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DeKalb Mission Statement

OUR MEDICAL MISSION AND VISION

Our Mission
At DeKalb Medical System, our mission is to earn our community’s trust every day, through our uncompromising commitment to quality.

Our Vision
In partnership with the best physicians, employees, and volunteers, DeKalb Medical System will be the healthcare provider of choice by delivering a superior patient experience every time.

WHO WE ARE
DeKalb Medical System is more than just a hospital. We are a not-for-profit health system, comprised of three hospital campuses; DeKalb Medical at North Decatur, DeKalb Medical at Hillandale, and DeKalb Medical at Downtown Decatur.

Known for premier clinical services, the latest technological advances, and a caring and highly trained staff, DeKalb Medical System serves DeKalb County and metro Atlanta. DeKalb Medical System includes 628 acute care beds, more than 700 doctors skilled in 55 medical specialties, over 30 physician practices in DeKalb and Gwinnett counties, and 3,900 employees. DeKalb Medical System is an established and active member of the community, offering a variety of award-winning, accessible services.

We are trusted to provide the highest possible level of patient safety and hospital quality when we are caring for our patients, their family members, and their friends. We take that trust seriously. At DeKalb Medical System, quality is defined as safety, superior clinical outcomes, and service excellence for every patient every day.
OUR CORE VALUES & QUALITY PRINCIPLES

DeKalb Medical System embodies the values of I REACH:

- **Integrity**: honest, ethical, trustworthy, and committed
- **Respect**: acknowledge and appreciate diversity and show respect for all
- **Excellence**: deliver high-quality care with great service, taking pride in all we do
- **Accountability**: hold ourselves responsible for achieving the goals that have been defined and measured, and we take responsibility for our actions
- **Compassion**: remember that those who come to us for help need us to care about them as much as we would our own families
- **Helping Hands**: we are part of a team; we work together, helping each other when we see a need, not just when we are asked to help
Executive Summary

DeKalb Medical System understands the importance of serving the health needs of its communities. In order to do that successfully, we must first take a comprehensive look at the issues our patients, their families, and neighbors face when making healthy life choices and health care decisions.

The first community health needs assessment was conducted in 2013. Beginning in October 2015, the organization began the process of re-assessing the current health needs of the communities served by all DeKalb Medical System hospitals. Truven Health Analytics was engaged to help collect and analyze the data for this process and to compile a final report made publicly available on July 1, 2016.

For the 2016 assessment, DeKalb Medical at Hillandale has defined its community to be ZIP codes 30034, 30038, 30035, and 30058, all located within DeKalb County. The community served was defined utilizing the ZIP codes from hospital inception in 2002; these ZIP codes were also utilized in the Certificate of Need submitted to Georgia’s Department of Community Health.

A quantitative and qualitative assessment was performed by Truven Health Analytics, an IBM Company, with the assistance of Jessica Korona and Kirsten Reed, both working with DeKalb Medical System through the master’s program at the Rollins School of Public Health at Emory University. More than 100 public health indicators were evaluated for the quantitative analysis. Community needs were identified by comparing the community’s value for each indicator to that of the state and nation. Where the community value was worse than the state, the indicator was identified as a community health need. After initial community needs were identified, an index of magnitude analysis was conducted to determine the relative severity of the issue.

Input from the community was gathered for the qualitative analysis via focus groups and interviews. Focus group participants and interviewees included community leaders, public health experts, and those representing the needs of minority, underserved, and indigent populations.

The outcomes of the quantitative and qualitative analyses were aligned to create a comprehensive list of community health needs. Next, the health needs were compiled to create a health needs matrix to illustrate where the qualitative and quantitative data correspond as well as differ.

In May 2016, a prioritization meeting was held in which the health needs matrix was reviewed by DeKalb Medical System leadership to establish and prioritize significant needs. The meeting was moderated by Truven Health Analytics and included an overview of the community demographics, summary of health data findings, and review of the identified community health needs.

Participants all agreed the health needs which deserved the most attention and considered significant were those identified through the quantitative analysis as worse than benchmark by a greater magnitude as well as those identified through the qualitative analysis.
The individuals participating in the prioritization meeting identified several criteria to prioritize the significant health needs for each community. Once the prioritization criteria were determined, each significant health need was rated on the criteria resulting in an overall score. The list of significant health needs was then prioritized based on the overall scores.

The meeting participants subsequently chose from the top prioritized health needs as those which will be addressed by DeKalb Medical at Hillandale. The needs to be addressed are as follows:

1. Incidence and disease management of breast and prostate cancer
2. Education and training of community providers
3. Community health education including available resources
4. Diabetes prevalence, screening, discharges, and disease management

A description of each chosen need is included in the body of this report. Subsequently, the hospital facility will develop an implementation strategy including specific initiatives to address the chosen health needs. The implementation strategy will be completed and adopted by DeKalb Medical at Hillandale on or before November 15, 2016.

A summary report of interventions and activities outlined in the implementation strategy drafted after the 2013 assessment was also completed and is included in Appendix D of this document.

The Community Health Needs Assessment for DeKalb Medical at Hillandale has been presented and approved by DeKalb Medical System's Regional Board of Director's Governing Risk and Compliance Committee and the full assessment is available to the public at no cost for download on our website at www.dekalbmedical.org.

This assessment and corresponding implementation strategies are intended to meet the requirements for community benefit planning and reporting as set forth in federal laws, including but not limited to: Internal Revenue Code Section 501(r).
Community Health Needs Assessment Requirement

As a result of the Patient Protection and Affordable Care Act (PPACA), all tax-exempt organizations operating hospital facilities are required to assess the health needs of their community through a Community Health Needs Assessment (CHNA) once every three years. A CHNA is a written document developed for a hospital facility that defines the community served by the organization and the process used to conduct the assessment. The explanation of the process includes how the hospital took into account input from community members, public health department(s), and members or representatives of medically underserved, low-income, and minority populations; the identification of any organizations with whom the hospital has worked on the assessment; the significant health needs identified through the assessment process are discussed.

The written CHNA Report must include descriptions of the following:

- The community served and how the community was determined
- The process and methods used to conduct the assessment including sources and dates of the data and other information as well as the analytical methods applied to identify significant community health needs
- How the organization took into account input from persons representing the broad interests of the community served by the hospital, including a description of when and how the hospital consulted with these persons or the organizations they represent
- The prioritized community health needs identified through the CHNA as well as a description of the process and criteria used in prioritizing the identified significant needs
- The existing health care facilities and other resources within the community available to meet the significant community health needs
- An evaluation of the impact of any actions that were taken, since the hospital facility(s) most recent CHNA, to address the significant health needs identified in that last CHNA

The PPACA also requires hospitals to adopt an Implementation Strategy to address prioritized community health needs identified through the assessment. An Implementation Strategy is a written plan that addresses each of the significant community health needs identified through the CHNA and is a separate but related document to the CHNA report.

The written Implementation Strategy must include the following:

- List of the prioritized needs the hospital plans to address and the rationale for not addressing other significant health needs identified
- Actions the hospital intends to take to address the chosen health needs
- The anticipated impact of these actions and the plan to evaluate such impact (e.g. identify data sources that will be used to track the plan’s impact)
- Identify programs and resources the hospital plans to commit to address the health needs
• Describe any planned collaboration between the hospital and other facilities or organizations in addressing the health needs

A CHNA is considered conducted in the taxable year that the written report of its findings, as described above, is approved by the hospital’s governing body and made widely available to the public. The Implementation Strategy is considered adopted on the date it is approved by the governing body. Organizations must approve and make public their Implementation Strategy by the 15th day of the 5th month following the end of the tax year. CHNA compliance is reported on IRS Form 990, Schedule H.
DeKalb Medical System: Community Health Needs Assessment Overview, Methodology and Approach

DeKalb Medical System partnered with Truven Health Analytics, an IBM Company (Truven Health) to complete a CHNA for DeKalb Medical at Hillandale.

Consultant Qualifications & Collaboration

Truven Health and its legacy companies have been delivering analytic tools, benchmarks, and strategic consulting services to the healthcare industry for over 50 years. Truven Health combines rich data analytics in demographics (including the Community Needs Index, developed with Catholic Healthcare West, now Dignity Health), planning, and disease prevalence estimates with experienced strategic consultants to deliver comprehensive and actionable CHNAs.

Defining the Community Served

For the purpose of this assessment, DeKalb Medical System defined the community served utilizing the ZIP codes from hospital inception in 2002; these ZIP codes were also utilized in the Certificate of Need submitted to Georgia’s Department of Community Health.
DeKalb Medical System Community Health Needs Assessment Community Served
Definition

For the 2016 assessment, DeKalb Medical at Hillandale has defined its community to be ZIP codes 30034, 30038, 30035, and 30058 all located within DeKalb County. The community was defined utilizing the ZIP codes from hospital inception in 2002; these ZIP codes were also utilized in the Certificate of Need submitted to Georgia’s Department of Community Health.

DeKalb Medical at Hillandale Community Health Needs Assessment
Map of Community Served
Assessment of Health Needs – Methodology and Data Sources

To assess the health needs of the community served, a quantitative and qualitative approach was taken. In addition to collecting data from public and Truven Health proprietary sources, interviews and focus groups were conducted with individuals representing public health, community leaders and groups, public organizations, and other providers.

Quantitative Assessment of Health Needs

Quantitative data in the form of public health indicators were collected and analyzed to assess community health needs. Eight categories consisting of 104 indicators were collected and evaluated for the counties where data was available. The categories and indicators collected are included in the table below. The sources of the indicators utilized in the quantitative assessment can be found in Appendix A.
### Population
- High School Graduation Rate
- Some College
- Median Household Income
- Births to Unmarried Women
- Children in Poverty
- Families in Poverty
- Children in Single-Parent Households
- Income Inequality
- Children Eligible for Free Lunch
- Unemployment
- Residential Segregation

### Injury & Death
- Alcohol-impaired Driving Deaths
- Drug Overdose Deaths
- Infant Mortality
- Child Mortality
- All Other Mental and Behavioral Disorder Deaths
- Infant Mortality by Race: Black
- Infant Mortality by Race: Hispanic
- Infant Mortality by Race: White
- Major Cardiovascular Deaths
- Lung Cancer Deaths
- COPD Deaths
- Diabetes Deaths
- Chronic Kidney Disease Deaths
- Heart Disease Deaths
- Overall Cancer Deaths
- Chronic Lower Respiratory Disease (CLRD) Deaths
- Stroke Deaths
- Motor Vehicle Crash Mortality Rate
- Injury Deaths
- Unintentional Injury Deaths
- Premature Deaths

### Mental Health
- Adults Lacking Social-Emotional Support
- Population to Mental Health Provider Ratio
- Mental Health Status
- Suicide Rate

### Health Outcomes
- Cancer (all causes) Incidence
- Breast Cancer Incidence
- Prostate Cancer Incidence
- Colon Cancer Incidence
- Diabetes
- All Other Endocrine, Nutritional, and Metabolic Diseases
- Alzheimer's/ Dementia
- All Other Mental and Behavioral Disorders
- Major Cardiovascular Disease
- HIV
- External Cause of Injury (all)
- Percent Low Birth Weight Births
- Preterm Births
- Poor or Fair Health Status
- Poor Physical Health Days
- Diseases of Musculoskeletal System and Connective Tissue
- Blood Poisoning (Septicemia)
- All Other Diseases of the Genitourinary System
- Pneumonia
- Falls
- Diabetes
- Hypertension
- Lung Cancer Incidence
- Heart Disease
- Smoking During Pregnancy
- Births to Mothers with No Diploma or GED

### Health Behaviors
- Youth Obesity
- Youth Exercise
- Excessive Drinking: Adults Reporting Binge / Heavy Drinking
- Sexually Transmitted Infections Incidence Rate
- Insufficient Sleep
- Adult Obesity
- Physical Inactivity
- Few Fruits/Vegetables
- Adult Smoking
- Adolescent Smoking
- Teen Births
- Chlamydia Incidence

### Prevention
- Diabetic Screening (Medicare Enrollees)
- Mammography Screening (Medicare Enrollees)
- Flu Vaccine 65+
- Pneumonia Vaccine
- Pap Smear
- Colorectal Screening

### Access to Care
- Uninsured Adults
- Uninsured Children
- Primary Care
- Primary Care Providers (non-physician)
- Ambulatory Sensitive Discharges for Avoidable Illnesses
- Health Care Costs
- Delayed Care Due to Cost
- Population to Dentist
- Ambulatory Sensitive Discharges for Acute Conditions
- Ambulatory Sensitive Discharges for Chronic Conditions
- Rate of Preventable Hospital Stays

### Environment
- Limited Access to Healthy Foods
- Food Insecurity
- Food Environment Index
- Drinking Water Violations
- Daily Particulate Matter Days
- Severe Housing Problems
- Long Commute – Driving Alone
- % Households with No Vehicle Available
- Social Associations
- Homicides
- Violent Crime Rate
- Recreational and Fitness Facilities
- Driving to Work Alone
- Unduplicated Count of Children With a Substantial Incident of Child Abuse and/or Neglect
To determine the public health indicators which demonstrate a community health need, a benchmark analysis was conducted. Benchmark health indicators collected included (when available) national, state, and goal setting benchmarks such as Healthy People 2020 and County Health Rankings Best Performer.

Health Indicator Benchmark Analysis Example

According the America’s Health Rankings, Georgia ranks 40th out of the 50 states. The health status of Georgia compared to other states in the nation identifies many opportunities to impact health within local communities even for those communities that rank highly within the state. Therefore, the benchmark for the community served was set to the state value. Needs were identified when one or more of the indicators for the community served did not meet state benchmarks. An index of magnitude analysis was then conducted on those indicators that did not meet state benchmarks in order to understand to what degree they differ from the benchmark in order to understand their relative severity of need.

The outcomes of the quantitative data analysis were then compared to the qualitative data findings.
Qualitative Assessment of Health Needs (Community Input)

In addition to analyzing quantitative data, two focus groups, collectively comprised of twenty-three (23) participants, and thirty-eight (38) key informant interviews were conducted December 2015 through January 2016. These were conducted to collect information from persons representing the broad interests of the community served. The focus groups and interviews were conducted to solicit feedback from leaders and representatives who serve the community and have insight into its needs.

Focus groups are designed to familiarize participants with the CHNA process and gain an understanding of population’s health needs from the community’s perspective. Focus groups are formatted for both individual and small group feedback; moreover, this forum also assists with the identification of other community organizations currently addressing health needs in the community.

The interviews conducted by Truven Health are intended to assist with gaining an understanding and achieving insight into the individual’s perception of the overall health status of the community and the primary drivers contributing to the identified health issues.

To qualitatively assess the health needs of the community, participation was solicited from state, local, tribal, or regional governmental public health departments (or equivalent departments or agencies) with knowledge, information, or expertise relevant to the health needs of the community. Also, individuals or organizations serving and/or representing the interests of the medically underserved, low-income, and minority populations in the community were included.

To ensure the input received also represented the broad interests of the community served, participation was also sought from community leaders, groups, public health organizations, other healthcare organizations, and other healthcare providers.

In addition to requesting input from public health and various interests of the community, hospitals are also required to take into consideration written input received on their most recently conducted CHNA and subsequent implementation strategies.

DeKalb Medical System has made the full report available and welcomes public comment or feedback on the findings. Public comments and feedback may be submitted by contacting Don Fears, Director of Regulatory and Government Relations for DeKalb Medical System at (404) 501-5790. To date we have not received such written input but continue to welcome feedback from the community.

The information collected from the interviewees and focus group participants were organized into primary themes surrounding community needs. The identified needs were then compared to the quantitative data findings.

Methodology for Defining Community Need

The interview and focus group feedback was combined with the health indicator data, and the primary issues currently impacting the health of the community served were consolidated and assembled in the Health Needs Matrix below. This was done to assist with the identification of the significant health needs for the community served.
The upper right quadrant of the matrix is where the qualitative data (interview and focus group feedback) and quantitative data (health indicators) converge.

**Putting It All Together: The Health Needs Matrix**

High Data = Indicators worse than state benchmark by greater magnitude

**High Data & Low Qualitative**
- Data was worse than state benchmark by a greater magnitude
- BUT
- Topic was not raised in interviews and focus groups

**High Data & High Qualitative**
- Data was worse than state benchmark by a greater magnitude
- AND
- Topic was frequent theme in interviews and focus groups

**Low Data & High Qualitative**
- Data was worse than state benchmark by a lesser magnitude
- BUT
- Topic was not raised in interviews and focus groups

**Low Data & Low Qualitative**
- Data was worse than state benchmark by a lesser magnitude
- AND
- Topic was not raised in interviews and focus groups

*Source: Truven Health Analytics, 2016*
**Information Gaps**

The majority of public health indicators are available for counties and do not exceed this level of granularity; moreover, in Georgia, health indicators are not available for every county due to variation in population density. In evaluating data for entire counties versus more localized data, it is difficult to understand the health needs for specific populations within a county. It can also be a challenge to tailor programs to address specific community health needs as placement and access to such programs may not actually impact the individuals in need of the service. Truven Health supplemented the health indicator data with Truven Health’s ZIP code estimates to assist in identifying specific populations within a community where health needs may be greater.

**Existing Resources to Address Health Needs**

Part of the assessment process included gathering input on community resources potentially available to address the significant health needs identified through the CHNA. A description of these resources is provided in *Appendix C*.

**Prioritizing Community Health Needs**

The prioritization of community health needs identified through the assessment was based on the weight of the quantitative and qualitative data obtained when assessing the community. It also included an evaluation of the severity of each need as it pertains to the state benchmark, value the community places on the need, and the prevalence of the need within the community. A thorough description of the process can be found in the “Prioritizing Community Health Needs” section of the assessment.

The community health needs identified through the assessment were reviewed and prioritized by the Senior Vice President and Chief Strategy Officer, Vice President of Legal Services and Chief Compliance Officer, Vice President of Marketing, Communications and Corporate Health, Vice President of the DeKalb Medical Foundation, and the Director of Regulatory and Government Relations.

**Evaluation of Implementation Strategy Impact**

As part of the current assessment, DeKalb Medical System conducted an evaluation of the implementation strategies adopted as part of the 2013 CHNAs. In 2013, DeKalb Medical at Hillandale chose to address the following identified needs:

1. Colon cancer
2. Pneumococcal vaccinations
3. Fall prevention

An implementation strategy was put into place in 2013 to address the above needs. That strategy has been evaluated as to its effectiveness and impact. Details for that evaluation can be found in *Appendix D* with the report of interventions and activities outlined in the implementation strategy drafted after the 2013 assessment.
Demographic and Socioeconomic Summary

When evaluating the population statistics for the community, the state of Georgia’s characteristics are similar in many categories. The primary differences exist in the projected growth over the next five years of older individuals and the percent of the population that is made up of non-white individuals. The community served by DeKalb Medical at Hillandale is projected to experience a slightly higher amount of growth when compared to the state over the next five years. The community is also similar to Georgia as it relates to socioeconomic barriers; differences include a lower proportion of the population faces language barriers, a lower median income, and fewer individuals have a high school diploma in the area served than in the state.

Demographic and Socioeconomic Comparison:
Community Served and State/US Benchmarks

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</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>319,459,981</td>
<td>4%</td>
<td>23%</td>
<td>15%</td>
<td>18%</td>
<td>29%</td>
<td>12%</td>
<td>10%</td>
<td>5%</td>
<td>14%</td>
</tr>
<tr>
<td>Georgia</td>
<td>10,120,651</td>
<td>5%</td>
<td>25%</td>
<td>12%</td>
<td>22%</td>
<td>42%</td>
<td>11%</td>
<td>17%</td>
<td>3%</td>
<td>15%</td>
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<tr>
<td>DeKalb Medical Hillandale</td>
<td>164,776</td>
<td>6%</td>
<td>25%</td>
<td>9%</td>
<td>40%</td>
<td>97%</td>
<td>13%</td>
<td>17%</td>
<td>1%</td>
<td>10%</td>
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</tbody>
</table>

Source: Truven Health Analytics, 2016

The population of the community served is expected to grow 6% (9,887 people) by 2020. The 6% population growth is higher than the state (5%) and nation (4%). The ZIP code expected to experience the most growth over the next five years is 30038, located in south of Interstate 20.

The cohort aged sixty-five years of age and older is currently the smallest; however, it is expected to experience the most growth over the next five years. This cohort is projected to increase by more than 40% (6,033 lives). Growth in this population will likely contribute to an increased need for health services as the population continues to age. Forty percent (40%) of the population is between the ages of 18-44 years with an expected growth of 2% (1,496 lives).
The Hillandale community is primarily of black race (92%). Diversity in the community will increase slightly due to the projected growth of minority populations over the next five years. The community will experience a 28% (343 lives) growth in the Asian/Pacific Islander population, which is the largest growth when compared to the growth of other races. The graphs below display the community’s total population breakdown by race (including all ethnicities).

The Hispanic population currently comprises 10% of the population and is not expected to experience growth over the next 5 years. The graphs below display the community’s population breakdown by ethnicity (including all races) and five year projected growth rates.
The median household income for the community served is $44,667. Sixty-one percent (61%) of the community is commercially insured. The commercially insured population includes those purchasing insurance through the health insurance exchange marketplace and those receiving insurance through an employer. Currently, 7% of the population has Medicare; this is projected to grow over the next five years due to the expected increase in those aged 65 years and above. The uninsured population makes up 17% of the community. Medicaid covers 13% of the community.

ZIP code 30058 is comprised of the largest number of individuals that are uninsured, this ZIP code also has more African-American residents than other ZIP codes in the community.
The Truven Health Community Need Index (CNI) is a statistical approach to identifying health needs in a community. The CNI takes into account vital socio-economic factors (income, cultural, education, insurance and housing) about a community to generate a CNI score for every populated ZIP code in the United States. The CNI is strongly linked to variations in community healthcare needs and is a strong indicator of a community’s demand for various healthcare services. The CNI score by ZIP code identifies specific areas within a community where healthcare needs may be greater.

Overall, the community served has a higher CNI than the national average. The ZIP code with the greatest anticipated need is 30035. On a scale of one to five with five indicating the greatest amount of need, the community has an overall CNI Score of 4.0.

2015 Community Need Index by ZIP Code

Source: Truven Health Analytics, 2016
Public Health Indicators

Public health indicators were collected and analyzed to assess the community’s health needs. For each health indicator, a comparison was made between the most recently available community data and benchmarks for the same/similar indicator. Benchmarks were based on available data and included the United States and the state of Georgia. A health need was identified when the community indicator did not meet the state’s comparative benchmark. The indicators that did not meet the state benchmark for this community included the following:

<table>
<thead>
<tr>
<th>Population</th>
<th>Prevention</th>
<th>Health Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• High School Graduation Rate</td>
<td>• Diabetic Screening (Medicare Enrollees)</td>
<td>• Youth Obesity</td>
</tr>
<tr>
<td>• Births to Unmarried Women</td>
<td>• Mammography Screening (Medicare Enrollees)</td>
<td>• Youth Exercise</td>
</tr>
<tr>
<td>• Children in Poverty</td>
<td>• Flu Vaccine 65+</td>
<td>• Excessive Drinking: Adults Reporting Binge or Heavy Drinking</td>
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<tr>
<td>• Families in Poverty</td>
<td>• Pneumonia Vaccine</td>
<td>• Sexually Transmitted Infections Incidence Rate</td>
</tr>
<tr>
<td>• Children in Single-Parent Households</td>
<td>• Pap Smear</td>
<td>• Insufficient Sleep</td>
</tr>
<tr>
<td>• Income Inequality</td>
<td></td>
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<tr>
<td>• Children Eligible for Free Lunch</td>
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<tr>
<td>• Unemployment</td>
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<td>• Residential Segregation</td>
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</tbody>
</table>

Injury & Death

• Alcohol-impaired Driving Deaths
• Drug Overdose Deaths
• Infant Mortality
• Child Mortality
• All Other Mental and Behavioral Disorder Deaths
• Infant Mortality by Race: Black
• Infant Mortality by Race: Hispanic
• Infant Mortality by Race: White

Mental Health

• Adults Lacking Social-emotional Support
• Population to Mental Health Provider Ratio

Health Outcomes

• Cancer (all causes) Incidence
• Breast Cancer Incidence
• Prostate Cancer Incidence
• Colon Cancer Incidence
• Diabetes
• All Other Endocrine, Nutritional, and Metabolic Diseases
• Alzheimer’s/ Dementia
• All Other Mental and Behavioral Disorders
• Major Cardiovascular Disease
• HIV
• External Causes of Injury (all)
• Percent Low Birth Weight Births
• Preterm Births

Access to Care

• Uninsured Adults
• Uninsured Children
• Primary Care
• Primary Care Providers (non-physician)
• Ambulatory Sensitive Discharges for Avoidable Illnesses

Environment

• Limited Access to Healthy Foods
• Food Insecurity
• Food Environment Index
• Drinking Water Violations
• Daily Particulate Matter Days
• Severe Housing Problems
• Long Commute – Driving Alone
• % Households with No Vehicle Available
• Social Associations
• Homicides
• Violent Crime Rate
Truven Health Community Data

Truven Health Analytics supplemented the publically available data with estimates of localized disease prevalence for heart disease and cancer as well as emergency department visit estimates.

Unsurprisingly, Truven Health Heart Disease Estimates identified hypertension as the most prevalent heart disease diagnosis (39,206 cases). This was followed by arrhythmias and ischemic heart disease.

2015 Estimated Heart Disease Cases

Truven Health’s 2015 Cancer Estimates predict prostate, breast, and colorectal cancers to be the most prevalent. The incidence of both breast and prostate cancers is higher in the community than in the state and nation. The incidence of colorectal cancer is equivalent to the state and nation.

2015 Estimated Cancer Cases

Source: Truven Health Analytics, 2016
Truven Health estimates emergent ED visits to increase 23% in the community over the next five years. Non-emergent, ED visits are lower acuity visits that present in the ED but possibly can be treated in other more appropriate, less intensive outpatient settings. Non-emergent ED visits can be an indication that there are systematic issues with access to primary care or managing chronic conditions. There is a slight projected increase of 1% in non-emergent visits over the next five years.

![Emergent and Non-Emergent ED Visits](image1)

Source: Truven Health Analytics, 2016

![2014 Estimated Non-Emergent Visits by ZIP Code](image2)

Source: Truven Health Analytics, 2016
Focus Groups and Interviews

DeKalb Medical System engaged Truven Health to conduct a series of focus groups and to assess the community’s perception of health needs in the populations they serve. There were two community focus groups; combined, twenty-three participants were included in the exercise. Participants included individuals from organizations serving medically underserved, low-income, minorities and populations with chronic disease needs in the community as well as public health representatives. The focus group was moderated by a Truven representative and was conducted in two parts. The first session was held with the entire group. Participants were divided into two groups for smaller breakout discussions for the second session. The discussions were oriented around the following questions:

1. Assess the health of the community on a scale of one to five (one being the worst and five being the best)
2. Identify the top three health needs of the community
3. Discuss the similarities/differences between the needs identified in the prior exercise and the needs identified in prior assessments

The groups included representatives from the counties of DeKalb, Fulton, and Gwinnett, all located in Georgia. The community served by DeKalb Medical at Hillandale includes ZIP codes 30034, 30038, 30035, and 30058, all located within DeKalb County.

The Hillandale community has minimal economic growth with the wealthier populations migrating to more northern portions of the county. According to focus group participants, new business opportunities are sought outside of the community. Interstate 20 divides DeKalb County both geographically and socioeconomically, the population residing next to, and south of, the interstate is perceived to be more disadvantaged. The Hillandale community is considered by the group to be part of this more disadvantaged population. The group reported the majority of those residing south of the interstate as being predominately African-American with a dense population of uninsured residents. Also, this southern-most region of the county possesses higher crime rates, food deserts and swamps, lower economic growth, and fewer health care providers. The group expressed belief that these factors contribute to more needs for the community as they pertain to health. Overall, the health of individuals in Hillandale is poor. Chronic diseases such as cardiovascular, diabetes, hypertension, sickle cell, congestive heart failure and HIV are prevalent in those less than 45 years old.

The represented communities included diverse populations with significant differences in socioeconomics, education, access to care, and health status. One of the major themes identified by the focus groups included access to health care. Specific drivers of this issue included transportation and the need for consolidating providers. Health literacy was also identified as a characteristic of the community increasing the health needs. The recognized needs that pertain to health literacy included the need for patient education and training and the lack of diversity and cultural competency in the community served. Lastly, the groups identified major needs surrounding the prevention and management of chronic diseases and mental health.
Access to Care

As previously stated, access to care, transportation and the need for the consolidation of providers were identified health needs. Much of the community served utilizes the ED for primary care services. This limits continuity of care due the absence of having a lasting relationship with a primary care physician in the community. For many, the necessary resources are not available; however, when resources are available, many do not access the system due to unaffordability. Access to primary care and specialty physicians is limited in the community which makes it difficult for chronic diseases to be managed. Focus group participants specifically mentioned the lack of physicians in Lithonia, located in the Hillandale community. The lack of Medicaid expansion in the state of Georgia also adds complexity to pre-existing issues. The working poor live in a “gap” which leaves them either uninsured or underinsured and unable to afford private coverage. The limits of the community surrounding access to care primarily include the lack of services and coverage. Focus group members also mentioned access to care being negatively impacted by the lack of support for DeKalb Medical System by the local government. For example, insurance provided to local government employees does not cover services provided by DeKalb Medical System; this not only limits access for the employees, but also reduces resources provided to the facility. Local businesses and the county do not collaborate on supporting the hospital which is impacting access to care within the community.

Transportation

Although the walkability of the community served has improved, much of the population continues to rely on public transportation. The expense and time consumption of the public transportation system often prohibits community members from receiving adequate medical treatment. Using the public transportation system to reach health care providers greatly increases the time utilized causing absenteeism from work or school. The focus group members felt that many residents forgo seeing a physician due to the loss of income from missing work.

Consolidation of Providers

Community partnerships are progressing with the goal of leveraging resources to better coordinate care; however, competitiveness remains a challenge. The consolidation of services by providers serving the same or similar needs would allow additional services to be provided, thus eliminating duplication.

Patient Education and Training

It was noted that health literacy is an issue as it pertains to issues surrounding the prevention and management of chronic disease. For many individuals, late diagnosis and treatment of chronic illnesses are leading to poor outcomes. Existing education programs are inadequate and do not reach those residing in rural areas. The groups also expressed the lack of understanding regarding chronic disease and the impact delayed care often has on the outcome. Understanding the signs and symptoms of a stroke is a specific example provided by the group that is vital to prevent serious, long-term complications that impact the quality of life. Other areas of education in which the
focus group identified include the importance of a healthy diet and exercise, the increased availability and use of wellness programs, and the impact of non-compliance.

Diversity and Cultural Competency

Existing health literacy issues are further complicated by language and cultural barriers that exist within the community. Cultural beliefs often lead to mistrust of the health care system and individuals refusing to seek care. Focus groups discussed the opportunities surrounding education and outreach; specifically, the need for health education in the Hispanic community.

Chronic Disease and Mental Health Management

As previously mentioned, a lack of knowledge exists within the community regarding chronic disease prevention and management. Diet and exercise is a factor contributing to the prevalence of chronic disease. Food swamps and deserts are prevalent; however, a mobile farmers market does exist to provide fresh fruits and vegetables throughout the community. As discussed by the group, the lack of specialty physicians in the community leaves many patients not seeing the providers needed to manage their conditions. Specific chronic diseases mentioned by the focus groups include diabetes, cancer, HIV/AIDS, chronic renal failure, and mental health. The Hillandale community is experiencing an increase in chronic diseases among younger residents. The lack of health and wellness in the community contributes to the prevalence of chronic disease.

As previously mentioned, Hillandale has a large African-American population. With this being said, the area is genetically predisposed to specific chronic diseases associated with race/ethnicity such as hypertension and sickle cell. Participants also mentioned heart failure and human immunodeficiency virus (HIV) in the community.

An additional population often suffering from chronic conditions are those with mental illness. The focus group also discussed the need for a better system to provide local services to this population, as they are often forced to seek care in the ED due to a lack of providers. Mental health and substance abuse are not controlled within the community, and there is a stigma associated with the diagnosis. The limited awareness of the disease often prevents individuals from seeking early intervention. Mental health and substance abuse are prevalent in all socioeconomic and demographic groups leading to the need for increased support and treatment options.

Funding and Leadership

Lastly, the group expressed the need for strong community leaders and funding to assist with improving factors that drive the health status of the community. The group expressed a primary factor contributing to the low economic growth in the community being the perception of corruption among local government agencies and school board members. The lack of trust has led to the absence of people investing in the community. With individuals from both in and outside of the community not investing in the area, there has been a decline in development leading to a lack of economic growth. This is also a contributing factor to entrepreneurs within the community starting business in other surrounding communities not served by DeKalb Medical System. The group
expressed the need for strong community leaders due to them being a key component necessary to build a healthy community.

To supplement the qualitative data provided by the focus groups, thirty-eight (38) key informant interviews were conducted by the Director of the Regulatory and Government Relations of DeKalb Medical System and DeKalb Medical System interns from the Rollins School of Public Health at Emory University. The individuals interviewed included individuals from organizations serving medically underserved, low-income, minorities and populations with chronic disease needs in the community as well as public health representatives and public officials. During the interview sessions, the participants were asked to identify the primary factors that contribute to the current health status of the community. The principal drivers contributing to this perceived health status included access to care, chronic diseases, and the health and wellness of the community. These three factors contributing to the health of the community were also identified by interviewees as the top three health needs of the community.

**Access to Care**

Similar to those included in the focus group discussions, access to care was also identified as a top health need among those interviewed. The lack of access to preventative care and gaps in primary care were identified as contributing factors. The interviewees discussed the existence of hospitals within the area, however, it is perceived that the lack of service availability is negatively impacting the community’s health. Participants expressed the need for free clinics for federally qualified health centers within the community. Clinics need to be placed on public transit routes or within walking distance of the most vulnerable populations that do not have access to private transportation. The survival of residents experiencing cardiac arrest was discussed due to the absence of a cardiac catheterization laboratory in the community; DeKalb Medical at Hillandale does not currently provide this service. Lastly, the absence of Medicaid expansion was felt to be a disadvantage to the working poor; preventing them from receiving appropriate coverage.

**Chronic Diseases**

The presence of chronic disease within the community was frequently mentioned as a top health need by interviewees. Specifically, diabetes, hypertension, hypercholesterolemia, heart disease, sickle cell, and obesity were mentioned. Participants stated that DeKalb Medical at Hillandale should become a center of excellence for chronic conditions often seen in African-Americans, such as diabetes. Diabetes screening in children was also a topic of discussion among interviewees. The need for preventative care was discussed; however, poor disease management was the primary topic of concern as it relates to chronic disease.

**Health and Wellness**

A community focused on health and wellness leads to healthier individuals, according to the individuals included in the interviews. However, it was mentioned that the community served has barriers preventing a health and wellness-focused community. Cultural differences exist among residents which serve as an obstacle due to varying beliefs and traditions. Currently, the majority of citizens possess poor diet and exercise
habits. Becoming more active and increasing efforts to improve nutrition are needed to improve the health and wellness of the community.

The focus groups were also asked to identify the barriers that lead to poor health in the community. Factors identified included cultural diversity, food swamps, non-compliance with disease management, lack of local resources, and the prevalence of mental illness. The following populations were identified by the interviewees as vulnerable groups that need additional consideration when addressing health needs:

- Minorities
- Low-income
- Elderly
- Children

The interview and focus group participants and the populations they serve for this community are documented in the table in Appendix B.
**Health Needs Matrix**

Quantitative and qualitative data were analyzed and displayed as a health needs matrix to help identify the most significant community health needs. The health needs bolded in the lower right quadrant of the matrix are those identified through qualitative data; however, there is no matching quantitative data measure available. Below is the matrix for the community served by DeKalb Medical at Hillandale.
Prioritizing Community Health Needs

In order to identify and prioritize the significant needs of the community, the hospital established a comprehensive method of taking into account all available relevant data including community input.

First, specific needs were pinpointed when an indicator for the community served did not meet the corresponding state benchmarks. Then an index of magnitude analysis was conducted on those indicators to determine the degree of difference from the benchmark to indicate the relative severity of the issue. The outcomes of this quantitative analysis were aligned with the qualitative findings of the community input sessions to bring forth a list of health needs in the community. These health needs were then classified into one of four quadrants within a health needs matrix: high data, low qualitative; low data, low qualitative; low data, high qualitative; or high data, high qualitative.

The matrix was reviewed on May 4, 2016 by DeKalb Medical System’s leadership in a session to establish the significant health needs and then to prioritize them. The meeting was moderated by Truven Health and included an overview of the community demographics, summary of health data findings and an explanation of the quadrants of the health needs matrix.

Session participants included:

<table>
<thead>
<tr>
<th>Executive Vice President of Strategy</th>
<th>Vice President of Legal Services and Chief Compliance Officer</th>
<th>Vice President of Marketing, Communications, and Corporate Health</th>
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</thead>
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<tr>
<td>Vice President DeKalb Medical Foundation</td>
<td>Director of Regulatory and Government Relations</td>
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</tbody>
</table>

Participants all agreed that the health needs indicated in the quadrants labeled “high qualitative, high quantitative”, “high data, low qualitative”, and “low data, high qualitative” should be considered the community’s significant health needs.

In order to prioritize the specific health needs, the participants identified four criteria for prioritization of the needs. The characteristics included feasibility, hospital capacity, ability to measure, and alignment with the hospital’s strategy. Feasibility ensures health needs are amenable to interventions, acknowledges the resources necessary for change to occur, and determines whether or not it is preventable. Determining if the hospital has the capacity to act on an issue was also a criteria utilized for prioritization of needs; this also included whether any economic, social, cultural, or political considerations are necessary. The ability to measure progress on the initiative must be quantifiable to determine whether not interventions are impacting the health need, this was also considered during prioritization. Finally, aligning the prioritized health needs with the strategy of the health system was considered to ensure current strengths and focuses are leveraged.

Once the prioritization criteria were determined, each significant health need was rated on each of the five criteria utilizing a scale of one to ten, with one being low and ten being high. Each participant’s criteria ratings were then summed to create the
participant’s rating for each need. The scores for each need were then summed across all participants to create an overall score. The list of significant health needs was then prioritized based on the overall scores.

The meeting participants subsequently chose from the top prioritized health needs as those which will be addressed by DeKalb Medical at Hillandale. The needs to be addressed are as follows:

1. Incidence and disease management of breast and prostate cancer
2. Education and training of community providers
3. Community health education and community resources
4. Diabetes prevalence, screening, discharges, and disease management

Description of Health Needs to be Addressed

Incidence and Disease Management of Breast and Prostate Cancer

The incidence and management of breast and prostate cancers in DeKalb County was identified as one of the community's top health needs. The focus group participants discussed the positive impact early detection and treatment have on outcomes for cancer patients. Despite these findings being present in the literature, focus group and interview participants did not feel this approach was utilized within the community.

Cancer was a concern for the community in the 2013 assessment, and improvements have been made. Previous interventions included the addition of oncologists, heightened cancer awareness, and the addition of breast cancer navigators. Despite these actions being made within the community, cancers, specifically breast and prostate, continue to impact the overall health of the community.

According to the National Cancer Institute, the 135 out of every 100,000 women have breast cancer in DeKalb County. This is compared to 123 in the United States and 123.5 in Georgia. The National Cancer Institute also provides prostate cancer rates per 100,000 men. The reported rates for prostate cancer are 179.6 in DeKalb County, 150.1 in Georgia, and 131.7 in the United States.¹ This evidence confirms the negative impact breast and prostate cancers have on the community served by DeKalb Medical at Hillandale.

Education and Training of Community and Providers

According to focus group and interview participants, the community struggles with health literacy and it is further complicated by language and cultural barriers. There is limited awareness of risk, disease prevention, and disease management as they relate to chronic conditions. For example, understanding the signs and symptoms of a stroke is vital in receiving early intervention, which is known to increase positive outcomes. Participants acknowledged the correlation that exists between chronic disease prevention, treatment, and control with diet and exercise. Arming the community with the appropriate knowledge will empower them to care for themselves.

¹ National Cancer Institute, 2008-2012 Rate of cancer per 100,000 (age-adjusted)
The lack of health literacy also presents problems related to navigating the healthcare system and understanding insurance coverage. Focus group participants discussed the large opportunity for education and outreach in the community surrounding coverage and navigation.

Participants also discussed the challenges that accompany the cultural diversity of the community served. The presence of various ethnic groups contributes to difficulties related to the cultural competence of providers. Ethnic and bi- and/or multi-lingual patient navigators are needed for care coordination; this would assist with ensuring patients are connected to appropriate resources. Education and outreach are needed to support the community with preventative care, chronic disease management and healthy living choices.

Existing education programs and those created in the future must be comprehensible by individuals with limited formal education. DeKalb County has a high school graduation rate of 59.7%. This is much lower than both the state (72.8%) and nation (82%).\(^2\) Creating health education programs in a manner in which community members can easily interpret the information will also assist with improving other health priorities.

**Community Health Education and Available Resources**

As previously mentioned, the focus group participants and interviewees identified multiple issues surrounding health literacy and the negative impact its absence places on the community. Specifically, it was noted that many residents in the community are now insured under the new health care exchanges implemented with the Affordable Care Act. According to Truven Health’s ZIP code estimates, the number of community members insured privately, provided through either an employer or the healthcare exchanges, is projected to increase five percent (5\%) between 2015 and 2020.\(^3\)

Resources need to be available to these individuals within the community to promote adequate utilization of coverage.

Providers must also be able to guide their patients across the continuum of care. Effectively educating providers and patients regarding the resources that are available within the community served is needed. Focus group participants and interviewees discussed the negative impact the providers’ lack of understanding of the available services is having on the health of the community.

Although there are new initiatives in the community focused on outreach and education, participants expressed the need for continued expansion to all areas in the community. Managing chronic disease from both a professional and personal standpoint is difficult due to the lack of resources in the community. Specifically, challenges present for community members with chronic disease due to the absence of resources focusing on care coordination and the lack of collaboration between existing resources.

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\(^2\) County Health Rankings, 2012-2013 Percentage of Ninth-grade Cohort that Graduates in Four Years

\(^3\) Truven Health Analytics, 2015 ZIP Code Estimates
Diabetes Prevalence, Screening, Discharges, and Disease Management

Focus groups and interviewees specifically discussed the prevalence of chronic disease in the Hillandale; particularly those such as diabetes that are prevalent in African-Americans. When discussing chronic conditions, the focus groups and interviewees discussed the prevalence of diabetes in the community. The disease is occurring among all age groups, young and old. The need for education related to prevention and treatment and screening among all age groups is necessary, as previously discussed.

According to the CDC, the prevalence of diabetes is higher in DeKalb County (11.8%) than both the State of Georgia (11.4%) and the United States (10%). Also, Georgia’s Department of Public Health states that the discharges in DeKalb County related to endocrine, nutritional, and metabolic diseases are higher than in the state, with a rate of 429.4 in the Hillandale community and 368.9 in the state.

Summary

DeKalb Medical System conducted its Community Health Needs Assessments beginning October 2015 to identify and begin addressing the health needs of the communities they serve. Using both qualitative community feedback as well as publically available and proprietary health indicators, DeKalb Medical System was able to identify and prioritize community health needs for their health care system. With the goal of improving the health of the community, implementation plans with specific tactics and time frames will be developed for the health needs chosen by DeKalb Medical System to address the community served.

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4 Centers for Disease Control and Prevention (CDC), 2012, Percentage of adults reporting to be diagnosed with diabetes (non-pregnancy related)
5 Georgia Department of Public Health, 2014, Age-adjusted discharge rate for endocrine, nutritional, and metabolic diseases (diabetes) per 100,000
## Appendix A: Key Health Indicator Sources

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<tr>
<th>Key Health Indicator Sources</th>
<th>Sources</th>
<th>Notes</th>
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<td>American Medical Association</td>
<td>Environmental Protection Agency (EPA)</td>
<td>National HIV Surveillance System</td>
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<td>Behavioral Risk Factor Surveillance System (BRFSS)</td>
<td>ESRI &amp; US Census Tigerline Files</td>
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<td>CDC Diabetes Interactive Atlas</td>
<td>FBI Crime in the United Locals</td>
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### Appendix B: Interview and Focus Group Participants and the Communities Served

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</tr>
<tr>
<td>Mercy Housing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DeKalb Medical Physicians Group</td>
<td>X</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Alpha Kappa Alpha (Tau Pi Omega Chapter)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>CDC: Epidemiology and Surveillance Unit on Heart Disease and Stroke</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physicians Care Clinic</td>
<td>X</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>South DeKalb Center of Healthy Living</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>First United Methodist Church of Decatur</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City of Clarkson</td>
<td>X</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>AMR Ambulance Service</td>
<td>X</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Senior Connections</td>
<td>X</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grady Health System</td>
<td>X</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>DeKalb Board of Health</td>
<td>X</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>
## Appendix C: Community Resources Identified to Potentially Address Significant Health Needs

### Resources Identified via Community Input

<table>
<thead>
<tr>
<th>Workwell Program</th>
<th>Heritage Hospice</th>
<th>St. Thomas Moore Catholic Church</th>
<th>South DeKalb Center of Healthy Living</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercy Housing/Allegra Point Senior Center</td>
<td>DeKalb Chamber of Commerce</td>
<td>DeKalb Medical Physicians Group</td>
<td>First United Methodist Church of Decatur</td>
</tr>
<tr>
<td>Sisters by Choice</td>
<td>DeKalb Medical Cancer Center</td>
<td>DeKalb County Government</td>
<td>City of Clarkson</td>
</tr>
<tr>
<td>DeKalb Board of Health</td>
<td>DeKalb Medical Community Outreach</td>
<td>North DeKalb Senior Center</td>
<td>AMR Ambulance Service</td>
</tr>
<tr>
<td>DeKalb Community Service Board</td>
<td>Women Watch Afrika</td>
<td>City of Lithonia Government</td>
<td>Senior Connections</td>
</tr>
<tr>
<td>Live Healthy DeKalb</td>
<td>Decatur Active Living</td>
<td>Healthcare Georgia Foundation</td>
<td>Grady Health System</td>
</tr>
<tr>
<td>Side by Side Brain Injury Clubhouse</td>
<td>Metro Atlanta Ambulance Services</td>
<td>National Coalition of Black Women</td>
<td>Bornelus Insurance Agency</td>
</tr>
<tr>
<td>Personal Care Home</td>
<td>Susan G. Komen - Atlanta</td>
<td>Center for Pan Asian Community Services</td>
<td>Mercy Housing</td>
</tr>
<tr>
<td>CDC</td>
<td>Georgians for a Healthy Future</td>
<td>Decatur Recreation Department</td>
<td>National Coalition of 100 Black Women Decatur – DeKalb Chapter</td>
</tr>
<tr>
<td>City of Lithonia Government</td>
<td>Clarkston Community Health Center</td>
<td>Panola Gardens - National Church Residences</td>
<td>First Medical Care/Clarkston Clinic</td>
</tr>
<tr>
<td>Physicians Care Clinic</td>
<td>CDC: Epidemiology and Surveillance Unit on Heart Disease and Stroke</td>
<td>Alpha Kappa Alpha (Tau Pi Omega Chapter)</td>
<td></td>
</tr>
</tbody>
</table>
# Appendix D: Healthcare Organizations Serving the Community

*Community Healthcare Facilities*

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Facility Type</th>
<th>Affiliation</th>
<th>Address</th>
<th>City</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td>DeKalb Medical Center At Hillandale</td>
<td>Hospital</td>
<td>DeKalb Medical</td>
<td>2801 DeKalb Medical Pkwy</td>
<td>Lithonia</td>
<td>30058</td>
</tr>
<tr>
<td>Georgia Regional Hospital Atlanta</td>
<td>Hospital</td>
<td></td>
<td>3073 Panthersville Rd</td>
<td>Decatur</td>
<td>30034</td>
</tr>
<tr>
<td>Georgia Regional Atlanta</td>
<td>Skilled Nursing</td>
<td></td>
<td>3073 Panthersville Rd</td>
<td>Decatur</td>
<td>30034</td>
</tr>
<tr>
<td>PruittHealth - Decatur</td>
<td>Skilled Nursing</td>
<td></td>
<td>3200 Panthersville Rd</td>
<td>Decatur</td>
<td>30034</td>
</tr>
<tr>
<td>Traditions Health And Rehabilitation</td>
<td>Skilled Nursing</td>
<td></td>
<td>2816 Evans Mill Rd</td>
<td>Lithonia</td>
<td>30058</td>
</tr>
</tbody>
</table>

*Facility type “hospital” includes short-term acute care, long-term acute care, inpatient mental hospitals, and inpatient rehab facilities.*

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6 Truven Health Analytics, 2016 Market Expert National Facility Database
Appendix E: Community Benefit Summary 2013 Needs Assessment

PRIORITY: Fall Prevention

Fall prevention is listed as one of the top three health priorities for DeKalb Medical Hillandale. In the 2013 Community Health Needs Assessment for Hillandale*, the leading cause of injury related emergency room visits was falls. From 2005 to 2010 in the Hillandale service area, 21.7 percent of injury-related emergency room visits were due to falls. From 2011 to 2012, there were 4213 emergency room visits due to falls (2106.5 per year) in the Hillandale** service area.

1. Data

Table 1. Emergency Room Visits due to Falls as a Percentage of all Injury-Related Emergency Room Visits

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent</td>
<td>21.7</td>
<td>Not Available</td>
<td>27.8</td>
<td>28.8</td>
</tr>
</tbody>
</table>

Table 2. Number of emergency room visits due to falls and average rate of falls per 100 people in the Hillandale service area, 2010-2012

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
<th>Total</th>
<th>Average per Year</th>
<th>Average rate per 100 people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>2082</td>
<td>2131</td>
<td>4213</td>
<td>2106.5</td>
<td>15.4</td>
</tr>
</tbody>
</table>

Table 3. Average fall rate per 1,000 patient days, DeKalb Medical Hillandale, 2010-2013

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate per 1000 Patient Days</td>
<td>3.34</td>
<td>3.86</td>
<td>3.26</td>
<td>4.46</td>
<td>0.99</td>
<td>2.65</td>
<td>3.21</td>
</tr>
</tbody>
</table>

* The Hillandale (Lithonia, Redan) service area for 2005 to 2010 is defined by the following census tracts for 2005-2010: 232.03, 232.04, 232.08, 232.09, 232.1, 232.11, 232.12, 233.02, 233.03, 233.09, 233.1, 233.07, 234.17, 234.18

** The Hillandale (Lithonia, Redan) service area for 2011 to 2012 is defined by the following census tracts for 2010-2012: 234.18, 234.27, 234.28, 233.10, 232.14, 232.12, 232.11, 232.10, 233.14, 233.09, 233.03, 233.15, 233.16, 232.13, 232.06, 232.04, 232.08, 232.09, 233.06

1 Online Analytical Statistical Information System (OASIS), Georgia Department of Public Health, Office of Health Indicators for Planning (OHIP). <February 20, 2015> http://oasis.state.ga.us/
Table 4. Number of heel scans performed during Hillandale outreach days

<table>
<thead>
<tr>
<th>Event</th>
<th>Number of Heel Scans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women’s Health Panel at Hillandale</td>
<td>35</td>
</tr>
<tr>
<td>Cancer Screening Day at Hillandale</td>
<td>28</td>
</tr>
<tr>
<td>Total</td>
<td>63</td>
</tr>
</tbody>
</table>

II. Current Objectives and Implementation Strategies

The objective for fall prevention is to decrease injuries caused by falls. The strategies to address this objective are as follows:

1. Continue to increase and improve employee awareness of negative impact of patient falls.
   a. Revamping and resurrection of Falls Committee
   b. Educate staff through weekly huddles, staff meetings, and case presentations regarding falls.
   c. Employees involved in falls cases to participate in investigation, assist with analysis of information, and present case study in huddles.
      i. UPDATE: Falls Committee is intact, focuses on internal falls at DeKalb Medical.

2. Increase/improve employee engagement in the prevention of falls.
   a. Development of Universal Process focused on Days Since Last Fall.(Attached)
   b. Collaborate with Quality Dept. to create database/graph template to enter information monthly to be reviewed at Falls Committee with competition between nursing units with recognition of achievements throughout hospital.

3. Revise falls analysis form.

4. Review and revise current Falls Management Policy to include Falls Risk Assessment tool and matching templates in computerized medical charting.

5. Formalize Nurse Managers reporting of Falls Prevention Action Plans and follow-ups to Falls Committee if they go above the monthly designated falls rate.


7. Development of Falls Prevention Guidelines for Post-Acute Rehab/3600 including piloting of voice activated Posey Alarm.

8. Explore opportunities to work with community groups, including senior centers, to offer programs on increasing strength and balance to decrease the number and severity of falls.
   i. UPDATE: Missing holistic update on this information.
PRIORITY: Pneumococcal Vaccination

Pneumococcal vaccination is listed as one of three top priorities for the DeKalb Medical Hillandale location. The 2013 Community Health Needs Assessment for Hillandale* found that over 5 years (2005-2010) there were 1,454 hospital discharges related to pneumonia, and that African-Americans were almost eight times more likely than Caucasians to be diagnosed with pneumonia. An average number of hospital discharges related to pneumonia per year was calculated at 290.8. From 2011-2012**, there were 527 hospital discharges related to pneumonia, or 263.5 discharges per year. From 2011-2012, African-Americans were more than 8 times more likely to receive a diagnosis of pneumonia than Caucasians.

I. Data†

Table 1. Percentage of Hospital Discharges due to Pneumonia by Race, by Year, by Location

<table>
<thead>
<tr>
<th></th>
<th>Hillandale, 2005-2010 (%)</th>
<th>Hillandale 2011-2012 (%)</th>
<th>DeKalb County, 2011-2012 (%)</th>
<th>Georgia, 2011-2012 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>86.0</td>
<td>89.2</td>
<td>62.9</td>
<td>27.8</td>
</tr>
<tr>
<td>White</td>
<td>12.7</td>
<td>9.3</td>
<td>31.4</td>
<td>68.1</td>
</tr>
<tr>
<td>Other</td>
<td>1.2</td>
<td>1.5</td>
<td>5.6</td>
<td>4.1</td>
</tr>
</tbody>
</table>

Table 2. Total and Average (per year) Number of Hospital Discharges Related to Pneumonia, by Year

<table>
<thead>
<tr>
<th></th>
<th>Hillandale, 2005-2010</th>
<th>Hillandale, 2011-2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>1,454</td>
<td>527</td>
</tr>
<tr>
<td>Average (per year)</td>
<td>290.8</td>
<td>263.5</td>
</tr>
</tbody>
</table>

Table 3. Percentage of Patients Admitted to DeKalb Medical at Hillandale with a Diagnosis of Pneumonia who Received a Pneumococcal Vaccination, by Year

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Vaccinated</th>
<th>Total Admitted</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>3</td>
<td>6</td>
<td>50.0</td>
</tr>
<tr>
<td>2006</td>
<td>13</td>
<td>44</td>
<td>29.5</td>
</tr>
<tr>
<td>2007</td>
<td>33</td>
<td>45</td>
<td>73.3</td>
</tr>
<tr>
<td>2008</td>
<td>63</td>
<td>75</td>
<td>84.0</td>
</tr>
<tr>
<td>2009</td>
<td>53</td>
<td>62</td>
<td>85.5</td>
</tr>
</tbody>
</table>

* The Hillandale (Lithonia, Redan) service area for 2005 to 2010 is defined by the following census tracts for 2005-2010: 232.03, 232.04, 232.06, 232.08, 232.09, 232.11, 232.12, 233.02, 233.03, 233.09, 233.1, 233.07, 234.17, 234.18
** The Hillandale (Lithonia, Redan) service area for 2011 to 2012 is defined by the following census tracts for 2010-2012: 234.18, 234.27, 234.28, 233.10, 232.14, 232.12, 232.11, 232.10, 233.14, 233.09, 233.03, 233.15, 233.16, 232.13, 232.06, 232.04, 232.08, 232.09, 233.06
† Online Analytical Statistical Information System (OASIS), Georgia Department of Public Health, Office of Health Indicators for Planning (OHIP). <February 20, 2015> http://oasis.state.ga.us/
Table 4. Percentage of a Sample of Patients Admitted to DeKalb Medical at Hillandale for any Diagnosis who Received a Pneumococcal Vaccination, by Year

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Vaccinated</th>
<th>Total Admitted</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>542</td>
<td>715</td>
<td>75.8</td>
</tr>
<tr>
<td>2013</td>
<td>635</td>
<td>695</td>
<td>91.4</td>
</tr>
<tr>
<td>2014</td>
<td>299</td>
<td>310</td>
<td>96.5</td>
</tr>
</tbody>
</table>

II. **Current Objectives and Implementation Strategies**

The objective of the pneumococcal vaccination priority is to increase the rate of pneumococcal vaccination. This was planned to be carried out through the following strategy:

1. Complete the revision and adoption of policies for screening and administration of flu and pneumococcal vaccinations. Revisions include:
   a. Vaccinations to be offered to all patients regardless to if the status is observation or inpatient
   b. Policies to remove fever as a contraindication for vaccination
   c. Require that, if no contraindicated, vaccination must be offered and administered prior to discharge date with electronic medical record making administration a timed task
   d. Policies to recommend that intensive care unit patients receive vaccinations only when patient's condition is stable and meeting criteria of administration
      i. UPDATE: Change in leadership since the CHNA was conducted. Continuing pneumonia vaccination policies as previously done.

---

Table 5. Rate of New Cases of Pneumonia in Comparison to the Healthy People 2020 Baseline and Goal (DeKalb County Board of Health, OASIS)

<table>
<thead>
<tr>
<th>Rate of new cases of pneumonia</th>
<th>Hillendale, 2005-2010</th>
<th>Hillendale, 2011-2012</th>
<th>Healthy People 2020 Baseline</th>
<th>Healthy People 2020 Goal</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of new cases of pneumonia</td>
<td>976.3 per 100,000 (&gt;65 years of age)</td>
<td>40.7 per 100,000 (&gt;65 years of age)</td>
<td>31.0 per 100,000 (&gt;65 years of age)</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

Note: Highlighted cell is missing information due to a postponed data request.

2. Reduce invasive antibiotic-resistant pneumococcal infections among adults aged 65 years and older.

Baseline: 12.2 new cases of laboratory-confirmed invasive antibiotic-resistant pneumococcal infection per 100,000 adults aged 65 years and older were diagnosed in 2008.

Target: 9.0 new cases per 100,000 population adults aged 65 years and older.

3. Increase the percentage of noninstitutionalized high-risk adults aged 18 to 64 years who are vaccinated against pneumococcal disease.

Baseline: 16.6 percent of high-risk persons aged 18 to 64 years in 2008 had ever received a pneumococcal vaccination.

Target: 60.0 percent.

Table 6. Percentage of noninstitutionalized persons aged 18-64 vaccinated against pneumococcal disease compared to the Healthy People 2020 Baseline and Goal (DeKalb County Board of Health, OASIS)

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Hillendale, 2005-2011 (all ages)</th>
<th>Hillendale, 2012-present (all ages)</th>
<th>Healthy People 2020 Baseline</th>
<th>Healthy People 2020 Goal</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>79.4</td>
<td>85.8</td>
<td>16.6</td>
<td>60.0</td>
<td></td>
</tr>
</tbody>
</table>

4. Increase the percentage of institutionalized adults (persons aged 18 years and older in long-term or nursing homes) who are vaccinated against pneumococcal disease.

Baseline: 66.4 percent of persons in long-term care facilities and nursing homes certified by the Centers of Medicare and Medicaid Services (CMS) reported having up-to-date pneumococcal vaccinations in 2005-06.

Target: 90.0 percent.
IV. Strategy Examples - Other Hospitals

Tri-City Regional Medical Center:

- Baseline: 78% of seniors have obtained a flu shot and 60.9% of seniors had a pneumonia vaccine.
- Strategy: Provide vaccines at community events. Community flu vaccines – 256 persons served at Community Fair at Ferguson Elementary School.

Mark Twain St. Joseph's Hospital:

- Goal: Increased rates of immunization/vaccination. (Have baseline # and goal is to increase vaccinations by 10%).
- Other Objectives: Decreased incidents of illness; decreased admissions and/or length of hospital stay for flu/pneumonia.

V. Suggestions for Strategies

Measurable Objectives:

1. Decrease the hospital discharge rate due to pneumonia by ____%
2. Decrease the hospital discharge rate due to pneumonia in the African-American population by ____%
3. Increase the number of pneumonia vaccines provided by ____%
4. Decrease the rate of new pneumonia cases in Hillandale to the Healthy People 2020 goal of 31.1 per 100,000 persons

Evidence based strategies for improving pneumococcal vaccination rates in the clinical setting include3:

- Utilize standing orders in EMR
- Utilize computerized record reminders and personal immunization history health records to determine when/ if the patient needs a vaccine
- Develop and encourage a provider protocol that ensures pneumococcal/ influenza vaccines are discussed during every visit and provided as needed
- Patient education
- Continue to enforce employee vaccinations

Marketing focused strategies4:

---

PRIORITy: Colon Cancer

The 2013 Community Health Needs Assessment for DeKalb Medical Hillandale listed identified colon cancer as one of the top three health priorities. The 2013 assessment findings\(^1\) revealed that colon cancer was the most common type of cancer diagnosis from 2005-2010. For the five year period, colon cancer accounted for 6.4% of all hospital discharges related to cancer. From 2011-2010\(^2\), the service area was slightly different.

I. Data\(^1\)

Table 1. Hospital Discharge due to Colon, Rectal and Anus Cancer, by Location 2005-2012

<table>
<thead>
<tr>
<th></th>
<th>Hillandale 2005-2010 (% of all other cancer discharges)</th>
<th>Hillandale 2010-2012</th>
<th>Hillandale 2010-2012 (% of all other cancer discharges)</th>
<th>Dekalb County 2010-2012</th>
<th>Dekalb County 2010-2012 (% of all other cancer discharges)</th>
<th>Georgia 2010-2012</th>
<th>Georgia 2010-2012 (% of all other cancer discharges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of discharges</td>
<td>6.4%</td>
<td>93</td>
<td>631</td>
<td>12.55%</td>
<td>10,419</td>
<td>13.53%</td>
<td></td>
</tr>
</tbody>
</table>

Note: Highlighted portions are missing due to a postponed data request.

Table 2. Hospital Discharge due to Colon, Rectal and Anus cancer, by Race 2005-2012

<table>
<thead>
<tr>
<th></th>
<th>Hillandale 2005-2010</th>
<th>Hillandale 2010-2012</th>
<th>Hillandale 2010-2012 (% of all other cancer discharges)</th>
<th>Dekalb County 2010-2012</th>
<th>Dekalb County 2010-2012 (% of all other cancer discharges)</th>
<th>Georgia 2010-2012</th>
<th>Georgia 2010-2012 (% of all other cancer discharges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>12</td>
<td>226</td>
<td>12.38%</td>
<td>6,962</td>
<td>13.70%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>78</td>
<td>369</td>
<td>12.93%</td>
<td>3,027</td>
<td>13.46%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>20</td>
<td></td>
<td>24.70%</td>
<td>140</td>
<td>16%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^1\) The Hillandale (Lithonia, Redan) service area for 2005 to 2010 is defined by the following census tracts for 2005-2010: 232.03, 232.04, 232.06, 232.08, 232.09, 232.11, 232.12, 233.02, 233.03, 233.09, 233.1, 233.07, 234.17, 234.18

\(^2\) The Hillandale (Lithonia, Redan) service area for 2011 to 2012 is defined by the following census tracts for 2010-2012: 234.18, 234.27, 234.28, 233.10, 232.14, 232.12, 232.11, 232.10, 233.14, 233.09, 233.03, 233.15, 233.16, 232.13, 232.06, 232.04, 232.08, 232.09, 233.06

\(^1\) Online Analytical Statistical Information System (OASIS), <name of tool used>, Georgia Department of Public Health, Office of Health Indicators for Planning (OHIP). <February 20, 2015> http://oasis.state.ga.us/
<table>
<thead>
<tr>
<th></th>
<th>&lt;5</th>
<th></th>
<th></th>
<th>24</th>
<th>20.17%</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian or Alaskan Native</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>24</td>
<td>20.17%</td>
</tr>
<tr>
<td>Native Hawaiian or Other Pacific Islander</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>16.67%</td>
</tr>
<tr>
<td>Multiracial</td>
<td>&lt;5</td>
<td>16</td>
<td>6.30%</td>
<td>264</td>
<td>9.80%</td>
</tr>
</tbody>
</table>

Note: Highlighted portions are missing due to a postponed data request.

Table 3. Hospital Discharge due to Colon, Rectal and Anus cancer, by Sex 2005-2012

<table>
<thead>
<tr>
<th></th>
<th>Hillandale 2005-2010</th>
<th>Hillandale 2010-2012</th>
<th>Hillandale 2010-2012 (% of all other cancer discharges)</th>
<th>Dekalb County 2010-2012</th>
<th>Dekalb County 2010-2012 (% of all cancer discharges)</th>
<th>Georgia 2010-2012</th>
<th>Georgia 2010-2012 (% of all cancer discharges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>47</td>
<td>319</td>
<td>11.34%</td>
<td>5,049</td>
<td>13.10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>46</td>
<td>312</td>
<td>14.10%</td>
<td>5,370</td>
<td>13.97%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Highlighted portions are missing due to a postponed data request.

II. Current Objectives and Implementation Strategies

The objective relating to the colon cancer priority is to reduce the incidence and enhance the treatment of colon cancer through expansion of the Colon Screening Initiative. This objective was planned to be carried out by the following strategies:

1. Ensure employee screening: Piloting with our DeKalb self-insured plan. Claims data leveraged through health plan administrator to identify employees who should be invited to comply with current screening recommendations. Initial pass was to communicate via enrollment packet to all employees about the importance of screening. A call center number was provided to answer questions and assist with making appointments. The next step will be to mine claims data. However, first issues of confidentiality and employer/employee trust must be addressed before implementation.
   a. UPDATE: A screening was done via open enrollment, which resulted in 2 calls and 1 colonoscopy. DeKalb Medical has not continued with claims data mining because IT personnel and data analysts felt uncomfortable with it. The goal was to increase compliance 10% from baseline; however, that goal was not met.

2. PCP-based screening initiative: Designed as an intervention that involves mining the electronic medical record (EMR) of a primary care physician, to identify the patients under his/her care
who have not complied with screening recommendations. Patients were communicated with by mail and followed up with three phone call attempts. Out of 146 appropriate patients contacted, 111 patient records were corrected or updated (patients who had, in fact, been screened but whose information had not been communicated back to the PCP), though there was significant resistance and/or reticence among those who chose not to received screening. For the next cycle of interventions, contact will move from the Contact Center to the physician’s office, since many patients were reluctant to discuss these matters with Contact Center personnel over the telephone.

a. UPDATE: The PCP-based screening resulted in 4 colonoscopies. DeKalb Medical may add a health coach to the primary care provider offices. The major barrier was that patients did not want to speak with someone overt the phone about colonoscopies and stated they would rather speak with their doctor. DeKalb Medical may need to start offering alternatives to colonoscopies such as a stool test, etc., as it is difficult to reach desirable compliance levels for colonoscopies.

3. Expand population-based direct-mail outreach using a computer-based program to identify residents of the Hillandale service area who fit the demographic profile of the target screening population. These residents will receive directed mailings encouraging them to call the DeKalb Medical Contact Center to set up an appointment with a GI specialist. Expansion will include more communities and a wider number of specialists, who have been vetted by our Quality management/clinical integration department.

   o UPDATE: The total number of pieces mailed for the colonoscopy campaigns is 22,725.
   The first campaign ran from February 2008 – April 2010. Then the renewal GI campaign ran from October 2010 – August 2011. Out of the initial group, 243 people came into the hospital for a colonoscopy and 15 cases of colon cancer were detected. 107 were a direct result of the mailer. Additionally, DeKalb Medical is considering adding a colorectal cancer navigator program similar to the breast cancer navigator program.

III. Related Healthy People 2020 Information

The objectives for Healthy People 2020 include:

1. **Reduce the colorectal cancer death rate.**
   a. Baseline: 17.1 deaths per 100,000 people (2007).
   b. Target: 14.5 deaths per 100,000 people.

2. **Increase the proportion of adults who receive a colorectal cancer screening based on the most recent guidelines.**
   a. Baseline: 52.1% aged 50 to 75 years received a colorectal screening based on the most recent guidelines (2008).

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b. Target: 70.5%

3. Increase the proportion of adults who were counseled by their providers about colorectal cancer screening.
PRIORITIY: Pertussis Vaccination

Pertussis had the highest number of cases in DeKalb County between the years 2005 and 2010 compared to Mumps, Measles, and Rubella. However, there is no information about pertussis vaccinations.

I. Data

Table 1. Pertussis cases, Location, Year

<table>
<thead>
<tr>
<th>Years</th>
<th>Cases in DeKalb County</th>
<th>Cases in Georgia</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011-2013</td>
<td></td>
<td>180 (2011)</td>
</tr>
<tr>
<td>2005-2010</td>
<td>27</td>
<td>810</td>
</tr>
<tr>
<td>Total Cases</td>
<td></td>
<td>990</td>
</tr>
</tbody>
</table>

Note: Highlighted data could be pulled using SENDSS or other database.

The CHNA says, “The number of deaths due to vaccine-preventable disease is not available from the surveillance systems (e.g., OASIS, SENDSS) used for this report.” However, number of discharges due to pertussis could be utilized.

II. Current Objectives and Implementation Strategies

The assessment findings and related objectives/strategies for Pertussis Vaccination are:

Assessment Findings: Pertussis (whooping cough) is overwhelmingly the leading vaccine-preventable disease in DeKalb County.

1. Increase the rate of pertussis vaccination
   a. Investigate efforts with physician practices concerning educational support and reporting pertussis vaccination prior to admission
      i. UPDATE: We have a nurse working on her DNP who has taken this on as her capstone project and is working on this for us to take it to the next level.
   b. Continue to identify and educate appropriate new mothers on the importance of pertussis vaccination
      i. UPDATE: The vaccine is offered to moms prior to discharge. Currently evaluating moving to the recommendation of administering prenatally. Also to our antepartum patients and looking if any of the pharmacies offer them inexpensively as the best practice is to administer prenatally to allow immunity to transfer to the baby during pregnancy.
   c. Continue to provide the availability of the pertussis vaccination to our patients

1 Online Analytical Statistical Information System (OASIS), <name of tool used>, Georgia Department of Public Health, Office of Health Indicators for Planning (OHIP). <February 20, 2015> http://oasis.state.ga.us/
i. UPDATE: Vaccination education materials given to every new mother.

III. Related Healthy People 2020 Information

Healthy People 2020 objectives include:

1. **Reduce cases of pertussis among children under 1 year of age.**

Baseline: 2,777 confirmed and probable cases of pertussis (including cases identified in outbreak settings) among children under age 1 year was reported during 2004–08.

Target: 2,500 cases among children under age 1 year.

Target-Setting Method: 10 percent improvement.

2. **Reduce cases of pertussis among adolescents aged 11 to 18 years.**

Baseline: 3,995 confirmed and probable cases of pertussis (including cases identified in outbreak settings) were reported among adolescents aged 11 to 18 years during 2000–04.

Target: 2,000 cases among adolescents aged 11 to 18 years.

3. **Maintain an effective vaccination coverage level of 4 doses of the diphtheria-tetanus-acellular pertussis (DTaP) vaccine among children by age 19 to 35 months.**

Baseline: 84.6 percent of children aged 19 to 35 months in 2008 received 4 or more doses of the combination of diphtheria, tetanus, and acellular pertussis antigens.

Target: 90.0 percent.