2020 COMMUNITY HEALTH NEEDS ASSESSMENT

Peach County, Georgia

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The Medical Center of Peach County - Navicent Health

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INTRODUCTION

PROJECT OVERVIEW

This Community Health Needs Assessment, a follow-up to similar studies conducted in 2012, 2015, and 2018, is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in Peach County, the service area of The Medical Center of Peach County - Navicent Health. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status.

This assessment was conducted on behalf of The Medical Center of Peach County - Navicent Health by PRC, a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Methodology

This assessment incorporates data from multiple sources, including primary research (through the PRC Community Health Survey and PRC Online Key Informant Survey), as well as secondary research (vital statistics and other existing health-related data). It also allows for trending and comparison to benchmark data at the state and national levels.

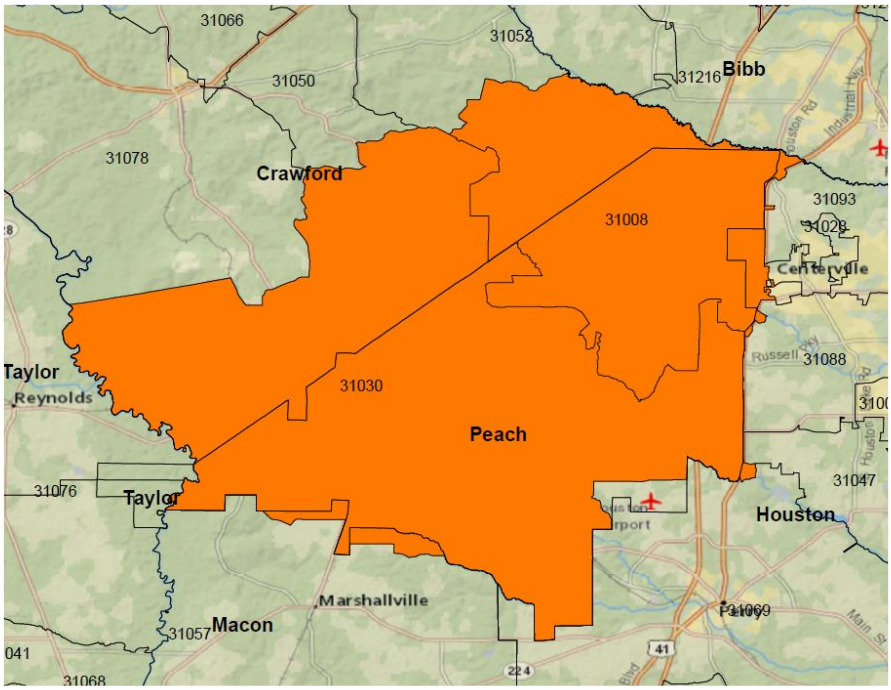
PRC Community Health Survey

Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by Navicent Health and PRC and is similar to the previous surveys used in the region, allowing for data trending.

Community Defined for This Assessment

The study area for the survey effort (referred to as the “Peach County” in this report) is defined as ZIP Codes 31008 and 31030. This community definition, determined based on the ZIP Codes of residence of recent patients of The Medical Center of Peach County - Navicent Health, is illustrated in the following map.



Sample Approach & Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology — one that incorporates both landline and cell phone interviews — was employed. The primary advantages of telephone interviewing are timeliness, efficiency, and random-selection capabilities.

The sample design used for this effort consisted of a random sample of 200 individuals age 18 and older in Peach County. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent Peach County as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

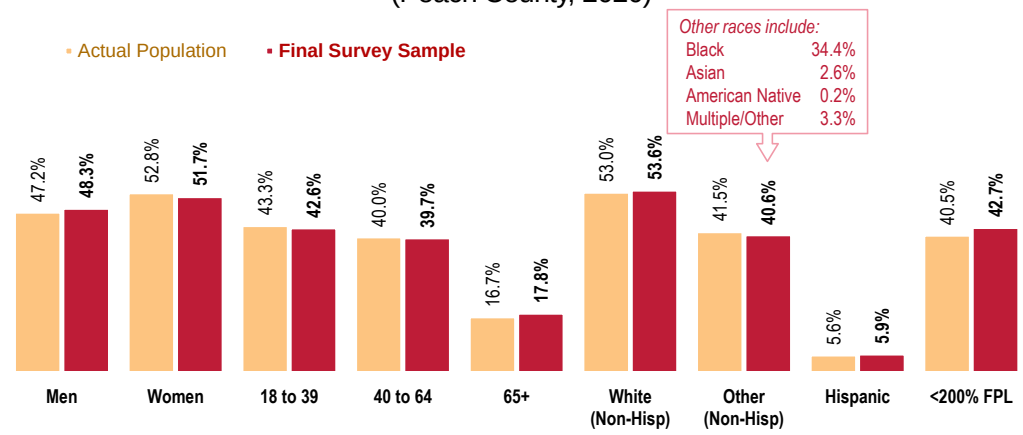
For statistical purposes, the maximum rate of error associated with a sample size of 200 respondents is ±6.9% at the 95 percent confidence level.

Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. While this random sampling of the population produces a highly representative sample, it is a common and preferred practice to “weight” the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias.

The following chart outlines the characteristics of the Peach County sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted of area residents age 18 and older.]

Population & Survey Sample Characteristics
(Peach County, 2020)



Sources:
- US Census Bureau, 2011-2015 American Community Survey.
- 2020 PRC Community Health Survey, PRC, Inc.

Notes:
- FPL is federal poverty level, based on guidelines established by the US Department of Health & Human Services.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

INCOME & RACE/ETHNICITY

INCOME ► Poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2019 guidelines place the poverty threshold for a family of four at $25,750 annual household income or lower). In sample segmentation: “low income” refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice (<200% of) the poverty threshold; “mid/high income” refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

RACE & ETHNICITY ► In analyzing survey results, mutually exclusive race and ethnicity categories are used. All Hispanic respondents are grouped, regardless of identity with any other race group. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey also was implemented as part of this process. A list of recommended participants was provided by Navicent Health; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 10 community stakeholders took part in the Online Key Informant Survey. Final participation included representatives of the organizations outlined below.

- City of Byron
- City of Ft. Valley
- Family Connections
- Ft. Valley State University
- The Medical Center of Peach County – Navicent Health
- Peach County
- Peach County Fire Department
- Peach County Health Department
- Peach County School System

Through this process, input was gathered from several individuals whose organizations work with low-income, minority, or other medically underserved populations.

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such and how these might better be addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

NOTE ► These findings represent qualitative rather than quantitative data. The Online Key Informant Survey was designed to gather input regarding participants' opinions and perceptions of the health needs of the residents in the area.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for Peach County were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension, SparkMap (sparkmap.org)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- ESRI ArcGIS Map Gallery
- Georgia Department of Public Health
- National Cancer Institute, State Cancer Profiles

- OpenStreetMap (OSM)
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Benchmark Data

Trending

Similar surveys were administered in Peach County in 2012, 2015, and 2018 by PRC on behalf of The Medical Center of Peach County - Navicent Health. Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available. Historical data for secondary data indicators are also included for the purposes of trending.

Georgia Risk Factor Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data represent the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trends Data* published online by the Centers for Disease Control and Prevention. State-level vital statistics are also provided for comparison of secondary data indicators.

Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2020 PRC National Health Survey*; the methodological approach for the national study is similar to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

Healthy People 2030

Healthy People provides 10-year, measurable public health objectives — and tools to help track progress toward achieving them. Healthy People identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being. Healthy People 2030, the initiative's fifth iteration, builds on knowledge gained over the first four decades.

Healthy People 2030's overarching goals are to:

- Attain healthy, thriving lives and well-being free of preventable disease, disability, injury, and premature death.
- Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
- Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.

- Promote healthy development, healthy behaviors, and well-being across all life stages.
- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

The Healthy People 2030 framework was based on recommendations made by the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. After getting feedback from individuals and organizations and input from subject matter experts, the U.S. Department of Health and Human Services (HHS) approved the framework which helped guide the selection of Healthy People 2030 objectives.

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, lesbian/gay/bisexual/ transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly medical conditions that are not specifically addressed.

Public Comment

The Medical Center of Peach County - Navicent Health made its prior Community Health Needs Assessment (CHNA) report publicly available on its website; through that mechanism, the hospital requested from the public written comments and feedback regarding the CHNA and implementation strategy. At the time of this writing, The Medical Center of Peach County - Navicent Health had not received any written comments. However, through population surveys and key informant feedback for this assessment, input from the broader community was considered and taken into account when identifying and prioritizing the significant health needs of the community. The Medical Center of Peach County - Navicent Health will continue to use its website as a tool to solicit public comments and ensure that these comments are considered in the development of future CHNAs.

IRS Form 990, Schedule H Compliance

For non-profit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Schedule H (Form 990), the following table cross-references related sections.

IRS FORM 990, SCHEDULE H (2019)	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	4
Part V Section B Line 3b Demographics of the community	26
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	102
Part V Section B Line 3d How data was obtained	4
Part V Section B Line 3e The significant health needs of the community	11
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs	12
Part V Section B Line 3h The process for consulting with persons representing the community's interests	6
Part V Section B Line 3i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	104

SUMMARY OF FINDINGS

Significant Health Needs of the Community

The following “Areas of Opportunity” represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the community stakeholders (key informants) giving input to this process.

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
ACCESS TO HEALTH CARE SERVICES	▪ Barriers to Access – Inconvenient Office Hours – Appointment Availability ▪ Primary Care Physician Ratio
CANCER	▪ Leading Cause of Death ▪ Cancer Deaths ▪ Cancer Incidence – Including Lung Cancer, Prostate Cancer, Colorectal Cancer
DIABETES	▪ Diabetes Deaths ▪ Blood Sugar Testing [Non-Diabetics] ▪ Kidney Disease Deaths ▪ Kidney Disease Prevalence ▪ Key Informants: Diabetes ranked as a top concern.
HEART DISEASE & STROKE	▪ Leading Cause of Death ▪ Heart Disease Deaths ▪ Heart Disease Prevalence ▪ Stroke Deaths ▪ Stroke Prevalence ▪ Overall Cardiovascular Risk ▪ Key Informants: Heart disease and stroke ranked as a top concern.
INFANT HEALTH & FAMILY PLANNING	▪ Low-Weight Births ▪ Infant Deaths
INJURY & VIOLENCE	▪ Unintentional Injury Deaths – Including Motor Vehicle Crash Deaths ▪ Violent Crime Rate ▪ Domestic Violence Experience
MENTAL HEALTH	▪ Diagnosed Depression ▪ Difficulty Obtaining Mental Health Services ▪ Key Informants: Mental health ranked as a top concern.

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AREAS OF OPPORTUNITY (continued)	
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Fruit/Vegetable Consumption ▪ Low Food Access ▪ Overweight & Obesity [Adults] ▪ Meeting Physical Activity Guidelines
POTENTIALLY DISABLING CONDITIONS	▪ Activity Limitations ▪ Multiple Chronic Conditions ▪ High-Impact Chronic Pain ▪ Alzheimer's Disease Deaths
RESPIRATORY DISEASE	▪ Chronic Lower Respiratory Disease (CLRD) Deaths
SEXUAL HEALTH	▪ Gonorrhea Incidence ▪ Chlamydia Incidence ▪ HIV/AIDS Deaths ▪ HIV Prevalence
SUBSTANCE ABUSE	▪ Use of Prescription Opioids ▪ Personally Impacted by Substance Abuse ▪ Key Informants: Substance abuse ranked as a top concern.
TOBACCO USE	▪ Use of Vaping Products

Community Feedback on Prioritization of Health Needs

Prioritization for The Medical Center of Peach County - Navicent Health was determined based on a joint, regional prioritization process, along with the other Navicent Health facilities in Central Georgia. On December 17, 2020, Navicent Health convened an online meeting with community stakeholders (representing a cross-section of community-based agencies and organizations) to evaluate, discuss, and prioritize health issues for the region, based on findings of this Community Health Needs Assessment (CHNA).

Professional Research Consultants, Inc. (PRC) began the virtual meeting with a presentation of key findings from the CHNA, highlighting the significant health issues identified from the research (see Areas of Opportunity above). Following the data review, PRC answered any questions. Finally, participants were provided an overview of the prioritization exercise that followed.

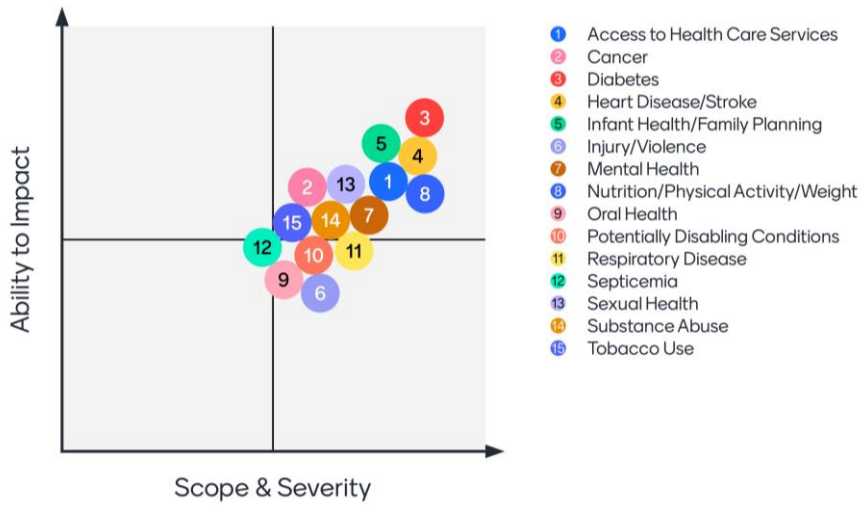
In order to assign priority to the identified health needs (i.e., Areas of Opportunity), a wireless audience response system was used in which each participant was able to register his/her ratings using a small remote keypad. The participants were asked to evaluate each health issue along two criteria:

- Scope & Severity — The first rating was to gauge the magnitude of the problem in consideration of the following:
  - How many people are affected?
  - How does the local community data compare to state or national levels, or Healthy People 2030 targets?
  - To what degree does each health issue lead to death or disability, impair quality of life, or impact other health issues?
- Ratings were entered on a scale of 1 (not very prevalent at all, with only minimal health consequences) to 10 (extremely prevalent, with very serious health consequences).
- Ability to Impact — A second rating was designed to measure the perceived likelihood of the hospital having a positive impact on each health issue, given available resources, competencies, spheres of influence, etc. Ratings were entered on a scale of 1 (no ability to impact) to 10 (great ability to impact).

Individuals' ratings for each criteria were averaged for each tested health issue, and then these composite criteria scores were averaged to produce an overall score. This process yielded the following prioritized list of community health needs:

1. Diabetes
2. Heart Disease & Stroke
3. Nutrition, Physical Activity & Weight
4. Infant Health & Family Planning
5. Access to Health Care Services
6. Sexual Health
7. Mental Health
8. Respiratory Disease
9. Cancer
10. Tobacco Use
11. Substance Abuse
12. Injury & Violence
13. Potentially Disabling Conditions

Plotting these overall scores in a matrix illustrates the intersection of the Scope & Severity and the Ability to Impact scores. Below, those issues placing in the upper right quadrant represent health needs rated as most severe, with the greatest ability to impact.



Hospital Implementation Strategy

The Medical Center of Peach County - Navicent Health will use the information from this Community Health Needs Assessment to develop an Implementation Strategy to address the significant health needs in the community. While the hospital will likely not implement strategies for all of the health issues listed above, the results of this prioritization exercise will be used to inform the development of the hospital's action plan to guide community health improvement efforts in the coming years.

Note: An evaluation of the hospital's past activities to address the needs identified in prior CHNAs can be found as an appendix to this report.

Summary Tables: Comparisons With Benchmark Data

The following tables provide an overview of indicators in Peach County, as well as trend data. These data are grouped by health topic.

Reading the Summary Tables

- In the following tables, Peach County results are shown in the larger, gray column.
- The columns to the right of the Peach County column provide trending, as well as comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Symbols indicate whether Peach County compares favorably (☀), unfavorably (☁), or comparably (⛅) to these external data.

TREND SUMMARY

(Current vs. Baseline Data)

SURVEY DATA INDICATORS:

Trends for survey-derived indicators represent significant changes since 2012.

OTHER (SECONDARY) DATA INDICATORS:

Trends for other indicators (e.g., public health data) represent point-to-point changes between the most current reporting period and the earliest presented in this report (typically representing the span of roughly a decade).

Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.

Tip: Indicator labels beginning with a "%" symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources.

SOCIAL DETERMINANTS	Peach County	PEACH vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
Linguistically Isolated Population (Percent)	1.2	3.1	4.4		
Population in Poverty (Percent)	21.5	16.0	14.1	8.0	
Children in Poverty (Percent)	27.9	22.9	19.5	8.0	
No High School Diploma (Age 25+, Percent)	16.0	13.3	12.3		
% Unable to Pay Cash for a $400 Emergency Expense	19.7		24.6		
% Worry/Stress Over Rent/Mortgage in Past Year	29.6		32.2		36.0
% Unhealthy/Unsafe Housing Conditions	15.6		12.2		
% Food Insecure	24.5		34.1		
% Attended a Religious/Spiritual Svc in the Past Month	37.4				68.2
		better	similar	worse	

OVERALL HEALTH	Peach County	PEACH vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
% "Fair/Poor" Overall Health	17.4	19.1	12.6		23.6
		better	similar	worse	

ACCESS TO HEALTH CARE	Peach County	PEACH vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
% [Age 18-64] Lack Health Insurance	**11.8**	21.8	8.7	7.9	29.4
% Difficulty Accessing Health Care in Past Year (Composite)	**45.5**		35.0		44.2
% Cost Prevented Physician Visit in Past Year	**15.5**	18.2	12.9		28.1
% Cost Prevented Getting Prescription in Past Year	**15.4**		12.8		29.5
% Difficulty Getting Appointment in Past Year	**22.5**		14.5		15.9
% Inconvenient Hrs Prevented Dr Visit in Past Year	**23.5**		12.5		16.0
% Difficulty Finding Physician in Past Year	**10.4**		9.4		15.0
% Transportation Hindered Dr Visit in Past Year	**13.8**		8.9		10.4
% Language/Culture Prevented Care in Past Year	**0.2**		2.8		1.9
% Skipped Prescription Doses to Save Costs	**12.9**		12.7		21.6
Primary Care Doctors per 100,000	**26.0**	65.6	76.6		
% Have a Specific Source of Ongoing Care	**79.3**		74.2	84.0	
% Have Had Routine Checkup in Past Year	**73.3**	78.3	70.5		73.0
% Two or More ER Visits in Past Year	**13.2**		10.1		15.2
% Eye Exam in Past 2 Years	**69.7**		61.0	61.1	59.0
% Rate Local Health Care "Fair/Poor"	**5.7**		8.0		22.2

better similar worse

CANCER	Peach County	PEACH vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
Cancer (Age-Adjusted Death Rate)	194.4	155.8	152.5	122.7	221.2
Cancer Incidence Rate (All Sites)	487.3	467.0	448.7		
Female Breast Cancer Incidence Rate	113.4	126.8	125.9		
Prostate Cancer Incidence Rate	136.0	124.2	104.5		
Lung Cancer Incidence Rate	68.7	62.8	58.3		
Colorectal Cancer Incidence Rate	60.5	41.3	38.4		
% Cancer	11.4	10.7	10.0		
% [Women 50-74] Mammogram in Past 2 Years	86.1	80.0	76.1	77.1	86.0
% [Age 50-75] Colorectal Cancer Screening	81.1	68.8	77.4	74.4	80.2
		better	similar	worse	

DIABETES	Peach County	PEACH vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
Diabetes (Age-Adjusted Death Rate)	42.0	21.6	21.3		38.6
% Diabetes/High Blood Sugar	16.3	12.6	13.8		17.3
% Borderline/Pre-Diabetes	8.5		9.7		7.3
% [Non-Diabetics] Blood Sugar Tested in Past 3 Years	43.4		43.3		55.3
		better	similar	worse	

HEART DISEASE & STROKE	Peach County	PEACH vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
Diseases of the Heart (Age-Adjusted Death Rate)	251.6	176.9	164.7	127.4	252.6
% Heart Disease (Heart Attack, Angina, Coronary Disease)	13.3	7.1	6.1		6.4
Stroke (Age-Adjusted Death Rate)	48.1	43.7	37.3	33.4	66.1
% Stroke	11.7	3.7	4.3		5.7
% Blood Pressure Checked in Past 2 Years	91.7		85.0		
% Told Have High Blood Pressure	44.2	33.1	36.9	27.7	39.9
% [HBP] Taking Action to Control High Blood Pressure	94.8		84.2		
% Cholesterol Checked in Past 5 Years	96.5		80.7		
% Told Have High Cholesterol	36.1		32.7		32.6
% [HBC] Taking Action to Control High Blood Cholesterol	92.3		83.2		
% 1+ Cardiovascular Risk Factor	91.0		84.6		86.7
		better	similar	worse	

INFANT HEALTH & FAMILY PLANNING	Peach County	PEACH vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
Low Birthweight Births (Percent)	9.9	9.5	8.2		9.6
Infant Death Rate	9.7	7.2	5.7	5.0	
Births to Adolescents Age 15 to 19 (Rate per 1,000)	23.7	26.3	22.7	31.4	
		better	similar	worse	

INJURY & VIOLENCE	Peach County	PEACH vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
Unintentional Injury (Age-Adjusted Death Rate)	70.8	44.2	48.3	43.2	70.4
Motor Vehicle Crashes (Age-Adjusted Death Rate)	30.9	14.3	11.5	10.1	
Violent Crime Rate	498.0	373.1	416.0		
% Victim of Violent Crime in Past 5 Years	9.0		6.2		6.0
% Victim of Intimate Partner Violence	20.9		13.7		19.4
		better	similar	worse	

KIDNEY DISEASE	Peach County	PEACH vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
Kidney Disease (Age-Adjusted Death Rate)	34.5	18.5	13.0		48.5
% Kidney Disease	10.4	3.2	5.0		5.3
		better	similar	worse	

MENTAL HEALTH	Peach County	PEACH vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
% "Fair/Poor" Mental Health	14.5		13.4		10.8
% Diagnosed Depression	28.2	17.1	20.6		20.2
% Symptoms of Chronic Depression (2+ Years)	30.1		30.3		27.0
% Typical Day Is "Extremely/Very" Stressful	10.7		16.1		8.7

MENTAL HEALTH (continued)	Peach County	PEACH vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
Mental Health Providers per 100,000	55.8	21.7	42.6		
% Have Ever Sought Help for Mental Health	31.1		30.0		
% Taking Rx/Receiving Mental Health Trtmt	21.0		16.8		27.0
% Unable to Get Mental Health Svcs in Past Yr	12.1		7.8		4.9
		better	similar	worse	

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	Peach County	PEACH vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
Population With Low Food Access (Percent)	27.6	30.8	22.4		
% "Very/Somewhat" Difficult to Buy Fresh Produce	13.8		21.1		18.8
% 5+ Servings of Fruits/Vegetables per Day	15.2		32.7		42.2
% No Leisure-Time Physical Activity	35.3	26.2	31.3	21.2	31.3
% Meeting Physical Activity Guidelines	14.4	20.6	21.4	28.4	11.7
% Healthy Weight (BMI 18.5-24.9)	23.9	30.8	34.5		25.8
% Overweight (BMI 25+)	73.6	67.2	61.0		74.2
% Obese (BMI 30+)	45.9	32.5	31.3	36.0	37.7
		better	similar	worse	

ORAL HEALTH	Peach County	PEACH vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
% Have Dental Insurance	71.9		68.7	59.8	53.8
% [Age 18+] Dental Visit in Past Year	61.1	62.5	62.0	45.0	51.9

better similar worse

POTENTIALLY DISABLING CONDITIONS	Peach County	PEACH vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
% 3+ Chronic Conditions	46.2		32.5		47.2
% Activity Limitations	31.3		24.0		24.3
% With High-Impact Chronic Pain	23.3		14.1	7.0	
Alzheimer's Disease (Age-Adjusted Death Rate)	74.2	45.8	30.6		
% Caregiver to a Friend/Family Member	25.4		22.6		26.4

better similar worse

RESPIRATORY DISEASE	Peach County	PEACH vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
CLRD (Age-Adjusted Death Rate)	67.2	46.4	40.4		43.6
% [Age 65+] Flu Vaccine in Past Year	71.6	52.6	71.0		60.0
% [Adult] Asthma	9.8	8.9	12.9		10.1
% COPD (Lung Disease)	5.3	7.3	6.4		12.8

better similar worse

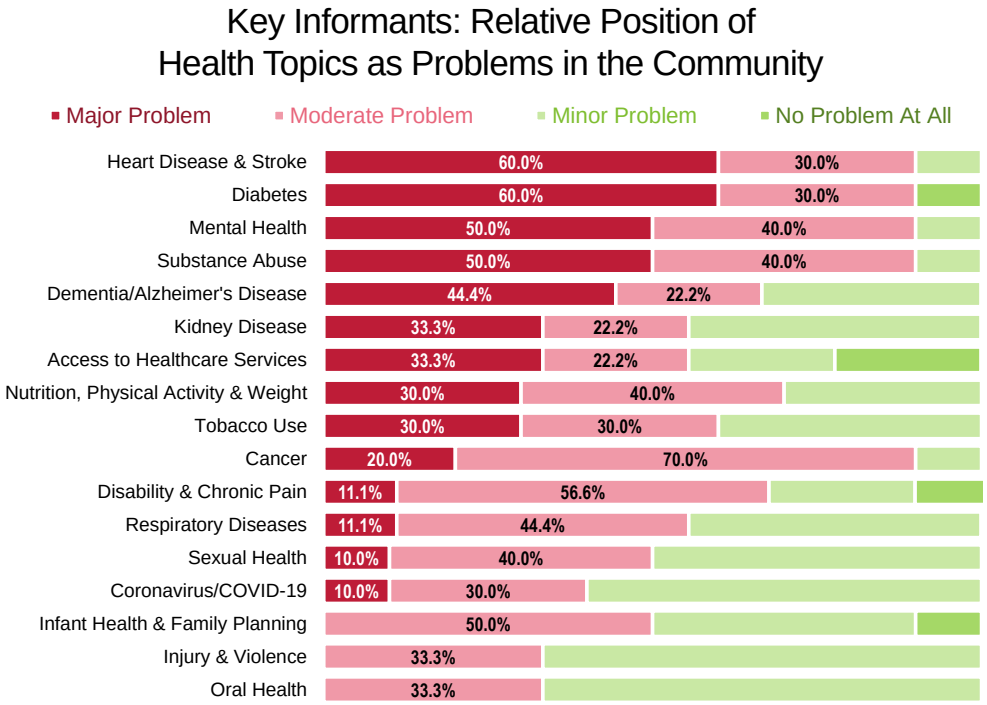
SEXUAL HEALTH	Peach County	PEACH vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
HIV/AIDS (Age-Adjusted Death Rate)	12.1	3.9	2.1		
HIV Prevalence Rate	568.7	624.9	372.8		
Chlamydia Incidence Rate	1011.1	632.2	539.9		
Gonorrhea Incidence Rate	383.8	200.1	179.1		
		better	similar	worse	

SUBSTANCE ABUSE	Peach County	PEACH vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
% Excessive Drinker	23.4	16.1	27.2		18.3
% Illicit Drug Use in Past Month	3.0		2.0	12.0	4.6
% Used an Opioid Drug in Past Year	28.9		12.9		
% Ever Sought Help for Alcohol or Drug Problem	8.3		5.4		5.6
% Personally Impacted by Substance Abuse	39.8		35.8		25.9
		better	similar	worse	

TOBACCO USE	Peach County	PEACH vs. BENCHMARKS vs. GA	vs. US	vs. HP2030	TREND
% Current Smoker	15.5	16.1	17.4	5.0	24.4
% Someone Smokes at Home	16.2		14.6		21.4
% Currently Use Vaping Products	10.1	4.4	8.9		3.1
		better	similar	worse	

Summary of Key Informant Perceptions

In the Online Key Informant Survey, community stakeholders were asked to rate the degree to which each of 17 health issues is a problem in their own community, using a scale of “major problem,” “moderate problem,” “minor problem,” or “no problem at all.” The following chart summarizes their responses; these findings also are outlined throughout this report, along with the qualitative input describing reasons for their concerns. (Note that these ratings alone do not establish priorities for this assessment; rather, they are one of several data inputs considered for the prioritization process described earlier.)



DATA CHARTS & KEY INFORMANT INPUT

The following sections present data from multiple sources, including the population- based PRC Community Health Survey, public health and other existing data sets (secondary data), as well as qualitative input from the Online Key Informant Survey.

Data indicators from these sources are intermingled and organized by health topic. To better understand the source data for specific indicators, please refer to the footnotes accompanying each chart.

COMMUNITY CHARACTERISTICS

Population Characteristics

Land Area, Population Size & Density

Data from the US Census Bureau reveal the following statistics for our community relative to size, population, and density,

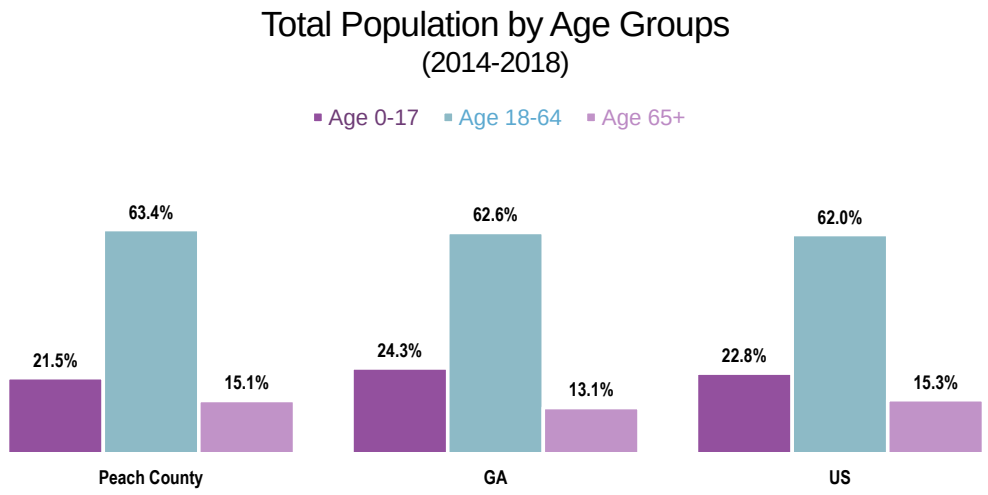
Total Population
(Estimated Population, 2014-2018)

	TOTAL POPULATION	TOTAL LAND AREA (square miles)	POPULATION DENSITY (per square mile)
Peach County	26,966	150.27	179.45
Georgia	10,297,484	57,594.80	178.79
United States	322,903,030	3,532,068.58	91.42

Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2020 via SparkMap (sparkmap.org).

Age

It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum.

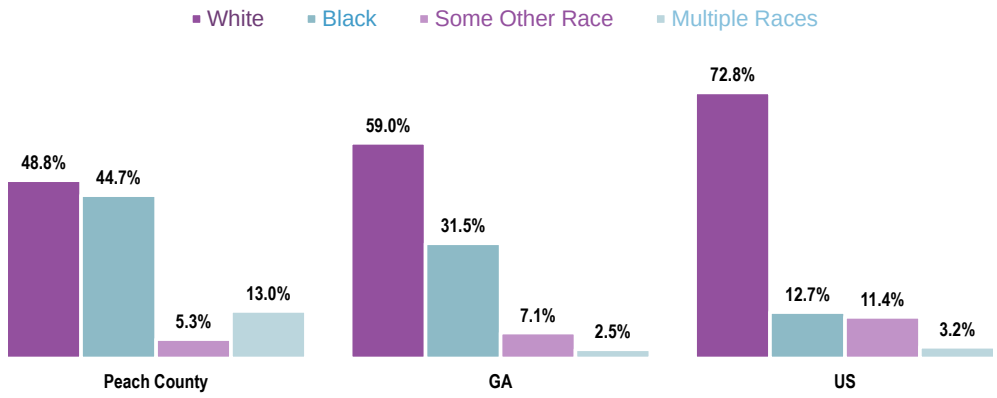


Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2020 via SparkMap (sparkmap.org).

Race & Ethnicity

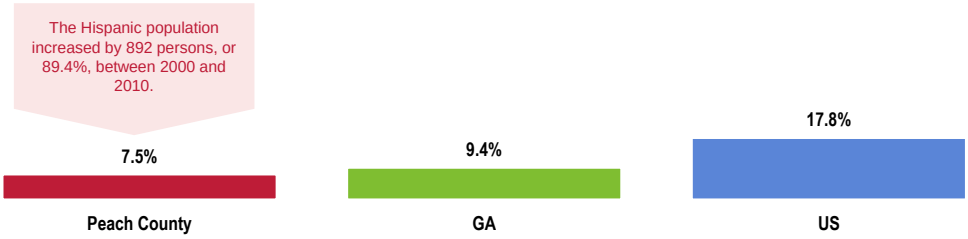
The following charts illustrate the racial and ethnic makeup of our community. Note that ethnicity (Hispanic or Latino) can be of any race.

Total Population by Race Alone
(2014-2018)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2020 via SparkMap (sparkmap.org).

Hispanic Population
(2014-2018)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2020 via SparkMap (sparkmap.org).

Notes:
- Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

Social Determinants of Health

ABOUT SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

Just promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.

- Healthy People 2030 (https://health.gov/healthypeople)

Income & Poverty

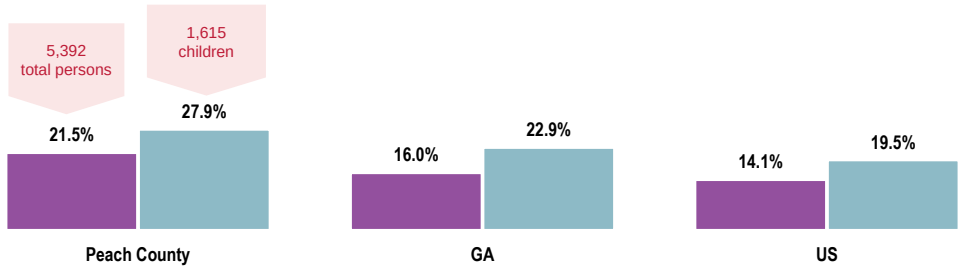
Poverty

The following chart outlines the proportion of our population below the federal poverty threshold, as well as below 200% of the federal poverty level, in comparison to state and national proportions.

Population in Poverty

(Populations Living Below the Poverty Level; 2014-2018)

Healthy People 2030 = 8.0% or Lower



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2020 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

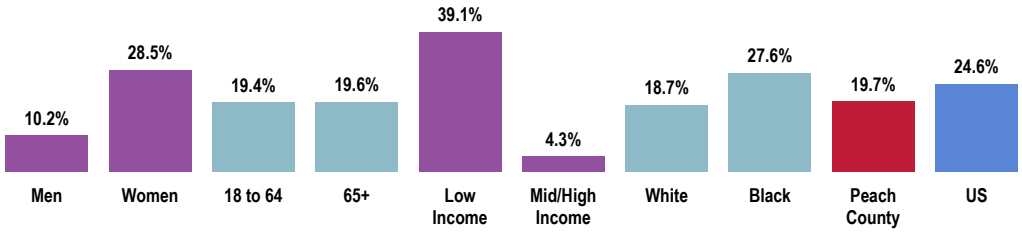
Notes:
- Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

Financial Resilience

"Suppose that you have an emergency expense that costs $400. Based on your current financial situation, would you be able to pay for this expense either with cash, by taking money from your checking or savings account, or by putting it on a credit card that you could pay in full at the next statement?"

Do Not Have Cash on Hand to Cover a $400 Emergency Expense

(Peach County, 2020)



Sources:
- 2020 PRC Community Health Survey, PRC, Inc.
- 2020 PRC National Health Survey, PRC, Inc.

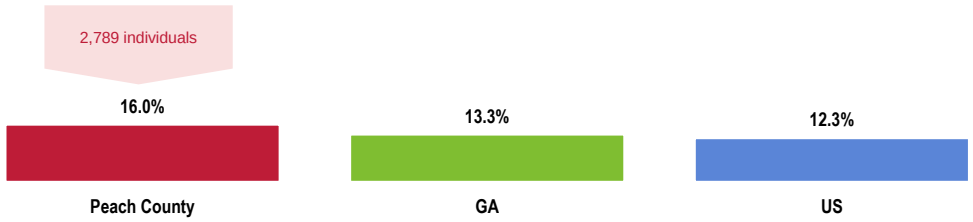
Notes:
- Asked of all respondents.
- Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

Education

Education levels are reflected in the proportion of our population without a high school diploma.

Population With No High School Diploma

(Population Age 25+ Without a High School Diploma or Equivalent, 2014-2018)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2020 via SparkMap (sparkmap.org).

Notes:
- This indicator is relevant because educational attainment is linked to positive health outcomes.

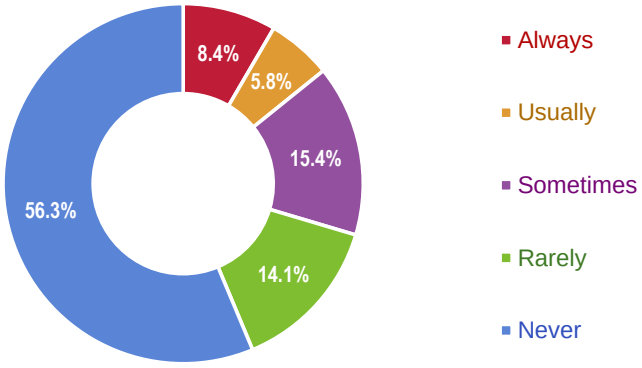
Housing

Housing Insecurity

"In the past 12 months, how often were you worried or stressed about having enough money to pay your rent or mortgage? Would you say you were worried or stressed: always, usually, sometimes, rarely, or never?"

Frequency of Worry or Stress Over Paying Rent or Mortgage in the Past Year

(Peach County, 2020)



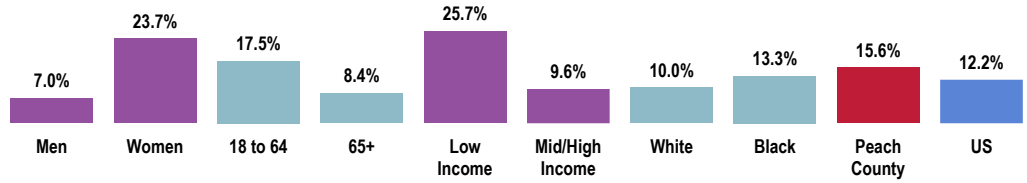
Sources:
- 2020 PRC Community Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Unhealthy or Unsafe Housing

"Thinking about your current home, over the past 12 months have you experienced ongoing problems with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe?"

Unhealthy or Unsafe Housing Conditions in the Past Year
(Peach County, 2020)



Sources:
- 2020 PRC Community Health Survey, PRC, Inc.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

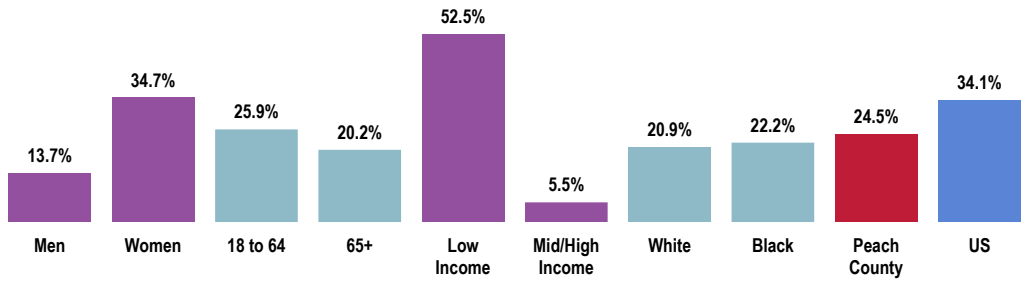
Food Insecurity

"Now I am going to read two statements that people have made about their food situation. Please tell me whether each statement was 'often true,' 'sometimes true,' or 'never true' for you in the past 12 months.

- The first statement is: 'I worried about whether our food would run out before we got money to buy more.'
- The next statement is: 'The food that we bought just did not last, and we did not have money to get more.'"

Agreement with either or both of these statements ("often true" or "sometimes true") defines food insecurity for respondents.

Food Insecurity
(Peach County, 2020)



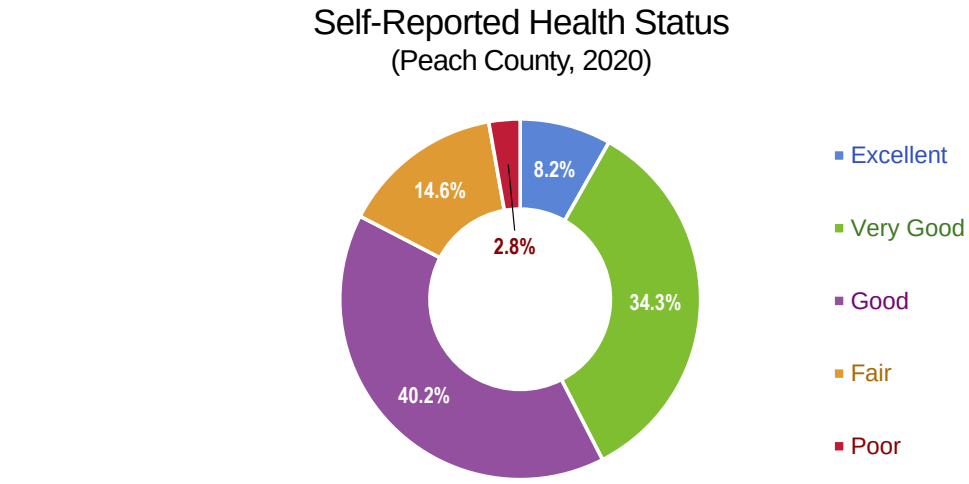
Sources:
- 2020 PRC Community Health Survey, PRC, Inc.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

HEALTH STATUS

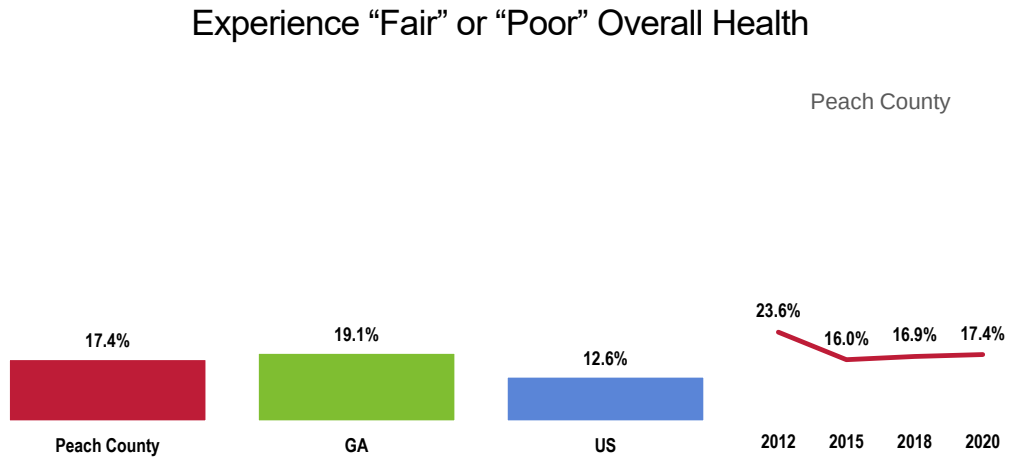
Overall Health

"Would you say that in general your health is: excellent, very good, good, fair, or poor?"



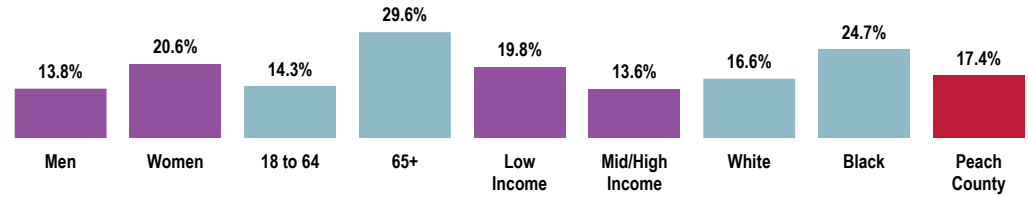
Sources: ● 2020 PRC Community Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

The following charts further detail "fair/poor" overall health responses in Peach County in comparison to benchmark data, as well as by basic demographic characteristics (namely by sex, age groupings, income [based on poverty status], and race/ethnicity).



Sources: ● 2020 PRC Community Health Survey, PRC, Inc.
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2018 Georgia data.
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Experience “Fair” or “Poor” Overall Health
(Peach County, 2020)



Sources: • 2020 PRC Community Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Mental Health

ABOUT MENTAL HEALTH & MENTAL DISORDERS

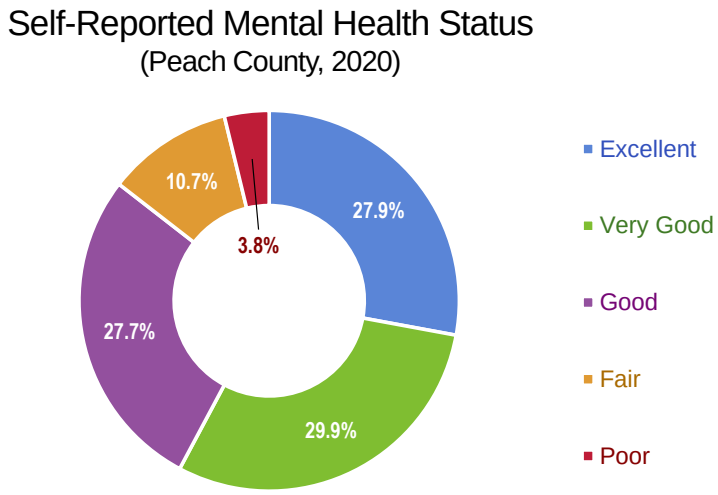
About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental disorders get the treatment they need.

In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Mental Health Status

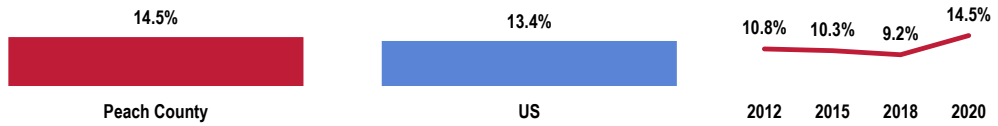
"Now thinking about your mental health, which includes stress, depression and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair, or poor?"



Sources: • 2020 PRC Community Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Experience “Fair” or “Poor” Mental Health

Peach County



Sources:
- 2020 PRC Community Health Survey, PRC, Inc.
- 2020 PRC National Health Survey, PRC, Inc.

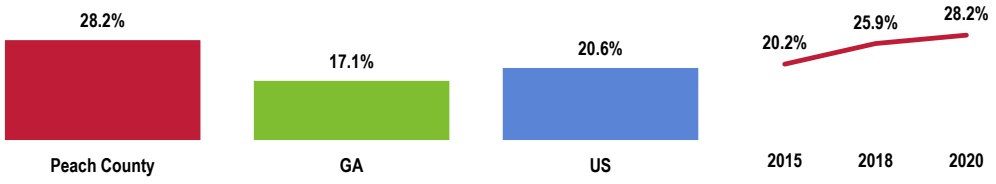
Notes:
- Asked of all respondents.

Depression

DIAGNOSED DEPRESSION ► **“Has a doctor or other healthcare provider ever told you that you have a depressive disorder, including depression, major depression, dysthymia, or minor depression?”**

Have Been Diagnosed With a Depressive Disorder

Peach County

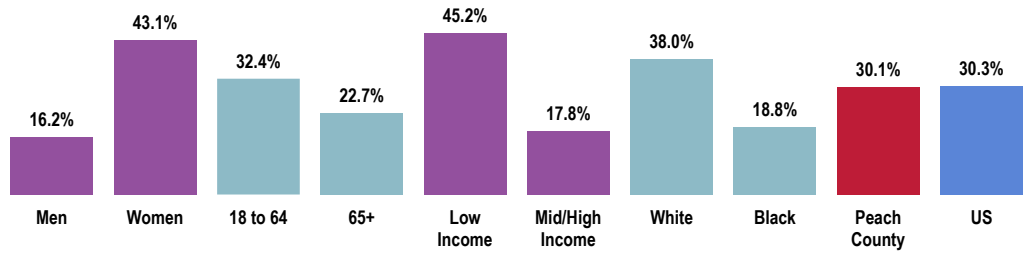


Sources:
- 2020 PRC Community Health Survey, PRC, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2018 Georgia data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Depressive disorders include depression, major depression, dysthymia, or minor depression.

SYMPTOMS OF CHRONIC DEPRESSION ► **"Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?"**

Have Experienced Symptoms of Chronic Depression
(Peach County, 2020)



Sources:
- 2020 PRC Community Health Survey, PRC, Inc.
- 2020 PRC National Health Survey, PRC, Inc.

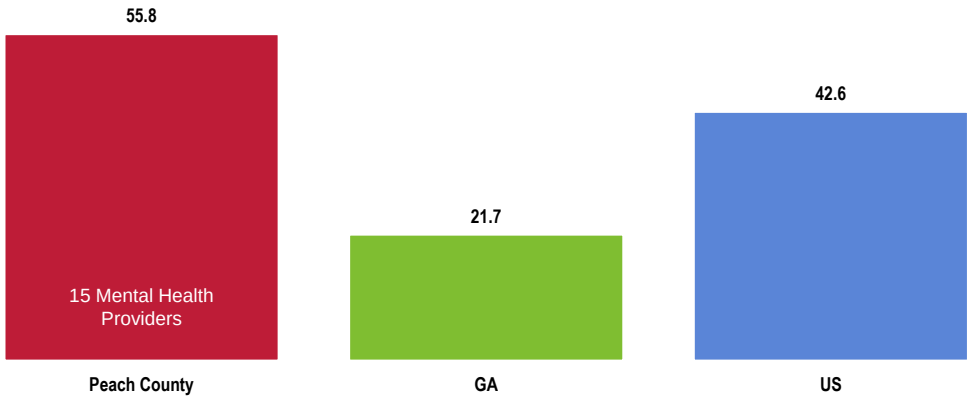
Notes:
- Asked of all respondents.
- Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

Mental Health Treatment

The following chart outlines access to mental health providers, expressed as the number of providers (psychiatrists, psychologists, clinical social workers, and counsellors who specialize in mental health care) per 100,000 residents.

Here, "mental health providers" includes psychiatrists, psychologists, clinical social workers, and counsellors who specialize in mental health care. Note that this indicator only reflects providers practicing in Peach County and residents in Peach County; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.

Access to Mental Health Providers
(Number of Mental Health Providers per 100,000 Population, 2020)



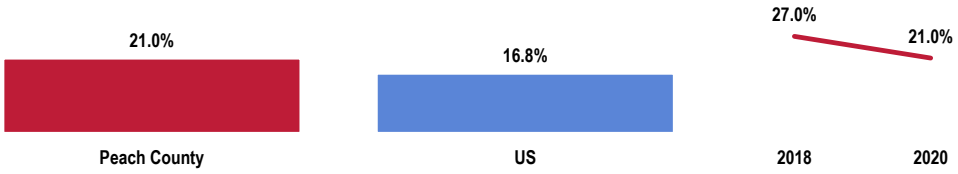
Sources:
- University of Wisconsin Population Health Institute, County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2020 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental health care.

"Are you now taking medication or receiving treatment from a doctor or other health professional for any type of mental health condition or emotional problem?"

Currently Receiving Mental Health Treatment

Peach County



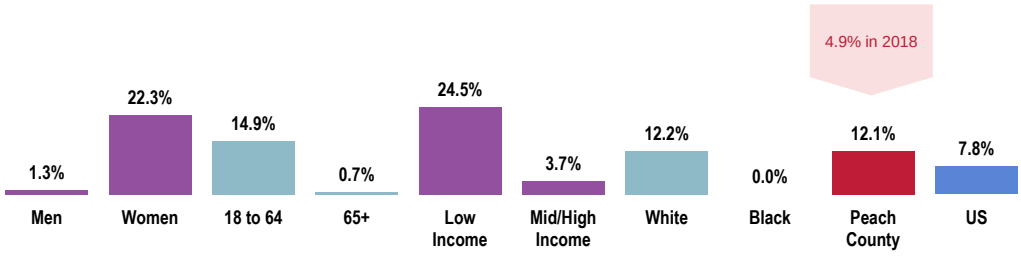
Sources:
- 2020 PRC Community Health Survey, PRC, Inc. [Items 103-104]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- "Treatment" can include taking medications for mental health.

"Was there a time in the past 12 months when you needed mental health services but were not able to get them?"

Unable to Get Mental Health Services When Needed in the Past Year

(Peach County, 2020)

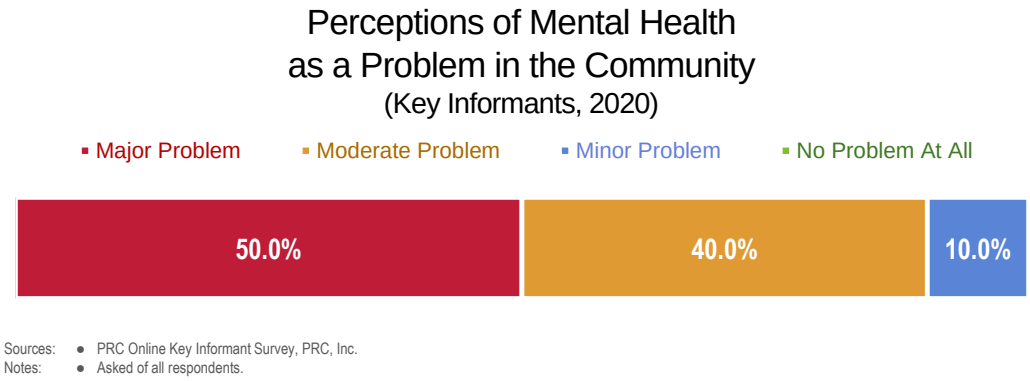


Sources:
- 2020 PRC Community Health Survey, PRC, Inc.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Key Informant Input: Mental Health

The following chart outlines key informants' perceptions of the severity of *Mental Health* as a problem in the community:



Sources: PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Access to care. – Physician (Peach County)

Homelessness

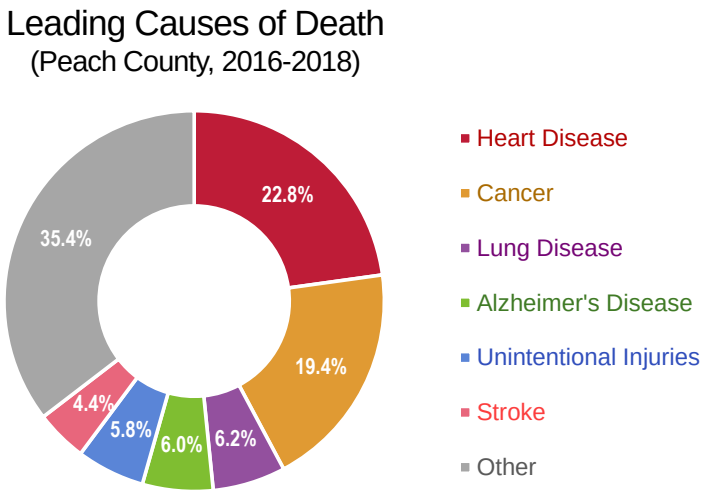
> Homelessness. – Community Leader (Peach County)

DEATH, DISEASE & CHRONIC CONDITIONS

Leading Causes of Death

Distribution of Deaths by Cause

Cancers and heart disease are leading causes of death in the community.



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2020.
Notes: ● Lung disease is CLRD, or chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

AGE-ADJUSTED DEATH RATES

In order to compare mortality in the region with other localities (in this case, Georgia and the United States), it is necessary to look at rates of death — these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 population, as is used here).

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these "age-adjusted" rates provides the most valuable means of gauging mortality against benchmark data, as well as Healthy People 2030 objectives.

The following chart outlines annual average age-adjusted death rates per 100,000 population for selected causes of death in Peach County.

For infant mortality data, see *Birth Outcomes & Risks* in the **Births** section of this report.

Age-Adjusted Death Rates for Selected Causes
(2016-2018 Deaths per 100,000 Population)

	Peach County	Georgia	US	HP2030
Diseases of the Heart	251.6	176.9	164.7	127.4*
Malignant Neoplasms (Cancers)	194.4	155.8	152.5	122.7
Unintentional Injuries	70.8	44.2	48.3	43.2
Chronic Lower Respiratory Disease (CLRD)	67.2	46.4	40.4	—
Cerebrovascular Disease (Stroke)	48.1	43.7	37.3	33.4
Diabetes Mellitus	42.0	21.6	21.3	—
Kidney Diseases	34.5	18.5	13.0	—
Motor Vehicle Deaths	30.9	14.3	11.5	10.1
Firearm-Related	19.2	15.4	11.9	10.7

Note:
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov.
- *The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.

Cardiovascular Disease

ABOUT HEART DISEASE & STROKE

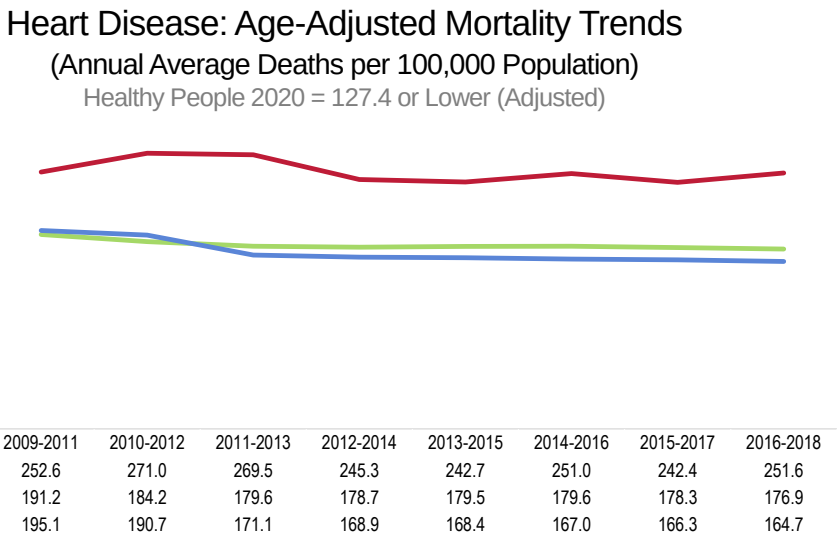
Heart disease is the leading cause of death in the United States, and stroke is the fifth leading cause. …Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Heart Disease & Stroke Deaths

The greatest share of cardiovascular deaths is attributed to heart disease. The following charts outline age-adjusted mortality rates for heart disease and for stroke in our community.



	2009-2011	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018
Peach County	252.6	271.0	269.5	245.3	242.7	251.0	242.4	251.6
GA	191.2	184.2	179.6	178.7	179.5	179.6	178.3	176.9
US	195.1	190.7	171.1	168.9	168.4	167.0	166.3	164.7

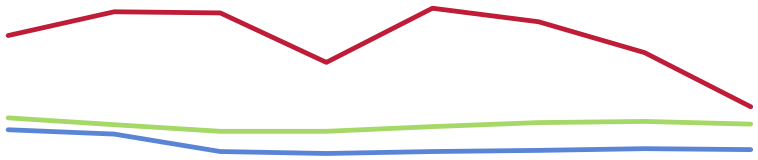
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2020.
- US Department of Health and Human Services. Healthy People 2020. August 2020. http://www.healthypeople.gov

Notes:
- The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.

Stroke: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 = 33.4 or Lower



	2009-2011	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018
Peach County	66.1	72.1	71.8	59.3	73.0	69.6	61.8	48.1
GA	45.3	43.6	41.9	41.9	43.1	44.1	44.4	43.7
US	42.3	41.2	36.8	36.3	36.8	37.1	37.5	37.3

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2020.
- US Department of Health and Human Services. Healthy People 2020. August 2020. http://www.healthypeople.gov

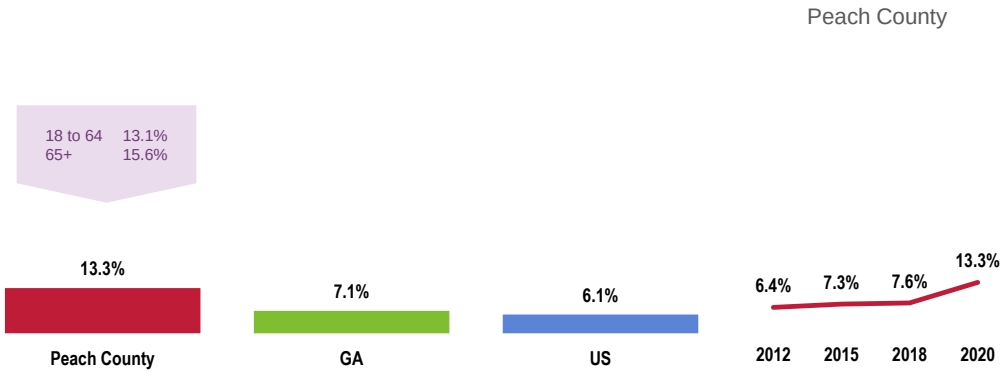
Prevalence of Heart Disease & Stroke

"Has a doctor, nurse, or other health professional ever told you that you had:

- A heart attack, also called a myocardial infarction?
- Angina or coronary heart disease?"

Heart disease prevalence here is a calculated prevalence that includes those responding affirmatively to either.

Prevalence of Heart Disease

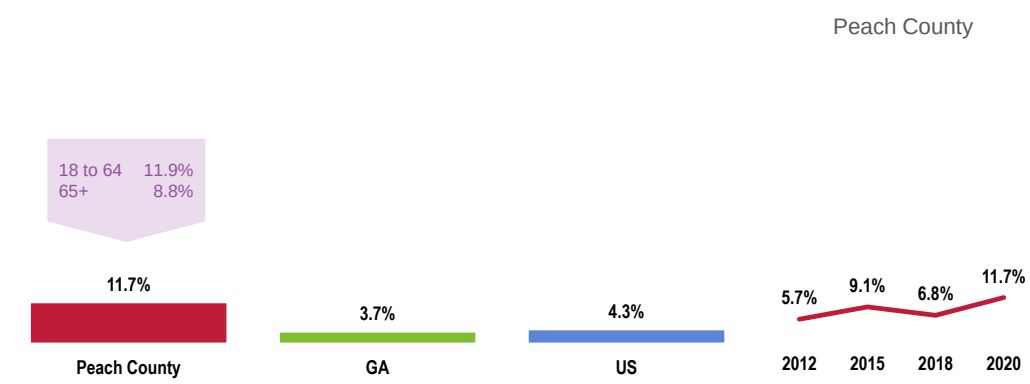


Sources:
- 2020 PRC Community Health Survey, PRC, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2018 Georgia data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes diagnoses of heart attack, angina, or coronary heart disease.

"Has a doctor, nurse, or other health professional ever told you that you had a stroke?"

Prevalence of Stroke



Sources:
- 2020 PRC Community Health Survey, PRC, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2018 Georgia data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Cardiovascular Risk Factors

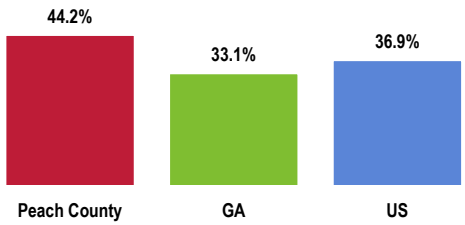
Blood Pressure & Cholesterol

"Have you ever been told by a doctor, nurse, or other health care professional that you had high blood pressure?"

"Blood cholesterol is a fatty substance found in the blood. Have you ever been told by a doctor, nurse, or other health care professional that your blood cholesterol is high?"

Prevalence of High Blood Pressure

Healthy People 2020 = 27.7% or Lower

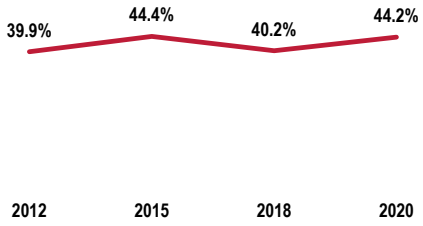


Prevalence of High Blood Cholesterol

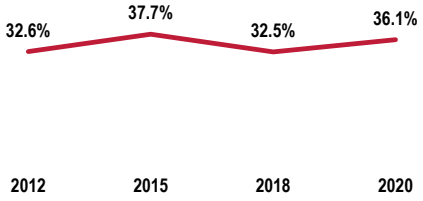
Sources:
- 2020 PRC Community Health Survey, PRC, Inc. [Items 41, 44, 129, 130]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2018 Georgia data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2020. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Prevalence of
High Blood Pressure
(Peach County)
Healthy People 2020 = 27.7% or Lower



Prevalence of
High Blood Cholesterol
(Peach County)



Sources: ● 2020 PRC Community Health Survey, PRC, Inc. [Items 129, 130]
● US Department of Health and Human Services. Healthy People 2020. August 2020. http://www.healthypeople.gov
Notes: ● Asked of all respondents.

Total Cardiovascular Risk

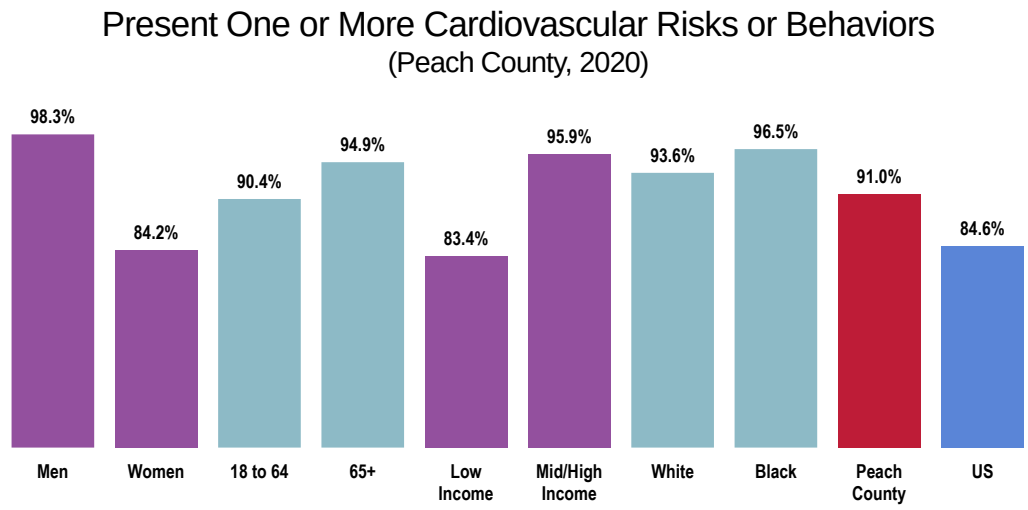
Total cardiovascular risk reflects the individual-level risk factors which put a person at increased risk for cardiovascular disease, including:

- High Blood Pressure
- High Blood Cholesterol
- Cigarette Smoking
- Physical Inactivity
- Overweight/Obesity

Modifying these behaviors and adhering to treatment for high blood pressure and cholesterol are critical both for preventing and for controlling cardiovascular disease.

RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

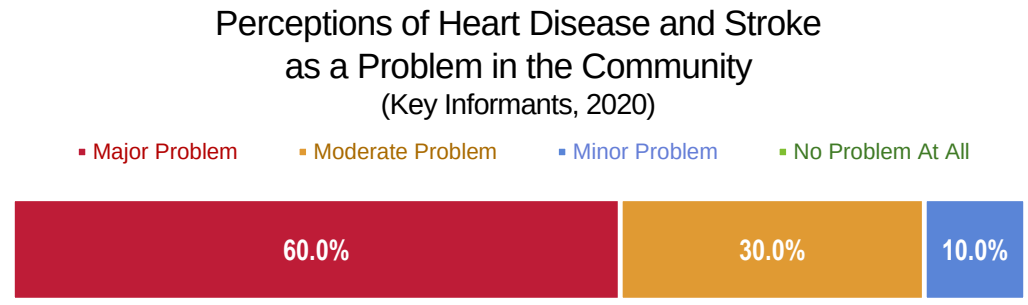
The following chart reflects the percentage of adults in Peach County who report one or more of the following: being overweight; smoking cigarettes; being physically inactive; or having high blood pressure or cholesterol.



Sources: ● 2020 PRC Community Health Survey, PRC, Inc.
Notes: ● Reflects all respondents.
● Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.

Key Informant Input: Heart Disease & Stroke

The following chart outlines key informants' perceptions of the severity of *Heart Disease & Stroke* as a problem in the community:



Sources: ● PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Incidence/Prevalence

> Number of people in the community and admission to hospitals with heart disease. – Physician (Peach County)

Awareness/Education

> Education and prevention services. – Social Services Provider (Peach County)

Cancer

ABOUT CANCER

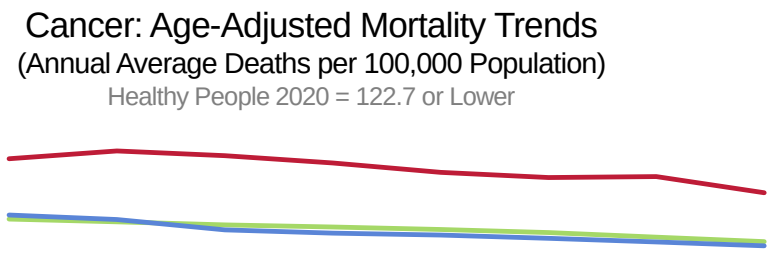
Cancer is the second leading cause of death in the United States. …The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social determinants of health, including education, economic status, and access to health care.

Interventions to promote evidence-based cancer screenings — such as screenings for lung, breast, cervical, and colorectal cancer — can help reduce cancer deaths. Other effective prevention strategies include programs that increase HPV vaccine use, prevent tobacco use and promote quitting, and promote healthy eating and physical activity. In addition, effective targeted therapies and personalized treatment are key to helping people with cancer live longer.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Cancer Deaths

The following chart illustrates age-adjusted cancer mortality (all types) in Peach County.



	2009-2011	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018
Peach County	221.2	227.4	223.7	217.9	210.5	206.4	207.2	194.4
GA	173.6	171.4	169.0	167.4	165.4	162.9	159.4	155.8
US	176.8	173.3	165.1	162.5	161.0	158.5	155.6	152.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2020.
- US Department of Health and Human Services. Healthy People 2020. August 2020. http://www.healthypeople.gov

Lung cancer is the leading cause of cancer deaths in Peach County.

Age-Adjusted Cancer Death Rates by Site
(2016–2018 Annual Average Deaths per 100,000 Population)

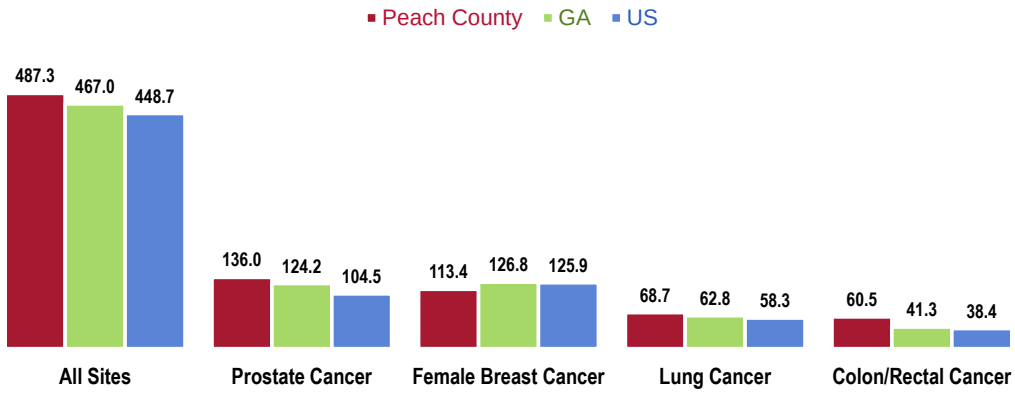
	Peach County	Georgia	US	HP2030
ALL CANCERS	194.4	155.8	152.5	122.7
Lung Cancer	46.5	39.0	36.6	25.1
Prostate Cancer	36.8	21.6	18.9	16.9
Colorectal Cancer	23.1	14.7	13.7	8.9
Female Breast Cancer	15.6	21.3	19.9	15.3

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2020.
- US Department of Health and Human Services. Healthy People 2020. August 2020. http://www.healthypeople.gov

Cancer Incidence

"Incidence rate" or "case rate" is the number of newly diagnosed cases in a given population in a given year, regardless of outcome. These rates are also age-adjusted. It is usually expressed as cases per 100,000 population per year.

Cancer Incidence Rates by Site
(Annual Average Age-Adjusted Incidence per 100,000 Population, 2013–2017)



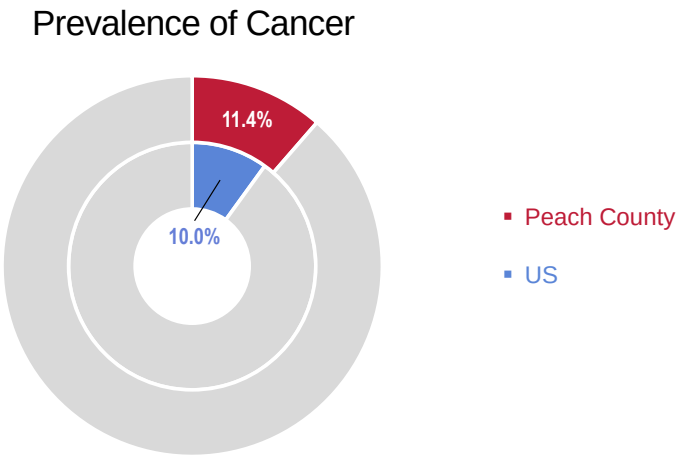
Sources:
- State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2020 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

Prevalence of Cancer

“Have you ever suffered from or been diagnosed with cancer?”

“Which type of cancer were you diagnosed with? (If more than one past diagnosis, respondent was asked about the most recent.)



The most common types of cancers cited include:

1)	Breast Cancer	18.1%
2)	Skin Cancer	13.7%
3)	Kidney Cancer	10.7%

Sources:
- 2020 PRC Community Health Survey, PRC, Inc. [Items 25-26]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Reflects all respondents.

RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

ABOUT CANCER RISK

Reducing the nation’s cancer burden requires reducing the prevalence of behavioral and environmental factors that increase cancer risk.

- All cancers caused by cigarette smoking could be prevented. At least one-third of cancer deaths that occur in the United States are due to cigarette smoking.
- According to the American Cancer Society, about one-third of cancer deaths that occur in the United States each year are due to nutrition and physical activity factors, including obesity.
  - National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Cancer Screenings

Screening levels in the community were measured in the PRC Community Health Survey relative to female breast cancer (mammography) and colorectal cancer (sigmoidoscopy and fecal occult blood testing).

The American Cancer Society recommends that both men and women get a cancer-related checkup during a regular doctor's checkup. It should include examination for cancers of the thyroid, testicles, ovaries, lymph nodes, oral cavity, and skin, as well as health counseling about tobacco, sun exposure, diet and nutrition, risk factors, sexual practices, and environmental and occupational exposures.

FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women aged 50 to 74 years.

COLORECTAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.

– US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

BREAST CANCER SCREENING ► **"A mammogram is an x-ray of each breast to look for cancer. How long has it been since you had your last mammogram?"**

Breast cancer screening is calculated here among women age 50 to 74 who indicate mammography within the past 2 years.

COLORECTAL CANCER SCREENING ► **"Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. How long has it been since your last sigmoidoscopy or colonoscopy?"**

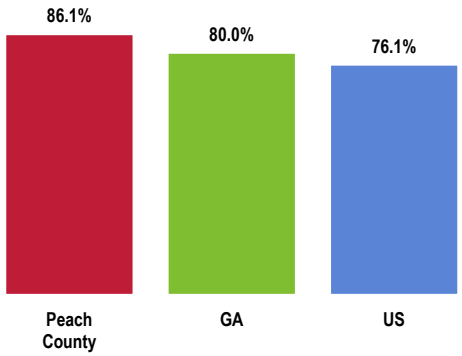
"A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. How long has it been since you had your last blood stool test?"

"Appropriate colorectal cancer screening" is calculated here among men and women age 50 to 75 years who have had a fecal occult blood test within the past year and/or a lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.

Breast Cancer Screening

(Women Age 50-74)

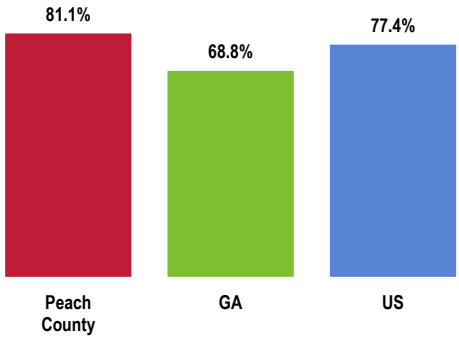
Healthy People 2020 = 77.1% or Higher



Colorectal Cancer Screening

(All Adults Age 50-75)

Healthy People 2020 = 74.4% or Higher



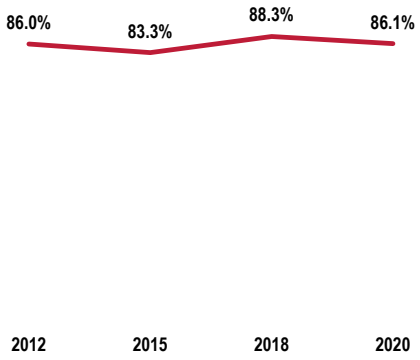
Sources:
- 2020 PRC Community Health Survey, PRC, Inc. [Items 133, 134, 137]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2018 Georgia data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2020. August 2020. http://www.healthypeople.gov

Notes:
- Each indicator is shown among the gender and/or age group specified.

Breast Cancer Screening

(Peach County Women Age 50-74)

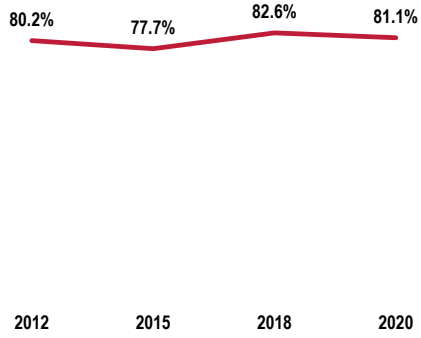
Healthy People 2020 = 77.1% or Higher



Colorectal Cancer Screening

(Peach County All Adults Age 50-75)

Healthy People 2020 = 74.4% or Higher

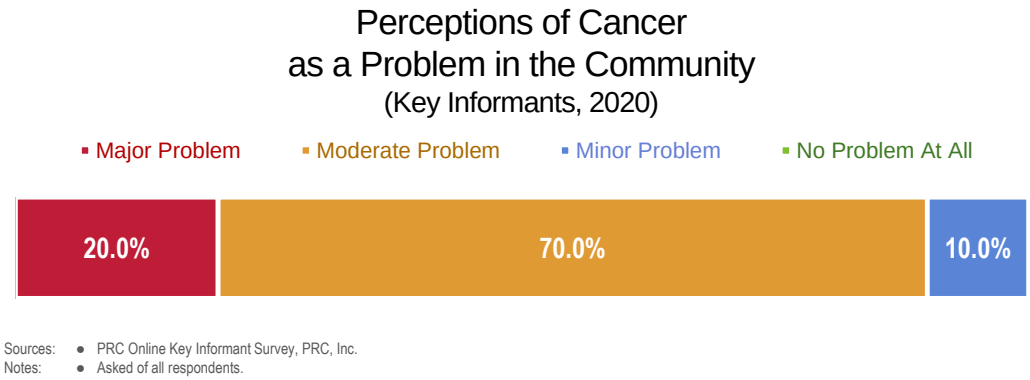


Sources:
- 2020 PRC Community Health Survey, PRC, Inc. [Items 133, 134, 137]
- US Department of Health and Human Services. Healthy People 2020. August 2020. http://www.healthypeople.gov

Notes:
- Each indicator is shown among the gender and/or age group specified.

Key Informant Input: Cancer

The following chart outlines key informants' perceptions of the severity of *Cancer* as a problem in the community:



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> I have seen many patients in the 20-40 age group with cancers usually seen in older individuals. – Physician (Peach County)
>
> The data shows that cancer is one of the leading health concerns in our area. – Community Leader (Peach County)

Respiratory Disease

ABOUT RESPIRATORY DISEASE

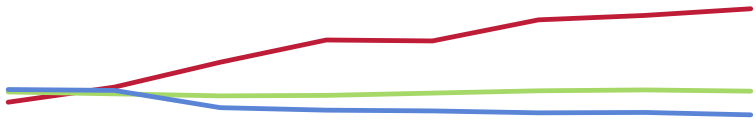
Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million people in the United States have COPD (chronic obstructive pulmonary disease), which is a major cause of death. Strategies to prevent the disease — like reducing air pollution and helping people quit smoking — are key to reducing deaths from COPD.

Interventions tailored to at-risk groups can also help prevent and treat other respiratory diseases — for example, pneumonia in older adults and pneumoconiosis in coal miners. And increasing lung cancer screening rates can help reduce deaths from lung cancer through early detection and treatment.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Respiratory Disease Deaths

Chronic lower respiratory diseases (CLRD) are diseases affecting the lungs; the most deadly of these is chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis. Mortality for CLRD is illustrated in the charts that follow.



	2009-2011	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018
Peach County	43.6	47.4	53.7	59.3	59.1	64.4	65.5	67.2
GA	46.2	45.7	45.2	45.3	45.9	46.5	46.7	46.4
US	46.8	46.6	42.2	41.6	41.4	40.9	41.0	40.4

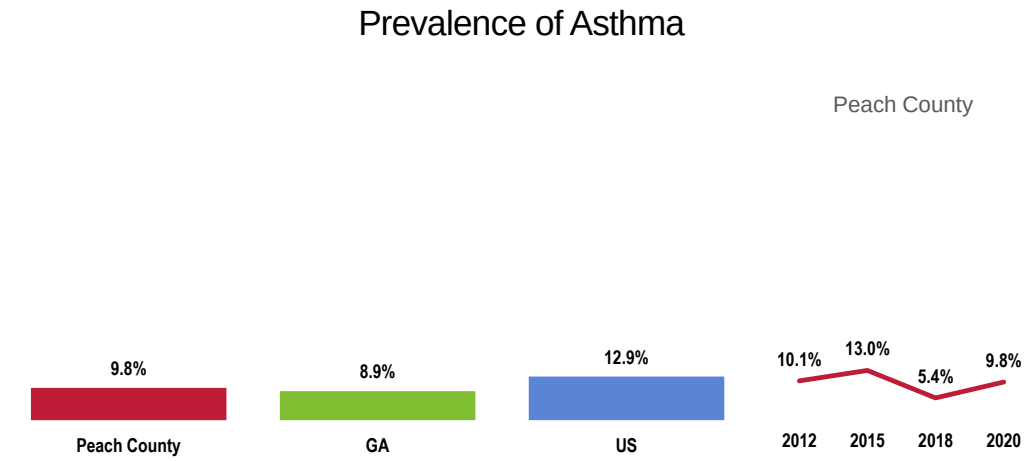
Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2020.

Notes: ● CLRD is chronic lower respiratory disease.

Prevalence of Respiratory Disease

Asthma

"Have you ever been told by a doctor, nurse, or other health professional that you had asthma?" and "Do you still have asthma?" (Calculated here as a prevalence of all adults who have ever been diagnosed with asthma and who still have asthma.)

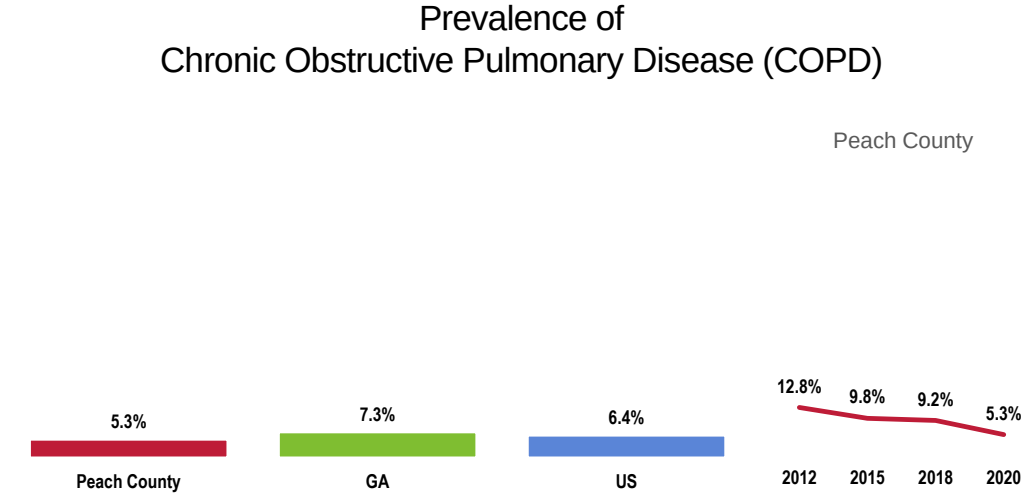


Sources:
- 2020 PRC Community Health Survey, PRC, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2018 Georgia data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those who have ever been diagnosed with asthma and report that they still have asthma.

Chronic Obstructive Pulmonary Disease (COPD)

"Would you please tell me if you have ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema?"

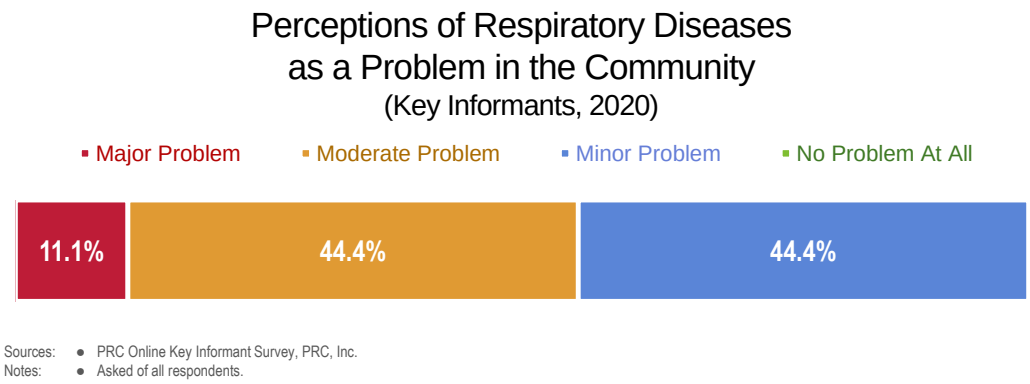


Sources:
- 2020 PRC Community Health Survey, PRC, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2018 Georgia data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.
- In prior data, the term "chronic lung disease" was used, which also included bronchitis or emphysema.

Key Informant Input: Respiratory Disease

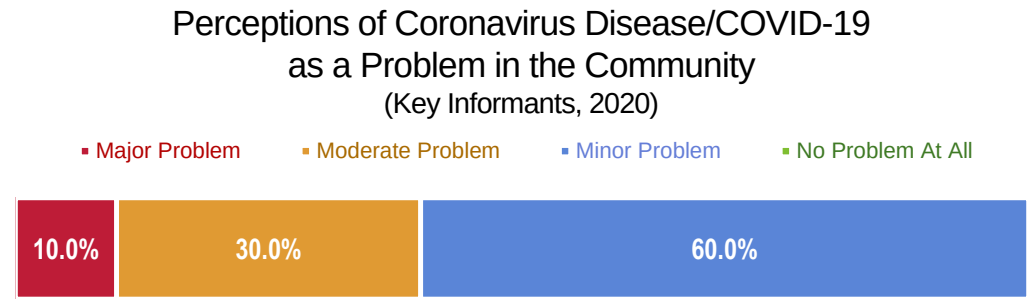
The following chart outlines key informants' perceptions of the severity of *Respiratory Disease* as a problem in the community:



Sources: PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Key Informant Input: Coronavirus Disease/COVID-19

The following chart outlines key informants' perceptions of the severity of *Coronavirus Disease/COVID-19* as a problem in the community:



Sources: PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Ignoring Public Health Recommendations

> People in my community still not wearing masks and still holding large community events. – Physician (Peach County)

Injury & Violence

ABOUT INJURY & VIOLENCE

INJURY ► In the United States, unintentional injuries are the leading cause of death in children, adolescents, and adults younger than 45 years. …Many unintentional injuries are caused by motor vehicle crashes and falls, and many intentional injuries involve gun violence and physical assaults. Interventions to prevent different types of injuries are key to keeping people safe in their homes, workplaces, and communities.

Drug overdoses are now the leading cause of injury deaths in the United States, and most overdoses involve opioids. Interventions to change health care providers' prescribing behaviors, distribute naloxone to reverse overdoses, and provide medications for addiction treatment for people with opioid use disorder can help reduce overdose deaths involving opioids.

VIOLENCE ► Almost 20,000 people die from homicide every year in the United States, and many more people are injured by violence. …Many people in the United States experience physical assaults, sexual violence, and gun-related injuries. Adolescents are especially at risk for experiencing violence. Interventions to reduce violence are needed to keep people safe in their homes, schools, workplaces, and communities.

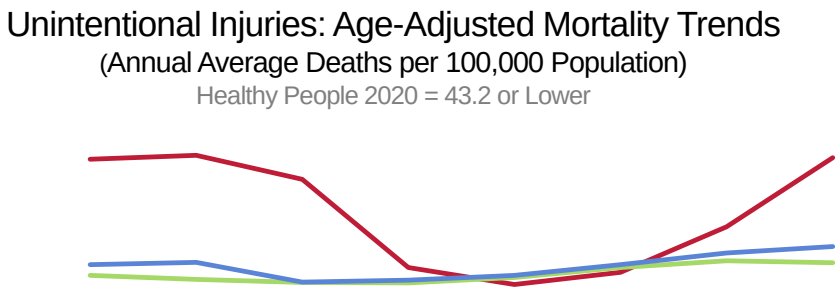
Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

– Healthy People 2030 (https://health.gov/healthypeople)

Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

The following chart outlines age-adjusted mortality rates for unintentional injury in the area.



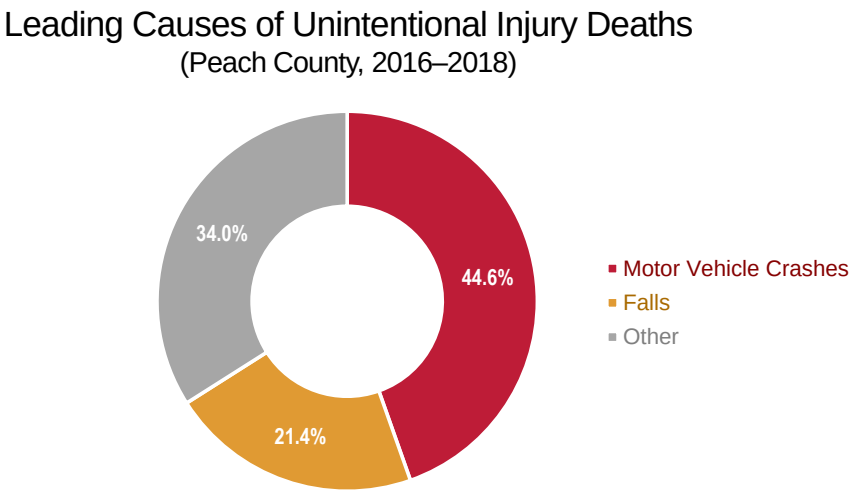
	2009-2011	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018
Peach County	70.4	71.4	65.3	43.0	38.7	41.8	53.3	70.8
GA	41.0	40.0	39.2	39.1	40.5	43.0	44.7	44.2
US	43.7	44.3	39.3	39.8	41.0	43.7	46.7	48.3

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2020.
- US Department of Health and Human Services. Healthy People 2020. August 2020. http://www.healthypeople.gov

Leading Causes of Unintentional Injury Deaths

RELATED ISSUE
For more information about unintentional drug-related deaths, see also *Substance Abuse* in the **Modifiable Health Risks** section of this report.

Leading causes of accidental death in the area include the following:



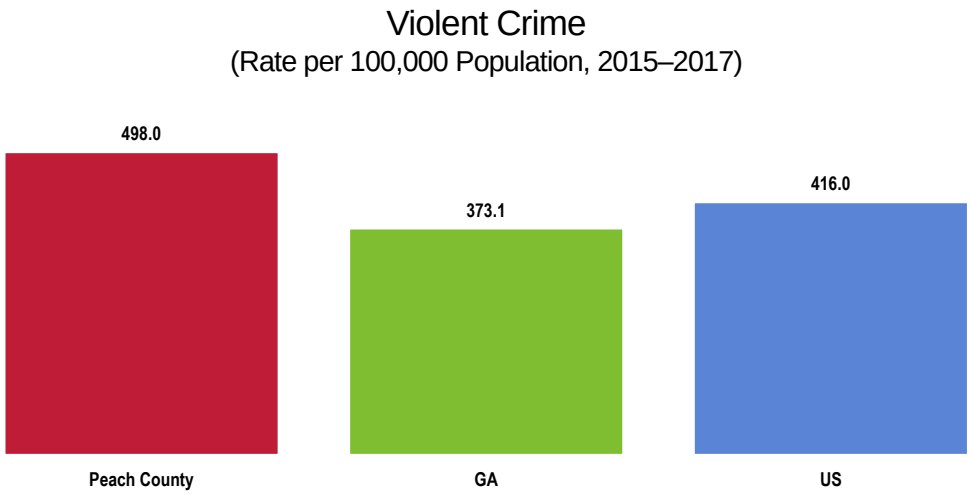
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2020.

Intentional Injury (Violence)

Violent Crime

Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions.

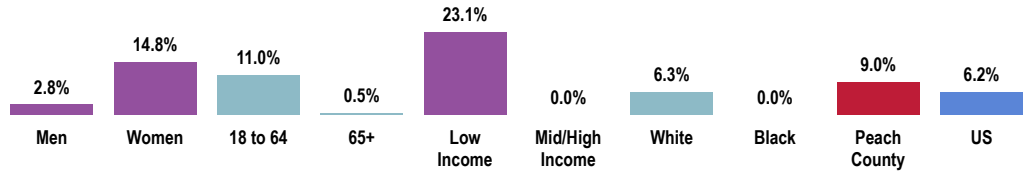


Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2020 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. This indicator is relevant because it assesses community safety.
- Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data do not necessarily represent an exhaustive list of crimes due to gaps in reporting. Also, some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds; these offenses are not included in the violent crime statistics but can be obtained from the Uniform Crime Reports Universities and Colleges data tables.

VIOLENT CRIME EXPERIENCE ► **"Have you been the victim of a violent crime in your area in the past 5 years?"**

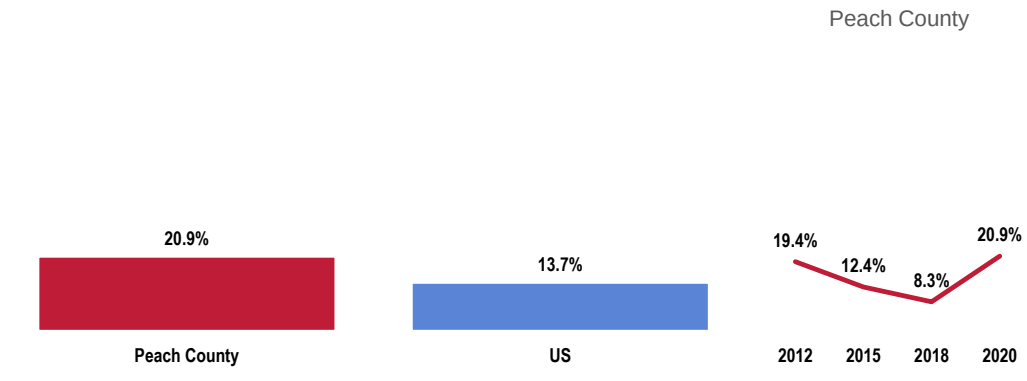
Victim of a Violent Crime in the Past Five Years
(Peach County, 2020)



Sources: ● 2020 PRC Community Health Survey, PRC, Inc.
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

INTIMATE PARTNER VIOLENCE ► **"The next questions are about different types of violence in relationships with an intimate partner. By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with, would also be considered an intimate partner. Has an intimate partner ever hit, slapped, pushed, kicked, or hurt you in any way?"**

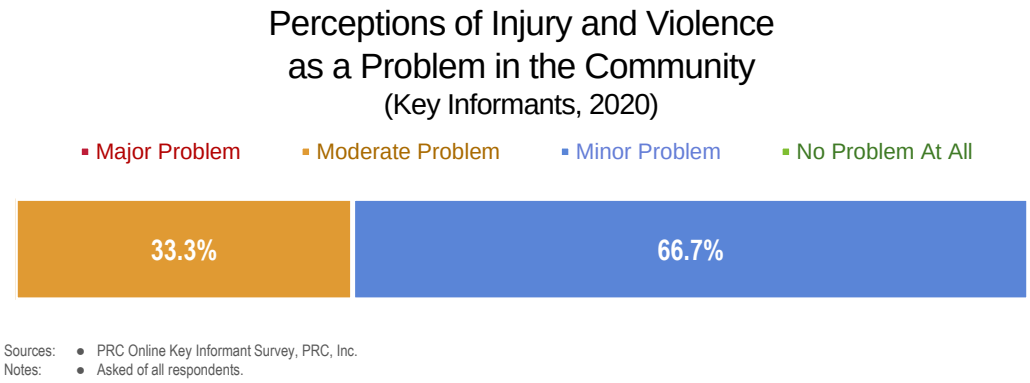
Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner



Sources: ● 2020 PRC Community Health Survey, PRC, Inc.
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Key Informant Input: Injury & Violence

The following chart outlines key informants' perceptions of the severity of *Injury & Violence* as a problem in the community:



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Diabetes

ABOUT DIABETES

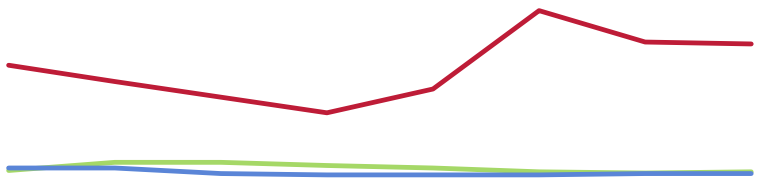
More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Diabetes Deaths

Age-adjusted diabetes mortality for the area is shown in the following chart.



	2009-2011	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018
Peach County	38.6	36.0		31.0	34.8	47.3	42.3	42.0
GA	21.8	23.1	23.1	22.6	22.2	21.6	21.4	21.6
US	22.2	22.2	21.3	21.1	21.1	21.1	21.3	21.3

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2020.
- US Department of Health and Human Services. Healthy People 2020. August 2020. http://www.healthypeople.gov

Notes:
- The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

Prevalence of Diabetes

"Have you ever been told by a doctor, nurse, or other health professional that you have diabetes? (If female, add: not counting diabetes only occurring during pregnancy?)**"**

"Have you ever been told by a doctor, nurse, or other health professional that you have pre-diabetes or borderline diabetes? (If female, add: other than during pregnancy?)**"**

[Adults who do not have diabetes] **"Have you had a test for high blood sugar or diabetes within the past three years?"**

Prevalence of Diabetes

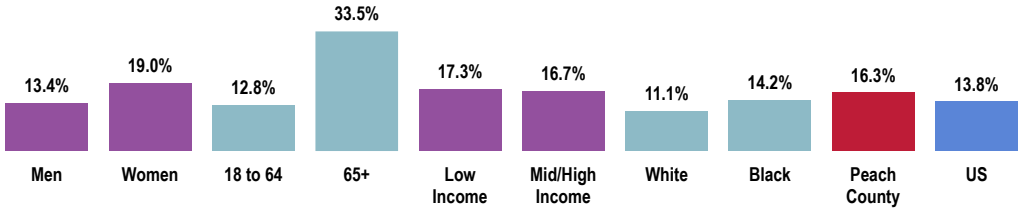
Another 8.5% of adults have been diagnosed with "pre-diabetes" or "borderline" diabetes.

Sources:
- 2020 PRC Community Health Survey, PRC, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2018 Georgia data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Prevalence of Diabetes
(Peach County, 2020)

Note that among adults who have not been diagnosed with diabetes, 43.4% report having had their blood sugar level tested within the past three years.

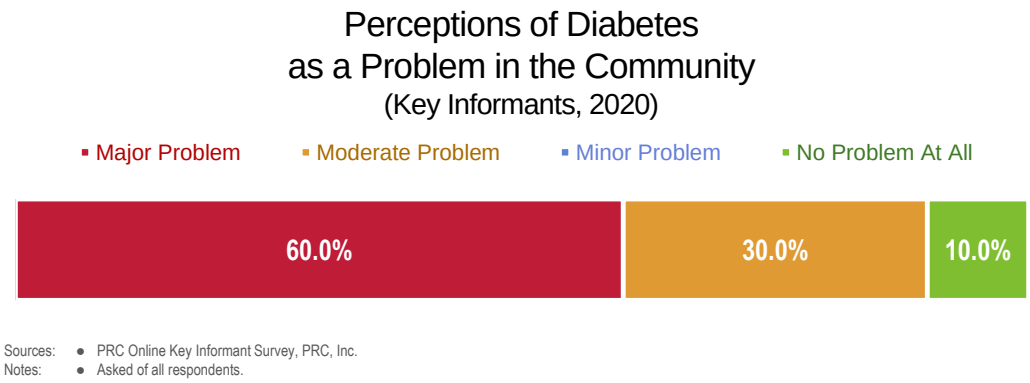


Sources:
- 2020 PRC Community Health Survey, PRC, Inc. [Items 37, 140]

Notes:
- Asked of all respondents.
- Excludes gestational diabetes (occurring only during pregnancy).

Key Informant Input: Diabetes

The following chart outlines key informants' perceptions of the severity of *Diabetes* as a problem in the community:



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Awareness/Education

> Education and prevention services. – Social Services Provider (Peach County)

Nutrition

> Food deserts in communities. – Physician (Peach County)

Lifestyle

> Lifestyle change. – Community Leader (Peach County)

Kidney Disease

ABOUT KIDNEY DISEASE

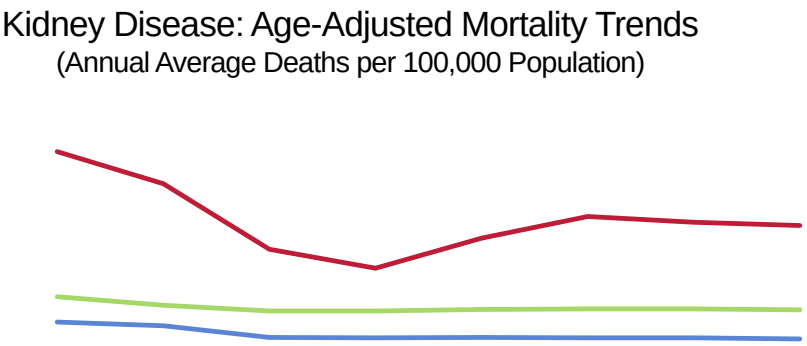
More than 1 in 7 adults in the United States may have chronic kidney disease (CKD), with higher rates in low-income and racial/ethnic minority groups. And most people with CKD don't know they have it. …People with CKD are more likely to have heart disease and stroke — and to die early. Managing risk factors like diabetes and high blood pressure can help prevent or delay CKD. Strategies to make sure more people with CKD are diagnosed early can help people get the treatment they need.

Recommended tests can help identify people with CKD to make sure they get treatments and education that may help prevent or delay kidney failure and end-stage kidney disease (ESKD). In addition, strategies to make sure more people with ESKD get kidney transplants can increase survival rates and improve quality of life.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Kidney Disease Deaths

Age-adjusted kidney disease mortality is described in the following chart.

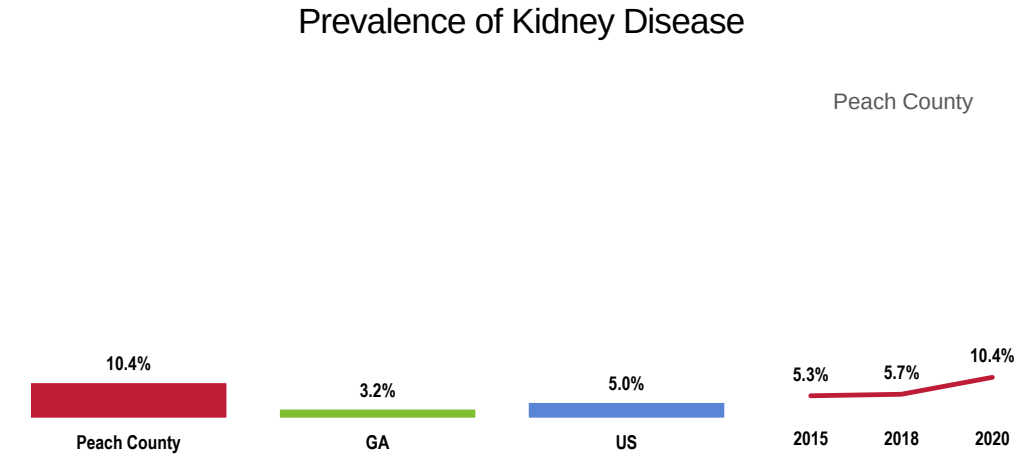


	2009-2011	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018
Peach County	48.5	42.4	30.0	26.4	32.1	36.2	35.1	34.5
GA	21.0	19.4	18.3	18.3	18.6	18.7	18.7	18.5
US	16.2	15.5	13.3	13.2	13.3	13.2	13.2	13.0

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted October 2020.

Prevalence of Kidney Disease

"Would you please tell me if you have ever suffered from or been diagnosed with kidney disease?"

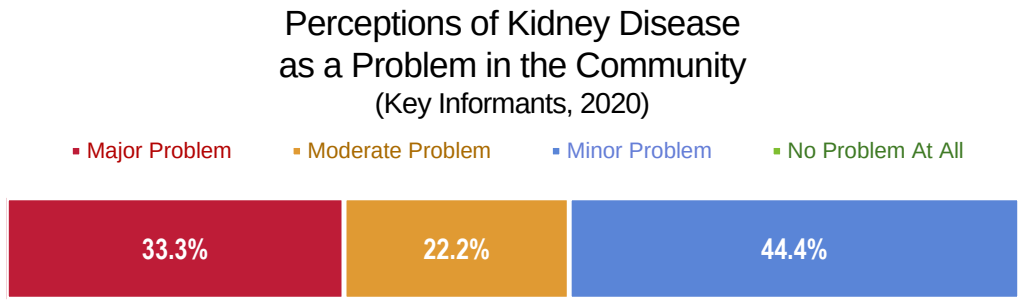


Sources:
- 2020 PRC Community Health Survey, PRC, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2018 Georgia data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Key Informant Input: Kidney Disease

The following chart outlines key informants' perceptions of the severity of *Kidney Disease* as a problem in the community:



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> Number of patients admitted to the hospital and on dialysis. – Physician (Peach County)

Lifestyle

> Lifestyle and education and access to healthcare for the uninsured. – Public Health Representative (Peach County)

Potentially Disabling Conditions

Multiple Chronic Conditions

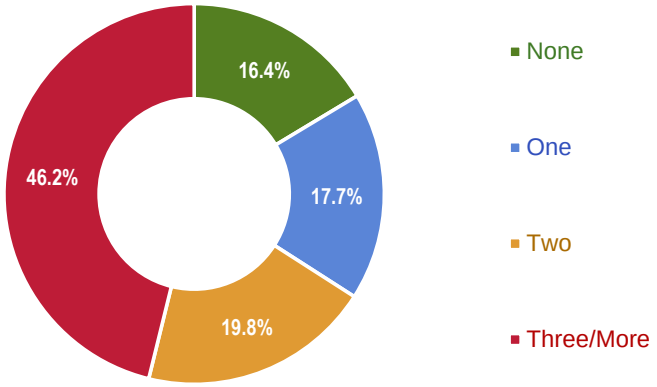
The following charts outline the prevalence of multiple chronic conditions among surveyed adults, taking into account all of the various conditions measured in the survey.

For the purposes of this assessment, chronic conditions include:

- Asthma
- Cancer
- Chronic pain
- Diabetes
- Diagnosed depression
- Heart attack/angina
- High blood cholesterol
- High blood pressure
- Kidney disease
- Lung disease
- Obesity
- Stroke

Multiple chronic conditions are concurrent conditions.

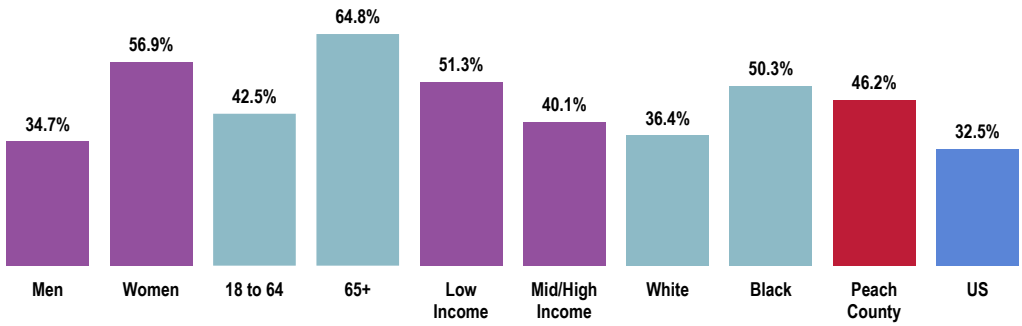
Number of Current Chronic Conditions
(Peach County, 2020)



Sources:
- 2020 PRC Community Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- In this case, chronic conditions include lung disease, cancer, kidney disease, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, obesity, chronic pain, and/or diagnosed depression.

Currently Have Three or More Chronic Conditions
(Peach County, 2020)



Sources:
- 2020 PRC Community Health Survey, PRC, Inc.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- In this case, chronic conditions include lung disease, cancer, kidney disease, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, obesity, and/or diagnosed depression.

Activity Limitations

ABOUT DISABILITY & HEALTH

Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

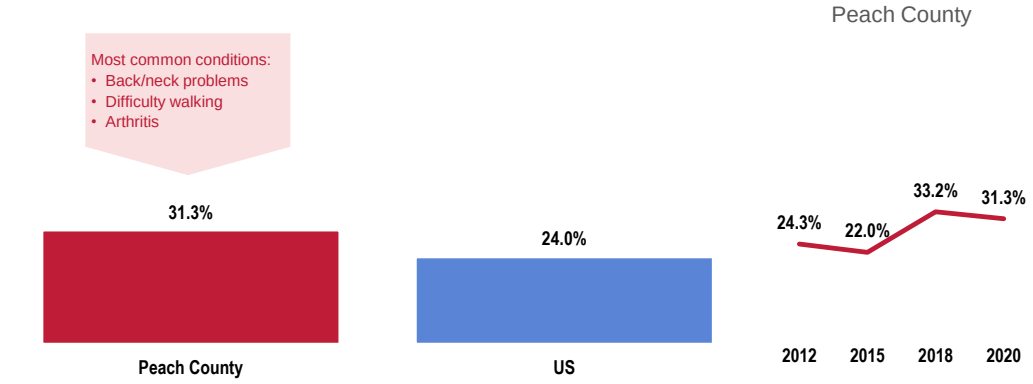
In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life and overall well-being for people with disabilities.

– Healthy People 2030 (https://health.gov/healthypeople)

"Are you limited in any way in any activities because of physical, mental, or emotional problems?"

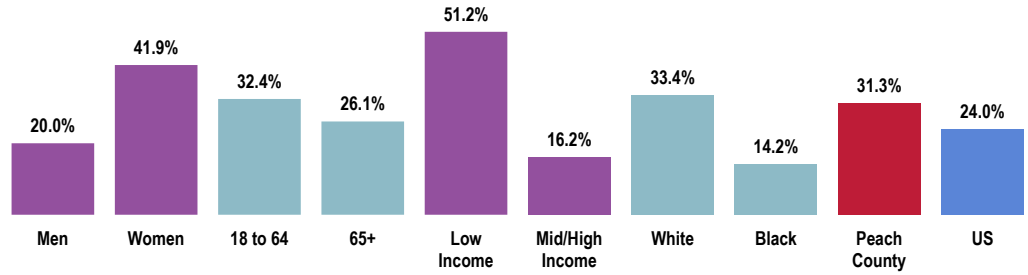
[Adults with activity limitations] **"What is the major impairment or health problem that limits you?"**

Limited in Activities in Some Way
Due to a Physical, Mental or Emotional Problem



Sources: ● 2020 PRC Community Health Survey, PRC, Inc. [Items 109-110]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem
(Peach County, 2020)

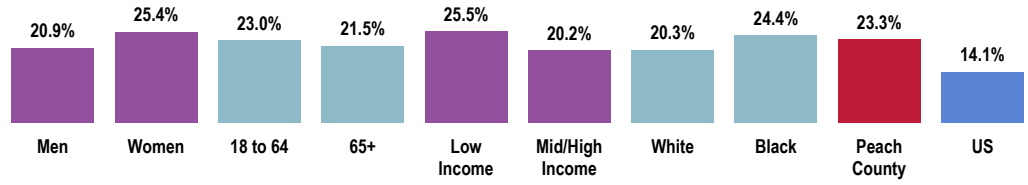


Sources: • 2020 PRC Community Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

High-Impact Chronic Pain

"Over the past six months, how often did physical pain limit your life or work activities? Would you say: never, some days, most days, or every day?" (Reported here among those responding "most days" or "every day.")

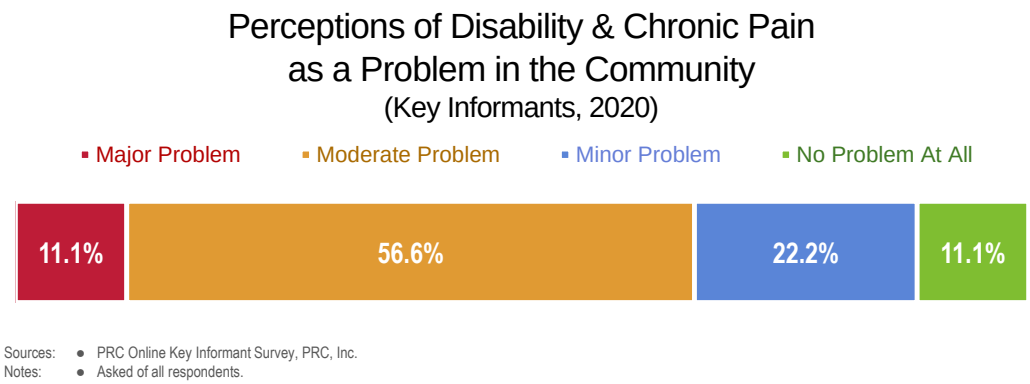
Experience High-Impact Chronic Pain
(Peach County, 2020)
Healthy People 2020 = 7.0% or Lower



Sources: • 2020 PRC Community Health Survey, PRC, Inc.
• 2020 PRC National Health Survey, PRC, Inc.
• US Department of Health and Human Services. Healthy People 2020. August 2020. http://www.healthypeople.gov
Notes: • Asked of all respondents.
• High-impact chronic pain includes physical pain that limits life or work activities on "most days" or "every day" of the past six months.

Key Informant Input: Disability & Chronic Pain

The following chart outlines key informants' perceptions of the severity of *Disability & Chronic Pain* as a problem in the community:



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Opiate Addiction

> Number of patients in the community with opiate and alcohol abuse. – Physician (Peach County)

Alzheimer's Disease

ABOUT DEMENTIA

Alzheimer's disease is the most common cause of dementia and the sixth leading cause of death in U.S. adults.1 Nearly 6 million people in the United States have Alzheimer's, and that number will increase as the population ages.

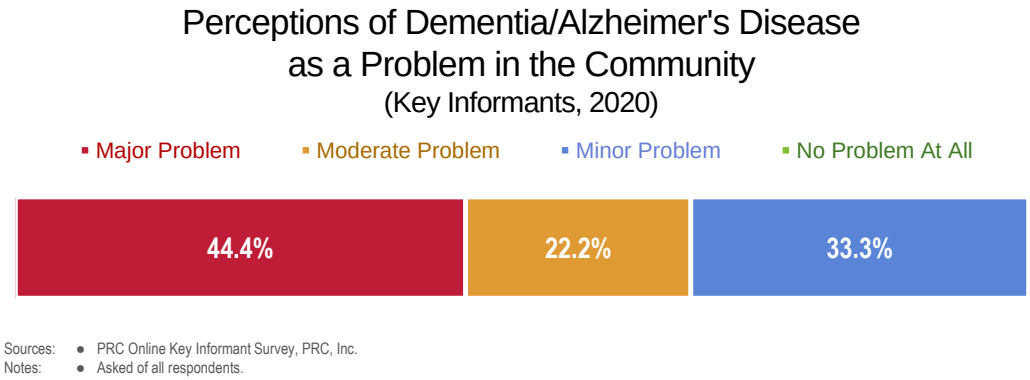
Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

While there's no cure for Alzheimer's disease, early diagnosis and supportive care can improve quality of life. And efforts to make sure adults with symptoms of cognitive decline — including memory loss — are diagnosed early can help improve health outcomes in people with dementia. Interventions to address caregiving needs can also help improve health and well-being in people with dementia.

– Healthy People 2030 (https://health.gov/healthypeople)

Key Informant Input: Dementia/Alzheimer's Disease

The following chart outlines key informants' perceptions of the severity of *Dementia, Including Alzheimer's Disease* as a problem in the community:



Among those rating this issue as a “major problem,” reasons related to the following:

Incidence/Prevalence

> Numerous patients with this disease and devastating effects on families. – Physician (Peach County)
>
> The overwhelming number of individuals affected by it. – Community Leader (Peach County)

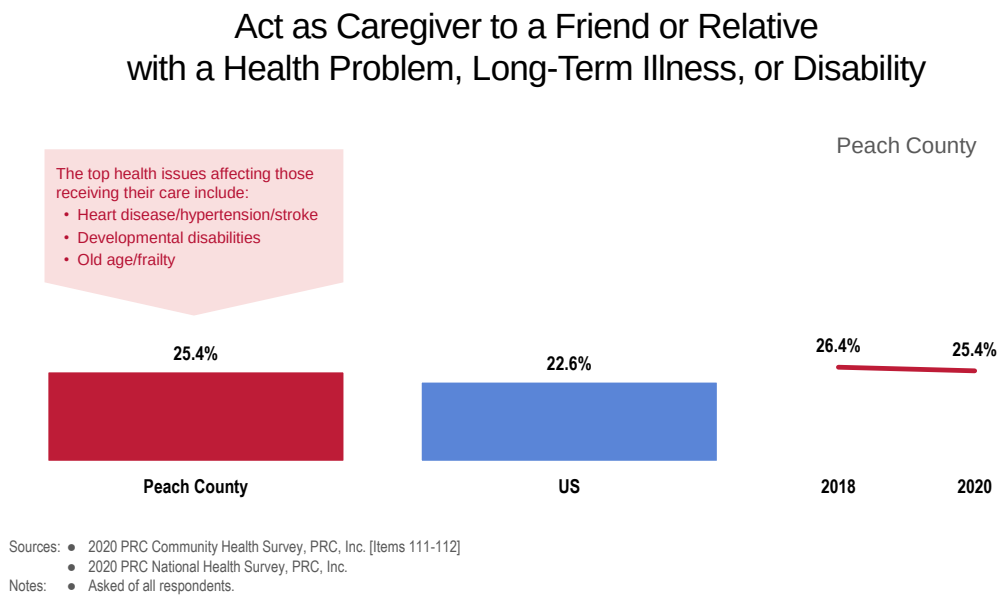
Access to Care

> There are very limited resources available for middle class income families to deal with this issue. – Community Leader (Peach County)

Caregiving

"People may provide regular care or assistance to a friend or family member who has a health problem, long-term illness, or disability. During the past 30 days, did you provide any such care or assistance to a friend or family member?"

[Among those providing care] **"What is the main health problem, long-term illness, or disability that the person you care for has?"**



Sources: ● 2020 PRC Community Health Survey, PRC, Inc. [Items 111-112]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

BIRTHS

ABOUT INFANT HEALTH

Keeping infants healthy starts with making sure women get high-quality care during pregnancy and improving women's health in general. After birth, strategies that focus on increasing breastfeeding rates and promoting vaccinations and developmental screenings are key to improving infants' health. Interventions that encourage safe sleep practices and correct use of car seats can also help keep infants safe.

The infant mortality rate in the United States is higher than in other high-income countries, and there are major disparities by race/ethnicity. Addressing social determinants of health is critical for reducing these disparities.

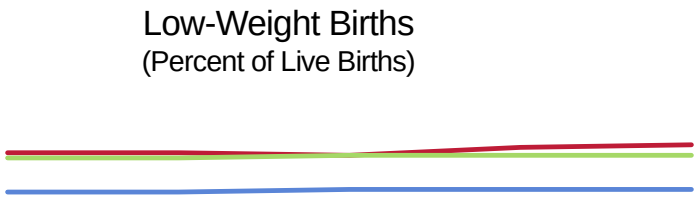
– Healthy People 2030 (https://health.gov/healthypeople)

Birth Outcomes & Risks

Low-Weight Births

Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight.

Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable.



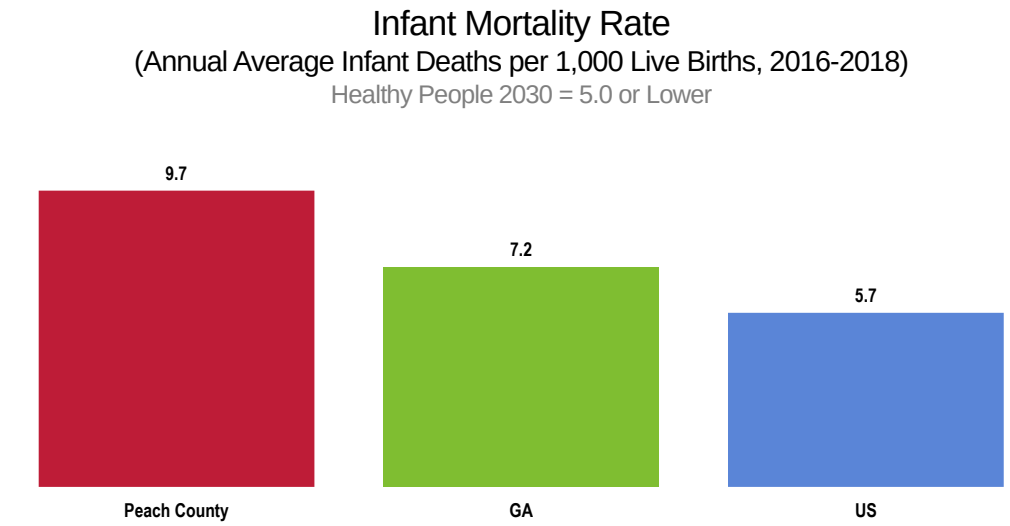
	2002-2008	2003-2009	2004-2010	2005-2011	2006-2012
Peach County	9.6%	9.6%	9.5%	9.8%	9.9%
Georgia	9.4%	9.4%	9.5%	9.5%	9.5%
US	8.1%	8.1%	8.2%	8.2%	8.2%

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted September 2020.

Note: ● This indicator reports the percentage of total births that are low birth weight (Under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.

Infant Mortality

Infant mortality rates reflect deaths of children less than one year old per 1,000 live births. These rates are outlined in the following chart.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted September 2020.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Infant deaths include deaths of children under 1 year old.
- This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.
- "Other Counties" is the combined area of Crawford, Jones, Monroe, and Twiggs counties.

Family Planning

ABOUT FAMILY PLANNING

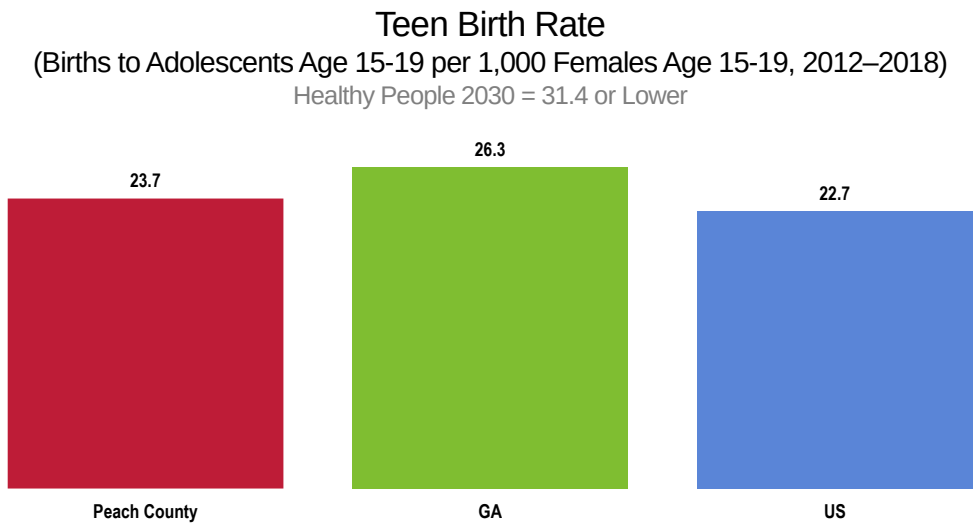
Nearly half of pregnancies in the United States are unintended, and unintended pregnancy is linked to many negative outcomes for both women and infants. …Unintended pregnancy is linked to outcomes like preterm birth and postpartum depression. Interventions to increase use of birth control are critical for preventing unintended pregnancies. Birth control and family planning services can also help increase the length of time between pregnancies, which can improve health for women and their infants.

Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy and sexually transmitted infections in this age group.

– Healthy People 2030 (https://health.gov/healthypeople)

Births to Adolescent Mothers

The following chart describes births to adolescent mothers under the age of 20 years.

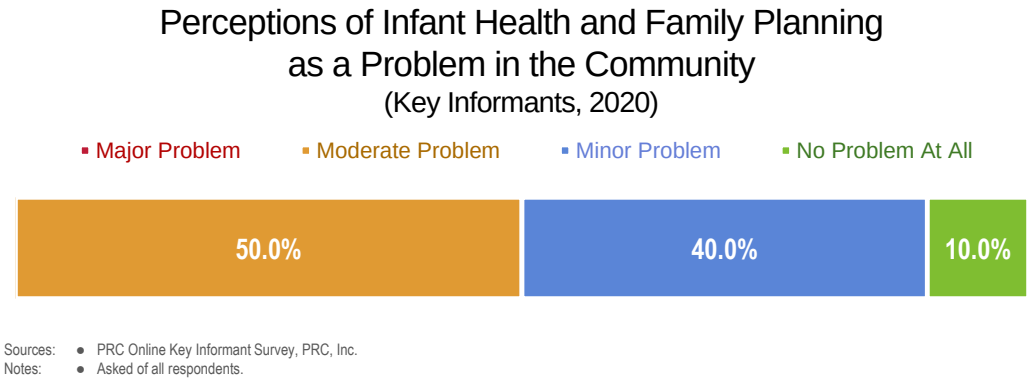


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Retrieved from Community Commons at http://www.chna.org.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.

Key Informant Input: Infant Health & Family Planning

The following chart outlines key informants' perceptions of the severity of *Infant Health and Family Planning* as a problem in the community:



Sources: PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

MODIFIABLE HEALTH RISKS

Nutrition

ABOUT NUTRITION & HEALTHY EATING

Many people in the United States don't eat a healthy diet. …People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy foods can help reduce their risk of chronic diseases and improve their overall health.

Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

– Healthy People 2030 (https://health.gov/healthypeople)

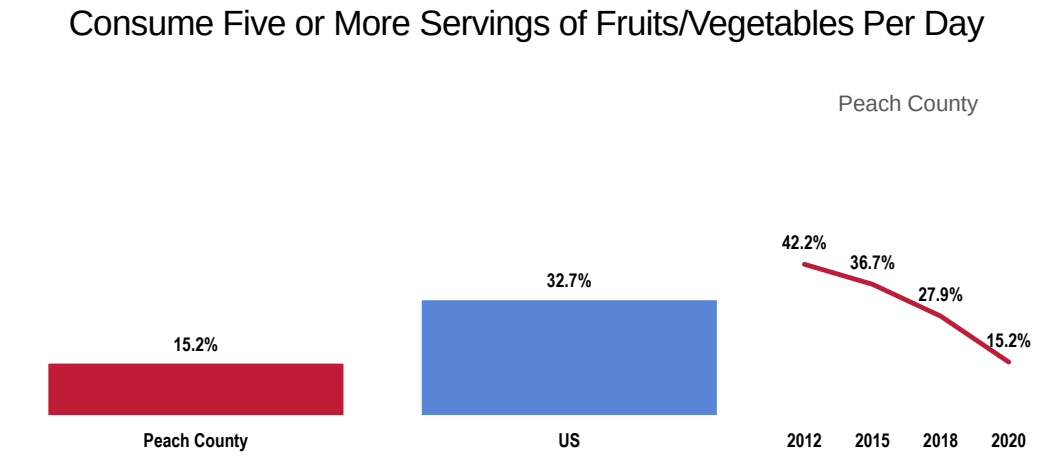
Daily Recommendation of Fruits/Vegetables

To measure fruit and vegetable consumption, survey respondents were asked multiple questions, specifically about the foods and drinks they consumed on the day prior to the interview.

"Now I would like you to think about the foods you ate or drank yesterday. Include all the foods you ate, both at home and away from home. How many servings of fruit or fruit juices did you have yesterday?"

"How many servings of vegetables did you have yesterday?"

The questions above are used to calculate daily fruit/vegetable consumption for respondents. The proportion reporting having 5 or more servings per day is shown here.



Sources:
- 2020 PRC Community Health Survey, PRC, Inc.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- For this issue, respondents were asked to recall their food intake on the previous day.

Access to Fresh Produce

"How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford — would you say: very difficult, somewhat difficult, not too difficult, or not at all difficult?"

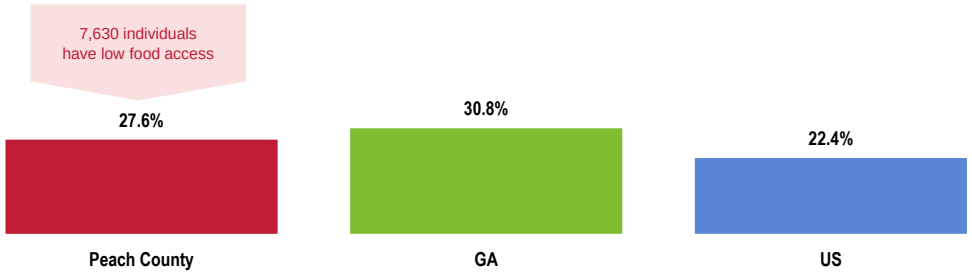
Find It "Very" or "Somewhat" Difficult to Buy Affordable Fresh Produce
(Peach County, 2020)

Sources:
- 2020 PRC Community Health Survey, PRC, Inc.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store. This related chart is based on US Department of Agriculture data.

Population With Low Food Access
(Percent of Population That Is Far From a Supermarket or Large Grocery Store, 2010)



Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2020 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the percentage of the population with low food access. Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store. This indicator is relevant because it highlights populations and geographies facing food insecurity.

Physical Activity

ABOUT PHYSICAL ACTIVITY

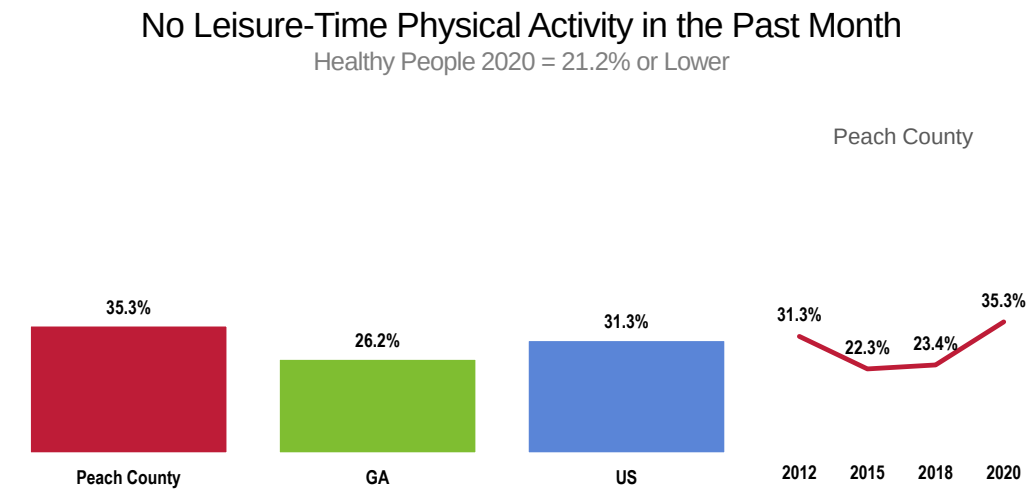
Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active — like providing access to community facilities and programs — can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

– Healthy People 2030 (https://health.gov/healthypeople)

Leisure-Time Physical Activity

"During the past month, other than your regular job, did you participate in any physical activities or exercises, such as running, calisthenics, golf, gardening, or walking for exercise?"



Sources:
- 2020 PRC Community Health Survey, PRC, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2018 Georgia data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2020. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Meeting Physical Activity Recommendations

ADULTS: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

Adults should do 2 hours and 30 minutes a week of moderate-intensity (such as walking), or 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity **aerobic** physical activity (such as jogging), or an equivalent combination of moderate- and vigorous-intensity aerobic physical activity. The guidelines also recommend that adults do **muscle-strengthening** activities, such as push-ups, sit-ups, or activities using resistance bands or weights. These activities should involve all major muscle groups and be done on two or more days per week.

The report finds that nationwide nearly 50 percent of adults are getting the recommended amounts of aerobic activity and about 30 percent are engaging in the recommended muscle-strengthening activity.

– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

To measure physical activity frequency, duration and intensity, respondents were asked:

"During the past month, what type of physical activity or exercise did you spend the most time doing?"

"And during the past month, how many times per week or per month did you take part in this activity?"

"And when you took part in this activity, for how many minutes or hours did you usually keep at it?"

Respondents could answer the above series for up to two types of physical activity. The specific activities identified (e.g., jogging, basketball, treadmill, etc.) determined the intensity values assigned to that respondent when calculating total aerobic physical activity hours/minutes.

Respondents were also asked about strengthening exercises:

"During the past month, how many times per week or per month did you do physical activities or exercises to strengthen your muscles? Do not count aerobic activities like walking, running, or bicycling. Please include activities using your own body weight, such as yoga, sit-ups, or push-ups, and those using weight machines, free weights, or elastic bands."

"Meeting physical activity recommendations" includes adequate levels of both aerobic and strengthening activity:

- Aerobic activity is at least 150 minutes per week of light to moderate activity, 75 minutes per week of vigorous physical activity, or an equivalent combination of both;
- Strengthening activity is at least 2 sessions per week of exercise designed to strengthen muscles.

Meets Physical Activity Recommendations

(Peach County, 2020)

Healthy People 2020 = 28.4% or Higher

Sources:
- 2020 PRC Community Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2020. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity *and* report doing physical activities specifically designed to strengthen muscles at least twice per week.

Weight Status

ABOUT OVERWEIGHT & OBESITY

Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Some racial/ethnic groups are more likely to have obesity, which increases their risk of chronic diseases.

Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce overweight and obesity. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight.

– Healthy People 2030 (https://health.gov/healthypeople)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared ($inches^2$)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI ≥30 kg/m^2. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m^2. The increase in mortality, however, tends to be modest until a BMI of 30 kg/m^2 is reached. For persons with a BMI ≥30 kg/m^2, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m^2.

– Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Adult Weight Status

CLASSIFICATION OF OVERWEIGHT AND OBESITY BY BMI	BMI (kg/m^2)
Underweight	<18.5
Normal	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

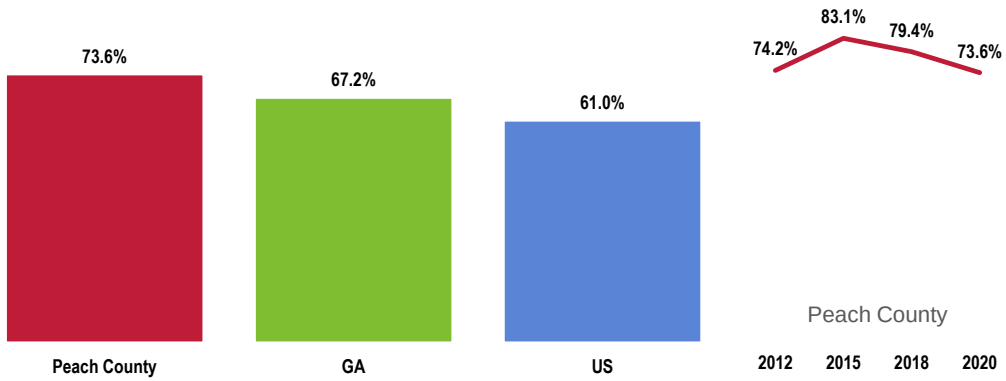
Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

“About how much do you weigh without shoes?”

“About how tall are you without shoes?”

Reported height and weight were used to calculate a Body Mass Index or BMI value (described above) for each respondent. This calculation allows us to examine the proportion of the population who is at a healthy weight, or who is overweight or obese (see table above).

Prevalence of Total Overweight (Overweight and Obese)

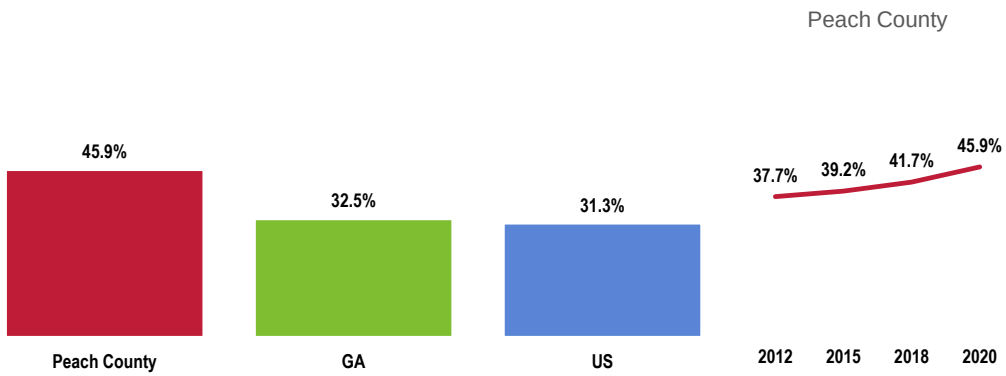


Sources:
- 2020 PRC Community Health Survey, PRC, Inc. [Items 155, 191]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2018 Georgia data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

Prevalence of Obesity

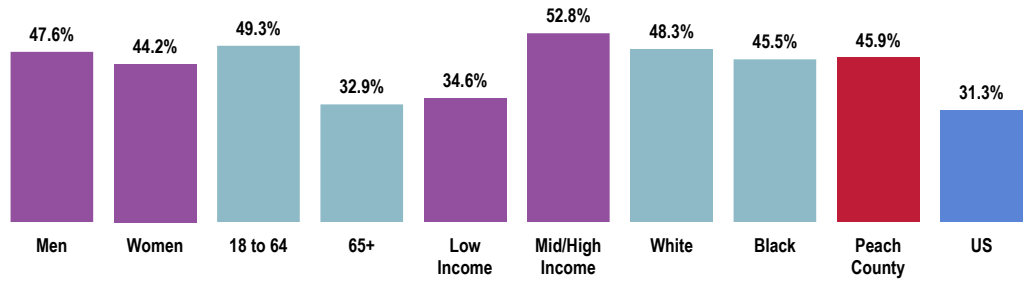
Healthy People 2020 = 36.0% or Lower



Sources:
- 2020 PRC Community Health Survey, PRC, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2018 Georgia data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2020. August 2020. http://www.healthypeople.gov

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Prevalence of Obesity
(Peach County, 2020)
Healthy People 2020 = 36.0% or Lower



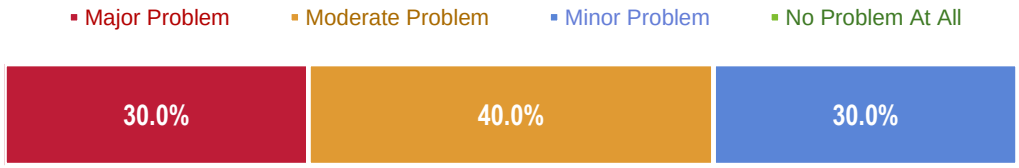
Sources:
- 2020 PRC Community Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2020. August 2020. http://www.healthypeople.gov

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Key Informant Input: Nutrition, Physical Activity & Weight

The following chart outlines key informants' perceptions of the severity of *Nutrition, Physical Activity & Weight* as a problem in the community:

Perceptions of Nutrition, Physical Activity, and Weight as a Problem in the Community
(Key Informants, 2020)



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Affordable Healthy Food

> Food deserts. – Physician (Peach County)

Substance Abuse

ABOUT DRUG & ALCOHOL USE

More than 20 million adults and adolescents in the United States have had a substance use disorder in the past year. …Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

– Healthy People 2030 (https://health.gov/healthypeople)

Alcohol

Excessive Drinking

Excessive drinking includes heavy and/or binge drinkers:

- HEAVY DRINKERS ► men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- BINGE DRINKERS ► men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

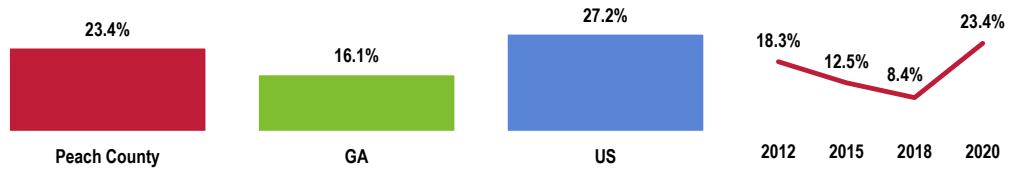
“During the past 30 days, on how many days did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?”

“On the day(s) when you drank, about how many drinks did you have on the average?”

“Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 (if male)**/4** (if female) **or more drinks on an occasion?”**

Excessive Drinkers

Peach County



Sources:
- 2020 PRC Community Health Survey, PRC, Inc.
- 2020 PRC National Health Survey, PRC, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2018 Georgia data.
- US Department of Health and Human Services. Healthy People 2020. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Drugs

Illicit Drug Use

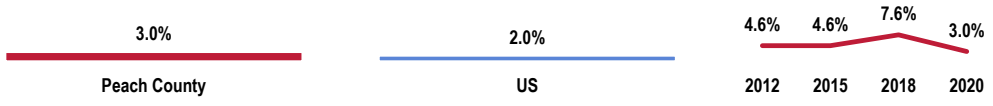
"During the past 30 days, have you used an illegal drug or taken a prescription drug that was not prescribed to you?"

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.

Illicit Drug Use in the Past Month

Healthy People 2020 = 12.0% or Lower

Peach County



Sources:
- 2020 PRC Community Health Survey, PRC, Inc.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2020. August 2020. http://www.healthypeople.gov

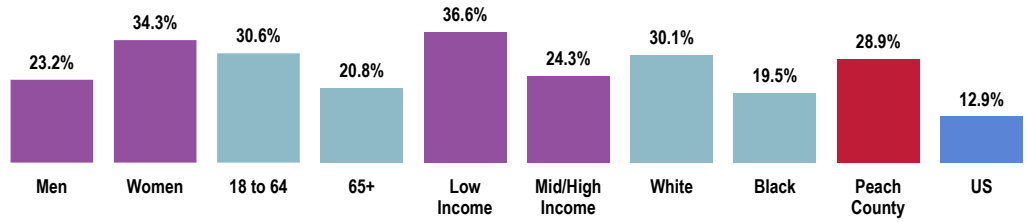
Notes:
- Asked of all respondents.

Use of Prescription Opioids

Opioids are a class of drugs used to treat pain. Examples presented to respondents include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. Common brand name opioids include Vicodin, Dilaudid, Percocet, OxyContin, and Demerol.

"Opiates or opioids are drugs that doctors prescribe to treat pain. Examples of prescription opiates include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. In the past year, have you used any of these prescription opiates?"

Used a Prescription Opioid Drug in the Past Year
(Peach County, 2020)



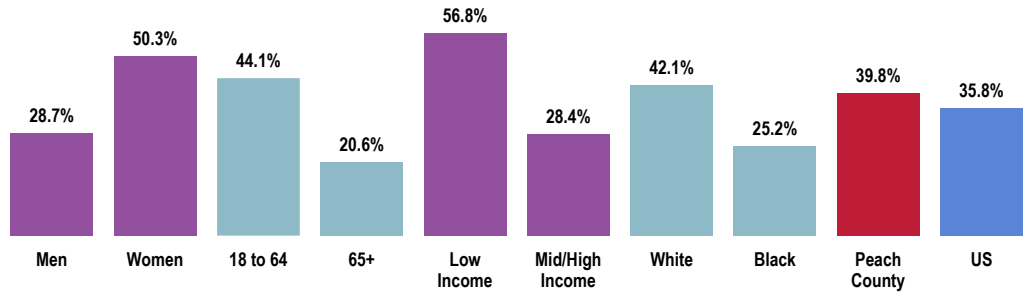
Sources:
- 2020 PRC Community Health Survey, PRC, Inc.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Personal Impact From Substance Abuse

"To what degree has your life been negatively affected by your own or someone else's substance abuse issues, including alcohol, prescription, and other drugs? Would you say: a great deal, somewhat, a little, or not at all?"

Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else)
(Peach County, 2020)

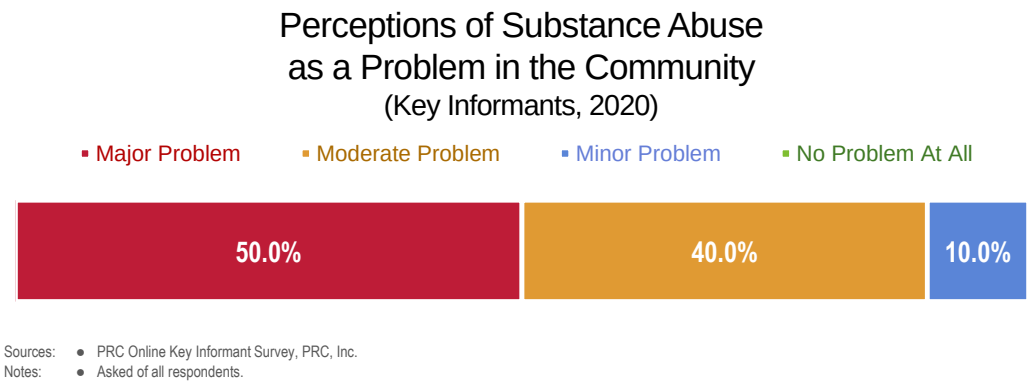


Sources:
- 2020 PRC Community Health Survey, PRC, Inc.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes response of "a great deal," "somewhat," and "a little."

Key Informant Input: Substance Abuse

The following chart outlines key informants' perceptions of the severity of *Substance Abuse* as a problem in the community:



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> No facilities. – Community Leader (Peach County)
> Lack of treatment centers and funding. – Community Leader (Peach County)
> Local facilities and health insurance. – Physician (Peach County)

Tobacco Use

ABOUT TOBACCO USE

More than 16 million adults in the United States have a disease caused by smoking cigarettes, and smoking-related illnesses lead to half a million deaths each year.

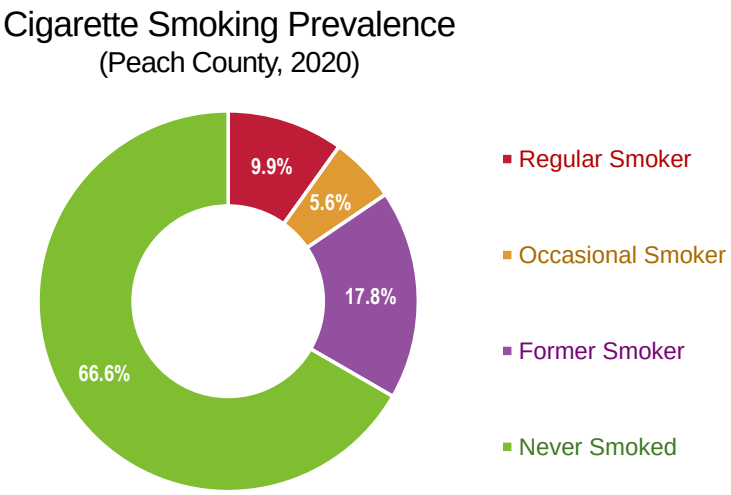
Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

– Healthy People 2030 (https://health.gov/healthypeople)

Cigarette Smoking

"Do you now smoke cigarettes every day, some days, or not at all?" ("Current smokers" include those smoking "every day" or on "some days.")

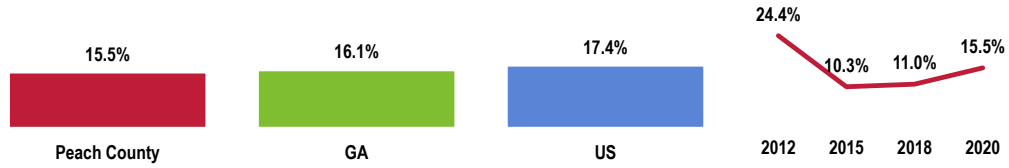


Sources: ● 2020 PRC Community Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Current Smokers

Healthy People 2020 = 5.0% or Lower

Peach County



Sources:
- 2020 PRC Community Health Survey, PRC, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2018 Georgia data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2020. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).

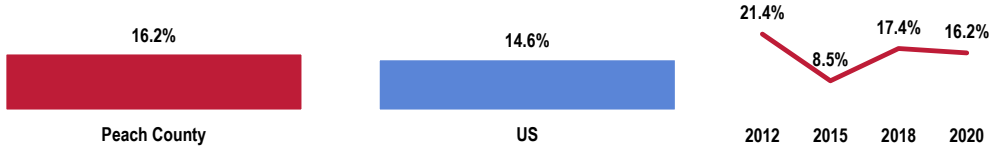
Environmental Tobacco Smoke

"In the past 30 days, has anyone, including yourself, smoked cigarettes, cigars or pipes anywhere in your home on an average of four or more days per week?"

The following chart details these responses among the total sample of respondents.

Member of Household Smokes at Home

Peach County



Sources:
- 2020 PRC Community Health Survey, PRC, Inc. [Items 52, 161-162]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

Use of Vaping Products

"The next questions are about electronic vaping products, such as electronic cigarettes, also known as e-cigarettes. These are battery-operated devices that simulate traditional cigarette smoking, but do not involve the burning of tobacco. The cartridge or liquid "e-juice" used in these devices produces vapor and comes in a variety of flavors. Have you ever used an electronic vaping product, such as an e-cigarette, even just one time in your entire life?"

"Do you now use electronic vaping products, such as e-cigarettes, "every day," "some days," or "not at all"?"

"Current use" includes use "every day" or on "some days."

Currently Use Vaping Products
(Peach County, 2020)

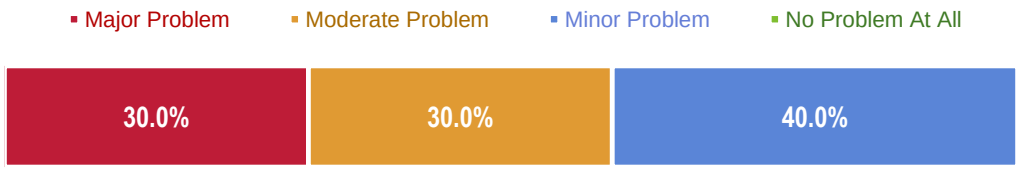
Sources:
- 2020 PRC Community Health Survey, PRC, Inc.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

Key Informant Input: Tobacco Use

The following chart outlines key informants' perceptions of the severity of *Tobacco Use* as a problem in the community:

Perceptions of Tobacco Use
as a Problem in the Community
(Key Informants, 2020)



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Comorbidities

> Number of patients with comorbidities related to tobacco use. – Physician (Peach County)

Sexual Health

HIV

ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

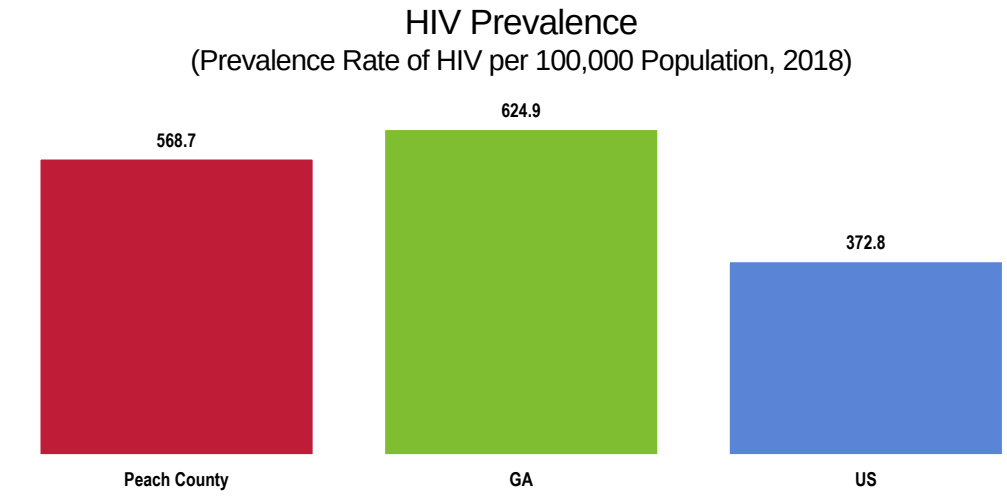
Although many sexually transmitted infections (STIs) are preventable, there are more than 20 million estimated new cases in the United States each year — and rates are increasing. In addition, more than 1.2 million people in the United States are living with HIV (human immunodeficiency virus).

Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

Strategies to increase screening and testing for STIs can assess people's risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the STI but doesn't prevent HIV from spreading.

– Healthy People 2030 (https://health.gov/healthypeople)

The following chart outlines prevalence (current cases, regardless of when they were diagnosed) of HIV per 100,000 population in the area.



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2020 via SparkMap (sparkmap.org).

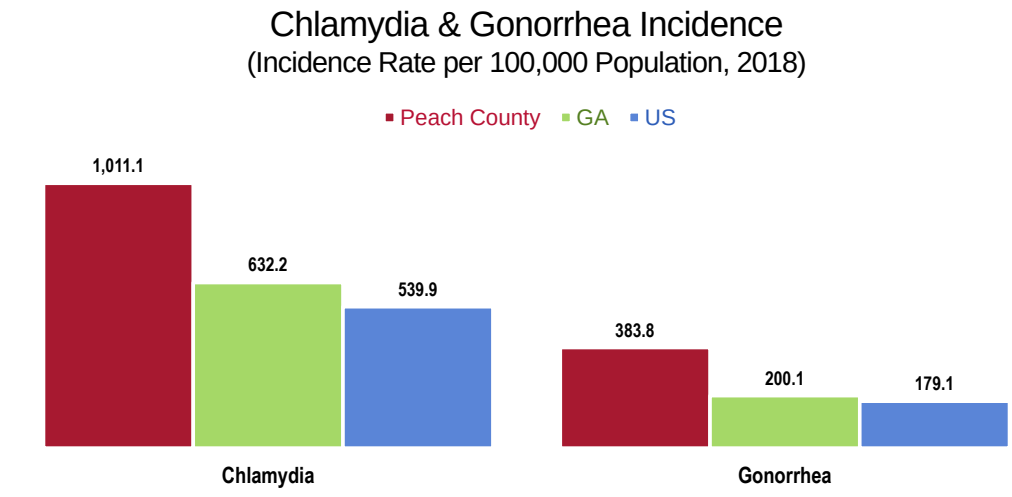
Notes:
- This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

Sexually Transmitted Infections (STIs)

CHLAMYDIA ► Chlamydia is the most commonly reported STI in the United States; most people who have chlamydia are unaware, since the disease often has no symptoms.

GONORRHEA ► Anyone who is sexually active can get gonorrhea. Gonorrhea can be cured with the right medication; left untreated, however, gonorrhea can cause serious health problems in both women and men.

The following chart outlines local incidence for these STIs.

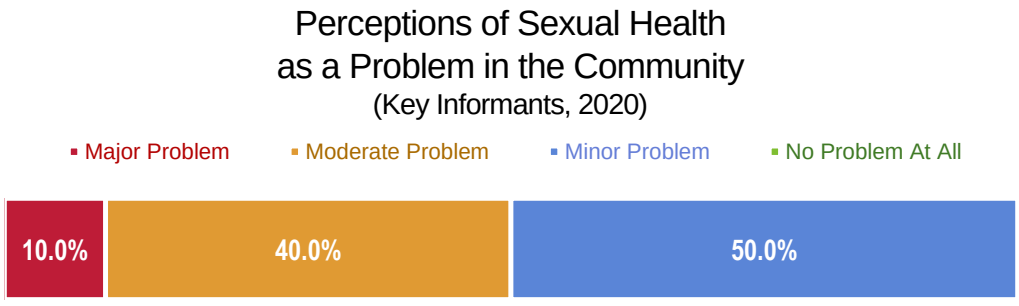


Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2020 via SparkMap (sparkmap.org).

Notes:
- This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

Key Informant Input: Sexual Health

The following chart outlines key informants' perceptions of the severity of *Sexual Health* as a problem in the community:



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

ACCESS TO HEALTH CARE

ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. …About 1 in 10 people in the United States don't have health insurance. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Lack of Health Insurance Coverage

Survey respondents were asked a series of questions to determine their healthcare insurance coverage, if any, from either private or government-sponsored sources.

"Do you have any government-assisted healthcare coverage, such as Medicare, Medicaid (or another state-sponsored program)**, or VA/military benefits?"**

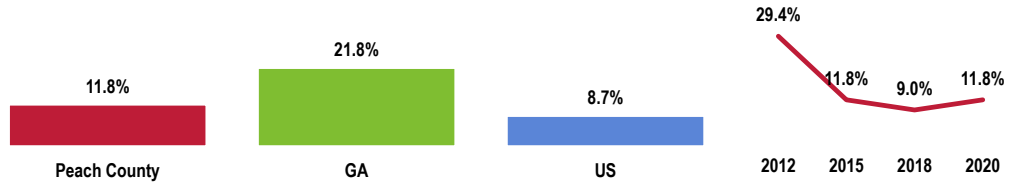
"Do you currently have: health insurance you get through your own or someone else's employer or union; health insurance you purchase yourself; or, you do not have health insurance and pay for health care entirely on your own?"

Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus excluding the Medicare population), who have no type of insurance coverage for healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

Lack of Health Care Insurance Coverage

(Adults Age 18-64)

Healthy People 2020 = 7.9% or Lower



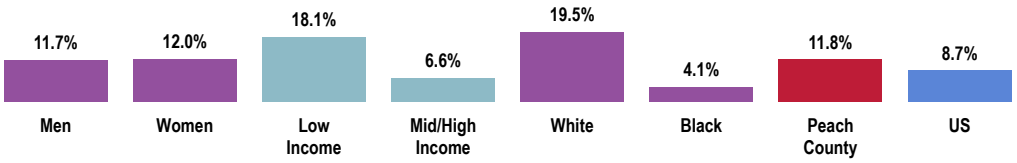
Sources:
- 2020 PRC Community Health Survey, PRC, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2018 Georgia data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2020. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents under the age of 65.

Lack of Health Care Insurance Coverage

(Adults Age 18-64; Peach County, 2020)

Healthy People 2020 = 0.0% (Universal Coverage)



Sources:
- 2020 PRC Community Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2020. August 2020. http://www.healthypeople.gov [Objective AHS-1]

Notes:
- Asked of all respondents under the age of 65.

Difficulties Accessing Health Care

Barriers to Health Care Access

To better understand healthcare access barriers, survey participants were asked whether any of the following barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

"Was there a time in the past 12 months when you needed medical care, but had difficulty finding a doctor?"

"Was there a time in the past 12 months when you had difficulty getting an appointment to see a doctor?"

"Was there a time in the past 12 months when you needed to see a doctor, but could not because of the cost?"

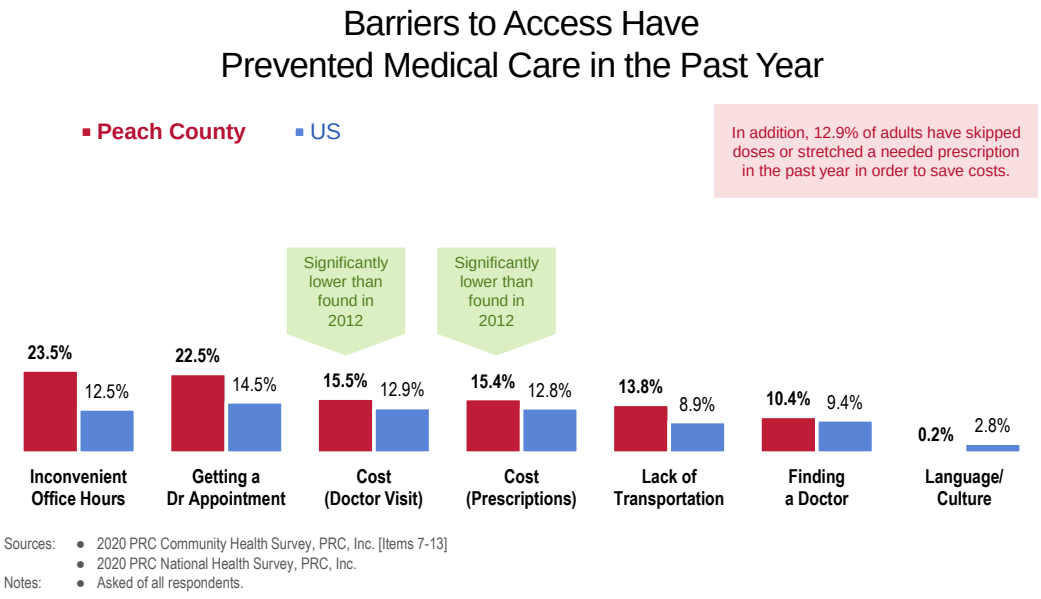
"Was there a time in the past 12 months when a lack of transportation made it difficult or prevented you from seeing a doctor or making a medical appointment?"

"Was there a time in the past 12 months when you were not able to see a doctor because the office hours were not convenient?"

"Was there a time in the past 12 months when you needed a prescription medicine, but did not get it because you could not afford it?"

"Was there a time in the past 12 months when you were not able to see a doctor due to language or cultural differences?"

The percentages shown in the following chart reflect the total population, regardless of whether medical care was needed or sought.

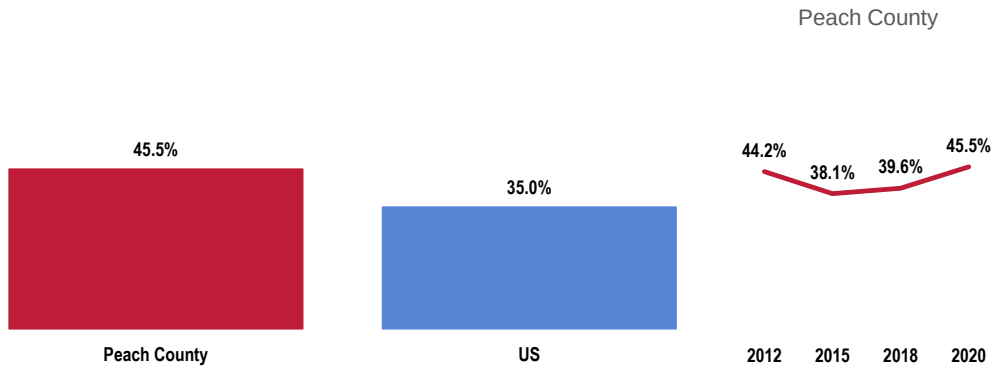


Sources:
- 2020 PRC Community Health Survey, PRC, Inc. [Items 7-13]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

The following charts reflect the composite percentage of the total population experiencing problems accessing healthcare in the past year (indicating one or more of the aforementioned barriers or any other problem not specifically asked), again regardless of whether they needed or sought care.

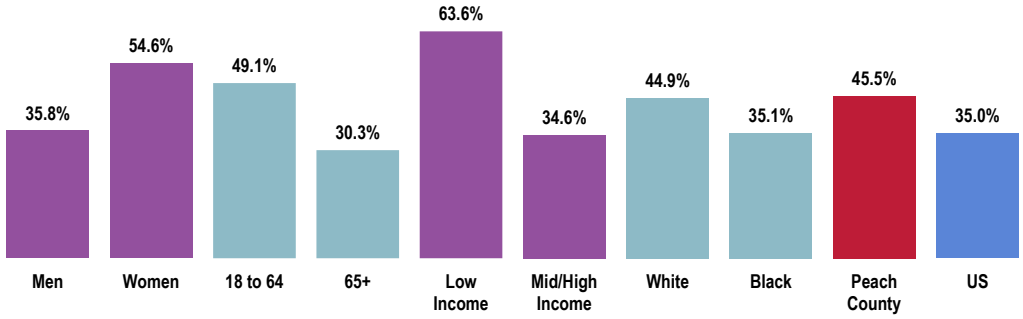
Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year



Sources:
- 2020 PRC Community Health Survey, PRC, Inc.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year
(Peach County, 2020)

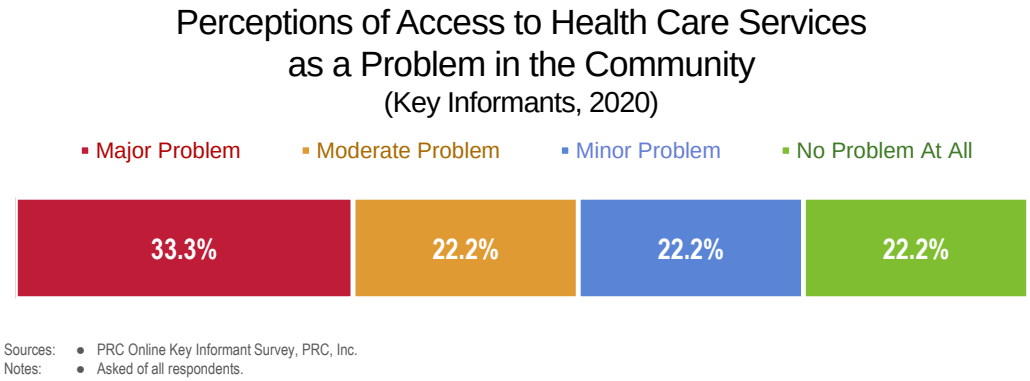


Sources:
- 2020 PRC Community Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Key Informant Input: Access to Health Care Services

The following chart outlines key informants' perceptions of the severity of *Access to Health Care Services* as a problem in the community:



Sources: PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

> Lack of affordable health insurance and transportation to medical facilities. – Physician (Peach County)

Transportation

> Lack of transportation and lack of insurance. – Public Health Representative (Peach County)

Primary Care Services

ABOUT PREVENTIVE CARE

Getting preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services.

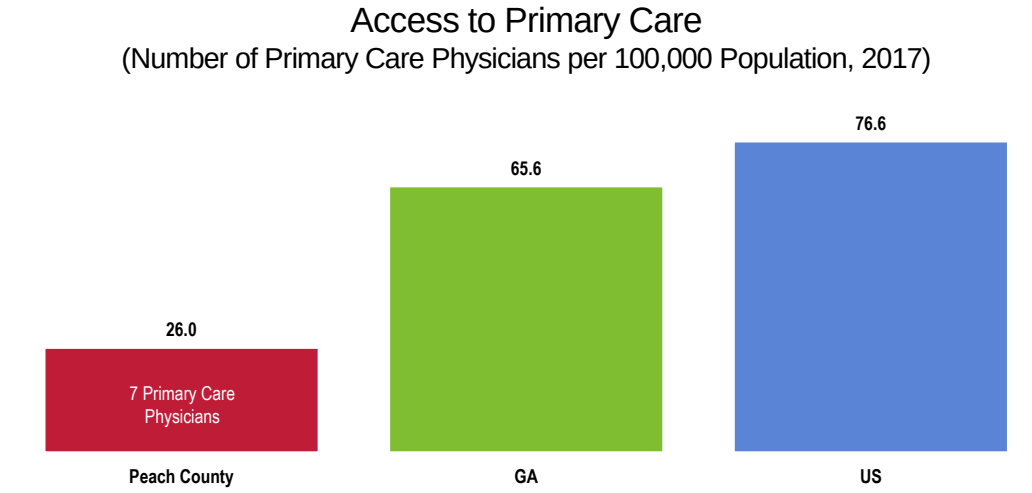
Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

– Healthy People 2030 (https://health.gov/healthypeople)

Access to Primary Care

This indicator is relevant because a shortage of health professionals contributes to access and health status issues.



Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved October 2020 via SparkMap (sparkmap.org).

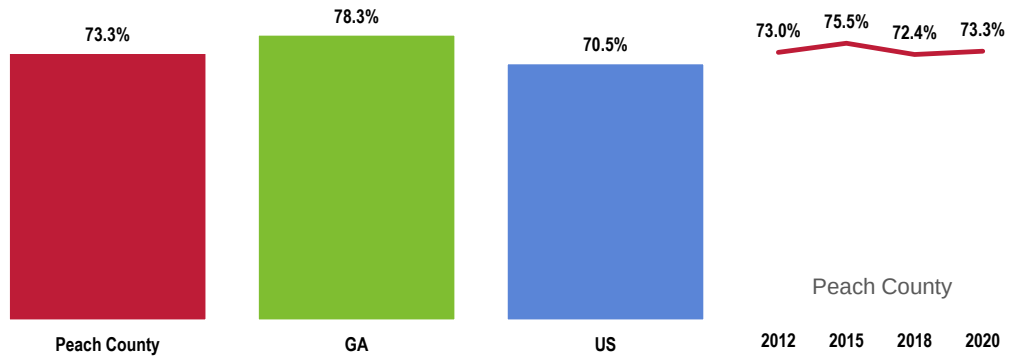
Notes:
- Doctors classified as "primary care physicians" by the AMA include: General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs, and General Pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Utilization of Primary Care Services

"A routine checkup is a general physical exam, not an exam for a specific injury, illness or condition. About how long has it been since you last visited a doctor for a routine checkup?"

CHILDREN ▶ **"About how long has it been since this child visited a doctor for a routine checkup or general physical exam, not counting visits for a specific injury, illness, or condition?"**

Have Visited a Physician for a Checkup in the Past Year



Sources:
- 2020 PRC Community Health Survey, PRC, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2018 Georgia data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Oral Health

ABOUT ORAL HEALTH

Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems can cause pain and disability and are linked to other diseases.

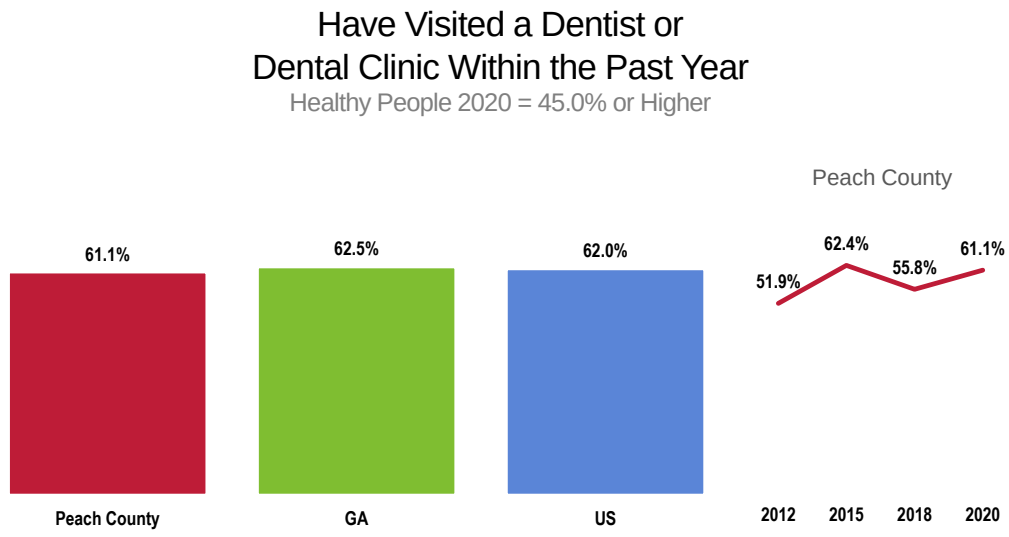
Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

– Healthy People 2030 (https://health.gov/healthypeople)

Dental Care

"About how long has it been since you last visited a dentist or a dental clinic for any reason?"

CHILDREN AGE 2-17 ► **"About how long has it been since this child visited a dentist or dental clinic?"**

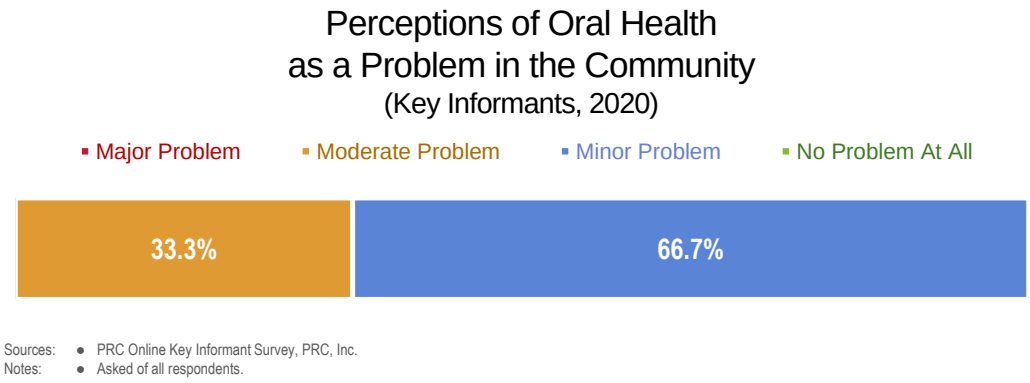


Sources:
- 2020 PRC Community Health Survey, PRC, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2018 Georgia data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2020. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Key Informant Input: Oral Health

The following chart outlines key informants' perceptions of the severity of *Oral Health* as a problem in the community:

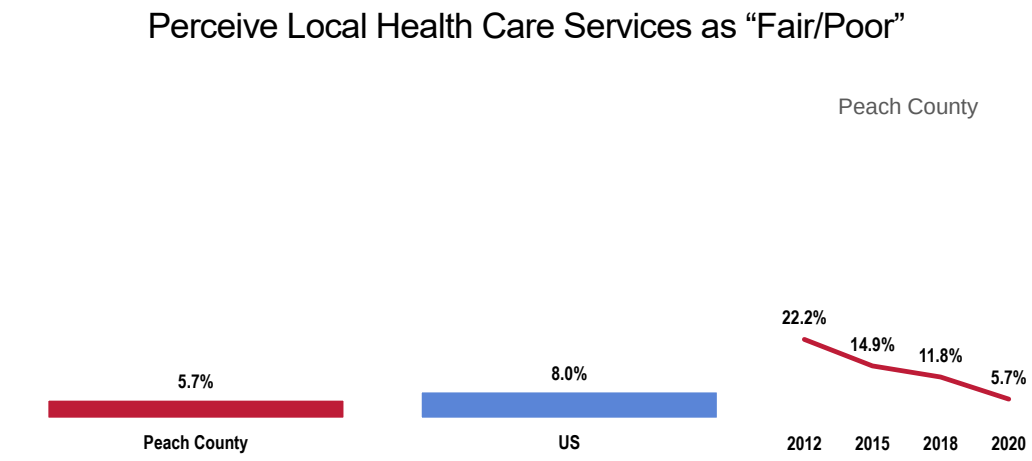


Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

LOCAL RESOURCES

Perceptions of Local Health Care Services

"How would you rate the overall health care services available to you? Would you say: excellent, very good, good, fair, or poor?"



Sources: ● 2020 PRC Community Health Survey, PRC, Inc.
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Resources Available to Address the Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

Access to Health Care Services

- Ambetter Insurance
- Department of Family and Children Services
- Department of Public Health
- Feed Center Free Clinic
- Phoenix Center
- Transportation Vans

Cancer

- Department of Public Health
- Health Department
- The Medical Center of Peach County - Navicent Health

Kidney Disease

- Dialysis Center
- Feed Center Free Clinic

Diabetes

- Doctor's Offices
- Fort Valley State University
- Health Department
- None
- Peach County School System
- The Medical Center of Peach County - Navicent Health

Heart Disease

- Doctor's Offices
- Feed Center Free Clinic
- Health Department
- The Medical Center of Peach County - Navicent Health

Mental Health

- Doctor's Offices
- Health Department
- Phoenix Center

Tobacco Use

- Doctor's Offices

Substance Abuse

- Doctor's Offices
- Health Department
- Phoenix Center
- River Edge Behavioral Health

APPENDIX: EVALUATION OF PAST ACTIVITIES

IMPLEMENTATION STRATEGY

Medical Center Navicent Health
Medical Center Peach County Navicent Health
Navicent Health Baldwin

For FY2018-2020 Summary

Navicent Health System is three hospitals with the total number of 802 beds, acute care hospital system located in Central Georgia (Baldwin, Bibb and Peach Counties). In 2018, the three hospitals conducted individual Community Health Needs Assessments (CHNA) to identify the health needs of the three counties. The Implementation Strategy for NH System was developed based on findings and priorities established in the CHNA and a review of each hospital's existing community benefit activities.

This report summarizes the plans for NH System to sustain and develop community benefit programs that 1) address prioritized needs from the 2018 from each hospital's CHNA and 2) respond to other identified community health needs.

The following Community Health (CH) prioritized needs were identified by the Integration teams of Atrium and Navicent Health. Particular focus was placed upon these needs in developing the Implementation Strategy.

- **CH Priorities (Structural)**
    - Access
    - Behavioral Health
    - Nutrition/Physical Activity
- **CH Priorities (Clinical)**
    - Diabetes
    - Cardiovascular Disease
    - Obesity
- **Social Determinants of Health is foundational to all of these priorities**

NH System has addressed each of the health needs identified in the CHNA. NH System developed implementation strategies to address each of the health issues identified over the next three years.

Specific implementation strategies for each of the CHNA identified health needs are addressed in the following appendices to this report.

Approval:

The NH System Board of Directors approved this Implementation Strategy through a board vote on 08/16/2019.

The following issues were identified as "priority: needs by the community participants. The findings are listed in the order of priority determined by the CHNA Steering Committee (CHSC).

1. **Behavioral Health**
    a. There is a need to improve access to mental health services.
    b. There is a need to implement strategies for promotion and prevention in mental health.

2. **Diabetes**
    a. There is a need for more awareness and education on diabetes and prevention.
        i. There is a need to increase prevention behaviors in persons a risk for diabetes with prediabetes.
        ii. There is a need to improve diabetes control among people with diabetes.
    b. There is a need for diabetes screening, testing, and diagnosis.

3. **Access**
    a. There is a need to improve access to quality health care and services.
        i. There is a need to expand the availability of health care access points.
        ii. There is a need to expand access to health care services in underserved and rural areas.
        iii. There is a needed to expand healthcare services to address chronic disease burdens.
        iv. There is a need to connect patient populations to primary care and preventive services.
    b. There is a need to improve health literacy and patient education.

4. **Nutrition /Physical Activity**
    a. There is a need to increase community efforts to increase physical activity.
        i. There is a need to create healthy environments for physical activity.
        ii. There is a need to educate regarding the benefits of physical activity.
    b. There is a need to improve nutrition and health efforts.
        i. There is a need to provide knowledge and skills to make healthier choices.
        ii. There is a need to increase access to healthy food.

5. **Cardiovascular Disease**
    a. There is a need to reduce cardiovascular disease mortality.
    b. There is a need to improve cardiovascular health and quality of life.
    c. There is a need for education regarding cardiovascular risk factors.

6. **Obesity**
    a. There is a need to educate and create awareness around obesity.
    b. There is a need to communicate best practices for obesity prevention.

7. **Other Strategies**
    a. There is a need to educate and create awareness around childhood asthma.
    b. There is a need to educate and create awareness around injury and fall prevention in senior citizens.

Appendix 1

Community Work Plan for Behavorial Health

CHNA Page Reference-pages 72-85

Health Problem	Outcome Objective (Anticipated Impact)
a. There is a need to improve access to mental health services. b. There is a need to implement strategies for promotion and prevention in mental health.	a. Improve access to mental health services. b. Develop and implement strategies for promotion and prevention in mental health. c. Increase knowledge and awareness of depression and suicide risks.

Background and contributing factors:

The CHNA process identified that the prevalence of mental illness is high in the region as well as many in this population have co-occurring substance abuse issues. This population self-medicate with alcohol and/or drugs. The community reported that the region has an inadequate number of psychiatrists and inpatient/outpatient programs available to adults and adolescent residents, including providers to oversee medication management and provide counseling resources. Additionally, the community input identified depression and suicide as a major concern.

Implementation Strategy:

a) Pledge to financially support the building and expansion of River Edge Behavioral Health Services' Crisis Stabilization Unit and Crisis Center.
b) Offer a myriad of Support Groups and Self-Help Groups to help the citizens of Central Georgia cope with various health issues (cancer, cardiovascular disease, etc.)
c) Offer a Smoking Cessation program including the addition of a Smoking Cessation Support Group within the next year.
d) Sponsors an intensive weekend retreat, Bo's Camp, for Central Georgia families to deal with grief and bereavement of the loss of children under the age of 18 years.
e) Provide free therapy services at Children Health Center in partnership with Mercer University Marriage and Family Therapist (MFT) Program.
f) Partner with Georgia College & State University to provide Behavioral Health Education to students in Baldwin County.

- OUTCOMES: Statistics will be recorded for the number of program participants and/or number of attendees at various events, tracking and analyzing the demographic data of program participants, participant history information, identification and tracking of key trends, and determining which programs and efforts are the most effective at achieving desired outcomes. (Reference "Outcome Objective" box on previous page)

Possible Collaborations:

- River Edge Behavioral Health
- Local public-school districts
- Georgia College & State University
- Mercer University

Outcomes:

Pledge to financially support the building and expansion of River Edge Behavioral Health Services' Crisis Stabilization Unit and Crisis Center.

- Medical Center NH contributed a $900,000 grant to financially support River Edge's Crisis Stabilization Unit and Crisis Center in 2019 and 2020, and another $300,000 in 2021.

Offer a myriad of Support Groups and Self-Help Groups to help the citizens of Central Georgia cope with various health issues (cancer, cardiovascular disease, etc.).

- Cancer Life Center- See data below:

2019 Support Groups and Self-Help Groups			
Support Group	Meeting Time	Total Participants	
Cancer Well Fit	Monthly	249	
Care for the Caregiver	Monthly	15	
Ribbons of Hope	Monthly	17	
Chemotherapy teaching	Weekly	119	
Pink Alliance	Monthly	321	
2020 Support Groups and Self-Help Groups			
Cancer Well Fit	Monthly	No data	Comments
Care for the Caregiver	Monthly	3	Stopped in 3/20 due to COVID-19
Ribbons of Hope	Monthly	5	Stopped in 3/20 due to COVID-19
Chemotherapy teaching	Twice a month	39	
Pink Alliance	Monthly	60	Stopped in 3/20 due to COVID-19

- Men to Men Support Group
    - The Men to Men Support Group had 227 people attend between 01/2019 to 03/2020. The support group stopped in 04/2020 (due COVID-19).
- Cardiac Support Groups
    - In the Congestive Heart Failure support group, fifteen (15) participated which meets four (4) times a year. The Afib support group has 20 participants which meets four (4) times a year also.
- Diabetes Support Group

Support Groups for Patients with diabetes		
Date	Group Name	Number of Participants
2/14/2019	DM Connection Support Group	11
5/9/2019	DM Connection Support Group	11
8/8/2019	DM Connection Support Group	15
11/14/2019	DM Connection Support Group	45
12/14/2020	Peds Family night @ Mayhem	40

- Diabetes Community Events

- The Diabetes Healthways teammates participated in the community events throughout CY 2019. Due to the COVID-19 pandemic, community events have been cancelled except the school staff training for Houston, Bibb and Laurens counties.

2019 Community Events	
02/02/2019	Heart Health Fair
02/27/2020	Westside High School Health Fair
03/11/2019	Bibb County Senior Center Diabetes Talk
06/27/2019	Stroke Health Fair
06/27/2019	Code Med
09/28/2019	Men's Health Fair
11/05/2019	Men to Men Support Group Talk

Offer a Smoking Cessation program including the addition of a Smoking Cessation Support Group within the next year.

- A total of 25 people participated in the Smoking Cessation classes during 2019. The Smoking Cessation program was temporarily suspended during CY 2020.

Sponsors an intensive weekend retreat, Bo's Camp, for Central Georgia families to deal with grief and bereavement of the loss of children under the age of 18 years.

- The Medical Center held Bo's Camp in 2019 but it was cancelled in 2020 due to COVID and we are currently working to develop social media platforms and online meetings to reach out to grieving families. For 2019 there were 22 families who participated in Bo's Camp.

Provide free therapy services at Children Health Center in partnership with Mercer University Marriage and Family Therapist (MFT) Program.

- The Children Health Center did provide free therapy sessions in partnership with the Mercer MFT program. We were able to service approximately 159 patients in 2019. Due to the COVID-19 pandemic, the participation has decreased.

Partner with Georgia College & State University to provide Behavioral Health Education to students in Baldwin County.

- Due to the COVID-19 pandemic, this partnership is on hold.

Appendix 2

Community Work Plan for Diabetes

CHNA Page Reference-pages 137-141

Health Problem	Outcome Objective (Anticipated Impact)
a. There is a need for more awareness and education on diabetes prevention. ▪ There is a need to increase prevention behaviors in persons at risk for diabetes with prediabetes. ▪ There is a need to improve diabetes control among people with diabetes. b. There is a need for diabetes screening, testing, and diagnosis.	a. Increase knowledge and awareness of diabetes prevention education. b. Increase knowledge and awareness of warning signs of hyperglycemia and the available resources and support groups for this disease. c. Continue to provide diabetes screening through community and corporate health fairs; follow-up with participants with abnormal screening results.

Background and contributing factors:

The CHNA focus groups process characterized Diabetes as a major problem in the community. The CHNA reported that that the number of adults in the Central Georgia region was higher than the statewide and national proportions with highest population diagnosed in Peach County. The highest age-adjusted death rate for diabetes in Peach County is 47.3 in comparison to Baldwin County 23.1, Bibb County 13.8 and Houston County 24.5.

Implementation Strategy:

a) Partnering with the Center for Disruption and Innovation and the Medical Center of Peach County, NH are examining ways to efficiently monitor patients with Diabetes in their homes via technology.
b) Assessing technology solutions through the Center for Disruption and Innovation to utilize in Peach County at a rural health clinic (RHC) and local Navicent Health Physician Group (NHPG) practice to manage patient with an A1C greater than 9 through interactive communication with their provider via an app on a smart phone.
c) Declare a clinical community health priority in Peach County.
d) Partner with faith community existing programs to provide blood glucose screening tools in Baldwin County.

- OUTCOMES: Statistics will be recorded for the number of program participants and/or number of attendees at various events, tracking and analyzing the demographic data of program participants, participant history information, identification and tracking of key trends, and determining which programs and efforts are the most effective at achieving desired outcomes. (Reference “Outcome Objective” box on previous page)

Possible Collaborations:

- Faith community organizations in local service area
- Diabetes Healthways

Outcomes:

Partnering with the Center for Disruption and Innovation and the Medical Center of Peach County, NH are examining ways to efficiently monitor patients with Diabetes in their homes via technology.

- The Medical Center of Peach County did not partner with the Center for Disruption and Innovation on monitoring patients with diabetes. This project was going to be in collaboration with Fort Valley State University Department of Behavioral Sciences, but the University did not approve moving forward with the project.

Assessing technology solutions through the Center for Disruption and Innovation to utilize in Peach County at a rural health clinic (RHC) and local Navicent Health Physician Group (NHPG) practice to manage patient with an A1C greater than 9 through interactive communication with their provider via an app on a smart phone.

- The Medical Center of Peach County did not partner with the Center for Disruption and Innovation on managing patients with an A1C greater than 9. This project was going to be in collaboration with Fort Valley State University Department of Behavioral Sciences, but the University did not approve moving forward with the project.

Declare a clinical community health priority in Peach County.

The clinical community health priority was health literacy. Some of the Peach County community engagement efforts are listed below.

- Faith-based Organizations
    - Health Literacy, Awareness of the Speaker's Bureau, and Education on CHNA and Robert Wood Johnson Foundation Health Rankings.
- Fort Valley State University
    - Hispanic Population- access to care-Health Fair with Lane Orchard, Mercer, Navicent, Fort Valley University
        - The Migrant Health Fair was not held to the COVID-19 pandemic. However, The Medical Center of Peach County provided education to the migrant workers regarding the pandemic on how they could be safe.
            - COVID safe behavior education was provided as written material in Spanish and through the Hispanic News Network.
    - Explored collaboration with Fort Valley for Community Garden to address healthier eating and nutrition.
    - Explored establishing a hydroponic garden with their Agriculture professors and students.

- Lion's Club
    - Education on CHNA and Robert Wood Johnson Foundation Health Ranking
    - Peach Family Connection
        - Convener to Peach Family Connection and Mental Health First Aid
        - Education on CHNA and Robert Wood Johnson Foundation Health Rankings and finding from diabetes. These are some of the areas that participate in the coalition.
        - Team developed a resource list for community.
            - Collaborative member agencies (some but not all coalition members) (Feed Center, Department of Human Services, Fort Valley State University, Peach Public Library, Georgia Department of Human Resources, Central Georgia Technical College, Commissioners Of Peach County office, Phoenix Center, Family Counseling Center, Southern Center for Choice Theory, Salvation Army, First Choice Primary, WellCare, Peach School system, Peach Pit, On the Path Georgia, Community Health Works, Amerigroup, and Fort Valley Housing Authority.

Partner with faith community existing programs to provide blood glucose screening tools in Baldwin County.

- Due to the COVID-19 pandemic, this partnership is on hold.

Appendix 3

Access to Care (includes education on prevention and communication of available resources)

CHNA Page Reference-pages 215-260

Health Problem	Outcome Objective (Anticipated Impact)
a. There is a need to improve access to quality health care and services. ▪ There is a need to expand the availability of health care access points. ▪ There is a need to expand access to health care services in underserved and rural area. ▪ There is a need to expand healthcare services to address chronic diseases. ▪ There is a need to connect underserved and/or uninsured patient populations to primary care and preventative services. b. There is a need to improve health literacy and patient education.	a. Improve access to quality health care and services through expansion of available health care access points. ▪ Expand access to health care services in underserved and rural areas. ▪ Expand access to health care services for the population with chronic diseases. ▪ Increase connection for underserved and/or uninsured populations to primary care and preventative services. b. Increase opportunities to provide health literacy and patient education.
Background and contributing factors:	

The CHNA process identified access to care as a major barrier to healthcare. Access to care involves everything from lack of transportation to lack of educational classes on prevention. A high number of adults in Central Georgia reported having no insurance coverage for healthcare expenses. The focus groups identified several barriers in accessing health which included difficulties or delays and the cost of prescriptions.

Implementation Strategy:

a) Continue partnership with First Choice Primary Care (FQHC).
b) Continue partnership with Macon Volunteer Clinic.
c) Continue support of the transformational community at Tindall Fields with the placement of a care coordinator (Bibb County).
d) Pledged to support another transformational community called Northside Senior Living with a placement of a care coordinator (Bibb County).
e) Develop a partnership with a local Federally Qualified Health Center (FHQC) (Baldwin County).
f) Recruit primary care physicians as well as midlevel providers to existing practices (Baldwin County).
g) Navicent Health Baldwin, The Medical Center of Peach County Navicent Health, and The Medical Center, Navicent Health are examining ways to increase access to healthcare via telemedicine.

- OUTCOMES: Statistics will be recorded for the number of program participants and/or number of attendees at various events, tracking and analyzing the demographic data of program participants, participant history information, identification and tracking of key trends, and determining which programs and efforts are the most effective at achieving desired outcomes. (Reference “Outcome Objective” box on previous page)

Possible Collaborations:

- First Choice Primary Health Care
- Macon Volunteer Clinic
- FQHC in Baldwin County

Outcomes:

Continue partnership with First Choice Primary Care (FQHC).

- Yes, First Choice Primary Care has two (2) staff members located in the Medical Center, Navicent Health for easy referrals.

Continue partnership with Macon Volunteer Clinic.

- Yes, a Health educator coordinates communication, events, etc. between Navicent Health and Macon Volunteer Clinic.

Continue support of the transformational community at Tindall Fields with the placement of a care coordinator (Bibb County).

- Yes, a Care Coordinator is assigned to Tindall Fields. The coordinator is assigned to 19 unique families at Tindall Fields from May 2019 to February 2020. Although COVID -19 pre-empted `face to face contacts, we continued on a very limited basis to provide care telephonically.

Pledged to support another transformational community called Northside Senior Living with a placement of a care coordinator (Bibb County).

- The Northside Senior Living Facility has not yet been built, but Navicent Health is partnering with this facility, its planning committee, and still plans to assign a Care Coordinator to Northside Senior Center once it is built.

Develop a partnership with a local Federally Qualified Health Center (FHQC) (Baldwin County).

- This partnership is in progress.

Recruit primary care physicians as well as midlevel providers to existing practices (Baldwin County).

- The recruitment is in process.

Navicent Health Baldwin, The Medical Center of Peach County Navicent Health, and The Medical Center, Navicent Health are examining ways to increase access to healthcare via telemedicine.

- Navicent Health Baldwin
    - Yes, the Virtual Critical Care was initiated. Five primary care physicians were interviewed in 2019-2020; however, none of them are under contract. In partnership with Atrium Health Intensivists, 199 telemedicine consultations for critically ill patients were completed.
- Total Referrals YTD: 336
    - Primary Care Associates, Baldwin: Launch December 2019
        - 3 providers
        - Averaging 10.9 referrals per month
    - Navicent: Family Health Center: Launch February 2020
        - 17 providers
        - Averaging 23.66 referrals per month
    - Central Georgia: Launch July 2020
        - 4 providers
        - Averaging 6 referrals per month
    - Children's Health: Launch September 2020
        - 8 providers
        - Averaging 5 referrals per month
- Primary and Specialty Care Referrals YTD: 20,555 virtual visits
    - Implemented January 2020 through 10/22/2020 through three (3) virtual platforms.
    - eBHI (Electronic Behavioral Health)
        - Virtual BH services in a non-stigmatic fashion during PCP visit
        - Four sites implemented in 2020:
            - Two rural locations: Milledgeville and Forsyth
            - Two Macon, GA locations: 1 Pediatric practice; 1 Family medicine practice.
        - 245 referrals to 10/2020 (all sites)
    - Four additional locations planned for implementation in 2021.

Appendix 4

Nutrition/Physical Activity

CHNA Page Reference-pages 174-195

Health Problem	Outcome Objective (Anticipated Impact)
a. There is need to improve community awareness to increase physical activity. ▪ There is a need to create health environments for physical activity. ▪ There is a need to educate regarding the benefits of physical activity. b. There is a need to improve nutrition and health efforts. ▪ There is a need to provide knowledge and skills to make healthier choices. ▪ There is a need to increase access to healthy food.	a. Improve community awareness and education to increase exercise/physical activity per CDC's guidelines. b. Improve nutrition and health efforts. ▪ Increase opportunities to provide knowledge and skills to make healthier choices. ▪ Increase access to healthy foods.

Background and contributing factors:

Food deserts exist in all three counties with highest in Bibb County. The U.S. Department of Agriculture data shows that 30.4% of the total Area population (representing over 135,000 residents) have low food access or live in a food desert. A total of 58.2% of Total Area adults do not participate in any types of physical activities or exercises to strengthen their muscles with the highest in Bibb County at 34.3%.

Implementation Strategy:

a) Continue to send volunteers to work at the Middle Georgia Food Bank and staff mobile food clinics.

b) Sponsor community road races (Bibb and Peach Counties).

c) Sponsor Heart Healthy luncheons and cooking classes (Bibb and Peach Counties).

d) Sponsor school system's community garden (Baldwin County).

e) Sponsor existing Weekend Backpack programs for feeding students in need during times school is not in session (Baldwin County).

- OUTCOMES: Statistics will be recorded for the number of program participants and/or number of attendees at various events, tracking and analyzing the demographic data of program participants, participant history information, identification and tracking of key trends, and determining which programs and efforts are the most effective at achieving desired outcomes. (Reference "Outcome Objective" box on previous page).

Possible Collaborations:

- Middle Georgia Food Bank
- Baldwin County Public Schools
- One South
- Loaves & Fishes

Outcomes:

Continue to send volunteers to work at the Middle Georgia Food Bank and staff mobile food clinics**.**

- A Navicent Health manager serves as the Vice Chairman for the Middle Georgia community Food Bank Board of Directors. In 2019, approximately 50 to 60 teammates were instrumental in a successful food drive. In 2020, approximately 100 Navicent teammates were sent to food drives around Bibb County.

Sponsor community road races (Bibb and Peach Counties).

- The Medical Center of Peach County sponsored the Peach Road Race on March 9, 2019 and March 14, 2020.

Sponsor Heart Healthy luncheons and cooking classes (Bibb and Peach Counties).

- The Heart Center Navicent Health sponsored the Health Healthy luncheon on February 14, 2019 in Fort Valley, GA.

Sponsor school system's community garden (Baldwin County).

- Due to the COVID-19 pandemic, Navicent Health Baldwin did not sponsor a school system's community garden.

Sponsor existing Weekend Backpack programs for feeding students in need during times school is not in session (Baldwin County). Added Medical Center NH in 8/2020.

- Medical Center Navicent Health is committed to sponsoring the Weekend Backpack program through the end of the school year (May 2021). Since August 2020 through 11/20/2020, a total 1705 people were served (see data below).

Date	# Volunteers	Hrs.	People Served
8/27/2020	4	8	250
9/10/2020	4	6	250
9/24/2020	1	2	130
10/08/2020	3	4.5	225
10/22/2020	4	6	250
11/05/2020	6	27	350
11/20/2020	4	8	250
	26	49	1705

- Due to the COVID-19 pandemic, Navicent Health Baldwin did not sponsor a Weekend Backpack program.

Appendix 5

Cardiovascular Disease

CHNA Page Reference-pages 89-102

Health Problem	Outcome Objective (Anticipated Impact)
a. There is a need to reduce cardiovascular disease mortality. b. There is a need to improve cardiovascular health and quality of life. c. There is a need to for education regarding cardiovascular risk factors.	a. Reduce the number of mortalities related to cardiovascular diseases. b. Improve the cardiovascular health and quality of life. c. Increase awareness and knowledge of risk factors for cardiovascular disease.

Background and contributing factors:

Key informants in the CHNA process characterized Heart Disease & Stroke as a major problem. Between 2014 and 2016, there was an annual average age-adjusted heart disease mortality rate of 229.5 deaths per 100,000 population in the Total Area which is much higher than Georgia and national rates. This rate is far from satisfying the Healthy People 2020 target of 156.9 or lower. Overall, the heart disease mortality rate in the Total Area has remained relatively constant, while trends across Georgia and the U. S. have decreased. In the same time frame, there was an annual average age-adjusted stroke mortality rate of 47.4 deaths per 100,000 population in the Total Area which is similar to Georgia's rate and slightly higher than the national rate. This rate fails to satisfy the target of 34.8 or lower with the highest rate in Peach County.

Implementation Strategy:

a) Provide Cardiac screening for neonates in Baldwin County.

b) Continue to assign care coordinators to provide services to patients with congestive heart failure (Bibb).

c) Continue hypertension screenings at community and corporate health fairs; provide follow-up referrals to participants with abnormal results.

d) Continue to provide the Toolkit with congestive heart failure and hypertension information to faith community organizations (Bibb County).

e) Sponsor Hands Only CPR training at community heart fairs.

f) Provide thousands of free blood pressure, cholesterol, and glucose screenings throughout Central Georgia (Navicent Health).

g) Provide free Angioscreens to U. S. Military veterans.

h) Partner with local school system to offer Early Heart Attack Care and Hands Only CPR to staff and students.

- OUTCOMES: Statistics will be recorded for the number of program participants and/or number of attendees at various events, tracking and analyzing the demographic data of program participants, participant history information, identification and tracking of key trends, and determining which programs and efforts are the most effective at achieving desired outcomes. (Reference "Outcome Objective" box on previous page)

Possible Collaborations:

- Faith Community Organizations
- American Heart Association
- Local School system
- Local businesses

Outcomes:

Provide Cardiac screening for neonates in Baldwin County.

- Yes, NH Baldwin performs cardiac screening to all neonates prior to discharge without a charge (free) with an exception of infants transferred to another facility for a higher level of care.

Continue to assign care coordinators to provide services to patients with congestive heart failure (Bibb).

- Healthy Communities provided care to 204 patients with heart failure diagnosis during this period.

Continue hypertension screenings at community and corporate health fairs; provide follow-up referrals to participants with abnormal results.

- Blood pressure screenings:

- Navicent Health provided 955 blood pressure screenings at Corporate and Community Wellness Health fairs in 2019 and 2020.
- 2800 blood pressure screenings were performed at Angioscreens events in 2019 and 2020.
- Provided screenings with a focus on health care disparities.

Continue to provide the Toolkit with congestive heart failure and hypertension information to faith community organizations (Bibb County).

- Navicent Health Healthy Communities implemented a Chronic Disease toolkit which provided to 40 Faith-based organizations. This number was lower than normal due to the COVID-19 pandemic; most of the toolkits were provided in 2019.
- The Chronic Disease toolkit is available on the Navicent Health website for easy access as well.
- In April 2020, a COVID-19 Virtual toolkit was implemented.

Sponsor Hands Only CPR training at community heart fairs.

- Hands Only CPR training was included in Community Health fairs.

Provide thousands of free blood pressure, cholesterol, and glucose screenings throughout Central Georgia (Navicent Health).

- Glucose screenings:
  - Navicent Health provided 241 random glucose screenings were performed at Community Health fairs in 2019 and 2020. 271 fasting glucose screenings were performed at Community Health fairs in 2019 and 2020.
  - All participants with abnormal results were notified at the point of care and referred to see their private physician.
- Blood pressure screenings:
  - Navicent Health provided 955 blood pressure screenings at Corporate Wellness Health fairs in 2019 and 2020.
  - 2800 blood pressure screenings were performed at Angioscreens events in 2019 and 2020.
  - All participants with abnormal readings were notified at the point of care and referred to see their private physician.
- Cholesterol screening
  - Between January 1, 2019 and June 1, 2020, a total of 236 fasting cholesterol screenings were conducted at community health fairs. Of the total, 28 screenings were abnormal.
  - Between January 1, 2019 and June 1, 2020, a total 307 random cholesterol screenings were conducted at community health fairs. Of the total, 19 were high.
  - All participants with abnormal results were notified at the point of care and referred to see their private physician.

Provide free Angioscreens to U. S. Military veterans.

- The Medical of Peach County NH provided free Angio screens to U.S. Military veterans on 2/16/2019 and 3/19/2019.

- During the period of 2019 – 2020, approximately 1500 veterans were provided free Angio screens throughout the Navicent Health communities including the two at MCPC.

Partner with local school system to offer Early Heart Attack Care and Hands Only CPR to staff and students.

- Due to limited resources and COVID-19, these services were not provided.

Appendix 6

Obesity

CHNA Page Reference-pages 187-195.

Health Problem	Outcome Objective (Anticipated Impact)
a. There is a need to educate and create awareness around obesity and weight status. b. There is a need to communicate best practices for obesity prevention.	a. Increase awareness and education of obesity and weight status. b. Increase communication for best practices for obesity prevention.

Background and contributing factors:

The CHNA participant process identified weight status as a major problem as there is a high prevalence of overweight and obesity in the community. Busy work-driven lifestyles lend themselves to fast, convenient meals and many people lack the knowledge on how to make healthy choices. Compounding the issue, the rural communities (Baldwin and Peach) do not have easy access to a grocery store, nor are they within proximity. However, the participants voiced that the level of physical activity has room for improvement.

Implementation Strategy:

a) Support and maintain walking trails on the hospitals' grounds (Bibb, Baldwin and Peach Counties).

b) Continue to offer healthy living and wellness seminars to the community.

c) Continue to offer the "Walk with a Doc" program for the community.

- OUTCOMES: Statistics will be recorded for the number of program participants and/or number of attendees at various events, tracking and analyzing the demographic data of program participants, participant history information, identification and tracking of key trends, and determining which programs and efforts are the most effective at achieving desired outcomes. (Reference "Outcome Objective" box on previous page)

Possible Collaborations:

- Macon-Bibb County Recreation Department
- Walk with a Doc
- Local school districts

Outcomes:

Support and maintain walking trails on the hospitals' grounds (Bibb, Baldwin and Peach Counties).

- NH Baldwin
    - The walking trail is supported and maintained at Navicent Baldwin. The participants who walk this trail are not registered or counted.

- Walking Club
    - A walking club was started in October 2019 in Tindall Fields. The club met once a week; the participants were encouraged to walk a couple more times/week. The program started with 16 interested participants and ended with seven (7) active members. Education was provided to all 16 participants on health benefits of walking and exercise.
- Relay for Life
    - In 2019, the total number of participants for the Bibb County was 1973. Navicent Health had 1313 registered participants.
    - Relay for Life 2020 was a Virtual Relay due to the COVID-19 pandemic of which was held on Facebook Live during the week of August 10-14, 2020. A total of 359 registered participants for the 2020 Relay for Life.
- Medical Center of Peach County
    - Faith-Based organizations
        - Physical Activity- Promotion of Peach Hospital Walking Trail.

- Heart Walk 2019

Heart Walk 2019:

Number of Teams	20
Number of Participants	101

Continue to offer healthy living and wellness seminars to the community.

- Elevate Magazine
    - The Elevate Magazine contains health and wellness articles, tips, and tricks as well as delicious and nutritious recipes, access to a health resource library and information about upcoming events at NH.
    - The print Elevate magazine is mailed to 20,000 homes quarterly and contiguous counties.
    - The Elevate digital newsletter is mailed to approximately 6500 subscribers monthly. Subscribers are primarily from central Georgia although there are approximately 20 from outside the area. Previous editions may be found on the Navicent Health website.
- Speaker's Bureau
    - In 2019 The Navicent Health Speakers Bureau spoke to 7,590 people at 124 events about various health topics.
    - In 2020, which was cut short due to COVID (in March 2020), The Navicent Health Speakers Bureau spoke to 524 people at 15 events.
- Interview the Doctor Program Navicent Knows, Medical Minute, etc.
    - In calendar years 2019 and 2020 Navicent Health provided healthcare experts for local, state, and national print, broadcast, and online news interviews. In calendar year 2019, Navicent Health was mentioned in 3,795 media hits. To date in calendar year 2020, Navicent Health has been mentioned in 3,266 media hits.

Continue to offer the "Walk with a Doc" program for the community.

- The "Walk with a Doc" program was started in April 2019 which met once a month on the 1st Saturday at Central City Park in Macon, GA. This program was led by a physician from Family Health Center.

  Due to the COVID-19 and organizational policy, the program was cancelled from April 2020 to November 6, 2020. The program resumed again on November 7, 2020.
- The "Walk with a Doc" met 12 times from April 2019 to March 2020. The goal of the program is to "Walk, Talk, and get Healthier."
- On an average 10-12 participants per walking event.

- Research was conducted on the effectiveness of the walking program. Twenty-two of the 24 walkers completed the program. One of the walkers who started in March 2020 reported that she has lost 25 lbs. thereby reducing her A1C from 10 to 6.3.

Appendix 7

Other Strategies

CHNA Page Reference-pages 116-123, 124-136

Health Problem	Outcome Objective (Anticipated Impact)
a) There is a need for education and awareness for other health concerns such as asthma and trauma. b) There is a need to provide access for sport physicals for special needs students participating in Special Olympics. c) There is a need to provide other health screenings for elementary school-aged children.	a) Increase education and awareness for other health concerns including asthma and trauma injuries. b) Continue to provide sport physicals for special needs students participating in the Special Olympics. c) Continue to provide other health screenings for elementary school-aged children.

Background and contributing factors:

The CHNA identified other areas of need for children as it relates to asthma and access for those with special services.

Implementation Strategy:

- Continue to sponsor Camp Open Airways for children with asthma.
- Continue to sponsor Stop the Bleed classes throughout Central Georgia.
- Continue to sponsor a Matter of Balance programs throughout Central Georgia.
- Continue to provide sports physicals for special needs students participating the Special Olympics.

- OUTCOMES: Statistics will be recorded for the number of program participants and/or number of attendees at various events, tracking and analyzing the demographic data of program participants, participant history information, identification and tracking of key trends, and determining which programs and efforts are the most effective at achieving desired outcomes. (Reference “Outcome Objective” box on previous page)

Possible Collaborations:

- Local school systems
- Community agencies
- Senior Centers
- Local fire departments

Outcomes:

Continue to sponsor Camp Open Airways for children with asthma.

- Medical Center Navicent Health sponsored the 3rd annual free Camp Open Airways Asthma Camp on 6/8/19 at Middle Georgia State University. This camp had 10 attendees with their caregivers who had been identified as the potential for high risk asthma emergencies. Zero readmissions for asthma documented for Navicent Health of attendees following camp. We were unable to sponsor Camp Open Airways for 2020 due to COVID 19 restrictions.

Continue to sponsor Stop the Bleed classes throughout Central Georgia.

- The Medical Center Navicent Health's Stop the Bleed programming was significantly impacted by COVID 19 in 2020. However, in 2020, prior to the COVID-19 closures, six (6) courses were taught with a total of 263 participants, in three (3) counties.
- In 2019, working with our regional partners, the Stop the Bleed program coordinator provided Stop the Bleed instruction to 2,015 community individuals in 53 separate offerings conducted in 15 counties.

Continue to sponsor a Matter of Balance programs throughout Central Georgia.

- Yes, Navicent Health Rehab sponsored the Matter of Balance program during the months of January 15 through March 5, 2020 and September 3 through October 22 for two (2) hours per weeks for eight (8) weeks. The January class had 11 participants and September had 14 participants for a total of 25.
- The Medical Center of Peach County placed 340 books in our three (3) elementary schools about self-image and taking care of yourself. The books are entitled "Eight Key Steps to A Better Me".

Continue to provide sports physicals for special needs students participating the Special Olympics.

- This program was not initiated.