Community Health Needs Assessment

Chattanooga-Hamilton County Hospital Authority

D / B / A

Erlanger Community Health Centers

Southside
3800 Tennessee Ave, Ste 124
Chattanooga, TN 37409

Dodson Avenue
1200 Dodson Ave.
Chattanooga, TN 37406

Premier Health
251 N. Lyerly St, Ste 300
Chattanooga, TN 37404

Erlanger Health System

2019

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ERLANGER HEALTH SYSTEM
Chattanooga, Tennessee

June 30, 2019

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Section A

EXECUTIVE SUMMARY

Section A: EXECUTIVE SUMMARY

Eranger Community Health Center ("*ECHC*") is a federally qualified health center ("*FQHC*") and a vital component of *Erlanger Health System* ("*EHS"*). This *Community Health Needs Assessment* ("*CHNA*") has been prepared for the community which is served by *ECHC*. We also utilize the *CHNA* of *Erlanger Medical Center* ("*EMC")* in addressing identified needs since the service area for *EMC* also encompasses the area served by *ECHC*.

The health center's primary service area, as determined by patient origin analysis of patients served in 2018, is Hamilton County, accounting for over 75% of our patients. Hamilton County, Tennessee, is designated by the *Health Resources & Services Administration* ("*HRSA*") as a Medically-Underserved Area ("*MUA*"). According to community health status indicators and utilization patterns derived from health center records and the Tennessee Department of Health ("*TDOH*"), along with a community survey and community focus group, Hamilton County needs to address an increasing rate of infant mortality and chronic disease, as well as provide patient education for themes such as substance abuse and navigating the health care system.

To address these needs, *ECHC* should focus additional effort on identifying ways to provide accessible services and educational services for patients, possibly through new sites of care, schools and/or other outreach initiatives, and place increased emphasis on prenatal care through the expansion of obstetrical services. Utilizing community partners and programs to extend the reach of *ECHC* to the patient population would be best to meet the need for accessible services and educational programs.

It is noted that in 2016 we submitted an application to *HRSA* for an *FQHC* in Sequatchie County, Tennessee, but the application was not approved. In 2019, we re-submitted an application to *HRSA* for approval of an *FQHC* in Sequatchie County, Tennessee. To meet the need for accessible primary care, we should also consider:

- Collaborate with community partners to provide resources and educational services.
- Implement an education program to explain pregnancy risk factors and infant mortality.
- Explore the possibility of a new *FQHC* location in the area of Red Bank. Tennessee.
- Explore the possibility of a mobile *FQHC* to reach under served schools in pediatric areas in collaboration with our *Children's Hospital*.

Section B

ERLANGER HEALTH CENTERS PROFILE

Section B: ERLANGER HEALTH CENTERS PROFILE

Erlanger Community Health Center ("ECHC") is a three (3) site *FQHC* and a vital component of *EHS*. *ECHC* brings academic medical expertise to the underserved residents of *Hamilton County*. *ECHC* focuses on comprehensive, multi-specialty and primary care. The health centers feature board-certified or board-eligible pediatricians, internal medicine specialists, nurse practitioners, and dentists.

The *FQHC* offers access to emergency care, hospitalization, or other specialized services through *EHS*. *ECHC* also offers a sliding fee scale to assist patients with medical and dental services. Further, *ECHC* provides on-site social support to its patients through insurance counseling, Women, Infant and Children's Program (WIC), onsite CVS Pharmacy, and programs such as diabetes management and smoking cessation. The *ECHC* physician has weekly clinics staffed by board-certified physicians in primary care, pediatrics, internal medicine, women's services (OB/GYN), and dental services.

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.

Excellence

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

Respect

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

Leadership

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

Accountability

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 April, 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

Additionally, in accordance with Section 330(k)(3)(H) of the Public Health Sservice Act, *ECHC* must be governed by a Board of Trustees specifically assigned to the health centers. The health centers board must consist of at least 9 members, of which the majority must be patients (51%). Non-patient health center board members must be a representative of the community served by the health center, and must be selected by their expertise in relevant subject areas. As of June, 2019, following are the current board members for the health centers.

Trustee	***Appointing Body***
Henry Hoss, Chair	Legislative Delegation
Rose Mary Geiger, Jr. Vice-Chair	Patient Representative

Nakeda Eady, Secretary	Patient Representative
Darwin Blandon	Patient Representative
Linda Mines	Legislative Delegation
Rosemary Porter	Patient Representative
Beverly Johnson	Patient Representative
Bernard Harris	Patient Representative
Philanger Smartt	Legislative Delegation
Gerald Webb, II	Legislative Delegation

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 COMMUNITY HEALTH CENTERS

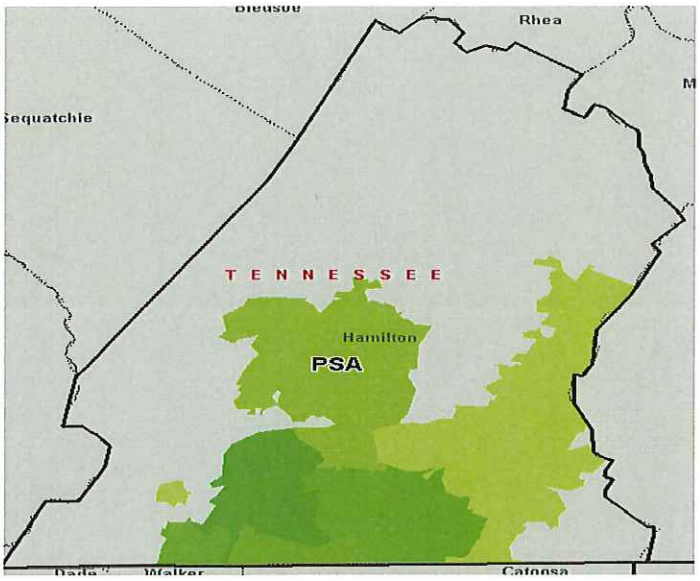
Section C: COMMUNITY SERVED

As a federally qualified health center located in Hamilton County, Tennessee, the community served by *ECHC* is represented by the county in which it is located. The eleven zip codes in Hamilton County which comprised 75% of *ECHC*'s patients during the fiscal year ended June 30, 2018, appear in the following table.

Zip Code	Description	No. Of Patients	%	Cumulative %
37406	Chattanooga, TN	1,855	12.3%	12.3%
37404	Chattanooga, TN	1,552	10.3%	22.6%
37411	Ridgeside, TN	1,535	10.2%	32.8%
37407	Chattanooga, TN	1,470	9.7%	42.5%
37421	Chattanooga, TN	1,203	8.0%	50.5%
37410	Chattanooga, TN	1,060	7.0%	57.5%
37412	East Ridge, TN	769	5.1%	62.6%
37416	Chattanooga, TN	746	4.9%	67.5%
37343	Hixson, TN	532	3.5%	71.0%
37402	Chattanooga, TN	455	3.0%	74.0%
37363	Ooltewah, TN	387	2.6%	76.6%

As an *FQHC* in Southeast Tennessee, the community served by ECHC is primarily Hamilton County. From a health planning perspective, the facility's general service area is traditionally defined as that geography which accounts for approximately 75% of its patient origin.

As shown above, the zip codes above account for 75% of *ECHC*'s patient volume. The remaining 25% of health center visits are from outside this geography. The defined service area which is comprised of these zip codes, may be seen graphically on the following map based on percentage of patient origin.



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 2016 *CHNA*, a need was identified for impacting social and racial disparities among the service area, as follows:

- Infant mortality, African-Americans 2.4 times more likely to die before 1st birthday.
- Low birth weight.
- Disparities among chronic diseases.
    i. Nephritis, 3.6 times higher for African Americans.
    ii. Diabetes, 2.7 times higher for African Americans.
    iii. Stroke, 32% higher for African Americans.
    iv. Heart Disease, 19% higher for African Americans.

For *ECHC*'s service area, the need for narrowing the gap among health disparities is clear. Among chronic diseases, age-adjusted mortality rates were significantly higher among African Americans. Additionally, mortality rates for all cancers were 16% higher for African Americans than whites, but for prostate cancer, black men experience a mortality rate which is double that of white men (51 vs. 26.3 per 100,000). For women, breast cancer mortality is 74% higher for African American women than white women (33 vs. 19 per 100,000).

Discussion Of Needs Identified In 2016

ECHC facilities are strategically located in areas which are medically underserved, low income, and minority populations, to serve the healthcare needs of the most vulnerable in our community. Health needs in these communities are most likely associated with social disparities surrounding key issues such as infant mortality, low birth weight, and chronic diseases. Gaps are narrowing, however, they are significant in the areas of life expectancy and disease specific mortality.

Pertaining to the need in Hamilton County to reduce infant mortality and the number low birth weight babies, the *2019 Community Health Profile (1)* 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 (2)* suggests that Hamilton County (9.6) is above the Tennessee average (8.2) as of 2019.

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

2 *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 Cmmons, 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. *(3)* In 2019, *Community Commons* shows Hamilton County at 10.5% compared to the Tennessee average of 9.2%.

For heart disease mortality between 2013-2015, *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*. However, *HCHD* reports that for blacks, the mortality rate is 30% higher than for whites.

For stroke mortality between 2013-2015, *HCHD* reports that Hamilton County is higher than Tennessee, with 46 compared to 45 deaths per 100,000. *HCHD* also reports that for blacks, the mortality rate is 35% higher than for whites.

For diabetes mortality between 2013-2015, HCHD reports that Hamilton county is higher than Tennessee, with 26 compared to 24 per 100,000. *HCHD* also reports that for blacks, the mortality rate is 250% higher than for whites.

3 *Picture Of Our Health, Hamilton County, Tennessee, 2019 Community Health Profile*, p. 42.

Section E

PROCESS, METHODS & INFORMATION

Section E: PROCESS, METHODS & INFORMATION

Information & Data - Change In Methodology From 2016 To 2019

As with the *CHNA* in 2016, our process utilized internal data analysis of community need. Additionally, our process was consistent with 2016 by collecting data from available public health sources such as Community Health Status Indicators from the *Community Commons*, the *Centers for Disease Control* ("*CDC*"), the *Tennessee Dept. of Health*, the *Health Resources & Services Administration*, the *Community Need Index* from *Dignity Health*, and the Uniform Data System ("*UDS*") from the *Bureau of Primary Health Care* ("*BPHC*"). Unlike our *CHNA* process in 2016, this year our process did not include an analysis of physician need, but was expanded to include input from the community through a community wide electronic survey and community focus groups, in an effort to ascertain the health needs from patients and residents. This information, along with input from the community, were the key drivers in determining the overall health needs of the service area.

Community Health Status Indicators -- Community Commons

We utilized health status indicators and data from *Community Commons.*(4) 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)
	Grocery Store Access (per 100,000)
	Fast Food Restaurants (per 100,000)

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

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*(5)* 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.

Community Survey & Focus Groups

5 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.

We conducted an online survey of the 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. The focus group for *ECHC* included some community leaders which have insight to the medically underserved, low income and minority populations. Such as participants from the *Chattanooga Area Food Bank*, *Chattanooga Police*, and *Hamilton County Medical Society*, among others. A complete list of participants for the *ECHC* focus group is attached to this *CHNA*. We also conducted a series of community focus groups for *Erlanger Medical Center*, *Erlanger East Hospital*, and *Erlanger North Hospital.*, which may also serve to inform this *CHNA*.

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 priorities of each sub-group. Where multiple sub-groups identified 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.

We have not received any written comments pertaining to the 2016 *CHNA* for the health centers.

Community Need Index – Dignity Health

We accessed the *Community Need Index* ("*CNI*") tool which is made available to the public by *Dignity Health.*(6) The *CNI* accounts for the underlying economic and structural barriers that 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

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

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.

Section F

INFORMATION FROM COMMUNITY SOURCES

Section F: COMMUNITY INFORMATION

For the *CHNA* in 2019 we utilized indicators and data from *Community Commons.(7)* Most of the indicators which were selected for evaluation in this *CHNA* are similar to the indicators which were evaluated in 2016. A few 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. 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 824 useable responses were received from within Hamilton County. 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. Specifically, we conducted a community focus group for *ECHC* which represents the interests of those who are members of medically underserved, low income and minority populations. Additionally, we conducted separate focus groups for *Erlanger* hospitals in Hamilton County, which may serve to inform this *CHNA*.

7 *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."(*8*)

In evaluating health indicators for Hamilton County, data from *Community Commons* illustrate the following indicators as a concern.

		===== Tennessee Range ======			Hamilton	Need
Category	Indicator	Tennessee	Low	High	County	Ind.
Demographic	Population w/ Any Disability	15.4%	14.6%	16.1%	14.0%	
Social & Economic	Public Assistance Income	2.9%	2.8%	3.1%	3.3%	X
	No HS Diploma (Age 25+)	14.0%	13.3%	14.7%	12.2%	
	Teen Births (per 1,000 females 15-19)	47.0	44.7	49.4	43.1	
Physical Environ.	Assisted Housing (per 10,000 HH)	375.6	356.9	394.4	526.9	X
	Liquor Store Access (per 100,000)	9.7	9.2	10.2	11.0	X
	Grocery Store Access (per 100,000)	16.9	16.0	17.7	17.2	
	Fast Food Restaurants (per 100,000)	77.7	73.8	81.6	97.5	X
Clinical Care	Population Living In HPSA	70.3%	66.8%	73.8%	43.9%	
	No Dental Exam (Adult)	34.0%	32.3%	35.7%	28.4%	
	Diabetes Mgmt - Hemoglobin A1c	86.6%	82.3%	90.9%	85.2%	
	Primary Care Providers (per 100,000)	83.0	78.9	87.2	127.3	
	FQHC's	2.4	2.3	2.6	1.2	X
Health Behaviors	Tobacco Use (Current Smokers)	22.8%	21.7%	23.9%	19.9%	
	Tobacco Use (Quit Attempt)	61.5%	58.5%	64.6%	62.1%	
	Walk Or Bike To Work	1.5%	1.4%	1.6%	2.4%	
	Physical Inactivity	29.0%	27.6%	30.5%	26.1%	
Health Outcomes	Cancer Incidence - Breast (per 100,000)	121.1	115.0	127.2	119.2	
	Cancer Incidence - Colon (per 100,000)	41.0	39.0	43.1	38.2	
	Cancer Incidence - Lung (per 100,000)	75.9	72.1	79.7	69.8	
	Chlamydia Incidence (per 100,000)	474.0	450.3	497.7	520.8	X
	Ghonorrhea Incidence (per 100,000)	110.8	105.3	116.3	169.8	X
	HIV Prevalence (per 100,000)	297.2	282.3	312.0	325.2	X
	Diabetes (Adult)	11.5%	10.9%	12.0%	11.0%	
	Heart Disease (Adult)	6.1%	5.8%	6.4%	5.9%	
	Low Birth Weight (Of Total Births)	9.2%	8.7%	9.7%	10.5%	X
	Mortality - Infant (per 1,000 Births)	8.2	7.8	8.6	9.6	X
	Mortality - Suicide (per 100,000)	15.8	15.0	16.6	13.6	
	Mortality - Heart Disease (per 100,000)	203.9	193.7	214.0	181.9	
	Mortality - Lung Disease (per 100,000)	53.4	50.8	56.1	51.0	

8 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.

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 *ECHC* 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.

Health Disparities

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 (*)

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 (**)

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, 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 all seem to suggest that an *FQHC* should be located in Red Bank, Tennessee.

Online Survey & Focus Groups

As indicated previously, we conducted an online survey for the service area to seek direct input from the community. For Hamilton County, Tennessee, there were a total of 824 useable responses. In summary, we can see 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, are also identified as health needs. However, the *Community Commons* data does not identify primary care as a need for Hamilton County.

Further, it would appear that *Obesity, Diabetes, and Obesity Related Diseases* are the highest need with 25% citing this issue by respondents. *Mental Health, Hypertension, and Access to Care* were second with a combined percentage of 22% citing these items. When considered in light of the most utilized preventive services, these items seem to be in line with concerns expressed in the survey results. For instance, 25% of respondents cited *Obesity, Diabetes*, and *Obesity* related diseases, over 40% had a blood sugar screening, and over 35% had a cholesterol screen.

The survey indicates that ER care is generally available, immunizations and vaccinations seem to be readily available, and that children can be seen by a doctor in a timely manner most of the time.

The *ECHC* focus group identified the following community health needs upon review and discussion of all available information.

High Priority

1.) Substance abuse / mental health (medical detoxification).
2.) Infant mortality / prenatal care (education).
3.) Chronic disease / obesity.
4.) Partnerships with community agencies.

Important

5.) After hours primary care availability.
6.) Patient education.
7.) Health care system navigation.

Nice To Have

8.) Transportation / day care for clients.

9.) "Equal" insurance coverage (partnerships).

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. *(9)* *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. *(10)*

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". *(11)* 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*. *(12)* In this regard, *EMC* has allocated a full time social worker that is dedicated to assisting our

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9 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.

10 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.

11 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.

12 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/.

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 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 *(13)*, 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.

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.

The zip codes which comprise the *ECHC* service area have been ranked according to population adjusted *CNI* scores.

Description	Description	Dignity Health CNI	Population 2019	Pop. Ratio	Weighted Pop. Adj. CNI
37404	Chattanooga, TN	5.0	14,269	3.9%	5.2
37406	Chattanooga, TN	5.0	14,675	4.0%	5.2
37402	Chattanooga, TN	5.0	4,075	1.1%	5.1
37407	Chattanooga, TN	5.0	9,209	2.5%	5.1
37410	Chattanooga, TN	5.0	4,292	1.2%	5.1
37411	Ridgeside, TN	4.4	18,613	5.0%	4.6
37412	East Ridge, TN	3.8	21,224	5.8%	4.0
37416	Chattanooga, TN	3.8	14,862	4.0%	4.0
37421	Chattanooga, TN	3.4	51,615	14.0%	3.9
37343	Hixson, TN	3.0	42,774	11.6%	3.3
37363	Ooltewah, TN	2.4	41,578	11.2%	2.7
	Total	4.2	237,186	100.0%	4.4

Interesting to note here is that eight (8) of the eleven (11) zip codes which comprise the *ECHC* service area, have a population weight adjusted *CNI* score above 4.0. For purposes of this comparison, a rank of 5.0 indicates the highest need, and a smaller numeric rank indicates the lowest need.

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

Section H

HEALTHCARE FACILITIES & RESOURCES AVAILABLE IN THE COMMUNITY SERVED

EHS operates the ECHC's in Hamilton County. HCHD also operates an *FQHC* in Hamilton County.

In neighboring Sequatchie County, EHS operates the Sequatchie Valley Emergency Department, which fills a void left when the Sequatchie County Hospital closed in the 80's, followed by its emergency room in August 2010, leaving the EMS as the only emergency care available to approximately 15,000 community residents. By 2019, Sequatchie County's health status was ranked 33, which is a significant improvement from 2016. Sequatchie partnered with Erlanger and the Southeast TN Development District to open Sequatchie Valley Emergency Department on July 29, 2014 as Tennessee's first cost-based satellite ED to serve local needs while also capturing downstream system referrals.

In 2018, *ECHC* opened a third site, Premier Healthcare, and relocated the *Southside Community Health Center* to a new location in a shopping center location, from an old school building. All *ECHC* sites are located within the defined service area.

Ocoee Regional Health Corporation ("*ORH*") is an *FQHC* with its primary office in Benton, Polk County, Tennessee. *ORH* has a total of seven sites of service, with two in Polk County and additional clinic sites in Bradley, Grundy, Bledsoe, Rhea, and Meigs Counties.

Primary Health Centers ("*PHCC*"), an *FQHC* headquartered in Trenton, Dade County, Georgia, has a satellite clinic in Rossville, Walker County, Georgia. It should be noted that *PHCC* has a referral agreement with the *ECHC* for dental patients.

Cherokee Health Systems ("*CHS*"), and FQHC organization headquartered in Knoxville, Knox County, Tennessee, has a satellite clinic in Chattanooga, Tennessee.

In addition, *EHS* operates several hospitals and many physician practices that serve Hamilton County. Other hospitals in Hamilton County include *CHI Memorial Hospital* and *Parkridge Medical Center*.

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".

As for substance abuse and mental health services identified by the *ECHC* 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. Pertaining to the concerns raised by the *ECHC* focus group, about this facility not accepting substance abuse / mental health patients with an accompanying medical condition and/or patients without some form of insurance coverage, we will seek to engage our joint venture partner to discuss and evaluate this situation with *EBHH*, and whether we can positively influence the criteria which are used to evaluate patients to be admitted by that facility.

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 *ECHC* focus group.

Within the context of partnerships with schools and community agencies to provide health and community education, as well as other community based health related programs, we will evaluate the concept of a "focal point" within *EHS* to coordinate community engagement efforts throughout the organization. The perception that *EHS* "waits for people to come to us", may need to change over time.

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 clinical 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 and engagement.

For the *FQHC* which seems to be indicated as a community health need, we will evaluate the feasibility of placing an *FQHC* in Red Bank, Tennessee.

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.

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

- ACA	Patient Protection & Affordable Care Act
- CAT	Community Action Team
- 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 Community Health Centers
- ED	Emergency Department
- EWCH	Erlanger Western Carolina Hospital
- 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)

ECHC Focus Group - List Of Participants

Rosemary Geiger, Board Member
Erlanger Community Health Centers

Danna Vaughn, Assistant Chief
Chattanooga Police

Jens Christensen, CEO
Chattanooga Community Kitchen

Sophie Moore, Director - Healthcare Partnerships
Chattanooga Area Food Bank

Rae Bond, President
Chattanooga-Hamilton County Medical Society

Aleetra Rice, CFO	(*)
Catherine Spruce, COO	(*)
Erical Beasley, Financial Analyst	(*)
Helen Pinkerton, Director - Community Outreach	(*)

(*) Staff members at Erlanger Community Health Centers.

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.	☐	☐	☐	☐	☐