Community Health Needs Assessment

GET HEALTHY LIVE WELL | TANNER HEALTH SYSTEM

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Part 1: Introduction

EXECUTIVE SUMMARY

Tanner Health System is a not-for-profit, community-based health system providing a continuum of high-quality healthcare services within our resource capabilities, leading a collaborative effort with the community to provide health education, support services and care for all of our neighbors.

Tanner was established more than 70 years ago when a forward-thinking group of community leaders in west Georgia gathered and sought to provide their neighbors and loved ones with the best healthcare services close to home. Since 1949, Tanner has grown from a single community hospital to a regional comprehensive healthcare provider that services a nine-county area of more than 600,000 people in west Georgia and east Alabama.

The health system's facilities include:

- The 181-bed acute care Tanner Medical Center/Carrollton*
- The 53-bed acute Tanner Medical Center/Villa Rica*
- The 25-bed critical access Higgins General Hospital in Bremen*
- The 92-bed inpatient behavioral health facility Willowbrooke at Tanner in Villa Rica
- The 15-bed critical access Tanner Medical Center/East Alabama
- The 64-unit senior living community, The Birches at Villa Rica

**These hospitals that are included as part of this Community Health Needs Assessment (CHNA) report*

Tanner also operates Tanner Medical Group, one of metro Atlanta's largest multi-specialty physician groups, with about 40 medical practice locations serving the region. More than 400 physicians representing 34 distinct specialties, from allergies and asthma to urology and vascular surgery. make up the health system's medical staff.

At Tanner Health System, we understand that a person's health is linked to the health of their community. We help our patients thrive under our care, as well as outside our hospital and clinic walls. A person's health is influenced by various factors, including physical, social and economic concerns like employment, housing and transportation. As a regional healthcare leader, we are committed to advancing health and partnering with others to facilitate community health improvement. Our efforts are primarily guided by the findings of our Community Health Needs Assessment (CHNA), which we conduct every three years.

Tanner's CHNA uses a methodical, organized and systematic approach to identify and pursue solutions for the needs of underserved communities across Tanner's geographic region.

The CHNA guides the development and implementation of a comprehensive plan to improve health outcomes for those disproportionately affected by illness, as well as social, environmental and economic barriers to health. The CHNA also informs the creation of a strategy for future community health programming and how to allocate community benefit resources for fiscal years 2023-2025 across Tanner's hospitals. As a not-for-profit organization, Tanner Health

System is required by the Internal Revenue Service (IRS) to conduct a CHNA every three years. Our CHNAs align with the Affordable Care Act guidelines and comply with IRS requirements.

Since the last report three years ago, many of our community's — and our organization's — priorities have changed. The COVID-19 pandemic strained our resources in unprecedented ways. The community and our team of healthcare professionals rallied to the challenge — and reimagined the importance of a community health system.

Using public health and healthcare utilization data, each hospital identified its geographic area of focus, called a Community Benefit Service Area (CBSA), which includes Carroll, Haralson and Heard counties (Tanner's primary service area). The CBSA serves as the geographic target area for the CHNA and for executing the strategies to address the health needs identified.

The CHNA is our roadmap for targeted health promotion strategies conducted in the CBSA. The impact of the hospitals' efforts in their respective CBSAs will be tracked and evaluated over the next three years.

Residents, community partners, stakeholders and hospital leadership were all involved in the CHNA process. Each hospital's CHNA was led by Tanner's Get Healthy, Live Well coalition members, including community activists, faith-based leaders, hospital leaders and representatives, public health leaders, residents, and other stakeholders. Coalition members used population-level data as well as feedback from community focus groups, online surveys and key informant interviews to create recommendations for each hospital's health priorities. They also used it to develop potential implementation strategies and identify key partners. More than 280 people were involved in the CHNA process, including those who participated in community focus groups, key informant interviews and online surveys.

Upon review, analysis and prioritization of the CHNA findings, the priority areas to be addressed during the FY 2023-2025 Implementation Strategy include:

1. Access to Care
2. Mental/Behavioral Health Services
3. Chronic Disease Education, Prevention and Management
4. Health and Nutrition Education
5. Substance Misuse
6. Social Determinants of Health

The CHNA report is available to the public on Tanner's website: tanner.org. Copies are also disseminated to the hospital's board and executive leadership; the assessment team; community stakeholders who contributed to the assessment; and multiple community leaders, volunteers and organizations that could benefit from the information. Other communication efforts will include presentations of assessment findings throughout the community. Tanner will also provide copies for distribution upon request. This final joint CHNA report for Tanner Health System's hospitals (Tanner Medical Center/Carrollton, Tanner Medical Center/Villa Rica and Higgins General Hospital) was approved by the Tanner Medical Center, Inc. Board of Directors in June 2022.

CHNA APPROACH AND PROCESS

Planning and Implementation

The Community Benefit Department at Tanner Health System coordinates the CHNA process and results, including deliverables to improve health outcomes throughout the system's service areas.

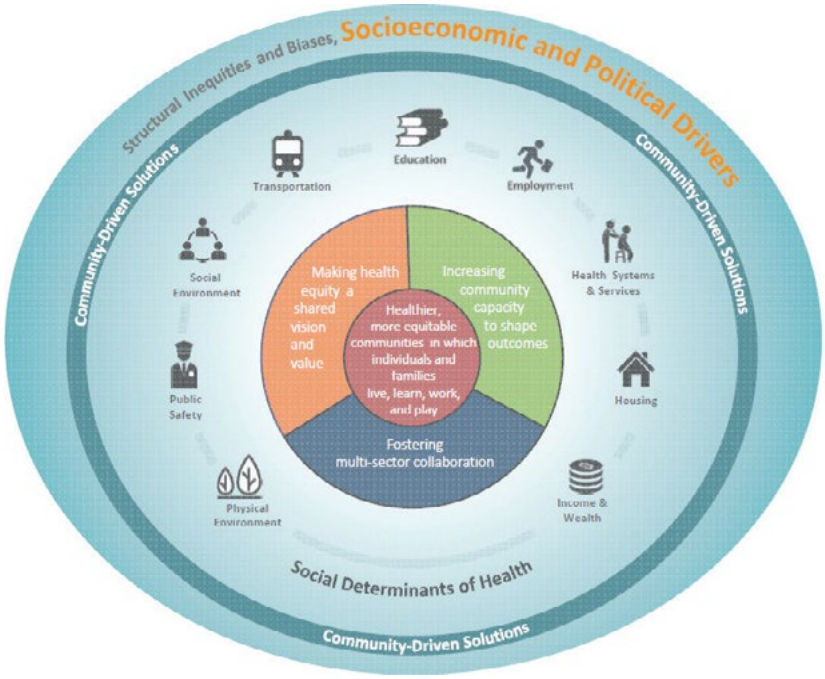
The department drives the CHNA report's implementation and evaluates community benefit reporting to the community and regulatory bodies.

With evidence-based methodologies, the department leverages internal and external stakeholder relationships and resources (i.e., the multisector Get Healthy, Live Well coalition) to target health disparities and address physical, social and economic contributors to suboptimal health. These efforts focus primarily on improving the health of underserved populations and addressing health disparities to achieve health equity.

CHNA Guiding Principles and Frameworks

The CHNA was guided by the National Academy of Medicine's Pathways to Health Equity Conceptual Model (Figure 1), the Robert Wood Johnson Foundation's County Health Rankings Model (Figure 2), and the socioecological model of health. The models assist in determining what contributes to the health of communities and how assets and strengths of communities should be identified and leveraged as part of community program development. They also help identify the most effective ways to address individual, organizational, community and policy-level contributors to health to realize health equity. These models frame Tanner's community benefit efforts to improve the health status of the people in Tanner's CBSAs.

FIGURE 1



CHNA Methodology and Data Collection

The CHNA's data came from four primary sources: quantitative secondary population-level data, hospital healthcare utilization data, qualitative community group input sessions, surveys and key informant interviews.

In past CHNA data collection efforts, community feedback played extensively in helping identify the region's health needs. The arrival and subsequent surges of COVID-19 and its variants made these efforts to gain insight in-person difficult. Further, the lack of in-home access to telecommunications technologies, like Zoom, especially hampered participation among our region's most underserved residents, so paper and online surveys were included.

The data gathered from available sources was used to broaden the types of information gathered and to engage a diverse group of internal and external stakeholders to inform the CHNA process and deliverables. The types of information collected for each data source were as follows:

- **Secondary Data:** National, state, local health and disparity data, public health priorities and community health improvement plans.

- **Core Indicators:** Secondary data was gathered primarily through Community Commons, a publicly available dashboard of multiple health indicators drawn from several national data sources, and Online Analytical Statistical Information System (OASIS), the Georgia Department of Public Health's standardized health data repository. U.S. Census American Community Survey Data was also consulted for demographic, education, and income statistics. Other data sources are noted in the county health profiles (as seen in Part 3).
- **Hospital Utilization Data:** Patient healthcare utilization was used to identify each hospital's CBSAs and geographic areas of focus for needs assessment and strategy implementation.
- **Community Input Session Discussions:** Hospitals facilitated community discussions with a diverse group of community stakeholders, and used paper and online surveys to identify the most critical community health issues. Guided discussion areas included topics related to community health and wellness, access to care and services and the social determinants of health.

Combined information from all of the above sources were used to:

1. Prioritize identified needs
2. Determine the appropriate hospital role in addressing the health issues prioritized
3. Establish system and hospital-specific approaches and outcome measures

This information was used to develop each hospital's implementation strategy for the next three years.

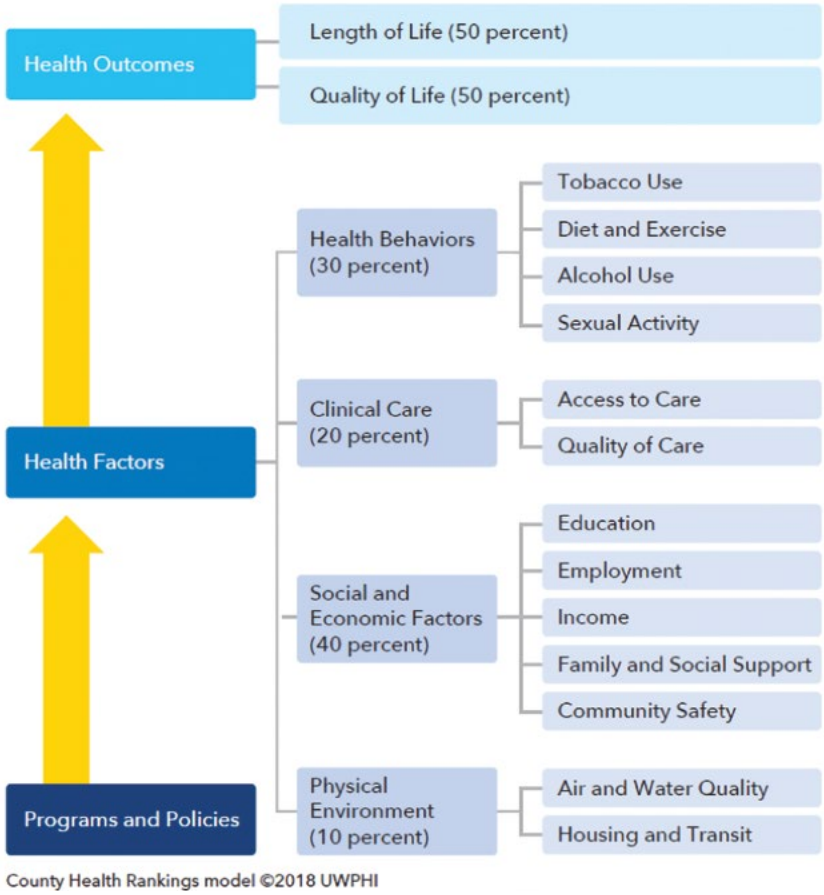


FIGURE 2

Prioritization Process and Criteria

Identification of health priorities was shaped by an understanding of the public health priorities, needs assessment data and each hospital's strengths within the context of the system's priorities.

Additionally, when selecting final targeted health priorities, Tanner considered additional criteria such as the availability of evidence-based approaches and existing partnerships and programming. These components were used to identify priority areas.

Tanner's Get Healthy, Live Well coalition participated in a comprehensive prioritization exercise that involved grouping and ranking identified needs and assets. It also included discussions about what existing and new initiatives and partners should be included in the hospital's three-year implementation plans. The purpose was to determine how to best support the highest prioritized needs while leveraging community assets and resources.

Part 2: Community Impact

EVALUATION OF IMPACT SINCE PREVIOUS CHNA

At the close of the last CHNA, Tanner set forth an ambitious plan to pursue solutions to the region's top identified health needs.

Then in March 2020, the first cases of COVID-19 were confirmed in our hospitals.

The health system led the way in community health advocacy throughout the pandemic, advising local leaders and facilitating the dissemination of reliable information on this unprecedented threat to public health.

The pandemic immediately reprioritized the community's health needs — and Tanner adapted to the challenge.

The following pages provide information on Tanner's commitment to helping residents access the health care and community health programs and resources they need.

The CHNA process should be viewed as a three-year cycle, with a major component being revisiting the progress made on priority health topics outlined in the previous CHNA. By reviewing the actions taken to address a priority health issue and evaluating the impact of those actions have made in the community, we can better target resources and efforts during the next round of the CHNA cycle.

Tanner Health System's priority health topics for each of its hospitals for fiscal years 2020-2022 were:

1. Access to Care
2. Healthy and Active Lifestyles and Education
3. Chronic Disease Education Prevention, Education and Management
4. Mental/Behavioral Health
5. Substance Misuse
6. Social Determinants of Health

These topics correlate well to the priority health topics selected for the current CHNA, and Tanner will be building upon previous years' efforts.

Community feedback on Tanner's CHNA and implementation strategy was collected in a variety of ways, including the ongoing monitoring and evaluation of Tanner's community benefit activities and programs through pre- and post-surveys; ongoing dialogue among community partners and volunteers; a dedicated community benefit committee of the Tanner Medical Center, Inc. Board of Directors; outside evaluators; and through comments from key informant interviews, paper and online surveys and community focus group participants.

Tanner's long-standing commitment to the community is deeply rooted in its mission. The organization remains committed to improving the community's health, not only through daily patient care activities but also through outreach, prevention, education and wellness opportunities.

These activities and opportunities continued as much as possible even while the health system grappled with the devastating effects of the COVID-19 pandemic. Already the leading need, access to care, took a much larger role as the need for intensive medical care surged and facility overflow appeared critical.

The health system nonetheless pressed on, retrofitting its hospitals to add beds while also expanding access to mental health care through telehealth, adapting its free wellness programs to an online format and pressing out information on identifying and managing the substance abuse problems that intensified during the pandemic.

Tanner's community health programs and resources continue to play an essential role in our local communities now and into the future as we strive to address evolving health needs and challenges.

RESPONDING TO THE PANDEMIC

Adapting Programs, Evolving Care In A New Age

The COVID-19 pandemic drastically altered our vision for expanding access to care.

Initially identified as the need for more providers in the region's underserved areas to help identify, prevent and manage chronic diseases, the definition of "access to care" quickly became much more acute as the pandemic spread: beds, critical care services, testing and ongoing care.

Education and aftercare are cornerstones of our approach to medicine. Rather than episodic care, we empower our residents to control their disease with programs and education. But COVID-19 limited our ability to meet in person and challenged our resources in unprecedented ways.

From launching new clinical programs — like telehealth and remote health monitoring — to responding to the pandemic to flexing our programs to ensure the safety and accessibility of participants, we've drastically changed our approach to care and education.

While some healthcare organizations paused their outreach efforts, we've adapted ours with new online offerings and lower class sizes to keep our residents safe and well as they pursue a better level of health for themselves and their loved ones.

COVID-19 RESPONSE

On March 14, 2020, Governor Brian Kemp signed a public health state of emergency to address COVID-19 — the first ever public health emergency declared in the state.

Tanner's efforts to respond to the COVID-19 public health emergency in fiscal years 2020 and 2021 included activities to ensure the highest quality of care for our communities and safe work environments for our employees. These activities were clear changes to operational and clinical norms targeted to identify, isolate, assess,

transport and treat patients with confirmed or suspected COVID-19 infections.

Tanner employed a variety of emergency protective measures as a result of the COVID-19 pandemic, with efforts at each of its hospital facilities focused on the management, control and reduction of the pandemic's immediate threat to public health and safety, including:

- Establishing a fully-activated emergency operations center (EOC) from March 16, 2020, through May 8, 2020, to serve as a hub for the coordination and control of COVID-19 response efforts to respond quickly and more efficiently to needs as they arise (i.e., staffing and labor pool, supplies, technology, equipment) related to COVID-19 and disseminate critical information to Tanner leadership, physicians, clinical staff, employees and the community. The EOC moved to a partial activation on May 9, 2020, and fully deactivated on March 31, 2022.
- Employing marketing and communications efforts to share key information to the public, providing warnings, updates and guidance on the COVID-19 pandemic.
- Hosting regular infectious diseases specialist-led education calls with medical staff and community partners.
- Establishing a call center specific to COVID-19 for information, referrals and screening resources.
- Purchasing food and covering temporary lodging costs for front-line healthcare providers who were triaging and caring for potential and positive COVID-19 patients as these providers were working such abnormal and long hours that going home or going out to get food was not possible.
- Increasing security operations to support COVID-19 response efforts to ensure policy compliance and safety of the public (i.e., visitor restrictions, temporary facility access, testing centers, etc.).
- Increasing disinfection efforts at Tanner's facilities specifically to combat the risk of spreading COVID-19.

Tanner implemented emergency medical care activities as well, including:

- Purchasing and distributing COVID-19 diagnostic tests and personal protective equipment (face shields, gloves, masks, gowns, scrubs) for staff.
- Leasing additional respiratory equipment (oxygen, respirators, BIPAP) to treat COVID-19 patients.
- Retrofitting separate areas to screen and treat individuals with suspected COVID-19 infections, including establishing temporary exterior patient care facilities outside its emergency departments to assess potentially large numbers of persons under investigation for COVID-19 infection.
- Establishing drive-thru testing centers and acute hospital care centers at Tanner Medical Center/Carrollton. Acute care is a level of health care in which a patient is treated for a brief, but severe episode of illness.
- Retrofitting existing hospital rooms to become negative pressure rooms at each hospital facility.
- Transferring COVID-positive patients to acute care.
- Renting additional hospital beds to increase capacity to treat COVID-19 patients.
- Increasing medical waste disposal services and cleaning/disinfection costs of scrubs, masks, linen bags and gowns.
- Expanding telehealth technologies to further support physical distancing efforts to reduce virus transmission and ensure care availability to those who need it most by triaging low-risk urgent care.
- Providing follow-up appointments for chronic disease and behavioral health patients who may require routine check-ins.

In addition, Tanner was one of almost 2,200 healthcare systems across the country that joined the Mayo Clinic Expanded Access Program to test the efficacy of convalescent plasma from someone who has overcome COVID-19 to help other sick patients survive the disease and recover faster. Tanner also quickly assessed its inventories of critical infection prevention supplies and chemicals which included pandemic-designated supplies from its emergency preparedness efforts.

Personal protective equipment (PPE) such as face masks, shields and gowns — as well as cleaning and disinfecting materials — were at the top of not only Tanner's list but also that of many consumers and other hospital systems. For those high priority needs when supplies were difficult to find, Tanner found support close to home from its community, including individuals and corporate citizens.

Thousands of cloth face masks were hand or machine-stitched and donated by volunteers throughout the region for use by patients and staff. Dozens of neighbors

volunteered to make special plastic face shields for Tanner staff to provide protection during patient care from respiratory droplets associated with COVID-19 and known to carry the disease.

In addition, thousands of meals were donated from the community to support front-line healthcare workers.

Since the first COVID-19 vaccine approvals in December 2020, Tanner has been committed to following guidance from the Centers for Disease Control and Prevention (CDC) and the Georgia Department of Public Health (DPH) to take a leadership role in vaccinating the community.

After inoculating its healthcare team, the health system began making the vaccine available to those 65 and older. Tanner administered three vaccines that received emergency use authorization from the Food and Drug Administration (FDA): Moderna, Pfizer-BioNTech and Janssen Pharmaceutical Companies of Johnson & Johnson. The Moderna and Pfizer vaccines required two doses to achieve 95% effectiveness. The Johnson & Johnson vaccine required one dose to achieve 66.3% effectiveness.

Tanner implemented multiple vaccination clinics as doses of the vaccine arrived at multiple locations in west Georgia, catalyzing regional partnerships to provide venues for vaccine administration, including area churches. The health system established an online form for patients and caregivers and community members to provide their information to be signed up for vital COVID-19 information, including upcoming vaccination clinics.

As of April 2022, the health system has administered more than 27,000 doses of the COVID-19 vaccine.

Tanner Health System led or participated in a range of community-focused activities to share expertise and updates on patient activity – from infection rates to patient deaths – with key leaders and the community as a whole. These included a weekly meeting of community coalition members from schools, emergency response and local government officials and periodic virtual panel presentations by physicians and school officials to update the community and address questions about the pandemic and vaccines.

In addition, in fiscal year 2021, a separate COVID-19 task force of Get Healthy, Live Well's Healthy Haralson coalition was established to better respond to the needs of the Haralson County community during the pandemic. Efforts included additional food donation support to the Community Christian Council (CCC) to respond to the increased food demand during the pandemic. In addition, over 450 washable masks were donated to elementary school students and touchless water dispensers were installed at four local schools.

In Haralson County, 5,000 rapid response testing kits were distributed to schools, senior centers, the CCC and other businesses and organizations.

Tanner's marketing department also developed and began sending a daily e-newsletter with the latest COVID-19 updates to keep the public and employees informed, reaching almost 75,000 email users. The goal was to provide timely, accurate and helpful information in a format that was easy to digest. As COVID-19 cases decreased, the newsletter transitioned to a weekly publication schedule, continuing to provide COVID-19 information and updates.

Tanner's response to the COVID-19 pandemic is just one example of the health system's long-standing commitment to collaborative community health efforts. Building on years of experience working with partners to improve population health, Tanner is uniquely positioned to continue playing a vital role in the community's response to the pandemic and other challenges facing west Georgia and east Alabama.

Access to Care

IMPROVING ACCESS TO CARE

Lack of access to care is a significant barrier to better health.

Those who have difficulty accessing care are more likely to have poor health outcomes, including increased morbidity and mortality rates. Improving access to care can help address some of the health disparities among different population groups.

EXPANDING THE CONTINUUM OF CARE

Grant Helps Tanner Expand Telehealth During COVID-19 Pandemic

In 2020, Tanner Health System received an $879,520 grant to help implement and expand telehealth services in west Georgia and east Alabama.

The Federal Communications Commission's Wireline Competition Bureau grant helps healthcare providers fund telehealth services during the pandemic.

Tanner used the grant for technology through InTouch Health to expand the presence of specialist providers, such as neurologists and psychiatrists, and provide access to Tanner Medical Group clinics. The health system also used the grant to implement a remote monitoring system through Vivify Health for patients who leave the hospital after receiving care for complex chronic conditions.

All technology is integrated with Tanner's electronic health record, Epic. Tanner utilizes its telehealth platform to expand inpatient, outpatient and post-acute care services to all patients throughout the community.

Tanner's inpatient teams use robots and tablets integrated into the telehealth platform, allowing remote specialists to consult patients for complex conditions. These conditions include those related to psychiatry, maternal fetal medicine, internal medicine and emergency medicine. All Tanner Medical Group practices can complete patient visits via telehealth.

Inpatient and Ambulatory Care Management can now assign patients a remote monitoring kit as patients discharge for hospital care to ensure close tracking of vital signs as patients heal in their homes. The Intouch platform and devices integrate, allowing Tanner's teams to schedule and launch visits out of Epic for improved clinician workflows.

The integration provides an added layer of security to ensure the visits are tied to a specific patient. The remote patient monitoring technology from Vivify also integrates with Epic to allow for patient information to flow across for registration into the Vivify system.

Tanner's expansion of telehealth supports physical distancing efforts to reduce COVID-19 transmission and ensure care availability to those who need it by triaging low-risk urgent care. It also provided follow-up appointments for chronic disease and behavioral health patients who require routine check-ins.

By reducing unnecessary visits to health care environments, Tanner's expanded telehealth platform aims to curb the exposure to and transmission of infectious disease while helping to keep our front lines safe and ensure they have the resources needed to take on the challenges presented by COVID-19.

Learn more: **tanner.org/telehealth-at-tanner**.

Bringing Health Care Home With RPM

When the pandemic struck, Tanner launched a remote patient monitoring (RPM) pilot program to empower patients to bring their health care home, equipping them with the tools and resources they need to better manage their health from wherever they reside.

REVVING UP HEALTH CARE WITH RPM

Remote patient monitoring (RPM) offers a way for patients — and their caregivers — to easily manage health issues and monitor chronic conditions virtually. RPM not only gives patients and providers a greater ability to manage health conditions but also reduces the need for frequent visits to the doctor's office.

RPM helps closely monitor a range of symptoms and chronic illnesses, including hypertension, diabetes, chronic obstructive pulmonary disease (COPD), heart disease, cancer, COVID-19 symptoms and more. This is accomplished by using digital health monitoring devices like digital glucometers, scales, blood pressure cuffs, finger blood oxygen meters and others.

RPM also empowers patients to take a more active role in managing their healthcare, providing a simple and convenient way to track symptoms, medications and appointments with the touch of a button.

EASY-TO-USE RPM KITS

RPM kits are designed to be easy to use for all patients right out of the box.

Each kit is sent directly to the patient's home with all the necessary equipment and instructions, and patients even have access to quick instructional videos on how to use the items in each kit. Now more than ever, programs like RPM and telehealth are revolutionizing the health care Tanner delivers, empowering patients and expanding access to a host of healthcare services further throughout the region.

A total of 450 patients have used the RPM program as of May 2022. The pilot program, which launched with limited access, has expanded to include patients referred at discharge from the hospital.

Learn more: tanner.org/News/Bringing-Health-Care-Home-With-RPM

Tanner, West Georgia Ambulance Partner in New Community Health Program

Tanner Health System and West Georgia Ambulance rolled out a new community paramedic program in west Georgia that's helping patients stay on top of their health to avoid unnecessary readmissions following a hospitalization.

The program, which began in February 2021, extends the role of local emergency medical service (EMS) paramedics by allowing them to work as a part of a patient's care team and make home health visits after a patient is discharged from the hospital. The program is expanding the reach of primary care and public health services in the community to help patients better manage their health care on their own.

In the program, community paramedics are essentially an extension of a patient's medical care team and are trained in primary care, disease management and more. During a visit, paramedics perform medical assessments and address questions and issues regarding medications, discharge instructions or follow-up care.

Paramedics schedule their initial visit within two days after their patient is discharged. Currently, West Georgia Ambulance has four paramedics in the program. Since the program began, 161 patients have been referred to the program.

Along with discharge instructions, patients in the community paramedic program also receive a remote patient monitoring kit, or RPM, to help them manage their care from home with the direct support of their care team at Tanner. Remote patient monitoring offers a way for patients to manage their health using digital health monitoring devices such as digital glucometers, weight scales, blood pressure cuffs and finger blood oxygen meters.

RPM can be used to monitor a range of symptoms and chronic illnesses, including hypertension, diabetes, COPD, heart disease, cancer, COVID-19 symptoms and more. There is no cost associated with the community paramedic program. However, patients must be referred by their physician or their care manager.

Currently, the program is only available at Tanner Medical Center/Carrollton but could soon expand to the health system's other facilities throughout the region.

Learn more: **tanner.org/community-impact**

Increasing Access to Senior Living Options

An entirely new, comprehensive concept in senior living is now available in west Georgia.

The Birches at Villa Rica is the only senior living community in west Georgia or east Alabama integrated into a regional health system. The project is a unique venture for a health system, expanding seamless health and wellness services to people looking to live longer, more active lives.

The Birches at Villa Rica

The Birches at Villa Rica interior photos

Built on an almost six-acre site along Permian Way in Villa Rica — next to the Tanner at Mirror Lake medical office building — the single-level development features 61 total apartments, including 36 assisted-living apartments and 25 memory care apartments. Construction was completed in the summer of 2021.

The Birches at Villa Rica is convenient to people throughout the metro area, just off Interstate 20 and Highway 78. The project is unique in the senior living market. Most senior living communities are stand-alone developments, but The Birches is fully incorporated into a full-service regional health system, overcoming one of the greatest challenges for senior living residents: access to medical care.

At The Birches, assisted living residents choose from single-bedroom or studio apartments. They have access to an on-site movie theater, salon, restaurant-style dining, fitness and activity rooms, concierge services and more.

Memory care patients have private and semi-private apartments, a private enclosed courtyard, restaurant-style dining, and holistic, specialized services to treat cognitive impairments. All residents enjoy chef-prepared meals each day, enriching activities, outings to local shopping centers and social events, and around-the-clock access to nursing and other healthcare professionals.

Residents also benefit from Tanner's extensive wellness services through Get Healthy, Live Well — including chronic disease management and prevention, nutrition education, exercise instruction and more — to lead longer, healthier lives. The community leverages the health system's integrated care offerings and leading-edge infection-prevention expertise — which has become even more vital in the age of COVID-19.

The Birches also provides an economic boost for the region, creating jobs for people at all skill levels. The Villa Rica project is the first of several anticipated senior living developments Tanner plans to build, with future communities planned throughout the west Georgia region, including The Birches on Maple development that Tanner is constructing in Carrollton.

Learn more: **tanner.org/the-birches**

New Health Pavilion Opens in Carrollton

Tanner Health System opened a new destination for health on Dixie Street across from Tanner Medical Center/Carrollton.

Tanner Health Pavilion opened to patients in Fall 2019. Along with primary care and specialist services, the pavilion also features a retail pharmacy and more. The facility opened for patients when Tanner Healthcare for Children — formerly Carousel Pediatrics and Children's Healthcare of West Georgia — began services in the building.

Since then, other services relocated to the facility, including Tanner Retail Pharmacy, Tanner Breast Health, Tanner Heart & Vascular Specialists, the John and Barbara Tanner Cardiac Rehab Center, Tanner Primary Care of Carrollton, West Georgia Internal Medicine, Comprehensive Breast Care Center and Tanner Healthcare for Women — formerly West Georgia Healthcare for Women and West Georgia OB/GYN. Additionally, administrative offices for Tanner Medical Group occupy space within the facility.

The new Tanner Imaging Center — offering MRI, CT, ultrasound, X-ray and fluoroscopy — is also located in the facility. The center is a convenient outpatient destination offering more affordable, hospital-quality imaging services for those with high-deductible health plans.

The 130,000-square-foot, $35 million pavilion makes care more convenient and accessible. It focuses on wellness, with park-like grounds around the facility, a trailhead to the Carrollton GreenBelt and a new GreenBelt spur to downtown.

Tanner Retail Pharmacy Opens at Tanner Health Pavilion

Tanner Health System is improving access to prescription medications with the full-service Tanner Retail Pharmacy at the Tanner Health Pavilion, across Dixie Street from Tanner Medical Center/Carrollton.

Conveniently located on the ground floor the new pharmacy is open weekdays, from 8 a.m. until 5 p.m. Most insurances are accepted. In addition to competitively-priced prescription drugs with a timely turnaround, the Tanner Retail Pharmacy also stocks over-the-counter medications and gift items.

Curbside service is also available on the south side of the Tanner Health Pavilion, nearest to the parking deck. The Tanner Retail Pharmacy is open to the public and offers special convenience to patients with doctor's appointments in the Tanner Health Pavilion

who can collect their prescriptions from the pharmacy before leaving the building.

Through an innovative new program — "Meds to Beds" — patients discharged from Tanner Medical Center/Carrollton can have their prescriptions delivered right to their bedside before they go home. This service option does not require the patient to change pharmacies.

The Tanner Retail Pharmacy offers four ways to order or transfer prescriptions:

- The handy mobile app, "Tanner Retail Pharmacy," can be downloaded to your smartphone from the Apple App Store for iPhones or Google Play for Android devices. A personal profile can be set-up on the app to manage prescriptions
- The Tanner Retail Pharmacy website, pharmacy.tanner.org, where prescriptions can be ordered
- Speak with the Tanner Retail Pharmacy staff by phone at 770-812-8222
- Drop by in person

The Tanner Retail Pharmacy is located inside the Tanner Health Pavilion at 706 Dixie Street, Suite 140, and is staffed by credentialed pharmacists and pharmacy techs.

Learn more: **thepharmacy.tanner.org**

Tanner Medical Center/Villa Rica Completes Its First Robotic-Assisted Surgery

In 2019, the surgical services team at Tanner Medical Center/Villa Rica completed the hospital's first robotic-assisted minimally invasive surgery in its new state-of-the-art surgical services center.

José Espinel, MD, a board-certified surgeon with **Carrollton Surgical Group** and a member of the medical staff at Tanner Health System, performed the surgery — a robotic-assisted cholecystectomy, which is a **procedure to remove the gallbladder** — on the hospital's new da Vinci X surgical system developed by Intuitive Surgical.

Robotic-assisted surgery with the da Vinci surgical system allows surgeons to perform a wide range of procedures with greater accuracy through a few tiny incisions. Surgery on the da Vinci system is less invasive and more precise, so patients experience less post-operative pain, less scarring, more comfortable recovery and a quicker return to normal activities.

Dr. Espinel explained that the small keyhole-sized incisions from minimally invasive surgery are also more cosmetic. In contrast, traditional procedures are often performed through larger incisions that can leave larger scars.

Dr. Espinel started performing robotic-assisted surgery in 2015, and since then, he has completed more than 200 procedures. He performs a variety of minimally invasive robotic-assisted surgeries at Tanner, including surgical treatment for gastroesophageal reflux disease, or **GERD**, with the LINX® Reflux Management System, as well as surgery for gallbladder removal for gallstones, myotomies for esophageal achalasia and procedures for hiatal and abdominal wall hernias.

In addition to the new da Vinci X system at Tanner Medical Center/Villa Rica, Tanner is also home to two more da Vinci systems; the **da Vinci Xi and the da Vinci Si HD**, both at Tanner Medical Center/Carrollton.

Tanner was one of the first health systems in the region to offer robotic-assisted minimally invasive surgery, and its surgical teams have completed more than **1,000 robotic-assisted surgeries** since the program launched in 2013.

Learn more: **SurgeryAtTanner.org**.

Tanner Earns CON to Offer Open Heart Surgery

Tanner Health System is moving ahead with its plans to establish an open-heart surgery program in Carrollton.

With open-heart surgery, residents will receive services — like coronary artery bypass graft (CABG) surgery — without traveling out of the area. More than 200,000 CABG procedures are performed nationally each year. The health system earned state approval to expand its cardiac services, overcoming objections from other regional hospitals.

Tanner Medical Center/Carrollton

The expansion of services will require Tanner to build out a new operating suite at **Tanner Medical Center/Carrollton** designed for the procedure and recruit cardiothoracic surgeons to its medical staff to perform the surgeries. Additional staff — in both clinical and non-clinical roles — will also be needed for the program.

IMPLEMENTATION STRATEGY

Open heart surgery in west Georgia results from years of need. From establishing a reputable outpatient heart care program to building a solid cardiac rehabilitation program to launching and building upon interventional cardiology — along with our many heart-related wellness programs that continued during the pandemic — we've continued our work against the leading cause of death in our region.

ADVANCING TOWARD OPEN HEART

The program will be the latest step in Tanner's growing heart program. The health system began offering interventional cardiology, including **angioplasty and stenting**, at its Carrollton hospital in 2006.

In 2008, it opened the four-story Tanner Heart and Vascular Center on the campus of Tanner Medical Center/Carrollton. Interventional heart services were expanded to **Tanner Medical Center/Villa Rica** in 2015.

Both hospitals earned accreditations as chest pain centers, with streamlined practices to ensure the fastest clinical response to heart attack treatment possible.

Cardiovascular disease is the leading cause of death in Georgia, which ranks 38th among the states for cardiovascular deaths. Counties primarily served by Tanner have higher age-adjusted death rates for major cardiac disease than the statewide rate and consistently have higher cardiovascular-related death rates than Georgia's average.

Tanner offers heart care services in Carrollton, Villa Rica, Bremen, and in Wedowee, Alabama.

Learn more at TannerHeartCare.org.

New Program Offers Direct-Access for Colon Cancer Screening at Tanner

A new program from Tanner Health System provides easier access to colonoscopy screenings — one of the most effective screening procedures for detecting colon cancer.

Typically, a colonoscopy requires a pre-procedure visit at a doctor's office. However, with the new direct-access colonoscopy helpline, men and women can make a single call and — depending on their responses to a series of confidential screening questions — possibly skip the pre-procedure visit and directly schedule their screening.

The program saves patients time and the cost of the pre-procedure visit.

As a person ages, their risk of developing colorectal cancer increases. The risk is even greater if they have certain risk factors or a history of the disease, making having more access to vital screening procedures like colonoscopies even more critical.

Learn more: tanner.org/direct-access

Radiation Innovation at Tanner's Roy Richards, Sr. Cancer Center Protects Breast Cancer Patients from Long-term Heart Damage

Millions of breast cancer survivors are alive and thriving today because of innovations in detecting and treating the disease — technologies that are continuously improved for safety and effectiveness.

Anil Dhople, lead radiation oncologist and radiation oncology advisor for Tanner Cancer Care, joined Tanner Cancer Care in 2020. Shortly after that, he introduced a new procedure to protect women's hearts during breast cancer treatments.

A recent innovation – deep inspiration breath hold – introduced in 2021 at Tanner's Roy Richards, Sr. Cancer Center, protects women from a potential side effect of their life-saving radiation treatments: heart damage.

Radiation therapy is a critical component in fighting cancer and has a solid risk/benefit profile in treating breast cancer, said Tanner's chief radiation oncologist Anil Dhople, MD.

Radiation therapy — or radiotherapy — is often combined with surgery and chemotherapy to provide the best possible outcomes for women diagnosed with the disease, which still ranks second among cancer killers of women. But radiation treatments can affect healthy tissue and organs, too.

This is especially true for women undergoing cancer treatment for the left breast — on the same side of the body as the heart.

The procedure has become especially valuable as women are living longer after breast cancer treatments. Longer survivorship means patients' heart health becomes much more important.

But the process isn't as simple as asking a patient to hold their breath while they receive a dose of radiation.

"The technique combines a network of scans and sensors, which create a map of the patient's body, with a breathing technique that involves the patient holding her breath for about 20 seconds while the radiation is delivered," said Dr. Dhople.

Anil Dhople, MD

"By carefully coaching our patients on their breathing during the treatment process with the deep inspiration breath hold technique, we significantly reduce their risk of heart complications later in life."

Dr. Dhople introduced the deep inspiration breath hold technique at Tanner Cancer Care shortly after his arrival in Fall 2020.

Learn more: **TannerCancerCare.org**

Tanner Earns Gold for Quality Stroke Care

In 2021, the American Heart Association/American Stroke Association has awarded Tanner Medical Center/Carrollton the Get With The Guidelines® - Stroke Gold Plus Quality Achievement Award.

The achievement recognizes the hospital's commitment to providing the most appropriate stroke treatment according to nationally recognized, researched-based guidelines. **This marked is the second consecutive year Tanner has earned this achievement**.

The designation is awarded to hospitals that meet specific quality measures for diagnosing and treating stroke patients, including the proper use of medications, therapies and other interventions according to the latest treatment guidelines. In addition to following treatment guidelines, hospitals awarded this achievement also educate patients to help them manage their health and rehabilitation once at home.

Get With The Guidelines

Stroke was developed to help healthcare professionals provide the most up-to-date guidelines for treating stroke patients. The Gold Plus Quality Achievement Award is an advanced level of recognition acknowledging hospitals that have consistently met the performance standards for 24 consecutive months or more.

According to the American Stroke Association, someone in the U.S. suffers a stroke every 40 seconds, and nearly 795,000 people suffer a new or recurrent stroke each year. However, early stroke detection and treatment are key to improving survival, minimizing disability and improving recovery times.

At Tanner, patients have access to a dedicated stroke care team, comprehensive rehabilitation programs, telemedicine services and the support and resources of the entire health care system.

Tanner's hospitals in Carrollton, Villa Rica and Bremen are **accredited stroke care facilities** credentialed by The Joint Commission and the American Heart Association/American Stroke Association.

Learn more: **tanner.org/stroke**

Tanner Expands Non-Hospice Palliative Care for Seriously Ill Patients

With advancements in medicine extending patients' lives every day, the options for how those patients spend their remaining days, weeks, months and years are growing, too.

Hospice care is a well-understood, defined bend in the road for patients, families and healthcare providers, with actions to treat or cure ending and the focus shifting to comfort during the patient's final days. However, the relatively new area of non-hospice palliative care is providing an interdisciplinary approach to ensure patients and families are educated and supported as they face a life-limiting diagnosis or serious illness.

Tanner palliative care services are currently offered on an inpatient basis at Tanner Medical Center/Carrollton and Tanner Medical Center/Villa Rica. Palliative care ensures the patient's voice is heard in critical quality-of-life discussions. If the patient is unable to make decisions, the patient's decision-maker is identified and supported while the patient's wishes are honored.

Other disciplines — chaplain, nutrition, speech therapy, clinical pharmacy, etc. — are involved as needed to help identify and meet the patient's needs and goals. A transition to hospice care may occur for some patients, but it is not a given.

Palliative care is managed by an interdisciplinary team. The plan for each patient is based on an assessment of several needs — physical, psychological and psychiatric, social, spiritual, religious and existential, and cultural. Other considerations include end-of-life care and ethical and legal needs.

The initial full-time palliative care staff of three — Tim Adams, BSN, palliative care coordinator, Briana Moore, LMSW, a master social worker in palliative care, and Tammy Owenby, director of care management — expanded during Summer 2020 to include Thomas E. Reeve, III, MD, surgeon for Carrollton Surgical Group, as the physician champion.

Increasing Access to Patient-Centered Medical Homes

During fiscal years 2020-2022, the Patient-Centered Medical Home (PCMH)/Patient-Centered Specialty Practice (PCSP)/Patient-Centered Connected Care (PCCC) models were expanded to more practices throughout west Georgia and east Alabama, furthering the ability of patients with greater medical needs to manage their care in an outpatient setting.

Accredited Tanner Medical Group practices now include:

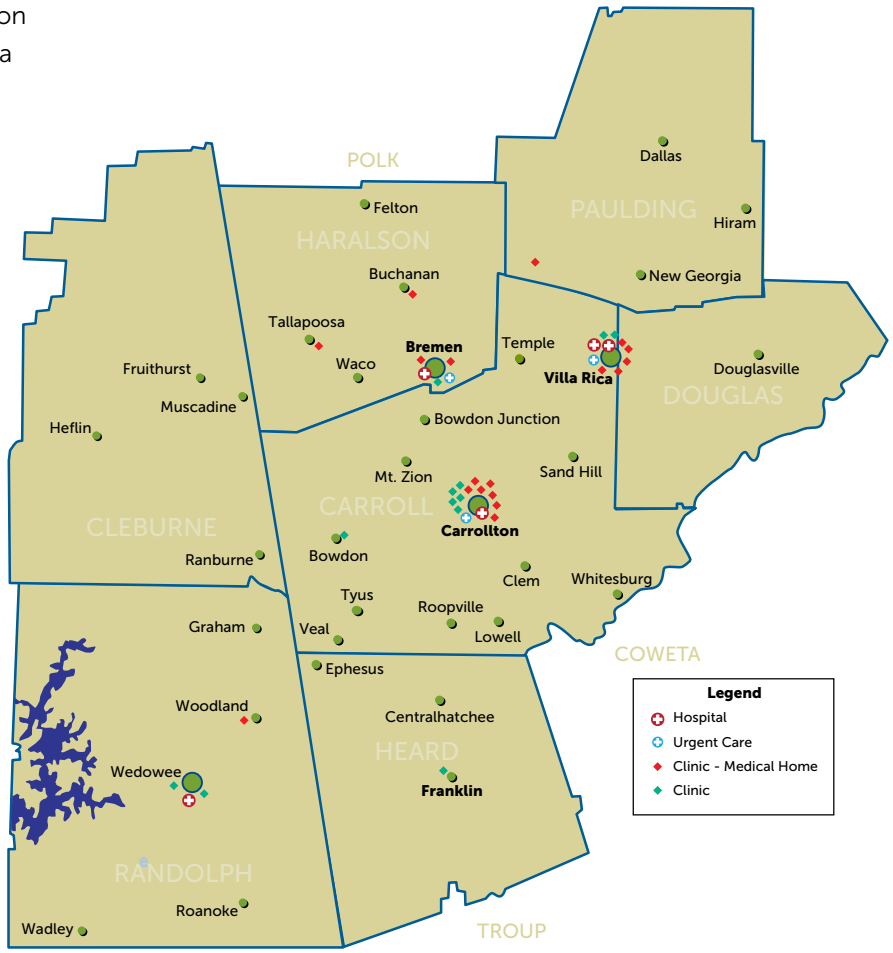
- Infectious Diseases of West Georgia
- Tanner Healthcare for Women – Carrollton
- Tanner Healthcare for Women – Villa Rica
- Comprehensive Breast Care Center
- West Georgia Center for Plastic Surgery
- Carrollton Surgical Group – Carrollton
- Carrollton Surgical Group – Villa Rica
- Carrollton Surgical Group – Bremen

Patient-Centered Connected Care (PCCC)

- Tanner Urgent Care – Carrollton
- Tanner Urgent Care – Villa Rica
- Tanner Urgent Care – Bremen

Patient-Centered Medical Home (PCMH)

- Tanner Primary Care at Mirror Lake
- Tanner Primary Care of West Paulding
- Tanner Primary Care of Carrollton
- Tanner Primary Care of Bremen
- Tanner Healthcare for Children
- Villa Rica Family Medicine
- Tallapoosa Family Healthcare
- Buchanan Medical Clinic
- Tanner Primary Care of Wedowee
- Woodland Family Healthcare



SUPPORTING AN INCREASE IN THE NUMBER OF PHYSICIANS AND HEALTHCARE PROFESSIONALS

Improving Access to Care Through Medical Staff Recruitment

The number of medical professionals available in a community directly impacts that community's ability to access care. Tanner's primary service areas of Carroll, Haralson and Heard counties are designated as medically underserved areas and health professional shortage areas. To combat this problem and improve access to medical care in the region, Tanner continued its work to recruit more physicians to practice in the area, enabling patients to choose from a greater number of providers in an expanded field of specialties.

In fiscal year 2020, Tanner welcomed 10 new physicians to its medical staff, with specialties covering:

- Addiction
- Cardiology
- Obstetrics and gynecology
- Psychiatry
- Vascular surgery

In fiscal year 2021, Tanner welcomed 15 new physicians and 11 advanced practice providers to its medical staff, representing specialties in:

- Anesthesiology
- Cardiology
- Family medicine
- Internal medicine
- Neurology
- Obstetrics & Gynecology
- Psychiatry
- Radiation oncology

In fiscal year 2022 (through April 2022), Tanner welcomed six new physicians to its medical staff, representing specialties in:

- Obstetrics & Gynecology
- Psychiatry
- Anesthesiology
- Cardiology
- Dermatology
- Primary Care
- Radiation oncology
- ENT

Improving Access to Care Through Education

Tanner has continued to offer scholarships to students across the region that are enrolled in medical school or advanced practice provider programs, including providing five "Future of Healthcare Scholarships" during fiscal year 2020.

Tanner also continues to foster its established, strong partnerships with local community colleges and universities, including the University of West Georgia (UWG) and West Georgia Technical College (WGTC). Tanner offers clinical, educational opportunities for nursing students at the UWG and WGTC throughout the health system's hospitals and clinics.

In addition, Get Healthy, Live Well is connecting senior nursing students at UWG to a variety of community health opportunities in west Georgia through a preceptorship program that will help them increase knowledge and gain skills in community health work. Before beginning the program, students attend an orientation where they learn more about Get Healthy, Live Well and practice skills that will help them communicate better with patients.

Students also learn skills they need to assist with one of Get Healthy, Live Well's evidence-based programs like the Diabetes Prevention Program, Freshstart, a nicotine cessation program and Food As Medicine program — an innovative program that provides health and nutrition education, cooking classes and free, fresh and healthy food for food-insecure participants. Each nursing student is required to complete 20 hours of programming assistance with Tanner's Get Healthy, Live Well.

Since launching in the fall of 2016, 670 nursing students have completed the preceptorship program, completing over 13,634 hours as of Spring 2022.

The Tanner Connections Program is a partnership between Carroll County, Bremen City, Carrollton City and Haralson County school districts, accepting eligible students (who are vetted through Work-Based Learning coordinators) enrolled in the following career pathways:

- Business office
- Criminal justice
- Engineering
- Food/nutrition
- Healthcare
- IT
- Marketing

Connections students first complete an orientation with the health system and then work closely with their professional mentor, observing and performing job-related tasks, for at least 10 hours a week at Tanner. More than 337 students from around the region have completed the program since 2010.

The Tanner Teen Institute is a summer program that runs from June 1-August 1. The program is a volunteer and leadership development opportunity for teens between the ages of 15 and 18. It includes a combination of informative, educational sessions (five sessions) in which students can engage with other medical professionals and four hours a week of volunteer service (24 total hours) in a designated hospital department.

Supporting Community-Based Clinics

Tanner continues to work closely with and provide financial support to two community-based indigent clinics, the Rapha Clinic and Latinos United Carroll County Clinic, to provide low-cost and free medical services to area residents who otherwise could not afford care.

INCREASING ACCESS TO CARE FOR THE UNINSURED AND UNDERINSURED

To ensure optimal access, Tanner continually evaluates financial assistance and self-pay discount policies and practices. Patients are provided with information about the organization's charity/indigent program at registration and on Tanner's website. Any self-pay or under-insured patients must meet the criteria for indigent care to have the cost of their care written off by the health system.

Patients are interviewed and financial statements are prepared. Those who meet the criteria for Medicaid eligibility are referred to an outside vendor for assistance. A patient with a family income up to 200% (twice) the Federal Poverty Guidelines (FPG) based on family size receives a 100% discount for medically necessary services.

Patients with large, medically necessary medical bills which have created a financial hardship are considered for a sliding scale discount. The lower the patient's discretionary income and the higher the healthcare bills allow more charity allowances. Patients whose family income exceeds two times the applicable FPG may also qualify for sliding scale discounts on medically necessary services.

Translation assistance is provided for patients as needed.

Learn more: **tanner.org/community-impact/health-of-our-system/indigent-and-charity-care**

Helping Patients Get More Affordable Prescriptions

Get Healthy, Live Well partnered with the Good Pill Pharmacy, a non-profit pharmacy dedicated to getting people the medication they need at an affordable price, regardless of insurance status.

Good Pill is affiliated with a nonprofit organization known as Sirum (Supporting Initiatives to Redistribute Unused Medicine), which students founded at Stanford

University in California. It was founded to help the uninsured and underinsured and others struggling to pay their prescription costs.

It's a mail-order operation where physicians can send a prescription electronically, by phone or fax, or a patient can get a doctor to send it or have Good Pill work a transfer from another pharmacy. Sirum operates such programs in five states, but Good Pill is the only one that distributes the medicines by mail order.

In 2016, the Georgia General Assembly passed a law establishing regulations for such a drug donation program.

Tanner Medical Group (TMG) physicians and discharge planners have been trained on the referral process. As of April 2022, more than 20,000 prescriptions have been made.

More Information: **goodpill.org**

USING INFORMATION TECHNOLOGY TO IMPROVE POPULATION HEALTH OUTCOMES AND HEALTHCARE QUALITY

Patients Benefit as Tanner Electronic Health Record Expands to Include Independent Practices

More patients in west Georgia and east Alabama will benefit from Tanner's 2019 investment in its Epic "one patient, one record" electronic health record (EHR) as independent physician practices are now invited to sign on, too.

Community Connect

Through Community Connect, independent physicians can share Tanner's Epic software for their practice, improving operations in their clinics and care for their patients.

Epic, the No. 1 platform of its kind in the United States, allows for a single, comprehensive medical record that follows the patient from the clinic to the hospital bedside, operating suite, emergency department or wherever a patient seeks care within the Tanner system.

In 2019, Tanner implemented the health record platform at all of its nearly 40 Tanner Medical Group practice locations and five hospitals. Now, independent medical practices can join the platform, ensuring seamless care between the practice and the health system.

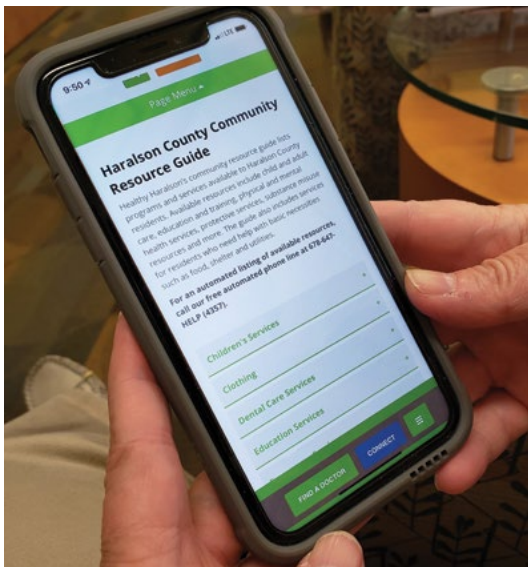
Three practices — Primary Care of West Georgia, West Georgia Internal Medicine and Children's Heart Specialists of Georgia — went live on Tanner's Epic platform during Summer 2020. Primary Care of West Georgia launched in June 2020, and the other two practices launched in August.

About 400 independent physicians with privileges at Tanner hospitals completed training on the Epic platform so they, too, could use the new system while providing inpatient care at Tanner hospitals. These providers currently use the new Epic-based system while at Tanner and another system in their own practices.

The move includes giving patients access to Tanner MyChart — the 24/7 secure patient portal that lets patients manage their healthcare information and routine tasks like requesting prescription results, checking lab results and paying bills online.

Each implementation will take about three months from preparation to Go-Live on the new system. Other practices are reviewing the opportunity as well and will be able to sign on in the future.

Discussions are underway with other practices on how they can participate in Community Connect and implementations are expected to continue through 2022.



INCREASING AWARENESS OF EXISTING RESOURCES

Healthy Haralson Resource Guide Links People to Local Support

To help connect residents with local community resources, Get Healthy, Live Well's Healthy Haralson committee created a searchable online database.

In 2018, the committee completed a comprehensive CHNA specific to Haralson County and developed a Community Health Improvement Plan (CHIP) to prioritize needs. The CHIP identified the need to increase the awareness of existing community resources as a critical component of improving the effective and efficient use of resources to promote the population's health.

In 2019, Healthy Haralson launched a community resource guide for Haralson County. Resource mapping through the development and promotion of an online community resource guide and automated phone line is evidenced to lead to:

- Faster identification of relevant programs and services for underserved populations.
- Increased interagency collaboration to serve the population.
- More networking and streamlined resources to allow better support for underserved populations.
- Greater awareness of the community's strengths and gaps in serving the underserved population, allowing agencies to work together to increase the frequency, duration, intensity and quality of existing services and community supports.
- More flexibility and choice for those in need.
- More support in navigating the system.
- A more accessible environment for underserved populations.

Haralson County's community resource guide lists programs and services available to Haralson County residents. Available resources include:

- Child and adult care
- Education and training
- Physical and mental health services
- Protective services
- Substance misuse resources

The guide also includes services for residents who need help with basic necessities such as food, shelter and utilities. A free automatic listing of available resources can be accessed by calling 678-647-HELP (4357). Since its launch, educational training has been provided to 81 community members, and the guide has been viewed 1,933 times.

Learn more: tanner.org/haralsonguide

Healthy, Active Lifestyles and Education

IMPROVING COMMUNITY HEALTH

Tanner has a long-standing commitment to advancing community health and successfully implementing population health approaches to best meet the needs of the communities it serves.

The health system does this by employing various strategies aimed at the deterrence, early detection and minimization or cessation of disease at the population level.

In 2012, Tanner joined community partners to establish Get Healthy, Live Well (GHLW), a multi-sector coalition with more than 35 task forces consisting of more than 600 community volunteers and more than 270 local, state and national partners. A shared partnership with community participants who serve on our coalition, GHLW is engaging people, ideas, and resources to develop and implement various evidence-based interventions to reduce chronic disease risks and promote healthy lifestyles for the 160,479 residents of Carroll, Haralson and Heard counties.

Taskforce members include representatives from:

- Boys and Girls clubs
- Business and industry
- Civic groups
- Chambers of commerce
- Colleges and universities
- Convenience stores
- County and city governments
- Faith-based institutions
- Farmers and farmers' markets
- Parks and recreation departments
- Private healthcare providers
- Other community leaders

Since its establishment, GHLW has made significant gains to improve the health of the communities Tanner serves. During fiscal year 2021, more than 9,700 individuals were touched by GHLW programs, health screening or other community-based educational events (i.e., Living Well Education Series, task force meetings, etc.).

The programs, screenings and events focused on various subjects so participants could learn more about their health and how to live well. More health education was provided through Tanner's sponsorship of the "Community Voice" radio program, which featured several physicians and health professionals discussing and taking calls on a wide range of subjects.

Tanner provided and sponsored several support groups on various diseases/topics, including breast cancer, cancer, diabetes, Parkinson's and grief, which more than 400 people attended during the year.

With the start of the 2020 COVID-19 pandemic, the health system continued hosting informational sessions with medical staff and providing recorded messages from experts in infectious diseases, obstetrics and gynecology, neonatology, pediatrics and more.

Learn more: GetHealthyLiveWell.org

Preventing and Reducing Tobacco Use

Several anti-nicotine initiatives have been launched in west Georgia to promote nicotine-free environments, teach youth about the dangers of secondhand smoke and nicotine use, and help current users quit for good.

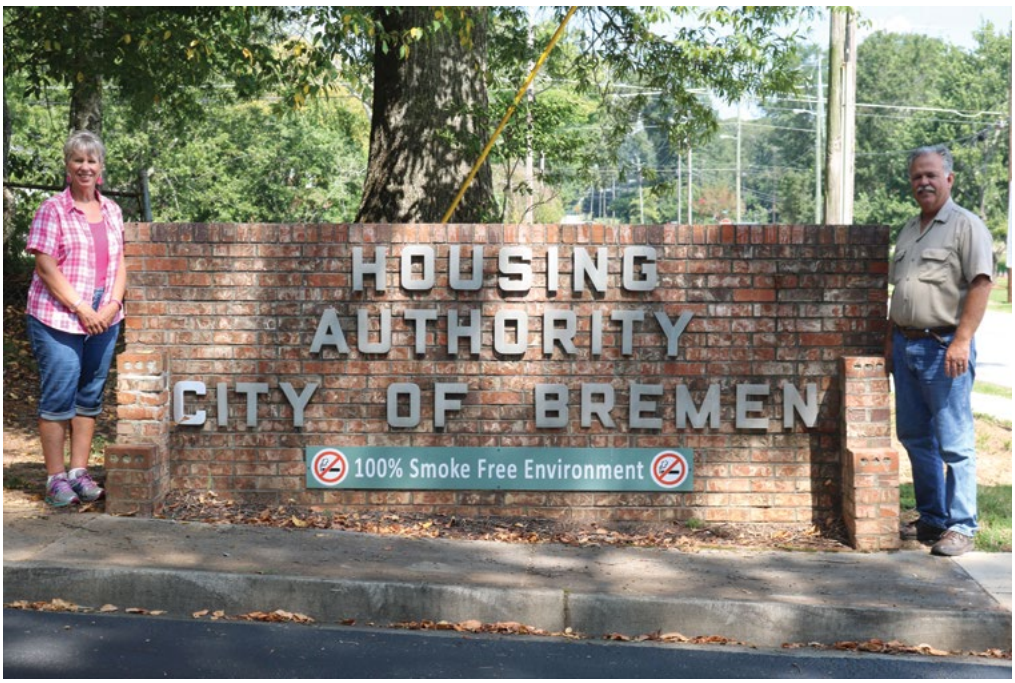
An interactive vaping awareness seminar was developed and held in December 2019, reaching more than 1,100 students and faculty at Haralson County middle and high schools. The seminar also marked the launch of Get Healthy, Live Well's anti-vaping social media campaign.

Haralson teens were encouraged to post photos on Instagram using #NotYourNextGeneration. In addition, more than 700 individuals have been served by Freshstart nicotine cessation programs since July 2013.

The Freshstart program, developed by the American Cancer Society, has been augmented by the GHLW coalition's efforts to assist over 20 local organizations since 2012 in implementing tobacco-free policies, impacting over 60,000 individuals. Those organizations include clinics, universities, schools, housing authorities, worksites and faith-based organizations.

GHLW also provided technical assistance to the Bremen Housing Authority in adopting a 100% smoke-free policy, impacting 46 housing units and 70 residents.

Due to these efforts, adult smoking rates in Carroll County showed decreases from 2013 (23%) to 2022 (22%), according to the County Health Rankings report published by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.



Improving Nutrition

Get Healthy, Live Well's West Georgia Regional Food System Collaborative continued to increase the accessibility, availability, affordability and identification of healthy foods. The group includes more than 30 representatives, including business and restaurant owners, concerned citizens, local farmers, master gardeners and school nutrition directors. Its task forces have:

- Conducted studies on food insecurity among rural residents
- Created a local Farm and Food Resource Guide
- Developed educational point-of-purchase materials to encourage local restaurants and convenience stores to offer more healthy food/menu items (including launching a mobile app Menu It, which had over 2,500 registered users) to increase the number of nutritious meals purchased and consumed
- Held workshops on business management for farmers
- Hosted networking meetings to encourage schools and restaurants to buy from local farmers
- Supported efforts to introduce and promote SNAP benefits at two area farmers' markets, making healthy food accessible to 16,500 low-income individuals
- Worked with three local summer feeding programs and more

Journeyman Farmer Certificate Program

Get Healthy, Live Well recognizes the critical need for new farmers in our region to help us supply the fresh fruits and vegetables needed for healthy communities.

Although we need new farmers, the barriers would-be farmers face when growing new agricultural businesses from the ground up can be formidable. In partnership with the UGA Extension and with support from a United States Department of Agriculture (USDA) Community Food Project grant, Get Healthy, Live Well aims to mitigate these barriers by providing enhanced farmer education programming and opportunities in the region.

Those who completed the Journeyman Farmer Certificate Program can participate in a 20-hour Journeyman Farmer mentorship with local farmers. At the completion of the mentorship program, participants can apply for an 80-hour working internship on a local farm. Interns are provided a stipend of $9 per hour.

During the first year of the program in 2018, 44 new or beginning farmers completed the Journeyman program, including three individuals who completed the mentorship program. In February 2019, 10 individuals completed the Journeyman Farmer Certificate Program, focusing on small ruminant production.

From post-surveys, most participants reported overwhelmingly positive feedback about the program format and material covered. Two individuals completed the Journeyman Farmer Mentorship program in June 2019, reporting positive feedback and significant gains in hands-on knowledge of small ruminant farming. One participant stated in an evaluation form:

"This is a valuable program for novice farmers. I did not find one or two aspects beneficial; I found the entire program beneficial!"

In February 2020, 22 individuals completed the Journeyman Farmer Certificate Program, focusing on fruit and vegetable production. The pandemic impacted the ability of local farmers to participate in the farmer mentorship program during Summer 2020.

On Feb. 25 and 27 of 2020, a West Georgia Small Farm Conference was held in Haralson County, in which over 100 individuals attended. Session topics included:

- Honeybees and pollinators
- Small ruminant production
- Vegetable crop scheduling
- Marketing
- Vegetable pests
- Nuisance animals
- Irrigation
- Fruit tree and vegetable farms
- Wine grapes
- Pasture/grazing

Participants also toured local farms during the conference.

In April 2022, 30 individuals completed the Journeyman Farmer Certificate Program, focusing on small fruit and vegetable production.

Community Gardens

During fiscal years 2020 and 2021, Get Healthy, Live Well's Healthy Haralson sub-committee joined forces with Honda Precision Parts of Georgia, Honda Lock and more than 20 organizational partners for the Hands on Haralson Community Week of Service. Volunteers helped plant community gardens and provided services to seniors and senior shut-ins, with more than 100 community volunteers participating each year.

Grow-a-row programming was implemented by the Haralson Junior Leadership team, encouraging residents to grow an extra row of vegetables in their garden and donate to local food banks, increasing access to healthy food options for the underserved. A free indoor pop-up produce market was established at the Community Christian Council (CCC) Food Bank in partnership with Atlanta Community Food Bank, including educational materials with basic recipes and informational discussions with clients. Conversations have been conducted with food pantries and individuals around access to fresh fruits and vegetables and policy changes in ordering healthy food items.

Power of Produce Club

Get Healthy, Live Well continued the Power of Produce (POP) Club program at area farmers' markets to empower kids to make healthier choices. Every time kids ages 4 to 12 come to the farmers' market and participate in a fun activity, they receive $2 to spend on fresh fruits and vegetables. The program also includes various educational activities around food, nutrition and food growing.

Over fiscal years 2017-2019, there was an average of 200 POP club members per year. Though impacted by the pandemic, the program garnered overwhelmingly positive feedback from local parents who appreciate that the program encourages healthy eating behavior in fun, new ways and gets kids excited about trying fruits and vegetables.

Food Pantries

Get Healthy, Live Well has worked with four area food pantries to improve the nutritional quality of the food donated and served.

The food pantries included Manna House, Community Christian Council (CCC), Bowdon Area United Christian

Ministries and Open Hands — who collectively serve over 1,500 families per month. The coalition has also provided education to clients on how to use their limited funds to purchase and prepare healthier foods.

The leadership of these food pantries have convened multiple times and developed guidelines to increase the nutritional quality of their food donations. During fiscal year 2020, the CCC formally implemented a food policy related to increasing the healthy food donations disseminated to food patrons and continues to uphold the fidelity of this policy and promote it to other food banks in the region.

Through Healthy Haralson's Healthy Lifestyles and Education task force, a free indoor produce market at the CCC was expanded in partnership with the Atlanta Community Food Bank to provide 37,590 hot meals, 663,809 pounds of fresh produce and healthy staples, to 37,590 underserved residents from 2020 to 2021.

During the pandemic, local food banks in Haralson County saw drastic increases in need, cutting down on the number of days open due to scarce food supply. For example, the CCC normally feeds 300 people twice a week and had more than 1,000 people show up in one day seeking food.

The Bowdon Area United Christian Ministries' "First Friday" Pop-up Market, hosted once a month from April to October, was held with food pantry giveaway days. The market's slogan was "Take What You Want, Pay What You Can, Eat What You Take." Get Healthy, Live Well provided nutrition education and cooking demonstrations during these pop-up markets.

The Bowdon Pop-Up Market has served approximately 60 individuals per month during fiscal year 2020. Through a partnership between the Atlanta Community Food Bank (ACFB) and their mobile food market during fiscal year 2021, 255 residents were served. A total of 12,900 pounds of fresh produce were distributed on 118 giveaway days, engaging approximately five volunteers per giveaway day to help with distribution.

The promotion of the Supplemental Nutrition Assistance Program (SNAP) and other EBT (Electronic Benefits Transfer) benefits at food giveaway days increased the utilization of these services at the Cotton Mill Farmers' Market each month. Get Healthy, Live Well developed "how to" healthy recipes utilized them at the farmers' market April-August 2019 and continued promoting them into 2020.

Cooking Matters

Cooking Matters is an evidence-based national program that empowers low-income individuals and families with the skills to prepare healthy and affordable meals.

The program, which includes six weekly, two-hour sessions, brings together local culinary and nutrition experts and volunteers to lead hands-on courses. Cooking Matters teaches low-income children, teens and adults how to select tasty and low-cost ingredients, stretch them across multiple meals and use healthy cooking techniques and recipes that help provide the best nourishment possible to their families.

Classes have been taught at:

- Boys and Girls Clubs
- Housing authorities
- Senior centers
- Libraries
- Churches
- Universities
- Schools
- Community centers
- Businesses

During fiscal year 2020, two six-week Cooking Matters class series were held, reaching 26 low-income residents. Classes were held at the Heard County Senior Center and Tallatoona Head Start in Haralson County. Due to the COVID-19 pandemic, additional Cooking Matters programming in fiscal year 2021 had to be canceled due to stay-at-home orders and social distancing guidance. The Cooking Matters program has significantly impacted participants' nutrition knowledge and behaviors. Several low-income adults reported how the course has helped them buy healthier meals with their SNAP benefits, further supporting their families' health and food security.

Participants' responses to post-surveys indicate increased occurrences of:

- Choosing low-fat dairy options, including milk
- Choosing whole-grain products
- Choosing lean meats or proteins that are low in fat
- Choosing healthy fast-food or other restaurant options
- Eating food from each food group daily
- Helping their families eat healthier
- Making meals from scratch at home using healthy ingredients
- Reading food labels to determine nutrition information

Learn more: **cookingmatters.org**

IMPROVING ACCESS TO HEALTHY FOODS AND INCREASING PHYSICAL ACTIVITY OPPORTUNITIES IN SCHOOLS

Kids 'N the Kitchen

In November 2016, Get Healthy, Live Well launched Kids 'N the Kitchen, an interactive teaching kitchen program for grades K-8 designed to help teach students healthy cooking skills and improve their nutrition. Not only does Kids 'N the Kitchen help teach students healthy eating habits, but it also provides an opportunity for them to take the lessons they learn home and educate their parents. A total of seven carts are utilized for Kids 'N the Kitchen and schools apply each semester (fall or spring) to bring the programming to their school.

The rolling steel kitchen cart features an induction cooktop, reversible griddle and food processor for cooking demonstrations. The kitchen also includes a stainless-steel pop-up table for additional prep space. Since its launch, Kids 'N the Kitchen has implemented 835 lessons, reaching more than 32,450 children.

Kids 'N the Kitchen class taught by Buchanan Primary School staff.

The nutrition carts have visited 17 different schools throughout Carroll, Haralson and Heard counties. Participating schools include:

- Bowdon Elementary School
- Buchanan Elementary School
- Buchanan Primary School
- Carrollton Elementary School
- Carrollton Upper Elementary School
- Central Elementary School
- Centralhatchee Elementary School
- Ephesus Elementary School
- Glanton-Hindsman Elementary School
- Providence Elementary School
- Roopville Elementary School
- Sandhill Elementary School
- Sharp Creek Elementary School
- Tallapoosa Primary School
- Villa Rica Middle School
- Whitesburg Elementary School

Outcomes from the program include:

- An increased willingness of children to try fruits and vegetables. Out of a sample of 176 students at Whitesburg Elementary that went through the programming, 100% of students tried the food prepared for the lesson, with 42% noting that they "loved it."
- Ongoing reporting by teachers and parents about the positive impact the programming has had in influencing healthy eating behaviors among children/families. They also reported an increase in knowledge about the connection between diet and health.

PROMOTING HEALTH THROUGH INCREASED PHYSICAL ACTIVITY

Through Get Healthy, Live Well's Healthy, Safe and Active Communities committee, community leaders have put complete streets and built environment strategies high on their agendas, moving forward with various infrastructure changes in the community.

Carrollton GreenBelt

The GreenBelt, an 18-mile bike and pedestrian path (the largest paved loop system in Georgia), provides an opportunity to integrate recreation with transportation, combating several negative health trends impacting Carrollton.

The trail connects existing neighborhoods with the Carrollton City Schools campus, University of West Georgia, city parks and several commercial shopping areas. Construction began on the $17 million project in 2011, and the GreenBelt fully opened to the public in 2017.

In May 2017 and 2021, the League of American Bicyclists recognized Carrollton as a Bicycle Friendly Community. In July 2018, Road Runners of America recognized Carrollton as a Runner Friendly Community.

Policy and Built Design

The city of Carrollton adopted a Complete Streets Policy during Fiscal Year 2017. Notable built design changes include the addition of bike lanes, sidewalks and traffic pattern reconfigurations to accommodate bicycles and safer crosswalks.

In August 2018, the city of Villa Rica developed and adopted a comprehensive Villa Rica Trail Master Plan to promote connectivity to destinations such as parks, neighborhoods and business districts and encourage active healthy living. The city of Bremen completed a plan for an additional walking trail and added or repaired multiple sidewalks throughout the city.

The University of West Georgia (UWG) developed a master bike plan with the addition of multiple bike lanes and pedestrian-friendly corridors. Additions include a 1.25-mile bicycle track and GreenBelt connector around the campus perimeter. In November 2017, UWG was recognized by the League of American Bicyclists as a Bike-Friendly University.

Safe Routes to School

Get Healthy, Live Well continued to promote the Safe Routes to School (SRTS) program at Carrollton City Schools. The program encourages increased student physical activity through safe and active transport to and from school, as well as infrastructure improvements and student traffic education. After new bike racks and walking lanes were installed in August 2015, a 500 percent increase in walking and cycling to school was realized.

Move It Mondays

Going for 30 minutes of exercise a day, at least five days a week, is a great way to get and stay in shape. Get Healthy, Live Well is helping people get started with Move It Mondays, an eight-week program designed to turn walkers into joggers. In partnership with the West Georgia Track Club, Get Healthy, Live Well developed the free program to help participants add distance and increase their pace over eight weeks. Move It Mondays has certified coaches and experienced runners available to encourage and motivate participants.

Since 2019, there have been 196 participants.

Carrollton Half Marathon

In September 2019 and September 2021, Tanner Health System presented the Carrollton Half Marathon in partnership with the City of Carrollton and the West Georgia Track Club, helping showcase the Carrollton GreenBelt with over 1,000 race participants.

Chronic Disease Education, Prevention and Management

INCREASING ACCESS TO CLINICAL AND COMMUNITY-BASED SERVICES

For people to lead healthier lives, they must have access to high-quality clinical and community-based services that can help them prevent or manage chronic diseases.

Our goal is to provide high-quality, evidence-based services that are available and accessible to all. When people have the knowledge and tools they need to manage their health, they are more likely to stay healthy and out of the hospital.

Increasing Access to Chronic Disease Preventive Services and Self-Management Programs

HELPING THE COMMUNITY GET HEALTHY AND LIVE WELL

Two threats are increasingly affecting individual quality of life and overall community health in west Georgia: unhealthy lifestyles and the growth of chronic disease.

Both pose many challenges, and no solutions are simple. However, those challenges can be overcome through prevention and management.

To address the community's healthcare needs, Tanner Health System is working to increase access to education, prevention and management programs. The increased prevalence of chronic disease in Carroll, Haralson and Heard counties has led Tanner to take the lead in improving the region's health status.

To help residents take charge of their health, Get Healthy, Live Well continues its efforts to increase access to community-based preventive services and self-management programs. This includes providing these services and programs in organizational and institutional settings (e.g., faith-based organizations, community-based organizations and worksites).

Faith-Based Wellness

Local faith-based organizations represent a substantial and largely untapped voluntary-sector resource for community health improvement efforts in small, rural communities. During the Centers for Disease Control and Prevention's Partnerships to Improve Community Health (PICH) project period, Get Healthy, Live Well's faith-based wellness efforts focused on improving health and reducing chronic disease and related risk factors. The project included the engagement of 14 area faith-based institutions (including focused efforts in 11 African American faith-based organizations), representing over 4,865 congregants, in the implementation of evidence-based strategies aimed at addressing:

- Tobacco use and exposure
- Poor nutrition
- Physical inactivity
- Lack of access to chronic disease prevention, risk reduction and management opportunities.

Get Healthy, Live Well conducted initial Policy, System and Environmental (PSE) assessments within the selected faith-based organizations to determine current efforts and prioritize evidence-based strategies based upon identified needs. Interventions have included the adoption of smoke-free or tobacco-free policies. They have also included the development of wellness councils to promote healthy lifestyle behaviors within the faith-based organization and community, including the training of congregation members in wellness programming promoting the following:

- Nicotine cessation
- Physical activity and nutrition
- Community gardens
- Physical activity groups
- Wellness challenges
- And more

Research shows faith-based health promotion interventions that engage congregations as change agents result in improved health status and medical outcomes such as better disease control, earlier diagnosis, and fewer comorbidities for the community.

A comprehensive evaluation of the Get Healthy, Live Well in Faith initiative determined if the initiative's efforts impact PSE change and health among African-American church members. This evaluation was an observational, longitudinal cohort study with pre-and post-observations of variables occurring over two years (May 2015 to June 2017). The sampling plan implemented included a convenience sample

of 11 African American churches, with a sample size of 776 church members 18 and older.

The key evaluation findings were as follows:

- Tobacco and water policies were adopted by 100% of the churches
- 90% of the churches integrated physical activity into church activities
- 82% of the churches implemented an evidence-based program during the intervention
- The percentage of church members with hypertension, Stage 1 or 2, decreased from 81% to 61%
- Church members reported improved nutrition knowledge each year from 24% (very knowledgeable) to 32%
- The percentage of church members who visited a healthcare professional 10 or more times in 12 months decreased each year, from 6% to 0%

Get Healthy, Live Well has held six screening events during fiscal year 2020 through partnerships with six faith-based organizations, offering blood pressure screenings and healthy lifestyle education, reaching over 305 residents.

Workplace Wellness

In January 2022, GHLW implemented a new wellness program for local employers, providing comprehensive chronic disease and healthy lifestyle education programs. Onsite vaccine clinics were also offered at local business and industry sites.

In the last three years, GHLW implemented new wellness programs for six employers representing more than 2,000 employees to determine current efforts and implement new strategies to increase access to affordable, healthy food and beverages and promote physical activity.

Initiatives included, but were not limited to, weight loss and walking meeting challenges, hydration challenges, providing technical assistance in vending machine policies and fitness center planning and more.

In September and October of 2021, GHLW and the Carroll County Chamber of Commerce hosted an online series for business leaders about navigating the pandemic. The event provided insight into how businesses can remain strong during a crisis. A panel of local experts and speakers discussed:

- Vaccinations
- How to keep the workplace safe
- How to help employees deal with the challenges they face at work and home
- And more

Tanner Health Source

Get Healthy, Live Well's employee wellness program employs registered dietitians, exercise specialists and health coaches who work with employees and lead group classes to help employees lose weight, manage chronic diseases and adopt healthier habits.

Each year, GHLW provides free wellness assessments to all employees that include a cholesterol screening, blood glucose reading, BMI check and more. GHLW continues to cultivate a healthier workforce through programs like HealthBridge/chronic disease management and Livongo for Diabetes. Tanner employees also have 24-hour access to Tanner Health Source exercise facilities, which feature cardio and weight-training equipment, at its hospital campuses in Carrollton, Villa Rica and Bremen.

The investments have paid dividends in improved health for Tanner's employees. Over the past eight years, the average BMI of Tanner's workforce has dropped from 35 in 2010 to 30.1 in 2021. The average blood pressure reading for employees also has dropped, from 125/76 in 2010 to 117/79 in 2021.

Get Healthy, Live Well Classrooms and Teaching Kitchen

When it comes to improving the health of a community, education — as well as access to healthy food and physical activity opportunities — is key.

That's why Get Healthy, Live Well (GHLW) moved into a new facility that will help fill the need for more spaces promoting healthy, active lifestyles.

GHLW hosts a variety of classes and programs in the building, including:

- Cooking Matters
- Diabetes Prevention Program
- Freshstart
- Food As Medicine
- Living Well With Diabetes
- Living Well Workshop
- Tai Chi for Health

The building includes a state-of-the-art teaching kitchen where GHLW staff host healthy cooking classes. It also features the Healthy Food Farmacy, providing free boxes of fresh, nutritious food for food-insecure participants

of its Food As Medicine program. The program is for area residents struggling with controlling diabetes or high blood pressure and the cost of healthy foods.

Through a collaboration with the Atlanta Community Food Bank, qualifying participants can visit the Healthy Food Farmacy and "shop" weekly with Get Healthy, Live Well's specially-trained team members. GHLW staff help participants choose healthier options, plan meals and learn healthier ways to prepare them.

The facility also offers lifestyle and cooking classes, diabetes and high blood pressure education and more, so participants can take control of their condition.

Food As Medicine

In July 2020, Get Healthy, Live Well launched a new innovative Food As Medicine program.

The program provides participants (low-income, food-insecure patients with A1C levels greater than 7.0 and high blood pressure) with free, nutritious food and a comprehensive suite of diabetes, hypertension, social and environmental education services.

Food As Medicine participants are provided support that includes:

- A free blood pressure monitor for patients with high blood pressure
- Free diabetes and high blood pressure education
- Free healthy cooking classes
- Tips on purchasing more nutritious foods on a budget
- Free advice on meal planning
- More intensive education on diabetes and blood sugar

They're also provided with ongoing care coordination/navigation, and they can visit the program's Healthy Food Farmacy weekly during the course of the program to receive amounts of food based on household size. A comprehensive evaluation of the Food As Medicine program was provided by an external evaluation team from the University of West Georgia's Department of Health and Community Wellness.

Initial evaluation results show potentially significant improvements in biometric results (BMI, A1C, blood pressure) and efficacy to better manage their disease by the end of the program as of 2022. As of May 2022, 174 participants have completed the program, receiving more than 36,000 pounds of food.

Learn more: **tanner.org/foodasmedicine**

Diabetes Prevention Program

The National Diabetes Prevention Program (DPP) from the Centers for Disease Control and Prevention (CDC) includes dietary coaching, lifestyle intervention, and moderate physical activity to prevent diabetes in pre-diabetic individuals. The program consists of 16 "core" sessions (one per week for an hour) in a group-based, classroom-style setting that provides practical training in long-term dietary change, increased physical

activity, and behavior change strategies for weight control. After the 16 core sessions, less intensive monthly follow-up meetings help ensure that the participants maintain healthy behaviors.

The primary goal of the intervention is at least 5% average weight loss among participants, which is evidenced to result in a 58% lower risk of getting diabetes, according to CDC estimates. Since 2014, DPP has helped over 500 residents slash their risk of developing type 2 diabetes. Of that number, 173 participants have completed the program in the last three years. In January 2017, Tanner was the first hospital in Georgia to receive CDC Full Recognition for participant achievement of DPP program goals (e.g., weight loss, physical activity).

This CDC Full Recognition status was subsequently achieved again by GHLW in July 2018, March 2019 and October 2020 for continued effective DPP delivery after receiving an average of 5.5% participant weight loss at the end of the 12-month instruction.

A survey of 61 individuals who completed the DPP program — representing a 51% completion rate — showed they achieved remarkable results, which include:

- Improved confidence and tools/skills to take care of health (self-management)
- Less missed work due to health issues in the previous month
- Fewer health issues that interfere with daily activities
- Reduction in the number of participants currently experiencing arthritis or gout
- Significant reduction in those with high cholesterol
- Significant reduction in overweight or obesity

Living Well With Diabetes

The Diabetes Self-Management Program (Living Well with Diabetes) is a two-hour workshop held once a week for six weeks. The workshop, which is led by two trained leaders, is designed for people diagnosed with type 2 diabetes. The typical class size is 12 to 16 people.

Topics covered include:

- Techniques to deal with the symptoms of diabetes, which include fatigue, pain, hyper/hypoglycemia, stress, and emotional problems such as depression, anger, fear and frustration
- Appropriate exercise for maintaining and improving strength and endurance
- Healthy eating
- Appropriate use of medication
- Working more effectively with health care providers

During the workshop, participants make weekly action plans, share experiences, and help each other solve problems they encounter in creating and carrying out their self-management program. A recent research study shows that participants who completed the program had significant improvements in depression, symptoms of hypoglycemia, communication with physicians, healthy eating and reading food labels. They demonstrate improvement in patient activation and self-efficacy. They also spent fewer days in the hospital, and there was a trend toward fewer outpatient visits and hospitalizations, yielding a cost to savings ratio of approximately 1:4.

A survey of 77 individuals who completed the Living Well With Diabetes program — representing a 43% completion rate — showed they achieved the following results:

- Self-assessed health improved by a quarter of a unit on a 4-point scale (0=poor to 4=excellent).
- The obesity rate fell a huge 14.7% (from 49.3% to 34.7%), accompanied by a marginally significant increase in the frequency of reading nutrition labels.
- Statistically significant improvements in three different aspects of confidence in taking care of one's health/interacting with one's doctor.
- Since 2019, 77 people have taken the class.

Living Well With Chronic Disease

The Chronic Disease Self-Management Program (Living Well Workshop) is a two-hour weekly workshop for six weeks. People with various chronic health problems (high blood pressure, arthritis, cancer, depression, heart disease, diabetes and more) attend the workshop, which is facilitated by two trained leaders. Family members and informal caregivers are also encouraged to attend.

Topics covered include:

- Techniques to deal with frustration, fatigue, pain and isolation
- Appropriate exercise for maintaining and improving strength, flexibility and endurance
- Appropriate use of medications
- Communicating effectively with family, friends and health professionals
- Nutrition
- Decision making
- How to evaluate new treatments

A recent research study shows that participants who completed the program demonstrated significant improvements in:

- Exercise
- Cognitive symptom management
- Communication with physicians
- Self-reported general health
- Health distress
- Fatigue
- Disability
- Social/role activities limitations

- Participants also spent fewer days in the hospital, and there was a trend toward fewer outpatient visits and hospitalizations, yielding a cost to savings ratio of approximately 1:4.

A survey of 77 individuals who completed the Living Well Workshop — representing a 49% completion rate — showed they achieved the following results:

- Greater confidence and tools/skills to take care of health (self-management)
- Great confidence in the management of health-related tasks and activities that reduce the need for doctor care
- Confidence in health-related self-management other than taking medication

Since 2019, 49 people have taken the class.

Freshstart Nicotine Cessation Program

Freshstart is the American Cancer Society's group-based nicotine cessation counseling program.

The Freshstart program is designed to help smokers, vapers, chewers and dippers quit nicotine and develop coping skills to combat the psychological and physical side effects of cessation. This straightforward, upbeat program is intended to stress the positives of the nicotine cessation experience — the reasons to quit and the benefits of quitting – while honestly exploring the very real, unpleasant feelings that are a part of beating the addiction.

Given the historically high level of tobacco use in the west Georgia region, in 2020, Tanner adapted the Freshstart program to an online platform, allowing participants to safely enjoy the support and benefits of the program from the comfort and safety of their own homes.

The program is easy to fit into a busy lifestyle since classes meet one hour a week for four weeks and are held free of charge by trained facilitators on a rolling basis every month at a variety of locations. Since July 2013, over 700 individuals have participated in the program.

A survey of 67 individuals who completed Freshstart showed they achieved the following results:

- Significant improvement in confidence in controlling cravings
- Significant reduction in the likelihood of having hypertension/high blood pressure
- A sizeable reduction in the probability of using tobacco (6.3%)

Get Healthy, Live Well Class Instructors

Get Healthy, Live Well is committed to maintaining a high level of training and certification for its instructors. Since 2012 GHLW has trained over 200 people to

teach its evidence-based wellness programs. Those numbers include:

- Two master trainers and over 60 lay leaders in the Living Well programs
- One master trainer and 49 lifestyle coaches in the Diabetes Prevention Program (DPP)
- Six Freshstart leaders
- 90 Cooking Matters facilitators
- 19 program facilitators of Get Healthy Kids
- 7 Tai Chi for Health instructors

During fiscal year 2021, Get Healthy, Live Well added four more certified instructors to teach Tai Chi for Health.

INCREASING PHYSICIAN REFERRALS

Get Healthy, Live Well has made it a priority to expand its community health efforts with an innovative community-clinical linkages (CCL) model that creates a bridge between the clinic or doctor's office and its evidence-based programs, which include the following:

- Diabetes Prevention Program (DPP)
- Food As Medicine
- Freshstart Nicotine Cessation Program
- Get Healthy Kids
- Living Well with Chronic Disease
- Living Well with Diabetes
- Tai Chi for Health

Tanner's Get Healthy, Live Well staff updates physicians on patient referrals, progress and outcomes. Since launching a robust CCL linkages referral process in early 2016, over 5,600 individuals have been referred to a Get Healthy, Live Well program, with nearly 100 area clinicians currently providing referrals.

INCREASING OUTREACH TO PREVENTIVE SERVICES

Tanner has been proactive in encouraging residents to undergo recommended health screenings based on various factors (including age, health habits, lifestyle, etc.) using emails, direct mail pieces, flyers, exposure at community events and more to raise awareness.

The health system has encouraged residents to use free online health risk assessments for various health conditions — including diabetes, heart disease and colorectal cancer.

Get Healthy, Live Well has held six screening events during fiscal year 2020 through partnerships with six faith-based organizations, offering blood pressure screenings and healthy lifestyle education, reaching over 305 residents. In addition, CPR educational events were held on five different occasions, reaching 140 residents.

Mammography on the Move

Breast cancer is the most common type of cancer diagnosed in west Georgia women, and early detection is key to successfully battling the disease. That's why Tanner's Mammography on the Move digital mammography unit hit the road, removing barriers of time, awareness and access that prevent women from getting mammograms.

The mobile unit visited 121 different regional locations sites during fiscal year 2020, including community events, indigent clinics, businesses, churches, civic groups and more, providing 599 mammograms and 109 bone density exams to area women. The mobile unit visited 159 different regional sites during fiscal year 2021, including community events, indigent clinics, businesses, churches, civic groups and more, providing 912 mammograms and 150 bone density exams.

During fiscal year 2022, the mobile unit visited 131 different regional sites, providing 660 screenings and 102 bone density exams.

Better Birth Days

In May 2021, Tanner Women's Care and several community partners launched a new effort to keep moms and their babies safe and healthy.

The public awareness campaign, "Better Birth Days," provided education on the potentially life-threatening health risks and complications for moms during pregnancy, delivery and postpartum — especially among Black and Latina women.

Tanner partnered with the Carroll County Health Department, the Pregnancy Resource Center, first responders and the faith-based Black and Latina communities — among other organizations — to reach more at-risk moms and their loved ones to build awareness of these risks and the importance of immediate medical intervention to save lives.

The outreach leverages Tanner's extensive care footprint in the region, the expertise and passion of its medical team for caring for moms and their babies, and an extensive network of existing community relationships established through Tanner's Get Healthy, Live Well to improve health outcomes in the communities Tanner serves.

The campaign included local media coverage, blog articles, social media promotion, a dedicated webpage, education classes and a radio show appearance. The Carroll County Health Department and Pregnancy Resource Center provide Better Birth Days rack cards to every woman visiting who has a positive pregnancy test. The campaign has reached over 200,000 residents.

Partnering in Community Health

Following the completion of the 2019 CHNA, the Tanner-led Get Healthy, Live Well (GHLW) Coalition was restructured to address the priorities outlined in the FY 2020-2022 Community Health Implementation Strategy.

Since the restructuring, the coalition has grown to include more than 35 task forces, more than 270 local, state and national partners and over 600 community volunteers.

GHLW also expanded to focus on Haralson County and received a grant from the Healthcare Georgia Foundation to address the persistent inequities in health outcomes that disproportionately impact rural Georgians.

Healthy Haralson consists of four task forces:

- Healthy minds and bodies
- Community resources
- Senior needs
- Substance misuse

Together, team members within each task force are working to identify obstacles to resident health and wellness and find innovative ways to overcome them.

From Fall 2019 through May 2022, GHLW volunteers have provided an average of 7,300 hours of service per year, an estimated worth of $176,200 per year.

Over the years, the coalition's efforts have received multiple accolades for effectively addressing public health challenges. These accolades include receiving the following awards or designations:

- Georgia Department of Public Health's **Partner Up! For Public Health Hero**, 2013
- Georgia Hospital Association's **Community Leadership Award**, July 2014
- Georgia Alliance of Community Hospital's **Large Hospital of the Year Award**, October 2014
- National Center for Healthcare Leadership's **Leadership Challenge Award**, August 2015
- American Hospital Association's **NOVA Award**, July 2016
- Georgia Department of Public **Health's Healthy Georgia Community Innovation Award**, October 2016
- Finalist for the International Hospital Federation's **Excellence Award for Corporate Social Responsibility**, August 2017.
- Finalist for the American Hospital Association **Foster McGaw Prize**, November 2018.
- Finalist for the Robert Wood Johnson Foundation **Culture of Health Prize** (City of Carrollton), March 2019.

PROMOTING SHARED OWNERSHIP OF COMMUNITY HEALTH

Healthy Haralson Task Forces

As a healthcare system, we seek to empower people to take control of their health through education, prevention and advocacy.

This has steered our efforts in Haralson County to improve the community's health. No one knows the challenges Haralson County faces better than its residents, and that's why Healthy Haralson is led by community leaders from across the county.

The goal of the Healthy Haralson Task Forces is to ensure all residents have equitable opportunities to get healthy and live well. This was accomplished through the work of six task forces:

- Healthy lifestyles and education
- Increase awareness of existing resources
- Increase provider resources
- Senior needs
- Substance misuse
- Youth mental health

After successfully implementing various programs to help improve health and reduce chronic disease, the committee reviewed its successes and decided to consolidate efforts for sustainability, reducing from six to four task forces:

- Healthy minds and bodies
- Community resources
- Senior needs
- Substance misuse

Together, team members within each task force are working to identify obstacles to resident health and wellness and find innovative ways to overcome them.

Community Resource Guide

Healthy Haralson continues its efforts to inform community members about the programs and resources available to them.

Healthy Haralson's community resource guide lists a wide variety of services available to residents, including child and adult care, education and training, physical and mental health services, protective services, substance misuse resources and more. The guide also includes services for residents who need help with basic necessities such as food, shelter and utilities.

It has been viewed almost 2,000 times.

Learn more: **tanner.org/haralsonguide**

Mental/Behavioral Health

PROMOTING MENTAL/BEHAVIORAL HEALTH IN THE COMMUNITY

Mental and behavioral health are essential to overall health and wellbeing.

That's why it's vital that everyone has access to resources and support to maintain good mental health. Increasing awareness is just one part of the puzzle — we need to focus on prevention, early intervention and treatment.

Increasing Access to Mental Health Services

Willowbrooke at Tanner, the behavioral health division of Tanner Medical Center, Inc., provides complete behavioral health care across Georgia and east Alabama through inpatient, outpatient and in-home counseling and psychiatric services.

With facilities closing and declines in residential treatment and inpatient care options across the state, Willowbrooke at Tanner continues to look at ways to provide a broad continuum of quality mental health treatment services while keeping patients in the communities in which they live. Tanner keeps access to a continuum of behavioral

health services a phone call away with free, confidential behavioral health screenings from Willowbrooke at Tanner.

With a call to Willowbrooke at Tanner's helpline, a behavioral health clinician trained in crisis intervention can arrange a full assessment and connect a person to an entire community-based network of resources and treatment options both within and outside Tanner's continuum of care. Willowbrooke at Tanner continued developing and providing specialized therapies to its patients during the year, including expressive therapy, rhythmic therapy, animal-assisted therapy and equestrian therapy.

Willowbrooke at Tanner participates in the Carroll County Crisis Response Team (CCCRT), which responds to 911 calls that are psychiatric or substance use-related with a Post Certified Law Enforcement Officer, who is also a paramedic, and a licensed clinician (LPC/LCSW) whose goal is to respond, resolve and refer for the community member to gain immediate access to behavioral health care, as well as, to avoid any unnecessary interaction/escalation with law enforcement, resulting in legal consequences or worse. This partnership will often allow those in crisis to bypass the Emergency Department (with long wait times) and receive care faster.

This team will also follow up with the individual days after the crisis to ensure they follow up with recommended care and continue monitoring their stability/progress. This unit responds to an average of 41 calls monthly.

Willowbrooke at Tanner has a clinician who provides treatment in Douglas County through Hope Court, Douglas County's mental health court. The division is also partnering with Douglas County Juvenile Court to create a juvenile mental health court called "Second Chance Court."

Willowbrooke at Tanner continued implementing and expanding its school-based behavioral health therapy services. In fiscal year 2021, Willowbrooke at Tanner partnered with eight school systems to have 20 licensed behavioral health counselors in 52 elementary, middle and high schools, offering direct access to mental health services to hundreds of school-aged children and their families.

In response to the COVID-19 pandemic, Willowbrooke at Tanner established an easy-access Help Line — a part of Tanner's Care Your Way, to assist patients with the stresses amplified by the pandemic. Patients can call 770-812-3266 to learn more or to schedule a free phone screening with a clinician, which is followed by an appointment for a telehealth visit with a licensed therapist.

Willowbrooke Counseling Center

In 2020, Tanner opened the Willowbrooke Counseling Center, with offices in Carrollton and Villa Rica.

The center's counselors offer comprehensive outpatient counseling and therapies to help patients get their lives back on track. The center serves children, adolescents, adults, couples and families.

Willowbrooke Counseling Center becomes each patient's treatment partner, providing personalized assessment, support and an actionable treatment plan that targets a variety of behavioral, emotional, mental health and substance abuse needs and conditions. The center helps patients with:

- Anger management
- Anxiety, phobias and panic
- Bipolar disorder and other mood disorders
- Coping and adjustment
- Depression and seasonal affective disorder
- Dual diagnosis (behavioral and substance abuse)
- Grief and loss issues
- LGBTQ health
- Identity
- Impulse control disorders
- Family discord
- Parenting
- Post-traumatic stress disorder (PTSD)
- Stress
- Substance abuse and recovery
- Trauma recovery

Willowbrooke Counseling Center's team of counselors and therapists is trained to work with individuals, families and groups to treat mental, behavioral, emotional, and substance abuse problems and disorders. The team includes:

- Licensed professional counselors
- Licensed associate professional counselors
- Licensed clinical social workers
- Licensed master social workers
- Licensed marriage and family therapists
- Licensed associate marriage and family therapists

Learn more: **WillowbrookeCounselingCenter.org**

Willowbrooke Psychiatric Center

Tanner also opened the Willowbrooke Psychiatric Center in 2020.

The center provides comprehensive psychiatric and medication management services to help patients of all ages find their way back to a healthy mind, life and body.

The center serves children, adolescents and adults, with a dedicated office for children and adolescents located in the Mirror Lake medical office building at 101 Quartz Drive and offices for adults located at 209 Cooley Drive in Villa Rica ,at 523 Dixie Street, Suite 4, in Carrollton, and at 958 Joe Frank Parkway, Suite 103-B, in Cartersville.

Willowbrooke Psychiatric Center's nine board-certified psychiatrists diagnose and treat a variety of mental health issues through psychiatric evaluations, psychotherapeutic intervention and medication management. The psychiatrists treating children and adolescents aged 5 to 17 at Willowbrooke Psychiatric Center all specialize in child and adolescent psychiatry.

Willowbrooke Psychiatric Center provides patient-focused psychiatric care for the following issues, depending on the patient's age and needs:

- Anger management
- Anxiety disorders
- Attention deficit hyperactive disorder (ADHD)
- Bipolar disorder
- Dual diagnosis (behavioral and substance abuse problems)
- Family issues
- Grief and loss issues
- Impulse control disorders
- Major depression
- Marriage and relationship issues
- Post-traumatic stress disorder (PTSD)
- Psychosomatic disorders
- Schizophrenia
- Substance abuse
- Trauma

Learn more: **WillowbrookePsychiatricCenter.org**

Reducing the Stigma of Mental Illness in the Community

According to the National Alliance on Mental Illness, about half of all mental illness begins by age 14.

One in five children aged 13 to 18 are either currently struggling with a mental health issue or will at some point during childhood — and the pandemic has made behavioral health services all the more necessary. More startling: these national statistics don't exclude west Georgia's and east Alabama's young people — and many of them, too, may be struggling with a mental health issue.

To address this problem, Willowbrooke at Tanner – the behavioral health service of Tanner Health System – offered a public education program to train adults in the community to help children and adolescents who are struggling with mental health issues. The Youth Mental Health First Aid (YMHFA) program was designed to help provide youth with the best opportunity to succeed in school, at home and throughout their lives. YMHFA taught individuals who work and interact with young people to respond when a child is experiencing a behavioral health challenge or crisis.

The program doesn't teach participants how to diagnose mental health issues; rather, it teaches them to use a five-step action plan to help and support young people in non-crisis and crisis situations. These situations include experiencing thoughts of suicide, self-harming or substance abuse.

YMHFA trainings were held for child advocates such as social workers, school counselors, members of the Department of Juvenile Justice, and other individuals who may regularly interact with children. These advocates included church youth group leaders, teachers, coaches, school counselors, family members, EMS first responders,

and other medical professionals. Training has been held in Bartow, Carroll, Coweta, Douglas, Haralson Paulding and Polk counties, making a huge impact on the community and the lives of many young people around the region.

In November 2020, 13 Healthy Haralson Youth Mental Health task force members attended a training class and were certified in Youth Mental Health First Aid. In January 2021, 13 task force members were trained and certified for this class. Also, in January 2021, 20 Healthy Haralson Junior Leadership Team students were trained in basic aspects of the Youth Mental Health First Aid (no certifications were given).

Integrating Behavioral Health and Primary Care

Through the COVID-19 pandemic, Willowbrooke at Tanner worked to ensure access to behavioral health services during a challenging time.

Through referrals made from Epic, our electronic health record system, Tanner was able to continue serving patients with leading-edge behavioral health services online as patients remained at home.

Tying in primary care providers with mental health providers is a vital part of Tanner's efforts to provide holistic care to every patient.

Partnering in Mental/Behavioral Health

Willowbrooke at Tanner has a strong history of successfully collaborating with other agencies, including law enforcement, area juvenile/truancy courts, the Department of Family and Children's Services, the Department of Juvenile Justice, physical offices and schools. Willowbrooke staff and administration frequently attend community meetings with these agencies and organizations, allowing for the identification of community needs to be shared and for Tanner to get involved with assistance when necessary.

During fiscal years 2020-2022, Willowbrooke at Tanner held multiple educational seminars for mental health professionals, including licensed professional counselors, social workers and marriage and family therapists. Most of the seminars offered Continuing Education Units (CEUs) to attendees.

Willowbrook at Tanner is continuing its partnership with Augusta University to provide medical school education to the Medical College of Georgia medical students' psychiatric clinical rotations.

Willowbrooke is also partnering with Morehouse School of Medicine to offer medical education training after the school requested to be the provider of all psychiatric clinical rotations for their medical students. Additionally, Willowbrooke is partnering with Emory to be a training site for their fourth and fifth-year child and adolescent physicians in their psychiatric fellowship training.

Substance Misuse

PREVENTING AND TREATING SUBSTANCE MISUSE

Substance misuse is a major public health problem.

It can lead to serious problems, including addiction, overdose and death. It can also lead to anxiety and depression. But the success of any treatment depends on the individual and whether they have access to the right resources.

Enhancing Substance Misuse Treatment

Willowbrooke at Tanner continued to expand its addiction treatment programs to help residents face and recover from substance misuse.

Addiction treatment programs include inpatient care, inpatient detox, suboxone medication-assisted treatment (MAT) therapy, Adult Substance Abuse Partial Hospitalization and Intensive Outpatient Programs. Programs also include addiction group meetings, outpatient "Journey at Willowbrooke" substance abuse program using the Matrix treatment model, outpatient "Regain at Willowbrooke"

substance abuse program for working professionals, and individual psychiatry and medication management from the Willowbrooke Psychiatric Center's locations in Carrollton, Villa Rica and Cartersville.

Willowbrooke at Tanner added an addiction medicine specialist, Nizam-Uddin Khaja, MD, to its medical staff. Dr. Khaja evaluates patients who have addictions and works with each patient to establish a personalized treatment plan.

That plan may include inpatient detox, partial hospitalization, or an outpatient program — such as Journey, offered through the Willowbrooke Counseling Center, or Regain at Willowbrooke, a recovery program for working professionals. Plans may also include dependency aftercare, sober living and more.

Reducing Barriers and Bridging Gaps in Substance Misuse Treatment

Get Healthy, Live Well's Healthy Haralson Substance Misuse task force partnered with state and local law enforcement agencies and fire departments in 2019 to train first responders on how to properly carry, store and administer naloxone, impacting more than 29,500 residents.

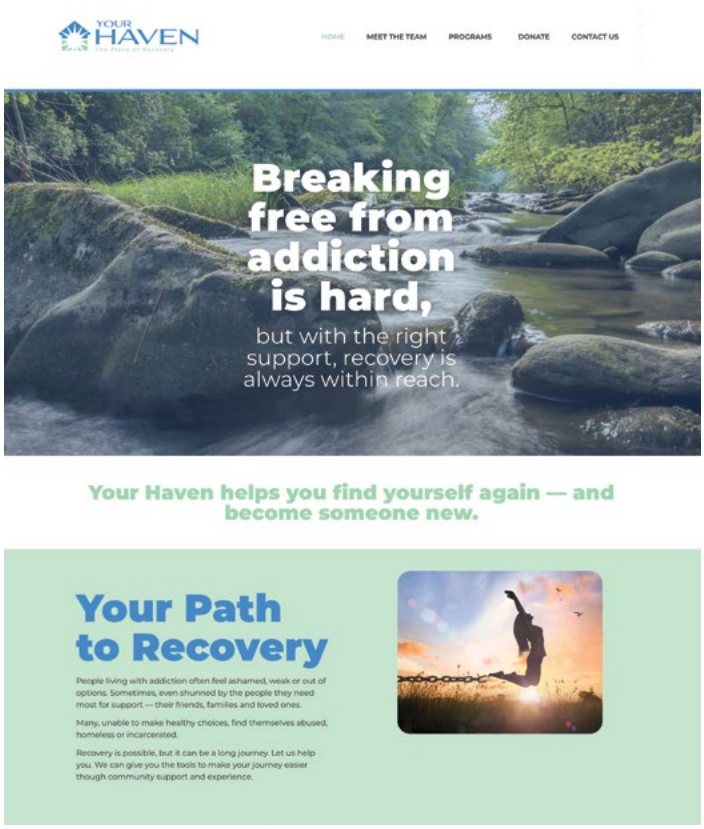
The agencies and departments include West Metro Drug Enforcement Task Force, Georgia Bureau of Investigation, Bremen City police, Bremen Fire Department, Haralson County Drug Task Force, Haralson County Fire Department and Tallapoosa City Police Department.

Policies were implemented with Bremen Police, Bremen Fire and Haralson County Fire and Tallapoosa Police, impacting over 9,400 residents.

YOUR HAVEN: A PLACE OF RECOVERY

One systematic and environmental change has been the substance misuse task force's efforts to establish a Recovery Community Organization (RCO).

A sub-committee was developed to conduct a feasibility study of a peer-led community services recovery center in Haralson County, with site visits conducted in February 2020. A site was identified in Haralson County for the recovery center with support from Tanner Health System.



In the fall of 2020, "Your Haven: A Place of Recovery" was established to offer recovery meetings and support resources to individuals in active recovery from substance addictions. The task force established sustainable partnerships with substance recovery counselors and other mental health providers to provide programming at Your Haven.

Your Haven has since been incorporated and is now a 501c3 nonprofit community organization (RCO) with a separate governing board and executive director. Your Haven, Inc. remains committed to providing support for long-term recovery from substance abuse. The center has served 500+ people through weekly recovery meetings.

DISPOSERx

During fiscal year 2020, Healthy Haralson's Senior Needs task force secured partnerships and implemented programming to distribute DisposeRx, a product that allows for the safe disposal of prescription medications.

Partners include four local pharmacies, one physician practice, a local hospice agency, an ambulance service and senior centers.

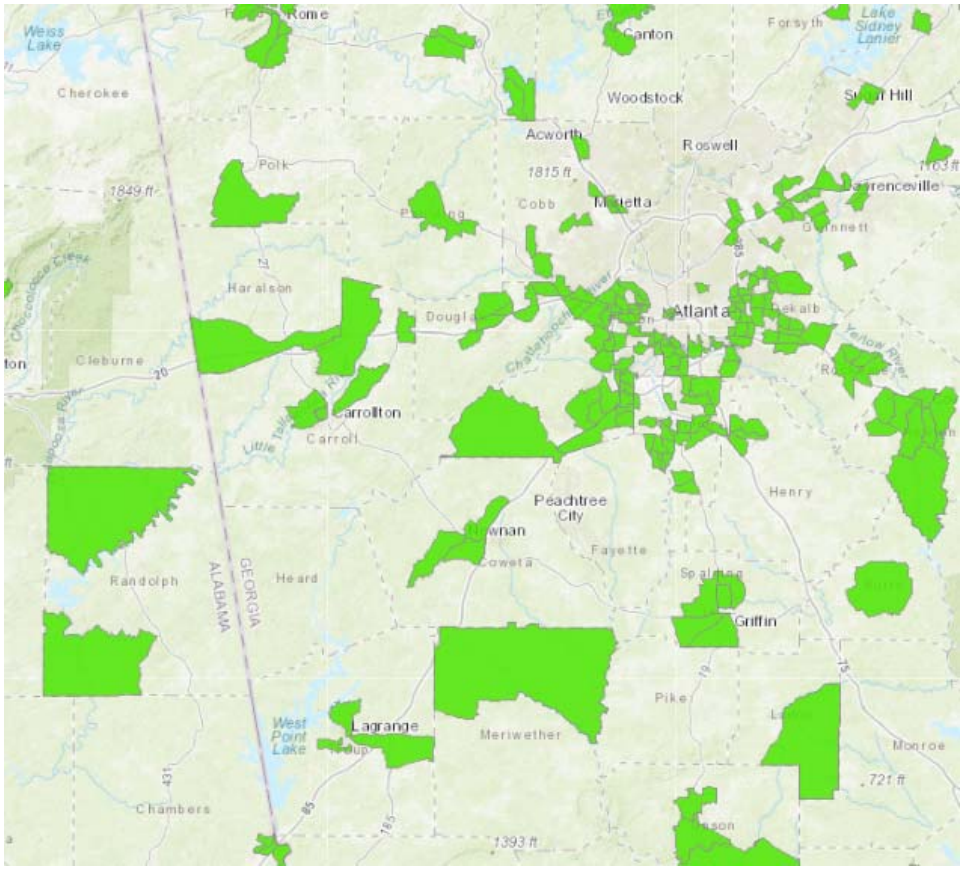
Social Determinants of Health

REDUCE INEQUITIES CAUSED BY THE SOCIAL DETERMINANTS OF HEALTH

At Tanner, efforts to promote the health of the communities it serves go beyond providing health services.

Tanner takes a proactive approach to address the social determinants of health and the underlying root causes of poor health. Tanner does this by supporting the World Health Organization's definition of health as a state of complete physical, mental and social well-being and not merely disease or infirmity.

One thing that needs to be addressed is food insecurity, which is defined as the lack of access to enough food for a healthy life. This is an increasing problem in the United States and west Georgia. According to the 2022 County Health Rankings, residents of Carroll, Haralson and Heard counties experience elevated rates of food insecurity (including a total of 21,890 residents in the three-county area that are food insecure) compared to state figures.



Food Desert Map

Source: USDA Economic Research Service, ESRI. For more information: http://www.ers.usda.gov/data-products/food-access-research-atlas/documentation.aspx

Low-income census tracts where a significant number or share of residents is more than 1 mile (urban) or 10 miles (rural) from the nearest supermarket.

Last updated: April 27, 2021

Table 2: Health Outcomes and Food Insecurity Data					
Measure	**Carroll County**	**Haralson County**	**Heard County**	**Georgia**	**National**
Premature death rate	9,700	11,500	11,200	8,000	5,600
Adult obesity	34%	34%	35%	33%	30%
Access to exercise opportunities	52%	16%	0%	70%	86%
Physical inactivity	31%	33%	33%	27%	23%
Adult food insecurity	14%	12.7%	13.4%	12%	10.5%

Sources: 2022 County Health Rankings

This problem is associated with decreased consumption of healthy foods and increased negative health outcomes. Concurrently, according to the USDA's food desert locator, approximately 15,800 residents in the target population live in food deserts — census tracts with a significant share of low-income residents more than 1 mile (urban) or 10 miles (rural) from the nearest supermarket.

Food insecurity and its associated poor dietary intake are linked to high blood pressure, type 2 diabetes, heart disease, depression, cancer, obesity and decreased life expectancy. Carroll, Haralson and Heard counties are also subjected to disproportionate levels of premature deaths, obesity and related risk factors (physical inactivity, poor diet) than state and national figures.

The effects of food insecurity are especially detrimental to children's health. Research shows a link between food insecurity and birth defects, developmental risk, low birth weight, mental health problems and poor educational outcomes for children – all of which have serious health and economic consequences.

In addition, because of limited resources, those who are food insecure often are forced to choose food over medication, dilute or ration infant formula, postpone preventive or needed medical care, or forgo the foods needed for special medical diets (e.g., diabetes-friendly diets). This not only exacerbates disease and compromises health but also increases expensive physician encounters, emergency room visits and hospitalizations.

BUILDING AWARENESS, UNDERSTANDING, CAPACITY AND ABILITY TO ADDRESS POVERTY

Bridges Out of Poverty

In November 2019, Healthy Haralson hosted Bridges Out of Poverty, a three-and-a-half-hour workshop designed for civic leaders, policymakers, educators and those concerned with developing sustainable solutions to poverty in their communities. The workshop was led by noted author Terie Dreussi-Smith, M.Ed., and had more than 130 community participants. Bridges Out of Poverty provided a complete approach to understanding poverty in the west Georgia area, offering tools and strategies for alleviating poverty and its impact.

DEVELOPING INNOVATIVE APPROACHES TO ADDRESS THE SOCIOECONOMIC DETERMINANTS OF HEALTH

Addressing Food Insecurity

Food insecurity is a huge problem in west Georgia. In Carroll (14%), Haralson (15%) and Heard counties (15%), the percentage of the population that lacks adequate access to food exceeds the state average of 12%. There are many reasons why people may struggle with food insecurity. Some may not have a steady income, others may have health conditions that make it difficult to cook or shop for food, and some may not have transportation to get to a grocery store. No matter the reason, we want to make sure that everyone in our community has nutritious food.

FOOD AS MEDICINE

Food As Medicine is an innovative approach that addresses food insecurity by helping patients overcome socioeconomic hurdles to a healthier diet and lifestyle.

The landmark initiative provides education, coaching and nutrition support for eligible patients and their families to help manage disease risks for diabetes and high blood pressure and make lifestyle changes. A unique program feature provides:

- Individualized health coaching
- Free healthy food weekly
- Fun cooking classes on how to prepare it

Each feature reflects the important link between diet and the management of diabetes and high blood pressure.

Individuals may apply for participation in the free program, consisting of 12 weekly sessions for diabetes and six weekly sessions for high blood pressure. Eligibility requirements include a confirmed diagnosis by a physician. If an individual does not have a physician, a referral for one will be provided.

Once enrolled in the program, patients receive a "prescription" for Get Healthy, Live Well Healthy Food Farmacy, where they can pick up boxed fresh produce that they can use to prepare nutritious meals for themselves and their families. The fresh produce in the Healthy Food Farmacy is important to support healthier food choices that will drive blood sugar and blood pressure numbers down.

Carroll County resident Don Young joined the new Food as Medicine program for diabetes nine months ago at the recommendation of his physician Fredrick Makori, MD, and credits it for helping him reduce his a1c blood sugar level from 13 to 9.5 and lose 50 pounds.

Learn more: tanner.org/foodasmedicine

COOKING MATTERS

Cooking Matters is a national campaign run by Share Our Strength, a nonprofit working to solve hunger and poverty in the U.S. and worldwide.

The program helps food-insecure families learn how to prepare healthy, tasty meals on a limited budget. Through a six-week series of classes, they learn hands-on techniques from Cooking Matters-certified educators.

Nutrition educators and class assistants also share their time and expertise to show them how to shop for nutritious foods on a budget.

A total of 1,600 Cooking Matters participants who participated in a national study by Alarum Institute revealed that they:

- Were more confident in your cooking skills.
- Saw fewer barriers to making nutritious and affordable meals.
- Were able to cook healthier, more budget-friendly meals.

It also showed that 83% of parents and caregivers said they were prepared to adopt healthier, budget-saving shopping techniques.

Learn more: **cookingmatters.org**.

JOURNEYMAN FARMER CERTIFICATE PROGRAM

The Journeyman Farmer Certificate Program is another program that we offer to help address food insecurity in our community.

The UGA Extension Office is working to develop the next generation of farmers in Georgia through the Journeyman Farmer Certification Small Fruit and Vegetable Program — a training program that provides education to beginning farmers. The program is supported by the Beginning Farmer Rancher Development Program and hosted in partnership with Tanner Health System's Get Healthy, Live Well, the University of Georgia Small Business Development Center and the Georgia Farm Bureau.

The program is designed to provide training for those interested in starting a farm or who have only been farming for a short period of time. Providing support to beginning farmers is part of a larger effort to increase the supply of fresh fruits and vegetables needed for healthy communities.

Addressing Transportation Issues

Lack of transportation can be a barrier to good nutrition and quality health care.

Each year, 3.6 million people in the United States don't obtain medical care because of transportation barriers, according to research cited in a 2017 American Hospital Association report. Transportation is also the third most cited barrier to accessing health care for older adults.

To address this problem, hospitals need to provide or connect patients with transportation services. This can be done through financial assistance, volunteer driver programs or by partnering with local transportation providers.

Hospitals can also advocate for policy and system changes at the state and federal levels to help increase access to transportation for all. The bottom line is that no one should miss out on necessary medical care or good nutrition because they don't have a ride.

CANCER PATIENT TRANSPORTATION PROGRAM

Tanner Health System continues to implement Tanner Cancer Care's Cancer Patient Transportation Program.

Through generous donations to the Tanner Foundation, the health system can ensure patients don't miss a necessary medical appointment just because they don't have a ride. The cancer center's convenient west Georgia location makes it easier for patients to get to appointments without needing a ride to Atlanta or Birmingham.

Tanner Cancer Care center staff are also available to pick patients up if needed so they can stay on track with their treatment.

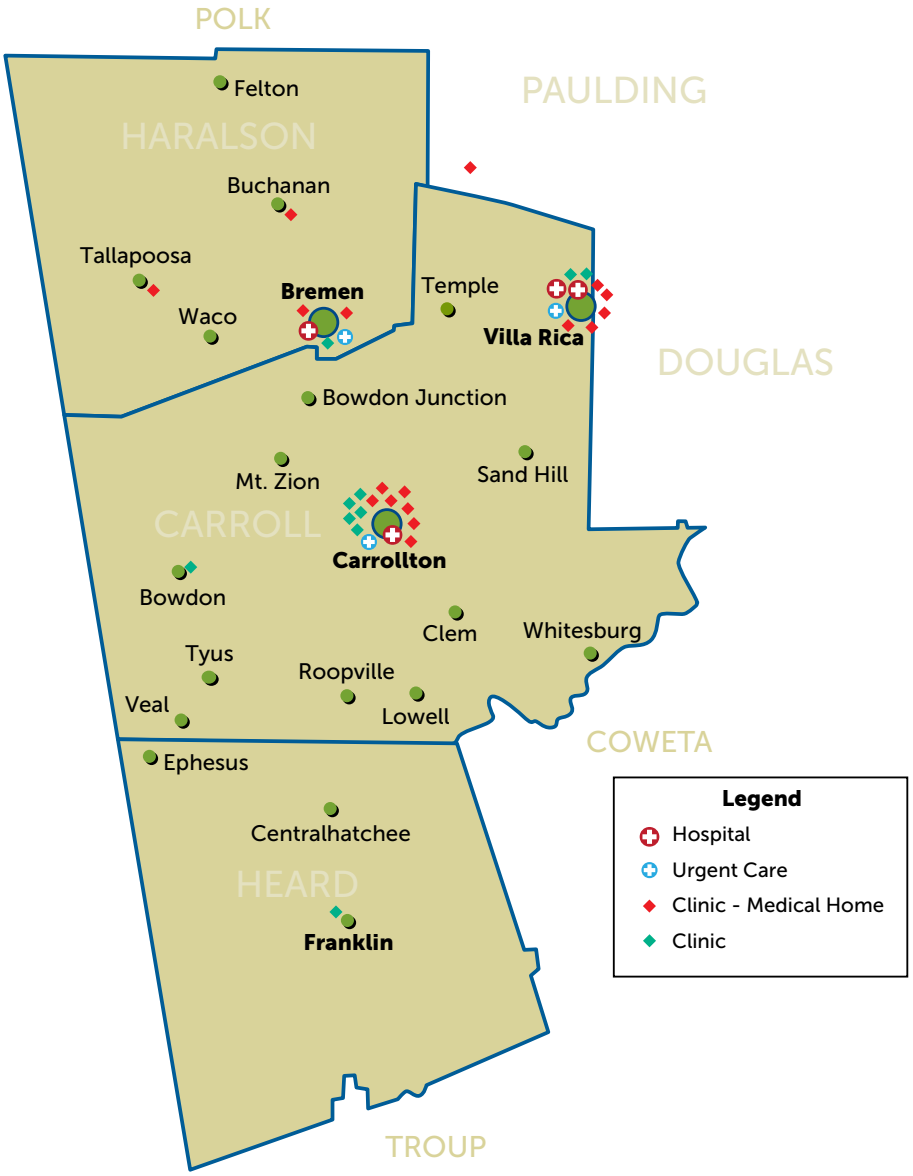
Part 3: Community Served

GEOGRAPHIC AREA SERVED

For the 2022 CHNA, each of Tanner Health System's hospitals identified a geographic area to serve over the next three-year CHNA cycle. These Community Benefit Service Areas (CBSAs) were selected based on hospital patient utilization data, proximity to the hospital, or an existing presence of programs and partnerships within these communities. Tanner's CBSA includes Carroll, Haralson and Heard counties, consisting of 1,077 square miles of predominately rural area (53%) with a total population of 160,149 (U.S. Census Bureau, Population Estimates 2020).

Tanner collaborated with each hospital to reduce duplication and make the best use of available resources to produce one system-wide CHNA to satisfy the Affordable Care Act (ACA) requirement for Tanner Medical Center/ Carrollton, Tanner Medical Center/Villa Rica and Higgins General Hospital. Due to the proximity of these hospitals, these facilities work collaboratively to leverage existing assets and resources throughout Tanner's CBSA to best meet the health needs of their communities.

Geographic and demographic data for each covered county are presented separately on the following pages, along with highlights of the most critical health needs identified in the particular counties.



Tanner Medical Center Carrollton CBSA

Carroll and Heard counties

Tanner Medical Center/Villa Rica CBSA

Carroll County

Higgins General Hospital CBSA

Haralson County

Carroll County

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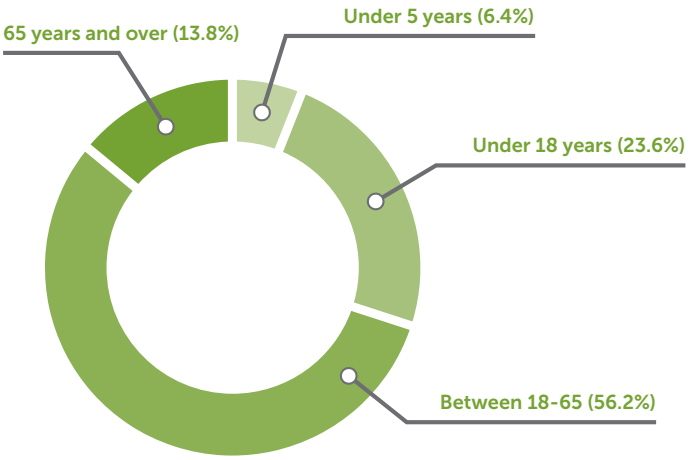
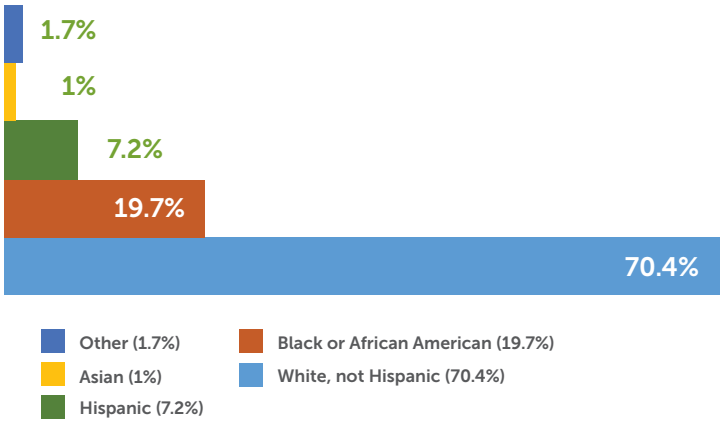
Population by Age[1]

Carroll County Total Population: 119,148



Population by Race[1]



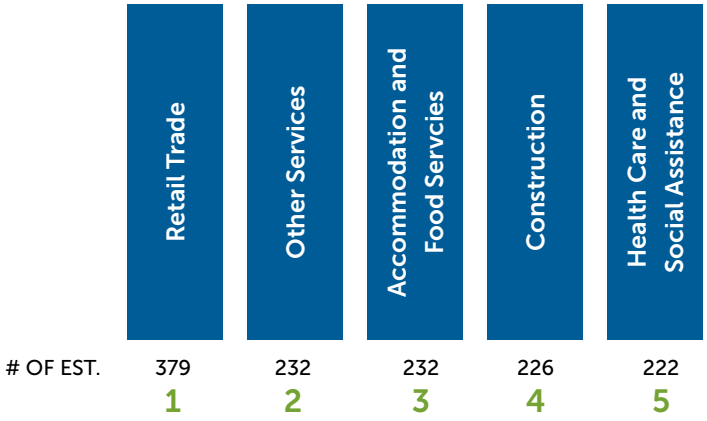
POPULATION

The population of Carroll County was estimated at 119,148 by the 2020 U.S. Census Bureau, reflecting a 7.5% population increase since the 2010 Census. The population is spread out over 499 square miles, translating into a population density of 238.77 persons per square mile. Approximately 46,228 residents (41.83%) live in rural areas of the county. In 2020, Carroll County residents 65 years or older were 13.8% of the population, slightly lower than the state average (14.3%). White people (70.4%) make up the majority of the population, followed by Black people (19.7%) and Hispanic people (7.2%).

County Health Rankings[3]

	Rank (of 159)
Health Outcomes	**55**
Mortality (Length of Life)	66
Morbidity (Quality of Life)	42
Health Factors	**63**
Health Behaviors	58
Clinical Care	75
Social and Economic Factors	59
Physical Environment	96

Top 5 Industries[5]

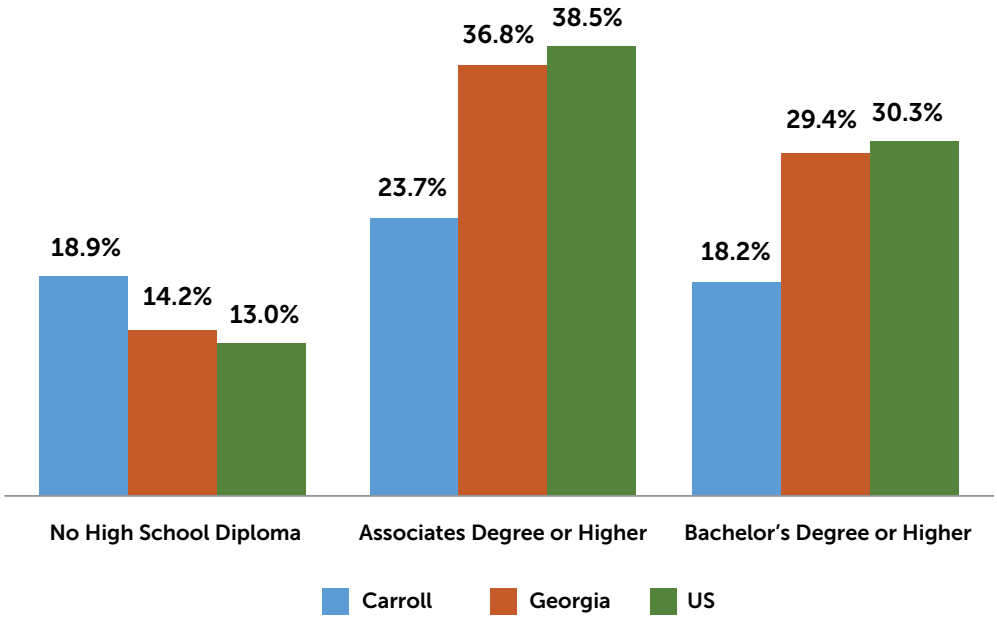


ECONOMY

Carroll County's median household income, of $59,197 is slightly lower than the state median income of $61,224. [2] The unemployment rate (3.2%) is slight higher than the state average (3.1%).[7] The county's percentage of children (23.1%), adults (15%) and seniors (10.2%) living in poverty exceeds the state average in all three indicators.[2]

[1]U.S. Census Bureau, Population Estimates, 2020
[2]U.S. Census Bureau, American Community Survey, 2016-2020
[3]County Health Rankings, 2022
[4]US Department of Labor, Bureau of Labor Statistics, 2022-March
[5]Carroll County Business Patterns, 2019
[6]Georgia Department of Public Health, OASIS, 2016-2020
[7]U.S. Department of Labor, Bureau of Labor Statistics, 2022-March 2022

Carroll Education Attainment



EDUCATION

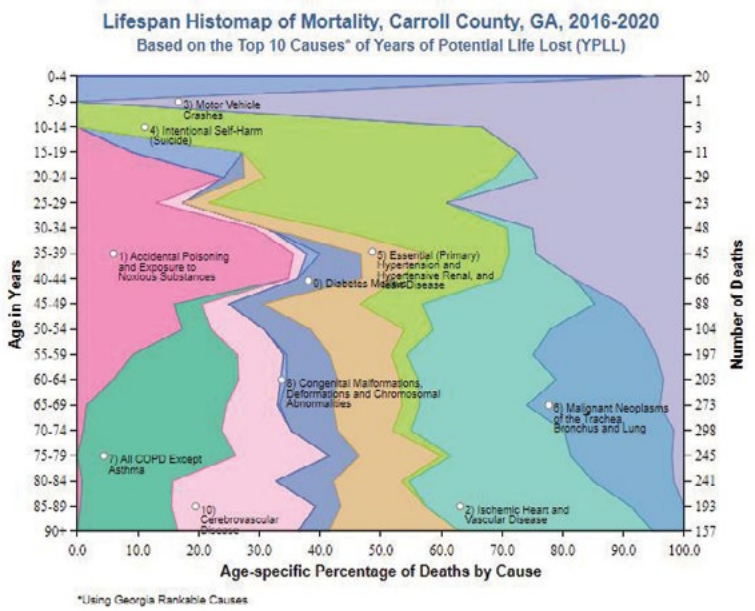
Poverty, unemployment and lack of educational attainment affect access to care and a community's ability to engage in healthy behaviors. Individuals with more education live longer, healthier lives than those with less education, and their children are more likely to thrive. The population age 25+ in Carroll County with no high school diploma (6.6%) exceeds state and national figures.[2] Concurrently, those 25+ with an associates degree (6.6%) falls below state and national figures. Those age 25+ with a bachelor's degree or higher (22.1%) is also lower than state and national figures.

HEALTH DISPARITIES

Race Disparities[6]	White	Black
High Blood Pressure Discharge Rate	11.7	25.8
High Blood Pressure ED Visit Rate	341.5	912.8
All STD Rate except Congenital Syphilis	295.0	1,568.6

TOP 10 CAUSES OF DEATH[6]

1. Ischemic Heart and Vascular Disease
2. All COPD Except Asthma
3. Malignant Neoplasms of the Trachea, Bronchus and Lung
4. Alzheimer's Disease
5. Essential (Primary) Hypertension and Hypertensive Renal and Heart Disease
6. Cerebrovascular
7. Diabetes Mellitus
8. Septicemia
9. All Other Diseases of the Nervous System
10. Pneumonia



Carroll County Health Profile

INDICATOR	COUNTY	STATE	NATIONAL	UNITS	SOURCE
Social and Economic Indicators					
Unemployment	3.2%	3.1%	3.6%	Percentage of population 16 years or older that is unemployed	U.S. Department of Labor, Bureau of Labor Statistics, 2022-March 2022
Population Receiving SNAP Benefits	14.6%	12.2%	11.4%	Percentage of households receiving Supplemental Nutrition Assistance Program (SNAP) benefits	U.S. Census 2020; American Community Survey 2016-2020
Adults in Poverty	15.0%	12.9%	12.1%	Percentage of adult population aged 18 to 64 years old living below the poverty line	U.S. Census 2020; American Community Survey 2016-2020
Seniors in Poverty	10.2%	10.2%	9.3%	Percentage of population aged 65 or older living below the poverty line	U.S. Census 2020; American Community Survey 2016-2020
Children in Poverty	23.1%	20.1%	17.5%	Percentage of population aged 0 to 17 years old living below the poverty line	U.S. Census 2020; American Community Survey 2016-2020
Population with No High School Diploma	10.6%	7%	6.6%	Percentage of population 25 years and older without a high school diploma or equivalency (GED)	U.S. Census 2020; American Community Survey 2016-2020
High School Dropout Rate	8%	17%	n/a	Percentage of ninth-grade cohort that graduates in four years	County Health Rankings 2022, EDFacts 2018-2019
Access to a Vehicle	3.9%	6.3%	8.5%	Percentage of occupied households with no motor vehicle	U.S. Census 2020; American Community Survey 2016-2020
Income Inequality (GINI Index)	0.42	0.48	0.48	GINI Index score that represents "a statistical measure of income inequality ranging from 0 to 1 where a measure of 1 indicates perfect inequality and a measure of 0 indicates perfect equality." Based on the total number of households for county and state values. National value measues GINI Index income inequality ranging from 0 to 100.	U.S.Census 2020; American Community Survey, 2016-2020
Premature Death Rate	9,700	8,000	5,600	Years of potential life lost before age 75 per 100,000	County Health Rankings 2022, National Center for Health Statistics 2018-2020

Red numbers indicate parameters worse than the national average. Green numbers indicate parameters better than the national average.

INDICATOR	COUNTY	STATE	NATIONAL	UNITS	SOURCE
Diabetes and Obesity					
Diabetes Prevalence	**12%**	11%	n/a	Percentage of adults aged 20 and above with diagnosed diabetes (age-adjusted)	County Health Rankings 2022; CDC, Behavioral Risk Factor Surveillance System 2019
Obesity	**34%**	33%	30%	Percentage of population 20 years or older with a self reported BMI greater than 30	County Health Rankings 2022; CDC, Behavioral Risk Factor Surveillance System 2019
Physical Inactivity	**32%**	27%	23%	Percentage of adults age 18 and over reporting no leisure-time physical activity (age-adjusted)	County Health Rankings 2022; CDC, Behavioral Risk Factor Surveillance System 2019
Population with low food access	**19%**	10%	n/a	Percentage of population who are low-income and do not live close to a grocery store	County Health Rankings 2022; USDA Food Environment Atlas
Food Insecurity	**14%**	12%	n/a	Percentage of population that experienced food insecurity in a designated year	County Health Rankings 2022; Map the Meal Gap, Feeding America 2019
Maternal and Infant Health					
Teen Births	**26**	23	11	Number of births per 1,000 female population ages 15-19	County Health Rankings 2022; National Center for Health Statistics 2014-2020
Low Birth Weight	**8%**	10%	6%	Percentage of live births with low birthweight (< 2,500 grams)	"County Health Rankings 2022; CDC National Center for Health Statistics 2014-2020"
Infant Mortality	**80**	7	n/a	Number of infant deaths (within 1 year) per 1,000 live births	County Health Rankings 2022, National Center for Health Statistics - Mortality Files
Child Mortality	**70**	60	n/a	Number of deaths among residents under age 18 per 100,000 population	County Health Rankings 2022; National Center for Health Statistics - Mortality Files 2017-2020
Premature Births	**9.6%**	11.5%	n/a	Percent of births before 37 weeks of gestation	Oasis, Georgia Department of Public Health 2020
Cardiovascular Health					
Heart Disease Mortality Rate	**208.2**	180.9	213	Age-adjusted rate of death due to heart disease (ICD10 Codes I00-I09, I11, I13, I20-I151) per 100,000 population	CDC, National Center for Health Statistics. National Vital Statistics System, Mortality: Compressed Mortality File 1999-2016
Stroke Mortality Rate	**53.5**	43.4	47.5	Age-adjusted rate of death due to Cerebrovascular disease (stroke)	CDC, National Center for Health Statistics. National Vital Statistics System, Mortality: Compressed Mortality File 1999-2016
Respiratory Health					
Air Pollution-Particulate Matter	**9.2**	8.6	5.9	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)	"County Health Rankngs 2022; CDC National Environmental Public Health Tracking Network 2018"
Adult Smoking	**22%**	17%	15%	Percentage of adults who are current smokers (age-adjusted)	County Health Rankings 2022; Behavioral Risk Factor Surveillance System (BRFSS) 2019

INDICATOR	COUNTY	STATE	NATIONAL	UNITS	SOURCE
Mental Health and Substance Misuse					
Suicides	109	14	n/a	Number of deaths due to suicide per 100,000 population (age-adjusted)	County Health Rankings 2022; National Vital Statistics System - Mortality Data (2020) via CDC Wonder
Poor Mental Health Days	5.5	4.8	4	Average number of mentally unhealthy days reported in past 30 days (age-adjusted)	County Health Rankings 2022; Behavioral Risk Factor Surveillance System (BRFSS) 2019
Frequent Mental Distress	18%	15%	n/a	Percentage of adults reporting 14 or more days of poor mental health per month (age-adjusted)	County Health Rankings 2022; Behavioral Risk Factor Surveillance System (BRFSS) 2019
Excessive Drinking	18%	18%	15%	Percentage of adults reporting binge or heavy drinking (age-adjusted)	County Health Rankings 2022; Behavioral Risk Factor Surveillance System (BRFSS) 2019
Alchohol-Impaired Driving Deaths	19%	21%	10%	Percentage of driving deaths with alcohol involvement	"County Health Rankings 2022; Fatality Analysis Reporting System 2016-2020"
Cancers					
Breast Cancer Deaths	24	22.1	19.9	Age-adjusted death rate deaths per 100,000	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology and End Results Program. State Cancer Profiles, 2015-2019
Breast Cancer Incidence	118.8	128.4	126.8	Age-adjusted death rate deaths per 100,000	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology and End Results Program. State Cancer Profiles, 2014-2018
Colorectal Cancer Deaths	19.2	15.3	13.4	Age-adjusted death rate deaths per 100,000	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology and End Results Program. State Cancer Profiles, 2015-2019
Colorectal Cancer Incidence	53.1	40.9	38	Age-adjusted death rate deaths per 100,000	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology and End Results Program. State Cancer Profiles, 2014-2018
Prostate Cancer Deaths	16.5	22.5	19.5	Age-adjusted death rate deaths per 100,000	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology and End Results Program. State Cancer Profiles, 2015-2019
Prostate Cancer Incidence	95.7	126.6	106.2	Age-adjusted death rate deaths per 100,000	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology and End Results Program. State Cancer Profiles, 2014-2018

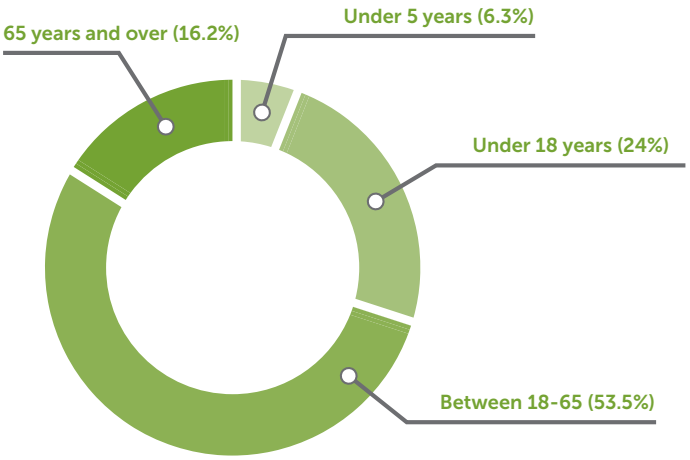
INDICATOR	COUNTY	STATE	NATIONAL	UNITS	SOURCE
Lung Cancer Deaths	**57.5**	39.1	36.7	Age-adjusted death rate deaths per 100,000	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology and End Results Program. State Cancer Profiles, 2015-2019.
Lung Cancer Incidence	**80.2**	61.3	57.3	Age-adjusted death rate deaths per 100,000	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology and End Results Program. State Cancer Profiles, 2015-2019
Injury Prevention and Safety					
Firarm Fatalities	**79**	16	n/a	Number of deaths due to firearms per 100,000 population	County Health Rankings 2022; National Center for Health Statistics 2016-2020
Violent Crime	**311**	388	63	Number of violent crimes reported per 100,000 population	County Health Rankings 2022, Uniform Crime Reporting - FBI 2012-2014
Child Abuse and/or Neglect	**5.9**	3.9	n/a	Children with Indication of abuse or neglect (rate per 1,000)	Child Protective Services Data System, Georgia Department of Human Resources, Division of Family and Children Services 2019
Motor Vehicle Crash Deaths	**116**	14	n/a	Number of motor vehicle crash deaths per 100,000 population	County Health Rankings 2022, National Center for Health Statistics, 2014-2020
Access to Care					
Uninsured Adults	**21%**	19%	n/a	Percentage of adults under age 65 without health insurance	"County Health Rankings 2022, US Census Bureau Small Area Health Insurance Estimates 2019"
Uninsured Children	**6%**	7%	n/a	Percentage of children under age 19 without health insurance	"County Health Rankings 2022, US Census Bureau Small Area Health Insurance Estimates 2019"
Primary Care Physicians	**2,000:1**	1,490:1	1,010:1	Ratio of population to primary care physicians	County Health Rankings 2022, Area Health Resource File/ American Medical Association 2020
Dentists	**3,290:1**	1,920:1	1,210:1	Ratio of population to dentists	County Health Rankings 2022, Area Health Resource File/ American Medical Association 2020
Mental Health Providers	**620:1**	640:1	250:1	Ratio of population to mental health providers	County Health Rankings 2022, CMS, National Provider Identification, 2021
Other Primary Care Providers	**940:1**	820:1	n/a	Ratio of population to primary care providers other than physicians.	"County Health Rankings 2022, Area Health Resource File/American Medical Association, 2019"
Preventable Hospital Stays	**4,400**	4,295	2,233	Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees	County Health Rankings 2022, Mapping Medicare Disparities Tool, 2019

Haralson County

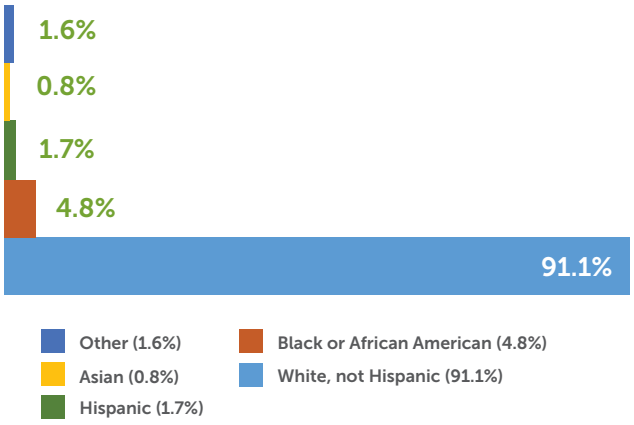
90 of 159

Population by Age[1]

Haralson County Total Population: 29,919



Population by Race[1]



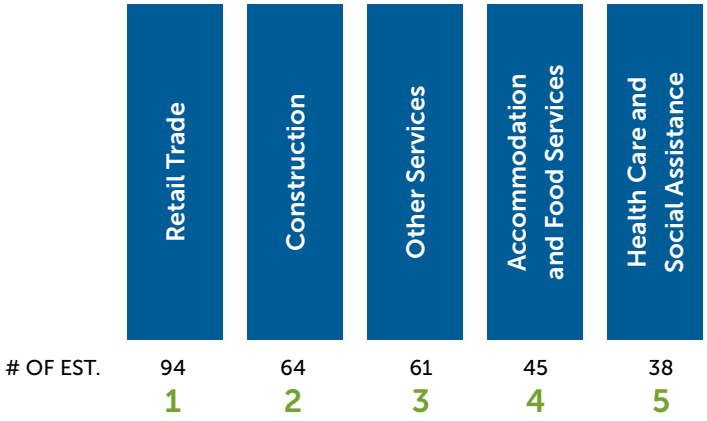
POPULATION

The population of Haralson County was estimated at 29,919 by the 2020 U.S. Census Bureau, reflecting a 3.8% population increase since the 2010 Census. The 77.4% rural population is spread out over 282.17 square miles, translating into a population density of 106.03 persons per square mile. In 2020, Haralson County residents 65 years or older were 16.2% of the population, slightly higher than the state average (14.3%). Whites (90.8%) make up the majority of the population, followed by Black people (4.5%) and Hispanic people (2%).

County Health Rankings[3]

	Rank (of 159)
Health Outcomes	**90**
Mortality (Length of Life)	124
Morbidity (Quality of Life)	59
Health Factors	**79**
Health Behaviors	64
Clinical Care	111
Social and Economic Factors	83
Physical Environment	59

Top 5 Industries[5]

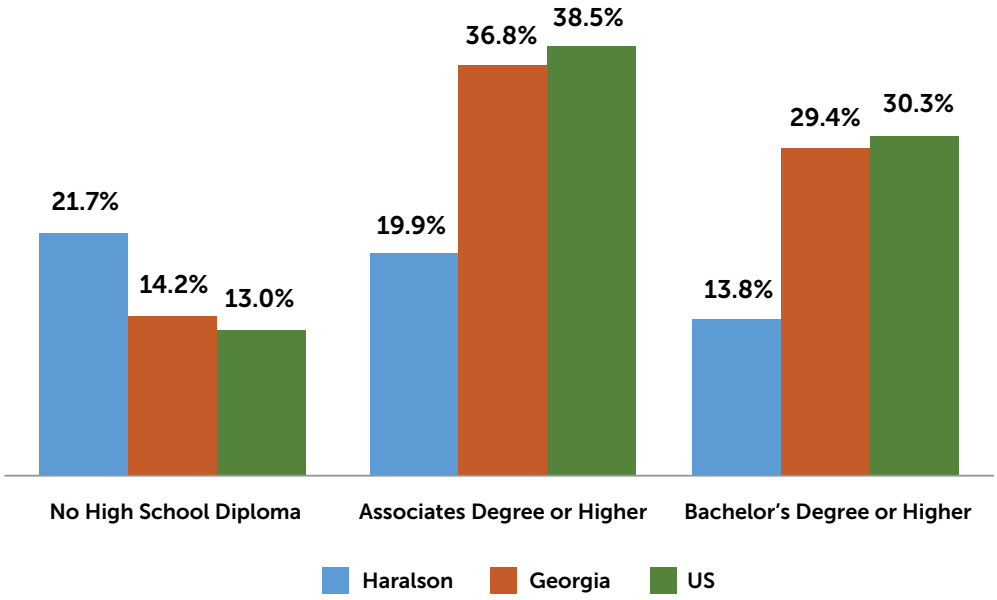


ECONOMY

Haralson County's median household income, of $52,021 is slightly lower than the state median income of $61,224.[2] The unemployment rate (3.1%) is the same as the state average (3.1%).[7] The county's percentage of seniors (10.9%) in poverty exceeds the state average (10.2%). But the percentage of children (17.4%) and adults (12.6%) in poverty is below the state averages (20.1% and 12.9% respectively).[2]

[1]U.S. Census Bureau, Population Estimates, 2020
[2]U.S. Census Bureau, American Community Survey, 2016-2020
[3]County Health Rankings, 2022
[4]US Department of Labor, Bureau of Labor Statistics, 2022-March
[5]Carroll County Business Patterns, 2019
[6]Georgia Department of Public Health, OASIS, 2016-2020
[7]U.S. Department of Labor, Bureau of Labor Statistics, 2022-March 2022

Haralson Education Attainment



EDUCATION

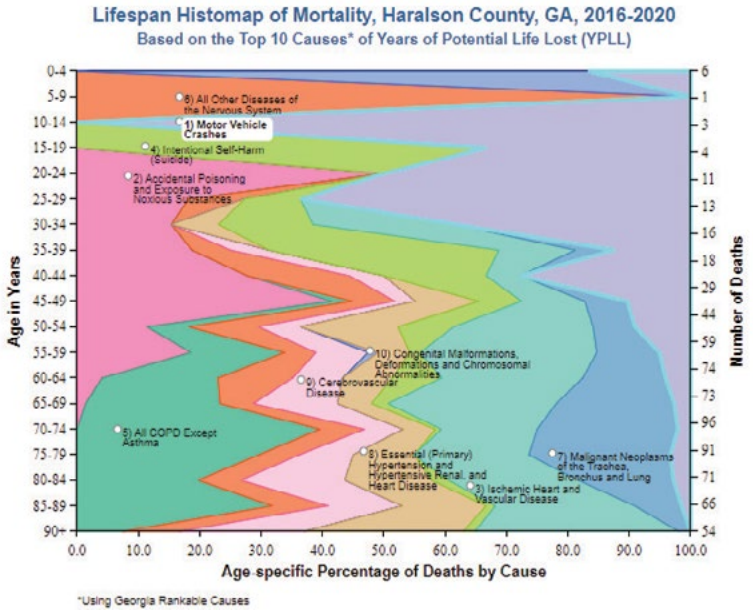
Poverty, unemployment and lack of educational attainment affect access to care and a community's ability to engage in healthy behaviors. Individuals with more education live longer, healthier lives than those with less education, and their children are more likely to thrive. The population age 25+ in Haralson County with no high school diploma (12.7%) exceeds state and national figures.[2] Concurrently, the population age 25+ in Carroll County with an associate's segree (5.9%) and bachelor's degree or higher (17.3%) fall significantly below state and national figures.

HEALTH DISPARITIES

Race Disparities[6]	White	Black
Diabetes ED Visit Rate	414.3	956.5
All STD except Congenital Syphilis	279.8	1,333.3

TOP 10 CAUSES OF DEATH[6]

1. Ischemic Heart and Vascular Disease
2. All COPD Except Asthma
3. Malignant Neoplasms of the Trachea, Bronchus and Lung
4. Alzheimer's Disease
5. Cerebrovascular Disease
6. Essential (Primary) Hypertension and Hypertensive Renal and Heart Disease
7. All Other Disease of the Nervous System
8. COVID-19
9. Septicemia
10. Pneumonia



Haralson County Health Profile

INDICATOR	COUNTY	STATE	NATIONAL	UNITS	SOURCE
Social and Economic Indicators					
Unemployment	3.1%	3.1%	3.6%	Percentage of population 16 years or older that is unemployed	U.S. Department of Labor, Bureau of Labor Statistics, March 2022
Population Receiving SNAP Benefits	14.4%	12.2%	11.4%	Percentage of households receiving Supplemental Nutrition Assistance Program (SNAP) benefits	U.S. Census 2020; American Community Survey 2016-2020
Adults in Poverty	12.6%	12.9%	12.1%	Percentage of adult population aged 18 to 64 years old living below the poverty line	U.S. Census 2020; American Community Survey 2016-2020
Seniors in Poverty	10.9%	10.2%	9.3%	Percentage of population aged 65 or older living below the poverty line	U.S. Census 2020; American Community Survey 2016-2020
Children in Poverty	17.4%	20.1%	17.5%	Percentage of population aged 0 to 17 years old living below the poverty line	U.S. Census 2020; American Community Survey 2016-2020
Population with No High School Diploma	12.7%	7%	6.6%	Percentage of population 25 years and older without a high school diploma or equivalency (GED)	U.S. Census 2020; American Community Survey 2016-2020
High School Dropout Rate	2%	17%	n/a	Percentage of ninth-grade cohort that fails to graduate in four years	County Health Rankings 2022, EDFacts 2018-2019
Access to a Vehicle	4.3%	6.3%	8.5%	Percentage of occupied households with no motor vehicle	U.S. Census 2020; American Community Survey 2016-2020
Income Inequality (GINI Index)	0.45	0.48	0.48	GINI Index score that represents "a statistical measure of income inequality ranging from 0 to 1 where a measure of 1 indicates perfect inequality and a measure of 0 indicates perfect equality." Based on the total number of households for county and state values. National value measues GINI Index income inequality ranging from 0 to 100.	U.S.Census 2020; American Community Survey, 2016-2020
Premature Death Rate	11,500	8,000	5,600	Years of potential life lost before age 75 per 100,000	County Health Rankings 2022, National Center for Health Statistics 2018-2020

Red numbers indicate parameters worse than the national average. Green numbers indicate parameters better than the national average.

INDICATOR	COUNTY	STATE	NATIONAL	UNITS	SOURCE
Diabetes and Obesity					
Diabetes Prevalence	**11.0%**	11.0%	n/a	Percentage of adults aged 20 and above with diagnosed diabetes (age-adjusted)	County Health Rankings 2022; CDC, Behavioral Risk Factor Surveillance System 2019
Obesity	**34%**	33%	30%	Percentage of population 20 years or older with a self reported BMI greater than 30	County Health Rankings 2022; CDC, Behavioral Risk Factor Surveillance System 2019
Physical Inactivity	**33%**	27%	23%	Percentage of adults age 18 and over reporting no leisure-time physical activity (age-adjusted)	County Health Rankings 2022; CDC, Behavioral Risk Factor Surveillance System 2019
Population with low food access	**6%**	10%	n/a	Percentage of population who are low-income and do not live close to a grocery store	County Health Rankings 2022; USDA Food Environment Atlas
Food Insecurity	**15%**	12%	n/a	Percentage of population that experienced food insecurity in a designated year	County Health Rankings 2022; Map the Meal Gap, Feeding America 2019
Maternal and Infant Health					
Teen Births	**35**	23	11	Number of births per 1,000 female population ages 15-19	County Health Rankings 2022; National Center for Health Statistics 2014-2020
Low Birth Weight	**9%**	10%	6%	Percentage of live births with low birthweight (< 2,500 grams)	"County Health Rankings 2022; CDC National Center for Health Statistics 2014-2020"
Infant Mortality	**n/a**	7	n/a	Number of infant deaths (within 1 year) per 1,000 live births	County Health Rankings 2022, National Center for Health Statistics - Mortality Files
Child Mortality	**13**	60	n/a	Number of deaths among residents under age 18 per 100,000 population	County Health Rankings 2022; National Center for Health Statistics - Mortality Files 2017-2020
Premature Births	**10.10%**	11.50%	n/a	Percent of births before 37 weeks of gestation	Oasis, Georgia Department of Public Health 2020
Cardiovascular Health					
Heart Disease Mortality Rate	**293.90**	180.90	213	Age-adjusted rate of death due to heart disease (ICD10 Codes I00-I09, I11, I13, I20-I151) per 100,000 population	CDC, National Center for Health Statistics. National Vital Statistics System, Mortality: Compressed Mortality File 1999-2016
Stroke Mortality Rate	**62.00**	43.40	47.5	Age-adjusted rate of death due to Cerebrovascular disease (stroke)	CDC, National Center for Health Statistics. National Vital Statistics System, Mortality: Compressed Mortality File 1999-2016
Respiratory Health					
Air Pollution-Particulate Matter	**9**	8.6	5.9	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)	"County Health Rankngs 2022; CDC National Environmental Public Health Tracking Network 2018"
Adult Smoking	**23%**	17%	15%	Percentage of adults who are current smokers (age-adjusted)	County Health Rankings 2022; Behavioral Risk Factor Surveillance System (BRFSS) 2019

INDICATOR	COUNTY	STATE	NATIONAL	UNITS	SOURCE
Mental Health and Substance Misuse					
Suicides	**32**	14	n/a	Number of deaths due to suicide per 100,000 population (age-adjusted)	County Health Rankings 2022; National Vital Statistics System - Mortality Data (2020) via CDC Wonder
Poor Mental Health Days	**5.8**	4.8	4	Average number of mentally unhealthy days reported in past 30 days (age-adjusted)	County Health Rankings 2022; Behavioral Risk Factor Surveillance System (BRFSS) 2019
Frequent Mental Distress	**19%**	15%	n/a	Percentage of adults reporting 14 or more days of poor mental health per month (age-adjusted)	County Health Rankings 2022; Behavioral Risk Factor Surveillance System (BRFSS) 2019
Excessive Drinking	**18%**	18%	15%	Percentage of adults reporting binge or heavy drinking (age-adjusted)	County Health Rankings 2022; Behavioral Risk Factor Surveillance System (BRFSS) 2019
Alchohol-Impaired Driving Deaths	**19%**	21%	10%	Percentage of driving deaths with alcohol involvement	"County Health Rankings 2022; Fatality Analysis Reporting System 2016-2020"
Cancers					
Breast Cancer Deaths	**n/a**	22.1	19.9	Age-adjusted death rate deaths per 100,000	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology and End Results Program. State Cancer Profiles, 2015-2019
Breast Cancer Incidence	**116.1**	128.4	126.8	Age-adjusted death rate deaths per 100,000	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology and End Results Program. State Cancer Profiles, 2014-2018
Colorectal Cancer Deaths	**16.9**	15.3	13.4	Age-adjusted death rate deaths per 100,000	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology and End Results Program. State Cancer Profiles, 2015-2019
Colorectal Cancer Incidence	**38.6**	40.9	38	Age-adjusted death rate deaths per 100,000	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology and End Results Program. State Cancer Profiles, 2014-2018
Prostate Cancer Deaths	**n/a**	22.5	19.5	Age-adjusted death rate deaths per 100,000	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology and End Results Program. State Cancer Profiles, 2015-2019
Prostate Cancer Incidence	**84**	126.6	106.2	Age-adjusted death rate deaths per 100,000	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology and End Results Program. State Cancer Profiles, 2014-2018

INDICATOR	COUNTY	STATE	NATIONAL	UNITS	SOURCE
Lung Cancer Deaths	**61.3**	39.1	36.7	Age-adjusted death rate deaths per 100,000	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology and End Results Program. State Cancer Profiles, 2015-2019
Lung Cancer Incidence	**93.1**	61.3	57.3	Age-adjusted death rate deaths per 100,000	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology and End Results Program. State Cancer Profiles, 2015-2019
Injury Prevention and Safety					
Firarm Fatalities	**32**	16	n/a	Number of deaths due to firearms per 100,000 population	County Health Rankings 2022; National Center for Health Statistics 2016-2020
Violent Crime	**640**	388	63	Number of violent crimes reported per 100,000 population	County Health Rankings 2022, Uniform Crime Reporting - FBI 2012-2014
Child Abuse and/or Neglect	**6.4**	3.9	n/a	Children with Indication of abuse or neglect (rate per 1,000)	Child Protective Services Data System, Georgia Department of Human Resources, Division of Family and Children Services 2019
Motor Vehicle Crash Deaths	**62**	14	n/a	Number of motor vehicle crash deaths per 100,000 population	County Health Rankings 2022, National Center for Health Statistics, 2014-2020
Access to Care					
Uninsured Adults	**20%**	19%	n/a	Percentage of adults under age 65 without health insurance	"County Health Rankings 2022, US Census Bureau Small Area Health Insurance Estimates 2019"
Uninsured Children	**7%**	7%	n/a	Percentage of children under age 19 without health insurance	"County Health Rankings 2022, US Census Bureau Small Area Health Insurance Estimates 2019"
Primary Care Physicians	**2,480:1**	1,490:1	1,010:1	Ratio of population to primary care physicians	County Health Rankings 2022, Area Health Resource File/ American Medical Association 2020
Dentists	**5,060:1**	1,920:1	1,210:1	Ratio of population to dentists	County Health Rankings 2022, Area Health Resource File/ American Medical Association 2020
Mental Health Providers	**1,690:1**	640:1	250:1	Ratio of population to mental health providers	County Health Rankings 2022, CMS, National Provider Identification, 2021
Other Primary Care Providers	**2,340:1**	820:1	n/a	Ratio of population to primary care providers other than physicians	"County Health Rankings 2022, Area Health Resource File/American Medical Association, 2019"
Preventable Hospital Stays	**4,120**	4,295	2,233	Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees	County Health Rankings 2022, Mapping Medicare Disparities Tool, 2019

Heard County

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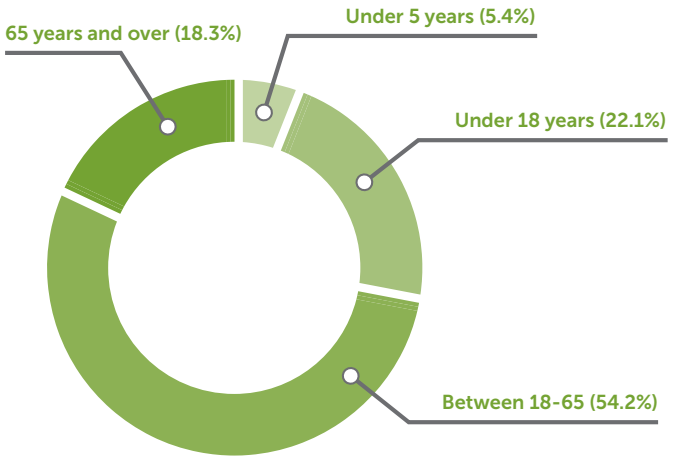
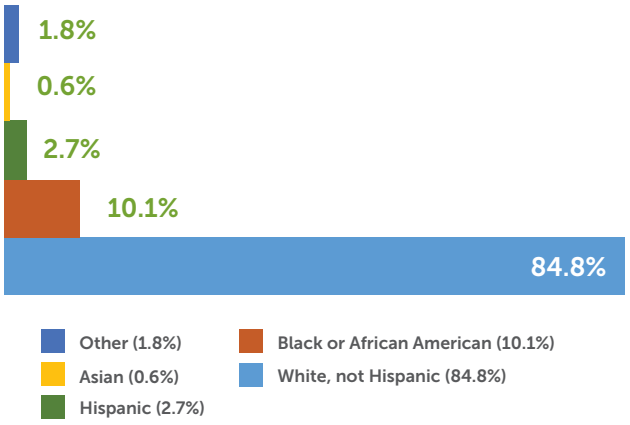
Population by Age[1]

Heard County Total Population: 11,412



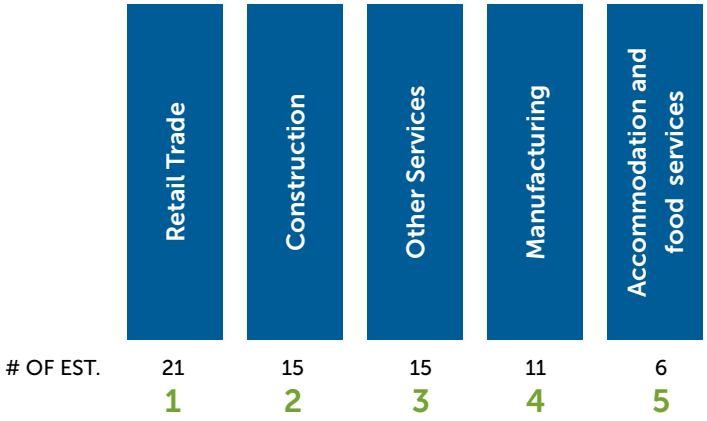
Population by Race[1]



County Health Rankings[3]

	Rank (of 159)
Health Outcomes	**88**
Mortality (Length of Life)	111
Morbidity (Quality of Life)	64
Health Factors	**100**
Health Behaviors	76
Clinical Care	103
Social and Economic Factors	104
Physical Environment	148

Top 5 Industries[5]



POPULATION

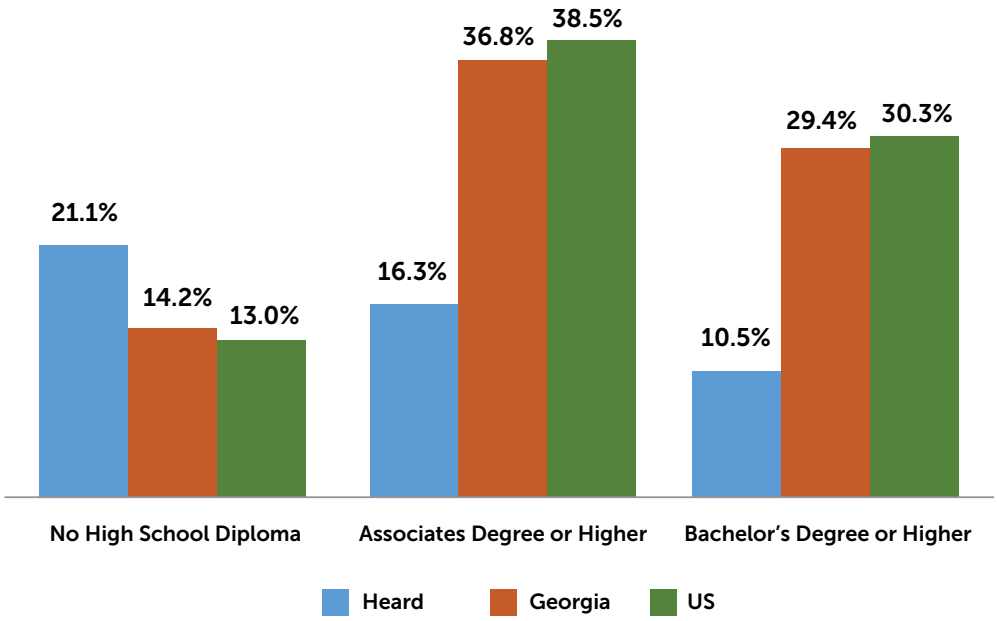
The population of Heard County was estimated at 11,412 by the 2020 U.S. Census Bureau, reflecting a 3.6% population decrease since the 2010 Census. The 100% rural population is spread out over 296 square miles, translating into a population density of 38.55 persons per square mile. In 2020, Heard County residents 65 years or older were 18.3% of the population, higher than the state average (14.3%). White people (84.6%) make up the majority of the population, followed by Black people (9.8%) and Hispanic people (2.9%).

ECONOMY

Heard County's median household income, of $50,583 is slightly lower than the state median income of $61,224.[2] The unemployment rate (3.2%) is slightly higher than the state average (3.1%).[7] The county's percentage of children (25.8%), adults (19.7%) and seniors (14.7%) living in poverty exceeds the state average in all three indicators.[2]

[1]U.S. Census Bureau, Population Estimates, 2020
[2]U.S. Census Bureau, American Community Survey, 2016-2020
[3]County Health Rankings, 2022
[4]US Department of Labor, Bureau of Labor Statistics, 2022-March
[5]Carroll County Business Patterns, 2019
[6]Georgia Department of Public Health, OASIS, 2016-2020
[7]U.S. Department of Labor, Bureau of Labor Statistics, 2022-March 2022

Heard Education Attainment



EDUCATION

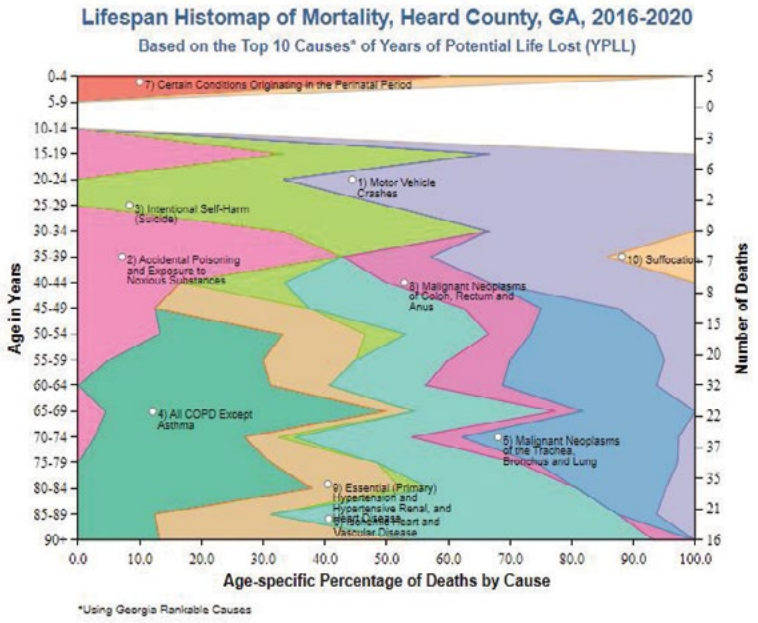
Poverty, unemployment and lack of educational attainment affect access to care and a community's ability to engage in healthy behaviors. Individuals with more education live longer, healthier lives than those with less education, and their children are more likely to thrive. The population age 25+ in Heard County with no high school diploma (13.3%) exceeds state and national figures.[2] Concurrently, the population age 25+ in Carroll County with an associate's degree (5.7%) and bachelor's degree or higher (9.2%) fall significantly below state and national figures.

HEALTH DISPARITIES

Race Disparities[6]	White	Black
Diabetes Hospital Discharge Rate	228.1	652.7
High Blood Pressure ED Visit Rate	356.8	1,425.6
All STD except Congenital Syphilis	245.7	618.3

TOP 10 CAUSES OF DEATH[6]

1. All COPD Except Asthma
2. Ischemic Heart and Vascular Disease
3. Malignant Neoplasms of the Trachea, Bronchus and Lung
4. Alzheimer's Disease
5. Cerebrovascular Disease
6. Essential (Primary) Hypertensive Renal and Heart Disease
7. Motor Vehicle Crashes
8. All Other Diseases of the Nervous System
9. Malignant Neoplasms of Colon, Rectum and Anus
10. Septicemia



Heard County Health Profile

INDICATOR	COUNTY	STATE	NATIONAL	UNITS	SOURCE
Social and Economic Indicators					
Unemployment	3.2%	3.1%	3.6%	Percentage of population 16 years or older that is unemployed	U.S. Department of Labor, Bureau of Labor Statistics, March 2022
Population Receiving SNAP Benefits	26.8%	12.2%	11.4%	Percentage of households receiving Supplemental Nutrition Assistance Program (SNAP) benefits	U.S. Census 2020; American Community Survey 2016-2020
Adults in Poverty	19.7%	12.9%	12.1%	Percentage of adult population aged 18 to 64 years old living below the poverty line	U.S. Census 2020; American Community Survey 2016-2020
Seniors in Poverty	14.7%	10.2%	9.3%	Percentage of population aged 65 or older living below the poverty line	U.S. Census 2020; American Community Survey 2016-2020
Children in Poverty	25.8%	20.1%	17.5%	Percentage of population aged 0 to 17 years old living below the poverty line	U.S. Census 2020; American Community Survey 2016-2020
Population with No High School Diploma	13.3%	7%	6.6%	Percentage of population 25 years and older without a high school diploma or equivalency (GED)	U.S. Census 2020; American Community Survey 2016-2020
High School Dropout Rate	17%	17%	n/a	Percentage of ninth-grade cohort that fails to graduate in four years	County Health Rankings 2022, EDFacts 2018-2019
Access to a Vehicle	4.8%	6.3%	8.5%	Percentage of occupied households with no motor vehicle	U.S. Census 2020; American Community Survey 2016-2020
Income Inequality (GINI Index)	0.41	0.48	0.48	GINI Index score that represents "a statistical measure of income inequality ranging from 0 to 1 where a measure of 1 indicates perfect inequality and a measure of 0 indicates perfect equality". Based on the total number of households for county and state values. National value measues GINI Index income inequality ranging from 0 to 100.	U.S.Census 2020; American Community Survey, 2016-2020
Premature Death Rate	11,200	8,000	5,600	Years of potential life lost before age 75 per 100,000	County Health Rankings 2022, National Center for Health Statistics 2018-2020

Red numbers indicate parameters worse than the national average. Green numbers indicate parameters better than the national average.

INDICATOR	COUNTY	STATE	NATIONAL	UNITS	SOURCE
Diabetes and Obesity					
Diabetes Prevalence	**11%**	11%	n/a	Percentage of adults aged 20 and above with diagnosed diabetes (age-adjusted)	County Health Rankings 2022; CDC, Behavioral Risk Factor Surveillance System 2019
Obesity	**35%**	33%	30%	Percentage of population 20 years or older with a self reported BMI greater than 30	County Health Rankings 2022; CDC, Behavioral Risk Factor Surveillance System 2019
Physical Inactivity	**33%**	27%	23%	Percentage of adults age 18 and over reporting no leisure-time physical activity (age-adjusted)	County Health Rankings 2022; CDC, Behavioral Risk Factor Surveillance System 2019
Population with low food access	**1%**	10%	n/a	Percentage of population who are low-income and do not live close to a grocery store	County Health Rankings 2022; USDA Food Environment Atlas
Food Insecurity	**15%**	12%	n/a	Percentage of population that experienced food insecurity in a designated year	County Health Rankings 2022; Map the Meal Gap, Feeding America 2019
Maternal and Infant Health					
Teen Births	**32**	23	11	Number of births per 1,000 female population ages 15-19	County Health Rankings 2022; National Center for Health Statistics 2014-2020
Low Birth Weight	**9%**	10%	6%	Percentage of live births with low birthweight (< 2,500 grams)	"County Health Rankings 2022; CDC National Center for Health Statistics 2014-2020"
Infant Mortality	**n/a**	7	n/a	Number of infant deaths (within 1 year) per 1,000 live births	County Health Rankings 2022, National Center for Health Statistics - Mortality Files
Child Mortality	**n/a**	60	n/a	Number of deaths among residents under age 18 per 100,000 population	County Health Rankings 2022; National Center for Health Statistics - Mortality Files 2017-2020
Premature Births	**11.5%**	11.5%	10.1%	Percent of births before 37 weeks of gestation	National Center for Health Statistics 2020
Cardiovascular Health					
Heart Disease Mortality Rate	**207.2**	180.9	213	Age-adjusted rate of death due to heart disease (ICD10 Codes I00-I09, I11, I13, I20-I151) per 100,000 population	CDC, National Center for Health Statistics. National Vital Statistics System, Mortality: Compressed Mortality File 1999-2016
Stroke Mortality Rate	**51.9**	43.4	47.5	Age-adjusted rate of death due to Cerebrovascular disease (stroke)	CDC, National Center for Health Statistics. National Vital Statistics System, Mortality: Compressed Mortality File 1999-2016
Respiratory Health					
Air Pollution-Particulate Matter	**8.9**	8.6	5.9	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)	"County Health Rankngs 2022; CDC National Environmental Public Health Tracking Network 2018"
Adult Smoking	**24%**	17%	15%	Percentage of adults who are current smokers (age-adjusted)	County Health Rankings 2022; Behavioral Risk Factor Surveillance System (BRFSS) 2019

INDICATOR	COUNTY	STATE	NATIONAL	UNITS	SOURCE
Mental Health and Substance Misuse					
Suicides	**11**	14	n/a	Number of deaths due to suicide per 100,000 population (age-adjusted)	County Health Rankings 2022; National Vital Statistics System - Mortality Data (2020) via CDC Wonder
Poor Mental Health Days	**5.8**	4.8	4	Average number of mentally unhealthy days reported in past 30 days (age-adjusted)	County Health Rankings 2022; Behavioral Risk Factor Surveillance System (BRFSS) 2019
Frequent Mental Distress	**19%**	15%	n/a	Percentage of adults reporting 14 or more days of poor mental health per month (age-adjusted)	County Health Rankings 2022; Behavioral Risk Factor Surveillance System (BRFSS) 2019
Excessive Drinking	**18%**	18%	15%	Percentage of adults reporting binge or heavy drinking (age-adjusted)	County Health Rankings 2022; Behavioral Risk Factor Surveillance System (BRFSS) 2019
Alchohol-Impaired Driving Deaths	**19%**	21%	10%	Percentage of driving deaths with alcohol involvement	"County Health Rankings 2022; Fatality Analysis Reporting System 2016-2020"
Cancers					
Breast Cancer Deaths	**n/a**	22.1	19.9	Age-adjusted death rate deaths per 100,000	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology and End Results Program. State Cancer Profiles, 2015-2019
Breast Cancer Incidence	**124.3**	128.4	126.8	Age-adjusted death rate deaths per 100,000	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology and End Results Program. State Cancer Profiles, 2014-2018
Colorectal Cancer Deaths	**n/a**	15.3	13.4	Age-adjusted death rate deaths per 100,000	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology and End Results Program. State Cancer Profiles, 2015-2019
Colorectal Cancer Incidence	**51.3**	40.9	38	Age-adjusted death rate deaths per 100,000	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology and End Results Program. State Cancer Profiles, 2014-2018
Prostate Cancer Deaths	**n/a**	22.5	19.5	Age-adjusted death rate deaths per 100,000	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology and End Results Program. State Cancer Profiles, 2015-2019
Prostate Cancer Incidence	**74.5**	126.6	106.2	Age-adjusted death rate deaths per 100,000	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology and End Results Program. State Cancer Profiles, 2014-2018

INDICATOR	COUNTY	STATE	NATIONAL	UNITS	SOURCE
Lung Cancer Deaths	**68.8**	39.1	36.7	Age-adjusted death rate deaths per 100,000	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology and End Results Program. State Cancer Profiles, 2015-2019
Lung Cancer Incidence	**84.5**	61.3	57.3	Age-adjusted death rate deaths per 100,000	National Institutes of Health, National Cancer Institute Surveillance, Epidemiology and End Results Program. State Cancer Profiles, 2014-2018
Injury Prevention and Safety					
Firarm Fatalities	**10**	16	n/a	Number of deaths due to firearms per 100,000 population	County Health Rankings 2022; National Center for Health Statistics 2016-2020
Violent Crime	**196**	388	63	Number of reported violent crime offenses per 100,000 population	County Health Rankings 2022, Uniform Crime Reporting - FBI 2012-2014
Child Abuse and/or Neglect	**5.6**	3.9	n/a	Children with Indication of abuse or neglect (rate per 1,000)	Child Protective Services Data System, Georgia Department of Human Resources, Division of Family and Children Services 2019
Motor Vehicle Crash Deaths	**28**	14	n/a	Number of motor vehicle crash deaths per 100,000 population	County Health Rankings 2022, National Center for Health Statistics, 2014-2020
Access to Care					
Uninsured Adults	**19%**	19%	n/a	Percentage of adults under age 65 without health insurance	"County Health Rankings 2022, US Census Bureau Small Area Health Insurance Estimates 2019"
Uninsured Children	**8%**	7%	n/a	Percentage of children under age 19 without health insurance	"County Health Rankings 2022, US Census Bureau Small Area Health Insurance Estimates 2019"
Primary Care Physicians	**5,960:1**	1,490:1	1,010:1	Ratio of population to primary care physicians	County Health Rankings 2022, Area Health Resource File/ American Medical Association 2020
Dentists	**n/a**	1,920:1	1,210:1	Ratio of population to dentists	County Health Rankings 2022, Area Health Resource File/ American Medical Association 2020
Mental Health Providers	**3,990:1**	640:1	250:1	Ratio of population to mental health providers	County Health Rankings 2022, CMS, National Provider Identification, 2021
Other Primary Care Providers	**2,990:1**	820:1	n/a	Ratio of population to primary care providers other than physicians	"County Health Rankings 2022, Area Health Resource File/American Medical Association, 2019."
Preventable Hospital Stays	**4,468**	4,295	2,233	Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees	County Health Rankings 2022, Mapping Medicare Disparities Tool, 2019

Part 4: Community Input

The pandemic complicated the process of getting community input for the 2022 CHNA.

Because of an increase in COVID-19 cases and the need for social distancing, Tanner's Community Benefit department was unable to host listening sessions in person. And meeting online wasn't ideal for residents in Tanner's service area — many of whom don't have access to broadband internet, which makes it difficult to participate via Zoom or any other teleconferencing software.

So, Tanner's Community Benefit department decided to use a mixed-methods approach that included focus groups, key informant interviews, and paper and online surveys.

Past years' events provided a diverse community listening session with the opportunity to have collaborative conversations and confirm priorities for the coming three years. Due to concerns regarding COVID-19 and population safety, Tanner Health System was not able to host a community-wide conversation during this cycle.

To obtain additional community input, a paper and online survey were created to gather basic demographics and administer several of the focus group and key informant interview questions to a broader audience in the region. A sample of 255 individuals was surveyed from 10 unique counties (two in Alabama, eight in Georgia), representing 29 different ZIP codes in Tanner's service region.

Focus Groups And Community Health Surveys

Primary qualitative data was collected through three community focus groups, and paper and online community health surveys from residents and area community leaders that represent the broad interests of the community, gathering input from a total of 296 individuals.

Participants were identified and recruited by Tanner Health System's Community Benefit Department. The focus groups were conducted by a Georgia Health Policy Center representative using focus groups and discussion guides drafted by the health policy center. The focus group questions and informed consent forms were reviewed and approved by the Georgia State University Institutional Review Board.

The purpose of the community health surveys and focus groups was to identify community health challenges, needs and concerns affecting residents, as well as solutions to health issues. Specifically, focus group participants were asked to identify and discuss what they perceived to be the top health issues or concerns in their communities.

The focus group process gathers valuable qualitative and anecdotal data regarding the broad health interests of the communities in the Tanner Health System service area. Focus group feedback is subject to the limitations of the identified target populations (i.e., vocabulary, perspective, knowledge, etc.) and, therefore, is not factual and is inherently subjective.

CARROLL, HARALSON AND HEARD FOCUS GROUPS

Qualitative data was gathered during two focus groups conducted with community leaders in Carroll County, Georgia, at City Station in Carrollton on Nov. 4, 2021. Due to the pandemic, measures were taken to ensure the safety of participants, including requiring participants to sit at least six feet apart. The focus group consisted of residents from Carroll, Haralson and Heard counties.

PARTICIPANTS

- Attendees: 34 focus group participants – 27 females, seven males
- Sectors represented: education (primary and secondary), county and state government, business and industry, health care, senior services and nonprofits.
- The majority of the group have lived in west Georgia/ Carroll County for more than 10 years. (Exceptions: those who worked in the region but did not live there).

ISSUE IDENTIFICATION

During the discussion group process, five primary themes were identified that impact the health of county residents:

1. Access to healthier, affordable food and physical activity opportunities – Education about what healthier food is, better/easier access to food and physical activity opportunities
2. Chronic disease prevention and management education – Need to continue education about healthier food, how to prevent and manage chronic disease (the health gap – the difference between knowing and doing), need to also focus on educating youth
3. Mental/behavioral health – There is a need for access to mental health services at all levels (education as well as inpatient and outpatient services)
4. Substance use/misuse – Need to address substance use/ misuse and vaping (as a gateway to tobacco) through awareness and misuse prevention
5. Social determinants of health – Need to address poverty, transportation, literacy, education, affordability, access, specialty care services and greenspace.

Progress on 2019 Priorities:

Attendees commented on several areas of progress in the 2019 priority areas and healthcare services arena, including:

- The education within the school systems throughout the region is excellent and offers a great opportunity to educate children at an early age about health and healthy lifestyles. Participants noted the schools have a caring staff and administration, and there is a great community collaboration between schools.
- The number and variety of resources available through our community partners.
- The availability of community health classes/programs and resources that address problems related to chronic disease and behavioral/mental health.

- The availability of physical activity at schools and senior centers.
- Efforts to increase access to senior programs to help seniors adopt healthy lifestyle habits and get the resources they need.
- The ability to build a coalition that comes up with solutions to improve the community's health.
- The ability to meet people where they are, whether through in-person/virtual classes, remote patient monitoring (RPM), or the paramedicine program.
- The establishment of memory and assisted living care (The Birches at Villa Rica).
- The availability of addiction and treatment services – education and Narcan administration training.
- The availability of a community resource guide.
- The availability of the crisis response team.
- The expansion of healthcare with more mental health clinicians and programming (Your Haven, Inc.) and school nurses.
- The availability of the Good Pill Pharmacy.

Attendees were candid about the issues that positively or negatively impacted the health of residents. A summary of the concerns and barriers is presented below.

Specific Concerns/Issues:

- The lack of access to healthier food is one of the most critical issues impacting the population.
- There is a need to expand health education in general (including chronic disease prevention and management), particularly among youth.
- There is a need to continue educating the community about the importance of physical activity and make environments that promote physical activity more accessible.
- Transportation continues to be a barrier. One participant noted that some residents are concerned a transit system to Carroll County will turn into something similar to Marta. Some providers offer transportation to pick up patients. But they can't refer patients to programs at other locations because of the lack of transportation to get them.
- Lack of safe, affordable, long-term housing, especially for the elderly, disabled populations, young adults (transitioning from parent's home or college), and others on fixed incomes.
- Lack of healthy behavior (poor nutrition and physical inactivity) leads to obesity, diabetes and other chronic conditions.
- There is concern about the supply chain – meds, food, basic needs (cost, time).
- There is a need to improve connectivity between programs and people who need to know about the resources available; also need to train people on how to refer people to those resources.
- There is a need for safe, healthy drinking water in Haralson County.

- Parks and recreation facilities need to provide targeted offerings for specific populations (youth, seniors).
- There are concerns about the misuse of prescription/medication.
- There is a need for social and healthcare services in Heard County.
- There are very few homeless shelters in the region.
- There is a lack of access to primary and dental care, especially for those on Medicaid/Medicare.

Barriers to Achieving Good Health:

- There are many health care providers, health programs and other services offered in Carroll County – a lack of knowledge or lack of interest in utilizing the services is an issue.
- Lack of community support and social isolation, particularly for seniors.
- Social media/technology use results in comparisons.
- Convenient and low cost transportation was identified as a concern.
- Fear (costs, what you'll hear, access/proximity)
- Lack of insurance
- Wait times

What Contributes to an Unhealthy Community?

Focus group attendees were asked to identify issues and concerns in Carroll County that have contributed to an unhealthy community.

- Substance misuse: Areas of concern include the opioid epidemic, prescription drug abuse, alcohol, illegal drug use, vaping use (gateway) and the inability to pass a drug test.
- Vulnerable children and families: Participants noted the need of support for families, especially parents with infants and toddlers. They also noted the need for parents to learn parenting skills and how to be good role models.
- Services and stigma associated with mental/behavioral health: It was noted that both youth and adults are struggling with anxiety, depression, panic attacks, suicidal ideations and other mental health concerns, especially during the COVID-19 pandemic. One participant noted that when she first started teaching, her students would say, "Hey, Ms..., What's up?" But during the last two years, they just sink in their seats and don't say a word.
- Access to Quality Food and Grocery Stores – One participant noted that the Community Christian Council (CCC) in Haralson County is doing it right when it comes to making quality food available to families who need it. They would like to see that in Carroll and Heard counties.
- Environmental Issues: Participants were concerned about tobacco use, smoking, secondhand smoke, pollen, water quality and emissions/air quality.
- Lack of transportation: There was a concern about the lack of transportation, particularly for those living in poverty, disabled or elderly. Participants stressed the need for flexible, convenient and low-cost transportation.
- Poverty: Many Carroll County residents are impacted by poverty.
- A lack of affordable housing: Affordable housing for senior citizens, low-income families and newly transitioning students (from home or college dorm to an apartment) was named as concerns.
- A lack of knowledge about available programs and services: Paricipants stated not having knowledge about available resources or lacking motivation to participate in programs contributes to an unhealthy community.

Group Suggestions/Recommendations

- Youth physical and mental health: Throughout the discussion, focus group participants stated that children need to be more physically active to help improve obesity rates. There is also a need to educate them on the importance of being vape-free.
- Continue exploring opportunities for healthy food access: Having and promoting community gardens and farmers' markets is important, but it is also necessary to have them in locations (churches and senior centers, for example) that are convenient to the residents who need access to healthy food and who will embrace gardening and farmstand produce.
- Expand and promote existing health resources and services like the evidence-based programs of Get Healthy Live Well (GHLW): Participants spoke very highly of GHLW and its programs and want to explore ways to increase demand. This could be done by providing more online classes/programming and increasing access to broadband internet in rural communities. Increasing communication/marketing through social media campaigns will help spread the word about programming availability. Getting more referrals from organizations, physicians, churches and employers will also help.
- Increase support for families with young children: Parent education, positive parental support, and starting early with nutrition, physical activity and health content integrated into the early childhood and school settings are important. Also, for all families and youth, promoting the reduction in social media use was noted.
- Bring in fewer fast-food chains.
- Create a health village for underserved populations. Provide a one-stop shop for health care services and resources with a qualified, diverse staff.
- Continue to expand access to environments that promote physical activity. Better facilities for park and recreation, create more walking paths and structured programs.
- Solving housing/homelessness problem. Provide homeless shelters within the city limits and low-income housing that provides personal development (micro-dwelling communities).
- Increase the number of physicians, including dentists, who accept Medicaid and Medicare. Also, need a dental center for those without insurance.
- Expand crisis response. Provide mental health services 24-hours a day, seven days a week.
- Provide transportation services. Address barriers and promote facilitators to use.
- Increase access to broadband internet.
- Increase access to grocery delivery services.
- Increase access to treatment for substance abusers and sex offenders.
- Increase healthcare access for uninsured residents.
- Address supply chain concerns. Consider the cost and time associated with providing medications, food and basic needs.

HARALSON COUNTY FOCUS GROUP

Qualitative data were gathered during a focus group with seven participants from Haralson County, Georgia, at Higgins General Hospital in Bremen on December 1, 2021.

PARTICIPANTS:

- Attendees: seven focus group participants – four females, three males
- Sectors represented: agriculture, business and industry, education, health care, social services

ISSUE IDENTIFICATION:

During the discussion group process, four primary concerns were identified that impact the health of county residents:

1. Access to affordable healthy food – Address food insecurity/deserts with a focus on variety
2. Physical activity access – Provide physical activity opportunities that are free, affordable, accessible and safe
3. Behavioral health/mental health – Address substance misuse, suicide, social isolation (especially for seniors)
4. Transportation – Provide transportation to get to food and other services

Specific Concerns/Issues:

- Lack of food variety
- Food insecurity, food deserts
- Limited access to healthy food
- Working hard to address substance misuse but missing the suicide piece
- Physical environment
- Mortality
- Premature age-adjusted mortality

Creating a Healthy Community:

Attendees were asked to comment on what will contribute to Haralson County becoming a healthier place to live. Responses included:

- Literacy is still a community issue
- Address homelessness. One thing almost every small town has is homelessness.
- Address substance misuse, mental/behavioral health, suicide and isolation.
- Address food insecurity by hosting more Cooking Matters classes. One participant noted that food banks are open at night when it's difficult for some people to find transportation.
- Safe drinking water
- Transportation needs to come regularly. One participant noted that many small towns lack a functioning transportation system. Some people have conquered the transportation issue by offering a service like Lyft or Uber with volunteers. Getting a copilot and using a tracking system could address the security problem.

Group Suggestions/Recommendations:

- Focus on healthy youth and parental support: The social, emotional and physical health of youth and their parents were a major concern. A participant noted the importance of parental involvement and mentioned a woman in Floyd County who talked about how her single mom support group is helping her. Having a support group would help with feelings of isolation.
- Increase literacy: Poverty is a barrier to everything. One participant wondered if focusing on literacy will help offset poverty in the long run.
- Increase access to healthy, affordable food and nutrition education: For mothers participating in the WIC program, it's not easy to reach someone at the health department and you can't get vouchers over the phone. The food bank has been giving out a lot of formula to mothers in need because they can't reach the health department. Having Cooking Matters classes and cooking carts in the schools would help residents learn more about healthy cooking and eating.
- Increase access to physical activity opportunities: Participants noted the need for more recreation facilities and a trail system.
- Inform residents: Participants noted health-related resources and services available to help. People from Carroll, Floyd and Polk counties call Haralson County Family Connections to ask about Haralson County resources. But residents are not always aware of these or choose to use the services. The Healthy Haralson resource guide is a great resource, but it's not always accessible to residents who don't have phone or internet access. It may help to have a print version of the resource guide and make it available to residents who need it.

COMMUNITY SURVEY

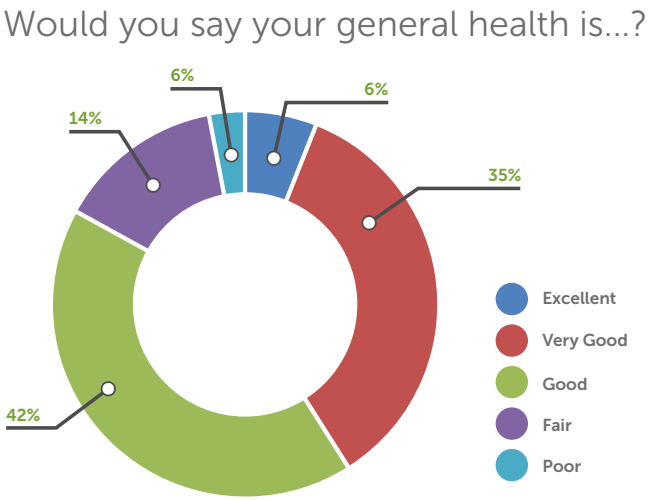
The 255 respondents ranged in age from 18 to 93 and 40% (n=101) of survey respondents fell into the 40-69 years age category. Eighty percent (80%) of the respondents were female. Most respondents (85%) indicated they were White/Caucasian, reflecting the region's population prevalence. Just over 100 respondents (43%) were not working or retired and 39% (n=98) worked full-time.

Category	Summary	Quantity
Gender n=255	Female	200
	Male	45
	Other	5
Age Range n=250	Total Range 18-93 years	
	18-29	23
	30-39	27
	40-49	37
	50-59	45
	60-69	56
	70-79	41
	80+	21
Work Status n=251	Full-Time	98
	Part-Time	22
	Not Working, Retired	108
	Seasonal	2
	Unemployed	21
Racial Ethnic Group n=250	Asian	2
	Black or African American	26
	Latino or Hispanic American	2
	White or Caucasian	213
	Multiple races	7

TABLE 1. TANNER HEALTH CHNA COMMUNITY SURVEY DEMOGRAPHICS

Respondents were asked, "Would you say your general health is...?" Response options were: Excellent, Very Good, Good, Fair, or Poor.

More than 75% of respondents indicated their general health is good or very good. Only 3% indicated their general health was poor.



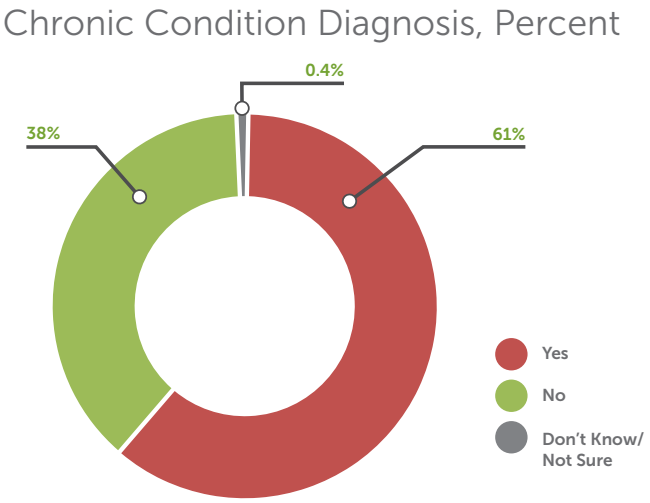
Respondents were asked about their chronic conditions or disease diagnoses.

The question was, "Has a doctor, nurse or other health professional ever told you that you have a chronic condition such as diabetes, heart disease, high blood pressure, arthritis, lupus, cancer or fibromyalgia?"

Answer options were: Yes, no, don't know/not sure. Just over 60% of individuals indicated a positive chronic condition diagnosis.

The table below summarizes responses to the question, "In your opinion, what are the 3 most important health issues that need to be addressed in your community?"

Responses are summarized according to concern (#1, #2, and #3), with the number of respondents indicating that response category.



#1 Concern	Qty	#2 Concern	Qty	#3 Concern	Qty
Chronic Diseases/Conditions:	55	Chronic Diseases/Conditions:	59	Chronic Diseases/Conditions:	49
Heart Disease/Cardiac Health		Heart Disease/Cardiac Health		Heart Disease/Cardiac Health	
High Blood Pressure/HTN		High Blood Pressure/HTN		High Blood Pressure/HTN	
Diabetes/Arthritis/Chol		Diabetes/Arthritis/Chol		Diabetes/Arthritis/Chol	
Access/Affordability of Healthcare/Rx; Lack of Insurance	26	Access/Affordability of Healthcare/Rx; Lack of Insurance	28	Exercise/PA/Fitness/Recreation Prevention/ Wellness/ Screenings/ Education	27
Mental Health	26	Food/Nutrition/Diet	20	Access/Affordability of Healthcare/Rx; Lack of Insurance	25
Obesity	25	Exercise/PA/Fitness/Recreation Prevention/Wellness/ Screenings/Education	16	Mental Health	20
Specialty Care	15	Obesity	16	Food/Nutrition/Diet	13
Food/Nutrition/Diet	14	Mental Health	13	Specialty Care	12
Exercise/PA/Fitness/Recreation Prevention/Wellness/ Screenings	13	Specialty Care	12	Obesity	11
COVID	9	Cancer	11	Substance Use/Drugs/ Addiction	8
Cancer	7	Substance Use/Drugs/Alcohol/ Addiction	10	COVID	7
Substance Use/Drugs	7	COVID	4	Cancer	7
Transportation	1	Transportation	3	Transportation	4

The most important concerns, according to the survey respondents, are:

- Chronic diseases and conditions: Diabetes and heart disease were the most frequently named conditions in this concern area.
- Access and affordability of healthcare (all types: physical, mental, oral and vision care): This concern includes prescription cost and access and those indicating concerns regarding a lack of Insurance which limits their access to care. Notably, respondents identified the need for specialty care as a priority. The two categories would make this priority concern #2 across all responses.
- Mental health: Mental healthcare is the third most important concern to respondents, including mental health services, counseling, anxiety management, depression, stress, and substance and alcohol use disorders.
- Healthy lifestyles, nutrition and physical activity: These categories are presented separately in the table, but collectively comments from respondents suggest healthy lifestyles, including support for nutrition education, cooking, gardening, wellness, physical activity support and exercise opportunities are important.

Healthy Haralson: The Two Georgias Initiative

When faced with providing and accessing high-quality health services, rural communities face various obstacles.

Geographic isolation, limited job prospects, lack of transportation and low availability of service providers are just a few barriers rural residents face. Healthy Haralson — a committee of Tanner's Get Healthy, Live Well — is leading the charge to tear down the barriers preventing people from adopting healthier habits and receiving the care they need.

GET HEALTHY LIVE WELL | HARALSON

In June 2017, the Healthcare Georgia Foundation awarded Tanner **The Two Georgias Initiative** grant to improve health outcomes for Haralson County residents.

THE MISSION OF HEALTHY HARALSON

Healthy Haralson is dedicated to advancing health equity among rural Haralson County residents by improving health care. The initiative will foster social, economic and educational environments that promote health while eliminating disparities.

HEALTHY HARALSON FUNDING AND GOVERNANCE

The Two Georgias Initiative was a five-year investment in rural communities represented by Community Health Partnerships (CHP), implementing bold and visionary **Community Health Improvement Plans** (CHIP) comprised of innovative solutions to improve health and increase healthcare access among Haralson County residents.

Tanner was one of only 11 nonprofit organizations in Georgia to receive the award. Tanner's The Two Georgias Initiative project works through Healthy Haralson to plan, coordinate and implement a comprehensive CHIP in Haralson County. During the project's first year, Tanner collaborated with the University of West Georgia (UWG) to conduct an intensive CHNA, asset mapping and gap analysis of Haralson County to develop the plan.

After analyzing the CHNA/gap analysis and asset mapping data results, a comprehensive work session was organized with 18 Healthy Haralson stakeholders. These key stakeholders collaborated in teams based on each priority initiative identified to develop ideas they thought would give Haralson County the best overall outcomes in terms of health, equity and healthcare system efficiency.

Based on this information, a clear set of priorities with actionable steps were identified to create and finalize the CHIP. The CHIP was given the green light by the Healthy Haralson leadership group and the Tanner Medical Center, Inc. Board of Directors.

Once the CHIP was approved, several task forces were created to ensure that the initiatives and programs designed to improve the health outcomes of residents in Haralson County were not only successful, but also sustainable. These task forces are:

- **Healthy minds and bodies** – This task force ensures Haralson County residents have access to free programs and classes focused on healthy living as well as disease prevention and management of chronic conditions. It also works to help children, teens and adults recognize and respond to symptoms of mental health issues while increasing access to behavioral health services and youth.
- **Community resources** – This task force works to increase awareness of existing community resources and increase provider resources to clinical and community services. It also strives to ensure that all residents have equitable opportunities to get healthy and live well.
- **Senior needs** – This task force works to increase access to resources for senior citizens to improve their independence and quality of life. It also ensures seniors have access to resources and services that promote their health and well-being.
- **Substance misuse** – This task force works to address the problem of substance misuse through partnerships with local government officials, first responders and addiction treatment providers. It also offers support and resources to individuals and families affected by addiction.

There are 110 task force members. Together, team members within each task force are working to identify obstacles to resident health and wellness and find innovative ways to overcome them.

Part 5: Significant Health Needs

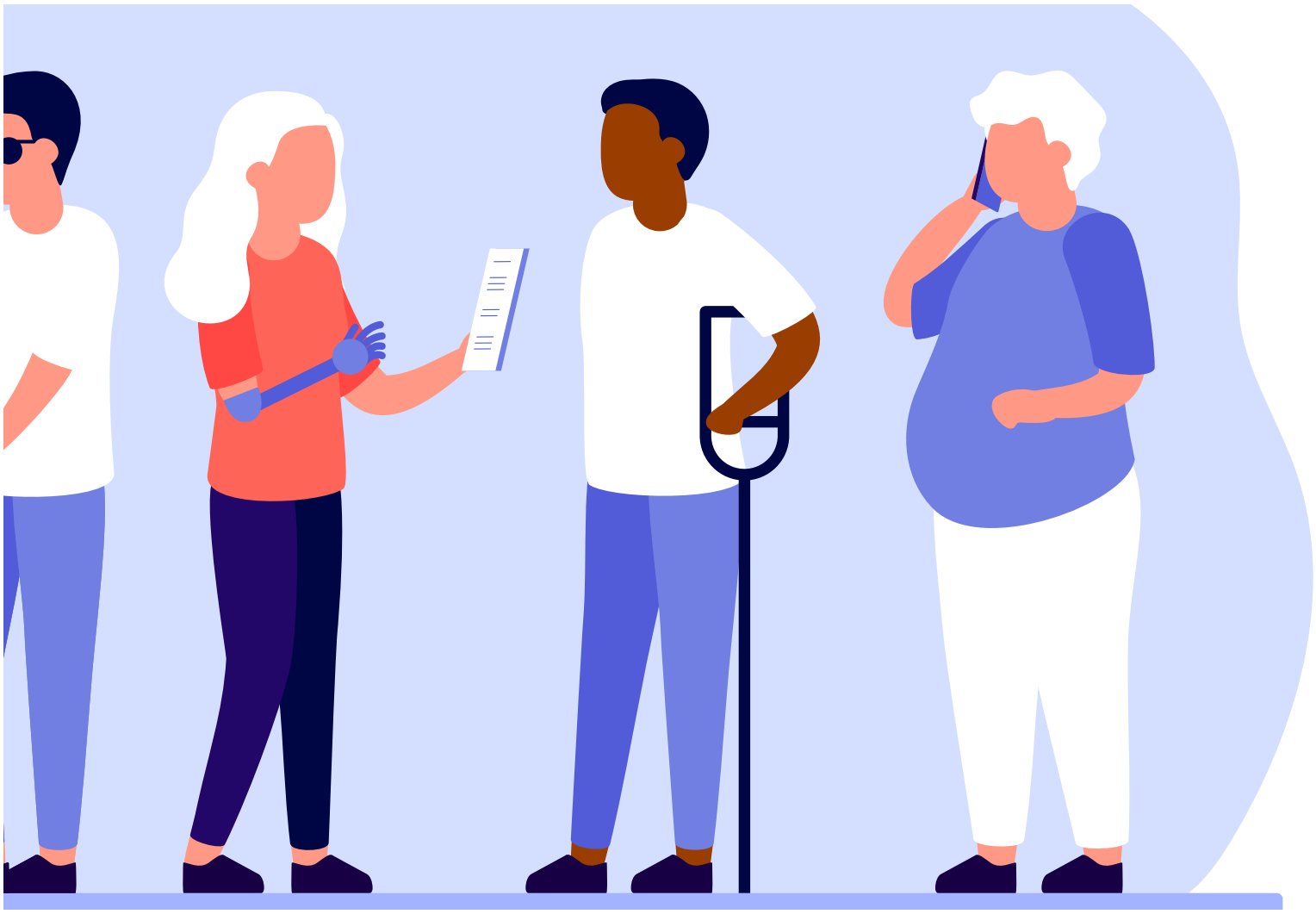
PRIORITIZED DESCRIPTION OF SIGNIFICANT HEALTH NEEDS

The identification of health needs was shaped by an awareness of public health concerns, assessment data and each hospital's strengths in the context of the system's priorities.

Additionally, when selecting final targeted health priorities, Tanner considered additional variables such as the availability of evidence-based solutions as well as existing partnerships and programming. These components were used to identify priority areas.

Focus groups participated in a prioritization exercise that involved classifying and ranking identified needs and assets. It also involved discussing what current or new initiatives and partners should be included in the hospital's three-year implementation plans.

The goal was to determine how to best support the highest prioritized needs while leveraging community assets and resources. Through this process of evaluation, six priority health issues were selected from the broader list of priorities identified in the CHNA as specific areas of focus for each



of Tanner's Health System's hospitals (Tanner Medical Center/Carrollton, Tanner Medical Center/Villa Rica, Higgins General Hospital) Community Health Implementation Strategy, including:

1. Access to Care
2. Mental/Behavioral Health Services
3. Chronic Disease Education, Prevention and Management
4. Health and Nutrition Education
5. Substance Misuse
6. Social Determinants of Health

Tanner's hospitals will follow the implementation strategy, which will be presented in a separate document over the next three years (fiscal years 2023-2025). Plans will concentrate on implementing programming for identified priority areas, then systematically measuring and tracking program effectiveness.

It will also focus on reporting progress and outcomes relative to internal measures as well as local and national public health goals.

MOVING FORWARD

Through the CHNA process, Tanner has identified the most urgent health issues in each of its hospital's communities.

This will assist the health system in ensuring its resources are appropriately allocated toward clinical program development, education, outreach, prevention services and wellness opportunities where the greatest impact can be made. Now that the community's health needs have been identified, implementation strategies will be developed to help people in Tanner's service area get and stay healthy.

GET HEALTHY
LIVE WELL

TANNER
HEALTH SYSTEM