 5-Year Dataset 2009-13
53. Georgia Department of Public Health Online Analytical Statistical Information System. 2009-2013
54. Georgia Department of Public Health Online Analytical Statistical Information System. 2013
55. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP). 2012.
56. National Highway Traffic Safety Administration, Fatality Analysis Reporting System. 2009-2013
57. ESRI Business Analysis/Delorme/US Census Bureau TIGER via County Health Rankings. 2010 & 2013.
58. Centers for Medicare and Medicaid Services, National Provider Identification File. 2014
59. US Census Bureau, Censtats Database, County Business Patterns. 2012
60. Dartmouth Atlas of Healthcare. 2012

APPENDIX B: Community Input Tracking Form

	DATA COLLECTION METHOD	TITLE/NAME	NUMBER	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP	DATE INPUT WAS GATHERED
	Meeting, focus group, interview, survey, written correspondence, etc.	**Respondent's title/role and organization or focus group name**	**Number of participants**	**List all that apply. (a) health department representative (b) minority, (c) medically underserved, and (d) low-income**	**Leader, representative, member**	**Date of data collection**
1	Key informant interview	District Health Director, Nursing Clinical Director, and Program Manager – Data & Analysis for Public Health District 2	*3*	Health department representatives	Leaders	9/23/2015
2	Key informant interview	District Health Director for Public Health District 3-4	1	Health department representative	Leader	9/28/15
3	Key informant interview	District Health Director for Public Health District 3-5	1	Health department representative	Leader	10/2/15
4	Key informant interview	Manager, Aging and Health Resources, Atlanta Regional Commission	1	Regional community services representative	Leader	10/2/15
5	Key informant interview	County Nursing Directors for Public Health District 1-1	3	Health department representatives	Leaders	10/7/15
6	Key informant interview	County Commissioner, Clarke County	1	Local government representative	Leader	10/9/15
7	Key informant interview	Senior Director of Strategy Integration, United Way of Metropolitan Atlanta	1	Regional community services representative	Leader	10/9/15
8	Key informant interview	Deputy Health Director for Public Health District 3-1	1	Health department representative	Leader	10/13/15
9	Key informant interview	County Commissioner, DeKalb County District 3	1	Local government representative	Leader	10/13/15
10	Key informant interview	Health and Physical Education Program Specialist, Georgia Department of Education	1	State Government Representative	Leader	10/14/15

11	Key informant interview	Executive Director, Clarkston Community Center	1	Local community services representative	Leader	10/15/15
12	Key informant interview	Clinical Nursing Director, Director of Administration, WIC Director for Public Health District 4	3	Health department representatives	Leaders	10/22/15
13	Key informant interview	Director of Programs, The Community Foundation for Greater Atlanta	1	Regional community services representative	Leader	10/28/15
14	Key informant interview	Health Policy Analyst for Public Health District 3-2	1	Health department representative	Leader	11/2/15
15	Key informant interview	Program Manager for Public Health District 10	1	Health department representative	Leader	11/4/15
16	Key informant interview	Health Programs Director, Center for Pan Asian Community Services	1	Regional community services representative	Leader	11/5/15
17	Key informant interview	County Commissioner, DeKalb County District 2	1	Local government representative	Leader	11/6/15
18	Key informant interview	District Health Director for Public Health District 1-2	1	Health department representative	Leader	11/20/15
19	Key informant interview	Executive Director, Hands of Hope	1	Local community services representative	Leader	12/4/15
20	Key informant interview	Superintendent, Henry County Schools	1	Local government representative	Leader	12/7/15
21	Key informant interview	Director - Continuing Education, Piedmont Technical College – Newton	1	Regional community services representative	Leader	12/7/15
22	Key informant interview	Executive Director, Coweta Samaritan Clinic	1	Local community services representative	Leader	12/715
23	Key informant interview	Vice President, COO, Chair of Newton Local Fund, Newton Federal Bank	1	Local business representative	Leader	12/8/15
24	Key informant interview	Executive Director, Newton County Mentoring	1	Local community services representative	Leader	12/9/15
25	Key informant interview	Superintendent, Coweta County Schools	1	Local government representative	Leader	12/10/15

26	Key informant interview	Mayor, Fayetteville, GA	1	Local government representative	Leader	12/11/15
27	Key informant interview	Director, Good Samaritan Health and Wellness	1	Local community services representative	Leader	12/11/15
28	Key informant interview	Consultant, Center for Preservation and Planning	1	Local community services representative	Leader	12/14/15
29	Key informant interview	State Representative, District 11	1	State Government Representative	Leader	12/14/15
30	Key informant interview	President, Newton County Chamber of Commerce	1	Local business representative	Leader	12/15/15
31	Key informant interview	Mayor, Peachtree City, GA	1	Local government representative	Leader	1/5/15
33	Key informant interview	Superintendent, Fayette County Schools	1	Local government representative	Leader	1/6/16
34	Key informant interview	Executive/Medical Director, Fayette Care Clinic	1	Local community services representative	Leader	1/6/16
35	Key informant interview	Superintendent, Newton County Schools	1	Local government representative	Leader	1/7/16
36	Key informant interview	County Manager, McIntosh Trail Community Service Board	1	Local government representative	Leader	1/8/16
37	Key informant interview	CEO, Georgia Mountains Health	1	Local community services representative	Leader	1/8/16
38	Key informant interview	Fire Chief, Pickens County Fire and EMS	1	Local government representative	Leader	1/11/15
39	Key informant interview	Housing Authority Board Chair	1	Local government representative	Leader	1/11/15
40	Key informant interview	Deputy District Health Director for Public Health District -2	1	Health department representative	Leader	1/11/15
41	Focus Group	Cobb County - Latino focus group ZIP Codes: 30216,30080	10	Minority, low income, medically underserved, and uninsured	Members and community representatives	10/17/15
42	Focus Group	Paulding County	7	Medically underserved, uninsured, and low income	Members and community	11/24/15

					representatives	
43	Focus Group	Douglas County	8	Medically underserved, uninsured, and low income	Members and community representatives	12/3/15
44	Focus Group	Cherokee County	7	Medically underserved and low income	Members and community representatives	12/8/15
45	Focus Group	Bartow County	9	Medically underserved, uninsured, and low income	Members and community representatives	12/15/15
46	Focus Group	DeKalb County ZIP Codes: 30032,30316	11	Minority, low income, medically underserved, and uninsured	Members and community representatives	1/5/16
47	Focus Group	Clayton County ZIP Codes: 30236, 30260, 30274, 30297	13	Minority, low income, medically underserved, and uninsured	Members and community representatives	1/6/16
48	Focus Group	Meriwether County	10	Minority, low income, medically underserved, and uninsured	Members and community representatives	1/26/16
49	Focus Group	Fulton County ZIP Codes: 30331, 30337, 30344, 30349	10	Minority, low income, medically underserved, and uninsured	Members and community representatives	1/28/16
50	Focus Group	Clarke County	11	Medically underserved, uninsured, and low income	Members and community representatives	2/2/16

APPENDIX B (cont.): List of Key Informants

Key Informant(s)	Title	Organization
Jared Bailey	County Commissioner	Clarke County
Cathy Green **Malinda Ely** **Donna Stafford**	County Nursing Directors	Public Health District 1-1
Larry Johnson	County Commissioner	DeKalb County
David Westfall **Angie Hanes** **Edie Parsons**	District Health Director Nursing Clinical Director Program Manager, Data & Analysis	Public Health District 2
Therese McGuire	Health and Physical Education Program Specialist	Georgia Department of Education
Lloyd Hofer	District Health Director	Public Health District 3-4
Sandra Ford	District Health Director	Public Health District 3-5
Zachary Taylor	District Health Director	Public Health District 1-2
Ginneh Baugh	Senior Director of Strategy Integration	United Way of Metropolitan Atlanta
Jeff Rader	County Commissioner	DeKalb County
Karuna Ramachandran	Health Programs Director	Center for Pan Asian Community Services
Kathryn Lawler	Manager, Aging and Health Resources	Atlanta Regional Commission
Kathy Palumbo	Director of Programs	The Community Foundation for Greater Atlanta
Kristin Dixon	Health Policy Analyst	Public Health District 3-2
Lisa Crossman	Deputy District Health Director	Public Health District 3-1
Louis Kudon	Program Manager	Public Health District 3-5
McKenzie Wren	Executive Director	Clarkston Community Center
Wendy LeVan **Bridget Smith** **Susan Wall**	Clinical Nursing Director Director of Administration WIC Director	Public Health District 4
Greg Clifton	Mayor	City of Fayetteville
Vanessa Fleisch	Mayor	City of Peachtree City
Loida Bonney	Executive/Medical Director	Fayette Care Clinic
Wendell Jordan	County Manager	McIntosh Trail Community Service Board
Joseph Barrow	Superintendent	Fayette County Schools
Mollie Cole	Executive Director	Hands of Hope
Rodney Bowler	Superintendent	Henry County Schools
Sloan Elrod	Fire Chief	Pickens County Fire and EMS
Carole Maddux	Director	Good Samaritan Health and Wellness
Rick Jaspere	State Representative	District 11
Stephen Miracle	CEO	Georgia Mountains Health

Louise Hamrick	Deputy Health Director	Public Health District 1-2
Lou Graner	Executive Director	Coweta Samaritan Clinic
Steve Barker	Superintendent	Coweta County Schools
Ralph Staffins	President	Newton County Chamber of Commerce
Margaret Washington	Executive Director	Newton County Mentoring
Landis Stephens	Chairman	Housing Authority Board
Greg Profitt	Vice President, COO	Newton Local Fund, Newton Federal Bank
Katrina Young	Director, Continuing Education	Piedmont Technical College – Newton
Samantha Fuhrey	Superintendent	Newton County Schools
Kay Lee	Consultant	Center for Preservation and Planning

APPENDIX C: List of Community Assets

Following is a list of community assets within the counties of the KPGA Region. Following the list of state-wide assets, the organizations are presented in alphabetical order by county. The total number of county-specific assets identified in each county follows the name of each county.

Organization	*Counties Served*
Boys and Girls Club	Barrow*, Bartow, Carroll, Cherokee, Clarke, Cobb, Coweta, Dawson*, DeKalb, Douglas*, Fayette, Fulton, Gilmer, Gwinnett, Hall, Madison**, Meriwether**, Paulding, Pickens*, Rockdale*, Troup, Walton*
Children's Advocacy Centers of Georgia	Barrow*, Bartow, Carroll, Cherokee, Clarke, Clayton, Cobb, Douglas*, Forsyth, Fulton, Gwinnett, Hall, Henry*, Spalding*, Troup, Walton*
Communities in Schools	Carroll, Clarke, Cobb, Coweta[+], DeKalb, Douglas*, Fulton, Henry[+], Walton*
Georgia Family Connection	All Counties
Georgia Head Start	All Counties
McIntosh Trail Management Services Inc.	Butts*, Carroll, Coweta, Heard**, Lamar**, Meriwether**, Newton*, Pike**, Spalding*, Troup
United Way	Bartow, Clarke[^], Forsyth, Fulton[#], Hall, Newton*, Spalding*, Troup, Walton*
YMCA	Barrow*, Bartow, Cherokee, Cobb, DeKalb, Fayette, Forsyth, Fulton, Gwinnett, Hall, Newton*

Georgia-wide

**Counties with only 1 or 2 unique assets*
***Counties with no unique assets*
[+]*Currently developing asset in this county*
[#]*United Way of Greater Atlanta is located in Fulton County, but also serves Butts*, Cherokee, Clayton, Cobb, DeKalb, Douglas*, Fayette, Gwinnett, Henry*, Paulding**, and Rockdale* Counties*
[^]*United Way of Northeast Georgia is located in Clarke County but serves Barrow*, Madison**, Oconee, and Oglethorpe** Counties*

Boys and Girls Clubs provides a structured and positive environment and programs for young people. http://bgcncg.org/

Children's Advocacy Centers of Georgia The majority of CAC Georgia's professional work product is designed to provide direct services to CACs across the state. A critical corollary is to provide direct services and support to those Georgia communities that seek to establish a CAC within their judicial circuit, by working with the base of stakeholders who will ultimately become active as multidisciplinary team members. http://www.cacga.org/

Communities in Schools is the nation's largest dropout prevention organization. The mission of Communities in Schools is to champion the connection of needed community resources with schools to help young people successfully learn, stay in school and prepare for life. By bringing caring adults into the schools to address children's unmet needs, CIS provides the link between educators and the community. For over 30 years, Communities In Schools has worked to ensure that every child needs and deserves these "Five Basics": a one-on-one relationship with a caring adult, a safe place to learn and grow, a healthy start and a healthy future, a marketable skill to use upon graduation, and a chance to give back to peers and community. http://www.communitiesinschools.org/

Georgia Family Connection collaborative organizations operate in independently in counties as local decision-making bodies, bringing community partners together to develop, implement, and evaluate plans that address the serious challenges facing Georgia's children and families. They are supported by the **Georgia Family Connection Partnership,** a nonprofit public-private intermediary which exists to: unify their commitment to Georgia's children and families, make sure their efforts to improve the lives of children and families work and, protect every dime of their investment in Georgia's future. http://www.gafcp.org/

Georgia Head Start and Early Head Start programs provide comprehensive early childhood and family development services to children from birth to five-years-old, pregnant women and families. Our programs have a long tradition of delivering comprehensive and high quality services designed to foster healthy development in low-income children and their families. Head Start agencies provide a range of individualized services in the areas of education and early childhood development; medical, dental, and mental health; nutrition; parent involvement and family support. In addition, the entire range of Head Start services is responsive and appropriate to each child and family's developmental, ethnic, cultural, and linguistic heritage and experience. They operate in 57 of 59 Georgia counties. http://www.georgiaheadstart.org/

United Way seeks to provide adequate funding and guidance for member agencies to:

- Provide for immediate needs of those in crisis situations
- Meet long-term needs through the educational, emotional and moral guidance of children
- Enable financially or physically disabled people to become self-supporting

Websites are regional, e.g. https://www.unitedwayatlanta.org/

YMCA makes accessible the support and opportunities that empower people and communities to learn, grow and thrive. With a focus on youth development, healthy living and social responsibility, the YMCA nurtures the potential of every youth and teen, improves the nation's health and well-being and provides opportunities to give back and support neighbors. Website are regional, e.g. http://www.ymcaatlanta.org/

County-specific

Barrow (1):

Barrow Community Foundation's mission is to enhance quality of life by focusing on educational, social, cultural, environmental, and economic needs of the residents of Barrow County, Georgia; and to fund projects and non-profit agencies that accomplish that mission. They connect philanthropic partners with receiving partners that can use funds provided by them through the Foundation to advance their service to the community. http://www.barrowcommunityfoundation.org/

Bartow (3):
Advocates for Children is a non-profit organization with eight programs all devoted to serving children and families in Bartow County and surrounding North Georgia counties. They are dedicated to preventing and treating child abuse. Flowering Branch Children's Shelter is their residential program for abused, neglected, and runaway youth. A national program, CASA trains volunteers to help abused and neglected children in the juvenile court system. http://www.AdvoChild.org

Allatoona Community Action Partnership assists low income individuals and families to acquire useful skills and knowledge, to gain new opportunities, and achieve self-sufficiency. Programs include: adult basic education/GED assistance, job readiness training, holistic case management, and emergency housing assistance. http://www.tallatoonacap.org/

Good Neighbor Homeless Shelter provides men, women, and families with temporary shelter and physical, emotional, and spiritual support. They assist guests with developing and prioritizing goals for their return to the community as productive members. Guests meet one-on-one with their Goals Coordinator on a weekly basis. Together they set and prioritize goals for independent living. In addition to getting a job, creating a budget, opening a savings account, and locating affordable housing, each guest has individual goals to achieve. http://www.goodneighborshelter.org

Butts (1):
The Butts County Life Enrichment Team serves as the collaborative and local decision-making body, bringing community partners together to develop, implement, and evaluate plans that address the serious challenges facing Butts County's children and families. http://butts.gafcp.org

Carroll (3):
Hope for the Journey is a non-profit organization giving women hope before, during, and after diagnosis of breast cancer. They provide monthly support groups, as well as financial, transportation, and spiritual support. http://www.hopeforthejourneywestga.org

The Community Care Services Program (CCSP) (Carroll, Coweta, Heard, Lamar, Pike, Spalding) helps people who are elderly and/or functionally impaired to continue living in their homes and communities. For elderly and/or functionally impaired people, CCSP offers community-based care as an alternative to nursing home placement and offers Georgians a greater choice in deciding where to live and what assistance they need. http://www.mtmsi.org/

Carroll County Extension Office Family and Consumer Sciences (FACS) Programs gives the residents of Carroll County non- biased, research-based information for the many facets of their lives including food preservation, parenting, personal financial management and healthy eating habits. The Carroll County Master Gardener Program and the Carroll County Junior Master Gardener (JMG) Program is an interactive program where youth in 3rd - 5th grade can learn about gardening, horticulture and much more all in a fun and educational "hands-on" environment. http://www.caes.uga.edu/extension/carroll/

Cherokee (5):

Bethesda Community Clinic Bethesda is a faith-based health clinic. They strive to not only deliver affordable, quality healthcare to the underserved, uninsured and underinsured populations of Cherokee County and the surrounding areas, but also to become a healthcare home for ongoing care. Bethesda is a fully-equipped medical clinic specializing in primary care for all age groups. They offer physical exams, well-woman exams, limited dental care, acute care, chronic disease management, diabetes education and nutrition classes, wellness coaching, prescription assistance, and blood lab testing including STD/HIV testing. http://www.bethesdacommunityclinic.org

Cherokee Day Training Center is a progressive CARF accredited non-profit organization that has assisted Cherokee County residents with developmental disabilities since 1969. This local public charity provides a meaningful array of training services, recreational activities and community based employment opportunities. http://cherokeetrainingcenter.com/

Cherokee Family Violence Center provides a comprehensive array of services that meets the needs of victims of domestic violence, educates stakeholders, and holds batterers accountable so that victims and the community are safe. Below are some of the free services that are offered through their Center:

- Safe and Secure Emergency Shelter
- 24 Hour Crisis Hotline in English and Spanish
- In-person Crisis Counseling
- Support Groups for Adults and Children
- Emergency Protective Orders
- Court Accompaniment
- Free Legal Assistance
- Income-Based Supportive Housing

http://cfvc.org/

Georgia Breast Cancer Coalition The Georgia Breast Cancer Coalition Fund is a non-profit education and advocacy organization founded by breast cancer survivors. The GBCCF exists to focus the attention of Georgians on the epidemic proportions of breast cancer and works diligently to bring together individuals and organizations with a commitment to ending this devastating disease. The GBCFF:

- Advocates in the Georgia General Assembly to ensure funds continue to be appropriated for breast cancer research and treatment.
- Partners with other organizations and coalitions to protect insurance provisions for breast cancer patients and hold our legislators accountable.
- Sponsors advocacy workshops to arm citizen advocates with essential tools to impact breast cancer-focused legislative and public policy issues at the state and national levels.
- Hosts targeted education workshops statewide to teach women about breast health, common myths and misconceptions about the disease and warning signs.
- Maintains an Advocacy Alert Network to respond quickly to legislative issues that impact access to medical treatment for those diagnosed with breast cancer and research funding for a cure.
- Brings together a group of Georgians annually to visit Capitol Hill and discuss with Georgia's state representatives the importance of legislation that impact breast cancer patients.

http://www.gabcc.org/

LEAD (Launch, Expose, Advise, Direct) is a 501 (c)3 nonprofit organization operating in whose mission is to provide at-risk, inner city, male youth with access to higher education and civic engagement. Using the sport of baseball as the motivating tool, LEAD provides young men with programming that shows them how to be productive citizens and allows them to turn citizenship from a noun to a verb.

- Launching student athletes towards educational opportunities after converting raw talent into the skills required for entry into college athletic programs
- Exposing teens to service and local enrichment activities in order to instill a sense of responsibility, belonging and investment; key requirements for building a civically engaged individual.
- Advising players, coaches and parents on the process of effectively supporting dreams of playing baseball on the college level.
- Directing young men towards their promise by using the historical journey of past African American legends as the road map.

http://lead2legacy.org/

Clarke (3):
Georgia Family, Career, and Community Leaders of America is a national student organization that helps young men and women become leaders and address important personal, family, work, and societal issues through family and consumer science education. GFCCLA's chapter projects focus on a variety of youth concerns including teen pregnancy, parenting, family relationships, substance abuse, peer pressure, environment, nutrition and fitness, inter-generational communication, and career education. http://www.gafccla.com/

Athens Community Council on Aging is a non-profit 501 (c) 3 organization that aims to maintain and enrich the lives of older persons in the 12 counties of Northeast Georgia. The services provided by the agency are broad based and reach seniors with a continuum of need. ACCA's programs enable older persons to live independently at home and offer opportunities for employment, volunteerism, and other activities. ACCA is a resource for education, information, referral, counseling, and general assistance. http://test.accaging.org/

Athens Neighborhood Health Center The mission of the Athens Neighborhood Health Center (ANHC) is to provide accessible and affordable, high quality primary health care to medically underserved and at risk individuals in Athens-Clarke County and surrounding areas. ANHC received Federally-Qualified Look Alike Status in 2010. The Athens Health Network is meant to be an umbrella organization that serves as a safety net for those in need of healthcare, promoting the existing infrastructure of the Athens-Clarke County healthcare system and identifying the presence of service gaps and ways of filling those gaps. The organization is composed of a multitude of entities with a stake in the healthcare of the community, including direct medical service providers and community healthcare resource agencies. Athens Health Network connects these healthcare and community leaders, equipping them with resources and information as community investment and collaboration are essential to the success of the public healthcare system. http://www.athenshealthnetwork.com/Athens-Neighborhood-Health-Center-v-22.html

Clayton (5):
The Good Shepherd Clinic provides medical services for adult residents of Clayton County who do not qualify for Medicare or Medicaid, do not have private insurance, and cannot afford to see a doctor. http://goodshep.org/

Palm House Recovery Center was established in 2005 to provide a safe, stable environment where clients can learn to manage their addictions and become productive, successful members of society. In 2008 Palm House added its women's facility to provide housing and recovery resources to women. The Palm House works closely with judges and probation officers to insure that their clients remain clean and sober while they learn the like skills and develop the tools to become productive citizens. http://www.palmhouseonline.com

Youth Empowerment Project YEP offers many different programs and services for children, teenagers, young adults, and families. YEP empowers youth through anti-crime, anti-drug, computer training centers, after school programs, and GED training classes in addition to job training for individuals of 14-21 years of age, quality affordable preschool child care, mentoring and tutoring, and GED and SAT tutoring. http://youthempowermentprojectinc.com/

Calvary Refuge, Inc. is a 501(c)(3) non-profit organization that provides emergency and transitional housing and food for homeless individuals and families in need. Through its Transitional and Emergency Housing programs, Calvary Refuge Center has helped hundreds of homeless adults and children in need. The primary purpose of the transitional housing program is to provide temporary shelter for those families wishing to move beyond their current situation, but are without the means to do so. The goal is to assist them in transitioning into the working community. The Emergency Night Shelter Program provides safe and secure lodging for those in need of immediate shelter, but are not qualified to participate in the transitional program. http://www.calvaryrefuge.org/

Clayton County Community Services Authority, Inc. is committed to the elimination of poverty and the associated conditions and circumstances of people in Clayton County and the surrounding areas. The agency advocates for the disenfranchised and provides for the delivery of essential services through structured programs which improve the quality of life, lead to self-sufficiency, and responsible community involvement among its citizens. The Community Support Component of the Agency provides emergency short term financial assistance along with case management services and resource referrals to families or individuals faced with crisis situations (i.e. evictions, foreclosures, utility disconnections and emergency food assistance) to help families move towards self-sufficiency. Through Case Management, families or individuals are provided financial counseling in consumer education and budgetary management along with referrals to other support service agencies, including Social Security, Supplemental Security Income, Veterans Benefits, and Unemployment Benefits. Individuals and families are also provided employment counseling and referral services to training, educational and vocational rehabilitation training services that will enhance their abilities to become self-sufficient. http://www.claytoncountycsa.org/

Cobb (6):
Anchor of Hope is a Christian organization providing financial and spiritual support, encouragement, community resources and services to families with disabilities. Parents can enjoy a break and have a night to be "normal" while leaving their children in the care of responsible volunteers. https://www.anchorofhopefoundation.com/

Adaptive Learning Center for Infants and Children Inc maximizes the potential of young children with disabilities, and creates awareness and acceptance between non-disabled people and people with disabilities. http://www.adaptivelearningcenter.org

The Adult Disability Medical Home (ADMH) is an innovative and comprehensive program providing health and wellness to teens and adults with developmental disabilities. http://www.adaptivelearningcenter.org

The Community Health Center (CHC) is a nonprofit organization whose mission is to provide quality, affordable medical and dental healthcare to the communities in north-west metro Atlanta. CHC partners with businesses, local governments, churches, other nonprofit organizations, and individuals to provide the best healthcare services possible at an affordable price. http://www.chcaustell.org/

Good Samaritan Health Center of Cobb is a nonprofit healthcare center that provides a comprehensive range of medical, dental, prescription, and select social services for patients without health insurance or the means to afford care. http://www.goodsamcobb.org/

Cobb Community Collaborative is a membership of nonprofit organizations, local government, businesses, faith- based organizations, educational institutions, professional organizations, associations and citizens who share ideas, expertise and resources to meet the needs of Cobb County. The Committees of CCC are community partners who provide oversight to the organization. The Councils of CCC are structured groups of community partners which carry out the mission, vision, goals and strategies of the councils. They represent topics the members collaboratively address to affect change. http://www.cobbcollaborative.org/

Coweta (6):
Bridging the Gap Community Outreach is a faith-based organization that has been meeting the needs of Coweta families and individuals since 2009. They distribute food, toiletries, and household items every Saturday without condition to those willing to see change in their personal circumstances. BTG is committed to fighting physical and spiritual hunger by providing wholesome food and valuable links to community resources. http://www.btgcommunity.org/

Cambridge House of Newnan Cambridge House Enrichment Center (CHEC) is an adult daytime program and adult day health care service, designed to meet the daily respite needs of caregivers caring for homebound adults with various functional disabilities. The primary objectives of the program are to: Restore or maintain optimal capacity for self-care to frail elderly persons and other adults with physical or mental disabilities; and delay or prevent inappropriate or personally undesirable institutionalization. As an adult day health care provider, Cambridge House offers caregivers an alternative to nursing home care; is an affordable option to assisted living facilities and in partnership with home health care, provides homebound individuals with a balanced range of care. http://www.cambridgehouseonline.com/

Community Welcome House serves as a transitional facility which provides shelter for women, and women with children, in need of shelter due to domestic violence. http://www.communitywelcomehouse.org

Coweta Samaritan Clinic Inc provides quality healthcare and compassionate support in a faith-based environment to uninsured and underinsured residents of Coweta County. http://www.cowetasamaritanclinic.org

Meals on Wheels of Coweta Over ten thousand meals are served to MOWOC clients annually. Approximately 80 volunteers are involved in meal delivery, handyman repairs, food preparation, and friendly visitors. The majority of MOWOC clients live alone with little or no help. The meal the client receives may be the only meal they eat that day.
Meals on Wheels of Coweta helps adults who:

- are 65 years old or older
- homebound because of disability or chronic illness
- are unable to prepare meals for themselves
- do not receive regular assistance from others

- may be on hospice care
- may live alone

http://mealsonwheelscoweta.org/

Rutledge Center, Inc. provides family centered and consumer responsive services to improve the quality of life and develop self-sufficiency for individuals with developmental disabilities. http://www.rutledgecenter.org/

Dawson (2):
KARE for Kids, Inc. uses the funds they raise to provide necessities to the children of Dawson County. Among some of the items KARE has purchased over the years are: winter coat, shoes, clothing, medicine, eye glasses, list of items required for boot camp, educational resources, summer school fees, toys, etc. With the exception of Christmas, these needs must come to KARE in the form of a referral from the school or other agency. http://kareforkids.org/about.html

Good Shepherd Center of Dawson County provides medical services to those who have no medical care and who live, work or attend school in Dawson County, without insurance and income 200% of the Federal Poverty Level (FPL) or less. Care includes:

- General medical, non-emergency care
- Women's Wellness screening, including PAP Smear
- Prescription Assistance Programs for medication prescribed by clinic practitioners
- Information, referral and advocacy for health and support services

The clinic does not provide emergency care or treat chronic pain requiring narcotics.
http://www.goodshepherddawsonco.org/

DeKalb (8):
All About Developmental Disabilities is a 501 (c)(3) Georgia non-profit organization. They work to ensure that individuals and families living with developmental disabilities are equipped with critical support services, broad-based education, community integration opportunities, and effective advocacy from age three to throughout their lifespan. http://aadd.org/

Care and Counseling Center of Georgia is a faith based, recognized non-profit organization offering counseling services to individuals and families in the greater Atlanta area. They are one of the largest mental health providers in Georgia. http://cccgeorgia.org/

CaringWorks helps those who are homeless stabilize their lives and move toward greater self-sufficiency. They provide the housing and support needed to get people to a better place in life. http://www.caringworksinc.org/index.html

Hispanic Health Coalition of Georgia is a 501 (c) (3) non-profit organization created to advance health policies that will improve access to services for Hispanic children and adults throughout the state. HHCGA is currently Georgia's only statewide organization that focuses on Latino/Hispanic health. Together with its members (both health-related and non-health centered organizations and professionals), HHCGA identifies needs and service gaps leading to health disparities for Georgia Hispanics and offers direct community services as well as supportive activities to help its members improve the health wellbeing of Georgia Latinos. HHCGA informs individuals and agencies on current health disparities and ways to reduce these disparities. As part of its efforts, HHCGA offers skills development services to organizations who desire to provide high quality, culturally and linguistically appropriate services. http://www.hhcga.org/

21st Century Leaders (21CL) was established by a group of executives in response to two alarming trends: 1) a lack of people prepared to accept leadership roles, and 2) the difficulty of employees in crossing class and racial barriers to work together. The group realized the key to reversing these trends is providing young people with the training, guidance and encouragement necessary to enter college and the workforce with a highly developed set of leadership skills. The mission of 21st Century Leaders is to inspire the next generation of Georgia leaders by empowering high school students with essential business and community leadership skills through programs connecting a diverse group of enthusiastic peers and passionate professionals. http://21stcenturyleaders.org/

The Wylde Center The Wylde Center teaches environmental awareness through hands-on gardening and outdoor education programs. The Wylde Center engages students in projects that address real needs, both through the community gardens and through outreach projects in Decatur City and DeKalb County schools and community centers. The Wylde Center has been instrumental in helping create the outdoor garden environments at many of the schools in Decatur and is also helping guide the Farms to School initiative in Decatur. http://wyldecenter.org/

Arms Wide Open Community Development Fund is a tax-exempt corporation specializing in home and community-based services. When people become frail due to age, accident, serious illness, injury or sickness, Arms Wide Open CDC helps them to live at home with dignity. Arms Wide Open CDC operates three programs: 1) Durable Medical Equipment Loan Program, 2) Community Chaplaincy Program, and 3) Life Care Program. Arms Wide Open CDC administers high-quality, cost-effective, and goal-oriented programs that help people with disabilities and chronic illnesses. http://armswideopen.org/

Center for Pan Asian Community Services CPACS is a private non-profit agency that promotes self-sufficiency and equity for immigrants, refugees, and the under-privileged through comprehensive health and social services, capacity building, and advocacy. http://www.icpacs.org/

Douglas (1):
Good Samaritan Center of Douglas County The Good Samaritan Center assists needy families in the Douglasville area with utility bills, prescriptions, food, and spiritual counsel. The

Center is a food bank and emergency assistance center for Douglas County residents.

Fayette (5):
Families United Services is a not-for-profit private organization that partners with the several state agencies and behavioral health groups to provide mental health, substance abuse, and wrap-around services to meet the needs of children, adolescents, and their families in need of intervention. The primary purpose of providing these services is to meet the needs of consumers struggling with mental health and addictive diseases that are inhibiting them from living a productive quality life. http://www.familiesunitedse.com/Home.asp

Fayette Care Clinic is a non-profit organization created to provide primary health care to members of our community who lack access to such services. Services include: Basic health screening, e.g., blood pressure, diabetes, primary medical, dental care, vision, dermatology, cardiology and physical therapy, In addition, prescription drug advocacy programs, healthcare education, and referrals to other medical resources, specialists and hospitals for laboratory tests, x-rays, etc. are available for eligible patients. http://fayettecareclinic.org/our-clinic-location-and-hours/

Fayette FACTOR The FACTOR collaborative is a 501 (C) (3) nonprofit organization comprised of community leaders that include families, local business and civic leaders, faith-based and school-based organizations, and public/private human services providers. FACTOR collaborative membership coordinates a planning process that identifies community needs and resources, sets goals and priorities, evaluates strategies and practices, and measures and reports quality of life improvements for Fayette County. FACTOR is involved in many community projects where collaboration is helping to promote healthy children and family. http://www.fayettefactor.org/

Healing Bridge Clinic Healing Bridge Clinic provides the residents of Fayette, Coweta, and South Fulton Counties holistic health care for the uninsured. The clinic provides routine, non-emergency medical and nursing care normally provided at family practice centers. http://www.healingbridgeclinic.org/

Joseph Sams School Inc is a school dedicated to the education and life skills development of children who are intellectually, physically, or developmentally challenged. http://www.josephsamsschool.org

Forsyth (5):
Forsyth County Family Haven is an advocate for victims and families of domestic violence providing shelter, programs and community education to end the cycle of violence. http://www.ForsythCountyFamilyHaven.info

Georgia Highlands Medical Services, Inc. (GHMS) is a nonprofit community-based medical facility with locations in Cumming, and Canton, Georgia. GHMS serves the broad health needs of North Georgia residents through a family practice model of care. A multi-site community based health center, GHMS works to ensure that its patients have access to all levels of the health care system. GHMS is committed to providing services for the medically underserved. A strong proponent of preventive education and public health activities, GHMS collaborates with other community agencies and organizations to identify health related needs and to develop resources to meet these needs. http://www.ghms-inc.org/

Jesse's House is a non-profit organization that provides emergency and long-term care to adolescent women from across the greater Atlanta who have suffered abuse or delinquency. http://www.jesseshouse.org

Meals by Grace meets weekly to create, prepare and deliver hot, nutritious meals and additional food items to families in need with limited or unreliable transportation. They also provide a full service pantry on Tuesdays and Thursday. The hot meals program is focused exclusively on children recommended to them by the Forsyth County School Social Workers, but the pantry is open to anyone with a self-declared need. www.mealsbygrace.org

The Place is a nonprofit Social Service Organization that has passionately served residents of Forsyth County since 1975. The Place assists resident families with emergency basic needs in difficult times. In addition, The Place also operates a thrift store onsite that provides affordable merchandise to the public. http://theplaceofforsyth.org/

Fulton (8):
100 Black Men of Atlanta Inc provides mentoring, physical fitness training, and college preparation for inner city youth, through activities such as Robotics. http://www.100blackmen-atlanta.org

Action Ministries serves homeless women through their Women's Community Kitchen and homeless children through their Children's Program. http://actionministries.net/

Aid Atlanta focuses on prevention and early diagnosis of common health issues such as diabetes and heart disease. Their services include physical exams, prostate and testicular exams, screening and treatment for sexually transmitted diseases, and blood glucose and cholesterol testing. https://www.aidatlanta.org/home

Agape Community Center Agape empowers and supports underserved families within its community to discover and embrace their full potential. Agape achieves this mission by offering programs and services that are responsive to a variety of needs for school-age children, disabled individuals, adults, senior citizens, and families of northwest Atlanta. Current programs offered include the following:

- Academic—based Afterschool for Elementary and Middle School Students
- ESOL for Spanish Speaking Students with language barriers
- The Ginger Kaney Mentoring Institute for High School Students
- Ragtime, A Day Program for Seniors and Disabled Adults
- Emergency Assistance for Families
- GOGIRLGO! and F.I.T. Camp for Boys, Athletic, Health & Wellness Summer Camp
- Camp Jumpstart – a summer early reading program for rising first and second graders
- Agape to Go – a family nutrition backpack program
- Annual Events: Great Backpack Giveaway, Great Thanksgiving Giveaway, Extreme Bedroom Makeover

http://agapeatlanta.org/

Atlanta Housing Authority – Quality of Life Initiative The Quality of Life Initiative allows families in AHA's remaining conventional public housing projects the opportunity to escape an environment of concentrated poverty, consistent with AHA's vision of providing eligible families with access to affordable housing, while de-concentrating poverty and building healthy communities. http://www.atlantahousing.org/portfolio/index.cfm?fuseaction=qli

The Center for Black Women's Wellness, Inc. is a non-profit organization that provides free and low-cost services to empower black women, and their families, toward physical, mental, and economic wellness. CBWW recognizes that empowering black women leads to the

empowerment of the family and, eventually, the empowerment of the community. CBWW's comprehensive services include: preventative health services, maternal and child health services, mental health screening and referrals, and self-employment training. http://www.cbww.org/

CHRIS Kids, Inc. offers an array of individualized programs through its Family of Services which includes: Behavioral Health, Safe Homes & Environments, Strong Communities and Education & Training. This holistic approach enables children, youth and families to unlock their potential for happiness, health and success despite challenging circumstances, often beyond their control. CHRIS Kids' ambition is to be Georgia's go-to place where every vulnerable child or traumatized youth discovers how to unlock their potential. http://www.chriskids.org/home-page

Health Education, Assessment, and Leadership (HEAL) HEAL provides health education and medical services to at risk and underserved populations. It is committed to assess the needs of communities and to build leaders from within those communities through health awareness and health education, training, and supportive programs. The HEALing Community Center is located in one of Atlanta's poorest neighborhoods (Zip Code 30314), where having no medical insurance is common place. The HEALing Community Center is dedicated to providing free specialty medical care to low income children, women, and men. http://healingourcommunities.org/

Gwinnett (7):
Good Samaritan Health Center of Gwinnett, Inc., a 501(c)3 non-profit organization, is a faith-based organization committed to caring for the uninsured and underinsured working poor in our community. They serve the community by helping to eliminate health disparities for uninsured and underinsured populations. www.goodsamgwinnett.org

Gwinnett Children's Food Umbrella's mission is to alleviate hunger and improve the nutritional well-being of Georgia's Children. http://www.gwinnettchildren.com/

The Gwinnett Coalition for Health and Human Services is a non-profit organization dedicated to addressing the health and human service needs of everyone in Gwinnett County, Georgia. The two primary functions of the Coalition are the management of a community Helpline, and coordination of a 3 year Strategic Plan for children and families. Major strategic focus areas include Positive Child and Youth Development, Strengthening Individuals and Families, and Strengthening Communities. http://www.gwinnettcoalition.org/

Gwinnett United in Drug Education Inc. has used data-driven, evidenced-based strategies since 1986 to reduce and prevent the use, misuse and abuse of alcohol, tobacco and other drugs by focusing on environmental strategies to achieve community-level change. In the past, they have made significant strides in reducing inhalant use, tobacco use and second hand smoke and underage drinking. GUIDE follows SAMHSA's Strategic Prevention Framework (SPF) for all strategic planning. http://www.guideinc.org

Health MPowers is a designated 501 (c) (3) non-profit organization working to improve the health status and environment for students in grades PreK-8. HealthMPowers is a comprehensive school health intervention program that exemplifies the key strategies that the Centers for Disease Control and Prevention (CDC) has outlined for improving health, physical activity and healthy eating in schools. The HealthMPowers' program is designed to provide students, school staff, and families with information, skills, resources, and motivation necessary to take responsibility for their own health. http://www.healthmpowers.org/

Hope Clinic The Hope Clinic, a non-profit primary care internal medicine clinic in Gwinnett County that provides an affordable alternative to the hospital emergency room for the primary

care medical needs of the uninsured. The clinic is a vital part of Gwinnett's healthcare safety net and supplies over half of the available charitable primary care capacity in the county. http://hopeclinicgwinnett.info/

Norcross Meals on Wheels has provided thousands of hot midday meals, five days a week, for over thirty-five years. Norcross Meals on Wheels began by delivering to the Norcross and Duluth areas, and has expanded to include Berkeley Lake and Peachtree Corners. They are now a 501C-3 nonprofit organization with a dedicated board of directors and program coordinator. https://norcrossmealsonwheels.org/

Hall (3):
Challenged Child and Friends offers a tailored and integrated experience where children with special needs learn and grow in a full inclusion program with children who have typical development. They serve children as young as six weeks of age up to six years. With a staff to student ratio that averages one-to-four, individualized programs occur for all students enrolled. http://www.challengedchild.org

Good News Clinics, Inc. Good News Clinics provides medical and dental care at no cost uninsured residents of Hall County who cannot afford to purchase health care services. Forty-four physicians, five mid-level providers, and forty-three dentists volunteer to treat patients at Good News Clinics. In addition, 218 specialist physicians volunteer to treat patients in their offices through referrals from Good News Clinics, Northeast Georgia Physicians Group practice at the Hall County Health Department and physicians in Hall County. http://www.goodnewsclinics.org/

Health Access Initiative, Inc. Health Access Initiative is a project of the Hall County Medical Society that seeks to expand access to medical care for uninsured adults who live in Hall County. HAI works to connect patients who qualify with physicians and other caregivers in the network who will see patients. HAI also assists in coordinating diagnostic testing, medications, etc. that are required to carry out a physician's care plan. HAI allows working people in Hall County who make too much to qualify for Medicaid (but who cannot afford medical insurance or medical care) to receive the medical attention they need. Health Access Initiative offers a medication assistance program so that patients can receive the medications they need. http://www.healthaccessinitiative.com/

Henry (1):
Hands of Hope Clinic Hands of Hope Clinic provides basic medical and dental care free of charge to uninsured Henry County residents who are unable to afford the health services they need. Piedmont Henry Hospital provides diagnostic services and specialty referral services are arranged either for free or at a reduced cost to the patient. http://www.handsofhopeclinic.org/

Newton (2):
Washington Street Community Center offers after-school programs, mentoring for high school students, physical activities, support for grandparents, and Girl Scouts activities. http://www.washington-street.org/

Willing Helpers Medical Clinic provides basic medical and dental care free of charge to uninsured Newton County residents who are unable to afford the health services they need. http://www.solidrockbaptist.com/outreach-ministries/willing-helpers-medical-clinic

Oconee (4):
Achieve Greater Success AGS' mission is to promote healthy growth and development in

females of all ages, races and socioeconomic levels. http://achievegreatersuccess.org/

Bethel Haven, Inc. (faith-based) serves those who are struggling through difficult life situations and experiences. In such moments, it is helpful to have the support of caring professionals to aid in the healing process. Bethel Haven exists to be a safe place for individuals and families in their journey towards healing. Programs and services are based on a sliding-fee scale. http://www.bethelhaven.net/

Butterfly Dreams Farm serves youth through two complimentary services: hippotherapy and therapeutic riding. While both are done on horseback, the horse serves a unique role in each. Some of the youth receive both forms of therapy or transition into therapeutic riding as their needs and goals change**.** http://butterflydreamsfarm.org/

Extra Special People, Inc. strives to enhance the lives of children with developmental disabilities and their families by focusing on their abilities – not disabilities. They provide services throughout the year to residents of nine counties in Northeast Georgia. ESP serves individuals with behavior disorders, Cerebral Palsy, Down Syndrome, Autism, Asperger's, Fetal Alcohol Syndrome, Angelman Syndrome, Spina Bifida, and many more. No child with a disability is turned away from ESP. http://extraspecialpeople.com/

Pickens (2):
CARES of Pickens County provides food and financial assistance on a temporary basis to those families in Pickens County that are in need and qualify for our help.
http://www.pickenscares.org

Good Samaritan Health and Wellness Center is a not-for-profit, volunteer-operated clinic which provides free or discounted health services to residents and workers of Pickens County who have no access to healthcare. http://www.goodsamhwc.org/

Rockdale (2):
Mercy Heart Clinic MHC provides medical, basic dental, and other supportive health services to Rockdale County residents who have chronic health problems and who have no access to affordable health care other than going to the local emergency room.
http://www.mercyheartclinic.org/

Rockdale Coalition for Children and Families The Coalition exists to serve as Rockdale County's official planning body for services to children, youth and families, as a coordinating organization for the various organizations and agencies which provide services to children, youth and families in the county and as a provider of educational and consulting services in the field of child and family development to the public and to service providers. Some of RCFCF's initiatives include: the Rockdale Early Learning Council which provides resources, education, and support to early educators, families, and community partners so that all children ages birth to 5 years old in Rockdale County are prepared to succeed in school; the Rockdale Early Learning Council is facilitated by the Rockdale Public School System; and the Rockdale HEALTH SafetyNet: Health Education and Linkages to Help which serves to increase access to primary health-care for the medically underserved & uninsured in Rockdale. http://www.rockdalecoalition.org/

Spalding (2):
Hope Health Clinic is a medical and dental clinic that serves the uninsured and under insured citizens of Spalding County. In addition to medical and dental services, The Hope Health Clinic offers a wide range of wellness classes that help promote the complete healing process.
http://www.hopehealthclinic.com/

Spalding County Collaborative Authority for Families and Children serves as the local decision-making body, bringing community partners together to develop, implement and evaluate plans that address the serious challenges facing Spalding County's children and families. The Collaborative's mission is to improve the well-being and health conditions of families through a collaborative system of physical, mental, emotional, and spiritual supports.
http://spalding.gafcp.org/

Troup (4):
Harmony House is a State of Georgia certified shelter that serves victims of domestic violence twenty-four hours a day, seven days a week by providing emergency shelter, crisis intervention, and advocacy for victims of domestic violence. http://www.harmonyhousega.org/

New Ventures, Inc. (NVI) is a community-based program that provides work-based training to

teach basic work skills needed for success in all career choices. We believe in the dignity of human life and that performing meaningful work is an essential part of a life lived with purpose. Preparation for meaningful work is critical to a smooth transition from education to success in work. The NVI effort began with a single purpose of training youth and adults with disabilities. Community leaders have identified a need for more basic skills training opportunities for persons with barriers. NVI has responded to that need and expanded its mission. Barriers addressed include educational, legal, attitudinal, behavioral, economic, underemployed or unemployed. http://www.newventures.org/

The Troup Cares Free Clinic provides a large range of services to patients. http://www.troupcares.org/

Twin Cedars Youth and Family Services, Inc. provides residential and community-based services in LaGrange. Connecting with the community, Twin Cedars provides a wide range of programs, in order to meet individual community need. Their programs are very diverse, from prevention to advocacy, to maximum oversight residential programs. http://www.twincedars.org/

Walton (2):
Walton County Health Care Foundation Walton County Health Care Foundation seeks to enhance the overall health of citizens residing in Walton County and the delivery of health services to these residents. It does so by giving grants of a charitable, scientific or educational nature to qualifying charitable or public service organizations. http://wchcfi.org/

Walton Wellness partners with local government, the faith community, and citizen groups to develop community projects that foster a healthy lifestyle. A few of these projects are: Community Gardens, Wellness Walks, the Agro Cycle Tour and The Blue Book health and wellness guide. In 2010, Walton Wellness and the Walton County Health Care Foundation joined forces to create the Healthy Walton 2020 Campaign. Healthy Walton 2020 operates under the umbrella of Walton Wellness, with specific goals related to the overall goal of reducing the number of Walton County citizens hospitalized and diagnosed with a lifestyle-related chronic disease. http://waltonwellness.org/

APPENDIX D - Health Needs Profiles

HEALTH NEEDS

1. Obesity/ Healthy eating/active living
2. Access to primary & mental health care
3. Obstructive & hypertensive cardiovascular diseases
4. Educational attainment
5. Cancers
6. HIV/AIDS
7. Diabetes
8. Poverty
9. Mental health
10. Transportation

HEALTH NEED CRITERIA

1. Meets the KP definition of a health need (either a poor health outcome and its associated driver or a health driver that is associated with a poor health outcome that hasn't yet itself arisen as a need)
2. The health need is confirmed by multiple data sources
3. Indicator(s) related to the health need perform(s) poorly against a defined benchmark (e.g., state averages)

NOTES:
Disparities were drawn from core indicators that had race and ethnicity data available on CHNA.org/kp. Other disparities may exist but are not included due to data gaps.
Contributing factors were drawn from related indicators on CHNA.org/kp. Other evidence-based contributing factors may exist but are not included due to data gaps.

* 1-2% difference from benchmark for service area overall
** > 2% difference from benchmark for service area overall

Obesity		
RATIONALE	**HEALTH OUTCOMES INDICATORS [Report Area (Range) // Georgia / National]**	**CONTRIBUTING FACTORS INDICATORS [Report Area (Range) // Georgia / National]**
Obesity is closely related to the top priority, healthy eating and active living. However, it can also be mediated by factors such as stress, environmental exposures, and other triggers. Obesity, now considered a health outcome, is believed to contribute to a wide range of other health conditions including sleep disorders, joint and bone disorders, and mental health issues. The economic burden of obesity, for both families and health systems, is tremendous. In the CHNA region, obesity is most prevalent in low-income and exurban/rural communities and people of color. Unfortunately, obesity is not well reported, especially in children, though both were concerns of the community.	Obesity (Adult) [26.9% (22.0%-35.1%) // 28.7% / 27.1%] Obesity - Children in healthy BMI range [53.3% (46.0%-66.9%) // 50.5% / N/A] Overweight (Adult) [34.7% // 35.1% / 35.8%] Children passing aerobic capacity test [53.5% (24.0%-74.8%) // 47.5% / N/A]	See also HE/AL, heart disease, diabetes
PRIMARY DATA:	Most respondents perceived this to be an issue in their community. There was a lot of frustration that more children in the community were becoming obese because of sedentary lifestyles and poor dietary habits. Work pressures and a changing culture were often blamed for both adults and children not being able to get the exercise they needed or preparing healthy foods which were generally not accessible in their communities. Latino stakeholders also agreed that increasingly more of their children were obese and recommended heath education and physical activity programs to improve health.	
GEOGRAPHIC IMPACT:	Detailed obesity rates were not available at less than county level. At the county level, obesity rates were lower in wealthy counties and in the core counties with more active transportation and transit options. Childhood obesity data were not available for the region. Statewide, childhood obesity rates are very high but starting to decline.	

Healthy Eating/Active Living (HE/AL)		
RATIONALE	**HEALTH OUTCOMES INDICATORS [Report Area (Range) // Georgia / National]**	**CONTRIBUTING FACTORS INDICATORS [Report Area (Range) // Georgia / National]**
A healthful diet and adequate physical activity are considered two of the most important determinants of many leading causes of morbidity and mortality, including many heart disorders, cancers, mental wellness, diabetes, and much more. They contribute to a number of the other priority health needs in the CHNA region. There was wide variation in diet quality and active living. Wealthier areas generally had higher access to food retailers and places to exercise, and also demonstrated higher rates of fruit and vegetable consumption and physical activity; more economically distressed areas fared poorly in these measures. The most central parts of the region had access to more supportive physical environments, followed by town centers and older suburbs.	Inadequate Fruit & Vegetable Consumption [74.1% (68.6%-92.2%) // 75.7% / 75.7%] Travel to work by transit, walk, or bicycle [4.0% (0.6%-14.2%) // 3.9% / N/A] Physically Inactive Adults [22.2% (18.5%-31.1%) // 24.5% / 22.6%] Poor physical health days [3.0 (2.0-5.4) // 3.5 / 3.9] Poor mental health days [3.1 (2.5-4.6) // 3.3 / 3.5] Mental Health ER Rate [894.5 (392.2-2165.2) // 1007.2 / N/A] See below for related health outcomes: cardiovascular diseases, cancers, diabetes	% Commute over 60 Minutes [11.2% (5.0%-21.1%) // 9.0% / 8.1%] Network density [4.6 // 2.6 / 1.5] Transit within 1/2 mile [6.5% (0.0%-25.6%) // 3.8% / 8.1%] % with Access to Exercise Facilities [69.3% (12.6%-95.4%) // 75.4% / N/A] % Households Receiving SNAP [13.1% (5.2%-28.8%) // 15.2% / 13.0%] *By race/ethnicity: non-Hispanic White=6.3%; Black=23.2%; Hispanic=21.0%* Food insecure households [16.1% (8.5%-22.8%) // 18.7% / 15.2%] Population with low food access [36.5% (0.0%-54.4%) // 31.5% / 23.6%] WIC stores per 100,000 [16.2 (5.6-34.9) // 17.9 / 15.6] SNAP food stores per 100,000 [83.2 (56.9-145.5) // 102.1 / 78.4]
PRIMARY DATA:	The community expressed concern over cost of healthy foods, lack of grocery stores, lack of safe places to walk or bike, inadequacy of SNAP benefits, and lack of time to be healthy due to long working hours and logistics. They expressed that it was much harder for lower income families to stay healthy.	
GEOGRAPHIC IMPACT:	Residents of the core counties generally live more active lives than those in exurban or rural counties. Access to places to be physically active was available at a higher rate in high income areas. Fruit and vegetable consumption were higher in areas with higher income and with a larger share of Hispanic residents. The region contains many food deserts. [See maps]	

Access to Primary & Mental Health Care		
RATIONALE	**HEALTH OUTCOMES INDICATORS [Report Area (Range) // Georgia / National]**	**CONTRIBUTING FACTORS INDICATORS [Report Area (Range) // Georgia / National]**
The supply, cost, and availability of services is correlated with usage. In particular, routine use of primary care and mental health services can contribute to disease management and prevent health crises. It also plays an essential role in prevention such as immunization and screening. In the CHNA region, mental health needs are one of the leading causes of hospital and ER utilization, suggesting inadequate community-based services. The supply of primary care is not evenly dispersed around the region. It is above benchmark levels in wealthier areas while there is a shortage in areas with lower levels of employment, income, and insurance coverage. Health insurance status is another important factor, as well as the overall household budget. Mental health services are generally adequate but may be more cost prohibitive due to insurance restrictions.	<u>Providers</u> Primary Care Provider Rate [66.1 (11.2-113.0) // 63.6 / 74.5] Dental Provider Rate [49.7 (0.0-90.4) // 47.6 / 63.2] Mental Health Provider Rate [126.2 (7.1-273.0) // 109.5 / 134.1] % of Adults with No Regular Doctor [25.8% (5.7%-40.8%) // 26.1% / 22.1%] % Population in Health Professional Shortage Area [14.7% (0%-100%) // 34.6% / 34.1%] Preventable hospitalization Rate [52.1 (36.7-81.7) // 60.6 / 59.2] Years of Potential Life Lost (YPLL75) Rate [6282.4 (4044.1-11460.5) // 7415.5 / 6851] Missed medical care due to cost [15.6% (7.1%-23.8%) // 15.9% / N/A] Mental Health ER Rate [894.5 (392.2-2165.2) // 1007.2 / N/A]	<u>Uninsurance</u> Total Population [18.1% (9.7%-26.7%) // 18.3% / 14.2%] Adult 18-64 [25.8% (16.3%-33.7%) // 25.8% / 20.4%] Children [10.5% (8.0%-12.5%) // 10.0% / 7.5%] Medicaid Enrollees [17.7% (7.7%-33.8%) // 20.6% / 20.8%] Federally Qualified Health Center Rate [0.93 (0-9.09) // 1.53 / 1.92] Housing cost burdened households [36.0% (24.1%-43.6%) // 34.8% / 34.9%] Transit within 1/2 mile [6.5% (0.0%-25.6%) // 3.8% / 8.1%] Households without motor vehicle access [6.2% (2.4%-12.0%) // 6.8% / 9.1%] Ratio of average medical spending : household income [18.4% (10.6%-27.4%) // 20.0% / N/A]
PRIMARY DATA:	There are barriers to care due to cost, transportation and differential treatment. Both public health practitioners and other key informants as well as community stakeholders reported that many residents were challenged to find regular access to quality care particularly primary care and mental health services. The major challenges referenced were - not having any or enough health insurance, not enough doctors or access to care after work hours, no access to transportation, especially in rural parts of the county and insufficient providers who are culturally and linguistically competent.	

GEOGRAPHIC IMPACT:	Viewed against other sociodemographic indicators, insurance status seems to be a function of educational attainment and age. Private insurance rates are high in areas with high educational attainment, mainly a wedge that extends north from the city of Atlanta into neighboring counties, plus several suburban counties. Adult uninsurance in high outside of these areas. Public insurance rates are higher where more of the population is over 65 or under 18. Primary, mental health, and dental care providers are present at much higher rates in high socioeconomic areas.

Obstructive & hypertensive cardiovascular disease		
RATIONALE	**HEALTH OUTCOMES INDICATORS [Report Area (Range) // Georgia / National]**	**CONTRIBUTING FACTORS INDICATORS [Report Area (Range) // Georgia / National]**
Obstructive heart and vascular diseases, including heart attack, congestive heart failure, and stroke, are a predominant cause of morbidity and mortality. High blood pressure and hypertensive heart diseases contribute to a lower rate of medical attention but are still prominent. Obstructive disorders tend to be more prevalent in White individuals, while hypertensive disorders are much more prevalent for Black individuals. They both have similar contributing factors, namely diet, physical activity, and tobacco use. Fine particulate matter is also an important factor in obstructive diseases. In the CHNA region, the distribution of cardiovascular diseases tracks closely with the racial distribution of the population, as well as age distribution. Lower income, non-immigrant, older, lower-resourced, low population density, and geographically isolated areas tend to show higher rates.	Hypertension / hypertensive heart disease hospital discharge [81.4 (24.2-130.7) // 87.0 / N/A] *By racial identity: White=35.7; Black=196.1* Unmanaged hypertension [16.9% // 19.8% / 21.7%] Obstructive heart disease/heart attack hospital discharge [313.5 (233.8-710.7) // 344.2 / N/A] *By racial identity: White=320.8; Black=284.3* Ischemic heart disease mortality [67.9 // 85.9 / 109.5] Stroke mortality [40.1 // 43.7 / 37.9]	Crude smoking rate [15.0% (10.8%-29.0%) // 18.1% / 17.8%] Attempted to quit smoking [65.3% (14.4%-91.5%) // 61.1% / 60.0%] Air quality - Fine particulate matter [2.9% // 2.3% / 1.2%] Also see HE/AL, obesity
PRIMARY DATA:	Stakeholders generally ranked heart attacks, hypertension and stroke as high level concerns linked to cultural habits and behaviors around nutrition, food preparation and physical activity. Some shared their own personal experiences as survivors of heart attacks and strokes and challenges they were facing affording medications and other life stressors.	

GEOGRAPHIC IMPACT:	Obstructive heart disease is most prevalent in the western edge of the region, followed by the outer southeastern edges, even among younger adults. By contrast, hypertensive disorders are most prevalent in the inner southern crescent comprising south-central Fulton County, south DeKalb County, and large portions of Clayton and Rockdale counties. Meriwether and Troup also have elevated hypertensive numbers.

Educational Attainment		
RATIONALE	**HEALTH OUTCOMES INDICATORS [Report Area (Range) // Georgia / National]**	**CONTRIBUTING FACTORS INDICATORS [Report Area (Range) // Georgia / National]**
Educational attainment is one of the	Lack of high school degree or equivalent (25+)	Asthma ER Visit Rate

strongest predictors of life expectancy and lifetime health status. Educational opportunity begins at or even before birth, as children are exposed to varying social and physical environments that support or inhibit their development. College/career preparedness is heavily determined by accomplishments in school from K-12, which is strongly influenced by educational quality, enrichment, and community support, as well as the development of social/emotional and pre-learning skills before entering kindergarten. In the CHNA region, there is wide variation in educational attainment. School quality is not evenly distributed. However, many of the educational outcome inequities are based in early childhood and extracurricular experiences due to economic instabilities that contribute to traumatic childhood experiences and barriers to parent involvement - for instance, parents who work multiple jobs, extremely long travel times to work, parents who are absent due to illness or violence, or loss of housing.	[12.4% (6.3%-28.0%) // 15.0% / 13.7%] High school graduation rate (4 year) [74.8% (60.0%-91.9%) // 74.8% 84.3%] Attended college [65.7% (34.4%-76.3%) // 60.8% / N/A] Children in preschool/pre-K (3-4) [52.8% // 49.8% / 47.7%] Reading below proficiency [36.4% (1.8%-20.6%) // 12.0% / 27.1%] Head Start facilities rate [2.6 // 4.3 / 7.6] Teen birth rate (10-19) [11.8 (3.3-37.5) // 15.2 / N/A]	[551.7 (185.1-807.7) // 560.0 / N/A] Vacant homes [11.7% (6.7%-19.5%) // 14.0% / 12.5%] Single parent homes [34.1% (14.6%-49.8%) // 37.0% / N/A] Housing cost burdened households [36.0% (24.1%-43.6%) // 34.8% / 34.9%] % Commute over 60 Minutes [11.2% (5.0%-21.1%) // 9.0% / 8.1%] Linguistically isolated households [4.6% (0.0%-8.8%) // 3.4% / 4.7%]
PRIMARY DATA:	Participants express concern about current opportunities and health literacy for under-educated adults, as well as the future implications of today's low graduation rates and academic performance.	

GEOGRAPHIC IMPACT:	In some areas, low educational levels are primarily due to foreign immigration, which helps protect against their effect on community and future generations. These are mainly clustered in parts of Cobb, north central Fulton, northwest DeKalb, Hall, and Clarke counties, with a few other small clusters scattered around the region. In other areas however, it indicates systemic failures in the early learning, public school, and college/career pipeline. These are primarily found in south DeKalb, Fulton, Clayton, and Spalding counties, and a number of the smaller rural counties.

Cancers		
RATIONALE	**HEALTH OUTCOMES INDICATORS [Report Area (Range) // Georgia / National]**	**CONTRIBUTING FACTORS INDICATORS [Report Area (Range) // Georgia / National]**

Taken together, cancers are one of the leading causes of death. However, each type of cancer has somewhat different causes and risk factors. Additionally, some cancers are more conducive to prevention or screening. Considerations for cancer prevalence and mortality rates include healthy living (nutrition, physical activity, substance use), environmental exposures, screening rates, and certain protective factors such as breastfeeding or HPV vaccination. In the CHNA region, there is moderate variation in the total cancer mortality burden. However, within key types of cancer, there are larger differences. In particular, where screening rates are low, prevalence can also be low but mortality rates are often higher. Tobacco use, diet, physical activity, vaccinations, and environmental exposures contribute to some variation as well.	Cancer mortality, age adjusted [161.4 (129.2-237.1) // 171.3 / 168.9] *Incidence by type* Breast [128.3 // 123.5 / 123.0] Cervical [7.5 // 8.0 / 7.7] Colorectal [41.7 // 42.3 / 41.9] Lung [63.9 // 65.8 / 63.7] Prostate [159.2 // 150.1 / 131.7]	Inadequate Fruit & Vegetable Consumption [74.1% (68.6%-92.2%) // 75.7% / 75.7%] Travel to work by transit, walk, or bicycle [4.0% (0.6%-14.2%) // 3.9% / N/A] Physically Inactive Adults [22.2% (18.5%-31.1%) // 24.5% / 22.6%] Crude smoking rate [15.0% (10.8%-29.0%) // 18.1% / 17.8%] Attempted to quit smoking [65.3% (14.4%-91.5%) // 61.1% / 60.0%] Air quality - Fine particulate matter [2.9% // 2.3% / 1.2%] Air quality - ozone [0.33% // 0.20% / 0.47%] Alcohol - excessive consumption [14.5% // 13.7% / 16.9%] *Screening by type* Mammogram (Medicare) [62.0% (44.0%-72.5%) // 61.6% / 63.0%] Pap [84.6% (54.1%-93.8%) // 82.7% / 78.5%] Colorectal [65.7% (55.2%-74.3% // 62.4% / 61.3%]
PRIMARY DATA:	Some stakeholders linked cancers to poor nutrition and exposure to environmental hazards, including tobacco, in their community. There was also some concern about not having enough access to screening services, care and support services.	
GEOGRAPHIC IMPACT:	The wealthier and the more populous counties have higher screening rates for several types of cancers. They also report higher breast cancer incidence rates. Colorectal cancer incidence rates appear higher in the most economically distressed counties. Cervical cancer was more prevalent in high-disparity areas. Lung cancer incidence had the highest rates in outlying counties, especially those with low economic resources.	

HIV/AIDS		
RATIONALE	**HEALTH OUTCOMES INDICATORS [Report Area (Range) // Georgia / National]**	**CONTRIBUTING FACTORS INDICATORS [Report Area (Range) // Georgia / National]**
As an infectious disease, HIV/AIDS	HIV Prevalence	Never tested for HIV

can present a serious health risk to the population. Treatment options have shifted the disease to have more similarities to a chronic, rather than acute, condition. However, like many of the other priority conditions, it contributes a heavy yet mostly preventable burden of disease. There are enormous differences in the distribution of HIV prevalence by geography, age, sex, and racial/ethnic identity in the CHNA region. Most notably, HIV prevalence is nearly five times higher for non-Hispanic Black residents of the region than for non-Hispanic White residents.	[493.7 (25.2-1307.3) // 481.8 / 353.2] Chlamydia prevalence [488.8 (94.0-724.1) // 534.0 / 456.7]	[53.8% (36.1%-92.0%) // 55.1% / 62.8%] Overcrowded housing [4.0% (1.0%-19.6%) // 3.8% / 4.3%] Vacant homes [11.7% (6.7%-19.5%) // 14.0% / 12.5%] Alcohol - excessive consumption [14.5% // 13.7% / 16.9%] Traffic crashes involving alcohol [22.8% (6.3%-35.7%) // 23.7% / N/A] Drug overdose ER visit [38.5 (17.8-96.2) // 39.9 / N/A] Transit within 1/2 mile [6.5% (0.0%-25.6%) // 3.8% / 8.1%] Housing cost burdened households [36.0% (24.1%-43.6%) // 34.8% / 34.9%]
PRIMARY DATA:	Public health practitioners in Fulton, DeKalb and Cobb county regarded infectious disease as an ongoing concern. While HIV was a predominant part of the discussion, chlamydia and other sexually transmitted infections were also seen to be an issue in those communities. Community stakeholders linked these outcomes with a perception of increased sexual promiscuity in youth which was also seen to be driving increased numbers of teen pregnancies in some communities.	
GEOGRAPHIC IMPACT:	Several counties in the region have some of the highest HIV incidence rates in the entire US. This includes Fulton and DeKalb, but also Butts. A few other counties have elevated rates but still much lower.	

Diabetes		
RATIONALE	**HEALTH OUTCOMES INDICATORS [Report Area (Range) // Georgia / National]**	**CONTRIBUTING FACTORS INDICATORS [Report Area (Range) // Georgia / National]**
Type II Diabetes is another outcome	Diabetes Prevalence	Diabetes management test (Medicare)

from diet quality and physical activity levels, as well as certain other risk factors including genetics, depression, and others. It can lead to severe complications, such as amputations, loss of eyesight, and organ damage or failure. Thus, there are disease management, disability, and mortality implications. In the CHNA region, diabetes tends to track with economic disadvantage, rurality, and non-immigrant status.	*General population* [9.9% (8.6%-12.8%) // 10.5% / 9.1%] Medicare enrollees [26.0% (22.6%-31.9%) // 27.7% / 27.0%] Diabetes ER visit rate [209.7 (96.9-519.4) // 251.1 / N/A]	[85.6% (78.1%-90.5%) // 84.7% / 84.6%] See also HE/AL, obesity
PRIMARY DATA:	Some respondents reported that there has been ongoing efforts to increase awareness and focus on disease management programs in many parts of the region. Many of the focus group participants linked nutrition and access to care as part of the contributing factors to instances of uncontrolled diabetes in the community.	
GEOGRAPHIC IMPACT:	Diabetes appears somewhat more prevalent in the inner southern crescent (Fulton, DeKalb, Clayton, Rockdale), and secondarily in most lower-income suburban and rural areas.	

Poverty		
RATIONALE	**HEALTH OUTCOMES INDICATORS [Report Area (Range) // Georgia / National]**	**CONTRIBUTING FACTORS INDICATORS [Report Area (Range) // Georgia / National]**

Poverty refers to household income level relative to the household size, but can include many contributors, such as unemployment or underemployment, cost of living burdens, low wage employment options, lack of assets, and barriers to employment such as spatial mismatch, inadequate transportation options, convictions or credit history, or low educational attainment. Neighborhoods with a very high percentage of poor households are likely to experience disinvestment by businesses, property owners, and community assets, leading to further distress and lack of opportunity. The effects of poverty can be greatly alleviated through policies that make housing, food, and transportation more affordable and accessible. Poverty is a serious issue in the CHNA region. There are insufficient resources to help poor families get ahead. Additionally, poverty is not evenly distributed, which results in extreme variation between concentrated areas of well-resourced high-amenity communities and areas without access to amenities.	Population under 100% federal poverty level [16.1% (7.1%-35.7%) // 18.5% / 15.6%] Population under 200% federal poverty level [34.9% (18.3%-54.9%) // 39.1% / 34.5%] Children in poverty [22.5% (7.8%-37.4%) // 25.9% / 21.9%) *Non-Hispanic White* [9.7% (4.7%-39.6%) // 13.6% / 13.0%] Black [29.7% (5.8%-52.0%) // 36.7% / 38.2%] *Hispanic* [40.5% (2.8%-54.9%) // 41.6% / 32.4%] Children eligible for free and reduced lunch [56.6% (18.7%-99.6%) // 62.1% / 52.4%] Food insecure households [16.1% (8.5%-22.8%) // 18.7% / 15.2%] Housing cost burdened households [36.0% (24.1%-43.6%) // 34.8% / 34.9%] Uninsurance *Total Population* [18.1% (9.3%-26.7%) // 18.3% / 14.2%] *Adult 18-64* [25.8% (16.3%-33.7%) // 25.8% / 20.4%] *Children* [10.5% (8.0%-13.4%) // 10.0% / 7.5%] Infant mortality [6.0 (3.6-9.2) // 6.9 / 6.5] *By race/ethnicity: non-Hispanic White=4.9; Black=10.0; Hispanic=3.9* Robbery [149.2 (5.6-349.0) // 126.8 / 116.4]	Unemployment Rate 2015 [5.9% (4.4%-8.3%) // 6.3% / 5.4%] *By race/ethnicity 2009-13: all=11.3%; non-Hispanic White=8.4%; Black=17.0%; Hispanic=10.6%* Single parent homes [34.1% (14.6%-49.8%) // 37.0% / N/A] % Commute over 60 Minutes [11.2% (5.0%-21.1%) // 9.0% / 8.1%] Transit within 1/2 mile [6.5% (0.0%-25.6%) // 3.8% / 8.1%] Households without motor vehicle access [6.2% (2.4%-12.0%) // 6.9% / 9.1%] Linguistically isolated households [4.6% (0.0%-8.8%) // 3.4% / 4.7%] Racial/ethnic spatial distribution gap [47.7% (1.2%-95.7%) // N/A / N/A] Population with a disability [9.8% (7.2%-22.4%) // 12.1% / 12.3%] Lack of high school degree or equivalent (25+) [12.4% (6.3%-28.0%) // 15.0% / 13.7%] Assisted housing [311.4 // 349.9 / 384.3] % Households Receiving SNAP [13.1% (5.2%-28.8%) // 15.2% / 13.0%]
PRIMARY DATA:	Participants identified lack of money as a critical health issue. Either families couldn't afford basic health-supportive purchases such as food, medicine, safe housing, and transportation, or they worked too many hours in order to pay for such needs which left insufficient time to engage in healthy behaviors; even with	

	overworking, many health needs were still unaffordable.
GEOGRAPHIC IMPACT:	Some poverty is present everywhere in the region. However, it is particularly concentrated, again, in the inner southern crescent, and in several character areas around the region: disinvested town centers, low amenity suburban counties, low amenity rural counties, and rapidly growing immigrant areas. Relative to non-Hispanic White children, Black children in the region are nearly 3 times more likely to live in poverty; this rate is elevated for all other racial identities as well. The disparity is less stark for adults.

Mental Health

RATIONALE	HEALTH OUTCOMES INDICATORS [Report Area (Range) // Georgia / National]	CONTRIBUTING FACTORS INDICATORS [Report Area (Range) // Georgia / National]
Mental wellbeing can be affected by biological, social/ emotional, sensory, and environmental factors. Stress, lack of social/emotional capacity, and exposure to contaminants can be greatly influenced by living conditions. Mental health is an important element that allows individuals to maintain their physical health and productivity. In the CHNA region, mental health needs are one of the leading causes of hospital and ER utilization. Additionally, there are many risk factors present such as economic stressors, exposure to traumatic events, and social isolation that may contribute to poor mental health.	Poor mental health days [3.1 (2.5-4.6) // 3.3 / 3.5] Mental Health ER Visit Rate [894.5 (392.2-2165.2) // 1007.2 / N/A] Mental Health Hospital Discharge Rage [548.0 (342.3-877.2) // 546.4 / N/A] Self-Harm ER Visit Rate [60.2 (40.5-175.5) // 62.9 / N/A] Assault ER Visit Rate [227.5 (73.8-599.3) // 264.1 / N/A] Legal intervention ER Visit Rate [8.8 (0.0-18.7) // 8.3 / N/A]	Mental Health Provider Rate [46.7 (7.1-273.0) // 109.5 / 134.1] Unemployment Rate 2015 [5.9% (4.4%-8.3%) // 6.3% / 5.4%] *By race/ethnicity 2009-13: all=11.3%; non-Hispanic White=8.4%; Black=17.0%; Hispanic=10.6%* Single parent homes [34.1% (14.6%-49.8%) // 37.0% / N/A] Transit within 1/2 mile [6.5% (0.0%-25.6%) // 3.8% / 8.1%] Linguistically isolated households [4.6% (0.0%-8.8%) // 3.4% / 4.7%] Overcrowded housing [4.0% (1.0%-19.6%) // 3.8% / 4.3%] Vacant homes [11.7% (6.7%-19.5%) // 14.0% / 12.5%] Alcohol - excessive consumption [14.5% // 13.7% / 16.9%] Travel to work by transit, walk, or bicycle [4.0% (0.6%-14.2%) // 3.9% / N/A] Physically Inactive Adults [22.2% (18.5%-31.1%) // 24.5% / 22.6%] Tree cover [58.9% (46.5%-75.1%) // 58.9% / 24.7%] Social associations [9.0 (4.6-14.6) // 9.0 / N/A] Assisted housing [311.4 // 349.9 / 384.3] Lack of Social or Emotional Support [19.4% (11.6%-31.6%) // 20.7% / 20.7%]

PRIMARY DATA:	Mental health is an increasing concern in the region. Some felt that substance abuse and depression was on the rise as people including youth attempted to cope with stress in their lives. Additionally most did not think that there was sufficient mental health providers in their community.
GEOGRAPHIC IMPACT:	Violence is more prevalent in impoverished central areas, while self-harm and drug use are a larger issue in wealthy and outlying areas. ER utilization for mental health needs is high in most parts of the region, except for a few areas with high mental health resources such as providers and higher income.

Transportation		
RATIONALE	**HEALTH OUTCOMES INDICATORS [Report Area (Range) // Georgia / National]**	**CONTRIBUTING FACTORS INDICATORS [Report Area (Range) // Georgia / National]**
Transportation is a key component to accessing the essentials of a healthy life, such as access to employment opportunities, social enrichment, greenspace, medical care, food and other daily needs, and much more. Private automobile travel is expensive, and also associated with reduced physical activity, reduced social interaction, and increased injuries and air pollution. In the CHNA region, there is very limited access to daily essentials without a private automobile. However, automobile ownership is expensive, imposing a major burden on lower income households in either cost or access. Additionally, there are long travel distances to amenities, associated with longer driving trips.	% Commute over 60 Minutes [11.2% (5.0%-21.1%) // 9.0% / 8.1%] Households without motor vehicle access [6.2% (2.4%-12.0%) // 6.9% / 9.1%] Racial/ethnic spatial distribution gap [47.7% (1.2%-95.7%) // N/A / N/A] Travel to work by transit, walk, or bicycle [4.0% (0.6%-14.2%) // 3.9% / N/A] Pedestrian fatality rate [1.7 (0.0-5.5) // 1.8 / 1.7]	Transit within 1/2 mile [6.5% (0.0%-25.6%) // 3.8% / 8.1%] Population density per square mile [618.6 (<51->5000) // 172.3 / 89.9] Network density [4.6 (1.0-39.0) // 2.6 / 1.5] Transit within 1/2 mile [6.4% // 3.8% / 8.1%] Access to Exercise Facilities (1/2,1, 3 mile radii) [69.3% (12.6%-95.4%) // 75.4% / N/A] Population with low food access [36.5% (0.0%-54.4%) // 31.5% / 23.6%]
PRIMARY DATA:	At almost every focus group or listening session, participants, especially those in lower income communities, described difficulties in getting around their community to find healthy foods, recreational spaces and/or care.	
GEOGRAPHIC IMPACT:	The metro Atlanta community in general has limited public transportation options and this issue is common across the service area. More urban counties are less affected though in some areas where low income and minority populations are isolated, transportation to care can be a challenge.	