



A W P 2 . 0

HEALTH REPORT



About AWP

The purpose of the Athens Wellbeing Project (AWP) is to provide comprehensive data from a representative sample of households on our unique needs and assets in Athens-Clarke County. Launched in 2016, the AWP is championed by the Athens Area Community Foundation. Two rounds of survey data collection have been completed--version 1.0 in Fall 2016 and version 2.0 in Fall 2018--with the intent of building a longitudinal dataset across time.

AWP data provide information across all domains of life in our community. These domains include **HEALTH, HOUSING, COMMUNITY SAFETY, LIFELONG LEARNING, and CIVIC VITALITY**. The AWP is pioneering an unprecedented collaboration of community leaders, using a data collection approach that is representative of our community. The research design and community participation incorporates vulnerable populations providing unique opportunities to understand wellbeing across all groups in our county.

About Community Health Needs Assessments

Every three years, nonprofit hospitals are required by the Patient Protection & Affordable Care Act (PPACA) to conduct a Community Health Needs Assessment (CHNA) in order to: 1) Identify health needs in the communities served by the hospital; 2) Prioritize those needs; 3) Identify resources to address the needs; and 4) Develop an implementation strategy in response to assessment.

The purpose of this report is to supplement the CHNA conducted by Piedmont Healthcare with local, representative data from AWP in addition to data from the 16 surrounding counties served by Piedmont Athens Regional Healthcare system.



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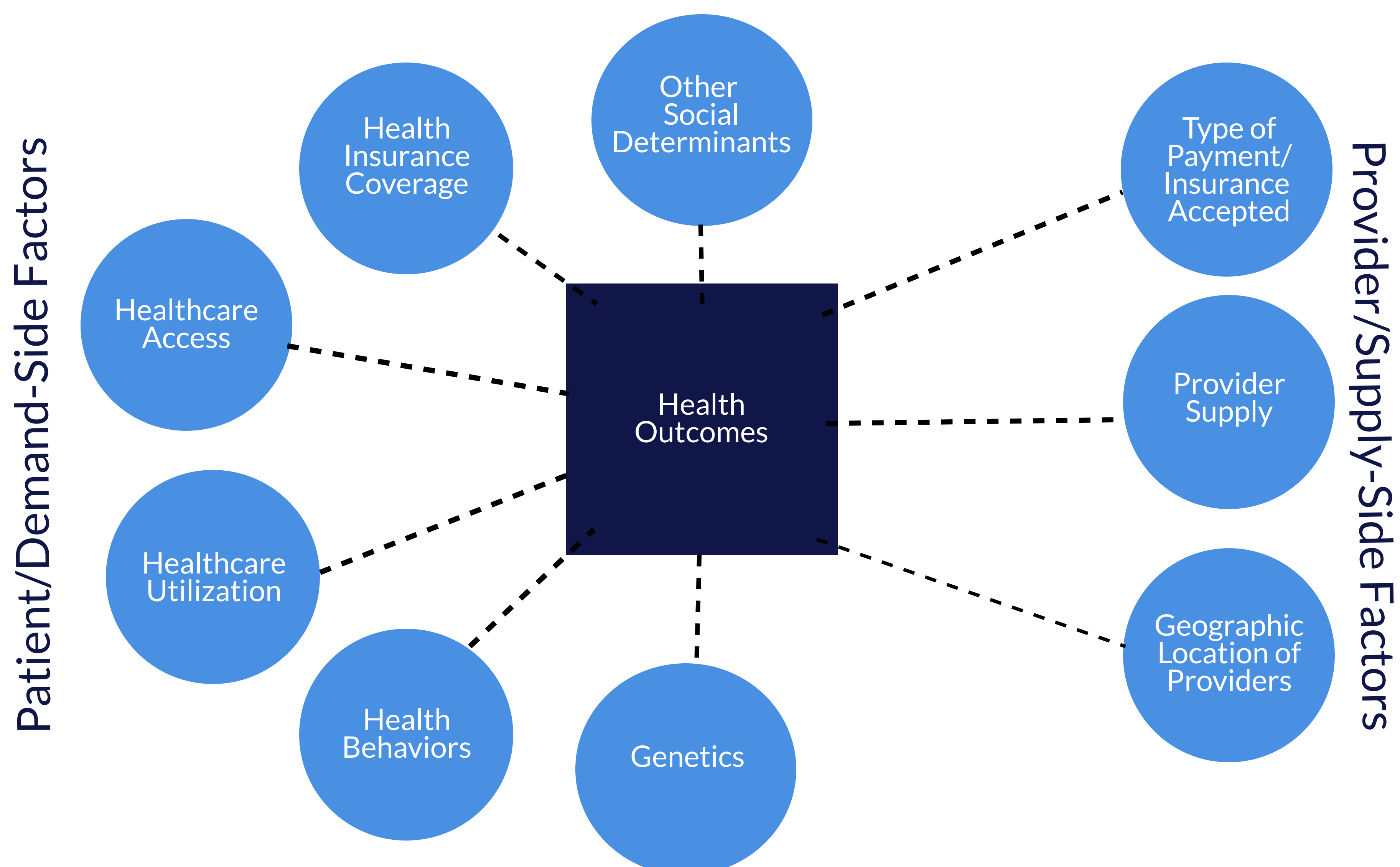
INTRODUCTION

Understanding Health

To understand health in our community, and to work towards improving wellbeing, we must look at multiple dimensions of individual and family life. Health outcomes are critical to examine, and are presented in the "health needs" section of this report. There are models that help us understand how health is determined that can be used to motivate examination of other aspects of health and healthcare in addition to health outcomes. The model below incorporates social determinants of health, healthcare access, healthcare utilization, health behaviors, and supply of providers on the health of families in our community.

Figure one presents a simple model of the determinants of health. In the following sections, we will examine aspects of social determinants (*e.g. socioeconomic status*), health insurance coverage, healthcare access, healthcare utilization, health behaviors, and supply-side data on healthcare providers. Each of these areas have distinct yet interconnected effects on health and health outcomes. First, survey data from AWP 2.0 are presented. Second, regional data on Athens-Clarke county and surrounding counties are shown. Third and finally, county profiles for the 17 county service area are available in an Appendix. Further information on project methods is provided in Appendix B.

Figure 1. Conceptual Model of Determinants of Health.



METHODS

1

RESEARCH DESIGN & SURVEY DEVELOPMENT

This study used both primary and secondary data. Primary data were collected through household surveys in Athens-Clarke County and surrounding counties in the hospital service area. The survey instrument was developed by the research team in conjunction with all institutional stakeholders. The instrument was specifically designed to collect information not available from other secondary data sources. Where available, validated measures from other nationally-representative surveys were utilized to ensure validity and the ability to compare data across county, state, and national findings.

To maximize available information and to provide comprehensive look at health in our community, we also collected secondary data. Secondary data were collected from publicly available sources, and were collected for multiple years when available. Both primary and secondary data sources were used to determine health needs and to develop county profiles.

2

DATA COLLECTION

In Athens-Clarke County, AWP online and paper surveys were available for respondents. Random sampling of single family homes and a census of vulnerable populations were conducted. Selected families received postcards notifying them of selection. Door-to-door data collection teams of University of Georgia students, led by Neighborhood Leaders, followed up with families to increase responses. A total of 1,078 households responded in Clarke County.

In surrounding counties, a shorter version of the survey instrument was administered that collected data on health, household demographics, employment, and health insurance coverage. This survey was administered online to counties in the hospital service area. Participation in the survey was voluntary and anonymous. The design for surrounding counties was a convenience sample. An additional 1,000 households responded in counties surrounding PARMC.

Secondary data collection occurred between January and March 2019. Data sources included the U.S. Census Bureau, the Robert Wood Johnson Foundation County Health Rankings (2019), Georgia Department of Public Health OASIS data (2010-2019), U.S. Department of Health and Human Services (HHS) Health Provider Shortage Area Locator Tool (2019), and the U.S. HHS Area Health Resource File. All data were collected for all counties in the service area.

METHODS

3

DATA ANALYSIS

Once survey data were collected, they were cleaned and coded for analysis. For AWP data, sample weights were created by the research team to increase representativeness of the sample. The resulting sample has a margin of error of +/-3%. Additional variables for analysis were created (e.g. *a poverty measure using income and household size*). Summary statistics were estimated for all variables in the sample, for the full sample and for sub-categorizations.

Survey data from surrounding counties are unweighted due to the nature of the convenience sample design. Where survey data were analyzed for the service area as a whole, averages were calculated across counties to report for the full service area in the *health needs* section.

Secondary data analysis included examining all variables at the county level, calculating averages across the service area, and comparing all data points to state averages to determine whether the service area and its respective counties were below, above, or the same as the state values for each variable. Time trend analysis was conducted where multiple years of data were available.

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INTERPRETATION

The data presented in this report are descriptive in nature. Measures are presented for the full sample, and in many cases for low-income families at 130% of the Federal Poverty Level and below for comparison purposes. AWP data are meant to be used in conjunction with other existing data sources--both primary and secondary, qualitative and quantitative--in order to get the most comprehensive understanding possible of outcomes of interest and general levels of wellbeing in our community. Where possible, data visualizations are used for ease of interpretation. Full tables of descriptive statistics will be made available in an online appendix and upon request.

The primary audience for this report is Piedmont Athens Regional Medical Center. This report presents data, analysis and information that provides supplementary data for Clarke County and the surrounding counties served by the hospital system to inform their Community Health Needs Assessment process.

AWP Data: Part I

Social Determinants of Health

Community Characteristics & Demographics

Athens-Clarke County is a diverse community with significant variation in income, education, health access and outcomes, housing, and civic participation. While the focus of this report is on health, a demographic overview of population characteristics is provided for two reasons: 1) this information is useful for descriptive context; and 2) AWP recognizes and promotes understanding of the intersectionality of domains across all aspects of life in our community.

The unit of analysis is the household, which means that the all variables are reported at the household level with the exception of a few individual measures answered from the individual respondent's perspective (e.g. *age*). The narrative of Athens-Clarke County often focuses on poverty. Indeed, we live in a community where over one third of our residents live below the poverty line. However, the county is more complex and the distribution of income has extreme variation. While many residents live in poverty, there are also many who are wealthy. The top ten percent of earners in our county have over \$10,000 in monthly take-home pay; the bottom ten percent of earners take home \$1,000 or less. This disparity is also reflected in educational attainment, which is strongly correlated with income. Over one third of survey respondents had a high school diploma or less, while 54% had a bachelor's degree, master's degree, or more.

Health is linked to income and education, which is also inextricable from health insurance coverage. The intersectionality of these characteristics is important to examine when trying to understand health need. Athens-Clarke County is a community that has extreme levels of poverty and need, but also significant wealth and resources. Systematic disparity cuts across all domains of life for low income families, racial and ethnic minorities, and those with a high school education or less. Poverty and health disparity falls disproportionately on children and older adults--which is important to consider given that over 40% of our population has school-aged children in the household and many Athens residents are older adults.

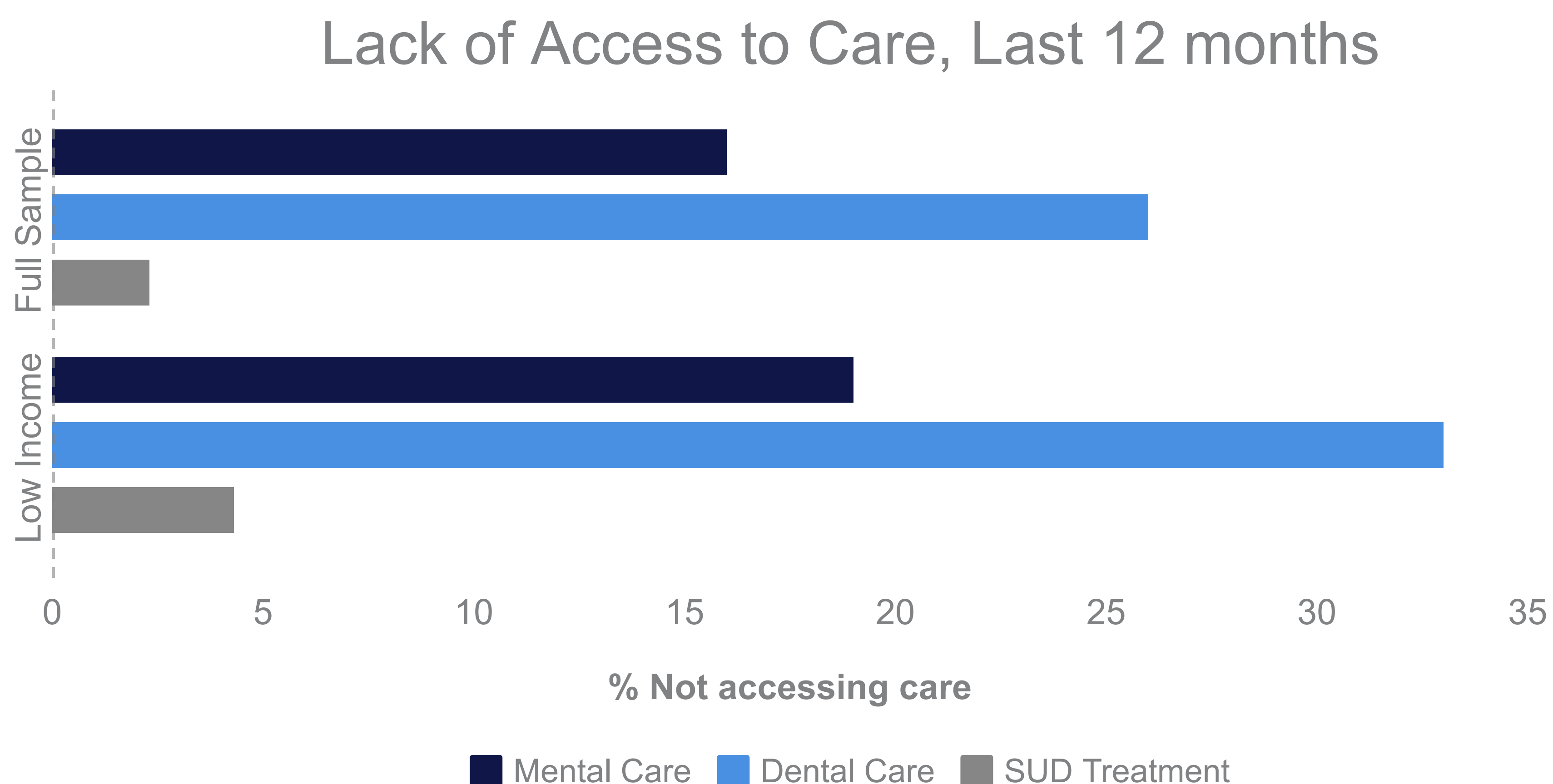
Finally, while healthcare access is a function of many factors, a primary consideration is transportation. While most respondents (93%) rely on a personal vehicle for transportation, many respondents use multiple sources of transportation in addition to personal vehicles, including public transportation (bus system), taxis or Uber/Lyft, or bicycles. Fifteen percent of low income residents rely on the bus as their primary transportation--which can make accessing healthcare and other services a challenge.

Part II: HEALTHCARE ACCESS

The Complexity of Healthcare Access

Healthcare access is complex. It includes some of the social determinants of health such as transportation and health insurance coverage, in addition to physical and mental ability and willingness to go to healthcare providers. Access is also a function of knowledge of service providers, and stigma of pursuing healthcare or treatment (especially for behavioral health). One of the greatest factors determining healthcare access, however, is affordability. While insurance coverage significantly assists patients in affording their care, it does not always guarantee access to care. Cost burdens of deductibles, co-pays, and co-insurance are prohibitive for many patients who are on a budget--especially older adults and low income families.

The AWP 2.0 estimates show that 81% of our population had health insurance coverage in 2018. This is a statistically significant decrease from the 2016 data, when 87% of families had coverage. Across income categories, over 87% of households are employed. **Though levels of employment remained steady across income levels, likelihood of having health coverage decreased incrementally as income decreased.** Families who are low income and employed were significantly less likely to have health and dental insurance through their job, and thus were less likely to have access to the healthcare they need. Survey respondents were asked about whether they were able to access the mental health care, dental care, and substance use disorder treatment (if needed) in the last 12 months.



While mental and primary care gaps exist, the single greatest need exists in access to dental care.

Part III: HEALTHCARE UTILIZATION

Use of Healthcare in Our Community

Healthcare utilization was captured by asking several questions about whether respondents had trouble finding a doctor in the last twelve months, with a follow up question on whether they ultimately found a physician after having trouble. In the full sample approximately 15% of households had trouble finding a doctor, compared to 17% of low income households struggled to find a doctor. Among these households, 76% indicated that they did ultimately find a provider. However, only 41% of low income households ultimately found a doctor. Households were also asked if their insurance had been refused by a provider in the last 12 months. In the full sample, 20% of households experienced insurance refusal. Among low income households, this increased to 30% of families having their insurance refused by a provider.

Families with children were asked whether their children had a child well visit in the last 12 months, which is the clinical standard of care for children. Ten percent of families in the full sample did not have a child well check in the last calendar year; 14% of families at or below 130% FPL did not have a child well check in the last year.

Emergency Department Utilization

The survey also asked about Emergency Department (ED) utilization in the last twelve months. Both the frequency of ED use and the reason for use was captured separately for adults and children in the household. Families were asked to select the reason for their ED use and were allowed to choose more than one reason.

Among adults, 39% of households had at least one ED visit in the last 12 months. Among those that had a visit, 28% indicated that they rely on the ED as their sole source of primary care. Only 2% of households had three or more ED visits, the overwhelming majority of households with a visit had only one in the last 12 months. Common reasons for going to the ED included other providers not being open (65%) and the ED being the closest provider in proximity (53%).

Child ED utilization was slightly less common. One in three (33%) of household respondents indicated that they had a child visit the ED in the last 12 months. Among those with a child's ED visit, 14% indicated that the ED is their child's source of primary care. Similar to adults, the vast majority of households with a child ED visit in the last year had only one visit. Only 1% of households had three or more visits in the last 12 months. Reasons for child ED visits also included other providers not being open (57%) and the ED being the closest provider in proximity (12%).

Part IV: HEALTH BEHAVIORS

Are Athens residents making healthy choices?

Health behaviors are integrally linked to health outcomes. The AWP survey captured several dimensions of such behavior, including: smoking, nutrition and dietary habits, misuse of prescription drugs, and aspects of social capital (e.g. frequency of interaction with friends and loved ones). Overall, there has been little change in smoking behavior since the last CHNA in 2015. Nutrition and dietary habits continue to be a major concern--especially in regards to underconsumption of fruits and vegetables. The prevalence of reported misuse of prescription drugs is concerning, as is the degree of isolation experienced by many individuals in our community.

Tobacco Consumption

One of the greatest public health challenges in our society is tobacco consumption. Smoking causes cancer and premature death, yet persists at alarming rates in our population. In Clarke County, AWP data show that 20% of households in the full sample and 24% of low income households report having a smoker in the home. Additional concerns arise from the prevalence of e-cigarettes which have increased in popularity, especially among adolescents.

Nutrition

Lack of adequate nutrition is linked to myriad adverse health outcomes, including chronic conditions such as diabetes and obesity. In our community, more than one in five families cannot afford to consistently eat balanced meals. This is reflected in direct measures of fruit and vegetable consumption. Over 55% of families indicated that they eat zero or one serving of fruit per day; approximately 35% of families indicated they eat zero or one serving of vegetables per day.

Misuse of Prescription Drugs

The rise of the opioid crisis has equated to loss of years in life expectancy in the United States. Much of the problem comes from misuse and abuse of prescription drugs, which can lead to substance use disorder, overdose, and death. The AWP survey asked households if they had ever, even once, used a prescription differently than it had been prescribed. Over 11% of households indicated that they had misused prescription drugs.

Social Capital

Loneliness and social isolation has direct implications for physical and mental health. When we are connected to friends, family, and loved ones, we are healthier and happier. Survey data indicated that 78% of Athens residents had talked to their neighbors for ten minutes or more in the last month. However, almost half of respondents indicated that they do not see family or friends outside of work on a weekly basis.



R e g i o n a l S u p p l e m e n t

HEALTH NEEDS

Healthcare Access

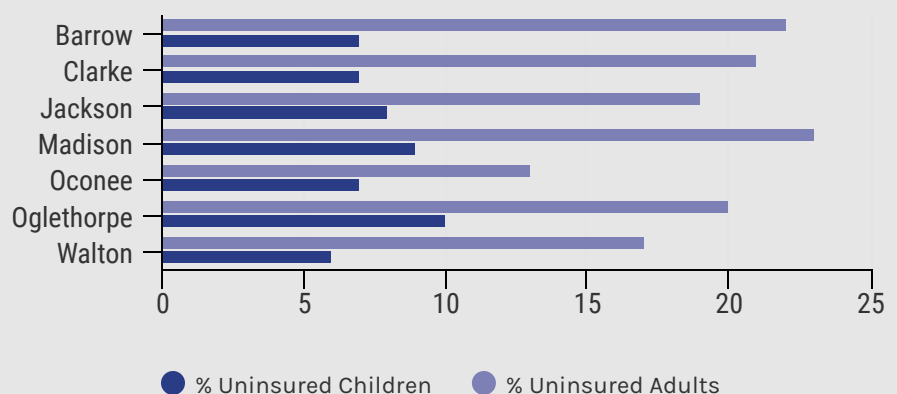
Healthcare access is a complex, multidimensional area of need that is ubiquitous in all communities and deeply connected to all the other health needs presented in this study. Access is substantively different in that it is the only need not defined by a specific set of conditions or health outcomes. Rather, Healthcare access stood out as a concern across all data sources. Similarly to other needs, health disparities are concentrated in low income, rural communities and are especially problematic for racial and ethnic minorities. Shortage of supply in health professionals of all types is a primary factor in this category. Transportation and drive time were two other predominant themes, as was being uninsured and underinsured. Addressing healthcare access presents an opportunity to simultaneously intervene on all health needs, because when access improves, so does community and public health.

Secondary Data

In Barrow, Jackson, Madison, Oconee, and Walton counties there were less **dental providers** per 100,000 than the state average and in Oglethorpe county there were none. (Source: AHRF, 2016)

In Barrow, Jackson, Madison, Oglethorpe, and Walton there were less **physicians** per 100,000 residents than in the state overall. (Source: AHRF, 2016)

Percentage of Uninsured Children & Adults by Service Area County, 2018



Survey Data

* **1 in 4** anticipate caregiving for a loved one in the next two years



* **1 in 4** needed dental care but could not get it



* **15% of households** reported having trouble finding a doctor that accepted their insurance in the last 12 months



85% of respondents traveled <30 minutes to the doctor



15% of respondents traveled 30-60 minutes to the doctor



97% relied on a personal car as their primary source of transport

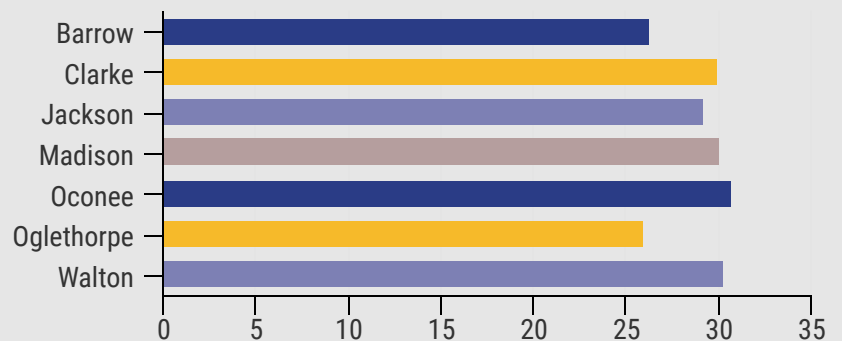
Cardiovascular Health

Cardiovascular health needs significant improvement in our community. Cardiovascular health covers incidence and prevalence of heart disease, which proportionally accounts for the most deaths in the service area (relative to all other causes). High blood pressure (hypertension), high cholesterol, and other cardiovascular indicators were examined across all data sources. Cardiovascular disease (CVD) and preliminary indicators of compromised cardiovascular health are also linked to many other health conditions, many of which are preventable. Further, there was significant health disparity present in cardiovascular outcomes for individuals in medically underserved communities, low income individuals, and racial and ethnic minorities. Cardiovascular deaths were the most commonly occurring preventable deaths.

Secondary Data

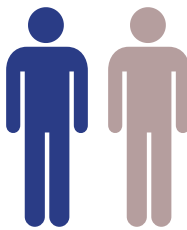
Among the 7 counties in this service area, **cardiovascular diseases** accounted for 29.1% of all deaths (all ages) between 2015 and 2017. Four of the counties in the service area are slightly higher than the state average (29.4%). (Source: OASIS, 2019)

Cardiovascular Deaths as a % of All Deaths, 2017

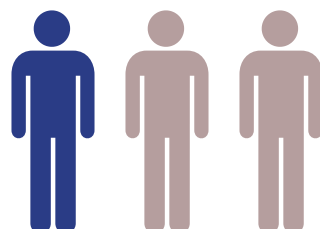


Survey Data

* More than **1 in 2** reported hypertension in their household.



* **1 in 3** respondents reported high cholesterol in their household.



42% reported walking less than 10 minutes on at least 3 of the last 7 days.

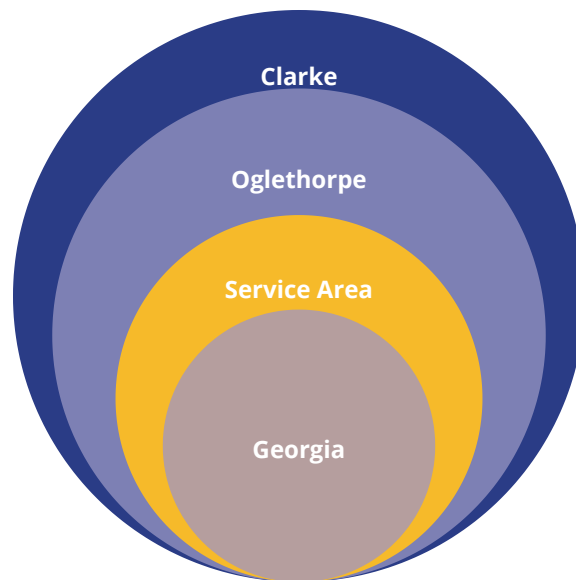
Persistent Disparities

In all counties with available data, Black residents were significantly more likely to die from cardiovascular disease (CVD) than White residents. In Clarke, Oconee, and Oglethorpe counties, a Black resident was more than twice as likely to die from CVD than a White resident, adjusting for age, in 2017 (Source: OASIS).

Across the service area, a Black resident was more likely to visit an emergency department (ED) for CVD than a White resident. In all counties, Black residents were more than twice as likely to visit an ED for CVD than White residents, adjusting for age, in 2017. When we examined these trends over time, evidence from secondary data showed persistent, statistically significant differences for the years observed (2007-2017) (Source: OASIS).

The figure below represents the orders of magnitude between the CVD related ED visit rates for Black residents as compared to White residents. The two counties with the greatest disparity were Clarke, where Black individuals are 3.87 times more likely than Whites to go to the ED for CVD, and Oglethorpe, where the ED rate is 3.38 times greater than that for Whites.

Emergency Department Visits for Cardiovascular Disease: Racial Disparity



Nutrition, Diabetes & Obesity

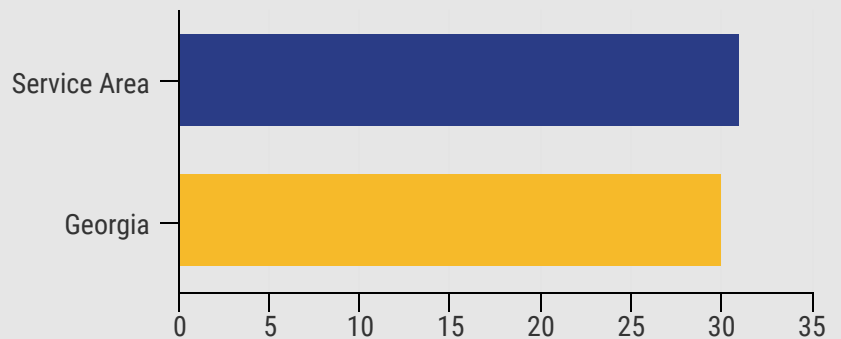
Following the *HealthyPeople 2020* categorization, one of the most prominent areas where improvement is needed is in food security (access to healthy food for all families), type II diabetes, and obesity. We examined both the demand for healthy food, health behaviors for food consumption, supply of healthy food, and incidence and prevalence of diabetes and obesity. Of course, many of these health needs categories are inextricably linked; cardiovascular health and this category is perhaps one of the best examples of the intersectionality of health issues. We observed this need as being one of the most pressing across all data sources. As with cardiovascular outcomes, there were significant health disparity present in nutrition, diabetes, and obesity outcomes for individuals in medically underserved communities, low income individuals, and racial and ethnic minorities.

Secondary Data

In Barrow, Jackson, Madison and Oglethorpe counties, mortality rates (per 100,000), adjusted for age, for **diabetes** exceeded the state rate of 207 in 2017. (Source: OASIS)

Obesity prevalence for the service area was comparable to the state average, but there has been a 27% increase in obesity over the last decade. (Source: OASIS)

Obesity Prevalence (%), Service area vs. Georgia, 2018



*One in three individuals in the service area is obese.

Survey Data

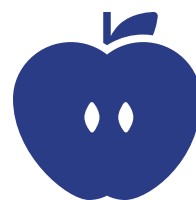
* **1 in 5** reported diabetes in their household.



* **1 in 4** respondents reported obesity in their household.



* Only **32% (WIC)** and **67% (SNAP)** of families eligible for food assistance are enrolled in Clarke County.



60% report eating one or less fruits per day



34% report eating one or less veggies per day



22% report experiencing food insecurity

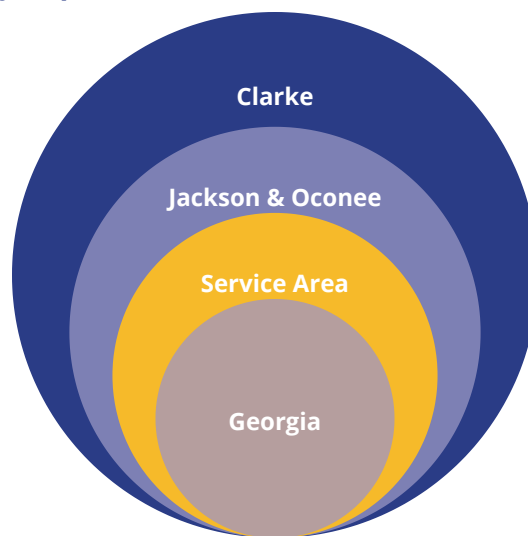
Persistent Disparities

In all seven counties, Black residents had a significantly higher rate of ED visits for diabetes than White residents. Additionally, in all counties (excepting Madison), a Black resident was more than twice as likely to visit the emergency department for diabetes than a White resident, adjusting for age, in 2017. According to U.S. Department of Health & Human Services data (HHS), Latinx males and females are significantly more likely to be obese or overweight than non-Latinx, white males and females.

In Clarke, Jackson, and Oconee counties, an Black resident was more than three times as likely to visit an ED for diabetes than a White resident, adjusting for age, in 2017. When we examined these trends over time, evidence from secondary data showed persistent, statistically significant differences for the years observed (2007-2017) (Source: OASIS).

The figure below represents the orders of magnitude between the state ED visit rate disparity for the Black population in the Service Area, and the three counties with the greatest disparity: Clarke, where Black residents were 4.41 times more likely than White residents to go to the ED for diabetes; Jackson, at 3.65 times greater than that for White residents; and Oconee, where the ED rate was 3.61 greater than that for Whites residents.

Emergency Department Visits for Diabetes: Racial Disparity



Behavioral Health

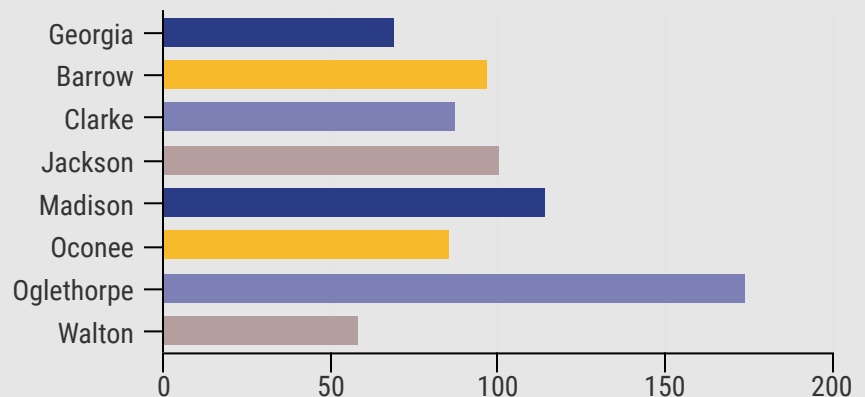
Behavioral health, which includes mental health and substance use disorder, is the health need that has increased most drastically since the last CHNA (2015). Due to the comorbidity of mental health and substance use disorder, the categorization of the two together is critically important and they must be addressed simultaneously. Across all data sources, this need was observed as being one of the most prevalent. Suicide and drug overdose were the leading causes of mortality within this health need. The demographic group most affected was working age white males. Within substance use disorder, licit and illicit opioid use and misuse has driven the increase in drug overdoses (many of which result in death). Health disparities for behavioral health were concentrated in low income, rural communities. Supply of behavioral health professionals and treatment for substance use disorder is a major concern in the service areas.

Secondary Data

In each county besides Barrow and Oglethorpe, age-adjusted mortality rates (per 100,000) for **suicide** exceeded the state rate in 2017, and was more than twice the state rate in Oconee county. (Source: OASIS)

Age-adjusted mortality rate (per 100,000) for **opioid overdose** exceeded the state mortality rate in Jackson, Madison, and Walton counties for 2014-2017. (Source: OASIS, 2019)

Age-Adjusted ED Visit Rates (per 100,000) for Suicide, 2017



Survey Data

* **1 in 4** reported depression in their household.



* **1 in 4** reported anxiety in their household.



5% reported another mental health disorder (e.g. bipolar disorder)



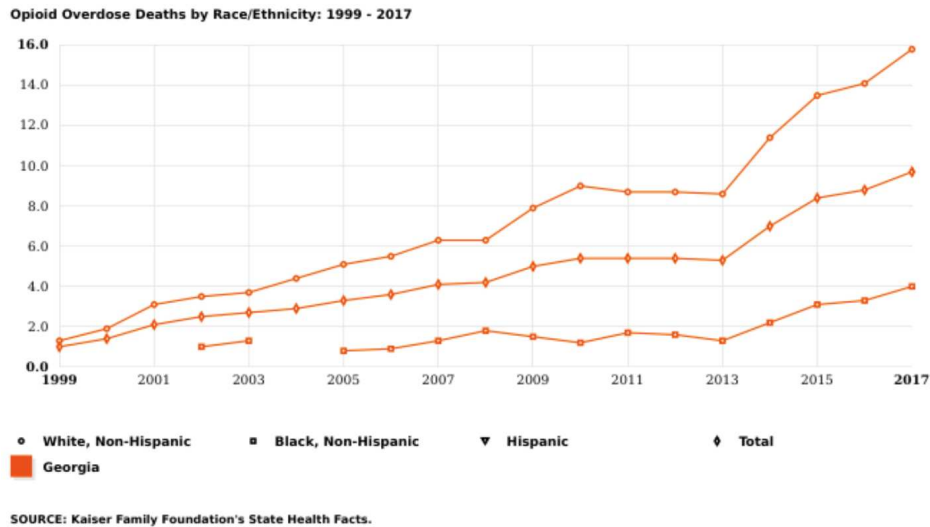
25% said they needed mental healthcare in the last 12 months but could not get it



Lack of affordability was the most common reason for not getting the mental or substance use treatment needed

Persistent Disparities

White residents in all seven counties were more than twice as likely to die from issues related to opioids, adjusting for age, in 2017. When we examined these trends over time, evidence from secondary data showed persistent, statistically significant differences for the years observed (2007-2017). The time trend line below shows opioid overdose deaths over time for the state of Georgia. The service area data reflect the same trends shown below. (Source: Kaiser, 2019)



Opioid Epidemic: Cost Analysis

Using county-level data from the Georgia Department of Public Health from 2014 through 2018, we conducted a cost analysis of emergency services related to opioid overdose across the service area. We used the number of Naloxone doses administered by EMS professionals and the number of opioid overdose calls made to EMS that resulted in a visit to the scene.

\$29,000

Spent on Naloxone in the Service Area, 2014-2018



\$844,480

Spent on EMS Opioid Overdose Calls in the Service Area, 2014-2018

Maternal & Child Health

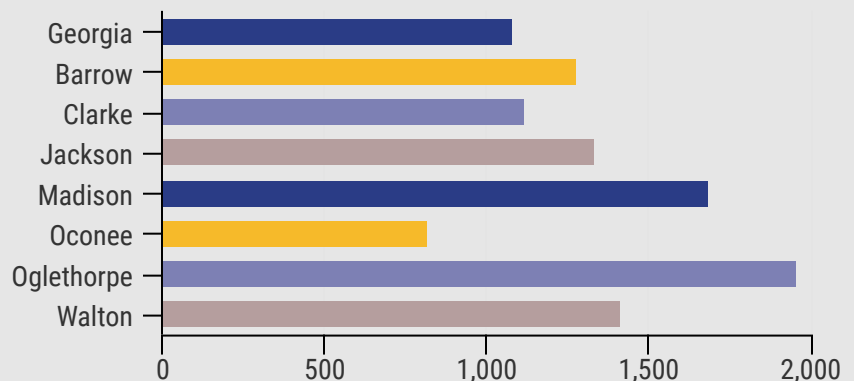
Maternal and child health is a significant health need across all data sources and observed as being a concern of county residents. Health disparities for maternal and child health are concentrated in low income, rural communities and are especially problematic for racial and ethnic minorities. Shortage in Ob-Gyn specialists, pediatricians, and other health professionals that serve pregnant and postpartum women and their children is a major barrier to health in the service area. Many women must travel significant distances for routine prenatal care, labor and delivery, and pediatric care for their children. Health behaviors during pregnancy are also a concern. Across the service area, the maternal smoking rate was more than twice the state's rate.

Secondary Data



In every county (except Oconee) the percent of births to women who reported **using tobacco while pregnant** exceeded the state percentage in 2017. The percent of women smoking during pregnancy was more than triple the state's value. (Source: OASIS, 2019)

In every county except Oconee, the age-adjusted ED visit rate (per 100,000) for **pregnancy & childbirth complications** exceeded the state rate in 2017. (Source: OASIS, 2019)

Age-Adjusted ED Visit Rates (per 100,000) for Pregnancy & Childbirth Complications, 2017



Survey Data

- * **1 in 3** reported taking a child to the ED in the last 12 months. 
- * **1 in 3** reported that the ED was the child's closest provider. 
- * **20% of Clarke households** said their child gets most of their care in the ED.

Healthcare Supply

According to the Area Health Resources File (2016), three counties in the service area do not have an **obstetrician-gynecologist** in the service area: Barrow, Madison, and Oglethorpe counties.

According to the same data, Oglethorpe does not have any **pediatricians**. Maternal and child health outcomes are also the worst for Oglethorpe relative to the other counties, adjusting for age and population size.

Persistent Disparities

Evidence from the Pregnancy Risk and Monitoring System data (PRAMS) indicate Latinx women are significantly more likely to delay prenatal care than non Latinx (58% vs 78% accessing care in first trimester, respectively).

In all counties in the service area, an African American resident was more than twice as likely to have less than five prenatal care visits than a white resident, adjusting for age and population, in 2017. In Clarke, Oconee, and Walton counties, an African American resident was more than four times as likely to have less than five prenatal care visits than a white resident, adjusting for age, in 2017.

Infant mortality and preterm birth were also significantly greater for African Americans relative to whites. In Clarke County, the five year average of infant mortality between 2013 to 2017 for whites was 4.5 (per 1,000 live births) and nearly three times greater for African Americans at 13.2 (per 1,000 live births). This trend has been sustained over time. While infant mortality has been declining in the aggregate for the last twenty years, the decrease has not been steady for racial and ethnic minorities.

Probability of African American Women Having <5 Prenatal Care Visits



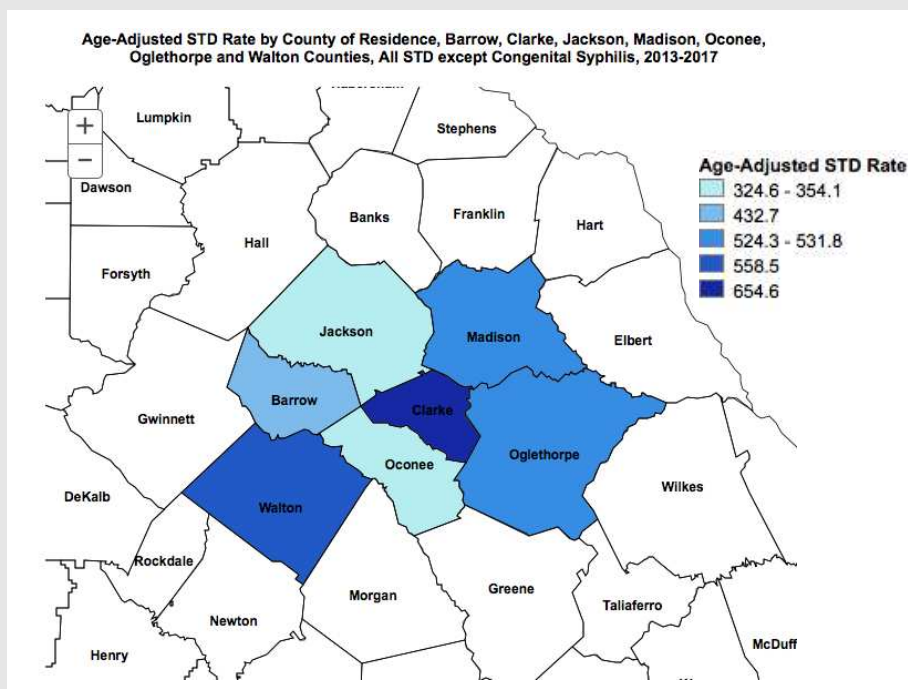
Reproductive Health

Reproductive health issues include sexually transmitted infections (STIs), family planning, and teen pregnancy. Prevalence of STIs were examined across all data sources. There was significant health disparity present in reproductive health outcomes for individuals in medically underserved communities, low income individuals, and racial and ethnic minorities. Service area rates (at 518.1 per 100,000) are lower than the 2013 to 2017 five-year state rate (752 per 100,000).

Secondary Data

Among the 7 counties in this service area, age-adjusted **STI** rates (per 100,000) were highest for Clarke County, followed by Walton, then Madison and Oglethorpe counties, respectively. (Source: OASIS, 2019)

HIV prevalence rates were more than twice the service area rate (per 100,000) for Clarke County (307, and significantly higher in Barrow and Walton, respectively. (Source: RWJF County Health Rankings, 2018)



Reproductive Health Education

According to GA's 2013 Youth Risk Behavior Survey of high school students, the percentage of students who report ever being taught about AIDS or HIV infection in school by race and ethnicity differed significantly.

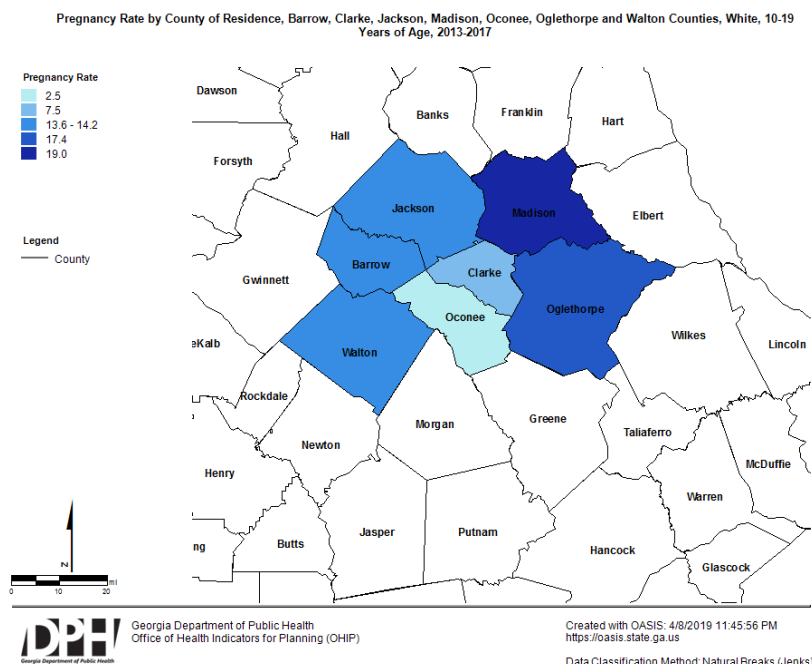
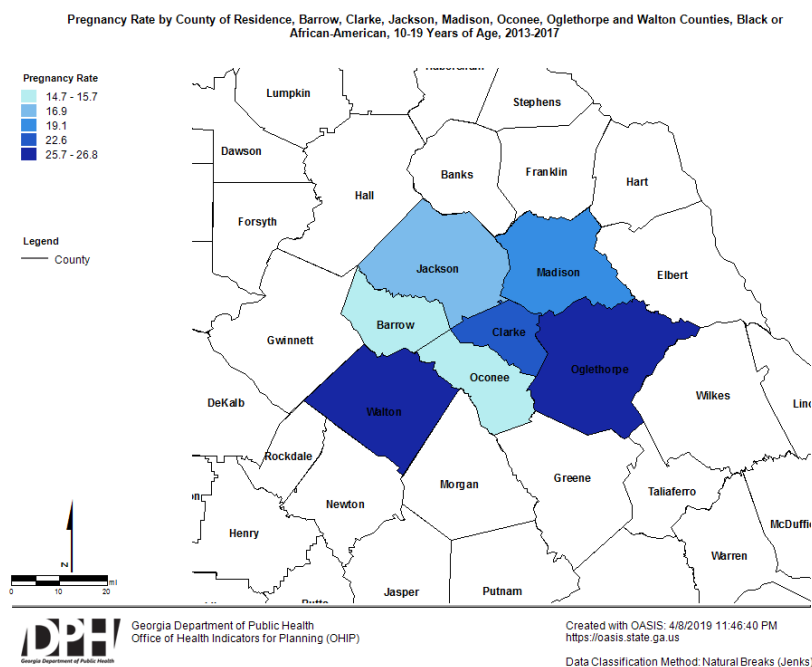
Race/Ethnicity	% Taught About HIV/AIDS
African American	85%
Latinx	81%
White	91%



Persistent Disparities

A Black resident in the seven county service area was eight times more likely to have an STI than a White resident after adjusting for age and county population from 2015 to 2017. This disparity was particularly pronounced in Clarke, Oconee, and Walton counties. (Source: OASIS, 2019)

Racial disparity also exists in the teen pregnancy rate. Teen pregnancy (ages 10-19) was significantly higher among Black women relative to White women. Differences between teen pregnancy rates by race are especially striking in Clarke, Oconee, Oglethorpe, and Walton counties. The maps below show teen pregnancy five year averages across service area counties by race. (Source: OASIS, 2013-2017)



Cerebrovascular Health

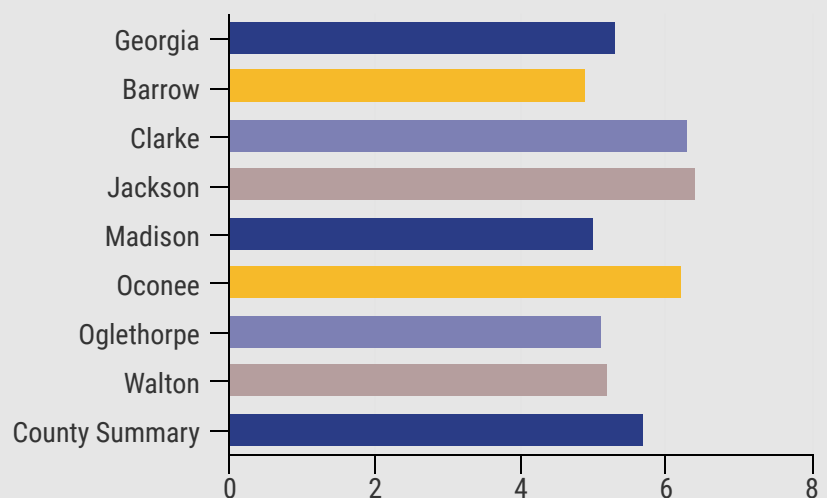
Cerebrovascular health covers both both ischemic and hemorrhagic stroke. Due to the time sensitive nature of getting a patient experiencing stroke to the hospital, healthcare access stood out as a concern across all data sources. According to the Georgia Department of Public Health, Georgia is part of the United States' "Stroke Belt" where stroke morbidity and mortality rates are well above those of other states. Eighty percent of strokes are preventable, which is an important reason for communities to intervene on preventive health in this area. In 2013, hospital charges related to stroke totaled over \$1 billion in Georgia (Source: Georgia Department of Public Health, 2017). As with other needs, health disparities were concentrated in low income, rural communities and were especially problematic for racial and ethnic minorities. Rural counties where access to ambulance transportation is limited or nonexistent is a major impediment to improving cerebrovascular outcomes when stroke occurs.

Secondary Data

Among the 7 counties, **strokes** accounted for 5.7% of all deaths (all ages) between 2015 and 2017. (Source: OASIS, 2019)

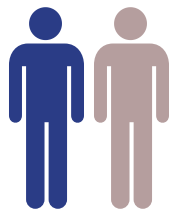
Georgia is part of the United States' "Stroke Belt" where stroke morbidity and mortality rates are well above those of other states. 80% of strokes are preventable. (Source: Georgia Department of Public Health, 2019)

Stroke Deaths as a % of ALL deaths, 2015 - 2017



Survey Data

* **1 in 2** households reported having high blood pressure



* Evidence shows that uncontrolled high blood pressure can lead to stroke. (Source: Mayo Clinic, 2019)



38% of hemorrhagic strokes result in death in <30 days (Source: NIH, 2012).

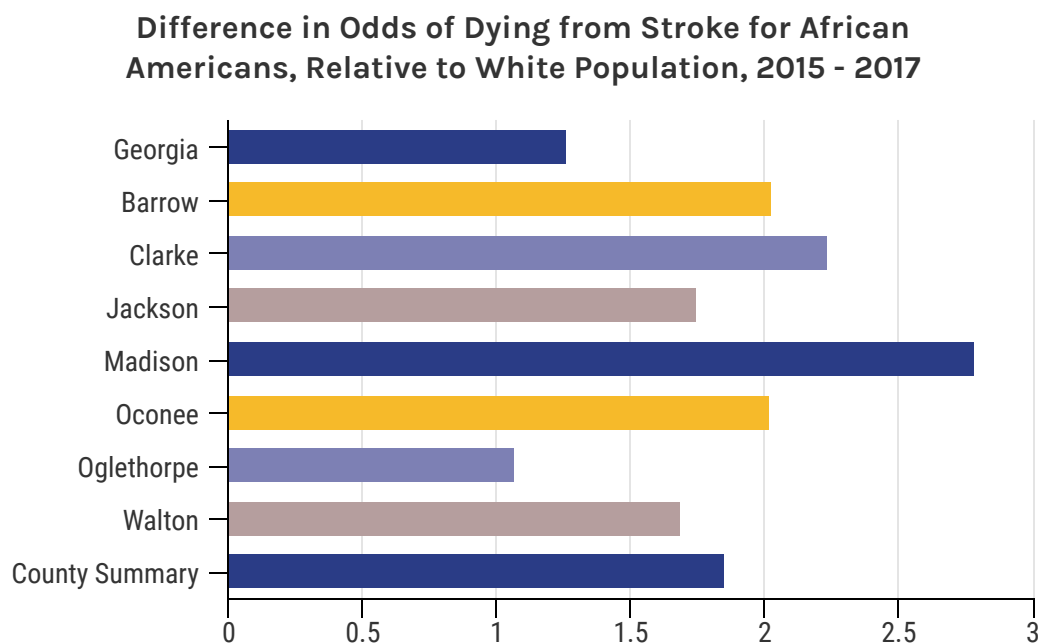


Being more than **37 miles** from a hospital increases the mortality rate for stroke by 3%

Persistent Disparities

In all counties in the service area, Black residents had a higher rate of death from stroke than White residents. In Madison, Oconee, Barrow, and Clarke counties, a Black resident was more than twice as likely to die from stroke than a White resident, adjusting for age and population between 2015 and 2017. (Source: OASIS, 2019)

The following graphic shows the magnitude of disparity by presenting the odds of dying from stroke for Black residents to White residents of the service area by county. The disparity is greatest in Madison and Clarke counties, respectively.



Cancer

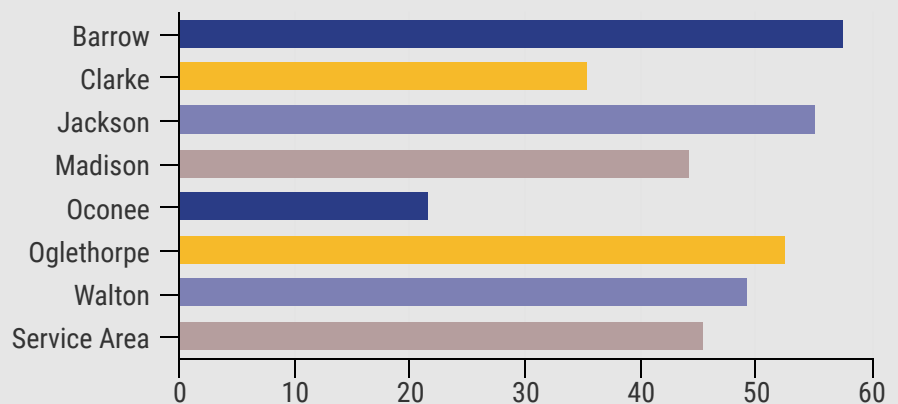
This category covers cancer of all types; the data in this overview is not comprehensive of cancer trends and specific diseases or stages within the category. According to the Georgia Department of Public Health, cancer is the second leading cause of death in the state. Here, secondary data are presented on lung cancer, which has some of the highest rates of prevalence and that are also largely preventable. As in each of the other health needs, healthcare access stood out as a concern across all data sources. Further, data are presented on risky behaviors, such as smoking, that have been shown to directly cause cancer. Similar to other needs, health disparities were concentrated in low income, rural communities.

Secondary Data

The service area age-adjusted death rate for **lung cancer** (at 45.5 per 100,000) was statistically significantly higher than the state rate of 40.1. (Source: OASIS, 2019)

Barrow, Jackson, Oglethorpe, and Walton counties had the highest age-adjusted death rates for **lung cancer** in the service area between 2015 and 2017 (Source: OASIS, 2019).

Age-Adjusted Lung Cancer Death Rate (Per 100,000), 2015 - 2017

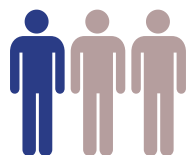


Survey Data

* **1 in 5** households reported having a smoker



* **1 in 3** households in **poverty** reported having a smoker



22% of respondents indicated that someone in their house had been diagnosed with cancer before

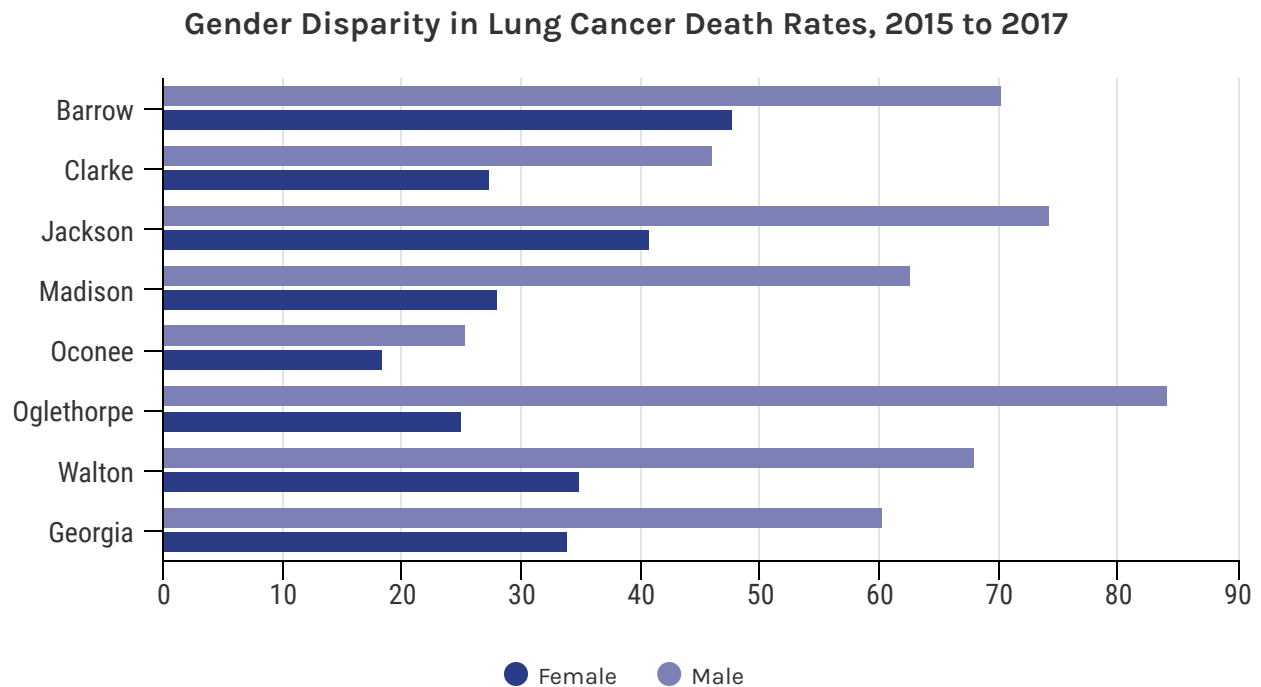


Average age of households with cancer: **60.4 years**

Persistent Disparities

In Clarke county, a Black resident was 2.68 times more likely to die from colon cancer than a White resident, adjusting for both age and population in 2017.

In all counties, male residents were more likely to die from lung cancer than female residents. The differences were especially pronounced in Barrow, Jackson, Madison, Oglethorpe, and Walton counties, respectively. (Source: OASIS, 2019)



APPENDIX A



R e g i o n a l S u p p l e m e n t

COUNTY PROFILES

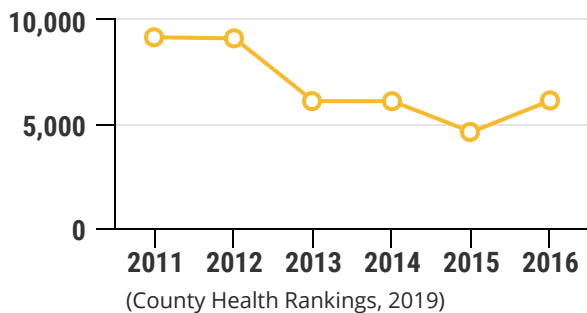
Banks County: Community Profile

Population: 18,634
Miles from Hospital: 42.5

Strengths

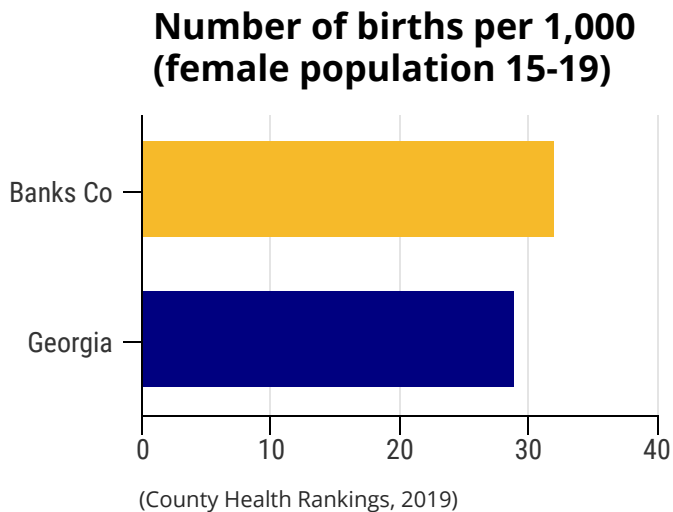
Access to primary care providers

The ratio of population to primary care providers in Banks County has been trending down since 2011, meaning more providers for the county



Challenges

Teen births

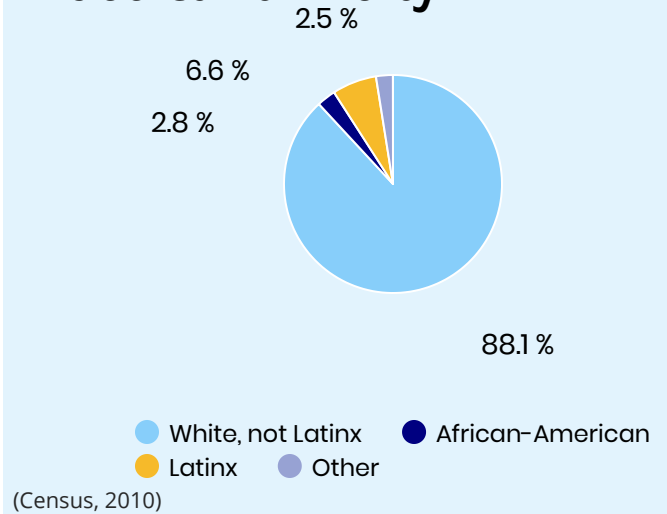


Access to health insurance

17.2% of population is without health insurance
compared to 15.4% statewide

(County Health Rankings, 2019)

Race & Ethnicity



Education

Less Than High School	High School diploma	Bachelor's Degree
23%	77.0%	11.9%

(Census, 2010)

Economy

% Living in Poverty	Median income	Unemployment Rate
13.5%	\$42,182	3%

(Census, 2010) (Dept. of Labor 2018)

Other Demographics

% with broadband internet	% without health insurance	County Health Ranking
60.7%	17.2%	65/159

(Census, 2010) (County Health Rankings, 2019)

Healthcare Labor Force



Primary
1 : 6,130



Mental
N/A



Dental
1 : 18,630

(County Health Rankings, 2019)

Barrow County: Community Profile

Population: 79,061
Miles from Hospital: 22.0

Strengths

Low birthweight

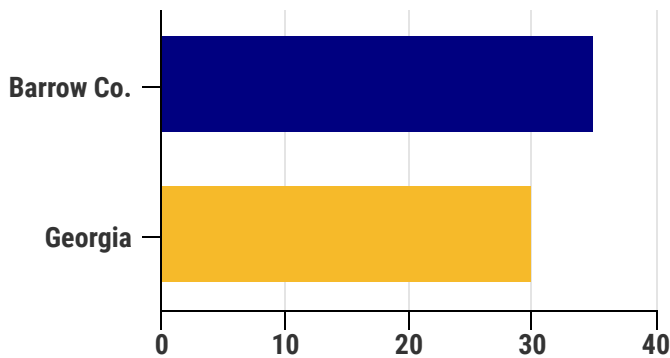
Only 7% of live births in Barrow County have a low birthweight, compared to 10% across the state.

(County Health Rankings, 2019)

Challenges

Obesity

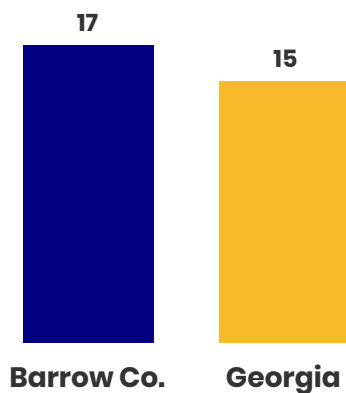
Adult obesity, as %



(County Health Rankings, 2019)

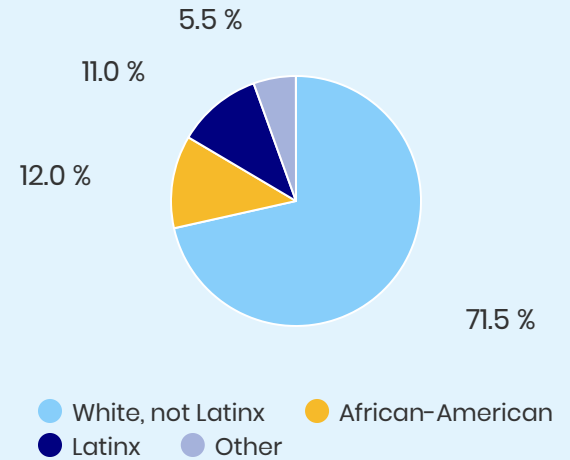
Excessive drinking

Excessive drinking, as %



(County Health Rankings, 2019)

Race & Ethnicity



(Census, 2010)

Education

Less Than High School	High School diploma	Bachelor's Degree
17%	83.0%	17.3%

(Census, 2010)

Economy

% Living in Poverty	Median income	Unemployment Rate
12.0%	\$56,119	3.7%

(Census, 2010)

(Dept. of Labor 2018)

Other Demographics

% with broadband internet	% without health insurance	County Health Ranking
78.7%	17.1%	25 / 159

(Census, 2010)

(County Health Rankings, 2019)

Healthcare Labor Force



Primary
1 : 5,025



Mental
1 : 6,427



Dental
1 : 5,009

(County Health Rankings, 2019)

Clarke County: Community Profile

Population: 127,064
Miles from Hospital: 0

Strengths

Life Expectancy

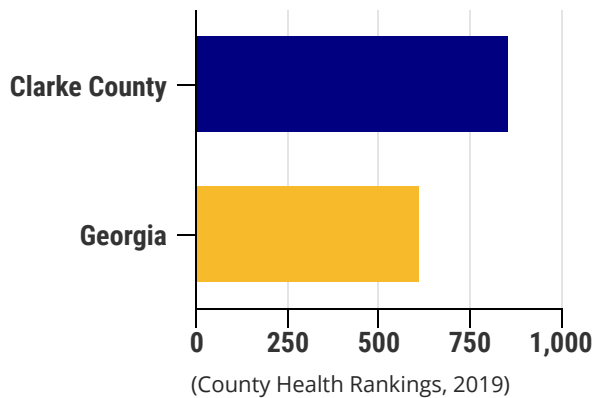
78.6 is life expectancy in Clarke County, compared to life expectancy of **77.7** across the state.

(County Health Rankings, 2019)

Challenges

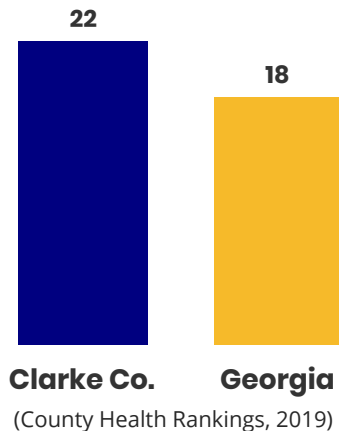
Sexually transmitted infections

857.9 newly diagnosed chlamydia cases (per 100,000 people), compared to the state rate of **614.6**

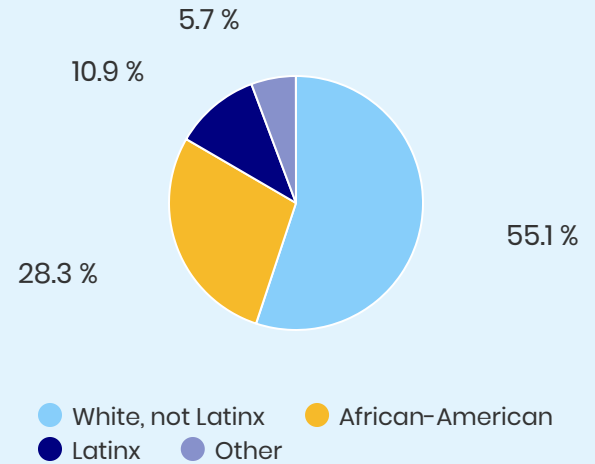


Smoking

22% of adults smoke, compared to **18%** in the state



Race & Ethnicity



Education

Less Than High School	High School diploma	Bachelor's Degree
13.3%	86.7%	41.3%

(Census, 2010)

Economy

% Living in Poverty	Median income	Unemployment Rate
26.6%	\$34,557	4.1%

(Census, 2010) (Dept. of Labor 2019)

Other Demographics

% with broadband internet	% without health insurance	County Health Rank
76.2%	15.5%	50 / 159

(Census, 2010) (County Health Rankings, 2019)

Healthcare Labor Force



Primary
1 : 1,580



Mental
1 : 400



Dental
1 : 1,840

(County Health Rankings, 2019)

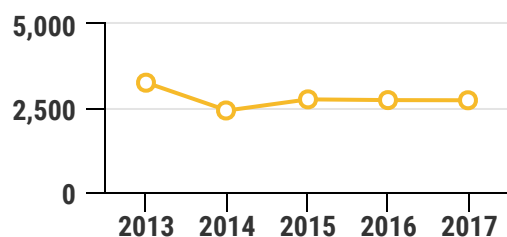
Elbert County: Community Profile

Population: 19,109
Miles from Hospital: 36.4

Strengths

Access to dentists

The ratio of population to dentists in Elbert County has been trending down since 2013, meaning more dentists for the county.

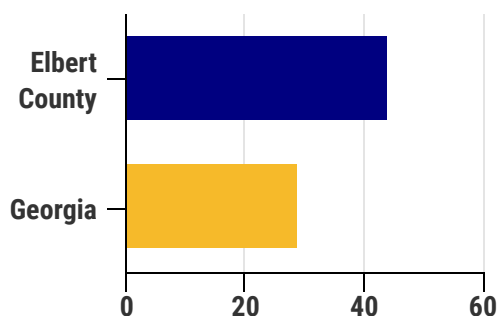


(County Health Rankings, 2019)

Challenges

Teen Birth Rate

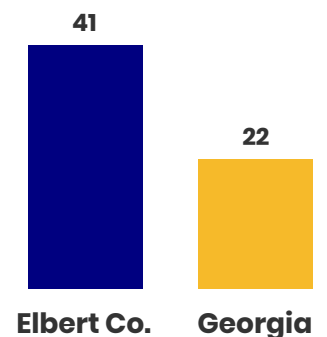
44 (per 1,000 births), compared to the state rate of 29



(County Health Rankings, 2019)

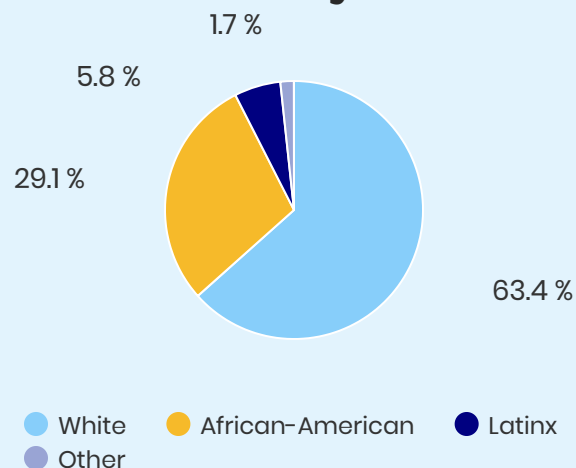
Alcohol-Impaired Driving Deaths

41% of driving deaths with alcohol involvement, compared to 22% in the state



(County Health Rankings, 2019)

Race & Ethnicity



(Census, 2010)

Education

Less Than
High School

21.4%

High School
diploma

78.6%

Bachelor's
Degree

11.1%

(Census, 2010)

Economy

% Living in
Poverty

22.9%

Median
income

\$35,207

Unemployment
Rate

4.2%

(Census, 2010)

(Dept. of Labor 2019)

Other Demographics

% with
broadband
internet

52.8%

% without
health
insurance

16.9%

County Health
Ranking

103/159

(Census, 2010)

(County Health Rankings, 2019)

Healthcare Labor Force



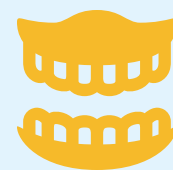
Primary

1 : 2,130



Mental

1 : 3,180



Dental

1 : 2,730

(County Health Rankings, 2019)

Franklin County: Community Profile

Population: 22,820
Miles from Hospital: 33.8

Strengths

Flu Vaccinations

51% of Medicare enrollees received annual flu vaccine in Franklin Co.

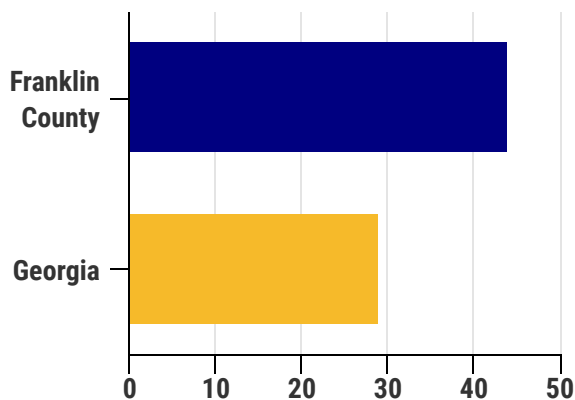
compared to 43% across the state

(County Health Rankings, 2019)

Challenges

Teen Birth Rate

44 (per 1,000 births), compared to the state rate of 29



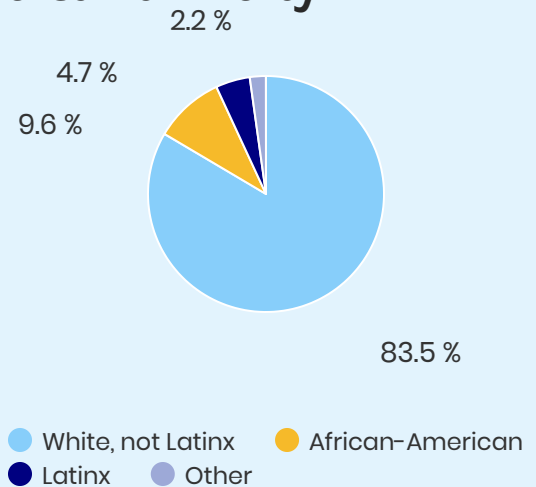
(County Health Rankings, 2019)

Opioid Use

14 age-adjusted death rate (per 100,000 people) for all opioids
compared to service area average death rate of 11.7

(OASIS Opioid, 2018)

Race & Ethnicity



(Census, 2010)

Education

Less Than High School	High School diploma	Bachelor's Degree
22.7%	77.3%	12.8%

(Census, 2010)

Economy

% Living in Poverty	Median income	Unemployment Rate
18.7%	\$39,246	4%

(Census, 2010)

(Dept. of Labor, 2019)

Other Demographics

% with broadband internet	% without health insurance	County Health Ranking
59.5%	18.8%	100/159

(Census, 2010)

(County Health Rankings, 2019)

Healthcare Labor Force



Primary
1 : 5,580



Mental
1 : 1,270



Dental
1 : 4,560

(County Health Rankings, 2019)

Greene County: Community Profile

Population: 17,281
Miles from Hospital: 35.3

Strengths

Access to Dentists

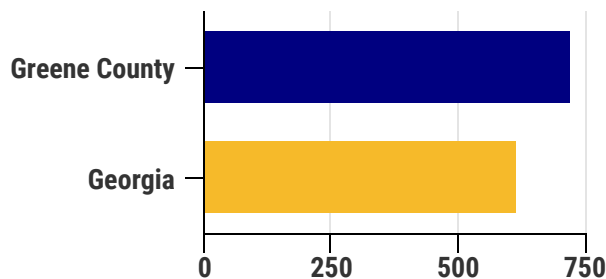
	Greene Co	Georgia
Ratio of residents to dentists	1,020:1	1,960:1

(County Health Rankings, 2019)

Challenges

Sexually Transmitted Infections

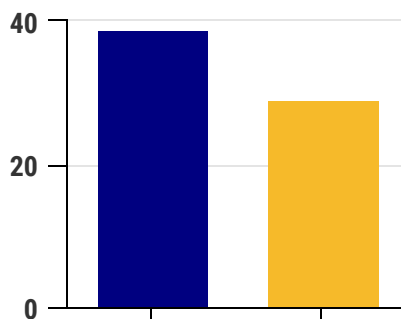
724.1 newly diagnosed chlamydia cases (per 100,000 people), compared to the state rate of 614.6



(County Health Rankings, 2019)

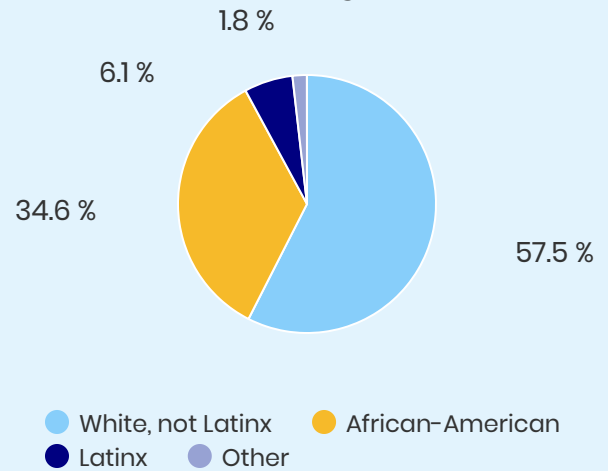
Teen Birth Rate

39 (per 1,000 births), compared to the state rate of 29



Greene County Georgia
(County Health Rankings, 2019)

Race & Ethnicity



(Census, 2010)

Education

Less Than High School	High School diploma	Bachelor's Degree
17.6%	82.4%	25.6%

(Census, 2010)

Economy

% Living in Poverty	Median income	Unemployment Rate
17.0%	\$45,069	4.5%

(Census, 2010)

(Dept. of Labor, 2019)

Other Demographics

% with broadband internet	% without health insurance	County Health Ranking
64.9%	18.7%	82/159

(Census, 2010)

(County Health Rankings, 2019)

Healthcare Labor Force



Primary
1 : 1,890



Mental
1 : 5,760



Dental
1 : 1,020

(County Health Rankings, 2019)

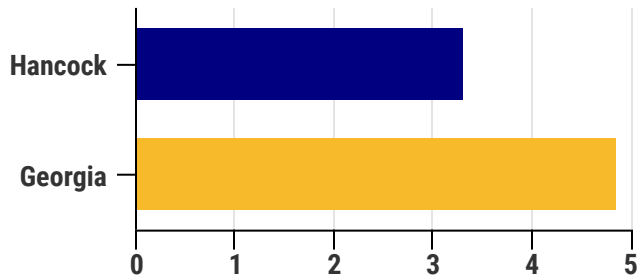
Hancock County: Community Profile

Population: 8,561
Miles from Hospital: 62.9

Strengths

Preventable Hospital Stays

Rate of hospital stays for ambulatory-care sensitive conditions (per 100,000 Medicare enrollees)



(County Health Rankings, 2019)

Challenges

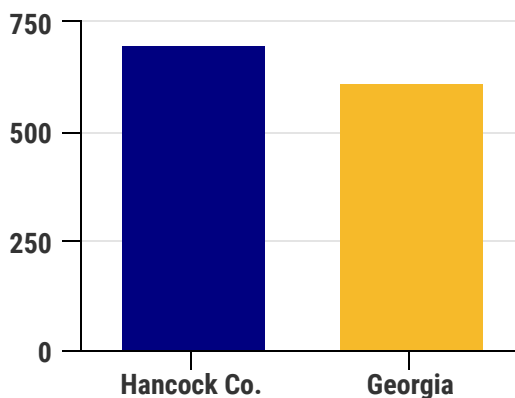
Income Disparity

45% of Hancock Co. children live in poverty, compared to 22% across the state.

(County Health Rankings, 2019)

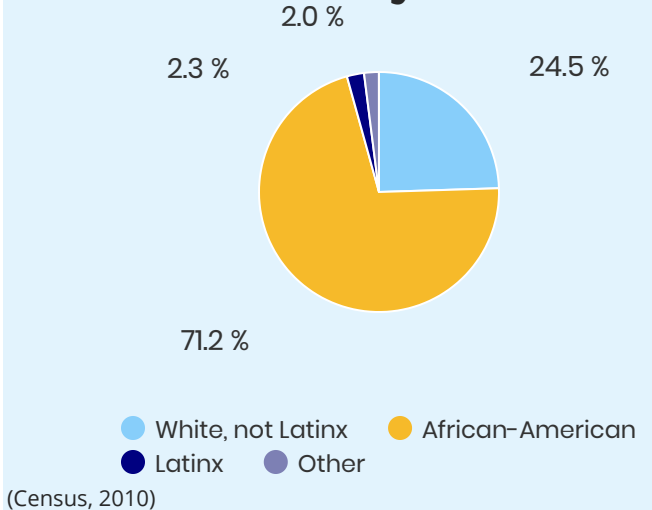
Sexually Transmitted Infections

701.7 newly diagnosed chlamydia cases (per 100,000 people), compared to the state rate of 614.6



(County Health Rankings, 2019)

Race & Ethnicity



(Census, 2010)

Education

Less Than High School

30.2%

High School diploma

69.8%

Bachelor's Degree

8.7%

(Census, 2010)

Economy

% Living in Poverty

30.3%

Median income

\$29,268

Unemployment Rate

6.3%

(Census, 2010)

(Dept. of Labor 2018)

Other Demographics

% with broadband internet

43.6%

% without health insurance

13.7%

County Health Ranking

153/159

(Census, 2010)

(County Health Rankings, 2019)

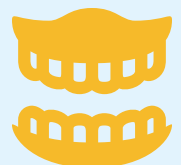
Healthcare Labor Force



Primary
1 : 4,320



Mental
1 : 4,280



Dental
1 : 8,560

(County Health Rankings, 2019)

Hart County: Community Profile

Population: 25,794
Miles from Hospital: 43.7

Strengths

Flu Vaccinations

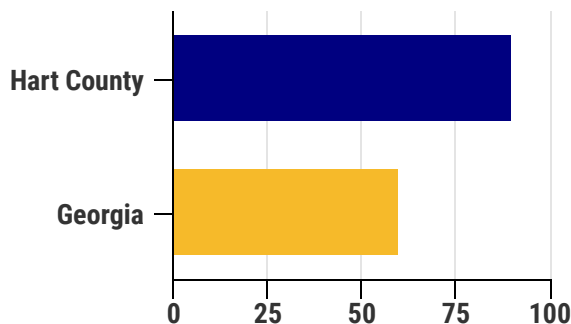
49% of Medicare enrollees received annual flu vaccine in Hart Co.
compared to 43% across the state

(County Health Rankings, 2019)

Challenges

Child Mortality

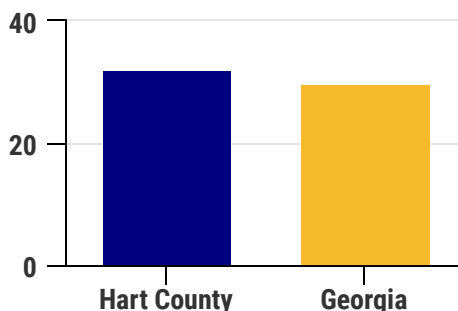
90 deaths among children under age 18
(per 100,000 population), compared to the state rate of 60



(County Health Rankings, 2019)

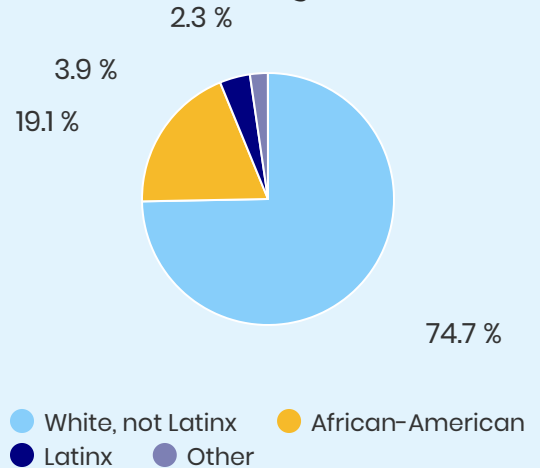
Obesity

32% of adults are obese,
compared to 30% in the state



(County Health Rankings, 2019)

Race & Ethnicity



(Census, 2010)

Education

Less Than High School	High School diploma	Bachelor's Degree
18.8%	81.2%	13.8%

(Census, 2010)

Economy

% Living in Poverty	Median income	Unemployment Rate
18.9%	\$41,216	3.8%

(Census, 2010) (Dept. of Labor 2018)

Other Demographics

% with broadband internet	% without health insurance	County Health Ranking
61.1%	16.2%	58/159

(Census, 2010) (County Health Rankings, 2019)

Healthcare Labor Force



Primary
1 : 2,560



Mental
1 : 6,450



Dental
1 : 3,680

(County Health Rankings, 2019)

Jackson County: Community Profile

Population: 67,519
Miles from Hospital: 17

Strengths

Obesity

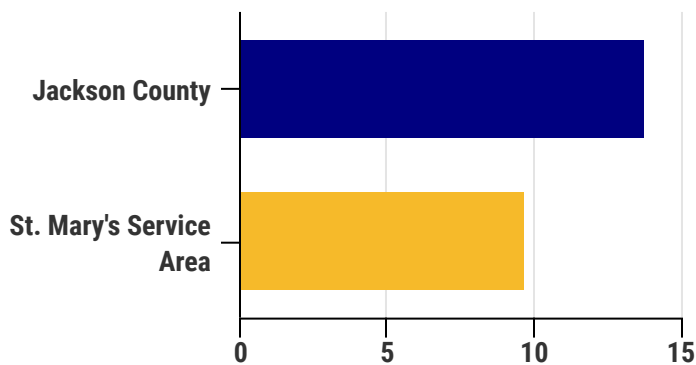
Only 27% of the county's adults are obese, which is only 1% more than top U.S. performers at 26%.

(County Health Rankings, 2019)

Challenges

Opioid Use

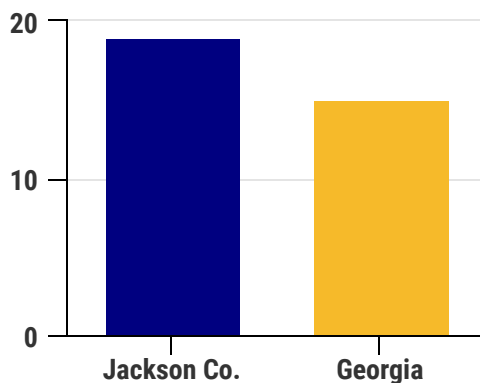
13.8 deaths related to all opioids (per 100,000 people), compared to the service area rate of 9.7



(OASIS Opioid, 2018)

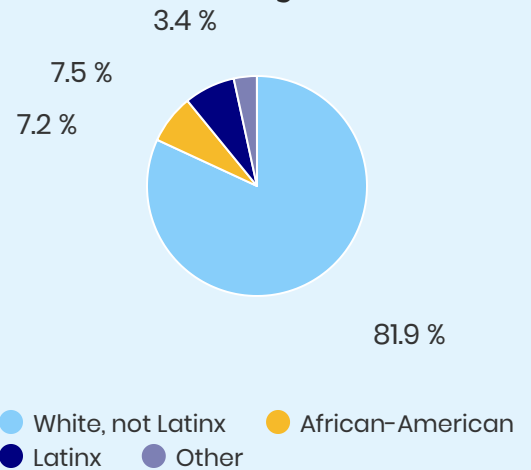
Excessive Drinking

19% of adults report binge or heavy drinking, compared to 15% in the state



(County Health Rankings, 2019)

Race & Ethnicity



(Census, 2010)

Education

Less Than High School	High School diploma	Bachelor's Degree
17.2%	82.8%	19.7%

(Census, 2010)

Economy

% Living in Poverty	Median income	Unemployment Rate
11.5%	\$57,999	3%

(Census, 2010)

(Dept. of Labor, 2018)

Other Demographics

% with broadband internet	% without health insurance	County Health Rank
74.8%	14.3%	12 / 159

(Census, 2010)

(County Health Rankings, 2019)

Healthcare Labor Force



Primary
1 : 1,620



Mental
1 : 2,250



Dental
1 : 2,050

(County Health Rankings, 2019)

Madison County: Community Profile

Population: 29,302
Miles from Hospital: 17.9

Strengths

Low birthweight

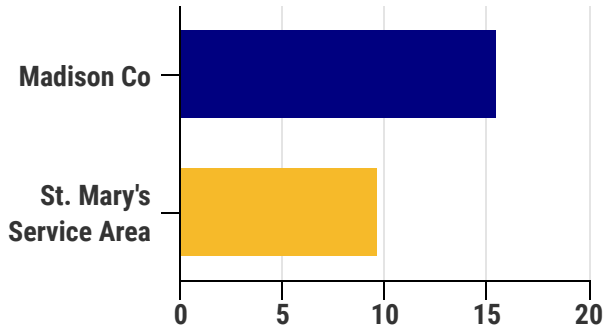
Only 8% of live births in Madison County have a low birthweight, compared to 10% across the state.

(County Health Rankings, 2019)

Challenges

Opioid use

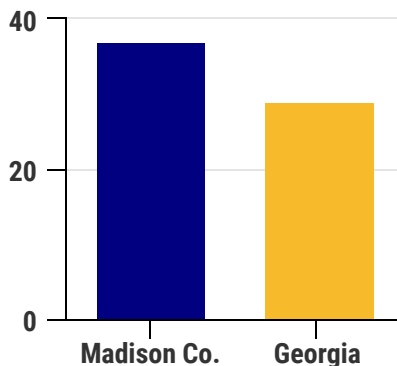
15.5 deaths related to all opioids (per 100,000 people), compared to the service area rate of 9.7



(OASIS Opioid, 2018)

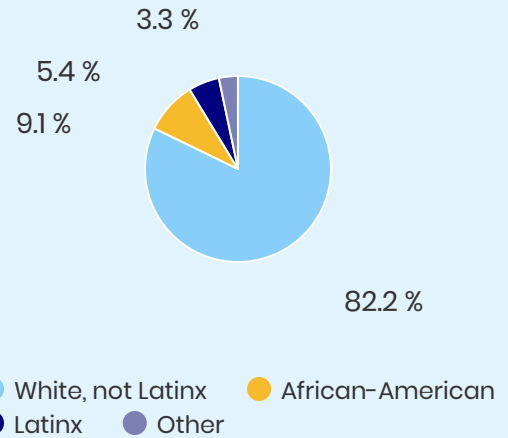
Teen births

Rate of 37 (per 1,000 females 15-19) teen births in Madison County, compared to 29 across the state



(County Health Rankings, 2019)

Race & Ethnicity



(Census, 2010)

Education

Less Than High School	High School diploma	Bachelor's Degree
17.7%	82.3%	16.7%

(Census, 2010)

Economy

% Living in Poverty	Median income	Unemployment Rate
15.9%	\$47,653	3.5%

(Census, 2010)

(Dept. of Labor 2018)

Other Demographics

% with broadband internet	% without health insurance	County Health Rank
66.9%	17.4%	34/159

(Census, 2010)

(County Health Rankings, 2019)

Healthcare Labor Force



Primary
1 : 7,210



Mental
1 : 7,330



Dental
1 : 29,300

(County Health Rankings, 2019)

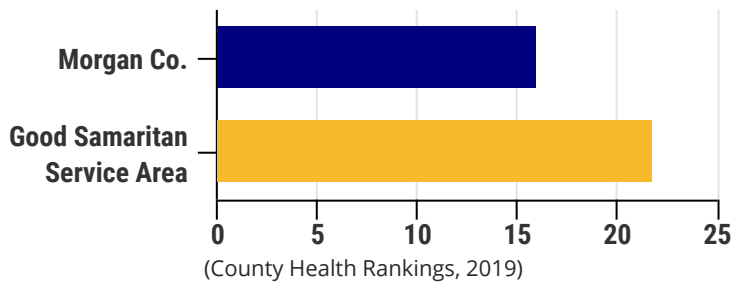
Morgan County: Community Profile

Population: 18,412
Miles from Hospital: 30.1

Strengths

Good Health Status

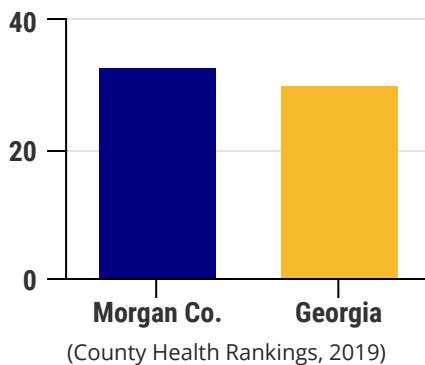
Percentage of adults reporting fair or poor health (age-adjusted)



Challenges

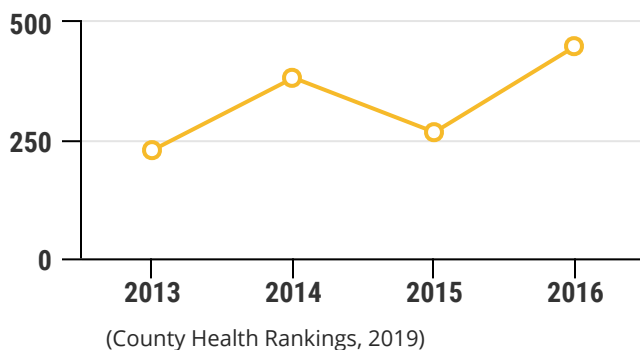
Obesity

33% of adults are obese in Morgan County, compared to 30% in the state.

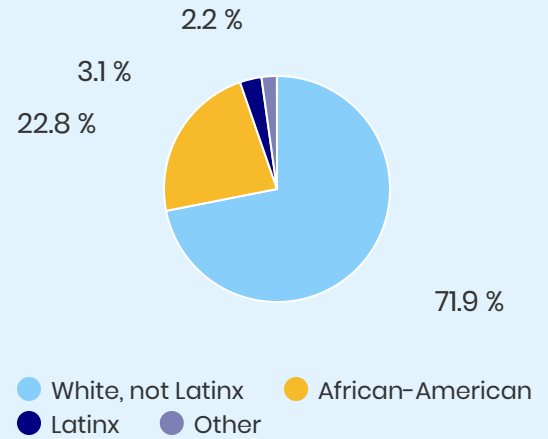


Sexually Transmitted Infections

The rate of newly diagnosed chlamydia cases in Morgan County (per 100,000 people) is trending up.



Race & Ethnicity



Education

Less Than High School

13.4%

High School diploma

86.6%

Bachelor's Degree

22.1%

(Census, 2010)

Economy

% Living in Poverty

12.0%

Median income

\$59,572

Unemployment Rate

3.7%

(Census, 2010)

(Dept. of Labor 2018)

Other Demographics

% with broadband internet

71.5%

% without health insurance

14.2%

County Health Ranking

27/159

(Census, 2010)

(County Health Rankings, 2019)

Healthcare Labor Force



Primary
1 : 1,820



Mental
1 : 3,680



Dental
1 : 2,300

(County Health Rankings, 2019)

Oconee County: Community Profile

Population: 39,028
Miles from Hospital: 10

Strengths

Lowest Rates of Poor Health Days in Service Area

Poor Physical
Health Days



3.2

(County Health Rankings, 2019)

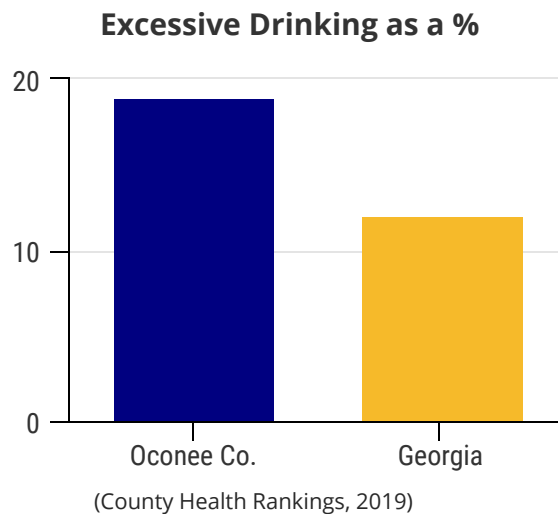
Poor Mental Health
Days



3.4

Challenges

Excessive Drinking

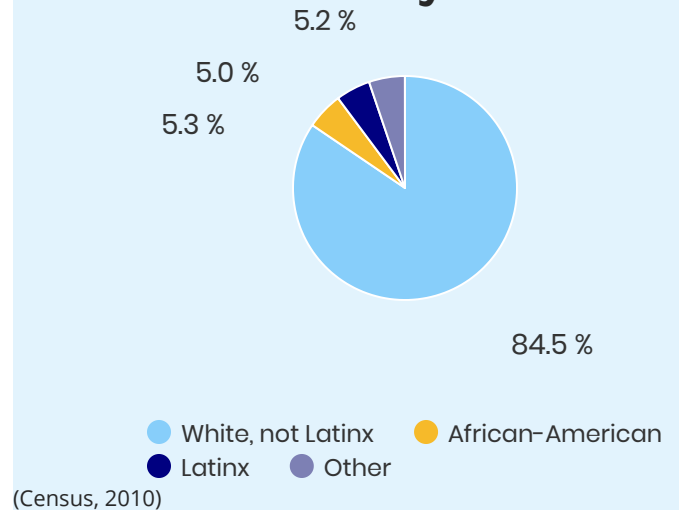


Suicide

Oconee County had a suicide death rate of **28.2 (per 100,000 people)** in 2017, compared to the statewide suicide rate of **13.6**.

(OASIS, 2018)

Race & Ethnicity



Education

Less Than High School	High School diploma	Bachelor's Degree
5.7%	94.3%	48.2%

(Census, 2010)

Economy

% Living in Poverty	Median income	Unemployment Rate
6.5%	\$77,388	4.1%

(Census, 2010) (Dept. of Labor 2018)

Other Demographics

% with broadband internet	% without health insurance	County Health Ranking
83.4%	9.6%	2/159

(Census, 2010) (County Health Rankings, 2019)

Healthcare Labor Force



Primary
1 : 799



Mental
1 : 576



Dental
1 : 1,842

(County Health Rankings, 2019)

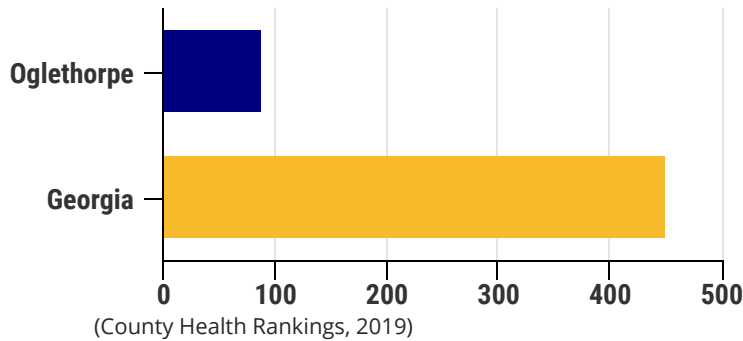
Oglethorpe County: Community Profile

Population: 38,028
Miles from Hospital: 19.4

Strengths

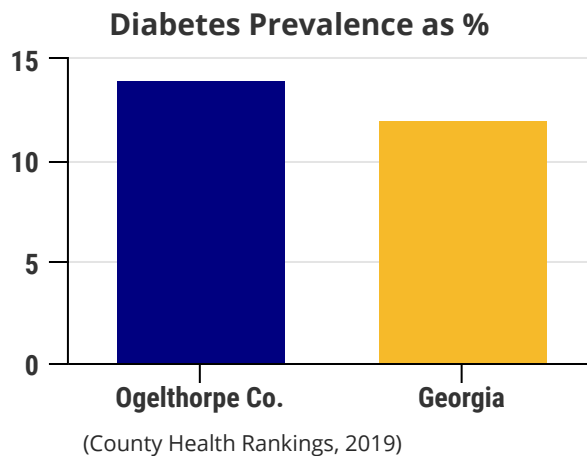
HIV Prevalence

Oglethorpe Co. has one of the lowest rates (per 100,000 people) of HIV prevalence in the St. Mary's service area.



Challenges

Diabetes Prevalence

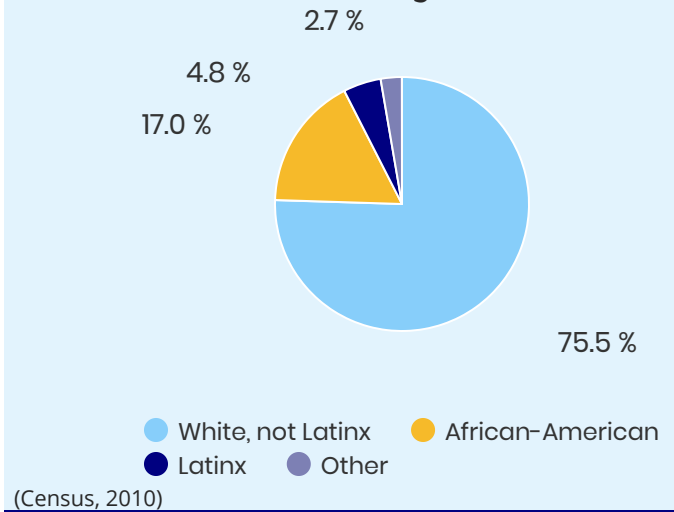


Physical Activity

Only 34% of Oglethorpe Co. residents have access to exercise opportunities, compared to 76% across the state.

(County Health Rankings, 2019)

Race & Ethnicity



Education

Less Than High School	High School diploma	Bachelor's Degree
22.1%	77.9%	15.5%

(Census, 2010)

Economy

% Living in Poverty	Median income	Unemployment Rate
13.4%	\$43,398	3.6%

(Census, 2010) (Dept. of Labor 2018)

Other Demographics

% with broadband internet	% without health insurance	County Health Ranking
61.6%	16.8%	32/159

(Census, 2010) (County Health Rankings, 2019)

Healthcare Labor Force



Primary
1 : 14,920



Mental
1 : 14,880



Dental
1 : 14,880

(County Health Rankings, 2019)

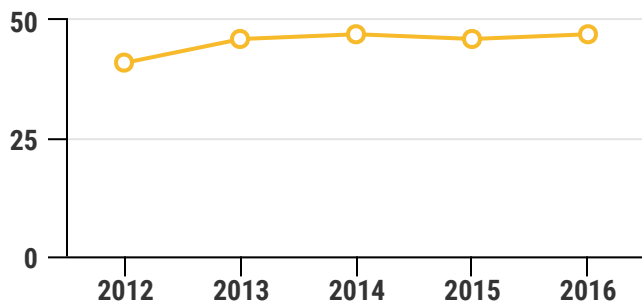
Putnam County: Community Profile

Population: 21,730
Miles from Hospital: 52.4

Strengths

Mammography Screenings

The percentage of female Medicare enrollees who received an annual mammography screening



(County Health Rankings, 2019)

Challenges

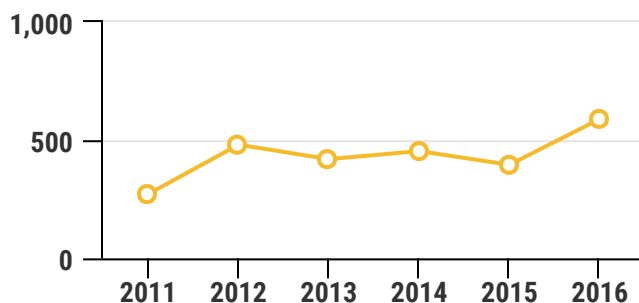
Income Disparity

31% of Putnam Co. children live in poverty, compared to 22% across the state.

(County Health Rankings, 2019)

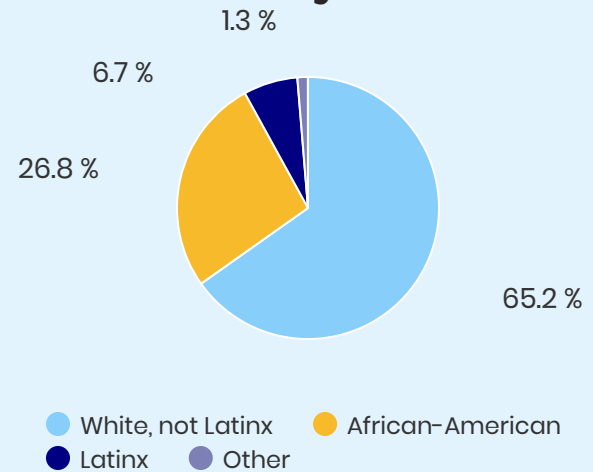
Sexually Transmitted Infections

The rate of newly diagnosed chlamydia cases in Putnam Co. (per 100,000 people) is trending up, at 590.1 in 2016.



(County Health Rankings, 2019)

Race & Ethnicity



(Census, 2010)

Education

Less Than
High School

13.2%

High School
diploma

85.9%

Bachelor's
Degree

21.4%

(Census, 2010)

Economy

% Living in
Poverty

17.2%

Median
income

\$48,340

Unemployment
Rate

5.5%

(Census, 2010)

(Dept. of Labor 2018)

Other Demographics

% with
broadband
internet

75.9%

% without
health
insurance

17.7%

County Health
Ranking

46/159

(Census, 2010)

(County Health Rankings, 2019)

Healthcare Labor Force



Primary
1 : 3,070



Mental
1 : 2,410



Dental
1 : 5,430

(County Health Rankings, 2019)

Stephens County: Community Profile

Population: 25,890
Miles from Hospital: 50.6

Strengths

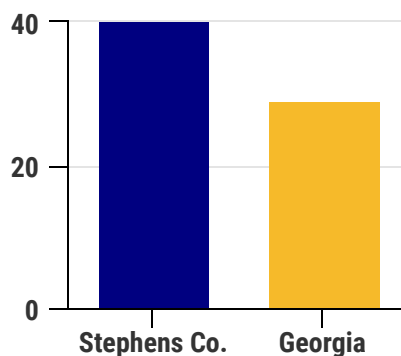
Access to PCPs and Dentists

	Stephens Co.	Georgia
Ratio of residents to PCPs (County Health Rankings, 2019)	1,430:1	1,520:1

Challenges

Teen Births

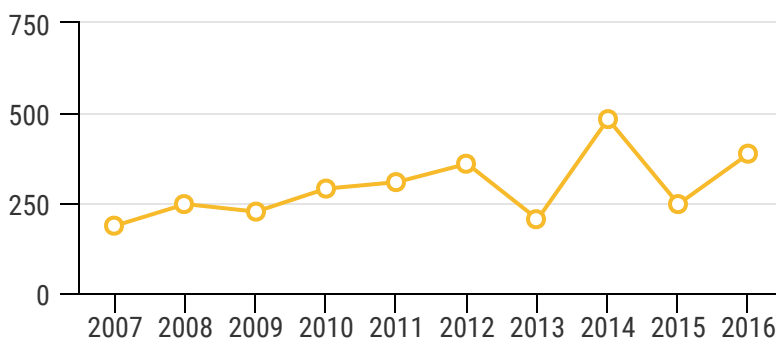
40 (per 1,000 births), compared to the state rate of 29



(County Health Rankings, 2019)

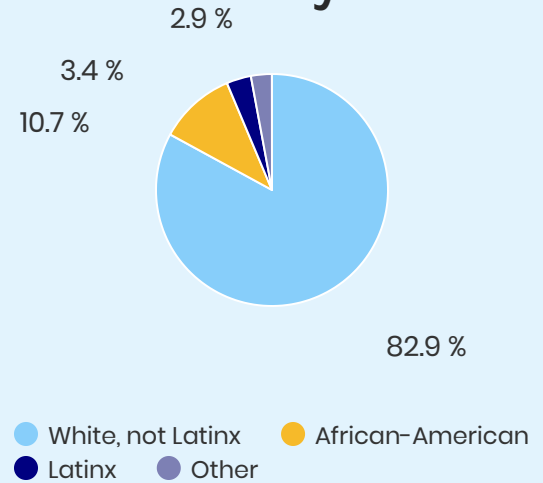
Sexually Transmitted Infections

Stephens County's rate of sexually transmitted infections has been trending up since 2007, with a rate of 386.9 in 2016.



(County Health Rankings, 2019)

Race & Ethnicity



(Census, 2010)

Education

Less Than High School	High School diploma	Bachelor's Degree
18.4%	81.6%	19.6%

(Census, 2010)

Economy

% Living in Poverty	Median income	Unemployment Rate
18.7%	\$39,756	4.2%

(Census, 2010)

(Dept. of Labor 2018)

Other Demographics

% with broadband internet	% without health insurance	County Health Ranking
66.6%	15.4%	105/159

(Census, 2010)

(County Health Rankings, 2019)

Healthcare Labor Force



Primary
1 : 1,430



Mental
1 : 1,620



Dental
1 : 2,590

(County Health Rankings, 2019)

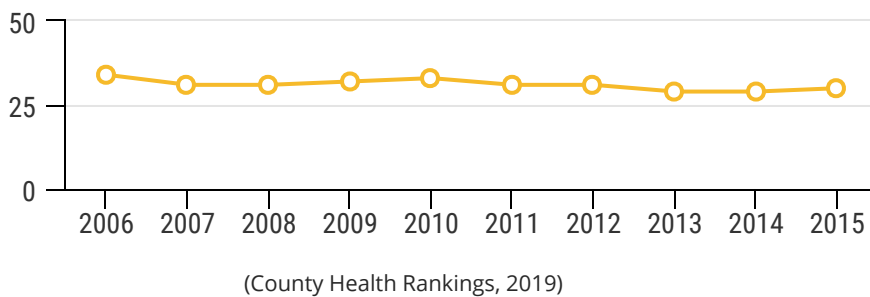
Taliaferro County: Community Profile

Population: 1,628
Miles from Hospital: 47.8

Strengths

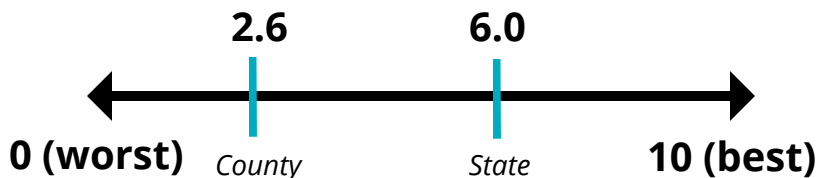
Physical Inactivity

The percentage of adults over 20 who report no leisure-time physical activity has decreased in Taliaferro Co. since 2006, from 35% to 30%.



Challenges

Food Environment Index

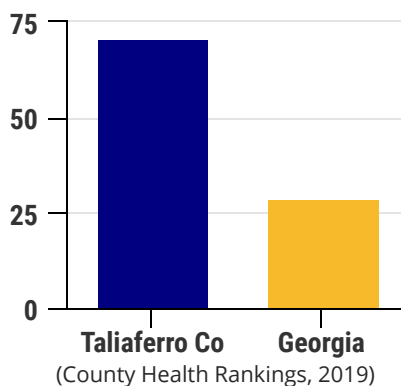


Index of factors that contribute to a healthy food environment

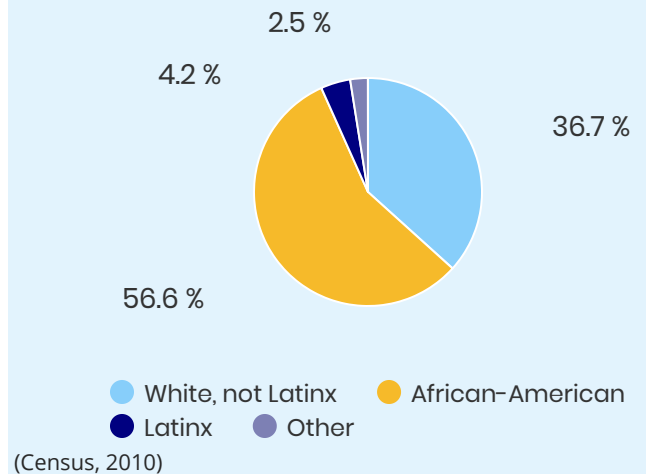
(County Health Rankings, 2019)

Teen Births

71 (per 1,000 births), compared to the state rate of 29



Race & Ethnicity



Education

Less Than High School	High School diploma	Bachelor's Degree
30.9%	69.1%	6.8%

(Census, 2010)

Economy

% Living in Poverty	Median income	Unemployment Rate
26.5%	\$30,500	5%

(Census, 2010) (Dept. of Labor 2018)

Other Demographics

% with broadband internet	% without health insurance	County Health Ranking
35.4%	19.2%	129/159

(Census, 2010) (County Health Rankings, 2019)

Healthcare Labor Force



Primary
0 : 1,590



Mental
N/A



Dental
0 : 1,630

(County Health Rankings, 2019)

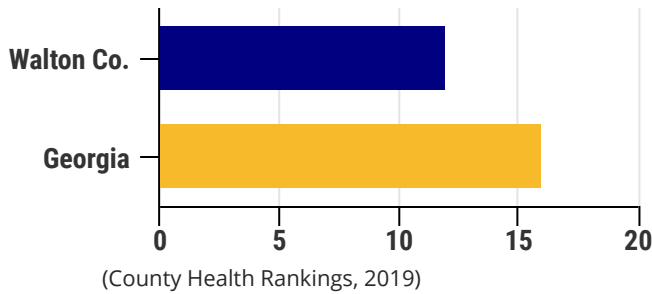
Walton County: Community Profile

Population: 91,600
Miles from Hospital: 23.7

Strengths

Low Rate of Death from Motor Vehicular Crash

Death rate from MV crashes (per 10,000)



Challenges

Built Environment Issues

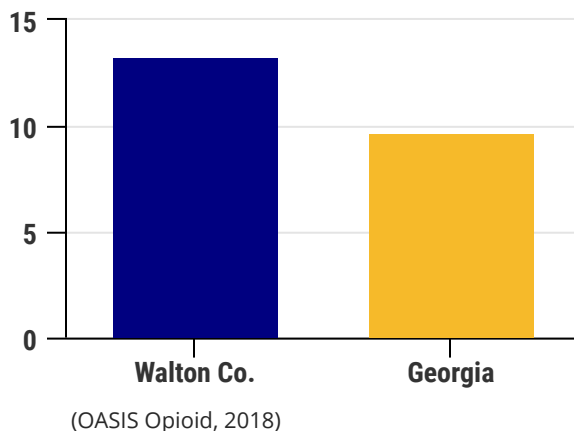


Residents of Walton Co. report longer commutes and higher rates of driving alone to work, compared to residents of other counties in the St. Mary's service area.

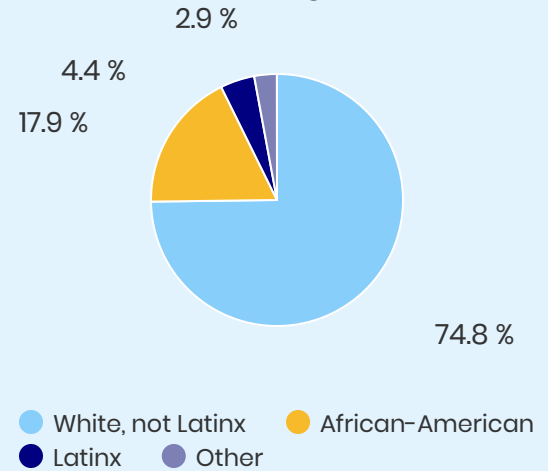
(County Health Rankings, 2019)

Death Rate from Opioids

Death rate from all opioids 13.3 (per 10,000), compared to the state rate of 9.7



Race & Ethnicity



Education

Less Than High School	High School diploma	Bachelor's Degree
13.2%	86.8%	19%

(Census, 2010)

Economy

% Living in Poverty	Median income	Unemployment Rate
22.9%	\$35,207	3.6%

(Census, 2010) (Dept. of Labor 2018)

Other Demographics

% with broadband internet	% without health insurance	County Health Ranking
52.8%	16.9%	30/159

(Census, 2010) (County Health Rankings, 2019)

Healthcare Labor Force



Primary
1 : 2,326



Mental
1 : 1,734



Dental
1 : 3,110

(County Health Rankings, 2019)

APPENDIX B



A W P 2 . 0

METHODS OVERVIEW

AWP 2.0 DATA OVERVIEW

More about the Athens Wellbeing Project.

The sampling plan for the Athens Wellbeing Project (AWP) was designed to obtain a random sample of county residents representative of the total population of Athens-Clarke County. The first step in selecting the AWP sample was to create a list of all residence or living communities (i.e. apartment buildings, public housing communities, mobile home parks, and retirement communities) in Athens-Clarke County. This list, hereafter referred to as the sampling frame, was used to select a residence. For the purposes of the AWP, the unit of analysis is conceptualized as the household. Within each selected residence, a single resident living in the household received the AWP survey and was asked to respond on behalf of all residents living in the household. This person is hereafter referred to as the respondent.

To create a sample that represented the population of interest the sampling frame needed to include all Athens-Clarke County residences. Sources for these lists included the Athens Clarke County Unified Government Department of Housing & Community Development and the Athens Housing Authority. The list of residences was comprised of the following types of dwellings:

- Single family residences, condos, and duplex buildings
- Apartment complexes
- Public Housing communities
- Mobile home parks
- Retirement communities

Next, the sampling frame was evaluated to determine which Athens-Clarke county residents might be underrepresented or missing from the frame completely. During the evaluation of the sampling frame, we determined that homeless and transitional residents could be missing from the frame. For the purposes of AWP, we defined homelessness according to the McKinney-Vento Homeless Assistance Act of 1987 (Pub. L. 100-77, July 22, 1987, 101 Stat. 482, 42 U.S.C. § 11301).

Using the McKinney-Vento definition means that we defined homelessness more broadly than only including individuals with no shelter or residing in homeless shelters. This definition also encompasses individuals who might be living with friends or family members or otherwise “transitional” situations. The vulnerable nature of homeless and transitional residents presented special challenges in constructing the sampling frame, and as a result we had to “select” them into the AWP sample differently from other residents.

The AWP data collection strategy used both postcard mailings and in-person, door-to-door follow up. Four rounds of postcard mailers were sent to each household in the sample. The postcards included information on the project, instructions to complete the survey online (or to request a paper copy), the household's unique Survey ID to complete the survey, and information on chances to win the incentive for completion.

The second mechanism for data collection was in-person follow up and administration of the survey instrument, conducted by data collection teams. Data collection teams were composed of a Neighborhood Leader—an infrastructure already existing in the community under Family Connection-Communities in Schools. Each neighborhood was assigned a Neighborhood Leader who has experience living and working in Athens and engaging with their local community. The Neighborhood Leader was the manager of each data collection team, composed of the NL and students from the University of Georgia. All data collection team members received training in Fall 2018 to prepare them for in-person collection.

AWP 2.0 data collection resulted in 1,078 households completing the survey in Athens-Clarke County, with a +/-3% margin of error. The response rate for the full sample was 12%, however, sampling weights were created and are utilized for all analysis and reporting to ensure representativeness of the data. The analysis weights account for variation in the probability of being included in the sample, and for varying rates of response across the sampling strata. The resulting sample from this round of collection is one that is robust and representative of Athens-Clarke County households.

Additional survey data were collected from surrounding counties with a shorter version of the survey that focused on health and demographics, using a convenience sampling method. This resulted in an additional 1,000 surveys that were used to supplement regional understanding of health needs in the counties served by healthcare providers in Athens-Clarke County.

A critical component of executing this work was achieving approval from the University of Georgia's Institutional Review Board (IRB) to conduct the project. The project was submitted to IRB in June 2016, and after being reviewed was determined that it was not deemed "research," but rather was a project designed to provide research and analysis to stakeholders in the Athens Clarke County community. Thus, the project was exempt from further IRB oversight (IRB Study ID #00003747).

AWP 2.0 DATA OVERVIEW



THANK YOU TO OUR INSTITUTIONAL PARTNERS

