Community Health Needs Assessment 2016
Mercy Care Chamblee Service Area

Georgia Health Policy Center

MERCY CARE
Contents

I. Executive Summary ................................................................................................................. 2
II. Introduction ............................................................................................................................. 4
III. Mercy Care’s Mission ............................................................................................................. 6
IV. Approach to Assessment ....................................................................................................... 7
    Community Definition ............................................................................................................. 7
    Community Input .................................................................................................................... 8
    Secondary Data ...................................................................................................................... 9
    Community Resource Inventory ............................................................................................. 9
V. Summary of Findings .............................................................................................................. 10
    Priority 1: Access to Affordable Health Care for Uninsured and Underinsured Residents ........ 10
    Priority 2: Integration of Primary and Behavioral Health Care Services ................................. 10
    Priority 3: Chronic Disease Prevention and Management ..................................................... 11
    Priority 4: Coordinated, Culturally Sensitive, and Patient-Centered Care ............................. 11
    Priority 5: Community Engagement to Facilitate Social Cohesion and Wellness ................... 12
    Recommendations .................................................................................................................. 13
    Non-Clinic Related Opportunities to Invest in Community Dialogue .................................... 14
VI. Community Resident Input ................................................................................................... 15
    Purpose ..................................................................................................................................... 15
    Methodology ........................................................................................................................... 15
    Characteristics ......................................................................................................................... 16
    Recommendations .................................................................................................................... 16
    Summary ................................................................................................................................... 17
VII. Community Leader Input ..................................................................................................... 22
    Purpose ..................................................................................................................................... 22
    Methodology ........................................................................................................................... 22
    Characteristics ......................................................................................................................... 22
    Recommendations .................................................................................................................... 22
    Summary ................................................................................................................................... 23
VIII. Secondary Data ................................................................................................................... 27
IX. Community Resources to Meet Needs .................................................................................. 41
X. Appendices ............................................................................................................................. 48
I. Executive Summary

Mercy Care is a Federally Qualified Health Center and Atlanta’s only Healthcare for the Homeless program (330h). Mercy Care provides affordable and comprehensive health and healthcare services to underinsured and uninsured residents throughout fourteen locations.

During a three month period, Mercy Care contracted with the Georgia Health Policy Center to collect primary and secondary data to assess the health needs of residents of its Chamblee, Georgia, service area—a contiguous group of 22 zip codes in DeKalb, Fulton, and Gwinnett counties. The information will help inform the design of programs and services that will be offered Mercy Care’s new clinic opening early 2017 in Chamblee. The new clinic will serve the patient population receiving care at the Buford Highway location (Mercy Care North) while expanding programs and services.

The assessment was developed using secondary health data pulled from sources in the public domain (e.g. Georgia Department of Public Health Online Analytical Statistical Information System - OASIS) reinforced by primary data and information collected from residents, community leaders, providers and public health experts through key informant interviews, focus groups, and community listening sessions.

While the health status and outcomes of residents living in DeKalb, Fulton, and Gwinnett counties rank relatively higher than that of people living in many other counties throughout the state, there are communities within these counties themselves with poor and disparate health outcomes linked to significant health risks and challenging socioeconomic conditions.

In the Mercy Care North service area:

- The majority of the population is between 35 and 54 years of age and very racially and ethnically diverse. In the Chamblee area, almost 60% of the population identifies as Latino, 38% are foreign born, and 48% speak a language other than English at home. Many residents in the service area have identified themselves as Hispanic and immigrant.
- One in four people live at, or below, the federal poverty level. Extreme poverty is present in the service area, particularly concentrated along the I-85 corridor and near Chamblee and Norcross. Children in poverty follow a similar pattern, with high rates along Buford Highway in the southern part of the service area.
- There are relatively low levels of educational attainment. In one census tract adjacent to the site of the proposed clinic, over 50% of adults have not obtained a high school diploma or equivalent certification.
- As is common throughout the rest of the county, chronic disease conditions and their risk factors (including obesity and tobacco use) continue to be a significant health burden.
- Increased barriers to healthcare (from the Community Need Index) are most significant in Tucker and Chamblee areas of DeKalb County. The zip codes with the highest barriers to accessing healthcare are:
  - 30340 (Doraville)
  - 30360 (Atlanta)
Five thematic health needs or priorities emerged from an analysis of both the primary and secondary data in the assessment.

- **Priority 1**: Access to affordable health and health care services for uninsured and underinsured residents
- **Priority 2**: Integration of primary care and behavioral health care services
- **Priority 3**: Chronic disease prevention and management (e.g. obesity, diabetes, asthma, cardiovascular disease, etc.)
- **Priority 4**: Patient-centered, coordinated, and holistic care
- **Priority 5**: Community engagement to increase knowledge, awareness, and healthy behaviors

Stakeholders made several recommendations about actions to address these priorities and broaden the scope of services to be provided in the new clinic facility. These include:

- Continue to provide ongoing outpatient wellbeing and healthcare services particularly to vulnerable populations;
- Use community and clinical approaches to address prevention, treatment, and coordination of care for patients with chronic disease;
- Ensure and/or facilitate access to appropriate treatment options, particularly affordable and effective prescription medications and treatments;
- Address other access issues related to transportation to and from clinic and service provision (including translation) after normal working hours;
- Track improvements to access and outcomes over time by conducting community health needs assessments at regular intervals;
- Focus on an approach to integrating primary care and behavioral services that considers life stage (i.e. substance abuse in teens, depression in seniors etc.) in care management;
- Include pastoral/spiritual counseling as part of treatment and coping protocols;
- Build trust and value cultural competency in providers; engage more providers and staff who are reflective of the diversity of the community and who can provide or facilitate services to non-English speaking clients;
- Use health education sessions to address burdensome health challenges including chronic diseases- nutrition, physical activity, obesity, diabetes, hypertension and cancer screening
- Use clinic physical infrastructure to build trust, engage the community (space for community meetings), and provide support for family members during client visit (e.g. child care, etc.).

The findings of this assessment are reinforcing of the qualitative study that was conducted by Emory University students in the fall of 2015.
II. Introduction

The Buford Highway corridor is home to a diverse population, many of whom are hard-working immigrant families. For more than ten years, Mercy Care North, located in the Northeast Plaza Shopping Center, has served the working poor of this community and is the only Federally Qualified Health Center (FQHC) in the immediate area. Mercy Care North (MCN) provides care to 3,300 patients per year – which amounts to more than 11,000 office visits – yet demand for affordable, comprehensive care far exceeds the clinic’s capacity.

To meet the great need for healthcare services in this part of Atlanta, Mercy Care purchased property in January 2015 near the Chamblee MARTA station and began construction of a 45,000-square-foot healthcare facility. The building will house a clinic, community health education center, and administrative offices.

The new clinic will accommodate 12 examination rooms, four dental operatories, and space for lab services and is expected to enable Mercy Care to double its service capacity. When service capacity is fully realized, it is expected that primary care will be available for up to 5,500 patients annually – a potential volume of 16,000 primary care, dental, and behavioral health office visits.¹

Over the past three months, Mercy Care and the Georgia Health Policy Center worked to collect data to assess the health needs of residents to inform the programs and services to be offered in the new Chamblee clinic. Mercy Care collaborated with the following organizations throughout the assessment:

- The Latin American Association
- Holy Spirit Catholic Center
- Our Lady of the Americas Catholic Mission
- Senior Connections
- Mercy Housing
- La Amistad After School Program
- Kaiser Permanente of Georgia
- Children’s Healthcare of Atlanta
- Gwinnett County Administration
- The City of Chamblee
- Futbol Pasion
- The Georgia House of Representatives
- Catholic Charities of Atlanta
- The Center for Pan Asian Community Services (CPACS)
- Emory-Saint Joseph’s Hospital
- Society of St. Vincent de Paul

¹ The Intersection of Hope and Healing, A Campaign for Mercy Care Chamblee; (Website 4/12/16)
Findings from a recent pre-assessment study completed by Emory University Public Health students, aimed at understanding the support for the Mercy Care North clinic (MCN) showed that "many of the needs of the Hispanic community are being met by MCN, including affordable, culturally, and linguistically competent care. The vast majority of patients are pleased with the care they receive at the clinic and will continue attending the clinic after its relocation to Chamblee. They are also looking forward to the clinic expansion and the services this will provide them in terms of increased pediatric care and a larger space in which to conduct health education classes".

Participants in that effort believed that there was a need for more flexible walk-in appointment hours, child care services, and a larger variety of mental and behavioral health classes. They also were hopeful for shorter wait times, a move linked to improved quality of services provided by the clinic.

Mercy Care seeks to understand the needs of the clients served, and has completed this assessment process to accurately comprehend and better serve the needs identified.

This report provides a summary of the secondary and primary data collected and the community-driven recommendations to inform programs and services.
III. Mercy Care’s Mission

Our mission is to honor the heritage and advance the ministry of the Sisters of Mercy by providing excellent healthcare to poor and marginalized persons. We promise to continue to serve with compassion and excellence those who are poor, marginalized, and unable to access healthcare. We will bring our hearts to work. Our fundamentals are compassion, commitment to the poor, excellence, integrity, justice, stewardship, and reverence for the dignity of each person. We are rich with workers, volunteers, board members, collaborators, funders; excellent facilities and vehicle fleets; and professional and technological expertise. Our approach is collaborative, purposeful, restorative, innovative, transforming, respectful, hopeful, integrated, joyful, comprehensive, efficient, and effective.

Since 1985, Mercy Care has been operating to "restore vulnerable individuals in the community through powerful outreach programs that care for body, mind and spirit. We provide preventive and curative services to Atlanta's homeless and poor with some of the highest needs, all the while seeking to make a positive difference in their lives and the overall wellbeing of the city.

Mercy Care is focused on providing compassionate, high-quality, comprehensive primary care and health services to the poor. For these patients, the cost of traditional medical care is overwhelming and sometimes exclusionary. Mercy Care embraces the patients often deemed “undesirable” by society. Of the 11,392 patients who received care from all Mercy Care clinic sites in 2015, 62% were homeless, 88% were uninsured, and 84% were living at, or below, the Federal Poverty Level.

The organization, which is a Mission Health Ministry of Trinity Health Systems following the health system's merger with Catholic Health East, is also a member of the Atlanta Safety Net collaborative, a group of providers committed to coordination of care for indigent patients. In this partnership, Mercy Care providers occasionally render onsite medical care at partner locations and Mercy Care clients are provided with additional services at these locations (e.g. Grady Health System). Mercy Care is an active member of the Atlanta Regional Collaborative for Health Improvement.

Many of Mercy Care's "services" are supported by community outreach programs. One of its flagship programs - the Community Homeless Outreach Program (CHOP) attempts to meet the needs of street bound homeless individuals by providing referrals for critical housing, medical, and behavioral health services. Direct care to this population is made possible through the Street Medicine program supported by doctors who travel to find and care for patients experiencing homelessness.

 Mercy Care's mission is accomplished through dedicated professionals serving at 15 locations in metro Atlanta. Key domains of service include:

- Primary Care
  - Preventive Care
  - Chronic Care
  - Health Screenings
- Pediatrics
  - Preventative & Routine Care
  - Well Child Services
  - Developmental Screenings
- Dental & Vision
  - Routine Examinations
  - Tooth Extractions
  - Eye Exams & Glasses
- Health Education
  - Community Classes
  - Patient Groups
  - Individual Sessions
- Behavioral Health
  - Counseling and Medication
  - Substance Abuse
  - Case Management
- HIV Integrated Treatment
  - Enrollment
  - Medication Management
  - Case Management
IV. Approach to Assessment

With input from a core group of Mercy Care providers and staff, the Georgia Health Policy Center designed and facilitated a comprehensive community health needs assessment process with a focus on the expressed needs of residents living in the service area. The assessment process valued input from residents and leaders alike, representing the broad interests of communities served by Mercy Care.

**Community Definition**

Though the focus of the assessment was the construction of the new clinic, the community was defined as the broader service area or region of the current Mercy Care North Clinic. The service region consists of 22 zip codes throughout DeKalb, Fulton, and Gwinnett Counties. (See map and table below). These zip codes were selected because they are home to approximately 80% of MCN's current clients, and the new clinic location is expected to expand access within this region.
Figure 1: Mercy Care’s Chamblee Clinic Service Area

On the map above, the “N” pin designates Mercy Care North’s current location, while the “C” represents the new Chamblee location.

Table 1: Communities Included in the Service Area by ZIP Code

<table>
<thead>
<tr>
<th>Zip</th>
<th>City</th>
<th>County</th>
<th>Zip</th>
<th>City</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td>30043</td>
<td>Lawrenceville</td>
<td>Gwinnett</td>
<td>30319</td>
<td>Atlanta (Sandy Springs)</td>
<td>DeKalb</td>
</tr>
<tr>
<td>30044</td>
<td>Lawrenceville</td>
<td>Gwinnett</td>
<td>30328</td>
<td>Atlanta (Sandy Springs)</td>
<td>Fulton</td>
</tr>
<tr>
<td>30045</td>
<td>Lawrenceville</td>
<td>Gwinnett</td>
<td>30329</td>
<td>Atlanta (N. Druid Hills)</td>
<td>DeKalb</td>
</tr>
<tr>
<td>30046</td>
<td>Lawrenceville</td>
<td>Gwinnett</td>
<td>30338</td>
<td>Atlanta (Dunwoody)</td>
<td>DeKalb</td>
</tr>
<tr>
<td>30047</td>
<td>Lilburn</td>
<td>Gwinnett</td>
<td>30340</td>
<td>Atlanta (Doraville)</td>
<td>DeKalb</td>
</tr>
<tr>
<td>30071</td>
<td>Norcross</td>
<td>Gwinnett</td>
<td>30341</td>
<td>Atlanta (Chamblee)</td>
<td>DeKalb</td>
</tr>
<tr>
<td>30075</td>
<td>Roswell</td>
<td>Fulton</td>
<td>30342</td>
<td>Atlanta (Sandy Springs)</td>
<td>Fulton</td>
</tr>
<tr>
<td>30084</td>
<td>Tucker</td>
<td>DeKalb</td>
<td>30345</td>
<td>Atlanta (Northlake)</td>
<td>DeKalb</td>
</tr>
<tr>
<td>30092</td>
<td>Norcross/ Berkeley Lake</td>
<td>Gwinnett</td>
<td>30346</td>
<td>Atlanta (Dunwoody)</td>
<td>DeKalb</td>
</tr>
<tr>
<td>30093</td>
<td>Norcross</td>
<td>Gwinnett</td>
<td>30350</td>
<td>Atlanta (Sandy Springs)</td>
<td>Fulton</td>
</tr>
<tr>
<td>30096</td>
<td>Duluth</td>
<td>Gwinnett</td>
<td>30360</td>
<td>Atlanta</td>
<td>DeKalb/Gwinnett</td>
</tr>
</tbody>
</table>

Community Input
Community input to the assessment occurred through interviews, focus groups, and listening sessions.

Community Leader Interviews:
GHPC worked closely with Mercy Care to identify leaders from organizations that included public health leaders, professionals with access to community health related data, and representatives of underserved populations (including the Asian community, Latino community, seniors, low-income residents, residents with limited English speaking skills, and residents who are uninsured). Such persons were interviewed as part of the needs assessment process. A series of 13 interviews including one large group interview with 12 participants were completed between March and April 2016. This allowed a total of 24 key informant interviews to be conducted with stakeholders in DeKalb, Fulton, and Gwinnett counties. For an overview of the stakeholder process and findings please see the “Community Leader Input” section of this report.
Resident Focus Groups and Listening Sessions:

Three focus groups and four listening sessions were conducted across the wider Mercy Care community between January and March 2016. Focus group audiences were identified using secondary data to surface the areas and target populations with overlapping health needs and deficits. Specific focus group participants included:

- Latino residents
- Women in prenatal education class
- Korean residents
- Senior citizens
- Residents of Chamblee, GA

Secondary Data

GHPC staff completed a comprehensive analysis of health status, socio-economic, and environmental factors related to the health of the community from existing data sources such as the Georgia Online Analytical Statistical Information System (OASIS), the U.S. Census Bureau, the Centers for Disease Control and Prevention, Health Indicators Warehouse, County Health Rankings, the Community Needs Index of Truven, the Behavioral Risk Factors Surveillance System, Community Commons, and other data sources. The data was used to generate maps to help tell the story of where challenges to health and wellbeing are still an issue in the service area.

Community Resource Inventory

In an attempt to fully understand local assets and gaps in services, the GHPC also conducted an environmental scan of the community resources that are currently available to residents. Additionally this scan will be helpful in identifying the types of partnerships that may have to be built or strengthened to support improved health outcomes in these communities.
V. Summary of Findings

The area included in this study covered a large geographic region, spanning some of the most diverse communities in the state. The study area is represented by rapidly growing populations of varying ethnicities, ages, incomes, education levels, cultures, and languages. Many of the areas’ health challenges are the result of interdependent social determinants of health such as: socio-economic status (represented by income, education, and housing), geographic location, immigration status, country of origin, culture, and ability to speak English.

Five thematic health needs or priorities emerged from both the primary and secondary data in the assessment. They are presented below along with stakeholder recommendations for action:

**Priority 1: Access to affordable health and health care services for uninsured and underinsured residents**

There is a large and growing population of immigrants in the clinic service area whose income and legal status restricts their access to health insurance and subsequently many types of health care services. Women who lack citizenship often lack access to prenatal care. Latino community members participating in primary data collection activities were most often uninsured and unconnected to medical homes. Data shows that there are pockets of poverty in DeKalb, Fulton, and Gwinnett Counties where socio-economic indicators correlate strongly with poor health outcomes. Primary data collected during this assessment indicates that there is a need for access to affordable health services, including pharmaceutical, primary, pediatric, and oral health care. Primary data also highlighted the need for affordable access to specialty care (orthopedic, oncology, etc.) for underinsured and uninsured residents, including residents who are not legal citizens and persons experiencing homelessness. The lack of access to health insurance and care may be, at least in part, driving the health disparities found in communities in the study area.

**Priority 2: Integration of primary and behavioral health care services**

Unmet behavioral health care needs is one of the most discussed health priorities across the country and the Mercy Care study area is no exception. Currently Mercy Care offers behavioral health services, including: counseling, medication, substance abuse, and case management. Data collected during the assessment validated the need for an increase in behavioral health and substance abuse services across the continuum of care.

Residents recognized that behavioral health was a need that cut across demographic and geographic parameters. Residents often discussed the need for behavioral health services for adolescents, adults, and seniors. Study participants discussed mental health issues often related to the prevalence of substance abuse among adolescents, stress in adult populations, and depression among senior populations. Discussions focused largely on the lack of resources in general for underinsured/uninsured people regardless of age and resistance to seek care due to the stigma associated with behavioral health diagnoses. Stakeholders discussed the need for a continuum of behavioral health services, citing a dearth of available referral sources in their communities.
Priority 3: Chronic disease prevention and management (e.g. obesity, diabetes, asthma, cardiovascular disease)

According to the Georgia Department of Public Health, chronic diseases—such as asthma, cancer, diabetes and heart disease—cost Georgia approximately $40 billion each year, keep children out of school, and result in more than 200,000 years of potential life lost annually. Chronic disease prevention and management were cited as major health issues, particularly for the Latino population. The most commonly discussed chronic diseases were diabetes, obesity, cardiovascular issues, high blood pressure, hypertension, and pediatric asthma. The underlying causal factors discussed are described below:

Poor nutrition — Community input indicated that residents often:

- Do not have access to affordable healthy food due to the limited number of affordable grocery stores and/or lack of transportation.
- Have cultural dietary preferences that are not healthy (i.e. fried foods, foods high in fat and sugar, habits of eating before bedtime, etc.).
- Are not always aware of how to prepare foods.
- Do not have the time to prepare healthy food.
- Are not aware of the impact of poor nutrition.

Lack of physical exercise — Community input indicated that residents:

- May not have access to resources that facilitate healthy physical activity.
- May not be aware of the impact that physical activity/no physical activity can have on health status.
- May not know how to engage in a healthy level of physical activity.

Priority 4: Offering coordinated, culturally sensitive, and patient-centered care

Patient-centered care shows up throughout the data linked to diversity, language of preference, cultural practices/traditions/beliefs, convenience of office hours, the inclusion of faith in primary care settings, and access to transportation. Mercy Care is recognized as a Patient-Centered Medical Home (PCMH) and seeks to build and maintain trusting relationships with community leaders, churches, and relevant community-based organizations in the study area. According to the data, there are growing immigrant and refugee populations that do not speak English and/or speak English as a second language. Both stakeholders and residents whose native language was not English discussed the need for health services to be provided in the patient’s language of origin as often as possible. Such action would minimize challenges with translation of health terminology, which might lead to misunderstanding of diagnosis and/or treatment recommendations. They specified that the need for service provision in a first language extends beyond medical care and includes outreach services, health education, printed materials, and more.

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2 Years of potential life lost (YPLL) is an estimate of the average years a person would have lived if he or she had not died prematurely (before age 75 years). It is, therefore, a measure of premature mortality - Georgia Department of Public Health, Chronic Disease Prevention, (Website 4/12/16) https://dph.georgia.gov/chronic-disease-prevention
Study participants talked about the importance of being able to receive care and services, including translation services, in their communities after traditional operating hours (Monday through Friday, 8 AM - 5/6 PM). Community members also discussed a cultural preference among Latino and Asian populations for alternative medicine and medical practices to be considered as part of their care. Many participants indicated that they were open to participating in health education sessions, though others perceived that some undocumented segments of the Latinos community might avoid public events, including health education sessions and health fairs, out of fear of deportation.

Respondents also identified transportation to and from the clinic as a significant issue. Public transportation is not always reliable, affordable, and/or accessible for residents, which can lead to inconsistency in appointment attendance.

**Priority 5: Community engagement to facilitate social cohesion and wellness**

Community engagement is integral to the health of the community, especially one that is so diverse. Isolation challenges are present due to lack of trust and awareness of community resources. More specifically, community members may not naturally gravitate to a new clinic or new location and may not be aware of the plans for relocation.

Many participants report that Mercy Care has a longstanding, trusted relationship in the community and suggest that the system should seize opportunities to deepen the trust between providers and the community in the Chamblee area, in order for the providers to effectively meet the needs of residents. This will require outreach efforts to engage community members both on site at the clinic and offsite at churches, civic meetings, and community events.
Recommendations

- **Continue to provide ongoing outpatient wellbeing and healthcare services particularly to vulnerable populations.** Such services should target individuals in greatest need of care, for example: low income, uninsured, underserved residents living in Doraville (30340), Norcross (30093 and 30071), Tucker (30084), North Druid Hills (30329), and Chamblee (30341). Services should include outreach and education, screening, primary care, "wrap-around" and specialty care, dental care, and social service connections.

- **Promote interventions across the disease control continuum in order to reduce the burden of the most common health issues.** The burden of conditions such as diabetes, obesity, cardiovascular issues, teen pregnancy, pediatric asthma, and cancer would be more efficiently diminished if interventions focused on prevention/education, screening/diagnostics treatment, support services, and maintenance/management. Efforts should value community clinical linkages and occur both onsite and in the community.

- **Ensure and/or facilitate access to affordable and effective treatment.** One of the major challenges to medication compliance, as reported by some stakeholders, is the affordability of drugs used to treat their chronic conditions, especially if they are uninsured or underinsured. Many stakeholders cited the need for programs that would make prescription medications and effective treatments affordable.

- **Measure change in access to care and health outcomes over time.** Mercy Care should promote continuous understanding of current and emergent health needs and progress by conducting community health needs assessments at regular intervals (e.g., every five years). Additionally, a client advisory board comprised of Mercy Care Chamblee patients would allow continuous realignment to the needs of the community in the period between needs assessments.

- **Value pastoral counseling.** Some residents believe that religion and faith play a central role in their physical and mental wellbeing. Many of the focus group participants discussed the need for behavioral health care services to include pastoral and/or spiritual counseling, given the religious backdrop and importance of faith to the lives of many of the patients seeking care at the clinic.

- **Engage more culturally competent providers.** It was important to stakeholders that the diversity of community be reflected in the types of behavioral health providers offering culturally competent care. People perceived this to be necessary for effective treatment and care. Key ethnicities and languages to be aware of include: Spanish, Korean, Vietnamese, Chinese, French, Kru, Ibo, Yoruba, Amharic, Hindi, and Russian. Efforts should also be made to ensure that documentation and forms are culturally sensitive and appropriate.

- **Outreach and education.** Use the integration of services to leverage the primary care platform to reach out to and educate families and the community about behavioral and mental health conditions and the benefits of seeking care.

- **Facilitate the transportation of patients to and from appointments.** Participants recommended that part of the clinic service might include some form of transportation to and from scheduled appointments (e.g. shuttle services and/or MARTA cards). This may be an opportunity to collaborate with community partners.
- **Consider extended clinic hours.** Being able to access provider services after the end of the workday (after-hours appointments) and on weekends is of high value to members of the community who are otherwise unable to benefit from clinic services during the work week.

- **Configure and design community friendly spaces in clinic.** Offer meeting and teaching spaces for community use to promote engagement. Additionally, provide specialized spaces that consider the unique needs of the populations Mercy Care serves (e.g. a chapel area/prayer room, an area for children to play, child care services).

- **Actively engage in outreach and educational services, particularly with the populations in greatest need.** Study participants recommended an array of health education, instruction, and demonstration classes. Some desired topic areas include: cooking and nutrition, physical activity, prevention of obesity and chronic conditions, stress management, and instruction for new mothers. Use awareness campaigns and screenings where appropriate to help prevent, bring attention to, and ensure early detection of the most common health issues (e.g. diabetes, obesity, cardiovascular issues, teen pregnancy, pediatric asthma, and cancer). This is an opportunity to consider the use of community outreach workers (perhaps from churches), to link clients to wrap-around care and social services.

## Non-Clinic Related Opportunities to Invest in Community Dialogue

There were a few topics discussed that did not relate directly to health and traditional health care. Many of these areas may present opportunities to engage the community and community leaders in dialogue about strategy and planning. Some participants reported that their community experienced barriers to health such as poverty, lack of educational opportunity, social exclusion, a lack of places to be active or experience nature, and limited policing - lending to the perception of an unsafe community. Many participants discussed the value of increasing collaboration with the local school system, noting that youth learn a lot about nutrition and exercise from the food that is served in schools and the importance placed on physical activities. Similarly, many participants discussed the need for recreational facilities that are safe and well-maintained to provide an optimal environment for youth to participate in physical activities.

The discussion often focused on the disconnection of neighboring communities. Participants felt that community members are not interacting with one another and families are disintegrating. Participants indicated that there are very few spaces for people to socialize in a healthy way in their communities. This leads to a recommendation for municipalities to focus on the built environment in such a way that it encourages interaction and activity.

Residents discussed the isolation of seniors, who may not be able to get to and from senior centers or easily access needed resources. Specifically, participants discussed the need for seniors with limited support to receive some oversight and assistance in medical treatment and home care to ensure they are not cycling through the emergency room.
VI. Community Resident Input

Purpose
This study engaged community residents to develop a deeper understanding of the health needs, existing opinions and perspectives related to the health status, health-seeking behaviors, and health needs of the populations in communities that will be served by the Mercy Care Chamblee Clinic.

Methodology
GHPC and Mercy Care worked together to recruit and conduct three focus groups and four listening sessions among residents living in the communities that Mercy Care intends to serve with the new clinic in Chamblee. GHPC designed facilitation guides for focus group discussions and listening sessions, which were reviewed by Mercy Care and approved by the University’s Internal Review Board. Mercy Care recruited participants for the focus groups and listening sessions by working with partners in the community. Focus groups lasted approximately 1.5 hours, during which time trained facilitators led 6-12 participants through a discussion about the health status of their communities, health needs, resources available to meet health needs, and recommendations to address health needs in their communities. All participants were offered appropriate compensation for their time. The following focus groups were conducted by GHPC on behalf of Mercy Care throughout the first quarter of 2016:

- Spanish-speaking participants in a chronic disease management program (conducted in Spanish): The Latin American Association - January 11, 2016
- Spanish speaking women participating in a prenatal education program (conducted in Spanish): The Society of St. Vincent DePaul – February 17, 2016
- Chamblee Residents: Chamblee, GA – March 23, 2016

Listening sessions were designed to facilitate community input in a larger forum. Each session lasted approximately 2 hours, during which time participants were asked to respond to a variety of questions about the health of their community using audience response technology. Instant results were offered to participants to encourage small and large group discussions about the collective responses. Also, participants were asked to visualize the ideal healthy community and discuss in small groups. The following listening sessions were conducted by GHPC on behalf of Mercy Care throughout January and February 2016:

- Latino Population (conducted in Spanish):
  - Holy Spirit Catholic Center- February 3, 2016
  - Our Lady of the Americas - February 7, 2016
- Older Adults Population:
  - Senior Connections - January 27, 2016
  - Mercy Housing - January 29, 2016 (English and Korean language translation provided)

Focus groups and listening sessions were recorded and transcribed with the consent of all participants. The Georgia Health Policy Center analyzed and summarized data from the focus groups and listening sessions to determine similarities and differences across populations related to the collective experience of healthcare, health needs, and recommendations. These similarities, differences, and recommendations are summarized in this section.
Characteristics
The study area covers a large geographic area, which houses some of the most diverse communities in the state. Chamblee itself is a rapidly growing area with communities that represent diverse incomes, ethnicities, and age. Often in group discussions and listening sessions, participants would speak of two populations: an affluent, insured, healthier population of professionals, and a lower-income earning, less educated, uninsured/underinsured, less healthy population that includes undocumented and documented community members with higher rates of immigration (i.e. Asian, African, and Latino). The majority of participants reported living in their communities for more than ten years.

Insurance Status: Seniors and residents in the Chamblee focus group were most often insured either through Medicare or employer-provided insurance coverage. Most of the Latino participants including pregnant females reported that they had no insurance coverage.

Health Status: The majority of Latino community members reported that they consider their communities to be either not very healthy or extremely unhealthy. A variety of responses were reported by the older adult residents with most reporting either moderately healthy or not very healthy communities.

Common Care Resources: The majority of seniors and residents in the Chamblee focus group reported a family physician as their primary source of care. However, Latino community members, including the prenatal women’s focus group, reported their family physician and a variety of ‘other’ responses such as a chiropractor and naturopath as their primary source of care. When health care was not readily available, participants indicated there were a variety of resources they use to secure health services. These resources included: Centro Internacional de Maternidad (CIMA) Women's Health Clinic, hospital programs offering care at a discounted rate, and clinics for underinsured and uninsured patients. All groups showed a strong preference for health providers whose practices were in close proximity and accepting new patients, with caring physicians who spend time with patients to explain their condition and to understand their health needs.

Recommendations
Participants had a wide range of recommendations for improving health in their communities. Many of these recommendations were not related to traditional clinical services, but could instead impact the health of residents and potentially reduce the need for clinical care.

- **Services for women and children**: Teen pregnancy was often mentioned among participants as a health concern for adolescents. Residents recommended that services for women and children be increased (i.e. faith based prenatal clinics/programs for expectant Latinas, childcare, and after school programs and services).
- **Increased access to affordable primary care**: Given high uninsured rates, residents recommended that affordable care for uninsured and underinsured residents be increased, including access to affordable prescription medications.
- **More convenient clinic hours**: Residents suggested that clinic hours could be extended earlier and later than standard business hours of 8am to 6pm, and that walk-in appointments be available to patients. Some in the community worked long hours and believed that after-hour services, including translation, would be of tremendous value and well utilized.
- **Increase in pediatric services**: Residents suggested that an increase in pediatric care (i.e. more accessible pediatricians with better hours and specialty care for children) would be beneficial.

- **Provider diversity representative of populations served in healthcare**: There were recommendations to better align the diversity of healthcare providers to the diversity of the patient population in the study area to increase the trust and use of health services. Participants believed that increasing the number of Latino and Asian health providers in the area could increase the use of health services in communities in the study area.

- **Increase in health services available within local communities**: Participants felt that there was a need to increase the following specific services: hospice care, auditory support and care, health education, pediatric care, and specialty care for underinsured/uninsured.

- **Community outreach and health promotion programs**: The recommendation was made by many participants to increase activities to promote community health and health education, both onsite at the Chamblee clinic and in the community where residents naturally gather. Some of the recommendations mentioned included: group exercise classes (specifically Zumba and yoga), nutrition education, cooking classes, disease management classes, English as a second language classes, programs that encourage socialization, space for religious reflection, and peer support programs.

- **Accessible transportation**: More accessible public transportation and general transportation to care is a top priority. Residents recommended a shuttle service for scheduled appointments.

- **Mental health services for individuals and families**: Participants felt that there was considerable need for counseling and other mental health services, but emphasized that providers should be competent in the language, culture, and spiritual beliefs of the community.

- **Realignment of community perspective**: Participants felt there was a need to realign community attitude in a way that prioritizes health, and eliminates stigmas associated with certain diseases/disorders such as HIV/AIDS and mental health conditions.

**Summary:**

**Providing Health Services to Underinsured and Uninsured Residents:**

Community members do not always have access to insurance due to their legal status or socio-economic status. Often community members in the study area cannot afford private health insurance. Others reported that they are not eligible for health insurance subsidies for plans offered through the Marketplace due to their legal status. The Chamblee resident group indicated that there is a growing population of homeless people in the community. The group felt there is a need to ensure that the health needs of the homeless are met.

Focus group populations discussed the need for access to affordable health services, which included pharmaceutical, primary, pediatric, and oral health care. Focus group populations also discussed the need for specialty care and affordable medications for underinsured/uninsured residents. While there are a variety of primary care clinics offering care to underinsured and uninsured community members, the demand is greater than the available services, and there are few specialists (e.g., orthopedics, etc.)
practicing in these clinics. Additionally, many clinics do not have the ability to provide prescription medications for underinsured/uninsured community members.

**Integration of Primary Care and Behavioral Health Care:**

One of the most discussed health needs among focus group and listening session participants was the need for behavioral health and substance abuse services. Residents recognized that behavioral health was a need that cut across demographic and geographic parameters.

Study participants specifically focused on mental health issues such as the prevalence of substance abuse among adolescents, stress in adult populations, and depression among senior populations. Residents often discussed the need for specialized behavioral health services for adolescents, adults, and seniors.

*Substance Abuse among Adolescents:* Many participants felt that youth were abusing substances for entertainment and/or to cope with life stressors. Participants felt that youth needed afterschool activities and opportunities for healthy recreational activity. They indicated that younger children have activities available, but that few activities are offered for older and transitional age children. The need for activities was attributed to parental obligations such as work, as well as lack of support for positive parenting.

*Stress in Adult Populations:* High levels of stress among adults was thought to be due to the various demands local adults face due to poverty and the impact poverty can have on mental health status.

*Depression in Senior Populations:* Depression in senior populations was often discussed as being connected to isolation, decreased sensory experience, and increased levels of grief.

Many of the groups discussed offering spiritual counseling as part of Mercy Care's behavioral health services, particularly given the religious practices and beliefs of so many patients.

**Chronic Disease Prevention and Management (obesity, diabetes, asthma, cardiovascular issues, etc.):**

The most commonly discussed health issues among focus group populations were diabetes, obesity, cardiovascular issues, teen pregnancy, pediatric asthma, and cancer. Management of these health conditions should therefore likely inform the development of services for the clinic in Chamblee, GA. Focus group participants believed that obesity was a universal health issue regardless of age. When looking across health concerns for specific age groups, respondents identified the following prioritized health concerns:

- **For adults and seniors** - the most cited health concerns were diabetes, heart disease, and mental health issues
- **For youth** - the most pressing health challenges were substance abuse, asthma, and teen pregnancy

Study participants discussed the need for chronic disease management and prevention in children, adults, and seniors. They also noted that youth seemed to be developing poor attitudes and habits
towards nutrition and physical activity that would have later consequences. The underlying factors discussed most often related to:

Poor nutrition –
- No access to affordable healthy food due to limited affordable grocery outlets and/or lack of transportation
- Cultural dietary preferences that are not healthy (i.e. fried foods, foods high in fat and sugar, habits of eating before bedtime, etc.)
- Lack of awareness of and preference for foods prepared in healthy ways
- Not enough time to prepare healthy food
- Ignorance of the impact of poor nutrition

Insufficient physical exercise –
- Poor access to resources that facilitate healthy physical activity (i.e., recreational space that is convenient, accessible and perceived as safe)
- Lack awareness of the impact that physical activity/no physical activity can have on health status
- Insufficient skills and motivation to incorporate a healthy level of physical activity into their current habits.

Offering Patient-Centered Care:

There are immigrant and refugee populations of significant size that do not speak English and/or speak English as a second language. Languages spoken in focus groups included Korean and Spanish. Study participants, including stakeholders and residents whose native languages were not English discussed the need for health services (i.e. medical care, outreach/education, printed materials, etc.) to be provided in the patient’s language of origin. While there is a Federally Qualified Health Center (FQHC) in the area that is the preferred provider for many residents that speak Asian dialects, there is a growing need for translation in the communities included in this study. There are a number of Asian dialects and cultures that do not translate into English very well, which may lead to misunderstanding of diagnosis and/or treatment recommendations. Latino participants had also encountered translators who lacked the medical knowledge to properly translate highly technical health terminology. Additionally, Latino community members were most often uninsured and without medical homes.

Many participants indicated that they do not eat as healthily as they should for a variety of reasons, including: cultural preferences for fried, sugary, and fatty foods; not enough time to prepare meals; and financial restraints. Many also indicated that they were open to participating in health education and outreach activities, though respondents suggested that there may be some hesitation among undocumented community members in the Latino community to participate in formal health fairs and public events.

Focus group participants talked about the importance of being able to access care in their communities after traditional operating hours (8am – 5 or 6pm). Residents suggested that the Mercy Care clinic offer after-hours appointments to increase the level of access to care for residents that work during normal business hours and their families. They also noted that translators were rarely available outside of traditional operating hours.
Participants discussed the importance of faith and the role of the church in healing mind and body. Many felt that their religious beliefs and practices should play a central role in the healing of their bodies and that medical providers should embrace and value faith and its role in healthcare (perhaps through pastoral counseling).

Study participants discussed difficulties related to transportation to and from the clinic. Transportation is not always reliable, affordable and/or accessible to residents, which was thought to cause inconsistency in appointment attendance. Participants recommended the clinic services include some form of transportation for scheduled appointments (for example, shuttle services or MARTA cards).

**Community Engagement:**

Focus group populations discussed the importance of community engagement. The clinic should be designed to include space (meeting rooms and classrooms) for community engagement.

Additionally, residents felt that offsite outreach in the community at churches, events, and other public spaces would increase the reach of the clinic, increase connectivity with the community, and raise awareness about prevention, healthy behaviors, and common health issues. Some of the onsite/offsite recommendations from focus group members were related to health education, instruction, and demonstration (cooking, nutrition, physical activity, disease prevention, stress management, instruction for new mothers, etc.); free screenings for common health issues (addressed above); reservable meeting space for community initiatives; and community outreach workers (i.e. in churches).

Participants discussed an interest in volunteering in their communities. Often community members indicated that they do not know about volunteer opportunities outside of their church due to a lack of communication about existing opportunities. Churches play a vital role in organizing and engaging community members in the study area.

In addition to the meeting space and classrooms, residents recommended that Mercy Care Chamblee include specialized spaces like a chapel area/prayer room, areas for children to play, child care services, etc. that take into consideration the populations Mercy Care is planning to serve.

**Non-Clinic Related Opportunities to Invest in Community Dialogue:**

There were a few topics discussed that did not relate directly with health and traditional health care. Many of these areas seem to present an opportunity to engage the community and community leaders in dialogue about strategy and planning. Some participants reported that their community experienced barriers to health, such as poverty, lack of educational opportunity, social exclusion and policing, and few places to be active or experience nature. Many participants discussed the value of increasing collaboration with the local school system, noting that youth learn a lot about nutrition and exercise from the food that is served in schools and the importance placed on physical activities. Similarly, many participants discussed the need for recreational facilities that are safe and well maintained to provide a safe environment for youth to participate in physical activities.

The discussion often focused on the lack of social connectedness in communities. Participants felt that community members were not interacting with one another and families were at risk of disintegration. Participants indicated that there are very few spaces for people to socialize in a healthy way in their
communities. Some recommended that municipalities focus on changes to the built environment in such a way that encourages more community interaction.

Residents discussed the isolation of seniors who are unable to get to and from senior centers and may not have access to resources in their home. Specifically, participants discussed the need for seniors with limited support to receive assistance and medical treatment through home care to ensure they are not cycling through the emergency room.
VII. Community Leader Input

**Purpose**
This study engaged community leaders to gain their input on, and develop a deeper understanding of, the health needs and health status of the residents they served as professionals and providers working in the community.

**Methodology**
GHPC worked closely with Mercy Care to identify the following organizational leaders and voices: 1) public health experts; 2) professionals with access to community health-related data; and 3) representatives of underserved populations (Asian community, Latino community, seniors, low-income residents, residents with limited English speaking skills, and residents that are uninsured). These individuals were interviewed as part of the needs assessment process. GHPC and Mercy Care developed a discussion guide (see Appendix C) that was used during each interview, which lasted approximately 45 minutes. All tools and processes were approved by the Georgia State Institutional Review Board. A series of 12 interviews and one group interview were completed with key stakeholders in DeKalb, Fulton, and Gwinnett Counties.

**Characteristics**
Stakeholders were identified across the above-mentioned categories, and participants were largely program directors, program managers, and a variety of medical professionals (including doctors, hospitalists, and medical directors). Stakeholders included participants from LaAmistad, Mercy Housing, and Center for Pan Asian Community Service (CPACS), Kaiser Permanente, Children's Healthcare of Atlanta, Gwinnett County Administration, Futbol Pasion, the Georgia House of Representatives, and Catholic Charities. A group interview with doctors and hospitalists at Emory Saint Joseph's Hospital (ESJH) was also conducted. Each participant was able to offer a unique perspective about the health needs of the population in the Chamblee area. All interviews were conducted by qualified GHPC staff and a complete list of the interviewees may be found in Appendix B.

The interview guide used for these interviews included a number of questions regarding the new Chamblee clinic. All stakeholders were at least aware of the clinic, and all responses regarding the location of the clinic were extremely positive. Nearly all stakeholders stressed the importance of culturally competent services, including language services extending beyond Spanish to serve the Asian community, and the importance of hiring staff with linguistic and cultural competency in mind. Additionally, nearly all stakeholders stressed the importance of providing after-hours appointment options, as many potential clients cannot afford to take time off work to visit the doctor.

**Recommendations**
Participants had a wide range of recommendations for improving health in their communities. Many of these recommendations are not related to traditional clinical services, but would impact the health of residents and potentially reduce the need for clinical care.

- **Linkage to care**: Emory Saint Joseph's Hospital (ESJH) participants emphasized the value of creating a liaison between the new clinic and ESJH or other area hospitals. They also emphasized the importance of increased community education regarding navigating the health care system and services available at Mercy Care clinics.
• **Obesity and healthy eating**: Intervention ideas expressed to combat obesity included: food pantries, community gardens, cooking classes, creation of a rewards system, nutrition education in schools, and a program specifically to educate and increase exercise and healthy behaviors among adolescent Latinas.

• **Important considerations for the new clinic and clinic services**: Culturally competent care and services (including front office staff and outreach), community workshops on healthy relationships, home health services, a physical therapy center, health education, outreach and enabling services, development of programs via churches and/or faith-based nursing, primary care, dental services, space for those with multiple children/childcare so parent can see their doctor one-on-one.

• **Heart health**: Education and early prevention programs.

• **Chronic disease**: Free community classes and handouts to give patients at clinic and in hospital on the availability of these classes.

• **Senior Health**: HIV and STI education for seniors, senior centers should provide culturally relevant meal services.

**Summary**

**Providing Health Services to Underinsured and Uninsured Residents:**

All participants in the ESJH group interview identified health care services for the underserved as the number one issue for the community. Stakeholders identified a number of challenges that result in such a large underserved population. In terms of insurance, this population has a relatively large proportion of people who are not adequately employed to be eligible for coverage assistance under the Affordable Care Act. Thus, they remain uninsured. However, of much greater significance, as reported by respondents are the other elements of access - geographic and transportation barriers, and issues related to immigration status. It was estimated that approximately 40% of the Latino population served by ESJH is undocumented, and issues related to undocumented status included:

- Fear of going to the doctor due to risk of deportation
- Many earn low incomes and cannot afford to miss work
- Some are unable to afford transportation to seek services
- Cultural norms may involve waiting to seek care until the situation is extremely dire
- Cultural norms may dictate it is better to receive care in a hospital setting
- Lack of understanding and education in how to navigate the health system

Stakeholders emphasized that they perceived these issues to be more critical than the barrier presented by lack of insurance. When asked about the most pressing health issues in the community, one stakeholder said, “Access to health care. It used to be affordability, but it’s not that anymore, just access.” This sentiment was echoed across the data. It was said that “transportation and culture and access to care has to be addressed before we can even get to disease management.”
Integration of Primary Care and Behavioral Health Care:

Overall, behavioral health needs were described as a major issue. Integration of primary care and behavioral health was chosen as the second most pressing health need in the community by half of the participants at ESJH. Unmet behavioral health needs were emphasized as a major problem particularly for children and the elderly, though the discussions focus largely on the lack of resources in general for underinsured/uninsured people regardless of age. Stakeholders discussed the need for a continuum of behavioral health services, citing a dearth of available referral sources in the communities within the study area.

In terms of youth, an issue identified was an inadequate supply of psychologists and psychiatrists to manage complex issues like psychosis that cannot be managed by a primary care provider. Among the elderly, one major issue identified was the taboo nature of speaking about mental illness and frequent refusal to treat a mental illness, as well as the cascading problem of mental illness exacerbating issues with medication adherence in this population. Feedback on possible solutions for the youth population was not provided. However, for the elderly population it was suggested that group education and conversations would be an appropriate initial method for intervention.

Chronic Disease Prevention/Management (obesity, diabetes, asthma, cardiovascular disease, etc.):

Chronic disease prevention and management were cited as major health issues, particularly for the Latino population. Most stakeholders who discussed chronic disease cited diabetes. In addition to diabetes, high blood pressure, hypertension, obesity, and cardiovascular diseases were also mentioned. Almost all stakeholders who discussed chronic disease issues noted the correlation between diet and the prevalence of chronic disease. Some noted that many in the Asian community tended to have lower rates of diabetes, high blood pressure, hypertension, and obesity due to an overall healthier diet. While cultural norms in terms of diet may play a role, access to healthy affordable foods is likely also a factor contributing to this difference.

Offering Patient-Centered Care:

The importance of culturally competent care was a feature of many of the stakeholder conversations. This was more strongly emphasized in interviews than any other issue. While some stakeholders focused on other issues as top priority from their perspective, all who discussed the new clinic pointed out that given Chamblee’s population, culturally competent care and trust-building will come before all other questions of service offerings. This encompasses language competencies beyond Spanish, from the front desk to the pharmacy, as well as culturally competent clinicians to understand needs specific to the diverse populations that will be served in the Chamblee area.

Transportation & Access:

Some respondents described the challenges of transportation and physical access to healthcare services as being driven by (a) work obligations that cannot be missed and clinic hours coinciding within work hours and (b) the inability to afford transportation to the clinic, both in terms of time and cost.

However, stakeholders said that the clinic’s location is ideal for convenience and should improve access despite geographical and transportation access barriers. These barriers will persist for some residents, particularly those who cannot afford to use MARTA, and those who live outside MARTA’s reach.
Community Engagement:

Stakeholders discussed the need to engage residents in the communities throughout the service area, as well as some of the challenges related to engaging this diverse population.

Stakeholders discussed the isolation of seniors, undocumented community members, and youth. The senior population can become isolated when they are aging in place for a variety of reasons: 1) they may not qualify for senior housing or home health services; 2) they may not have family that are involved in their everyday lives; 3) they may not be able to drive or afford public transportation; and 4) they may not be mobile or may have a physically limiting disability. These seniors can become isolated without adequate food, necessary medications, or proper hygiene, which can cause a health hazard.

Undocumented community members can become isolated due to: 1) language/cultural barriers; 2) fear of deportation; 3) lack of awareness of available programs; 4) limited access to transportation; and 5) lack of income. Often community members are much unhealthier due to a lack of awareness and limited education, which has an impact on individual health status and mortality and may lead to health disparities.

Youth often become isolated due to: 1) their parent(s) working long hours with limited resources to provide oversight and 2) being exposed to trauma of immigration and poverty (often associated with violence, abuse, neglect, etc.). Stakeholders also discussed the prevalence of substance abuse and teen pregnancy. They discussed the need to provide guidance and direction as well as programmed activities geared toward youth participation throughout the study area.

Engaging community members across the study area will present opportunities to think strategically due to the diversity of the population (in terms of age, education, profession, citizenship, culture, and language). Stakeholders believed that the success of the Mercy Care Chamblee clinic will depend upon the success of their community engagement. Many stakeholders noted that Mercy Care has a longstanding, trusted reputation in the community.

Recommendations were made during interviews to engage the community where members naturally gather (churches, shopping centers, etc.). Respondents also recommended strengthening relationships with residents, businesses, and community leaders. Finally, the recommendation was made to engage the community through the use of faith-based nursing and/or community health workers.

Community engagement is integral to the health of the community in this study area, where the community is so diverse and isolation challenges are present due to lack of trust and awareness of community resources. More specifically, community members may not naturally gravitate to a new clinic or new location and may not be aware of the plans for relocation.

Non-Clinic Related Opportunities to Invest in Community:

Stakeholders mentioned that, in addition to the trust-building necessary with an immigrant population of whom many are undocumented, building general health literacy should be a major point of intervention. This is related to the importance of education and outreach regarding navigation of Mercy Care services, other health services in the area, and raising awareness of available resources. Stakeholders suggested that health fairs have been effective in the area, but that more could be done to
engage non-English speakers including translation and distribution of materials in multiple languages at the clinics, hospitals, and other community-based locations.

The importance of home health care was mentioned, but a member of the ESJH group also mentioned that this is not always the most effective method for residents, as often they live in crowded homes and may not welcome outsiders into their homes. This person suggested alternatively that follow-up services to hospital care such as physical/occupational therapy should be offered at the clinic itself. Stakeholders also stressed the value of free classes on issues such as violence and nutrition to be offered at community-based locations and/or the clinic itself. The group at ESJH mentioned that it would be useful to produce and distribute materials on the availability, timing, and location of these classes to offer to patients prior to hospital discharge.

Transportation was perceived as impeding many from not only going to the doctor, but also from accessing healthy foods. Stakeholders noted that this area is relatively devoid of true grocery stores: there are some, but they are located in wealthier areas, closer to those who are not likely to have issues with transportation.

It was also noted that in parts of Chamblee, in particular, where there are no true grocery stores, there is a high availability of fast food options. The lack of affordable healthy food options, coupled with the stressors of living in a low income community and cultural norms that reinforce poor eating habits will likely result in many families being affected by obesity and diabetes over time.
VIII. Secondary Data

**Purpose**
Secondary data was used in the assessment to develop an understanding of the population characteristics, demographics, socioeconomic and health status factors that can help inform decisions related to space utilization and program development.

**Methodology**
GHPC considered data from several sources as it related to the 22 zip codes throughout DeKalb, Fulton, and Gwinnett Counties. The sources included: the Georgia Online Analytical Statistical Information System, the U.S. Census Bureau, County Health Rankings, Health Indicators Warehouse, and Community Commons, the Centers for Disease Control and Prevention, and Truven Health Analytics. See Appendix 4 for complete listing of data sources and descriptions of each.

**Characteristics**
The population in DeKalb, Fulton, and Gwinnett counties on average is younger, better educated, and more diverse when compared to other counties nationally. On average, residents of Fulton and Gwinnett counties show achieve higher levels of educational attainment and earn higher wages than their counterparts in DeKalb County. The average income in Fulton County is higher than DeKalb and Gwinnett counties and the nation. Gwinnett and DeKalb County are more racially diverse than Fulton County. Extreme economic and racial/ethnic segregation is present in all three counties, with the highest rates seen in Fulton and DeKalb counties.

The population is projected to grow at a more rapid pace across the tri-county area than the projected national growth (3.7%) between 2016 and 2021. Gwinnett County is slated to see the greatest growth (8.1%), with Fulton (6.7%) and DeKalb (5.2%) counties showing slightly slower growth rates. The entire study area is projected to see the highest increase in the older adult (55+) population.

**DeKalb County** encompasses a wide range of urban and suburban areas, as well as a wide range of socio-demographic characteristics. It has the third highest proportion of linguistically isolated households. Nine percent of residents are Hispanic and 53.6% identify as non-Hispanic Black. Thirty percent of the residents identify as non-Hispanic White, and the county has the second-largest segregation gap in places, ranging from 0% to 95.1% non-Hispanic White by census tract. Forty-four percent of children live in single-parent households. The birth rate is highest in the region (45 per 1,000), although the average teen birth rate (14.2) is only slightly above the regional average of 12. The four-year graduation rate was just 57.6% and 9.6% of third-graders did not read at their age level.

**Fulton County** encompasses many different populations and development areas. This county of almost a million residents is 40.7% non-Hispanic White and 43.5% Black. However, it is also extremely clustered, with the share of non-Hispanic White residents by census tract ranging from 0.0% to 95.7%. Nearly 10% of residents identify as Asian, other, or two or more races. The share of adults under 65 years is one of the highest in the region. Seventy-six percent of adults have attended college, and just 9.6% lack a high school degree equivalent. However, 42% of children live in single parent homes, which may be reflected in the low four-year graduation rate (64.5% relative to an 82.2% national benchmark, and 70.3% regional average). More children live in poverty (24.2%) than the regional average (21.9%). Additionally, 19.8% of households had experienced food insecurity.
Gwinnett County has one of the lowest shares of people over 65 years (7.4%), an above average population under 18 years (28.7%), and low levels of residents with disabilities (7.3%). The county has a large Hispanic population (20.5%), and 9.6% of households are linguistically isolated. While just 41.6% of residents are non-Hispanic White, by census tract this share ranges from 5.6% to 90.0%, which is a relatively high level of clustering. Nearly 40% of households pay over 30% of their income for housing, above the 36.8% regional average, and 5.4% of households are overcrowded. Twenty-nine percent of adults were uninsured, which was above the regional mean of 25.8%. Additionally, 12.1% of children were uninsured, versus 10.5% regionally. The four year graduation rate in Gwinnett County was 71.3%, above the Georgia average but below the national benchmark of 82.2%.

In some parts of the county, more than 25.3% of commuters travel over an hour each way to work, mainly by car. There are also parts of the county where more than 25% of commuters do not have access to a car. Many socioeconomic indicators in the county are positive, such as a low unemployment rate and low poverty rate. However, population-wide data indicated disparities in employment for non-Hispanic White (8.4%), Hispanic (11.5%), or Black (14.0%) labor force participants. The county has a low percentage of single parent households (28% versus 37% statewide). County residents are also less likely to experience food insecurity (13.9% versus 16.4% regionally).

**Summary**

Current research points to a correlation between socioeconomic status, level of language isolation, etc. and health outcomes. For this study, data related to socioeconomic status were considered from a variety of sources (i.e., Truven Health Analytics Community Need Index (CNI), Community Commons, American Community Survey (ACS), etc.). See Appendix D for a brief description of each data source considered in this study. The following is a review of the notable secondary data findings related to socioeconomic status. Additional data table, charts, maps, and analysis can be found in Appendix D. Note that the marker on all maps is the location of Mercy Care's new Chamblee clinic.

**Sociodemographic Barriers**

Extreme poverty is present in the service area, particularly concentrated along the I-85 corridor and near Chamblee and Norcross. At this concentration, poverty may result in disinvestment, blight, and a lack of jobs and services. Children in poverty follow a similar pattern, with high rates along Buford Highway in the southern part of the service area. The following map depicts the 22-Zip code CHNA Study area (note the marker for the location of the clinic) and the 188 census tracts that are fully or partially within its boundaries. The shading indicates the level of poverty as a percentage of the total population, which ranges from 5% of the population (lightest color) to more than 30% of the population (darkest color) living below poverty.
Fulton County, as a whole, aligns with regional averages for many health factors and outcomes, although there are disparities concealed within these averages. Disparities are also reflected in employment. While the 8.6% unemployment rate in 2015 was only slightly higher than the state average (8.2%), population-wide data from 2010-14 found that the unemployment rate for Black residents (18.4%) was about three times higher than the rate for non-Hispanic White residents (6.2%). In one part of the county, women were employed at 3.8 times the rate of males in the labor force.

Relative to statewide rates of health insurance coverage, both adults and children in the service area were much more likely to be uninsured. The majority of adults did not have insurance in many areas around Chamblee and Norcross. Uninsured children were more widely distributed, but exceeded 30% in some places. The American Community Survey (ACS) data do not capture recent improvements in coverage rates resulting from the Affordable Care Act and from increased employment. However, many families in the area may continue to be ineligible for coverage.

While Fulton County has had higher socioeconomic barriers to accessing care related to income, culture, education, insurance, and housing, DeKalb County saw the greatest increase in these barriers from 2014

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3 US Census Bureau, American Community Survey 2010-14
to 2015 with 63% (12 of 19) of zip code areas in DeKalb County experiencing an increase in barriers. Fulton County saw the greatest improvements during the same period of time with 83% (5 of 6) of zip code areas showing improvement in barriers.

According to the table below, which displays the Community Needs Index (CNI) scores by zip code; socio-economic barriers to accessing health care are most significant in Doraville (30340), Norcross (30093 and 30071), Tucker (30084), North Druid Hills (30329), and Chamblee (30341).

Table 2: Truven Health Analytics Community Need Index Detail by Zip Code

<table>
<thead>
<tr>
<th>Zip</th>
<th>County</th>
<th>CNI 2015</th>
<th>CNI 2014</th>
<th>Change</th>
<th>Poverty 65+</th>
<th>Child Poverty</th>
<th>Poverty Single w/Kids</th>
<th>Limited English</th>
<th>Minority</th>
<th>No High School Diploma</th>
<th>Unemployed</th>
<th>Uninsured</th>
<th>Renting</th>
</tr>
</thead>
<tbody>
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<td>Atlanta (Doraville) 30340</td>
<td>DeKalb</td>
<td>5.0</td>
<td>4.8</td>
<td>0.2</td>
<td>10%</td>
<td>38%</td>
<td>54%</td>
<td>23%</td>
<td>76%</td>
<td>29%</td>
<td>10%</td>
<td>22%</td>
<td>59%</td>
</tr>
<tr>
<td>Norcross 30071</td>
<td>Gwinnett</td>
<td>4.8</td>
<td>4.8</td>
<td>0.0</td>
<td>12%</td>
<td>36%</td>
<td>51%</td>
<td>22%</td>
<td>80%</td>
<td>28%</td>
<td>12%</td>
<td>21%</td>
<td>46%</td>
</tr>
<tr>
<td>Norcross 30093</td>
<td>Gwinnett</td>
<td>4.8</td>
<td>4.8</td>
<td>0.0</td>
<td>9%</td>
<td>38%</td>
<td>49%</td>
<td>23%</td>
<td>90%</td>
<td>30%</td>
<td>11%</td>
<td>22%</td>
<td>65%</td>
</tr>
<tr>
<td>Atlanta (N. Druid Hills) 30329</td>
<td>DeKalb</td>
<td>4.6</td>
<td>4.4</td>
<td>0.2</td>
<td>14%</td>
<td>34%</td>
<td>48%</td>
<td>14%</td>
<td>58%</td>
<td>15%</td>
<td>7%</td>
<td>19%</td>
<td>72%</td>
</tr>
<tr>
<td>Lawrenceville 30046</td>
<td>Gwinnett</td>
<td>4.4</td>
<td>4.4</td>
<td>0.0</td>
<td>13%</td>
<td>23%</td>
<td>38%</td>
<td>6%</td>
<td>69%</td>
<td>19%</td>
<td>11%</td>
<td>18%</td>
<td>41%</td>
</tr>
<tr>
<td>Atlanta (Chamblee) 30341</td>
<td>DeKalb</td>
<td>4.4</td>
<td>4.0</td>
<td>0.4</td>
<td>11%</td>
<td>25%</td>
<td>40%</td>
<td>18%</td>
<td>62%</td>
<td>20%</td>
<td>8%</td>
<td>16%</td>
<td>57%</td>
</tr>
<tr>
<td>Lawrenceville 30044</td>
<td>Gwinnett</td>
<td>4.2</td>
<td>4.0</td>
<td>0.2</td>
<td>12%</td>
<td>20%</td>
<td>30%</td>
<td>8%</td>
<td>73%</td>
<td>15%</td>
<td>11%</td>
<td>15%</td>
<td>35%</td>
</tr>
<tr>
<td>Dunwoody 30338</td>
<td>DeKalb/Fulton</td>
<td>3.0</td>
<td>3.0</td>
<td>0.0</td>
<td>6%</td>
<td>7%</td>
<td>16%</td>
<td>3%</td>
<td>35%</td>
<td>4%</td>
<td>7%</td>
<td>12%</td>
<td>42%</td>
</tr>
<tr>
<td>Lawrenceville 30045</td>
<td>Gwinnett</td>
<td>2.6</td>
<td>2.6</td>
<td>0.0</td>
<td>3%</td>
<td>11%</td>
<td>19%</td>
<td>3%</td>
<td>66%</td>
<td>12%</td>
<td>10%</td>
<td>8%</td>
<td>13%</td>
</tr>
<tr>
<td>Roswell 30075</td>
<td>Fulton</td>
<td>2.2</td>
<td>2.2</td>
<td>0.0</td>
<td>6%</td>
<td>6%</td>
<td>21%</td>
<td>3%</td>
<td>22%</td>
<td>4%</td>
<td>8%</td>
<td>8%</td>
<td>19%</td>
</tr>
</tbody>
</table>

Total - DeKalb County | 4.1 | 3.9 | 0.2 | 15% | 25% | 40% | 6% | 70% | 13% | 14% | 18% | 42% |
Total - Fulton County | 3.7 | 3.6 | 0.1 | 14% | 21% | 37% | 3% | 60% | 10% | 12% | 18% | 45% |
Total - Gwinnett County | 3.5 | 3.5 | 0.0 | 9% | 17% | 32% | 7% | 59% | 12% | 10% | 12% | 29% |

---

Barriers to healthcare increased the most in DeKalb County, with Tucker and Chamblee showing the greatest increases from 2014 to 2015. In general, zip code areas with the highest barriers in 2014 show an increase in barriers from 2014 to 2015, while low barrier areas have remained unchanged or decreased.

In the central corridor of the service area, the share of residents over the age of 5 who do not speak English well or at all, exceeds 30%. This includes many households that are linguistically isolated; meaning no one in the household over the age of 14 speaks English well. In several sections of the service area, at least one quarter of households are linguistically isolated. The following map depicts the CHNA Study area (note the marker for the location of the clinic) by census tract. The shading indicates the percentage of the total population, which ranges from 5% or less of the population (lightest purple) to more than 30% of the population (darkest purple) that are older than 5 years of age and speak English less than well.

**Figure 3: Language Barrier as a Percentage of the Population by Census Tract**

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5 US Census Bureau, 2010-14 American Community Survey
According to the CNI Scores found in Table 2, there are pockets of community residents where the percentage of population with limited English speaking skills is higher than is average for the region or state: Doraville (30340-23%), Norcross (30093 and 30071 with 20% and 23% respectively), Tucker (30084-12%), North Druid Hills (30329-14%), and Chamblee (30341-18%). Variation within the service area related to English proficiency and languages spoken are presented in the following table.

- In DeKalb County, 81.4% (527,947 people) of residents speak English as their primary language. Of the 18.6% (120,832 people) of residents for whom English is a second language, 50% (60,332 people) speak English less than “very well.”
- In Fulton County, 83.3% (737,120 people) of residents speak English as their primary language. Of the 16.7% (147,932 people) of residents for whom English is a second language, nearly 37.4% (55,314 people) speak English less than “very well.”
- In Gwinnett County, 67% (512,095 people) of residents speak English as their primary language. Of the 33% (251,753 people) of residents for whom English is a second language, nearly 46.2% (116,224 people) speak English less than “very well.”

<table>
<thead>
<tr>
<th>Language Indicator</th>
<th>DeKalb County</th>
<th>Fulton County</th>
<th>Gwinnett County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population 5 years and over</td>
<td>648,779</td>
<td>885,052</td>
<td>763,848</td>
</tr>
<tr>
<td>Speak only English at home</td>
<td>527,947</td>
<td>737,120</td>
<td>512,095</td>
</tr>
<tr>
<td>Speak a language other than English at home</td>
<td>120,832</td>
<td>147,932</td>
<td>251,753</td>
</tr>
<tr>
<td>Speak English less than &quot;very well&quot;</td>
<td>60,332</td>
<td>55,314</td>
<td>116,224</td>
</tr>
<tr>
<td>Top languages spoken at home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spanish (46.9%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian (17.1%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Vietnamese</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Chinese</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Korean</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African (11.8%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Amharic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Cushite</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>French (4.3%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hindi (2.2%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spanish (43.0%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian (21.4%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Chinese</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Korean</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>French (5.0%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hindi (4.2%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African (3.5%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Kru, Ibo, Yoruba</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Amharic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Russian (3.2%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spanish (54.8%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian (22.4%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Korean</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Vietnamese</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>French (2.5%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African (3.6%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Kru, Ibo, Yoruba</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Amharic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Russian (3.2%)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Table 3: English Proficiency and Languages Spoken at Home by County**

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**Access to Care Barriers**

While DeKalb and Fulton counties have higher primary care provider rates than Gwinnett County, the percentage of the population in a health professional shortage area is greater in DeKalb and Fulton counties. However, none of the zip codes in Mercy Care’s service area are designated as health professional shortage areas for primary care, dental care, or mental health providers, nor are they considered medically underserved areas or populations. According to the Health Resources and Services

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6 U.S. Census Bureau, 2010-14 American Community Survey
Health Center Service Delivery Sites (HCSD) are community-based and patient-directed organizations that serve populations with limited access to health care, including low-income populations, the uninsured, those with limited English proficiency, migrant and seasonal farm-workers, individuals and families experiencing homelessness, and those living in public housing. Health center service delivery site information includes data for Health Center Program grantees as well as health center look-alike facilities, which are entities that operate and provide services consistent with all policy requirements that apply to Section 330-funded health centers (grantees), but do not receive funding under Section 330. It is important to note that there is no standard measure, to-date, of the number of providers that are accepting patients that are underinsured, uninsured, or insured by Medicare/Medicaid, especially undocumented individuals. What the data tells us is that the rate of FQHCs is lower in the study area than is average for the state (1.53 per 100,000 pop.), which may point to less access to primary care services for lower income populations in the study area.

Of the three counties, Gwinnett County has the lowest rate of mental health providers while DeKalb and Fulton have higher rates than the state and the nation. Fulton County does have one of the highest rates of mental health providers per 100,000 residents (189.4), though not all residents may be able to access these services at the same rate. Twenty-seven percent of the county residents live in a health care professional shortage area. It is important to note that there is no standard measure of the number of behavioral health providers that serve underinsured or uninsured populations. Fulton County has higher ER utilization for mental health than any other county. However, African American residents show higher utilization rates when compared to other races. Emergency Department utilization for mental health appears relatively low in the service area. Note that the maps, in the Appendix, show counts, since rates cannot be accurately calculated for small areas with the given population data. Self-harm events have been decreasing in the area since 2009, while state and national rates have increased during the same period. Asian residents show lower rates of self-harm when compared to other races. There have also been a relatively low number of cases in the service area.

Table 4: Availability of Health Services by County with State and National Comparison

<table>
<thead>
<tr>
<th>Health Care Access</th>
<th>DeKalb</th>
<th>Fulton</th>
<th>Gwinnett</th>
<th>GA</th>
<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Providers / 100,000 (2012)</td>
<td>102.4</td>
<td>98.6</td>
<td>58.4</td>
<td>63.6</td>
<td>74.5</td>
</tr>
<tr>
<td>Dental Providers / 100,000 (2013)</td>
<td>54.8</td>
<td>65.1</td>
<td>57.0</td>
<td>47.6</td>
<td>63.2</td>
</tr>
<tr>
<td>Mental Health Providers / 100,000 (2014)</td>
<td>246.7</td>
<td>189.4</td>
<td>86.3</td>
<td>71.1</td>
<td>134.1</td>
</tr>
<tr>
<td>% of Adults with No Regular Doctor (2011-2012)</td>
<td>26.9%</td>
<td>29.7%</td>
<td>25.5%</td>
<td>26.1%</td>
<td>22.1%</td>
</tr>
<tr>
<td>Federally Qualified Health Centers / 100,000 (2014)</td>
<td>1.3</td>
<td>1.19</td>
<td>0.25</td>
<td>1.53</td>
<td>1.92</td>
</tr>
<tr>
<td>% Population in Health Professional Shortage Area (2015)</td>
<td>10.0%</td>
<td>27.0%</td>
<td>0%</td>
<td>34.6%</td>
<td>34.1%</td>
</tr>
</tbody>
</table>

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7 CHNA.org/Community Commons from Centers for Medicare & Medicaid Services, Health Resources and Services Administration, Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System
8 University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps from Centers for Medicare & Medicaid Services
Access to Goods and Services Barriers

Transit access varies from excellent to poor in the service area. Many households have little or no transit access, but also do not have access to a private motor vehicle. This can significantly limit their ability to patronize health care facilities, supermarkets, educational opportunities, and much more. According to US Department of Agriculture (USDA)’s Low Income/Low Food Access (LILA) database, the corridor along I-85 in the service area has many census tracts which are classified as low income and residents do not have a supermarket within a half-mile (orange) or one mile (green) travel distance. See Figure 34 in the Appendix for transportation services.

9 U.S. Census Bureau, 2010-14 American Community Survey; Health Resources and Services Administration 2016
DeKalb County does have many good health determinant indicators. Over 95% of the population has access to a fitness or recreational facility, and only 21.4% of the population did not participate in intentional physical activity. Over 10% of workers travel to work by walking, bicycling, or taking transit, which are associated with higher physical activity levels. By census tract, the proportion of commuters without access to a private motor vehicle ranges from 0% to 35.5%. Seventy-one percent of the population did not eat five servings of fruits and vegetables, versus the regional average of 74.2%. However, 20.6% of households experienced food insecurity.

Fulton County contains the census tract with the highest percentage of long commutes (34.6%), but is also one of the four core counties where very few individuals commute more than 60 minutes each way. On average, Fulton has one of the lowest countywide averages of long commuting (8.7%). The tract with the highest share of active commuting (53.5%) is also located in Fulton, and the county had the lowest share of commuters who drive alone (73%). Nine percent of commuters did not have a private motor

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10 US Department of Agriculture, Food Access Research Atlas 2013 from 2010/2012 data sources
vehicle (8.6%), ranging as high as 46.1% of the commuters in one census tract, and 11.8% of all households in the county did not have a motor vehicle.

**Gwinnett County** had low unemployment rates but long travel times from some areas of the county.

**Health Status Indicators**  
Georgia shows higher cancer, diabetes, obesity, and teen pregnancy rates than the nation. DeKalb County shows higher incidence and mortality rates in general for each of the health issues addressed in focus groups (i.e. diabetes, obesity, cardiovascular issues, teen pregnancy, pediatric asthma, and cancer). African American residents show higher death and incidence rates than any other race across most measures except breast cancer (white) and teen pregnancy (Hispanic). Hispanic and Asian residents show lower rates of cancer incidence and mortality when compared with other racial identities. Using combined death, hospital discharge, and ER utilization as a proxy for cancer incidence, there are a few areas in the service area with a higher number of cancer cases than the surrounding area. However, they cannot be calculated or compared as rates due to lack of accurate small area population data.

Approximately one in four residents was reported to be obese across the study area counties, with one in three being overweight. DeKalb County has higher rates of adults that are overweight than the state and the other two counties in the study area. No obesity data was readily available for adults at a sub-county scale.

Georgia shows higher teen births than the nation. DeKalb County shows the highest rate of teen births when compared to the counties in the study area and the U.S. While not discussed directly in the focus groups, the prevalence of HIV is much higher in DeKalb and Fulton Counties than Gwinnett County and the state. It is important to note that screening rates are higher in these areas, which could increase prevalence rates over areas with lower screening rates. The service area has very high hospital utilization levels for pregnancy and childbirth for women of all ages. These utilization rates are above state average for Fulton, DeKalb, and Gwinnett, and DeKalb is notably the highest. Rates could not be accurately calculated for the service area due to limitations on population data. However, among women ages 19 and under, above-average utilization levels were primarily concentrated in an area between Norcross, Tucker, and Lilburn. The area with the highest utilization numbers also had the highest number of teen births.

Cardiovascular disease is the leading cause of death in Georgia. There are higher rates of hypertensive heart disease in DeKalb and Fulton Counties than is average for the state. African American residents show higher rates than any other race or geography. More than 2.3 million adults (33%) in Georgia are unaware of modifiable risk factors (lack of physical activity, poor diet, smoking, etc.) that may impact cardiovascular disease.

Asthma rates are not as high as the state rate when considered at the county level; however, asthma rates among African American residents are higher than any other race as well as higher than the state and county rates. The service area also has somewhat higher amounts of ER utilization for asthma attack, including for children. Areas along I-85 saw higher utilization for asthma. The number of pediatric asthma ER visits was high in parts of the service area outside the Perimeter (Interstate 285), generally between Buford Highway and Lawrenceville Highway.
<table>
<thead>
<tr>
<th>Health Need</th>
<th>DeKalb</th>
<th>Fulton</th>
<th>Gwinnett</th>
<th>Asian</th>
<th>African American</th>
<th>Hispanic / Latino</th>
<th>White</th>
<th>US</th>
<th>GA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer Mortality Age-adjusted11</td>
<td>156.5</td>
<td>165.2</td>
<td>145.2</td>
<td>89.6</td>
<td>185.6*</td>
<td>64.4</td>
<td>149.0*</td>
<td>168.9</td>
<td>171.2</td>
</tr>
<tr>
<td>Cancer Incidence – Lung11</td>
<td>55.1</td>
<td>56.1</td>
<td>54.1</td>
<td>26.6</td>
<td>60.0</td>
<td>31.5</td>
<td>53.9</td>
<td>63.7</td>
<td>68.8</td>
</tr>
<tr>
<td>Cancer Incidence – Breast11</td>
<td>135.0</td>
<td>135.0</td>
<td>129.4</td>
<td>133.1</td>
<td>104.6</td>
<td>139.8</td>
<td>123.0</td>
<td>123.5</td>
<td></td>
</tr>
<tr>
<td>Cancer Incidence – Colorectal11</td>
<td>42.4</td>
<td>41.0</td>
<td>37.6</td>
<td>28.1</td>
<td>49.4</td>
<td>31.3</td>
<td>35.3</td>
<td>41.9</td>
<td>42.3</td>
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<tr>
<td>Cancer Incidence – Prostate11</td>
<td>179.6</td>
<td>188.4</td>
<td>145.2</td>
<td>61.7</td>
<td>241.0</td>
<td>128.4</td>
<td>145.9</td>
<td>131.7</td>
<td>150.1</td>
</tr>
<tr>
<td>Diabetes (Age Adjusted %)11</td>
<td>10.4%</td>
<td>8.6%</td>
<td>8.6%</td>
<td></td>
<td></td>
<td></td>
<td>9.11%</td>
<td>10.48%</td>
<td></td>
</tr>
<tr>
<td>Diabetes Mortality (Age-adjusted rate)12</td>
<td>20.4</td>
<td>18.3</td>
<td>18.6</td>
<td>11.3</td>
<td>39.3</td>
<td>11.8</td>
<td>18.6</td>
<td>21.3</td>
<td>23.1</td>
</tr>
<tr>
<td>Medicare Enrollee Diabetes11</td>
<td>27.6%</td>
<td>23.5%</td>
<td>25.1%</td>
<td></td>
<td></td>
<td></td>
<td>26.9%</td>
<td>27.6%</td>
<td></td>
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<tr>
<td>Adult Obesity12</td>
<td>26%</td>
<td>22%</td>
<td>27%</td>
<td></td>
<td></td>
<td></td>
<td>27.10%</td>
<td>29%</td>
<td></td>
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<tr>
<td>Adult Overweight12</td>
<td>36.8%</td>
<td>33.3%</td>
<td>34.4%</td>
<td></td>
<td></td>
<td></td>
<td>35.8%</td>
<td>34.6%</td>
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<tr>
<td>Teen Pregnancy (per 1,000 pop)11</td>
<td>28.9</td>
<td>26.0</td>
<td>18.4</td>
<td>--</td>
<td>39</td>
<td>41.7</td>
<td>18.6</td>
<td>26.5</td>
<td>30.5</td>
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<tr>
<td>Pregnancy &amp; Childbirth (per 100,000 women)11</td>
<td>3191.1</td>
<td>2794.7</td>
<td>2805.6</td>
<td>2588</td>
<td>3119.8</td>
<td>2072.5</td>
<td>2670.5</td>
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<tr>
<td>Heart Disease (Hypertensive)11</td>
<td>11.4</td>
<td>12.7</td>
<td>5.4</td>
<td>--</td>
<td>19.2</td>
<td>--</td>
<td>5.8</td>
<td>9.9</td>
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<tr>
<td>Heart Disease (Obstructive)11</td>
<td>27.9</td>
<td>39.4</td>
<td>40.3</td>
<td>67.1</td>
<td>216.3</td>
<td>--</td>
<td>311.6</td>
<td>274.5</td>
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<tr>
<td>Asthma11</td>
<td>15</td>
<td>13.2</td>
<td>11</td>
<td>25.0</td>
<td>131.5</td>
<td>--</td>
<td>72.2</td>
<td>--</td>
<td>98.4</td>
</tr>
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</table>

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11 Georgia Department of Public Health Online Analytical Statistical Information System 2010-14
12 Health Indicators Warehouse
DeKalb County averages may reflect the variation of disparate outcomes between advantaged and disadvantaged populations based on income, race, immigrant status, and other factors. For instance, the average infant mortality rate (6.7 per 1,000 live births) is only slightly higher than the state average (6.1), but when sorted by race the non-Hispanic White rate is better than state average for this population (3.7 versus 4.9) while for Black infants it is worse (10.4 versus 10). DeKalb County has relatively high utilization of hospital services for pregnancy and childbirth-related needs (1052.2 versus 887.1 regionally), and much of that utilization is concentrated in the northwest near I-85. By contrast, this area has lower rates of heart disease while the southeastern portion of the county has higher rates. DeKalb also has the lowest smoking rates in the region (10.8%) and one of the highest shares of attempts to quit smoking (77.3% versus 64.5% regionally). County residents reported only 2.5 days of poor health-related quality of life per month compared with a regional average of 3.5 days.
Overall, it seems that county residents enjoy above average health if they can avoid particular health and safety hazards. Assault is a greatly elevated cause of premature death, at 11.1 deaths per 100,000 population and 39 hospital discharges per 100,000 population, both age-adjusted, versus 6.4 and 21.4 statewide. Premature death due to HIV/AIDS is also significantly elevated, as are hypertension, maternal and infant health problems, and asthma. County residents are also more likely to die from common types of cancer, excluding lung cancer. HIV prevalence is 1247.9 per 100,000 population, one of the highest rates in the country. Chlamydia (651.3) and gonorrhea (234.0) prevalence are also higher than the regional averages (421.0 and 124.0). Anemia is also an elevated cause of hospitalization (89.1 versus 51.2). However, residents are less likely to be hospitalized for mental health needs; the county has the highest ratio of mental health providers in the region. Twenty seven percent of adults lack health insurance, which is slightly higher than the regional average. The county has elevated rates of ER usage for asthma (796.8 versus 551.6).

**Fulton County** residents report the second-lowest number of days of poor physical health per month (2.4 versus 3.5), average premature death rates, and very low rates of preventable hospitalization (43.5 versus 60.6 statewide). County residents also report the third-lowest number of poor mental health days (2.7 versus 3.3). However, ER utilization for mental health needs is above average (1,146.2 versus 902.9 per 100,000 population). Fulton also has elevated rates of assault-related hospitalizations (46.6 versus 33.0 per 100,000 population) and ER visits (368.6 versus 230.0). Overall, traffic related fatality rates are very low.

In the county, just 19.1% of adults reported that they did not engage in intentional physical activity, versus 22.3% of the region. Fourteen percent of workers used a physically active form of commuting. Diabetes diagnoses were relatively low (8.6% age adjusted versus 10.0% regionally), though hospitalization for this condition was slightly above average (181.4 versus 155.4). Most cardiovascular disease rates were average or below average, with the exception of hypertension-related conditions; Fulton residents were hospitalized for hypertension at a rate of 107.7 versus 81.7 per 100,000 population regionally.

Smoking rates were below average at 13.3% compared with 15% regionally. However, asthma-related ER visits were elevated (674.1 versus 551.6). Approximately five percent of households were overcrowded (4.7%), and 16.0% of residential properties were vacant. Sexually transmitted infections continue to be a concern for the county as well. Chlamydia prevalence was 556.9 versus 421 per 100,000 population region-wide, and gonorrhea was prevalent at 239.5 versus 124. At 1,307.3, HIV/AIDS rates were the highest in the region, and one of the highest rates in the U.S. HIV testing rates, 55.0%, were also some of the highest in the region.

**Gwinnett County** had the lowest percentage of residents reporting poor dental health in the region, at 8.3%. Most health indicators are better than average. Rates of heart disease, respiratory disease, cancers, injuries, mental health, maternal and infant health, and most other leading health conditions were all well below regional and state averages. Premature mortality was less likely to result from traffic fatalities but more likely to occur by gun violence. The birth rate (38.7) was nearly equivalent to the regional average (38.6), and hospital utilization for pregnancy and childbirth was only marginally above average. The teen birth rate, 9.1, was below the regional average of 12.0. The prevalence of sexually transmitted illnesses (STIs) was below average, and HIV testing rates were above average.
The premature death rate, 4,827.5, is much lower than the regional average (6,330.5). Residents report fewer poor physical health days (2.6 versus 3.5) and fewer poor mental health days (2.7 versus 3.3). However, the county’s elderly appear to have some elevated health risks for their age, such as slightly elevated mortality due to dementia and hospital utilization for Alzheimer’s.
IX. Community Resources to Meet Needs

**Purpose**
Taking an inventory of the resources available to improve health is an important step in assessing the health needs of communities served by Mercy Care. Knowing what resources are available to improve health offers an understanding of the capacity and potential partners in the community which can increase the success of any efforts to address health needs.

**Methodology**
GHPC completed an environmental scan of community resources that may meet health needs of residents by collecting information from Mercy Care, primary data sources (i.e., interviews, focus groups and listening sessions), secondary data, and internet research to identify the community resources that are currently operating in the community to meet the needs identified by the CHNA.

GHPC focused specifically on assets that were deemed to be operational and of notable value to the community. Not all assets in each county have been included in this report. Assets were prioritized based on their scope and level of activity so far as could be determined. We have not listed organizations without a functioning website or food banks that do not distribute food or meals. A strong focus has been placed on representing organizations that provide services to vulnerable populations, as well as organizations that provide free or sliding scale services.

The organizations GHPC documented were broken out into three separate categories based on their primary focus: health care, community focused, and education. Of the 23 county-specific assets, 1 has a focus on education, 7 have a healthcare or health related focus, and 15 are community focused. The region includes assets with a regional, and in some cases, a statewide reach. A table has been provided showing in which counties larger organizations are operating.

**Characteristics**
Community assets are people, places, and relationships that can conceivably be used in acting to bring about the most equitable functioning of a community. Community assets can include grocery stores, parks, schools, and hospitals. The Mercy Care Chamblee service area has a multitude of community and organizational assets ranging from local healthcare facilities, to faith-based institutions, to independent community groups. To analyze the community assets in the region, GHPC focused on those providing health and health related services. GHPC included faith-based institutions when they provide health-related services to the community. Reviewing data from the National Center for Charitable Statistics, the Georgia Center for Nonprofits, and Community Commons GHPC was able to document 33 county-specific organizations within the region. Each of the region’s counties has within its boundaries or is proximate to the basic community assets of schools, parks, and healthcare facilities.

**Recommendations**
GHPC recommends that Mercy Care continue to foster and facilitate a partnership with community resources. It will be important to convene stakeholders around important issues and goals. Mercy Care’s new clinic can lend space for community meetings. Mercy Care can also participate in the broader community discussions related to the health of residents.
Summary

Existing health care facilities

Access is a crucial component of achieving health. An estimated 2,180 primary care physicians (86 per every 100,000 people) are available in the region. Twenty-seven (27) federally qualified health centers and 21 acute care hospitals are located in the 3 counties.

Table 6: Acute Care Hospitals in Mercy Care Chamblee Service Area

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>City</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children's Healthcare of Atlanta at Egleston</td>
<td>Atlanta</td>
<td>DeKalb</td>
</tr>
<tr>
<td>DeKalb Medical</td>
<td>Decatur</td>
<td>DeKalb</td>
</tr>
<tr>
<td>DeKalb Medical Hillandale</td>
<td>Lithonia</td>
<td>DeKalb</td>
</tr>
<tr>
<td>Emory University Hospital</td>
<td>Atlanta</td>
<td>DeKalb</td>
</tr>
<tr>
<td>Emory University Orthopedics and Spine Hospital</td>
<td>Tucker</td>
<td>DeKalb</td>
</tr>
<tr>
<td>Wesley Woods Geriatric Hospital of Emory University</td>
<td>Atlanta</td>
<td>DeKalb</td>
</tr>
<tr>
<td>Atlanta Medical Center</td>
<td>Atlanta</td>
<td>Fulton</td>
</tr>
<tr>
<td>Children's Healthcare of Atlanta at Hughes Spalding</td>
<td>Atlanta</td>
<td>Fulton</td>
</tr>
<tr>
<td>Children's Healthcare of Atlanta at Scottish Rite</td>
<td>Atlanta</td>
<td>Fulton</td>
</tr>
<tr>
<td>Emory Johns Creek Hospital</td>
<td>Johns Creek</td>
<td>Fulton</td>
</tr>
<tr>
<td>Emory University Hospital Midtown</td>
<td>Atlanta</td>
<td>Fulton</td>
</tr>
<tr>
<td>Grady Memorial Hospital</td>
<td>Atlanta</td>
<td>Fulton</td>
</tr>
<tr>
<td>North Fulton Regional Hospital</td>
<td>Roswell</td>
<td>Fulton</td>
</tr>
<tr>
<td>Northside Hospital</td>
<td>Sandy Springs</td>
<td>Fulton</td>
</tr>
<tr>
<td>Piedmont Hospital</td>
<td>Atlanta</td>
<td>Fulton</td>
</tr>
<tr>
<td>Emory Saint Joseph’s Hospital</td>
<td>Atlanta</td>
<td>Fulton</td>
</tr>
<tr>
<td>South Fulton Medical Center</td>
<td>East Point</td>
<td>Fulton</td>
</tr>
<tr>
<td>Emory Eastside Medical Center</td>
<td>Snellville</td>
<td>Gwinnett</td>
</tr>
<tr>
<td>Emory John’s Creek Hospital</td>
<td>Duluth</td>
<td>Gwinnett</td>
</tr>
<tr>
<td>Gwinnett Medical Center Duluth</td>
<td>Duluth</td>
<td>Gwinnett</td>
</tr>
<tr>
<td>Gwinnett Medical Center</td>
<td>Lawrenceville</td>
<td>Gwinnett</td>
</tr>
</tbody>
</table>

Other existing community resources

Below is a listing of community assets by county. Following the list of state-wide assets, the organizations are presented in alphabetical order by county. The total number of county-specific assets identified in each county follows the name of each county.
### Table 7: State-wide Community Resources

<table>
<thead>
<tr>
<th>Organization</th>
<th>Counties Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boys and Girls Club</td>
<td>DeKalb, Fulton, Gwinnett</td>
</tr>
<tr>
<td>Children’s Advocacy Centers of Georgia</td>
<td>Fulton, Gwinnett</td>
</tr>
<tr>
<td>CIMA International Women’s Health Services</td>
<td>Fulton, Gwinnett</td>
</tr>
<tr>
<td>Communities in Schools</td>
<td>DeKalb, Fulton</td>
</tr>
<tr>
<td>Georgia Family Connection</td>
<td>All Counties</td>
</tr>
<tr>
<td>Georgia Head Start</td>
<td>All Counties</td>
</tr>
<tr>
<td>United Way</td>
<td>Fulton*</td>
</tr>
<tr>
<td>YMCA</td>
<td>DeKalb, Fulton, Gwinnett</td>
</tr>
</tbody>
</table>

*United Way of Greater Atlanta is located in Fulton County, but also serves DeKalb and Gwinnett.

**Boys and Girls Clubs** provide a structured and positive environment and programs for young people. [http://bgcncg.org/](http://bgcncg.org/)

**Children’s Advocacy Centers of Georgia** The majority of CAC Georgia’s professional work product is designed to provide direct services to CACs across the state. A critical corollary is to provide direct services and support to those Georgia communities that seek to establish a CAC within their judicial circuit, by working with the base of stakeholders who will ultimately become active as multidisciplinary team members. [http://www.cacga.org/](http://www.cacga.org/)

**CIMA Women’s Clinic** primarily serves the immigrant female population through its five locations in Doraville, Norcross, Sandy Springs, Indian Trail and Chamblee. The clinic, which has been serving the community for 13 years, offers maternity and family planning services as well as routine Ob/Gyn services. [http://www.cimasalud.net/cima--about-us.html](http://www.cimasalud.net/cima--about-us.html)

**Communities in Schools** is the nation’s largest dropout prevention organization. The mission of Communities in Schools is to champion the connection of needed community resources with schools to help young people successfully learn, stay in school and prepare for life. By bringing caring adults into the schools to address children’s unmet needs, CIS provides the link between educators and the community. For over 30 years, Communities In Schools has worked to ensure that every child needs and deserves these “Five Basics”: a one-on-one relationship with a caring adult, a safe place to learn and grow, a healthy start and a healthy future, a marketable skill to use upon graduation, and a chance to give back to peers and community. [http://www.communitiesinschools.org/](http://www.communitiesinschools.org/)

**Georgia Family Connection** collaborative organizations operate in independently in counties as local decision-making bodies, bringing community partners together to develop, implement, and evaluate plans that address the serious challenges facing Georgia’s children and families. They are supported by the **Georgia Family Connection Partnership**, a nonprofit public-private intermediary which exists to: unify their commitment to Georgia’s children and families, make sure their efforts to improve the lives of children and families work and, protect every dime of their investment in Georgia’s future. [http://www.gafcp.org/](http://www.gafcp.org/)

**Georgia Head Start** and Early Head Start programs provide comprehensive early childhood and family development services to children from birth to five-years-old, pregnant women and families. Their programs have a long tradition of delivering comprehensive and high quality services designed to foster healthy development in low-income children and their families. Head Start agencies provide a range of
individualized services in the areas of education and early childhood development; medical, dental, and mental health; nutrition; parent involvement and family support. In addition, the entire range of Head Start services is responsive and appropriate to each child and family's developmental, ethnic, cultural, and linguistic heritage and experience. They operate in 57 of 59 Georgia counties. 
http://www.georgiaheadstart.org/ 

**United Way** seeks to provide adequate funding and guidance for member agencies to:

- Provide for immediate needs of those in crisis situations
- Meet long-term needs through the educational, emotional and moral guidance of children
- Enable financially or physically disabled people to become self-supporting
- Websites are regional, https://www.unitedwayatlanta.org/

**YMCA** makes accessible the support and opportunities that empower people and communities to learn, grow and thrive. With a focus on youth development, healthy living and social responsibility, the YMCA nurtures the potential of every youth and teen, improves the nation’s health and well-being and provides opportunities to give back and support neighbors. Website is regional, http://www.ymcaatlanta.org/ 

**County-specific Community Resources**

**DeKalb (8):**

**All About Developmental Disabilities** is a 501(c)(3) Georgia non-profit organization. They work to ensure that individuals and families living with developmental disabilities are equipped with critical support services, broad-based education, community integration opportunities, and effective advocacy from age three and throughout their lifespan.  http://aadd.org/ 

**Care and Counseling Center of Georgia** is a faith based non-profit organization offering counseling services to individuals and families in the greater Atlanta area. They are one of the largest mental health providers in Georgia. http://cccgeorgia.org/ 

**CaringWorks** helps those who are homeless stabilize their lives and move toward greater self-sufficiency. They provide the housing and support needed to get people to a better place in life. http://www.caringworksinc.org 

**Hispanic Health Coalition of Georgia** is a 501 (c) (3) non-profit organization created to advance health policies that will improve access to services for Hispanic children and adults throughout the state. HHC is currently Georgia's only statewide organization that focuses on Latino/Hispanic health. Together with its members (both health-related and non-health centered organizations and professionals), HHC identifies needs and service gaps leading to health disparities for Georgia Hispanics and offers direct community services as well as supportive activities to help its members improve the health wellbeing of Georgia Latinos. HHC informs individuals and agencies on current health disparities and ways to reduce these disparities. As part of its efforts, HHC offers skills development services to organizations who desire to provide high quality, culturally and linguistically appropriate services.  http://www.hhcga.org/
21st Century Leaders (21CL) was established by a group of executives in response to two alarming trends: 1) a lack of people prepared to accept leadership roles, and 2) the difficulty of employees in crossing class and racial barriers to work together. The group realized the key to reversing these trends is providing young people with the training, guidance, and encouragement necessary to enter college and the workforce with a highly developed set of leadership skills. The mission of 21st Century Leaders is to inspire the next generation of Georgia leaders by empowering high school students with essential business and community leadership skills through programs connecting a diverse group of enthusiastic peers and passionate professionals. [http://21stcenturyleaders.org/]

The Wylde Center teaches environmental awareness through hands-on gardening and outdoor education programs. The Wylde Center engages students in projects that address real needs, both through the community gardens and through outreach projects in Decatur City and DeKalb County schools and community centers. The Wylde Center has been instrumental in helping create the outdoor garden environments at many of the schools in Decatur and is also helping guide the Farms to School initiative in Decatur. [http://wyldecenter.org/]

Arms Wide Open Community Development Fund is a tax-exempt corporation specializing in home and community-based services. When people become frail due to age, accident, serious illness, injury or sickness, Arms Wide Open CDC helps them to live at home with dignity. Arms Wide Open CDC operates three programs: 1) Durable Medical Equipment Loan Program, 2) Community Chaplaincy Program, and 3) Life Care Program. Arms Wide Open CDC administers high-quality, cost-effective, and goal-oriented programs that help people with disabilities and chronic illnesses. [http://armswideopen.org/]

Center for Pan Asian Community Services CPACS is a private non-profit agency that promotes self-sufficiency and equity for immigrants, refugees, and the under-privileged through comprehensive health and social services, capacity building, and advocacy. [http://www.icpacs.org/]

**Fulton (8):**

100 Black Men of Atlanta Inc. provides mentoring, physical fitness training, and college preparation for inner city youth, through activities such as Robotics. [http://www.100blackmen-atlanta.org]

Action Ministries serves homeless women through their Women’s Community Kitchen and homeless children through their Children’s Program. [http://actionministries.net/]

AID Atlanta focuses on prevention and early diagnosis of common health issues such as diabetes and heart disease. Their services include physical exams, prostate and testicular exams, screening and treatment for sexually transmitted diseases, and blood glucose and cholesterol testing. [https://www.aidatlanta.org/home]

Agape Community Center empowers and supports underserved families within its community to discover and embrace their full potential. Agape achieves this mission by offering programs and services that are responsive to a variety of needs for school-age children, disabled individuals, adults, senior citizens, and families of northwest Atlanta. Current programs offered include the following:

- Academic—based afterschool for elementary and middle school students
- ESOL for Spanish speaking students with language barriers
- The Ginger Kaney Mentoring Institute for high school students
• Ragtime, a day program for seniors and disabled adults
• Emergency assistance for families
• GOGIRLGO! and F.I.T. Camp for Boys, athletic, health & wellness summer camp
• Camp Jumpstart – a summer early reading program for rising first and second graders
• Agape to Go – a family nutrition backpack program
• Annual Events: great backpack giveaway, great Thanksgiving giveaway, extreme bedroom makeover

http://agapeatlanta.org/

Atlanta Housing Authority – Quality of Life Initiative allows families in AHA’s remaining conventional public housing projects the opportunity to escape an environment of concentrated poverty, consistent with AHA’s vision of providing eligible families with access to affordable housing, while de-concentrating poverty and building healthy communities. http://www.atlantahousing.org/portfolio/index.cfm?fuseaction=qli

The Center for Black Women’s Wellness, Inc. is a non-profit organization that provides free and low-cost services to empower black women, and their families, toward physical, mental, and economic wellness. CBWW recognizes that empowering black women leads to the empowerment of the family and, eventually, the empowerment of the community. CBWW’s comprehensive services include: preventative health services, maternal and child health services, mental health screening and referrals, and self-employment training. http://www.cbww.org/

CHRIS Kids, Inc. offers an array of individualized programs through its Family of Services which includes: Behavioral Health, Safe Homes & Environments, Strong Communities and Education & Training. This holistic approach enables children, youth and families to unlock their potential for happiness, health and success despite challenging circumstances, often beyond their control. CHRIS Kids’ ambition is to be Georgia’s go-to place where every vulnerable child or traumatized youth discovers how to unlock their potential. http://www.chriskids.org/home-page

Health Education, Assessment, and Leadership (HEAL) provides health education and medical services to at risk and underserved populations. It is committed to assess the needs of communities and to build leaders from within those communities through health awareness and health education, training, and supportive programs. The HEALing Community Center is located in one of Atlanta’s poorest neighborhoods (Zip Code 30314), where having no medical insurance is commonplace. The HEALing Community Center is dedicated to providing free specialty medical care to low income children, women, and men. http://healingourcommunities.org/

Los Niños Primero is an educational enrichment program for Latino children in Sandy Springs. The program aids at-risk Latino children increase their school readiness through their Saturday School and Summer School programs. The program serves over one hundred children each year and yields positive outcomes in increasing reading proficiency and language skills. http://www.losninosprimeroga.org

Gwinnett (7):

Good Samaritan Health Center of Gwinnett, Inc., a 501(c) (3) non-profit organization, is a faith-based organization committed to caring for the uninsured and underinsured working poor in our community.
They serve the community by helping to eliminate health disparities for uninsured and underinsured populations. www.goodsamgwinnett.org

Gwinnett Children’s Food Umbrella’s mission is to alleviate hunger and improve the nutritional well-being of Georgia’s children. http://www.gwinnetrchildren.com/

The Gwinnett Coalition for Health and Human Services is a non-profit organization dedicated to addressing the health and human service needs of everyone in Gwinnett County, Georgia. The two primary functions of the Coalition are the management of a community Helpline, and coordination of a 3 year Strategic Plan for children and families. Major strategic focus areas include Positive Child and Youth Development, Strengthening Individuals and Families, and Strengthening Communities. http://www.gwinnettcoalition.org/

Gwinnett United in Drug Education Inc. has used data-driven, evidenced-based strategies since 1986 to reduce and prevent the use, misuse, and abuse of alcohol, tobacco and other drugs by focusing on environmental strategies to achieve community-level change. In the past, they have made significant strides in reducing inhalant use, tobacco use, second hand smoke, and underage drinking. GUIDE follows SAMHSA’s Strategic Prevention Framework (SPF) for all strategic planning. http://www.guideinc.org

Health MPowers is a designated 501(c)(3) non-profit organization working to improve the health status and environment for students in grades PreK-8. HealthMPowers is a comprehensive school health intervention program that exemplifies the key strategies that the Centers for Disease Control and Prevention (CDC) has outlined for improving health, physical activity, and healthy eating in schools. The HealthMPowers’ program is designed to provide students, school staff, and families with information, skills, resources, and motivation necessary to take responsibility for their own health. http://www.healthmpowers.org/

The Hope Clinic, a non-profit primary care internal medicine clinic in Gwinnett County provides an affordable alternative to the hospital emergency room for the primary care medical needs of the uninsured. The clinic is a vital part of Gwinnett's healthcare safety net and supplies over half of the available charitable primary care capacity in the county. http://hopeclinicgwinnett.info/

Norcross Meals on Wheels has provided thousands of hot midday meals, five days a week, for over thirty-five years. Norcross Meals on Wheels began by delivering to the Norcross and Duluth areas, and has expanded to include Berkeley Lake and Peachtree Corners. They are now a 501(c)(3) nonprofit organization with a dedicated board of directors and program coordinator. https://norcrossmealsonwheels.org/

CPACS’ Cosmo Health Center (Center for Pan Asian Community Services) is a Federally Qualified Health Center located in Norcross. This new status as an FQHC allowed CPACS to purchase a new facility and expand its existing health services to accommodate a larger population including more low-income, underserved, uninsured individuals and those with low English language proficiency. It also allowed CPACS to expand its existing primary and preventative care clinics as well as expand its hours. In addition to primary and preventative care, Cosmo Health Center also offers Internal Medicine, In-Office Minor Surgeries, Immigration Physical Exams, Ob/Gyn and Dental services. Cosmo also provides health education resources on HIV/AIDs, Family Planning, Medical Insurance, Mental Health and Counseling and Breast Cancer awareness. http://cpacscosmo.org/
Appendix A: Focus Group Discussion Guide

Overview of Purpose of Discussion and Rules of a Focus Group

- Facilitator introduces self and thanks those in attendance for participating
- Facilitator explains purposes of discussion:
  The project is being undertaken by Mercy Care. The health system is planning to open a clinic in the Chamblee area. Mercy Care would like to hear from people who live in these communities. They are particularly interested in your feelings about the location of the clinic, health and health needs of the community, how the health-related challenges might be addressed and what is already in place in your community to help make change happen. More than just determining what the problems are, they want to hear what solutions you all have to address the needs and what you would be willing to support in terms of programs, services, and opportunities.

- Explain about focus groups:
  - Give and take conversation
  - I have questions I want to ask, but you will do most of the talking
  - There are no right or wrong answers
  - You are not expected to be an expert on health care, we just want your opinion and your perspective as a member of this community
  - You don’t have to answer any questions you are uncomfortable answering
  - It is important to speak one at a time because we are recording this conversation
  - Your names will not be used when the tapes are transcribed, just male or female will appear on any transcript
  - I want to give everyone the opportunity to talk, so I may call on some of you who are quiet or ask others to “hold on a minute” while I hear from someone else, so don’t take offense
  - Here is an informed consent form for you to read along with me and then sign. (Read informed consent, collect signatures)

Participant Introductions

Please go around the table and introduce yourself and tell us how long you have lived in the Chamblee area.

I am going to ask you all a series of questions about your opinions related to healthcare and the locations where you seek health services (primary care, hospital care, urgent care, etc.).

1. Where do you secure health services (primary care, hospital care, urgent care, etc.)?
2. If you have a regular doctor, what do you like about the practice? If you do not have a regular doctor, what do you look for when seeking health services? (Primary care, hospital care, urgent care, etc.)

I am going to ask you all a series of questions about your own health and healthcare first, and then some questions about what you see happening in your larger community related to health and wellbeing.

Thoughts on Health for Your Family and Community

3. Do you think that most people in your community are healthy?
4. Do you think that there is something about your community that contributes to people having these types of issues?
5. What do you think might be effective solutions to addressing these issues in the community?

I am going to ask you all a series of questions about Mercy Care as a health provider.
6. What are your thoughts/feelings regarding the location of a Mercy Care clinic in your community?
7. What should be the focus areas for health education programs at the new Mercy Care Clinic in the community?
8. What types of services would you like to see provided?
9. Are there any other ways you would like to be engaged by Mercy Care (information, volunteerism, etc.)?

Healthy Behaviors

I want to go a bit deeper in a few areas related to your and your family’s health.

10. Let’s start with healthy eating. Most of the time, do you and your family eat as healthily as you would like? What prevents you from eating healthily? (Probe for cultural issues, access to healthy food)
11. Now let’s talk about physical activity. What kinds of physical activity do you and your family engage in? Do you think you get enough physical activity to be healthy?
12. What keeps you and your family from being as physically active as you would like to be? What would help you and your family get more exercise?
13. If you could make 2 or 3 changes that would promote better health, what would they be?
14. How about tobacco use? How prevalent is tobacco use among your family and friends? Do you think most people are aware of the risks related to tobacco use? What do you think it would take to change people’s habits when it comes to tobacco use?
15. Are drug and alcohol abuse a problem in your community? What contributes to this problem? What could be done to address the problem?
16. Another health issue of concern is risky sexual behavior among teens. Do you see this as prevalent in your community? Are there support services to help teens deal with this type of issue?
17. When you think about the health concerns we have discussed – do you know of any resources/programs/services in your community that help with these issues? Are there different types of services that would be more appropriate or effective?

Health Outcomes and Access

18. What is your reaction to this information? Does it ring true to what you know about your community? Is there anything missing from these data that you believe to be true about your community?
19. What do you think is the best/most effective way to begin to address these issues?
20. What do you see as the role of the hospital or health system to address these issues?
21. Considering the information that I just presented to you, along with your own experience with critical health needs here, which 1 or 2 of these health issues should be the priorities for addressing over the next three years?

Health Concerns in the Community

22. Now let’s talk about what about your community. Please tell me about the strengths/positives in your community.
23. In communities, people often talk about community leaders- these are organizations or individuals that everyone knows, places/people that you seek out when you need information that is trusted. Do you know of these types of organizations or people who are concerned about health issues and serve as leaders in trying to improve health in your community? Who are they – what are they doing? Are their efforts successful? Why or why not?
24. Would these organizations or people be good leaders for addressing other health issues in the community? If not them, then who?

Closing:

How would you like your community to be different in 5 years in order to be a healthier place for you and your family to live?
## Appendix B:
Stakeholders Interviewed for Community Leader Input

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shirley Anne Cruz</td>
<td>LaAmistad</td>
<td>Assistant Director</td>
</tr>
<tr>
<td>Selena Freeman</td>
<td>Mercy Housing</td>
<td>Chamblee Program Manager</td>
</tr>
<tr>
<td>Keun Kim</td>
<td>The Center for Pan Asian Community Services, Inc.</td>
<td>Marketing and Development</td>
</tr>
<tr>
<td>Adam Causey</td>
<td>The City of Chambleee</td>
<td>Economic Development Manager</td>
</tr>
<tr>
<td>Evonne Yancey</td>
<td>Kaiser Permanente</td>
<td>Director of Government and Community Affairs</td>
</tr>
<tr>
<td>Emily VanderWiele and Dr. Lennon</td>
<td>CHOA, Children’s at Chamblee Primary Care Center</td>
<td>Director of Physician Practice Operations and Medical Director, Primary Care</td>
</tr>
<tr>
<td>Nicole Hendrickson</td>
<td>Gwinnett County Administration</td>
<td>Community Outreach Program Director</td>
</tr>
<tr>
<td>Salvador Arias</td>
<td>Retired</td>
<td>Mercy Care Board Member</td>
</tr>
<tr>
<td>Morgan Alexander</td>
<td>The Georgia Lions Lighthouse Foundation Inc.</td>
<td>Program Manager</td>
</tr>
<tr>
<td>ESJH Group Interview (12)</td>
<td>Emory Saint Joseph’s Hospital</td>
<td>Doctors and Hospitalists</td>
</tr>
<tr>
<td>Jose Almaraz</td>
<td>Futbol Pasion</td>
<td>Director</td>
</tr>
<tr>
<td>Pedro Marin</td>
<td>Georgia State House of Representatives</td>
<td>State Representative</td>
</tr>
<tr>
<td>Sandra Valencia Thompson</td>
<td>Catholic Charities</td>
<td>Program Manager, Clinical Services</td>
</tr>
</tbody>
</table>
Appendix C: Community Leader/Stakeholder/Key Informant In-Depth Interview Guide

INTRODUCTION

1. What in your opinion are the district/county’s biggest health issues or challenges that need to be addressed?
2. What do you think are some of the root causes for these challenges?
3. How important an issue to the district/county is the reduction/elimination of health disparities? What is your perception of current disparities?
4. How would you describe the present level of public/private partnerships that are occurring to improve health and reduce health disparities in the county?
5. What are the challenges to beginning and sustaining such partnerships?
6. What specific programs and local resources have been used in the past to address health improvement/disparity reduction? (might cite examples of programs by disease state, life stage or otherwise)

COMMUNITY CAPACITY

1. Who/What are some of key individuals/organizations/programs to health and health care in the community?
2. Which community based organizations are best positioned to help improve the community’s health?
   - Private sector agencies
   - Public sector agencies
3. Are there individuals, agencies or organizations you’d like to see more engaged in your community’s health improvement journey?
4. Are you familiar Mercy Care’s plan to open a clinic in the Chamblee area?
5. What are your thoughts about the Mercy Care building a clinic in the Chamblee community (i.e., appropriateness of location, who might be likely users, etc.)?
6. What should be the focus areas of programs and services at the new Mercy Care Clinic in the Chamblee area (serving parts of DeKalb, Fulton and Gwinnett Counties)? Clinic services: Other programs and services (e.g. health education, health promotion, outreach and enabling services, etc.)

MOVING THE NEEDLE

1. If you could only pick 3 of these health issues, which are the most important ones to address either now (short term) or later (long term)? What should be the focus of intervention by county/district/community?
2. Why did you pick these?
3. What interventions do you think will make a difference?
   a. Probe for different types of interventions related to:
      i. Policy
      ii. Environment
      iii. Program
4. Do you have any other recommendations that you would make to Mercy Care as they develop intervention strategies?
Appendix D: Secondary Data

Data Sources - Descriptions

Centers for Disease Control and Prevention (CDC): The Behavioral Risk Factor Surveillance System (BRFSS) is the nation’s premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. Established in 1984 with 15 states, BRFSS now collects data in all 50 states as well as the District of Columbia and three U.S. territories. BRFSS completes more than 400,000 adult interviews each year, making it the largest continuously conducted health survey system in the world.

County Health Rankings and Roadmaps: The annual County Health Rankings measure vital health factors, including high school graduation rates, obesity, smoking, unemployment, access to healthy foods, the quality of air and water, income, and teen births. The annual rankings provide a revealing snapshot of how health is influenced by where we live, learn, work and play. Building on the work of America's Health Rankings, the University of Wisconsin Population Health Institute has used this model to rank the health of Wisconsin’s counties every year since 2003. The County Health Rankings measure the health of nearly all counties in the nation and rank them within states. The rankings are compiled using county-level measures from a variety of national and state data sources. These measures are standardized and combined using scientifically-informed weights.

Georgia Department of Public Health Online Analytical Statistical Information System (OASIS): The Online Analytical Statistical Information System (OASIS) is a web-based tool that allows access publicly available health data and statistics for the state of Georgia. The standardized health data repository used by OASIS is currently populated with Vital Statistics (births, deaths, fetal deaths, induced terminations, and pregnancies), Hospital Discharge, Emergency Room Visit, Arboviral Surveillance, Youth Risk Behavior Survey (YRBS), Behavioral Risk Factor Surveillance Survey (BRFSS), and STD, Motor Vehicle Crash, and Population data. Where applicable, data can be stratified by age groups, race, ethnicity, sex (person), census tract, county commission district, county, health district, legislative district, perinatal region, state (place), and year (time).

Health Indicators Warehouse: The Health Indicators Warehouse (HIW) is a user-friendly web-accessible database of pre-tabulated national, state, and local health indicators, reflecting multiple dimensions of population health, health care, and health determinants. The HIW also contains supporting descriptive data to facilitate understanding and appropriate use of the indicators, as well as links to evidence-based interventions. The National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention data is also accessible through the Health Indicators Warehouse.

Community Commons: This toolkit is a free web-based platform designed by a collaborative body in response to the IRS requirement outlined in the Affordable Care Act. This tool was built to assist hospitals and organizations seeking to better understand the needs and assets of their communities as well as collaborate to make measurable improvements in community health and well-being. It aggregates up-to-date data from dozens of sources, including the American Community Survey, Centers for Medicare and Medicaid Services, Dartmouth Atlas of Health Care, Environmental Protection Agency, National Cancer Institute, National Center for Education Statistics, National Highway Traffic Safety Administration, and others.
Truven Health Analytics Community Need Index: The CNI score is an average of five different barrier scores that measure various socio-economic indicators. The insurance barrier is drawn from their own health insurance coverage estimates using multiple data inputs. The other four barriers are obtained from Nielsen (formerly Claritas) which derives estimates from decennial census data from 2000 and 2010, and Five-Year American Community Survey data with 2008-12 as the most recent published update. These barriers, and the statistics that comprise them, were chosen and tested by Dignity Health and Truven Health. Every populated ZIP code in the United States is assigned a barrier score of 1, 2, 3, 4, or 5 depending upon the ZIP code national rank (quintile). A score of 1 represents the lowest rank nationally for the statistics listed, while a score of 5 indicates the highest rank nationally. For the two barriers with only one statistic each (education and housing), Truven Health used only the single statistic listed to calculate the barrier score. For the three barriers with more than one component statistic (income, cultural and insurance), Truven Health analyzed the variation and contribution of each statistics for its barrier; Truven Health then weighted each component statistic appropriately when calculating the barrier score. Once each ZIP code is assigned its barrier scores from 1 to 5, all five barrier scores for each ZIP code are averaged together to yield the CNI score. Each of the five barrier scores receives equal weight (20% each) in the CNI score.

Health Resources and Services Administration (HRSA). The HRSA Data Warehouse (HDW) map and feature services provide access to the spatial data available in the HDW. Services include HRSA data as well as additional layers, such as state and county boundaries, that help establish the geographic context of HRSA-specific data. Map layers can be directly viewed with ArcGIS for Desktop Software or through custom applications using the service's REST or SOAP endpoints. The Primary Health Care Facilities feature service provides information on Health Center Service Delivery Sites and Health Center Service Delivery Grantees.

US Department of Agriculture Food Access Research Atlas. In the Food Access Research Atlas, several indicators are available to measure food access along these dimensions. The criteria for identifying a census tract as low income are from the Department of Treasury’s New Markets Tax Credit (NMTC) program. This program defines a low-income census tract as any tract where the tract’s poverty rate is 20 percent or greater; or the tract’s median family income is less than or equal to 80 percent of the State-wide median family income; or the tract is in a metropolitan area and has a median family income less than or equal to 80 percent of the metropolitan area's median family income. In the Food Access Research Atlas, low access to healthy food is defined as being far from a supermarket, supercenter, or large grocery store ("supermarket" for short). A census tract is considered to have low access if a significant number or share of individuals in the tract is far from a supermarket. Low access was measured as living far from a supermarket, where 1 mile was used in urban areas and 10 miles was used in rural areas to demarcate those who are far from a supermarket. In urban areas, about 70 percent of the population was within 1 mile of a supermarket, while in rural areas over 90 percent of the population was within 10 miles. A slightly more complex measure incorporates vehicle access directly into the measure, delineating low-income tracts in which a significant number of households are located far from a supermarket and do not have access to a vehicle.
US Census Bureau. The decennial census is conducted once every 10 years to provide an official count of the entire U.S. population to Congress. The American Community Survey (ACS) is conducted every year to provide up-to-date information about the social and economic needs of the community. Every year, the U.S. Census Bureau contacts over 3.5 million households across the country to participate in the ACS. The ACS shows how people live—education, housing, jobs and more. For example, results may be used to decide where new schools, hospitals, and emergency services are needed. The Census Bureau aggregates individual ACS responses into estimates at many geographic summary levels, such as states, counties, cities, tracts, block groups, and census designated places. In order to balance geographic resolution, temporal frequency, statistical significance, and respondent privacy, ACS estimates released each year are aggregated from responses received in the previous one, three, or five calendar years. 1-year estimates are available for areas with a population of at least 65,000 people; 3-year estimates were available for areas with 20,000 people or more (this data product was discontinued in 2015 due to budget cuts); and 5-year estimates are available for all areas down to the block group scale.
Supplementary Maps and Tables.

Figure 7: Community Need Index by Zip Code

* Note* - Darker color indicates high socio-economic barriers to accessing healthcare.
Figure 8: Children in Poverty by Census Tract\textsuperscript{14}

\textbf{CHNA Service Area}

\textbf{Percent of Children Under 18 Living Below 100\% Poverty Level}

(2010-2014)

\textsuperscript{14} US Census Bureau, 2010-2014 American Community Survey
In Figure 9, the proportion of single-parent households is shown in orange, with more heavily-shaded areas having the highest rates. The lightest areas have less than 25% single-parent households, medium-shaded areas have >25% to 50%, and the brightest orange areas have >50% to 75%. None of the census tracts in the service area had more than 75% single parent households, but several had rates over 50%.

For families with limited parental resources, schools can play a larger role in child care and development. The College and Career Readiness Performance Index (CCRPI), developed by the Georgia Department of Education, rates schools not only on grades and test scores, but also on factors such as attendance, enhanced curricula, and the performance gaps between English-learners, economically disadvantaged students, and students with disabilities relative to other students. Scores range from 0 to 100 plus up to 10 bonus points. There were around twenty failing schools in the service area (60 points or under) but also many high-performing schools.

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15 US Census Bureau, 2010-2014 American Community Survey; Georgia Department of Education
Figure 10: Language Barriers by Census Tract

CHNA Service Area
Percent Over Age 5 Speak English Less Than Well (2010-2014)

16 US Census Bureau, 2010-2014 American Community Survey
Figures 10 and 11 indicate the extent of language barriers in the service area. In Figure 10, the areas of darkest purple show an extensive corridor along I-85 and Buford Highway, in and outside of the perimeter, in which over 30% of residents above the age of 5 do not speak English well. This concentration may support businesses and services which can serve these individuals in their native language; however, they may encounter difficulties accessing goods and services elsewhere, such as specialty medical care. Figure 11 shows the distribution of households in which no person over the age of 14 speaks English well. In the darkest shade of periwinkle, over a quarter of households are isolated by language barriers, and at least 10% in the second-darkest areas. Thus, at least one in ten households is linguistically isolated in much of the service area.
Figure 12: Racial/Ethnic Distribution by Census Tract

Figure 12 shows the distribution of people who identify themselves and their family members as non-Hispanic White, as a percentage. Due to structural discrimination relative to race and ethnicity, spatial concentration by racial or ethnic identity also results in disparities in goods, services, and living environments. In an unsegregated area, racial and ethnic identities will be relatively evenly dispersed. In the service area, nearly half of the census tracts are highly segregated (more than 80% or less than 20% non-Hispanic White).

17 US Census Bureau, 2010-2014 American Community Survey
Educational attainment is one of the strongest determinants of health outcomes and life expectancy. However, these rates can be misleading relative to first-generate immigrants, who may have a different educational background from their home country, and who also tend to benefit from certain cultural protective factors. In Figure 13, many communities in the service have more than 25% of working age adults who lack a high school degree equivalent (dark yellow), and the area around the airport is over 50% (red).

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18 US Census Bureau, 2010-2014 American Community Survey
About half of the service area had above average unemployment rates, especially in the outermost areas, for the 2010-2014 estimates shown in Figure 14. Unemployment rates have decreased by about half as of 2016, but only state and county level rates are available. However, spatial patterns in unemployment tend to persist even as their mean rates rise and fall.

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19 US Census Bureau, 2010-2014 American Community Survey
Figures 15 & 16: Uninsured Adults and Children by Census Tract

CHNA Service Area
Percent of Adults 18-64 Without Health Insurance
(2010-2014)

US Census Bureau, 2010-2014 American Community Survey

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20 US Census Bureau, 2010-2014 American Community Survey
Figure 17 indicates a wide range of tenure in the service area, from fewer than 25% renting households in the lightest green to more than 75% in the darkest green. Research has indicated that around 62% homeownership provides an equilibrium between households who wish to invest deeply in a community and those who wish to retain greater mobility due to age, career, or other factors. Very high renting household rates (>50%) may indicate lack of adequate investment or continuity leading to lack of amenities, lack of civic involvement, and potential health hazards. However, very low rates (<25%) can indicate inadequate rental housing supply and the potential for housing cost burdens or reduced job access. Both conditions are associated with reduced access to health needs, risky behavior, and mental health issues.

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21 US Census Bureau, 2010-2014 American Community Survey
Table 8: Measures of Behavioral Health Need by County and Race/Ethnicity

<table>
<thead>
<tr>
<th>Health Need</th>
<th>DeKalb</th>
<th>Fulton</th>
<th>Gwinnett</th>
<th>Asian</th>
<th>African American</th>
<th>Hispanic/Latino</th>
<th>White</th>
<th>US</th>
<th>GA</th>
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</thead>
<tbody>
<tr>
<td>Mental Health Providers per 100,000</td>
<td>246.7</td>
<td>189.3</td>
<td>86.3</td>
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<td></td>
<td></td>
<td></td>
<td>134.1</td>
<td>109.5</td>
</tr>
<tr>
<td>Mental Health ER Rates</td>
<td>761.1</td>
<td>1,146.2</td>
<td>557.4</td>
<td>136.5</td>
<td>1,187.8</td>
<td>598.4</td>
<td>1,007.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor Mental Health Days</td>
<td>3.0</td>
<td>2.7</td>
<td>2.7</td>
<td></td>
<td></td>
<td></td>
<td>3.5</td>
<td>3.3</td>
<td></td>
</tr>
<tr>
<td>Self-Harm/Suicide ER Rates</td>
<td>50.6</td>
<td>57.5</td>
<td>45.9</td>
<td>14.1</td>
<td>61.8</td>
<td>44.6</td>
<td>62.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Enrollee Depression*</td>
<td>14.1%</td>
<td>13.3%</td>
<td>14.2%</td>
<td></td>
<td></td>
<td></td>
<td>15.8%</td>
<td>14.9%</td>
<td></td>
</tr>
</tbody>
</table>

Figure 18: ER Visits for Mental and Behavioral Disorders (includes Substance Use)23

Number of ER Visits by Census Tract of Residence, DeKalb, Fulton and Gwinnett Counties, Mental and Behavioral Disorders, 2010-2014

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22 CHNA.org/Community Commons from Centers for Medicare & Medicaid Services, Health Resources and Services Administration, Centers for Disease Control and Prevention 2006-12 Behavioral Risk Factor Surveillance System
23 Georgia Department of Public Health Online Analytical Statistical Information System 2010-14
24 University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps from Centers for Medicare & Medicaid Services
Cancer did not appear to be highly prevalent in the service area, relative to surrounding areas. Rates could not be established by census tract or ZIP code, and the OASIS interface provides limited mapping options for scale or identifying factors. Overall, Figure 19 indicated that cancers were low in prevalence except for some wealthier, predominantly non-Hispanic areas by Perimeter Center and Tucker.
Breast cancer prevalence appeared extremely low in Figure 20.

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26 Georgia Department of Public Health Online Analytical Statistical Information System 2010-14
Figure 21 indicates moderate to low colon cancer prevalence in the service area. The largest number of cases, in darker shades of orange/brown, appear mainly south of I-85 and north of I-285. However, risk factors may change over time.
Figure 22: Lung Cancer Mortality/Hospital/ER Combined Cases by Census Tract, 2010-2014

Figure 22 shows moderate to low lung cancer cases. The highest numbers, shaded darker, appear outside of the perimeter to the north and east.
Prostate cancer appeared low in Figure 23 except for some higher numbers of cases, in darker orange/brown, in the Perimeter Center and Chastain areas.
Figure 24: Diabetes Mortality by Census Tract, 2010-2014

Figure 24 shows very low risk from diabetes in the service area. However, diabetes mortality may take much longer to manifest than risk factors or diagnoses.

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30 Georgia Department of Public Health Online Analytical Statistical Information System 2010-14
Figure 25: ER Visits for Suicide/Self-Harm

Figure 25 indicates moderately low risk for self-harm in the service area.

Note: This is a color map.
Deaths from cancers were low to moderate in the service area.
Among women ages 19 and under, above average utilization levels were primarily concentrated in an area between Norcross, Tucker, and Lilburn, shown in Figure 27.
The area with the highest utilization numbers also had the highest number of teen births, shown in Figure 28.

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34 Georgia Department of Public Health Online Analytical Statistical Information System 2010-14
There were low numbers of hospital utilization for hypertensive heart disease and high blood pressure in the service area, which is consistent with the population profile.
While a leading cause of death and disease in the service area, as in most places, Figure 30 indicates that the number of individuals needing hospitalization for obstructive or congestive heart conditions (such as heart attack) was fairly average. The highest numbers were in the Tucker area, in the darkest shades of brown.
As indicated in Figure 31, asthma cases were highest along the I-85 corridor outside of the perimeter.
Figure 32 shows the highest number of ER visits for pediatric asthma in the I-85 corridor outside of the perimeter, in Norcross, and in Lawrenceville. Rates are not available at this scale; some variance may be due to differences in population size or demographics.
Supplemental Nutrition Assistance Program (SNAP) benefits provided substantial food budget benefits in the service area, with more than a quarter of households in some places using SNAP to afford nutritious foods in the year prior to participating in the American Community Survey.

39 US Census Bureau, 2010-2014 American Community Survey
Although more than a quarter of households in the core of the service area do not have a car available, and although there are several high-frequency transit corridors in those areas, large expanses lack transit or bicycle facilities to connect residents from their homes to jobs, services, and transit routes. This can limit their ability to access health care and other health supporting goods and services even if they are just a few miles away. Figure 34 shows regional bicycle facilities as of 2015 in light green, bus transit in purple, and heavy rail transit in gold and red. The percentage of households with no motor vehicle available is indicated by gray shading, ranging from less than 5% in the lightest areas to more than 30% in the darkest.

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40 US Census Bureau, 2010-2014 American Community Survey; Atlanta Regional Commission