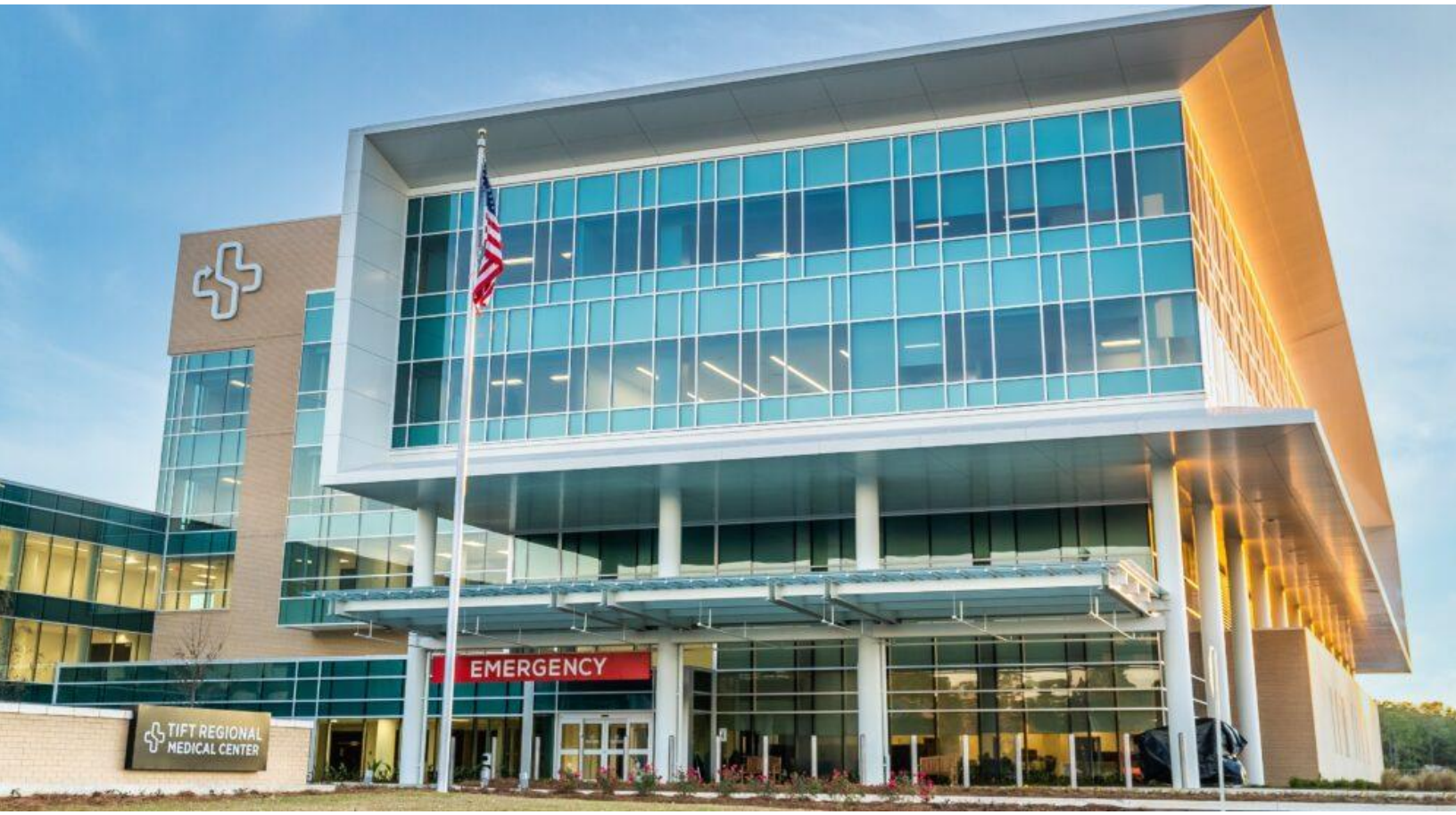
SOUTHWELL



Tift Regional Medical Center

2024 Community Health Needs Assessment

crescendo

Table of Contents

Introduction

With a reputation as an innovative provider of quality care, Southwell (formerly Tift Regional Health System) is a growing, not-for-profit health system serving South Central Georgia. Southwell offers more than 135 physicians with expertise in over 30 specialties. Southwell provides a wide range of care, including signature services in surgery, oncology, cardiovascular care, women's health, neurodiagnostics, geriatric psychiatric care, radiology and more.

Every three years, Southwell undertakes an evaluation of community members' well-being and identified needs and challenges, as well as the resources available to meet those needs. This evaluation comprises the Community Health Needs Assessment (CHNA), serving as the basis for the health system's planning for the subsequent years to develop and bolster programs and services aimed at addressing identified needs. Southwell's 2024 CHNA process yielded two distinct reports: one for Tift Regional Medical Center (Tifton, GA) and another for Southwell Medical (Adel, GA). Although the reports share some content, there are important differences in prioritized needs that delineate between needs unique to each facility.

For the 2024 CHNA, Crescendo Consulting Group utilized a mix of qualitative and quantitative primary research, including strategic secondary data research, focus groups, community member interviews, and a needs prioritization process to evaluate identified community health needs, a mixture of longer standing community needs and emerging challenges.

Background & Mission

Southwell is a growing, not-for-profit health system serving South Central Georgia. Southwell offers more than 135 physicians with expertise in over 30 specialties. Southwell provides a wide range of care, including signature services in surgery, oncology, cardiovascular care, women's health, neurodiagnostics, geriatric psychiatric care, radiology and more.

Mission

Our mission is to deliver a lifetime of quality and compassionate care for each patient we serve.

The Main Campus is **Tift Regional Medical Center**, a 181-bed regional referral hospital located in Tifton. The Tifton West Campus houses various diagnostic services and the region's largest multi-specialty clinic. The Cook County campus is anchored by Southwell Medical, an acute care facility which includes state-of-the-art surgical services and a 12-bed geriatric psychiatric unit. This campus also includes Southwell Health and Rehabilitation, a 95-bed skilled rehabilitation facility.

The CHNA plays a pivotal role for Southwell, enabling the organization to tailor services and strategies to meet the evolving needs of the community. By aligning inpatient hospitalization, outpatient services, and integrated care capabilities with identified community needs, Southwell strives to effectively allocate resources for maximum impact.

Previous CHNAs have provided Southwell with comprehensive insights into healthcare priorities, focusing on medical health, behavioral health, and co-existing conditions. These assessments have served as the foundation for developing Implementation Plans and fostering ongoing community engagement efforts.

In pursuit of its strategic objectives, Southwell remains committed to understanding community health needs and ensuring adequate healthcare capacity to meet those needs. To this end, concurrent research has been conducted to formulate a Medical Staff Development Plan (MSDP), a related but distinct assessment process entailing research activities that overlapped with (and informed) Southwell's 2024 CHNA.

CHNA Requirements

Some of the key requirements of the Community Health Needs Assessment, as directed by the guidelines reflected in the Affordable Care Act and as noted in the Internal Revenue Service document: Community Health Needs Assessment for Charitable Hospital Organizations - Section 501(r)(3)[1]

1. Define the community it serves.
2. In assessing the community's health needs, solicit and consider input received from persons who represent the broad interests of that community, including those with special knowledge of or expertise in public health.
3. Describe activities taken to address previous Community Needs rankings.
4. Assess the health needs of that community.
    1. Clear methodology to identify needs and to prioritize needs
    2. A distinct list of prioritized needs
    3. A resource guide or other information available to help community members locate services
5. Document the CHNA in a written report (CHNA report) that is adopted for the hospital facility by an authorized body of the hospital facility.
6. Make the CHNA report widely available to the public.

[1] U.S. Internal Revenue Service. Available at https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3

Update on Progress of Previous Action Plan

The previous CHNA was conducted in 2021. At this time, prioritized needs included:

- Transportation services for people needing to go to a doctor or to the hospital
- Affordable prescription medications
- Senior health services (grouped):
    - Care coordination, diagnosis and treatment
    - Dementia spectrum services
- Behavioral health services (grouped):
    - Substance abuse screening, intervention, treatment, care coordination
    - Behavioral health services for adults for depression, anxiety, or other mental health conditions.
- Health and wellness enhancement (grouped):
    - Access to healthful food
    - Wellness initiatives for adults—exercise and nutrition
    - Obesity—education and prevention

The health system implemented actions to address these needs, with updates on implementation progress described in Appendix A.

FOCUS ON: TRANSPORTATION & ACCESS TO CARE

Southwell's **Mobile Clinic** was deployed following the 2021 CHNA to mitigate access to care issues in hard-to-reach communities. When COVID-19 vaccines were made available, the Mobile Clinic was used to help with mass vaccinations within the community. Following these efforts, the Clinic was re-deployed for a brief period. More recently operation of the Mobile Clinic was suspended due to underutilization.

As an alternative strategy, Southwell implemented an in-home Palliative Care service and a Community Paramedicine Program (CPP). With the **in-home Palliative Care program**, patients receive treatment to relieve symptoms of a disease along with those that may occur under the strain of dealing with a serious, life-limiting disease, such as anxiety, depression, a loss of appetite, fatigue, and difficulties sleeping.

The Southwell Community Paramedicine Program is designed to enhance community wellness, decrease hospital readmissions, and minimize patient utilization of the emergency department for chronic and non-emergent cases. Participants receive visits in their home by a paramedic to address chronic conditions and medication adherence.

Definition of Communities Served

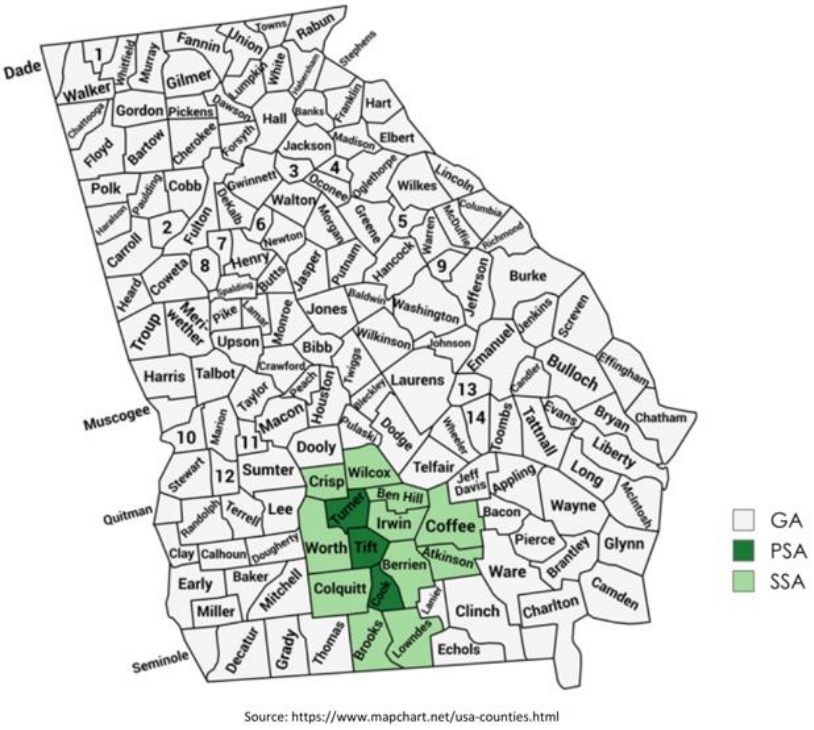
Southwell's service area, for the purposes of this assessment, includes 14 counties in South Central Georgia. Due to the health system's expansion, two additional counties (Brooks and Lowndes) bordering Florida were added to this report as compared to previous reports.

Primary Service Area (PSA)

- Tift County
- Turner County
- Cook County

Secondary Service Area (SSA)

- Atkinson County
- Ben Hill County
- Berrien County
- Brooks County
- Coffee County
- Colquitt County
- Crisp County
- Irwin County
- Lowndes County
- Wilcox County
- Worth County



Source: https://www.mapchart.net/usa-counties.html

The Primary Service Area (PSA) comprises Tift, Turner, and Cook Counties. This area includes more than 67,000 people with high levels of racial, economic, and health status diversity:

- Tift County includes over half of the service area population. Approximately one in three people (29.0%) in the county identify as Black or African American The median household income in Tift County is higher than the median household income in Turner and Cook Counties, which can correlate with better community health.
- Tift, Turner, and Cook Counties have comparable levels of population living in poverty (approximately one in five people).
- Tift County has a notably lower unemployment rate (2.9%) compared to Turner (7.0%) and Cook Counties (5.5%).
- Nearly half of the population in Tift and Turner Counties identify as a minority or person of color, with slightly lower levels in Cook County.

Community Health Needs Assessment Participants

The CHNA Project Team includes members drawn from Southwell and from the broader community. The Project Team was engaged in the CHNA through participation in interviews, support for focus groups and community survey activities (where possible), assistance in identifying other stakeholder who could inform the project, and participation in prioritization of identified needs.

Project Team Participants

Southwell participants

Name	Title
Dr. Cameron Nixon	Chief Transformation Officer
Dr. Flavia Rossi	Pediatrician
Chris Efaw	VP, Marketing and Communications
Monica Morris	Director, Physician Recruitment
Carla Hall	Director, Medical Clinics
Jill McIntyre, RN	Director, Diversity, Inclusion and Wellness
Mary Perlis, RN	Director, Outpatient Case Management
Ken Kiser, NP-C	Nurse Practitioner
Amanda Ramshead	Director, Behavioral Services
LeAnn Pritchett	Director, Patient Safety
Karen Rodriguez	Credentialing Coordinator

Community participants

Name	Title/Organization
Melissa Hughes	County Commissioner District 2, Tift County Board of Commissioners
Joel Presley	Georgia State Office of Rural Health
Wasdon Graydon	Board Member, Southwell Board of Directors
Nancy Bryan	Executive Director, Ruth's Cottage & Patticake House
Fran Kinchen	Director, Leroy Rogers Center
Renata Elad	Dean, Stafford School of Business
Dina Willis	Tifton Tift County Public Library/Hispanic Community Activist
Marcus Seigle	Chiropractor/Hispanic Community Activist
Dr. Joel Johnson	Retired General Surgeon
Tom Riddle	President, M.R.S. Homecare
Melissa Hughes	County Commissioner District 2, Tift County Board of Commissioners

In addition to the Project Team, other members of both the Southwell organization and the greater community were invited to participate in the CHNA research, including:

INTERVIEWS

Southwell participants

Name	Title
Chris Dorman	President/CEO
Claire Byrnes	SVP, Ambulatory Services
Dr. Andrew Nackashi	General Surgeon
Dr. David McEachin	Chief Medical Officer
Dr. Jessica Beier	Medical Director, Laboratory, Quality and Safety
Dr. Raymond Moreno	Internist, Southwell Medical Clinic
Dr. Rubal Patel	Medical Director, Pulmonary and Critical Care
Dr. Shannon Price	OB/GYN
Jay Carmichael	Chief Operating Officer, Southwell Medical
Kristy Walters	Physician Liaison

In addition to the CHNA, these Southwell executives and directors, and clinicians from across medical specialties (both within the health system and in the community) were engaged regarding the Medical Staff Development Plan. Each member was invited to provide feedback regarding perceptions of patient acuity changes, quantity of providers of various specialties, retirement plans, and area health needs. These individuals had a breadth of community health vision, knowledge, and power to impact the well-being of the service area.

Community Participants

Name	Title/Organization
Jim Carter	County Manager
Joel Presley	Georgia State Office of Rural Health
Judge Chase Daughtery	Southwell, Inc., Board of Directors/Cook County Probate Court
Judge Herbert Benson	State Court of Tift County
Julie Smith	Mayor, City of Tifton
MJ Hall	District 4 Councilman, Tift City Council
Nancy Bryan	Executive Director, Ruth's Cottage & Patticake House
Thomas Fausett, MD	Family Physician
Toni Reid	Tifton Area Manager, Georgia Power
Tony McBrayer	Chairman, Tift County Board of Commissioners

Assessment Methodology

The CHNA methodology utilized both quantitative and qualitative research methods in order to evaluate perspectives and opinions of area stakeholders and healthcare consumers, particularly underserved populations. This methodology was directed towards prioritization of identifed needs, establishing a basis for continued community engagement in addition to simply developing a broad, community-based list of needs.

Major elements of the methodology include the following:

- Strategic secondary research and data analysis;
- One-on-one interviews with Southwell leaders, Project Team members, other community leaders and service providers, and healthcare consumers in the primary and secondary service areas;
- Qualitative discussion groups with community leaders and service providers, members of underserved populations, and other healthcare consumers in the primary and secondary service areas;
- Surveys of community stakeholders and medical staff; and
- Prioritization of identified needs.

Each of these components of the CHNA methodology is described below.

Strategic secondary research. This includes a thorough analysis of published materials that provide insight regarding the community profile and health-related measures. Examples of data sources considered as part of this research are included in the table below.

Data Source Examples	Data Goal

• Demographic Data
  ○ U.S. Census Bureau
  ○ U.S. Centers for Disease Control and Prevention
  ○ Georgia Department of Health
• CDC Health Risk Behavior Data
  ○ Behavioral Risk Factor Surveillance System Survey
  ○ Robert Wood Johnson Foundation
• Existing materials (including hospital discharge data) from TRHS and other organizations
• Health profile and incidence data from Georgia Department of Public Health and others
• Birth and Death Statistics
• Chronic disease data from the Cancer Registry and others
	Strategic secondary research data goals include properly framing the service area in terms of lifestyle, demographic factors, and general health trends, and to better understand previous research conducted for the hospital.
	
	In addition, goals include developing a better understanding of community health, morbidity and mortality data, key health-related factors that impact the PSA or SSA, and disease-based incidence levels that exceed Georgia or national averages.

One-on-one interviews with providers, Southwell leaders, Project Team members, other community leaders and service providers, and healthcare consumers in the primary and secondary service areas. One-on-one interviews allowed for an in-depth and confidential discussion of issues relevant to the interviewee and the community.

Qualitative discussion groups with community leaders and service providers, and healthcare consumers in the primary and secondary service areas. Participants in the discussion groups represented a variety of stakeholders, including underserved populations and public health representatives. While each meeting did not include representatives from each group, information and insights were gathered either from their participation in a focus group or in a one-on-one telephone interview. Discussion group goals involve creating a broad list of community health needs. A thorough review of the research includes extensive input from community group participants in an effort to "cast a broad net" to secure opinions from across the service area, especially among the underserved.

Community surveys. To receive input from local residents, Southwell conducted a Community Health Needs Survey among adults (age 18+) in the service area. The health system created a successful marketing campaign to encourage the community to participate in the online survey, which was made available in English and in Spanish. There were nearly 550 total participants in the survey. The survey included representation across the PSA counties and a diverse mix of economic strata and educational attainment levels.

Prioritization of needs. A two-part prioritization process was conducted with the Project Team in order to narrow down the list of needs and gaps identified during the qualitative and quantitative research process. The Project Team first received a list of all identified needs and were asked to rate them on a seven-point scale and provide a short comment regarding the rationale for the rating. The second round included a virtual meeting where the results were presented and participants had the opportunity to discuss the results, make comments, and determine if any changes to the prioritized list were needed.

Community Needs Assessment Research Summary

The following sections present results of the secondary research, primary quantitative research, and primary qualitative research. Major sub-sections include the following:

- Primary Service Area Data Focus
- Social and Physical Environment
- Health Status Profile
- Hospital Inpatient Discharge Data Patterns
- Patient, Community Stakeholder, Provider, and Staff Discussions
- Community Survey Results
- Implementation Strategy Considerations

Secondary Population Research

Secondary data provides an essential framework from which to better understand the fabric of the community. This analysis highlights sociodemographic factors, social determinants of health, behavioral health risk factors, and other key indicators to further guide the development of effective strategies to meet evolving needs. The following data was primarily gathered from the United States Census Bureau 2018-2022 American Community Survey (ACS) Five-year Estimates, the Centers for Disease Control and Prevention (CDC), County Health Rankings and Roadmaps, and the Georgia Department of Public Health, among others.

American Community Survey Five-year Estimates

There is an intentional purpose in using five-year data estimates compared to one-year data estimates. Five-year estimates are derived from data samples gathered over several subsequent years and provide a more accurate estimate of measures, especially among numerically smaller high-risk populations or subgroups, compared to one-year estimates, which are based on more limited samples with greater variance.[2]

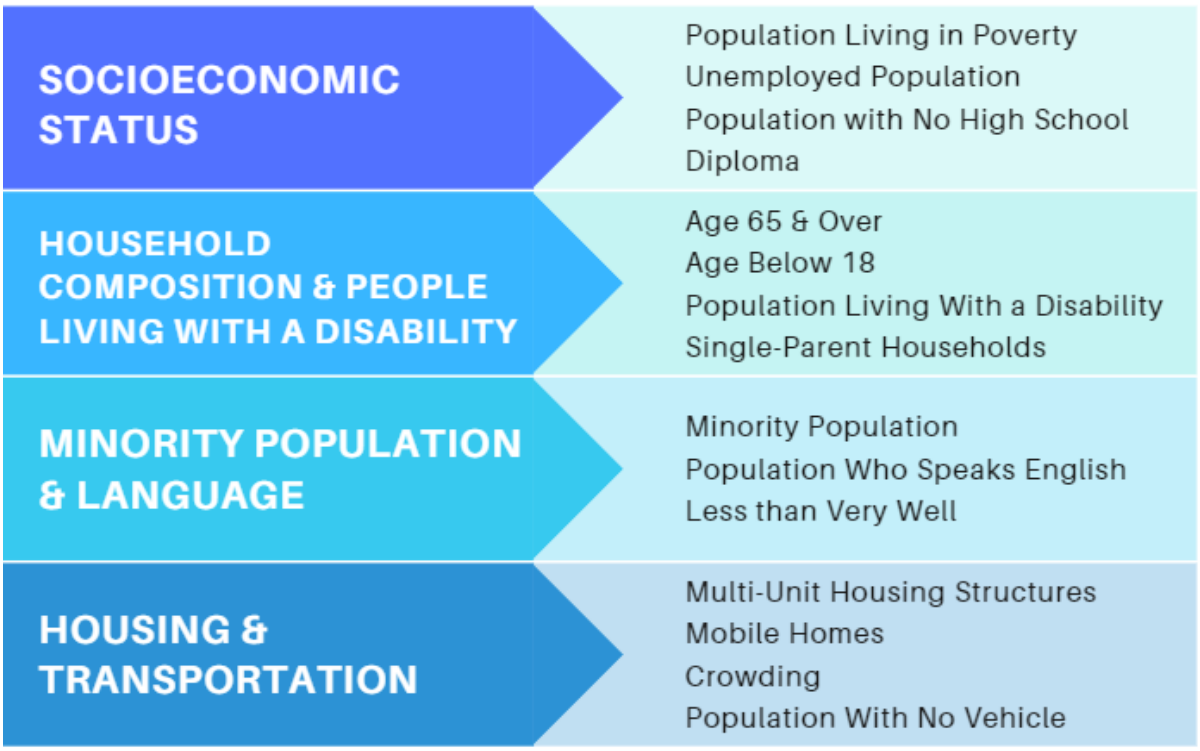
This assessment incorporates data indicators at the county and zip code level, where available, to provide the most granular overview of the population in Southwell's service area.

[2] American Community Survey, 2010 and 2019 Five-year Estimates. Link: census.gov/programs-surveys/acs

The Social Vulnerability Index

The Social Vulnerability Index (SVI) was developed by the U.S. Centers for Disease Control and Prevention as a metric for analyzing population data to identify vulnerable populations. The SVI may be used to rank overall population well-being and mobility relative to county and state data. The SVI can also be used to determine the most vulnerable populations during disaster preparedness and public health emergencies, including pandemics.[3]

The SVI measures are grouped into four major categories:



Source: CDC/ATSDR Social Vulnerability Index

[3] Agency for Toxic Substances & Disease Registry, CDC/ATSDR Social Vulnerability Index. Link: atsdr.cdc.gov/placeandhealth/svi/index.html

Exhibit 1: Social Vulnerability Index (SVI)

	United States	Georgia	Tift PSA	Tift County	Turner County	Cook County	Tift SSA	Atkinson County	Ben Hill County
SVI Score[4]	ND	ND	ND	0.70	0.81	0.68	ND	0.86	0.88
Total Population	331,097,593	10,722,325	67,383	41,247	8,894	17,242	326,309	8,265	17,169
Living in Poverty	12.5%	13.5%	21.4%	21.0%	22.4%	21.8%	22.2%	27.5%	26.5%
Unemployment Rate[5]	5.3%	5.2%	4.5%	2.9%	7.0%	5.5%	5.5%	4.6%	5.0%
Median Household Income	$75,149	$71,355	$54,307	$52,561	$39,666	$46,706	$54,935	$38,007	$38,255
No High School Diploma (Age 25+)	10.9%	11.3%	17.2%	16.1%	20.5%	18.1%	16.6%	29.6%	16.3%
65 and Older	16.5%	14.4%	15.9%	15.3%	18.6%	16.2%	15.4%	13.3%	17.7%
Under 18	22.1%	23.4%	25.0%	25.0%	24.6%	25.2%	24.0%	25.7%	24.6%
Living With a Disability[6]	12.9%	12.7%	13.3%	10.8%	19.5%	16.2%	14.6%	12.9%	12.0%
Single-parent Households	24.6%	30.6%	ND	36.6%	50.3%	26.0%	ND	29.9%	45.7%
Minority Population[7]	41.1%	49.2%	43.7%	45.9%	45.9%	37.4%	43.8%	45.8%	45.5%
Speak English Less than Very Well	8.2%	5.5%	3.4%	3.6%	3.8%	2.6%	3.5%	15.3%	2.1%
Mobile Homes	5.8%	8.1%	23.2%	21.6%	21.6%	27.9%	21.7%	43.4%	21.4%
Living in Group Quarters	2.4%	2.3%	3.7%	4.7%	3.9%	1.4%	3.4%	0.4%	1.9%
Multi-Unit Properties	26.5%	20.8%	ND	17.3%	9.1%	7.9%	ND	6.1%	17.0%
With No Vehicle	8.3%	6.0%	8.2%	8.2%	9.5%	7.5%	7.5%	4.4%	10.0%

Source: U.S. Census Bureau American Community Survey 2018-2022 Five-year Estimates

[4] A percentile ranking represents the proportion of tracts (or counties) that are equal to or lower than a tract (or county) of interest in terms of social vulnerability. For example, a CDC/ATSDR SVI ranking of 0.85 signifies that 85% of tracts (or counties) in the state or nation are less vulnerable than the tract (or county) of interest and that 15% of tracts (or counties) in the state or nation are more vulnerable, CDC/ATSDR SVI Frequently Asked Questions (FAQ) | Place and Health | ATSDR

[5] Civilians 16 years old and over are classified as unemployed if they (1) were neither "at work" nor "with a job but not at work" during the reference week, and (2) were actively looking for work during the last 4 weeks, and (3) were available to accept a job.

[6] Base on population of all U.S. civilians not residing in institutional group quarters facilities such as correctional institutions, juvenile facilities, skilled nursing facilities, and other long-term care living arrangements.

[7] Data values were calculated by taking the total population minus the white (not Latino, not Hispanic) population.

Exhibit 2: Social Vulnerability Index, Continued

	Berrien County	Brooks County	Coffee County	Colquitt County	Crisp County	Irwin County	Lowndes County	Wilcox County	Worth County
SVI Score[8]	0.47	0.76	0.81	0.95	0.99	0.53	0.55	0.52	0.46
Total Population	18,187	16,551	43,056	45,813	20,255	9,487	118,257	8,839	20,706
Living in Poverty	23.2%	26.5%	20.0%	24.4%	23.6%	22.0%	20.6%	23.0%	19.6%
Unemployment Rate[9]	4.6%	4.9%	4.3%	6.1%	8.2%	6.2%	5.1%	5.3%	7.0%
Median Household Income	$48,670	$42,263	$48,398	$47,235	$47,463	$46,383	$52,821	$46,759	$56,496
No High School Diploma (Age 25+)	18.7%	17.5%	21.7%	22.3%	17.8%	18.3%	10.4%	19.6%	14.5%
65 and Older	17.7%	19.7%	14.7%	15.3%	19.3%	18.3%	12.7%	19.2%	19.5%
Under 18	24.0%	21.5%	24.3%	25.8%	23.5%	22.0%	24.2%	18.0%	22.3%
Living With a Disability[10]	17.3%	17.0%	16.9%	20.3%	21.3%	9.1%	11.5%	12.9%	17.1%
Single-parent Households	29.7%	45.1%	37.8%	42.1%	53.3%	38.6%	36.7%	40.3%	40.4%
Minority Population[11]	19.9%	46.5%	43.2%	45.6%	51.4%	32.2%	47.9%	40.5%	32.9%
Speak English Less than Very Well	1.1%	1.1%	5.8%	7.7%	1.7%	0.7%	2.2%	3.5%	1.0%
Mobile Homes	32.6%	29.3%	33.7%	26.0%	19.6%	24.7%	8.3%	33.9%	35.2%
Living in Group Quarters	1.0%	1.1%	5.9%	2.2%	1.9%	3.0%	3.6%	20.7%	0.9%
Multi-Unit Properties	5.3%	9.4%	7.7%	10.8%	16.3%	4.6%	20.7%	2.4%	7.3%
With No Vehicle	3.8%	7.2%	6.4%	6.9%	13.0%	6.8%	7.5%	6.5%	7.8%

Source: U.S. Census Bureau American Community Survey 2018-2022 Five-year Estimates

[8] A percentile ranking represents the proportion of tracts (or counties) that are equal to or lower than a tract (or county) of interest in terms of social vulnerability. For example, a CDC/ATSDR SVI ranking of 0.85 signifies that 85% of tracts (or counties) in the state or nation are less vulnerable than the tract (or county) of interest and that 15% of tracts (or counties) in the state or nation are more vulnerable, CDC/ATSDR SVI Frequently Asked Questions (FAQ) | Place and Health | ATSDR

[9] Civilians 16 years old and over are classified as unemployed if they (1) were neither "at work" nor "with a job but not at work" during the reference week, and (2) were actively looking for work during the last 4 weeks, and (3) were available to accept a job.

[10] Base on population of all U.S. civilians not residing in institutional group quarters facilities such as correctional institutions, juvenile facilities, skilled nursing facilities, and other long-term care living arrangements.

[11] Data values were calculated by taking the total population minus the white (not Latino, not Hispanic) population.

- Approximately one in five people in the service area are living in poverty, with some counties having slightly higher levels.
- Approximately one in five people in Turner, Coffee, and Wilcox Counties and nearly one in three people in Atkinson County do not have a high school diploma, which can lead to limited career opportunities, fewer earnings, and poverty.[12]
- More than half of children in Turner and Crisp Counties live in single-parent households. Single-parent households are more likely to experience difficulties finding affordable child care, paying for expenses, and are at a higher risk of experiencing poverty.[13]

- Nearly one in six people (15.3%) in Atkinson County speaks English less than very well, indicating there is a vulnerable population that needs translation services and culturally sensitive providers.
- Nearly half of the population in Tift and Turner Counties identifies as a minority.
- Approximately one in five people in Turner County are living with a disability. Similarly, there are high levels of population that is aged 65 and older in Turner County. People living with a disability and older adults are vulnerable populations with specific needs, such as accessible transportation, safe and affordable housing, and services that offer different types of assistance (e.g., assistance with daily living tasks).

12 High School Graduation - Healthy People 2030 | health.gov
13 Economic Precarity among Single Parents in the United States during the COVID-19 Pandemic - Zachary Parolin, Emma K. Lee, 2022 (sagepub.com)

Demographics

Age

About one in four people living in the PSA is under age 18, and more than one in seven are age 65 or older. Turner County has a larger proportion of older residents compared to Tift and Cook counties.

Exhibit 3: Population by Age Group

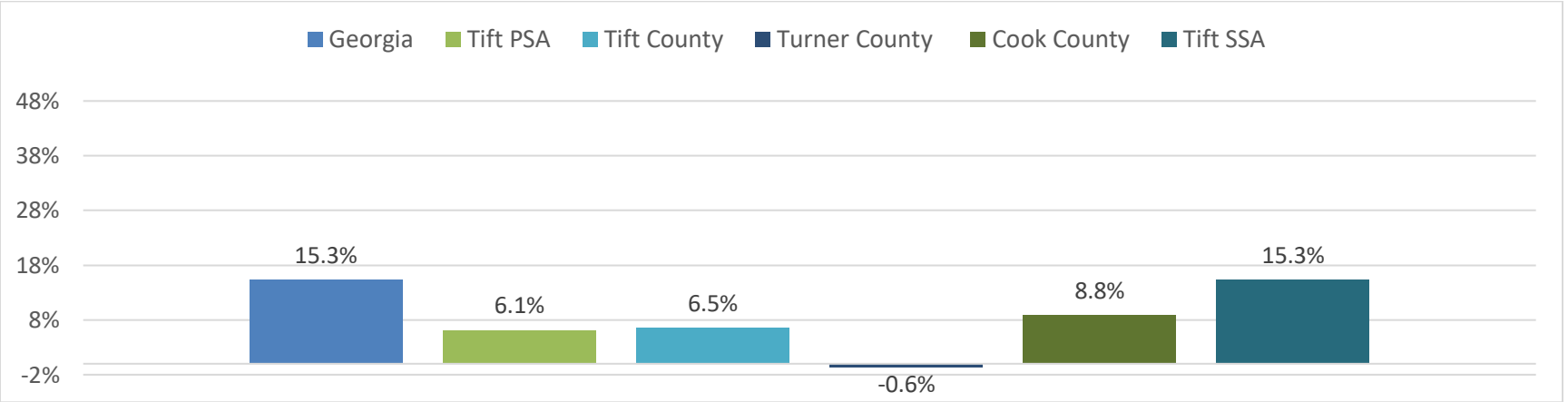
	Tift PSA	Tift County	Turner County	Cook County
Under Age 18	**25.0%**	25.0%	24.6%	25.2%
Age 18 to 64	**59.1%**	59.8%	56.8%	58.6%
Age 65 and Over	**15.9%**	15.3%	18.6%	16.2%
Median Age	**38.2**	36.5	38.9	37.3
Age Under 5	**6.6%**	6.7%	6.8%	6.5%
Age 5 to 9	**5.3%**	5.7%	6.0%	4.0%
Age 10 to 14	**8.8%**	8.4%	8.2%	9.9%
Age 15 to 19	**8.2%**	8.2%	7.2%	8.6%
Age 20 to 24	**5.5%**	5.7%	3.8%	6.0%
Age 25 to 34	**12.5%**	12.9%	12.5%	11.5%
Age 35 to 44	**12.6%**	13.3%	10.9%	11.9%
Age 45 to 54	**11.9%**	11.7%	11.2%	12.6%
Age 55 to 59	**6.6%**	7.2%	4.4%	6.3%
Age 60 to 64	**6.1%**	5.0%	10.4%	6.4%
Age 65 to 74	**9.6%**	9.2%	11.2%	9.6%
Age 75 to 84	**4.8%**	4.5%	6.0%	4.7%
Age Over 85	**1.6%**	1.5%	1.3%	1.9%

Source: U.S. Census Bureau American Community Survey 2018-2022 Five-year Estimates

Population Trends

Turner County is the only county in the service area that is projected to experience an overall percent change decrease (-0.6%) from 2010 to 2031. All other counties and the state are projected to experience an overall percent change increase during that time period.

Exhibit 4: Projected Percent Change in Population, 2010 to 2031



	United States	Georgia	Tift PSA	Tift County	Turner County	Cook County	Tift SSA
Total Population (2010) [14]	308,745,538	9,687,653	66,260	40,118	8,930	17,212	322,536
Total Population (2022)	331,097,593	10,722,325	67,383	41,247	8,894	17,242	326,309
Percent Change, 2010 to 2022	+7.2%	+10.7%	+1.7%	+2.8%	-0.4%	+0.2%	+1.2%
Total Population (2031)	363,255,837	12,364,082	71,526	43,915	8,845	18,766	358,525
Projected Percent Change, 2010 to 2031	+9.7%	+15.3%	+6.1%	+6.5%	-0.6%	+8.8%	+15.3%

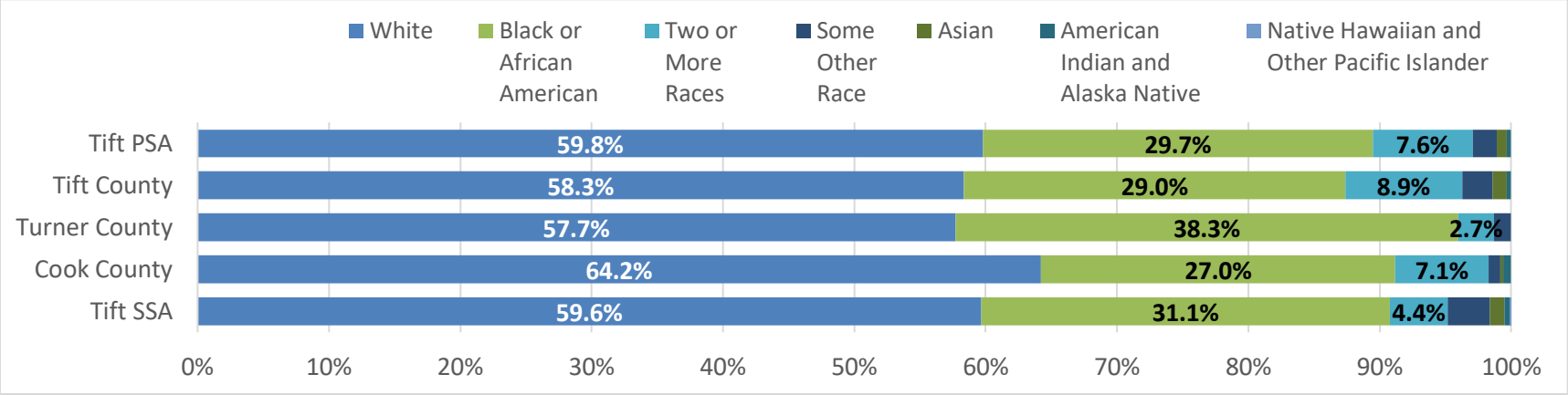
Source: U.S. Census Bureau. American Community Survey Five-Year Estimates, 2018-2022

[14] Totals reported in this row are Census 2010 population counts. The remainder of this report features more recent estimates of population, as derived from the Census Bureau's American Community Survey over the 2018-2022 period.

Race & Ethnicity

The majority of the service area is comprised of people who identify as White alone, or Black or African American. Tift and Cook counties have notable percentages of population identifying as two or more races. About one in eight people in Tift County identify as Hispanic, which may indicate a need for translation services and culturally sensitive providers.

Exhibit 5: Population by Race (Alone)



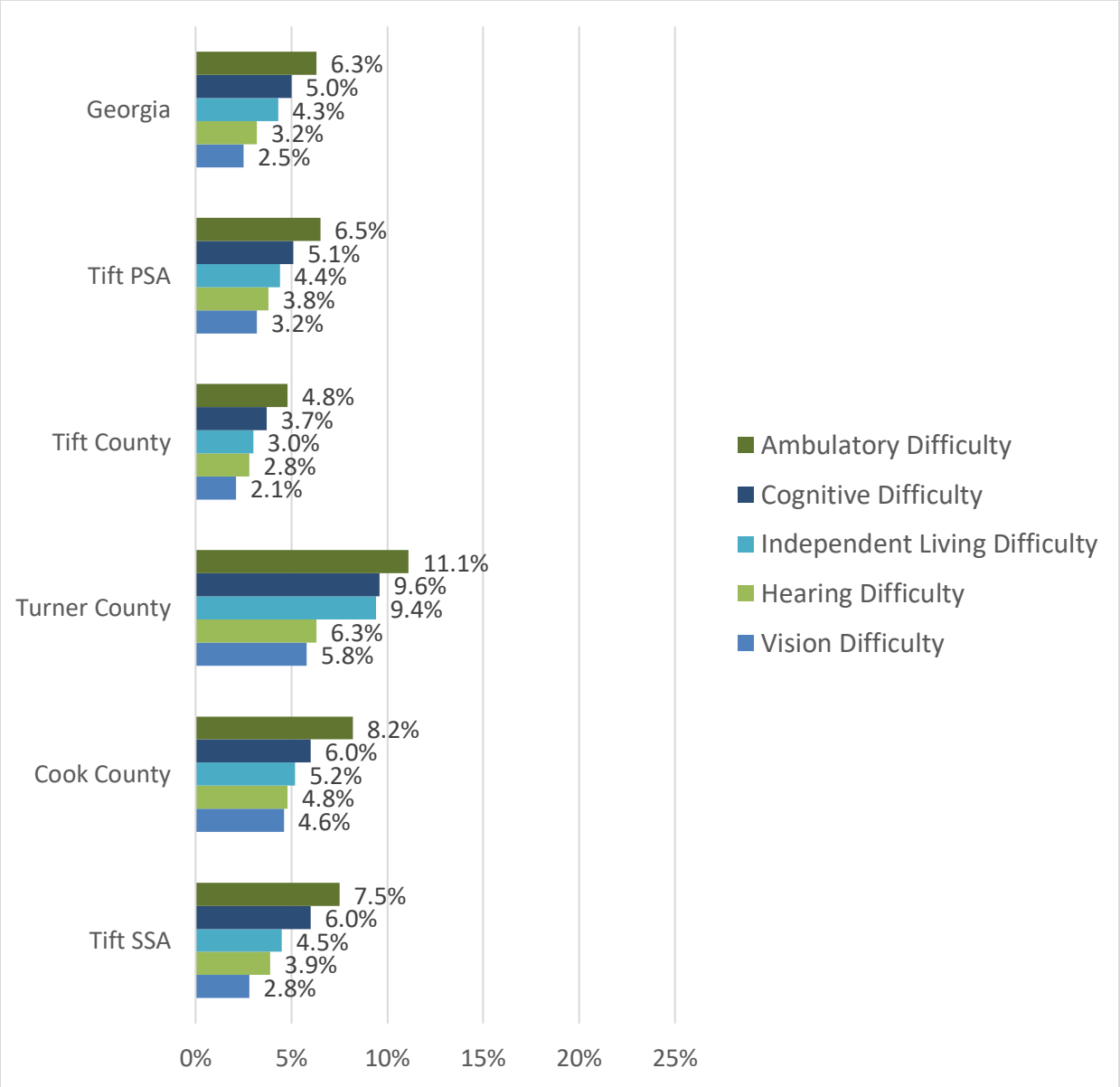
	United States	Georgia	Tift PSA	Tift County	Turner County	Cook County	Tift SSA
RACE							
White	65.9%	54.3%	59.8%	58.3%	57.7%	64.2%	59.6%
Black or African American	12.5%	31.5%	29.7%	29.0%	38.3%	27.0%	31.1%
Two or More Races	8.8%	6.0%	7.6%	8.9%	2.7%	7.1%	4.4%
Some Other Race	6.0%	3.5%	1.8%	2.3%	1.3%	0.9%	3.2%
Asian	5.8%	4.3%	0.8%	1.1%	0.0%	0.2%	1.1%
American Indian and Alaska Native	0.8%	0.4%	0.3%	0.3%	0.0%	0.6%	0.4%
Native Hawaiian and Other Pacific Islander	0.2%	0.1%	0.0%	0.0%	0.0%	0.0%	0.1%
ETHNICITY							
Hispanic	18.7%	10.1%	10.1%	12.6%	5.1%	6.6%	9.1%

Source: U.S. Census Bureau American Community Survey 2018-2022 Five-year Estimates

People Living with a Disability

Most commonly, people in the service area who are living with a disability have an ambulatory difficulty, which is defined as serious difficulty climbing stairs or walking,[15] followed by those who are living with a cognitive difficulty. Turner County has the highest levels among the service area of any type of difficulty.

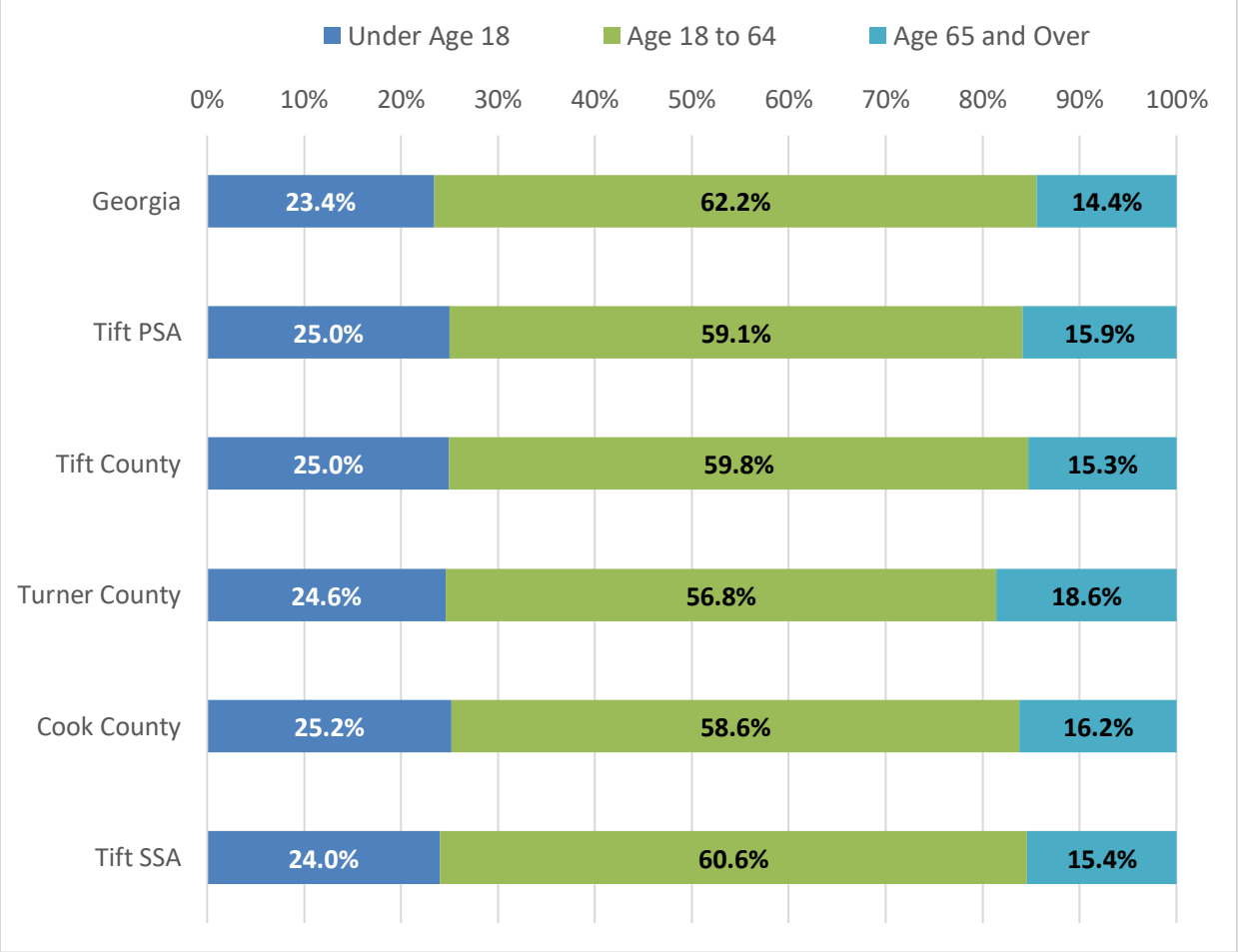
Exhibit 6: Population Living with Disability by Type



[15] How Disability Data are Collected from The American Community Survey (census.gov)

Approximately three in five people in the primary service area are between the ages of 18 and 64. There are also higher levels of children in the service area compared to levels of adults age 65 and older, which indicates a need for services that support children. However, the large adult population indicates there is a need for services that support older adults, such as gerontologists, aging-in-place services, and long-term care planning.

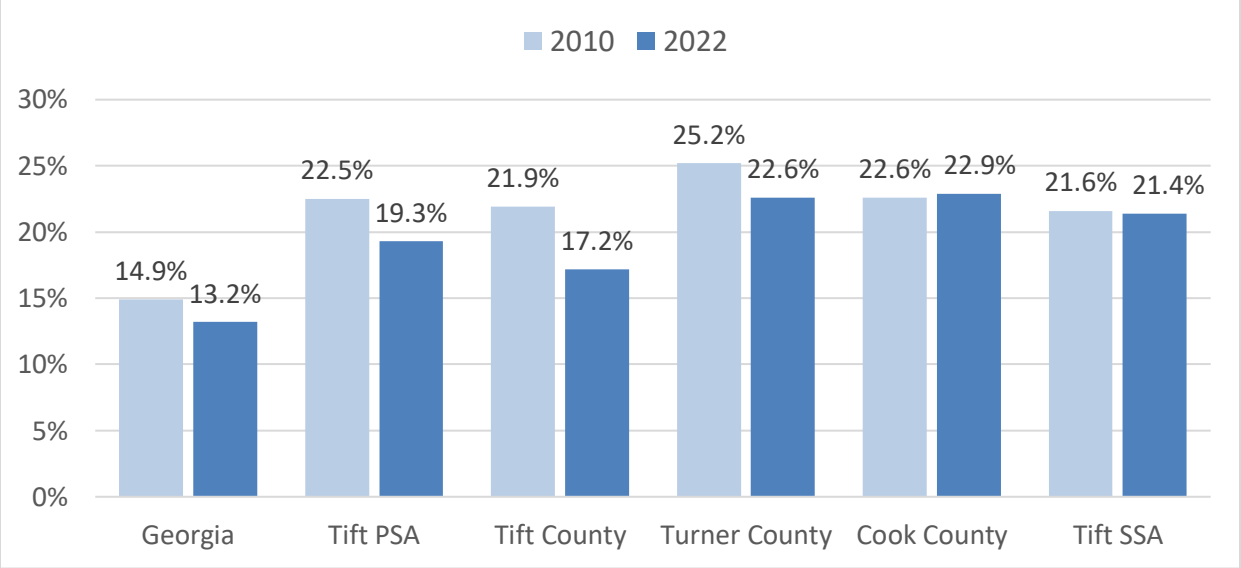
Exhibit 7: Population by Age Group



Economic Stability

People living in poverty are less likely to have access to healthcare, healthy food, stable housing, and opportunities for physical activity. Research suggests that low-income status is associated with adverse health consequences, including shorter life expectancy, higher infant mortality rates, and other poor health outcomes.[16]

Exhibit 8: Poverty Percent Change



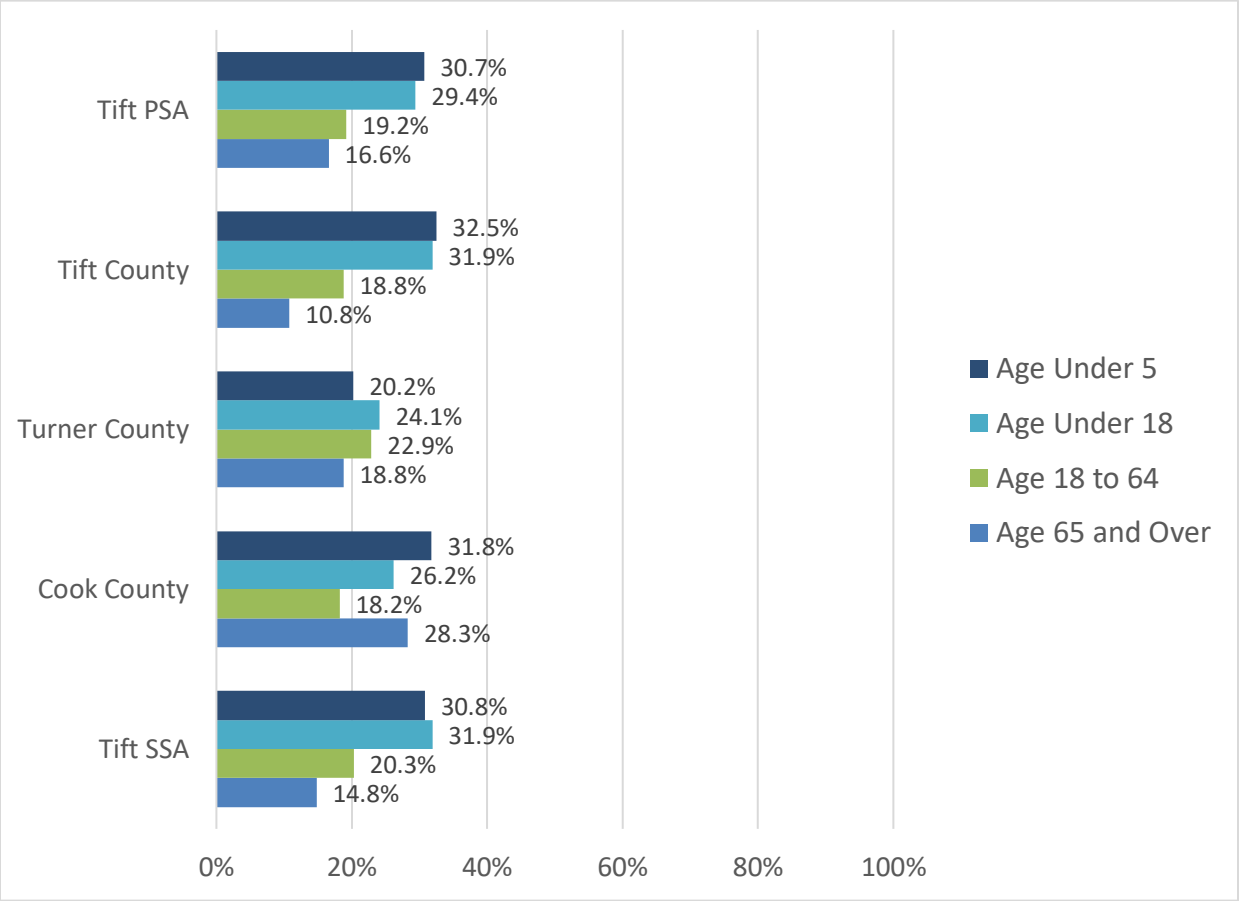
	United States	Georgia	Tift PSA	Tift County	Turner County	Cook County	Tift SSA
Total Households Below Poverty Level per household (2010)	13.1%	14.9%	22.5%	21.9%	25.2%	22.6%	21.6%
Total Households Below Poverty Level per household (2022)	12.4%	13.2%	19.3%	17.2%	22.6%	22.9%	21.4%
Percent Change (2010-2022)	-5.5%	-11.3%	-14.2%	-21.2%	-10.1%	+1.1%	-1.1%

Sources: U.S. Census Bureau American Community Survey 2010 One-Year Estimates | U.S. Census Bureau American Community Survey 2018-2022 Five-year Estimates

[16] American Academy Of Family Physicians, Poverty & Health. The Family Medicine Perspective, April 2021. Link e: www.aafp.org/about/policies/all/poverty-health.html

Approximately one out of five people in the service area live in poverty. High percentages of children live in poverty, with one-third of children under age five in Tift County, Cook County, and the Tift PSA and SSA living in poverty. There are similar levels of children under age 18 living in poverty throughout the service area. Poverty is interconnected with income, education, opportunity, hunger, and wellbeing.[17] Children who grow up in poverty do not have their fundamental needs met, which makes it more difficult for them to focus on learning in schools, which can lead to lifelong impacts.

Exhibit 9: Percent of Population Living in Poverty



[17] Poverty Overview: Development news, research, data | World Bank

Exhibit 10: Percent of Population Living in Poverty, by Race, Ethnicity, and Age

	United States	Georgia	Tift PSA	Tift County	Turner County	Cook County
People Below Poverty Level	12.5%	13.5%	**21.4%**	21.0%	22.4%	21.8%
Black or African American	21.5%	19.0%	**31.3%**	30.9%	36.0%	28.7%
Two or More Races	14.8%	15.4%	**28.5%**	31.7%	55.3%	13.7%
Hispanic or Latino	17.2%	18.9%	**24.7%**	26.0%	19.9%	20.7%
American Indian and Alaska Native	22.6%	23.7%	**20.3%**	39.4%	0.0%	0.0%
Asian	10.1%	9.7%	**16.4%**	17.9%	ND	0.0%
White	10.1%	10.0%	**15.7%**	14.4%	12.0%	20.2%
Some Other Race	18.6%	20.5%	**12.9%**	13.6%	6.2%	13.2%
Native Hawaiian and Other Pacific Islander	17.0%	19.2%	**0.0%**	0.0%	ND	ND
Age Under 5	18.1%	20.3%	**30.7%**	32.5%	20.2%	31.8%
Age Under 18	16.7%	18.9%	**29.4%**	31.9%	24.1%	26.2%
Age 18 to 64	11.7%	12.2%	**19.2%**	18.8%	22.9%	18.2%
Age 65 and Over	10.0%	10.3%	**16.6%**	10.8%	18.8%	28.3%

Source: U.S. Census Bureau American Community Survey 2018-2022 Five-year Estimates

Poverty Status, by Educational Attainment

In the primary service area, the proportions of people with advanced levels of education living below the poverty level, including those with a bachelor's degree or higher (7.0%), were greater than the levels observed at the state and national levels (4.3-4.4%).

Exhibit 11: Percent of Population Below the Poverty Level, by Educational Attainment

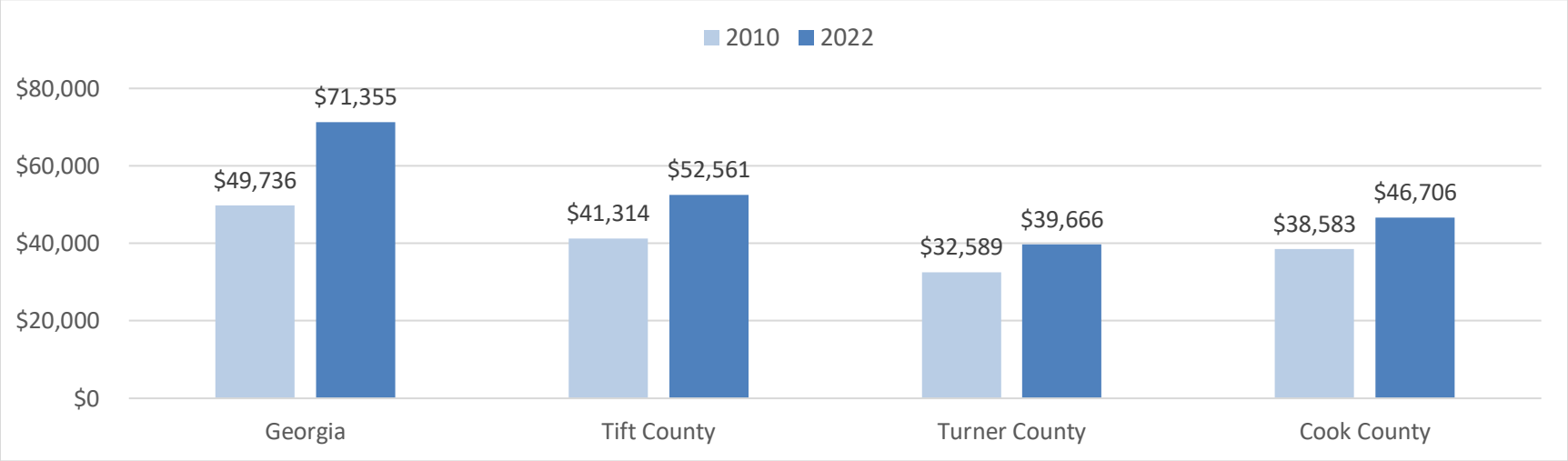
	United States	Georgia	Tift PSA	Tift County
Less than High School	24.0%	24.7%	**26.2%**	25.5%
High School Degree	13.7%	14.5%	**21.1%**	20.2%
Some College or Associate's Degree	9.5%	10.0%	**16.2%**	15.3%
Bachelor's Degree or Higher Education	4.4%	4.3%	**7.0%**	2.3%

Source: U.S. Census Bureau American Community Survey 2018-2022 Five-year Estimates

Income Distribution

From 2010 to 2022, there was an overall percent change increase in the median household income in each county across the primary service area, although each of these increases was less than the increases that occurred at the national and state levels over the same period.

Exhibit 12: Median Household Income



	United States	Georgia	Tift County	Turner County	Cook County
Median Household Income (2022)	$75,149	$71,355	$52,561	$39,666	$46,706
Median Household Income (2010)	$52,762	$49,736	$41,314	$32,589	$38,583
Percent Change	+42.4%	+43.5%	+27.2%	+21.7%	+21.1%

Source: U.S. Census Bureau. American Community Survey Five-Year Estimates, 2018-2022Exhibit 13: Median Household Income Continued

Unemployment

Tift County's unemployment rate is lower thant the other counties that comprise the PSA, and the rate for the PSA itself is lower than the corresponding rate for the state and nation.

Exhibit 14: Unemployment Rate by Race

	United States	Georgia	Tift PSA	Tift County
Total Unemployed (Civilian Population Ages 16 and Over)	5.3%	5.2%	**4.5%**	2.9%
BY RACE				
Native Hawaiian and Other Pacific Islander	7.3%	6.7%	**100.0%***	100.0%*
Black or African American	8.9%	7.8%	**7.9%**	4.6%
Some Other Race	6.4%	3.8%	**2.9%**	2.0%
White	**4.4%**	**3.9%**	**2.8%**	**2.6%**
Two or More Races	6.8%	5.8%	**0.6%**	0.9%
American Indian and Alaska Native	8.4%	4.3%	**0.0%**	0.0%
Asian	4.4%	3.5%	**0.0%**	0.0%

Source: U.S. Census Bureau American Community Survey 2018-2022 Five-year Estimates
*Interpret with caution due to small population size

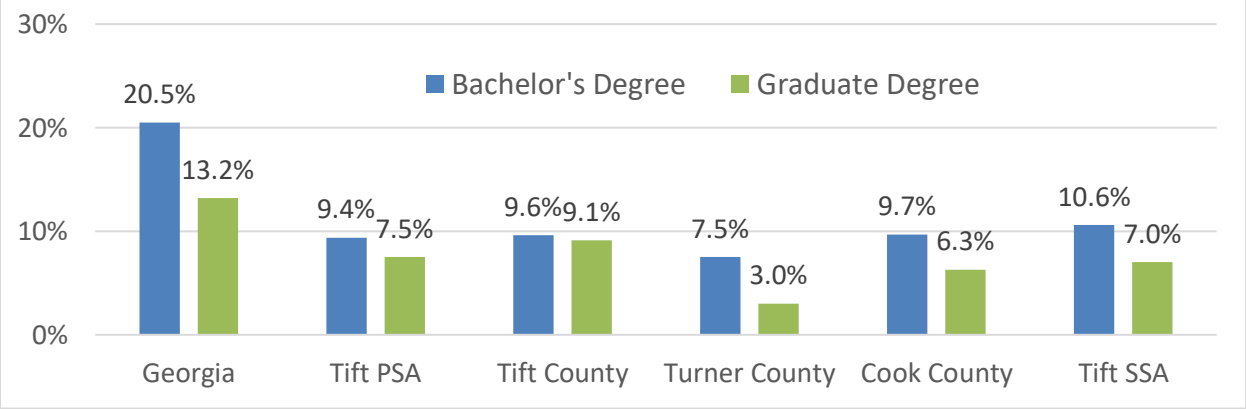
Social and Physical Environment

Educational Attainment

Education is not only about the schools or higher education opportunities within a community, but also includes languages spoken, literacy, vocational training, and early childhood education.[18] Some children live in places with poorly performing schools, and the stress of living in poverty can affect children's brain development, making it harder to do well in school.[19]

Compared to the state, the service area has lower levels of population whose highest level of educational attainment is a bachelor's degree or a graduate degree. Among the service area, Turner County has the lowest levels of population with a postsecondary education, which has an impact on opportunity, income, and therefore quality of life and access to healthcare.

Exhibit 15: Highest Level of Educational Attainment



	United States	Georgia	Tift PSA	Tift County	Turner County	Cook County
Less than 9th Grade	4.7%	4.3%	**6.0%**	5.4%	8.8%	6.0%
9th to 12th Grade, No Diploma	6.1%	7.0%	**11.2%**	10.7%	11.6%	12.0%
High School Degree	26.4%	27.1%	**33.8%**	33.3%	34.8%	34.4%
Some College No Degree	19.7%	19.6%	**19.3%**	18.3%	20.7%	21.2%
Associate degree	8.7%	8.3%	**12.8%**	13.6%	13.6%	10.3%
Bachelor's Degree	20.9%	20.5%	**9.4%**	9.6%	7.5%	9.7%
Graduate Degree	13.4%	13.2%	**7.5%**	9.1%	3.0%	6.3%

Source: U.S. Census Bureau American Community Survey 2018-2022 Five-year Estimates

18 Kaiser Family Foundation. Beyond Health Care: The Role of Social Determinants in Promoting Health & Health Equity, 2018. https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

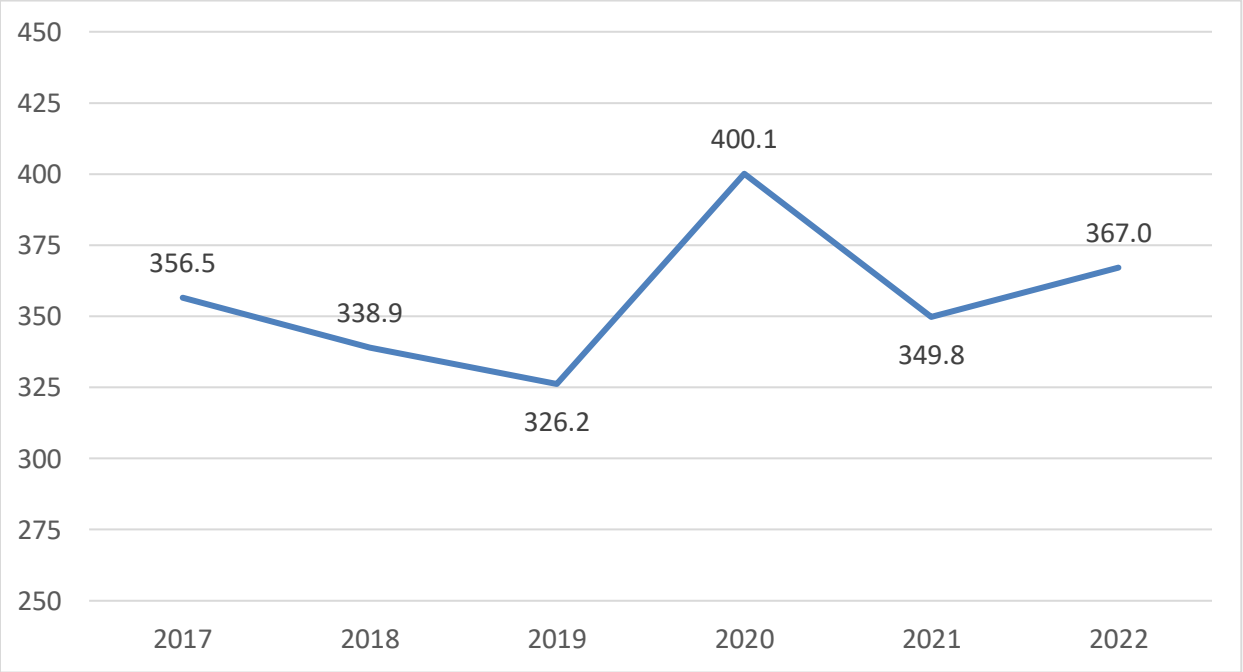
19 U.S. Department of Health and Human Services, Healthy People 2030. Social Determinants of Health, Education Access & Quality. https://health.gov/healthypeople/objectives-and-data/browse-objectives/education-access-and-quality

Violent Crime

Neighborhoods are important in influencing health and health equity, therefore, policies or actions that focus on neighborhood context can improve health inequities among community members.[20]

There was an overall 2.9% change increase in violent crime in Georgia from 2017 to 2022.

Exhibit 16: Georgia Violent Crime Trend, Rate per 100,000 Population



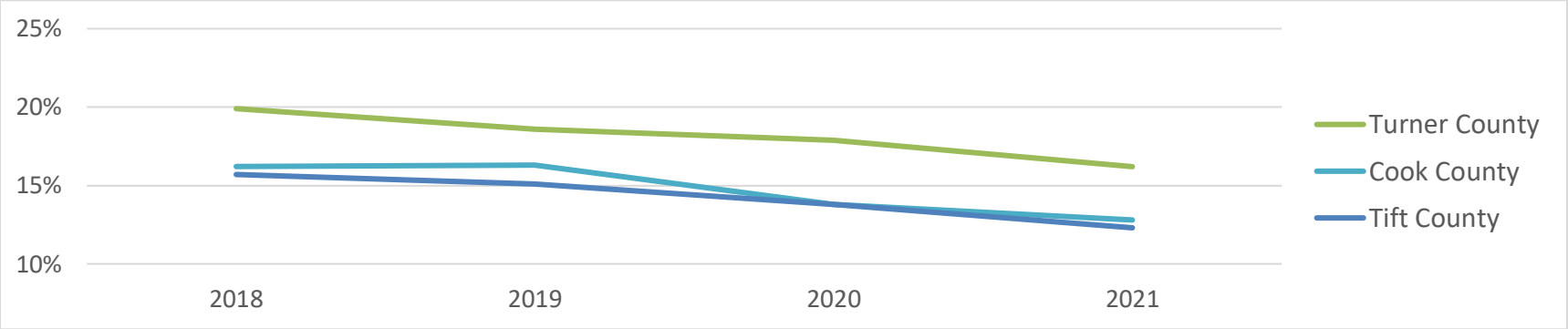
Source: Federal Bureau of Investigation Crime Data Explorer, CDE (cjis.gov)

[20] American Society on Aging. Addressing Health Equity for Older Adults at the Neighborhood Level (2021). Link: https://generations.asaging.org/health-equity-elders-neighborhood-level

Healthy Eating, Physical Activity, and Overweight/Obesity

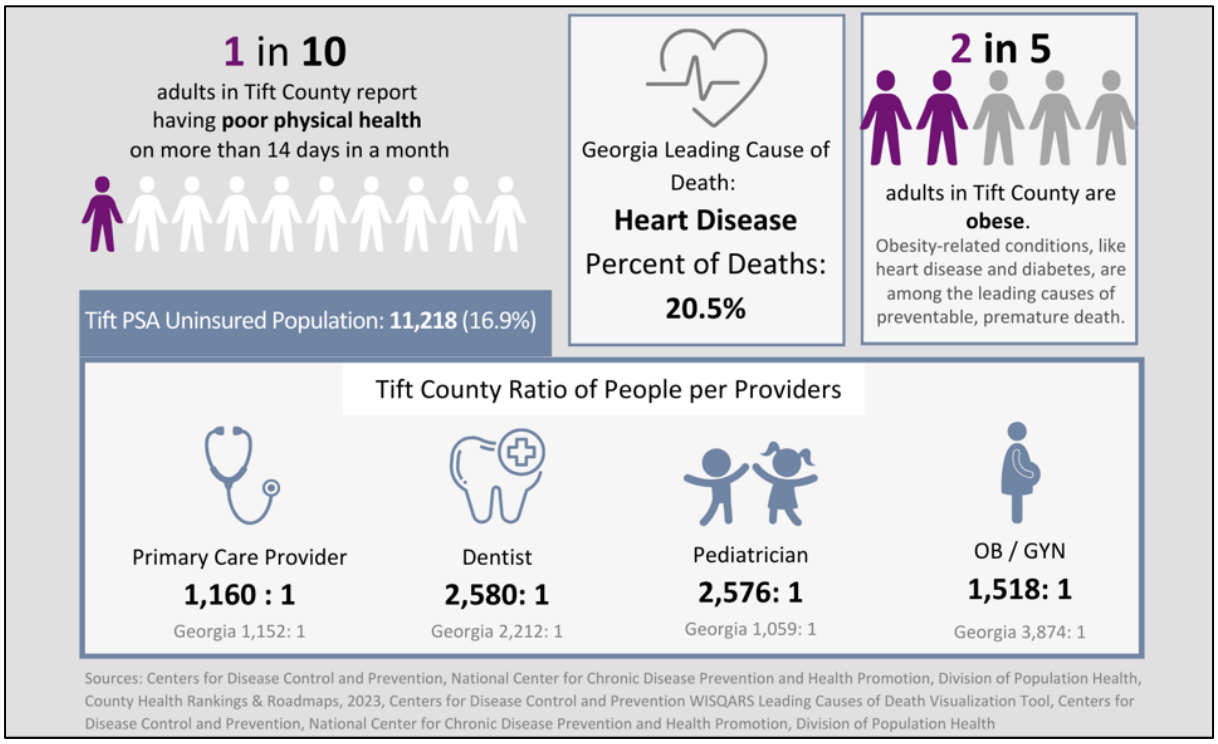
Food insecurity rates in the primary service area have trended downward since 2018, decreasing 21.7% in Tift County, 21% in Cook County, and 18.6% in Turner County. However, despite notable decreases, Turner County has the highest rates of food insecurity for all ages and children. Food insecurity rates in the primary service area for children decreased more significantly compared to those for all ages during the same time period.

Exhibit 17: Primary Service Area Food Insecurity Rate Trends Among All Ages, 2018-2021



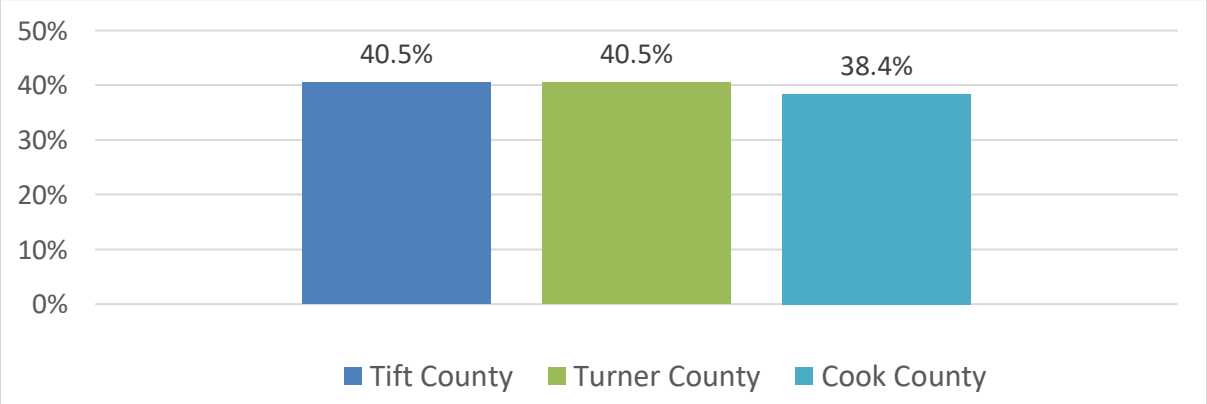
	2018		2019		2020		2021		Percent Change 2018-2021	
	Overall (all ages)	Children (less than age 18)	Overall (all ages)	Children (less than age 18)	Overall (all ages)	Children (less than age 18)	Overall (all ages)	Children (less than age 18)	Overall (all ages)	Children (less than age 18)
Tift County	15.7%	21.8%	15.1%	20.1%	13.8%	19.1%	12.3%	15.6%	-21.7%	-28.4%
Turner County	19.9%	30.2%	18.6%	28.5%	17.9%	25.7%	16.2%	23.6%	-18.6%	-21.9%
Cook County	16.2%	21.6%	16.3%	21.4%	13.8%	17.6%	12.8%	14.2%	-21.0%	-34.3%
Georgia	12.5%	16.2%	12.0%	15.0%	10.9%	14.4%	10.7%	13.3%	-14.4%	-17.9%

Source: Feeding America Map the Meal Gap, 2021



Approximately two in five adults in the primary service area are considered to have obesity, which is a risk factor for stroke. According to an article in Georgia Public Broadcasting, "state leaders have blocked access to affordable healthcare via Medicaid." Medicaid recipients are disproportionately people of color, which aligns with data that supports that the Black and Latino communities in Georgia have higher rates of obesity. Nearly one in five high school students in Georgia (18.3%) also have obesity.[21]

Exhibit 18: Obesity Among Adults



Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. PLACES Data [online]. 2022 [accessed Jan 10 2024].. URL: https://www.cdc.gov/PLACES

21 State Data - State of Childhood Obesity

Low access to healthy food is defined as a significant number of individuals within the geography being far from a supermarket, wholesale club, supercenter, or grocery store [22]

Exhibit 19: Access to Healthy Food for People with Low Income, 2019

Distance from Healthy Food	Georgia	Tift PSA	Tift County	Turner County	Cook County
1/2 Mile	79.6%	**83.3%**	79.8%	93.3%	86.6%
1 Mile	50.9%	**57.1%**	48.5%	59.1%	74.7%
10 Miles	1.3%	**0.7%**	0.0%	1.8%	1.6%
20 Miles	0.0%	**0.0%**	ND	ND	ND

Source: USDA Economic Research Service2019

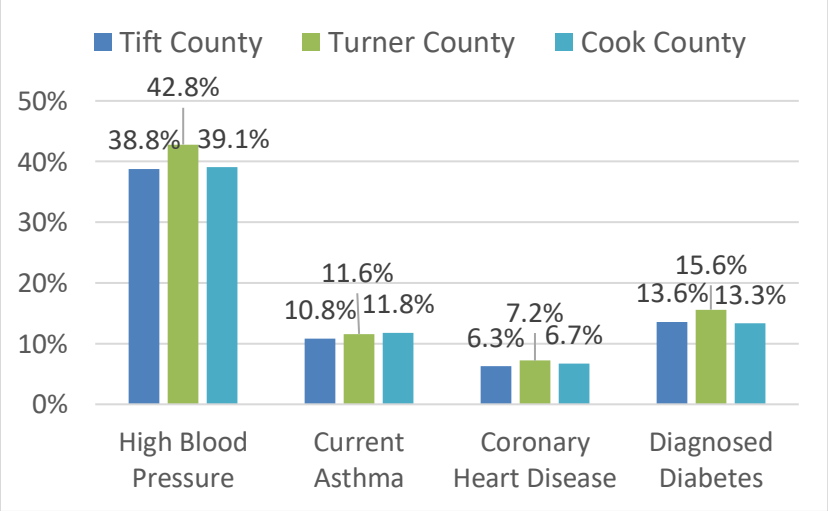
[22] USDA ERS Food Access Definitions).

Health Status Profile

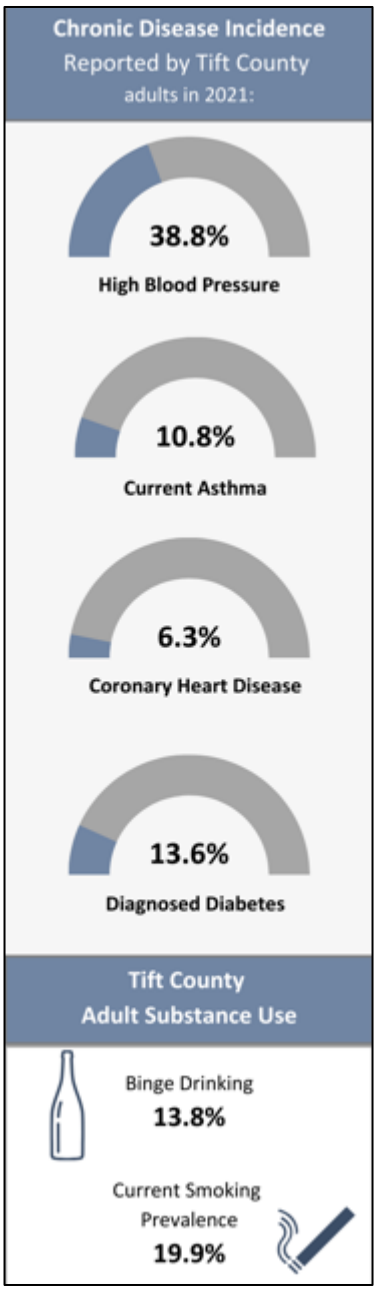
Health Status

More than one in three adults in the primary service area have high blood pressure, which contributes to cardiovascular disease and stroke. More than one in 10 adults have been diagnosed with diabetes, which also contributes to cardiovascular disease and stroke. Turner County has slightly higher levels of coronary heart disease compared to Tift and Cook.

Exhibit 20: Chronic Disease Incidence Summary Among Adults, 2021

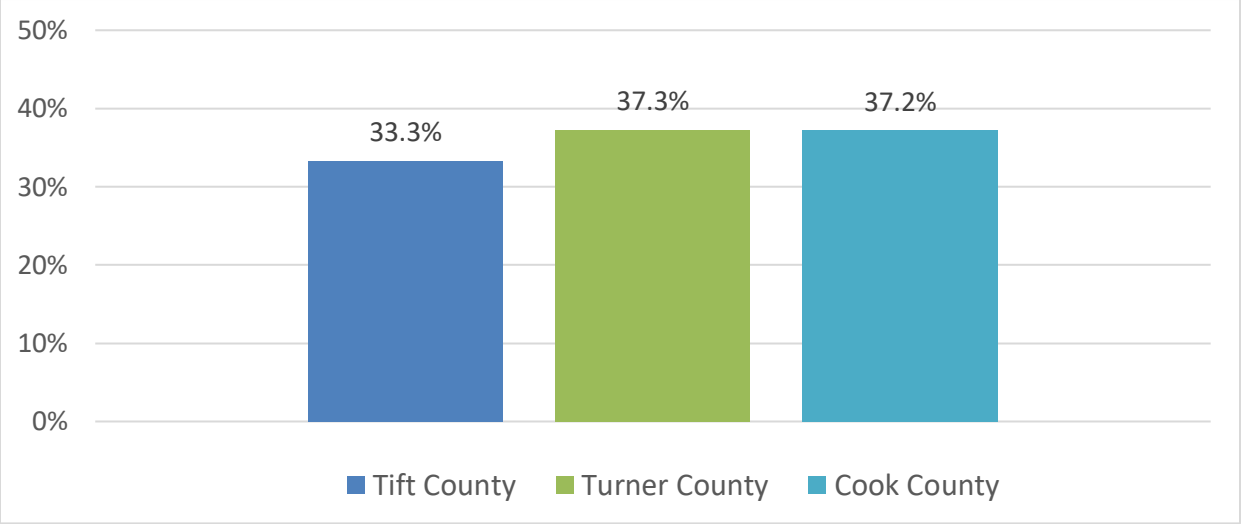


Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. PLACES Data [online]. 2022 [accessed Jan 10 2024].. https://www.cdc.gov/PLACES



As of 2019, more than one in three adults in the primary service area who were screened in the past five years had high cholesterol, which is a health risk for stroke and cardiovascular disease.

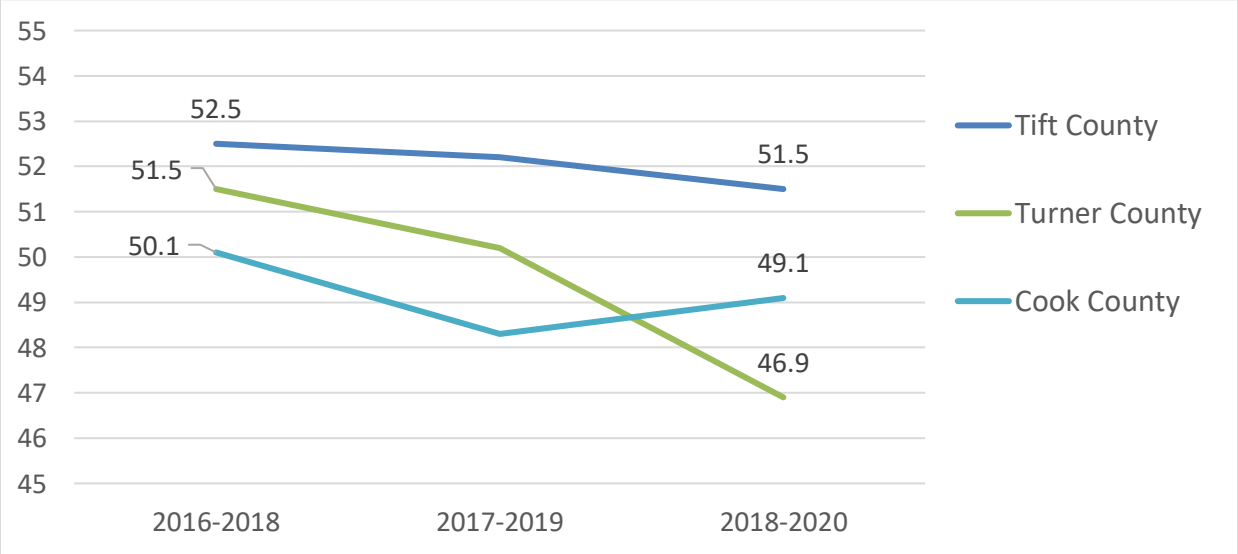
Exhibit 21: High Cholesterol Among Adults, 2019



Source: Centers for Disease Control and Prevention, Interactive Atlas of Heart Disease and Stroke

Georgia is part of a region in the southeastern United States known as the "stroke belt," due to the high stroke mortality rates in the state.[23] Compared to Tift and Cook Counties, Turner County experienced the greatest overall decrease in the stroke death rate for all ages from 2016-2018 to 2018-2020.

Exhibit 22: Stroke Death Rate for All Ages

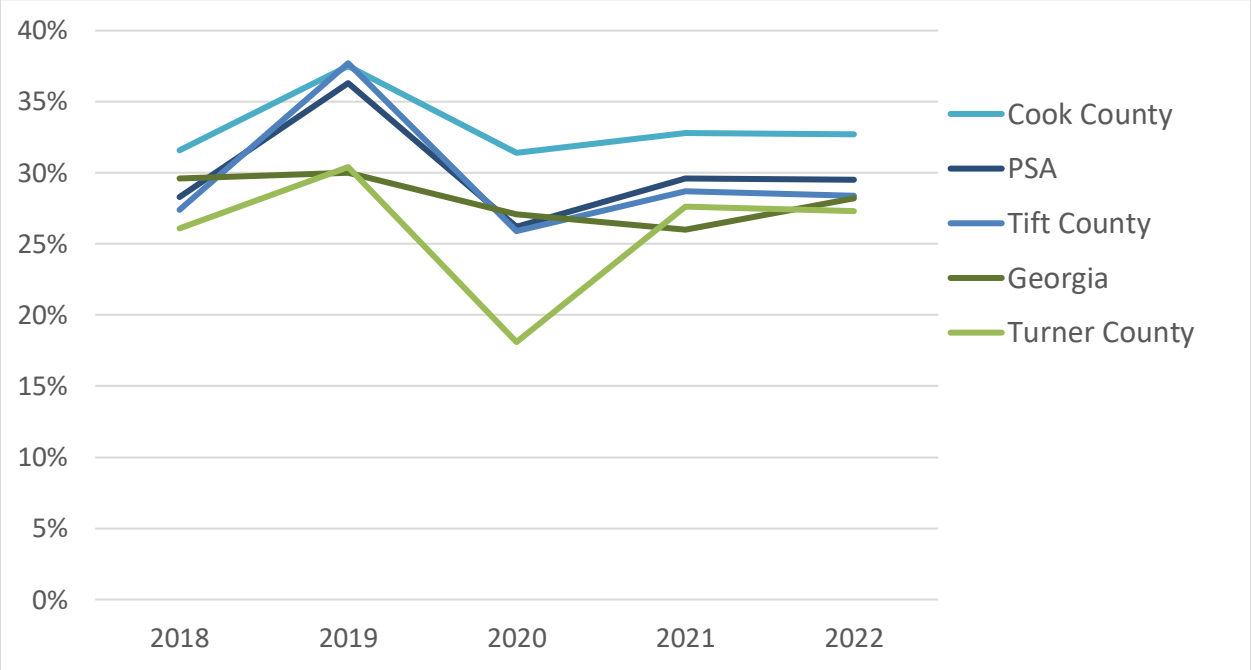


Source: Centers for Disease Control and Prevention, Interactive Atlas of Heart Disease and Stroke

23 Stroke | Georgia Department of Public Health

Approximately one-third of deaths in Georgia and in the service area are due to major cardiovascular diseases. Though the state experienced an overall 4.7% change decrease from 2018 to 2022 of deaths attributed to cardiovascular disease, the service area experienced an overall percent change increase of 4.2%, with the largest percent change increase in Turner County (4.6%).

Exhibit 23: Percent of Deaths by Major Cardiovascular Diseases[24]



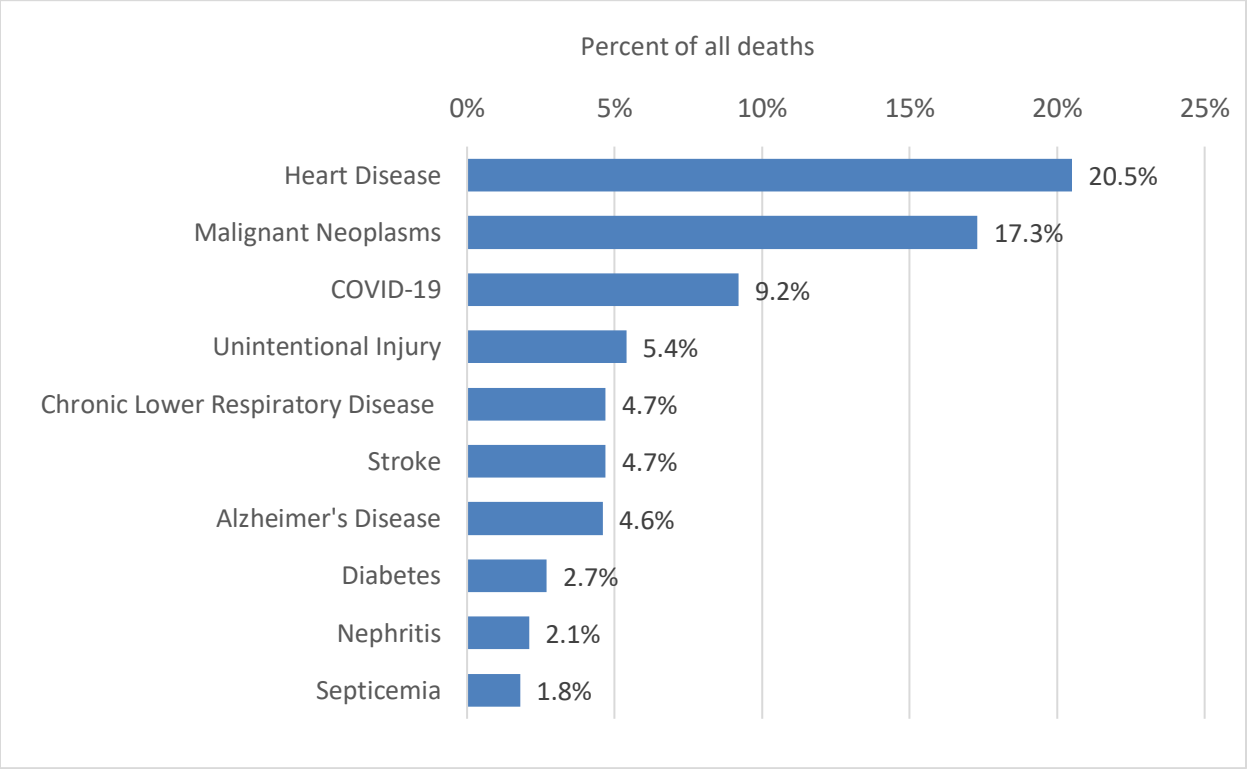
Source: Georgia Department of Public Health | Office of Health Indicators for Planning (OHIP) Online Analytical Statistical Information System (OASIS), Mortality Web Query

24 High blood pressure, Rheumatic fever and heart diseases, hypertensive heart disease, obstructive heart disease (including heart attack), stroke, hardening of the arteries, aortic aneurysm and dissection, all other disease of the heart, all other diseases of circulatory system, Georgia Department of Public Health, Office of Health Indicators for Planning OASIS (state.ga.us)

Leading Causes of Death

Approximately one in five Georgians died from heart disease in 2020, followed by malignant neoplasms and COVID-19. The Georgia Department of Public Health is promoting healthy cardiovascular living by encouraging the "ABCDE's of heart health", which include using aspirin when appropriate, blood pressure control, cholesterol management, diabetes management, and smoking cessation.[25]

Exhibit 24: Georgia Age-Adjusted Leading Causes of Death, 2020

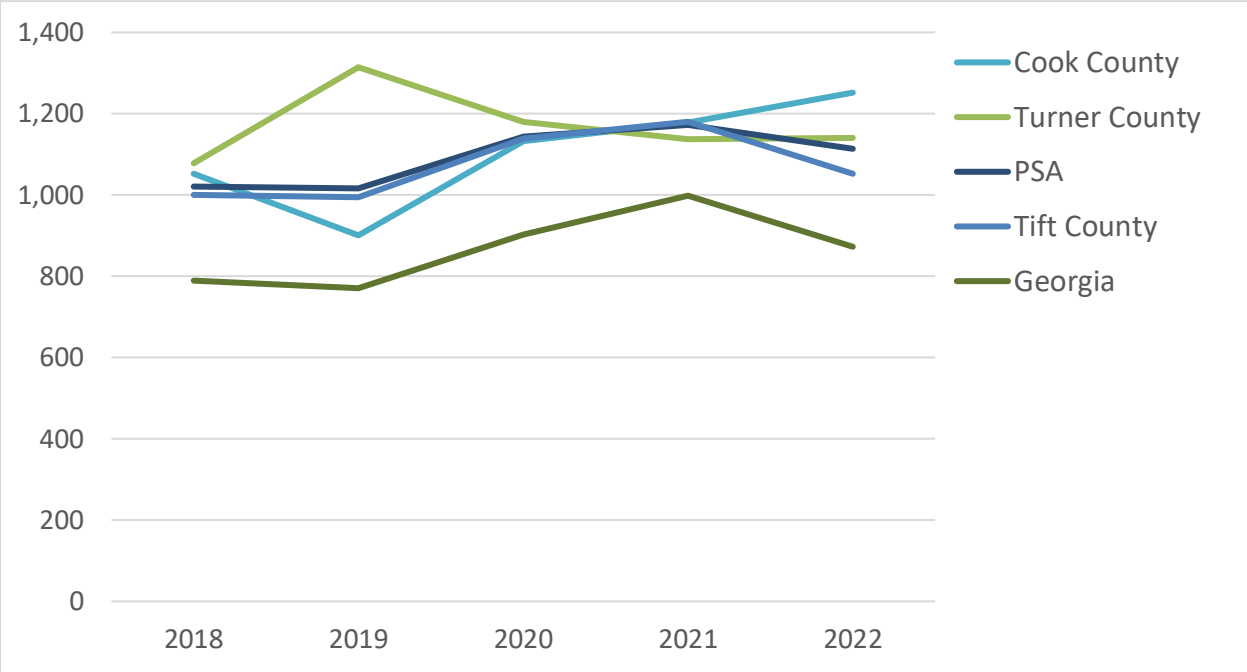


Source: Centers for Disease Control and Prevention WISQARS Leading Causes of Death Visualization Tool

25 Heart Disease | Georgia Department of Public Health

The death rate in Cook County experienced an overall percent change increase of 33.4% from 2018 to 2022. In contrast, Turner County experienced an overall percent change decrease of 16.1% during the same period.

Exhibit 25: Age-Adjusted Death Rate Trend, 2018-2022



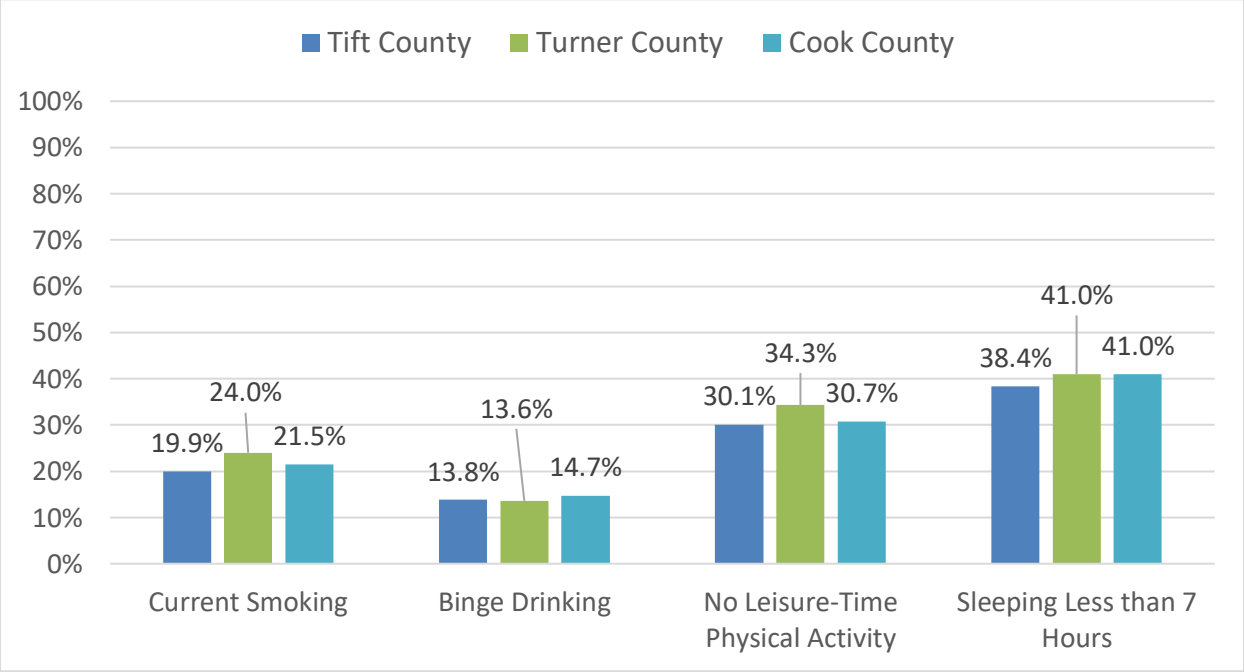
Rate per 100,000	Tift PSA	Tift County	Turner County	Cook County	Georgia
2018	**1,020.0**	1,000.10	1,077.90	1,052.30	789.4
2019	**1,016.1**	994.3	1,314.20	900.5	770.5
2020	**1,143.4**	1,138.20	1,180.30	1,131.80	902.3
2021	**1,172.3**	1,180.00	1,136.90	1,178.30	998.1
2022	**1,113.8**	1,052.60	1,140.30	1,251.70	872.5
Percent Change 2018-2022	**+9.6%**	+5.8%	-16.1%	+33.4%	+12.9%

Source: Georgia Department of Public Health | Office of Health Indicators for Planning (OHIP) Online Analytical Statistical Information System (OASIS), Community Health Needs Assessment Dashboard

Alcohol and Illicit Substance Use

Approximately two in five people in the primary service area sleep less than seven hours per night, which is "associated with an increased risk of chronic conditions" such as obesity, diabetes, hypertension, heart disease, anxiety, and depression.[26] In addition, approximately one in three people in the primary service area do not engage in leisure-time physical activity, and nearly one in four people in Turner County is a current smoker, with slightly lower levels in Tift and Cook Counties. More than one in ten people in the primary service area engage in binge drinking. Binge drinking, smoking, and physical inactivity are risk factors for stroke.

Exhibit 26: Health Risk Behaviors Among Adults, 2021



Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. PLACES Data [online]. 2022 [accessed Jan 10 2024].. URL: https://www.cdc.gov/PLACES

26 Prevalence and Geographic Patterns of Self-Reported Short Sleep Duration Among US Adults, 2020 (cdc.gov)

Current Tobacco Users

Approximately one in five adults in the tri-county primary service area are regular smokers. This is slightly higher than state levels.

Exhibit 27: Regular Smoking Among Adults

	Tift PSA	Tift County	Turner County	Cook County	Georgia
Percent	**20.6%**	19.2%	22.7%	21.0%	16.8%

Source: CDC BRFSS PLACES 2021

Exhibit 28: Drug Overdose Mortality Rate per 100,000 Population, 2018-2022

	Tift PSA	Tift County	Turner County	Cook County	Georgia
2022	**21.9**	33.2	0	ND	24.8
2021	**28.8**	38.4	ND	ND	22.5
2020	**7.6**	ND	ND	ND	17.9
2019	**7.8**	ND	ND	ND	12.9
2018	**8.2**	ND	ND	ND	13.1
Selected Years Total	**15.0**	18.6	ND	9.5	18.3

Source: Georgia Department of Public Health's Data Warehouse | Online Analytical Statistical Information System: Drug Overdoses – Mortality Web Query Tool, Georgia Department of Public Health, Office of Health Indicators for Planning OASIS (state.ga.us)

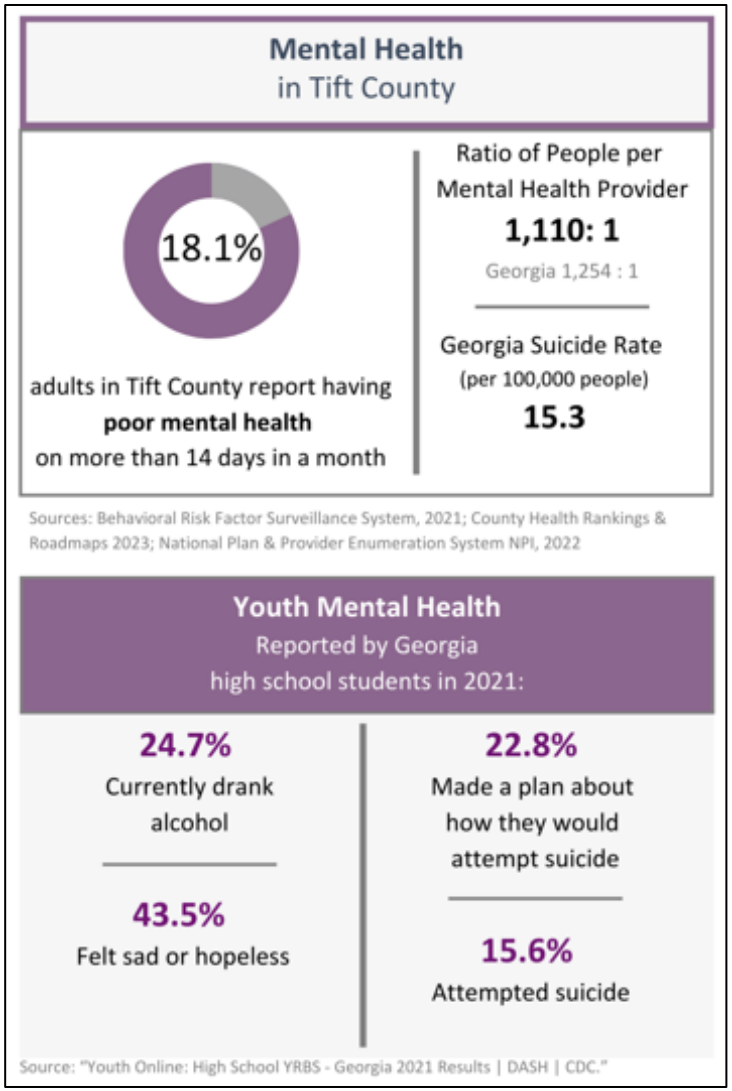
General Health or Quality of Life

Turner County has slightly higher levels of population who self-rated a fair or poor health status compared to Tift and Cook Counties.

Exhibit 29: Quality of Life Among Adults

	Tift County	Turner County	Cook County
Mental health not good 14 or more days	18.1%	19.9%	18.9%
Physical health not good for 14 or more days	13.8%	15.9%	14.6%
Fair or poor self-rated health status	21.4%	25.5%	22.6%

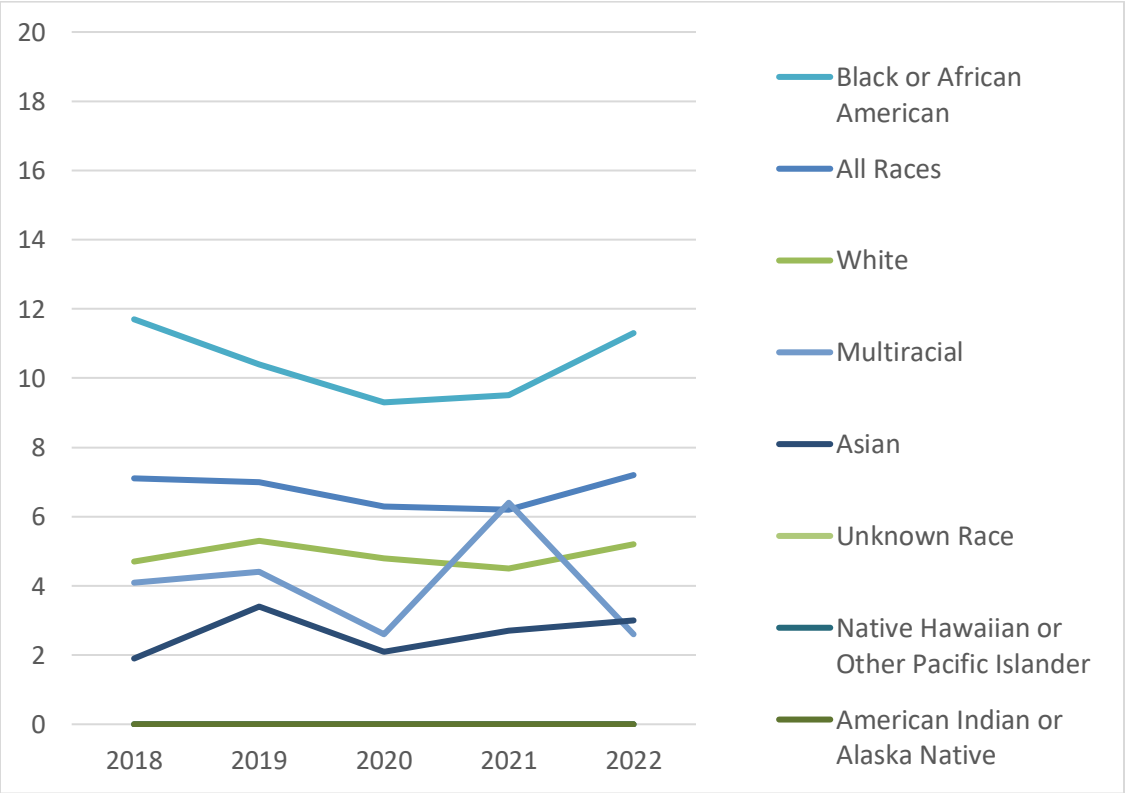
Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. PLACES Data, URL: https://www.cdc.gov/PLACES



Maternal and Child Health

Per the Georgia Department of Public Health, infant mortality is the death of an infant before his or her first birthday.[27] The infant mortality rate for the Black or African American population is notably higher than the infant mortality rate for all other races, though the infant mortality rate for the multiracial population spiked in 2021, increasing by 146.2%. The Georgia Department of Health is focused on reducing infant mortality by focusing on five strategies, which include smoking cessation among pregnant women and preventing sudden infant death syndrome (SIDS). Since 2018, the majority of infant deaths were due to fetal and infant conditions, such as prematurity, lack of oxygen to the fetus, respiratory distress syndrome, and birth-related infections.[28]

Exhibit 30: Infant Mortality Rate in Georgia by Race, 2018-2022, Rate per 1,000 Live Births



27 Infant Mortality | Georgia Department of Public Health
28 Georgia Department of Public Health's Data Warehouse | Online Analytical Statistical Information System (OASIS), Infant Mortality Web Query

Exhibit 31: Infant Mortality Rate in Georgia by Race, 2018-2022, Rate per 1,000 Live Births

Rate per 1,000 live births	Tift PSA	All Races	White	Black or African American	Asian	American Indian or Alaska Native	Native Hawaiian or Other Pacific Islander	Multiracial	Unknown Race
2018	**ND**	7.1	4.7	11.7	1.9	0.0	0.0	4.1	0.0
2019	**5.7**	7.0	5.3	10.4	3.4	0.0	ND	4.4	0.0
2020	**ND**	6.3	4.8	9.3	2.1	0.0	ND	2.6	0.0
2021	**11.1**	6.2	4.5	9.5	2.7	0.0	0.0	6.4	0.0
2022	**ND**	7.2	5.2	11.3	3.0	0.0	ND	2.6	0.0
Percent Change 2018-2022	**ND**	+2.8%	-2.1%	+7.7%	-21.1%	0.0%	ND	-43.9	0.0%

Source: Georgia Department of Public Health's Data Warehouse | Online Analytical Statistical Information System (OASIS), Infant Mortality Web Query

Access to Healthcare Providers

Among the counties, Turner County has the lowest number of primary care physicians, with one physician for every 7,880 people, compared to one physician for every 1,160 people in Tift County, and one physician for every 1,730 people in Cook County.

Exhibit 32: Ratio of Primary Care Providers, 2020

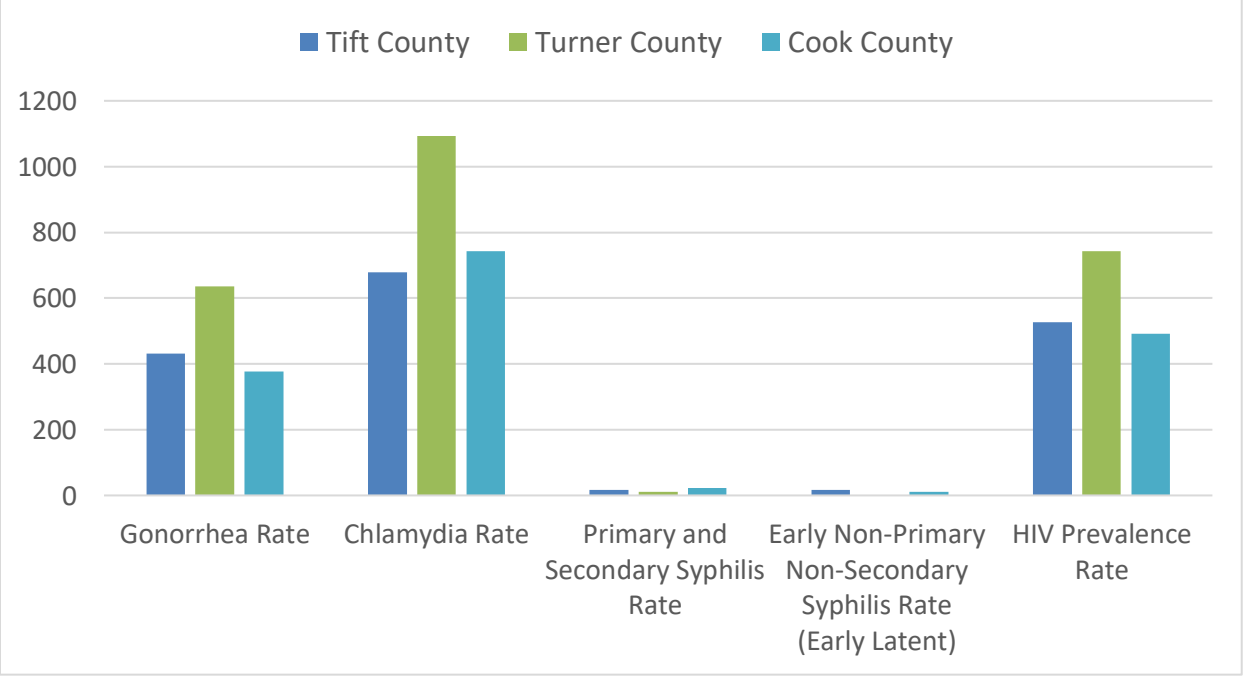
	Tift County	Turner County	Cook County
Primary Care Physicians	1,160:1	7,880:1	1,730:1
Dentists	2,580:1	2,240:1	3,450:1
Mental Health Providers	1,110:1	8,970:1	2,460:1

Source: County Health Rankings & Roadmaps, 2023

Communicable Diseases

Rates of sexually transmitted infections are notably higher in Turner County compared to Tift and Cook Counties. This may indicate a need for sexual education, resources, and outreach.

Exhibit 33: Sexually Transmitted Infections, Rate per 100,000 people



Source: Centers for Disease Control and Prevention | The National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) AtlasPlus 2021 , AIDSVu Emory University 2020

Health Insurance

Exhibit 34: Uninsured Population[29]

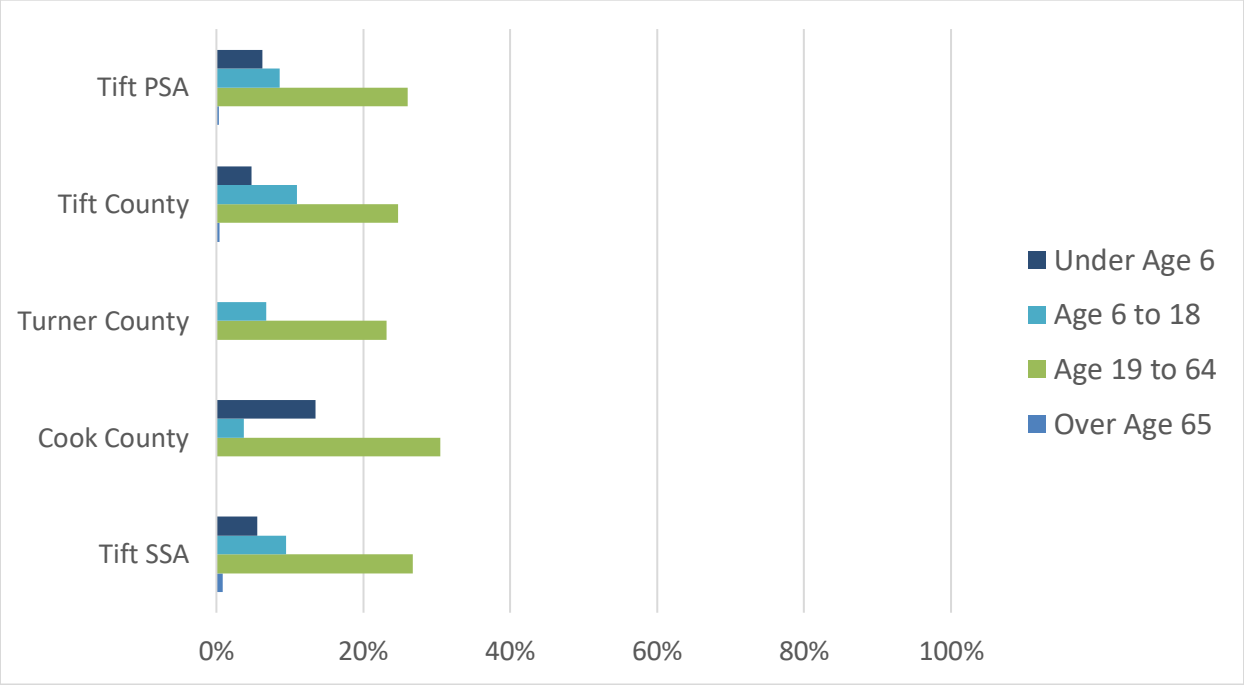
	United States	Georgia	Tift PSA	Tift County	Turner County	Cook County	Tift SSA
Uninsured Population	28,315,092	1,361,380	**11,218**	6,811	1,201	3,206	56,112
Percent Uninsured	8.7%	12.9%	**16.9%**	16.8%	13.8%	19.0%	17.8%
Under Age 6	4.4%	5.7%	**6.3%**	4.8%	0.0%	13.5%	5.6%
Age 6 to 18	5.7%	7.8%	**8.6%**	11.0%	6.8%	3.7%	9.5%
Age 19 to 64	12.2%	18.1%	**26.0%**	24.7%	23.2%	30.5%	26.7%
Over Age 65	0.8%	1.0%	**0.3%**	0.4%	0.0%	0.0%	0.9%
People with Private Health Insurance	74.0%	75.9%	**62.2%**	64.7%	50.2%	62.7%	67.9%
People with Public Health Insurance	39.3%	36.5%	**48.4%**	45.4%	61.4%	48.6%	47.6%
Children Age 18 and Under with a Disability - without Health Insurance	3.9%	4.8%	**3.2%**	4.9%	7.5%	0.0%	1.9%
Adults Age 19 to 64 with a Disability - without Health Insurance	10.1%	16.9%	**26.1%**	25.0%	18.8%	34.2%	20.2%
People in Labor Force without Health Insurance	11.5%	16.8%	**25.5%**	24.8%	23.2%	28.3%	25.5%

Sources: U.S. Census Bureau American Community Survey 2018-2022 Five-year Estimates

29 Private and public insurances can add up to more than 100% since many people have more than one health plan. About 43 Million People in the U.S. Had Multiple Health Plans in 2021 (census.gov)

Approximately one in four people aged 19 to 64 in the service area are uninsured. Compared to the United States and Georgia, there are high levels of population who are in the workforce and are uninsured. There are also notably high levels of population in the service area who have a disability who are uninsured. People who do not have insurance are less likely to get necessary medical care and are more likely to "skip preventive services," which can lead to undetected chronic diseases.[30]

Exhibit 35: Uninsured Population[31]



Sources: U.S. Census Bureau American Community Survey 2018-2022 Five-year Estimates

Preventable Hospital Events for the Medicare Population

Cook County experienced an overall percent change increase of birth rates from 2018 to 2022, compared to Tift and Turner Counties, which experienced overall percent change decreases during the same period.

Exhibit 36: Medicare Preventable Hospital Stays, 2021

	United States	Georgia	Tift County
Rate per 100,000 Medicare Enrollees	2,681	3,076	3,618

Source: Centers for Medicare & Medicaid Services Mapping Medicare Disparities Tool 2021

30 The Uninsured and the ACA: A Primer – Key Facts about Health Insurance and the Uninsured amidst Changes to the Affordable Care Act – How does lack of insurance affect access to care? – 7451-14 | KFF

31 Private and public insurances can add up to more than 100% since many people have more than one health plan. About 43 Million People in the U.S. Had Multiple Health Plans in 2021 (census.gov)

Hospital Inpatient Discharge Data Patterns

Most Common Diagnoses

A sample of more than 100,000 diagnostic observations for nearly 23,000 unique patients over the period from July 1, 2021, through December 31, 2023, was analyzed to determine the most common diagnoses in the Southwell service area.

More than half of Southwell patients (54.4%) live in a zip code found in one of the three counties (Tift, Turner, or Cook) comprising the primary service area.

Tift Regional Medical Center

At Tift Regional Medical Center, several of the most common diagnosis related group (DRG) codes were related to childbirth. Other commonly treated conditions include septicemia, as well as heart and respiratory failures.

Exhibit 37: Most Common Diagnosis Related Group Codes, Tift Regional Medical Center, July 2021 – December 2023

Rank	DRG Description
1	Septicemia Or Severe Sepsis Without Mechanical Ventilation >96 Hours With MCC
2	Neonate Birth Weight > 2499 Grams, Normal Newborn or Neonate with Other Problem
3	Vaginal Delivery
4	Septicemia And Disseminated Infections
5	Heart Failure and Shock With MCC
6	Normal Newborn
7	Pulmonary Edema and Respiratory Failure
8	Vaginal Delivery w/o Complicating Diagnoses
9	Respiratory Infections and Inflammations With MCC
10	Heart Failure

Southwell Medical

At Southwell Medical, nutritional, metabolic, and digestive disorders were most common, along with heart and respiratory failure, disease, and infections. Kidney and urinary tract infections were also high on the list of conditions treated.

Exhibit 38: Most Common Diagnosis Related Group Codes, Southwell Medical, July 2021 – December 2023

Rank	DRG Description
1	Miscellaneous Disorders of Nutrition, Metabolism, Fluids and Electrolytes Without MCC
2	Heart Failure and Shock With MCC
3	Esophagitis, Gastroenteritis and Miscellaneous Digestive Disorders Without MCC
4	Kidney And Urinary Tract Infections Without MCC
5	Chronic Obstructive Pulmonary Disease with CC
6	Chronic Obstructive Pulmonary Disease
7	Respiratory Infections and Inflammations with MCC
8	Major Respiratory Infections and Inflammations
9	Heart Failure
10	Simple Pneumonia and Pleurisy With CC

Qualitative Analysis

Qualitative Interviews & Discussion Groups

Community members, healthcare providers, and hospital leadership actively engaged in discussion groups and one-on-one interviews for this community health needs assessment. Participants were invited to join via email and telephone outreach. Throughout the recruitment phase, the significance of these meetings and interviews was underscored, emphasizing their pivotal role in identifying avenues for enhancing community health.

Crescendo conducted one-on-one telephone interviews with an array of stakeholders to offer further insights into community health assets and challenges. Southwell provided Crescendo with contact details for prospective interviewees, while additional suggestions were made by interviewees. While most calls lasted around 30 minutes, some community members opted to share extensive information, resulting in some conversations extending beyond this time frame.

In addition, virtual Zoom focus group opportunities were directed using a structured moderator's guide (please refer to appendix) to gain insight on community perspectives on social determinants of health. Discussions began with a broad exploration of their perceptions of health and more focused identification of pressing health issues facing the community.

During group sessions and interviews, participants conveyed their evaluations of the community's most urgent health needs and their potential impacts, especially in areas where Southwell could offer meaningful contributions. Additionally, clinical providers provided valuable insights into community health from their unique perspectives drawing upon their years of experience serving patients, further enhancing the depth of discussion.

One-on-One Interviews & Focus Group Discussions

A total of **33** stakeholder interviews were conducted via Zoom or phone, lasting approximately 30 minutes, and **three (3)** focus groups were conducted with a total of **21** participants. Organizations and populations represented include:

- Abraham Baldwin Agricultural College
- City of Tifton
- Cook County Probate Court
- Georgia Power
- Georgia State Office of Rural Health
- Hope EMS
- Ruth's Cottage & Patticake House
- Southwell
- State Court of Tift County
- Tifton City Council
- Tift County
- Tift County Commission on Children and Youth
- Tift County High School students

Focus group discussions began with brief introductions, followed by hearing participants' broad thoughts. Participants were encouraged to speak about their insight and experiences.

Interviews and focus groups provided the opportunity for in-depth conversations regarding a variety of issues, including (but not limited to):

- Affordability of healthcare and basic needs
- Vulnerable populations and/or communities
- Health equity
- Social determinants of health
- Community connection and social support

Community Strengths

Qualitative research participants were asked to share positive traits about their community. Direct quotes are included below.

Overall, the community is characterized by its supportive environment, diverse economy, accessible healthcare, and strong sense of pride and involvement. The community boasts a diverse industrial base, strong school systems including Abraham Baldwin Agricultural College, and a vibrant downtown area. It has robust healthcare resources, including various specialties, mobile clinics, and satellite clinics. The community is supportive and comes together in times of need, with unique partnerships between community and county to develop facilities. Tifton is well-connected with highways, has a mix of socioeconomic status, and attracts businesses due to its updated hospital and educational institutions. The sense of family and community support is strong, with resources readily available when needed.

Access to Resources and Leadership

Community members expressed the availability of resources, which is not always the case in rural communities. Respondents emphasized resources and services are available if people are aware of (and able to access) them.

> ***"Everybody is like family. If you need resources, somebody knows who can get you those resources."***

Growing Pains and Diverse Economy

As Tifton undergoes a period of growth, it grapples with the typical challenges associated with expansion. This surge in population and economic activity is evident in various facets of the town, notably in its industrial sector. The industrial base of Tifton is encompasses a range of sectors and businesses, including healthcare, that contribute to the town's economic vitality.

> ***"The town is going through growing pains due to the growth shown in the most recent Census. We have a good, diverse industrial base."***

Rural Livability and Healthcare

In this safe and family-oriented environment, residents benefit from a network of neighbors and organizations ready to lend a helping hand in times of need. This collective spirit fosters a sense of belonging and security, enhancing the overall quality of life for individuals and families alike.

"Family atmosphere and schools. We don't have to worry about bigger city issues."

Community Pride and Involvement

Community pride runs deep, evident in the active involvement of residents who consistently unite in support of one another, particularly during times of adversity. This spirit is further bolstered by unique partnerships forged between various stakeholders, paving the way for impactful community development initiatives. Through collaborative efforts and a shared commitment to progress, Tifton continues to thrive as a resilient and interconnected rural hub.

"Community involvement has never changed. Everybody knows everybody – when someone has issues, community comes in and pulls together."

Healthcare Access and Services

Across the service area, a number of community members underscored the accessibility of key services as a notable strength. Specifically, access to healthcare is prominently highlighted, with infrastructure that includes mobile and satellite clinics, ensuring widespread coverage across the region. This comprehensive healthcare network reflects the community's commitment to prioritizing preventive services, facilitating early intervention, and promoting overall well-being. Despite being a smaller community, residents benefit from ready access to specialists and

"Amazing health system for the size of the community. We have many specialties that small communities don't have, and well-trained specialists."

conveniently located school clinics, further enhancing the healthcare landscape, and addressing the diverse needs of the population.

Quality of Life and Economic Development

Community voices underscored the prime location and the array of amenities that contribute to the region's allure for residents and businesses alike. Community members have consistently emphasized this as a key strength, recognizing the town's ability to provide a high quality of life. Schools play a pivotal role in these communities, serving as hubs of community activity and fostering a family-oriented environment that resonates with residents. This sentiment is echoed throughout the community, with locals expressing pride in Tifton's educational offerings and the nurturing atmosphere they provide for students. Overall, the region’s quality of life and family-centric focus solidifies its reputation among residents as a desirable place to live and thrive.

“We enjoy a quality of life that other rural counties don't.”

Key Qualitative Findings

The following high-level need areas are most representative of participants' consensus in both qualitative interviews and focus group discussions. Selected quotes are included in the table below.

High-level Need Areas	Voices from the Community
Motor Vehicle Collisions: Increased incidents of motor vehicle collisions, often attributed to factors like alcohol use, adverse weather conditions, and road hazards, highlight the need for comprehensive road safety measures and public awareness campaigns.	▪ "I see a lot of motor vehicle collisions [MVCs]. More than I would have expected. If I'm going on a shift, I expect at least one call for an MVC. Could be for any number of reasons – alcohol use, 'animal came out of nowhere,' weather (more during rain)." ▪ "I once found a car upside down in a ditch, completely empty, covered in empty bottles. There are multiple major roads that come through the county. This is so common that even the non-emergent side is seeing this." ▪ "[There have been] so many losses of life could have been prevented."
Limited Specialized Healthcare Services: Specialized medical services are often accompanied by lengthy waits for appointments, requiring residents to travel long distances for timely services, including for pediatric care.	▪ "Providers struggle with referring out to specialists – they sometimes have to refer out to Atlanta." ▪ "As a mom of two younger children, often times you have to drive all the way to Moultrie or Atlanta for specialty services." ▪ "Safety-wise, there's a limited blood supply locally."

High-level Need Areas	Voices from the Community
Access to Care Disparities: Access to quality healthcare, especially for underserved populations, is a concern. Limited transportation options make it difficult for people to reach medical facilities outside their immediate area.	▪ "A lot of offices don't have anyone who speaks Spanish, sometimes don't have access to translator. I recommend they bring someone who speaks English; some don't have this. It can be hard to schedule as well. We finally were able to get a Spanish-speaking nurse – this took 10 years!" ▪ "In the Hispanic community, for instance, some need speech therapy. There are no providers who can provide this locally. This creates a language barrier between parents and children (a child who is learning English while their parents are speaking Spanish)."
Mental Healthcare Access: There's a lack of mental health resources, both in terms of inpatient and outpatient facilities. This leads to difficulties in accessing medication and treatment, exacerbating issues such as incarceration due to mental health problems.	▪ "I get phone calls from parents whose child(ren) may be incarcerated – at least in part due to mental health issues. They can't get medicine while they're in there. We don't have mental health places in Tifton." ▪ "Mental health [is a challenge]– one provider just got booted from their location – they may have to relocate to Valdosta." ▪ "When I see people who struggle, stay in the ER, don't have insurance – that increases the jail population. Nobody seems to want to connect those dots or recognize mental health."
Housing Instability: The community is struggling with a growing homelessness problem, which presents risks to individuals and burdens the emergency services.	▪ "House pricing is going through the roof. Workforce housing is needed. We're inundated with rental housing. Homelessness is sort of out of control – we're struggling with this." ▪ "Seems like it [homelessness] has increased significantly over the past five years. Now we have encampments on vacant properties/ buildings." ▪ "Homelessness – I'm seeing more and more people walking Highway 82. It's a danger to themself or others – they'll probably end up in jail."

High-level Need Areas	Voices from the Community
Workforce Challenges in Healthcare: The medical community faces difficulties in retaining physicians, with some leaving after paying off student loans, leading to gaps in coverage and healthcare provision.	▪ "We need some sort of program to coordinate activities for physicians and families to help them assimilate into the community. Some doctors come here to work and pay off their student loans and then they leave to work in the city. Surrounding health systems have been able to retain their staff, I wonder what they are doing differently or better." ▪ "Access to primary care providers, osteopaths, and internists is lacking. Doctors are retiring or are leaving town and they're not being replaced. Primary care is being taken over by mid-level staff in some areas." ▪ "We have primary care doctors and pediatricians, but there aren't many. There are eight elementary schools, less than 10 pediatricians."
Transportation: The lack of reliable public transportation further exacerbates existing challenges, making it difficult for residents to access essential services like healthcare and employment opportunities.	▪ "Some people do not want to travel outside of the county for specialists – this is limiting. The population tends to be an older population – they don't want to travel very far." ▪ "Transportation is [the] number one [challenge]. Getting to places, getting to appointments is the biggest challenge." ▪ "Access to [health] care, mostly because of lack of transportation. It's a rural system – we don't have a bus system; we don't have a train system." ▪ "Information [about transportation] is not readily available. Nobody knows about it. I could not tell anybody how to go about getting medical transportation."

High-level Need Areas	Voices from the Community
Nutrition and Food Insecurity: Limited healthy food options contribute to health issues such as obesity and diabetes. Food insecurity is prevalent, with some relying on emergency services for basic needs.	▪ **"**Salvation Army provides box lunches; some community farmers do baskets of fresh fruits and vegetables. They run out before they can give half the people lined up fresh food." ▪ "Fast food is cheaper and more accessible. If people are on the go, it's easier to go to McDonald's than to go to the grocery store and prepare a healthy meal." ▪ "Even as a rural agricultural society, not everyone is getting fresh foods. Dollar Generals, Walmarts – not as good choices, not as healthy."
Health Behavior and Chronic Diseases: Diabetes, obesity, and smoking are prevalent health issues, exacerbated by unhealthy eating habits and limited access to nutritious food options. Chronic conditions like hypertension, diabetes, and respiratory illnesses are widespread, leading to significant healthcare burdens.	▪ "We see a lot of chronic conditions. Obesity, diabetes, hypertension. COPD and congestive heart failure are big things, too. Generationally, education is getting better. But a lot of people still smoke. There is a large cancer population – breast, colon, lung..." ▪ "The obesity rate is pretty dramatic. A specialist just started recently – this will help. It is a struggle with nutrition – you're talking about culture and how people are raised to eat, lack of knowledge – things like why [managing] BMI is essential to health."

High-level Need Areas	Voices from the Community
Cultural and Linguistic Barriers: Cultural and language barriers impact access to healthcare, with some communities, such as the Hispanic population, facing challenges in accessing services due to language differences and a lack of culturally competent care.	▪ "The Hispanic population is underserved – there are many members of this group with no (or sporadic) prenatal care. Migrants may have moved here [from elsewhere] and we don't have their previous records. We see gestational diabetes, large babies, sick babies. This is an area to focus on going forward. Few providers speak Spanish; they have to use tablets for interpretation. The iPads can be a bit of a challenge." ▪ "I have a concern about the Mexican population – there are questions that are never asked about whether they are taking antibiotics that are regularly available at Latin American stores; when they see the doctor, if they do not disclose, they end up taking a double dose. Others might stop after taking part of a course (not full course of treatment). Also, they use a lot of herbal medicines – they're under the impression that these do not have medical effects, when they should be telling their doctor."

Most Pressing Healthcare Needs

Community members were asked to identify the most pressing healthcare-related needs. Respondents highlighted that the community faces significant healthcare challenges, including high rates of diabetes and obesity exacerbated by limited access to affordable, nutritious food options.

Substance use disorders, often linked to untreated mental health issues, pose another major concern. Mental health resources are insufficient, leading to a reliance on emergency services and incarceration for individuals in crisis. Access to healthcare services is hindered by transportation barriers, particularly in rural areas, and difficulties in securing timely appointments. Language barriers further complicate access to care, particularly for Hispanic populations.

Addressing these needs requires a multifaceted approach, including improving transportation options, expanding mental health services, and increasing cultural competency within healthcare facilities. Additionally, efforts to recruit and retain primary care providers, along with initiatives to promote preventative care and healthy lifestyle choices, are essential for improving community health outcomes.

Substance Use and Mental Health

Substance use disorders, frequently intertwined with untreated mental health conditions such as depression and bipolar disorder, pose a significant challenge in the community. The underutilization of local programs like OASIS underscores the pressing need for expanded mental health resources and specialized interventions. Social media was mentioned as a contributor to youth's poor mental health. Moreover, enhancing access to mental healthcare providers is crucial to prevent the incarceration of individuals grappling with mental illnesses.

- "Kids are using substances more and more. Kids are good at hiding it. Social media tells you how good it makes you feel."
- "Kids don't know if we can talk about mental health issues without feeling like we're going to be called crazy. We see more anxiety and depression now. Also, people are not afraid to speak their mind, talk back to teachers/parents. In part think this is due to social media."
- "We need more mental health resources in general. The state is building more mental health facilities – right now, a lot of these people end up in jail. Funding is a huge issue. Still a large stigma – especially within the African American community, and less so with the Hispanic community."
- "Wish someone would open a detox for drug addicts. A lot of opioid and substance use deaths in community – these aren't really publicized."
- "Fentanyl – hear a lot about it on the radio. Sometimes it will get cut or laced into other drugs. Tifton is on the I-75 corridor – it runs into Florida. Drugs come up from Miami towards Atlanta."
- "Social media affects you mentally because it raises your standards a lot. You see different girls with certain body types - if you have a different body type, you can feel lesser."

Access to Care

The lack of transportation infrastructure in rural areas, coupled with difficulties in securing appointments, hampers access to essential healthcare services. Initiatives like mobile clinics aim to address these challenges but face financial and utilization barriers.

- "Access also in terms of not being able to get an appointment."
- "There's a lot of people that can't afford it. People get treated differently and don't get the quality of care they need."

Accessibility issues extend to prenatal care, with transportation and resource limitations hindering access to timely care. Cultural barriers and insurance complexities further exacerbate the problem.

- "Prenatal care is huge concern."
- "One provider they are acquiring speaks Spanish – excited about the prospects of this for patient care and encouraging prenatal care (through outreach)."

Chronic Diseases and Preventive Care

The prevalence of chronic diseases like respiratory illnesses, hypertension, and cancer underscores the importance of preventive care and early intervention. Diabetes and obesity is exacerbated by unhealthy dietary habits, cultural components of the region, and limited access to nutritious food options. Economic challenges further compound this burden, making it difficult for residents to afford healthier alternatives and maintain balanced diets. Education and outreach efforts are crucial in addressing lifestyle factors contributing to these conditions and requires comprehensive interventions focused on promoting healthy eating habits, improving food accessibility, and providing education on nutrition and lifestyle modifications.

- "Heart failure is huge. We have a lot of people who don't start with primary care when they should. Not being diagnosed early on when they should be – turns into multiple diseases."
- "We're seeing later presentations of cancer diagnosis, due in part to people delaying care. Missed appointments – after a lesion or potential diagnosis, we have seen several of these. These are missed opportunities."
- "Access to healthy food is limited. The prevalent obesity is morbid obesity. We brought in a bariatric surgeon who is focused on metabolic disorders. We have a lot of optimism here about weight loss options. Good attendance at seminars to date (300-400)."
- "In the Deep South, unhealthy behaviors abound – obesity, diabetes, smoking. It's a population with so many comorbidities."

Cultural Competency

Language barriers, particularly among Hispanic populations, hinder access to care and necessitate improvements in language services and cultural competency within healthcare settings.

- "In the Hispanic community, for instance, some need speech therapy. There are no providers who can provide this locally. It creates a language barrier between parents and children (child learning English, parents speaking Spanish)."
- "A lot of offices don't have anyone who speaks Spanish, they sometimes don't have access to a translator. We recommend they bring someone who speaks English; some don't have this. It can be hard for them to schedule as well. We finally were able to get a Spanish speaking nurse – this took 10 years!"

Workforce Shortages

Shortages in primary care providers and specialists pose significant challenges, requiring efforts to recruit and retain healthcare professionals, along with innovative solutions like residency programs. Overcrowding in emergency departments, compounded by staffing shortages, can jeopardize patient safety and healthcare delivery during critical situations.

- "We tried to get a residency program started but there was some resistance in relation to guaranteed pay given the amount of work that comes with a residency program."
- "Some staff are leaving Tift Regional and going down to Moultrie. Some people have spoken to differences in service – it is disappointing to hear."
- "I hear community members talk about waits in the emergency room – they are not seeking urgent care or primary care for whatever reason."
- "So many people go to the ER now, and they probably could be better served in a different location. Wait times are awful, getting into the hospital is difficult."

Actionable Solutions

To further identify sustainable solutions, participants were asked to identify Action Areas, or what could potentially be done to address community healthcare needs.

The major themes highlighted in the discussion revolve around improving access to healthcare services, particularly leveraging technology for virtual access and ensuring equitable distribution of resources across different districts within the community.

There is a concerted effort to bridge disparities in access to essential amenities like grocery stores and housing, aiming to create safer neighborhoods and foster a sense of inclusivity across racial, ethnic, and cultural backgrounds. Mental health emerges as a critical concern, with calls for expanded resources, including mobile services and inpatient facilities, to address the growing need for comprehensive mental health and substance abuse treatment.

Additionally, there are aspirations for enhanced transportation infrastructure to facilitate access to healthcare and other essential services, along with initiatives to promote community wellness and education. Overall, the community seeks to address systemic challenges in healthcare access, affordability, and quality while promoting holistic well-being and collaboration across generations.

Action Area	Ideas from the Community
Community Engagement and Leisure Activities: Desiring more recreational options for outdoor activities to incite community engagement.	▪ "I wish the community had a little bit more to do – things like putt putt golf, trampoline parks."
Socioeconomic Equality Addressing disparities between different districts, advocating for equal access to amenities and safe neighborhoods.	▪ "I wish those in the poorest districts in Tift County could have the resources to live like the rest of the community." ▪ "I would like to see barriers removed from North and South sides of Tifton. Should not matter where you live to have a safe neighborhood. Equal access to grocery stores, decent housing, etc., no matter where you live in the community."

Action Area	Ideas from the Community
Mental Health and Substance Use: Urgent need for expanded resources and facilities, particularly inpatient care for mental health and substance abuse.	▪ "More inpatient mental health and substance use facilities." ▪ "Biggest concern is mental health – resources are so limited. People need more than just a telemed appointment each month."
Healthcare Infrastructure: Enhancing access to specialists, improving transportation for medical appointments, and advocating for expanded Medicaid.	▪ "Mobile units going out into the communities that I can count on to be there and can use to improve my health." ▪ "It would be great to have some of those specialists – endocrinologist, neurosurgery, heart surgeon."
Wellness and Preventative Care: Providing mobile services for mental health, prenatal care, and wellness activities, along with community check-ups.	▪ "I would offer a once-a-month community checkup. Park somewhere, do a random blood pressure check, the top five or 10 things you could check for somebody." ▪ "I would like to transform SNAP program to ensure that people get fresh fruits and vegetables and make these vouchers available to just about everyone."
Infrastructure and Transportation: Establishing better transportation systems for healthcare access and healthy food, addressing issues in rural communities.	▪ "I would create solid infrastructure for transportation. Not just for medical appointments – to get healthy foods, to get to the doctor. A lot of issues in rural communities could be solved with this type of system." ▪ "[The] dream is to get a grant to address the transportation issue."

Action Area	Ideas from the Community
Community Services and Education: Promoting affordable dental care, enhancing communication of services, and addressing mental health challenges in schools.	▪ "We need a dental clinic for the underserved and underinsured. We need dentists to come in to take care of folks. Bad oral health impacts overall health." ▪ "Communicate, communicate, communicate. What people don't know; they don't know. Take services to the people so that everybody is clear – 'Why is that bus sitting there?' You have to write it and make it plain. Word of mouth is very powerful."
Healthcare Affordability and Quality: Advocating for more affordable and accessible healthcare, improving insurance coverage, and ensuring quality care for all ages.	▪ "More primary care physicians on the ground. Better organizations for dealing with healthcare issues in the community." ▪ "Enough primary care where people would choose that instead of going to the ER. It used to be a large number of people were uninsured – having people be able to afford care is the great thing."
Social Issues and Peer Pressure: Addressing social challenges like addiction and road safety, emphasizing education and community support.	▪ "I wish more people were safer on the road and less susceptible to peer pressure – it can lead to addictions like opioids. These are the most common situations that could be avoided with different life choices. Better education could help, too."

Community Survey

The community survey enabled a greater share of community residents across Southwell's service area to share their perspectives on the unique challenges, barriers, and possible solutions to healthcare and social service access, and other community needs.

Survey Methodology

The community survey was made available online in English and in Spanish. The questionnaire included closed-ended, need-specific questions; open-ended questions; and demographic questions. Invitations to participate were distributed by project partners through channels including social media and email. There were 548 survey responses, all of which were to the English language survey.

Special care was exercised to minimize the amount of non-sampling error through assessment of design effects (e.g., question order, question wording, response alternatives). The survey was designed to maximize accessibility and comprehensively evaluate respondents' insights. Sub-questions included requests to rate community health needs on a five-point scale. See appendix for the survey instrument.

The survey served as a practical tool for capturing insights of individuals across Southwell's service area. This was not a random sample, and findings should not be taken as representative of the full population. Additionally, sample sizes of demographic subpopulations are not large enough to consider samples to be representative of the broader populations from which responses were received. Differences in responses have not been tested for statistical significance as part of this assessment.

Respondent Demographics

Among respondents to the community survey (n=548), nearly one in two (47.6%) live in the Tifton area zip codes of 31794 and 31793. More than wo in five respondents (43.2%) are age 55 or older, and one in three (33.3%) report having graduated college and/or completing graduate or professional school.

Exhibit 39: Community Survey Respondent Demographics

DEMOGRAPHIC VARIABLE	PERCENT OF RESPONDENTS
ZIP CODE	
31794 (Tifton)	32.4%
31793 (Tifton)	15.2%
31620 (Adel)	8.0%
31750 (Adel)	4.0%
31714 (Ashburn)	4.0%
31774 (Ocilla)	3.5%
31639 (Nashville)	2.9%
31637 (Lenox)	2.7%
31791 (Sylvester)	2.1%
31795 (Ty Ty)	2.1%
AGE	
18-24	2.5%
25-34	11.1%
35-44	14.6%
45-54	18.8%
55-64	27.9%
65-74	15.3%
75 and older	4.9%
Prefer not to disclose	4.9%
EDUCATIONAL ATTAINMENT	
Less than high school	0.0%
Graduated high school	9.1%
Some college or vocational training	23.5%
Completed a 2-year college degree or a vocational training program	27.4%
Graduated college (4-year Bachelor Degree)	19.0%
Completed Graduate or Professional school (Masters, PhD, etc.)	14.3%
Prefer not to disclose	6.7%

More than four in five respondents (80.7%) identify as female, and a similar proportion (80.5%) identify as White (Caucasian). The median household income reported by respondents falls in the $75,001-$100,000 range, which is substantially greater than the median household income range estimated for the population in Southwell's PSA ($39,666-$52,561).[32] Two in five reported a household size of two, and another one in five have a household size of three.

Exhibit 40: Community Survey Respondent Demographics (continued)

DEMOGRAPHIC VARIABLE	PERCENT OF RESPONDENTS
GENDER IDENTITY	
Female	80.7%
Male	13.1%
Non-binary	0.7%
Prefer not to disclose	5.4%
RACE	
White (Caucasian)	80.5%
Black	15.9%
American Indian	1.6%
Mixed Race	1.6%
Hispanic	1.4%
Asian	0.8%
Other	1.1%
ANNUAL HOUSEHOLD INCOME	
Less than $25,000	5.2%
$25,001-$50,000	18.4%
$50,001-$75,000	16.7%
$75,001-$100,000	16.9%
More than $100,000	23.1%
Prefer not to disclose	19.7%
HOUSEHOLD SIZE	
1	12.7%
2	42.9%
3	20.8%
4	14.7%
5	5.8%
More than 5	3.0%

[32] U.S. Census Bureau. American Community Survey Five-Year Estimates, 2018-2022.

Findings

Routine Care

The vast majority of respondents (87.7%) reported having a family doctor, family health center, or clinic to go for routine or annual care.

Exhibit 41: Do you have a place where you go for routine or annual care?

	PERCENT
Yes, family doctor, family health center, or clinic	87.7%
Walk-in urgent care	3.7%
No	3.5%
I do not get care even when I need it	0.9%
Yes, emergency room	0.7%
Other (please specify)	3.5%

It was relatively uncommon for respondents to report having unmet medical or mental health needs, with one in four (26.1%) needing care in the past year but choosing not to get it.

Exhibit 42: In the past 12 months, have there been times when you needed medical help but chose NOT to seek it?

	PERCENT
Yes	26.1%
No	70.0%
Not sure	3.8%

Among those who reported choosing not to get care in the past year, more than one in two (53.1%) reported that they did not have the money, and nearly one in four (23.0%) identified doctor or clinic hours to be a barrier.

Exhibit 43: Reason for Not Getting Need Care

	PERCENT
Did not have the money	53.1%
Doctors or clinics not open at a convenient time	23.0%
Could not get off work	16.8%
Had no transportation to get to the doctor or clinic	5.3%
Doctor might not know my language; difficult to communicate	0.9%
No doctors or clinics near me; too far away	0.9%
Could not find child care	0.0%

Quality of Care

A minority of respondents reported the care they receive from Southwell (formerly Tift Regional Health System) to be “somewhat low quality” or “very low quality.”

Exhibit 44: How would you describe the quality of care from the following?

	PERCENT RESPONDING ‘SOMEWHAT LOW QUALITY’ OR ‘VERY LOW QUALITY’
The overall Tift Regional Health System of care	22.0%
Tift Regional Health System providers (e.g., Physicians, Nurse Practitioners, Physician's Assistants)	15.6%
Tift Regional Health System staff (e.g., Nurses, Patient Care Technicians, Other Therapists)	13.8%

Specialty Area Needs

Respondents most commonly identify the need for more **psychiatry** providers, followed by **family practice**, **emergency medicine**, and **nursing home care** providers.

Exhibit 45: Which medical specialties do you think your community is most in need of? (Check all that apply)

RANK	SPECIALTY
1	Psychiatry
2	Family Practice
3	Emergency Medicine
4	Nursing Home Care
5	Neurology
6	Infectious Disease
7	Dental Care
8	Rheumatology
9	Pediatrics
10 (tie)	Cardiology
10 (tie)	Internal Medicine

Communication

Two in three respondents (64.0%) reported seeking out information about healthcare providers or hospitals from **friends and relatives**. Two in five reported using **a physician or other healthcare worker** (43.2%) and/or **a hospital's website** (40.8%).

Exhibit 46: What sources do you normally use to find out about healthcare providers or hospitals? (Check your top three)

	PERCENT
Friends and relatives	64.0%
A physician or other healthcare worker	43.2%
A hospital's website	40.8%
Social media	37.2%
A physician's website	20.8%
Healthcare rating sites like HealthGrades or US News & World Report	13.1%
Healthcare.gov	9.8%
Television	6.9%
Newspaper	3.8%
Magazine	2.6%
Radio	2.1%

When it comes to finding information about their own health (or monitoring their own health), respondents most commonly reported relying on **a patient portal** (57.3%) and/or **a physician or other healthcare worker** (56.8%).

Exhibit 47: What sources do you normally use to find out about your own health or to monitor your own health? (Check your top three)

	PERCENT
A patient portal	57.3%
A physician or other healthcare worker	56.8%
Medical websites such as WebMD or Mayo Clinic	30.3%
Friends and relatives	18.9%
A fitness tracker website like Fitbit or My Fitness Pal	14.6%
A hospital's website	13.8%
A physician's website	9.1%
Telehealth resources such as a telehealth doctor or nurse, or virtual urgent care	6.7%
Healthcare.gov	5.3%

When asked the first, second, and third-best ways to connect with them as a consumer, respondents most commonly selected **social media** (29.3%) as the number one way, followed by **word of mouth** (19.6%) and **physician referral** (15.6%). Beyond these ways, **mailer** (11.5%) was the most common second-best way to connect to consumers identified by respondents. The third-best ways selected by respondents were more evenly distributed, also including **Google search** (11.6%) and **community events** (10.1%).

Exhibit 48: In regards to Tift Regional's providers and services, what is the (#1/#2/#3) way to connect with you as a consumer? Choose only one.

WAYS TO CONNECT TO CONSUMERS	#1	#2	#3
Social media	29.3%	18.2%	11.9%
Word of mouth	19.6%	20.7%	13.9%
Physician referral	15.6%	10.2%	13.6%
Mailer	9.7%	11.5%	8.6%
Commercial (video) - TV and Streaming	4.7%	8.5%	7.3%
Google Search	4.5%	5.7%	11.6%
Community event	3.7%	6.2%	10.1%
News story	3.5%	1.7%	3.5%
Print advertisement	3.0%	7.2%	6.1%
Web advertisement	2.0%	4.2%	5.6%
Billboard	0.5%	2.0%	4.0%
Commercial (audio) - Radio and Streaming	0.2%	1.0%	1.8%
Other (please specify)	3.7%	2.7%	2.0%

Ranked Survey-based Needs

Overall, respondents prioritized behavioral health needs, including counseling services for adolescents/children and adults, drug and other substance abuse education, prevention, early intervention, treatment, and rehabilitation services, as well as emergency mental health services. Affordable quality child care was the second highest prioritized need. Other high priorities, such as healthcare services for seniors and long-term care or dementia care, signal the need to focus on needs of the aging population. A full table of all ranked needs is available in the appendix.

Exhibit 49: Which of the following community and health-related issues do you feel need more attention for improvement?

RANK	NEED
1	Counseling services for mental health issues such as depression, anxiety, and others for adolescents / children
2	Affordable quality child care
3	Counseling services for mental health issues such as depression, anxiety, suicidal thinking, anger management, and others for adults
4	Emergency mental health services
5	Drug and other substance abuse treatment and rehabilitation services, including detox
6	Healthcare services for seniors
7	Long-term care or dementia care
8	Drug and other substance abuse education, prevention, and early intervention services
9	Increased neurology coverage
10	Emergency care and trauma services

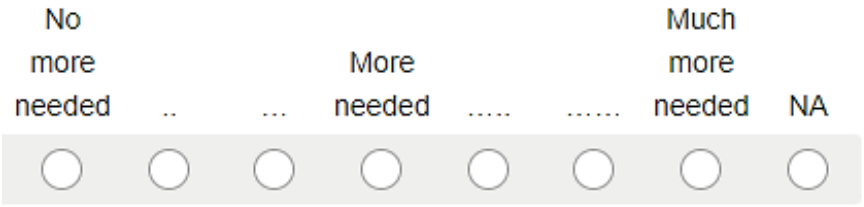
Needs Prioritization

Building consensus among local leadership was essential in prioritizing the needs identified throughout the Community Health Needs Assessment. The needs prioritization process provided Southwell an opportunity to review key findings and categorize which identified needs fall within its scope of work to address, as well as to assess levels of resources available to meet needs, among other considerations.

The prioritization process consisted of two steps:

1

First, an online survey was open for approximately one week to allow each Project Team participant to answer the following question about each of the identified needs: *"How great is the need for additional focus…"* This tool was used to gauge the level of focus necessary to impact the issue in the community. Participants were permitted to provide comments supporting their selection.



2

The second step was the collaborative prioritization session. The Project Team participated in a virtual needs prioritization session to review the needs identified through the Community Health Assessment process.

Each need was evaluated using the following scales:

Locus of Control:
1 = Lead
3 = Collaboration or Partnership
5 = Support or Advocate

Timeline:
1 = "Impact within Year 1"
3 = "Impact in Year 2 or Year 3"
5= "Impact would be long-term, 3+ years"

Needs not selected as consensus high-priority by the Project Team were frequently identified as being more directly under the scope of work of another partner organization and/or associated with a long-term time frame for anticipated impact.

The table below indicates the 'Need for More Focus' score of each need ranked by the Project Team **for Tift Regional Medical Center** via the survey and collaborative prioritization session.

Exhibit 50: Identified Needs as Scored by the Project Team

NEED	AVERAGE 'NEED FOR MORE FOCUS' SCORE (SCALE OF 1 TO 7)
Counseling services for mental health issues such as depression, anxiety, and others for adolescents / children	6.5
Emergency mental health services	6.5
Transportation services for people needing to go to doctor's appointments or the hospital	6.5
Increased neurology coverage	6.3
Counseling services for mental health issues such as depression, anxiety, suicidal thinking, anger management, and others for adults	6.2
Case workers or "navigators" for people with chronic diseases such as diabetes, cancer, asthma, and others.	6.0
Drug and other substance abuse treatment and rehabilitation services, including detox	5.7
Drug and other substance abuse education, prevention, and early intervention services	5.7
Services to help people learn about, and enroll in, programs that provide financial support for people needing healthcare	5.7
Coordination of patient care between the hospital and other clinics, private doctors, or other health service providers	5.6
Programs for obesity prevention, awareness, and care	5.5
Long-term care or dementia care	5.3
Secure sources for affordable, nutritious food	5.3
Affordable housing	5.3
Primary healthcare services (such as a family doctor or other provider of routine care)	5.2
Timely access to emergency care and trauma services	5.2
Affordable healthcare services for individuals or families with low income	5.2
Equitable access to healthcare services, including access to information and services in Spanish	4.7
Teen substance use prevention and treatment, including vaping	4.7
Access to dental services	4.5
Healthcare services for seniors	4.3
"Integrated care" where people can get medical care and counseling at the same time	4.2
Affordable quality child care	4.0
Road safety, including measures to prevent motor vehicle collisions	3.8

Following scoring of the identified needs, the Leadership Group approved the following set of high-priority needs **for Tift Regional Medical Center** by consensus. The 2024 needs fall into four categories: Behavioral Health, Transportation, Care Coordination, and Basic Needs.

Exhibit 51: High-Priority Identified Needs, by Domain and Rank

DOMAIN & RANK	SPECIFIC HEALTH NEED
Behavioral Health	
1 (tie)	Counseling services for mental health issues such as depression, anxiety, and others for adolescents / children
1 (tie)	Coordination of emergency mental health services with other regional providers and resources
5	Counseling services for mental health issues such as depression, anxiety, suicidal thinking, anger management, and others for adults
7 (tie)	Drug and other substance abuse treatment and rehabilitation services, including detox
7 (tie)	Drug and other substance abuse education, prevention, and early intervention services
Transportation	
1 (tie)	Availability, quality, and consistency of transportation services for people needing to access primary care or to go to doctor's appointments or the hospital
Care Coordination	
6	Case workers or "navigators" for people with chronic diseases such as diabetes, cancer, asthma, and others.
7 (tie)	Services to help people learn about, and enroll in, programs that provide financial support for people needing healthcare
10	Coordination of patient care between the hospital and other clinics, private doctors, or other health service providers
Basic Needs	
11	Programs for obesity prevention, awareness, and care
12	Secure sources for affordable, nutritious food

Implementation Strategy Considerations

Southwell's strategic approach to implementation will help operationalize activities designed to address prioritized needs. The health system's leadership supports an active, collaborative, community-based set of actions to enhance community health. Based on Project Team discussions, there is particular interest in strategies and initiatives including the following:

- Increasing lobbying efforts at the state level to ensure that patients with emergent mental health needs can be sent to appropriate emergency receiving facilities
- Collaborating as possible with local programs providing substance use prevention and education services to youth through SAMHSA's Center for Substance Abuse Prevention services[33]
- Providing first responders, including local law enforcement, appropriate information (e.g., rack cards and/or resource guides) to disseminate to community members in need of behavioral health services
- Working with county and state transportation agencies to ensure that consistent, high-quality services are available
- Enhancing care coordination through broader outreach and expanded communications strategies, including engagement with Community Health Workers to help community members connect to local resources[34]
- Partnering with local agencies, such as Georgia's community action associations, to address intersectional needs, such as homelessness and food insecurity
- Expanding health and nutrition education offerings through the SNAP-Ed program within the Public Health District[35]

Specific implementation strategies will be developed by Southwell leadership in coordination with community partners.

[33] Georgia Department of Behavioral Health and Developmental Disabilities. Available at: https://dbhdd.georgia.gov/bh-prevention/substance-abuse-prevention

[34] Georgia Community Health Worker Network. Available at: https://gachw.org/about/

[35] Georgia Department of Public Health. SNAP-Ed. Available at: https://dph.georgia.gov/snap-ed

Appendices

Appendix A: CHNA Implementation Strategy FY 2021-2023

Rank	Health Need	Domain(s)
1	Transportation services for people who need to go to a doctor's appointment or to the hospital	Access to Care
Implementation Strategy		
• Deploy Mobile Health Clinic to medically-underserved areas within primary service area. • Launch Southwell Connect virtual visit program through a partnership with AmWell.		
Implementation Strategy Status Report		
• The Mobile Clinic was deployed, then was sidelined during the COVID-19 pandemic. Once COVID-19 vaccines were made available, the Mobile Clinic was used to help with mass vaccinations within the community. When the pandemic ended, the Mobile Clinic was re-deployed for a brief period. Unfortunately, due to underutilization, operation of the Mobile Clinic was suspended. As an alternative strategy, Southwell implemented an in-home Palliative Care service and a Community Paramedicine Program (CPP): With the in-home Palliative Care program, patients receive treatment to relieve symptoms of a disease along with those that may occur under the strain of dealing with a serious, life-limiting disease, such as anxiety, depression, a loss of appetite, fatigue, and difficulties sleeping. The Southwell Community Paramedicine Program is designed to enhance community wellness, decrease hospital readmissions, and minimize patient utilization of the emergency department for chronic and non-emergent cases. Select patients receive visits in their home setting by a paramedic to address chronic conditions and medication adherence. • The Southwell Connect virtual visit program was launched in 2021.		

Rank	Health Need	Domain(s)
2	Affordable prescription medications	Access to Care

Implementation Strategy

- Through Southwell Medical Community Health Center, offer a Prescription Assistance Program (PAP) with pharmaceutical companies, the Tift Regional Medical Center Foundation, government-assisted programs, and nonprofit-sponsored initiatives. • Leverage Section 340B of the Public Health Service Act which requires pharmaceutical manufacturers participating in Medicaid to sell outpatient drugs at discounted prices to healthcare organizations that care for uninsured and low-income patients, especially oncology patients.

Implementation Strategy Status Report

- All of the above action items have been completed and are ongoing.

Rank	Health Need	Domain(s)
3	Senior health services (grouped): • Care coordination, diagnosis and treatment • Dementia spectrum services	Care Coordination Services and System Capacity

Implementation Strategy

- Increase telemedicine utilization in local nursing homes.
- Continue to educate the public and referring providers about the new, 95-bed Southwell Health and Rehabilitation skilled nursing facility and the 12-bed Sylvia Barr Center geriatric psychiatric unit at Southwell Medical in Adel.
- Complete a feasibility study on the recruitment of a board-certified geriatric primary care physician to serve as system medical director for senior care.
- Continue to serve as a community partner for Meals-on-Wheels, the Leroy Rogers Center, Delle Beamguard Community Center, and other local senior programs.

Implementation Strategy Status Report

- . Southwell explored the recruitment of a board-certified geriatric primary care physician to serve as system medical director for senior care. It was determined that the needs for senior care coordination, diagnosis and treatment were being

adequately covered by our internal medicine and family medicine providers under the medical direction of our Chief Transformation Officer.

- All of the other above action items have been completed and are ongoing.

Rank	Health Need	Domain(s)
4	Behavioral health services (grouped): • Substance abuse screening, intervention, treatment, care coordination • Behavioral health services for adults for depression, anxiety, or other mental health conditions.	Care Coordination Services and System Capacity

Implementation Strategy

- Continue to serve as a community partner with the OASIS Substance Abuse Recovery Center.
- Recruit a psychiatrist to serve as system medical director for Southwell's Behavioral Health Department and recruit additional advanced practice providers and licensed clinical social workers as needed.
- Further integrate behavioral health into the primary care setting to help improve access to mental health services and treatment of co-morbid physical conditions.
- Launch Southwell Connect virtual visit program through a partnership with AmWell (to include behavioral health component).
- Continue to educate the public and referring providers about the new, 12-bed Sylvia Barr Center geriatric psychiatric unit at Southwell Medical in Adel.
- Continue to serve as a community partner for Meals-on-Wheels, whose clients include seniors with dementia.

Implementation Strategy Status Report

- . All of the above action items have been completed and are ongoing.

Rank	Health Need	Domain(s)
5	Health and wellness enhancement (grouped): • Access to healthful food • Wellness initiatives for adults—exercise and nutrition • Obesity—education and prevention	Access to Care

Implementation Strategy

- • Continue to serve as a community partner with the Tift area YMCA.
- Conduct periodic food insecurity screening surveys and guide patients to proper community resources as needed.
- Develop affordable, farm-to-table, fresh food access points in partnership with local farmers.
- Develop fun nutrition educational programs ("Eat This, Not That") for primary school students with Southwell's dietitians and the University of Georgia Family and Consumer Sciences-Tift County Extension Service.
- At school-based clinics, provide ongoing education to children on the benefits of being active and eating healthy.
- Develop educational activities (both web-conference based and in-person events) and informational videos and posts (for social media and website) that touch on preventive health, fitness, nutrition, and other wellness topics.
- Include prevention and wellness articles in Southwell's health magazine (mailed to residents three-times-a-year).

Implementation Strategy Status Report

- Southwell has collaborated with Front Door Produce to offer a periodic service called "Produce with a Purpose." Local residents can purchase and pick-up a bountiful box with an assortment of farm-fresh vegetables at either Tift Regional Medical Center in Tifton or Southwell Medical in Adel. With every four boxes purchased, a fifth box is donated to a local food bank, ensuring that those less fortunate can also benefit from the goodness of fresh vegetables.
- All of the other above action items were completed and are ongoing.

Appendix B: Secondary Data Population Research

Exhibit 52: Population by Age Group

	United States	Georgia	Tift PSA	Tift County	Turner County	Cook County	Tift SSA
Under Age 18	22.1%	23.4%	25.0%	25.0%	24.6%	25.2%	24.0%
Age 18 to 64	61.4%	62.2%	59.1%	59.8%	56.8%	58.6%	60.6%
Age 65 and Over	16.5%	14.4%	15.9%	15.3%	18.6%	16.2%	15.4%
Age Under 5	5.7%	5.9%	6.6%	6.7%	6.8%	6.5%	6.3%
Age 5 to 9	6.0%	6.3%	5.3%	5.7%	6.0%	4.0%	7.0%
Age 10 to 14	6.5%	7.0%	8.8%	8.4%	8.2%	9.9%	6.6%
Age 15 to 19	6.6%	7.1%	8.2%	8.2%	7.2%	8.6%	7.3%
Age 20 to 24	6.7%	6.9%	5.5%	5.7%	3.8%	6.0%	8.3%
Age 25 to 34	13.7%	13.8%	12.5%	12.9%	12.5%	11.5%	13.5%
Age 35 to 44	12.9%	13.2%	12.6%	13.3%	10.9%	11.9%	12.4%
Age 45 to 54	12.4%	13.1%	11.9%	11.7%	11.2%	12.6%	11.4%
Age 55 to 59	6.5%	6.4%	6.6%	7.2%	4.4%	6.3%	6.1%
Age 60 to 64	6.4%	5.9%	6.1%	5.0%	10.4%	6.4%	5.7%
Age 65 to 74	9.7%	8.8%	9.6%	9.2%	11.2%	9.6%	9.4%
Age 75 to 84	4.8%	4.1%	4.8%	4.5%	6.0%	4.7%	4.4%
Age Over 85	2.0%	1.4%	1.6%	1.5%	1.3%	1.9%	1.6%

Source: U.S. Census Bureau American Community Survey 2018-2022 Five-year Estimates

Exhibit 53: Projected Percent Change in Population, 2010 to 2031 Continued

	Atkinson County	Ben Hill County	Berrien County	Brooks County	Coffee County
Total Population (2010) [36]	8,375	17,634	19,286	16,243	42,356
Total Population (2022)	8,265	17,169	18,187	16,275	43,056
Percent Change, 2010 to 2022	-1.3%	-2.6%	-5.7%	+0.2%	+1.7%
Total Population (2031)	9,136	17,633	20,099	16,551	48,697
Projected Percent Change, 2010 to 2031	+9.1%	0.0%	+4.2%	+1.9%	+15.0%

Source: U.S. Census Bureau. American Community Survey Five-Year Estimates, 2018-2022

Exhibit 54: Projected Percent Change in Population, 2010 to 2031 Continued

	Colquitt County	Crisp County	Irwin County	Lowndes County	Wilcox County	Worth County
Total Population (2010) [37]	45,498	23,439	9,538	109,233	9,255	21,679
Total Population (2022)	45,813	20,255	9,487	118,257	8,839	20,706
Percent Change, 2010 to 2022	+0.7%	-13.6%	-0.5%	+8.3%	-4.5%	-4.5%
Total Population (2031)	49,699	20,929	9,930	135,028	9,618	21,206
Projected Percent Change, 2010 to 2031	+9.2%	-10.7%	+4.1%	+23.6%	+3.9%	-2.2%

Source: U.S. Census Bureau. American Community Survey Five-Year Estimates, 2018-2022

[36] Totals reported in this row are Census 2010 population counts. The remainder of this report features more recent estimates of population, as derived from the Census Bureau's American Community Survey over the 2018-2022 period.

[37] Totals reported in this row are Census 2010 population counts. The remainder of this report features more recent estimates of population, as derived from the Census Bureau's American Community Survey over the 2018-2022 period.

Exhibit 55: Population Living with Disability by Type

	United States	Georgia	Tift PSA	Tift County	Turner County	Cook County	Tift SSA
Ambulatory Difficulty	6.3%	6.3%	6.5%	4.8%	11.1%	8.2%	7.5%
Cognitive Difficulty	5.0%	5.0%	5.1%	3.7%	9.6%	6.0%	6.0%
Independent Living Difficulty	4.5%	4.3%	4.4%	3.0%	9.4%	5.2%	4.5%
Hearing Difficulty	3.6%	3.2%	3.8%	2.8%	6.3%	4.8%	3.9%
Vision Difficulty	2.4%	2.5%	3.2%	2.1%	5.8%	4.6%	2.8%

Source: U.S. Census Bureau American Community Survey 2018-2022 Five-year Estimates

Exhibit 56: Population Living With a Disability by Age Group

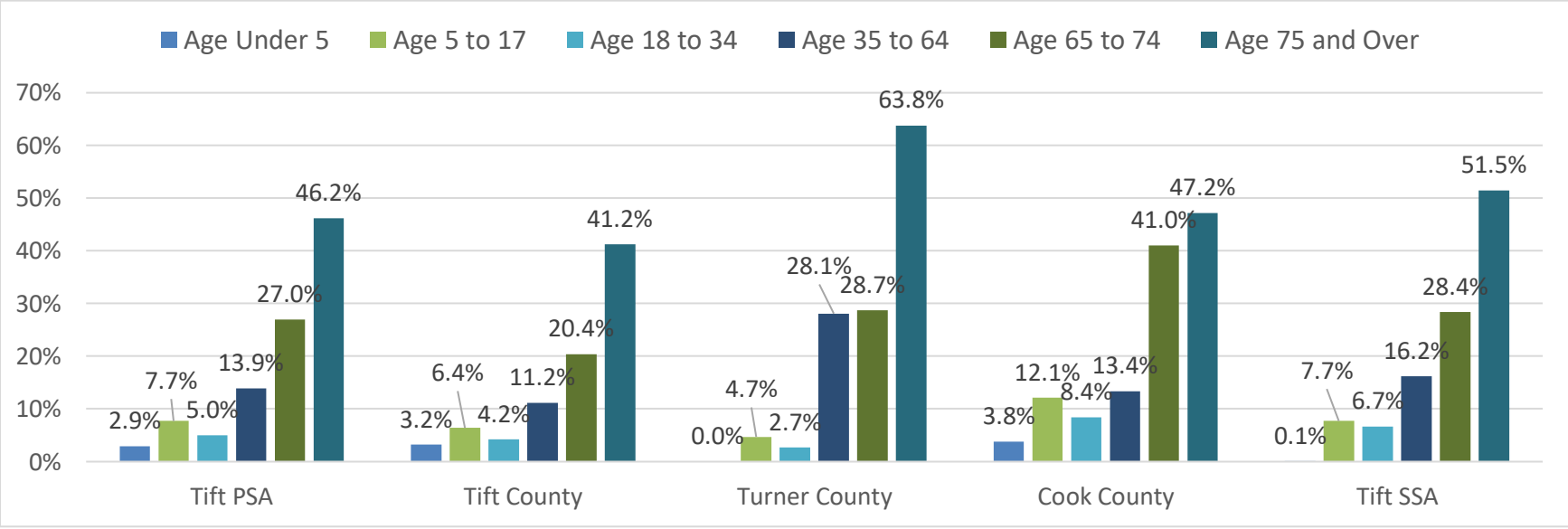


Exhibit 57: Population Living With a Disability by Age Group (Table)

	United States	Georgia	Tift PSA	Tift County	Turner County	Cook County	Tift SSA
Age Under 5	0.7%	0.8%	2.9%	3.2%	0.0%	3.8%	0.1%
Age 5 to 17	5.9%	6.0%	7.7%	6.4%	4.7%	12.1%	7.7%
Age 18 to 34	7.2%	7.2%	5.0%	4.2%	2.7%	8.4%	6.7%
Age 35 to 64	12.4%	12.8%	13.9%	11.2%	28.1%	13.4%	16.2%
Age 65 to 74	24.1%	25.9%	27.0%	20.4%	28.7%	41.0%	28.4%
Age 75 and Over	46.9%	48.5%	46.2%	41.2%	63.8%	47.2%	51.5%

Source: U.S. Census Bureau. American Community Survey Five-Year Estimates, 2018-2022

Exhibit 58: Families with Children Under Age 18

	Tift PSA	Tift County	Turner County	Cook County
Married with Children with Age Under 6	20.2%	19.9%	13.7%	22.7%
Married with Children with Both Under Age 6 and Age 6 to 17	16.2%	19.4%	12.0%	10.5%
Married with Children with Age 6 to 17	63.6%	60.7%	74.2%	66.8%
Single Male Householder with Children with Age Under 6	36.3%	31.1%	49.2%	43.2%
Single Male Householder with Children with Both Under Age 6 and Age 6 to 17	29.7%	31.6%	23.0%	27.8%
Single Male Householder with Children with Age 6 to 17	34.0%	37.3%	27.9%	29.0%
Single Female Householder with Children with Age Under 6	23.3%	24.0%	17.4%	23.3%
Single Female Householder with Children with Both Under Age 6 and Age 6 to 17	19.0%	12.3%	63.1%	25.0%
Single Female Householder with Children with Age 6 to 17	57.7%	63.6%	19.5%	51.8%

Source: U.S. Census Bureau American Community Survey 2018-2022 Five-year Estimates

Exhibit 59: Median Household Income

	Tift SSA	Atkinson County	Ben Hill County	Berrien County	Brooks County	Coffee County
Median Household Income (2022)	$54,935	$38,007	$38,255	$48,670	$42,263	$48,398
Median Household Income (2010)	$39,078	$31,570	$32,233	$34,461	$39,765	$35,680
Percent Change	+40.6%	+20.4%	+18.7%	+41.2%	+6.3%	+35.6%

Source: U.S. Census Bureau. American Community Survey Five-Year Estimates, 2018-2022

Exhibit 60: Median Household Income, Continued

	Colquitt County	Crisp County	Irwin County	Lowndes County	Wilcox County	Worth County
Median Household Income (2022)	$47,235	$47,463	$46,383	$52,821	$46,759	$56,496
Median Household Income (2010)	$34,427	$36,547	$40,651	$44,055	$32,549	$40,681
Percent Change	+37.2%	+29.9%	+14.1%	+19.9%	+43.7%	+38.9%

Source: U.S. Census Bureau. American Community Survey Five-Year Estimates, 2018-2022

Exhibit 61: Highest Level of Educational Attainment

	Tift SSA
Less than 9th Grade	5.6%
9th to 12th Grade, No Diploma	11.0%
High School Degree	37.1%
Some College No Degree	19.7%
Associate degree	8.9%
Bachelor's Degree	10.6%
Graduate Degree	7.0%

Source: U.S. Census Bureau American Community Survey 2018-2022 Five-year Estimates

Exhibit 62: Georgia Violent Crime Trend, Rate per 100,000 Population

	2017	2018	2019	2020	2021	2022
Rate per 100,000 population	356.5	338.9	326.2	400.1	349.8	367.0

Source: Federal Bureau of Investigation Crime Data Explorer, CDE (cjis.gov)

Exhibit 63: Obesity Among Adults

	Tift County	Turner County	Cook County
Percent	40.5%	40.5%	38.4%

Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. PLACES Data [online]. 2022 [accessed Jan 10 2024].. URL: https://www.cdc.gov/PLACES

Exhibit 64: Georgia Age-Adjusted Leading Causes of Death, 2020

Cause of Death	Number of Deaths	Percent of Deaths
Heart Disease	21,116	20.5%
Malignant Neoplasms	17,827	17.3%
COVID-19	9,453	9.2%
Unintentional Injury	5,517	5.4%
Chronic Lower Respiratory Disease	4,826	4.7%
Cerebrovascular (Stroke)	4,821	4.7%
Alzheimer's Disease	4,782	4.6%
Diabetes Mellitus	2,833	2.7%
Nephritis	2,134	2.1%
Septicemia	1,841	1.8%
All Deaths	103,075	100.0%

Source: Centers for Disease Control and Prevention WISQARS Leading Causes of Death Visualization Tool

Exhibit 65: Health Risk Behaviors Among Adults, 2021

	Tift County	Turner County	Cook County
Current Smoking	19.9%	24.0%	21.5%
Binge Drinking	13.8%	13.6%	14.7%
No Leisure-Time Physical Activity	30.1%	34.3%	30.7%
Sleeping Less than 7 Hours	38.4%	41.0%	41.0%

Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. PLACES Data [online]. 2022 [accessed Jan 10 2024]. URL: https://www.cdc.gov/PLACES

Exhibit 66: Sexually Transmitted Infections

Rate per 100,000 people	Tift County	Turner County	Cook County
Gonorrhea Rate (2021)	431.9	635.7	377.4
Chlamydia Rate (2021)	679.4	1093.0	743.1
Primary and Secondary Syphilis Rate (2021)	17.0	11.2	23.2
Early Non-Primary Non-Secondary Syphilis Rate (Early Latent) (2021)	17.0	0.0	11.6
HIV Prevalence Rate (2020)	526.0	743.0	492.0

Source: Centers for Disease Control and Prevention | The National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) AtlasPlus 2021 , AIDSVu Emory University 2020

Exhibit 67: High Cholesterol Among Adults, 2019

	Tift County	Turner County	Cook County
High Cholesterol Among Adults Screened in Past 5 Years	33.3%	37.3%	37.2%

Source: Centers for Disease Control and Prevention, Interactive Atlas of Heart Disease and Stroke

Exhibit 68: Chronic Disease Incidence Summary Among Adults, 2021

	Tift County	Turner County	Cook County
High Blood Pressure	38.8%	42.8%	39.1%
Current Asthma	10.8%	11.6%	11.8%
Coronary Heart Disease	6.3%	7.2%	6.7%
Diagnosed Diabetes	13.6%	15.6%	13.3%

Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. PLACES Data [online]. 2022 [accessed Jan 10 2024].. URL: https://www.cdc.gov/PLACES

Exhibit 69: Stroke Death Rate for All Ages

Rate per 100,000	Tift County	Turner County	Cook County
2016-2018	52.5	51.5	50.1
2017-2019	52.2	50.2	48.3
2018-2020	51.5	46.9	49.1
Percent Change 2016-2018 to 2018-2020	-1.9%	-8.9%	-2.0%

Source: Centers for Disease Control and Prevention, Interactive Atlas of Heart Disease and Stroke

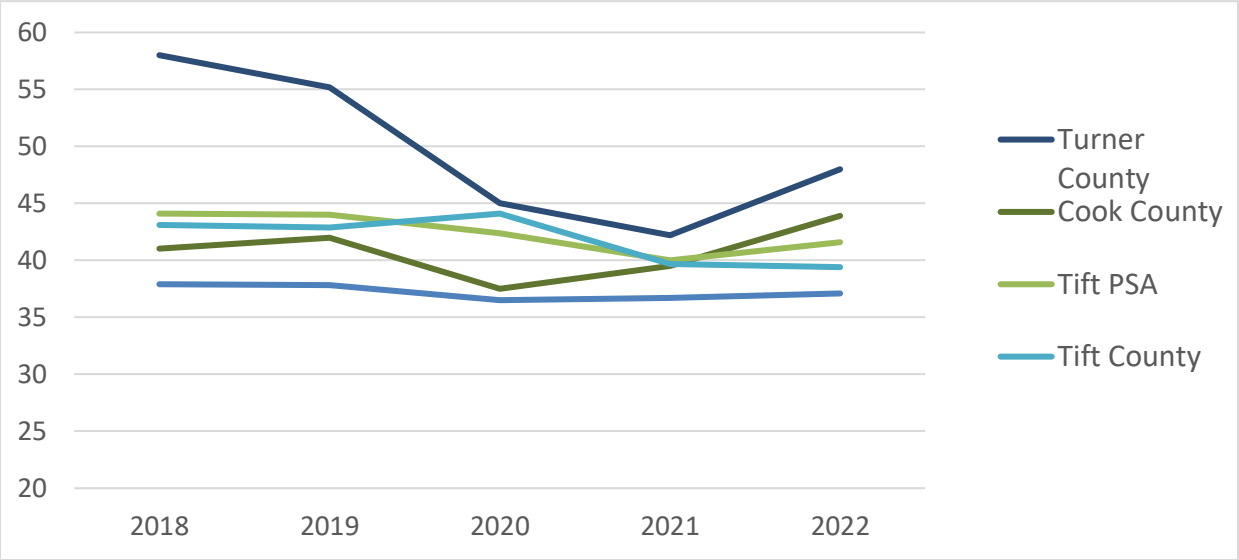
Exhibit 70: Percent of Deaths by Major Cardiovascular Diseases[38]

	Tift County	Turner County	Cook County	Tift PSA	Georgia
2018	27.4%	26.1%	31.6%	28.3%	29.6%
2019	37.7%	30.4%	37.5%	36.3%	30.0%
2020	25.9%	18.1%	31.4%	26.2%	27.1%
2021	28.7%	27.6%	32.8%	29.6%	26.0%
2022	28.4%	27.3%	32.7%	29.5%	28.2%
Percent Change 2018-2022	+3.6%	+4.6%	+3.5%	+4.2%	-4.7%

Source: Georgia Department of Public Health | Office of Health Indicators for Planning (OHIP) Online Analytical Statistical Information System (OASIS), Mortality Web Query

38 High blood pressure, Rheumatic fever and heart diseases, hypertensive heart disease, obstructive heart disease (including heart attack), stroke, hardening of the arteries, aortic aneurysm and dissection, all other disease of the heart, all other diseases of circulatory system, Georgia Department of Public Health, Office of Health Indicators for Planning OASIS (state.ga.us)

Exhibit 71: Birth Rate Trend 2018-2022



Rate per 1,000 females aged 10-55	Georgia	Tift PSA	Tift County	Turner County	Cook County
2018	37.9	44.1	43.1	58.0	41.0
2019	37.8	44.0	42.9	55.2	42.0
2020	36.5	42.4	44.1	45.0	37.5
2021	36.7	40.0	39.7	42.2	39.5
2022	37.1	41.6	39.4	48.0	43.9
Percent Change 2018-2022	-1.8%	-5.4%	-8.1%	-12.4%	+4.6%

Source: CDC WONDER Natality Birth Rate, 2021 https://wonder.cdc.gov/, Georgia Department of Public Health | Office of Health Indicators for Planning (OHIP) Online Analytical Statistical Information System (OASIS),Maternal Child Health – Birth Web Query

Exhibit 72: Asthma in Children by Public Health District[39] 2016-2018

	Percent	Rate per 100,000	2018 Annual Numbers
Prevalence	10.5%	ND	ND
Asthma Hospitalization Rate	N/A	112	53
ED Visits Rate	N/A	620	439

Source: 2020 Georgia Child Asthma Data Summary

39 Public Health District that includes Ben Hill, Berrien, Brooks. Cook, Echols, Irwin, Lanier, Lowndes, Tift, Turner, 2020 Georgia Child Asthma Data Summary .pdf

Appendix C: Stakeholder Interview Guide

Stakeholder Interview Guide

Good morning [or afternoon]. My name is [Interviewer Name] from Crescendo Consulting Group. We are working with Tift Regional Health System to conduct a regional community health needs assessment.

The purpose of this conversation is to learn more about the strengths and resources in the community as well as collect your insights regarding healthcare-related needs, ways that people seek services, ongoing impacts of the COVID-19 pandemic, and to identify service gaps and ways to better meet the needs of the community.

We are also very interested to hear your insights about equal access to healthcare services and the challenges or advantages that some communities may experience, if any. We will describe our discussion in a written report; however, individual names will not be used. **Please consider what you say in our conversation to be anonymous.**

Do you have any questions for me before we start?

Self-introduction Questions

Please tell me a little about yourself and the ways that you like to interact with the community where you live [where appropriate, "… and the populations your organization (or you) serves."].

1. When you think of the good things about living/working in this community, what are the first things that come to mind? *[PROBE: things to do, parks or other outdoor recreational activities, a strong sense of family, cultural diversity]*
2. Generally, what are some of the challenges to living here?
3. What would you say are the two or three most urgent healthcare-related needs in the (these) community/communities? *[PROBE: obesity, diabetes, depression]*

Healthcare System

4. To what degree are community members or families struggling with finding and accessing quality healthcare? [*PROBE: Are there certain types of care that are more difficult to find?]*
    a. Quality primary care and/or specialty care availability (Services for adults, children & adolescents).
    b. What specialty care services are available or missing?
5. Is maternal care for expectant mothers accessible in your community? Other OB/GYN services?
    a. What are the barriers and facilitators, if any, to accessing prenatal or maternal health services?
6. What are some of the healthcare challenges and benefits that older adults may experience in your community? *(PROBE: hospice, end-of-life care, specialists, etc.).*
7. Do people have access to affordable prescription medications and a local place to pick them up?
8. How are people accessing care, for example, virtual/telemedicine, face-to-face?
9. What types of prevention programs are available in your community (e.g., drug and alcohol, smoking cessation, HIV/AIDS/STI, diabetes, etc.)?
10. How do you think COVID-19 has impacted how people take care of themselves and how people interact with the healthcare system or doctors and other providers? *[PROBE: such as for screenings or routine services, vaccine perceptions, virtual healthcare, or others?]*
    a. How, if at all, has COVID-19 affected the trust of healthcare providers or systems and the public health system?
11. What would improve access to services, medications, and programs?

Behavioral Health

12. When community members need help in a mental health crisis, who do they tend to turn to for assistance (healthcare-related, community services, or otherwise)?
    a. What about in a substance use crisis? What substances do you see or hear about in the community?
    b. Are there existing early intervention programs for local youth that may be experimenting or initiating substance use?
    c. Are there supports in place to help with treatment? *[Probe: AA/NA meetings]*
    d. What is or is not working?
13. From what you have seen and experienced, how has the pandemic affected mental health or substance misuse issues?
14. Is there a stigma around seeking substance use disorder treatment?

Health Equity

15. Are healthcare services equally available to everyone regardless of gender, race, age, or socioeconomics?
    a. Are there any barriers to access to services based on economic, race/ethnicity, gender, or other factors?
    b. Is there an experience of yours or someone you know about finding a doctor or getting needs met that you would like to share?
16. To what degree do healthcare providers care for patients in a culturally sensitive manner?
17. What are some of the biggest needs for those who are more vulnerable than others? *[PROBE: veterans, youth, immigrants, LGBTQ+ populations, people of color, older adults, people living with disabilities]*
    a. How does the community support or not support them?
18. What are some of the local or community-level actions that can be done to provide for community health and make wellbeing more equitable?
    a. Are there any 'low hanging fruit' that could be addressed quickly?
19. Do you feel that there is any stigma around the local healthcare facilities (e.g., a person may choose not to utilize the health department's services because "it's for poor people")?

Neighborhood & Physical Environment

20. How difficult is it to find safe and affordable housing in your community? Name some of the greatest challenges. Are there any services to help with housing?
21. Do you feel there is good access to broadband and high-speed internet in the region? What are some of the challenges to not having good, reliable internet?

22. How would you describe access to healthful, affordable food? What are some features or services that are working well? Where are the service gaps? What communities face unique challenges?
23. Does everyone typically have reliable transportation to work or go to the grocery store, doctors, or school? If not, are there services in the community that help those experiencing barriers/without a vehicle?

Education, Employment & Basic Needs

24. How easy is it for families to find affordable and safe childcare in the area? What are some of the challenges or facilitators?
25. Describe the job market in the area before the pandemic and currently. *[PROBES: Generally, are "good" jobs here, and can people get them? Is it easy to find a full-time job with good pay, benefits, and retirement?]*
    a. If people mention community education classes, PROBE: What are some ideas/suggestions to increase attendance?
26. Do people in the community struggle with accessing other basic needs besides healthcare such as accessing nutritious/healthy food?

Enhancing Outreach & Disseminating Information

Reference: Health literacy is: [from Healthy People 2020]: "The degree to which individuals can obtain, process, and understand basic health information and services needed to make appropriate health decisions."

27. To what degree is health literacy a community advantage or challenge?
    a. How do you th

b. How can health organizations improve the health literacy of the community?

28. How do community members generally learn about access to and availability of services in the area (e.g., online directory; social media; hotline; word of mouth)? What method tends to work the best or worst?
29. What do you think are some challenges to spreading awareness and understanding of the availability of services and ways to access them? What might help overcome the challenges?
30. What types of activities would best reach those more vulnerable parts of the community? (people experiencing homelessness, people living with disabilities, or other diverse or hard-to-reach populations)
    a. What resources are you aware of that are already helping those populations?

Community Connection & Social Support

Reference: Social associations can help us live healthier lives. These associations may include civic organizations, bowling centers, golf clubs, fitness centers, sports organizations, religious organizations, political organizations, labor organizations, business organizations, professional organizations, and others.

31. Do you as a resident of your community get enough social interaction? Where do you get that interaction, and which of those are the most fulfilling sources?
32. Do you wish there were more opportunities for social interaction? If so, what would you like to see? *[PROBE: how about for youth specifically?]*
33. What barriers are there to participating in social interaction for you and others in your community?
34. Do you wish there were more opportunities for social support between community members? If so, what would you like to see?

RESEARCHER NOTES

- Bring up each of the following topics and include probes and subcategories in the dialogue.
- Note comments and particular areas of emphasis. Include comparisons between topics where helpful,
- *e.g., "So which do you think requires more attention: substance abuse education in schools or opioid abuse intervention among the homeless?"*
- Not all topics will be covered with all interviewees. Discussion content will be modified to respond to the interviewees' professional background and availability of time during the interview.

Appendix D: Focus Group Moderator Guide

Welcome and Introductions

Good morning [or afternoon]. My name is [*Moderator Name*] from Crescendo Consulting Group. We are working with Southwell to conduct a community health needs assessment across the organization's service area.

Explain the general purpose of the discussion

The purpose of this conversation is to learn more about the strengths and resources in the community as well as collect your insights regarding healthcare-related needs, ways that people seek services, impacts of the COVID-19 pandemic, and to identify service gaps and ways to better meet the needs of the community. We are also very interested to hear your insights about equal access to healthcare services and challenges or advantages that some communities may experience, if any.

Explain the necessity for notetaking

We're taking notes to assist us in recalling your throughts. We will describe our discussion in a written report; however, individual names will not me used. Please consider what you say and hear today to be confidential.

Describe logistics (virtual groups)

Logistics are a bit different than normal since we're virtual, but we'd appreciate it if you gave us your full attention for the next hour or so. If you need to take a break to use the restroom, please do.

If you have a private question, feel free to type it in the chat area of the software and I'll respond as soon as possible.

Describe the protocol for those who have not been to a group before

For those of you who have not participated in a focus group before, the basic process is that I will ask questions throughout our session, however, please feel free to speak up at any time. In fact, I encourage you to respond directly to the comments other people make, as this is a conversation. If you don't understand a question, let me know. We are here to ask questions, listen, and make sure everyone has a chance to share and feels comfortable. Be respectful of the opinions of others. Honest opinions are the key to this process, and there are no right or wrong answers. I'd like to hear from each of you and learn more about your opinions, both positive and negative.

Do you have any questions before we start?

Introductions

Please feel free to tell us your name and include your organization or role in the community. Please briefly share how you interact with the community and the populations your organization (or you) serves, if any.

Access and Availability of Services

1. When you think of the good things about living in this community, what are the first things that come to mind? *[PROBE: things to do, parks or other outdoor recreational activities, strong sense of family, cultural diversity]*
2. What would you say are the two or three most urgent health-related needs in your community? *[PROBE: heart disease, obesity, diabetes, depression, health equity, access to care, etc.]*

Affordability of Healthcare and Basic Needs

3. To what degree are community members or families struggling with finding and accessing quality healthcare? [*PROBE: are there certain types of care that are more difficult to find?]*
    a. Are healthcare services equally available to everyone regardless of gender, race, age, sexuality, socioeconomics? Are there any barriers in access to services based on economic, race / ethnicity, gender, or other factors? Is there an experience of your or someone you know finding a doctor or getting needs met that you would like to share?
    b. To what degree do healthcare providers care for patients in a culturally sensitive manner?
    c. How are people accessing care, for example, virtual/telemedicine, face-to-face?
    d. To what degree is quality primary care and/or specialty care available? For youth specifically?
4. When community members need help in a mental health crisis, who do they tend to turn to for assistance (healthcare-related, community services, or otherwise)? [*PROBE: friends and family, local Health Department, their doctor, churches*]
    a. What about in a substance use crisis? What substances do you see or hear about in the community?
    b. What services are most helpful? What other services or supports would you like to see?

5. Do people in the community struggle with accessing other basic needs besides healthcare such as accessing nutritious / healthy food, washing and hygiene, or affordable prescription medications?
    a. What are some resources or services in the community that work really well? What doesn't work?
6. What are some of the healthcare challenges that seniors may experience in your community? (Probe: hospice, end of life care, specialists, etc.).

Health Equity

7. Health equity is an important consideration. First, what does health equity mean to you?
8. We know some people in our community struggle to get the medical care they need. What do you think we can do about this? How can we ensure doctors and medical care are available to all people?

Social determinants of health

9. What are some non-healthcare-related challenges or barriers people in the community might have?
    a. How difficult is it to find safe and affordable housing in your community? Name some of the greatest challenges.
    b. To what degree of homelessness is a concern in your community? Are there any programs that are available for those who are experiencing homelessness?
    c. Describe the job market in the area before the pandemic and currently. Generally, are "good" jobs here, and can people get them? Is it easy to find a full-time job with good pay, benefits, and retirement?
    d. Do you feel there is good access to broadband and high-speed internet in the region? What are some of the challenges to not having good, reliable internet?
    e. Does everyone typically have reliable transportation to work, the grocery store, doctors, school? If not, are there services in the community that help those without a vehicle? Do you or the people you know have reliable transportation? What personal stories or stories from friends, family or neighbors do you have to share?

f. How easy is it for families to find affordable and safe childcare in the area? What are some of the challenges or barriers?

IMPACT OF COVID-19

10. How do you think COVID-19 will impact the way that people take care of themselves and how people interact with the healthcare system or doctors and other providers, such as for screenings or routine services, vaccine perceptions, virtual healthcare, or others?
    a. How, if at all, did COVID-19 affected trust of healthcare providers or systems?
11. From what you have seen and experienced, how did the pandemic affected mental health or substance misuse issues?

Enhancing Outreach and disseminating Information

12. Is there adequate health information available – especially in diverse or marginalized communities? How do you think health organizations can improve health literacy of the community? *Reference: Health literacy is: [from Healthy People 2020]: "The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions."*
13. When community members need help, who do they tend to turn to for assistance (healthcare-related, community services, or otherwise)? [*PROBE: friends and family, Town Hall, local Health Department, their doctor, churches*]

Community connection and social support

14. To what degree is social support between community members an advantage or challenge? So, for example, acts such as helping, sharing, comforting, donating, volunteering, or cooperation, that are intended to benefit others.
    a. Do you as a resident of your community get enough social interaction? Where do you get that interaction, and which of those are the most fulfilling sources?
    b. Do you wish there were more opportunities for social interaction? If so, what would you like to see? [*PROBE*: how about for youth specifically?]
    c. Are there opportunities to support your community through helping, sharing, comforting, donating, volunteering, or other types of cooperation? If so, in where and in what ways? What barriers are there to participation in such activites?
    d. Do you wish there were more opportunities for social support between community members? If so, what would you like to see?

Magic Wand

What would a vibrant, healthy, flourishing community look like? Let's assume that money and resources weren't issues. Where would you start … what is the first thing you would do for your community?

RESEARCHER NOTES

- Bring up each of the following topics and include probes and subcategories in the dialogue.
- Note comments and particular areas of emphasis. Include comparisons between topics where helpful,
- *e.g., "So which do you think requires more attention: substance abuse education in schools or opioid abuse intervention among the homeless?"*
- Not all topics will be covered with all discussants. Discussion content will be modified to respond to the discussants' backgrounds and availability of time during the discussion.

Appendix E: Community Survey Instrument

Southwell CHNA 2024 Community Survey

Introduction

We need your feedback! Please participate in our Community Health Needs Survey and help us identify the community's current health status, needs, and issues.

The survey will take about 8 to 10 minutes, and your comments will be kept confidential.

Please complete the survey before Friday, April 12th, by 5:00 p.m.

Thank you for being willing to share your thoughts!

If you would like to take the survey in Spanish, click here.

Accessing Care

1. Do you have a place where you go for routine or annual care?
   - □ Yes, family doctor, family health center, or clinic
   - □ Yes, emergency room
   - □ Walk-in urgent care
   - □ No
   - □ I do not get care even when I need it
   - □ Other (please specify)

2. In the past 12 months, have there been times when you needed medical help but chose NOT to seek it?
   - □ Yes □ No □ Not sure

3. If YES, why did you NOT get care?
   - □ Doctor might not know my language; difficult to communicate
   - □ Did not have the money
   - □ No doctors or clinics near me; too far away
   - □ Had no transportation to get to the doctor or clinic
   - □ Doctors or clinics not open at a convenient time
   - □ Could not get off work
   - □ Could not find child care
   - □ Other (please specify)

Community and Health-related Issues

A "healthy" community can include a variety of aspects such as the availability of healthcare services (including behavioral/mental health), social services, economic vibrancy and good jobs, environmental factors, lifestyle topics (such as obesity, smoking, substance abuse, and healthy living issues), and others. The next few questions ask you about your opinions on these issues.

4. Which of the following community and health-related issues do you feel need more focus or attention for improvement?

	No More Focus Needed	**Somewhat More Focus Needed**	**Much More Focus Needed**	**Don't Know**
Transportation services for people needing to go to doctor's appointments or the hospital	☐	☐	☐	☐
Transportation services for patients AFTER receiving outpatient services	☐	☐	☐	☐
Transportation services for people needing to go out of town for healthcare services or appointments	☐	☐	☐	☐
General public transportation	☐	☐	☐	☐
Affordable housing	☐	☐	☐	☐
Access to your preferred housing situation -- location, size of home, access to services, Americans with Disabilities Act (ADA) needs, etc.	☐	☐	☐	☐
Job training (or, re-training)	☐	☐	☐	☐
Affordable healthcare services for individuals or families with low income	☐	☐	☐	☐

	No More Focus Needed	Somewhat More Focus Needed	Much More Focus Needed	Don't Know
Services to help people learn about, and enroll in, programs that provide financial support for people needing healthcare	☐	☐	☐	☐
Primary healthcare services (such as a family doctor or other provider of routine care)	☐	☐	☐	☐
Emergency care and trauma services	☐	☐	☐	☐
Urgent care services (that is, walk-in care for immediate health needs not requiring the Emergency Department)	☐	☐	☐	☐
A conveniently located place to purchase prescription drugs, when needed	☐	☐	☐	☐
Healthcare services for people experiencing homelessness	☐	☐	☐	☐
Social services (other than healthcare) for people experiencing homelessness	☐	☐	☐	☐
Long-term care or dementia care	☐	☐	☐	☐
Additional capacity for High Intensity Rehabilitation services (i.e., more intensive, shorter-duration services focused on a particular health need)	☐	☐	☐	☐
Counseling services for mental health issues such as depression, anxiety, suicidal thinking, anger management, and others for adults	☐	☐	☐	☐

	No More Focus Needed	Somewhat More Focus Needed	Much More Focus Needed	Don't Know
Counseling services for mental health issues such as depression, anxiety, and others for adolescents / children	☐	☐	☐	☐
Emergency mental health services	☐	☐	☐	☐
Drug and other substance abuse education, prevention, and early intervention services	☐	☐	☐	☐
Drug and other substance abuse treatment and rehabilitation services, including detox	☐	☐	☐	☐
"Integrated care" where people can get medical care and counseling at the same time	☐	☐	☐	☐
Programs to help people stop smoking	☐	☐	☐	☐
Coordination of patient care between the hospital and other clinics, private doctors, or other health service providers	☐	☐	☐	☐
Case workers or "navigators" for people with chronic diseases such as diabetes, cancer, asthma, and others	☐	☐	☐	☐
Programs for diabetes prevention, awareness, and care	☐	☐	☐	☐
Programs for heart health or cardiovascular health	☐	☐	☐	☐
Increased neurology coverage	☐	☐	☐	☐

	No More Focus Needed	Somewhat More Focus Needed	Much More Focus Needed	Don't Know
Access to dental services	☐	☐	☐	☐
Women's health services	☐	☐	☐	☐
Men's health services	☐	☐	☐	☐
Pediatric / child health services	☐	☐	☐	☐
Services or education to help reduce teen pregnancy	☐	☐	☐	☐
Parenting classes for the "new mom" or the "new dad"	☐	☐	☐	☐
Affordable quality child care	☐	☐	☐	☐
Early childhood education	☐	☐	☐	☐
Healthcare services for seniors	☐	☐	☐	☐
Urgent food capacity or services such as food pantries, soup kitchens, or a "backpack" program	☐	☐	☐	☐
Secure sources for affordable, nutritious food	☐	☐	☐	☐
Programs for obesity prevention, awareness, and care	☐	☐	☐	☐
Healthcare services for people in the Hispanic community	☐	☐	☐	☐

Are there any other issues that require more focus and attention? (If YES, please specify)

8. Explain any of your answers, if needed or interested in doing so.

9. What are the top THREE greatest health-related issues -- that is, items that need more focus and attention -- in the community?

10. How would you describe the quality of care from the following?

	Very low quality	**Somewhat low quality**	**Somewhat high quality**	**Very high quality**	**Not sure**
The overall Tift Regional Health System of care	☐	☐	☐	☐	☐
Tift Regional Health System providers (e.g., Physicians, Nurse Practitioners, Physician's Assistants)	☐	☐	☐	☐	☐
Tift Regional Health System staff (e.g., Nurses, Patient Care Technicians, Other Therapists)	☐	☐	☐	☐	☐
Other (please specify):					

11. Which medical specialties do you think your community is most in need of? (Check all that apply)
    - □ Adult Gerontology
    - □ Anesthesiology
    - □ Cardiology
    - □ Dental Care
    - □ Emergency Medicine
    - □ Family Practice
    - □ Gastroenterology
    - □ General Surgery
    - □ Hospital Medicine
    - □ Infectious Disease
    - □ Internal Medicine
    - □ Medical Oncology/Hematology
    - □ Nephrology
    - □ Neurology
    - □ Nursing Home Care
    - □ OB/GYN
    - □ Occupational Medicine
    - □ Opthamology
    - □ Orthopedic Surgery and Sports Medicine
    - □ Otolaryngology
    - □ Pain Management
    - □ Palliative Care
    - □ Pathology
    - □ Pediatrics
    - □ Physical Medicine and Rehabilitation
    - □ Plastic and Reconstructive Surgery
    - □ Podiatry
    - □ Psychiatry
    - □ Pulmonary and Critical Care Medicine
    - □ Radiation Oncology
    - □ Radiology
    - □ Rheumatology
    - □ Urology
    - □ Vascular Surgery
    - □ Wound Care
    - □ Other (please specify):

Communications

12. What sources do you normally use to find out about healthcare providers or hospitals? (Check your top three)

- □ Social media
- □ A hospital's website
- □ A physician's website
- □ Healthcare.gov
- □ Healthcare rating sites like HealthGrades or US News & World Report
- □ Newspaper
- □ Television
- □ Radio
- □ A physician or other healthcare worker
- □ Magazine
- □ Friends and relatives
- □ Other (please specify)

13. What sources do you normally use to find out about your own health or to monitor your own health? (Check your top three)

- □ A hospital's website
- □ A physician's website
- □ Medical websites such as WebMD or Mayo Clinic
- □ A patient portal
- □ Healthcare.gov
- □ A fitness tracker website like Fitbit or My Fitness Pal
- □ A physician or other healthcare worker
- □ Friends and relatives
- □ Telehealth resources such as a telehealth doctor or nurse, or virtual urgent care
- □ Other (please specify)

14. In regards to Tift Regional's providers and services, what is the #1 way to connect with you as a consumer? Choose only one.

- □ Billboard
- □ Social Media
- □ Word of Mouth
- □ Mailer
- □ Physician Referral
- □ Community Event
- □ Google Search

- □ Web Advertisement
- □ Print Advertisement
- □ Commercial (Audio) – Radio and Streaming
- □ Commercial (Video) – TV and Streaming
- □ News Story
- □ Other

15. In regards to Tift Regional's providers and services, what is the #2 way to connect with you as a consumer? Choose only one.

- □ Billboard
- □ Social Media
- □ Word of Mouth
- □ Mailer
- □ Physician Referral
- □ Community Event
- □ Google Search
- □ Web Advertisement
- □ Print Advertisement
- □ Commercial (Audio) – Radio and Streaming
- □ Commercial (Video) – TV and Streaming
- □ News Story
- □ Other

16. In regards to Tift Regional's providers and services, what is the #3 way to connect with you as a consumer? Choose only one.

- □ Billboard
- □ Social Media
- □ Word of Mouth
- □ Mailer
- □ Physician Referral
- □ Community Event
- □ Google Search
- □ Web Advertisement
- □ Print Advertisement
- □ Commercial (Audio) – Radio and Streaming
- □ Commercial (Video) – TV and Streaming
- □ News Story
- □ Other

17. Do you have any additional comments or questions? If so, please enter them here.

A Little Bit About You!

18. What is your zip code?

19. What is your gender?
    - □ Male
    - □ Female
    - □ Non-binary
    - □ Prefer not to disclose

20. What is your age?
    - □ 18 to 24
    - □ 25 to 34
    - □ 35 to 44
    - □ 45 to 54
    - □ 55 to 64
    - □ 65 to 74
    - □ 75 or older
    - □ Prefer not to disclose

21. What is your race? [Check all that apply]
    - □ African American
    - □ American Indian
    - □ Asian Caucasian
    - □ Hispanic
    - □ Mixed Race
    - □ Other
    - □ Prefer not to disclose

22. What is the highest grade or year in school you completed?

- □ Less than high school
- □ Graduated high school
- □ Some college or vocational training
- □ Completed a 2-year college degree or a vocational training program
- □ Graduated college (4-year bachelor's degree)
- □ Completed Graduate or Professional school (Masters, PhD, etc.)
- □ Prefer not to disclose

23. Which of the following ranges best describes your total annual household income in the last year?

- □ Less than $25,000
- □ $25,001 to $50,000
- □ $50,001 to $75,000
- □ $75,001 to $100,000
- □ More than $100,000
- □ Prefer not to disclose

24. How many people (including you) live in your household?

Thank you for your participation!

Appendix F: Community Health Resources and Facilities

Southwell Information Guide

Click on the picture above for more information

Appendix G: Top 20 Hospital Diagnosis Related Codes

Exhibit 73: Most Common Diagnosis Related Group Codes, Southwell Health System, July 2021 – December 2023

Rank	DRG Description
1	Septicemia Or Severe Sepsis Without Mv >96 Hours with MCC
2	Neonate Birth Weight > 2499 Grams, Normal Newborn or Neonate with Other Problem
3	Vaginal Delivery
4	Septicemia And Disseminated Infections
5	Heart Failure and Shock with MCC
6	Normal Newborn
7	Pulmonary Edema and Respiratory Failure
8	Vaginal Delivery w/o Complicating Diagnoses
9	Respiratory Infections and Inflammations with MCC
10	Heart Failure
11	Esophagitis, Gastroenteritis and Miscellaneous Digestive Disorders Without MCC
12	Cesarean Section Without Sterilization
13	Septicemia Or Severe Sepsis Without Mv >96 Hours Without MCC
14	Major Respiratory Infections and Inflammations
15	Chest Pain
16	Neonate, Birthwt >2499g, w/o Signif O.R. Proc, W Other Prob
17	Respiratory Failure
18	Vaginal Delivery Without Sterilization Or D&C Without CC/MCC
19	Kidney And Urinary Tract Infections Without MCC
20	Syncope And Collapse

Appendix H: List of Survey-based Needs

Exhibit 74: Which of the following community and health-related issues do you feel need more attention for improvement?

RANK	NEED
1	Counseling services for mental health issues such as depression, anxiety, and others for adolescents / children
2	Affordable quality child care
3	Counseling services for mental health issues such as depression, anxiety, suicidal thinking, anger management, and others for adults
4	Emergency mental health services
5	Drug and other substance abuse treatment and rehabilitation services, including detox
6	Healthcare services for seniors
7	Long-term care or dementia care
8	Drug and other substance abuse education, prevention, and early intervention services
9	Increased neurology coverage
10	Emergency care and trauma services
11	Coordination of patient care between the hospital and other clinics, private doctors, or other health service providers
12	Secure sources for affordable, nutritious food
13	Services to help people learn about, and enroll in, programs that provide financial support for people needing healthcare
14	Primary healthcare services (such as a family doctor or other provider of routine care)
15	"Integrated care" where people can get medical care and counseling at the same time
16	Affordable healthcare services for individuals or families with low income
17	Affordable housing
18	Case workers or "navigators" for people with chronic diseases such as diabetes, cancer, asthma, and others.
19	Programs for obesity prevention, awareness, and care
20	Access to dental services
21	Services or education to help reduce teen pregnancy
22	Urgent food capacity or services such as food pantries, soup kitchens, or a "backpack" program

RANK	NEED
23	Transportation services for people needing to go to doctor's appointments or the hospital
24	Early childhood education
25	Parenting classes for the "new mom" or the "new dad"
26	Social services (other than healthcare) for people experiencing homelessness
27	Urgent care services (that is, walk-in care for immediate health needs not requiring the Emergency Department)
28	Healthcare services for people experiencing homelessness
29	Programs for diabetes prevention, awareness, and care
30	Job training (or, re-training)
31	Programs for heart health or cardiovascular health
32	Additional capacity for High Intensity Rehabilitation services (i.e., more intensive, shorter-duration services focused on a particular health need)
33	Transportation services for patients AFTER receiving outpatient services
34	Transportation services for people needing to go out of town for healthcare services or appointments
35	Pediatric / child health services
36	General public transportation
37	Women's health services
38	Access to your preferred housing situation -- location, size of home, access to services, Americans with Disabilities Act (ADA) needs, etc.
39	Men's health services
40	Healthcare services for people in the Hispanic community
41	A conveniently located place to purchase prescription drugs, when needed
42	Programs to help people stop smoking

Appendix I: Identified Needs and Prioritization Scores

The following table describes the 24 needs considered and scored by individual members of the Project Team for Tift Regional Medical Center. Average scores are scaled from 1 to 7, with a score of 7 representing the need for much more focus. The final determination of prioritized needs included this scoring process, as well as a discussion of each need in relation to Southwell's mission and locus of control, among other factors.

Exhibit 75: Prioritized Needs, by Average Score on Needs Prioritization Survey

RANK	AVERAGE SCORE (SCALE OF 1 TO 7)	NEED
1	6.5	Counseling services for mental health issues such as depression, anxiety, and others for adolescents / children
1	6.5	Emergency mental health services
1	6.5	Transportation services for people needing to go to doctor's appointments or the hospital
4	6.3	Increased neurology coverage
5	6.2	Counseling services for mental health issues such as depression, anxiety, suicidal thinking, anger management, and others for adults
6	6.0	Case workers or "navigators" for people with chronic diseases such as diabetes, cancer, asthma, and others.
7	5.7	Drug and other substance abuse treatment and rehabilitation services, including detox
7	5.7	Drug and other substance abuse education, prevention, and early intervention services
7	5.7	Services to help people learn about, and enroll in, programs that provide financial support for people needing healthcare
10	5.6	Coordination of patient care between the hospital and other clinics, private doctors, or other health service providers
11	5.5	Programs for obesity prevention, awareness, and care
12	5.3	Long-term care or dementia care
12	5.3	Secure sources for affordable, nutritious food
12	5.3	Affordable housing
15	5.2	Primary healthcare services (such as a family doctor or other provider of routine care)
15	5.2	Timely access to emergency care and trauma services

RANK	AVERAGE SCORE (SCALE OF 1 TO 7)	NEED
15	5.2	Affordable healthcare services for individuals or families with low income
18	4.7	Equitable access to healthcare services, including access to information and services in Spanish
18	4.7	Teen substance use prevention and treatment, including vaping
20	4.5	Access to dental services
21	4.3	Healthcare services for seniors
22	4.2	"Integrated care" where people can get medical care and counseling at the same time
23	4.0	Affordable quality child care
24	3.8	Road safety, including measures to prevent motor vehicle collisions