COMMUNITY HEALTH
NEEDS ASSESSMENT

GEORGIA
HEALTH POLICY CENTER

Grady

1. BACKGROUND

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, added new requirements which nonprofit hospital organizations must satisfy to maintain their tax-exempt status under section 501(c)(3) of the Internal Revenue Code. One such requirement added by the ACA, Section 501(r) of the Code, requires nonprofit hospitals to conduct a community health needs assessment (CHNA) at least once every three years. As part of the CHNA, each hospital is required to collect input from designated individuals in the community, including public health experts, as well as members, representatives, or leaders of low-income, minority, and medically underserved populations and individuals with chronic conditions. Grady Health System (GHS) is a member organization of the Atlanta Regional Collaborative for Health Improvement (ARCHI). ARCHI is an interdisciplinary coalition working to improve the region's (DeKalb and Fulton Counties) health through a collaborative approach to community health needs assessment and improvement. The Georgia Health Policy Center, The United Way of Metropolitan Atlanta, and the Atlanta Regional Commission provide ongoing project management, data and planning resources, facilitation, and partnership building assistance to ARCHI. As supported by guidance from the federal government, GHS has conducted its CHNA with and through ARCHI in order to maximize the impact of community investment in health improvement.

2. DEFINITION OF COMMUNITY

GHS was created by and named for Henry W. Grady, editor of the Atlanta Constitution, who worried about the lack of quality health care for Atlanta's poor. Since that time, GHS has grown considerably from its original three-story, 110-bed facility. It now stands as one of the largest health systems in the United States.

GHS today continues to maintain its strong commitment to the health-care needs of Fulton and DeKalb counties' underserved, while also offering a full-range of specialized medical services for all segments of the community. Grady Memorial Hospital Corporation (GMHC) is governed by 17-member Board of Directors appointed in 2008. Because Grady Health System is supported by the taxpayers of Fulton and DeKalb Counties and because the residents of these counties make up the majority of the GHS catchment area, the focus of this CHNA is the geographic boundaries of Fulton and DeKalb Counties, with an emphasis on the poor and underserved.

3. DEMOGRAPHICS OF THE COMMUNITY

GHS's primary service area is Fulton and DeKalb Counties. As of the 2010 Census, these counties were two of the three most populous in the state (Fulton #1, DeKalb #3). DeKalb and

Fulton Counties contain 17 percent of the total state population, with a combined total of over 1.6 million residents. DeKalb County's population is expected to increase by 9.7 percent between 2010 and 2020; the population in Fulton County is projected to grow by 22.8 percent during this same time period.

Both counties are relatively diverse with majority-minority populations. The following table shows the total population for each county by race and ethnicity. The white-alone population is less than 50 percent in each county. The Black/African-American population constitutes 53.9 percent of the total population in DeKalb County and 43.7 percent of the total population in Fulton County. Comparatively, Blacks/African-Americans make up about one-third of the total state population. The Hispanic/Latino population makes up 9.5 percent and 7.8 percent of the population in DeKalb and Fulton Counties, respectively.

Table 1 - Population by Race/Ethnicity

	Total Population	Percent White Alone	Percent Black/African-American Alone	Percent Hispanic/Latino	Percent Other Race or Two or More Races
DeKalb County	690,003	29.7%	53.9%	9.5%	11.0%
Fulton County	907,811	41.5%	43.7%	7.8%	9.7%
Georgia	9,600,612	56.3%	30.1%	8.6%	8.7%

Source: American Community Survey, 2007-2011

The service area's population is also relatively young, with a median age of 34 in both counties. The following table shows the service area's population by age and gender. Females make up slightly more than half of the total population, and the bulk of the population in both counties is in the 18-44 age cohort. The 0-17 age group is 24.2 percent of the total population in DeKalb County and 28.4 percent of the total Fulton County population. Residents age 65 and older make up less than 9 percent of the population in both counties.

Table 2 - Population by Gender and Age Group

	Male	Female	Age 0-17	Age 18-44	Age 45-64	Age 65+
DeKalb County	47.9%	52.1%	24.2%	42.9%	24.1%	8.8%
Fulton County	48.8%	51.2%	28.4%	38.8%	24.6%	8.2%
Georgia	48.9%	51.1%	26.4%	28.9%	32.3%	12.4%

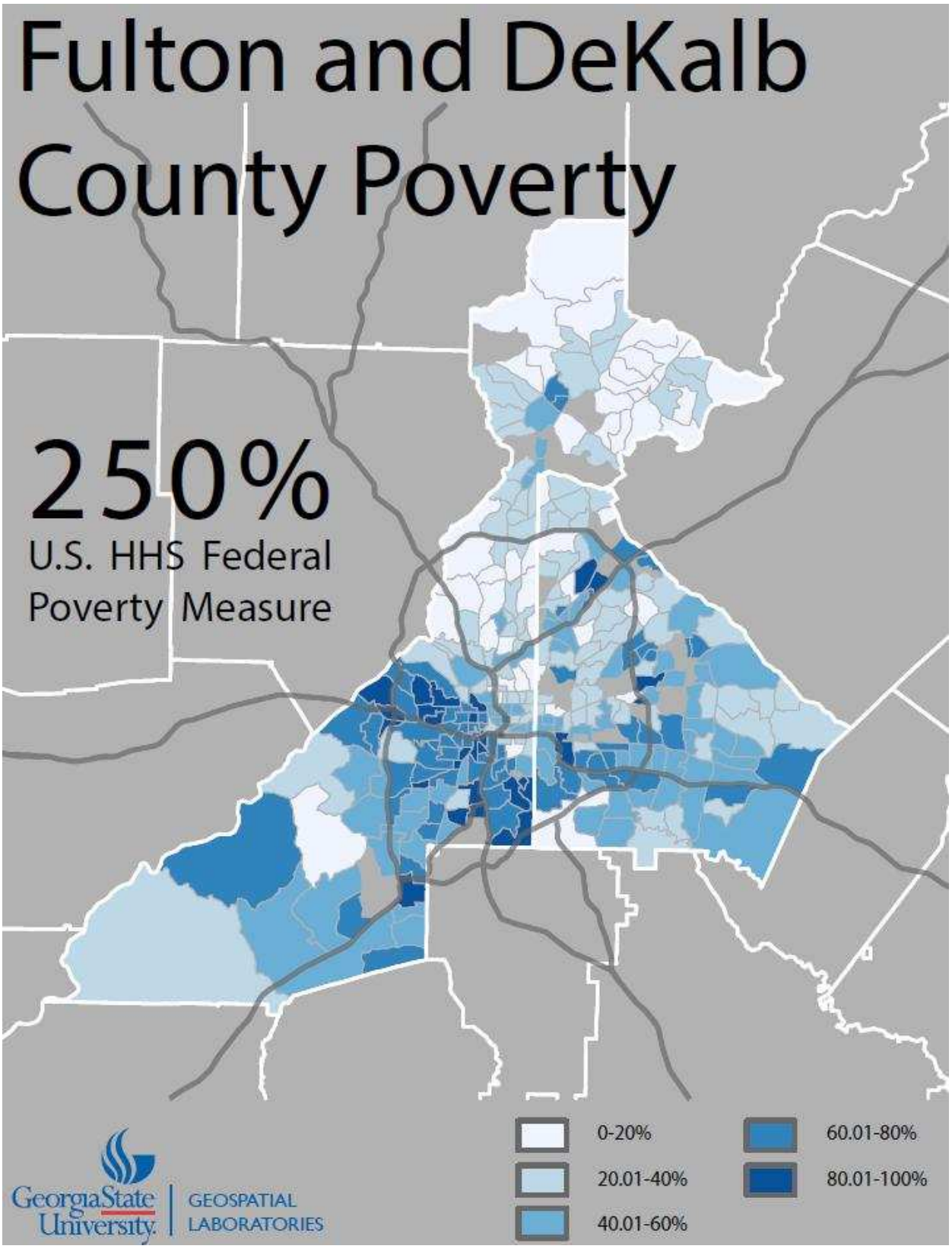
Source: American Community Survey, 2007-2011

Socioeconomic Factors

Social and economic drivers can influence an individual's health. Among the factors are education, access to insurance, and income. These factors, in turn, influence an individual's ability to obtain employment, safe housing, nutritious foods, and access to healthcare, all of which also have an impact on health.

Seventeen percent of the population in DeKalb County and almost 16 percent of Fulton County's population lives below the Federal Poverty Line (FPL), which is $23,550[1] for a family of four. Nearly 37 percent and 32 percent of residents in DeKalb and Fulton Counties, respectively, live at or below 200 percent of the FPL. GHS's target service population includes those residents who are at or below 250 percent of the FPL. The map on the following page shows income levels of DeKalb and Fulton County residents. There are many census tracts within both counties where at least 40 percent of the population has income that equals or is below 250 percent of the FPL.

[1] 2013 Federal Poverty Guidelines


Fulton and DeKalb County Poverty
250%
U.S. HHS Federal Poverty Measure
0-20%
20.01-40%
40.01-60%
60.01-80%
80.01-100%
Georgia State University
GEOSPATIAL LABORATORIES

Access to insurance is closely related to poverty and income, as low-income residents are more likely to be un- or underinsured. In Fulton County, 18 percent of residents are uninsured and in DeKalb County, 23 percent of residents are uninsured compared to 19 percent uninsured statewide. Almost 20 percent of Fulton County's population and 17.5 percent of DeKalb County's population is enrolled in Medicaid. Statewide, less than 16 percent of the total population is enrolled in Medicaid. The lack of access to insurance inhibits access to healthcare services, in particular, preventive services.

Coupled with the lack of insurance, a shortage in the health care workforce is another barrier to accessing healthcare services. The metropolitan Atlanta area has a significant number of healthcare facilities. Fulton and DeKalb Counties have the highest number of hospitals (all types) in the state, 11 and 9, respectively. The counties also have a total of 18 Federally Qualified Health Centers and 19 county public health clinics. There are 108 primary care providers per 100,000 population in DeKalb County and 131 per 100,000 population in Fulton County. However, 34 percent of the population in Fulton County lives in a Health Professional Shortage Area (HPSA), defined as having a shortage of primary medical care, dental, or mental health professionals. In contrast, 84 percent of the population of DeKalb County lives in a HPSA for primary medical care and mental health professionals. The percentage of DeKalb County residents in a HPSA is more than 20 percent higher than the state HPSA population. In DeKalb County, almost 19 percent of adults report that they do not have a regular doctor. Twenty percent of adults in Fulton County report the same.

Education and poverty have a cyclical relationship. Those who are less educated have a greater chance of living in poverty. Likewise, those who live in poverty are more likely to be less educated. Those living in poverty do not have as good access to quality schools as do their counterparts not living in poverty. There is also an interrelationship between poor health and low student achievement, which, if not addressed or corrected over time, can lead to lower high school graduation rates and higher unemployment.

The following table lists selected education indicators for DeKalb and Fulton County compared to the state. The on-time high school graduation rates (those who receive a high school diploma within four years) for both counties are higher than the state rate. While the percentage of each county's population without a high school diploma is lower than the state's, each county's unemployment rate is higher than the state's. Compared to the state, DeKalb and Fulton Counties appear to fare better, but when compared with the poverty statistics described earlier, the impact these factors have on GHS's service area population is unclear.

Table 3 - Selected Education Indicators – GHS CHNA Service Area

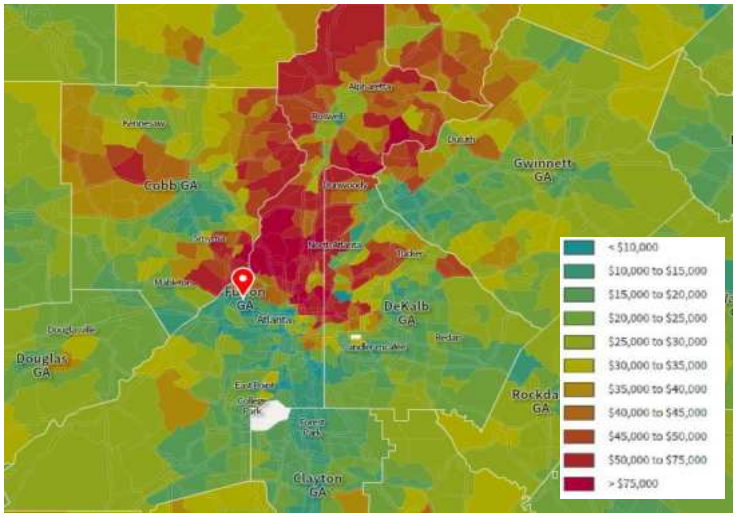
Select Education Indicators	DeKalb	Fulton	Georgia
On-time High School Graduation Rate	79.4	79.8	67.8
Percent of Population Age 25+ without HS diploma	11.7%	10.0%	16.0%
Unemployment Rate	8.2%	8.3%	7.9%

Sources: US Department of Education, US Bureau of Labor Statistics, American Community Survey, 2007-2011

There is a more complex picture of GHS's service area beyond the aggregate county level data. Fulton and DeKalb Counties are socioeconomically diverse. This diversity is not always captured in county-level statistics. In both counties, there are areas that are very wealthy and areas whose residents live below the poverty level. Among the over 1.6 million residents in the counties, the level of educational attainment ranges from the very well educated to those with less than a high school diploma. The same variance is seen among the uninsured. While there are exceptions, these divisions exist distinctly between the northern and southern ends of each county, especially in Fulton County.

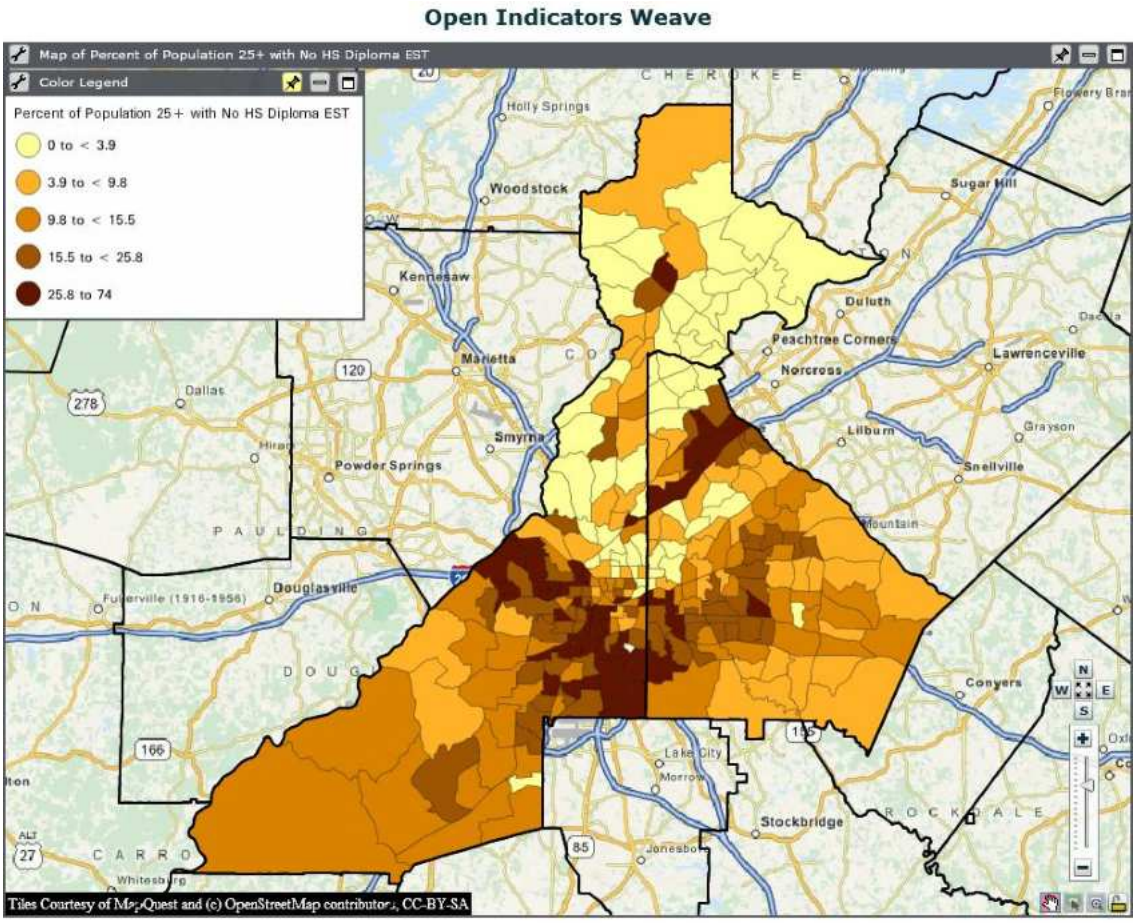
For example, the following map shows the per-capita income by census tract for Fulton and DeKalb Counties. In the northernmost ends of each county, there are census tracts with a minimum per capita income of $50,000. Conversely, in many areas in the southern ends of the counties, the per capita income ranges from $20,000 to $25,000.

Per Capita Income by Census Tract – Fulton and DeKalb Counties
American Community Survey, 5 Year Estimates - 2007-2011

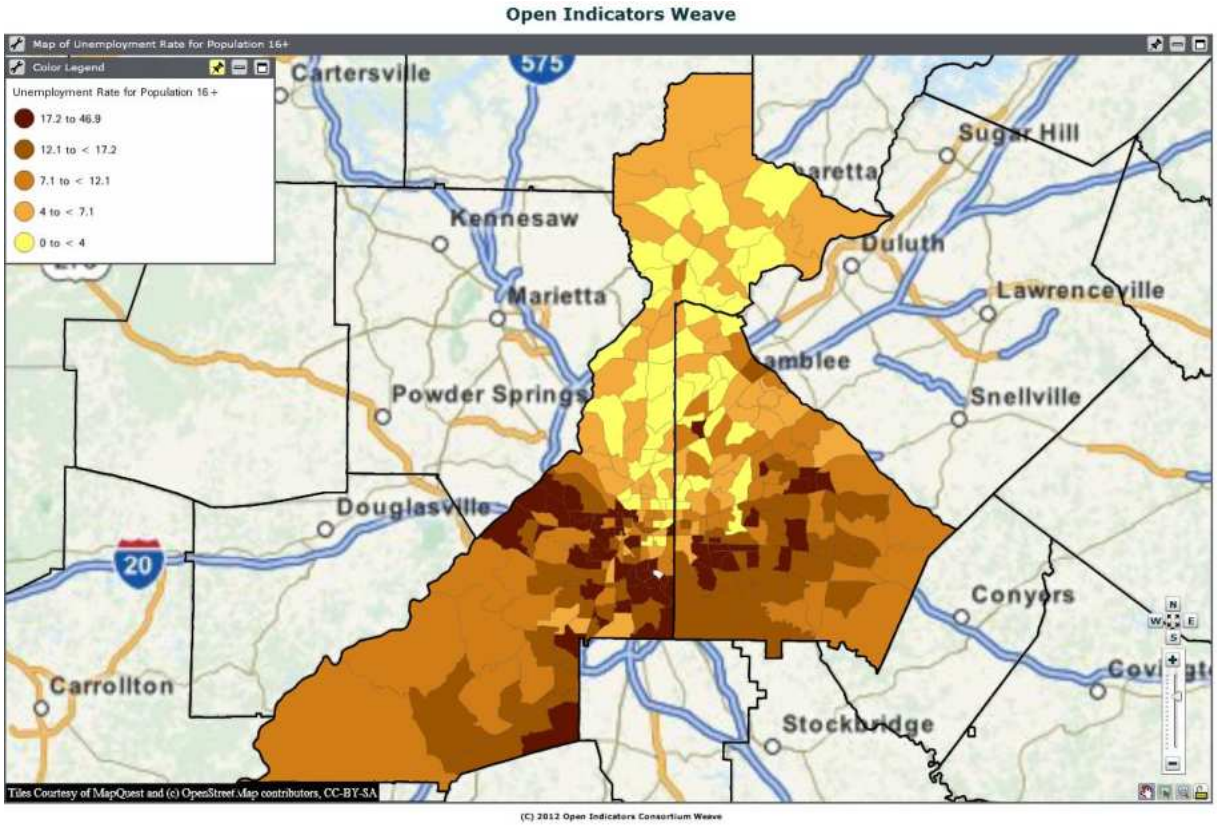


Within the service area, educational attainment and unemployment follow a similar pattern. The following maps show the percentage of adults age 25 and older without a high school diploma and unemployment by census tract. The concentrations of those without a high school diploma and high unemployment are concentrated in the southern ends of each county.

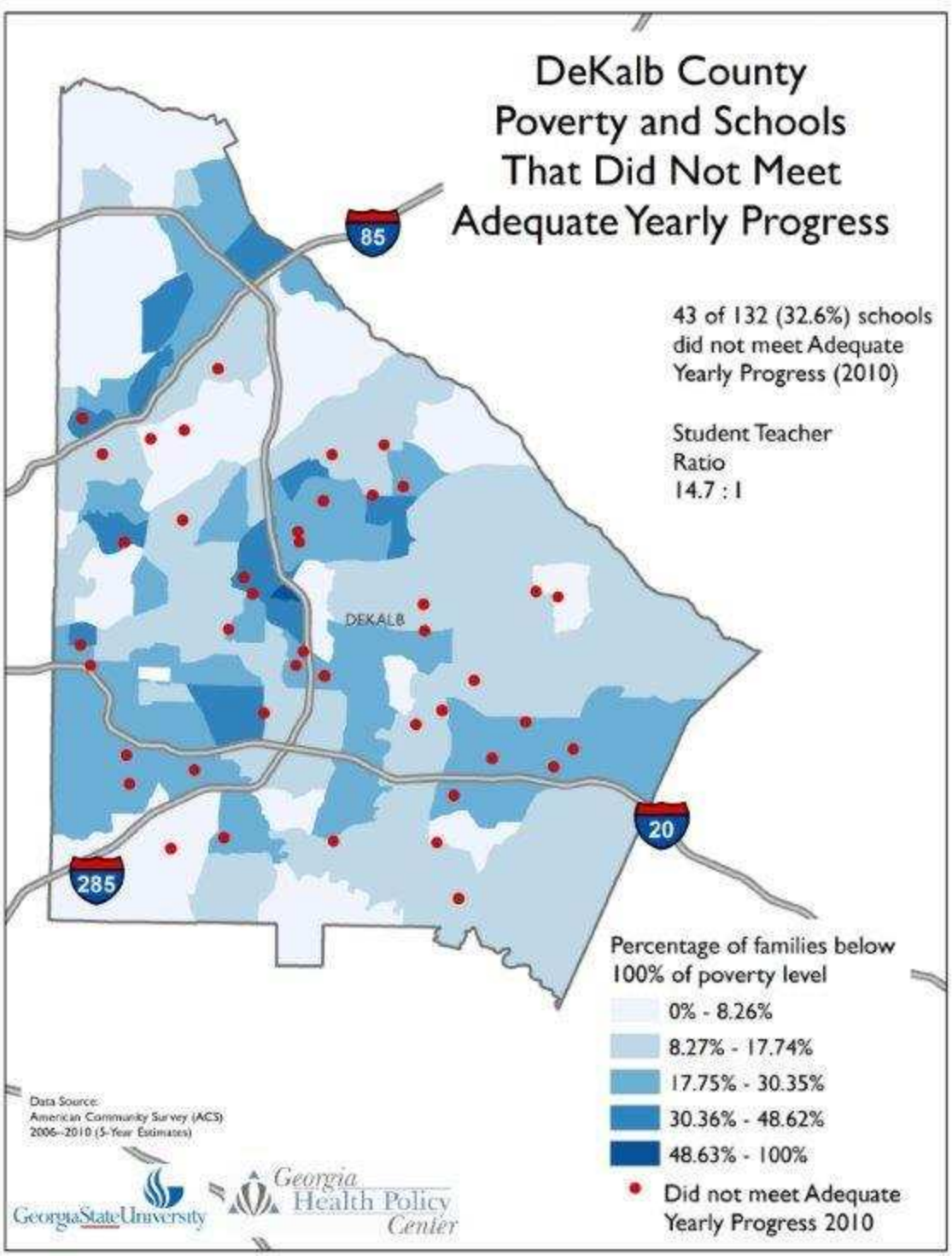
Percentage of Population Age 25+ Without a High School Diploma – Fulton and DeKalb Counties, 2010

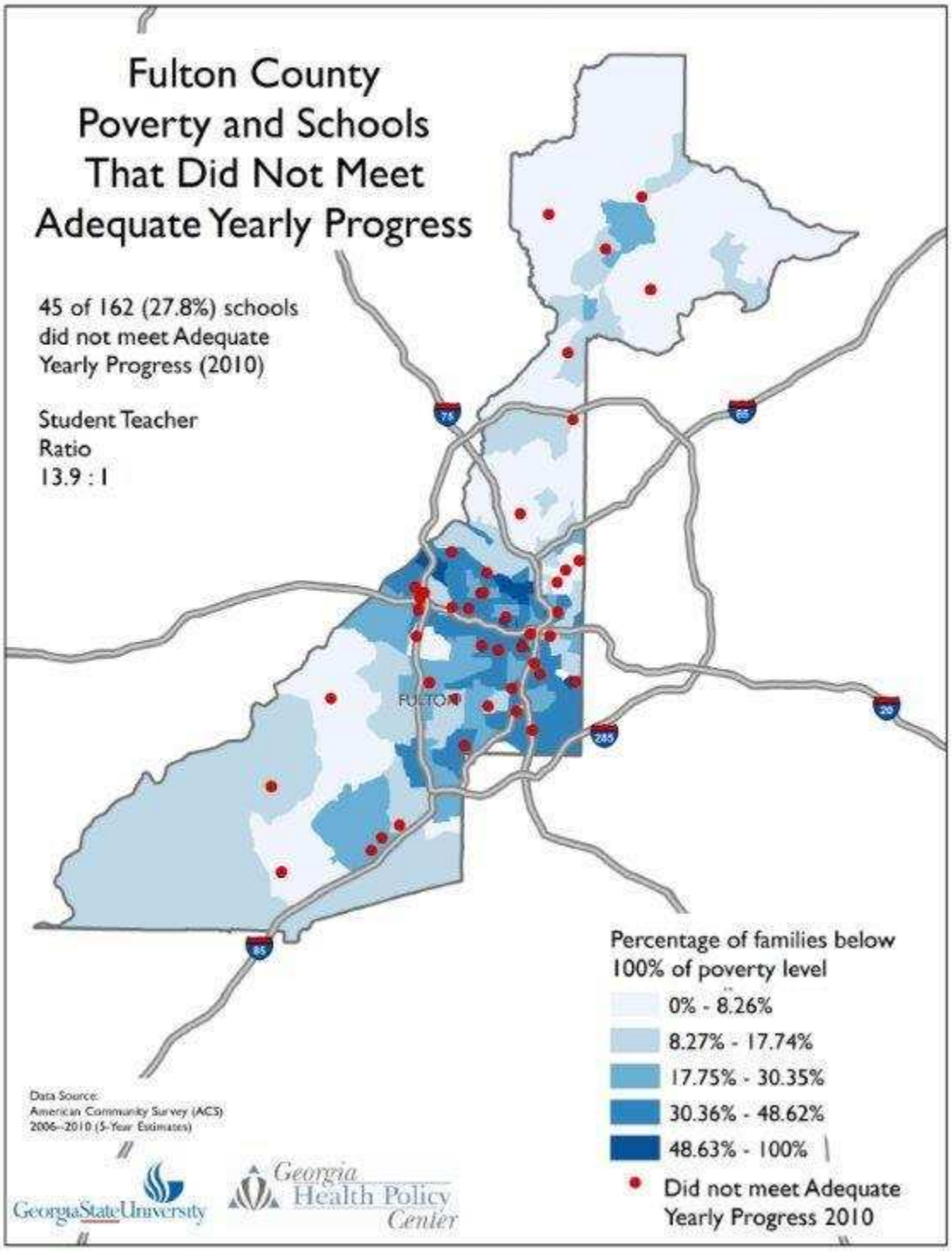


Percentage of Population Age 16+ Unemployed –
Fulton and DeKalb Counties, 2010



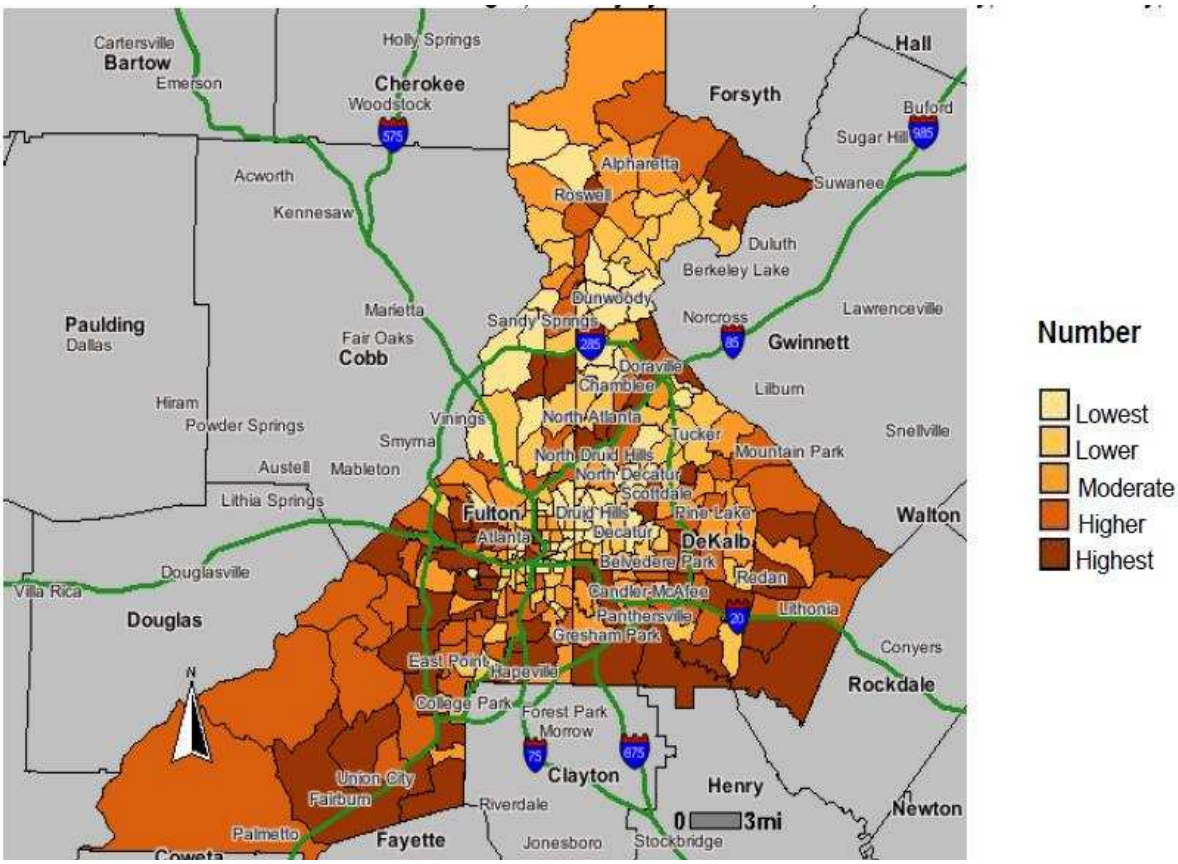
To further illustrate the counties' inequitable distribution of income and education, the maps on pages 10 and 11 show schools that did not meet the Annual Yearly Progress benchmarks in 2010 in relation to poverty in DeKalb and Fulton Counties, respectively.


DeKalb County
Poverty and Schools
That Did Not Meet
Adequate Yearly Progress
43 of 132 (32.6%) schools did not meet Adequate Yearly Progress (2010)
Student Teacher Ratio
14.7 : 1
DEKALB
85
20
285
Percentage of families below 100% of poverty level
0% - 8.26%
8.27% - 17.74%
17.75% - 30.35%
30.36% - 48.62%
48.63% - 100%
Did not meet Adequate Yearly Progress 2010
Data Source:
American Community Survey (ACS)
2006--2010 (5-Year Estimates)
Georgia State University
Georgia Health Policy Center


Fulton County
Poverty and Schools
That Did Not Meet
Adequate Yearly Progress
45 of 162 (27.8%) schools did not meet Adequate Yearly Progress (2010)
Student Teacher Ratio
13.9 : 1
FULTON
Percentage of families below 100% of poverty level
0% - 8.26%
8.27% - 17.74%
17.75% - 30.35%
30.36% - 48.62%
48.63% - 100%
Did not meet Adequate Yearly Progress 2010
Data Source:
American Community Survey (ACS)
2006--2010 (5-Year Estimates)
GeorgiaStateUniversity
Georgia Health Policy Center

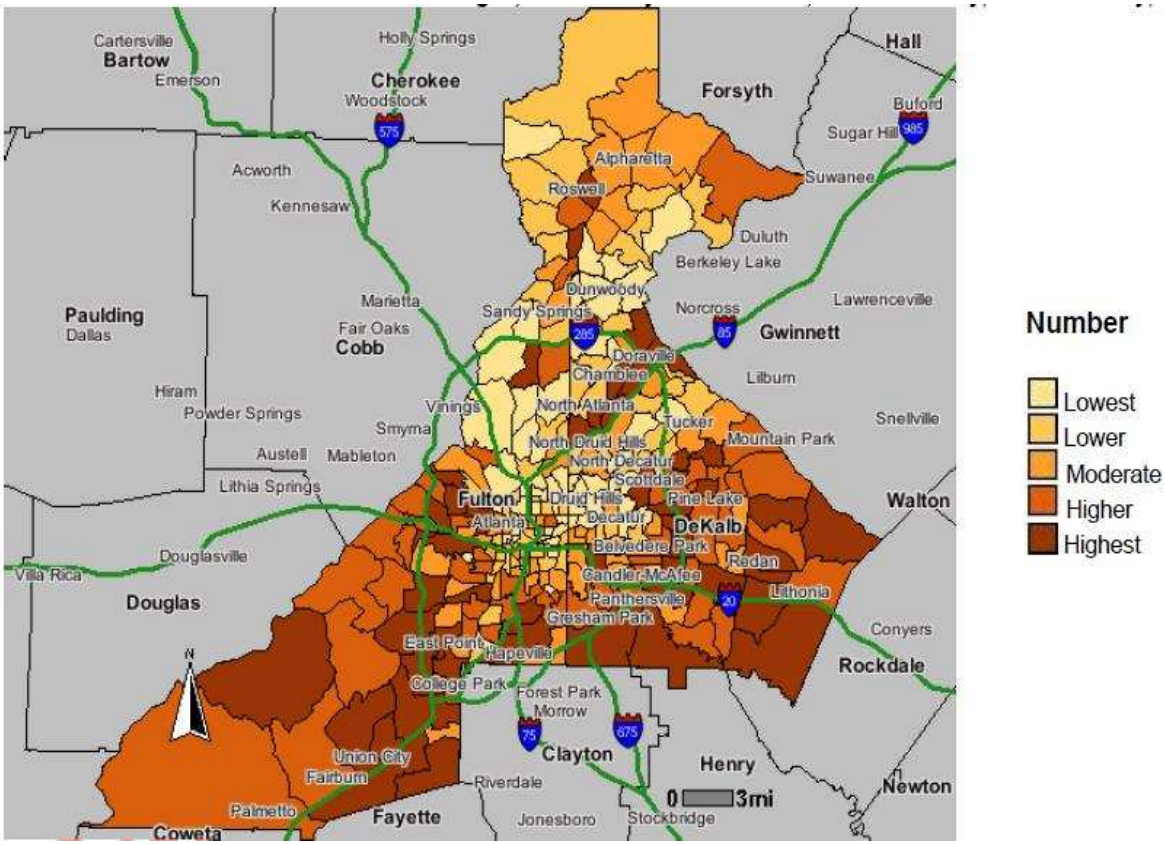
The following maps show the distribution of uninsured and Medicaid hospital discharges in Fulton and DeKalb Counties by census tract. Both maps are similar and show the largest numbers of each type of discharges occurred in the southern ends of each county.

Uninsured Hospital Discharges by Census Tract – Fulton and DeKalb Counties 2008-2010



Source: Georgia Department of Community Health, Online Analytical Statistical Information System

Medicaid Hospital Discharges by Census Tract – Fulton and DeKalb Counties
2008-2010



Source: Georgia Department of Community Health, Online Analytical Statistical Information System

Each of the maps shows that, at the county level, both Fulton and DeKalb generally appear to perform well on various socioeconomic indicators compared with the state as a whole; however, there are challenges at the sub-county level.

4. EXISTING RESOURCES AVAILABLE TO RESPOND TO THE HEALTH NEEDS OF THE COMMUNITY

Community assets are people, places, and relationships that can be used in acting to bring about the most equitable functioning of a community. In addition to community-based non-profit agencies, assets can include grocery stores, parks, schools, and hospitals. GHS's primary service area, Fulton and DeKalb Counties, has significant community assets both in terms of volume and breadth. For the purposes of this assessment, GHPC reviewed several sources to identify community assets including the Georgia Center for Nonprofits and the National Center for Charitable Statistics. Due to the volume of community assets that are located in or serve

these two counties, the list was narrowed to include those with substantial assets and/or those with current and significant activity in Fulton and DeKalb Counties. The organizations were then classified into three groups based on their primary focus: health, wellness, or philanthropy. Those classified as health either directly provide healthcare services or have a primary focus on health related activities. Those classified as wellness have a focus on determinants of health – education, housing, physical activity, etc. Philanthropic assets are those that support a wide range of initiatives, including health and wellness. The following table lists community assets in GHS's service area. It is important to note that this list is not exhaustive.

Table 4 – GHS Service Area Community Assets

Health	Wellness (Determinants of Health)	Philanthropic
Hispanic Health Coalition of GA	DeKalb Initiative for Children and Families	Grady Health Foundation
Health Education, Assessment, and Leadership Clinic (HEAL)	Center for Pan Asian Community Services	United Way of Greater Atlanta
The Center for Black Women's Wellness, Inc.	Communities in Schools Atlanta	Kaiser Permanente Community Benefit
Federally Qualified Health Centers (FQHCs)	CHRIS Kids, Inc.	Healthcare Georgia Foundation
Public Health Department clinics	Atlanta Housing Authority – Quality of Life Initiative	R Howard Dobbs, Jr. Foundation
Hospitals	Georgia Growers	Atlanta Women's Foundation
Georgia Charitable Care Network	Georgia Organics	Woodruff Foundation
Feminist Women's Health Center	YMCA of Metro Atlanta	Community Foundation of Greater Atlanta
Health MPowers	YMCA of Greater Atlanta	Goodwill Industries
Diabetes Association of Atlanta	Boys and Girls Clubs of Metro Atlanta	Just Heart Foundation
Healthy Mothers Healthy Babies Coalition of Georgia	Georgia Coalition for Physical Activity and Nutrition	Coca-Cola Foundation
	Voices for Georgia's Children	American Red Cross
	Atlanta Community Food Bank	Action Ministries
	Atlanta Public Schools	North Fulton Community Charities
	Fulton County Board of Education	
	City of Decatur Schools	
	DeKalb County Board of Education	
	Agape Community Center	
	Atlanta Neighborhood Development Partnership	
	Community Assistance Center	
	City of Refuge	
	Open Hand	
	The Sheltering Arms Early Education and Family Centers	
	Care and Counseling Centers of Georgia	

5. HOW DATA WERE OBTAINED

Throughout this assessment, secondary data sources in the form of maps and tables were accessed and evaluated by researchers. Data were collected from national resources and Georgia specific entities to provide a more targeted focus on GHS's primary service area. The sources include the Census Bureau, the American Community Survey, Social Explorer, and the Online Analytical Statistical Information System (OASIS) from the Georgia Department of Public Health. The data were divided into several categories including: demographics, social and economic factors, physical environment, access to care, health behaviors, health outcomes, and community assets. Most of the data, particularly health behaviors and outcomes, were only available at the county level; however, wherever possible the data was analyzed at the ZIP Code or census tract level, to get a more comprehensive understanding of the challenges in GHS's primary service area. A detailed listing of the data sources reviewed for this assessment can be found in Appendix A.

6. HEALTH NEEDS OF THE COMMUNITY

Health Behaviors

Health behaviors are actions or activities performed by an individual with the purpose of improving or promoting one's health. Risky health behaviors are those that negatively affect an individual's health regardless of the intent of that behavior (e.g. cigarette smoking, heavy alcohol consumption, etc.). Socioeconomic drivers and physical environment affect an individual's health behaviors as well as his or her health outcomes. For example, living in poverty increases the probability of living in an environment that is not conducive to physical activity or one with limited access to fresh nutritious foods. Twenty-five percent of the population in DeKalb County and almost 30 percent of the population in Fulton County lives in a food desert - a low-income census tract where a substantial number or share of residents has limited access to a supermarket or large grocery store. In DeKalb County, 71 percent of adults report consuming less than five servings of fruits and vegetables per day compared to 74 percent in Fulton County, and 75 percent of adults statewide.

Approximately 20 percent of both counties' adult population is physically inactive. There are no county-level data for youth physical inactivity; it is only reported at the state level. However, FitnessGram® data collected by school systems can be used as a proxy for county-level data. Fitnessgram® is a fitness assessment and reporting program for youth. The assessment includes a variety of health-related physical fitness tests that assess aerobic capacity; muscular strength, muscular endurance, and flexibility; and body composition. The table below shows the percentage of third through twelfth graders in the in Fulton and DeKalb County school systems whose aerobic capacity is in the healthy fitness zone. Atlanta Public Schools and

DeKalb County Schools had the lowest scores in this category, with 62 percent and 59 percent, respectively.

Table 5 - Georgia Select FITNESSGRAM Results
June 2011 to June 2012
Percentage of 3rd – 12th Graders in Fulton and DeKalb – Aerobic Capacity in Healthy Fitness Zone

School District*	Aerobic Capacity
Atlanta Public Schools	62%
Decatur City	68%
DeKalb County	59%
Fulton County	69%

Cigarette use is also disproportionately high among low-income populations. In Georgia, smoking prevalence is highest among those with an annual income of less than $15,000 (35 percent) and those with an annual income between $15,000 and $24,000 (29 percent). At the census tract level, it is difficult to determine pervasiveness of cigarette use as 13 percent of adults Fulton County report being a cigarette smoker and 11 percent of adults DeKalb County smoke cigarettes.

Lack physical activity and low consumption of fruits and vegetables are drivers for obesity, which is, in turn, a driver for chronic conditions including heart disease and diabetes. Tobacco use is also a major factor for several chronic diseases, among them various types of cancers and respiratory diseases.

Health Outcomes

Health behaviors, in addition to socioeconomic factors, are drivers of health outcomes. A health outcome is a change in the health status of an individual, group, or population that is attributable to a planned intervention or series of interventions, regardless of whether or not the intervention was intended to change health status. Health outcomes typically measure morbidity and mortality. An analysis of secondary health outcome data found that both counties have better health status when compared to the state as a whole. Health data are usually collected at the county level; however, like the socioeconomic data, census tract level data provide a more comprehensive picture of the health status in DeKalb and Fulton Counties. For the purpose of this analysis, health outcomes were divided into three categories: chronic diseases or conditions, infectious diseases or conditions, and injury-related conditions.

Chronic Conditions

The chronic conditions included in this category are asthma, cardiovascular disease, diabetes, and cancer. Obesity is also included in this category, as it was recently classified as a disease by the American Medical Association. The following table summarizes incidence and mortality data for each of these conditions for Fulton and DeKalb Counties and the state. Where the county's measures are better than the state average, the measure is highlighted in green. Red highlights represent health outcomes that are worse than the state average. As the table shows, DeKalb and Fulton Counties appear similar across each of the health outcomes, and with the exception of breast and prostate cancer incidence rates, fare better than the state. Compared to the state, both counties have a lower percentage of adults who are obese, fewer adults with diabetes and heart disease, and a lower stroke mortality rate.

Table 6 - Selected Chronic Disease Outcome Measures - GHS CHNA Service Area

Health Outcome Measure	DeKalb	Fulton	Georgia
Percentage of Obese Adults	26.1%	23.8%	28.2%
Percentage of Adults with Asthma	11.1%	12.0%	12.1%
Percentage of Adults with Diabetes	9.9%	9.2%	10.3%
Percentage of Adults with Heart Disease	2.3%	2.4%	3.8%
Stroke Mortality (Per 100,000 Pop.)	42.3	48.2	49.6
Cancer Mortality (Per 100,000 Pop.) (All Cancers)	165.1	175.2	178.9
Breast Cancer Incidence Rate (Per 100,000 Pop.)	127.5	120.8	119.7
Cervical Cancer Incidence Rate (Per 100,000 Pop.)	7.2	7.1	8.2
Colon and Rectum Cancer Incidence Rate (Per 100,000 Pop.)	41.3	41.5	45.0
Lung Cancer Incidence Rate (Per 100,000 Pop.)	54.4	56.6	71.5
Prostate Cancer Incidence Rate (Per 100,000 Pop.)	195.7	204.7	167.7

Sources: Centers for Disease Control and Prevention - Behavioral Risk Factor Surveillance System 2006-2010, National Center for Health Statistics 2006-2010, National Cancer Institute: State Cancer Profiles 2006-2009, National Diabetes Surveillance System 2009

The maps of Fulton and DeKalb Counties on the following pages show:

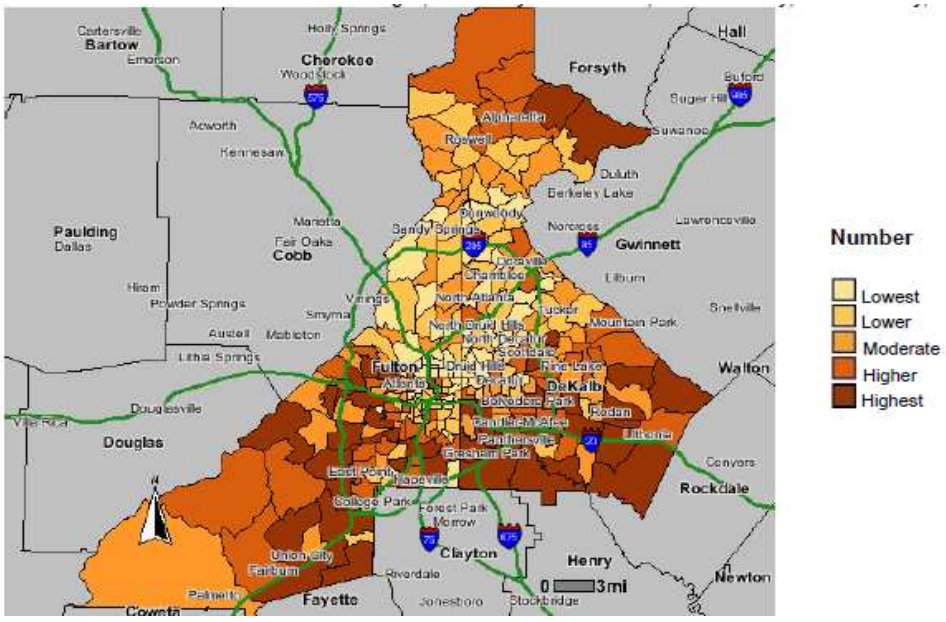
- Asthma Discharges by Census Tract, 2008-2010;
- Diabetes Discharges by Census Tract, 2008-2010;
- Percentage of Deaths from Heart Disease by Census Tract, 2009-2011;
- Percentage of Deaths from Stroke by Census Tract, 2009-2011; and
- Prostate Cancer Discharges by Census Tract, 2008-2010.

The asthma and diabetes discharges maps follow the same pattern as many of the socioeconomic maps presented previously; the highest numbers of discharges are concentrated in the southern end of each county[2]. For both asthma and diabetes, there are small pockets in north Fulton County with high numbers of discharges. These areas correspond to the same areas in north Fulton County with poor socioeconomic conditions.

The picture is similar for each of the other chronic condition maps. For example, the highest percentage of deaths from heart disease and stroke occur in the central and southern regions of both DeKalb and Fulton Counties. It is important to note that the areas that have socioeconomic challenges also have high chronic disease death and discharge rates.

The exception is prostate cancer discharges, as higher numbers of discharges are found throughout both counties and are not limited to a particular area.

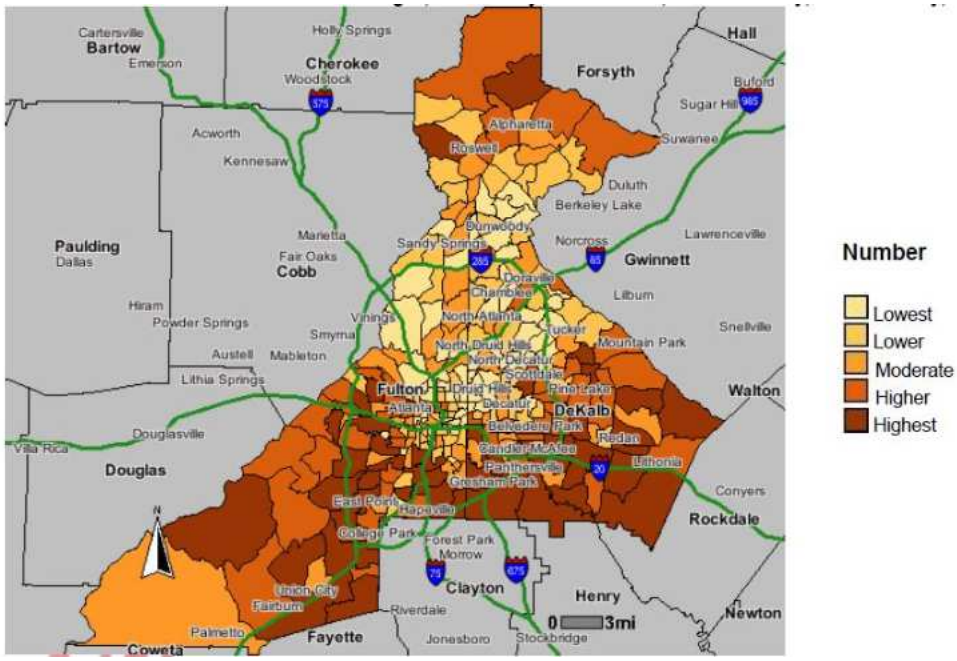
Asthma Discharges by Census Tract – Fulton and DeKalb Counties 2008-2010



Source: Georgia Department of Community Health, Online Analytical Statistical Information System

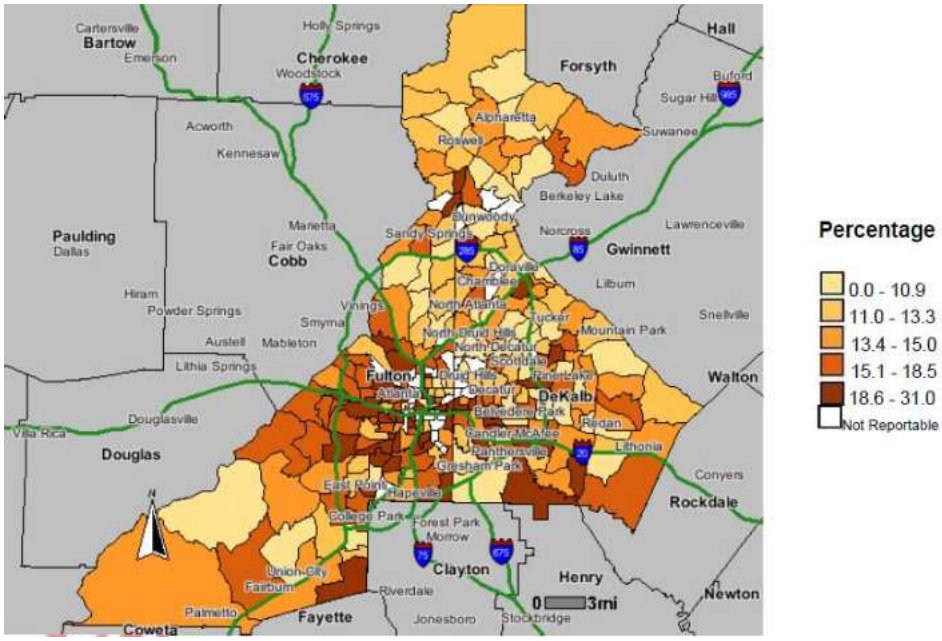
[2] Please note discharges are presented as numbers, not a rate.

Diabetes Discharges by Census Tract – Fulton and DeKalb Counties 2008-2010



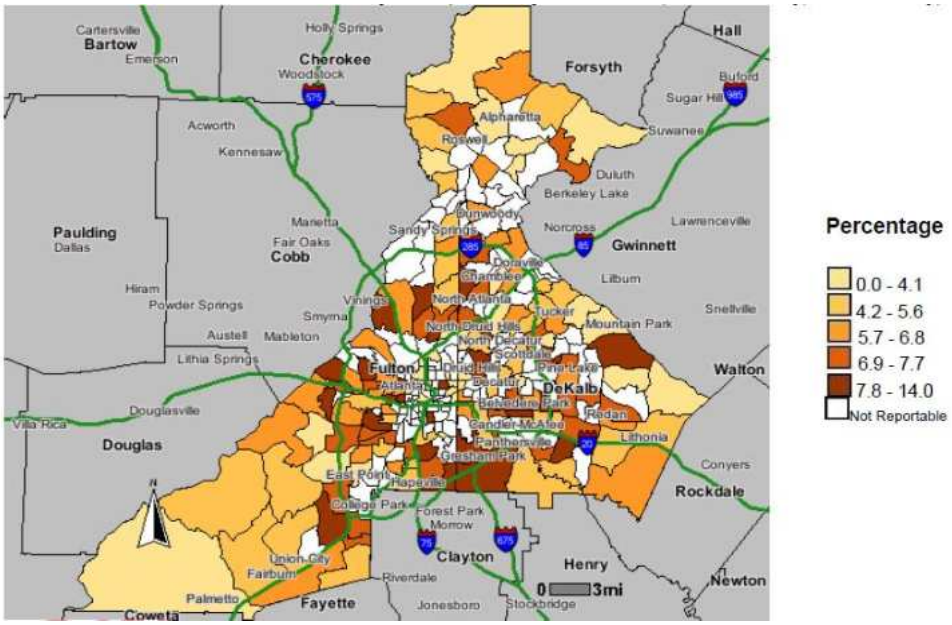
Source: Georgia Department of Community Health, Online Analytical Statistical Information System

Percentage of Deaths from Heart Disease Deaths by Census Tract – Fulton and DeKalb Counties 2009-2011



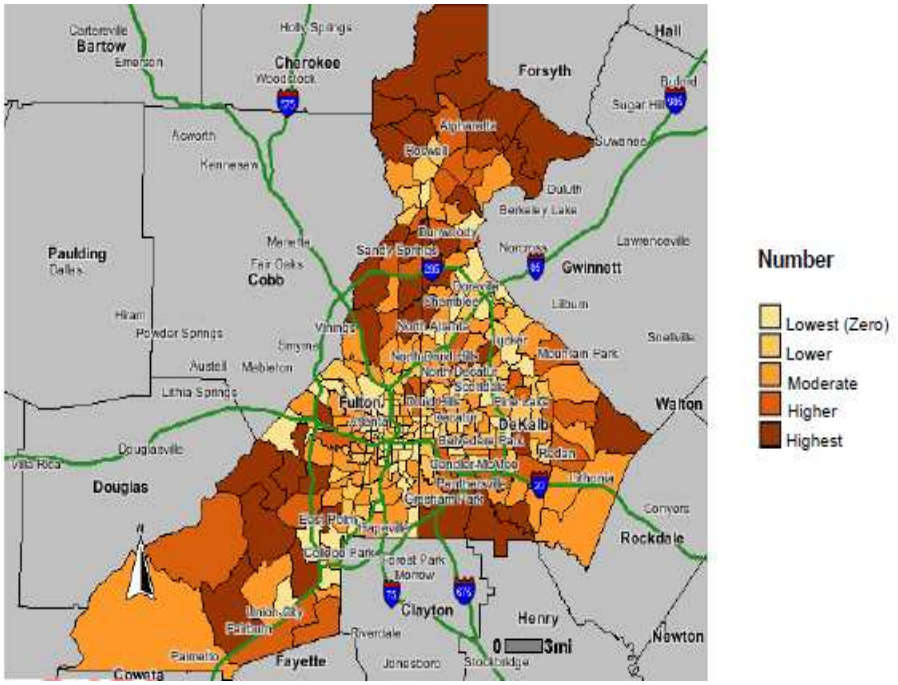
Source: Georgia Department of Community Health, Online Analytical Statistical Information System

**Percentage of Deaths from Stroke by Census Tract –
Fulton and DeKalb Counties 2009-2011**



Source: Georgia Department of Community Health, Online Analytical Statistical Information System

**Prostate Cancer Discharges by Census Tract – Fulton and DeKalb Counties
2008-2010**

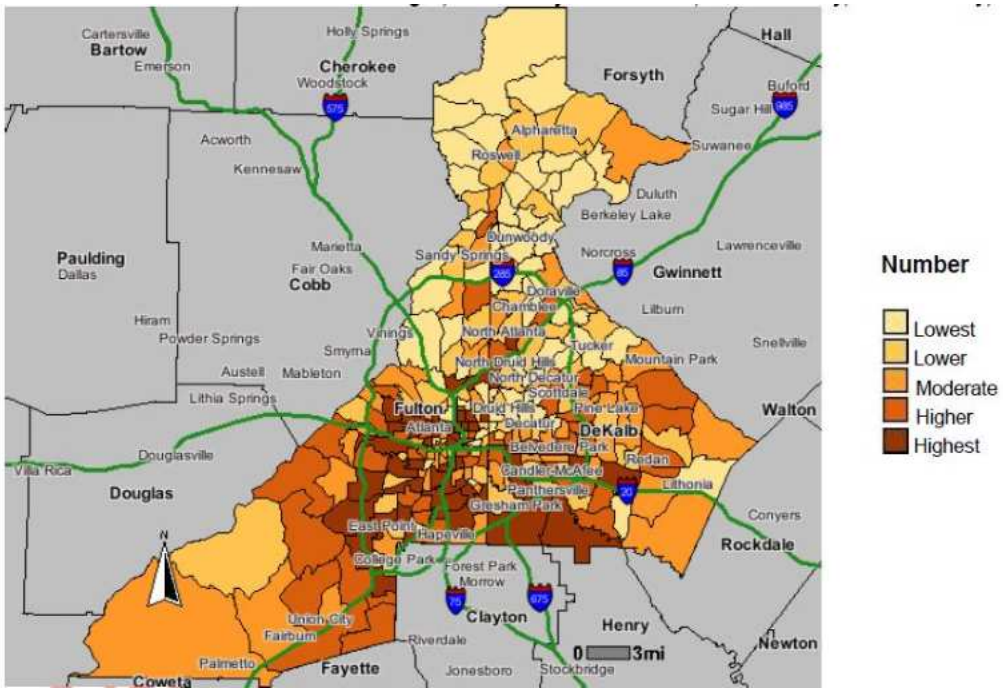


Source: Georgia Department of Community Health, Online Analytical Statistical Information System

Infectious Diseases

The rates of infectious diseases in both DeKalb and Fulton Counties exceed state averages. In DeKalb County, the chlamydia rate is 195.7 per 100,000 population and 204.7 per 100,000 population in Fulton County. The state average is 167.7 per 100,000 population. Gonorrhea incidence is 269.1 per 100,000 population in DeKalb County and 336.0 per 100,000 population in Fulton County, much higher than the state incidence rate of 163.3 per 100,000 population. The HIV prevalence rate in Fulton County is almost three times the state rate at 1,228 per 100,000 population. The DeKalb County HIV prevalence rate is 1,009 per 100,000 population, more than double the state prevalence rate of 442.6 per 100,000 population. The following map shows HIV/AIDS discharges by census tract for DeKalb and Fulton Counties for 2008 through 2010. There are fewer HIV/AIDS discharges in the northern sections of both counties, with larger numbers in the southwestern part of DeKalb and the south central and southeastern parts of Fulton County.

HIV/AIDS Hospital Discharges by Census Tract – Fulton and DeKalb Counties 2008-2010



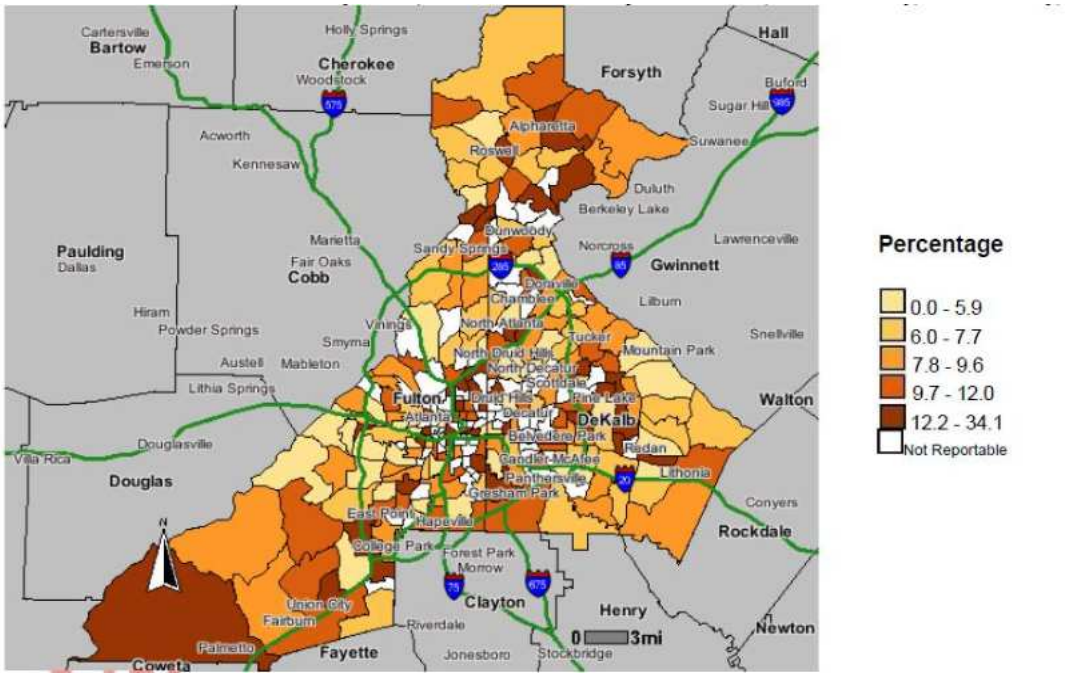
Source: Georgia Department of Community Health, Online Analytical Statistical Information System

Injury Related Conditions

Injury related conditions include both intentional and unintentional injuries. Fulton and DeKalb Counties look similar across each of these measures as well. The homicide death rates are 13.93 and 12.36 per 100,000 population for DeKalb and Fulton Counties, respectively. The DeKalb County homicide death rate is nearly double that of the statewide rate of 7.21 per 100,000 population. The suicide death rate per 100,000 population for both counties is lower than the state average (11.02): 8.11 in DeKalb County and 9.02 in Fulton County. Similarly, the average annual motor vehicle crash death rate in Fulton County is 11.71 per 100,000 population, 11.2 per 100,000 population in DeKalb County, and 16.42 per 100,000 population in Georgia. The average annual pedestrian death rate per 100,000 population is 2.89, 2.35, and 1.5 for DeKalb County, Fulton County, and Georgia, respectively.

The map on the following page illustrates the percentage of deaths caused by external causes (including motor vehicle deaths and homicide deaths) by census tract for both counties. High rates of deaths from external causes occurred in multiple areas of both DeKalb and Fulton Counties. Of note is the high percentage of deaths in the southernmost part of Fulton County.

Percentage of Deaths from External Causes by Census Tract –
Fulton and DeKalb Counties 2009-2011



Source: Georgia Department of Community Health, Online Analytical Statistical Information System

7. PRIMARY AND CHRONIC DISEASE NEEDS OF UNINSURED PERSONS, LOW-INCOME PERSONS, AND MINORITY GROUPS

This analysis identified a number of health needs and drivers that affect GHS's service area and identified sub-county level geographic areas that are more adversely affected by these health needs and drivers. Within in DeKalb and Fulton Counties, there are specific populations – racial and ethnic minorities, low-income, and uninsured, who are impacted by socioeconomic and health factors disproportionately and who have greater needs than the general population. For example, high poverty and low educational attainment affects minority populations more, whereas obesity affects people of all races and income levels at relatively the same rate in Fulton and DeKalb Counties.

Socioeconomic Factors

In both DeKalb and Fulton Counties, more minority populations are affected by poverty. In DeKalb County, 30.8 percent of the Hispanic population and 19.8 percent of the Black population live at or below the Federal Poverty Level. In Fulton County, 23.3 percent and 25 percent of the Hispanic and Black populations, respectively, live in poverty. The same is true among the population younger than age 18. In this age group, 41.5 percent of Hispanic children and 39.8 percent of Black children in DeKalb County and 31.3 percent of Hispanic children and 37.6 percent of Black children in Fulton County live in poverty.

Similar to poverty, educational attainment and health insurance status impact minority populations more. Forty-five percent of the Hispanic population in DeKalb County age 25 and older does not have a high school diploma. In Fulton County, 36.4 percent of the Hispanic population does not have a high school diploma. Among the Black population in DeKalb and Fulton Counties, 11.5 percent and 14.3 percent, respectively, do not have a high school diploma. In Fulton County, the Hispanic and Black populations make up the largest proportion of the uninsured at 47.9 percent and 23.3 percent, respectively. In DeKalb County, 56.1 percent of the Hispanic population and 24.4 percent of the Black population are uninsured.

Health Outcomes

Racial minorities report worse health outcomes than Whites in both DeKalb and Fulton Counties. Black adults in Fulton (16.8 percent vs. 6.7 percent) and DeKalb (13.6 percent vs. 8.0 percent) Counties report being in fair or poor health at higher rates than White adults. Diabetes is more prevalent among Blacks than Whites in DeKalb (9.9 percent vs. 6.3 percent) and Fulton (12.0 percent vs. 4.0 percent) Counties, respectively. The stroke mortality rate per 100,000 for the Black population in DeKalb County is 59.44 compared with 45.39 for the White population. In Fulton County, the stroke mortality rate in the Black population is 95.24 per 100,000 and 81.05 in the White population. In addition to these chronic conditions, infant

mortality is also more prevalent among Blacks – 11.38 per 1,000 live births in DeKalb County and 11.58 per 1,000 live births in Fulton County.

Health Behaviors

Poor health behaviors are more prevalent among both the minority and low-income populations in GHS's service area. Twenty-five percent and 29 percent of the total population in DeKalb and Fulton Counties, respectively, have poor food access (access to healthy and affordable foods). According to the Behavioral Risk Factor Surveillance System, which reports data at the public health district level, higher rates of physical inactivity and cigarette smoking are found among the low-income. In both counties, Blacks report higher levels of physical inactivity than Whites. Similarly, 18.5 percent of Blacks in Fulton County are cigarette smokers as compared with 10.3 percent of Whites. In DeKalb County, 13.7 percent of Blacks are cigarette smokers compared with 6.2 percent of Whites.

8. PROCESS FOR CONSULTING WITH PERSONS REPRESENTING THE COMMUNITY'S INTERESTS

A number of organizations provided input, data, and context for this CHNA. Within Georgia State University, the following entities were involved in the CHNA process: the Department of Geosciences, Institute of Public Health, and the Georgia Health Policy Center.

A number of state agencies contributed to the data and report, including: the Georgia Department of Education, Georgia Department of Public Health, Georgia Department of Community Health, and the Georgia Department of Agriculture. The DeKalb and Fulton County District Health Directors participated in stakeholder interviews as well as representatives from the Health Promotion Section of Fulton County Department of Health and Wellness Health. Non-profit organizations were also engaged via key informant interviews including leaders from the Atlanta Women's Foundation, the Community Foundation for Greater Atlanta, and the United Way of Metro Atlanta.

Key Informant Interviews

Much of ARCHI's work, including the input of collaborative partners, has contributed to the assessment of the health needs and the identification of health priorities in GHS's service area. ARCHI received community input from a variety of sources including stakeholder meetings, one-on-one interviews, and written feedback. Many different types of organizations and individuals with many different types of expertise were represented, including:

- Behavioral Health
- Business Community
- Civic and Advocacy Organizations
- Faith Community

- Federally Qualified Health Centers
- Health Plans
- Hospitals
- Local Governments
- Media
- Philanthropy
- Physicians
- Primary Care Community
- Public Health
- Social Service providers
- Universities

Appendix B lists the ARCHI stakeholders who provided input to inform the needs assessment and priority-setting process.

As a part of the data collection process for ARCHI, the GHPC conducted several key informant interviews with public health leaders, county government representatives, and representatives of the philanthropic community in Fulton and DeKalb Counties. Because ARCHI's target area is the same as GHS's primary service area, these interviews also meet the needs of the GHS CHNA process. The key informants were asked to discuss:

- the greatest health issues/challenges;
- the root causes of these challenges;
- the level of existing public/private partnerships that are working to improve health/reduce health disparities;
- individuals/organizations that are key to improving health in the community;
- the three most important health issues that should be addressed and why; and
- interventions that will make a difference to the community.

Representatives from Fulton County named asthma, diabetes, cardiovascular disease, and HIV/AIDS as some of the county's health challenges. Likewise, DeKalb County representatives mentioned obesity (among adults and children), heart disease, infant mortality and low birth weight babies, and sexually transmitted diseases (STD) as challenges facing their county. The philanthropic community included teen pregnancy and mental health as challenges to both counties. Lack of access to care, poverty, unemployment, poor education, poor health literacy, poor nutrition, and alcohol consumption were cited as some of the root causes of many of these health challenges. Among all of the key informants, chronic diseases, STDs (including HIV/AIDS), and mental health were the top three most common health issues they felt should be addressed. The key informants also suggested interventions that could be put into place to

address these issues. For both counties, key informants suggested a focus on healthy eating and physical activity through community garden initiatives and mandated physical activities in schools. They also suggested built environment interventions that improve the walkability of communities, improve food access, and encourage the improvement of air quality.

Appendix C lists the name, title, affiliation, and a brief description of each individual's special knowledge or expertise, and how and when these individuals were contacted.

Focus Groups

A total of five focus groups were held in the target counties. Table 7 details the recruitment areas within DeKalb and Fulton Counties. These areas were identified as being hot spots within the counties after a review of the following key indicators: demographics, poverty, uninsured population, educational attainment, social and economic factors, physical environment, clinical care, health behaviors, and health outcomes. Wherever possible, census tract-level data were examined to determine with even greater specificity those areas for additional qualitative data collection and analysis.

Focus Group Recruitment Process

English-speaking focus group recruitment was completed by the market research company Wilkins Research Services, LLC (WRS). WRS recruited focus group participants for specific census tracts in DeKalb and Fulton Counties. For the Buford Highway corridor-area focus group that targeted Hispanic/Latino residents, DeKalb County Cooperative Extension (DCCE) assisted with recruitment. Focus group participants were recruited from Hispanic/Latino parents of pre-school children participating in DCCE nutrition education and English language programs.

Table 7 - CHNA Focus Group Details

County	Recruitment Area
DeKalb County 1	Zip codes 30032 and 30316 (Southwest parts of the county- Belvedere and Avondale areas)
DeKalb County 2	Zip codes 30034 and 30288 (Southern part of the county - Adair and Cedar Grove areas)
DeKalb/Fulton Counties (Hispanic/Latino)	Buford Highway corridor; Chamblee and Doraville areas
Fulton County 1	Zip code 30315 (Southeast of Atlanta - Pittsburgh/West End areas)
Fulton County 2	Zip codes 30314, 30318 (West and Northwest of Atlanta - Bankhead and Vine City areas)

For the English-speaking focus groups recruitment process, GHPC created a county demographic profile that included racial make-up and age bands. Recruitment targets were set for each racial and age category to approximate the county or targeted ZIP code demographic profile (e.g. if a targeted area had 70 percent African American population and a 30 percent white population, WRS attempted to recruit a focus group participant list that reflected that demographic profile). WRS utilized lists of land line phone numbers for the targeted ZIP codes and randomly called phone numbers to screen for participants. Table 8 details the demographics of participants in the five focus groups.

Table 8 - Demographic Profiles of DeKalb and Fulton County Focus Group Participants

Focus Group Location	Gender		Age				Race				Totals
	Male	Female	25-34	34-44	45-64	65+	African American	Caucasian	Hispanic/ Latino	Other	
Buford Highway Corridor/Doraville 3/13/2013	1	8	5	4	0	0	0	0	9	0	**9**
DeKalb County #1 3/13/2013	6	4	2	1	7	0	8	2	0	0	**10**
DeKalb County #2 3/14/2013	4	8	3	4	4	1	11	0	0	1	**12**
Fulton County #1 3/19/2013	7	3	2	1	6	0	9	1	0	0	**10**
Fulton County #2 3/21/2013	4	7	5	2	4	0	11	0	0	0	**11**
Total	22	30	17	12	21	1	39	3	9	1	52

Focus Group Themes

Focus group participants were asked about their perceptions of their families' health and health in their communities, barriers to better health, and their suggestions for how to address key health concerns in their communities. The following summarizes the themes that were common across the focus groups. Additional details about the focus group responses are included in Appendix D.

Healthy Living: Participants defined "living a healthy lifestyle" consistently across the focus groups. They most often cited the importance of eating well and getting regular exercise. Getting enough sleep, managing stress and having access to regular health screenings and medical care were also cited as important components of a healthy lifestyle. Living a "balanced lifestyle" or a life of moderation was mentioned by participants as important. When asked whether they and their families lead a healthy lifestyle, the majority of participants reported that they were not as healthy as they should be.

Community/Social Connections: Participants wanted to be able to connect and interact with peers and their community members to learn about and achieve better health. Using community gathering locations such as schools, libraries and churches to offer education about health topics, health screenings, community information and local resources available to residents was supported by a number of focus group attendees.

Physical Activity: There was a critical lack of physical activity by residents in the target communities and a number of barriers to becoming more active. Barriers included: 1) accessibility – there were few or no fitness facilities in the target region and schools with tracks were often "locked down" and not available to the residents; 2) safety – neighborhood crime or safety issues for children in getting to parks and trails was identified as a concern; 3) quality – a number of focus group participants indicated the existing parks and trails were poorly maintained, didn't have playground equipment or simply weren't appropriate for "exercise."

Marketing "Healthy" to Children: "Kids are very impressionable and 'marketing' of healthy behaviors should start at home and continue in school." This was a common theme heard from focus group attendees. Participants agreed that health-related education and marketing of healthy products should start in organized day cares targeting the parents of infants, toddlers, and preschoolers and continue for students throughout the school years. Engaging retail food outlets, in particular grocery stores, in marketing healthy foods was also suggested as an action item in this theme.

Health Care and Health Insurance: The expense of and access to low cost health care services was identified as a critical concern by many focus group participants; particularly considering the issue of health care reform. A number of older focus group members indicated transportation to health care services was a challenge while others indicated a lack of knowledge about the free or low cost services available to them in their community. Those that were aware of health care services in the region indicated that long waits and limited hours often made it difficult to get care at a convenient time particularly when working two jobs or having small children to care for. Assistance in understanding how health care report will impact those without insurance and in getting access to health care insurance as part of the reform process was important to participants.

9. PROCESS FOR IDENTIFYING AND PRIORITIZING COMMUNITY HEALTH NEEDS

GHS's participation in ARCHI's priority setting process helped it to better understand the health status of its service area and refine its approach to addressing the needs of the population within in the service area. With the leadership of the Georgia Health Policy Center, the United Way of Metropolitan Atlanta and the Atlanta Regional Commission, ARCHI stakeholders participated in a series of community conversations to review the metro area health system, analyze current health data, and build consensus on the challenges and the potential solutions from July 2012 to November 2012. The results included a collaborative regional health assessment and short and long-term strategies that encourage multiple partners to invest in health improvement according to their interests and needs.

This phase of ARCHI's work culminated with a six-hour work session on November 14, 2012 during which Dr. Bobby Milstein presented the ReThink Health Model. The model uses extensive data on the metro region's healthcare system and the health of the metro region's residents to explore different intervention and investment scenarios and the short and long term impact they can have on the health and economic productivity of the region's residents while creating efficiencies in the current healthcare delivery system. Seventy collaborative members explored a range of options during the work session. After hours of consideration and subsequent review by additional professionals, a clear set of priorities emerged. The members used polling technology to select a preferred future scenario, the Atlanta Transformation scenario, which 87 percent of the participants selected. The Atlanta Transformation scenario focuses on seven key priorities:

- ***Adopting healthy behaviors*** - Promoting healthy behavior and helping people to stop behaviors that can lead to chronic physical illness; specifically, smoking, poor diet, inadequate exercise, alcohol and drug abuse, and unprotected sex, can lead to improved short- and long-term health outcomes. Focusing on health behavior may reduce onset of mild and severe chronic physical illness, the likelihood of urgent events, as well as the onset of mental illness associated with drug abuse.
- ***Care coordination*** – care coordination includes the provision of coaching for patients and physicians to reduce duplicative or unnecessary referrals and admissions and to reduce medication costs.
- ***Pathways to advantage for students and families*** – This includes providing programs for disadvantaged high school and college students to improve graduation and matriculation rates, and instituting policies and programs (e.g. living wage policies, tax credits and subsidies, and housing vouchers) to improve economic prospects. The impacted population is less likely to engage in unhealthy behavior, or to live in

hazardous or high-crime environments, or to develop chronic physical or mental illness, or to be uninsured, or to go to the hospital for non-urgent care.

- ***Shift to a contingent global payment scheme*** - A contingent global payment (CGP) scheme combines payment on a per-capita basis with basic care standards and rewards for certain beneficial activities. Thus, CGP by itself can lead to provider-driven improvements, for example, better preventive and chronic care, better coordination of care, and better post-discharge planning, even without community-level initiatives.
- ***Capturing and reinvesting savings*** - This process involves negotiating with payers – commercial, Medicare, and Medicaid – to achieve an arrangement in which they calculate healthcare cost savings against appropriate benchmarks and then return to the community some fraction of those savings. These savings may be used to fund the implementation strategies determined through the CHNA process or collaborative projects such as those selected by ARCHI.
- ***Establishing an innovation portfolio*** - This portfolio may contain both evidence-based programming, best practices in care, and health behavior changes as well as strategic financial investment. GHS and its strategic partners may agree upon an intervention strategy or strategies focused on specific target audiences and then determine investment of a given dollar amount per year, starting in a specified year and extending for a specified duration, after which time no new funds are provided.
- ***Insurance expansion*** – This involves a reduction in the uninsured population due to federal mandates or expanded eligibility. Although Georgia has chosen not to expand Medicaid, the state will have a federally facilitated Exchange, and it is expected that the proportion of Georgians without health insurance will begin to fall after 2014.

A Playbook for Action was created by ARCHI subcommittee members to begin to operationalize the initiatives in the Atlanta Transformation Scenario and to provide opportunities for community-wide alignment of health improvement investment. The ARCHI strategy encourages a distributed approach to health improvement, and many of the partners, including GHS, have established mechanisms for shifting the focus of their organizations to the priority areas selected in the scenario. The Playbook for Action can be found online at http://www.archicollaborative.org/archi_playbook.pdf.

Appendix A
Secondary Data Sources

Data	Source	Geography
Demographics	U.S. Census Bureau	County, Census Tract
	American Community Survey - 5-Year Estimates, 2006-2010	County, Census Tract
	American Community Survey - 5-Year Estimates, 2007-2011	County, Census Tract
Social and Economic Factors	U.S. Census Bureau	County, Census Tract
	U.S. Department of Education, National Center for Educational Statistics	County
	Georgia Department of Education	County
	Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System 2005-2011	County
	American Community Survey - 3-Year Estimates, 2008-2010	County, Census Tract
	Small Income and Poverty Estimates 2011	County, Census Tract
	CDC National Vital Statistical Systems 2003-2009	County
	U.S. Bureau of Labor Statistics	County
Physical Environment	CDC National Environmental Public Health Tracking Network	County
	U.S. Department of Agriculture	County
	U.S. Health Resources and Services Administration Area Resource File	County, Census Tract
	Dartmouth Atlas of Healthcare	County
	GA Association for Primary Health Care	County
	Georgia Health Policy Center independent research	County
	Fulton County Health and Wellness	County
	DeKalb County Board of Health	County
Health Behaviors	CDC Behavioral Risk Factor Surveillance System 2005-2011	County
Health Outcomes	CDC Behavioral Risk Factor Surveillance System 2005-2011	County
	Georgia Comprehensive Cancer Registry	County
	CDC Wonder	County
Health Outcomes (continued)	CDC National Diabetes Surveillance System	County
	National Highway Traffic Safety Administration	County
	2012 County Health Rankings	County

Appendix B
ARCHI Stakeholders

Name	Organization
Susan Bertonaschi	Atlanta Civic Site/Annie E. Casey Foundation
Pete Correll	Atlanta Equity
Lynne Scoggins	Atlanta Medical Center
Doug Hooker	Atlanta Regional Commission
Tad Leithead	Atlanta Regional Commission
Katryn Lawler	Atlanta Regional Commission
Mike Carnathan	Atlanta Regional Commission
Cathie Berger	Atlanta Regional Commission
Adam Edge	Atlanta Regional Commission
Chariss White-Fulks	Atlanta Regional Commission
Morgan Kendrick	Blue Cross Blue Shield of Georgia
Robert Bunch	Blue Cross Blue Shield of Georgia
Lei Ellingson	Carter Center
Anita Zervigion-Hakes	Carter Center
Satvinder Dhingra	Centers for Disease Control and Prevention
Catherine Okoro	Centers for Disease Control and Prevention
Paul Stange	Centers for Disease Control and Prevention
David Tatum	Children's Healthcare of Atlanta
Reverend Frank Brown	Concerned Black Clergy of Metropolitan Atlanta
Reginald Figures	Concerned Black Clergy of Metropolitan Atlanta
Commissioner Larry Brown	DeKalb County Commission
Dr. S. Elizabeth Ford	DeKalb County Board of Health
Debbie Bloom	Emory University
Dr. Joyce Essien	Emory University
Betty Willis	Emory University
Eve Byrd	Emory University/Fuqua Center
Dr. Bobby Milstein	Fannie E. Rippel Foundatoin
Commissioner Joan Garner	Fulton County Commission
Emil Runge	Fulton County Commission
Bobbie Battista	Fulton County Commission
Dr. Matthew McKenna	Fulton County Department of Health Services
Dr. Patrice Harris	Fulton County Department of Health Services
Katie Bell	Gallup
Faizah Muheb	Georgia Hospital Association
Erin Stewart	Georgia Hospital Association
Joyce Reid	Georgia Hospital Association
Richard Turner	Georgia Association for Primary Healthcare

Graham Thompson	Georgia Association of Health Plans
Cindy Cheatham	Georgia Center for Nonprofits
Nancy Paris	Georgia Center for Oncology Research/Georgia Health Foundation
Gordon Freyman	Georgia Department of Public Health
James Howgate	Georgia Department of Public Health
David Bayne	Georgia Department of Public Health
Kimberly Stringer	Georgia Department of Public Health
Dr. Rhodes Haverty	Georgia Health Foundation
Lisa Medellin	Georgia Health Foundation
Dr. Karen Minyard	Georgia Health Policy Center
Dr. Glenn Landers	Georgia Health Policy Center
Kristi Fuller	Georgia Health Policy Center
Dr. Chris Parker	Georgia Health Policy Center
Dr. Holly Avey	Georgia Health Policy Center
Robyn Bussey	Georgia Health Policy Center
Andrew Young	Georgia State University
John Haupert	Grady Health System
Michael Wright	Grady Health System
Shannon Sale	Grady Health System
Dr. Charles Moore	Grady Health System
Dr. Carolyn Aidman	Grady Health System
Dr. Bill Sexton	Grady Health System
Dr. Jada Bussey-Jones	Grady Health System
Dr. Bill McDonald	Grady Health System/Emory University
Mary Judson	Jesse Parker Williams Foundation
Kerry Kohnen	Kaiser Permanente
Evonne Yancey	Kaiser Permanente
Beverly Thomas	Kaiser Permanente
Madelyn Adams	Kaiser Permanente
Mark Wilson	Langdale Industries
Camilla Grayson	Medical Association of Georgia
Teresa Cutts	Methodist Healthcare / Memphis, Tennessee
Reverend Bobby Baker	Methodist Healthcare / Memphis, Tennessee
Renay Bluementhal	Metro Atlanta Chamber of Commerce
Dr. Tanisha Johnson	Next Level Coaching
Dr. Jeff Taylor	Oakhurst Medical
Holly Lang	Piedmont Healthcare
Kim Marchner	St. Joseph's Health System
Tom Andrews	St. Joseph's Health System
Ellen Mayer	The Civic League for Regional Atlanta
Alicia Philipp	The Community Foundation of Greater Atlanta

Lesley Grady	The Community Foundation of Greater Atlanta
Bobbi Cleveland	Tull Charitable Foundation
Milton Little	United Way of Metropolitan Atlanta
Linda Blount	United Way of Metropolitan Atlanta
Dante McKay	Voices for Georgia's Children

Appendix C
Key Informant Interviewees

Name	Title	Affiliation	Date	Method of Contact:	Brief description of individual's special knowledge or expertise.
Linda Blount	President at WFG Equity and VP of Programmatic Impact, UWGA	United Way of Metropolitan Atlanta (UWGA)	1/25/13	Interview	Serves as Vice President of Programmatic Impact at UWGA. Blount worked as National Vice President, Health Disparities at the American Cancer Society for 6 years. Before that she was responsible for analyzing and instituting global e-sourcing systems initiatives at the Coca Cola Company. Blount also served as President at William Foster Group and was an Expert Scientist at the US Centers for Disease Control and Prevention where she consulted on healthcare program management to create the first executive-level geo-spatial analysis system that provided visibility to global HIV/AIDS data and program development and implementation costs.

Dishonda Hughes (DH) **&** **Deborah Ryan (DR)**	DH: Director of Community Initiatives DR: Vice President Development and Communications Interim Director)	The Atlanta Women's Foundation (AWF) The Atlanta Women's Foundation (AWF)	1/15/13	Interview	DiShonda Hughes joined the AWF team in 2000. She has been responsible for the management and coordination of various grantmaking initiatives and special projects. She has extensive experience in grantmaking in the areas of women's health; economic justice; homelessness; and prevention of violence against women. Dishonda has managed the distribution of over $11,000,000 to local women and girl serving nonprofits. Deborah Ryan is an experienced fundraising and communications professional, who serves as Vice President of Philanthropy at AWF and is currently it's Interim Communications Director. Deborah brings more than 16 years of experience in nonprofit management and administration, most recently as Director of Development at Oglethorpe University. Prior to Oglethorpe, she was Senior Director of Development and Communications at Atlanta Contemporary Art Center. A Georgia native, Deborah earned her Bachelor of Arts in History (with a minor in Business) from Auburn University.
Lesley Grady	Senior Vice President of Community Partnerships	Community Foundation for Greater Atlanta	1/24/13	Interview	Oversees the Community Partnerships department including grant making and scholarships as well as multiple community initiatives and helps connect this work with donors interested in critical community needs.
Nazeera Dawood	Health Promotion Program Manager	Fulton County Dept. of Health & Wellness	11/26/12	Interview	Manages Fulton County Health Promotion Section; Leads Health Promotion Advisory Council (HPAC) for Fulton County.

Patrice Harris	District 3-3 Health Director	Georgia Dept. of Public Health	1/10/13	Interview	Serves as the District Health Director for the Fulton Health District, District 3-2. Harris was the medical director of the Fulton County Dept. of Behavioral Health and Developmental Disabilities before she became the director of health services. She is a graduate of the West Virginia University School of Medicine and completed residency and fellowship training at the Emory University School of Medicine. In addition to her general psychiatry training, she completed fellowships in child and adolescent psychiatry and forensic psychiatry. Harris was recently elected to the Board of Trustees of the American Medical Association.
Joan Garner	District 6 Fulton Country Commissioner	Fulton County	1/29/13	Interview	Commissioner Garner was previously president and CEO of the Historic District Development Corporation, a community-based, nonprofit organization that facilitates the preservation and revitalization of the Martin Luther King, Jr. National Historic District and other historic/preservation communities. She also served as executive director of the Southern Partners Fund, a community-based public foundation committed to equal rights; as co-director of the National Network of Grantmakers, which supports social justice work; and as executive director of the Fund for Southern Communities, which fosters social change in Georgia, North Carolina and South Carolina.

Larry Johnson	District 3 DeKalb County Commissioner	DeKalb County	1/23/13	Interview	Commissioner Johnson a long-term advocate of health and health-related issues has been working in DeKalb prior to and during his tenure as Commissioner to improve the health outcomes for the residents of DeKalb. He has worked to co-host Let's Move! DeKalb event (the local representation of First Lady Michelle Obama's childhood obesity initiative). Professionally, Commissioner Larry Johnson served as the Manager for the Fulton County Health & Wellness, the Office of Healthy Behaviors. One of the programs he managed was the REACH Program -- REACH -- Racial and Ethnic Approaches to Community Health a federal initiative that includes the goal of eliminating racial and ethnic disparities in health by the year 2010; served as the Vice-President, Community Relations for the Association of Black Cardiologists where he is in charge of development and implementation of community programs that has its goal the reduction of cardiovascular disease in the African-American community, through education, research and advocacy.

Appendix D

Community Health Needs Assessment:

Findings from Community Focus Groups

May 2013

Introduction

As part of the community health needs assessment conducted by The Georgia Health Policy Center (GHPC) for the Atlanta Regional Collaborative for Health Improvement (ARCHI), five focus groups were conducted with adults in DeKalb and Fulton Counties. The focus groups were implemented to gather community input for the needs assessment. The objectives of the focus groups were to:

- gather participants' feelings about the health and health needs of their communities;
- solicit their input on how their health-related challenges might be addressed; and
- understand the assets and resources that are already in place in their communities to facilitate health improvement.

Five focus groups were held in targeted areas within the two counties (see Table 1), with a total of 52 participants. These locations were identified as being hot spots within the counties after review of the following indicators: demographics, key drivers (poverty, uninsured population, and educational attainment), social and economic factors, physical environment, clinical care, health behaviors, and health outcomes. Wherever possible, census tract level data was examined to determine with even greater specificity those areas for additional qualitative data collection and analysis. For four of the focus groups, the targeted recruitment areas were based on specific ZIP codes within the counties. A fifth focus group was held with Spanish-speaking Latinos in the Buford Highway corridor (with residents drawn from DeKalb and Fulton Counties).

Table 1. ARCHI Health Needs Assessment Focus Group Locations

County	Recruitment Area
DeKalb County 1	ZIP codes 30032 and 30316 (Southwest parts of the county- Belvedere and Avondale areas)
DeKalb County 2	ZIP codes 30034 and 30288 (Southern part of the county - Adair and Cedar Grove areas)
DeKalb/Fulton Counties	The Buford Highway corridor and Chamblee, Doraville areas (focus on Spanish-speaking Latinos).
Fulton County 1	ZIP code 30315 (Southeast of Atlanta - Pittsburgh/West End areas)
Fulton County 2	ZIP codes 30314, 30318 (West and Northwest of Atlanta - Bankhead and Vine City areas)

Focus Group Participant Recruitment Process

Wilkins Research Services (WRS) was contracted to conduct participant recruitment for four of the focus groups [DeKalb (2) and Fulton (2)]. Recruitment for the focus group with Spanish-speaking Latinos in DeKalb/Fulton Counties was conducted separately and is described below. For the focus groups for which WRS recruited, a county demographic profile was created that included the racial make-up (African American and White) and age range (25-34 years old, 35-44 years old, 45-54 years old, 55-64 years old, and 65+). Participant recruitment targets were set for each racial and age category to approximate the county or targeted ZIP code demographic profile (e.g. if a targeted area had 80% African American population and a 20% white population, WRS attempted to recruit a focus group participant list that reflected that demographic profile). WRS utilized lists of landline phone numbers for the targeted ZIP codes in the focus counties and randomly called phone numbers to screen for participants for the focus groups.

Participants for the focus group with Spanish-speaking Latinos in the Buford Highway corridor were recruited from English language and nutrition classes held at a local Pre-K site in Doraville. See Table 2 for a summary demographic profile of the focus group participants.

Table 2. Summary Demographic Profile of Focus Group Participants

Focus Group	Gender		Age				Race				Total
	Male (N)	Female	25-34	34-44	45-64	65+	African American	Caucasian	Hispanic/ Latino	Other	
Buford Highway Corridor/Doraville 3/13/2013 N = 9	1	8	5	4	0	0	0	0	9	0	**9**
DeKalb County #1 3/13/2013 N = 10	6	4	2	1	7	0	8	2	0	0	**10**
DeKalb County #2 3/14/2013 N = 12	4	8	3	4	4	1	11	0	0	1	**12**
Fulton County #1 3/19/2013 N = 10	7	3	2	1	7	0	9	1	0	0	**10**
Fulton County #2 3/21/2013 N = 11	4	7	5	2	4	0	11	0	0	0	**11**
Totals	**22**	**30**	**17**	**12**	**22**	**1**	**39**	**3**	**9**	**1**	**52**

All of the focus groups were held in a location central to the targeted area. Participants were provided a light meal and a stipend for their participation. They were provided a copy of an informed consent form approved by the Institutional Review Board of Georgia State University and asked to sign these consent forms prior to beginning the group discussion.

Focus groups lasted an average of 90 minutes. There was a facilitator and note taker present at each focus group. Each discussion was recorded and transcribed. Focus group participants were asked about their perceptions of their families' health and health in their communities, barriers to better health, and their suggestions for how to address key health concerns in their communities. This summary report reflects the main themes from the discussions in the five communities. Themes that are common across the focus groups are summarized and presented here. When appropriate, differences within and across focus groups are noted.

Participant Views on Healthy Living

Participants defined "living a healthy lifestyle" consistently across the focus groups. They most often cited the importance of eating well and getting regular exercise. Getting enough sleep, managing stress, and having access to regular health screenings and medical care were also cited as important components of a healthy lifestyle. When asked whether they and their families lead a healthy lifestyle, most participants reported that they were not as healthy as they should be, though there were individuals in each group who described efforts to incorporate exercise and healthy eating into their daily lives. The barriers to leading a healthy lifestyle described by participants were:

Lack of Time

Participants described having long work hours, leaving them with little time to exercise and to plan and prepare healthy meals. Multiple participants described working two jobs or twelve hour shifts. A Fulton County resident described the challenge of preparing healthy meals at home in this way: "I was commuting…45 minutes when there was no traffic. I have a child, and it was difficult to have to go home after work, get there by 7:30 because of traffic, cook and end up eating at 9 pm. The choice was either that or eating something quick and easy." Participants in the Buford Highway group noted that the lack of time was especially true for men. One participant observed, "there's not enough time because they [men] come home from work and they are tired and there are things to do around the house. The kids need help with their homework and they don't have the time to take the kids to the park."

Expense

Expense was cited as a barrier to healthy eating in all the focus groups. Participants said that healthy foods are more expensive than junk food and fast food. Many acknowledged that they know what they need to be doing, but often cannot afford to eat healthier. A resident of DeKalb County observed, "We all know what we are supposed to do… I feel like I should get the organic bananas but they are ten cents a pound more [than the regular bananas] and I am trying to stretch a dollar." A resident of Fulton County described the issue this way: "…at this point economics play a big part, because if you are on a limited budget or you don't have a whole lot of money, you can buy 5000 calories worth of product for

$3.00, but it doesn't mean that it has nutrition. If you want a nutritional product, that $3.00 will buy you 100 calories. A lot of people eat unhealthy because that is what they can afford."

Participants in the Buford Highway focus groups were immigrants and commented on how much more accessible fast food is in this country as compared to their home countries. They described how they struggled to adjust to the change in diet and more readily available and affordable unhealthy food options. For many in their home countries, eating outside the home was not an option because of the high cost. Multiple participants across the five focus groups commented that it was cheaper to eat out at a fast food restaurant than it is to prepare a meal for your family at home.

Ease of Access/Location

Participants in the DeKalb and Fulton focus groups pointed out geographic disparity in the availability of healthy food options - where you live determines what food you have access to. The sentiment expressed by participants in Fulton County illustrates this perception: "You must shop elsewhere [outside of this community] to make the better choices." Participants described local grocery stores with poor produce selections and limited to no opportunities to buy organic foods. Participants talked about having to go to "downtown" or to the "white areas" (i.e. Decatur, Intown Atlanta) to shop for healthy foods from places like Whole Foods or local farmers markets. Another resident noted that "if you live in this neighborhood, we don't have access to a grocery store. You have to go all the way to Moreland. If you don't have a car, you are in trouble. Have you ever gone grocery shopping on MARTA?" A participant in DeKalb County described how location affects eating habits in this way: "From the south end of the county to the north end of the county you have different options. I love Whole Foods but the locations are [far away]." On the other hand, fast food is readily available in many communities.

Participants from DeKalb County and Buford Highway described the high numbers of fast food restaurants in their communities. One participant described it this way: "I was going to say also the total notion of what some people call food deserts, depending on access of healthy choices in food, depending on where we live, depends on the type of nutritious foods that you have access to. Like you said, when you have small children and it may be quick to go pick up something, but in certain areas all you have are fast-food restaurants." Another participant from DeKalb County observed: "There is a fast food place on every corner…they are pulling us in, and we know that is bad food. It leads to diabetes… somebody is competing to give it to us, and the health care industry and trying to compete to slow it down."

Lack of Access to Opportunities for Physical Activity

Similar to the role that location plays in access to healthy food, participants described how their communities offered limited opportunities for recreation and physical activity. Lack of local opportunities for recreation was cited in all of the focus groups but one (one of the Fulton County groups). Participants lamented the lack of parks with facilities for promoting exercise, the lack of gyms nearby, and in one Fulton County group, the closing of local community centers. While residents in both DeKalb County groups mentioned the growth in green spaces in the county through the county green space initiative, some residents in the county complained that the green spaces in the county were not

conducive to exercise. One participant described the local parks this way: “What I would consider to be a park is not really what we have around here. I think that what they are calling a park is geared towards kids, or is just a small clearing. There is no place for you to actually get out and run or walk. You would have to go to Piedmont Park or Inman Park. You have to go into the city.”

For participants across the focus groups, safety in their communities was cited as a barrier to exercise – lack of sidewalks for walking or running, fear of allowing children to play outside, and lack of public safety in their communities. A resident of DeKalb County described rules in her community that prohibit children from playing outside. “I can’t go outside where I live… they don’t allow children to be outside and play in the apartment complex. They say there are too many accidents and dangers, and there are so many kids in the complex, that they don’t want any of them playing outside. There is no play yard for them to play in.”

Culture and Environment

Culture (familial, community, and even Southern) and “where you come from” were mentioned as factors that affect people’s health behaviors, particularly related to food. Participants described habits learned from an early age and food preparation methods as being highly ingrained and difficult to change. In addition, cultural and familial customs impact food preferences. One participant described trying ground turkey as a substitute for beef, but could not tolerate a burger made with the healthier option. Another described how he “came up in the ‘40s. We cooked a lot of things with grease and that is what you liked and that was the taste that you wanted. That is why it is hereditary, because mama and daddy cooked in that and now you are eating it too.”

Some participants talked about the influence of community on health habits. A resident of Fulton County described this in this way: “If you live in a certain environment, people mimic what they see, so there could be certain communities might not be conducive to perpetuating a wholesome lifestyle… so an individual can try and improve but community has a lot to do with it.”

Lack of Education

Participants mentioned the lack of information about or awareness of strategies for healthier living. One resident in DeKalb County mentioned that his mother has diabetes, but does not know how to eat right to help control her condition. Another said that “some people know what to eat, some don’t. Some people know how to exercise, and some don’t. They need education about this stuff.”

Lack of Motivation

In each focus group, there was at least one individual who stated that leading a healthy lifestyle was up to the individual and the responsibility of that person to make the right choices. They often disagreed with the other participants who placed much of the blame for unhealthy lifestyles on environmental, economic, and cultural factors. These participants often talked about “laziness” and the tendency to “make excuses” for not incorporating healthier habits into their lives, despite the obstacles. A Fulton County resident stated, “there are some places that don’t have fresh products, but healthy eating is

really a mind thing and if you want to do it, you can do it." A participant from DeKalb said that, "for me healthy living is discipline. We know what to do, it is the discipline of doing it. It's personal, I don't think that it is economics."

Factors that Support Healthy Living

When asked what factors help support healthier living, participants talked about the importance of family, both as a motivator for being healthy and as a support system for sustaining healthy habits. Many participants described how having children motivated them to stop smoking or to make other lifestyle changes so that they would be around longer for their families. Participants described how they planned recreational activities and exercise as part of time spent with their children or other family members. A participant from Fulton County meets a family member at a track to walk each week. One participant in the Buford Highway corridor described how she put Zumba on her computer and gets her children to dance along with her for exercise.

Family medical history is also a motivator for health behavior change. Knowing that there is a family history of cancer, high blood pressure, or hypertension was cited by a few respondents as a motivating factor to improve their habits. A participant from Fulton County described how he came from a family of "big people" and tried to be around active people to help support healthier habits. Another started a walking program in an effort to avoid issues with high blood pressure, which runs in her family.

Other enabling factors mentioned included: an intervention by a medical provider to spark behavior change, wanting to lose weight, and wanting to feel better.

Community Health Concerns and their Causes

Following the discussion about healthy living and the factors that support and hinder healthy habits, participants were asked to reflect on specific health concerns within their families and their communities and the causes of those issues. Below is a summary of participant perceptions of tobacco use, drug and alcohol abuse, risky sexual behavior, and chronic disease in their families and communities.

Tobacco Use

Participant perceptions about the prevalence of smoking in the communities varied within and across focus groups. Most thought that tobacco use continues to be an issue of concern in the community, even though it is "getting better." They cited the expense of cigarettes and laws that have passed that prohibit smoking in many establishments, like restaurants and the work place, as having helped to reduce the prevalence of smoking. Some participants in one of the Fulton County groups observed that they see a lot of people smoking and believe it to be more prevalent than before.

When asked to consider the causes of smoking, participants responded that it was an addiction that many were unable or unwilling to overcome. Participants in the DeKalb and Fulton County groups commented that smoking is a group behavior – people do it because of peer pressure or because it is a

social activity. Participants in one of the DeKalb and one of the Fulton County groups observed that it was easy to obtain cigarettes in the community because of the number of convenience and liquor stores that sell them. In one DeKalb County group, participants talked about how smoking is "pushed at you" by the media and society. One participant observed, "Now that's one of the things I think society kind of plays a hand in, because it's pushed at you. You know cigarettes are everywhere and anywhere, so it's easy to pick that habit up and use it for a long length of time." Participants in DeKalb and Fulton County suggested that cigarette companies will do "whatever it takes" to get young people to start smoking. As one Fulton County resident observed, "Cigarettes are a money-making business…So they want to sell the products and they are going to do whatever they can do to advertise them." Others noted the role that smoking plays in stress management for those who smoke. A DeKalb County resident described tobacco as a "pacifier."

When asked to consider what might help smokers stop smoking, participants observed that nowadays, everyone knows the harmful effects of smoking and continue to use tobacco anyway because it is addictive. Multiple respondents called cigarettes a "drug" that is more addictive than other street drugs. Participants across the focus groups observed that smokers only stop once they have a health scare. A DeKalb County resident observed that most people he knows who had stopped smoking did so only after a tragedy occurred. Some recounted interventions by doctors to warn of the harmful effects of smoking as being motivation for family members struggling to quit smoking. Others described family as being a motivator to stop. A mother from Fulton County recounted how she stopped smoking after having children. A participant in the Buford Highway group suggested that a message that would likely resonate with smokers is to describe how smoking (i.e. the harmful effects of secondhand smoke) affects their family's health.

Drug and Alcohol Abuse

Participants across all the focus groups were uniform in their assessment of the presence of drug and alcohol abuse in their communities. In the Buford Highway group, one of the DeKalb groups, and in both Fulton County groups, residents observed that alcohol abuse was more of an issue than drug abuse and attributed the problem to the ease of access to alcohol and the fact that it is legal to purchase. They described liquor stores on every block selling inexpensive alcohol. Participants in one DeKalb County group observed that the number of liquor stores and convenience stores selling alcohol have increased over time, particularly in certain areas of their communities where there had been a more limited supply in the past. A participant from the other DeKalb County group observed that "every store has cheap beer, on every block in DeKalb County." A resident of Fulton County observed that there are laws that these stores can't be within a certain distance of a church or school but that it "seems like this law doesn't apply to our community."

The participants from the Buford Highway group described alcohol abuse as being more serious than drug abuse in their community, particularly among men. In the Buford Highway group, they described it as a problem with its roots in the experience of immigrants. Young men immigrate to this country alone to work. They drink because they are lonely and miss their families and friends back home. One participant described the phenomenon in this way: "there are a lot of men who are alone, who don't

have their families here. And the only thing they do when they have free time on Saturday and Sundays when they don't work is drink. And perhaps they think that by drinking they are forgetting."

In addition, the Buford Highway participants observed that there are more opportunities to drink in the United States than in their home countries. Liquor is cheaper here and because people have more opportunity to work and earn a better wage in the U.S., they have more disposable income and are able to purchase alcohol.

When asked about drug abuse in their communities, most participants viewed this as an issue but observed that it was less obvious because it is illegal. Many mentioned that the problem is concentrated among teens and young adults in their twenties and that they seem to be using different drugs now. As one resident of DeKalb observed, "I think that crack and cocaine are becoming obsolete, because the younger generation is into popping pills, ecstasy, they are trying to get this artificial reefer now." Drugs such as ecstasy, mollies, and marijuana were the perceived drugs of choice. Residents of DeKalb County also described problems with addictions to pain medication and other prescription drugs in their communities.

Participants blamed the problem of drug use on the influence of the media, music (particularly rap music), and access to information on the internet. One participant described the role of the internet in fueling drug abuse this way: "You would be surprised at the knowledge a person gains just by doing research on the internet about what that drug can do. He doesn't know if the drug gives a high until he gets through doing his research on the internet." Peer pressure was also cited as a driving force behind drug use in all of the focus groups. A participant from DeKalb County described the influence that peer pressure exerts on youth this way: "You would be amazed at how greatly that affects these kids nowadays. So it's not just, 'Oh well I'm tough and I don't have to listen to them.' It's like 'No, everybody is doing this one thing.'"

Risky Sexual Behavior among Teens

Participants across and within the focus groups had differing opinions about whether risky sexual behavior was an issue in their communities. Some participants observed that sexual activity among teens is the same everywhere and has not changed that much over time. A participant from DeKalb County said, "I really don't honestly think that it is any different than when we came up… These kids are no different from us. We all did the things these kids do sexually… this is going to happen as long as there are males and females." In the Buford Highway and Fulton County focus groups, participants did express concern over the level of sexual activity among teens. Many commented on how sexual initiation is occurring in younger children. They specifically commented on the role that peer pressure plays in sexual initiation and activity. A resident from Fulton County explained that teens are not thinking about morals and values instilled by their families but about impressing their friends.

Multiple participants across focus groups observed that parents were often ill-equipped to teach their children about safer sex and abstinence. In the Fulton County focus groups, residents cited the relative youth of parents ("babies raising babies") and their perception that young parents do not know how to be good parents as a key factor.

Participants in the Buford Highway focus group said that parents did not know how to have frank conversations with their children about sex. They talked about the need for parent education to help them feel more comfortable having the sex talk. As one participant said, “You are not going to stop sex, you have to teach them about protection.” This issue was discussed at length among the participants in the Buford Highway group who described the centrality of culture in this issue. “Our parents never spoke to us about sexuality and how to protect ourselves. It was a taboo subject,” observed one participant. “For us in the Latino community, it is an off-limits subject, and we don’t know how to begin a conversation [with our kids].”

Chronic Disease

There was a perception across all the focus groups that chronic disease, especially diabetes, high blood pressure, and heart disease, are of concern in their communities. While behavioral and lifestyle factors were the main causes of chronic illness (and are described above), multiple participants spoke of the role of family history, describing chronic conditions as being hereditary.

For participants in the Buford Highway and one of the DeKalb County focus groups, lack of access to a regular source of health care was seen as a contributing factor to the prevalence of chronic disease. Participants from the Buford Highway focus group described how the high rate of uninsurance meant that many people do not get screened and do not realize that they have a chronic disease, and that those who are sick do not have the resources or support to help them manage their chronic illness.

Environmental Factors

Though mentioned less often than other factors, a few participants from DeKalb and Fulton Counties mentioned environmental pollutants and hormones and other additives in foods as concerns for community health and well-being. They talked about air pollution and exposure to chemicals as being causes for an increased incidence of asthma, cancer, and other health issues in their communities.

Access to Care

In all of the focus groups, except the Buford Highway focus group, there was a mix of insured and uninsured individuals. Those without insurance lamented the prohibitively high cost of purchasing health insurance. Residents in one DeKalb County focus group said that they were hopeful that the implementation of health reform would result in better access to affordable health insurance.

Residents mentioned Grady as the most known source of care for the uninsured, as well as other free or sliding scale clinics located in their neighborhoods and communities (among those mentioned were, St Joseph’s Mercy Care, the “clinic on Sunset,” and the Health Department). Participants noted however, that many people do not know where to go for care if they are uninsured and that those without insurance who seek out care often have to wait for long periods for an appointment.

Access to care was a particularly difficult challenge for the participants in the Buford Highway focus group. None of the participants reported having health insurance, and very few had any access to health services. A few respondents described waiting in line for three or four hours at community health fairs to take advantage of free screenings. Others described how they tried to take care of themselves so that they would not get sick and require medical care. "I pray to God that I don't get sick because it is so expensive." Another described the fear this way: "We are all terrified of getting sick. If one of us gets sick, your husband can't pay for medical care. I always say that I'm not allowed to get sick."

Community Resources and Programs to Address Health Issues

Focus group participants were asked to describe their knowledge of, and experience with, health-related programs and resources in the community. Overall, their experience with health programs was limited. Multiple participants across the focus groups commented that there were probably programs and services available to address health concerns, but they had never accessed them and were not aware of them. Some programs mentioned by participants included efforts by sororities to do outreach and education and programs offered by the Boys and Girls Club and the YMCA to try and engage youth in activities and recreation. These efforts, as one participant put it, are often limited to "small pockets of people doing things, but it is not enough."

Prioritizing Health Issues

In each focus group, participants were presented with six data points related to health and health-related behaviors in their counties. The data were generated from the Kaiser Permanente Community Health Needs Assessment Portal or the Georgia Department of Public Health OASIS database. The data shared with participants were a combination of health behavior data (smoking, alcohol use, etc.) from the Behavioral Risk Factor Surveillance System survey; disease prevalence data from the Georgia OASIS database; and information on the county built environment (proximity of green space and parks, number of fast food establishments, etc.) from the 2010 U.S. Census and 2009 USDA Food Desert Locator.

Participants were asked to review the county-level health data and to reflect on their own perceptions of health and health concerns in the community and prioritize the issues that should be the focus of community health improvement efforts over the next three years. The most often mentioned priority areas coming from the group discussions were:

- Healthy Living: Respondents in all five focus groups recommended that efforts be focused on helping people live healthier lives through increased exercise and better nutrition. Comments focused on the problem with rates of overweight/obesity, diabetes, and other health issues related to lack of physical activity and poor diet. Specific recommendations included:
    - Increasing opportunities for recreation and physical activity in the county through expanding park/green space and adding recreational facilities and programs (both DeKalb County groups and both Fulton County groups)

- Increasing local access to healthy food options through addressing food desert issues and expanding access to local and fresh produce (DeKalb County and Fulton County)

- Access to Care: Increasing access to health care through expansion of affordable health insurance options was a priority area mentioned in three focus groups (Buford Highway, one of the DeKalb County groups, and one of the Fulton County groups).

- Sexual risk-taking behavior: Participants in the Buford Highway and one of the Fulton County groups prioritized sexual risk taking behavior (teen sexual activity and teen pregnancy; STDs and HIV).

Ideas for Addressing Issues of Concern

When asked what areas of health they would prioritize, participants began to speak about how to address health concerns in their communities. Ideas for how to address the prioritized health issues focused primarily around health promotion education, including parent-focused education; healthy cooking classes; increased opportunities for recreation for youth; local solutions to health issues; and expanding access to health care.

Health Promotion Education: The most mentioned priority was the need to provide information and tips for skill-building for healthier living in the community. When asked to reflect on the best way to provide education, respondents in all the focus groups mentioned training/classes for parents. Many stressed the importance of teaching parents how to set a good example for their children as it relates to healthy eating and exercise. "The education should start with the parents. I don't think that most parents know what is healthy eating or healthy living," stated a resident of DeKalb County. Some participants stressed the need to start early and provide education to children as a way to create new habits in the home. A resident of Fulton County spoke of educating elementary school kids who can come home and teach their parents.

Participants also talked about the need for programs to help parents learn how to communicate better with their kids, particularly related to sexual behavior and drug and alcohol use. The Buford Highway participants spoke about the need for education to "teach us how to be better parents" as a way to help address issues like drug and alcohol use and teen sexual behavior.

When asked how to best provide education and information on healthier living, participants stressed the importance of using personal outreach and health counselors, rather than more passive methods for communicating health information, such as pamphlets or papers. A resident of DeKalb County talked about health and wellness coaches that can "get on a personal level and discuss how to live healthier." Participants from Fulton County said that any education should be through contact with people and focus on outreach that is personable, not just sending something in the mail. Others agreed that sending brochures in the mail or handing out information on paper is not reliable because people just throw it away.

Increased Recreation Opportunities for Youth: Participants in the focus groups commented that there is a dearth of activities for youth. They talked about the need for activities in local communities to keep kids off the streets. Participants across the two counties spoke of their own experiences as adolescents participating in activities through their local community centers and Boys and Girls Clubs. One resident described his experience with programming this way: "You made a comment earlier about there are no more recreation centers. When I came up, we had a recreation center called Vine City Recreation Center, and believe it or not I learned a lot…And come summertime instead of you being out doing bad stuff, you had something to participate in. They taught you how to swim. They taught you how to play baseball and run track. That is a nice role model." They went on to observe that there did not seem to be the same opportunities for kids today.

Healthy Cooking Classes: Participants in four focus groups mentioned the need for healthy cooking classes offered in community settings like grocery stores, churches, health departments, and community centers.

Local Action to Improve Health: Multiple participants across the focus groups suggested that communities form small action groups. These participants commented that the experience of participating in the focus group had been a positive one and thought that bringing groups of residents together to discuss health concerns and develop local solutions to the issues would be effective. Some participants suggested building upon neighborhood associations as a way to ignite action. In one DeKalb County group, participants lamented the lack of connection and communication among neighbors and in the community. One resident suggested that "people in the community should actually get together more and have discussions about what is going on in their community, you know, person-to-person."

Access to Care: Participants stressed the need for expanded access to care either through lower cost health insurance or local clinics that provide affordable care. Participants in each group suggested the creation of an affordable insurance program for those who don't have access to other options for coverage.

Community Health Leaders

Focus group participants were asked to reflect on organizations and individuals who are seen as leaders and who would be effective in addressing local health concerns. Residents in both of the DeKalb, one Fulton, and Buford Highway groups struggled to name local community leaders (organizations or individuals). Some participants admitted that there were probably leaders focused on health concerns, but they were not aware of them. As a resident of DeKalb County stated, "I really think there are leaders that are doing this [health improvement efforts]. Nobody comes to mind, but that is my fault, because I am not paying attention." Others stated that no one was focused on addressing health concerns for the community because they were focused on other issues - there is no one whose job it is to focus on health issues. Residents from Fulton County complained about the lack of elected officials who really worked for their communities to improve quality of life and health.

Participants in all of the focus groups spoke of the important role churches have in communities and suggested that they could play a central role in health programming at the local level. Participants in one Fulton County group saw a potential role for neighborhood watch and local community groups in addressing health concerns.

Focus Group Summary

There was agreement across the focus groups that the health issues of most concern were obesity, heart disease, diabetes, and other conditions related to poor nutrition and lack of physical activity. Barriers to better health most often cited were lack of time, expense, lack of local access to healthy food options and recreational opportunities, and challenges posed to healthy living by the built environment. In every group, participants acknowledged the role that personal responsibility and motivation play in behavior change and were clear that most people know what they need to do but just do not do it.

Participant ideas on how to most effectively address health issues of concern were focused on health promotion and education and the need for changes to the local environment to support behavior change.

Health Promotion Education: Participants across the focus groups saw value in focusing educational efforts on young children and providing reinforcement for that education by providing skills building education for parents in communication (related to sexual behavior and alcohol and drug use) and healthy living (healthy food preparation, incorporating physical activity, etc.). Any educational efforts should be provided in person by health counselors or outreach workers, as participants saw limited effectiveness in brochures or mailings.

Changes to the Local Envirnment: Participants described the ways that their local environment was a barrier to healthier living. Safety was a concern for many and cited as a reason that people do not exercise more (i.e. lack of sidewalks for walking, concerns about public safety/crime). A lack of accessible and affordable recreational space was an issue in these counties. The abundance of fast food restaurants and liquor stores combined with a dearth of outlets selling fresh and affordable food posed a challenge for many participants and their families who want to eat better.

There appears to be a shared sentiment that any solutions should be local. Participants commented on the positive experience of the focus group and how small groups of citizens coming together to discuss issues of concern and share ideas for solutions could be a powerful approach to addressing health problems.

Focus group participants had not had a lot of direct experience with health-related programming and had limited knowledge of programs and other supports. Similarly, most participants were unable to name local leaders that were focused on health issues. They identified the need to educate themselves and the community on programs and resources available to them locally. Churches were mentioned most often as a local resource and trusted presence.