Community Health Needs Assessment

Report

2015-2016

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About this Report

This Community Health Needs Assessment report was completed using data obtained as part of a Rural Community Health Systems Planning Grant funded by the Georgia State Office of Rural Health. (Rural Community Health Systems Planning Grant # 15055G)

GEORGIA SOUTHERN UNIVERSITY
JIANN-PING HSU COLLEGE OF PUBLIC HEALTH

SORH
GEORGIA STATE OFFICE OF RURAL HEALTH

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Acknowledgement

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KEY FINDINGS

Secondary Data Analysis

Compared to the state, the service area had:

- Higher uninsurance rates
- Higher rates of preventable hospital stays
- Higher proportion of residents who were smokers, obese and physically inactive
- Higher rates of teenage pregnancies
- Higher prevalence of chronic conditions such as obesity, heart disease and diabetes
- Higher all-cause mortality rates
- Fewer healthcare providers per population
- Lower utilization of preventative services

Primary Data Analysis

- Participants in the focus groups and community surveys had a favorable view of the community, but were dissatisfied with the lack of jobs and social amenities
- Their perceptions about the adequacy and quality of medical services within the community was low
- Participants consistently listed several health conditions as issues in their community: obesity, diabetes, HIV, and high blood pressure. Participants linked the poor health outcomes in the community to poverty and the lack of healthy dining options.

EXECUTIVE SUMMARY

Purpose

This report summarizes findings from the Community Health Needs Assessment (CHNA) conducted between June 2015 and December 2016. Data are reported for Evans Memorial Hospital's primary service area of Evans and Tattnall Counties.

Methodology

Data for this assessment were obtained from primary and secondary data sources. Primary data were collected via community focus groups and a community survey. Secondary data were obtained from multiple sources including the Georgia Department of Public Health's Online Analytical Statistical Information System (OASIS), the County Health Rankings and the U.S. Census Bureau. Interactive community planning meeting with hospital and community representatives were held to prioritize emerging community health issues. Top priority issues were identified using the nominal group technique (NMT) approach for prioritizing health issues.

Prioritization

The following community issues emerged from the data and community interactions: Need for Hospital Community Outreach, Health Promotion and Education to Address Chronic Disease Conditions and Other Health Issues; Economic Development Issues; Social-Behavioral Health Issues; Low Use of Preventative Services; Health Care Access and; Mental and Behavioral Health Issues.

The top three priority areas identified included: Need for Hospital Community Outreach, Health Promotion, and Education;
Health Care Access and; Mental Health and Behavioral Health Issues.

1 PURPOSE

The purpose of this report is to summarize findings from the Community Health Needs Assessment (CHNA) for Evans Memorial Hospital's primary service area of Evans and Tattnall Counties. This CHNA fulfills the Patient Protection and Affordable Care Act (PPACA) mandate that requires all nonprofit, tax-exempt hospitals to complete a community health needs assessment every 3 years. Data for this assessment were collected as part of the Rural Community Health Systems Planning Grant. (2015-2016).

About the Rural Community Health Systems Planning Grant (2015-2016)

The Jiann-Ping Hsu College of Public Health was commissioned by the Georgia Department of Community Health, State Office of Rural Health to conduct a financial sustainability needs assessment of four rural non-profit community hospitals in Georgia in 2015. The purpose of this hospital collaborative community planning initiative was to identify health care access and other critical needs and to develop a financial sustainability plan to meet the needs identified. Organizational performance and community assessments were conducted. The initiative was conducted between June 2015 and December 2016.

2 METHODOLOGY

The project team worked with hospital leadership and the community advisory board (CAB) to recruit community members for four focus groups, with an average of seven participants in each focus group. One focus group was conducted with members of the CAB, while the remaining focus groups included residents of the community, business leaders, and hospital leadership. Findings from the focus groups informed the identification and prioritization of community health access needs and organizational financial health needs, as well as provided suggested solutions to address these needs.

Further, findings from the focus groups were used to develop a community survey aimed at assessing local health care access and other needs critical for the stabilization of the local rural community hospital. The community survey was mailed to a 20% random address-based sample of residents (N=1,538) living in the hospital's primary service area (top two patient zip codes).

Information from these primary data collection efforts was supplemented by secondary quantitative data on community profile, health care access, and utilization. These data were obtained from multiple publicly available sources including the US Census Bureau, the Area Resource File, Georgia Department of Public Health's Online Analytical Statistical Information System (OASIS) and County Health Rankings.

Data Analysis

Data from the community survey were analyzed using descriptive statistics, including frequencies, means, and standard deviation. Analyses were completed using the IBM SPSS Statistics 23 software package. Charts and graphs were created using Microsoft Excel 2013 Software. Qualitative data from the focus groups were analyzed using the NVIVO10 qualitative analysis software.

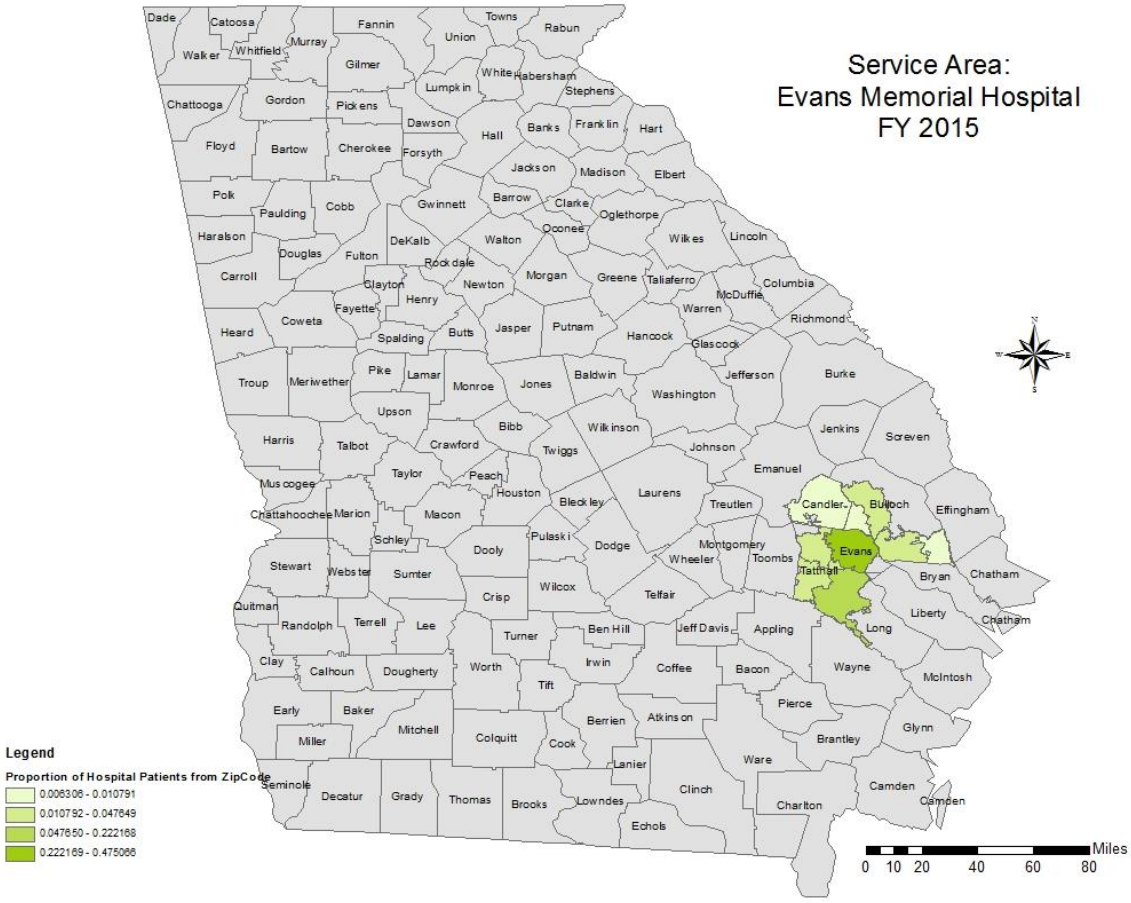
Ranking Strategic Priorities.

The project team facilitated two interactive community planning meetings with hospital and community representatives. Results from the secondary and primary data collection efforts were presented to participants at the beginning of this meeting. At second meeting, the top three community health priority areas were identified using a nominal group technique approach. The process included silent brainstorming, list generation, group discussion and three rounds of anonymous voting. Specifically, participants were asked to jot down potential community health issues during the review of the secondary and primary data. Following the presentation of the data, the facilitator recorded all potential health issues written by participants on a flip chart. The facilitator led a discussion, where everyone was given an opportunity to provide input on the list. Three anonymous rounds of voting were conducted until the top three health issues were identified. Participants were allowed to vote for as many issues as they liked in each round. Only issues receiving more than 50% of total votes cast made it to the next voting stage.

Development of Goals and Objectives. For each of the top three selected health priority areas, participants worked together through discussion and consensus building to articulate the goals and objectives for addressing the identified health issues.

SERVICE AREA

Evans Memorial Hospital serves Evans County (53.8%), Tattnall County (30.3%) and parts of Bryan (3.8%), Bulloch (3.2%) and Candler (1.0%) counties. Evans and Tattnall Counties make up the hospital's primary service area.



3 SECONDARY DATA ANALYSIS

3.1 POPULATION DEMOGRAPHICS OF PRIMARY SERVICE AREA

Demographic information for Evans and Tattnall Counties (primary service areas) are presented in Table 1.

The proportion of adults 65 years and older in Evans County (16%) is higher than the state average of 13%. The proportion of the elderly population in Tattnall County (13%) is similar to the state average. Compared with the state, Evans and Tattnall County are more diverse, with approximately 12% and 11% of their population being Hispanic, respectively. Similar to other rural counties in the state, educational attainment in these two counties, as measured by high school graduation rate, is lower than the state average (74% versus the state average of 85%). More than a quarter of both counties' population live in poverty, and per capita income in both counties is lower than the state average (Table 1).

Table 1. Population Demographics, Evans County, 2015

Indicator	Evans	Tattnall	Georgia
Population	10,787	25,229	10,214,860
% below 18 years of age	26.4	20.9	24.5
% 65 and older	15.6	12.5	12.8
% Non-Hispanic African American	30.0	28.8	30.9
% American Indian and Alaskan Native	0.2	0.2	0.2
% Asian	0.7	0.5	3.9
% Native Hawaiian or Other Pacific Islander	*	*	0.1
% Multi-racial/Other	1.1	1.0	1.7
% Hispanic	11.7	10.9	9.4
% Non-Hispanic white	56.3	58.5	53.9
% Females	51.8	42.1	51.2
% High School graduate or higher, age 25+	74.3	73.6	85.4
Unemployment Rate	5.5	6.0	6.0
% Below Poverty Level	27.4	27.5	17.0
Per capita Income ($)	19,625	14,957	25,737
% Foreign Born	5.3	4.3	9.8
% Language Other than English Spoken at Home	12.6	10.8	13.6

* Less than 0.1% Data sources: (1) Georgia Department of Public Health Online Analytical Statistical Information system: Population Web Query (2015 data: population size, population by age and race). (2) US Census Bureau Quick Facts (2011-2015 data: educational attainment, poverty rate, per capita income, foreign-born population, and language spoken at home). (3) Bureau of Labor Statistics (2015 data: unemployment rates).

3.1.1 Population Change

Between 2010 and 2015 overall population growth declined in both Evans and Tattnall County, despite increasing population growth at the state level. Over this time period, Evans County experienced increased population growth for children under 18 years (greater than state growth rate for this population sub-group), elderly population (lower than state growth rate for this population sub-group), and other non-Hispanic, non-Caucasian racial groups (lower than state growth rate for these population sub-groups). On the other hand, there were declines in non-Hispanic White and Hispanic populations, despite an increased growth rate for these sub-populations at the state level (Table 2).

Between 2010 and 2015, Tattnall County experienced increased population growth for elderly population (lower than state growth rate for this population sub-group), Hispanic population and multi-racial population (lower than state growth rate for these population sub-groups) as well as for the American Indian/Alaska Native, Asian and Native Hawaiian/Pacific Islander populations (higher than state growth rate for these population sub-groups). There were declines in population growth for children under 18 years, non-Hispanic White and African American populations (compared to population growth at the state-level for these population sub-groups).

Table 2. Population Trends, 2010 – 2015

	Percent Change, 2010-2015		
Indicator	**Evans**	**Tattnall**	**Georgia**
Total Population	-2.0%	-1.1%	+5.2%
Population Under 18 years old	+1.5%	-2.3%	+0.6%
Population 65 years and Older	+11.3%	+5.9%	+25.4%
Hispanic Population	-12.1%	+8.2%	+11.3%
Non-Hispanic White Population	-5.1%	-1.5%	+2.3%
Non-Hispanic African American Population	+2.0%	-1.5%	+2.3%
American Indian/Alaskan Native Population	+40.9%	+13.1%	+5.5%
Asian Population	+16.2%	+34.0%	+25.0%
Native Hawaiian/Pacific Islander Population	+18.9%	+29.0%	+16.0%
Multi-racial Population	+53.8%	+18.8%	+22.7%

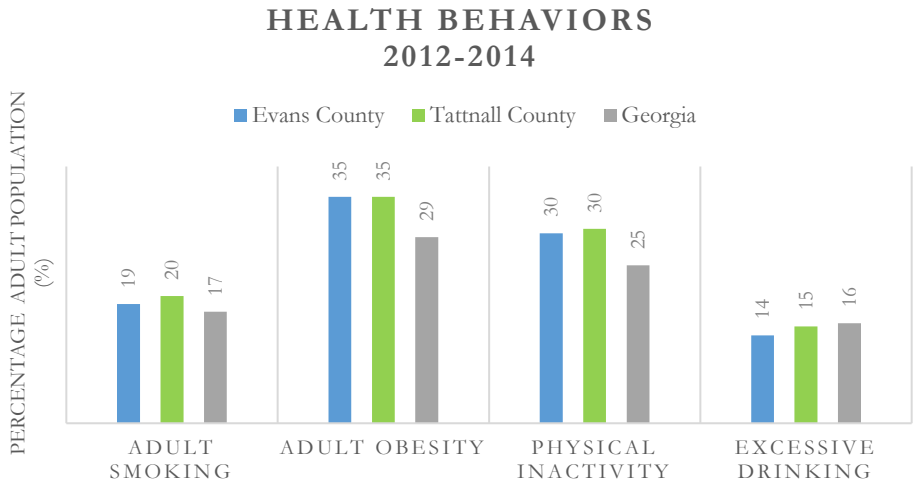
Data source: Proximity One analysis of Census Bureau data. Obtained from http://proximityone.com/countytrends2015.htm

3.2 Health Needs and Health Outcomes

3.2.1 Health Behaviors

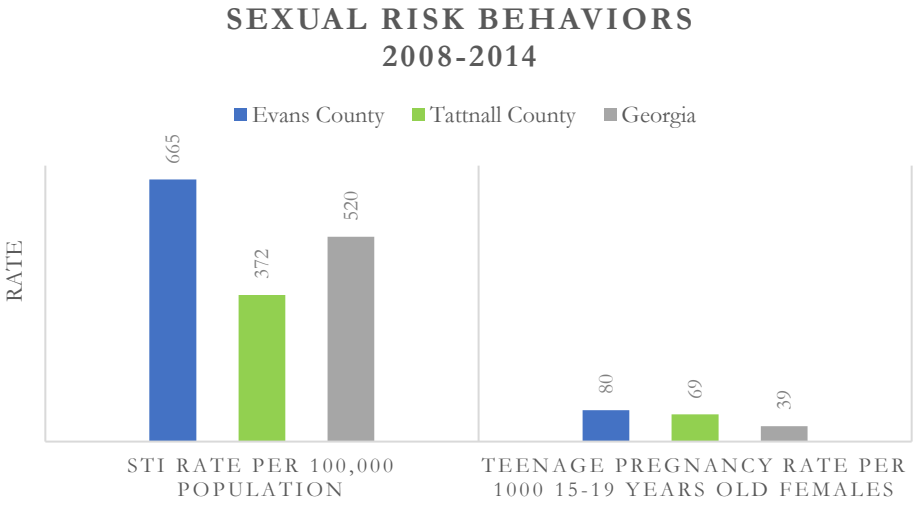
Compared to the state, a higher proportion of adults in Evans and Tattnall County are smokers, obese and physically inactive. However, the proportion of adults engaged in excessive drinking behavior was found to be lower in both counties, in comparison to the state (Figure 1). Teenage pregnancy rates were higher in both counties, compared to the state. Sexually transmitted infection (STI) rate was higher in Evans County, compared to the state (Figure 2).

Figure 1. Health Behaviors



Data Source: 2016 County Health Rankings by the University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation (Data Years: smoking and excessive drinking (2014); obesity and physical inactivity (2012)

Figure 2. Sexual Risk Behaviors



3.2.2 Morbidity

In general, Evans and Tattnall County experience a greater chronic disease burden, in comparison to the state. The prevalence rates of obesity, diabetes and cancer were higher than the respective average rates at the state level. The prevalence of HIV is higher in Evans County, compared to Tattnall County; the rates in both counties were at or lower than the state average. In both counties, a higher proportion of residents reported being in poor or fair health, compared to the state average. On average, residents reported being physically unhealthy on 4.4 (Evans) and 4.5 (Tattnall) days, respectively, in the last 30 days, compared to a state-level average of 3.9 days. Similarly, on average, residents reported being mentally unhealthy on 4.2 (Evans) and 4.1 (Tattnall) days, respectively, in the last 30 days, compared to a state-level average of 4.0 days.

Table 3. Morbidity Indicators

Indicator	Measurement	Evans	Tattnall	Georgia
Obesity Prevalence (2012)	Percentage of adults that report BMI >= 30	35.3	35.3	29.0
Diabetes Prevalence (2012)	Percentage of adults diagnosed with diabetes	13.5	12.5	11.4
Low Birthweight (2007-2013)	Percentage of births with low birth weight (<2500g)	10.0	9.4	9.5
Age-Adjusted Cancer Rates, All Sites (2009-2013)	Annual Incidence Rate per 100,000 persons	469.7	479.0	455.8
HIV Prevalence Rate (2012)	Per 100,000 persons	476.7	243.3	481.7
Poor or Fair Health (2014)	Percentage reporting to be in poor or fair health	21.0	23.0	18.5
Poor Physical Health Days (2014)	Average number of physically unhealthy days reported in the past 30 days	4.4	4.5	3.9
Poor Mental Health Days (2014)	Average number of mentally unhealthy days reported in the past 30 days	4.2	4.1	4.0

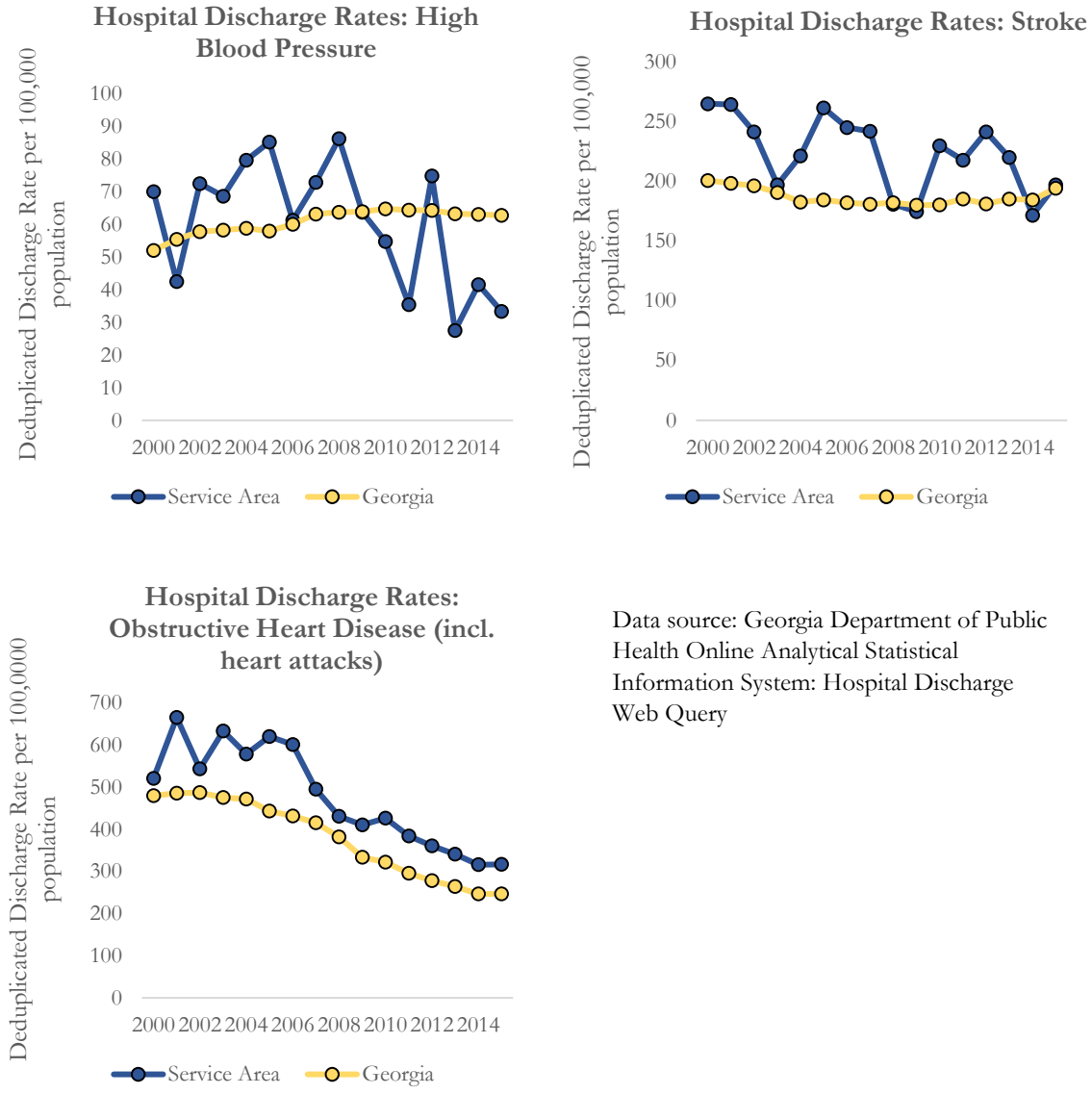
Data sources: (1) National Cancer Institute and the Center for Disease Control and Prevention State Cancer Profiles (cancer rates). (2) The 2016 County Health Rankings by the University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation (all other variables).

3.2.2.1 Trends in Morbidity

Cardiovascular Diseases

Between 2000 and 2014, hospitalization rates for cardiovascular diseases have decreased in the hospital's service area of Tattnall and Evans County (Figure 3).

Figure 3. Trends in Hospital Discharges for Cardiovascular Diseases

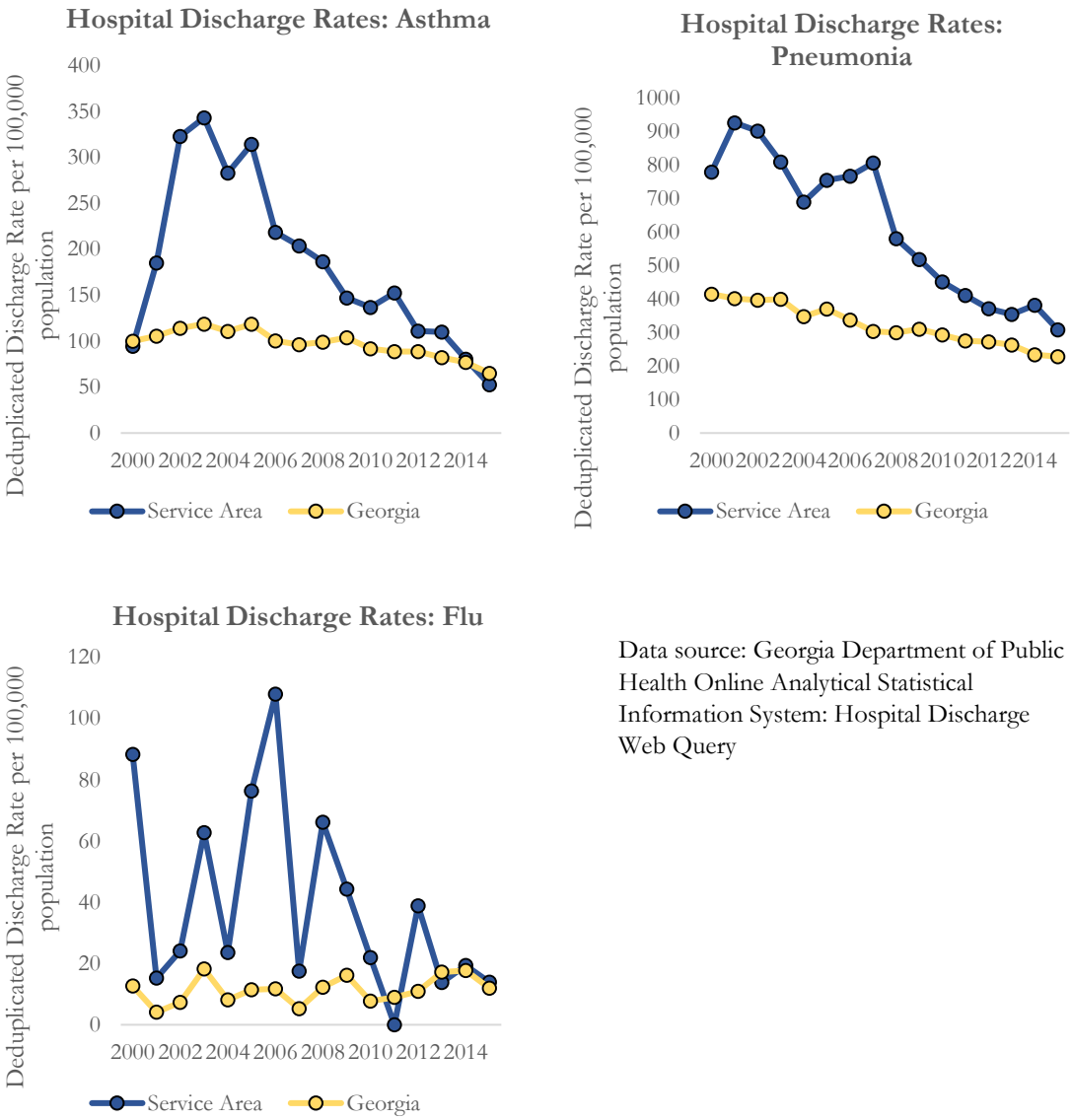


Data source: Georgia Department of Public Health Online Analytical Statistical Information System: Hospital Discharge Web Query

Respiratory Disorders

Similarly, hospitalization rates for respiratory disorders, including asthma, pneumonia, and flu have also been on the decline since 2000Figure 4).

Figure 4. Trends in Hospital Discharges for Respiratory Disorders

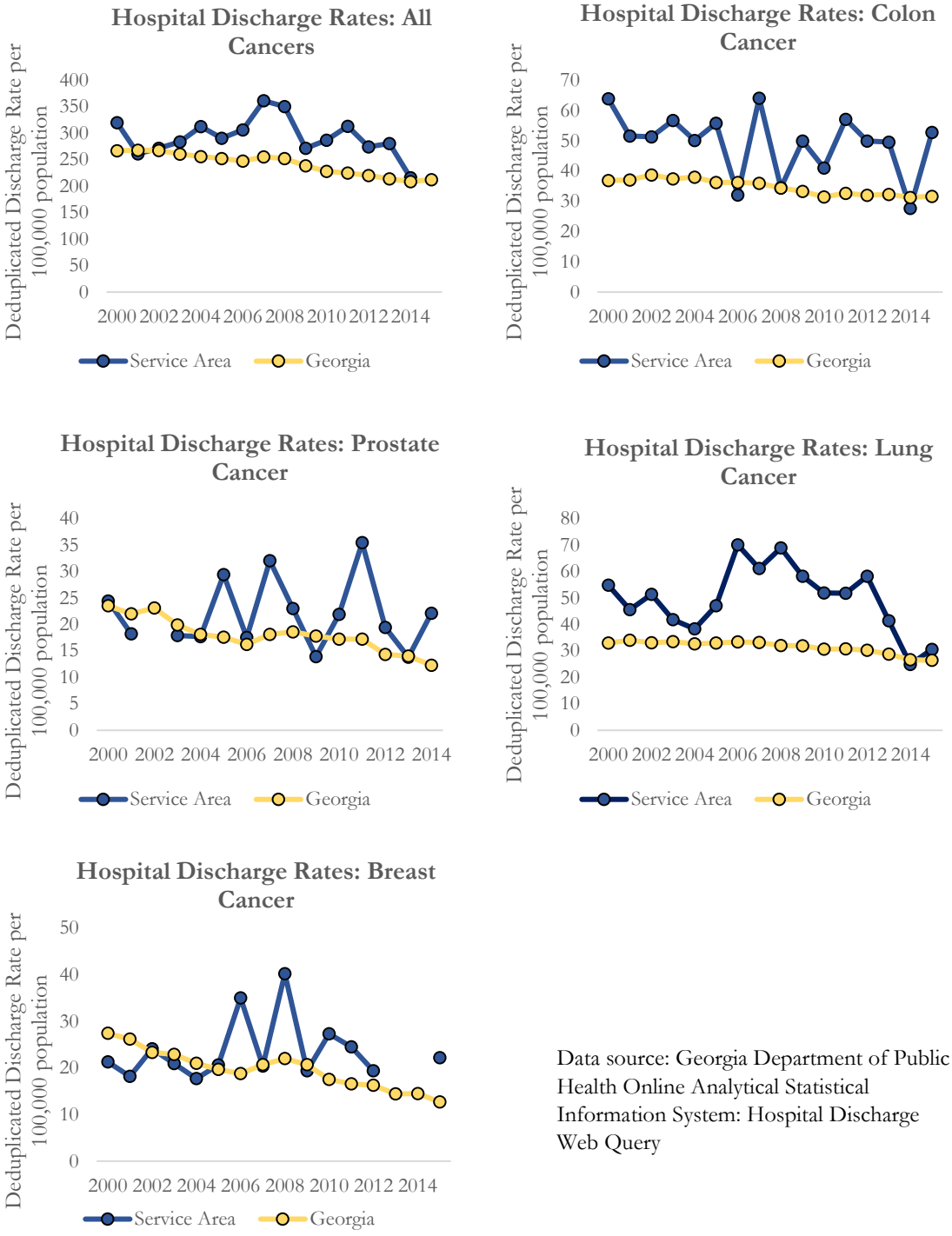


Data source: Georgia Department of Public Health Online Analytical Statistical Information System: Hospital Discharge Web Query

Cancers

While the service area hospitalization rates have declined slightly for all cancers since 2011, the most significant decline has been observed for lung cancer-related hospitalizations (Figure 5).

Figure 5. Trends in Hospital Discharges for Cancer

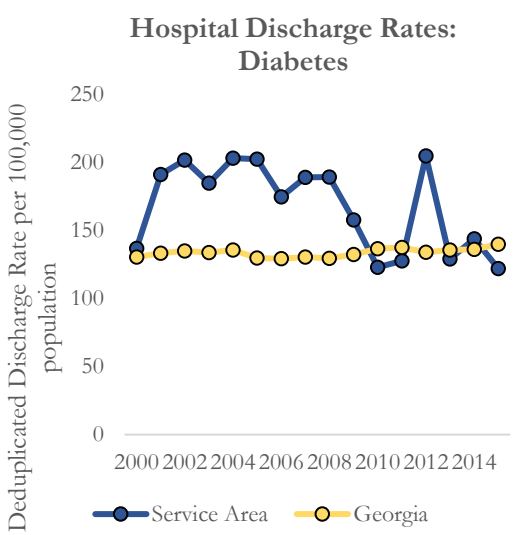


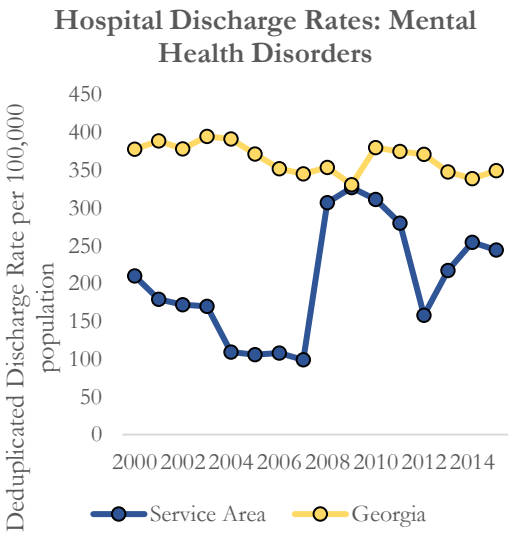
Data source: Georgia Department of Public Health Online Analytical Statistical Information System: Hospital Discharge Web Query

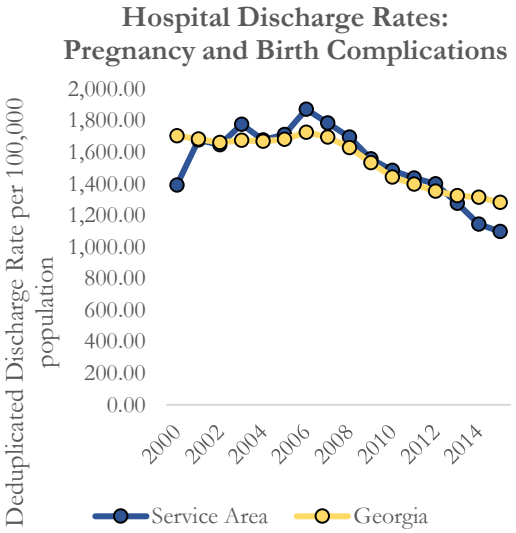
Other Selected Conditions

Hospitalization rates for diabetes in Evans and Tattnall County have declined since 2011 and are now comparable to state hospitalization rates for the condition. Compared to the state, hospitalization rates for mental health disorders have been lower in the service area. However, there has been an increase in hospitalizations for mental health disorders in the service area since 2011. Similar to statewide trends, hospitalization rates for pregnancy and birth complications have declined in the service area since 2006 (Figure 6).

Figure 6. Trends in Hospital Discharges for Other Selected Conditions





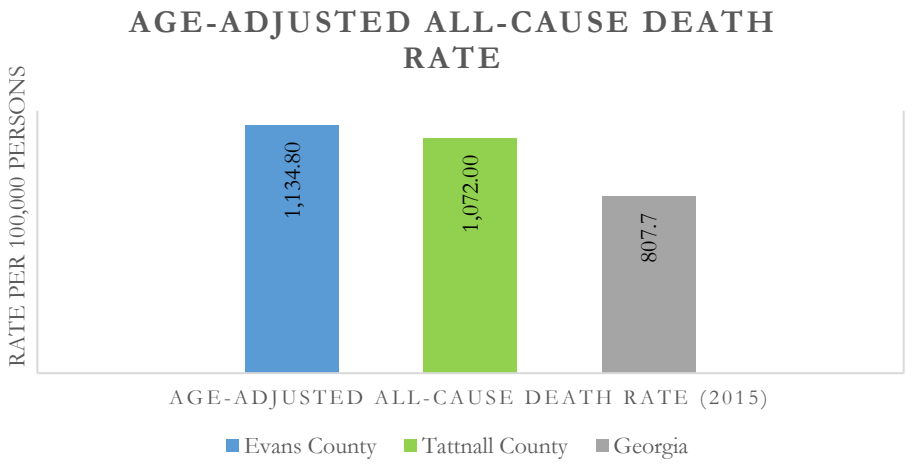


Data source: Georgia Department of Public Health Online Analytical Statistical Information System: Hospital Discharge Web Query

3.2.1 Mortality

Compared to the state, the age-adjusted all-cause death rate is higher in Evans and Tattnall County (Figure 7). The number one cause of death in Evans and Tattnall County is Ischemic Heart and Vascular Disease. The other top 5 causes of death include Alzheimer's disease (#2 in Evans & #4 in Tattnall), Chronic Obstructive Pulmonary Disease (COPD) (#3 in Evans & # 2 in Tattnall), Cerebrovascular Disease (#4 in Evans & #5 in Tattnall) and cancer of the trachea, bronchus and lung (#5 in Evans & # 3 in Tattnall). The top 10 causes of death for Evans County, Tattnall County and the state of Georgia are listed in Table 4.

Figure 7. Age-Adjusted All-Cause Death Rate



Data source: Georgia Department of Public Health Online Analytical Statistical Information System

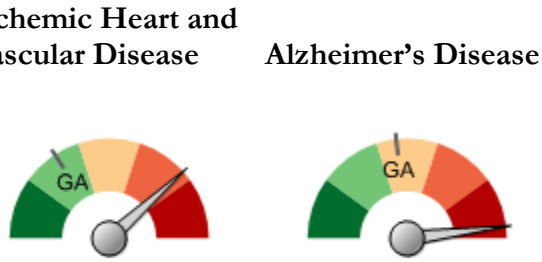
Table 4. Top 10 Causes of Death (2011-2015)

Causes of death	Evans Rank	Tattnall Rank	Georgia Rank
Ischemic Heart and Vascular Disease	1	1	1
Alzheimer's Disease	2	4	7
All COPD Except Asthma	3	2	3
Cerebrovascular Disease	4	5	5
Malignant Neoplasms of the Trachea, Bronchus, and Lung	5	3	2
Diabetes Mellitus	6	10	8
All Other Mental and Behavioral Disorders	7	7	4
Essential (Primary) Hypertension and Hypertensive Renal, and Heart Disease	8	6	6
Septicemia	9		11
Motor Vehicle Crashes	10	8	14
Nephritis, Nephrotic Syndrome, and Nephrosis		9	

Data source: Georgia Department of Public Health Online Analytical Statistical Information System: Community Health Needs Assessment Dashboard

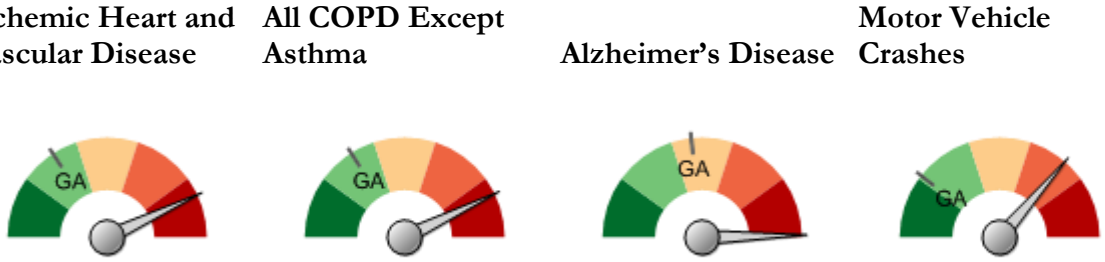
The death rates for Ischemic Heart and Vascular disease and for Alzheimer's disease is significantly higher than the state rate in both Evans and Tattnall County. There is a higher proportion of deaths attributable to COPD and motor vehicle crashes in Tattnall, in comparison to the state (Figures 8 & 9).

Figure 8. Significantly High Causes of Death: Evans County



Data source: Georgia Department of Public Health Online Analytical Statistical Information System: Community Health Needs Assessment Dashboard

Figure 9. Significantly High Causes of Death: Tattnall County



Data source: Georgia Department of Public Health Online Analytical Statistical Information System: Community Health Needs Assessment Dashboard

3.3 Health Care Access and Utilization

3.3.1 Access to Providers and Services

The medically uninsured rates in Evans and Tattnall County were higher than the average rates for the state in 2015 (25% and 24%, respectively versus 19%) (Table 5). Similar to statewide trends, the uninsured and underinsured rates in the two counties have declined, both for children and adults. In 2015, however, the adult uninsured rate increased from its 2014 levels in both counties and in the state. The medically uninsured rate in the hospital's service delivery area has consistently remained higher than the state average (Figure 10).

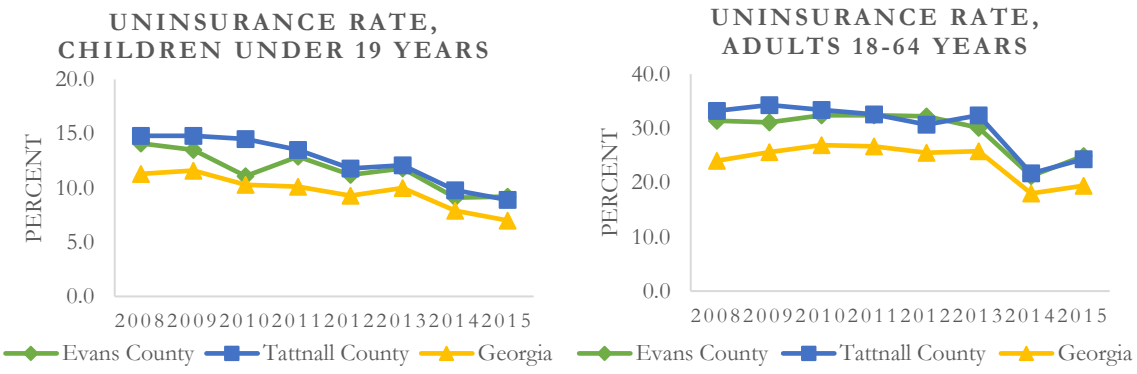
The supply of health care providers in the service delivery area, including primary care providers, mental health providers, and dentists, remain lower than the state average (Table 5).

Table 5. Health Care Access Indicators (2013-2015)

Indicator	Measurement	Evans	Tattnall	Georgia
Adult Uninsurance (2015)	Percentage of people 18-64 without insurance	24.9	24.3	19.4
Children Uninsurance Rate (2015)	Percentage of people under age 19 without insurance	9.2	8.9	7.0
Provider Supply				
Primary Care Physician Rate (2013)	Ratio of population to primary care physicians	2708:1	5105:1	1536:1
Other Primary Care Provider Rate (2013)	Ratio of population to primary care providers, other than physicians	1557:1	2803:1	1349:1
Mental Health Provider Rate (2015)	Ratio of population to mental health providers	Data unavailable	8408:1	847:1
Dentist Rate (2014)	Ratio of population to dentists	3633:1	8408:1	2059:1

Data source: (1) Small Area Health Insurance Estimates from the Census Bureau, 2015 (insurance variables) (2) The 2016 County Health Rankings by the University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation (all other variables).

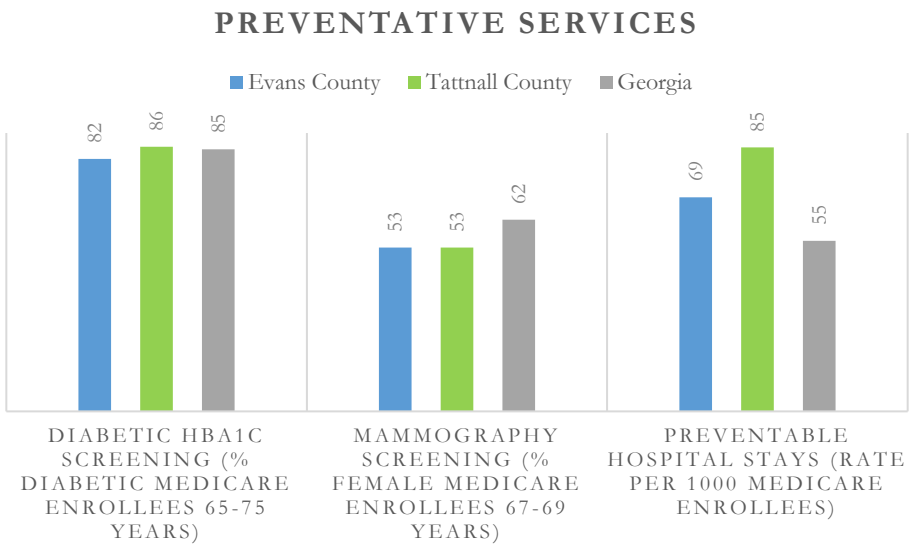
Figure 10. Trends in Uninsurance



3.3.2 Use of Preventative Services

While diabetes HbA1c screening rates in the service area are somewhat comparable to the state screening rate, screening rates for mammography in the service area are lower compared to the state. Preventable hospitalization rates (i.e. conditions that respond to timely and effective care in the outpatient (ambulatory care) setting are higher in the service delivery area, compared to the state (Figure 11).

Figure 11. Utilization of Preventative Services



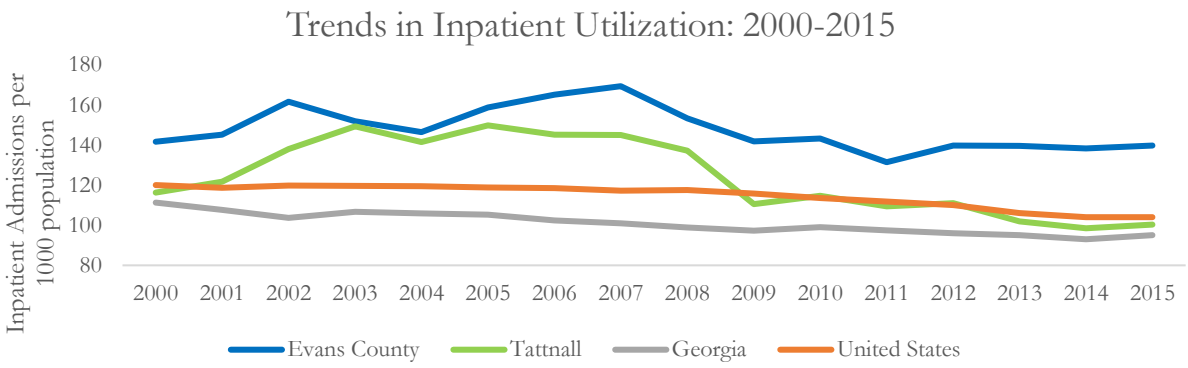
Data Source: 2016 County Health Rankings by the University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation. Data Year: 2013

3.3.3 Hospital Utilization

3.3.3.1 County-Level Utilization

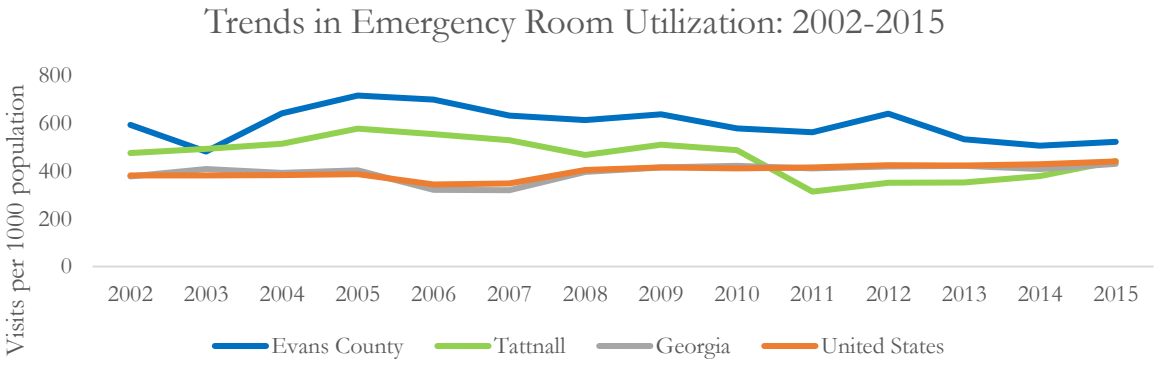
Similar to a national and statewide trend, inpatient utilization in Tattnall County has been declining in the past few years. Inpatient utilization in Evans County declined between 2007 and 2011, increasing slightly thereafter (Figure 12). Emergency department utilization declined between 2005 and 2011 in both counties, with the rate of decline being greatest for Tattnall County. However, there has been a slight increase in ED utilization since 2011 and 2013 for Tattnall and Evans County, respectively. (Figure 13). Despite the decline, the utilization of inpatient and emergency department services in Evans County is still higher than national or state averages. As of 2015, inpatient and ED utilization rates for Tattnall County were similar to state and national averages (Figures 12 & 13).

Figure 12. Trends in Inpatient Utilization



Data Source: County data from Georgia Department of Community Health Annual Hospital Survey, 2000-2015. National and State data from the Kaiser Family Foundation, available at http://kff.org/other/state-indicator/admissions-by-ownership/

Figure 13. Trends in Emergency Department Utilization

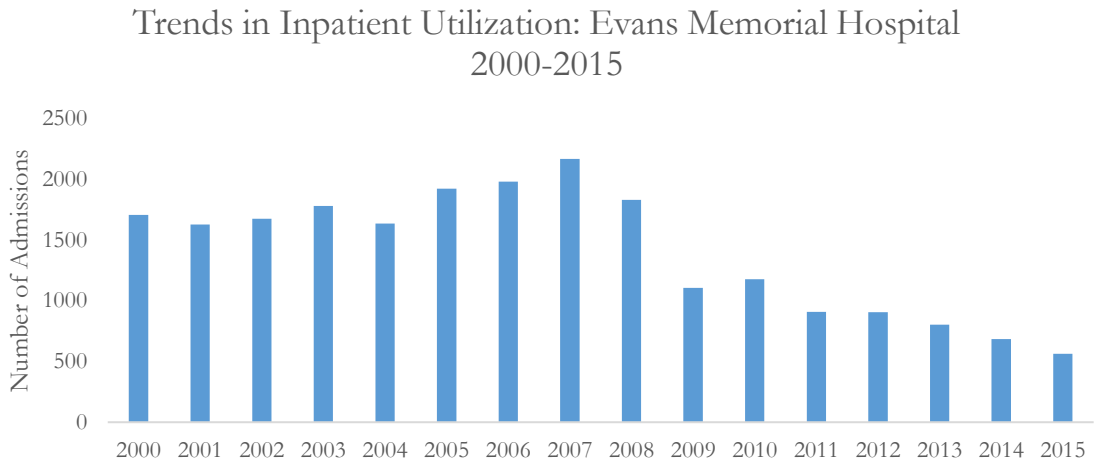


Data Source: County data from Georgia Department of Community Health Online Analytical Statistical Information System. National and State data from the Kaiser Family Foundation, available at http://kff.org/other/state-indicator/emergency-room-visits-by-ownership/

3.3.3.2 Facility Utilization

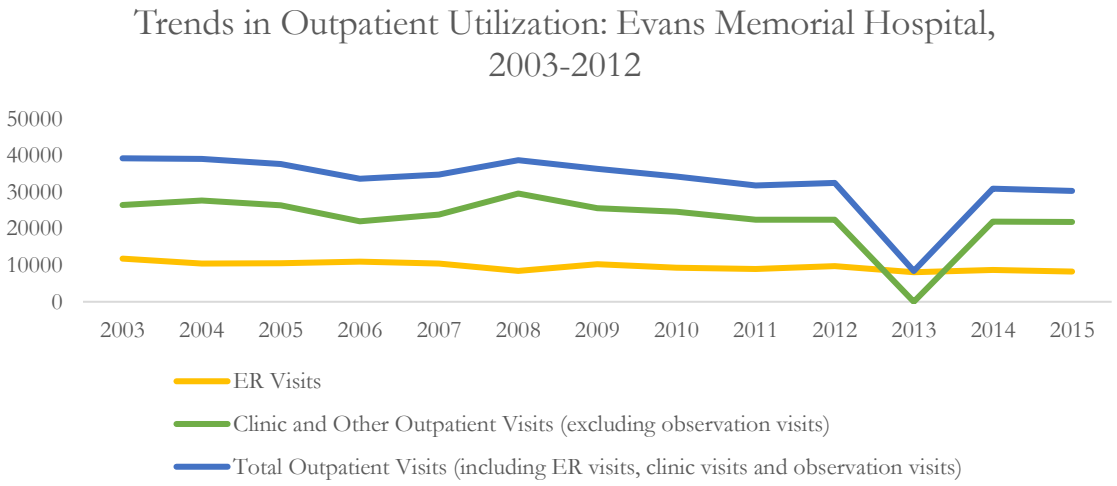
There has been a significant decline in the utilization of inpatient services at Evans Memorial Hospital in the past 7 years. Between 2007 and 2014, the number of inpatient admissions at Evans Memorial Hospital declined by 67.5%, with the most significant decline occurring between 2008 and 2009 (39.6% decline in a year) (Figure 14). Outpatient utilization declined after 2008 and increased slightly between 2011 and 2012 (Figure 15). Over time, the proportion of admissions originating from the Emergency Department (ED) has increased (Figure 16).

Figure 14. Trends in Inpatient Utilization at Evans Memorial Hospital



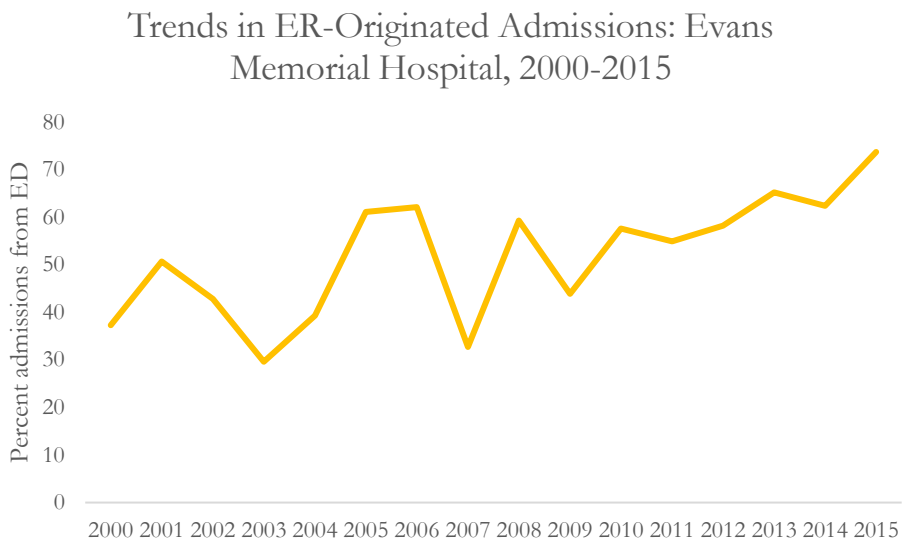
Data Source: Georgia Department of Community Health Annual Hospital Survey, 2000-2015.

Figure 15. Trends in Outpatient Utilization at Evans Memorial Hospital



Data Source: Georgia Department of Community Health Annual Hospital Survey, 2003-2015. Note: Zero clinic and other outpatient visits recorded for 2013. This may have been due to data entry error.

Figure 16. Trends in Emergency Room-Originated Admissions at Evans Memorial Hospital



Data Source: Georgia Department of Community Health Annual Hospital Survey, 2003-2015

4 COMMUNITY SURVEY

One hundred and twenty-four community surveys were completed and returned for a response rate of 8.1%

4.1 RESPONDENT DEMOGRAPHIC CHARACTERISTICS

Almost two-thirds of the survey respondents resided in Evans County (60.5%); the remainder resided in Tattnall County (39.5%). The respondent characteristics were similar to what has been observed in most surveys. The majority of survey respondents were female (71.8%), White (87.1%), aged 55 years and older (60.5%), married or partnered (62.9%) and retired (47.9%), with at least some college or associate degree (66.9%). The majority reported an annual household income above $40,000 (47.6%) (Table 6).

Table 6. Demographic Characteristics of Survey Respondents

	Frequency (N)	Percentage (%)
County of Residence		
Evans	75	60.5
Tattnall	49	39.5
Gender		
Male	32	71.8
Female	89	25.8
Missing	3	2.4
Age		
Under 35 years	9	7.3
35-44 years	17	13.7
45-54 years	21	16.9
55-64 years	20	16.1
65-74 years	27	21.8
75 years and older	28	22.6
Missing	2	1.6
Race		
Non-Hispanic Black	12	9.7
Non-Hispanic White	108	87.1
Hispanic	2	1.6
Non-Hispanic Other	2	1.6
Education		
Less than High School	7	5.6
High School graduate or GED	30	24.2
Some College or Associate Degree	52	41.9
Bachelor Degree	14	11.3
Graduate or Advanced Degree	17	13.7
Missing	4	3.2
Marital Status		
Married/Partnered	78	62.9

Divorced/Separated	16	12.9
	Frequency (N)	**Percentage (%)**
Widowed	24	19.4
Single/Never Married	5	4.0
Missing	1	0.8
Household Income		
Below $16,000	15	12.1
$16,001 - $24,000	9	7.3
$24,001 - $32,000	6	4.8
$32,001 - $40,000	15	12.1
Above $40,000	59	47.6
Refused/Don't Know/Missing	20	16.1
Employment Status		
Full-time	46	37.1
Part-time	7	5.6
Retired	56	45.2
Unemployed	8	6.5
Missing	7	5.6

4.2 HEALTH STATUS

Over half of the survey respondents (61.1%) described their health as good or excellent, although a third (33.7%) reported having three or more chronic conditions. The most common chronic conditions reported were high blood pressure (51.6%), high cholesterol (36.1%) and being overweight/obese (26.2%) (Figures 17-19).

Figure 17. Self-Reported Health Status

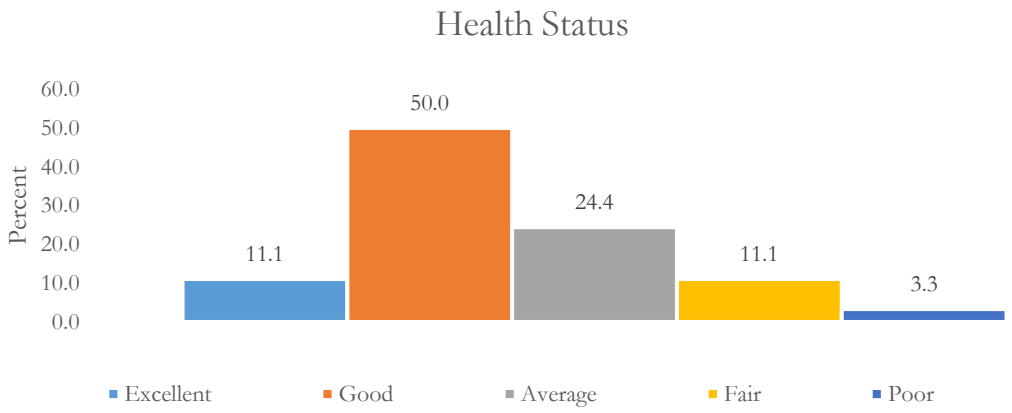


Figure 18. Burden of Multiple Chronic Conditions

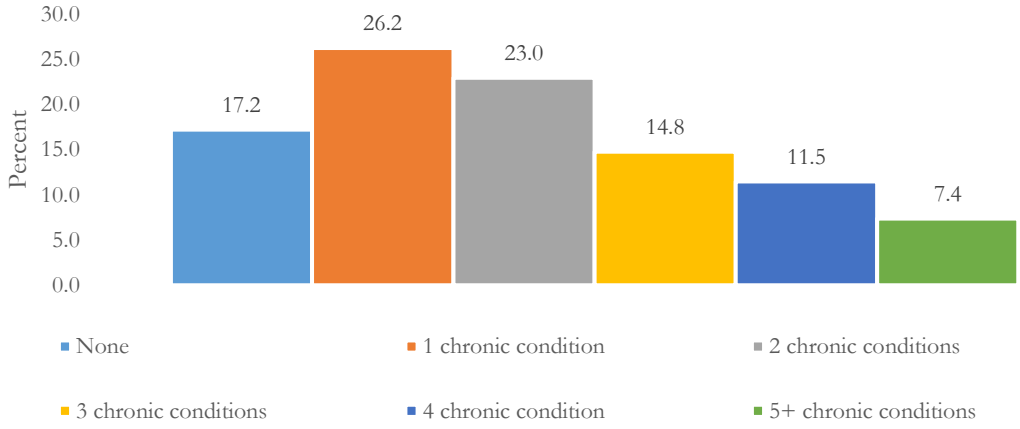
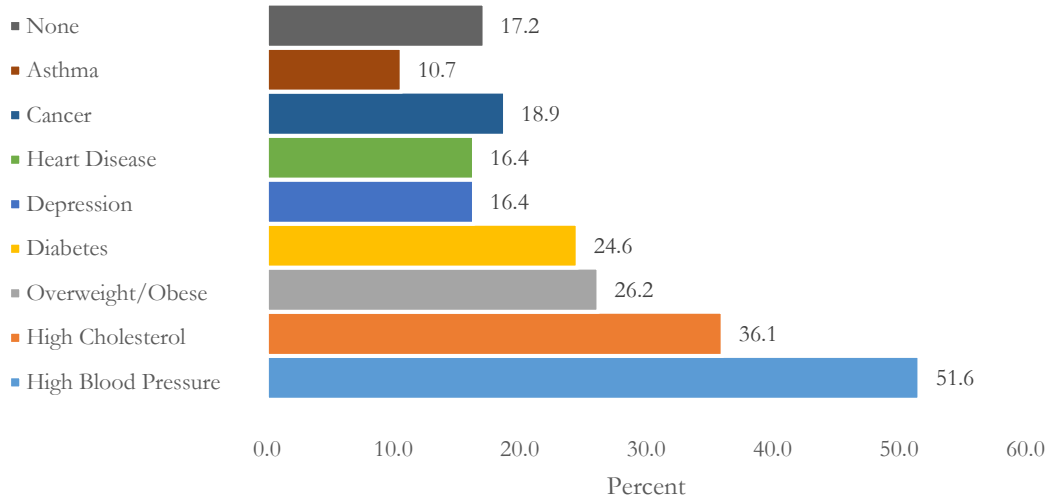


Figure 19. Most Common Chronic Conditions

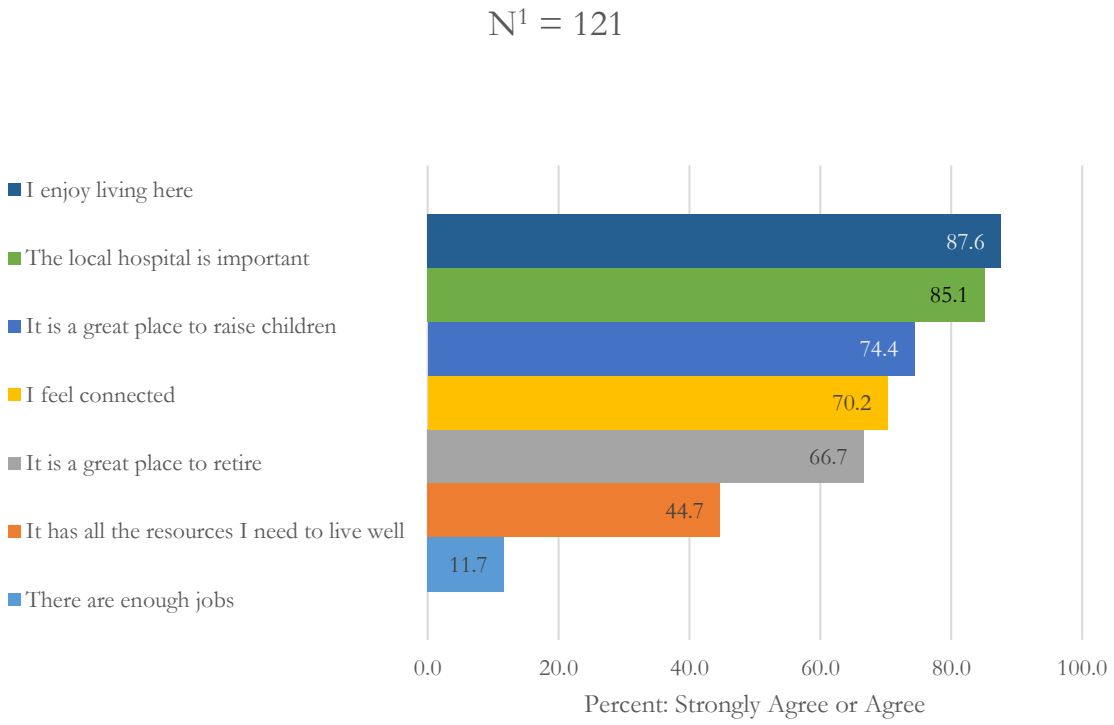


4.3 COMMUNITY PERCEPTION

4.3.1 General Community Perception

In general, respondents had a favorable view of the community, with the exception of the availability of jobs and resources. Almost nine out of ten (87.6%) respondents strongly agreed or agreed that they enjoyed living in the community, while only approximately 1 in 10 (11.7%) felt there were enough jobs. Almost nine out of ten respondents (85.1%) strongly agreed or agreed that the local hospital was important (Figure 20).

Figure 20. Community Perceptions



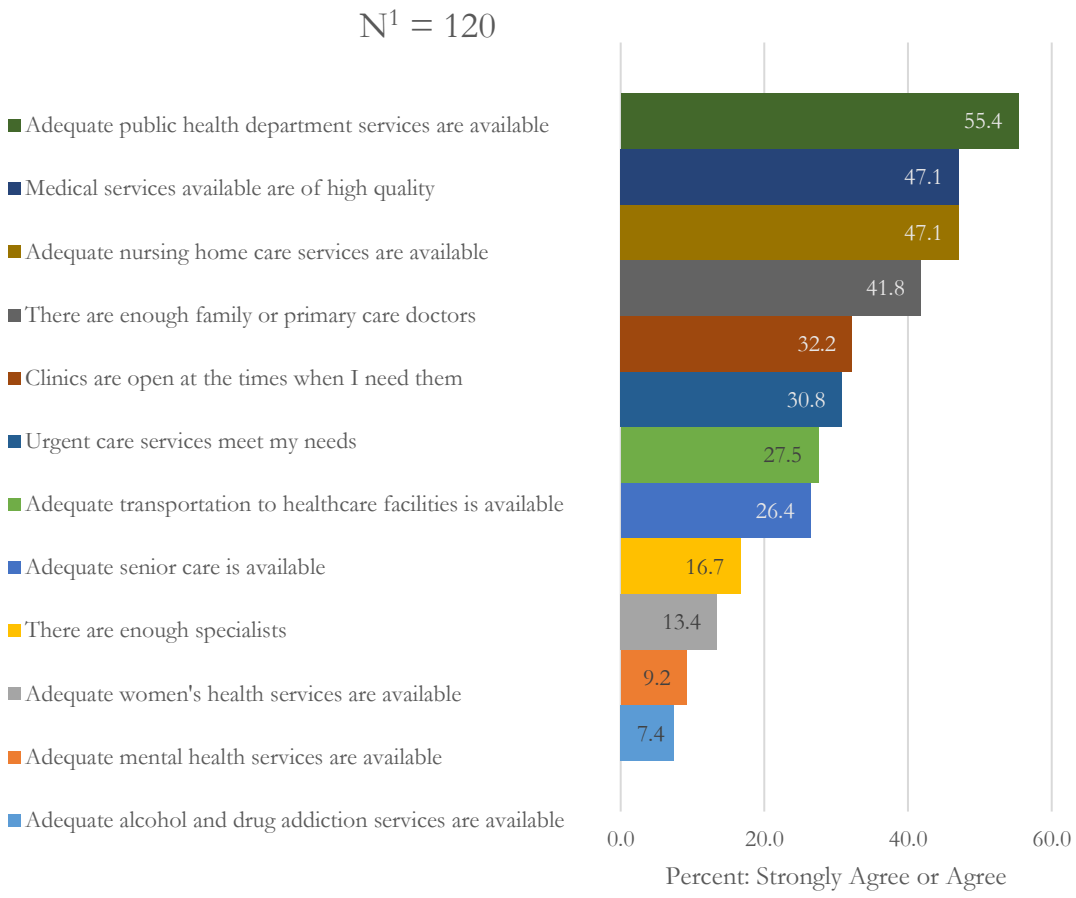
[1]Average sample size is reported. For each statement, we report valid percentage based on respective sample size. Sample size ranged from a minimum of 120 to maximum of 123.

4.3.2 Community Perception Concerning Health Care Services

The respondents' perception about the adequacy of medical services within the community was low. Less than half reported availability and adequacy of nursing home services and family care providers. Less than a third reported adequacy of urgent care services, accessible clinics, senior care and medical transportation. Less than a quarter reported the availability of specialists as well as adequate women's health services, mental health services, and alcohol and drug addiction recovery services were available within the hospital service delivery area (Figure 21).

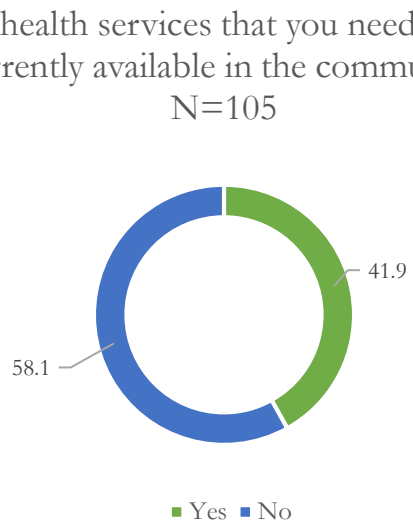
More than half (58.1%) believed there were unmet needs for health services in their community (Figure 22).

Figure 21. Community Perceptions Concerning Health Care Services



[1]Average sample size is reported. For each statement, we report valid percentage based on respective sample size. Sample size ranged from a minimum of 119 to maximum of 122.

Figure 22. Unmet Need for Health Services



In an open-ended question, respondents were asked to identify community health issues. The ten most commonly cited issues included:

1. Limited physician supply, including primary care and specialists
2. Chronic Diseases, including high blood pressure, diabetes, cancer and HIV/AIDS
3. Lack of access to affordable and accessible medical services, including urgent care
4. Lack of health care options for the uninsured
5. Lack of access to dental services
6. Lack of access to pediatric services
7. Mental health and behavioral health issues
8. Limited availability of transportation to medical services
9. Teenage pregnancy
10. Limited access to pharmacies and help with medication costs

4.4 Specialist Needs Within The Community

Most respondents reported seeing a primary care specialist in the past year – family medicine physician (88.7%), obstetrics/gynecology physician (OB/GYN) (41.1%) and internal medicine physician (31.5%). The three most common specialists seen were a cardiologist (33.1%), gastroenterologist (29.8%) and radiologist (29.8%) (Figure 23).

Almost a third of respondents (33.1%) had seen an OB/GYN outside of the community (i.e. out-migrated for care). Specialist mostly commonly seen outside of the community were family physicians (26.6%), cardiologists (24.2%), gastroenterologists (23.4%) and Ear, Nose, and Throat (ENT) specialists (21.0%) (Figure 24).

Figure 23. Proportion of Respondents Who Had Seen a Specialist in the Last Year

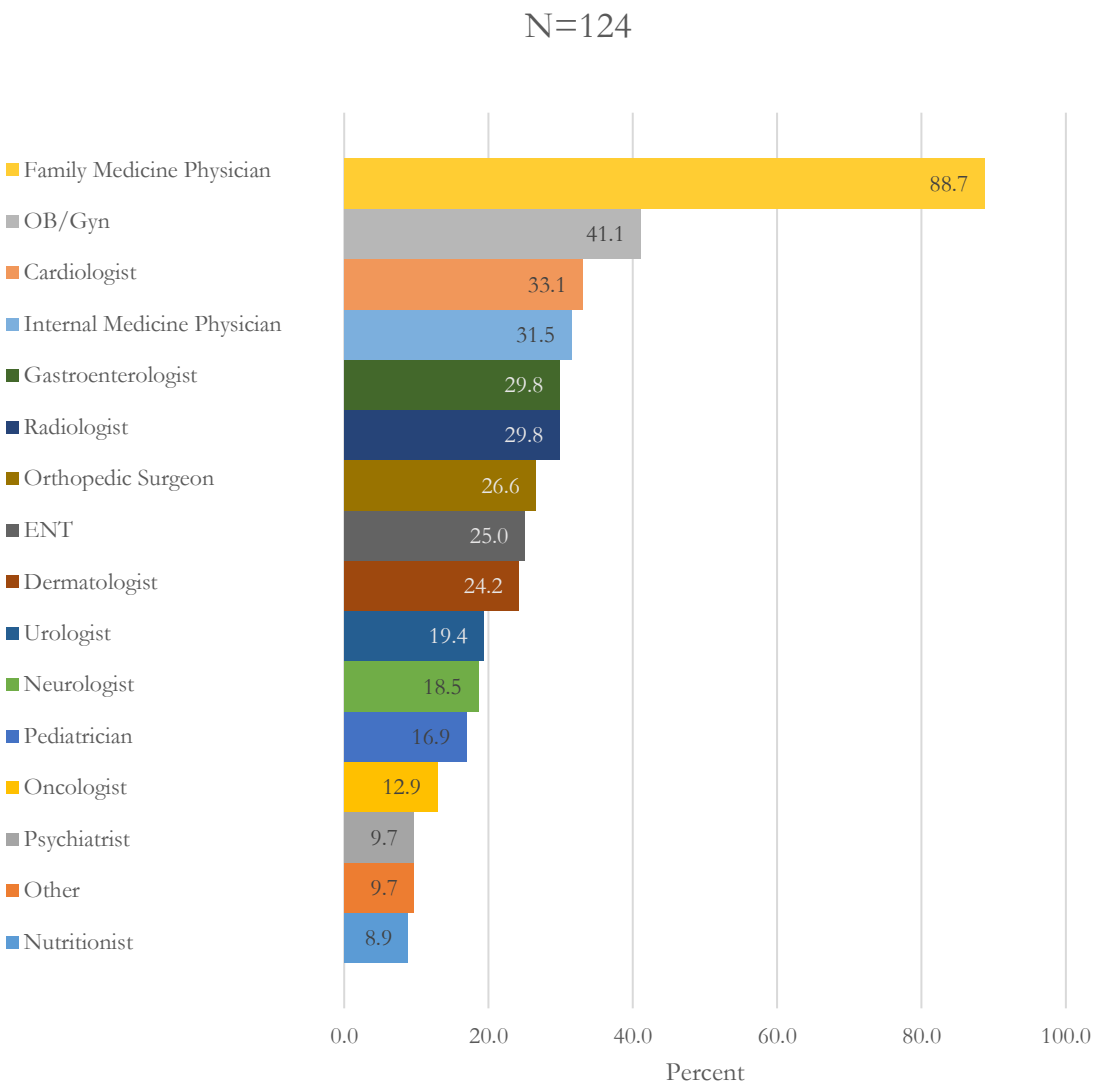
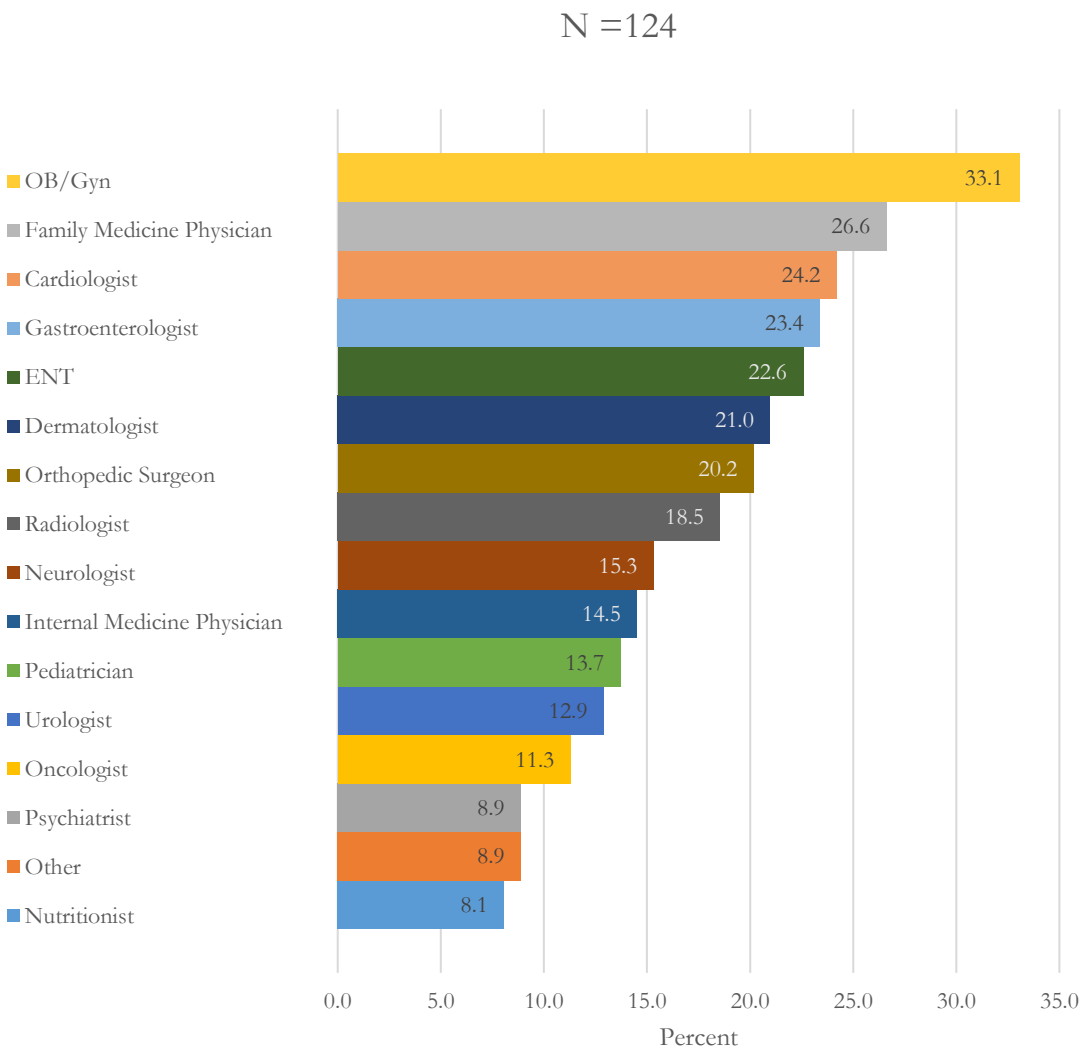


Figure 24. Proportion of <u>All</u> Respondents Who Had Seen a Specialist Outside of the Community in the Last Year



4.5 HOSPITAL UTILIZATION

When asked if they had used services from **any** hospital, almost three-quarters of respondents (74.2%) reported they had utilized hospital laboratory, imaging, and testing services in the past year. In comparison, 30.9% and 25.0% had used hospital emergency room (ER) and inpatient services, respectively, in the last year (Figure 25). Of those who had utilized the ER in the last year, less than one in ten (6.7% of all respondents) had utilized the ER more than three times during the year (Figure 26).

Figure 25. Proportion Using Hospital Services Use in the Past Year

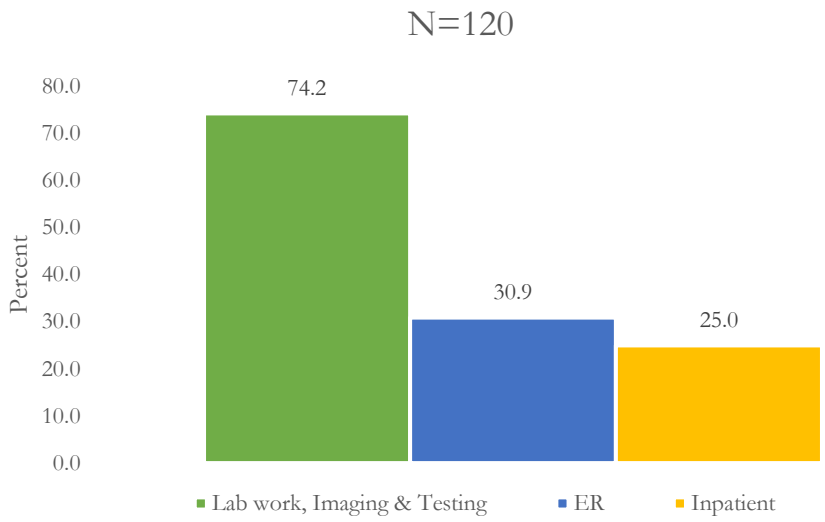
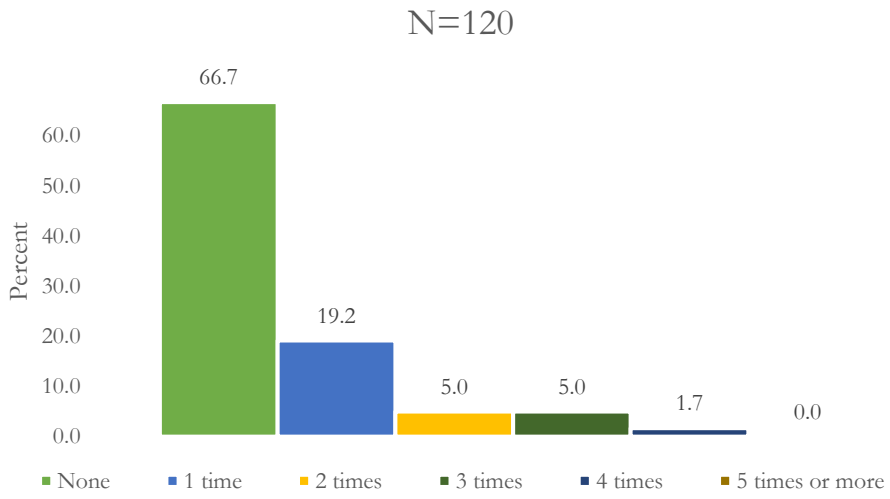


Figure 26. Emergency Room Utilization in Past Year

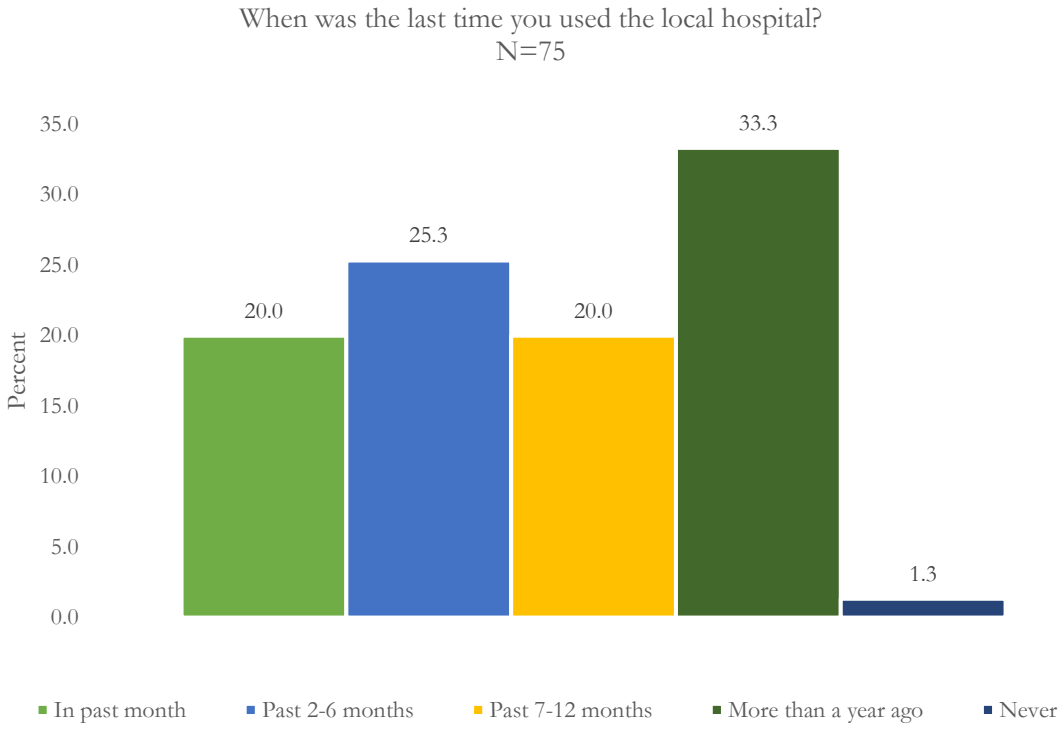


4.6 EXPERIENCE WITH LOCAL HOSPITAL[1]

Almost two-thirds of the respondents (65.3%) had utilized Evans Memorial Hospital (the local hospital) within the past year (Figure 27). Among local hospital services most commonly utilized by respondents were ER services (62.8%), laboratory, medical imaging and testing services (59.0%), primary care services (44.9%) and physical rehabilitation services (35.9%) (Figure 28).

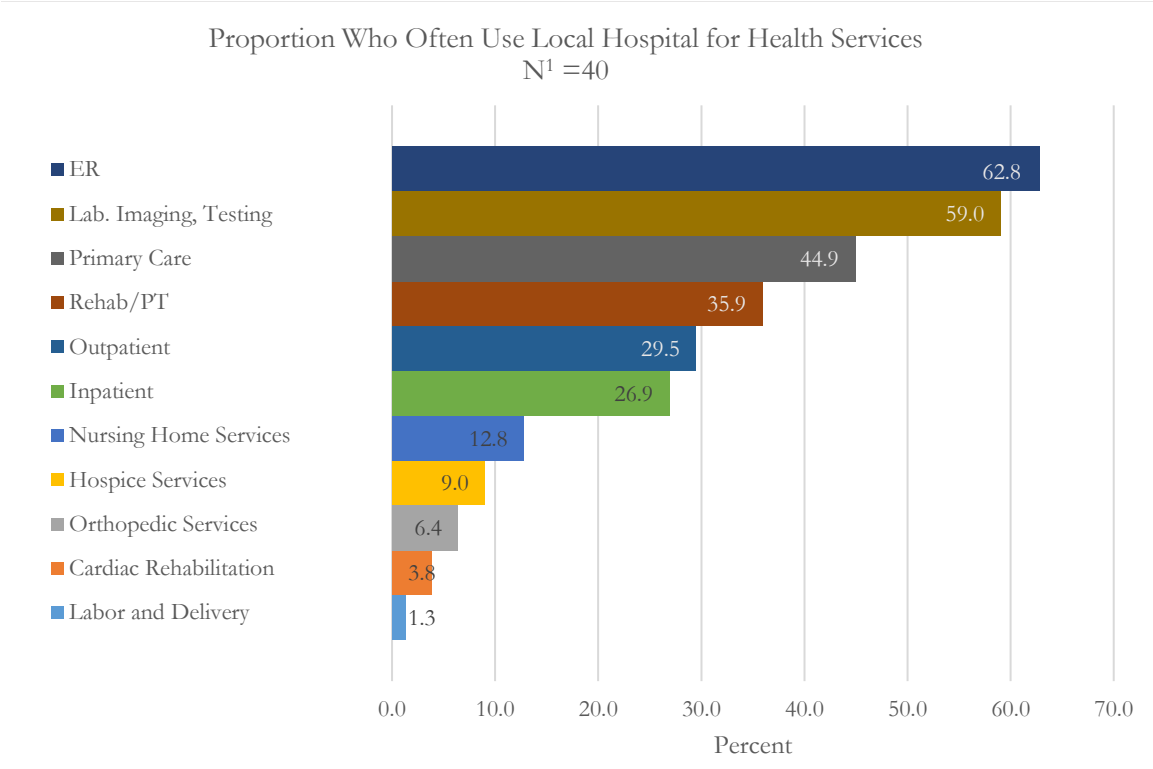
Respondents were mostly very satisfied or satisfied with staff friendliness (85.7%) at Evans Memorial Hospital. About three-quarters were very satisfied or satisfied with the staff knowledge (77.3%) and quality (74.7%). They were least satisfied with the hospital's community outreach efforts (46.8%) (Figure 29). Overall, three out of four respondents (78.0%) reported being very satisfied or satisfied with the care they had received from the hospital in the past year (Figure 30).

Figure 27. Use of Evans Memorial Hospital



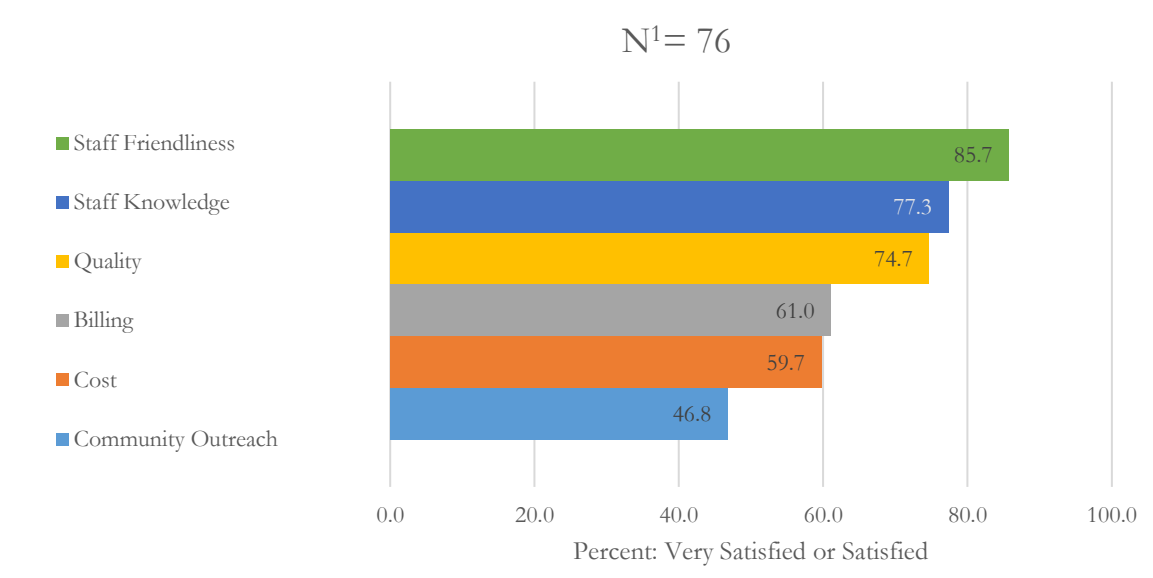
[1] Analysis restricted only to respondents who identified Evans Memorial Hospital as their Local Hospital (N=78). Those identifying another hospital as their local hospital were excluded for this analysis.

Figure 28. Services Commonly Used at Evans Memorial Hospital



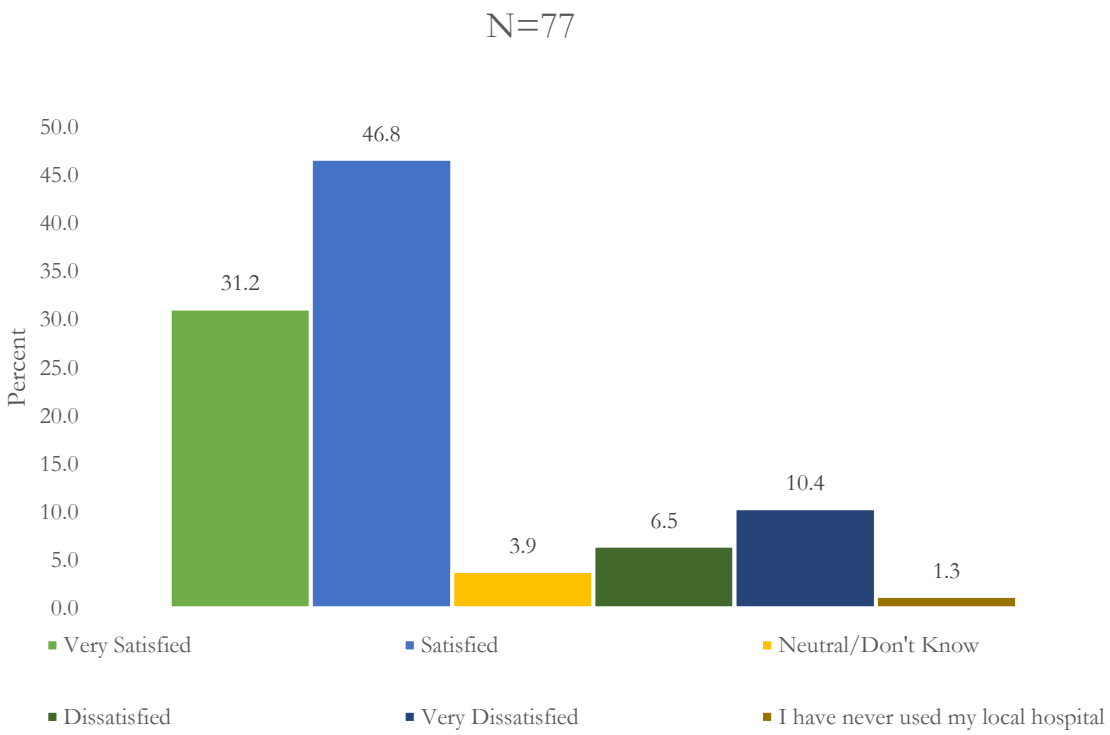
[1]Average sample size is reported. For each service, we report percentage based on the number of valid responses (users of those services). Sample size ranged from a minimum of 15 (hospice) to maximum of 65 (ER & laboratory, imaging, and medical testing services).

Figure 29. Satisfaction with Aspects of Local Hospital Services



[1]Average sample size is reported. For each aspect, we report percentage based on the number of valid responses. Sample size ranged from a minimum of 75 to maximum of 77.

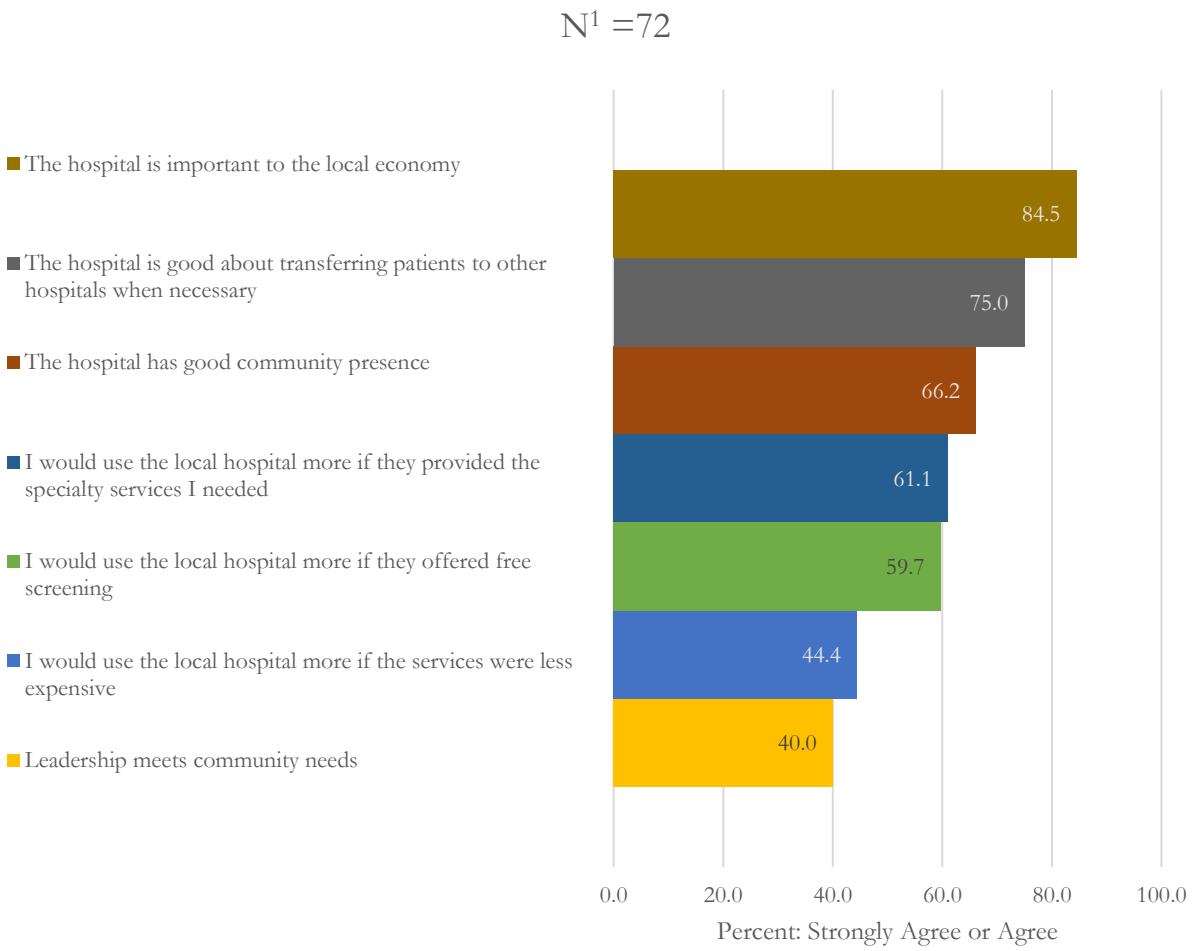
Figure 30. Overall Satisfaction with Local Hospital



4.7 PERCEPTIONS ABOUT LOCAL HOSPITAL[2]

The majority of the respondents either strongly agreed or agreed that their local hospital was important to the local economy (84.5%) and was good at transferring patients when necessary (75.0%). About two-thirds either strongly agreed or agreed that the local hospital had good community presence (66.2%) and 61.1% either strongly agreed or agreed that they would use the local hospital more if additional specialty services were provided. Only four out of ten felt that the hospital leadership effectively met community needs (Figure 31).

Figure 31. Perceptions about Local Hospital



[1]Average sample size is reported. For each statement, we report percentage based on the number of valid response. Sample size ranged from a minimum of 70 to maximum of 76.

[2] Analysis restricted only to respondents who identified Evans Memorial Hospital as their Local Hospital (N=78). Those identifying another hospital as their local hospital were excluded for this analysis.

5 COMMUNITY FOCUS GROUPS

5.1 PARTICIPANTS' CHARACTERISTICS

Six focus groups were held, with an average of 11 participants in each focus group. Categories of groups were as follows: 1) Steering committee (individuals who were employed by the hospital or who were highly knowledgeable of the hospital's financial situation); 2) Community Advisory members (Individuals from the community who currently partnered with the hospital); 3) Business Leaders within the community; and 4) Lay Community Members. The six groups were recruited by hospital leadership. Two of the six focus groups took place at Evans Memorial Hospital on November 18, 2015, and two were held at Evans County's Rotary Club Meeting November 18, 2015. The last two focus groups were held at Evans Memorial Hospital on December 16, 2015. The first and second focus groups began at 12:00 PM and consisted of the Business Community Representatives. The third began at 4:00 PM and consisted of the Lay Community Members. The fourth began at 5:30 PM and consisted of the Lay Community Members. The fifth and sixth began at 1:30 PM and consisted of the Steering Committee and Community Advisory Board respectively. On average, focus groups lasted about an hour and a half.

The six focus groups consisted of 63 participants: 37 men (58.7%) and 23 women (36.5); 3 participants did not respond (4.8%). Participants' age ranged from 27 years old to 95 years old, with a median age of 58. The racial breakdown was as follows: White (74.6%), African American/Black (17.5%), and American Indian (1.6%); six participants did not provide race information (6.4%). All of the participants spoke English. However, three also spoke Spanish, two also spoke German, and one also spoke French.

The majority of participants were residents of Evans County. They resided in the towns of Claxton (46.0%), Hagan (12.7%), Belleville (7.9%), Glennville (7.9%), Statesboro (6.4%), Collins (4.8%), Daisy (3.2%) and other surrounding towns (9.5%); one person did not provide information on where he/she lived (1.6%).

All participants had at least a high school diploma; 55.6% had a Bachelor or advanced degree. The majority of participants (68.2%) reported an annual household income of at least $50,000.

The following sections divide the focus group discussions by common thread or topic.

Community

Theme: friendly town, low traffic, lack of jobs especially for young people, limited amenities

Focus group participants described several consistent themes regarding the city of Claxton and Evans County. On the positive side, they admired their community for its friendly residents, lack of congested traffic, and low cost of living. On the negative side, however, multiple participants mentioned a lack of jobs and limited shopping and other amenities. Several participants discussed younger residents leaving the area for Savannah, Atlanta, and Statesboro in search of jobs.

We're limited as far as where we have to shop, and for example, just 20 miles down the road in Statesboro there are a lot more options for shopping; grocery, clothes, everything. So that's one aspect of a small town.

You do know everybody. 90 percent of the patients I see, probably all of us, we know everybody that walks in. I mean I think every patient I've seen today I know them. I mean you know them, you know like everything about them, and that can be good for – it's good for us because in healthcare we – the more you know about somebody, the better you can treat them. Sometimes it's not so great for the patients if we know every little intimate detail of their life, but I do like knowing people. I've worked in places that weren't close to my home, and it's just – it's very different when you don't know any of the people. It's more difficult to work, as in healthcare, all the people that you don't know – there's a big advantage to knowing people in small towns.

Well I live in Statesboro, but I work here, and I'd rather work here in Evans County than Statesboro anytime 'cause Statesboro is just too – it's too big, you know? Here it's more personable. Everybody knows everybody, everybody treats you like your friend, your neighbor, and everybody that we work with are – we're like a family. So I feel like in a bigger city you wouldn't get that.

We need some industry real bad.

They've got no choice. (Responding to a comment about why young people leave the community to find jobs elsewhere.)

Community Health

Theme: obesity, diabetes, HIV, teen pregnancy, high blood pressure, poverty, lack of healthy dining options, clean air, poultry plant odor

Participants described their community as having clean air and being less environmentally polluted than more urbanized areas. They noted that getting an appointment with a doctor was usually quick and easy, unless one was a new patient and/or on Medicaid or Medicare.

Participants consistently listed several health conditions as issues in their community: obesity, diabetes, HIV, and high blood pressure. Participants linked the poor health outcomes in the community to poverty and the lack of healthy dining options in the area. One participant who worked in social services also pointed out the statistics of high teen pregnancy rates for Evans County.

A lot of diabetes.

Open spaces and clean air.

This is a poverty community, and many of the people do not have the income to buy healthy foods. They go to the grocery store, and you see them shopping, and you look in their carts and the things that are in there that they are eating and feeding their children are the cheapest things that they can buy because they have to make their money stretch.

Community Economic Status

Theme: poverty, lack of jobs, low cost of living

Participants described enjoying living in a smaller town or rural area. Some were retirees or others who chose to move to the area for its lifestyle. On the other hand, they believed the area continues to struggle with poverty, lower educational attainment, a lack of industry and job creation.

We have a lot of people of this community that are not technically trained and I think that is a major portion of employment. As we grow as a society and workplaces now, you've got to be computer literate. You've got to be able to adapt to the new work. And if you don't have the education to do it, you've got a problem because you will always be at the low end of the pay scale.

We definitely need new industry to create new jobs. We realize that all industries in the county and the city are working hard to try to improve that and hopefully in time we will. The taxes are low. Cost of living is reasonable – rent and things of that nature compared to some other places. But we're just a little bit weak, you know, with new jobs which would lead to new people coming in. The growth is sort of stagnant in the county now.

Hospital Use

Theme: critical access, links to physician referrals

Participants consistently described the local hospital as a critical component of their community. Most participants and their families had used the hospital for emergency care and/or other services. They noted that their use of the hospital for medical care depended heavily on their physician's referral and they believed the hospital offered the medical service they needed. On the other hand, participants perceived that younger people were drawn to other larger, nearby hospitals because of a perception of "bigger is better."

If I have to go to the emergency room, I use Evans.

We have a concern of supporting our local hospital here, of course, number one. We don't want to lose our hospital. Ease of convenience of having them here at home and receiving excellent healthcare weighs in. Good local physician here that takes really good care of the whole family. But we're very supportive of the hospital, very satisfied with the care we have received. My father recently had to be in the Savannah hospital for a heart situation that he really almost begged his cardiologist, "Can't I just go to Evans Memorial and you care for me through my local doctor?" And what he needed, he had to spend a few days in Savannah, but otherwise, he's been here and been cared for very well.

We mentioned it earlier, but one of the things here, I mean some of the physicians that come out of Savannah have offices here, they do a great job, and that's great that they come here. And they try to support our hospital, but we, like they said, we've got a lot of great testing and tools here that we can use, but the people that come from out of town here, they try to persuade their patients and their customers to use their facility…just like I've had a knee replacement and done MRIs and everything. They say, "No, you've got to go to Savannah down there to our imaging center." I say, "Why can't I have it here?" You have to really just about get into a knock down drag out with them to make them let us use our hospital here.

Hospital View

Theme: good medical equipment, caring, and friendly staff

Participants spoke highly of Evans Memorial Hospital in terms of its caring and friendly staff. Employees and residents who had used medical services at the hospital in the past also pointed to the hospital having new, quality medical equipment. Some participants, however, pointed to bad experiences with the hospital and acknowledged that there was a perception among some community members of lower quality care.

I think they're limited on the services that they do have now…– I always believe that you know, you should have a facility in your town that if something does occur that, you know, you can get somewhere fast.

They always say, "You can check into this place, but you won't check out." And I ain't talkin' bad about people because they do have some good people working here.

Yeah, what we struggle with – every small rural hospital in Southern Georgia struggles with – in that there's a perception that bigger is higher quality. The more floors in the hospital, the better it is, you know?

[People say] "Yeah, I went here for rehab or I went here for an x-ray. I had to go to Savannah for this," and I'm like you know you can get that done here, but a lot of patients don't realize that. They think because of their primary care, or because their specialist tells them that you need to go here and have this done, they do exactly what their doctor says. Okay, I gotta go to Statesboro to get my MRI. I have to go to Savannah to get my blood work. I have to go to Reedsville to get my therapy because they did my surgery, but that's not true, but patients don't realize that they have a choice.

Hospital Marketing

Theme: need for more marketing

Participants reported a need for more marketing and pointed to the widely read local newspaper and word of mouth as possible channels for disseminating hospital communication. Employees and others with greater ties to the hospital felt that the hospital already did a good job of advertising its services widely through media, health fairs, and community events. However, it was noted that these efforts often failed to educate residents about the services the hospital offered.

Hospital leadership pointed to a lack of resources to embark on a comprehensive marketing campaign. Community members noted that information travels faster by word-of-mouth in rural areas. The hospital, therefore, needs to utilize effective word-of-mouth strategies to alert residents of the positive things that are happening in the hospital, including the fact that area residents can receive certain services faster and cheaper at Evans Memorial Hospital.

Unfortunately, yes, we can tell people about that, but we don't have the funding to advertise and send out, you know, pretty slick mailings. We just don't have the resources to do that yet.

I think employees are major ambassadors. So, you know, the more we speak positively about the hospital, the medical staff, word of mouth is the most powerful. Now obviously, we can do things like going to the civic labs and advertising in the paper and other places, so there are lots of ways to get the message out. But the most powerful is word of mouth.

One bad thing and it runs through town like wildfire, and because everybody knows each other and they're all eating dinner at Mrs. Rogers Restaurant together, they're talking about – I hear it. People know – people there know us, and they have no problem telling us, oh you're – they did that up there to me. They almost killed my mama; they almost killed my – did she leave alive?

Hospital Improve Community

Theme: hospital is supportive of community health

Participants reported that the hospital is supportive of community health. They valued the health fairs organized by the hospital and the availability of emergency care through the hospital's Emergency Department.

In the past, there have been some health screenings. Actually, I think maybe three health screenings that the hospital was involved. I'm not really sure if they were partnered with, but what comes to mind is the free PSA health screening that they offered to men over 50 or whatever. There are several cases of cancer that was discovered by that free screening that the person had no idea. They apparently hadn't had any symptoms or that this screening revealed and I'm not sure where the money came from to pay for this, but it was offered for free in the past.

Hospital/Community Working Together to Improve Community Health and Hospital Viability

Theme: need for residents to use the hospital more

A consistent theme among participants was an appreciation of the hospital and a wish for it to stay open. Participants generally noted that they were more knowledgeable about the hospital because they either used it or worked there. They wished that more people in the community would learn of the quality and the variety of services offered by the hospital and utilize its services, noting that the hospital will not exist if community members did not use and support it. To achieve this, it was important for community stakeholders, including community leaders, to take a vested interest in the hospital and spearhead its promotion within the community.

I think it would be helpful if the people – you know, us in healthcare and then, you know, like our county commissioners, people who are vested in the hospital, they know the importance of the hospital but then, you know, the average layperson doesn't see how they not using us directly affects us. So if, you know, some of the people who are in the know could reach out and – like I said, I'm not from here, so I'm just kind of speaking in general terms, but if we could really reach the average person who really doesn't understand, you know, all the changes that are going on in healthcare, but you know, let them know that we really depend on their support, and without it, you know, it – the results could be detrimental.

Conclusion

In summary, the focus group participants were generally over 65 years old and had used the medical services at the hospital. They were supportive of the hospital and described the staff as friendly and caring. A theme that emerged was one of Evans Memorial Hospital offering high-quality care. Participants also noted that the hospital struggled with low patient volume because of the perception that other nearby and bigger hospitals were better. They noted that residents' use of other hospitals were in part due to physician referral practices. Several participants mentioned that their physicians had in the past referred them for services in other, mostly urban facilities even though they could have received those services at Evans Memorial Hospital. These sentiments expressed in the focus groups were echoed in the community survey.

6 COMMUNITY ASSETS

6.1 EVANS COUNTY ASSETS

Name of the company	Phone number	Address	Services
Evans Memorial Hospital	(912) 739-2611	200 N River St, Claxton, GA 30417	Hospitals, Medical Clinics, Nursing Homes-Skilled Nursing Facility
My Senior Care	(888) 258-9535	Bellville Area	Home Health Services, Alzheimer's Care & Services, Assisted Living Facilities
Georgia Health Services	(770) 466-7771	Bellville Area	Personal Care Homes, Assisted Living & Elder Care Services, Elderly Homes
All About Treatment	(877) 414-5329	Claxton Area	Counseling Services, Drug Abuse & Addiction Centers, Alcoholism Information & Treatment Centers
Drug & Alcohol Treatment Centers-	(888) 296-6597	Hagan Area	Counseling Services, Counselors-Licensed Professional, Physicians & Surgeons, Addiction Medicine
My Senior Care	(888) 258-9535	Daisy Area	Home Health Services, Alzheimer's Care & Services, Assisted Living Facilities
Southeast Sleep Disorder Ctr	(912) 739-0657	201 N River St, Claxton, GA 30417	Clinics, Medical Clinics
Hames Physicians	(912) 739-2574	200 N River St, Claxton, GA 30417	Medical Clinics
Women's Center	(912) 739-2509	602 E Long St # B, Claxton, GA 30417	Physicians & Surgeons

6.2 TATTNALL COUNTY ASSETS

Name of the company	Phone number	Address	Services
Doctors Hospital-Tattnall	(912) 557-1000	247 S Main St, Reidsville, GA 30453	Hospitals, Medical Clinics, Medical Centers
Tattnall Surgical Assoc	(912) 557-3164	131 Memorial Dr, Reidsville, GA 30453	Hospitals
East Georgia Health Care Ctr	(912) 557-3300	222 S Main St, Reidsville, GA 30453	Medical Clinics, Physicians & Surgeons, Internal Medicine
Oh Clinic PC	(912) 557-4315	257 S Main St, Reidsville, GA 30453	Medical Clinics
Tattnall Healthcare Ctr	(912) 557-4345	142 Memorial Dr, Reidsville, GA 30453	Medical Clinics, Nursing & Convalescent Homes
Sylvan Learning Center	(866) 404-3173	Serving the Reidsville Area	Youth Organizations & Centers, Special Education, Educational Services

7 PRIORITIZATION

The following community issues emerged from the data and community interactions:

1. Need for Hospital Community Outreach, Health Promotion, and Education to Address Chronic Disease Conditions and Other Health Issues
2. Economic Development (Lack of Industry, Unemployment, Poverty)
3. Social Health Issues (Low educational attainment, Teenage Pregnancy, STI prevalence, Lack of social amenities)
4. Low Utilization of Preventative Services
5. Health Care Access (high rates of uninsurance, low provider supply, community perceived lack of access to adequate medical services; overutilization of ER for primary care-treatable or non-emergent conditions)
6. Mental and Behavioral Health Issues

The top three priority areas identified were

1. Need for Hospital Community Outreach, Health Promotion, and Education to Address Chronic Disease Conditions and Other Health Issues
2. Health Care Access
3. Mental Health and Behavioral Health Issues

7.1 IMPLEMENTATION STRATEGY

Need for Hospital Community Outreach, Health Promotion, and Education to Address Chronic Disease Conditions and Other Health Issues: The hospital will work collaboratively with faith-based organizations and other community-based organizations to "take health fairs to the community." The hospital will begin with a nurse-sponsored health screening program organized in local churches. In addition, the hospital will explore a partnership with the local newspaper for the purposes of publishing health-related content, for the purposes of health education, health promotion, and disease prevention.

The hospital will also take leadership in forming a community coalition, comprised of representatives from local government, local businesses, community-based organizations, schools and other community representatives. The overarching goal of the coalition will be to address community health issues through shared decision-making.

Health Care Access: As a means of addressing identified limited access to primary care services within the community, Evans Memorial Hospital's rural health clinics will develop and implement a plan for operating on an extended hours schedule, including weekends and evening hours, at selected times. The hospital will also actively work with individuals without insurance to identify potential sources of insurance and /or connect them with the appropriate social service agencies.

Mental Health and Behavioral Health Issues: Evans Memorial Hospital will be opening a new geriatric psychiatry unit by September 2017 as a means of increasing access to the mental and behavioral health services within the hospital's service delivery area. The 10-bed behavioral health unit will typically admit patients age 55 or older whose mental condition warrants acute inpatient psychiatric care. Some conditions may include suicide attempt, violent behavior, dementia, or mental disorders where outpatient therapy has failed. The goal of the unit will be to stabilize the condition and discharge either to long-term care or outpatient therapy. The average length of stay is 12 days. The primary service area will be Evans, Bulloch, Tattnall, Candler, and Bryan counties

RESOURCES

County Health Rankings and Roadmaps (2016). Rankings Data. Retrieved from http://www.countyhealthrankings.org/rankings/data

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United States Census Bureau Small Area Health Insurance Estimates (2016). Model-based Small Area Health Insurance Estimates (SAHIE) for Counties and States. Retrieved from https://www.census.gov/did/www/sahie/