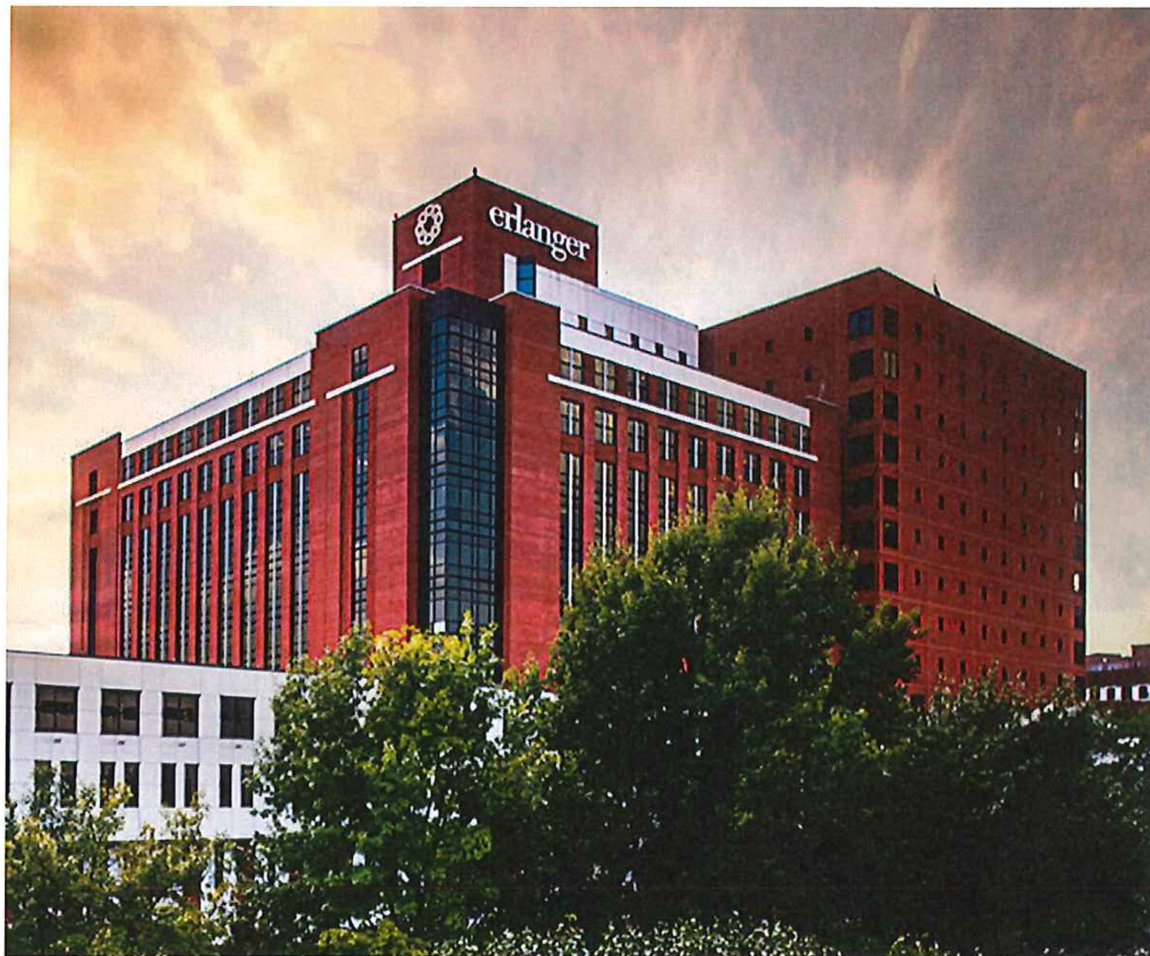

Community Health Needs Assessment

Chattanooga-Hamilton County Hospital Authority

D / B / A

Erlanger Medical Center
975 East 3rd Street
Chattanooga, TN 37403

Erlanger Health System

2019

COMMUNITY HEALTH NEEDS ASSESSMENT

Chattanooga-Hamilton County Hospital Authority

D / B / A

Erlanger Medical Center

Children's Hospital At Erlanger
975 East 3rd Street
Chattanooga, TN 37403

Erlanger East
1755 Gunbarrel Road
Chattanooga, TN 37421

Erlanger North
632 Morrison Springs Road
Chattanooga, TN 37415

ERLANGER HEALTH SYSTEM
Chattanooga, Tennessee

June 30, 2019

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Section A

EXECUTIVE SUMMARY

Section A: EXECUTIVE SUMMARY

Erlanger Medical Center ("*EMC*") is a non-profit, academic teaching hospital affiliated with the *University of Tennessee College Of Medicine* ("*UT-COM*"), *Vanderbilt Medical Center – Health Network*, and *Technion Institute* in Haifa, Isreal. *EMC* is a component hospital of *Erlanger Health System* ("*EHS*"). This *Community Health Needs Assessment* ("*CHNA*") has been prepared in compliance with the *Patient Protection & Affordable Care Act* ("*ACA*") as well as applicable regulations implemented by the *Internal Revenue Service* ("*IRS*") which support the *ACA*.

We ranked the thirteen (13) counties in *EMC*'s regional service area according to community health need indicators derived from *Community Commons* ("*CC*"). The analysis indicates that the rural counties with the greatest need for health status improvement are to the West of Hamilton County (Marion, Grundy, Sequatchie & Bledsoe). Specifically, primary care is a significant need. We have re-applied for approval of a *Federally Qualified Health Center* ("*FQHC*") for primary care in Sequatchie County, Tennessee, to provide primary care . We will also explore the need for an *FQHC* in the area of Red Bank, Tennessee.

The focus group specifically feels that *EMC* should make more of an outreach effort to engage with community agencies, such as schools, etc., instead of "waiting for people to come to us". We will evaluate the possibility of creating a focal point for community education and engagement.

Pertaining to concern about chronic disease, and obesity in particular, our *Children's Hospital* seeks grant funding to support the clinic for childhood obesity, and will seek grant funding to provide community education for obesity and nutrition. For adult obesity, we will explore what services we may offer in this regard. As to heart disease, the community education component of our *Heart & Lung Institute* will seek to collaborate with evaluation to establish a "focal point" for community education.

For needs relating to substance abuse and opioid addiction in the community, we will seek to engage our joint venture partner with the behavioral health hospital, emphasizing the need to accept behavioral health patients with medical conditions. We will also explore the possibility of a Medical / Psychiatric unit at *Erlanger North Hospital* for dual diagnosed emergency patients.

While transportation is recognized as an integral component of healthcare, it is unknown whether we will be able to address this need, but we will explore the community need and resources to determine whether we can make an improvement and how best to address.

Pertaining to the need to evaluate care provided by *EHS* physicians, we will explore ways to further enhance patient engagement.

Section B

HOSPITAL PROFILE

Section B: HOSPITAL PROFILE

EMC is a non-profit, academic teaching hospital affiliated with *UT-COM. EMC* is also a Level I Trauma Center for adults and provider of tertiary care services for the citizens of the four-state region encompassing southeast Tennessee, northwest Georgia, northeast Alabama and southwest North Carolina.

With a history that dates back more than a century, *EMC* is one of the nation's leading public hospitals and is also a leader in medical education through it's affiliation with *UT-COM. EHS* has more than a million *(1)* visits for people who are treated by the team of healthcare professionals at *Erlanger. EMC* has been highly rated in the region several times by *U.S. News and World Report*, and recognized nationally for high-performance in several medical specialties.

Co-located on *EMC's* main campus is *Children's Hospital @ Erlanger* ("*Children's*"). Children have physical and emotional needs which are unique. When ill or injured, they require specialized care and equipment. *Children's* is a place where caregivers know hugs and caring play an important role in healing, where laughter is prescribed in large doses, and where the whole family can find comfort in times of worry and stress.

Children's is the sort of full service facility usually found only in very large cities. The *Neonatal Intensive Care Unit* ("*NICU*") is designated as Level IV, providing the very highest level of care for premature or sick newborns. The Level I Pediatric Trauma Team, Emergency Department and Pediatric Intensive Care Unit provide immediate, 24-hour care for critically ill or injured children. *Erlanger's* LifeForce Air Ambulance and Neonatal/Pediatric Ground Transport unit make the services of *Children's* quickly accessible to pediatric patients. No other facility in our region offers these services.

To provide the best in children's healthcare requires not just special equipment and training, it takes viewing the world from the unique perspective of children and understanding what they need. Providing this special environment of healing for all children, regardless of their ability to pay, is the daily and ultimate goal of everyone at *Children's*. No other facility in the region can say they do the same.

Erlanger East ("*EE*") provides women's services among other programs and is a "lifestyle" hospital. It is a community hospital and a vital part of the system of care that comprises *Erlanger Health System* ("*EHS*"). This multi-faceted hospital campus also meets the needs of a growing community with a surgical center, 24/7 full service emergency department, outpatient imaging center, physician offices, outpatient cancer center, pharmacy and more. *EE* is currently licensed for 124 inpatient beds, and holds a Certificate of Need ("*CON*") to initiate neonatal intensive care services ("*NICU*") with a Level III *NICU*.

Erlanger North ("*EN*") is a community hospital with a full service emergency department along with ambulatory programs, which include an Accredited Sleep Disorders Center, offering a home-like environment for adult and child sleep studies and treatment.

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1 This figure includes the *Erlanger Physician Network* of employed practitioners.

Erlanger has centered its culture and entire patient care effort around its *Mission, Vision & Values*, as follows.

Mission

We compassionately care for people.

Vision

Erlanger is a nationally acclaimed health system anchored by a leading academic medical center. As such, we deliver the highest quality, to diverse populations, at the lowest cost, through personalized patient experiences across all patient access points. Through innovation and growth, we will sustain our success and spark economic development across the Chattanooga region.

Values

Our values define who we are and how we act as stakeholders, individually and collectively. Values in action create a culture.

***E*xcellence**

We distinguish ourselves and the services we provide by our commitment to excellence, demonstrating our results in measurable ways.

***R*espect**

We pay attention to others, listening carefully, and responding in ways that demonstrate our understanding and concern.

***L*eadership**

We differentiate ourselves by our actions, earning respect from those we lead through innovation and performance.

***A*ccountability**

We are responsible for our words and our actions. We strive to fulfill all of our promises and to meet the expectations of those who trust us for their care.

***N*urturing**

We encourage growth and development for our staff, students, faculty and everyone we serve.

Generosity

We are giving people. We give our time, talent and resources to benefit others.

***E*thics**

We earn trust by holding ourselves to the highest standards of integrity and professional conduct.

***R*ecognition**

We value achievement and acknowledge and celebrate the accomplishments of our team and recognize the contributions of those who support our mission.

It is not by accident that our values form ***E.R.L.A.N.G.E.R.*** It is who we are and what we do.

Erlanger is governed by a *Board of Trustees* consisting of eleven (11) members who serve without compensation. The County Mayor appoints six (6) Trustees with the approval of a majority of the County Commissioners. The Tennessee General Assembly appoints four (4) Trustees by majority vote. The *Chief Of Staff* for Erlanger also serves as a Trustee. Trustees are appointed for an initial term of four years and may serve for no more than eight consecutive years.

Following are the current *Trustees*, as of June, 2019.

Trustee	***Appointing Body***
Michael J. Griffin, Chair	County
Philander K. Smartt, Jr., Vice-Chair	Legislative Delegation
Linda Moss-Mines, MA, Secretary	Legislative Delegation
James P. Bolton, M.D.	Chief of Staff
Steven R. Angle, Ph.D.	County
Blaise Baxter, M.D.	County
Sheila C. Boyington, P.E.	County
R. Phillip Burns, M.D.	County
Henry A. Hoss, C.P.A.	Legislative Delegation
James F. Sattler	County
Gerald Webb, III	Legislative Delegation

EMC has 848 licensed beds that are currently allocated, as follows.

Bed Type	**Main (Adult)**	**Children's @ Erlanger**	**Erlanger East**	**Erlanger North**	**Total**
Medical	272		50	35	357
Surgical	136		26	18	180
ICU / CCU	97	14	6	4	121
Obstetrical	40		31		71
Neonatal ICU		70			70
Pediatric		49			49
TOTAL	545	133	113	57	848

Erlanger wishes to be transparent and make known that it currently has contracts in place with a broad range of payors. So the public will know and be able to access our facilities and services, these contracts are briefly listed in an attachment to this *CHNA*. Erlanger serves all patients regardless of their ability to pay and does not discriminate on the basis of race or ethnic origin.

Section C

COMMUNITY SERVED BY

ERLANGER MEDICAL CENTER

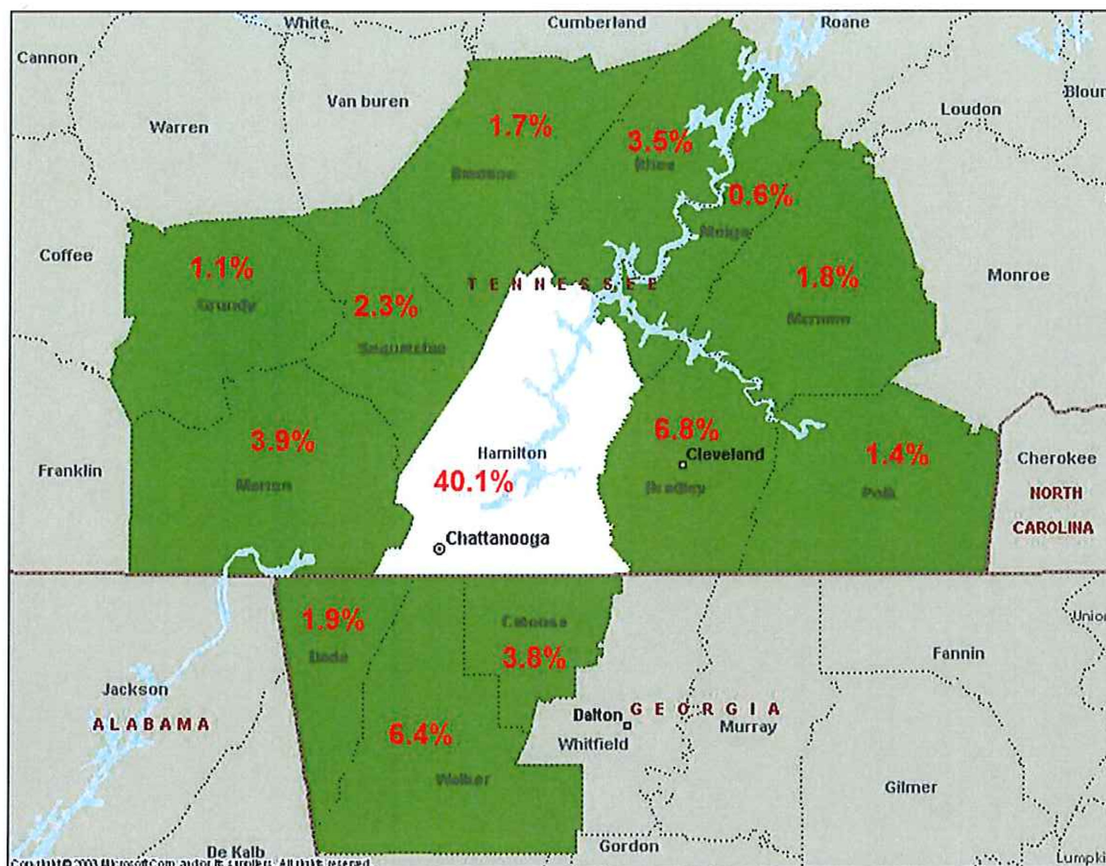
Section C: COMMUNITY SERVED

As the tertiary level academic medical center in Southeast Tennessee, the community served by *EMC* is represented by the thirteen (13) counties in the regional service area. From a health planning perspective, a hospital's general service area is traditionally defined as that geography which accounts for approximately 75% of its business. The primary service area is that geography which generally accounts for 50% and the secondary service area is that geography which generally accounts for 25%. Once 75% or so of a hospital's patient origin is explained in this manner, this is generally held to be the service area for which a facility "plans" to meet the needs of those served. *Erlanger* also attracts a large number of patients from beyond this geography who access many of the highly specialized services, staff and physicians.

For the *EMC* main campus, the primary and secondary service area accounted for 75.3% of the inpatient admissions during the calendar year ended December 31, 2018. As shown below, Hamilton County, TN, accounts for 40.1% of inpatient admissions for the Main campus; and the secondary service area accounts for 35.2%. The remaining 24.7% are from outside this geography, where patients are drawn, or seek, the specialized tertiary services that *Erlanger* provides.

County	Service Area	Discharges	Cumulative Total	%	Cumulative %
Hamilton, TN	Primary	12,590	12,590	40.1%	40.1%
Bradley, TN	Secondary	2,140	14,730	6.8%	46.9%
Marion, TN	Secondary	1,227	15,957	3.9%	50.8%
Grundy, TN	Secondary	341	16,298	1.1%	51.9%
Sequatchie, TN	Secondary	730	17,028	2.3%	54.2%
Bledsoe, TN	Secondary	524	17,552	1.7%	55.9%
Rhea, TN	Secondary	1,106	18,658	3.5%	59.4%
Meigs, TN	Secondary	173	18,831	0.6%	60.0%
McMinn, TN	Secondary	553	19,384	1.8%	61.8%
Polk, TN	Secondary	432	19,816	1.4%	63.2%
Dade, GA	Secondary	599	20,415	1.9%	65.1%
Walker, GA	Secondary	2,017	22,432	6.4%	71.5%
Catoosa, GA	Secondary	1,193	23,625	3.8%	75.3%
Other / Unknown		7,808	31,433	24.7%	100.0%
	TOTAL	31,433		100.0%	

The regional service area for *EMC's* Main campus is represented graphically in the following map, by percentage of inpatient admissions.



EE is licensed, and operates as, a satellite hospital of *EMC*. As such, part of its mission is to serve as a referral facility for patients that need additional services, but may not require tertiary level care. It is difficult to determine precisely the number of patients which would choose *EE* for services unique to that hospital. For this reason, we have defined the service area for *EE* as the zip codes surrounding that facility which would be most likely to utilize this facility for healthcare services. For *EE*, the designated service area accounted for 50.2% of the inpatient admissions during the calendar year ended December 31, 2018. The following table shows the percentage by zip code.

Zip Code	Description	County	Discharges	Cumulative Total	%	Cumulative %
37421	Chattanooga	Hamilton, TN	1,500	1,500	20.3%	20.3%
37363	Ooltewah	Hamilton, TN	811	2,311	11.0%	31.3%
30736	Ringgold	Catoosa, GA	474	2,785	6.4%	37.7%
37416	Chattanooga	Hamilton, TN	225	3,010	3.0%	40.7%
37412	East Ridge	Hamilton, TN	222	3,232	3.0%	43.7%
37341	Harrison	Hamilton, TN	188	3,420	2.5%	46.2%
37411	Ridgeside	Hamilton, TN	188	3,608	2.5%	48.7%
37353	McDonald	Bradley, TN	62	3,670	0.8%	49.5%
30742	Fort Oglethorpe	Catoosa, GA	55	3,725	0.7%	50.2%
Other / Unknown			3,695	7,420	49.8%	100.0%
		TOTAL	7,420		100.0%	

Similar to *EE*, *EN* is licensed and operates as, a satellite hospital of *EMC*. As such, part of its mission is to serve as a referral facility for patients that need additional services, but may not require tertiary level care. It is difficult to determine precisely the number of patients which would choose *EN* for services unique to that hospital. For this reason, we have defined the service area for *EN* as the zip codes surrounding that facility which would be most likely to utilize this facility for healthcare services. For *EN*, the designated service area accounted for 50.2% of the inpatient admissions during the calendar year ended December 31, 2018. The following table shows the percentage by zip code.

Zip Code	Description	County	Discharges	Cumulative Total	%	Cumulative %
37415	Red Bank	Hamilton, TN	40	40	7.7%	7.7%
37343	Hixson	Hamilton, TN	37	77	7.1%	14.8%
37405	North Chattanooga	Hamilton, TN	33	110	6.4%	21.2%
37379	Sody-Daisy	Hamilton, TN	31	141	6.0%	27.2%
37377	Signal Mountain	Hamilton, TN	24	165	4.6%	31.8%
37373	Sale Creek	Hamilton, TN	8	173	1.5%	33.3%
37351	Rivermont / Lupton City	Hamilton, TN	0	173	0.0%	33.3%
Other / Unknown			345	518	66.7%	100.0%
		TOTAL	518		100.0%	

Section D

REVIEW OF

COMMUNITY HEALTH NEEDS ASSESSMENT

FOR 2016

Section D: REVIEW OF COMMUNITY HEALTH NEEDS ASSESSMENT FOR 2016

Summary Of Needs Identified In 2016

In the *CHNA* for 2016, generally speaking, the six (6) counties in the regional service area that were identified with the greatest need were Marion, Grundy, Rhea, Bradley, Walker, and Hamilton. Of note, three (3) of the five (5) rural counties are to the west of Hamilton County.

For Hamilton County, in 2016, significant health needs identified were infant mortality, with 9.6 per thousand live births, compared to 8.2 for Tennessee (a 17% variance), and low birth weight, with 10.5% compared to 9.2% for Tennessee (a 14% variance).

For the rural counties, in 2016, the health need indicators which were utilized, reflected health issues common to the overall rate of mortality, high coronary heart disease, tobacco use and obesity. The need to increase the number of primary care providers was also identified.

The community health needs identified in 2016, may be summarized as follows.

- Infant mortality – seek to reduce
- Teen births – seek to reduce
- Primary care providers – seek to increase (for rural counties)
- Tobacco use – seek to reduce
- Lung cancer – seek to reduce
- Heart disease – seek to reduce
- Mental health / substance abuse – seek to increase access

Discussion Of Needs Identified In 2016

Pertaining to the need in Hamilton County to reduce infant mortality and the number low birth weight babies, the *2019 Community Health Profile* (2) published by the Hamilton County Health Department ("*HCHD*"), shows a decrease for infant mortality in Hamilton County from 9 to 7 for the period 2014-2016 compared to 2010-2012. However, information from *Community Commons* (3) suggests that Hamilton County (9.6) is above the Tennessee average (8.2) as of 2019. For the rural counties, six (6) of the twelve (12) are identified as being a health need in 2019.

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2 *Picture Of Our Health, Hamilton County, Tennessee, 2019 Community Health Profile.* Published by the Hamilton County, Tennessee, Health Department, Chattanooga, Tennessee, p. 43.

3 *Community Commons, 2019 Community Health Data.* Retrieved from – www.CommunityCommons.org. Please note that Community Commons updated its website in January, 2019, therefore, some data referenced in this *CHNA* report may not be available from the new website. However, it appears from information provided directly from community commons, the health status indicators which we used may now be available at – www.EngagementNetwork.org.

For low birth weight, which is a complementary measure to infant mortality, Hamilton County is identified by both *Community Commons* and *HCHD* as being a continuing need. *HCHD* reported a slight decrease from 11% to 10% from 2010 to 2016. *(4)* In 2019, *Community Commons* shows Hamilton County at 10.5% compared to the Tennessee average of 9.2%. For the rural counties, three (3) of the twelve (12) are identified as being a health need.

For teen births, *HCHD* reports success in this area, with a decrease in Hamilton County from 35% to 23%, between 2010-2016. *(5)* For the rural counties, Community Commons shows a continuing need in nine (9) of the twelve (12) counties.

For primary care providers in the rural counties, *Community Commons* shows a continuing need in 2019 for all twelve (12) counties. It is noted, that this is the most critical need in the service area, as identified by *Community Commons* unweighted data.

For tobacco use in 2019, *HCHD* reports that of adults in Hamilton County, 20% use tobacco products compared to 22% for Tennessee. *(6)* *Community Commons* reports 19.9% for Hamilton County, compared to 21.7% for Tennessee. For the rural counties, *Community Commons* shows that ten (10) out of twelve (12) have a continuing need.

For lung cancer mortality in 2019, *HCHD* did not specifically break out lung cancer, but for all types of cancer reports that Hamilton County is lower than Tennessee, with 170 compared to 183 deaths, per 100,000. (7) *Community Commons* data is consistent with *HCHD*. For the rural counties, *Community Commons* shows that eleven (11) out of twelve (12) counties have a continuing need as to lung cancer mortality.

For heart disease mortality in 2019, *HCHD* reports that Hamilton County is less than Tennessee, with 183 compared to 205 deaths, per 100,000. *Community Commons* data is consistent with *HCHD*. For the rural counties, *Community Commons* shows that eleven out of twelve counties have a continuing need as to heart disease mortality.

Pertaining to the need for *Psychiatric, Mental Health & Substance Abuse* services in the service area, we identified the need in 2016 and highlighted that we had obtained a Certificate Of Need ("*CON*") for a new eighty-eight (88) bed behavioral health hospital in Chattanooga, Tennessee, to address this need. The new behavioral health hospital is a joint venture between *Erlanger Health System* and *Acadia Healthcare*, and opened in June, 2018.

For the rural counties west of Hamilton County, which were identified as having significant community health needs, in 2014 *Erlanger Health System* established a free standing Emergency Dept. in Sequatchie County, through it's affiliate *Erlanger Bledsoe Hospital*. *Erlanger Bledsoe Hospital* is a critical access hospital serving the needs of Bledsoe County. The free standing ED in *Sequatchie County* is a division of *Erlanger Bledsoe Hospital*. With the free standing ED, the

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4 *Picture Of Our Health, Hamilton County, Tennessee, 2019 Community Health Profile*, p. 42.
5 *Picture Of Our Health, Hamilton County, Tennessee, 2019 Community Health Profile*, p. 38.
6 *Picture Of Our Health, Hamilton County, Tennessee, 2019 Community Health Profile*, p. 52.
7 *Picture Of Our Health, Hamilton County, Tennessee, 2019 Community Health Profile*, p. 48.

overall health rank for *Sequatchie County* improved to a rank of 33 in 2019 out of 95 Tennessee counties, from a rank of 91 in 2013.*(8)*

Erlanger Bledsoe - Replacement Hospital

As noted, the counties west of *Hamilton County* have significant health needs, and *EHS* has been able to alleviate this burden and improve the health status to a certain extent as evidenced by the noted improvement for *Sequatchie County* by the presence of the free standing ED in Dunlap, Tennessee.

While *Erlanger Bledsoe Hospital* ("*EBH*") is still operating in Pikeville, Bledsoe County, Tennessee, it is noted that this facility is 48 years old, is out of date with current building codes and in need of replacement. In this regard, *EHS* sought to relocate *EBH* to Dunlap, Sequatchie County, Tennessee, where a new replacement hospital would be located. We obtained a *Certificate of Need* ("*CON*") from the *Tennessee Health Services & Development Agency* ("*HSDA*") to replace *EBH* with a new critical access hospital to be located in Dunlap, Tennessee. Further, we also obtained a *CON* from the *HSDA* to relocate the free standing ED in Dunlap, Tennessee, to Pikeville, Bledsoe County, Tennessee. These CON's were approved by the *HSDA* at its regular meeting on December 13, 2017.

Essentially, the current hospital and free standing ED would "switch locations", and the new hospital would serve as *Erlanger Sequatchie County Regional Hospital* ("*ESVRH*"), serving the healthcare needs of three (3) counties in the rural regional service area. Since *EBH* currently has low utilization, and the replacement critical access hospital would have much higher utilization of approximately 80%, it was determined that the rural counties west of Hamilton County would be much better served by this arrangement.

However, after approval of these projects by the *HSDA*, and subsequent discussions with the counties involved on project financing, in October, 2018, it was determined that these projects were no longer viable. In short, certain details of the proposed financing arrangement had changed after approval of the CON's. EHS will continue to look for ways to better serve the healthcare needs of this rural area.

8 *Sequatchie County* health outcomes rank as published by www.CountyHealthRankings.org.

Section E

PROCESS, METHODS & INFORMATION

Section E: PROCESS, METHODS & INFORMATION

Information & Data

Our process began with collection of data from *Community Commons*, a website designed to facilitate data gathering for hospitals and other organizations which prepare *CHNA* analyses. The next step was to collect data from available public health sources such as local and state health department plans, such as *HCHD* and the Tennessee Dept. of Health ("*TDOH*"), as well as the *Community Need Index* ("*CNI*") from the *Dignity Health* website. In addition, in 2019 we conducted an online survey to seek direct input from the community at large, as to their understanding of health needs in the community where they reside.

All of this information was presented in summary form to a series of community based focus groups, and they were asked to prioritize the health needs of the service area. Separate focus groups were held for *Erlanger East Hospital* and *Erlanger North Hospital*. However, since they are licensed, and operate as, satellite facilities of *Erlanger Medical Center*, the results of the these focus groups will be discussed in summary as a component element of this *CHNA* for the regional service area, as it pertains to *Erlanger Medical Center*.

Community Health Status Indicators -- Community Commons

We utilized health status indicators and data from *Community Commons*.*(9)* From it's internet site, the purpose for *Community Commons* is as follows …

> "*Community Commons* is a place where data, tools, and stories come together to inspire change and improve communities. We provide public access to thousands of meaningful data layers that allow mapping and reporting capabilities so you can thoroughly explore community health."

The health statu indicators which were selected from *Community Commons* for the 2019 *CHNA*, are similar to the indicators which were evaluated in 2016. The indicators selected for the 2019 *CHNA*, are as follows …

Category	Indicator
Demographic	Population w/ Any Disability
Social & Economic	Public Assistance Income
	No HS Diploma (Age 25+)
	Teen Births (per 1,000 females 15-19)
Physical Environ.	Assisted Housing (per 10,000 HH)
	Liquor Store Access (per 100,000)

9 *Community Commons* internet site is … www.CommunityCommons.org.

	Grocery Store Access (per 100,000)
	Fast Food Restaurants (per 100,000)
Clinical Care	Population Living In HPSA
	No Dental Exam (Adult)
	Diabetes Management – Hemoglobin A1c
	Primary Care Providers (per 100,000)
	FQHC's
Health Behaviors	Tobacco Use (Current Smokers)
	Tobacco Use (Quit Attempt)
	Walk Or Bike To Work
	Physical Inactivity
Health Outcomes	Cancer Incidence - Breast (per 100,000)
	Cancer incidence - Colon (per 100,000)
	Cancer Incidence - Lung (per 100,000)
	Chlamydia Incidence (per 100,000)
	Ghonorrhea Incidence (per 100,000)
	HIV Prevalence (per 100,000)
	Diabetes (Adult)
	Heart Disease (Adult)
	Low Birth Weight (Of Total Births)
	Mortality - Infant (per 1,000 Births)
	Mortality - Suicide (per 100,000)
	Mortality - Heart Disease (per 100,000)
	Mortality - Lung Disease (per 100,000)

These indicators were evaluated by comparing them to the State average, plus or minus five percent (5%), for the state in which each county is located. Where an indicator value is higher than the range of 5% of the State average, a marker[10] was assigned to that item in the analysis where a higher value is not desirable (i.e.-Population w/ Any Disability). Where an indicator value is within the range of 5% of the State average, no marker was assigned to that item in the analysis. Where an indicator value is lower than the range of 5% of the State average, a marker was assigned to that item in the analysis where a lower value is not desirable (i.e.-Physical Inactivity).

All markers were then tallied to identify which counties have the most need after evaluation of all indicators. Finally, in consideration of the need by population, the *Total Indicators* were weighted by county population, to take this element into account.

10 A "marker" simply means that a particular community health indicator has been "flagged" as being an item of concern pertaining to the health status of that county. Then the number of markers are totaled to determine a score for that county.

Community Survey & Focus Groups

We conducted an online survey of the regional service area in an effort to ascertain health needs directly from community input. We conducted our survey of the community by placing the survey on the internet in an electronic format for both *Erlanger* employees and members of the community to complete over a two (2) week period. For those employees and community members which completed the survey, their responses have been evaluated and are discussed later in this *CHNA*.

Additionally, we conducted a community focus group which represent the interests of those who are members of medically underserved, low income and minority populations. With this thought in mind, the focus group for the *Erlanger Community Health Centers*, which draw a significant portion of their patients from the medically underserved, low income and minority populations, will serve to inform this *CHNA* for *Erlanger Medical Center*.

We also conducted a series of community focus groups for *Erlanger Medical Center*, *Erlanger East Hospital*, and *Erlanger North Hospital*. Since *Erlanger East Hospital* and *Erlanger North Hospital* are licensed, and operate as, satellite facilities of *Erlanger Medical Center*, the results of the these focus groups will be discussed in summary as a component element of this *CHNA* for the regional service area, pertaining to *Erlanger Medical Center*.

Upon presentation of all information, each focus group was divided into sub-groups of 3-4 participants, to independently discuss the community health needs for the service area. Upon independent discussion, each sub-group identified community health needs and prioritized them into categories, as follows … 1.) High Priority, 2.) Important, and 3.) Nice To Have. When each sub-group had completed this process, the entire focus group was brought back together to review the health needs and priority of each sub-group. Where multiple sub-groups identified a similar community health needs, these are the items which were automatically highlighted, and some additional items were identified by the entire focus group through general discussion among all participants. Upon conclusion of the process, a list of community health needs was identified and prioritized with general consensus among the participants.

Further, the rules which govern development of this *CHNA*, require that we consider any comments received from the community over the period of the last three (3) years regarding the *CHNA* which was prepared in 2016. After adoption of our *CHNA* in 2016, we received comments in 2017 from members of the community at our *Children's Hospital*, expressing concern that we had not identified childhood obesity as a community need. We will discuss this in more detail in this 2019 *CHNA* document, in *Section F – Community Health Needs*.

Community Need Index – Dignity Health

We accessed the *Community Need Index* ("*CNI*") tool which is made available to the public by *Dignity Health*.[11] The *CNI* accounts for the underlying economic and structural barriers that

11 The *Community Need Index* tool is offered by *Dignity Health* and may be accessed at the following website …

affect overall health rather than relying solely on public health data. Using a combination of research, literature, and experiential evidence, *Dignity Health* identified five prominent barriers that enable them to quantify health care access in communities across the nation. These barriers include income level, culture/language, education, insurance and housing, which otherwise may be commonly known as "social determinants of health". Using this data, a score is assigned to each barrier (with 1 representing less community need and 5 representing more community need). The scores are then aggregated and averaged for a final *CNI* score (each barrier receives equal weight in the average). A score of 1.0 indicates the lowest socio-economic barriers, while a score of 5.0 represents the highest socio-economic barriers.

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http://www.dignityhealth.org/Who_We_Are/Community_Health/STGSS044508/. It is noted that *Dignity Health* partnered with Truven Health Analytics for development of this project. *Truven Health* has now been acquired by *IBM – Watson Health Group*.

Section F

INFORMATION FROM COMMUNITY SOURCES

Section F: COMMUNITY INFORMATION

For the *CHNA* in 2019 we utilized indicators and data from *Community Commons.* *(12)* Most of the indicators which were selected for evaluation in this *CHNA* are similar to the indicators which were evaluated in 2016. A few of the indicators were replaced in the 2019 *CHNA*, because they are no longer available with *Community Commons*.

In March, 2019, the Hamilton County, Tennessee, Health Department ("*HCHD*") issued a report, *Picture Of Our Health: 2019 Hamilton County Community Health Profile*, in which a compilation of health status information was presented. Since the rural counties in the defined service area do not issue "Health Plans" or ""Health Profiles", we relied primarily on data available from *Community Commons*, in an effort to ensure a consistent methodology for our analysis. However, we have referenced the *2019 Heath Profile* by *HCHD* where it is appropriate.

In 2018, the *Division of Health Planning* of the *Tennessee Dept. of Health*, issued an update to the *Tennessee State Health Plan: 2017-2018 Edition* (" the Plan"). The *Plan* puts forth several goals, and certain aspects will be broadly discussed in this *CHNA*.

Between March 1-18, 2019, we conducted an online survey for public input to our *CHNA*. With this survey, a total of 1,308 useable responses were received from the service area identified. It is noted that a significant number of people "logged on" to the survey, but did not answer any of the questions, therefore, only those which answered at least 1 question have been included in our survey results.

Between March 25 – April 9, 2019, we conducted a series of community based focus groups, and asked them to prioritize the health needs of their respective service area. Separate focus groups were held for *Erlanger East Hospital* and *Erlanger North Hospital*. However, since they are licensed, and operate as, satellite facilities of *Erlanger Medical Center*, the results of these focus groups will be discussed in summary as a component element of this *CHNA* for the regional service area, as it pertains to *Erlanger Medical Center*.

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12 *Community Commons* internet site is … www.communitycommons.org.

Section G

COMMUNITY HEALTH NEEDS

Section G: COMMUNITY HEALTH NEEDS

The value of assessing and improving community health is evident when looking at life expectancy. Health improvements are directly responsible for the thirty (30) year increase in life expectancy from 1900 to the present time. "The *Centers for Disease Control & Prevention* ("*CDC*"), estimated in 1999, that 25 of the 30 years of increased life expectancy in the United States in the 20th Century was attributable to advances in public health. McKinlay & McKinlay calculated that only 3.5 of the total mortality decline between 1900 and 1970 could be 'ascribed to medical matters'. Bunker calculated that clinical prevention and therapeutic interventions could be credited with five and a half of the thirty-year increase that occurred in the United Kingdom from 1900 to 2000. Hence, public health interventions and improved social conditions can take most of the credit for the increase in life expectancy experienced since the mid-1800's." *(13)*

It is noted that *Hutcheson Medical Center*, a major provider of health services in the defined service area and which was located in Walker County, Georgia, closed in 2015 due to negative financial performance and associated sustainability issues. However, that facility was acquired by Memorial Hospital in Chattanooga, Tennessee, in December, 2017. As such, some health status indicators for recent years may have been negatively impacted for the counties in the service area which are in Georgia … Dade, Walker and Catoosa.

Community Commons Health Status Indicators

In evaluating community health needs at the county level utilizing data from *Community Commons*, the analysis has identified that the rural counties to the west of Hamilton (Marion, Grundy, Bledsoe & Rhea) have significant community health needs. Further, Walker County to the south of Hamilton, as well as Bradley County to the east of Hamilton, also have significant community health needs.

In consideration of the need by population, the *Total Indicators* were weighted by population to account for proportionality in the analysis, and the *Weighted Population Indicators* have been used to determine the rank order for the counties in the defined service area. The detail analysis of the indicators is attached to this *CHNA*.

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13 Lindsay, Gordon B., Merrill, Ray M., and Hedin, Riley J. *The Contribution of Public Health & Improved Social Conditions to Increased Life Expectancy: An Analysis of Public Awareness* . Abstract, published October 31, 2014. Retrieved from - https://www.omicsonline.org/open-access/the-contribution-of-public-health-and-improved-social-conditions-to-increased-life-expectancy-an-analysis-of-public-awareness-2161-0711-4-311.php?aid=35861.

County	Total Comm. Commons Indicators	Population 2019	Pop. Ratio	Total Weighted Pop. Indicators
Marion, TN	20	28,479	3.5%	21
Grundy, TN	17	13,263	1.6%	17
Bradley, TN	15	107,444	13.2%	17
Sequatchie, TN	16	14,914	1.8%	16
Walker, GA	15	68,991	8.5%	16
McMinn, TN	15	53,051	6.5%	16
Rhea, TN	15	32,943	4.0%	16
Polk, TN	15	16,737	2.1%	15
Bledsoe, TN	15	15,243	1.9%	15
Hamilton, TN	10	368,799	45.2%	15
Meigs, TN	13	12,158	1.5%	13
Catoosa, GA	12	67,296	8.3%	13
Dade, GA	12	16,185	2.0%	12
Total	190	815,503	100.1%	203

Within the primary population center of *EMC*'s service area, the community's health is not similar to other counties. In Hamilton County, the needs are reflected by physical environment factors such as low grocery store access, as well as high access to liquor and fast food. Also, by additional items such as sexually transmitted diseases (Chlamydia & Ghonorrhea), HIV prevalence, and low birth weight & infant mortality.

For Hamilton County, primary care practitioners doesn't appear to be an issue, however, the issue would appear to be access to available care rather than a lack of practitioners to provide care. For low birth weight, *HCHD* reports that between 2010 and 2016, there was a slight decrease to approximately 9% around 2013, but with a slight increase in 2016 to 10%. For infant mortality, *HCHD* reports that between 2010 and 2016, there was a decrease from 9% in 2010 to approximately 6% in 2014, with a slight increase to 7% in 2016. For comparative purposes, it is noted that the overall infant mortality rate for Hamilton County in 2016 was 7.7 per thousand live births, for Tennessee in 2017-18 was 6.9, and for *Erlanger* hospitals in 2018 was 5.7. Since the rate for Hamilton County is higher than *Erlanger*, the focus group for the *Erlanger Health Centers* suggested that *Erlanger* hospitals should consider providing newborn families with a *Pack n' Play* baby crib at the time of discharge, as this would likely reduce infant mortality post discharge from the hospital.

For the rural counties in the service area, the top 10 community needs are:

<u>*Community Needs*</u>

1.) Primary care providers (per 100,000)
2.) Population with any disability
3.) Population Living In HPSA
4.) Heart Disease (adult)
5.) Mortality – heart disease (per 100,000)
6.) Mortality – lung disease (per 100,000)

7.) No HS diploma
8.) Tobacco use (current smokers)
9.) Mortality – suicide (per 100,000)
10.) Physical inactivity

For the rural counties in the service area, among the top 10 community needs are primary care providers, heart disease and related mortality, tobacco use / mortality from lung disease, and suicide. Other indicators include no high school diploma and percent of the population living with any disability. The data pertaining to the *Community Commons* health status indicators are attached to this *CHNA*.

Erlanger Online Community Survey

As stated previously, we conducted an online survey for the service area to seek direct community input to our *CHNA*. For the service area, there were a total of 1,308 useable responses and the top 10 community needs identified were, as follows:

Community Needs

1.) Chronic conditions
2.) Cardiovascular (i.e.-heart disease)
3.) Substance / Mental Health
4.) Basic services (i.e.-common cold, dental, etc.)
5.) No insurance / affordable insurance
6.) Access to / Affordable care
7.) Cost of healthcare
8.) Primary care
9.) Oncology / Cancer
10.) Allergies / Respiratory

In this summary, we can see some commonalities with the *Community Commons* data. For instance, heart disease, cancer, and mental health are all chronic conditions which should be addressed. Primary care and basic services, or more precisely, a general shortage of primary care providers, is identified by the entire service area as being a need. However, the *Community Commons* data does not identify this as a need for Hamilton County. Items 5 and 7, pertaining to the general cost of healthcare, affect *Erlanger* directly because we serve as the safety net provider for southeast Tennessee, northwest Georgia, northeast Alabama and western North Carolina. We have not had allergies and respiratory illness highlighted to us previously as a community need in previous *CHNA*'s. We will need to study this in more detail.

An enhanced presence of primary care practitioners in the rural counties may tend to alleviate some of the health issues common to these counties. This could potentially suggest the need for an *FQHC* and/or other outreach services. It is noted that there are already some FQHC's in the rural counties, however, we may need to study the possibility of *FQHC* placement in locations that don't have access to an *FQHC*.

Dignity Health – Community Need Index

The purpose of referencing the *Community Need Index* ("*CNI*") from *Dignity Health*, is an effort to compare our findings under the *Community Commons* methodology, with an independent source of information. Here the *CNI* ranking has been weight adjusted for population, in the same manner as the *Community Commons* data.

County	Dignity Health CNI	Population 2019	Pop. Ratio	Weighted Pop. Adj. CNI
Hamilton, TN	3.4	368,799	45.2%	4.9
Rhea, TN	4.1	32,943	4.0%	4.3
McMinn, TN	4.0	53,051	6.5%	4.3
Walker, GA	3.9	68,991	8.5%	4.2
Bradley, TN	3.8	107,444	13.2%	4.3
Sequatchie, TN	4.0	14,914	1.8%	4.1
Bledsoe, TN	4.0	15,243	1.9%	4.1
Meigs, TN	3.9	12,158	1.4%	4.0
Marion, TN	3.9	28,479	3.5%	4.0
Dade, GA	3.8	16,185	2.0%	3.9
Grundy, TN	3.6	13,263	1.6%	3.7
Polk, TN	3.3	16,737	2.1%	3.4
Catoosa, GA	2.9	67,296	8.3%	3.1
Total	3.7	815,503	100.0%	4.0

The *Community Need Index* ("*CNI*") obtained from *Dignity Health*, when adjusted for population size, results in a different ranking from that derived from the *Community Commons* indicators. Interesting to note is the fact that under the weighted population *CNI* methodology, Hamilton County is shown with the highest need, while the rural counties of Marion, Grundy and Bledsoe are shown in the lower half of the ranking. This is different from what the health status indicator analysis for *Community Commons* seems to suggest.

A comparison of the final ranking for both methodologies is presented below to highlight the differences:

County	Community Commons Unadjusted Rank	Dignity Health Unadjusted Rank	Community Commons Weighted Pop. Adj. Rank	Dignity Health Weighted Pop. Adj. Rank
Marion, TN	1	3	1	5
Bradley, TN	4	4	2	2
Grundy, TN	2	5	2	7
McMinn, TN	4	2	3	2
Rhea, TN	4	1	3	2
Sequatchie, TN	3	2	3	4
Walker, GA	4	3	3	3
Bledsoe, TN	4	2	4	4
Hamilton, TN	7	6	4	1
Polk, TN	4	7	4	8
Catoosa, GA	6	8	5	9
Meigs, TN	5	3	5	5
Dade, GA	6	4	6	6

For purposes of this comparison, a rank of 1 indicates the highest need, and largest numeric rank indicates the lowest need for each category.

Focus Group -- Erlanger Medical Center

All of the information which has been reviewed and discussed in this *CHNA*, was presented to a community based focus group. The focus group consisted of several staff members from *Erlanger*, along with community based health organizations with specific knowledge of low income, minority and ethnically diverse populations, as well as an actual patient. A list of the specific participants in the focus group is attached to this *CHNA*.

The focus group for *Erlanger Medical Center* was a total of 13 participants. Upon conclusion of the process outlined previously, the following list of community health needs were identified for the defined service area.

Community Health Needs – High Priority

- Access to care
- Collaboration
- Chronic Conditions
- Substance / Opioid

Community Health Needs – Important

- Sexually Transmitted Diseases
- Community Team Involvement
- Transportation

Community Health Needs – Nice To Have

Physician Quality Metrics
Safety Prevention

For community health needs which are *High Priority*, the focus group agreed that *Access To Care* and *Colaboration* go "hand in hand". *Access To Care* includes the typical items such as primary care after normal business hours and knowledge of health access points. However, some unusual items are now found in this category … such as community paramedicine, integration of care on the spot, and "community education". Community paramedicine refers to a paramedic being sent to the patient home to perform triage before an ambulance is dispatched, or, to make a referral to an urgent care center or physician office, or, before the patient is sent to a hospital for admission or the emergency department. Community education in this context is specifically directed to concern about the need for education in the schools pertaining to "life skills". As an illustration, young adolescents should receive education about "nutrition and the 4 basic food groups". The focus group was very pointed in their belief that Erlanger should provide education in this regard, and also in relation to other health related topics. It is noted that the focus group suggested that *Erlanger* does not have a track record of collaborating with schools on projects of this nature.

It was acknowledged that chronic conditions are a rather high priority as well. By chronic conditions, it is meant to include heart disease, cancer, and obesity. Also, substance & opioid is listed as a high priority. It is noted that among substances, tobacco use is included.

EMC has historically provided education to the community for wellness, fitness and nutritional enhancement, and these are the traditional types of activity which have been conducted through the lens of public health improvement. However, *EMC* is pleased that it has brought to the service area, technology which will make a significant contribution in the realm of chronic conditions. The technology which has been implemented in the *ED* at *EMC* is artificial intelligence ("*AI*"). For a suspected stroke patient, the *CT* scan will be uploaded to "the cloud" and the image will be read by the *AI* application for determination of whether it is a true stroke patient. If it is a true stroke, the *AI* application will pinpoint the cerebral area where the occlusion has occurred, thus enabling *ED* physicians to correctly prioritize patient severity for appropriate treatment. We mention this technology because cerebrovascular conditions are a component in the realm of chronic conditions generally referred to as cardiovascular diseases, which are truly chronic in nature. *EHS* is pleased to bring this technology to bear in the treatment of *EMC* patients.

For community health needs which are *Important*, the focus group agreed that sexually transmitted diseases should be in this category. Not previously seen in this category is the need for patients to have some type of transportation available in order to facilitate provision of needed healthcare services. As a social determinant of health, transportation is a key component of the individual healthcare paradigm. Also, some form of coordination between various members of the "community healthcare team" (i.e.-allied health professionals). Stated otherwise, there is currently a severe need for even minimal coordination for elderly patients who are bewildered by the maze of healthcare entities and services.

For community health needs which would be *Nice To Have*, there is interest in ways to evaluate patient engagement with physician quality metrics. Also, that an effort should be made to provide education about safety prevention, with a focus on injury prevention, as well as traffic accidents.

During our review of medical facility utilization trends for the service area, we noticed that inpatient hospital utilization is trending upward while the general trend seems to be no growth, or downward. For example, for the service area total inpatient discharges were 89,751 in 2017, and 91,756 in 2018, an increase of 2.2%, compared to the *State of Tennessee* with total inpatient discharges of 745,592 in 2017, and 745,701 in 2018, an increase of .015% (for patient origin in Tennessee), which is essentially flat, or no growth. We also noticed that ED utilization in the service area decreased for all counties except Bradley.

Emergency Visits By County Of Patient Origin

	2017	2018	Change	%
Hamilton	193,267	189,075	-4,192	-2.2%
Bradley	49,964	51,050	1,086	2.2%
Polk	9,549	7,562	-1,987	-20.8%
Group	59,513	58,612	-901	-1.5%
Marion	13,864	12,659	-1,205	-8.7%
Grundy	8,850	8,474	-376	-4.2%
Sequatchie	16,977	16,511	-466	-2.7%
Bledsoe	7,064	6,804	-260	-3.7%
Group	46,755	44,448	-2,307	-4.9%
Rhea	26,232	25,131	-1,101	-4.2%
Meigs	10,270	10,022	-248	-2.4%
McMinn	36,896	35,088	-1,808	-4.9%
Group	73,398	70,241	-3,157	-4.3%
Dade	6,815	6,331	-484	-7.1%
Walker	35,730	32,735	-2,995	-8.4%
Catoosa	20,065	18,894	-1,171	-5.8%
Group	62,610	57,960	-4,650	-7.4%
Total	435,543	420,336	-15,207	-3.5%

NOTES -- 1.) ED information from THA market data.
2.) Decline in Dade, Walker & Catoosa counties may be due to competitor hospital opening in 2018.
3.) Decline in Polk County may be due to Copper Basin Hospital closing in Polk County, Tennessee, in 2017.

This general decrease in ED utilization is consistent with the *State of Tennessee* which had total ED visits of 3,459,188 in 2017, and 3,358,805 in 2018, a decrease of 2.9% (for patient origin in Tennessee). *(14)*

14 Market data from *Tennessee Hospital Association.*

Of particular note with the *ECHC*, *EMC* and *Erlanger Western Carolina Hospital* ("*EWCH*") focus groups, is that a suggestion was made which posited *Erlanger* should begin to evaluate how it might address the housing need for chronically ill patients which have multiple chronic conditions. In essence, at the *ECHC* focus group, that *Erlanger* likely spends more on multiple hospitalizations per year for this patient subset, and that since housing (i.e.-the lack of housing, or, sub-standard housing) is a social determinant of health, *Erlanger* really should begin to provide appropriate housing for these patients. This was suggested through either direct funding (i.e.-ownership) of a housing development and/or funding through a third party housing agency. While we acknowledge that housing is a social determinant of health, such a suggestion for a hospital organization like *Erlanger*, would represent a fundamental paradigm shift.

It is noted that some hospital organizations are beginning to undertake initiatives in the realm of housing, such as *Atrium Health* in Charlotte, NC, which has announced that they will contribute $10 million to affordable housing in that city through local social service agencies. *(15)* *Kaiser Permanente* has made several donations to social service agencies in California and Oregon. Further, *CommonSpirit Health* funded a loan to a housing agency which was paid back in full with interest, and *CommonSpirit* attributes a 24% reduction in ED visits to this effort, along with other positive outcomes. *(16)*

Further, a member of the *EMC* focus group, provided information about how *United Healthcare* and the *American Medical Association* are proposing new codes to the *International Classification of Diseases – 10th Edition* ("*ICD-10*") that are more specific to a patients' social determinants of health. If approved these new codes could be in place and ready for use "as early as 2020". *(17)* The point being conveyed here was that as the prevalence of social determinant data becomes more widely available within the healthcare community, so the regulatory framework may be modified at some point in the future so as to require some sort of direct response by hospital organizations.

Although *EHS* is not in a financial position to undertake such an endeavor at the present time, we will contribute to efforts designed to alleviate issues surrounding affordable housing. For example, the *City of Chattanooga* has initiated a new interagency council designed to alleviate the homeless situation locally. This effort involves many local organizations including *Erlanger*. *(18)* In this regard, *EMC* has allocated a full time social worker that is dedicated to assisting our homeless patients with completion of necessary forms and applications for *Supplemental Security Income* and/or *Social Security Disability Income* (*SSI/SSDI*), as well as possible

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15 Gooch, Kelly. *Atrium Health Commits $10 M To Affordable Housing*. Becker's Hospital Review, June 4, 2010. Retrieved from - https://www.beckershospitalreview.com/finance/atrium-health-commits-10m-to-affordable-housing.html.

16 Daly, Rich. *How Providers Can Finance, Profit From Programs To Tackle Social Determinants*. Healthcare Financial Management Association, May 21, 2019. Retrieved from - https://www.hfma.org/Content.aspx?id=64043.

17 Livingston, Shelby. *United Healthcare, AMA Unveil More Medical Codes For Social Determinants*. Modern Healthcare, April 2, 2019. Retrieved from – https://www.modernhealthcare.com/technology/unitedhealthcare-ama-unveil-more-medical-codes-social-determinants.

18 Walton, Judy. *New Front Opens In Battle Against Homelessnes In Chattanooga*. Chattanooga Times-Free Press, March 20, 2019. Retrieved from - https://www.timesfreepress.com/news/local/story/2018/mar/20/new-front-opens-battle-against-homelessness/466337/.

assistance with *TennCare* or other health insurance, apartment applications, etc., for those who need such assistance. Further, *Erlanger* has committed for this person to be *SOAR* accredited *(19)*, which means they have special training and certification in the field of homeless related social services. Where we are able to make a positive contribution, *Erlanger* will make an effort to support like minded programs.

Focus Groups – Erlanger East Hospital & Erlanger North Hospital

As indicated previously, the focus groups for *Erlanger East Hospital* and *Erlanger North Hospital*, will be discussed as component elements in this CHNA, because they are licensed, and operate as, satellite hospitals of *Erlanger Medical Center*. The service areas for these hospitals are a geographic subset of the defined regional service area for *Erlanger Medical Center*.

The focus group at *Erlanger East Hospital* had two items for community health needs which are *High Priority*, 1.) Substance / mental health, and 2.) medical specialties (to include Vascular, Critical Care & Intensivist, Oncology, Urology, and Infectious Diseases). They had three items for community health needs which are *Important*, 1.) heart disease, 2.) primary care, and 3.) sexually transmitted diseases.

The focus group at *Erlanger North Hospital* had three items for community health needs which are *High Priority*, 1.) Substance / mental health, 2.) access to care (i.e.-specialty care firstly and then primary care), and 3.) urgent care. For health needs which are *Important*, 1.) no insurance / affordable insurance, and 2.) basic services (i.e.-shots, patient education, etc.). For health needs which are *Nice To Have*, 1.) "clothes closet" for new garments, due to DNV accreditation requirement, and 2.) health screenings (i.e.-cancer, etc.).

It is noted that both focus groups have listed substance / mental health as the number one priority, even with the opening of the new *Erlanger Behavioral Health Hospital* ("*EBHH*") in 2018. They have indicated that the behavioral health problem may actually be more severe now, because *EBHH* will not accept substance & mental health patients with medical conditions. For elderly patients, this is now a particularly acute issue, since the Geriatric / Psychiatric unit at *Erlanger North Hospital* has closed and "these patients have nowhere to go" if they have medical issues. However, it is noted that the focus group for the regional service area ranked substance / mental health as the number 4 item under high priority, not number 1.

As for *Erlanger North Hospital*, during the discussion of the sub-group findings, it was suggested that all of the things which they were saying are community health needs, seem to be indicating the need for an *FQHC* in the area of Red Bank, Tennessee, or in that "general vicinity". When this was stated, there was general agreement on this suggestion.

Health Disparities

19 SSI / SSDI Outreach Access & Recovery (*SOAR*). Website - https://www.samhsa.gov/soar/.

When *HCHD* published their health findings on March 4, 2019, we found health disparities to be of interest. The total population in 2019 of Hamilton County, Tennessee, is estimated to be 368,799, with 18.9%, or 69,759, of those being Black. In terms of mortality and chronic conditions, the following table highlights greater risk for Blacks in Hamilton County, as reported by *HCHD*.

Health Disparities In Hamilton County, Tennessee

Mortality Indicators (*)

Mortality Indicators (*)	
Hypertension	400%
Diabetes	250%
Infant Mortality	260%
Kidney Disease	200%
Prostrate Cancer	200%
Stroke	35%
Heart Disease	30%
Breast Cancer	23%

(*) Blacks more likely to die than Whites.

Health Condition Incidence (**)

Health Condition Incidence (**)	
Gonorrhea	1000%
Chlamydia	600%
Syphilis	360%
Low Birth Weight	240%
Pre-Term Birth	80%

(**) Black incidence more likely than White incidence.

It is noted that of the health status indicators from *Community Commons* outlined previously for Hamilton County, Tennessee, that infant mortality, low birth weight, chlamydia incidence and gonorrhea incidence, are identified as health needs in Hamilton County.

Further, the *Community Commons* health status indicators show a need for additional *FQHC*'s in Hamilton County, Tennessee. This also came up for discussion with the focus group at *ENH*, that they believe there is a need for an *FQHC* in the area of Red Bank, Tennessee. *ECHC* utilization data indicates that 348 patients originated from Red Bank, and demographic data indicates that 14.5% of the population is minority, along with 52.3% of the households having an income less than $50,000. These indicators seem to suggest that an *FQHC* should be located in Red Bank, Tennessee.

Tennessee State Health Plan – 2017-18 Update

The *Tennessee State Health Plan – 2017-18 Edition* has identified "*The Big Four*" behaviors "which directly influence six of the top ten leading causes of death in the state, and also influence numerous other health conditions".*(20)* The four behaviors are smoking, obesity, physical inactivity, and substance abuse.

20 Tennessee State Health Plan – 2017-18 Edition, p. 22.

It is noted that *TDOH* is embarking on a new pathway pertaining to the state health plan. The 2017-18 edition of the state health plan includes what is referred to as a "deep dive" into faith based organizations. "The specific purpose of the deep dive is to explore specific places and spaces where health is being addressed."*(21)* In his foreword message to the 2017-18 edition of the state health plan, Tennessee Health Commissioner – John Dreyzehner, M.D., states that "the human spirit and our bodily health are profoundly linked. Considering that, according to the Pew Research Center, in 2017, 75% of adults in Tennessee reported going to religious ceremonies at least a few times a year (51% every week), spirituality plays an important role in Tennesseans lives".*(22)* Further, he stated that "our engagement with faith communities in Tennessee represents a new path forward".

Of particular note here, is that *TDOH* conducted a series of focus groups around the State of Tennessee with various faith communities to explore the interplay between physical health and spiritual health. Within this framework, one of the focus groups was conducted in Bradley County, Tennessee, with a Latino community focus. This is mentioned because Bradley County is within the defined service area for this *CHNA*. While *TDOH* is embarking on a "new path" in this regard, and didn't recognize any specific community health needs or goals pertaining to faith of the community, we will need to be cognizant of this new path for future assessment purposes.

Comments Received Pertaining To 2016 CHNA

In early 2017, after conclusion of the *CHNA* for 2016, including adoption by the *EHS* Board of Trustees, we received feedback from physicians and staff members at our *Children's Hospital*, that we should have recognized childhood obesity as a community health need.

In the *CHNA* for 2016, the indicators which were evaluated pertaining to pediatrics were Teen Births, Low Birth Weight and Infant Mortality. While these indicators evaluate a portion of the pediatric community health need, primarily needs at the beginning of life, some concern has been expressed concerning the need for a broader evaluation of the pediatric community.

Specifically, there is a concern about childhood overweight and obesity. Information for the *CHNA* in 2016 for specific health indicators was derived largely from *Community Commons*. While this data source is a good reference for community health information, it does have limited data for some indicators related to pediatrics and child health. For instance, the indicator for *Obesity* specifically states that it has measured adults over twenty (20) years of age, but did not measure childhood obesity. For this reason, childhood obesity was not identified as a community health need in our 2016 *CHNA*.

The *Tennessee State Health Plan – 2015 Edition* stated that "Tennessee's children struggle with obesity. Tennessee sees a greater prevalence of obesity among children 10 to 17 years old than the national average (20.5% in Tennessee compared to 17% nationally.) More significantly, obesity rates for Tennessee children between the ages of 2 and 4 are seven times higher than the national average, as 14.2% of these children are obese compared to the national average of

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21 *Ibid.*, p. 35.
22 *Ibid.*, p. 2.

2%."(23) For obesity, Tennessee ranked 45th in the nation in 2017, with an obesity rate of 34.8%. "Obesity rates are measured as the percentage of adults who are estimated to be obese, defined as having a body mass index ("*BMI*") of 30.0, or higher."(24)

In its 2019 report, *HCHD* identified obesity as a community health need for both adults and children. For children, it is reported that 33% of Hamilton County public school students were overweight or obese during the 2016-17 school year, compared to 39% of public school students in Tennessee.(25)

In the online survey which we conducted, chronic conditions were the highest rated community health need. In this context, chronic conditions include obesity. In fact, of the 298 responses to the survey which listed chronic conditions, a total of 170 were specific to obesity. While this refers to adult and children, the message seems to be clear, that the community believes obesity is a community health need in our service area. The focus group for the regional service area also found that chronic conditions are a community health need, and this also includes obesity. Again however, this generally refers to adults and children. However, of interesting note, is that the focus group did identify "Access To Care" and specifically stated that they were concerned about children receiving education about nutrition and "the 4 basic food groups".

Also of interesting note here, is that both the Tennessee and Hamilton County health plans enumerate physical inactivity, for both adults and children, as being a community health need because the lack of physical activity is essentially concomitant with overweight and obesity.

23 Tennessee State Health Plan – 2015 Edition, p. 49.
24 Tennessee State Health Plan – 2017-18 Edition, p. 26.
25 Picture Of Our Health: 2019 Hamilton County Community Health Profile, p. 55.

Section H

HEALTHCARE FACILITIES & RESOURCES AVAILABLE IN THE COMMUNITY

Section H: COMMUNITY FACILITIES & RESOURCES

EHS operates the *Erlanger Health Centers* ("*EHC*") in Hamilton County, which are *FQHC*'s. *HCHD* also operates an *FQHC* in Hamilton County.

Ocoee Regional Health ("*ORH*"), is an *FQHC* with it's primary office in Benton, Polk County, Tennessee. *ORH* has a total of six (6) sites of service in the counties of Polk, Bradley, Grundy, Bledsoe, Rhea and Meigs. *(26)*

Primary Health Care Centers ("*PHCC*"), is an *FQHC* headquartered in Trenton, Dade County, Georgia, and a satellite clinic in Rossville, Walker County, Georgia. *PHCC* has a referral agreement with *EHC* for dental patients.

Memorial Healthcare System operates *Memorial Hospital* (336 I/P beds) and *Memorial Hospital – Hixson* (69 I/P beds) in the City of Chattanooga, as well as a community clinic to serve low income and vulnerable populations.

Parkridge Health System operates *Parkridge Medical Center* (275 I/P beds), Parkridge East Hospital (128 I/P beds), Parkridge West Hospital (46 I/P beds), Parkridge Valley Child & Adolescent Hospital (108 Psychiatric Beds), Parkridge Valley Adult & Senior Services (64 Psychiatric Beds).

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26 Additional sites may be either school based, telehealth or mobile clinic services.

Section I

NEXT STEPS / IMPLEMENTATION STRATEGY

Section I: Next Steps

Through our analysis of community health indicators, along with input from the online survey and focus groups, certain community health needs have "risen to the top". While *EHS* cannot meet all the health needs of the identified service area, the rules which govern promulgation of this *CHNA*, do require that we determine which community health needs we will seek to address.

Pertaining to infant mortality, we will explore the possibility of providing a *Pack n' Play* baby crib to each newborn family which may be in need of such assistance, as suggested by the *HC* focus group.

In the rural counties, we will continue to work to recruit primary care providers to the counties west of Hamilton County, although we have had some difficulty in doing so since the *CHNA* in 2016. The EMC focus group identified "access to care" as the number one (1) priority for the service area. In this regard, our previous application for a new *FQHC* in Dunlap, Sequatchie County, Tennessee, was not approved, we have now re-applied to the *Bureau of Primary Health Care*, within the *U.S. Health Resources & Services Administration*, for approval and funding of a new *FQHC* in Sequatchie County, Tennessee, to be co-located in the same premises as *SVED* in Dunlap, Tennessee.

Further, with the suggestion by the *EN* focus group that an *FQHC* is needed in the area of Red Bank, Tennessee, we will further explore the need, and the possibility of establishing and *FQHC* in this area of Hamilton County.

The *EMC* focus group also identified "collaboration" as the second highest priority. Within this context, they specifically stated that *EHS* should collaborate with community agencies and entities beyond the typical healthcare realm. As a specific example, with the schools to provide health and nutrition community education. While *EHS* has several initiatives designed to provide education in school based programs, the discussion on this point was that *EHS* usually "waits for people to come to us, instead of reaching out to the community". This perception may need to change over time and it seemed that we should try to organize a focal point for community education, instead of each department attempting to do so for itself. The concept of a focal point will be evaluated.

Pertaining to chronic conditions, we specifically recognize obesity as a community health need, in both adults and children. Our *Children's Hospital* seeks out grant funding for childhood obesity where it is available, to provide clinic services for the morbidly obese and/or over weight. We will evaluate the availability for additional grant funding to provide community education in the schools for obesity and nutrition. For adults, we will need to explore what services we may offer in this regard. Further, as to heart disease, the community education component of our *Heart & Lung Institute* will seek to collaborate with evaluation of the "focal point" discussed above, for community education.

As for substance abuse and opioid addiction services identified by the *EMC* focus group, *EHS* has entered into a joint venture with Acadia Healthcare, Inc., to operate a new eighty-eight (88) bed behavioral health hospital, which opened in June, 2018. This new facility includes services

for substance abuse and addiction. Pertaining to the concerns raised by the EN focus group, about this facility not accepting substance abuse / mental health patients with an accompanying medical condition, we will seek to discuss and evaluate this situation with *EBHH*, and whether we can positively influence the criteria for patients which are accepted by that facility.

For the community health need identified as to transportation, it is currently unknown whether we will be able to address this need directly. However, we will further explore the community need, and determine whether there is an avenue of resolution in this regard.

Pertaining to the need to evaluate care provided by *EHS* physicians, we will explore ways to further enhance patient engagement.

It is not known at this time whether or not these strategies will be successful. For all of these strategies, there is the potential for issues beyond our control to influence whether they are fully realized.

Section J

ATTACHMENTS

TABLE OF ATTACHMENTS

List Of Acronyms

List Of Payor Contracts

Community Commons Health Need Indicators By County

EMC Focus Group - List Of Participants

Community Health Survey Form

List Of Acronyms

Acronym	Meaning
ACA	Patient Protection & Affordable Care Act
CDC	Centers For Disease Control
Children's	Children's Hospital @ Erlanger
CHNA	Community Health Needs Assessment
C-MSA	Chattanooga - Metropolitan Statistical Area
EHS	Erlanger Health System
EMC	Erlanger Medical Center
EE	Erlanger East Hospital
EN	Erlanger North Hospital
EBH	Erlanger Bledsoe Hospital
ECHC	Erlanger Health Centers
EWCH	Erlanger Western Carolina Hospital
ED	Emergency Department
FQHC	Federally Qualified Health Center
HCHD	Hamilton County Health Department
IRS	Internal Revenue Service
NICU	Neonatal Intensive Care Unit
ORH	Ocoee Regional Health
PHCC	Primary Health Care Centers
PCP	Primary Care Practitioner
EHC	Erlanger Health Centers
TDOH	Tennessee Dept. of Health
UT-COM	University of Tennessee - College of Medicine

List Of Payor Contracts

A. TennCare Managed Care Organizations

-- BlueCare
-- TennCare Select
-- AmeriGroup Community Care
-- United Healthcare Community Plan

B. Georgia Medicaid Managed Care Organizations

-- AmeriGroup Community Care
-- CareSource
-- Peach State Health Plan
-- WellCare of Georgia

C. Commercial Managed Care Organizations

-- Ambetter (TN and GA)
-- Blue Cross / Blue Shield of Tennessee
  - Blue Network P
  - Blue Network S
  - Cover Kids
  - AccessTN
  - Blue Advantage
-- Blue Cross of Georgia (HMO & Indemnity)
-- Baptist Health Plan
-- CIGNA Healthcare of Tennessee, Inc.
  (includes LocalPlus & SureFit)
-- Cigna-HealthSpring (Medicare Advantage)
-- CIGNA Lifesource (Transplant Network)
-- UNITED Healthcare of Tennessee, Inc.
  (Commercial & Medicare Advantage)
-- Aetna Health
  (commercial, Medicare Advantage, First Health Network)
-- Employers Health Network
-- Health Value Management D/B/A Choice Care Network
  (Commercial & Medicare Advantage)
-- HUMANA
  (Choicecare Network, HMO, PPO, POS & Medicare Advantage)
-- HUMANA Military
-- WellCare Medicare
-- Olympus Managed Health Care, Inc.
-- TriWest (VAPC3 & Veteran's Choice)

D. Alliances

-- Health One Alliance

E. Networks

-- Multi-Plan (includes Beech Street & PHCS)
-- MCS Patient Centered Healthcare
-- National Provider Network
-- NovaNet (group health)
-- USA Managed Care Corp.
-- MedCost
-- Alliant Health Plan
-- Crescent Preferred Provider Organization
-- Evolutions Healthcare System
-- Prime Health Services
-- Galaxy Health Network
-- Integrated Health Plan
-- HealthSCOPE Benefits, Inc.
-- HealthCHOICE (Oklahoma State & Education Employees Group Insurance Board)

F. Other

-- Medicare
-- Alexian Brothers Community Services (PACE)
-- Point Comfort Underwriters
-- OccuNet
-- BlueCare Plus (SNP)
-- United HealthCare Dual Complete (SNP)
-- PruittHealth Premier (I-SNP)
-- Simpra Advantage (I-SNP & D-SNP)

EMC Focus Group - List Of Participants

Daniel Lamsey, Administrator
Anesthesiology Consultants Exchange

Zac McCullough, Assistant Chief
Chattanooga Police

Diana Summerlin, Consultant
Representative - Hispanic Community

Steven Fox, M.D., Physician
University of Tennessee - College of Medicine

Deroneasha Smartt, Social Worker
University of Tennessee - College of Medicine

Ione Farrar, Program Manager - Assessment & Planning
Health Department, Hamilton County, Tennessee

Jennie Mahaffey, M.D., Medical Director
Erlanger Behavioral Health Hospital

Tyler Davis, Interim CEO/ CNO
Erlanger Behavioral Health Hospital

Christin McWhorter, Community Outreach Manager
Southeast Tennessee Area Agency On Aging

Sophie Moore, Director - Healthcare Partnerships
Chattanooga Area Food Bank

Chris Ramsay, President
Southeast Tennessee Health Consortium Foundation

Mollie Triplet, RN, Erlanger Trauma Program Coord. (*)
Tamekia Brewer, Erlanger Office of Patient Experience (*)
Abigail Aguilar, Erlanger Diversity Department (*)

(*) Staff members at *Erlanger Medical Center*.

Erlanger East Focus Group - List Of Participants

Becky Howe, ED -Director of Nursing (*)
Hillary Rogers, Clinical Coord./House Supervisor (*)
Christine Gordon, Marketing Manager (*)
Janet Kramer-Mai, Director - Oncology (*)

Chris Dill, Paramedic
Hamilton County EMS

David Burdett, Paramedic
Hamilton County EMS

(*) Staff members at *Erlanger East Hospital.*

Erlanger North Focus Group - List Of Participants

Rachel Harris, Administrator (*)
Shannon Kitchings, Physician Office Manager (*)
Shari Hicks, Case Manager (*)
Rhonda Johnson, Physical Therapy (*)
Lor Siv Lee, Pharmacist (*)
Roy Cairns, RN (*)
Raigh Kinsler, RN, CSL (*)
Candi Skiles, Admitting / Registration (*)
Carrie Burton, Administrative Assistant (*)

(*) Staff members at *Erlanger North Hospital.*

Erlanger Health System
Community Health Needs Assessment -- 2019

Thank you for participating in Erlanger's Community Health Needs Assessment. The only required information is the zip code of residence and whether you are an Erlanger employee, all other information is voluntary. We need the zip code of residence, so that we will be able to tally the responses and align our health needs assessment to general areas of interest.

If you would like to provide your name and occupation, we would welcome this information to add clarity to our assessment of the health needs for the service area.

Zip Code of Residence (required) ______________

Are you an Erlanger employee ? (required) ☐ Yes ☐ No

Name ______________________________
First Last

What is your primary occupation ? ______________________________

1.) In general terms, does the community have health insurance coverage ?

☐ Yes ☐ No ☐ Not Sure

2.) In general terms, how would you rate the health status of the community ?.

☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent

3.) Generally speaking, are you aware of whether or not members of the community have had the following preventive health services in the past year ?

☐ Mammogram ☐ Pap Smear ☐ Glaucoma Test ☐ Flu Shot
☐ Colonoscopy ☐ Blood Pressure Check ☐ Blood Sugar Check
☐ Cholesterol Screen ☐ Prostate Screening ☐ Vision Screening
☐ Hearing Screening ☐ Cariovascular Screening ☐ Dental Cleaning / X-Rays
☐ Screening For Sexually Transmitted Diseases

4.) Where do members of the community receive routine healthcare ?

☐ Physician Office ☐ Hospital Emergency Room ☐ Urgent Care Center
☐ Health Dept. Clinic ☐ Health Center ☐ Other

5.) Are members of the community able to visit a doctor, or practitioner, when they need to ?

☐ Always ☐ Most Of The Time ☐ Sometimes ☐ Never

6.) For members of the community that have children, are they able to visit a Pediatrician when they need to ?

☐ Always ☐ Most Of The Time ☐ Sometimes ☐ Never

7.) What are the three (3) most significant health issues in the community ?

____

8.) What do you think would reduce the use of the Emergency Room for non – emergencies ?

____

9.) Generally speaking, what do you believe should be the health goals for the community ?

____

10.) Please select the Erlanger locations where you have been a patient.

☐ Baronness Erlanger Hospital (Main – Adult)
☐ Children's Hospital @ Erlanger
☐ Erlanger East Hospital
☐ Erlanger North Hospital
☐ Erlanger Bledsoe Hospital
☐ Erlanger Carolina Hospital
☐ Erlanger Behavioral Health Hospital
☐ Erlanger – Premier Health Center
☐ Erlanger – Southside Health Center
☐ Erlanger – Dodson Avenue Health Center

Erlanger Health System

Community Health Needs Assessment -- 2019

	Strongly Disagree	Disagree	Don't Know	Agree	Strongly Agree
Immunizations & vaccinations are available in my community.	☐	☐	☐	☐	☐
Emergency care is available in my community.	☐	☐	☐	☐	☐
There are enough primary care doctors in my community.	☐	☐	☐	☐	☐
There are enough specialty care doctors in my community.	☐	☐	☐	☐	☐
There are enough children's doctors in my community.	☐	☐	☐	☐	☐
Doctor's can see children in a timely manner.	☐	☐	☐	☐	☐
Dental care is available in my community.	☐	☐	☐	☐	☐
Mental health services are available in my community.	☐	☐	☐	☐	☐
Children are safe from abuse and neglect in my community.	☐	☐	☐	☐	☐
There are adequate opportunities for children's fitness in my community.	☐	☐	☐	☐	☐
My community makes a good effort to prevent drug & alcohol abuse by children.	☐	☐	☐	☐	☐

Erlanger Medical Center
Summary Of Need Indicators By Total
From Community Commons

Category	Indicator	Hamilton	Bradley	Marion	Grundy	Sequatchie	Bledsoe	Rhea	Meigs	McMinn	Polk	Dade	Walker	Catoosa	Total
Clinical Care	Primary Care Providers (per 100,000)		X	X	X	X	X	X	X	X	X	X	X	X	12
Demographic	Population w/ Any Disability		X	X	X	X	X	X	X	X	X	X	X	X	12
Clinical Care	Population Living In HPSA		X	X	X	X	X	X	X	X	X		X	X	11
Health Outcomes	Heart Disease (Adult)		X	X	X	X	X	X		X	X	X	X	X	11
Health Outcomes	Mortality - Heart Disease (per 100,000)		X	X	X		X	X	X	X	X	X	X	X	11
Health Outcomes	Mortality - Lung Disease (per 100,000)			X	X	X	X	X	X	X	X	X	X	X	11
Social & Economic	No HS Diploma (Age 25+)		X	X	X	X	X	X	X	X	X	X	X		11
Health Behaviors	Tobacco Use (Current Smokers)		X	X	X	X	X		X		X	X	X	X	10
Health Outcomes	Mortality - Suicide (per 100,000)			X		X	X	X	X	X	X	X	X	X	10
Health Behaviors	Physical Inactivity		X	X	X		X	X		X	X	X	X		9
Health Outcomes	Cancer Incidence - Lung (per 100,000)			X	X	X	X	X	X		X	X	X		9
Social & Economic	Teen Births (per 1,000 females 15-19)			X	X	X	X	X	X		X		X	X	9
Physical Environ.	Grocery Store Access (per 100,000)		X	X		X	X			X	X		X	X	8
Health Outcomes	Mortality - Infant (per 1,000 Births)	X		X		X	X		X		X	X			7
Clinical Care	No Dental Exam (Adult)		X		X	X				X	X		X		6
Social & Economic	Public Assistance Income	X	X		X			X		X		X			6
Clinical Care	FQHC's	X	X	X		X				X					5
Health Behaviors	Walk Or Bike To Work					X			X	X			X	X	5
Health Behaviors	Tobacco Use (Quit Attempt)		X	X				X						X	4
Health Outcomes	Low Birth Weight (Of Total Births)	X		X	X	X									4
Health Outcomes	Cancer incidence - Colon (per 100,000)				X			X	X						3
Health Outcomes	Diabetes (Adult)		X	X	X										3
Physical Environ.	Assisted Housing (per 10,000 HH)	X						X		X					3
Physical Environ.	Liquor Store Access (per 100,000)	X		X	X										3
Health Outcomes	Chlamydia Incidence (per 100,000)	X					X								2
Health Outcomes	Ghonorrhea Incidence (per 100,000)	X	X												2
Health Outcomes	Cancer Incidence - Breast (per 100,000)			X											1
Health Outcomes	HIV Prevalence (per 100,000)	X													1
Physical Environ.	Fast Food Restaurants (per 100,000)	X													1
Clinical Care	Diabetes Mgmt - Hemoglobin A1c														0
	Total	10	15	20	17	16	15	15	13	15	15	12	15	12	

Erlanger Medical Center

Community Health Needs Assessment -- 2019

Category	Indicator	===== Tennessee Range ======			===== Tennessee Counties =======				=== Community Need Indicators ===			
		Tennessee	Low	High	Hamilton	Bradley	Marion	Grundy	Hamilton	Bradley	Marion	Grundy
Demographic	Population w/ Any Disability	15.4%	14.6%	16.1%	14.0%	17.7%	21.9%	26.5%		X	X	X
Social & Economic	Public Assistance Income	2.9%	2.8%	3.1%	3.3%	4.3%	2.7%	4.1%	X	X		X
	No HS Diploma (Age 25+)	14.0%	13.3%	14.7%	12.2%	16.5%	21.7%	26.0%		X	X	X
	Teen Births (per 1,000 females 15-19)	47.0	44.7	49.4	43.1	46.1	59.0	50.4			X	X
Physical Environ.	Assisted Housing (per 10,000 HH)	375.6	356.9	394.4	526.9	299.8	286.4	240.7	X			
	Liquor Store Access (per 100,000)	9.7	9.2	10.2	11.0	0.0	21.3	14.6	X		X	X
	Grocery Store Access (per 100,000)	16.9	16.0	17.7	17.2	14.2	14.2	43.8		X	X	
	Fast Food Restaurants (per 100,000)	77.7	73.8	81.6	97.5	75.8	74.4	36.5	X			
Clinical Care	Population Living In HPSA	70.3%	66.8%	73.8%	43.9%	100.0%	100.0%	100.0%		X	X	X
	No Dental Exam (Adult)	34.0%	32.3%	35.7%	28.4%	38.0%	32.6%	57.3%		X		X
	Diabetes Mgmt - Hemoglobin A1c	86.6%	82.3%	90.9%	85.2%	87.8%	85.5%	86.6%				
	Primary Care Providers (per 100,000)	83.0	78.9	87.2	127.3	54.4	66.9	0.0		X	X	X
	FQHC's	2.4	2.3	2.6	1.2	1.0	0.0	7.3	X	X	X	
Health Behaviors	Tobacco Use (Current Smokers)	22.8%	21.7%	23.9%	19.9%	26.6%	25.8%	24.9%		X	X	X
	Tobacco Use (Quit Attempt)	61.5%	58.5%	64.6%	62.1%	57.4%	46.6%	88.4%		X	X	
	Walk Or Bike To Work	1.5%	1.4%	1.6%	2.4%	2.2%	2.5%	2.0%				
	Physical Inactivity	29.0%	27.6%	30.5%	26.1%	33.7%	31.0%	35.2%		X	X	X
Health Outcomes	Cancer Incidence - Breast (per 100,000)	121.1	115.0	127.2	119.2	106.0	136.4	111.3			X	
	Cancer incidence - Colon (per 100,000)	41.0	39.0	43.1	38.2	44.2	44.2	59.7				X
	Cancer Incidence - Lung (per 100,000)	75.9	72.1	79.7	69.8	79.4	95.9	96.5			X	X
	Chlamydia Incidence (per 100,000)	474.0	450.3	497.7	520.8	390.8	373.6	88.9	X			
	Ghonorrhea Incidence (per 100,000)	110.8	105.3	116.3	169.8	127.6	56.4	14.8	X	X		
	HIV Prevalence (per 100,000)	297.2	282.3	312.0	325.2	128.3	95.4	52.6	X			
	Diabetes (Adult)	11.5%	10.9%	12.0%	11.0%	13.0%	13.6%	12.8%		X	X	X
	Heart Disease (Adult)	6.1%	5.8%	6.4%	5.9%	8.9%	13.2%	10.5%		X	X	X
	Low Birth Weight (Of Total Births)	9.2%	8.7%	9.7%	10.5%	8.3%	11.9%	9.9%	X		X	X
	Mortality - Infant (per 1,000 Births)	8.2	7.8	8.6	9.6	5.3	9.7	8.0	X		X	
	Mortality - Suicide (per 100,000)	15.8	15.0	16.6	13.6	13.4	19.0	16.3			X	
	Mortality - Heart Disease (per 100,000)	203.9	193.7	214.0	181.9	245.2	247.2	292.1		X	X	X
	Mortality - Lung Disease (per 100,000)	53.4	50.8	56.1	51.0	50.9	77.8	73.6			X	X
								Total Indicators >>>>	10	15	20	17

Erlanger Medical Center

Community Health Needs Assessment -- 2019

Category	Indicator	Tennessee Range: Tennessee	Tennessee Range: Low	Tennessee Range: High	Tennessee Counties: Sequatchie	Tennessee Counties: Bledsoe	Tennessee Counties: Rhea	Tennessee Counties: Meigs	Community Need Indicators: Sequatchie	Community Need Indicators: Bledsoe	Community Need Indicators: Rhea	Community Need Indicators: Meigs
Demographic	Population w/ Any Disability	15.4%	14.6%	16.1%	23.2%	26.5%	22.1%	23.5%	X	X	X	X
Social & Economic	Public Assistance Income	2.9%	2.8%	3.1%	1.9%	2.5%	3.4%	3.0%			X	
	No HS Diploma (Age 25+)	14.0%	13.3%	14.7%	18.2%	25.4%	24.1%	21.1%	X	X	X	X
	Teen Births (per 1,000 females 15-19)	47.0	44.7	49.4	65.7	52.5	65.5	64.6	X	X	X	X
Physical Environ.	Assisted Housing (per 10,000 HH)	375.6	356.9	394.4	232.4	255.3	434.4	204.3			X	
	Liquor Store Access (per 100,000)	9.7	9.2	10.2	7.1	7.8	0.0	0.0				
	Grocery Store Access (per 100,000)	16.9	16.0	17.7	0.0	7.8	18.9	34.0	X	X		
	Fast Food Restaurants (per 100,000)	77.7	73.8	81.6	63.8	0.0	62.9	8.5				
Clinical Care	Population Living In HPSA	70.3%	66.8%	73.8%	100.0%	100.0%	100.0%	100.0%	X	X	X	X
	No Dental Exam (Adult)	34.0%	32.3%	35.7%	45.7%	30.4%	27.6%	0.0%	X			
	Diabetes Mgmt - Hemoglobin A1c	86.6%	82.3%	90.9%	83.9%	83.8%	85.3%	81.0%				
	Primary Care Providers (per 100,000)	83.0	78.9	87.2	20.4	0.0	42.9	51.3	X	X	X	X
	FQHC's	2.4	2.3	2.6	0.0	7.8	3.1	8.5	X			
Health Behaviors	Tobacco Use (Current Smokers)	22.8%	21.7%	23.9%	30.7%	37.8%	20.4%	36.3%	X	X		X
	Tobacco Use (Quit Attempt)	61.5%	58.5%	64.6%	62.0%	71.5%	50.0%	-			X	
	Walk Or Bike To Work	1.5%	1.4%	1.6%	0.3%	3.4%	2.4%	0.4%	X			X
	Physical Inactivity	29.0%	27.6%	30.5%	30.5%	34.7%	36.8%	30.1%		X	X	
Health Outcomes	Cancer Incidence - Breast (per 100,000)	121.1	115.0	127.2	124.5	84.1	117.9	105.3				
	Cancer incidence - Colon (per 100,000)	41.0	39.0	43.1	42.8	40.9	45.7	47.8			X	X
	Cancer Incidence - Lung (per 100,000)	75.9	72.1	79.7	101.4	91.7	99.6	95.9	X	X	X	X
	Chlamydia Incidence (per 100,000)	474.0	450.3	497.7	115.8	1,464.1	295.3	257.5		X		
	Ghonorrhea incidence (per 100,000)	110.8	105.3	116.3	20.4	70.1	36.9	17.2				
	HIV Prevalence (per 100,000)	297.2	282.3	312.0	-	90.9	66.4	89.7				
	Diabetes (Adult)	11.5%	10.9%	12.0%	11.4	10.9	11.9	11.7				
	Heart Disease (Adult)	6.1%	5.8%	6.4%	20.5%	8.4%	10.2%	-	X	X	X	
	Low Birth Weight (Of Total Births)	9.2%	8.7%	9.7%	10.6%	7.2%	9.1%	8.7%	X			
	Mortality - Infant (per 1,000 Births)	8.2	7.8	8.6	9.2	10.7	8.4	9.1	X	X		X
	Mortality - Suicide (per 100,000)	15.8	15.0	16.6	25.8	23.3	21.6	18.7	X	X	X	X
	Mortality - Heart Disease (per 100,000)	203.9	193.7	214.0	177.2	224.6	245.9	219.9		X	X	X
	Mortality - Lung Disease (per 100,000)	53.4	50.8	56.1	71.9	59.6	65.1	68.3	X	X	X	X
								Total Indicators >>>>	16	15	15	13

Erlanger Medical Center

Community Health Needs Assessment -- 2019

Category	Indicator	Tennessee Range: Tennessee	Tennessee Range: Low	Tennessee Range: High	Tennessee Counties: McMinn	Tennessee Counties: Polk	Community Need Indicators: McMinn	Community Need Indicators: Polk
Demographic	Population w/ Any Disability	15.4%	14.6%	16.1%	17.8%	18.5%	X	X
Social & Economic	Public Assistance Income	2.9%	2.8%	3.1%	4.2%	3.1%	X	
	No HS Diploma (Age 25+)	14.0%	13.3%	14.7%	16.8%	21.0%	X	X
	Teen Births (per 1,000 females 15-19)	47.0	44.7	49.4	47.9	57.3		X
Physical Environ.	Assisted Housing (per 10,000 HH)	375.6	356.9	394.4	448.6	61.3	X	
	Liquor Store Access (per 100,000)	9.7	9.2	10.2	5.7	5.9		
	Grocery Store Access (per 100,000)	16.9	16.0	17.7	11.5	11.9	X	X
	Fast Food Restaurants (per 100,000)	77.7	73.8	81.6	65.1	23.8		
Clinical Care	Population Living In HPSA	70.3%	66.8%	73.8%	100.0%	100.0%	X	X
	No Dental Exam (Adult)	34.0%	32.3%	35.7%	38.1%	50.0%	X	X
	Diabetes Mgmt - Hemoglobin A1c	86.6%	82.3%	90.9%	72.7%	83.5%		
	Primary Care Providers (per 100,000)	83.0	78.9	87.2	53.2	47.8	X	X
	FQHC's	2.4	2.3	2.6	1.9	5.9	X	
Health Behaviors	Tobacco Use (Current Smokers)	22.8%	21.7%	23.9%	21.5%	29.2%		X
	Tobacco Use (Quit Attempt)	61.5%	58.5%	64.6%	53.8%	73.5%		
	Walk Or Bike To Work	1.5%	1.4%	1.6%	0.9%	1.8%	X	
	Physical Inactivity	29.0%	27.6%	30.5%	33.3%	31.5%	X	X
Health Outcomes	Cancer Incidence - Breast (per 100,000)	121.1	115.0	127.2	102.4	106.6		
	Cancer incidence - Colon (per 100,000)	41.0	39.0	43.1	39.1	31.8		
	Cancer Incidence - Lung (per 100,000)	75.9	72.1	79.7	81.4	110.8		X
	Chlamydia Incidence (per 100,000)	474.0	450.3	497.7	252.2	191.7		
	Ghonorrhea Incidence (per 100,000)	110.8	105.3	116.3	32.5	36.0		
	HIV Prevalence (per 100,000)	297.2	282.3	312.0	108.2	77.1		
	Diabetes (Adult)	11.5%	10.9%	12.0%	12.0	11.5		
	Heart Disease (Adult)	6.1%	5.8%	6.4%	6.6%	19.7%	X	X
	Low Birth Weight (Of Total Births)	9.2%	8.7%	9.7%	8.2%	8.8%		
	Mortality - Infant (per 1,000 Births)	8.2	7.8	8.6	5.8	10.8		X
	Mortality - Suicide (per 100,000)	15.8	15.0	16.6	17.1	22.7	X	X
	Mortality - Heart Disease (per 100,000)	203.9	193.7	214.0	229.7	250.4	X	X
	Mortality - Lung Disease (per 100,000)	53.4	50.8	56.1	60.4	64.7	X	X
						Total Indicators >>>>	15	15

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Community Health Needs Assessment -- 2019

Category	Indicator	====== Georgia Range ======			======= Georgia Counties ========			=== Community Need Indicators ===		
		Georgia	Low	High	Dade	Walker	Catoosa	Dade	Walker	Catoosa
Demographic	Population w/ Any Disability	12.4%	11.7%	13.0%	16.3%	19.2%	14.7%	X	X	X
Social & Economic	Public Assistance Income	1.9%	1.8%	2.0%	3.2%	1.7%	1.2%	X		
	No HS Diploma (Age 25+)	14.2%	13.5%	14.9%	19.9%	20.3%	14.4%	X	X	
	Teen Births (per 1,000 females 15-19)	45.3	43.0	47.6	33.9	60.1	50.0		X	X
Physical Environ.	Assisted Housing (per 10,000 HH)	328.4	312.0	344.9	28.8	166.1	130.1			
	Liquor Store Access (per 100,000)	9.6	9.1	10.1	0.0	4.4	3.1			
	Grocery Store Access (per 100,000)	18.1	17.2	19.0	18.0	8.7	11.0		X	X
	Fast Food Restaurants (per 100,000)	83.1	78.9	87.3	54.1	32.0	79.8			
Clinical Care	Population Living In HPSA	37.9%	36.0%	39.8%	0.0%	100.0%	100.0%		X	X
	No Dental Exam (Adult)	29.1%	27.6%	30.6%	25.5%	40.6%	24.4%		X	
	Diabetes Mgmt - Hemoglobin A1c	85.3%	81.0%	89.6%	86.0%	83.3%	84.7%			
	Primary Care Providers (per 100,000)	72.9	69.3	76.5	18.3	26.4	44.2	X	X	X
	FQHC's	2.4	2.3	2.5	6.0	4.4	3.1			
Health Behaviors	Tobacco Use (Current Smokers)	17.8%	16.9%	18.7%	20.3%	26.1%	25.0%	X	X	X
	Tobacco Use (Quit Attempt)	61.1%	58.0%	64.1%	66.7%	66.8%	57.5%			X
	Walk Or Bike To Work	1.8%	1.7%	1.9%	6.5%	1.4%	0.7%		X	X
	Physical Inactivity	23.1%	21.9%	24.3%	25.7%	28.7%	24.1%	X	X	
Health Outcomes	Cancer Incidence - Breast (per 100,000)	123.5	117.3	129.7	95.3	96.4	90.7			
	Cancer Incidence - Colon (per 100,000)	41.4	39.3	43.5	28.1	34.0	32.3			
	Cancer Incidence - Lung (per 100,000)	65.9	62.6	69.2	82.3	86.0	68.1	X	X	
	Chlamydia Incidence (per 100,000)	516.5	490.7	542.3	145.4	165.7	229.7			
	Ghonorrhea Incidence (per 100,000)	137.8	130.9	144.7	48.5	44.0	72.0			
	HIV Prevalence (per 100,000)	512.7	487.1	538.4	120.2	114.9	127.0			
	Diabetes (Adult)	10.6%	10.1%	11.2%	10.6%	10.8%	10.9%			
	Heart Disease (Adult)	4.4%	4.2%	4.6%	13.3%	12.0%	5.1%	X	X	X
	Low Birth Weight (Of Total Births)	9.5%	9.0%	10.0%	8.3%	9.8%	8.7%			
	Mortality - Infant (per 1,000 Births)	7.6	7.2	8.0	10.4	7.4	6.5	X		
	Mortality - Suicide (per 100,000)	12.7	12.0	13.3	20.8	13.8	14.0	X	X	X
	Mortality - Heart Disease (per 100,000)	179.1	170.1	188.0	236.1	307.6	190.7	X	X	X
	Mortality - Lung Disease (per 100,000)	46.1	43.8	48.4	62.8	80.7	64.3	X	X	X
							Total Indicators >>>>	12	15	12