Phoebe

2020-2022
Community Health Needs Assessment

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Introduction

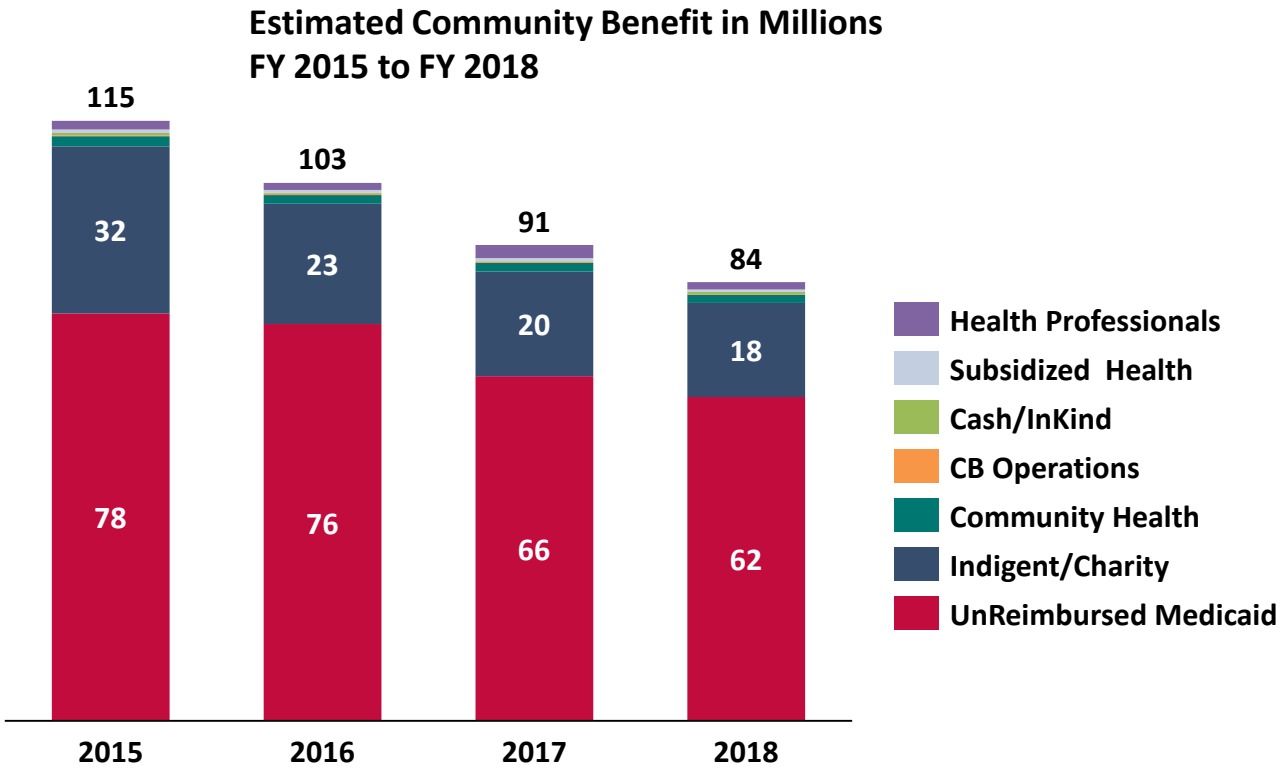
Phoebe Putney Memorial Hospital (PPMH) opened its doors in 1911 with a founding mission to embrace all who come to her doors. More than 100 years later, that mission is unchanged, providing care and healing to all, regardless of personal circumstances or ability to pay. PPMH has a long and documented history of providing care and services to the most vulnerable among us, and the hospital works in partnership with the community to address health needs and develop plans that will improve and sustain the health of the community. PPMH has relied on a broad-ranging partnership model to create community actions that translate into better access for all citizens in Southwest Georgia. These strategic partnerships have resulted in health improvement initiatives that are most often hospital-led and community-owned, reaching out across diverse needs, and ultimately becoming the ties that bind people, resources and organizations together with a common focus on improving community health for the long term.

PPMH conducted a Community Health Needs Assessment in compliance with the provisions of the Patient Protection and Affordable Care Act (ACA), which requires all non-profit hospitals in the United States to conduct a community health needs assessment to identify health priorities and adopt an implementation strategy to meet the identified community health needs. The assessment process requires hospitals to take into account input from individuals who represent a broad interest of the community served, including those with special knowledge or expertise in public health.

This work resulted in identifying four priorities: Behavioral Health and Addictive Disease, Birth Outcomes and Reproductive Responsibility, Diabetes Prevention and Management, and Cancer Prevention and Screening. The PPMH Board of Directors approved the priorities at its monthly meeting held July 10, 2019.

Community Benefits are programs or activities that provide treatment and/or promote health and healing as a response to identified community needs. They are not provided for marketing purposes and are guided by these four principles:

1. *Improves access to health care services.*
2. *Enhances health of the community.*
3. *Advances medical or health knowledge.*
4. *Relieves or reduces the burden of government or other community efforts*.

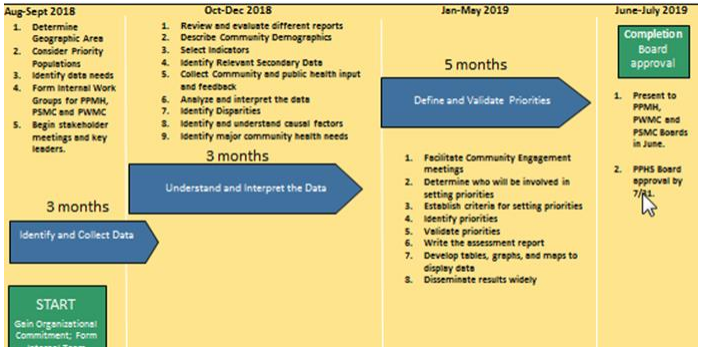


Data Source: Draffin and Tucker, LLP

SECTION I: Planning and Preparing for Assessment

The Internal Assessment Team was a blend of hospital staff and strategic community partners located in Phoebe-Albany's defined five county primary service area. The project Team Lead was Mark Miller, Strategy Analyst with oversight from Lori Jenkins, Director of Strategy and Planning, and Darrell Sabbs, Community Benefit Coordinator. Early on, hospital leadership made the decision to use the Multiple Organization Partnership Model as the approach to Determine How the Community Health Needs Assessment Will Be Conducted. This approach engages multiple organizations, provides a broader focus, and allows greater input in need identification and determining appropriate strategy for action.

2020 Community Health Needs Assessment Timeline to Meet Requirements



Phoebe Albany Community Benefit Board Subcommittee

Dr. John Culbreath, Subcommittee Board Chair
Jay Sharpe, Phoebe Board Member
Lem Edwards, Phoebe Board Member
Karin Middleton, Phoebe Board Member
Dr. Jim Hotz, Albany Area Primary Health Care*
Tary Brown, Albany Area Primary Health Care-Retired CEO*

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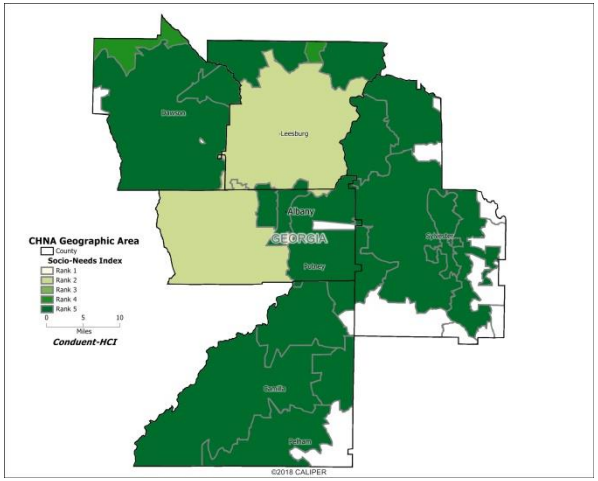
Lori Jenkins, Director of Strategy and Planning
Phoebe Health System

Mark Miller, Strategy Data Analyst, Project Lead
Phoebe Health System

Sherry McMurtrey, CHNA Contracted Employee
Phoebe Putney Memorial Hospital

SECTION II: Defining Community and Key Demographic Data

The Internal Work Team defined the community as Phoebe-Albany's Primary Service Area comprised of Dougherty, Lee, Mitchell, Terrell and Worth Counties. [Map1] However, the implementation plan will mostly target the city of Albany, where the most vulnerable populations live.



The five county area [Chart 1] expects little growth up through 2023. In our last assessment the projected population was said to be 190,329 through 2020, but actual numbers for 2018 were 178,133. The projected rate of growth through 2023 is less than one percent , with 65 to 84 year olds and 85+ seeing the growth. Current population is 53.2% black/AA , 43.7% White, and 3.1% all others.

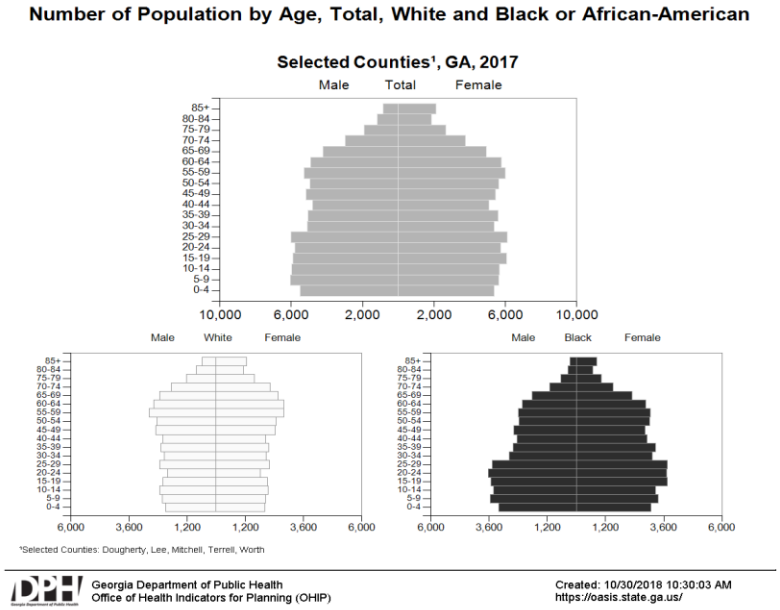
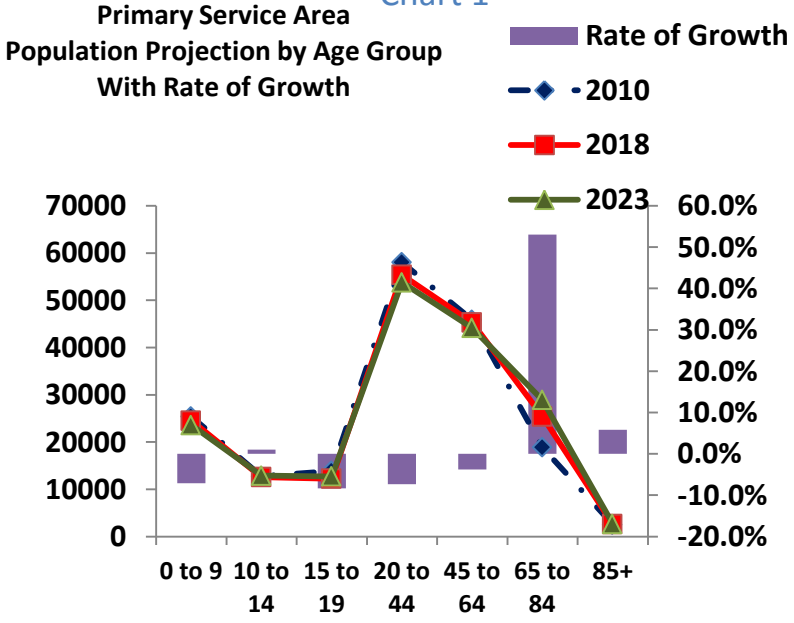


Chart 1



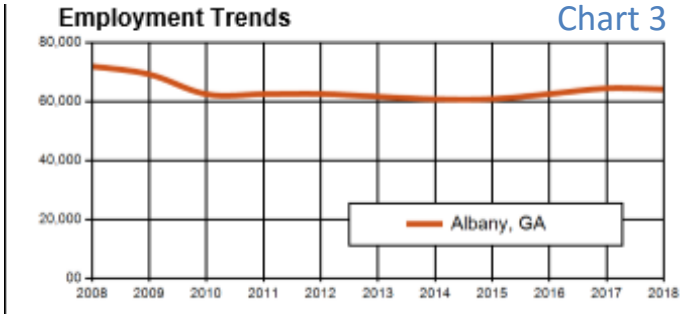
Albany Metropolitan Statistical Area

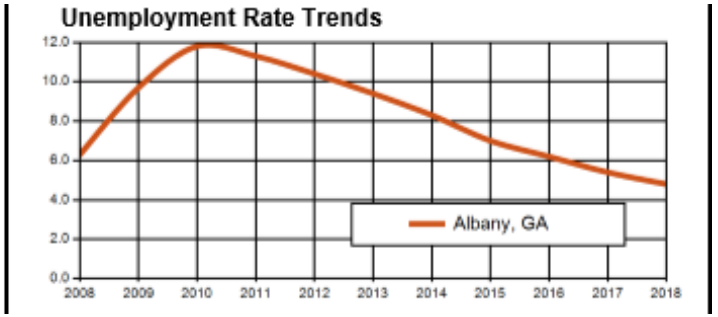
Population

Chart 2

	2010 Census	2018 Rank	2018 Estimate	% Change 2010-2018	2025 Projected*	% Change 2010-2025
Dougherty	**94,565**	**28**	**91,243**	**-3.5**	**93,243**	**-1.4**
Albany, GA	**157,308**		**153,009**	**-2.7**	**160,631**	**2.1**
Georgia	9,687,653		10,519,475	8.6	11,538,707	19.1
United States	308,745,538		327,167,434	6.0	349,439,199	13.2

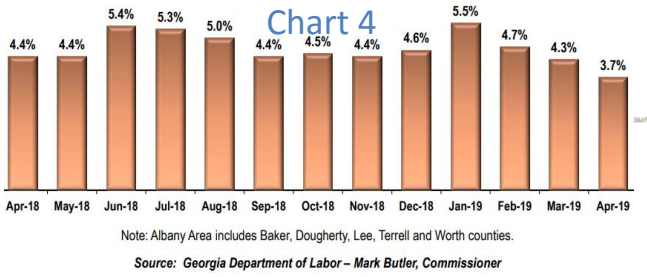
Source: Population Division, U.S. Census Bureau, *Governor's Office of Planning and Budget.





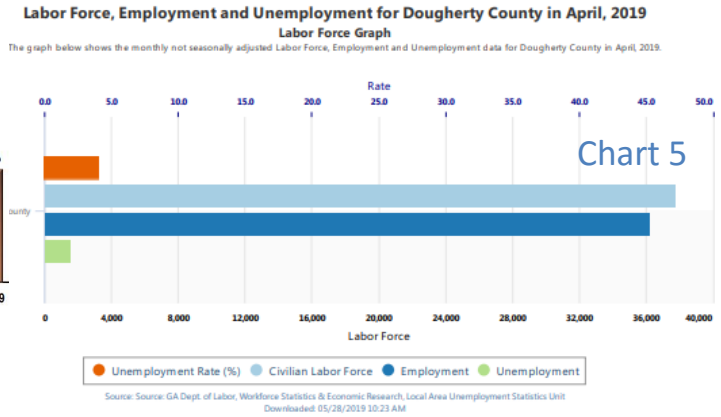
Unemployment has decreased and so has the labor force, [compare chart 2&3] keeping the employment trend with only a minimal increase. Proximity One's forecast for both 2020 and 2030 populations indicate a **decline of 11%** throughout the region compared to the 2010 census report, with growth only in Lee County.

Unemployment reached a record low in April 2019 to reach 3.7%, down from 4.4% a year earlier. [Chart 4 & 5]



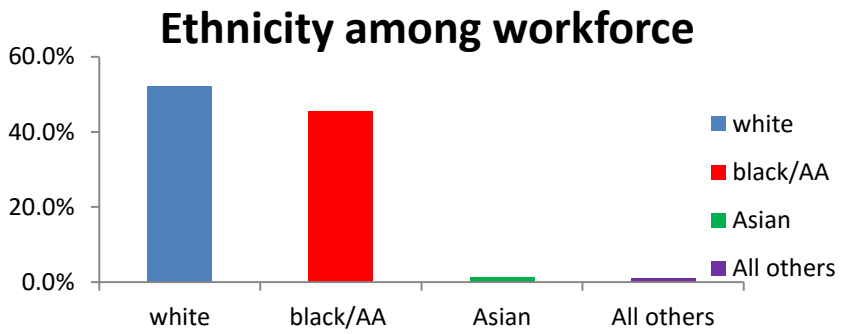
Note: Albany Area includes Baker, Dougherty, Lee, Terrell and Worth counties.

Source: Georgia Department of Labor – Mark Butler, Commissioner

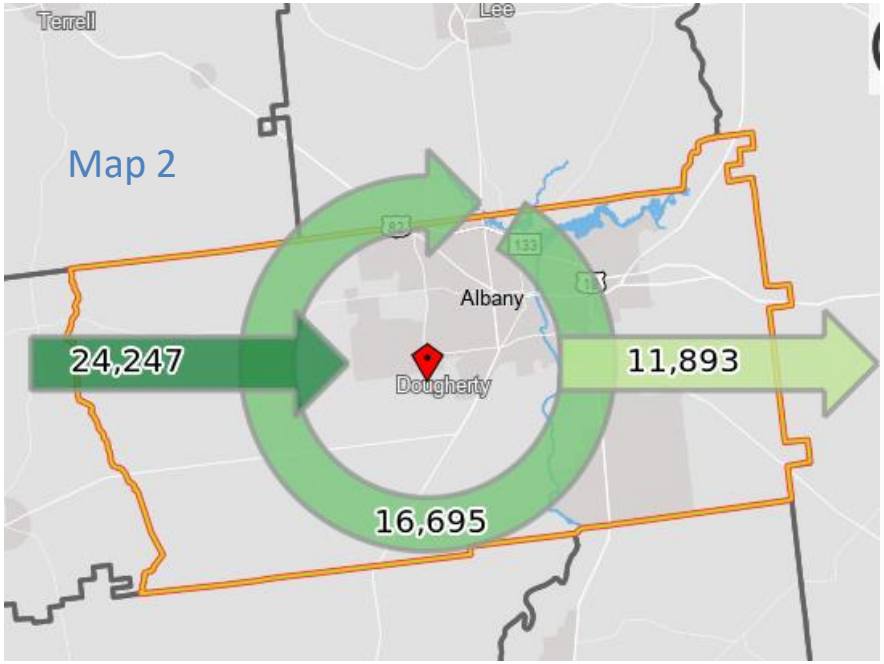


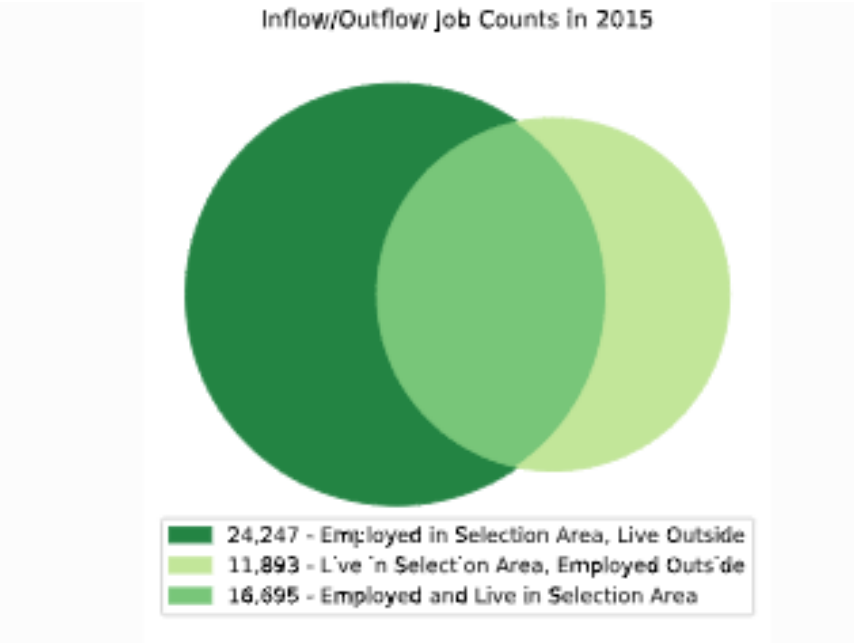
An Inflow/Outflow count of Primary jobs shows 24,247 workers were employed in Dougherty County but lived outside of the county, 16,695 lived and worked in Dougherty and 11,893 lived in Dougherty, but worked outside the county. [Chart 6] The breakout of ethnicity within those jobs shows whites made up 52.1% of the workforce and AA/Blacks comprised 45.6%. [Map 2]

Chart 6



Map 2





The number of workers with a college degree has risen by 12 million since the recession, [Chart 7] while the number with only a high-school degree or less has fallen by more than 4 million.

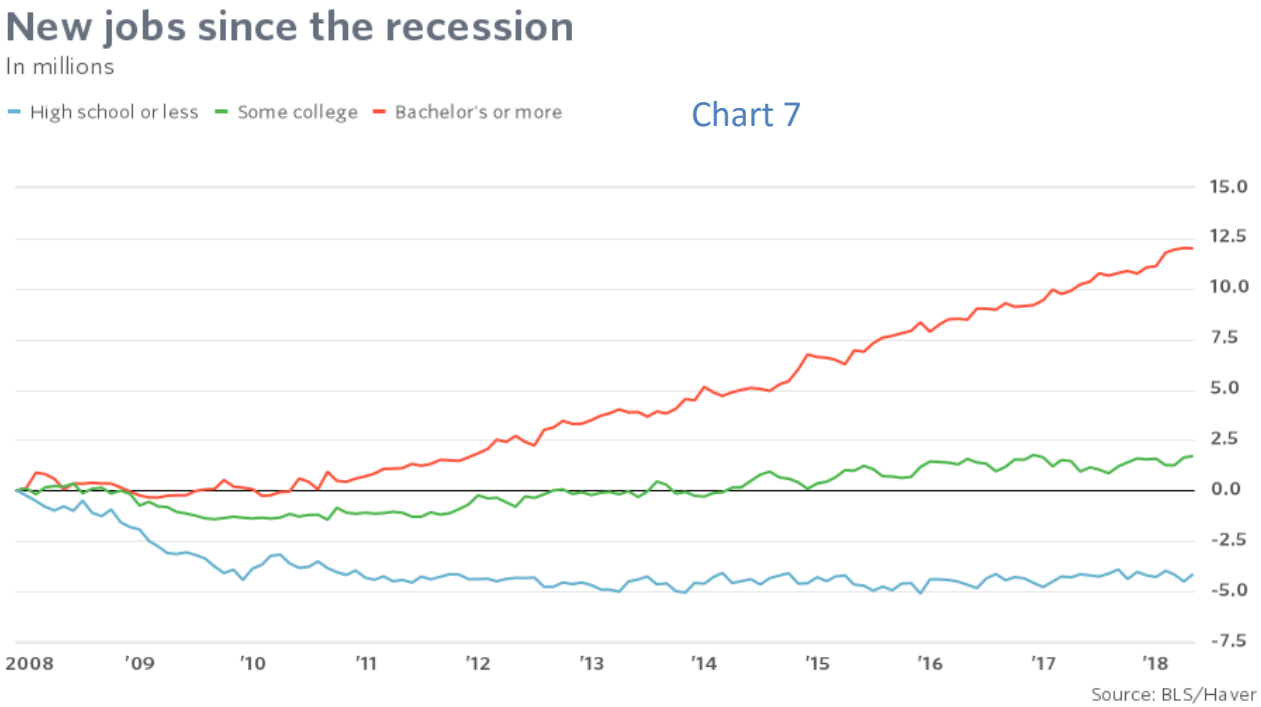


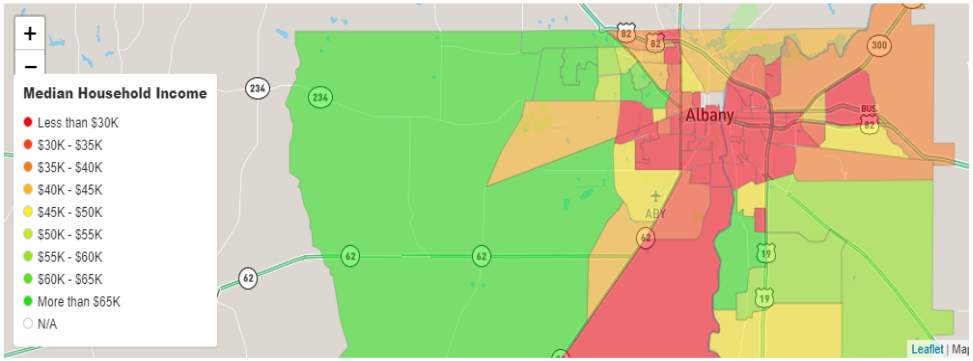
Chart 7

Albany, GA

	PERCENT OF TOTAL	PERCENT DISTRIBUTION BY AGE				
		18-24	25-34	35-44	45-64	65+
Elementary	5.9%	3.3%	2.9%	2.2%	4.3%	19.3%
Some High School	15.6%	21.4%	13.1%	13.0%	14.0%	18.8%
High School Grad/GED	30.7%	26.2%	28.0%	33.3%	33.1%	30.1%
Some College	26.5%	41.5%	32.0%	26.5%	22.7%	14.5%
College Grad 2 Yr	6.1%	3.9%	7.8%	8.4%	6.2%	3.5%
College Grad 4 Yr	9.2%	3.5%	10.9%	10.6%	10.8%	7.7%
Post Graduate Studies	6.0%	0.2%	5.3%	6.0%	8.9%	6.1%
Totals	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Other Areas in Dougherty County, Georgia

U.S. Median Household Income: **$57,652 (2017)**



Area	Total	Race					
		White	Black	Asian	Indian	Islander	Other
United States	57,652 8.7%↑	61,363 9.2%↑	38,183 7.4%↑	80,398 12.1%↑	40,315 7.6%↑	57,372 4.4%↑	44,168 9.3%↑
Georgia	52,977 6.8%↑	60,671 6.8%↑	40,112 9.5%↑	73,101 16.6%↑	39,767 -1.2%↓	45,833 9.8%↑	38,946 17.7%↑
Dougherty County, Georgia	34,541 8.7%↑	53,046 8.3%↑	29,301 16.9%↑	31,489 -30.6%↓	26,935 -19.3%↓		16,799 -14.3%↓

Area	Total	Race					
		White	Black	Asian	Indian	Islander	Other
United States	57,652 8.7%↑	61,363 9.2%↑	38,183 7.4%↑	80,398 12.1%↑	40,315 7.6%↑	57,372 4.4%↑	44,168 9.3%↑
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Lee County, Georgia	65,018 11.3%↑	69,324 13.0%↑	52,877 29.6%↑	105,469 60.9%↑			

Area	Total	Race					
		White	Black	Asian	Indian	Islander	Other
United States	57,652 8.7%↑	61,363 9.2%↑	38,183 7.4%↑	80,398 12.1%↑	40,315 7.6%↑	57,372 4.4%↑	44,168 9.3%↑
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Mitchell County, Georgia	34,122 3.9%↑	40,897 -5.4%↓	27,442 11.2%↑				24,286 -1.0%↓

Area	Total	Race					
		White	Black	Asian	Indian	Islander	Other
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Terrell County, Georgia	32,219 -1.9%↓	51,759 -6.4%↓	23,500 1.1%↑				

Area	Total	Race					
		White	Black	Asian	Indian	Islander	Other
United States	57,652 8.7%↑	61,363 9.2%↑	38,183 7.4%↑	80,398 12.1%↑	40,315 7.6%↑	57,372 4.4%↑	44,168 9.3%↑
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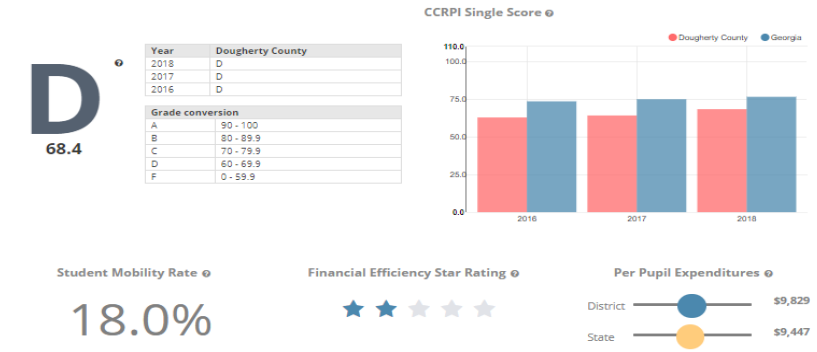
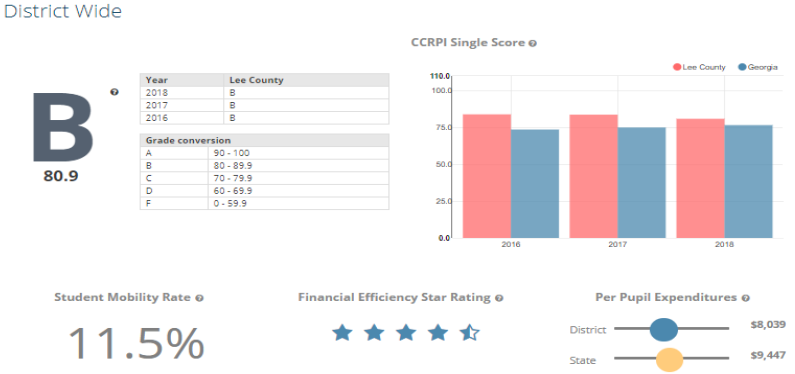
Worth County, Georgia	40,369 3.0%↑	48,889 7.2%↑	22,858 0.0%↑		73,701 76.0%↑		

District Wide



District Wide



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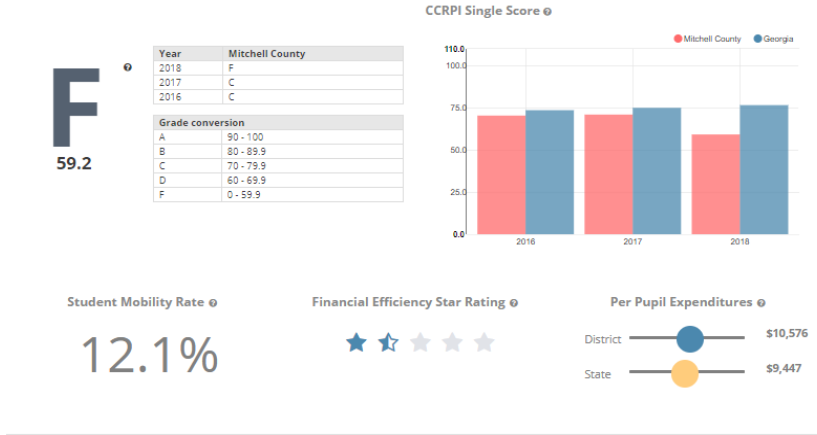

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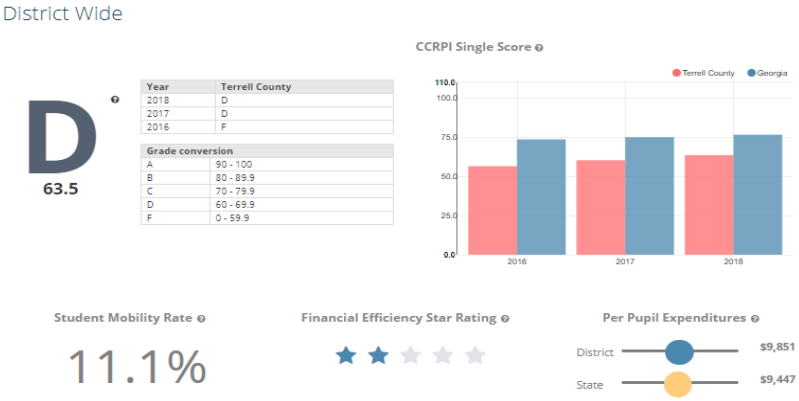

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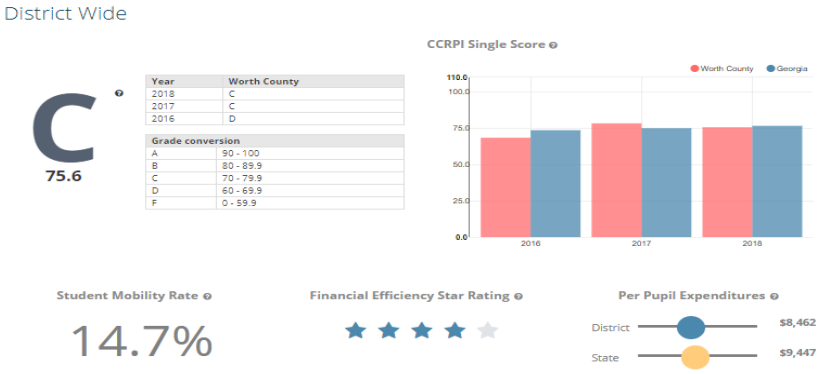


School district score cards have seen little change aside from Mitchell County's two letter grade decline from the previous year. Not reaching benchmark goals for reading at grade level is likely reflected in that score. On the following page is a breakdown of each district seen side by side in regards to those goals.

Chart 8

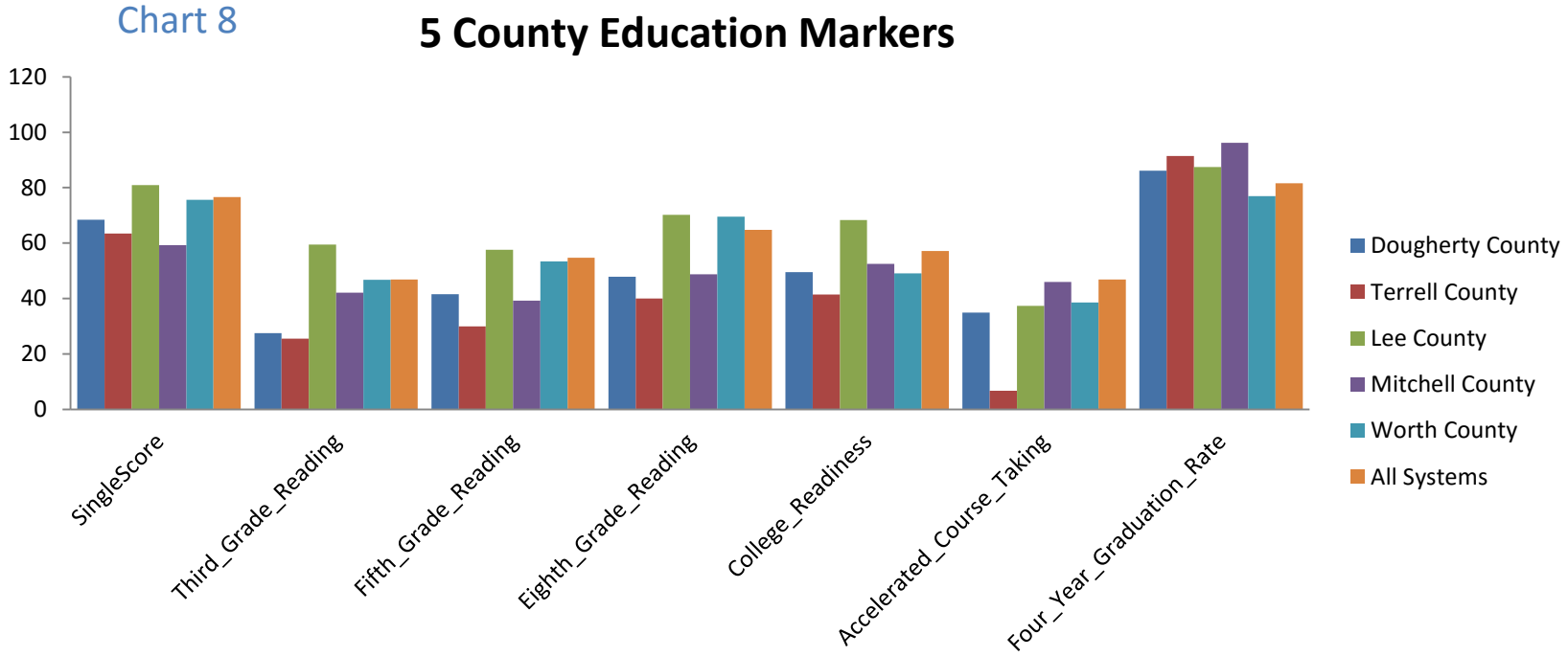
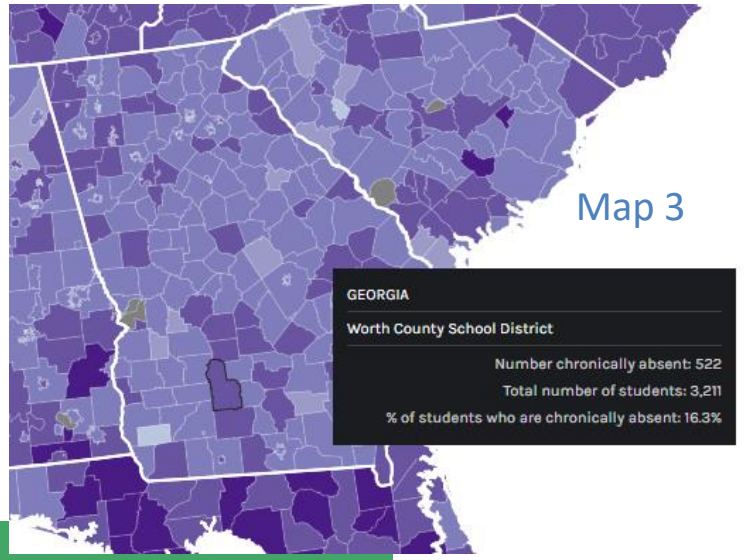


Chart 9	Performed % better than all GA school districts				
	Doughtery	Lee	Mitchell	Terrell	Worth
over all performance	35%	89%	7%	14%	68%
elementary academic growth	38%	34%	46%	24%	76%
middle school academic growth	28%	45%	32%	84%	92%
high school academic growth	40%	95%	6%	92%	21%
	Individual school performance				
3rd grade reading at or above	27.5%	59.5%	42.1%	25.5%	46.8%
8th grade reading at or above	47.9%	70.2%	48.8%	40.0%	69.5%
four-year graduation rate	86.1%	87.5%	96.2%	91.4%	76.9%
college and career ready graduates	49.5%	68.3%	52.5%	41.4%	49.1%

Lee County was the top school, performing better than 89% of all Georgia school districts while Mitchell was the worst, only performing better than 7%. US News recently released High School rankings for the nation showing Lee County with a score of 67%. Mitchell was in the very bottom quartile and therefore not ranked. Their data shows the AP® participation rate at Mitchell County High School is 4%. The total minority enrollment is 91%, and 100% of students are economically disadvantaged. The AP® participation rate at Lee County High School is 27%. The total minority enrollment is 33%, and 38% of students are economically disadvantaged. [chart 9]

Truancy is an early warning sign for a student headed toward school failure and dropping out. Truant students also are at greater risk of drug and alcohol abuse, teen pregnancy and delinquency. Mitchell had the lowest percent absent with 5.3% and Worth had the highest with 16.3%. [Map 3]



Map 3

In the Dougherty school district , truant behavior includes:

- Being absent because of sickness for more than five days without a note from the doctor
- Missing classes without a valid excuse
- Missing whole days of school without a valid excuse
- Frequently being late for school

Chronic absenteeism may prevent children from reaching early learning milestones.	Children who are chronically absent in preschool, kindergarten, and first grade are much less likely to read at grade level by the third grade. Students who cannot read at grade level by the end of third grade are four times more likely than proficient readers to drop out of high school.
Irregular attendance can be a better predictor of whether students will drop out before graduation than test scores.	A study of public school students in Utah found that an incidence of chronic absenteeism in even a single year between 8th and 12th grade was associated with a seven-fold increase in the likelihood of dropping out.
Frequent absences from school can shape adulthood.	High school dropout, which chronically absent students are more likely to experience, has been linked to poor outcomes later in life, from poverty and diminished health to involvement in the criminal justice system.

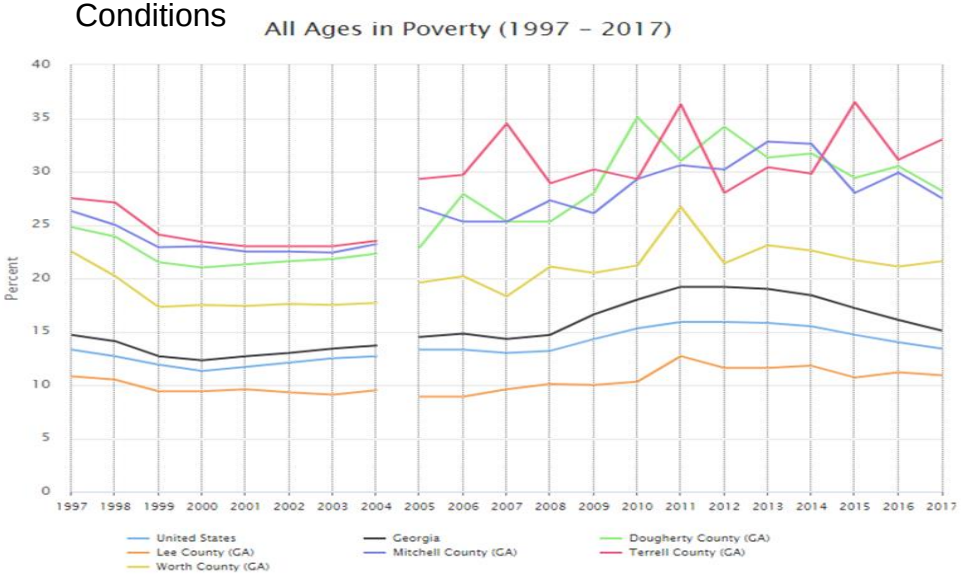
The 500 Cities project is a collaboration between CDC, the Robert Wood Johnson Foundation, and the CDC Foundation. The purpose of the 500 Cities Project is to provide city- and census tract-level small area estimates for chronic disease risk factors, health outcomes, and clinical preventive service use for the largest 500 cities in the United States….Among the 500 largest cities Albany ranked 486.

500 Cities: Local data for better health

A multitude of different social, economic and cultural factors determine a person's health. A growing body of evidence indicates that the keys to improving population-level health are social and economic in nature. These social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age affect a wide range of health, functioning, and quality-of-life outcomes and risks.

5 Key Areas-Social Determinants of health

1. **Economic** Stability — Poverty, Employment, Food Security, Housing Stability
2. **Education** — High School Graduation, Enrollment in Higher Education, Language and Literacy, Early Childhood Education and Development
3. **Social** and Community Context — Social Cohesion, Civic Participation, Discrimination, Incarceration
4. **Health** and Health Care — Access to Health Care, Access to Primary Care, Health Literacy
5. Neighborhood and **Built Environment** — Access to Healthy Foods, Quality of Housing, Crime and Violence, Environmental Conditions

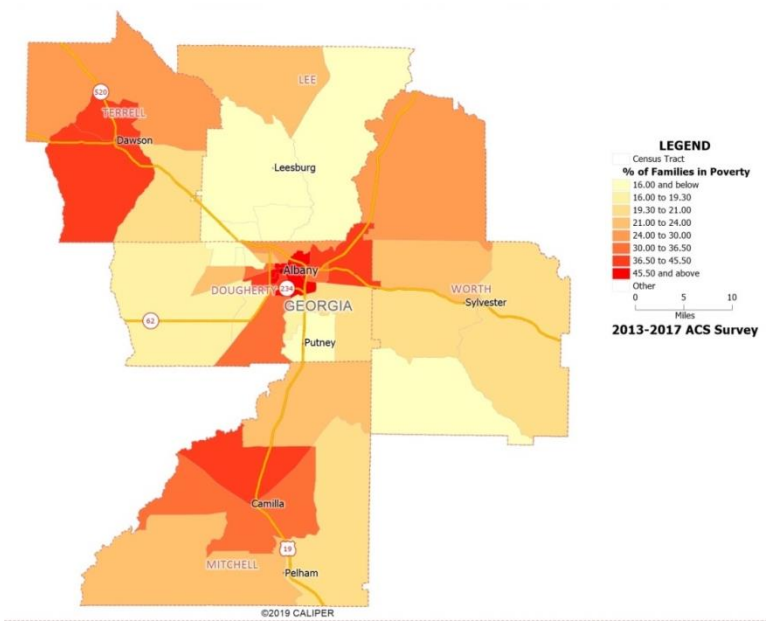


According to the Department of Health and Human Services, the Federal Poverty Line for a family of 4 in 2018 is $25,100. Research suggests that, on average, families need an income of about twice the federal poverty threshold to meet their most basic needs. Children living in families with incomes below this level—$50,200 for a family of four with two children —are referred to as low income. Poverty is both a cause and a consequence of poor health. In our five counties, only one county ranks better than both the US and state average.

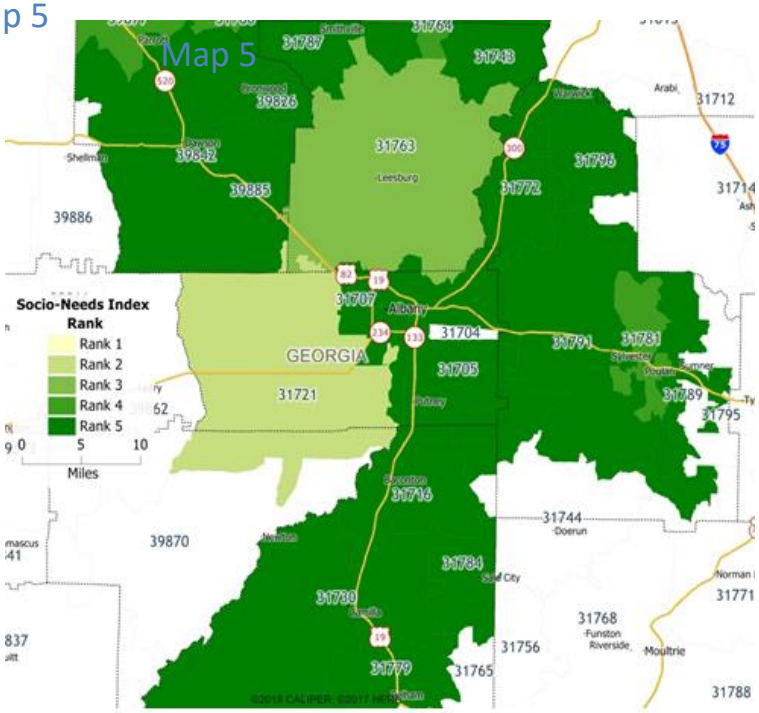
Poverty and Health Outcomes

Nationally, the median percent of people in poverty hovers at 15.9%. Southwest Georgia experiences widespread poverty with just a few tracts of the 52 shown below at or under that threshold [Map 4], mainly in Northwest and West Albany, Putney area, and the majority of Lee County. Research shows that a high poverty rate indicates local employment opportunities are scarce and not sufficient to provide for the community. A decreased buying power and tax base adversely impacts quality schools and business survival. Map 5 shows the socio-needs index, created by HCI-Conduent. The SocioNeeds Index takes factors, which range from poverty to education, and generates an Index Value (from 1-100) for each zip code in the nation. Those with the highest values have the highest socioeconomic need and would have a rank of 5, which majority of ours do.

Map 4



Map 5

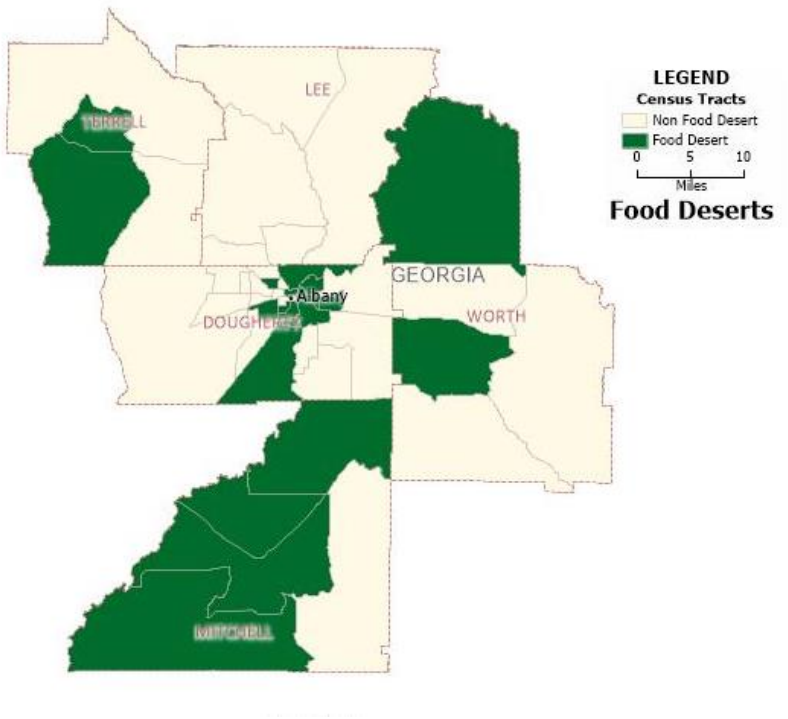


Food Deserts and Swamps

The relationship between where people live and their risk of obesity has led to research on the relationship between one's food environment and health. "Food deserts", defined as residential areas with limited access to affordable and nutritious food, have been suggested as one driver of the obesity epidemic. Living in a food desert has been linked to a poor diet and greater risk of obesity; while people who live near a grocery store are more likely to consume fruits and vegetables and less likely to be obese .

Food deserts are often assessed by measuring the distance between people's homes and supermarkets [Map 6]. Surprisingly, studies evaluating the impact of opening new grocery stores have shown that while perceived access to healthy food improves, diet quality and body mass index (BMI) do not . These findings suggest that the influence of introducing healthier foods into a neighborhood faces a barrier of continued accessibility of unhealthy foods.

Map 6



Food swamps have been described as areas with a high-density of establishments selling high-calorie fast food and junk food, relative to healthier food options. The International Journal of Environmental Research and Public Health studied these two food environments and found that the presence of a food swamp is a stronger predictor of obesity rates than the absence of full-service grocery stores, plus the food swamp effect was stronger in counties with greater income inequality and where residents are less mobile

Single Parent Households

24 million U.S. children younger than 18 are living with an unmarried parent. The map to the right [Map 7] reflects single parent households by census tract and the FRED report [Chart 11] displays the increasing trend in four of our five counties.

The share of children who are living with an unmarried parent varies by race and ethnicity. More than half (58%) of black children are living with an unmarried parent – 47% with a solo mom. At the same time, 36% of Hispanic children are living with an unmarried parent, as are 24% as white children. The share of Asian children living with unmarried parents is markedly lower (13%). [Chart 10]

Map 7

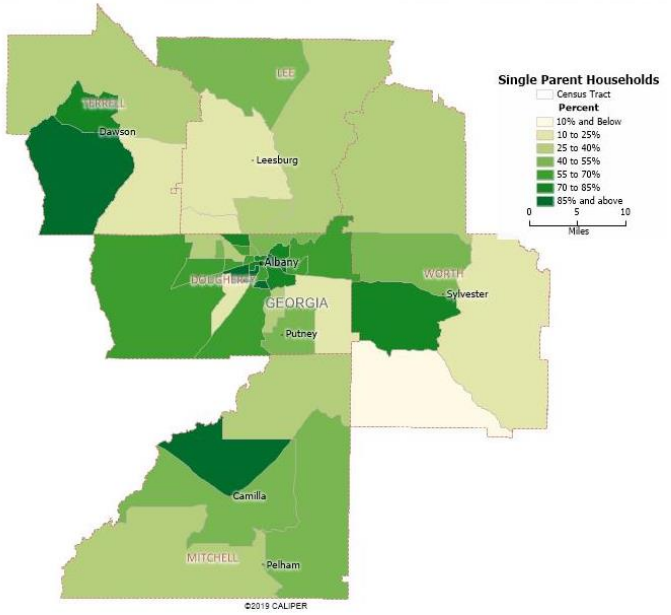


Chart 10

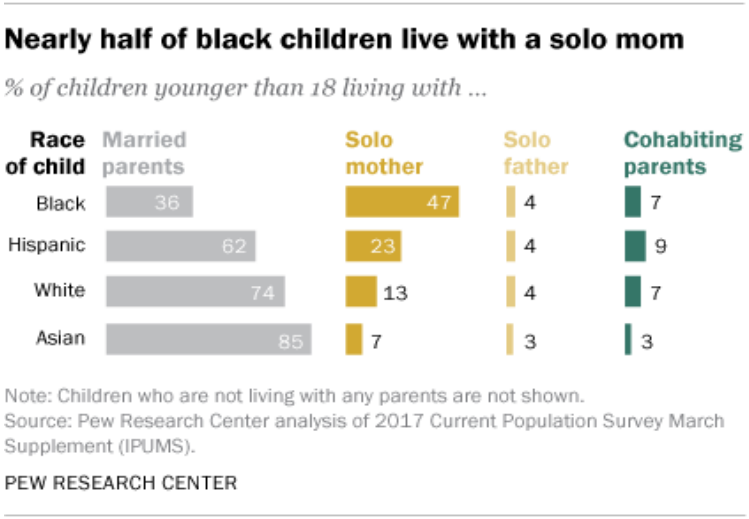
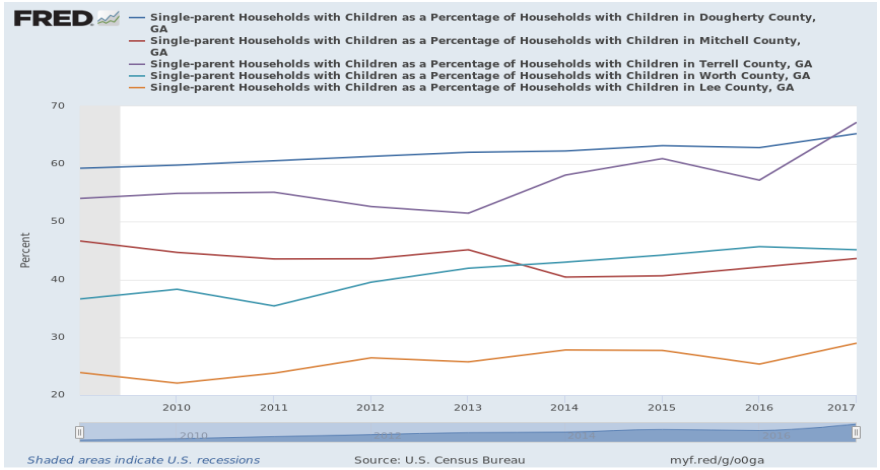


Chart 11



SECTION III: Indicators and Types of Data

Indicator selection was determined by reviewing the Age Adjusted Leading Cause of Death, 2018 hospital Inpatient Discharge data, previous Community Health Needs Assessment, the hospital's Community Health Dashboard, input from key leader interviews and conversations with community and hospital leaders, engagement sessions, and indicators which can be accurately measured using HCI-Conduent Priority Scoring Tool (on the right). There were no comments from the previous assessment received, otherwise, they would have been included in the findings. Phoebe Putney has a response link located in the Community Benefit online landing page. The assessment process included qualitative and quantitative data from both primary and secondary sources. Qualitative data was primarily sourced using key leader interviews (Lee and Worth County), County Level Engagement Session (Dougherty and Worth) to identify gaps in service and priority identification. Careful attention to assure that people and/or organizations representing the broad interest of the community and medically underserved, low income and minority were specifically targeted to participate in the planning and engagement process. Selection process for the Key-Leader Interviews process was directed by District Public Health staff in Worth County and Horizons Community Solutions in Lee County. Hospital-related data originated from Phoebe Decision Support, Quality Improvement, Women's and Children data reports, the Tumor Registry, and the Department of Public Health OASIS web-based data sets.

TOP TEN AGE ADJUSTED LEADING CAUSES OF DEATH-DOUGHERTY COUNTY

Mortality Data in Dougherty County

	County		Value		Target				
					HP20				
Indicator	State	US	State	US	20	Local	Trend	Score	Precision
Age-Adjusted Death Rate due to Diabetes	3	1.5	3	3	1.5		3	2.58	Medium
Age-Adjusted Death Rate due to Prostate Cancer	1.5	3	3	3	3		2	2.53	High
Age-Adjusted Death Rate due to Cancer	2	2	3	3	3		2	2.44	High
Age-Adjusted Death Rate due to Lung Cancer	2	2	3	3	3		2	2.44	High
Age-Adjusted Death Rate due to High Blood Pressure	3	1.5	3	1.5	1.5		3	2.33	Medium
Age-Adjusted Death Rate due to Influenza and Pneumonia	2	1.5	3	3	1.5		2	2.19	Medium
Infant Mortality Rate	1.5	1.5	3	1.5	3		1	1.81	Medium
Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	2	1.5	2	3	3		0	1.75	High
Mortality Ranking	3	1.5	1.5	1.5	1.5		1.5	1.75	Low
Age-Adjusted Death Rate due to Motor Vehicle Collisions	0	1.5	1	1.5	1.5		2	1.28	Medium

Data Source: Health Community Institute-Conduent Priority Scoring Tool, 2019

Top Inpatient Discharges

Phoebe-Albany

Date Range: 01/01/2018 to 12/31/2018

According to an inpatient report extracted from GHA's discharge data warehouse, pulmonary medicine is the top discharge when excluding normal newborns and vaginal deliveries with Cardiology and General Surgery following 2nd and 3rd. Pulmonary discharges coincide with significantly higher age-adjusted hospitalization due to Asthma. Reports from the school nurse program suggest a high asthma rate among school aged children. High Neurology accounts for the 5th highest number of discharges reflective of the region's relatively high age-adjusted death rate due to Cerebrovascular Disease (Stroke) and even higher stroke incidence rate.

Care Service Line	Discharges
Newborn	2225
Pulmonary Medicine	1797
Obstetrics	1777
Cardiology	1613
General Surgery	1324
Neurology	1229
Gastroenterology	1103
General Medicine	1083
Infectious Disease	841
Psychiatry	789

PQI Condition	Discharges	ALOS Index	Comp Index	Mort Index	Readmit SES Index
O A Asthma	3,688	1.28	1.07	1.28	1.12
Y A Asthma	33	1.60	0.00	0.00	0.00
Hypertension	6,811	1.24	0.88	1.21	1.21
Dehydration	3,963	1.44	1.25	1.64	1.22
UTI	1,826	1.52	1.46	1.08	1.14
LT Diabetes	233	0.94	0.76	3.23	2.11
ST Diabetes	178	1.17	0.00	5.90	1.17
LE Amp	126	0.79	1.46	1.21	2.34
Uncontrolled	101	1.21	0.00	3.45	1.69

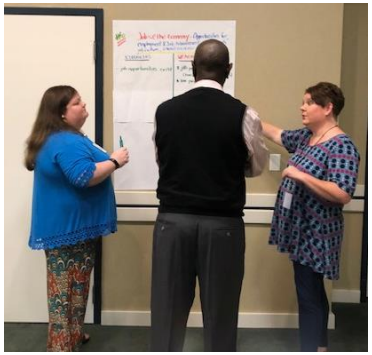
Calendar Year 2018

(PQIs) are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions". These conditions are potentially avoidable with timely outpatient care. Data pulled by Phoebe's quality team are compared to all other hospitals of our type in the State of Georgia. An index of 1 or less is desirable.

Data Source: Jim Franklin, Quality PPMH. 2019

ALOS- Average Length of Stay
Comp Index- Complexity Index
Mort Index- Mortality
Readmit Index- Readmissions

Section IV: Community **Engagement** & Priority Identification



John Howard, City Commissioner
Karen Hills, Network of Trust, RN PPMH*
Shawnae Motley, United Way of SWGA, CEO
Michael Persley, Chief of Police-Albany GA
Babs Hall, Aspire BHDDS, Corporate Compliance Officer*
Joffe Wright, DPH, YDC*
Lisa Spears, Aspire BHDD, CCO*
Harriet Hollis, DCSS, YA/UBL Coordinator*
Angela Patterson, NAMI-Albany*
Cheryl Vinson, Family Literacy Connection*
Jacquelyn Teemer, Downtown Business Development Manager
Jacqueline Jenkins, SWHD-DPH, Epidemiologist
Vamella Lovett, Dougherty County Health Department*
Jimmy Bennett, DBHDD-Region 4, Transition Coordinator
Vicki Phillips, Albany State University, Student Health Director
Shannon Rodgers, YMCA, Chief Development and Marketing Office
Samantha Helton, YMCA, Membership Director
Rachael Holloman, DBHDD-Region 4, TC
Jay Sharpe, U-Save-It Pharmacy, Public Relations
Lisa Schexnayder, PPMH, OP Behavioral Health Manager
Carl White Jr. Friendship Baptist Church, Senior Pastor

Engagement Meeting-Gallery Walk Results 4-10-2019

Community Identified Health & Health Related Issues:

- ✓ Inpatient Child and Adolescent Crisis Stabilization Unit
- ✓ C&A Psychiatrist
- ✓ Intermediate Inpatient Crisis Stabilization Unit
- ✓ Pediatric Dentistry
- ✓ Endocrinologists
- ✓ Nursing Staff Shortage
- ✓ Medicaid Expansion
- ✓ Transportation to Healthcare Visits & Work
- ✓ Homelessness
- ✓ Affordable and Quality Childcare
- ✓ Obesity
- ✓ Metabolic Syndrome [Diabetes, High Blood Pressure]
- ✓ Addiction
- ✓ Food Deserts
- ✓ Teen Pregnancy
- ✓ Mental Health
- ✓ Quality Affordable Housing
- ✓ Community Resource Center

Section IV: Community Engagement & Priority Identification

Identified Significant Health Issues and/or Community Conditions

Workforce Development

Health and Wellness

Behavioral Health

Quality, Affordable Housing

Healthcare Access

Community Education and Awareness

Crime and Prevention

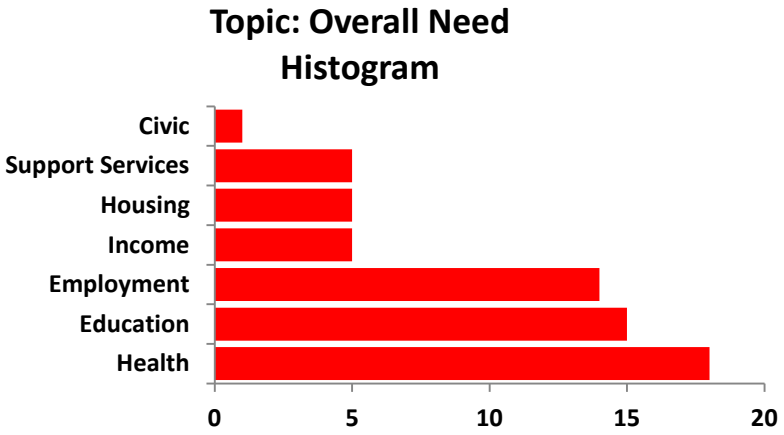
The Community Input Session

Methodology

The participant list was drafted by the internal work team members. Phoebe Putney Memorial Hospital and its partners completed a Community Input Session using elements of MAPP (Mobilizing Action through Planning and Partnerships-"**Community Themes and Strengths**") assessment in early spring of 2019 as part of the Community Health Needs Assessment process. The **Community Themes and Strengths Assessment** provide a deep understanding of the issues that organizations and residents feel are important by answering the questions: "What is important to our community?" "How is quality of life perceived in our community?" and "What assets do we have that can be used to improve community health?" The methodology used in conducting the Community Input Session was the "Technology of Participation" gallery walk and consensus workshop approach . The consensus workshop key question to explore was "What are the most significant health issues and/or community conditions facing our area at this time.? Ebonee Kirkwood, Department of Public Health led the Gallery Walk and Kimberly Scott and Denise Ballard both from Horizons Community Solutions facilitated the Consensus Workshop.

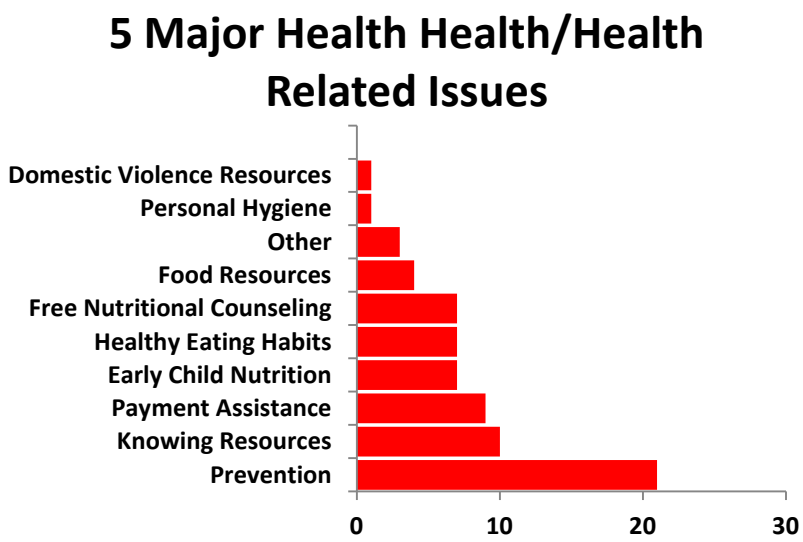
Responses by Engagement Participants to selected questions from a Community Health Survey

Engagement Meeting Questionnaire



5 Major Overall Needs

- **Health**
- **Education**
- **Employment**
- **Income**
- **Housing**



5 Major Health or health related issues

- **Prevention Services**
- **Knowledge of Health Resources**
- **Payment Assistance**
- **Early Child Nutrition**
- **Healthy Eating Habits**

Health concerns facing the community include healthcare Costs, cancer, obesity, diabetes, tobacco use and drug abuse.

Lee County Interviewees

- Tony Goodman, retired military, employee of Marine Corp Logistics Base & concerned citizen
- Dana Hager, RN, Director, Lee County Health Department
- Jennifer Johnston, Lee County Housing Authority Board of Commissioners & parent/concerned citizen
- Claire Leavy, Director, Lee County Library
- Dr. Jason Miller, Superintendent, Lee County Schools
- Rick Muggridge, Vice Chairman, Lee County Board of Commissioners
- Dr. Rhonda Porter, College of Professional Studies, Teacher Education Interim Chair, Albany State University & parent/concerned citizen
- Jim Quinn, Mayor and publisher of the Lee County Ledger weekly newspaper
- Marteen Quiros, parent/concerned citizen
- Patsy Shirley, Executive Director, Lee County Family Connection
- J.K. Veluswamy, small business owner
- Danielle Willis, concerned citizen and employee of the Marine Corp Logistics Base

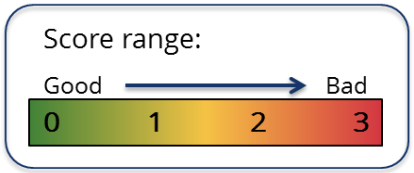
5 Healthcare Related Themes

- Access to healthcare for the uninsured and availability of providers
- High costs of health insurance and out of pocket expenses. Complicated billing practices make understanding true costs difficult
- The health effects of pesticide exposure to both those who work in agriculture and to those living in subdivisions built on top of land previously used for farming
- Poor diet, combined with high cost, lack of availability of nutritious food contributes to high rates of obesity and diabetes within the community. Lack of safe places to engage in physical activity. Gyms and YMCA
- Tobacco use continues to be a health concern. New concerns are being raised about the use of electronic cigarettes, especially among teenagers.
- Availability of mental health services for all ages.

PRIORITY SETTING

*Hospital staff pre-met with Dr. Jim Hotz, a nationally recognized expert in Population Health, to review and recommend to the **Selection Team** identified community need using Healthy Communities Institute Priority Setting Tool and Catholic Health Association Selection Filter. The Pre-selection team recommended Birth outcomes and reproductive responsibility, cervical cancer, Behavioral Health and Diabetes for consideration.*

For each indicator, your county is assigned a score based on its comparison to other communities, whether health targets have been met, and the trend of the indicator value over time. These comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities, and changes in methodology over time.



Comparison to a Distribution of County Values: Within State and Nation

For ease of interpretation and analysis, indicator data on the Community Dashboard is visually represented as a green-yellow-red gauge showing how the community is faring against a distribution of counties in the state or the United States. A distribution is created by taking all county values within the state or nation, ordering them from low to high, and dividing them into three groups (green, yellow, red) based on their order. Indicators with the poorest comparisons ("in the red") scored high, whereas indicators with good comparisons ("in the green") scored low.

Comparison to Values: State, National, and Targets

Your county is compared to the state value, the national value, and target values. Targets values include the nation-wide Healthy People 2020 (HP2020) goals as well as locally set goals. Healthy People 2020 goals are national objectives for improving the health of the nation set by the Department of Health and Human Services' (DHHS) Healthy People Initiative. For all value comparisons, the scoring depends on whether the county value is better or worse than the comparison value, as well as how close the county value is to the target value.

Compared to State or National Value

Compared to Health People 2020 Target

Dougherty

County: Dougherty
Phoebe Putney Hospital
Total indicators: 139
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Indicator	County State	County US	Value State	Value US	Target HP2020	Trend	Score	Precision
Alzheimer's Disease or Dementia: Medicare Population	3	3	3	3	1.5	3	2.83	High
Homeownership	3	3	3	3	1.5	3	2.83	High
People 65+ Living Alone	3	3	3	3	1.5	3	2.83	High
Severe Housing Problems	3	3	3	3	1.5	3	2.83	High
Colorectal Cancer Incidence Rate	3	3	3	3	3	2	2.78	High
Adults who Smoke	3	3	3	3	3	1.5	2.67	High
Liquor Store Density	3	2	3	3	1.5	3	2.67	High
Stroke: Medicare Population	3	3	3	3	1.5	2	2.61	High
Students Eligible for the Free Lunch Program	3	3	3	3	1.5	2	2.61	High
Age-Adjusted Death Rate due to Diabetes	3	1.5	3	3	1.5	3	2.58	Medium

Lee

County: Lee
Phoebe Putney Hospital
Total indicators: 132
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Indicator	County Distribution State	County Distribution US	Value State	Value US	Target HP2020	Local	Trend	Score	Precision
Age-Adjusted Death Rate due to Breast Cancer	3	3	3	3	3		2	2.78	High
Colorectal Cancer Incidence Rate	3	3	3	3	3		2	2.78	High
Age-Adjusted Death Rate due to Lung Cancer	3	3	3	3	3		1.5	2.67	High
Rheumatoid Arthritis or Osteoarthritis: Medicare Population	2	3	3	3	1.5		3	2.67	High
Oral Cavity and Pharynx Cancer Incidence Rate	3	3	3	3	1.5		2	2.61	High
Osteoporosis: Medicare Population	3	3	3	3	1.5		2	2.61	High
Social Associations	3	3	3	3	1.5		2	2.61	High
All Cancer Incidence Rate	3	3	3	3	1.5		1.5	2.50	High
Food Insecure Children Likely Ineligible for Assistance	3	3	3	3	1.5		1.5	2.50	High
Alcohol-Impaired Driving Deaths	3	2	3	3	1.5		2	2.44	High

Here is a sample of Healthy Communities Institute Data Scoring tool. These tables show Dougherty and Lee Counties' top ten Worse Health or Health related outcome indicators. The filled colors go from green (best) to a caution yellow followed by red(worst). The numerical score is calculated using an algorithm. The Precision measures the accuracy of the Indicator Score. Dougherty County's complete workbook will be displayed in the Appendix and other workbooks in our Primary Service Area can be sent upon request.

Section V: Priority Selection

CATHOLIC HEALTH ASSOCIATION RECOMMENDATION SELECTION FILTERS

Magnitude. The magnitude of the problem include the number of people impacted by the problem.

Severity. The severity of the problem includes the risk of morbidity and mortality associated with the problem.

Historical Trends.

Alignment of the problem with the organizations strengths and priorities.

Impact of the Problem on Vulnerable Populations.

Importance of the problem to the community.

Existing Resources Addressing the Problem.

Relationship of the Problem to other Community Issues.

Feasibility of change, availability of tested approaches.

Value of Immediate Intervention vs. any delay, especially for long-term or complex threats.

Facilitated by the project lead, the selection committee reviewed potential priorities using the HCI-Conduent Priority Tool, previous CHNA, input sessions and using the Catholic Health Association Recommendation Strategic Selection Filter. Listed below are the four priorities recommended by the Selection Committee for Phoebe board approval on July 10, 2019.

Recommendation

1. ***Birth Outcomes and Reproductive Responsibility***
2. ***Diabetes Management and Prevention***
3. ***Behavioral Health and Addictive Disease Advocacy***
4. ***Cancer Prevention and Treatment***

Selection Committee

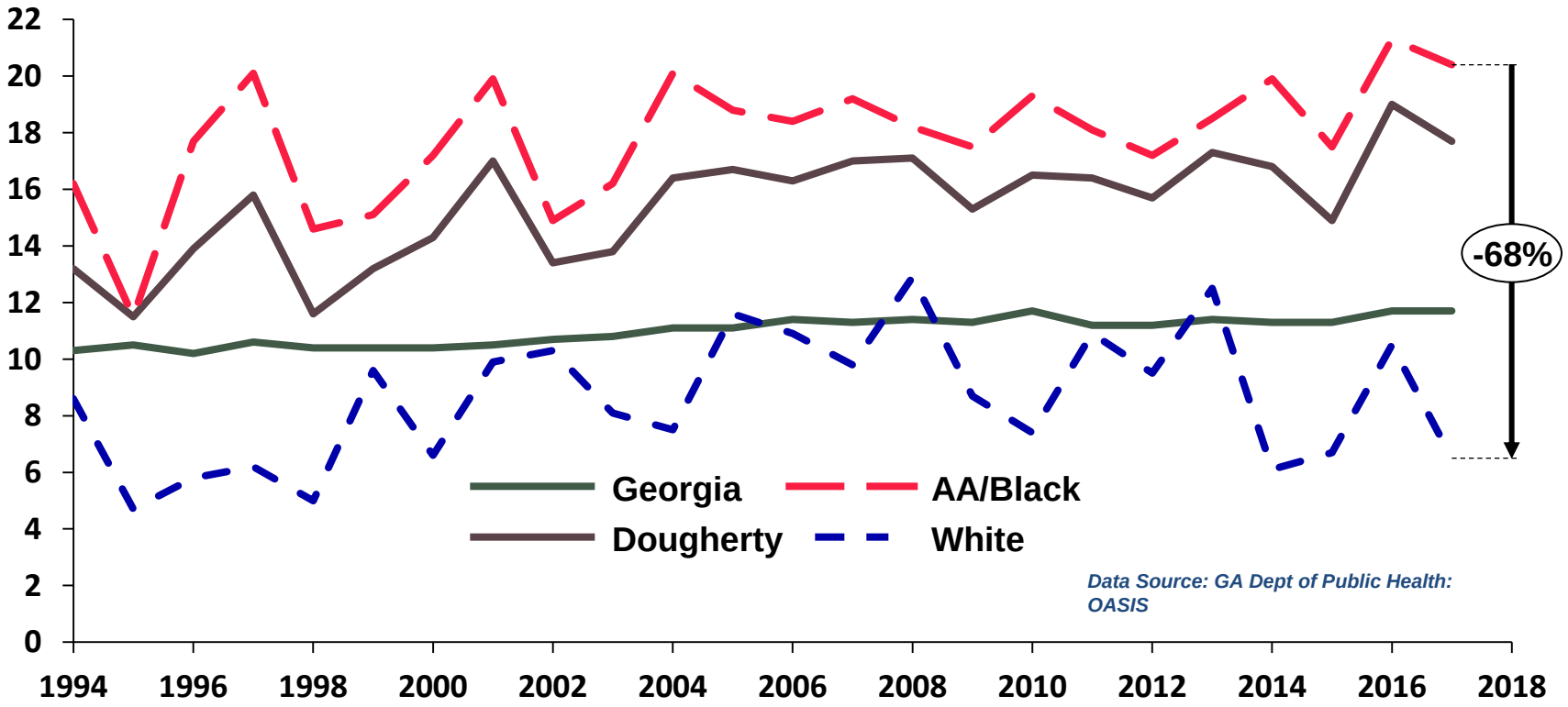
John Culbreath- Ph.D., PPMH Board Chair**, Tary Brown-** Retired CEO AAPHC**, Joe Austin-**COO**,** Phoebe Putney Health System**, Dr. Jim Hotz M.D.-** AAPHC***, Brian Church-**CFO, Phoebe Putney Health System**, Evelyn Olenick-** SVP and CNO, PPMH**, Dr. Derek Heard, M.D.-**Medical Director for Primary Care

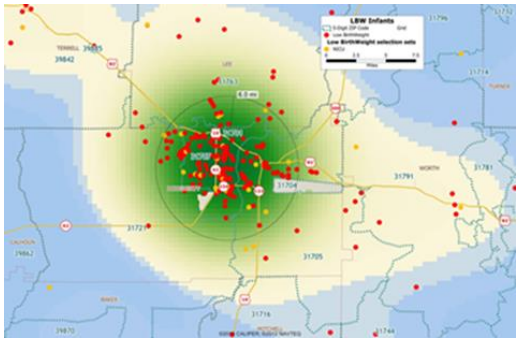
** Represents Low Income, Medically Underserved, and Minority Populations*

PRIORITY I: *Improving Birth Outcomes and Reproductive Responsibility*

Low and Very Birth Weight Infants
1994 thru 2017
Dougherty County

Since 1994 not much as changed in the percent of low birth weight infants born in Dougherty County. While state trend line ebbs upward, the gap between the state and county widen as the gap between black and white infants in Dougherty County. Almost 1in 4 black infants are born with low birth weight which is three times the white infant percentage.





DOT DENSITY MAP OF LOW AND VERY LOW BIRTHWEIGHT INFANTS—18 months thru January 2018

Number of Births

2017	White		AA/Black		All Others	
	LBW	VLBW	LBW	VLBW	LBW	VLBW
Dougherty	16	3	169	27	0	1
Lee	16	2	16	3	2	
Mitchell	8	2	19	6	2	1
Terrell	2	0	7	3	0	0
Worth	17	0	14	0	0	0
Summary	**59**	**7**	**225**	**39**	**4**	**2**

Source: Georgia Department of Public Health, Office of Health Indicators for Planning

Percent of Births

2017	White		AA/Black		All Others	
	LBW	VLBW	LBW	VLBW	LBW	VLBW
Georgia	7.3	1.2	14.3	3	9.3	1.3
Dougherty	6.5	*	17.6	2.8		
Lee	6.6	*	21.1	*		
Mitchell	6.8	*	12.3	3.9		
Terrell	*	0	11.7	*		
Worth	11.6	0	17.7	0		
County TOT	**7.4**	**0.9**	**17**	**2.9**	**11.1**	*

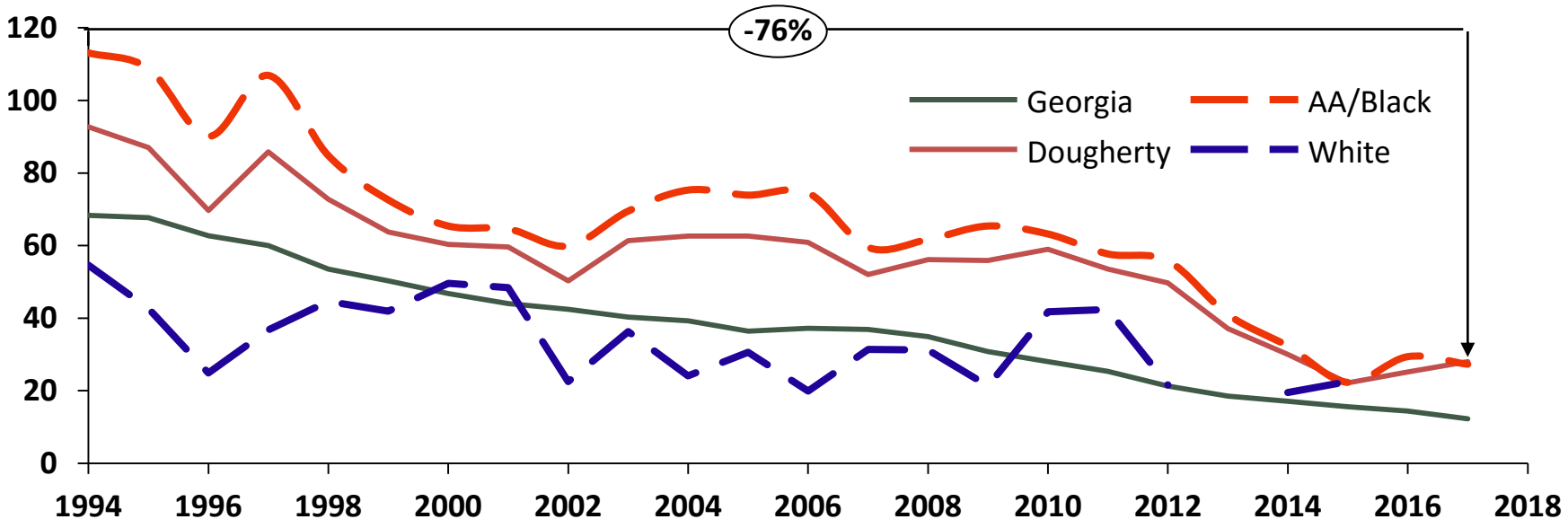
**** Less than 5 occurrences are not calculated***

Source: Georgia Department of Public Health, Office of Health Indicators for Planning

WHY IT'S IMPORTANT

- ***The percentage of births that are Low Birth Weight [LBW] is one of the most widely used indicators of population-level health around the globe, and reducing LBW is a common public health policy objective.***
- ***Is associated with worse health outcomes over the entire life course.***
- ***LBW infants are more likely to suffer from chronic conditions such as asthma, high blood pressure and compromised cognitive development.***
- ***The disadvantage from LBW persists into adulthood, with lower weight individuals scoring lower on IQ tests at age 18, attaining less education, and earning less income than their peers.***
- ***It is estimated that raising the birth weight of a LBW infant by even a half pound saves an average of more than $28,000 in first year medical expenses alone.***
- ***The average cost of Medicaid Services for the first four years of life of a very low birth weight infant is $62,000 compared to $7,000 for a normal weight infant.***

TEEN PREGNACY AGE 15 TO 17: 1994 TO 2017-*Rate Per 1000 Teens*



Teen Pregnancy has drastically decreased since 1994. The biggest driver in this decline is the three-hold decrease in Teen Pregnancy among AA/Black teens and a two-fold decrease among white teens. While above the state average, the 15-17 rate is well below the World Health Organization targeted benchmark.

teen pregnancy age 15 to 17

2017	White		AA/Black		All Others	
	Number	Rate	Number	Rate	Number	Rate
Georgia	1112	9.5	1294	16.8	199	11.6
Dougherty	10	38.8	37	27.3	0	0
Lee	2	*	5	39.9	0	0
Mitchell	3	*	3	*	0	0
Terrell	0	0	3	*	0	0
Worth	4	*	3	*	2	0
County TOT	**19**	**15.5**	**51**	**26.5**	**2**	*

**** Less than 5 occurrences are not calculated***

Source: Georgia Department of Public Health, Office of Health Indicators for Planning

REPEAT PREGNANCY AGE 18-19: 1994 TO 2017-*Percent of Pregnancies*

Although teen birth rates have been falling for the last two decades, more than 365,000 teens, ages 15–19, gave birth in 2010. Teen pregnancy and childbearing can carry high health, emotional, social, and financial costs for both teen mothers and their children. Teen mothers want to do their best for their own health and that of their child, but some can become overwhelmed by life as a parent. Having more than one child as a teen can limit the teen mother's ability to finish her education or get a job. Infants born from a repeat teen birth are often born too small or too soon, which can lead to more health problems for the baby.
Repeat teen births can be prevented.

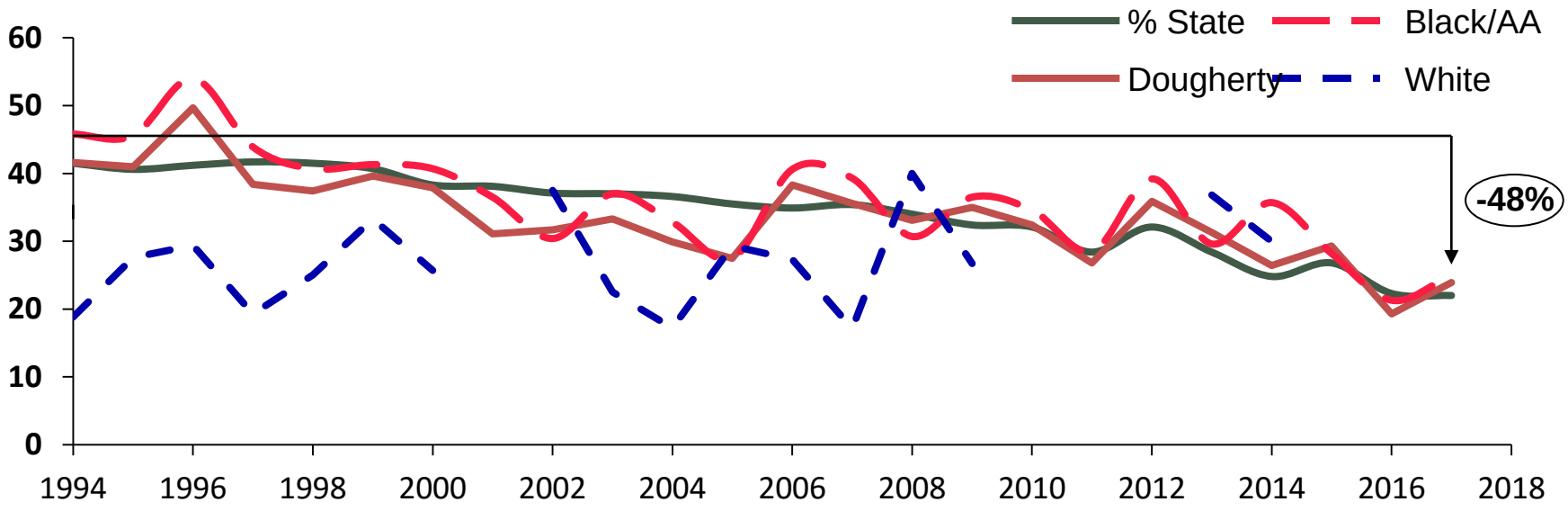
Source:
www.cdc.gov/vitalsigns/teenpregnancy/index/html

repeat pregnancy age 18 to 19

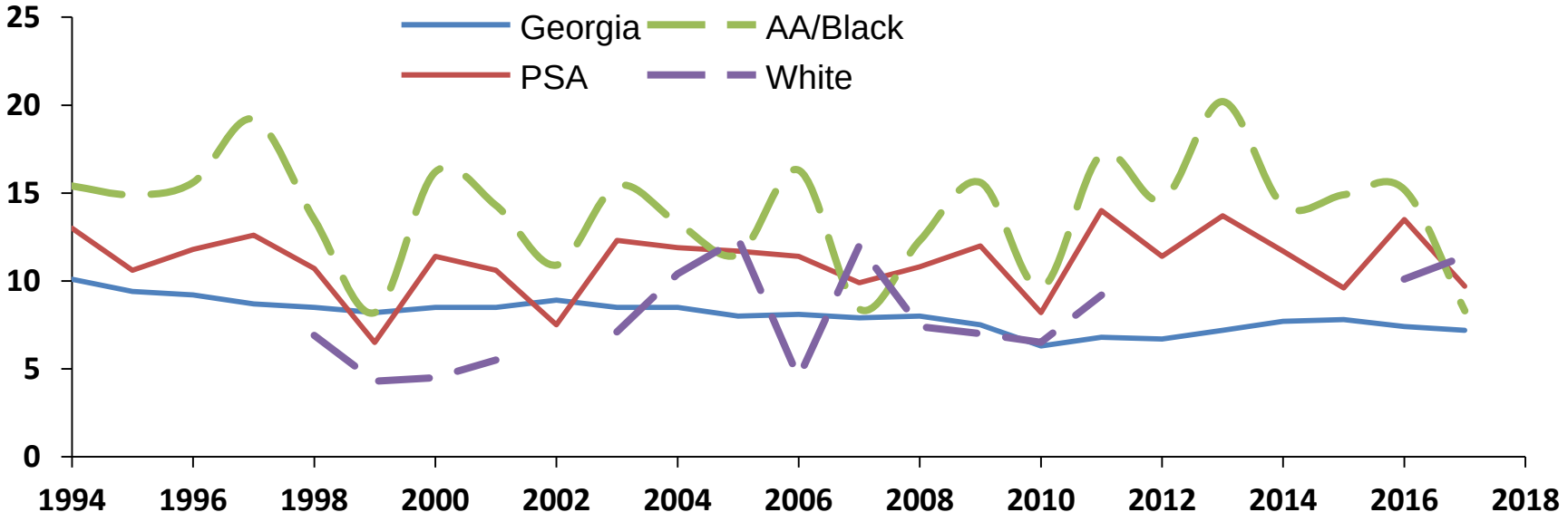
2017	White		AA/Black		All Others	
	Number	Rate	Number	Rate	Number	Rate
Georgia	754	20.6	790	23.2	130	24.20
Dougherty	2	*	21	21.9	0	0.00
Lee	2	*	1	*	0	0.00
Mitchell	4	*	2	*	0	0.00
Terrell	0	0.0	3	*	0	0.00
Worth	1	*	1	*	0	0.00
County TOT	**9**	**20.5**	**28**	**21.2**	**0**	**0.00**

**** Less than 5 occurrences are not calculated***

Source: Georgia Department of Public Health, Office of Health Indicators for Planning



INFANT MORTALITY RATE: 1994 TO 2017



Infant mortality is the death of an infant before his or her first birthday. The infant mortality rate is the number of infant deaths for every 1,000 live births. In addition to giving us key information about maternal and infant health, the infant mortality rate is an important marker of the overall health of a society. In 2017, the infant mortality rate in the United States was 5.8 deaths per 1,000 live births.

Source: www.cdc.gov/reproductivehealth/maternalinfanthealth

infant mortality rate

2017	White		AA/Black		All Others	
	Number	Rate	Number	Rate	Number	Rate
Georgia	354	4.8	529	11.6	49	5.10
Dougherty	3	*	9	9.4	0	0.00
Lee	4	*	0	0	1	*
Mitchell	2	*	2	*	0	0.00
Terrell	0	0.0	0	0	0	0.00
Worth	0	*	0	0	0	0.00
County TOT	**9**	**11.4**	**11**	**8.3**	**1**	*

**** Less than 5 occurrences are not calculated***

Source: Georgia Department of Public Health, Office of Health Indicators for Planning

Priority I: Birth Outcomes and Reproductive Responsibility—Community Assets

Phoebe Putney Memorial Hospital provides a full service labor and delivery unit and includes:
(1) 10 Suites for routine delivery
(2) High risk pregnancy monitoring, 2 ante-partum suites, 2 caesarian birthing suites, Mother/baby Unit, Neo-natal Intensive Care Unit, Network of Trust, and a Neonatal Outreach and Maternal Outreach Education program.

- PPMH is also designated as a Regional Perinatal Center by the State of Georgia, providing the most advanced care for high risk mothers and infants.
- In 2018, Phoebe added an OB/GYN hospitalist program and earned a "Baby-Friendly " designation. A process that took 5 years of training in lactation support and new practices of skin-to-skin contact after birth, and leaving the baby with the mother at all possible times.

Albany Area Primary Health Care offers birthing classes quarterly to provide information for expectant parents on the child birth process, breastfeeding, newborn care, and pediatrics.

District Public Health offers

- Centering , a group model of prenatal care with ten weekly 2-hour sessions located at the Dougherty County Health Department. During Centering appointments, eight to 12 women with similar due dates meet with each other and a designated health practitioner to access health assessments, education and peer support. Studies show that group prenatal care reduces premature birth, results in higher birth-weight babies and increased breastfeeding.
- Women, Infants and Children (WIC) program services women who are pregnant, non-lactating up to six month postpartum, and lactating up to twelve months postpartum, and children up to five years of age who are at nutritional risk.
- Family Planning services are designed to support families in planning and spacing their children to improve the heath of women so that with pregnancy the potential for a healthy outcome for the mother and child is improved. They offer LARC (Long Acting Reversible Contraceptives) procedures free of charge to those unable to pay to approximately 500 women in the health district.
- Perinatal Case Management connects low-income pregnant women to health care providers for prenatal care, assists the expectant mother with obtaining the services of a pediatrician in preparation for delivery and follows an established plan with periodic reassessment to identify support services needed throughout the pregnancy.
- Acute, Chronic and Infectious Disease Program provides HIV/AIDS counseling, testing and referral services and oversees testing, treatment and management of common STD's as well as prevention education.

Priority I: Birth Outcomes and Reproductive Responsibility—Community Assets

- Well women- Provides **Preventive** WH screenings to women that do not need contraception and that do not qualify for BCCP
- PrEP- Pre-exposure Prophylaxis -prevents HIV infection in high risk individuals by providing medication that is taken daily
- STD- screening, testing and treatment for sexually transmitted diseases

Department of Community Health offers the Planning for Health Babies Program (P4HB), to women uninsured, or underinsured . P4HB was designed to improve Georgia's very low birth weight (VLBW) and low birth weight (LBW) rates and consists of three services:

- Family planning
- Inter-pregnancy care (IPC) (for those with a previous VLBW delivery)
- Resource Mother (care management) (for those with a previous VLBW delivery)

Parent to Parent of Georgia 1st Care program, offers in-home visits for families with high-risk infants with conditions identified in the newborn period or who have been discharged from a Neonatal Intensive Care Unit(NICU). They provide continued screening, nursing assessments, interventions, follow-ups and referrals.

The Alpha Pregnancy Center provides free counseling, pregnancy testing, ultrasound and support and personalized education including healthy pregnancy and parenting. The Center provides support to women of all ages and from all walks of life who may be pregnant and are possibly facing difficult decisions.

The Boy's and Girl's Club of Albany, GA uses Smart Moves which is a prevention based program that addresses the tough issues of drug and alcohol use and premature sexual activity. The program is designed to promote abstinence from substance abuse and adolescent sexual involvement.

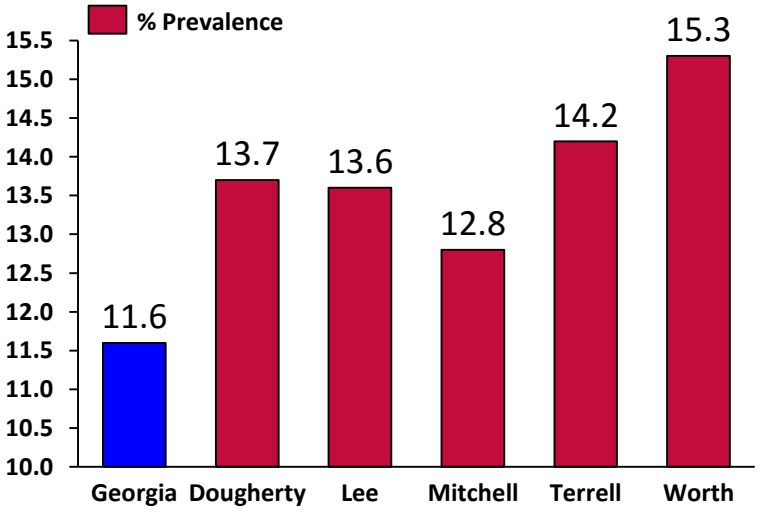
Girls Inc. Preventing Adolescent Pregnancy is a knowledge and skills based program designed to teach girls how to take charge of and make informed decisions about their sexual health.

Phoebe's Network of Trust provides teen pregnancy and parenting classes in the high schools to pregnant teens age 15-19. Phase 1 is Pre-natal and Phase II is Parenting with Phase III case management after the infant is born. The NOT team uses the "Making a Difference" curriculum aimed at decreasing the number of teams who become pregnant. Along with many community partners, host an annual Teen Maze geared that replicates real life choices in a simulated environment.

Priority II: Preventing and Managing Diabetes

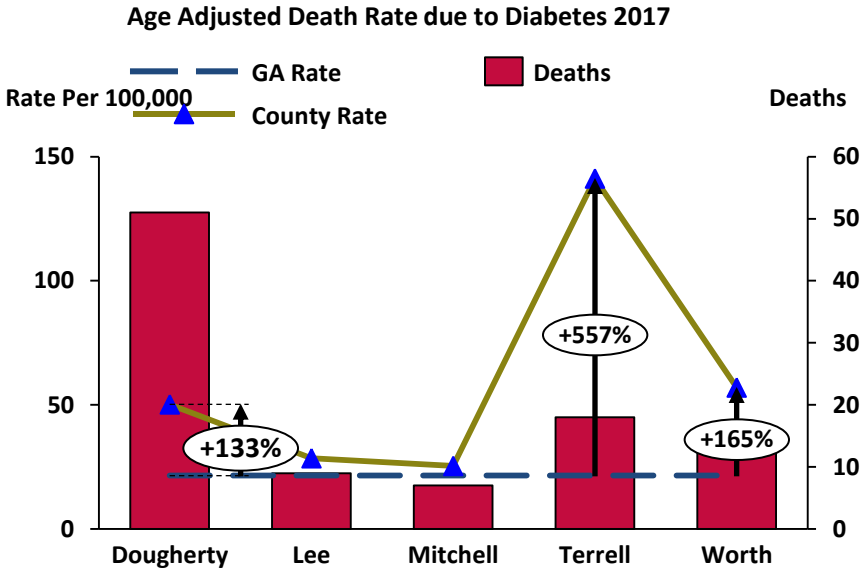
Compared to State Average, all five counties in the Primary Service Area had higher diabetes prevalence rates. While all counties had a higher age-adjusted death rate compared to the Georgia average, Dougherty and Worth rates were 2 to 3 times higher with Terrell **7** times higher than the State Average. In 2017, Blacks/AA are more than twice as likely to die from diabetes than whites.

Prevalence of Diabetes Among Adults Age 20 or older-2015

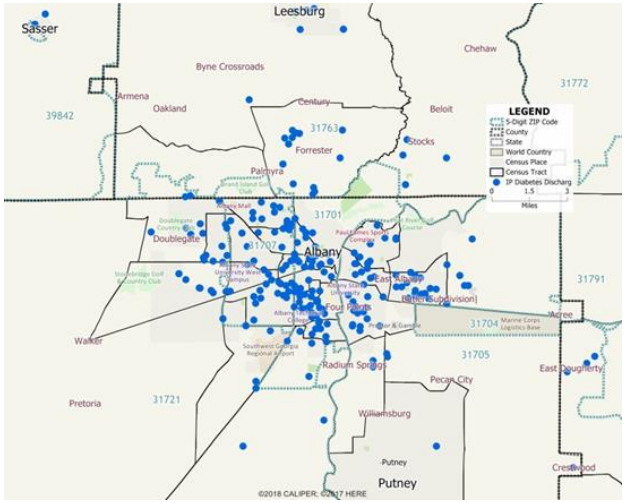


Data Source: Centers for Disease Control and Prevention

Age Adjusted Death Rate due to Diabetes 2017



Date Source: Georgia Department of Public Health, Oasis, 2016



The heat map to the right shows all Phoebe-Albany Inpatient Discharges from diabetes including Lower Extremity Amputations due to diabetes for fiscal Year 2018. The Hotspot follows the same pattern as Low Birth Weight Infants with concentration in zip codes 31701 and 31705. The same Zip Codes with the worst SocioNeeds Index that correlates with low health outcomes.

WHY IT'S IMPORTANT

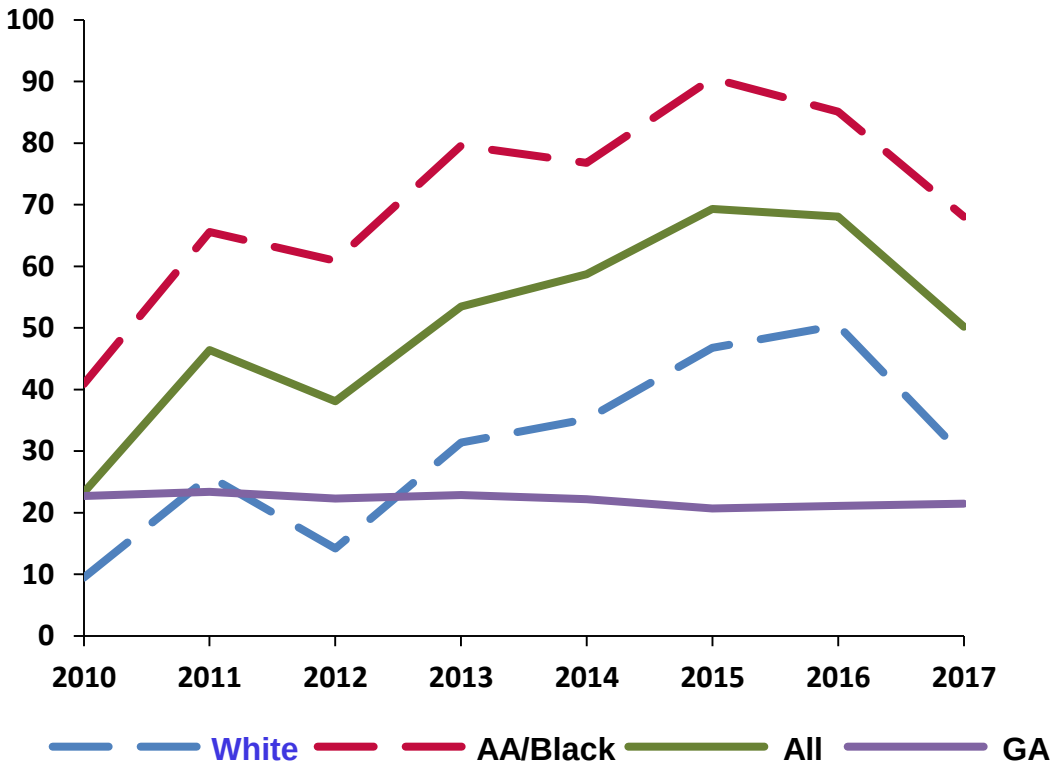
Diagnosed diabetes costs an estimated $11 billion in Georgia each year.
The serious complications include heart disease, stroke, amputation, end-stage kidney disease, blindness—and death.

GEORGIA'S DIABETES EPIDEMIC:

Approximately **1,111,000 people in Georgia,** or 13.9% of the adult population, **have diabetes.**

- Of these, an estimated **241,000 have diabetes but don't know it,** greatly increasing their health risk.
- In addition, **2,599,000 people in Georgia,** 36.1% of the adult population, **have prediabetes** with blood glucose levels higher than normal but not yet high enough to be diagnosed as diabetes.
- **Every year** an estimated **50,000 people in Georgia** are diagnosed with diabetes.

Dougherty County
Age Adjusted Death Rate due to Diabetes by Race
2010 to 2017



Dougherty County death rate due to diabetes is more than twice the State Average in 2017 and AA/Black rate is more than twice of whites.

Source: www.oasis.state.ga.us

Southwest Georgia Diabetes Coalition has three strategies, with accomplishments in each during 2018.

1. Working towards adopting and coordinating standards of Care and Resources
    - Tabulated number of A1c of pre-diabetes age 18 and older, completed pre-diabetes cohort study, strategy and planning hired a grant writer, created and developed a physicians workgroup for standardized care, and hired a diabetes management navigator.
2. Promoting and increasing awareness of healthy lifestyle
    - Developed and launched a Multi-prong Media campaign, created a Voucher program with local farmers, created Wellness policies in churches, at-risk population participated in a CDC Prevention program.
3. Advocating for health policies
    - Established relationships with Policy Makers, and completed a White paper coordinated with Residency program.

Georgia Dept. of Public Health(DPH) was approved for two grants 1815 and 1817 to implement a Medicare/diabetes Prevention program(DPP) for the community with eligible reimbursements, providing lifestyle coaches with tele-health capabilities, and creating community pharmacy relationships to offer the DPP to their qualifying patrons.

Phoebe Putney Memorial Hospital provides a full suite of services through the hospital's diabetes education program.

The Veranda offers an array of services to those with diabetes, including monitoring numbers, meal planning, healthy dining out options, carb counting, exercise, and travel, foot care and eye care, managing sick days, low blood sugar and complications.

YMCA offers a Diabetes Prevention Program and is a heart healthy ambassador partnering with DPH. This small-group program helps people with pre-diabetes eat healthier, increase their physical activity and lose weight.

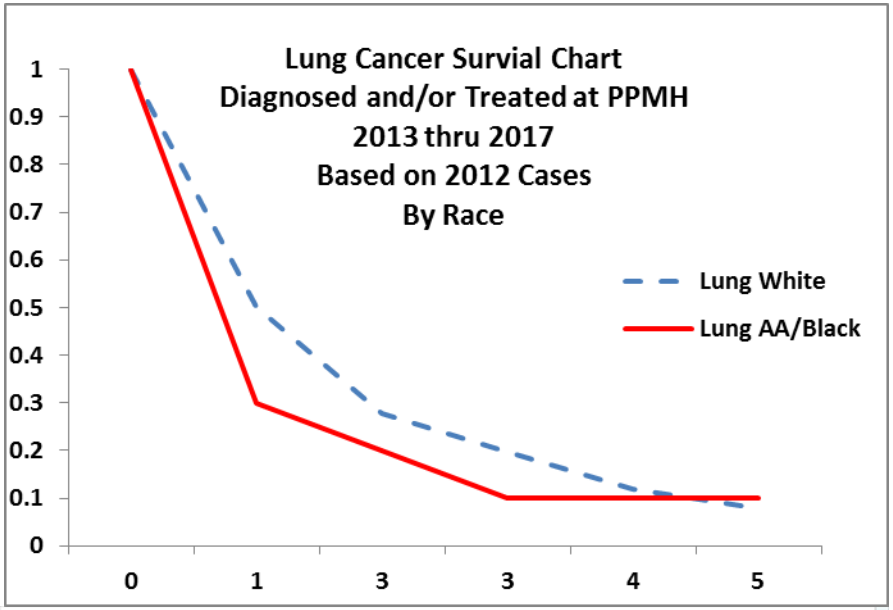
AAPHC and Albany Internal Medicine, among others, employed full diabetes counselors and case management services to monitor diabetic control.

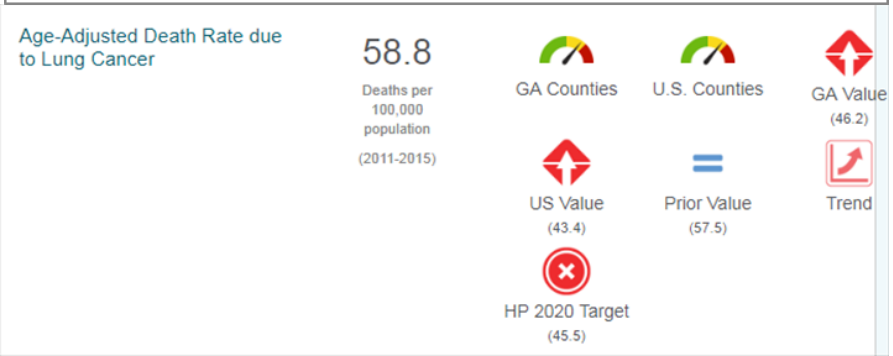
Phoebe's Network of Trust (NOT) through it's school nurse program provides diabetic awareness and prevention programs and monitors children with Type I diabetes. To encourage health eating, NOT provides funding to school system to maintain its 15 school gardens throughout the district.

Priority III: Cancer

LUNG CANCER

LUNG CANCER CASES DIAGNOSED OR TREATED





Source: National Cancer Institute & PPMH Tumor Registry

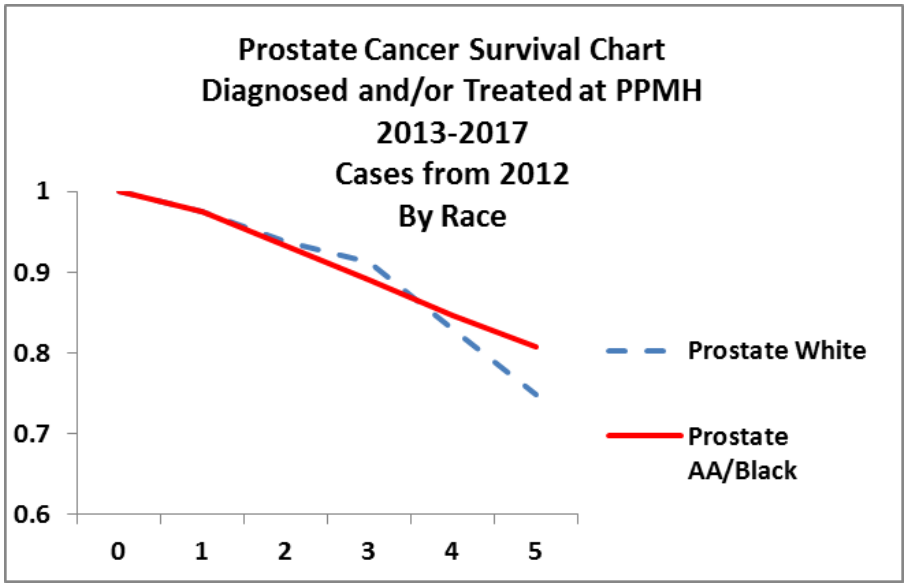
WHY IT'S IMPORTANT

According to the American Lung Association, more people die from lung cancer annually than any other type of cancer, exceeding the total deaths caused by breast cancer, colorectal cancer, and prostate cancer combined. The greatest risk factor for lung cancer is duration and quantity of smoking. While the mortality rate due to lung cancer among men has reached a plateau, the mortality rate due to lung cancer among women continues to increase. African Americans have the highest risk of developing lung cancer.

The Healthy People 2020 national health target is to reduce the lung cancer death rate to 45.5 deaths per 100,000 population.

2017 New CASES		
Stage	**AA/Black**	**White**
0	0	0
1	16	25
2	7	11
3	20	20
4	43	58

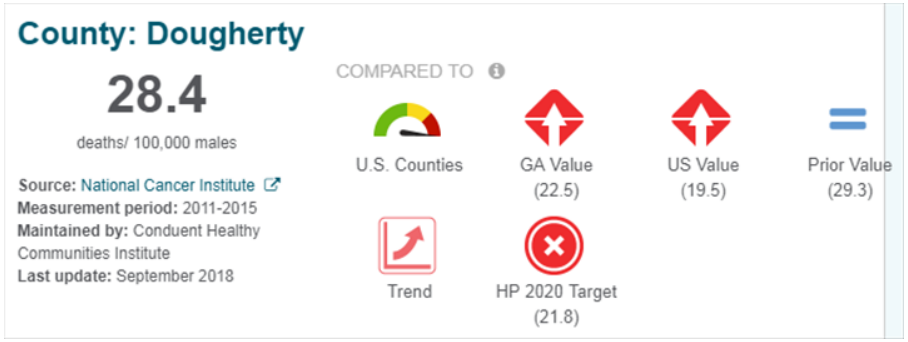
PROSTATE CANCER CASES TREATED OR DIAGNOSED



WHY IT'S IMPORTANT

According to the American Cancer Society, about 1 in 7 men will be diagnosed with prostate cancer. And about 1 in 36 will die from prostate cancer. The two greatest risk factors for prostate cancer are age and race, with men over the age of 65 and men of African descent possessing the highest incidence rates of prostate cancer in the U.S.

The Healthy People 2020 national health target is to reduce the prostate cancer death rate to 21.8 deaths per 100,000 males.

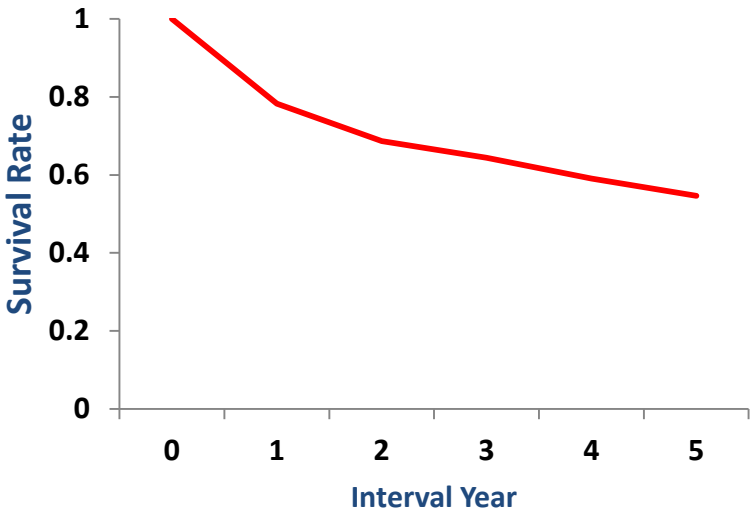


2017 New Cases		
Stage	**AA/Black**	**White**
0	0	0
1	32	20
2	70	50
3	9	7
4	7	11

Source: National Cancer Institute and PPMH Tumor Registry

CERVICAL CANCER

Cervical Cancer Survival Rate Based from 2012 Cases



2017 Cases Treated or Diagnosed

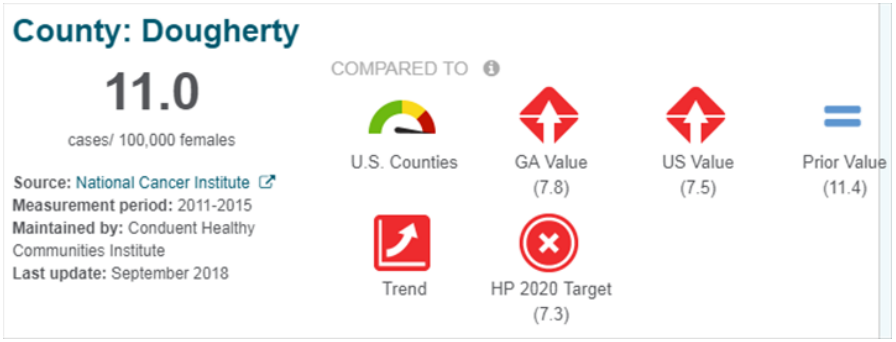
	white	black
Stage 1	1	2
Stage 2	1	0
Stage 3	0	1
Stage 4	1	2
Unknown	1	0

Cervical cancer forms in tissues of the cervix (the organ that connects the uterus and vagina) and is slow-growing. Cervical cancer that is detected early is one of the most successfully treatable cancers, and can be cured by removing or destroying the pre-cancerous or cancerous tissue. Cervical cancer is detected by Pap test screenings and is most often caused by human papillomavirus (HPV), which is a type of infection transmitted through sexual contact and can lead to cervical cancer. The American College of Obstetricians and Gynecologists recommends that all women aged 21-29 have a Pap test every 3 years while women aged 30-65 should have a Pap test and an HPV test every 5 years or a Pap test alone every 3 years.

The Healthy People 2020 national health target is to reduce the uterine cervical cancer incidence rate to 7.3 cases per 100,000 population.

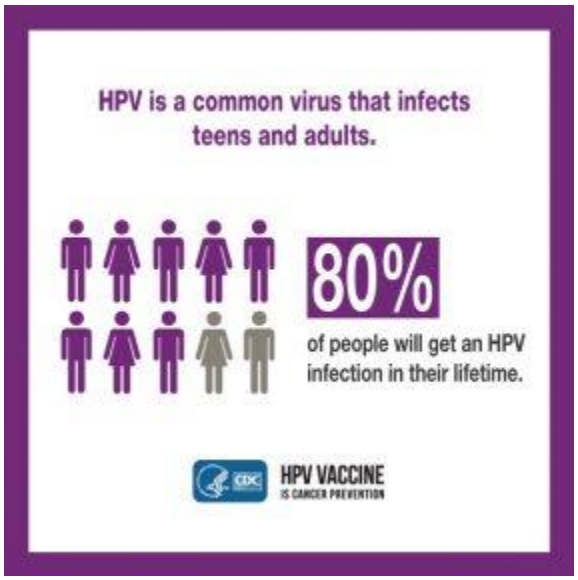
Source: PPMH Tumor Registry

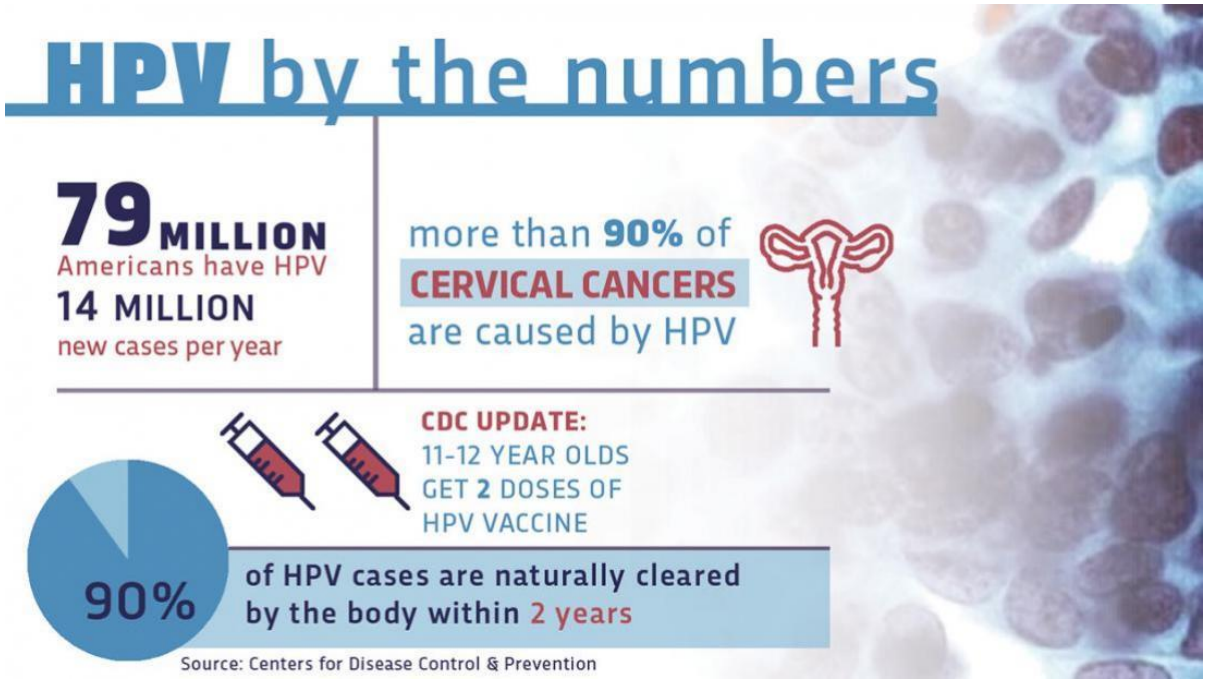
CERVICAL CANCER by the numbers



Dougherty County has one of the highest cervical cancer incidence rates compared to all other US counties. However, 90% of all cervical cancer caused by HPV could be wiped out if we follow the recommended vaccine treatment seen below.

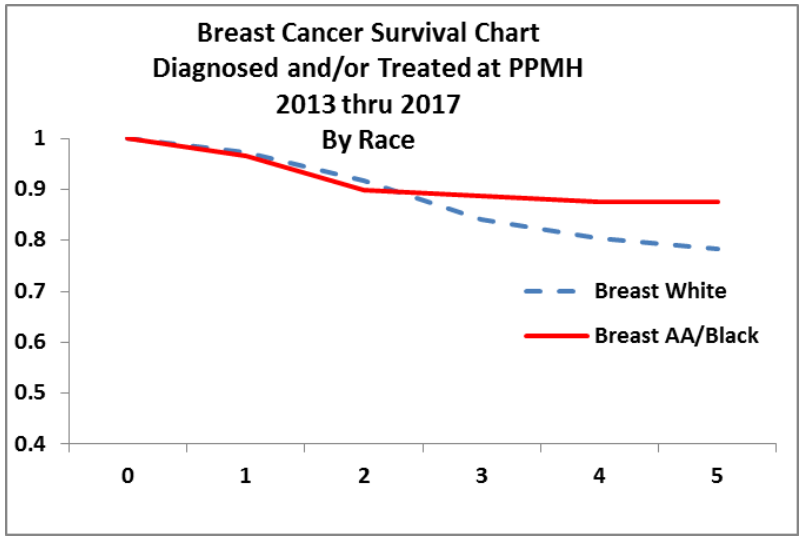
Source: National Cancer Institute





Source: Center for Disease Control & Prevention

Breast Cancer



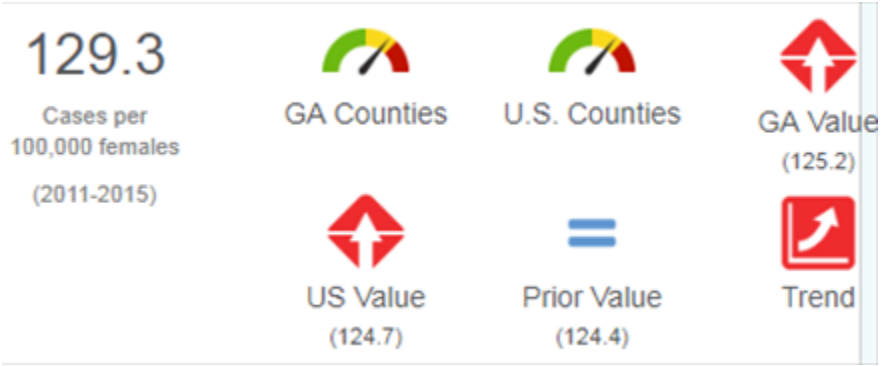
Breast cancer is a leading cause of cancer death among women in the United States. According to the American Cancer Society, about 1 in 8 women will develop breast cancer and about 1 in 36 women will die from breast cancer. Breast cancer is associated with increased age, hereditary factors, obesity, and alcohol use. Since 1990, breast cancer death rates have declined progressively due to advancements in treatment and detection.

Dougherty Counties incidence rate (129.3) is in the 2nd worst quartile compared to all over US counties and trending upward.

2017 New BREAST CANCER CASES

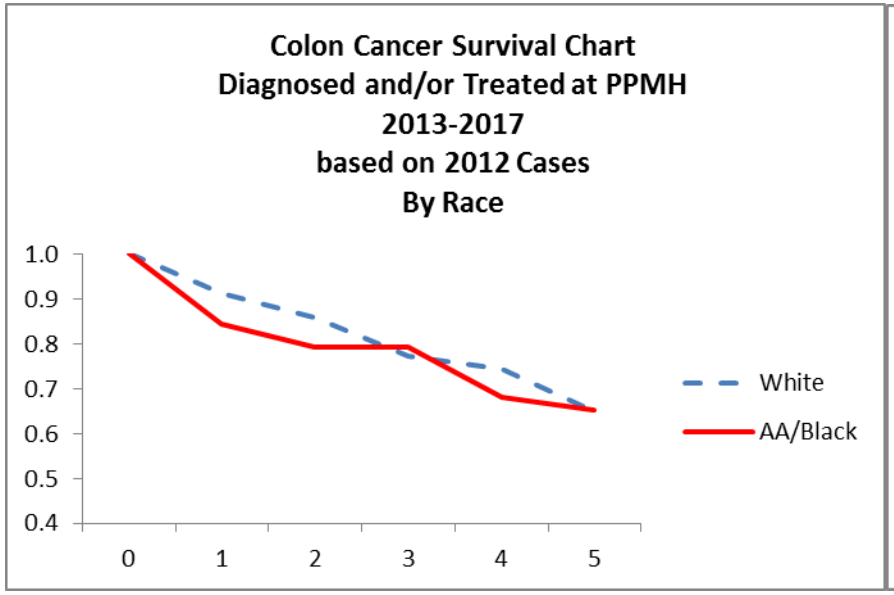
	White		AA/Black	
Stage	**Cases**	**Percent**	**Cases**	**Percent**
0	10	**9.6%**	17	**13.9%**
1	47	**45.2%**	46	**37.7%**
2	31	**29.8%**	37	**30.3%**
3	14	**13.5%**	14	**11.5%**
4	2	**1.9%**	8	**6.6%**
2017 Tot	**104**		**122**	

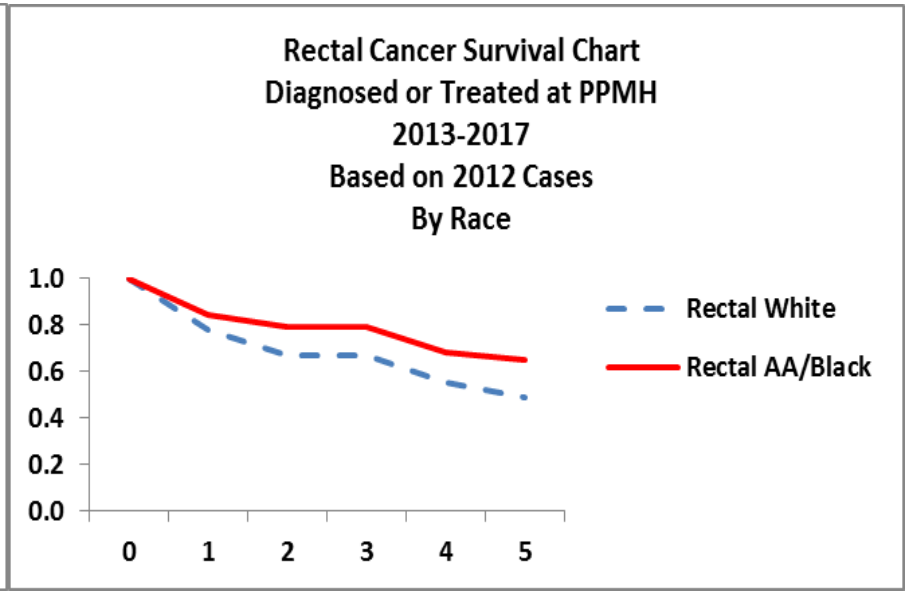
Source: PPMH Tumor Registry



Source: National Cancer Institute

Colorectal Cancer





2017 new COLON CANCER CASES

	White		AA/Black	
Stage	**Cases**	**Percent**	**Cases**	**Percent**
0	0	**0.0%**	5	**14.7%**
1	9	**28.1%**	11	**32.4%**
2	10	**31.3%**	3	**8.8%**
3	7	**21.9%**	7	**20.6%**
4	6	**18.8%**	8	**23.5%**
2017 Tot	**32**		**34**	

2017 New RECTAL CANCER CASES

	White		AA/Black	
Stage	**Cases**	**Percent**	**Cases**	**Percent**
0	0	**0.0%**	0	**0.0%**
1	1	**8.3%**	4	**36.4%**
2	4	**33.3%**	1	**9.1%**
3	4	**33.3%**	4	**36.4%**
4	3	**25.0%**	2	**18.2%**
2017 Tot	**12**		**11**	

Source: PPMH Tumor Registry

Priority III: Resources

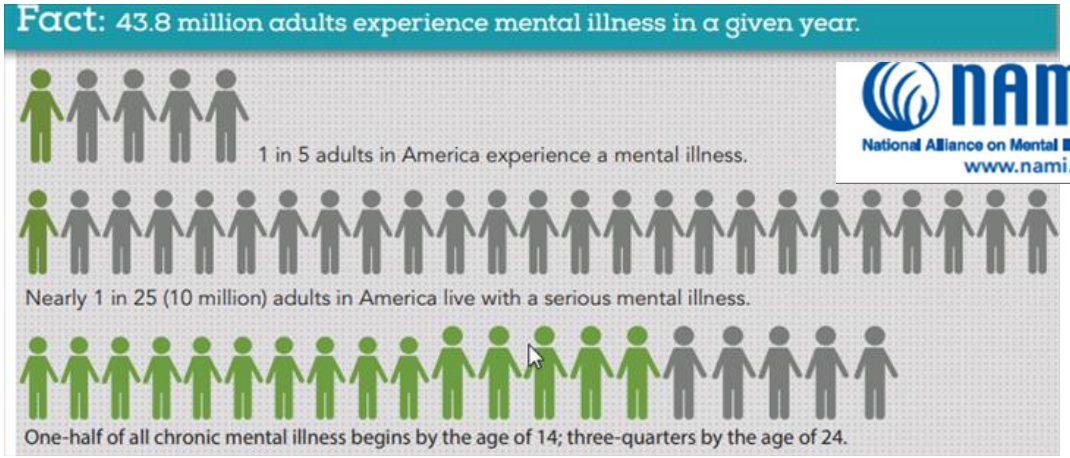
Phoebe's Cancer Center has a full suite of services designed to support the patient throughout their cancer treatment (case managers, social services, financial advisors, chemotherapy educators and navigators and clinical trials). The Cancer Center offers Breast Cancer Genetic Testing (12 to 14% estimated to be hereditary) and the Lung Watch Program for Cancer launched in 2013. In 2019, the Cancer Center-Carlton Breast Center will implement a high risk screening and genetics program and then expand to other cancers. Currently, there is an estimated 2 to 3% of breast cancer identified as Inflammatory. This is a particularly aggressive form of cancer with poor survival rates and disproportionately affects African-American women. The cancer center is closely looking at the impact of HPV on pre-teens and early teens of specific cancers such as gynecologic and other types of oral cancers. The HPV vaccine is one easy preventative measure. For those with little means to pay, the cancer center has a detailed process to assure patients exhaust every means of possible financial support—and if all else fails, then the case is referred to the Senior Leadership Taskforce.

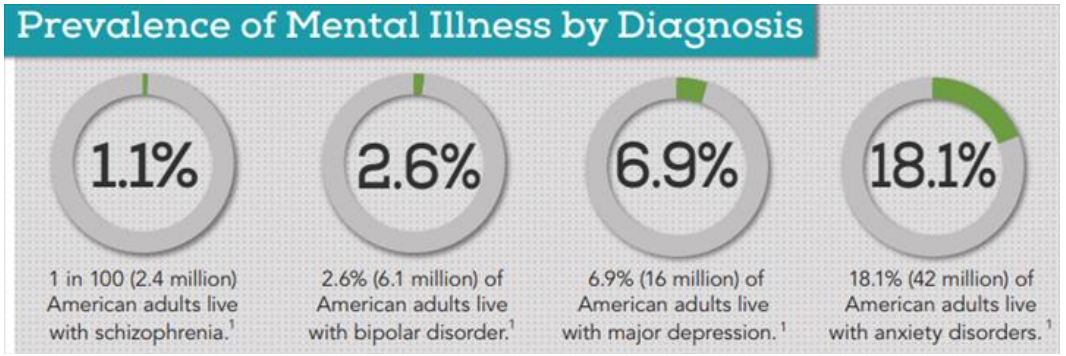
In coordination with Horizons Community Solutions(HCS), Phoebe offers free colonoscopies to those who are unable to pay. The uninsured are referred through HCS.

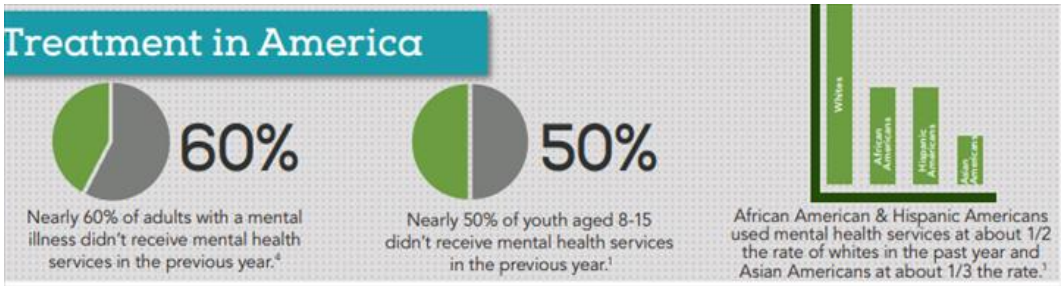
Likewise, Phoebe partners with the Local Health Department and offers up to 200 free mammography's to women unable to afford one. If they need a follow-up diagnostic mammography, they are referred to the health department.

Priority IV: Behavioral Health/Addictive Disease Awareness &Advocacy

- Approximately 1 in 5 adults in the U.S. (46.6 million) experiences mental illness in a given year.
- Approximately 1 in 25 adults in the U.S. (11.2 million) experiences a serious mental illness in a given year that substantially interferes with or limits one or more major life activities.
- Approximately 1 in 5 youth aged 13–18 (21.4%) experiences a severe mental disorder at some point during their life. For children aged 8–15, the estimate is 13%.
- 1.1% of adults in the U.S. live with schizophrenia.
- 2.6% of adults in the U.S. live with bipolar disorder.
- 6.9% of adults in the U.S.—16 million—had at least one major depressive episode in the past year.
- 18.1% of adults in the U.S. experienced an anxiety disorder such as posttraumatic stress disorder, obsessive-compulsive disorder and specific phobias.
- Among the 20.2 million adults in the U.S. who experienced a substance use disorder, 50.5%—10.2 million adults—had a co-occurring mental illness.







Available Resources Behavioral Health/Substance Abuse Services

With somewhere between 375 to 400 employees, Aspire Behavioral Health and Developmental Disability Services offer an array of services throughout southwest Georgia. Client base is a50-50 split between AA/Black and White patients with a payor-mix of 40% Medicaid, 20% Commercial and Medicare with the remainder either self-pay or underinsured. They provide a Crisis Stabilization Unit with 30 inpatient beds and 6 temporary observation beds for those with MH/SA lasting less than 24 hours. They offer MH/SA/DD on an outpatient basis. The Assertive Community Treatment Team provides intensive services to 100 chronically Mentally Ill patients with an application to request a second team. For those not needing that level of care, they offer Community Support Teams and Peer support which continues to grow. Aspire has a successful Child and Adolescent clubhouse with plans to open a clubhouse for early-aged adults 18-24 downtown in the near future. With the recent storms that ravaged our area, they opened a Crisis Counseling service for those impacted by the storm(s). Aspire operates an Intensive Residential Forensic Treatment Program and Treatment Court for those with Addictive Diseases. They operate three DD services located in Albany, Dawson and Blakely for those diagnosed with a developmental disability. For slightly more than year, they opened and operated an Inpatient Drug and Alcohol Rehab Center located in Arlington, GA—in rural Georgia.

Recommendations from Local NAMI

- Increase Funding for Wellness and Respite Centers
- Increase Capacity for Longer Term Treatment
- Expansion of Tele-health Services to Increase Access
- Increase Accountability Courts in Georgia to Divert Mentally Ill, Non-violent offenders to treatments

Recommendations from Engagement Session

- A Need for more Child and Adolescent Psychiatrists
- BH/AD Recovery Capital once Discharged
- Lack of Child/Adolescent Inpatient Services
- Expansion of Substance Abuse Counseling

Recommendations from Local Providers

- Licensed Clinical Social Workers, Psychiatrists and Individual counselors
- Medication Assistance
- Loan Forgiveness to Attract qualified Staff to handle program growth

According to Aspire, as they ramp up programming, they need more clinical people, counselors and CNA, etc.—and more peer workforce applicants who are passionate and effective. The service additions of APEX (autism), the downtown adult clubhouse (EMERGE—age 18 to 24), EVOLVE (Treatment of first Psychotic episode) necessitate an influx of qualified staff.

Phoebe Behavioral Health provides Inpatient and Outpatient Behavioral Health Services. The 18 bed Inpatient Unit includes a 10 Bed Unit for the Chronically Mentally Ill and an 8 Bed Unit for higher-functioning patients. The emergency center houses a dedicated Behavioral Health Wing that screens, treats, and refers patients. Outpatient services offer Intensive Outpatient group therapy for Adults and Children and offer medication management and transportation. Recently, the behavioral health team added Transcranial Magnetic Stimulation (TMS) to treat drug-resistant depression. As an emerging technology, this technology has implications with those suffering from PTSD. Currently, Tri-care and Medicare reimburse for this therapy. The OP/IP behavioral health services share 2 Psychiatrists and 3 Nurse Practioners. Network of Trust provides "Too good for drugs" in middle and high schools and provides funding to organizations to fight the opioid crisis through Morehouse School of Medicine funding source.

Albany Area Primary Healthcare(AAPHC) provides behavioral health outpatient services to resident of Southwest Georgia. The behavioral health team offers case management services, counseling services, psychiatric services, mental health services, and substance abuse services and group therapy. The Renaissance Center recently merged with AAPHC and located in Northwest Albany at the Osler Court location. A board certified Licensed Clinical Psychologist provides counseling and testing services for children, adolescents, adults and families across Southwest Georgia. The group also consists of three licensed professional counselors, an advanced nurse practitioner, a licensed clinical social worker and a licensed marriage & family therapy counselor.

The Veranda offers integrated behavioral healthcare, such as addressing mental health and substance use conditions, health behaviors, barriers to care, and their potential contribution to chronic medical illnesses, life stressors and crises, stress-related physical symptoms and other patterns of a patient's overall health. Screening and assessment tool, psychological testing (for depressive disorder, anxiety, etc.) incorporating the latest in medical technology for children and adults by a Psychiatric Mental Health Nurse Practitioner (PMHNP-BC).

Behavioral Health Group Albany (BHG) is an outpatient facility and strictly licensed to treat opioid addiction.

GraceWay Recovery Residence is a non-profit recovery community for women dedicated to providing women with the environment and tools necessary to achieve and maintain long-term sobriety. GraceWay utilizes the twelve step methodology to provide holistic and abstinence-based recovery support services. Incorporated in their "transition back into society" is the opportunity to serve/work at the Bread House restaurant/bakery.

Albany ARC (Advocacy Resource Center) holds CARF accreditation in the following programs: Mental Health, Residential, Adult Day, Project ARC, and Kids' Corner Child Development Center. The Mental Health program has three major components: Mental Health Case Management, Dougherty County Treatment Court, and Substance Abuse Treatment Court.

National Alliance on Mental Illness(NAMI) provides support, education and advocacy for individuals and families who are impacted by mental illness.

- NAMI Nights –educational program open to the public and free of charge @ Albany ARC 3005 Old Dawson Rd ,Albany
- Support Groups, Connections & Family- peer-led groups for individuals living with mental illness & family and friends of individuals living with an illness.

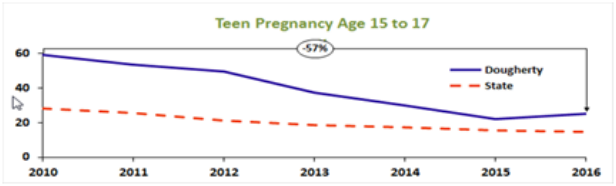
Dept. of Behavioral Health & Development Disabilities (DBHDD) operates state hospitals and provides for community-based services across the state through contracted providers. The department serves ,primarily ,uninsured individuals living with mental health challenges, substance abuse disorders, intellectual and developmental disabilities or any combination of these.

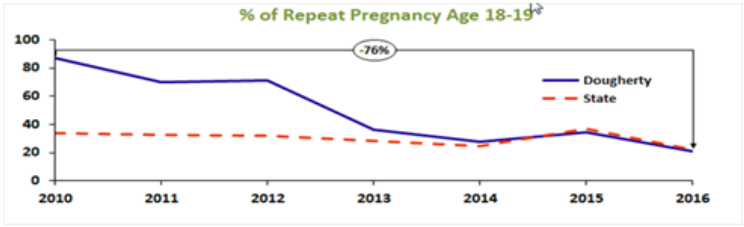
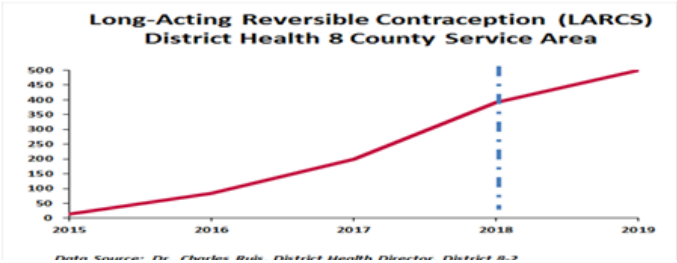
Southwest Georgia is Region 4 which operates a field office in Thomasville

- Adult Core Services provided by a Community Service Board (CSB) for Albany the CSB is Aspire
    - Treatment Court Services Dougherty County partners with Albany CSB and Albany ARC to operate a treatment court for individuals who have committed non-violent felony or misdemeanor crimes.
- Assertive Community Treatment (ACT)- “known as a hospital without walls” offering more intense services in the community.
- Behavioral Health Crisis Center (BHCC) – short-tern, walk in crisis intervention and counseling services with emergency receiving capability and crisis stabilization beds.
- 24-hr accessibility to specialists and services through Georgia Crisis & Access Line (**GCAL) 800-715-4225**
    - **Benchmark Crisis Response Team-** mobile teams respond to a behavior related crisis in the individuals home or community within 1 hour, to prevent a crisis, harm to individual or others, reduce involvement of law enforcement agencies and recommend appropriate support services.
- Georgia Council on Substance Abuse – offers the CARES warm line 1-844-326-5400 to provide a listening ear
    - DBHDD Addition Recovery Support Center supports a person’s ability to promote their own recovery and eliminate barriers to independence and continued recovery trough voluntary activities .
        - Services include, employment assistance, transportation, recreational, prosocial, spiritual and family supports
- Mental Health First Aid training provided by Jennifer Dunn, 229-977-4885 (Jennifer.Dunn@dbhdd.ga.gov)
- Georgia APEX Program--increase mental health access for children and youth, provide early detection of mental health needs and increase coordination with providers and schools. Assessments, therapy, and education at each level of the program; prevention, early intervention and intensive intervention.
- Housing vouchers for individuals with Severe Persistent mental illness (SPI) to cover rent and utilities.

FY 2017-FY 2019

PLAN EVALUATION

NEED IDENTIFIED:	To Improve Maternal, Infant, and Child Health and Reproductive Responsibility		
Objective:	To improve the birth outcomes to include low and very low birth weight, infant mortality, pre-term births, and teen pregnancy		
Initiative/Program/Service Population Target	**Timeline**	**Action Steps/Responsible Party**	**Target Completion Date & Metrics-status**
Initiatives: **(1) Develop Partnerships and Support Collaboration** Population Target: At-risk Teens, Single Moms, At-risk Mothers-particularly living in Census Tract 8, low socio-economic status, Pregnant Women and High-risk neonates	*FY 2017*	a. To build a Birth Outcome and Reproductive Responsibility Coalition • Beginning in August of 2016, a group of people met and made the decision to create a coalition to address this issue. 1. Pre-Plan design to Create Action Plan to Build the Coalition. 2. Action Plan Meeting Held in November 2016. 3. Follow-up Meetings held in winter of 2017. 4. Coalition Launched in May 2017. 5. Environmental Scan (Preplanning) held in summer of 2017). 6. Comprehensive-community driven strategic plan work will be completed by fall, 2017. 7. Strategic Plan completed and signed off in November 2017.	**Completed**  Since 2010, Teen Pregnancy Rates have decreased by 57% in Dougherty County due in large part to the efforts of Phoebe's School Nurse Program and its "Taking Time of Teens" coalition. The decrease is larger than the State average during that time frame and the gap between the State and Dougherty County has just about closed. **BENCHMARKS:** **HEALTHY PEOPLE 2020 TRACKER: 36.2** **GA: 14.4** **DOUGHERTY COUNTY: 25.2**

Project Network of Trust **Target:** Teen Moms in High School **Teen Maze & Dougherty County AIDS/STD Taskforce** **Target**: Teens and young college students	*On-going*	**FY2017** Network of Trust provided parenting classes to teens through its three-phase program. The total number served was 67. The goal of the program is the birth of a healthy infant and to reduce the likelihood of a repeat birth prior to age 19. **FY 2018** Network of Trust provided teen parenting class to 77 participants in FY2018. **FY 2019** Network of Trust provided teen parenting to 78 participants in the 208-2019 school year. Of the 28 seniors, 22 graduated on time. There were 2 repeat pregnancies. **FY 2017** Get-A-Life Teen Maze & Wellness Events were held in September and March of fiscal year-totaling 450 participants. The Maze gives real life scenarios and the consequence of choices made. **FY 2018** Get-A-Life Teen Maze & Wellness Events (8) were held throughout the year with 1136 school-age participants. **FY 2019** NOT and School Nurses held 4 8th grade wellness events with 566 participants.	The Repeat Pregnancy rate plummets by 76% since 2010 representing a three-fold decrease. In the School Year 2017-2018, not reflected in the data below, two of the 77 participants were repeat pregnancies or 2.5% repeat pregnancy rate. Of the 30 seniors enrolled in the teen parenting program, 90% completed high school and above the Dougherty County graduation rate as a whole. Additionally, the Public Health Department has ramped up Long Acting Reproductive Contraceptive also not reflected in the most recent available dataset (see 2nd chart below)  
Early Elective Deliveries **Breast Feeding Support Groups** **Target: Breastfeeding Moms**		**FY 2017-FY 2019** No elective deliveries at 37 weeks or less. **FY 2018** As part of the Implementation strategy, PPMH reinstituted a breast feeding support group. **FY 2019** Received Baby Friendly Designation which promotes breastfeeding and breastfeeding support.	

NEED IDENTIFIED:	Behavioral Health		
Objective:	To Facilitate a sustainable community mental health continuum of care model with an emphasis on addressing identified gaps in service.		
Initiative/Program/Service Population Target	Timeline	Action Steps/Responsible Party	Target Completion Date & Metrics-status
Initiatives: **Network of Trust**-{Go Noodle] Teens	On-going	**FY 2017** Go Noodle Program has an anti-bullying component and during the 2016-2017 school year. **FY2018** With over two million minutes of physical activity and other components logged, go noodle provided exercise, brain stimulation and some behavior health related activities. **FY 2019**	
School Nurse Program Managing Behavioral Health Medication for School Age Children	On-going	**FY2018** Gave out behavioral medication to school age children throughout the school year. **FY2018** Gave out behavioral medication to school age children	Appropriate and Safe administration of behavioral medication
Project Network of Trust-Opioid Awareness and Prevention (Adults and	As Needed	**FY2018** Recipient of a $100,000 from the Morehouse School of Medicine, Network of Trust launched an Opioid Awareness and Prevention Campaign. Through this campaign, they have reached 3939 High School Students and 1390 adults. **FY 2019**	
Phoebe Strategy and Planning To Provide issue/topic related strategy and action planning to the local BH/AD Collaborative		**FY2017** -Held an emergency meeting with law enforcement staff regarding the OPIOID and Fentanyl Crisis. Agreed to meet to again—Possible funding has been identified based on the needs of the group. - Identified a GAP with those patients receiving ACT services falling through the cracks. We facilitate and troubleshoot.	Assure first responders have the necessary supplies needed.
Phoebe Strategy and Planning Work with State Legislature on Planned Efforts Associated with Behavioral Health		**FY2017** Kept Jerry Usury updated via the Community Benefit Coordinator. **FY2018** With over 150 in attendance, Phoebe hosted an opioid community forum featuring GA Senator Renee Utterman.	Advocacy Policy Change

Opioid Prevention - Number Reached	
Presentations	2,340
Trainings	111
Events	2,439
Too Good for Drugs Curriculum	94
Teen Conference	250
Opioid Reenactment	2,500

NEED IDENTIFIED:	Healthy Lifestyles to Reduce Chronic Disease		
Objective:	Prevention and Management of Chronic Diseases		
Initiative/Program/Service Population Target	Timeline	Action Steps/Responsible Party	Target Completion Date & Metrics-status
Initiatives: (1) Develop Partnerships and Support Collaboration	FY 2017	**To build a Diabetes Coalition** Beginning in August of 2016, a group of people met and made the decision to create a coalition to address this issue. • Pre-Plan design to Create Action Plan to Build the Coalition. • Action Plan Meeting Held in November 2016. • Follow-up Meetings held in Winter of 2017. • Coalition Launched in May 2017. • Environmental Scan (Preplanning) held in Summer of 2017. • Comprehensive-community driven strategic plan work will be completed by Fall 2017.	**Completed**
(2) Chronic Disease Management (diabetes, Asthma, Sickle Cell) of school age children (School Nurse Program) (3) Diabetes Related Education	On-Going	**FY 2018** The Diabetes Coalition applied for a $750,000 federally funded REACH grant each year for 5 years to provide a myriad of services directed toward diabetes prevention by addressing social determinants of health through various identified evidence-based practices. **FY 2018** The school nurse program provided treatment to 231 Asthma related and 1,604 students with diabetes related chronic illnesses. FY 2019 →	
	On-going	**FY 2017** Diabetes Educators participated in health fairs and Lunch and Learns to various organizations during the year(7 events 448 reached)	

Total Student Visits	20,987
Top 5 Visits	
Medication Administration & Management	8,420
Headache	2,906
GI Related Illnesses	2,400
Cold & Allergy Related Illnesses	2,233
Injury Management	1,738
Physician Referred Cases	354
Chronic Illnesses	
Asthma Related	246
Diabetes Related	1,369

(4) Community Benefits		**FY 2019** Diabetes Educators, from a Department of Public Health grant, have completed one cohort and beginning another using the CDC's Evidence-Based diabetes prevention curriculum. Provided two health fairs for women in October and Men in June. With approximately 600 total participants, screening for PSA, blood pressure, cholesterol checks and glucose screening were provided.	Numbers are not final—yet.

FY 2020

FINANCIAL ASSISTANCE POLICY

Phoebe Putney Health System, Inc.

POLICY TITLE: **Financial Assistance Program**
ENTITY: **PPHS**

Approved by: PPHS Board of Directors
Effective Date: 3-31-2016
Review Period: 3 Years
Contact Information: VP, Revenue Cycle
Review Date: 3-6-19

SCOPE: This Policy applies to Phoebe Putney Health System (PPHS) hospital facilities and Phoebe Physician Group (PPG) providers providing care within PPHS facilities.

PURPOSE: PPHS as a not-for-profit charitable corporation is committed to fulfilling its charitable mission of each hospital by providing high quality medical care to all patients in their service areas, regardless of their financial situation.

POLICY: PPHS hospitals and PPG physicians shall provide financial assistance according to the PPHS Financial Assistance Program (FAP) policy for persons who have healthcare needs and are uninsured or under-insured, ineligible for government program, and otherwise unable to pay for medically necessary care based on their individual financial situation. Based on financial need, either reduced payments or free care may be available. The Financial Assistance Program is administered by the Revenue Cycle of each PPHS hospital and PPG, with authority and approval from the PPHS Board of Directors

DEFINITIONS

Amounts Generally Billed (AGB) means the amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care, determined in accordance with § 1.501(r)-5(b). AGB is determined by dividing the sum of claims allowed by health insurers during the previous fiscal year, by Medicare fee-for-service and all private health insurance, including payments and allowed amounts received from beneficiaries and insured patients, by the sum of the associated gross charges for those claims.

Applicant: Applicant may include the patient, the guarantor of a patient's financial account, or a designated patient's representative such as a legal guardian.

Assets: Assets include but are not limited to: bank accounts; investments including 401k and 403b accounts; real property; businesses whether or not incorporated; personal property including vehicles, boats, airplanes, and other such items. Assets shall be reported on the FAP application as a source of revenue.

Financial Assistance Program (FAP): PPHS program that provides financial assistance to persons who have emergent and/or medically necessary healthcare needs and are uninsured or under-insured, ineligible

for a government program, and otherwise unable to pay for such care based on their individual financial situation, and who meet the requirements contained within this Policy.

Federal Poverty Guidelines (FPG): Poverty guidelines issued by federal government at the beginning of each calendar year that are used to determine eligibility for poverty programs. The current FPG can be found on the U.S. Department of Health and Human Services website at www.hhs.gov.

Gross Charges, or the chargemaster rate, means a hospital facility's full, established price for medical care that the hospital facility consistently and uniformly charges patients before applying any contractual allowances, discounts, or deductions.

Gross Income: Income as defined by the Internal Revenue Service (IRS), which includes but is not limited to: income from wages, salaries, tips; interest and dividend income; unemployment compensation, individual income policy, alimony, all social security income, disability income, self-employment income, rental income, k-1 income, and other taxable income. For applicants who are financially dependent on another individual, that individual's income will become part of the gross income of the applicant. Examples of other sources of income that are not included in the definition of Gross Income are food stamps, student loan, and foster care disbursement.

Household: Number or people claimed on income tax filing, or individuals the Applicant is legally responsible for, and any person whose income is included in the applicant's gross income.

Limited Health Insurance: means benefits that are considered "excepted benefits" per 42 U.S.C. 300gg-91(c) that do not provide coverage for the plan of care to be approved for financial assistance under this policy, individual and group market coverage whose benefit package does not cover the applicant's plan of care, and individual and group market coverage where applicant's cost sharing responsibility exceeds his or her liquid assets in addition to 9.66% of his or her annual household income.

Medical Necessity: Any procedure reasonably determined to prevent, diagnose, correct, cure, alleviate, or avert the worsening of conditions that endanger life, cause suffering or pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, if there is no other equally effective, more conservative or less costly course of treatment available.

PPHS Hospital Facilities: Phoebe Putney Memorial Hospital (PPMH), Phoebe Sumter Medical Center (PSMC), and Phoebe Worth Medical Center (PWMC).

PPG Physicians: Emergency Room Physicians, Anesthesiologists, Radiologists, Hospitalists, Critical Care Physicians, Oncology, Neurosurgery, Cardiovascular Surgery, and other specialists as listed on https://www.phoebehealth.com/media/file/PrintablePhysicianDirectory.pdf . Community physicians and independent specialists who are not PPG physicians will not be subject to the Phoebe FAP.

PROCEDURE

Urgent or Emergency Care

Any patient seeking urgent or emergent care [within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd)] at a PPHS Hospital Facility shall be treated without discrimination and without regard to a patient's ability to pay for care. PPHS Hospital Facilities shall operate in accordance with all federal and state requirements for the provision of urgent or emergent health care services, including screening, treatment and transfer requirements under the federal Emergency Medical Treatment and Active Labor Act (EMTALA). This policy prohibits any action that would discourage individuals from seeking emergency medical care (EMC) including but not limited to demanding pay before treatment for emergency medical conditions or by permitting debt collection activities that interfere with the provision, without discrimination, of EMC.

Financial Assistance

PPHS Hospital Facilities will extend free or discounted care to eligible individuals for all other medically necessary services. The FAP applies to medically necessary services that are not elective in nature.

Who may apply for financial assistance?

Patients, or the person legally responsible for their bill, may request financial assistance in regards to their obligation at any time before or during the billing process. Patients, or the person legally responsible for their bill, may meet guidelines for full or partial assistance.

Who is eligible for financial assistance?

You will be eligible for financial assistance if you:

- Have limited or no health insurance
- Are not a member of any healthcare sharing ministry
- Are not eligible for a Federal or State health care program that would cover the specific services, or a specified episode or plan of care, for which you are making this application
- Have limited household income, within 400% of Federal Poverty Guidelines, as listed on Exhibit 1
- Have medical bills in excess of 25% of household income
- You are a legal resident of a county within the PPHS service area
- Were transferred to a PPHS hospital for a higher level of service from outside of the PPHS service area
- You have less than $175,000 in assets

The PPHS service area encompasses the following counties (see map in Exhibit 3):

- **PPMH and PSMC**: Baker, Calhoun, Dooly, Dougherty, Lee, Macon, Marion, Mitchell, Randolph, Schley, Stewart, Sumter, Terrell, Webster, and Worth
- **PWMC**: Dougherty and Worth
- Georgia residents who are existing patients of PPG physicians will be deemed to have met the residency requirement regardless of which county in Georgia they currently reside.

Management reserves the right to evaluate special circumstances and extend financial assistance outside of the above listed criteria.

You are not eligible for financial assistance if you:

- Refuse to apply for a State or Federal health care program.
- Refuse to apply for an individual or a group market health plan when legally entitled to do so
- Not a legal resident of a county within the PPHS service area
- Not a US resident
- Your plan of care is covered under liability or worker's compensation with no proof of denial of coverage
- Your plan of care is covered under liability still in litigation or where the payment went to the subscriber

A. What services are eligible for financial assistance?

Financial assistance is available for eligible patients who require:

- Emergency medical services
- Other non-elective and medically necessary services

Financial assistance is not available for the following:

- Elective plastic surgery
- Services that are not medically necessary
- Services covered by State or Federal agencies such as, but not limited to, Cancer State Aid, Disability Adjudication

A. When do you have to apply for financial assistance?

- For non-emergent services, patients who expect to need assistance must apply for a financial assistance determination prior to obtaining care.

- Patients may also request financial assistance at any time during pre-registration, registration, inpatient stay, or throughout the course of the billing and collections cycle by requesting and completing an application for financial assistance.

- The time limit to apply for financial assistance is twelve (12) months from the time the patient became responsible for the account balance, unless the patient initiated a payment plan. There is no time limit to apply for the FAP when the patient was participating in a payment plan but has a change in financial circumstances.

- Phoebe uses prior FAP eligibility determinations approved within six (6) months of the medically necessary services, unless originally deemed eligible only for those dates of service as a clinical exception or a result of a transfer from outside of the PPHS service area.

B. How does an eligible person apply for financial assistance?

1. *Download or request the FAP Application*

The FAP application, along with a complete list of any required documentation that you may be required to submit, is available in English and Spanish at http://www.phoebehealth.com. To request an application for financial assistance, a copy of the detailed financial assistance policy, or if you have any questions about the process please contact the Financial Counseling team.

Note: PPHS may use a propensity-to-pay or presumptive charity scores to determine a patient's financial status and a patient's ability to pay for bills already incurred. These scores are obtained by using a data analytics model that helps us identify patients that qualify for financial assistance but may not have specifically requested it.

2. *Complete the FAP Application.*

Complete the FAP application and submit it, along with the documentation listed in the FAP application, directly to the Financial Counseling team or by mailing it to the PPHS Facility of application. Financial Assistance will not be denied based solely upon an incomplete application initially submitted. A PPHS representative will contact patients or financial guarantors via mail to notify of additional documentation requirements. Patients will have fourteen (14) business days to return additional information.

3. *The Financial Counseling team with review your application and notify you of their decision*

PPHS will review all FAP applications in a timely fashion. PPHS employees may require an interview with the applicant. If an interview is required, the FAP application may be completed at that time if all required documents have been provided. Once a completed application is reviewed, a decision will be made and the patient/applicant will be notified in writing of the decision Patients who do not qualify for financial assistance will be billed in accordance with PPHS policy as a means of making arrangements for payments or obtaining payment in full.

4. *You may appeal the decision*

Applicants who receive a letter of denial may appeal the denial. The appeal must be made within thirty (30) days of the date of the letter of denial.

A. <u>What financial assistance is available?</u>

- **<u>Level 1 Status:</u>** Household incomes at or below 125% of the FPG are eligible for free care as provided in the FAP.
- **<u>Level 2 Status:</u>** Household incomes between 126% and 400% of FPG qualify for discounted charges for care (see Exhibit 1).

- Additionally, PPHS hospitals and physicians provide financial assistance to indigent patients for services needed that a physician deems necessary for post-discharge care, in accordance with PPHS policies and procedures

- Medically necessary healthcare services within 12 months of a favorable FAP eligibility determination will be discounted at the previously verified FAP level.

3. Billing and Collection

PPHS makes reasonable efforts to ensure that patients are billed for their services accurately and timely. PPHS will attempt to work with all patients to establish suitable payment arrangements if full payment cannot be made at the time of service or upon delivery of the first patient statement. PPHS will make every effort to work with patients who owe large balances, yet do not qualify for financial assistance, to arrange mutually acceptable payment terms.

PPHS maintains a separate billing and collections policy which describes in detail the actions PPHS hospital facilities and PPG may take in the event of non-payment. Copies of the PPHS Billing and Collections Policy are available to members of the community for no charge at http://www.phoebeputney.com and also upon request to the Financial Counseling Department.

4. Communication of the Financial Assistance Program

PPHS shall take the following measures to widely publicize its FAP:

- Notice of the PPHS FAP is posted in areas where patients may present for registration prior to receiving medical services at any of the PPHS hospital facilities, or where any patients/patient representatives may make inquiries regarding their hospital bills. Information is available in English and Spanish.
- All patients of PPHS hospitals will be offered a plain language summary of the FAP and upon request, receive a FAP Application prior to being discharged from a PPHS hospital.
- The FAP Policy, FAP Application, and a plain language summary are available on the PPHS website in English and Spanish at http://www.phoebeputney.com. A plain language summary is also in the PPHS Patient Handbook, in the "Guide to Understanding Your Hospital Bill", and is referenced in patient statements and letters.
- The FAP Policy, FAP Application, and plain language summary are available without charge upon request and by mail. In-person requests may be made to any registration area of any PPHS hospital, the Financial Counseling Department, and the Patient Accounting Department. Written requests can be submitted to addresses set forth in Exhibit 2 to this Policy.
- The FAP plain language summary will also be made available at community health centers,

- Financial Counselors are available to discuss the Financial Assistance Program and to accept and assist with applications. Hours of operations are set forth in Exhibit 2 to this Policy.

REFERENCES:

Federal Poverty Guidelines
Patient Protection and Affordable Care Act, Public Law 111-148 (124 Stat. 119 (2010))
Internal Revenue Service Regulations s. 1.501(r)-1 through s. 1.501(r)-7

REVISION HISTORY

Revision Number	Description of Changes	Approvals	Date
N/A	Initial Release of Policy for PPHS Policy Management System (Compliance 360 Program). This policy replaces all previous versions.	Phoebe Putney Health System	3-31-2016
1	FPL increase to 400% and elimination of catastrophic qualification, Exhibit 1 updated with 2018 AGB and FPL, healthcare ministry co-operative exclusion	Phoebe Health System Board	3/8/2018
		Phoebe Worth Medical Center Board	4-26-18
		Phoebe Sumter Medical Center Board	5-1-18
		Phoebe Putney Memorial Hospital Board	5-2-18
2	Refinement of terms and additional AGB detail	VP Revenue	10/23/2018
3	Exhibit 1 updated with 2019 AGB and FPL	VP Revenue	3/1/2019
		Phoebe Putney Memorial Hospital Board	3-6-19
		Phoebe Putney Health System board	3-7-19
		Phoebe Sumter Hospital Board	3-5-19
		Phoebe Worth Hospital Board	5-2-19

EXHIBIT 1

Patients who are eligible individuals will not be charged more for emergency or other medically necessary care than the AGB for individuals who have insurance coverage. The minimum percentage discount to be applied to FAP eligible individuals shall be calculated on an annual basis, and in the event the percentage discount changes for any year, Exhibit 1 shall be amended. Financial Assistance Guidelines shall be adjusted annually, in accordance with updated AGB from the previous fiscal year and current year Federal Poverty Level (FPL) guidelines.

The hospital Amount Generally Billed (AGB) and corresponding discount off gross charges are, as follows, effective 3/1/2019:

- Phoebe Putney Memorial Hospital (PPMH) – AGB = 38%, after 62% discount off gross charges
- Phoebe Sumter Medical Center (PSMC) – AGB = 37%, after 63% discount off gross charges
- Phoebe Worth Medical Center (PWMC) – AGB = 44%, after 56% discount off gross charges

AGB = Maximum Amount Due under FAP

AGB and Financial Assistance Discounts Off of Gross Charges

2018 FPL	100%	125%	140%	150%	160%	170%	180%	190%	200%	225%	250%	275%	300%	325%	350%	375%	400%
PPMH																	
Discount	100%	100%	95%	92%	90%	88%	85%	82%	80%	78%	75%	72%	70%	68%	65%	64%	62%
Pt. Responb.	0%	0%	5%	8%	10%	12%	15%	18%	20%	22%	25%	28%	30%	32%	35%	36%	38%
PSMC																	
Discount	100%	100%	95%	92%	90%	88%	85%	82%	80%	78%	75%	74%	72%	70%	68%	65%	63%
Pt. Responb.	0%	0%	5%	8%	10%	12%	15%	18%	20%	22%	25%	26%	28%	30%	32%	35%	37%
PWMC																	
Discount	100%	100%	96%	93%	90%	88%	86%	83%	80%	76%	73%	70%	66%	63%	60%	58%	56%
Pt. Responb.	0%	0%	4%	7%	10%	12%	14%	17%	20%	24%	27%	30%	34%	36%	40%	42%	44%

EXHIBIT 2

ALL FINANCIAL ASSISTANCE INFORMATION MAY BE OBTAINED FREE OF CHARGE, UPON REQUEST, AT THE LOCATIONS BELOW OR AT WWW.PHOEBEHEALTH.COM

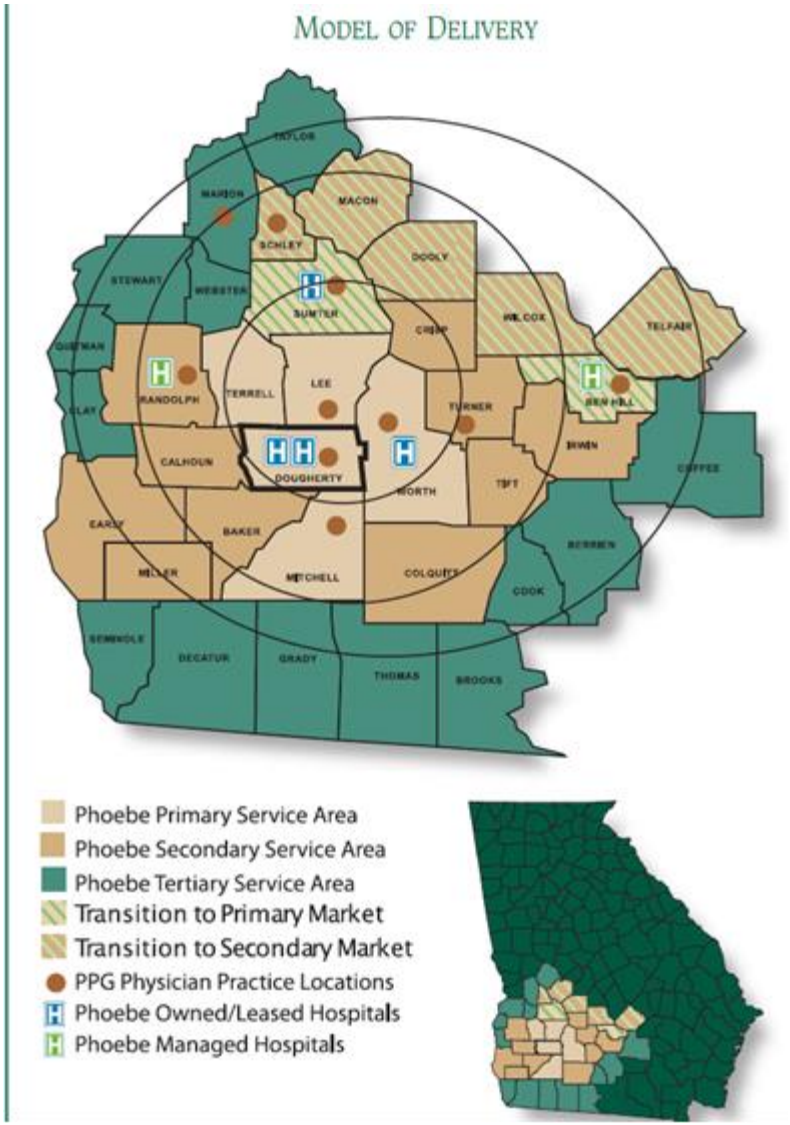
Mailing Address	Hours of Operation
Phoebe Financial Counseling Dept Phoebe Putney Memorial Hospital 417 Third Avenue P.O. Box 3770 Albany, GA 31706-3770 229-312-4220 or 866-514-0015 229-312-4225 (fax)	By telephone at 229-312-4220 or 866-514-0015 from 8:30AM-4:30PM, Monday-Friday Walk-in hours from 8:00AM-5:00PM, Monday-Friday Scheduled appointments from 9:00AM-4:00PM, Monday-Friday Floor visits are available upon request from a patient or responsible party, or any staff member within the organization
Phoebe Financial Counseling Dept. Phoebe Sumter Medical Center 126 Highway 280 West P.O. Box 527 Americus, GA 31719 229-931-1292 229-931-1186 (fax)	By telephone at 229-931-1292 from 8:30AM-4:30PM, Monday-Friday Walk-in hours from 9:00AM-12:00PM, Monday-Friday Scheduled appointments from 1:00PM-4:00PM, Monday-Friday Floor visits are available upon request from a patient or responsible party, or any staff member within the organization

Phoebe Worth Medical Center 807 S Isabella Street P.O. Box 545 Sylvester, GA 31791 229-776-6961 229-776-7062 (fax)	By telephone at 229-776-6961 from 8:30AM-4:30PM, Monday-Friday Walk-in hours from 9:00AM-12:00PM, Monday-Friday Scheduled appointments from 1:00PM-4:00PM, Monday-Friday Floor visits are available upon request from a patient or responsible party, or any staff member within the organization
Phoebe Financial Counseling Dept. Phoebe Physicians Group, Inc. 500 3rd Ave. Ste. 101 P.O. Box 3109 Albany, GA 31706-3770 229-312-5815 (fax)	By telephone at 229-312-5841, 229-312-5842 or 877-844-1943 from 8:30AM-4:30PM, Monday-Friday

EXHIBIT 3

- **PPMH and PSMC**: Baker, Calhoun, Dooly, Dougherty, Lee, Macon, Marion, Mitchell, Randolph, Schley, Stewart, Sumter, Terrell, Webster, and Worth
- **PWMC**: Dougherty and Worth
- Georgia residents who are existing patients of PPG physicians will be deemed to have met the residency requirement regardless of which county in Georgia they currently reside.

Model of Delivery



DOUGHERTY COUNTY

PRIORITY SCORING TOOL

Indicator	County State	County US	Value State	Value US	Target HP2020	Trend	Score	Precision
Alzheimer's Disease or Dementia: Medicare Population	3	3	3	3	1.5	3	2.83	High
Homeownership	3	3	3	3	1.5	3	2.83	High
People 65+ Living Alone	3	3	3	3	1.5	3	2.83	High
Severe Housing Problems	3	3	3	3	1.5	3	2.83	High
Colorectal Cancer Incidence Rate	3	3	3	3	3	2	2.78	High
Adults who Smoke	3	3	3	3	3	1.5	2.67	High
Liquor Store Density	3	2	3	3	1.5	3	2.67	High
Stroke: Medicare Population	3	3	3	3	1.5	2	2.61	High
Students Eligible for the Free Lunch Program	3	3	3	3	1.5	2	2.61	High
Age-Adjusted Death Rate due to Diabetes	3	1.5	3	3	1.5	3	2.58	Medium
Age-Adjusted Death Rate due to Prostate Cancer	1.5	3	3	3	3	2	2.53	High
Babies with Low Birth Weight	3	1.5	3	3	3	2	2.53	High
Cervical Cancer Incidence Rate	1.5	3	3	3	3	2	2.53	High
Food Insecurity Rate	3	3	3	3	1.5	1.5	2.50	High
Insufficient Sleep	3	3	3	3	1.5	1.5	2.50	Medium
Oral Cavity and Pharynx Cancer Incidence Rate	2	2	3	3	1.5	3	2.50	High
Poor Physical Health: Average Number of Days	3	3	3	3	1.5	1.5	2.50	Medium
Self-Reported General Health Assessment: Poor or Fair	3	3	3	3	1.5	1.5	2.50	Medium
Total Employment Change	3	3	3	3	1.5	1.5	2.50	Medium
Age-Adjusted Death Rate due to Cancer	2	2	3	3	3	2	2.44	High
Age-Adjusted Death Rate due to Lung Cancer	2	2	3	3	3	2	2.44	High
Adults 20+ who are Obese	3	3	3	1.5	3	1.5	2.42	Medium
Babies with Very Low Birth Weight	3	1.5	3	3	3	1.5	2.42	High
Preterm Births	3	1.5	3	3	3	1.5	2.42	Medium
Child Food Insecurity Rate	3	3	3	3	1.5	1	2.39	High
Children Living Below Poverty Level	3	3	3	3	1.5	1	2.39	High
Families Living Below Poverty Level	3	3	3	3	1.5	1	2.39	High
Food Environment Index	3	3	3	3	1.5	1	2.39	High
Median Household Income	3	3	3	3	1.5	1	2.39	High
People Living 200% Above Poverty Level	3	3	3	3	1.5	1	2.39	High

Indicator	County		Value		Target			
	State	US	State	US	HP2020	Trend	Score	Precision
People Living Below Poverty Level	3	3	3	3	1.5	1	2.39	High
Single-Parent Households	3	3	3	3	1.5	1	2.39	High
Unemployed Workers in Civilian Labor Force	3	3	3	3	1.5	1	2.39	High
Chlamydia Incidence Rate	3	1.5	3	3	1.5	2	2.36	Medium
Gonorrhea Incidence Rate	3	1.5	3	3	1.5	2	2.36	Medium
Persons with Disability Living in Poverty	1.5	3	3	3	1.5	2	2.36	Medium
Violent Crime Rate	3	1.5	3	3	1.5	2	2.36	Medium
Age-Adjusted Death Rate due to High Blood Pressure	3	1.5	3	1.5	1.5	3	2.33	Medium
Frequent Physical Distress	3	3	3	2	1.5	1.5	2.33	Medium
Poor Mental Health: Average Number of Days	3	2	3	3	1.5	1.5	2.33	Medium
Food Insecure Children Likely Ineligible for Assistance	3	2	2	3	1.5	2	2.28	High
Hypertension: Medicare Population	2	3	2	3	1.5	2	2.28	High
Lung and Bronchus Cancer Incidence Rate	2	2	3	3	1.5	2	2.28	High
Inadequate Social Support	3	3	3	1.5	1.5	1.5	2.25	Medium
People 65+ Living Below Poverty Level	2	3	3	3	1.5	1	2.22	High
Age-Adjusted Death Rate due to Influenza and Pneumonia	2	1.5	3	3	1.5	2	2.19	Medium
Median Housing Unit Value	2	1.5	3	3	1.5	2	2.19	Medium
Frequent Mental Distress	3	3	3	1	1.5	1.5	2.17	Medium
Prostate Cancer Incidence Rate	3	3	3	3	1.5	0	2.17	High
Rheumatoid Arthritis or Osteoarthritis: Medicare Population	2	2	2	2	1.5	3	2.17	High
Teen Birth Rate: 15-17	3	1.5	3	3	1.5	1	2.14	Medium
Fast Food Restaurant Density	3	3	1.5	1.5	1.5	2	2.11	Medium
Osteoporosis: Medicare Population	3	2	3	1	1.5	2	2.11	High
All Cancer Incidence Rate	3	3	2	2	1.5	1	2.06	High
Cancer: Medicare Population	3	3	2	2	1.5	1	2.06	High
4th Grade Students Proficient in English/Language Arts	3	1.5	3	1.5	1.5	1.5	2.00	Low
4th Grade Students Proficient in Math	3	1.5	3	1.5	1.5	1.5	2.00	Low
8th Grade Students Proficient in English/Language Arts	3	1.5	3	1.5	1.5	1.5	2.00	Low
8th Grade Students Proficient in Math	3	1.5	3	1.5	1.5	1.5	2.00	Low
Access to Exercise Opportunities	1	2	3	3	1.5	1.5	2.00	Medium

Indicator	County		Value		Target			
	State	US	State	US	HP2020	Trend	Score	Precision
Children with Low Access to a Grocery Store	3	3	1.5	1.5	1.5	1.5	2.00	Low
Low-Income and Low Access to a Grocery Store	3	3	1.5	1.5	1.5	1.5	2.00	Low
People 65+ with Low Access to a Grocery Store	3	3	1.5	1.5	1.5	1.5	2.00	Low
People with Low Access to a Grocery Store	3	3	1.5	1.5	1.5	1.5	2.00	Low
Asthma: Medicare Population	2	2	2	2	1.5	2	1.94	High
Breast Cancer Incidence Rate	2	2	2	2	1.5	2	1.94	High
Life Expectancy for Males	2	3	2	2	1.5	1	1.89	High
Renters Spending 30% or More of Household Income on Rent	3	3	1	2	1.5	1	1.89	High
Student-to-Teacher Ratio	3	3	2	1	1.5	1	1.89	High
Annual Particle Pollution	1.5	3	1.5	1.5	1.5	2	1.86	Low
Median Monthly Owner Costs for Households without a Mortgage	3	1.5	2	1	1.5	2	1.86	Medium
Chronic Kidney Disease: Medicare Population	1	2	1	2	1.5	3	1.83	High
Households with No Car and Low Access to a Grocery Store	2	3	1.5	1.5	1.5	1.5	1.83	Low
Per Capita Income	1	3	3	3	1.5	0	1.83	High
Infant Mortality Rate	1.5	1.5	3	1.5	3	1	1.81	Medium
Diabetes: Medicare Population	1	2	2	2	1.5	2	1.78	High
Adults 20+ who are Sedentary	2	2	3	1.5	0	1.5	1.75	Medium
Adults 20+ with Diabetes	1	2	3	1.5	1.5	1.5	1.75	Medium
Adults with Health Insurance	2	3	2	1.5	3	0	1.75	High
Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	2	1.5	2	3	3	0	1.75	High
Health Behaviors Ranking	3	1.5	1.5	1.5	1.5	1.5	1.75	Low
Infants Born to Mothers with <12 Years Education	2	1.5	3	3	1.5	0	1.75	Medium
Morbidity Ranking	3	1.5	1.5	1.5	1.5	1.5	1.75	Low
Mortality Ranking	3	1.5	1.5	1.5	1.5	1.5	1.75	Low

Indicator	County		Value		Target	Trend	Score	Precision
	State	US	State	US	HP2020			
Social and Economic Factors Ranking	3	1.5	1.5	1.5	1.5	1.5	1.75	Low
Syphilis Incidence Rate	1.5	1.5	3	1.5	1.5	1.5	1.75	Low
Life Expectancy for Females	1	3	2	2	1.5	1	1.72	High
People 25+ with a Bachelor's Degree or Higher	1	1	3	3	1.5	1	1.72	High
High School Graduation	3	1.5	1	2	2	1	1.69	High
COPD: Medicare Population	1	2	2	2	1.5	1.5	1.67	High
Persons with Health Insurance	1	3	2	1.5	3	0	1.58	High
Physical Environment Ranking	2	1.5	1.5	1.5	1.5	1.5	1.58	Low
People 25+ with a High School Degree or Higher	1	2	2	2	1.5	1	1.56	High
Population 16+ in Civilian Labor Force	1	2	2	2	1.5	1	1.56	High
Teen Pregnancy Rate	2	1.5	3	1.5	0	1	1.56	Medium
Farmers Market Density	1	2	1.5	1.5	1.5	1.5	1.50	Medium
Voter Turnout: Presidential Election	2	1.5	2	0	1.5	1.5	1.42	Medium
Households with Cash Public Assistance Income	2	1	3	0	1.5	1	1.39	High
Mental Health Provider Rate	0	1	2	3	1.5	1	1.39	High
PBT Released	1.5	1.5	1.5	1.5	1.5	1	1.39	Low
Workers Commuting by Public Transportation	0	0	2	3	3	1	1.39	High
Female Population 16+ in Civilian Labor Force	0	1	2	2	1.5	1.5	1.33	High
Grocery Store Density	1	1	1.5	1.5	1.5	1.5	1.33	Medium
Recreation and Fitness Facilities	1	1	1.5	1.5	1.5	1.5	1.33	Medium
Social Associations	1	2	0	0	1.5	3	1.33	High
Age-Adjusted Death Rate due to Motor Vehicle Collisions	0	1.5	1	1.5	1.5	2	1.28	Medium
Depression: Medicare Population	1	1	1	1	1.5	2	1.28	High
SNAP Certified Stores	1	0	1.5	1.5	1.5	2	1.28	Medium
Workers who Drive Alone to Work	0	1	1	2	1.5	2	1.28	High
Clinical Care Ranking	0	1.5	1.5	1.5	1.5	1.5	1.25	Low
Substantiated Child Abuse Rate	1	1.5	3	1	1.5	0	1.25	Medium
Median Household Gross Rent	2	1.5	0	0	1.5	2	1.19	Medium
Recognized Carcinogens Released into Air	1.5	1.5	1.5	1.5	1.5	0	1.17	Low
Age-Adjusted Death Rate due to Alzheimer's Disease	0	1.5	0	3	1.5	1	1.14	Medium
Age-Adjusted Death Rate due to Colorectal Cancer	1	1	1	1	1	1.5	1.11	High

Indicator	County		Value		Target			
	State	US	State	US	HP2020	Trend	Score	Precision
Hyperlipidemia: Medicare Population	0	1	1	1	1.5	2	1.11	High
Heart Failure: Medicare Population	1	1	1	1	1.5	1	1.06	High
Children with Health Insurance	0	1	1	1.5	2	1	1.03	High
Mothers who Smoked During Pregnancy	0	1.5	1	0	3	1	0.97	High
Mammography Screening: Medicare Population	0	1	1	1	1.5	1	0.89	High
Drinking Water Violations	0	0	0	1.5	1.5	1.5	0.75	Medium
Mortgaged Owners Median Monthly Household Costs	2	1.5	0	0	1.5	0	0.75	Medium
Linguistic Isolation	1	1	0	0	1.5	1	0.72	High
Diabetic Monitoring: Medicare Population	0	1	1	1	1.5	0	0.67	High
Age-Adjusted Death Rate due to Unintentional Poisonings	0	1.5	0	0	1.5	1	0.64	Medium
Death Rate due to Drug Poisoning	1.5	0	0	0	1.5	1	0.64	Medium
Alcohol-Impaired Driving Deaths	0	0	0	0	1.5	2	0.61	High
Atrial Fibrillation: Medicare Population	0	0	0	0	1.5	2	0.61	High
Solo Drivers with a Long Commute	0	0	0	0	1.5	2	0.61	High
Age-Adjusted Death Rate due to Breast Cancer	0	0	0	1	1	1	0.50	High
Dentist Rate	0	0	0	2	1.5	0	0.50	High
Primary Care Provider Rate	0	0	0	0	1.5	1.5	0.50	High
Age-Adjusted Death Rate due to Falls	0	1.5	0	0	0	1	0.47	High
Age-Adjusted Death Rate due to Suicide	0	1.5	0	0	0	1	0.47	High
Age-Adjusted Death Rate due to Obstructive Heart Disease	1	1.5	0	0	0	0	0.42	High
Ischemic Heart Disease: Medicare Population	0	0	0	0	1.5	1	0.39	High
Adults who Drink Excessively	0	0	0	0	0	1.5	0.33	High
Mean Travel Time to Work	0	0	0	0	1.5	0	0.17	High
Non-Physician Primary Care Provider Rate	0	0	0	0	1.5	0	0.17	High