As part of the Affordable Care Act, all not-for-profit hospitals must conduct a Community Health Needs Assessment every three years to identify their communities’ health care needs and plan for how they will address those needs.

University’s 2013 Community Health Needs Assessment was created with the help of a number of people and organizations that researched community demographics, socio-economic factors and health service utilization trends. Using the CHNA process outlined in this report, along with resources such as the Richmond County Health Department and Healthy Communities Institute, University was able to narrow its assessment scope to the following health issues: Chronic Disease Prevalence (Diabetes, Heart Failure, etc.); Obesity and Nutrition; Access to Care; and Prevention and Screenings. This report offers suggestions for how we might collaborate with local organizations and agencies to improve our community’s health and illustrates how University is meeting its obligation to deliver efficient health care services.

We do not have adequate resources to solve all the problems identified during this assessment process. Some issues are beyond the mission of University Hospital and require action from other people or organizations. We view this as a plan for how we, along with other organizations and agencies, can collaborate to bring the best each has to offer to address the more pressing identified needs.

University Hospital will use this assessment as a guide for strengthening, creating and/or implementing programs that address the identified health needs of our community.
University Health Care System's Mission and Vision

Our Mission

The mission of University Health Care System is to provide health care services which help the citizens of our communities achieve and maintain optimal health.

Our Vision

The vision of University Health Care System is to set the standard for quality as a comprehensive health care network. We will achieve improved health status, exceptional clinical outcomes, customer satisfaction and value. In partnership with our medical staff, employees, volunteers, patients and other community providers, we will build a continuum of care which includes health promotion, illness prevention, and primary, tertiary and after-care services.

Our Commitments

The employees, management and medical staff of University Health Care System share a deep commitment to the health of the citizens of our communities. We are guided by the following commitments:

Quality Service
We will serve others as we, ourselves, would wish to be served. Everyone who comes in contact with our organization -- patients, employees, physicians, visitors, suppliers and payers -- will be treated with consideration, dignity, kindness and respect. We will provide technical excellence coupled with compassion. We will strive to meet and exceed what is expected of us.

Teamwork
We will work as a team in a culture that nurtures and encourages innovation and self-esteem. We will communicate with each other and share our concerns with open, helpful, honest, solution-focused discussions. We will anticipate change and cultivate creative problem solving. We will challenge established routines to find better ways to get the job done.

Professionalism
We will conduct ourselves with the highest ethical standards and integrity. Our professionalism will be reflected in our actions and appearance.

Financial Stewardship
We will use resources wisely, completing tasks without waste or excess. We will charge fair prices, deliver good value and achieve a reasonable margin of return to further our mission.

Community
We will make our community a healthier place to live and reach out to embrace a larger community. Through collaboration with providers and in cooperation with government and business, University will set the standard for quality as the comprehensive health care network.
Process and Methodology

University Hospital identified community health needs by undergoing an assessment process. This process incorporated a comprehensive review by the hospital’s Community Needs Assessment Team along with secondary and primary data input using the expertise of local partners and community health agencies. The team used several sources of quantitative health, as well as social and demographic data specific to the service area of University Hospital. UH took advantage of this opportunity to collaborate with its administrators, physicians, public health agencies and local organizations in identifying and addressing the needs of the community.

As allowed by IRS guidelines, University Hospital sought outside assistance from the Dixon Hughes Goodman CHNA team in this process. DHG Healthcare facilitated priority sessions and supported the report drafting process.

The assessment process consists of five steps pictured below:
Community Served

University Hospital has a long tradition of service with roots that go deep into the community. The oldest hospital in the Augusta area and the second oldest in the state of Georgia, University's volunteer trustees and medical staff have never lost sight of the founders' original mission of improving the delivery of healthcare to the people of the community.

University Hospital’s service area is defined as Richmond County for this assessment. Using a county definition as the service area is crucial for analysis as many secondary data sources are county specific and serve as a comparison tool to other counties, the state of Georgia and the United States. Also, many of our community input sources consider Richmond County their primary service area. These include public health officials, as well as many different community advocacy groups with whom University Hospital has relationships.
Data Assessment - Secondary Data

In order to present the data in a way that would tell a story of the community and also identify needs, the framework of Healthy People 2020 was selected to guide secondary data gathering and also community input. This framework was selected based on its national recognition as well as its mission listed below:

- Identify nationwide health improvement priorities.
- Increase public awareness and understanding of the determinants of health, disease and disability and the opportunities for progress.
- Provide measurable objectives and goals that are applicable at the national, state and local levels.
- Engage multiple sectors to take actions to strengthen policies and improve practices that are driven by the best available evidence and knowledge.
- Identify critical research, evaluation, and data collection needs.

Within this framework, 12 Topics were chosen as “Leading Health Indicators.” These topics guide discussion and research related to this CHNA.
Sources used in the data assessment process

University Hospital utilized the expertise of Healthy Communities Institute to provide a community dashboard of Richmond County. This tool is housed on the University Health System website and provides numerous health indicators and demographic data. In addition, there are also analysis tools, such as the Healthy People 2020 Tracker to compare Richmond County to other counties in Georgia and the United States. This tool is also used to compare county scores against Healthy People 2020 targets or benchmarks.

Nielsen Claritas: Nielsen Claritas demographics were used to create maps and tables of total population and breakdowns of certain other population segments. This information was pulled for Richmond County and the state of Georgia, and 2013 and 2018 demographics were included. Nielsen Claritas also provided certain education and income level data used in the social determinants section.

2013 County Health Rankings: This source is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. It gives a general snapshot of how healthy each county is in relation to others in the same state. It measures and ranks both health outcomes and health factors that lead to those outcomes. Each indicator is weighed, standardized and ranked in order to come up with an overall health ranking for each Georgia county. Ranking areas included:

- **Health Outcomes**: Mortality and Morbidity
- **Health Factors**: Tobacco Use, Diet and Exercise, Alcohol Use, Sexual Activity, Access to Care, Quality of Care, Education, Income, Family and Social Support, Community Safety

Other sources used in Healthy Community Institute’s dashboard include the National Cancer Institute, Environmental Protection Agency, US Census Bureau and the US Department of Education.
Data Assessment Highlights and Findings

The data assessment piece of the CHNA process included health indicators from various sources widely available. These data elements identified at-risk populations, underserved populations, health need areas and possible areas of improvement. A summary of findings was created to highlight areas of need within the service area. Many of these indicators were pulled from a community dashboard found on the University Hospital website. As mentioned in the sources above, this dashboard is powered by Healthy Communities and is continuously updated as new data is available.

**Demographics:** Nielsen Claritas demographics were used to create maps and tables of total population and breakdown other population segments. This information was pulled for Richmond County and the state of Georgia, and 2013 and 2018 demographics were included. Below is a snapshot of the county population showing growth in all age groups over the next five years.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 00-04</td>
<td>15,046</td>
<td>15,634</td>
<td>3.91%</td>
<td>588</td>
</tr>
<tr>
<td>Age 05-09</td>
<td>13,919</td>
<td>14,677</td>
<td>5.45%</td>
<td>758</td>
</tr>
<tr>
<td>Age 10-14</td>
<td>12,888</td>
<td>13,738</td>
<td>6.60%</td>
<td>850</td>
</tr>
<tr>
<td>Age 15-17</td>
<td>7,890</td>
<td>7,670</td>
<td>-2.79%</td>
<td>-220</td>
</tr>
<tr>
<td>Age 18-44</td>
<td>78,431</td>
<td>78,539</td>
<td>0.14%</td>
<td>108</td>
</tr>
<tr>
<td>Age 45-54</td>
<td>25,532</td>
<td>22,811</td>
<td>-10.66%</td>
<td>-2,721</td>
</tr>
<tr>
<td>Age 55-64</td>
<td>23,683</td>
<td>24,722</td>
<td>4.39%</td>
<td>1,039</td>
</tr>
<tr>
<td>Age 65-74</td>
<td>14,158</td>
<td>17,057</td>
<td>20.48%</td>
<td>2,899</td>
</tr>
<tr>
<td>Age 75-84</td>
<td>7,493</td>
<td>8,133</td>
<td>8.54%</td>
<td>640</td>
</tr>
<tr>
<td>Age 85+</td>
<td>2,882</td>
<td>3,232</td>
<td>12.14%</td>
<td>350</td>
</tr>
<tr>
<td>Total</td>
<td>201,922</td>
<td>206,213</td>
<td>2.13%</td>
<td>4,291</td>
</tr>
</tbody>
</table>

Additionally, many races will see their population grow over the next five years in Richmond County.
Nielsen Claritas also provides information on income and education. Below is a summary of this information for Richmond County compared to the state of Georgia and the United States.

<table>
<thead>
<tr>
<th></th>
<th>Average Median HH Income 2013</th>
<th>% Families Below Poverty 2013</th>
<th>% Adults (25+) with &lt; 9th Grade Education 2013</th>
<th>% Adults (25+) with Some High School Education-No Diploma 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Richmond County - GA</td>
<td>$38,902</td>
<td>19.99%</td>
<td>5.68%</td>
<td>10.45%</td>
</tr>
<tr>
<td>State of GA</td>
<td>$45,069</td>
<td>13.12%</td>
<td>5.92%</td>
<td>9.92%</td>
</tr>
<tr>
<td>USA</td>
<td>$49,297</td>
<td>10.89%</td>
<td>6.18%</td>
<td>8.41%</td>
</tr>
</tbody>
</table>
Access to Health Services

Healthy People 2020 Overview: “A person’s ability to access health services has a profound effect on every aspect of his or her health, yet at the start of the decade, almost 1 in 4 Americans do not have a primary care provider (PCP) or health center where they can receive regular medical services. Approximately 1 in 5 Americans (children and adults under age 65) do not have medical insurance. People without medical insurance are more likely to lack a usual source of medical care, such as a PCP, and are more likely to skip routine medical care due to costs, increasing their risk for serious and disabling health conditions. When they do access health services, they are often burdened with large medical bills and out-of-pocket expenses.”

Why this is important: Medical costs in the United States are extremely high, so people without health insurance may not be able to afford medical treatment or prescription drugs. They are also less likely to get routine checkups and screenings, so if they become ill they will not seek treatment until the condition is more advanced and therefore more difficult and costly to treat. Many small businesses are unable to offer health insurance to employees due to rising health insurance premiums.

The Healthy People 2020 national health target is to increase the proportion of people with health insurance to 100 percent.

Source: American Community Survey
Clinical Preventive Services

Healthy People 2020 Overview: “Clinical preventive services, such as routine disease screening and scheduled immunizations, are key to reducing death and disability and improving the nation’s health. These services both prevent and detect illnesses and diseases — from flu to cancer — in their earlier, more treatable stages, significantly reducing the risk of illness, disability, early death, and medical care costs. Yet, despite the fact that these services are covered by Medicare, Medicaid, and many private insurance plans under the Affordable Care Act, millions of children, adolescents and adults go without clinical preventive services that could protect them from developing a number of serious diseases or help them treat certain health conditions before they worsen.”

Below are indicators of possible concern relating to screenings or diseases detected from preventive screenings.

**Why this is important:** A mammogram is an X-ray of the breast that can be used to detect changes in the breast such as tumors and calcifications. The test may be done for screening or for diagnostic purposes. A positive screening mammogram leads to further testing to determine if cancer is present. Mammograms may also be used to evaluate known cases of breast cancer. Although mammograms do not detect all cases of breast cancer, they have been shown to increase early detection, thus reducing mortality. Centers for Disease Control and Prevention provides low-income, uninsured and underserved women access to free or low-cost mammograms through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP).

**Why this is important:** Regular HbA1c screening among diabetics helps assess whether or not the patient is properly managing their disease and is considered the standard of care. In 2007, diabetes was the seventh leading cause of death in the United States and an estimated 23.6 million people or 7.8 percent of the population had diabetes. Diabetes disproportionately affects minority populations and the elderly and its incidence is likely to increase as minority populations grow and the U.S. population becomes older.

Diabetes can have a harmful effect on most of the organ systems in the human body; it is a frequent cause of end-stage renal disease, non-traumatic lower-extremity amputation, and a leading cause of blindness among working age adults. Persons with diabetes are also at increased risk for ischemic heart disease, neuropathy and stroke. In economic terms, the direct medical expenditure attributable to diabetes in 2007 was estimated to total $116 billion.

Source: County Health Rankings
Why this is important: In 2007, diabetes was the seventh leading cause of death in the United States. In 2010, an estimated 25.8 million people or 8.3% of the population had diabetes. Diabetes disproportionately affects minority populations and the elderly and its incidence is likely to increase as minority populations grow and the U.S. population becomes older. Diabetes can have a harmful effect on most of the organ systems in the human body; it is a frequent cause of end-stage renal disease, non-traumatic lower-extremity amputation, and a leading cause of blindness among working age adults. Persons with diabetes are also at increased risk for ischemic heart disease, neuropathy, and stroke. In economic terms, the direct medical expenditure attributable to diabetes in 2007 was estimated to be $116 billion.

Source: County Health Rankings

Why this is important: Diabetes is a group of diseases marked by high levels of blood glucose, also called blood sugar, resulting from defects in insulin production, insulin action, or both. In 2007, diabetes was the seventh leading cause of death in the United States and an estimated 23.6 million people or 7.8% of the population had diabetes. The prevalence of diagnosed type 2 diabetes increased six fold in the latter half of the last century. Diabetes risk factors such as obesity and physical inactivity have played a major role in this dramatic increase. Age, race, and ethnicity are also important risk factors.

Source: Georgia Department of Public Health OASIS
Why this is important: Cancer is the second leading cause of death in the United States. The National Cancer Institute (NCI) defines cancer as a term used to describe diseases in which abnormal cells divide without control and are able to invade other tissues. There are over 100 different types of cancer. According to the NCI, lung, colon and rectal, breast, pancreatic and prostate cancer lead to the greatest number of annual deaths.

The Healthy People 2020 target is to reduce the overall cancer death rate to 160.6 deaths per 100,000 population.

Source: National Cancer Institute
Environmental Quality

Healthy People 2020 Overview: “Poor environmental quality has its greatest impact on people whose health status is already at risk. For example, nearly 1 in 10 children and 1 in 12 adults in the United States have asthma, which is caused, triggered and exacerbated by environmental factors such as air pollution and secondhand smoke.”

Why this is important: Ozone is an extremely reactive gas composed of three oxygen atoms. It is the primary ingredient of smog air pollution and very harmful to breathe. Ozone essentially attacks lung tissue by reacting chemically with it. It also damages crops, trees and other matter – even breaking down rubber compounds.

Source: American Lung Association

Injury and Violence

Healthy People 2020 Overview: “Motor vehicle crashes, homicide, domestic and school violence, child abuse and neglect, suicide and unintentional drug overdoses are important public health concerns in the United States. In addition to their immediate health impact, the effects of injuries and violence extend well beyond the injured person or victim of violence, affecting family members, friends, coworkers, employers and communities. Witnessing or being a victim of violence is linked to lifelong negative physical, emotional and social consequences.”

Why this is important: A violent crime is a crime in which the offender uses or threatens to use violent force upon the victim. Violent crimes include homicide, assault, rape and robbery. Violence negatively impacts communities by reducing productivity, decreasing property values and disrupting social services. In the United States in 2009, an estimated 1,318,398 violent crimes occurred. This equates to an estimated 429.4 violent crimes per 100,000 population nationwide.

Source: Georgia Statistics System
Maternal, Infant, Child Health

Healthy People 2020 Overview: “The well-being of mothers, infants, and children determines the health of the next generation and can help predict future public health challenges for families, communities and the medical care system. Moreover, healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential. “

Why this is important: Infant mortality rate continues to be one of the most widely used indicators of the overall health status of a community. The leading causes of death among infants are birth defects, pre-term delivery, low birth weight, Sudden Infant Death Syndrome (SIDS) and maternal complications during pregnancy.

The Healthy People 2020 national health target is to reduce the infant mortality rate to 6 deaths per 1,000 live births.

Source: GA Dept. of Public Health OASIS

Why this is important: Babies born with a low birth weight are more likely than babies of normal weight to require specialized medical care, and often must stay in the intensive care unit. Low birth weight is often associated with premature birth. While there have been many medical advances enabling premature infants to survive, there is still risk of infant death or long-term disability. The most important things an expectant mother can do to prevent prematurity and low birth weight are to take prenatal vitamins, stop smoking, stop drinking alcohol and using drugs, and most importantly, get prenatal care.

The Healthy People 2020 national health target is to reduce the proportion of infants born with low birth weight to 7.8 percent.

Source: GA Dept. of Public Health OASIS
Mental Health

Healthy People 2020 Overview: “Mental health is essential to a person’s well-being, healthy family and interpersonal relationships, and the ability to live a full and productive life. People, including children and adolescents, with untreated mental health disorders are at high risk for many unhealthy and unsafe behaviors, including alcohol or drug abuse, violent or self-destructive behavior and suicide.”

Why this is important: Suicide is a major, preventable public health problem. In 2007, suicide was the 11th leading cause of death in the United States. Based on 2007 age-adjusted death rates, men were nearly four times more likely to die of suicide than females, and white individuals were over two times more likely to die of suicide than black or Hispanic individuals. Older Americans are disproportionately likely to die by suicide. An estimated eight to 25 attempted suicides occur for every suicide death.

The Healthy People 2020 national health target is to reduce the suicide rate to 10.2 deaths per 100,000 population.

Source: Georgia Dept. of Public Health OASIS

Why this is important: Social and emotional support refers to the subjective sensation of feeling loved and cared for by those around us. Research has shown that individuals with social and emotional support experience better health outcomes compared to individuals who lack such support. For example, when individuals are exposed to stress, emotional support has been shown to decrease stress hormones and reduce blood pressure. In addition, it has been shown that social and emotional support have beneficial effects on recovery time post cardiac surgery, coping with cancer pain and overall longevity.

Source: County Health Rankings
Nutritional, Physical Activity and Obesity

**Healthy People 2020 Overview:** “Good nutrition, physical activity, and a healthy body weight are essential parts of a person’s overall health and well-being. Together, these can help decrease a person’s risk of developing serious health conditions, such as high blood pressure, high cholesterol, diabetes, heart disease, stroke, and cancer. A healthful diet, regular physical activity, and achieving and maintaining a healthy weight also are paramount to managing health conditions so they do not worsen over time. “

**Why this is important:** The percentage of obese adults is an indicator of the overall health and lifestyle of a community. Obesity increases the risk of many diseases and health conditions including heart disease, Type 2 diabetes, cancer, hypertension, stroke, liver and gallbladder disease, respiratory problems, and osteoarthritis. Losing weight and maintaining a healthy weight help to prevent and control these diseases. Being obese also carries significant economic costs due to increased healthcare spending and lost earnings.

The Healthy People 2020 national health target is to reduce the proportion of adults aged 20 and older who are obese to 30.6 percent.

**Why this is important:** Adults who are sedentary are at an increased risk of many serious health conditions. These conditions include obesity, heart disease, diabetes, colon cancer, and high blood pressure. In addition, physical activity improves mood and promotes healthy sleep patterns. The American College of Sports Medicine (ACSM) recommends that adults perform physical activity three to five times each week for 20 to 60 minutes at a time to improve cardiovascular fitness and body composition. The ACSM also recommends that you include strength and flexibility training in your exercise program. If you are not currently exercising, please consult your physician before beginning any exercise program.

The Healthy People 2020 national health target is to reduce the percentage of adults (ages 18 and up) who do not engage in any leisure-time physical activity to 32.6 percent.

Source: County Health Rankings
Why this is important: The accessibility, availability and affordability of healthy and varied food options in the community increase the likelihood that residents will have a balanced and nutritious diet. A diet comprised of nutritious foods, in combination with an active lifestyle, can reduce the incidence of heart disease, cancer and diabetes and is essential to maintain a healthy body weight and prevent obesity. Low-income and under-served areas often have limited numbers of stores that sell healthy foods. People living farther away from grocery stores are less likely to access healthy food options on a regular basis and thus more likely to consume foods which are readily available at convenience stores and fast food outlets.

Source: USDA Food Environment Atlas

Why this is important: People engaging in an active lifestyle have a reduced risk of many serious health conditions including obesity, heart disease, diabetes, and high blood pressure. In addition, physical activity improves mood and promotes healthy sleep patterns. The American College of Sports Medicine recommends that active adults perform physical activity three to five times each week for 20 to 60 minutes at a time to improve cardiovascular fitness and body composition. People are more likely to engage in physical activity if their community has facilities which support recreational activities, sports and fitness.

Source: USDA Food Environment Atlas

Why this is important: The physical environment includes all of the parts of where we live and work (e.g., homes, buildings, streets, and parks). The environment influences a person's level of physical activity and ability to have healthy lifestyle behaviors. For example, inaccessible or nonexistent sidewalks or walking paths increase sedentary habits. These habits contribute to obesity, cardiovascular disease, and diabetes. Other factors that contribute to healthy lifestyle behaviors are access to grocery stores and farmer's markets, recreation facilities, and the presence of a clean and safe physical environment.

Source: County Health Rankings
Oral Health

Healthy People 2020 Overview: “Oral diseases ranging from dental caries (cavities) to oral cancers cause pain and disability for millions of Americans. The impact of these diseases does not stop at the mouth and teeth. A growing body of evidence has linked oral health, particularly periodontal (gum) disease, to several chronic diseases, including diabetes, heart disease and stroke.”

Why this is important: Oral health has been shown to impact overall health and well-being. Nearly one-third of all adults in the United States have untreated tooth decay, or tooth caries, and one in seven adults ages 35 to 44 years old has periodontal (gum) disease. Tooth decay is the most prevalent chronic infectious disease affecting children in the U.S., and impacts more than a quarter of children ages 2 to 5 and more than half of children ages 12 to 15. Given these serious health consequences, it is important to maintain good oral health. It is recommended that adults and children see a dentist on a regular basis. Professional dental care helps to maintain the overall health of the teeth and mouth, and provides for early detection of pre-cancerous or cancerous lesions. People living in areas with low rates of dentists may have difficulty accessing the dental care they need.

Source: County Health Rankings

Social Determinants

Healthy People 2020 Overview: “A range of personal, social, economic, and environmental factors contribute to individual and population health. For example, people with a quality education, stable employment, safe homes and neighborhoods, and access to preventive services tend to be healthier throughout their lives. Conversely, poor health outcomes are often made worse by the interaction between individuals and their social and physical environment.

Why this is important: Family income has been shown to affect a child’s well-being in numerous studies. Compared to their peers, children in poverty are more likely to have physical health problems like low birth weight or lead poisoning, and are also more likely to have behavioral and emotional problems. Children in poverty also tend to exhibit cognitive difficulties, as shown in achievement test scores, and are less likely to complete basic education.

Source: American Community Survey
Why this is important: Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. A high poverty rate is both a cause and a consequence of poor economic conditions. A high poverty rate indicates that local employment opportunities are not sufficient to provide for the local community. Through decreased buying power and decreased taxes, poverty is associated with lower quality schools and decreased business survival.

Source: American Community Survey

Why this is important: The unemployment rate is a key indicator of the local economy. Unemployment occurs when local businesses are not able to supply enough and/or appropriate jobs for local employees and/or when the labor force is not able to supply appropriate skills to employers. A high rate of unemployment has personal and societal effects. During periods of unemployment, individuals are likely to feel severe economic strain and mental stress. Unemployment is also related to access to health care, as many individuals receive health insurance through their employer. A high unemployment rate places strain on financial support systems, as unemployed persons qualify for unemployment benefits and food stamp programs.

Source: U.S. Bureau of Labor Statistics
Sexual/Reproductive Health

Healthy People 2020 Overview: “An estimated 19 million new cases of sexually transmitted diseases (STDs) are diagnosed each year in the United States—almost half of them among young people age 15 to 24. An estimated 1.1 million Americans are living with the human immunodeficiency virus (HIV), and 1 out of 5 people with HIV do not know they have it. Untreated STDs can lead to serious long-term health consequences, especially for adolescent girls and young women, including reproductive health problems and infertility, fetal and perinatal health problems, cancer and further sexual transmission of HIV.”

Why this is important: Chlamydia, the most frequently reported bacterial sexually transmitted disease (STD) in the United States, is caused by the bacterium, Chlamydia trachomatis. Although symptoms of chlamydia are usually mild or absent, serious complications that cause irreversible damage, including infertility, can occur “silently” before a woman ever recognizes a problem. Chlamydia also can cause discharge from the penis of an infected man. Under-reporting of chlamydia is substantial because most people with chlamydia are not aware of their infections and do not seek testing.

Source: Georgia Dept. of Public Health OASIS

Why this is important: AIDS cases provide a valuable measure of the impact of the disease in various areas and populations. In the mid-to-late 1990s, advances in HIV treatments led to dramatic declines in AIDS deaths and slowed the progression from HIV infection to AIDS. Better treatments have also led to an increase in the number of persons who are living with AIDS.

Source: Georgia Statistics System
Substance Abuse/Tobacco

Healthy People 2020 Overview: “Substance abuse – involving drugs, alcohol, or both – is associated with a range of destructive social conditions, including family disruptions, financial problems, lost productivity, failure in school, domestic violence, child abuse and crime.”

Why this is important: Tobacco is the agent most responsible for avoidable illness and death in America today. Tobacco use brings premature death to almost half a million Americans each year, and it contributes to profound disability and pain in many others. Approximately one-third of all tobacco users in this country will die prematurely because of their dependence on tobacco. Areas with a high smoking prevalence will also have greater exposure to secondhand smoke for non-smokers, which can cause or exacerbate a wide range of adverse health effects, including cancer, respiratory infections, and asthma.

Source: County Health Rankings

Why this is important: Drinking alcohol has immediate physiological effects on all tissues of the body, including those in the brain. Alcohol is a depressant that impairs vision, coordination, reaction time, judgment, and decision-making, which may in turn lead to harmful behaviors. According to the CDC, excessive alcohol use, either in the form of heavy drinking (drinking more than two drinks per day on average for men or more than one drink per day on average for women), or binge drinking (drinking more than 5 drinks during a single occasion for men or more than four drinks during a single occasion for women), can lead to increased risk of health problems, such as liver disease and unintentional injuries. Alcohol abuse is also associated with a variety of other negative outcomes, including employment problems, legal difficulties, financial loss, family disputes, and other interpersonal issues.

Source: County Health Rankings

Please visit [http://www.universityhealth.org/body.cfm?id=39539&hcn=CommunityDashboard](http://www.universityhealth.org/body.cfm?id=39539&hcn=CommunityDashboard) to view all health indicators included in our Community Dashboard powered by Healthy Communities Institute.

Next Steps

Data collected in this phase will be overlaid with community input findings to prioritize needs of the community and ultimately lead to strategies on many of the issues identified above.
Community Input Findings – Primary Data

In addition to the secondary data assessment, the Community Needs Assessment Team with the assistance of Georgia Health Sciences University students, entered into dialogue with key hospital administrators, physicians, those with knowledge/expertise in public health, and those serving underserved and chronic disease populations. During this phase, the team conducted interviews, facilitated discussions, and held focus groups in which respondents were able to comment and discuss general community health issues of their specific service area. Through these numerous interviews and discussions, a summary of community input was created. This summary would eventually be used to help focus in on priorities and ultimately, implementation strategies.

The list below includes respondents who participated in this phase. They included experts in the field of public health, hospital administration members, community outreach groups, and other local organizations. All input was collected over a period starting in late 2012 and ending in April 2013. A summary priority session was then held in August of 2013. Respondents included:

- Marilyn Bowcutt, RN, MSN, FAAN Executive Vice President/COO -- University Health Care System, President – University Hospital
- William P. Kanto, Jr., MD, Senior Vice President for Medical Affairs, CMO -- Georgia Health Sciences Medical Center
- Sarah “Teri” Perry, MSN, RN, Interim CNO -- Georgia Health Sciences Medical Center
- Vikki Pruitt, Deputy Director -- Augusta Partnership for Children, Inc.
- L. Monique Hillman, Health and Wellness Coordinator -- CSRA Regional Commission Augusta Area on Aging
- Dr. Beulah Nash-Teachey, President -- Concerned National Black Nurses of the Central Savannah River
- Janice Sherman, Executive Director -- Belle Terrace Health and Wellness Center
- Susan Dillard, Nurse Supervisor -- Richmond County School System
- Health District RNs (14 people) East Central Health District

Respondents were asked the following questions and were encouraged to elaborate on any topics that were of significance to their services, service area, or target populations.

- What are the five most important health issues facing our Augusta Community?
- What are the five most important health needs facing our Augusta Community?
- What suggestions do you have for addressing each of these issues and needs identified?
- What community partnerships could be a resource for addressing each of the issues and needs identified?
- Are resources available to address the issues and the needs identified?
A summary of the interview and discussion responses can be found below:

Health & Social Services Community Voices: Priority Health Problems

Top 5 Health Illnesses

- Obesity
- Diabetes
- Sexually Transmitted Infections (STI)
- Teen Pregnancy
- Hypertension

Health & Social Service Community Voices: Priority Needs – Factors that influence overall health

<table>
<thead>
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<th>Access - to Care / Insurance / Providers</th>
<th>18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education (health, literacy)</td>
<td>14</td>
</tr>
<tr>
<td>Transportation</td>
<td>8</td>
</tr>
<tr>
<td>Nutritious Food</td>
<td>6</td>
</tr>
<tr>
<td>Financial (clinic, population)</td>
<td>5</td>
</tr>
<tr>
<td>Recreation</td>
<td>4</td>
</tr>
<tr>
<td>Patient Compliance/ follow-up</td>
<td>2</td>
</tr>
<tr>
<td>Environment/sanitation</td>
<td>2</td>
</tr>
</tbody>
</table>
Each group was then asked to identify barriers to both medical and community resources, as well as identify possible improvement plans in which University Hospital could possibly participate through local partnerships.

**How can we build on existing partnerships to create a healthier Augusta-Richmond County?**

**Suggestions and Partnerships to Address Health Issues and Needs**

- Financial and resource support for community clinics
- Volunteer students and other healthcare personnel
- Engage GHSU students in service learning projects to help teach health self-management
- Community health classes
- Health education in schools
- Referral coordinators in Emergency Department
- Transition coaches
  - From hospital to home
  - Peers in the community
  - One-on-one patient education
- Collaboration for access to patient health data between providers
  - To facilitate continuity of care

These responses were overlaid with data from secondary sources when considering which needs to prioritize and ultimately implement strategies to address.
Community Benefit:

Indigent and Charity Care
In 2012, University Health Care System provided $28,813,764 in indigent and charity care. These costs include:

$20,132,839 for inpatient and outpatient services for indigent patients. This includes Project Access, which University helped develop in 2002 with the Richmond County Medical Society to care for Richmond and Columbia County indigent patients. University continues to be Augusta’s largest hospital contributor of funds and services to this program.

$2,204,576 to help support community clinics such as Christ Community Clinic, the Lamar Medical Center, Belle Terrace Health and Wellness Center, St. Vincent dePaul and the Harrisburg Family Healthcare Clinic.

$7,203,007 in uncompensated physician services for indigent and charity patients.

$195,133 for disease management programs coordinated and staffed by University to help people with chronic diseases such as congestive heart failure, asthma and congestive obstructive pulmonary disease (COPD) better manage their conditions so they live longer, healthier lives.

Not included in the community benefit amount, but a significant contribution by University Hospital is the loss sustained by “bad debt,” or the amount of care provided for which payment was expected but not received and “Medicare and Medicaid shortfalls,” or the difference between the cost of care provided to those patients and the payment received from the state and federal government for that care.

Community Outreach
Staying true to our mission of helping people stay healthy, University reached more than 200,000 people in 2012 and invested nearly $1.4 million on free screenings, community education classes and free publications to spotlight the importance of prevention and early detection of disease.

Health Professions Education
At University we know that a skilled and educated workforce is an important part of providing advanced health. In 2012, University invested $643,690 in three University-based programs — Harry T. Harper Jr., M.D., School of Cardiac and Vascular Technology; Augusta Dietetic Internship; and Stephen W. Brown School of Radiography — to train excellent allied health professionals.

* Dollar amounts reflect estimated costs, not charges. Information may not be IRS Form 990 Schedule H compliant.

To view the entire 2012 Community Benefit Report, visit www.universityhealth.org/aboutus.
Other Programs and Services:

**FREE Focused Education and Screenings**

**Physician-led education seminars**
- Colon, skin and cervical cancer
- Nutrition and cancer
- Weight management
- Preventing heart disease
- Controlling hypertension
- Smoking cessation
- Childbirth preparation
- First six weeks of infant care
- Importance of breastfeeding
- Infant CPR

**Screenings**
- Mobile mammography
- Melanoma screening
- Community health fairs
- Outreach to business and industry

**Community Events**
- Diabetes Expo
  - Multiple physician-led classes
  - Counseling
  - Cooking demonstration
  - Attended by 800+
- Sweet Success diabetes education program geared toward at-risk population
- Diabetes camp for adolescents
- Cardio on the Canal to educate kids on healthy eating and exercise
- Healthy cooking demonstrations
Local Organizations and Staff

In addition to those interviewed, many other local organizations and staff contributed to this year’s Community Health Needs Assessment. These individuals and their local organizations represent an inventory of community services already available to address needs of the Augusta area.

Public Health Department

*Key Staff* - Dr. Ketty Gonzalez, Director

Dr. Gonzalez was appointed as the East Central Public Health District Director in October 2007.

Public health nurses comprise the single largest part of Georgia's public health workforce. The capacity of the public health system to fulfill its mission, "... to promote, protect and improve the health and safety of the people of Georgia" depends to a great extent on the work of public health nurses. The success of public health will continue to rely on the skills and abilities of nurses to serve as vital members of the public health team in planning for, and responding to, the changing needs of a complex and diverse population.

Every day, public health nurses make a difference in the health of the public. Public health nurses provide a wide range of direct clinical services, such as administering vaccines to prevent communicable diseases and providing family planning services to prevent unintended pregnancies. Public health nurses also provide complex population-based services that are aimed at improving the health status of the community, such as assisting with plans to investigate a disease outbreak, presenting information about health trends to local policy makers within their communities and serving on the community's local emergency preparedness planning team.

Georgia Regents University Augusta School of Nursing

*Key Staff* - Christine O'Meara, Special Projects Coordinator

Coordinated Community Health Needs Assessments with University Hospital, GRU School of Nursing, and GRU Administration.

Project Access

*Key Staff* - Dr. Terence Cook

Richmond County Medical Society Project Access, Inc. is an outreach program of the Richmond County Medical Society which assists the uninsured indigent people of Richmond and Columbia Counties with accessing physician services and assists Richmond and Columbia County physicians with expanding their role in caring for these patients. RCMS Project Access, Inc. is a participant in the CSRA Partnership for Community Health and the Greater Augusta Healthcare Network (GAHN).

Greater Augusta Healthcare Network (GAHN)

*Key Staff* - Lucy Marion, Dean of the School of Nursing, Medical College of Georgia

The network, founded in 2007 with initial grant funding from The Georgia Healthcare Foundation, includes the Georgia Health Sciences University College of Nursing, six hospitals, seven community clinics, five community service providers and the East Central Public Health District. Its mission is to
improve health in greater Augusta by increasing access to quality, cost-effective health care for the medically underserved.

Christ Community Clinic
Key Staff- Dr. Robert Campbell

In response to God’s grace we desire to be a part of the redemptive work of Christ to the economically, socially and spiritually impoverished communities of Augusta. We envision an incarnational ministry through a community of Believers who use their particular gifts to care for the poor and who bring them into their fellowship.

1st Stop 211
Key Staff- Amy Rickard

United Way’s 2-1-1 is a comprehensive information and referral service, providing FREE, CONFIDENTIAL ASSISTANCE in finding the help you need from among the many resources available in the CSRA. 2-1-1 is not a crisis or emergency line. It is, however, an excellent resource for gaining information that can put you in touch with professionals who care. The service is available 24 hours a day, 7 days a week.

University Medical Associates
Key Staff- Dr. Daniel Boone

University Medical Associates is an internal medicine physician practice. UMA doctors are dedicated to providing compassionate and comprehensive care to patients in the areas of Internal Medicine, Lipidology, Endocrinology, and Diabetes care.

University Medical Associates specializes in complex medical management and strives to improve the value of medical care through innovation and excellence. UMA serves Augusta and Evans with an on-site lab, x-ray, and bone-density analysis capabilities.

University Health Care Foundation
Key Staff- Laurie Ott, President of University Health Care Foundation

As the philanthropic arm of University Health Care System since 1978, the Foundation has helped provide innovative services and projects that truly make a difference in people's lives. From helping construct state-of-the-art patient care facilities; making medical procedures possible for uninsured and underinsured patients; giving children with asthma and diabetes a chance to enjoy a true camping experience; to helping fund vital medical equipment, University Health Care Foundation is an important part of University Health Care System’s heritage and ability to serve patients.

University Health Care System Departments
Key Staff:
- Lynda Watts, CNO
- Lynn Beaulieu, Emergency Department Director, EMS Council, GAHN
- Denise Gibson-Cato, Emergency Department Nurse Manager
- Marie Jackson, Pharmacy Director
- Heidi Nelson, Disease Management Director
Ellen Tereshinski, Home Health/Hospice/University Extended Care Director
Mary Goolsby, National Nurse Practitioner
Debra Whitley, Manager of Diabetes Services

The mission of University Health Care System is to provide health care services which help the citizens of our communities achieve and maintain optimal health. The key staff above play an integral role in this mission and were also involved in this Community Health Needs Assessment Process.

Emory University Nell Hodgson Woodruff School of Nursing
Key Staff- Dr Bonnie Jennings, Professor

The Nell Hodgson Woodruff School of Nursing is committed to a trajectory that includes becoming an international leader in the advancement of nursing science, education, practice and policy.

Area Agency on Aging
Key Staff- Jeanette Cummings

The Area Agency on Aging provides a variety of services and support to improve the lives of senior citizens in 14 counties of the Central Savannah River Area (CSRA), including Richmond County. The Area Agency on Aging’s primary activities are:

- identifying and planning for aging-service needs throughout the region
- connecting senior citizens and caregivers with needed aging services and information
- providing staff support and leadership to outside agencies that address aging issues
- administering grants and contracts to quality organizations that provide services to older CSRA residents
Prioritization of Needs

In August 2013, a priority session was held at University Hospital with members of the senior leadership team. The purpose of this session was to discuss data and input that had been collected and to prioritize the needs of the hospital’s defined community. Criteria used to prioritize these needs included importance to the service area, relevance of the health issues to the population served, and the ability of University Hospital to effectively impact and improve the health issue. Also discussed in this session were those needs that were already being addressed by other community partners or organizations.

Results from the data assessment, survey, interviews, and focus groups were compiled and discussed among the team. Eleven topics from these phases of the CHNA process emerged as possible improvement opportunities for University Hospital’s service area.

A prioritization grid was created that compared University Hospital’s ability to impact to the need to how significant the need was in the community. Those needs identified in the upper right sectors of the grid were viewed as the most significant needs that UH leadership felt they had the ability to impact. These are the needs that would ultimately be chosen as priorities. A sample is shown below:
University Hospital identified current programs and the development of other programs for each priority identified.

After discussing these priorities in depth and examining University Hospital’s expertise and outreach, the expertise of other community organizations, and UH’s wide range of services currently available, the following issues were chosen to create implementation strategies:

A. **Chronic Disease Prevalence (Diabetes, Heart Failure, etc.):** According to CDC, Chronic Diseases are the leading causes of death and disability in the U.S., with 7 out of 10 deaths among Americans each year from chronic diseases. Heart disease, cancer and stroke account for more than 50 percent of all deaths each year, while diabetes continues to be the leading cause of kidney failure, non-traumatic lower extremity amputations, and blindness among adults, aged 20-74. Four modifiable health risk behaviors – lack of physical activity, poor nutrition, tobacco use and excessive alcohol consumption – are responsible for much of the illness, suffering and early death related to chronic disease.

University Hospital will create strategies in an effort to reduce chronic disease incidence, as well as the economic and emotion burden of these conditions. These will be addressed through disease management programs, education and screenings.

B. **Obesity and Nutrition:** According to Healthy People 2020, the health impact of eating a healthful diet and being physically active cannot be understated. Together, a healthful diet and regular physical activity can help people achieve and maintain a healthy weight, reduce the risk of heart disease and stroke, reduce the risk of certain cancers, and strengthen muscles, bones and joints.

Chief among the benefits of a healthful diet and physical activity is a reduction in the risk of obesity. Obesity is a major risk factor for several of today’s most serious health conditions and chronic diseases, including high blood pressure, high cholesterol, diabetes, heart disease and stroke and osteoarthritis. Obesity also has been linked to many forms of cancer.

University Hospital will create strategies around nutrition and obesity with special focus on educational opportunities that promote a healthy lifestyle.

C. **Access to Care, Financial (Insurance Coverage):** According to the Healthy People 2020 website, people without medical insurance are more likely to lack a usual source of medical care, such as a primary care physician (“PCP”), and are more likely to skip routine medical care due to costs, increasing their risk for serious and disabling health conditions. When they do access health services, they are often burdened with large medical bills and out-of-pocket expenses.

University Hospital will create strategies dedicated to increasing access to medical services and screenings for uninsured persons.
D. **Prevention and Screenings:** According to Healthy People 2020, Clinical preventive services offer tremendous opportunity to save years of life and to help people live better during those years. Moreover, science-based prevention can save money – and provide high-quality care – by helping people avoid unnecessary tests and procedures. Evidence-based preventive services are effective in reducing death, disability and disease, including cancer, chronic diseases, infectious diseases and mental health/substance abuse disorders.

University Hospital will create strategies to increase community health literacy and awareness through various outreach programs that empower personal health.
University Hospital’s Community Needs Assessment Team will initiate the development of implementation strategies for each health priority identified above. This Implementation Plan will be rolled out over the next three years. Strategies will be clearly defined along with a matrix of which areas the hospital will address. The team will work with community partners and health issue experts on the following for each of the approaches to addressing health needs listed:

- Identify what other local organizations are doing to address the health priority
- Develop support and participation for these approaches to address health needs
- Develop specific and measurable goals so that the effectiveness of these approaches can be measured
- Develop detailed work plans
- Communicate with the assessment team and ensure appropriate coordination with other efforts to address the issue

The team will then develop a monitoring method at the conclusion of the Implementation Plan to provide status and results of these efforts to improve community health. University Hospital is committed to conducting another health needs assessment in three years.

In addition, we will continue to play a leading role in addressing the health needs of those within our community, with a special focus on the health needs of local residents. As such, community benefit planning is integrated into our health care system’s annual planning and budgeting processes to ensure we continue to effectively support community benefits.

**Board Approval**

This Community Health Needs Assessment Report for fiscal Dec. 31, 2013, was approved by the University Hospital Board of Directors at its meeting held Dec. 19, 2013.