2019 Community Health Needs Assessment

Kaiser Foundation Health Plan Georgia

Approved by Kaiser Foundation Hospitals Board of Director's Community Health Committee

September 16, 2019

KAISER PERMANENTE®

Kaiser Permanente Georgia Region Community Benefit

CHNA Report for Kaiser Permanente Georgia

Contents

I. Introduction/background

A. 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. We were 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. Among the innovations Kaiser Permanente has brought to U.S. health care are:

- Prepaid health plans, which spread the cost to make it more affordable
- A focus on preventing illness and disease as much as on caring for the sick
- An organized, coordinated system that puts as many services as possible under one roof—all connected by an electronic medical record

Kaiser Permanente is an integrated 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 more than 12 million members in nine 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.

B. About Kaiser Permanente Community Health

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. Good health for the entire community requires equity and social and economic well-being. These are the vital signs of healthy communities.

Better health outcomes begin where health starts, in our communities. 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. Our community health strategy focuses on three areas:

- Ensuring health access by providing individuals served at KP or by our safety net partners with integrated clinical and social services;

- Improving conditions for health and equity by engaging members, communities, and Kaiser Permanente's workforce and assets; and
- Advancing the future of community health by innovating with technology and social solutions.

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. And we've 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 strong relationships we have with other organizations that are working to improve community health.

C. 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). The required written IS plan is set forth in a separate written document. Both the CHNA Report and the IS for each Kaiser Foundation Hospital facility are available publicly at https://www.kp.org/chna.

D. 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 whenever possible, 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 120 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 constitutes a health need in their community. Once all the community health needs were identified, they were prioritized, based on identified 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 conjunction with this report, Kaiser Permanente Georgia (KPGA) will develop an implementation strategy for the priority health needs the hospital will address. 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. Both the CHNA and the Implementation Strategy, once they are finalized, will be posted publicly on our website, https://www.kp.org/chna.

II. Community served

A. Kaiser Permanente's definition of community served

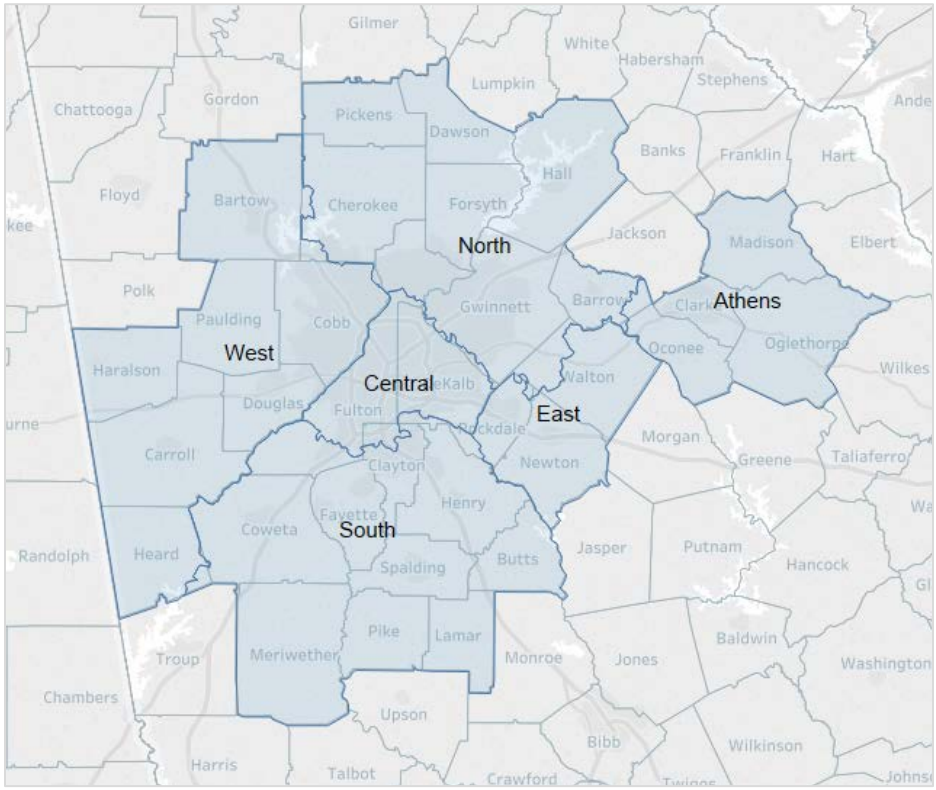
Kaiser Permanente defines the community served as those individuals residing within its service area. A service area includes all residents in a defined geographic area surrounding its medical facilities and does not exclude low-income or underserved populations.

Kaiser Permanente Georgia (KPGA) region does not operate a hospital, but there are 28 medical facilities scattered across the region.

B. Map and description of community served

i. Map

KPGA Service Area



ii. Geographic description of the community served

The KPGA service region is geographically comprised of 31 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.

iii. Demographic profile of the 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.

The population in the region has increased since 2016 and is expected to grow faster than the national average over the next five years, with 25 counties increasing in total population by 4.0% to 10.3%.

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. Accordingly, county-level data, especially in more urban and diverse counties, do not necessarily represent the nuanced picture of health for all county residents.

Demographic profile: KPGA

Race/ethnicity		**Socioeconomic data**	
Total Population	5,971,911	Living in poverty (<100% federal poverty level)	15.3%
Race		Children in poverty	21.9%
Asian	5.3%	Unemployment	4.2%
Black	32.2%	Adults with no high school diploma	11.9%
Native American/Alaska Native	0.3%		
Pacific Islander/Native Hawaiian	0.0%		
Some other race	3.3%		
Multiple races	2.3%		
White	56.5%		
Ethnicity			
Hispanic	21.3%		
Non-Hispanic	78.7%		

III. Who was involved in the assessment?

A. Identity of hospitals and other partner organizations that collaborated on the assessment

The 2019 Community Health Needs Assessment was a joint undertaking of KFHP and two other health systems in the metro Atlanta area that are part of the Atlanta Regional Collaborative for Health Improvement – Grady Health System and Wellstar Health System. This collaboration

allowed for more in-depth primary data collection through additional interviews and focus groups.

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

B. 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. Led by Dr. Chris Parker, GHPC Associate Project Director, the GHPC team members bring expertise in health impact assessments, built environment analysis, health disparities, health system evaluation, obesity, physical activity and nutrition interventions, epidemiology, and geographical information systems.

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. Also assisting with the focus group arrangements were Ms. Sacha Gayle and Ms. Torrian Percy who helped to secure locations, arrange catering, and complete recording and transcription of the groups' comments.

IV. Process and methods used to conduct the CHNA

A. Secondary data

i. Sources and dates of secondary data used in the assessment

KPGA used the Kaiser Permanente CHNA Data Platform (http://www.chna.org/kp) to review 120 indicators from publicly available data sources.

KPGA also used additional data sources beyond those included in the CHNA Data Platform.

For details on specific sources and dates of the data used, please see Appendix A.

ii. Methodology for collection, interpretation, and analysis of secondary data

Kaiser Permanente's CHNA Data Platform is a web-based resource provided to our communities as a way to support community health needs assessments and community collaboration. This platform includes a focused set of community health indicators that allow users to understand what is driving health outcomes in particular neighborhoods. The platform provides the capacity to view, map and analyze these indicators as well as understand racial/ethnic disparities and compare local indicators with state and national benchmarks.

As described in section IV.A.i above, KPGA also leveraged additional data sources beyond those included in the CHNA Data Platform. Supplementary data were obtained from:

- Truven Health Analytics' 2018 Community Need Index (CNI) is a national ZIP code-level measure of the socio-economic barriers to accessing healthcare (poverty, culture, education, insurance, and housing). Data sources include:
    - 2018 Demographic Data, The Nielsen Company
    - 2018 Poverty Data, The Nielsen Company
    - 2018 Insurance Coverage Estimates, Truven Health Analytics;
- Georgia Department of Public Health Online Analytical and Statistical Information System (OASIS);

- US Census Bureau American Community Survey 5-Year Dataset (census.gov); and
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas (www.cdc.gov/NCHHSTP/Atlas/).

B. Community input

i. Description of who was consulted

Community input was provided by a broad range of community members using key informant interviews, focus groups, and/or surveys. Individuals with the knowledge, information, and expertise relevant to the health needs of the community were consulted. These individuals included representatives from state, local, tribal, or other regional governmental public health departments (or equivalent department or agency) as well as leaders, representatives, or 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.

ii. Methodology for collection and interpretation

Key informant interviews: Individual key informant interviews were conducted with 51 community leaders. Community leaders were volunteers, recruited by email, and interviewed over the phone. Interviews lasted approximately 45 minutes. Community leaders who were asked to participate in the interview process encompassed a wide variety of professional backgrounds, including (1) public health expertise, (2) professionals with access to community health-related data, and (3) representatives of under-resourced populations. The interviews offered community leaders an opportunity to provide feedback on the needs of the community, secondary data resources, and other information relevant to this assessment. Community leaders were asked what they thought had improved, remained unchanged, or declined in the health status of their community over the past three years. Leaders were also asked to prioritize the health challenges in their communities and describe their causes.

Resident Focus Groups: Twelve focus groups were conducted to gather input from more than 100 residents living and working in the communities served by KPGA. Focus group participants were asked to discuss their opinions related to the health status and outcomes; context, facilitating, and blocking factors of health; what is needed to be healthier in their communities, and what leads their community to be healthy or unhealthy. Focus groups lasted approximately 1.5 hours, during which time trained facilitators led 6-12 participants through a discussion about the health of their communities, health needs, resources available to meet health needs, and recommendations to address health needs in their communities. All participants were offered appropriate compensation ($50) and refreshments for their time.

Focus groups and key informant interviews were recorded and transcribed with the informed consent of all participants. The Georgia Health Policy Center analyzed and summarized data from the interviews and focus groups using emergent methods to determine similarities and differences across populations related to the collective experience of healthcare, health needs, and recommendations, and included this information in the health needs profiles found in Appendix C of this report. A list of participants can be found in Appendix B.

Community input influenced the CHNA report in a variety of ways.

- During focus groups, residents were offered a dashboard of common data points and asked to provide their thoughts about the root causes for data points that were higher than state and national benchmarks. Residents offered insight into several of the local factors driving higher rates in their communities.
- Focus group participants and community leaders were able to validate the severity of health needs in their communities, as well as offer insight into the specific populations and geographic areas that experience disparities and inequities relating to specific health needs.
- Community leaders were able to offer a prioritized list of the top three health needs in the communities they serve, which informed the initial prioritization of health needs.
- The final list of community health needs was ranked in order of priority using a facilitated approach to the presentation of primary and secondary data along with a group application of the Hanlon Method for Prioritizing Health Problems.[1]

C. Written comments

KP provided the public an opportunity to submit written comments on the facility's previous CHNA Report through CHNA-communications@kp.org. This email will continue to allow for written community input on the facility's most recently conducted CHNA Report.

As of the time of this CHNA report development, KPGA 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.

D. Data limitations and information gaps

The KP CHNA data platform includes approximately 120 secondary indicators that provide timely, comprehensive data to identify the broad health needs faced by a community. However, there are some limitations with regard to these data, as is true with any secondary data. Some data were only available at a county level, making an assessment of health needs at a neighborhood level challenging. Furthermore, disaggregated data around age, ethnicity, race, and gender are not available for all data indicators, which limited the ability to examine disparities of health within the community. Lastly, data are not always collected on a yearly basis, meaning that some data are several years old.

Truven Health Analytics' 2018 Community Need Index (CNI) scores are not calculated for non-populated ZIP codes. These include such areas as national parks, public spaces, post office boxes, and large unoccupied buildings. Additionally, CNI scores for ZIP codes with small populations (especially less than 100 people) may be less accurate. This is due to the fact that the sample of respondents to the 2010 Census is too small to provide accurate statistics for such ZIP codes. This issue is mitigated by either eliminating such ZIP codes from analysis completely or by making sure that low population ZIP codes are combined with other surrounding high population ZIP codes using a weighted average technique.

[1] The Hanlon Method for Prioritizing Health Problems requires a consideration of baseline data and uses a quantitative approach to ranking health needs based on the severity, magnitude, and ability to influence the health need.

Georgia Department of Public Health Online Analytical and Statistical Information System (OASIS): Due to ICD10-CM coding rules being more widely adopted, there are some significant changes in certain disease categories. In Hospital Discharge data, Bacterial Pneumonia doubled, while Hypertension, Iron Deficiency Anemia, and Kidney/Urinary Infection show sharp decreases. In ER data, even though overall Diabetes counts remained in trend, Diabetes Mellitus without Mention of Complications or Unspecified Hypoglycemia shows a very sharp decrease, while Diabetes with Other Specified or Unspecified Complications doubles.

Primary data are collected from individuals and groups of residents. While valuable to understanding the needs of a given community, the data collected is anecdotal, based on personal experiences and limited by vocabulary, education, and personal perspective.

V. Identification and prioritization of the community's health needs

A. Identifying community health needs

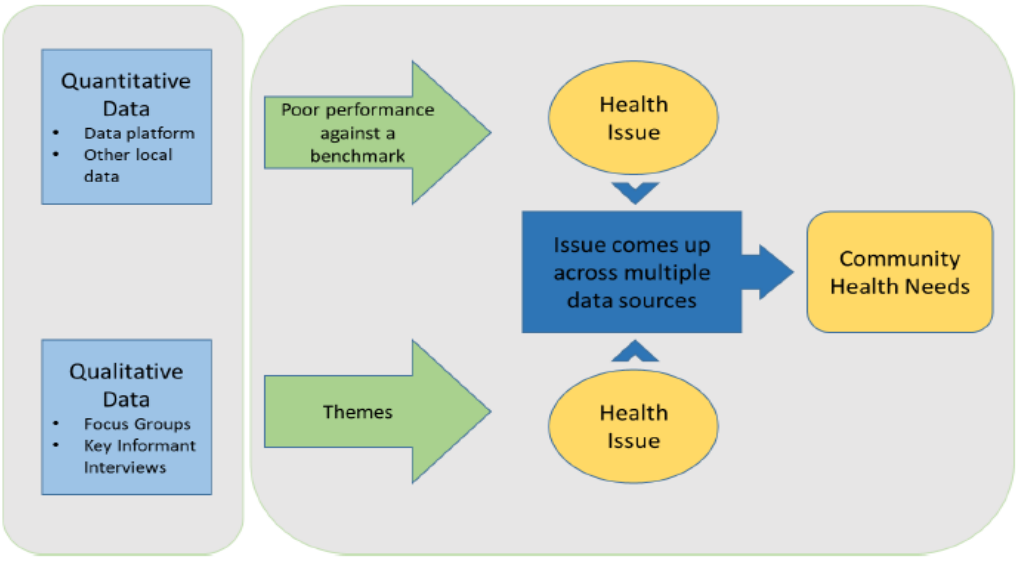
i. Definition of "health need"

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.

ii. Criteria and analytical methods used to identify the community health needs

To surface the community's health needs, KPGA analyzed secondary data on health indicators from the KP Data Platform and other supplemental data sources and gathered community input through interviews and focus groups. Health needs were surfaced if 1) the issue fit the KP definition of a "health need" and 2) the issue was confirmed by at least two of the three data collection methods (key informant interviews, focus groups, or secondary data).

Developing Health Needs



B. Process and criteria used for prioritization of health needs

Required criteria:

Before beginning the prioritization process, KPGA chose a set of criteria to use in prioritizing the list of health needs. The criteria were:

- **Severity of need:** This refers to how severe the health need is (such as its potential to cause death or disability) and its degree of poor performance against the relevant benchmark.
- **Magnitude/scale of the need:** The magnitude refers to the number of people affected by the health need.
- **Clear disparities or inequities:** This refers to differences in health outcomes by subgroups. Subgroups may be based on geography, languages, ethnicity, culture, citizenship status, economic status, sexual orientation, age, gender, or others.

KPGA ranked health needs using the Hanlon Method: D=[A+92xB]xC where: D=Priority rank, A=Magnitude of the health problem ranking, B=Severity of the health problem ranking, and C=Effectiveness of intervention ranking.

KPGA hosted a meeting, during which KP staff were presented the preliminary CHNA findings and asked to rank health needs in order of a) the magnitude of the health need, b) the severity of the health need, and c) the level of influence KPGA can exert in changing the health need. There were no needs identified as missing from the 11 preliminary health needs that were ranked.

Rank	**Health Priority**	**Mean**	**Median**
1	Obesity/Healthy Eating/Active Living	1.75	1.5
2	Access to Care	2.875	2
3	Social Determinants of Health	3.625	3.5
4	Chronic Disease - Cardiovascular Conditions Chronic Disease - Diabetes Chronic Disease - Cancer	3.75 5.13 7.13	3.5 4 7
5	Mental Health Conditions	6.25	6
6	Infectious Disease	6.63	6.5
7	Maternal and Child Health	8.13	7
8	Substance Abuse	9.5	9.5
9	Violence and Injury	10	11

Once the health priorities were established, needs were further consolidated into discrete categories based on data collected that points to shared root causes and common interventions. Specifically, cardiovascular conditions, diabetes, and cancer were consolidated into one chronic disease category; and poverty, education, transportation, and housing were consolidated into one social determinants of health category.

C. Prioritized description of all the community needs identified through the CHNA

Many of the prioritized preliminary health needs are similar to the health needs that were surfaced in the 2016 and 2013 CHNAs completed for the KPGA Region. This is primarily due to the time and effort it takes to have a measurable influence on the health of a population that is as large as the KPGA Region serves. That having been said, there are several shifts in the magnitude and rate of change for several health needs.

1. Healthy eating and active living – In the region, there remains wide variation in diet quality and active living. Wealthier areas generally had higher access to healthy 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. Obesity has increased since 2016, though at a slower rate than previous assessments have shown. In several counties, obesity has decreased slightly. There remain high (and increasing) rates of fast food restaurants coupled with low (and decreasing) rates of food access in low-income areas. Additional barriers to healthy eating and active living throughout the KPGA Region are time spent commuting, the perception of safety from crime, and poor infrastructure (e.g., sidewalks, lighting, and recreation areas).

2. Access to care (primary, specialty, mental and dental) – The supply of primary, mental and dental care is not evenly dispersed around the region. Similar to the 2016 CHNA, it is above benchmark levels in urbanized-affluent areas while there is a shortage in areas with lower levels of employment, income, and insurance coverage – regardless of population density. The rates of Federally Qualified Health Centers (FQHCs) have increased in some areas and decreased in others, leaving the KPGA Region with lower rates than is average for Georgia. Health insurance status and type is another important factor, as well as the overall household budget in areas with lower rates of safety-net providers (e.g., FQHCs). Dental provider rates have increased in the CHNA Region slightly since the previous assessment, yet the shortage of dental services for uninsured adults throughout the KPGA Region remains a challenge. Mental health provider rates are well below the benchmark in approximately half of the geographic region. The percentage of the population that is uninsured in the region has decreased over time, yet remains higher than national rates. There are also barriers due to transportation, language, culture, hours of operation, and lack of specialty care providers. Limited access to care is evident in higher than average emergency room, hospitalization, and death rates.

3. Social determinants of health (poverty/income; employment status; challenges related to race, ethnicity, and culture; education; housing; and single parent status) – This health need combines three health need priorities from the 2016 CHNA into one; namely educational attainment, poverty, and transportation. Housing has been included as an emerging health need in 2019.

Educational Attainment - Educational attainment is one of the strongest predictors of life expectancy and lifetime health status. In the CHNA region, there is a 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.

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, criminal 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, particularly among single-parent families. 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.

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, increased injuries, and increased 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.

4. Chronic disease (cardiovascular disease: hypertension, stroke and heart disease; diabetes; cancer; kidney disease; and respiratory illness: COPD, emphysema, and asthma) – this preliminary health need combines multiple health need priorities from the 2016 CHNA into one. While these are drastically different diagnoses, root causes are often related to lifestyle, the environment and the burden related to cost, care coordination, self-management, health literacy, and motivation, after diagnosis.

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. African American residents show higher mortality rates than other races, and lower income, non-immigrant, older, lower-resourced, low population density, and geographically isolated areas tend to show higher incidence rates.

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, particularly for populations with limited care coordination and congruency. In the CHNA region, diabetes has continued to increase and continues to trend with economic disadvantage, rural residency, non-immigrant status, and food access.

Cancer - Taken together, cancers remain 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. The combined cancer incidence rate for the KPGA Region is slightly higher than the benchmark. Since 2016, mortality rates have decreased in several counties that showed above-average rates in the previous assessment. Today, the combined cancer mortality rate is below the state average, and there remains moderate variation within cancer types. For example, where screening rates are low, prevalence can also

be low, but mortality rates are often higher due to late stage diagnosis. Tobacco use, diet, physical activity, vaccinations, access to treatment options, and environmental exposures contribute to some variation in the outcome as well.

5. 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 has increased and remains a challenge in some communities. African American residents tend to have higher emergency room visit rates, while White residents show higher rates of suicide. There are many risk factors such as economic stressors, exposure to traumatic events, and social isolation that may contribute to poor mental health.

6. Infectious Disease (HIV/AIDS and STDs) – 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 and Gonorrhea infection rates remain relatively high and increasing in more dense and urban populations.

7. Maternal and child health - When compared to the nation, Georgia consistently shows higher mortality rates among mothers and infants year over year. Mortality and infant mortality rates vary by geography, race, income, and age in the CHNA region. Maternal mortality is more than two times higher for Black residents of the region than for White residents. Infant mortality is nearly three times higher among Black residents than for White residents. Birth outcomes tend to be poorest among women that have poor health statuses before conception. Maternal and infant mortality rates are often related to the level of access women of childbearing age have to affordable healthcare, lifestyle choices (e.g., nutrition, fitness, substance use), social determinants (e.g., poverty, education, safety, healthy housing, hygiene, etc.), and behavioral health.

8. Substance abuse – In the last decade, substance abuse has become an increasing concern in many parts of the United States, specifically related to opioid abuse and overdose. Georgia ranks among the 11 worst states in the nation for substance abuse. The CHNA region shows elevated emergency room visit rates that have increased significantly since the last assessment. During the same period, drug overdoses have increased. According to primary data sources, the most common substances used throughout the CHNA Region are tobacco or vaping, marijuana, alcohol, heroin, methamphetamine, crack/cocaine, and prescription pills. White residents have higher mortality rates, though substance abuse contributes to poor health outcomes, and higher rates of crime, incarceration, as well as death.

9. Violence and injury - The KPGA Region has slightly elevated rates of violence and pedestrian accident deaths. Violence and injury rates vary by population density, infrastructure (sidewalks, crosswalks, street lights, etc.), income, education, and racial/ethnic identity in the CHNA region. Violent crime rates tend to be highest in urban low-income communities; whereas pedestrian accident deaths are highest in rural areas. When compared to all other races and

ethnicities, Black residents are two times more likely to die of homicide, and White residents are slightly more likely to die of unintentional injury.

D. Community resources potentially available to respond to the identified health needs

The service area for KPGA contains community-based organizations, government departments and agencies, hospital and clinic partners, and other community members and organizations engaged in addressing many of the health needs identified by this assessment.

Key resources available to respond to the identified health needs of the community are listed in Appendix D Community Resources.

VI. KP Georgia 2016 Implementation Strategy evaluation of impact

A. Purpose of 2016 Implementation Strategy evaluation of impact

KP Georgia's 2016 Implementation Strategy Report was developed to identify activities to address health needs identified in the 2016 CHNA. This section of the CHNA Report describes and assesses the impact of these activities. For more information on KP Georgia's Implementation Strategy Report, including the health needs identified in the facility's 2016 service area, the health needs the facility chose to address, and the process and criteria used for developing Implementation Strategies, please visit https://www.kp.org/chna. For reference, the list below includes the 2016 CHNA health needs that were prioritized to be addressed by KPGA in the 2016 Implementation Strategy Report.

1. Access to Care
2. Behavioral Health
3. Cardiovascular Conditions
4. Diabetes Prevention and Management
5. Educational Attainment
6. HIV/AIDS Prevention and Treatment
7. Obesity/Healthy Eating-Active Living (HEAL)

KPGA is monitoring and evaluating progress to date on its 2016 Implementation Strategies for the purpose of tracking the implementation and documenting 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, KPGA tracks outcomes, including behavior and health outcomes, as appropriate and where available.

The impacts detailed below are part of a comprehensive measurement strategy for Community Health. KP's measurement framework provides a way to 1) represent our collective work, 2) monitor the health status of our communities and track the impact of our work, and 3) facilitate shared accountability. We seek to empirically understand two questions 1) how healthy are Kaiser Permanente communities, and 2) how does Kaiser Permanente contribute to community health? The Community Health Needs Assessment can help inform our comprehensive community health strategy and can help highlight areas where a particular focus is needed and support discussions about strategies aimed at addressing those health needs.

As of the documentation of this CHNA Report in March 2019, KPGA had evaluation of impact information on activities from 2017 and 2018. These data help us monitor progress toward

improving the health of the communities we serve. While not reflected in this report, KPGA will continue to monitor impact for strategies implemented in 2019.

B. 2016 Implementation Strategy evaluation of impact overview

In the 2016 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 2017 and 2018, 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 2017-2018, 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 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. From 2017-2018, KPGA awarded 207 grants amounting to a total of $15,196,525 in service of 2016 health needs. Additionally, KPGA has funded significant contributions to Community

Foundation for Greater Atlanta in the interest of funding effective long-term, strategic community benefit initiatives within KPGA. During 2017-2018, a portion of money managed by this foundation was used to award 30 grants totaling $1,809,609 in service of 2016 health needs.

In-kind resources: In addition to our significant community health investments, Kaiser Permanente is aware of the significant impact that our organization has on the economic vitality of our communities as a consequence of our business practices including hiring, purchasing, building or improving facilities and environmental stewardship. We will continue to explore opportunities to align our hiring practices, our purchasing, our building design and services and our environmental stewardship efforts with the goal of improving the conditions that contribute to health in our communities. From 2017-2018, KPGA leveraged significant organizational assets in service of 2016 Implementation Strategies and health needs, including $27 million in purchasing from women-, veteran-, and minority-owned businesses, contributing to economic growth in our local and underserved communities in 2018. KPGA exceeded our goal of spending $16 million with diverse suppliers by 77% percent.

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 2017-2018, KPGA engaged in several partnerships and collaborations in service of 2016 Implementation Strategies and health needs, including:

- Georgia Department of Public Health: KPGA partnered with the Georgia Department of Public Health to develop and implement a strategy designed to create a defined job description for Community Health Workers (CHW) in Georgia. The purpose of this effort is to professionalize the role of Community Health Workers and begin the process of working with Care Management Organizations to seek reimbursement for the critical services that CHWs provide across the state.
- Atlanta BeltLine Partnership: KPGA funded the build-out of the Atlanta BeltLine trail on the westside of Atlanta. The BeltLine is a “rails to trails” infrastructure initiative that connects neighborhoods and communities across Atlanta to opportunities for active living, exercise, and community connection.
- Children’s Mental Health Collaborative: KPGA is one of several funders and foundations that came together in 2017 to explore issues related to children’s mental health. The Collaborative engaged with local leaders on a learning journey to better understand the issues facing Georgia’s children that relate to mental health. Due to the work of the partners in the collaborative and the Governor’s Commission on Children’s Mental Health, the Governor of Georgia recently made an unprecedented investment in mental health services and commitment to the mental health workforce, proposing nearly $23 million in new funding for children’s mental health.

C. 2016 Implementation Strategy evaluation of impact by health need

KPGA Priority Health Needs

Need	Summary of impact	Top 3-5 Examples of most impactful efforts
Need #1: Access to Care	*During 2017 and 2018, KP Georgia provided $88.9M in medical care services for vulnerable patients through our charity care programs (Medicaid, MFA & CHC) and provided services for 46,719 Medicaid members.* *During 2017 and 2018, KPGA awarded 27 grants totaling $1,998,156 that address Access to Care in the KPGA service area.*	Medicaid and Charity Care: Over the course of 2017 and 2018, KP provided care to 46,719 Medicaid members, approved 92,450 applications for Medical Financial Assistance (MFA) – totaling $47.6M – and provided Charitable Health Coverage (CHC) to 3,935 members. Increasing Access through the Safety Net: In 2017 and 2018, KPGA awarded over $1.76 million to 26 Safety Net Organizations, whose missions are aimed at improving access to care for the most vulnerable patients. Given that Georgia is not a Medicaid Expansion state, many individuals in the KPGA service area rely on these organizations for basic primary care and more advanced specialty services. For 2017 Safety Net grantees, the following highlights are worth noting: • 3,110 individuals screened, treated, served, or otherwise reached through the Safety Net as a direct result of KPGA funding. • An average of 63.5% of patients screened and diagnosed with diabetes achieved A1C control within a 12-month period. • An average of 63.3% of patients screened and diagnosed with hypertension were able to reach normotensive status within a 12-month period. • 96.2% of patients who received a prescription for their chronic condition were able to obtain affordable or free medications and remained compliant with medications through the recommended treatment period. Mobile Health Vehicle: In 2017 and 2018, over 2,000 individuals received free health screenings on our Mobile Health Vehicle (MHV). In addition to screenings, 100% of MHV patients whose screening results suggested they were high-risk for a chronic condition received health education and referrals for an affordable, local medical home.

Need	Summary of impact	Top 3-5 Examples of most impactful efforts
Need #2: Behavioral Health	*During 2017 and 2018, KPGA provided 35 grants totaling $2,427,250 to Behavioral Health in the KPGA service area.* *Additionally, we are leveraging all our organizational assets in Behavioral and Workforce Health to address this need.*	School-Based Mental Health: In 2017, two organizations were awarded grants totaling $275,000 because of their explicit focus on school-based mental health. Through the United Way and Chris 180, over 980 children and their families were able to access behavioral health care in a setting where they otherwise would not have had access. These funds also provided training for staff and teachers to understand the complex intersections of trauma, health, and educational attainment, and to manage their classrooms and curricula delivery with a trauma-informed lens. Nearly 1,000 students (and their families in some cases) were referred for screening and 80.6% received behavioral health treatment. Among those who were treated, 52.8% experienced improvement in functioning and 49.6% experienced a decrease in school disciplinary referrals. Overall, 125 teachers, staff, and administrators were trained on the recognition of trauma in children and teens as part of the integrated support system designed to help children at risk of early drop-out.
		Improving Access to Behavioral Health Care for Underserved Women: With funding from KPGA in 2017, the Atlanta Women's Foundation's "Promoting Women's Mental Health & Wellness Project" was able to provide financial support to organizations that provide culturally competent mental and behavioral health services to underserved populations of women across Atlanta. A total of 9 organizations served thousands of women at or below 200% of the federal poverty level. In all, there were: • 11,249 behavioral health consultations provided • 1,248 women received behavioral health services • 1,117 women with diabetes and/or cardiovascular disease were identified and targeted for intensive services Among those with chronic conditions who also had a behavioral health need treated, 40% achieved blood pressure or A1C control within the study period.
		Partnering to Strengthen the Behavioral Health Workforce: In partnership with Voices for Georgia's Children, KPGA Community Health participated in the convening of local experts to understand why child and adolescent mental health needs continue to go largely unmet. KPGA served in an advisory capacity on the Behavioral Health Philanthropic Collaborative. The collaborative identified an overwhelming lack of early identification of mental health problems in pediatric populations and that this is at least partially due to the fact that there are not enough practitioners specializing in child and adolescent mental health in the state of Georgia. To grow and strengthen the mental health workforce, the coalition took on the task of analyzing the education and training required to develop new behavioral health providers, opportunities to improve current providers' scope and practice environment, and the support necessary to retain high quality practitioners to serve children in our state's System of Care. Findings from this analysis were repackaged into a list of specific recommendations for the Governor's office; these recommendations will equip policymakers with information needed to strategize and support the development of a well-defined, coordinated, and sustainable behavioral health workforce.

Need	Summary of impact	Top 3-5 Examples of most impactful efforts
Need #3: Cardio-vascular Conditions	*During 2017 and 2018, KPGA provided 11 grants totaling $795,564 to address Cardiovascular Conditions in the KPGA service area. The majority of funding in this area occurs through Safety Net grants.*	Blood Pressure Control in the Safety Net: In 2017, Safety Net funding in the area of Cardiovascular Conditions totaled $290,000 for 6 grantees. A total of 1,072 individuals were identified, screened, and served in cardiovascular clinics in the KPGA service area through the Safety Net. Among these patients, an average of 80.5% were classified as medication compliant. (It is worth noting that the percentage of medication compliant patients increased when there was an on-site dispensary and medication counseling). With regard to measurable health outcomes, an average of 71% of patients reduced blood pressure or achieved blood pressure control.
		Hypertension Management in a Safety Net Setting: In 2017, KPGA funded the Cobb and Douglas County Board of Health in the amount of $50,000 to identify and treat hypertension in adult clients accessing services in their local clinic. Fifty-two individuals were seen and treated in the hypertension clinic and were able to receive medications for free. Cobb and Douglas Public Health surpassed their goals by retaining 70% of enrollees and achieving blood pressure control in 88% of patients. Because of their success in 2017, funding was increased to $75,000 for 2018 with the intent to reach and achieve hypertension control in more patients.
		Street Medicine to Improve Hypertension for Unsheltered Homeless Individuals: In 2017, KPGA funded Mercy Care in the amount of $50,000 in support of their Street Medicine program. This program screened and served 341 unique patients. For many of the patients encountered, Street Medicine services are the only way they will consent to health care. Street medicine patients receive outpatient behavioral and primary care, which is a cost-effective outreach option for Mercy Care and keeps patients out of Emergency Room unnecessarily. A total of 328 patients were screened for hypertension and approximately 29% (n=94) were diagnosed. Among those diagnosed, 91% (n=86) received treatment. 12% of patients reported engaging in healthy behavior changes (e.g., 31% of smokers reported cutting back on the number of cigarettes smoked daily). Half of patients diagnosed with hypertension were classified as having improved hypertension, as measured by a reduction of 20 points in systolic, 10 points in diastolic, or a total blood pressure of less than 140/90. Given that this patient population dealt with so many issues related to chronic homelessness, it is a mission of the Street Medicine team to refer patients who are willing to a permanent housing situation. 57% of patients with hypertension were referred for housing and follow-up case management, and 26% of patients were placed in long-term housing.

Need	Summary of impact	Top 3-5 Examples of most impactful efforts
Need #4: Diabetes Prevention and Management	*During 2017 and 2018, KPGA provided 12 grants totaling $647,813 to address Diabetes Prevention and Management in the KPGA service area. Through grantmaking and targeted collaborations, we have impacted the prevention and management efforts of local organizations and other healthcare systems.*	Prevention through the Diabetes Association of Atlanta: In 2017, KPGA funded the Diabetes Association of Atlanta's Diabetes Prevention and Control program (DPC). The goal of the DPC program is to increase access to affordable and effective diabetes care which will delay or prevent the onset of diabetes and its complications. This goal is met through the services of diabetes education, medical assistance, and early detection glucose screenings. Participants learn how to take control of their health through proper nutrition, regular exercise, and impactful health goals with supportive follow up. This support will reach 1,250 individuals in metro Atlanta and outlying counties with its services. As of mid-year, 67% of the intended reach has been met. Ninety percent of diabetes self-management participants reported an increase in knowledge on how to manage their diabetes and 85% of DPC participants reported an increase in knowledge of how to prevent diabetes. Half of this group also maintained at least one health goal for a three-month period.
		Self-Management through the Atlanta-Area Diabetes Collaborative: KPGA partners with Grady Health System, Piedmont Healthcare, St. Joseph's Mercy Care, and WellStar in the Atlanta-Area Diabetes Collaborative. The collaborative utilizes shared resources to improve diabetes self-management and service utilization outcomes in the metro-Atlanta area by increasing access to evidence-based Diabetes Self-Management Education via a novel technology platform, telephonic coaching, and wraparound services for those most at-risk for poor outcomes. All individuals aged 18 and older, regardless of insurance status, who have an A1C level greater than 7 and are being treated in participating medical facilities in Fulton and DeKalb Counties are eligible to participate in this effort. Patients who enroll will receive one or a combination of the three interventions above, depending on their demonstrated diabetes self-management capacity and additional needs. In the fall of 2018, the pilot site was launched. In January 2019, the group plans to come together to discuss lessons learned and to adjust the approach to optimize the program before launching at additional sites.
		Prevention and Self-Management through the Safety Net: In 2017, KPGA supported two Safety Net grantees (Good Sam Cobb and the Hands of Hope Clinic) in the amount of $112,000 to impact the areas of diabetes prevention and self-management among the high-risk populations they serve. Across these two organizations, access to care was increased for a total of 2,261 individuals. At Good Sam Cobb, 71% of diabetics obtained A1C control and 70% were compliant with diabetes medications after receiving pharmacy counseling. At the Hands of Hope Clinic, 56% of individuals diagnosed with diabetes improved A1C and 100% of individuals identified as pre-diabetic either maintained or improved their A1C, thus decreasing risk for a clinical diabetes diagnosis.

Need	Summary of impact	Top 3-5 Examples of most impactful efforts
Need #5: Educational Attainment	*During 2017 and 2018, KPGA provided 44 grants totaling $3,100,500 to address Educational Attainment in the KPGA service area. Our focus in this area spans early childhood education to college enrollment and leverages resources to improve reading levels of 1st graders and trauma-informed training for teachers and school administrators.*	Increasing On-Time Graduation and Seamless College Enrollment in Atlanta Public Schools: In 2017, KPGA partnered with Achieve Atlanta—an organization dedicated to the success of the Atlanta Public Schools system—to fund the College Advising Project. Funds supported the training and placement of an additional College Advising Corps near-peer adviser in four Atlanta Public Schools high schools: Carver High, Douglass High, Mays High and Washington High. Advisers coach and advise seniors on the necessary steps to apply to, afford, and enroll in college. Within one academic year, the following results were noted: • Three schools met their target goal related to college applications submitted; the average percentage of seniors applying to one or more post-secondary opportunity increased from 77.3% to 86%. • All four schools met their target goal for financial aid applications; the average percentage of seniors applying for financial aid through the FAFSA mechanism increased from 47.3% to 55%. • Two schools met their target goal of seamless enrollment; the average percentage of seniors enrolling in college the following fall increased from 37% to 44%. • Among two schools the percentage of seniors accepted to college increased from 40.5% to 58.5% and the total amount of scholarships awarded for the entire first-year cohort was over $14.4M.
		Thriving Schools and Tutor Mate: Leveraging Workforce Volunteerism to improve reading scores among 1st grade students: KPGA has partnered with Fulton County Schools to pilot a literacy-based volunteer engagement program called TutorMate. During the pilot year (2017), KPGA sponsored two first grade classrooms at Asa Hilliard Elementary School located in East Point, GA. TutorMate is an online platform that connects adult volunteers (in this case, full-time KPGA employees) with 1st grade students identified by school administrators and teachers as below grade-level readers. Throughout the school year, each volunteer-student pair met virtually (30 minutes per week) to complete student-paced literacy games and reading exercises. In the first year, 20 employees committed 144 volunteer hours to this effort, 20 students completed the program, and there was an average growth of 3.1 reading levels among all student participants. For year two (2018), TutorMate was expanded to include 3 elementary schools, 65 volunteers, and 80 students.
		Resilience in School Environments: 2017 was the launch of Kaiser Permanente's Resilience in School Environments (RISE) initiative. RISE aims to improve staff/teacher efficacy through creating specific policies and practices that focus on wellness. KPGA currently hosts two out of the 20 RISE (pilot) sites, reaching approximately 200 Fulton County teachers and staff.

Need	Summary of impact	Top 3-5 Examples of most impactful efforts
Need #6: HIV/AIDS Prevention and Treatment	*During 2017 and 2018, KPGA provided 11 grants totaling $689,400 to address HIV/AIDS Prevention and Treatment in the KPGA service area. During the 2016 CHNA cycle, KPGA worked strategically to increase funding in this area by developing and launching an RFP specifically for HIV/AIDS Prevention and Treatment.*	Supportive Housing Improves HIV-Related Health Outcomes: In fall 2017, KPGA funded Jerusalem House, a local non-profit dedicated to improving life for individuals living with HIV/AIDS through housing, education, and medical and non-medical support. KPGA contributed $65,000 to a funding initiative that will support a range of Jerusalem House's housing and support services for residents and their children. As of the mid-year report, 78% of the targeted reach has been met. With the addition of 14 new housing units, Jerusalem House is now able to serve 500 individuals affected by HIV/AIDS. 79% of residents have lived at their residence for at least one year, which allows them access to the benefits of stable housing. 100% of eligible adult residents have access to job training and employment supportive services and currently 85% are employed with steady income. As of the mid-year report, 80% of residents have achieved viral suppression and 85% reported improved health and quality of life. Additionally, 100% of residents under age 5 have access to education assistance scholarships and those already enrolled are meeting the literacy goals for their developmental age.
		Reducing Viral Load among HIV-Positive Patients: In KPGA's 2017 funding ($75,000) for Positive Impact Health Centers focused on reducing viral load among members of the LGBTQ community living with HIV/AIDS. As of the mid-year report, 62% of the target reach has been met. Among new patients enrolled, 100% have had a biopsychosocial assessment, 97% had at least one medical encounter in the first 6 months of the grant period, and 41% received transportation assistance to decrease the primary barrier to care. Forty-nine percent of patients received referrals for additional support by a community health worker and 60% were referred specifically for housing-related services. The viral suppression rate among patients seen is 79% (61 of the 77 individuals enrolled thus far are classified as virally suppressed).
		Internal Changes in Grantmaking Nearly Doubles Reach: Given the increasing burden of new HIV cases in the Atlanta area, the shortage of affordable housing and transportation, and lack of access to social, non-medical needs, the KPGA Community Benefit team initiated an RFP specifically to increase our grant giving in HIV/AIDS Prevention and Treatment and related supportive services. This special RFP doubled our number of grantees in this health need area; funding totaled to $489,400, nearly doubling our investment in the area of HIV/AIDS Prevention and Treatment. This additional investment also increased our reach from 25,713 in 2017 to a proposed reach of 34,393 among the 2018 cohort of grantees. Final reports are not due until the end of 2019, but KPGA's ability to intentionally increase our investment in the area of HIV/AIDS—to support organizations doing evidence-based work in this area—is an impactful success.

Need	Summary of impact	Top 3-5 Examples of most impactful efforts
Need #7: Obesity / HEAL	*During 2017 and 2018, KPGA provided 24 grants totaling $1,977,500 to address Obesity/HEAL in the KPGA service area. KPGA has made tremendous contributions in this area by building on previous work to address issues around food insecurity and access to safe infrastructure for outdoor physical activity.*	Increasing Physical Activity through the Atlanta BeltLine Grant Program: In support of the Atlanta BeltLine Partnership's efforts to increase physical activity on Atlanta's Westside, KPGA contributed $500,000 to a grant fund intended to get neighborhood residents active on the BeltLine Westside trail. Through a community vetted process, a total of eight grantees were selected. During Year 1 of this grant program, a total of 6,735 individuals were reached. Following are highlighted results from Year 1: • All 6 grantees met or exceeded their goal to increase participants' level of physical activity via using the Westside Trail • Participants reported ongoing use of the trail after program completion and increased frequency and duration of physical activity because of each program Select programs were associated with improved health education, increased healthy food consumption, and improvement in clinical health outcomes related to weight management, diabetes management, and blood pressure.
		Addressing Food Insecurity through the Atlanta Community Food Bank: In 2017, KPGA partnered with the Atlanta Community Food Bank (ACFB) to address issues related to food insecurity across 24 counties in the KPGA service region. With these funds, nearly 430,000 pounds of produce were purchased and distributed and approximately 13,400 individuals experienced increased access to affordable quality produce. During the grant program, a Nutrition Education team served 2,800 individuals through 191 events. Further, the ACFB began participating in the Southeast Regional Co-op, resulting in an increase in Georgia-grown and sourced produce.
		Increasing Access to Healthy Foods through School Gardens: In 2017, KPGA funded Georgia Organics in the amount of $75,000 under an Obesity/HEAL grantmaking initiative. Georgia Organics reached 850,709 individuals through this initiative. A total of 6 farm-to-school trainings were implemented for 130 school nutrition specialists and educators. Post-workshop knowledge reportedly increased for an average of 93% of participants. During the *Make Room for Legumes Campaign*, nearly 170,000 students were introduced to school gardens, tastes tests and other related activities. 74% of school districts in the KPGA service area (26 of 35 districts) were recognized with a 2017 Golden Radish Award – seven were first-time awardees. The awards ceremony was leveraged to garner positive media attention for school district's farm-to-school efforts and in 2017, 31 media outlets in the KPGA service area released 32 different stories about the Golden Radish Awards. Six Food Corps AmeriCorps service members served in the KPGA service area. As of March 31, 2018, service members have directly served 2,501 students, built and/or maintained 9 school gardens, taught 862 farm-to-school lessons, and conducted 61 taste tests with an estimated 9,400 students.

VII. Appendix

A. Secondary data sources and dates
    i. KP CHNA Data Platform secondary data sources
    ii. “Other” data platform secondary data sources
B. Community Input Tracking Form
C. Health Need Profiles
D. Community resources
E. Leading causes of premature death, death, ER visits, & hospital discharges, KPGA region

Appendix A. Secondary data sources and dates

i. Secondary sources from the KP CHNA Data Platform

	Source	Dates
1.	American Community Survey	2012-2016
2.	American Housing Survey	2011-2013
3.	Area Health Resource File	2006-2016
4.	Behavioral Risk Factor Surveillance System	2006-2015
5.	Bureau of Labor Statistics	2016
6.	Center for Applied Research and Environmental Systems	2012-2015
7.	Centers for Medicare and Medicaid Services	2015
8.	Climate Impact Lab	2016
9.	County Business Patterns	2015
10.	County Health Rankings	2012-2014
11.	Dartmouth Atlas of Health Care	2012-2014
12.	Decennial Census	2010
13.	EPA National Air Toxics Assessment	2011
14.	EPA Smart Location Database	2011-2013
15.	Fatality Analysis Reporting System	2011-2015
16.	FBI Uniform Crime Reports	2012-14
17.	FCC Fixed Broadband Deployment Data	2016
18.	Feeding America	2014
19.	Food Environment Atlas (USDA) & Map the Meal Gap (Feeding America)	2014
20.	Health Resources and Services Administration	2016
21.	Institute for Health Metrics and Evaluation	2014
22.	Interactive Atlas of Heart Disease and Stroke	2012-2014
23.	Mapping Medicare Disparities Tool	2015
24.	National Center for Chronic Disease Prevention and Health Promotion	2013
25.	National Center for Education Statistics-Common Core of Data	2015-2016
26.	National Center for Education Statistics-EDFacts	2014-2015
27.	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2013-2014
28.	National Environmental Public Health Tracking Network	2014
29.	National Flood Hazard Layer	2011
30.	National Land Cover Database 2011	2011
31.	National Survey of Children's Health	2016
32.	National Vital Statistics System	2004-2015
33.	Nielsen Demographic Data (PopFacts)	2014
34.	North America Land Data Assimilation System	2006-2013
35.	Opportunity Nation	2017
36.	Safe Drinking Water Information System	2015
37.	State Cancer Profiles	2010-2014
38.	US Drought Monitor	2012-2014
39.	USDA - Food Access Research Atlas	2014

ii. Additional sources

	Source	Dates
1.	Georgia Department of Public Health Online Analytical and Statistical Information System (OASIS)	2017
2.	Truven Health Analytics Community Needs Index	2017

Appendix B. Community input tracking form

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
Organizations						
1	*Key Informant Interview*	*Director/Associate Director/Assistant Director, A.L. Burruss Institute for Public Service & Research*	*1*	*Minority, medically underserved, low income*		*8/23/18*
2	*Key Informant Interview*	*Deputy Executive Director, Atlanta BeltLine Partnership*	*1*	*Minority, medically underserved, low income*		*9/18/18*
3	*Key Informant Interview*	*Manager of the Research & Analytics Division, Atlanta Regional Commission*	*1*	*Minority, medically underserved, low income*		*10/29/18*
4	*Key Informant Interview*	*Chairman, Austell Community Task Force*	*1*	*Minority, medically underserved, low income*		*8/15/18*
5	*Key Informant Interview*	*Chief Executive Officer, Bethesda Community Clinic*	*1*	*Minority, medically underserved, low income*		*8/23/18*
6	*Key Informant Interview*	*Executive Director/Coordinator, Butts Collaborative*	*1*	*Minority, medically underserved, low income*		*1/15/18*
7	*Key Informant Interview*	*Former Administrator/Board Member, Butts County Hospital Authority*	*1*	*Minority, medically underserved, low income*		*1/15/18*
8	*Key Informant Interview*	*Vice President & Program Director, Center for Pan Asian Community Services (CPACS)*	*1*	*Minority, medically underserved, low income*		*9/7/18*
9	*Key Informant Interview*	*President & Pastor, Cherokee Christian Ministerial Association*	*1*	*Minority, low income*		*9/13/18*
10	*Key Informant Interview*	*President & CEO, Cherokee County Chamber of Commerce*	*1*	*Low income*		*11/2/18*
11	*Key Informant Interview*	*Director of Economic Development, City of East Point*	*1*	*Minority, medically underserved, low income*		*10/31/18*
12	*Key Informant Interview*	*City Council, City of Jackson*	*1*	*Minority, medically underserved, low income*		*1/15/18*
13	*Key Informant Interview*	*Executive Director, Clarkston Community Center*	*1*	*Minority, medically underserved, low income*		*9/4/18*
14	*Key Informant Interview*	*Cobb 2020*	*1*	*Minority, medically underserved, low income*		*9/19/18*
15	*Key Informant Interview*	*Deputy Director, District Health Director, Epidemiology Director, Cobb Douglas Public Health*	*3*	*Health department, Minority, medically underserved, low income*		*9/19/18*
16	*Key Informant Interview*	*Evidence-Based Coordinator, Cobb Senior Services*	*1*	*Minority, low income*		*8/17/18*
17	*Key Informant Interview*	*Chief Quality Officer; Director of Specialty Services; Director of Child and Adolescent Services, Cobb/Douglas Community Services Board*	*3*	*Minority, medically underserved, low income*		*10/30/18*

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
18	*Key Informant Interview*	*Executive Director, Community Voices-Morehouse School of Medicine*	*1*	*Minority, medically underserved, low income*		*9/1/18*
19	*Key Informant Interview*	*Coordinator, Fulton County Schools-Student Health Services*	*1*	*Minority, medically underserved, low income*		*10/30/18*
20	*Key Informant Interview*	*Commissioner- District 5, Fulton County Board of Commissioners*	*1*	*Minority, medically underserved, low income*		*11/1/18*
21	*Key Informant Interview*	*District Health Director, Fulton County Board of Health*	*1*	*Health department, Minority, medically underserved, low income*		*11/11/18*
22	*Key Informant Interview*	*Director, Fulton County Department of Behavioral Health and Developmental Disabilities*	*1*	*Health department, Minority, medically underserved, low income*		*11/11/18*
23	*Key Informant Interview*	*Wellness Director, G. Cecil Pruett Community Center Family YMCA*	*1*	*Low income*		*8/14/18*
24	*Key Informant Interview*	*President/District Coordinator, Georgia Association for Positive Behavior Support*	*1*	*Medically underserved*		*1/15/18*
25	*Key Informant Interview*	*Georgia Department of Public Health*	*1*	*Health department, medically underserved, low income*		*1/15/18*
26	*Key Informant Interview*	*Chief Executive Officer, Good Samaritan Health Center*	*1*	*Medically underserved, low income*		*10/29/18*
27	*Key Informant Interview*	*Chairman, Griffin-Spalding County Board of Education*	*1*	*Minority, medically underserved, low income*		*1/15/18*
28	*Key Informant Interview*	*Nursing Director, Griffin-Spalding County Health Department*	*1*	*Health department, Minority, medically underserved, low income*		*12/28/17*
29	*Key Informant Interview*	*Griffin-Spalding County School System*	*1*	*Minority, medically underserved, low income*		*1/15/18*
30	*Key Informant Interview*	*Performance Management & Community Health Director, Health District 3-4 - Gwinnett, Newton, and Rockdale County Health*	*1*	*Health department, Minority, medically underserved, low income*		*9/19/18*
31	*Key Informant Interview*	*Program Coordinator, Health Promotion Resource Center - Morehouse School of Medicine*	*1*	*Minority, medically underserved, low income*		*11/6/18*
32	*Key Informant Interview*	*Chief Executive Office, Highland Rivers Behavioral Health*	*1*	*Medically underserved*		*10/30/18*
33	*Key Informant Interview*	*Police Chief, Jackson Police Department*	*1*	*Minority, medically underserved, low income*		*12/29/17*
34	*Key Informant Interview*	*Pastor, Jackson United Methodist Church*	*1*	*Medically underserved, low income*		*1/15/18*
35	*Key Informant Interview*	*Chief Executive Officer, Mercy Care*	*1*	*Medically underserved, low income*		*9/14/18*

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
36	*Key Informant Interview*	*Senior Director, MUST Ministries*	*1*	*Low income*		*10/30/18*
37	*Key Informant Interview*	*Program Director, National Alliance on Mental Illness (NAMI)*	*1*	*Minority, medically underserved, low income*		*9/26/18*
38	*Key Informant Interview*	*District Director, Northeast Health District 10 Athens (DPH)*	*1*	*Health department, medically underserved, low income*		*9/7/18*
39	*Key Informant Interview*	*Executive Director, Partners for H.O.M.E.*	*1*	*Low income*		*9/25/18*
40	*Key Informant Interview*	*District Coordinator, Project AWARE*	*1*	*Medically underserved*		*1/15/18*
41	*Key Informant Interview*	*Administrative Director, Rock Springs Clinic*	*1*	*Medically underserved, low income*		*1/15/18*
42	*Key Informant Interview*	*Executive Director & Project Coordinator, HEALTH SafetyNet, Rockdale Coalition for Children and Families*	*2*	*Medically underserved, low income*		*9/11/18*
43	*Key Informant Interview*	*Executive Director, Southside Medical Center*	*1*	*Medically underserved, low income*		*10/31/18*
44	*Key Informant Interview*	*Executive Director, Spalding Collaborative*	*1*	*Minority, medically underserved, low income*		*1/15/18*
45	*Key Informant Interview*	*Deputy Chief – Administration, Spalding County Fire Department*	*1*	*Minority, medically underserved, low income*		1/15/18
46	*Key Informant Interview*	*Executive Vice President of Mission, The Atlanta Women's Foundation*	*1*	*Minority, medically underserved, low income*		9/20/18
47	*Key Informant Interview*	*Vice President of Strategy and Knowledge Development, United Way of Metro Atlanta*	*1*	*Medically underserved, low income*		9/26/18
48	*Key Informant Interview*	*CRC Screening Navigator, WellStar Cancer Screening and Prevention*	*1*	*Medically underserved*		9/7/18
49	*Key Informant Interview*	*Pilot Program for CRC Screening, WellStar Congregational Health Network Wellstar East Paulding Primary Care Group*	*1*	*Medically underserved*		8/21/18
50	*Key Informant Interview*	*Pilot Program for CRC Screening, WellStar Kennestone Community Clinic*	*1*	*Medically underserved*		8/17/18
51	*Key Informant Interview*	*Executive Director, Wholesome Wave Georgia*	*1*	*Low income*		9/10/18
52	*Key Informant Interview*	*President & CEO, Woodward Academy*	*1*	*NA*		8/17/18

	Data collection method	Title/name	Number	Target group(s) represented	Role in target group	Date input was gathered
Community residents						
53	*Spalding County Senior Center Griffin, GA 30223*	*Residents from Spalding, Butts, and Pike Counties*	*13*	*Minority, medically underserved, low-income*	*Member*	*Jan 9*
54	*Duluth Festival Center Duluth, GA 30096*	*Cherokee, Cobb, and Fulton Counties*	*9*	*Minority, medically underserved, low-income*	*Member*	*Jan 10*
55	*Club e Atlanta College Park, GA 30337*	*Clayton, DeKalb, and Fulton Counties*	*11*	*Minority, medically underserved, low-income*	*Member*	*Jan 11*
56	*E.P. Roberts Center Barnesville, GA 30204*	*Residents from Butts, Henry, Lamar, Pike, and Spalding Counties*	*11*	*Minority, medically underserved, low-income*	*Member*	*Sept 25*
57	*Atlanta Technical College Atlanta, GA 30310*	*Residents from Clayton, DeKalb, and Fulton Counties*	*9*	*Minority, medically underserved, low-income*	*Member*	*Oct 1*
58	*Sibley Public Library Marietta, GA 30060*	*Residents from Bartow, Carroll, Cobb, Cherokee, DeKalb, Douglas, Fulton, and Paulding Counties*	*11*	*Minority, medically underserved, low-income*	*Member*	*Oct 2*
59	*Duluth Festival Center Duluth, GA 3009*	*Residents from Cherokee, Cobb, Fulton, Forsyth, and Gwinnett Counties*	*10*	*Minority, medically underserved, low-income*	*Member*	*Oct 3*
60	*Gainesville, 30501 in Hall County*	*Residents from Barrow, Cherokee, Cobb, Dawson, DeKalb, Forsyth, Fulton, Gwinnett, Hall, Newton, Oconee, Pickens, Rockdale, and Walton Counties*	*8*	*Minority, medically underserved, low-income*	*Member*	*Oct 15*
61	*Forest Park Library Forest Park, GA 30297*	*Residents from Butts, Clayton, Coweta, DeKalb, Fayette, Fulton, Harris, Henry, Lamar, Meriwether, Pike, Rockdale, and Spalding Counties*	*9*	*Minority, medically underserved, low-income*	*Member*	*Oct 16*
62	*South Cobb Recreation Center Austell, GA 30168*	*Residents from Bartow, Carroll, Cobb, Cherokee, Douglas, Haralson, and Paulding Counties*	*11*	*Minority, medically underserved, low-income*	*Member*	*Oct 17*
63	*Athens, 30601 in Clarke County*	*Residents from Clarke, Madison, Oconee, Oglethorpe*	*10*	*Minority, medically underserved, low-income*	*Member*	*Oct 18*
64	*Clarkston Community Center Clarkston, GA 30021*	*Residents from Clayton, DeKalb, Fulton, Gwinnett Counties*	*9*	*Minority, medically underserved, low-income*	*Member*	*Oct 23*

Appendix C. Health Need Profiles

Access to Care (Primary and dental care)

Rationale and possible health factors influencing the health need

Access to care (primary, specialty, mental and dental) –The supply of primary, mental and dental care is not evenly dispersed around the region. Similar to the 2016 CHNA, it is above benchmark levels in urbanized-affluent areas while there is a shortage in areas with lower levels of employment, income, and insurance coverage – regardless of population density. The rates of Federally Qualified Health Centers (FQHCs) have increased in some areas and decreased in others, leaving the KPGA Region with lower rates than is average for Georgia. Health insurance status and type is another important factor, as well as the overall household budget in areas with lower rates of safety-net providers (e.g., FQHCs). Dental provider rates have increased in the CHNA Region slightly since the previous assessment, yet the shortage of dental services for uninsured adults throughout the KPGA Region remains a challenge. Mental health provider rates are well below the benchmark in approximately half of the geographic region. The percentage of the population that is uninsured in the region has decreased over time yet remains higher than national rates. There are also barriers due to transportation, language, culture, hours of operation, and lack of specialty care providers. Limited access to care is evident in higher than average emergency room, hospitalization, and death rates.

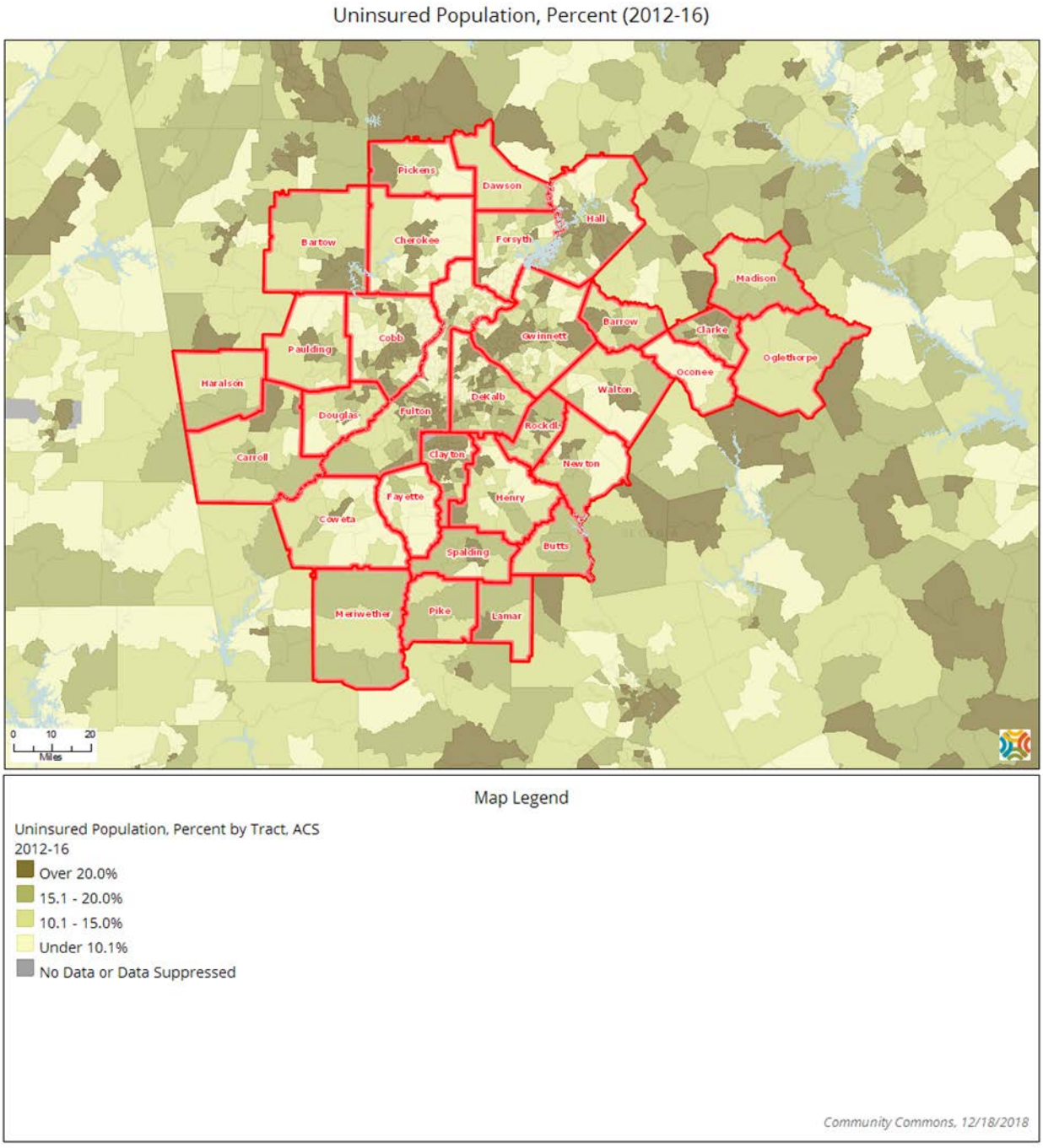
Communities disproportionately impacted

There are a number of geographic areas with access to care rates worse than Georgia. The KPGA Region has a lower FQHC availability rate than the state (0.5 vs. 2.1), with five of 31 counties showing higher rates than the state. The KPGA Region has average primary care provider rates when compared to the state average (68.3 vs. 66.1) with ten counties showing significantly lower rates than the state. The KPGA Region has average dental care provider rates when compared to the state average (51.1 vs. 49.2) with nine counties showing significantly lower rates than the state. In percent of the population uninsured, the KPGA Region is average for the state of Georgia (15.8%); however, ten counties have higher rates of uninsured residents than is average. It is important to note that the higher FQHC rates do not occur in most of the counties where uninsured rates are highest.

According to the Community Need Index, which measures socioeconomic barriers (income, insurance, culture, education, and housing) to accessing healthcare, five counties in the KPGA Region have the highest barriers to accessing care. In fact, of the 234 ZIP codes in the KPGA Region – 24.8% (58) of them showed increases in barriers in the past year; whereas, 27.4% (64) showed a decrease in barriers during the same period. There are eight ZIP code areas with significant socioeconomic barriers to accessing care. Of the remaining 226 ZIP code areas in the KPGA Region, 80.8% of them have CNI scores above the median, which indicates above average barriers to accessing health care.

Populations disproportionately impacted

Populations that are less likely to have health insurance than their counterparts are communities of color, undocumented immigrants, residents with poor educational attainment, unemployed and underemployed residents, residents on Medicaid or marketplace insurance, and residents in rural communities.



Primary data

Residents and community leaders noted that the barriers to accessing appropriate care are connected to the cost of uninsured care, the lack of acceptance of certain types of insurance (Medicaid and marketplace insurance), eligibility for Medicaid, and the cost of co-pays and deductibles; location of providers, access to transportation and hours of operation; the wait-times to schedule appointments; personal choices and resistance to seek care; and ability to navigate and coordinate care.

Healthy eating and active living

Rationale and possible health factors influencing the health need

In the region, there remains wide variation in diet quality and active living. Wealthier areas generally had higher access to healthy 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. Obesity has increased since 2016, though at a slower rate than previous assessments have shown. In several counties, obesity has decreased slightly. There remain high (and increasing) rates of fast food restaurants coupled with low (and decreasing) rates of food access in low-income areas. Additional barriers to healthy eating and active living throughout the KPGA Region are time spent commuting, the perception of safety from crime and poor infrastructure (e.g., sidewalks, lighting, and recreation areas).

Communities disproportionately impacted

The KPGA Region shows above-average rates of fast food establishments when compared to Georgia (87.3 vs. 83.1 per 100,000 population), and four counties have higher rates than the KPGA Region. The KPGA Region has an average rate of grocery stores when compared to Georgia (18.2 and 18.1 per 100,000 population); though 8 counties have grocery store rates that are significantly below the state average. A higher percentage of the population in the KPGA Region experiences low food access when compared to Georgia (35.3 vs. 30.8%); which includes higher percentages in 16 counties. An average percentage of the population in the KPGA Region engage in no leisure-time physical activity when compared to Georgia (22.0 and 23.8%); though 17 counties show higher percentages than the state. An average percentage of the population in the KPGA Region are considered obese (BMI over 30.0) when compared to Georgia (28.5 and 30.0%); though 16 counties show higher percentages than the state. The percentage of the population commuting more than 60 minutes is higher in the KPGA Region when compared to Georgia (12.3 vs. 9.8%); though six counties have lower percentages.

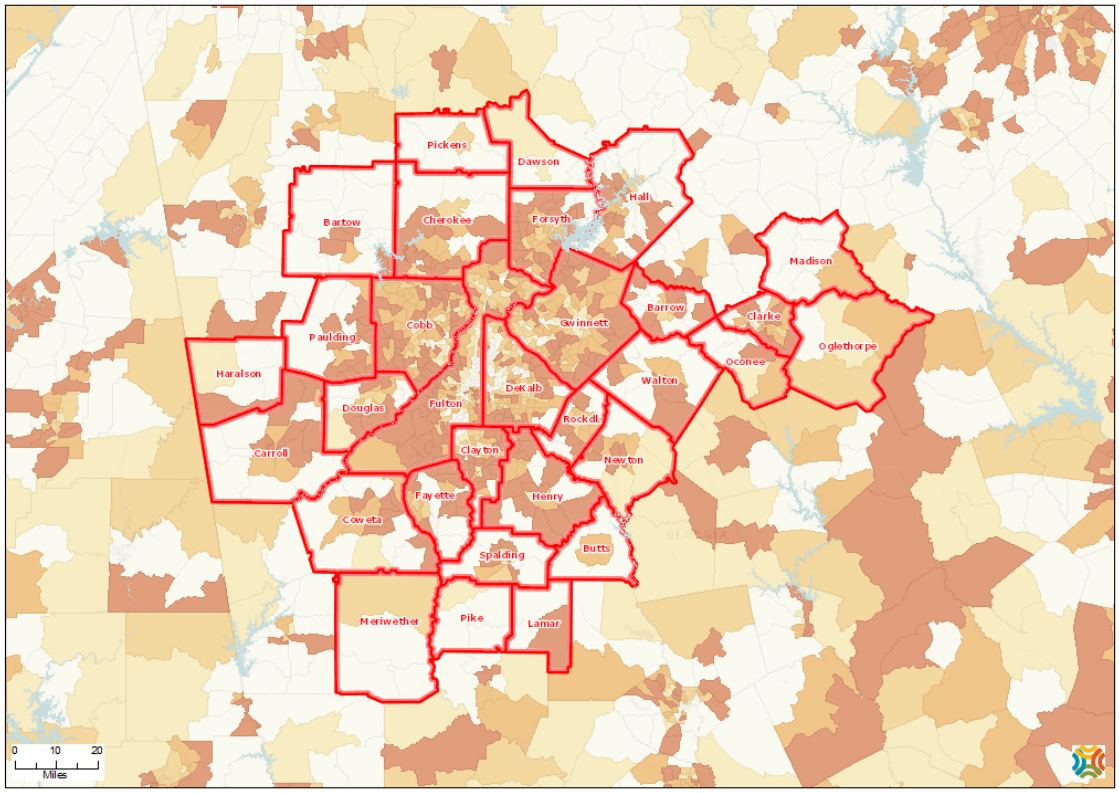
Populations disproportionately impacted

No information is available.

Primary data

Community leaders and residents made connections between many of the poor health outcomes they see in their communities and dietary and activity practices. Discussions most often emphasized: limited access to healthy nutrition, education and nutrition literacy, fast food prevalence in low-income areas, cultural preferences that may not be healthy, physical activity that is limited by commuting times, and the perception of unsafe communities due to crime and the built environment.

Low Food Access, Low Income KP Region



Map Legend

Population with Limited Food Access, Low Income, Percent by Tract, FARA 2015

- Over 50.0%
- 20.1 - 50.0%
- 5.1 - 20.0%
- Under 5.1%
- No Low Food Access

Community Commons, 12/18/2018

Chronic disease

Rationale and possible health factors influencing the health need

Chronic disease and illness (cardiovascular disease – hypertension, stroke and heart disease, diabetes, cancer, kidney disease, and respiratory illness – COPD, emphysema, and asthma) - this preliminary health need combines three health need priorities from the 2016 CHNA into one. While these are drastically different diagnoses; root causes are often related to lifestyle, the environment, and the burden related to cost, care coordination, self-management, health literacy and motivation.

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. African American residents show higher mortality rates than other races, and lower income, non-immigrant, older, lower-resourced, low population density, and geographically isolated areas tend to show higher incidence rates.

Cancer - Taken together, cancers remain 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. The combined cancer incidence rate for the KPGA Region is slightly higher than the benchmark. Since 2016, mortality rates have decreased in several counties that showed above-average rates in the previous assessment. Today, the combined cancer mortality rate is below the state average, and there remains moderate variation within cancer types. For example, where screening rates are low, prevalence can also be low, but mortality rates are often higher due to late stage diagnosis. Tobacco use, diet, physical activity, vaccinations, access to treatment options, and environmental exposures contribute to some variation in the outcome as well.

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; particularly for populations with limited care coordination and congruency. In the CHNA region, diabetes has continued to increase and continues to trend with economic disadvantage, rural residency, non-immigrant status, and food access.

Communities disproportionately impacted

The KPGA Region has a higher than average cancer incidence rate and lower than average death rate when compared to Georgia (129.8 vs. 125.2 per 100,000 population and 155 vs. 164.9 per 100,000 population). Higher incidence rates than state averages can be found in 16 counties and higher than average death rates can be found in 19 counties. The percentage of the population diagnosed with diabetes in the KPGA Region is average when compared to Georgia (10.2 and 11.0%); though higher percentages can be found in 16 counties. The KPGA

Region has an average percentage of adults diagnosed with heart disease when compared to GA (3.9 and 4.4%); though 15 counties show higher rates of diagnosis. Fourteen counties have higher rates of premature death due to Ischemic Heart and Vascular Disease (GA Avg: 524.8), 11 counties have higher rates of death due to Ischemic Heart and Vascular Disease (GA Avg: 73.1), and 18 counties have higher hospital discharge rates due to Ischemic Heart and Vascular Disease (GA Avg: 255.3). The percentage of adults diagnosed with high blood pressure in the KPGA Region is average when compared to Georgia (29.3 and 31.6%); though ten counties show above average percentages. Twenty counties have higher rates of death due to COPD (excluding Asthma) (GA Avg: 45.2). The KPGA Region has a below average death rate due to kidney disease when compared to Georgia (16.8 vs. 18.4); though 13 counties show higher than average rates.

Populations disproportionately impacted

Whites have slightly higher rates of death due to COPD, Blacks have higher rates of death due to Cerebrovascular Disease, and African American and White residents have higher rates of mortality related to heart disease.

Primary data

Community leaders and residents noted that the most common diagnoses they see in their communities were: obesity/overweight (adult and pediatric), cardiovascular disease (stroke, hypertension/high blood pressure, etc.), diabetes, cancer, HIV, kidney disease, and respiratory illness (COPD, emphysema, and asthma). It is important to note that the majority of these are chronic illnesses related to lifestyle (e.g., diet, exercise, and smoking) or environment (e.g., pollution, carcinogens).

HIV/AIDS/STDs

Rationale and possible health factors influencing the health need

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 and gonorrhea infection rates remain relatively high and increasing in more dense and urban populations.

Communities disproportionately impacted

Three counties all have much higher rates of STIs including HIV when compared to the state (588.0 per 100,000 population) and KPGA Region (630.3 per 100,000 population). Chlamydia increased in the CHNA Region and the state from 417.7 and 458.2 per 100,000 population respectively in 2013 to 611.5 and 627.3 per 100,000 population in 2017. Gonorrhea increased in the CHNA Region and the state from 125 and 128.6 per 100,000 population respectively in 2013 to 220.1 and 217.2 per 100,000 population in 2017.

Populations disproportionately impacted

Rates of STIs are highest among African American residents.

Primary data

Community leaders and residents noted that there had been little change in the last three years in the rates of STIs in their communities. HIV, syphilis, gonorrhea, and chlamydia were the most mentioned infectious diseases; though Hepatitis C and tuberculosis came up in several conversations about the health needs among older populations and homeless populations. Community leaders and residents often discussed the following related to STIs:

- Rates are increasing among young adults (15-24 years old).
- The lack of prevention education in schools (schools teach abstinence only) was often noted as a driving factor.
- A few stakeholders noted that rates tend to be higher among specific populations (prostitutes, substance abusers, and men who have sex with other men), and tuberculosis in homeless populations.

Mental health

Rationale and possible health factors influencing the health need

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 has increased and remains a challenge in some communities. African American residents tend to have higher emergency room visit rates, while White residents show higher rates of suicide. There are many risk factors such as economic stressors, exposure to traumatic events, and social isolation that may contribute to poor mental health. According to data retrieved from the Georgia Department of Public Health's Online Analytical Statistical Information System, ER visit rates in the Georgia Region due to Mental Health and Behavior Disorders increased from 889.7 to 1041.5 between 2013-2017. However, death rates due to these conditions also decreased from 64.7 to 26.5 during this period. Regarding suicide, rates increased from 11.0 to 12.4 between 2013-2017.

Communities disproportionately impacted

The KPGA Region is average or better than Georgia in ER Visit Rates for Mental Health and Behavior Disorders (1041.5 vs. 1098.5), Death Rates due to Mental Health and Behavior Disorders (26.5 vs. 30.8) and Death Rates due to Suicide (12.4 vs. 13.6). Yet many counties have higher than average rates for some indicators:

- 17 counties have higher ER Visit Rates for Mental Health and Behavior Disorders (GA Avg:1,098.5);
- 16 counties have higher rates of Premature Death due to Suicide (GA Avg: 429.8);
- 15 counties have higher rates of Death due to Mental and Behavioral Disorders (GA Avg: 30.8); and
- 13 counties have higher Hospital Discharge Rates due to Mental and Behavioral Disorders (GA Avg: 531.5).

Populations disproportionately impacted

African American residents have higher rates of Hospital Discharge and Death due to Mental and Behavioral Disorders. White residents have higher rates of Premature Death due to Suicide.

Primary data

The need to address mental health was one of the most discussed challenges by both community leaders and residents. Community leaders and residents focused on:

- Resistance to seek care due to the stigma associated with treatment and diagnosis
- The increasing rate of suicide in some communities

- Social supports are not always available (e.g., seniors not living close to family, African Americans due to cultural norms around mental health, and youth whose parent(s) may be largely absent)
- Lack of providers (particularly for children) and general psychiatry shortage
- Unaffordable cost of uninsured care
- The prevalence of stress among people of color and residents in poverty

Substance abuse

Rationale and possible health factors influencing the health need

In the last decade, substance abuse has become an increasing concern in many parts of the United States, specifically related to opioid abuse and overdose. Georgia ranks among the 11 worst states in the nation for substance abuse. The CHNA region shows elevated emergency room visit rates that have increased significantly since the last assessment. During the same period, drug overdoses have increased. According to primary data sources, the most common substances used throughout the CHNA Region are tobacco or vaping, marijuana, alcohol, heroin, methamphetamine, crack/cocaine, and prescription pills. White residents have higher mortality rates, though substance abuse contributes to poor health outcomes, and higher rates of crime, incarceration, as well as death. Between 2013 and 2017, ER Visit Rates for Disorders Related to Drug Use in the Georgia Region increased significantly from 37.7 to 368.8 per 100,000 population. Death rates from drug overdoses also increased during this period from 10.1 to 12.6 per 100,000 population.

Communities disproportionately impacted

The KPGA Region shows average or better rates for ER Visit Rates for Disorders Related to Drug Use (368.8 vs. 362.2), Death Rates due to Drug Overdoses (14.3 vs. 14.6), and the Percent of Population Who Currently Smokes (14.6 vs. 17.8). However, there are higher rates for ER Visit Rates for Disorders Related to Drug Use in 17 counties; Death Rates due to Drug Overdoses in 17 counties; and Percent of Population Who Currently Smokes in 14 counties.

Populations disproportionately impacted

White residents have much higher mortality rates due to drug overdose.

Primary data

Community leaders and residents discussed substance abuse focusing discussions on:

- The most commonly used substances - tobacco/vaping, marijuana, alcohol, heroin, methamphetamine, crack/cocaine, and prescription pills
- Prevalence of liquor stores in low-income communities
- It is becoming difficult to effectively manage pain due to the opioid crisis
- Drug trafficking that is prevalent (Gwinnett County was specifically mentioned)
- Reduced employment options due to lower functioning and incarceration
- A perception that substance abuse is often a byproduct of pain, stress, or weight loss in their communities

Social determinants of health

Rationale and possible health factors influencing the health need

Social determinants of health include poverty/income; employment status; challenges related to race, ethnicity, and culture; education; housing; and single-parent status. This preliminary health need combines three health need priorities from the 2016 CHNA into one; namely educational attainment, poverty, and transportation.

Educational Attainment - Educational attainment is one of the strongest predictors of life expectancy and lifetime health status. In the CHNA region, there is a 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, working multiple jobs, extremely long travel times to work, parents who are absent due to illness or violence, or loss of housing.

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.

Transportation - Transportation is a key component to accessing the essentials of a healthy life, such as 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.

Communities disproportionately impacted

According to the Community Need Index, there are several notable areas where the primary health drivers—poverty, uninsured rate, population without a high school diploma, and limited English proficiency—are highest in the region. In the KPGA Region, more than 1 in 4 children are living in single-parent, female-headed households in poverty. Cobb, DeKalb, Clayton, Gwinnett, and Hall Counties have the highest percentages of populations with limited English skills. More than 1 in 5 adults do not have a high school diploma in six counties. Unemployment is more than double the state rate (4.3%) in seven counties. More than 1 in 5 residents are uninsured in five KPGA counties. The percentage of the population with no motor vehicle in the

KPGA Region is average when compared to the state (6.1 and 6.72% respectively); though there are more than average percentages found in six counties.

Populations disproportionately impacted

Hispanic residents are far less likely to earn a high school diploma (or equivalent) when compared to all other races and ethnicities. African American and Hispanic residents are more likely to earn an income below poverty than any other race or ethnicity.

Primary data

Community leaders and residents often discussed social determinants of health (poverty/income; employment status; challenges related to race, ethnicity, and culture; education; housing; and single parent status) as the root cause of many of the health issues they mentioned. Conversations focused on:

- Lack of employment options lead to unemployment or underemployment and low wages; temporary and part-time employment undermines full-time employment opportunities; single-parent homes are often in poverty; working parents may provide limited supervision of youth (food, physical activity, and crime).
- Aging housing stock issues (i.e., asbestos, poor piping/sewage, lead-based paint) can cause health issues; affordable housing is limited in areas where healthy opportunities are readily available and is not always accessible by public transportation; housing burden may influence the ability to pay for basic necessities (healthcare), affordable housing has extensive waiting lists that are often closed to new applicants, affordable housing is not being built at the same rates as luxury dwellings and student housing, there is displacement due to gentrification, homelessness is on the rise, and the homeless population is aging.
- Refugees and newcomers may face barriers to navigating health services, (e.g., lack of legal documentation, language barriers, awareness), culture and preferences are not always healthy (e.g., African-American, Hispanic were mentioned), there is a cultural preference for alternative medicines in some communities that may not always be effective, there is limited access to diverse and culturally relevant services, and there are disparities in health outcomes by race and ethnicity.
- Transportation - disconnected public transit systems from county-to-county, the amount of time spent commuting due to traffic and location, access to private transportation, the struggle getting to and from grocery stores, health providers, employment, and other locations for daily life.
- Education – Limited educational attainment has a negative influence on awareness about healthy behaviors and health resources, health literacy, comprehension, and earning potential.

Maternal and Child Health

Rationale and possible health factors influencing the health need

When compared to the nation, Georgia consistently shows higher mortality rates among mothers and infants year over year. Mortality and infant mortality rates vary by geography, race, income, and age in the CHNA region. Maternal mortality is more than two times higher for Black residents of the region than for White residents. Infant mortality is nearly three times higher among Black residents than for White residents. Birth outcomes tend to be poorest among women that have poor health statuses prior to conception. Maternal and infant mortality rates are often related to the level of access women of childbearing age have to affordable healthcare, lifestyle choices (e.g., nutrition, fitness, substance use), social determinants (e.g., poverty, education, safety, healthy housing, hygiene, etc.), and behavioral health.

Communities disproportionately impacted

Maternal mortality is average in the KPGA Region (44.7 per 100,000 live births) when compared to the state (50.7 per 100,000 live births), and both are more than double the national rate (20.7 per 100,000 live births) reported by the CDC.

Infant mortality is below average in the KPGA Region (6.6 per 1,000 live births) when compared to the state (7.6 per 1,000 live births), and both are more than the national rate (6.5 per 1,000 live births) reported by the CDC. Between 2013 and 2017, infant mortality decreased slightly in the KPGA Region from 6.8 to 6.6. In the state, infant mortality remained the same between 2013 and 2017 (7.6 per 1,000 live births).

Populations disproportionately impacted

Rates of maternal and infant mortality are highest among minority residents, and Black residents have the highest rates. Teen birth is much more likely among African American and Hispanic adolescents.

Primary data

Community leaders and residents noted that a lack of documentation among immigrant populations might lead to avoiding prenatal care more often. Women are showing up in the ER giving birth without ever receiving prenatal care in these communities.

Violence and Injury

Rationale and possible health factors influencing the health need

The KPGA Region has slightly elevated rates of violence and pedestrian accident deaths. Violence and injury rates vary by population density, infrastructure (sidewalks, crosswalks, street lights, etc.), income, education, and racial/ethnic identity in the CHNA region. Violent crime rates tend to be highest in urban low-income communities; whereas pedestrian accident deaths are highest in rural areas.

Communities disproportionately impacted

Six counties all have much higher rates of violence when compared to the state (377 per 100,000 population) and KPGA Region (394 per 100,000 population). Four counties all have much higher rates of pedestrian accident deaths when compared to the state (1.96 per 100,000 population) and KPGA Region (1.97 per 100,000 population).

Populations disproportionately impacted

Black residents are more than twice as likely to die of homicide. White residents are slightly more likely to die of unintentional injury.

Primary data

Residents and stakeholders noted that children are not playing outside as a result of safety concerns related to violence and crime.

Appendix D. Community resources

Resource provider name	Summary description
Access to Care and Chronic Disease	
Athens Neighborhood Health Center, Inc.	The mission of the Athens Neighborhood Health Center is to provide affordable, high quality primary healthcare to medically under-served individuals in Athens-Clarke County and surrounding areas.
Lifetime Personal Care Home Inc.	The mission of Lifetime is to empower children, adults, and the elderly with developmental disabilities to achieve their potential based on personal choice and interest. The mission of Lifetime is accomplished through person-centered services, support to families, advocacy and leadership, which together will inspire the community to value the inclusion of people with developmental disabilities.
MedLink Georgia	The mission of MedLink Georgia, Inc. is to partner with patients to support their wellness through compassionate quality healthcare.
Tendercare Clinic, Inc.	The mission of TenderCare Clinic is to provide cost-effective and accessible primary healthcare with dedication to the highest quality of customer service delivered with a sense of warmth, friendliness, individual pride and company spirit.
Clayton County Board of Health	The mission of the Clayton County Board of Health is to improve the overall health and safety of the community through health promotion, prevention, protection, and preparedness planning activities that are evidence-based and data-driven.
DeKalb County Board of Health	The mission of DeKalb County Board of Health is to protect, promote, and improve the health of those who work, live, and play in DeKalb County. The DeKalb County Board of Health's Ryan White Early Care Clinic has a team of experts – physician, nurse, dentist, dental hygienist, social workers and counselors – who work together to provide quality services to persons with HIV.
Four Corners Primary Care Center at VPH	The mission of the Four Corners Primary Care Centers is to serve our community by seeking to meet the primary and preventive health care needs of the medically underserved by providing culturally sensitive quality, affordable, accessible healthcare and supportive services, regardless of ability to pay, race, religion, or other barriers.
Oakhurst Medical Center	Oakhurst Medical Center provides affordable, accessible, quality primary care services to ethnically diverse patients and their families. As a grassroots medical option for the underserved and uninsured, Oakhurst saves the county and state money by providing primary care to those who would typically seek help in an emergency room setting for non-emergency problems. It continues to be the healthcare safety net for DeKalb County.
Gwinnett, Newton, Rockdale Health Departments	The Gwinnett, Newton, & Rockdale County Health Departments work to protect and improve the health of those who work, live, and play in our community, and continually strive to meet the varied health needs of residents and visitors.
Fulton County Board of Health	The Fulton County Board of Health is committed to promoting and protecting the health of individuals, families and communities.

Resource provider name	Summary description
North Georgia Health District	Our mission is to promote and protect the health of the people in the North Georgia Health District wherever they live, work and play, through population-based preventive programs including: prevention of epidemics and the spread of disease, protection against environmental hazards, injury prevention, promotion and encouragement of healthy behaviors, responding to disasters and assisting communities to recover, and assisting communities in assessing the quality and accessibility of health services
District 4 Public Health	District 4 Public Health is comprised of 12 counties in west Georgia: Butts, Carroll, Coweta, Fayette, Heard, Henry, Lamar, Meriwether, Pike, Spalding, Troup and Upson. To protect and improve the health of our communities through the prevention of disease, the promotion of healthy behaviors, access to quality services, strong community partnerships, and disaster preparedness.
Cobb & Douglas Public Health	Cobb & Douglas Public Health, with our partners, promotes and protects the health and safety of the residents of Cobb and Douglas counties. We work to achieve healthy people in healthy communities by: preventing epidemics and spread of disease, protecting against environmental hazards, preventing injuries, promoting and encouraging healthy behaviors, responding to disasters and assisting in community recovery, and assuring the quality and accessibility of health care.
Southside Medical Center	Southside Medical Center is committed to providing exceptional primary health care and related services to the medically underserved of Metropolitan Atlanta. Southside Behavioral Lifestyle Enrichment Center (SBLEC) serves all men and women, aged 18 and older, who seek to overcome the use of any type of drug or alcohol.
YourTown Health	YourTown Health's network of seven non-profit Community Health Centers serves the communities of Meriwether, Pike, Lamar, Carroll, Coweta, and South Fulton counties. YourTown Health's mission is to provide comprehensive preventative, curative, and life-enhancing services in a non-judgmental and compassionate environment.
Harris County Health Department	Recognizing the ever changing complexity of the health care community, Harris County Health Department and West Central Health District exist as resources to ensure an environment where all people can obtain health care services and attain optimum health and well-being by valuing themselves, by valuing others, and by caring.
Northeast Health District	The Northeast Health District is comprised of 18 clinics within a 10-county region including Barrow, Clarke, Elbert, Greene, Jackson, Madison, Morgan, Oconee, Oglethorpe and Walton counties. The goal of the Northeast Health District is to offer free or low-cost services to all people within our area and to promote healthy lifestyles among all member of our community.
Healthy eating and active living	
Georgia Division of Family and Children Services	The Georgia Division of Family and Children Services (DFCS) investigates reports of child abuse; finds foster and adoptive homes for abused and neglected children; issues SNAP, Medicaid, TANF and child care assistance to low-income families; helps out-of-work parents get back on their feet; and provides numerous support services and innovative programs to help families in need.
Mental Health	

Resource provider name	Summary description
Advantage Behavioral Health Systems	It is the mission of Advantage Behavioral Health Systems to provide person-centered community-based services and treatment to individuals and families experiencing mental illness, developmental disabilities, and addictions, by collaboratively using personal, community and organizational resources.
Oconee Center for Behavioral Health	OCBH is dedicated to providing the highest level of care for those individuals and families who are experiencing difficult life stressors and/or struggling with ongoing mental health disorders.
Clayton County Association Against Family Violence – Securus House	For the last twenty-nine years, the Clayton County Association Against Family Violence, Inc., a.k.a. Securus House, has provided shelter, support, counseling and advocacy for victims of family violence in Clayton County and the surrounding Metro Atlanta counties.
Fulton County Family Violence Task Force	The Fulton County Family Violence Task Force was created to coordinate agencies, departments and the courts to promote safety and justice for victims while holding perpetrators accountable and to improve the response to family violence so as to reduce incidents thereof.
Men Stopping Violence	The mission of Men Stopping Violence is to organize men to end male violence against women and girls through innovative trainings, programs and advocacy.
Diversion Center	Diversion Center is a court-approved outpatient treatment facility headquartered in Marietta, GA. They provide court mandated and employer mandated counseling on topics including family violence, anger management, alcohol and other drugs, and parenting.
HIV/AIDS/STDs	
AID Atlanta	AID Atlanta currently offers HIV/AIDS prevention and care services, including (but not limited to) Primary Care, HIV/STD Screening, PrEP, Community HIV Prevention Programs, Linkage Services, Case Management, and a state-wide Information Hotline. The mission of AID Atlanta is to reduce new HIV infections and improve the quality of life of its members and the community by breaking barriers and building community.
Empowerment Resource Center	The mission of Empowerment Resource Center is to provide programs, services, and community-level solutions that improve the health-related quality of life of people infected and affected by HIV and other sexually transmitted infections (STI).
Positive Impact Health Centers	The mission of Positive Impact Health Centers is to provide client centered care for the HIV community to have a life worth living.
Social Determinants of Health	
Bobby Dodd Institute	The mission of the Bobby Dodd Institute is to empower people with differing abilities to maximize their potential by securing economic self-sufficiency, independence and inclusion within their communities. BDI and our supporters equip people with the skills, experience, and support they need to be competitive in the job market and build their careers.
Atlanta Center for Self Sufficiency	The mission of the Atlanta Center for Self Sufficiency is to empower financially vulnerable individuals in our community to become self-sufficient, sustainably employed and economic contributors to society.

Resource provider name	Summary description
Goodwill of North Georgia	The mission of Goodwill of North Georgia is to put people to work. Resources include local job listings, career preparation workshops and classes, and job fairs.
Butts County Development Authority	Southern Crescent Technical College has a campus center in Jackson, Georgia that offers college classes in the fields of nurse aide, patient care assistant, commercial truck driving, and diesel equipment technology. Southern Crescent Technical College develops programs that are designed to meet the changing needs of the regional economy with the flexibility and creativity necessary to sustain the workforce of the future. Georgia's Quick Start program offers pre-employment training using industry-specific certificate programs administered through Southern Crescent Technical College and post-employment training through the Quick Start program customized to the specific needs of a company. The Butts County School System also partners with Griffin Region College and Career Academy which is willing to tailor a program to meet a company's needs.
WorkSource Atlanta Regional	WorkSource Atlanta Regional, which is managed by ARC, maintains career resource centers that serve Cherokee, Clayton, Douglas, Fayette, Gwinnett, Henry and Rockdale counties. Professionals at these centers assist job-seekers with career assessment testing, job readiness training in areas such as effective communication and problem solving, job search training assistance and help locating approved training and education providers and registering for programs.
Department of Labor Career Centers Georgia Department of Labor	The Georgia Department of Labor provides a wide range of services to job seekers and employers. These include administration of Georgia's unemployment insurance, employment service, provision of workforce information to the public and private sectors, and oversight of child labor issues.

Appendix E. Leading causes of premature death, death, ER visits, & hospital discharges, KPGA region

According to 2017 data from the Georgia Department of Health Online Analytical and Statistical Information System (OASIS), the following conditions were identified as the top causes of premature death, death, ER visits, and hospital discharges.

Top Causes of…			
Years of life lost (Premature Death)	**Age-adjusted Death Rates**	**Age-adjusted ER Visit Rate**	**Hospital Discharge Rates**
• Ischemic Heart and Vascular Disease • Accidental Poisoning and Exposure to Noxious Substances • Motor Vehicle Crashes • Intentional Self-Harm (Suicide) • Certain Conditions Originating in the Perinatal Period	• Ischemic Heart and Vascular Disease • Malignant Neoplasms of the Trachea, Bronchus and Lung • Cerebrovascular Disease • All COPD Except Asthma • All Other Mental and Behavioral Disorders	• All Other Unintentional Injury • Diseases of the Musculoskeletal System and Connective Tissue • All Other Diseases of the Genitourinary System • Falls • Motor Vehicle Crashes	• Pregnancy, Childbirth and the Puerperium • Diseases of the Musculoskeletal System and Connective Tissue • All Other Mental and Behavioral Disorders • Septicemia • Ischemic Heart and Vascular Disease

Regarding **conditions that contribute to premature death**, 14 counties have higher rates of premature death due to Ischemic Heart and Vascular Disease (GA Avg: 524.8), 15 counties have higher rates of premature death due to Accidental Poisoning and Exposure to Noxious Substances (GA Avg: 477.9), 14 counties have higher rates of premature death due to Motor Vehicle Crashes (GA Avg: 491.1), 16 counties have higher rates of premature death due to Suicide (GA Avg: 429.8), 7 counties have higher rates of premature death due to Suicide Conditions originating in the Perinatal Period (GA Avg: 360.0). The following racial groups have rates higher than the state average:

- Whites have higher rates of premature death due to Accidental Poisoning and Suicide.
- Blacks have higher rates of premature death due to Motor Vehicle Crashes and Pregnancy-related Complications.
- Multiracial residents have higher rates of premature death due to Conditions Originating in the Perinatal Period.

Regarding **conditions that are the predominant causes of death** in the 31-county area:11 counties have higher rates of death due to Ischemic Heart and Vascular Disease (GA Avg: 73.1), 16 counties have higher rates of death due to Malignant Neoplasms of the Trachea, Bronchus and Lung (GA Avg: 42.4), 14 counties have higher rates of death due to Cerebrovascular Disease (GA Avg: 43.4), 20 counties have higher rates of death due to COPD (GA Avg: 45.2), 15 counties have higher rates of death due to Mental and Behavioral Disorders (GA Avg: 30.8). The following racial groups have rates higher than the state average:

- Whites have slightly higher rates of death due to COPD.
- Blacks have higher rates of death due to Cerebrovascular Disease and Mental and Behavioral Disorders.

Regarding conditions that are the **predominant causes of ER visits** in the KPGA Region: 19 counties have higher rates of ER visits due to unintentional injury (GA Avg: 3,030.0), 19 counties have higher rates of ER visits due to Diseases of the Musculoskeletal System and Connective Tissue (GA Avg: 3,276.9), 18 counties have higher rates of ER visits due to Diseases of the Genitourinary System (GA Avg: 2,394.2), 20 counties have higher rates of ER isits due to Falls (GA Avg: 1,918.4), 20 counties have higher rates of ER visits due to Motor Vehicle Crashes (GA Avg: 1,168.8). The following racial groups have rates higher than the state average:

- Blacks have higher rates of ER visits due to Diseases of the Musculoskeletal System and Connective Tissue, Diseases of the Genitourinary System, and Motor Vehicle Crashes.
- Multiracial residents have higher rates of ER visits due to Unintentional Injury, Diseases of the Genitourinary System, Falls, and Motor Vehicle Crashes.

Regarding conditions that are the **predominant causes of hospital discharge rates**: 21 counties have higher hospital discharge rates due to Pregnancy, Childbirth and the Puerperium (GA Avg: 1,289.5), 17 counties have higher hospital discharge rates due to Diseases of the Musculoskeletal System and Connective Tissue (GA Avg: 489.3), 13 counties have higher hospital discharge rates due to Mental and Behavioral Disorders (GA Avg: 531.5), 18 counties have higher hospital discharge rates due to Septicemia (GA Avg: 514.5), 18 counties have higher hospital discharge rates due to Ischemic Heart and Vascular Disease (GA Avg: 255.3). The following racial groups have rates higher than the state average:

- Whites have higher hospital discharge rates due to Diseases of the Musculoskeletal System and Connective Tissue.
- Blacks have higher hospital discharge rates due to Pregnancy, Childbirth and the Puerperium, Mental and Behavioral Disorders and Septicemia.
- American Indian or Alaska Native have higher hospital discharge rates due to Pregnancy, Childbirth and the Puerperium.
- Multiracial residents have higher hospital discharge rates for all conditions identified.