# Table of Contents

## Part 1: Introduction
- Letter to our Community ................................................................. 4
- Executive Summary ........................................................................ 5

## Part 2: Community Health Improvement Plan (2017-2021)
- Introduction ...................................................................................... 8
- Community Health Improvement Plan Overview .......................... 10

### Cobb County CHIP
- What’s Contributing to Cobb’s Health? ........................................ 16
- Strategic Priority 1: Healthy Lifestyles ........................................... 20
- Strategic Priority 2: Access to Health Services ........................... 26

### Douglas County CHIP
- What’s Contributing to Douglas’ Health? ....................................... 36
- Strategic Priority 1: Healthy Lifestyles ........................................... 40
- Strategic Priority 2: Access to Health Services ........................... 46

- Next Steps/Action Cycle .................................................................. 52

## Part 3: Appendices/Resources/References
- Appendix 1: Action Plan Template .................................................. 54
- Appendix 2: MAPP Process .............................................................. 55
- The Six MAPP Phases .................................................................... 55
- Cobb2020 Overview ...................................................................... 56
- Live Healthy Douglas Overview ..................................................... 56

- Appendix 3: 2016 Community Health Assessments ...................... 57
- Appendix 4: 2017-2021 Community Healthy Improvement Plan Development Process .............................................................. 58
- Appendix 5: Partner Acknowledgments .......................................... 59
- Cobb2020 – A Partnership for a Healthier Cobb County ............. 59
- Live Healthy Douglas ................................................................. 60
- Cobb & Douglas Public Health (CDPH) Staff .............................. 60
- Kennesaw State University (KSU) Faculty & Staff ...................... 60
- Special Recognition ....................................................................... 60
- Local Resources in Cobb and Douglas Counties ......................... 61
- Additional Resources ................................................................. 62
- References .................................................................................. 63
Part 1: Introduction
Dear Community Member,

Cobb County and Douglas County are two thriving communities in Georgia. Excellent economic growth, strong educational systems, world class health care and a history of effective and creative collaboration are characteristics of our counties. However, many of our children and adults face preventable health risks such as inadequate physical activity, poor nutrition, obesity, substance abuse and tobacco use. Many of our neighbors have limited access to health care and other community resources that support healthy choices and healthy living.

The Steering Committees representing Cobb2020 – A Partnership for a Healthier Cobb County and Live Healthy Douglas believe strongly that we all have an important role to play in solving these problems. Guided by the 2012 Community Health Assessment and Improvement Plan, the partnerships have worked over the past five years to strengthen the local public health system, to increase collaboration around common health goals and to improve our community’s health. Community residents and representatives of health care, businesses, nonprofit organizations, faith communities, schools, and government agencies have joined together to assess the health needs of our community, to identify priorities, develop plans for mobilizing resources and take action.

In 2016, Cobb & Douglas Public Health, along with Kennesaw State University, Cobb2020 and Live Healthy Douglas, conducted our second thorough Community Health Assessment (CHA) to determine the most current leading community health issues, resident priorities and community resources. Information collected from this assessment and other community health needs assessments influenced the development of this 2017-2021 Cobb & Douglas Community Health Improvement Plan (CHIP).

The Cobb and Douglas CHIP focuses on two key priorities to improve the health and well-being for all who work, live, learn or play in our community. Because a healthy community means more than good medical care, our plan focuses on providing all members of our community the opportunity to make healthy choices and have access to health care when they need it.

It will take all of us doing our part to transform our community. The Public Health 3.0 model emphasizes that public health leaders must embrace the role of Chief Health Strategist for their communities—working with all relevant partners so that they can drive initiatives including those that explicitly address “upstream” social determinants of health. As our partnerships plan and implement change, we look forward to working with you to improve the health of the entire community in Cobb and Douglas Counties. Please join us!

Sincerely,

John D. Kennedy, M.D.
District Health Director
Cobb & Douglas Public Health

Rebecca Shipley
Chair
Cobb2020

Carol Lindstrom
Chair
Live Healthy Douglas
The Community Health Improvement Plan (CHIP) - A Partner-Driven Process

The Community Health Improvement Plan (CHIP) is a long-term systematic effort to address public health problems identified by our Community Health Assessment (CHA). Such a plan is typically updated every three to five years. Cobb & Douglas Public Health (CDPH) underwent development of its first CHIP beginning in 2011, engaging over 60 partners in a multi-phase CHA. These partners worked in coalitions that are now known as Cobb2020 - A Partnership for a Healthier Cobb County and Live Healthy Douglas. Together they used the Mobilizing for Action through Planning and Partnerships (MAPP) framework to complete their CHA and prioritize each county’s public health issues. (The outcomes of the first MAPP process are documented in the 2012 Community Health Assessment and Improvement Plan for Cobb and Douglas Counties.) In fall 2016, both coalitions began work on the second iteration of their CHIP, starting again with assessment of the communities’ strengths, needs, and desires to create their second truly community-driven health improvement plan.

The 2017-2021 CHIP for Cobb and Douglas Counties

Reflects Our Unique Communities

The 2017-2021 CHIP is broken out by county and is organized by strategic priorities, goals and strategies. It reflects a district-wide understanding that the opportunity for health begins in our families, neighborhoods, schools and workplaces. Below is a listing of each county’s strategic priorities and goals.

Cobb 2020’s 2017-2021 CHIP - Strategic Priorities and Goals:

Strategic Priority 1: Healthy Lifestyles
- **Goal 1.1:** Tobacco Product use - Reduce illness, disability and death related to tobacco product use and secondhand smoke exposure.
- **Goal 1.2:** Physical Activity - Improve health and the quality of life through daily physical activity.
- **Goal 1.3:** Healthy Eating - Promote health and reduce overweight and obesity through the consumption of healthy foods.

Strategic Priority 2: Access to Health Services
- **Goal 2.1:** Access to Primary Care - Increase access to quality primary health services for the underserved community.
- **Goal 2.2:** Chronic Disease Management - Increase access to local services that screen for and help control chronic conditions.
- **Goal 2.3:** Infant Mortality - Reduce infant mortality disparities through access to prenatal care.
- **Goal 2.4:** Behavioral Health - Improve access to appropriate, quality behavioral health services.
Live Healthy Douglas’s 2017-2021 CHIP - Strategic Priorities and Goals:

Strategic Priority 1: Healthy Lifestyles

- **Goal 1.1:** Tobacco Product Use - Reduce illness, disability and death related to tobacco product use and secondhand smoke exposure.
- **Goal 1.2:** Healthy Eating - Promote health through portion control and the consumption of healthy foods to reduce overweight and obesity.
- **Goal 1.3:** Youth Behavior - Improve the health, safety, well-being and mental and emotional development of youth (<10), adolescents (10-19) and young adults (20-24).

Strategic Priority 2: Access to Health Services

- **Goal 2.1:** Access to Primary Care - Improve access to quality primary health services for the under-served community.
- **Goal 2.2:** Chronic Disease Management - Increase access to local services that screen for and help control chronic conditions.
- **Goal 2.3:** Behavioral Health - Improve access to appropriate, quality mental/behavioral health services.
Part 2: Community Health Improvement Plan (2017-2021)
Community Health Improvement Plan (2017-2021)

Introduction

The 2017-2021 Community Health Improvement Plan (CHIP) is an update of our 5-year goals and strategies in response to the 2016 Community Health Assessment (CHA). The CHA and CHIP processes were implemented in partnership with members of Cobb2020 - A Partnership for a Healthier Cobb County and Live Healthy Douglas. Following the Mobilizing for Action through Planning and Partnerships (MAPP) framework, community leaders and members, representing various community groups and organizations, came together to analyze health status data. They then used that knowledge to determine priorities, goals and strategies for action.

The community health priorities are continued from the 2012 CHIP and represent two broad areas of focus for improvement in Cobb and Douglas Counties: Healthy Lifestyles and Access to Health Services. This version updates the 2012 CHIP with a new commitment to advance health equity within the communities at greatest risk for negative health outcomes. Using place-based (e.g., school, church, workplace, and neighborhood) efforts, we will address health disparities created by social determinants of health. Healthy People 2020 defines social determinants of health as conditions in the environments in which people live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. The health equity plans will be made along with countywide efforts.

The goals that have been set under each strategic priority highlight the long-term improvements we are hoping to achieve within the community. We also include the selected strategies that will help us reach our goals. The goals and strategies for each county were developed with the help of community health experts and align with national and state priorities. As a guide for planning, the CHIP is designed to organize, inspire and activate community members dedicated to creating a healthier place for themselves, their families, their employees and the people they serve.
**The 2017-2021 CHIP was a Data Driven Process**
The CHIP relies on findings from the CHA, which contains primary and secondary statistics on county characteristics such as causes of death and injury, chronic and infectious diseases, maternal and child health, behavioral health, and environmental health—all with a focus on economic and social conditions that contribute to health disparities. The 2016 CHA utilized the MAPP framework (see Appendix 2) and was led by Cobb & Douglas Public Health and Kennesaw State University in partnership with Cobb2020 and Live Healthy Douglas.

**The 2017-2021 CHIP Aligns with National and State Priorities**
Each CHIP goal is accompanied by a hyperlinked alignment chart to demonstrate that the planning process included consideration of both national and state health improvement priorities. These include:

- **The 10 Essential Public Health Services** – a national framework for the public health activities that all communities should undertake to contribute to their health and well-being.
- **Healthy People 2020** – a 10-year national agenda for improving the nation’s health.
- **CDC’s Health Impact in 5 Years (HI-5) framework** – an initiative that highlights cost-effective, non-clinical and community-wide approaches that are evidenced to have positive health impacts within a 5-year time-frame.
- **Georgia Department of Public Health’s State Health Improvement Plan (SHIP)** – statewide health improvement goals and strategies.

**Our CHIP’s Evolution - 2012 to 2021**
The CHIP outlines the priority health issues for the district as identified through analysis of CHA data. The original CHIP (2012 to 2016) was organized by each county (Cobb and Douglas) and divided by strategic priorities—Healthy Lifestyles and Access to Health Services. The CHIP was then further broken down by goals, which were accompanied by evidence-based strategies. The 2017-2021 CHIP will build on the successes in the original two priority areas with a targeted approach that emphasizes a commitment to health equity, ensuring everyone has an opportunity to live a healthy life.

*Technical and community-level CHA reports may be accessed at: cobbanddouglaspublichealth.org/publications/*.
Cobb2020 and Live Healthy Douglas partners have been working together since 2012 to improve healthy lifestyles and access to health services. As we look forward to the next 5 years, it is important to build upon the successes already achieved.

Here are a few highlights:

**District-wide**

- There has been significant implementation of Georgia Shape/Power Up for 30 physical activity components in Cobb, Douglas and Marietta school systems.
- We promoted seasonal Walk Georgia campaigns with the Cobb and Douglas Cooperative Extension Agencies, inspiring hundreds of residents to be more active.
- Cobb and Douglas Counties both showed increases in the number of children fully immunized, reflecting better access to health services over the five-year period.
- WellStar’s new Graduate Medical Education program was established, increasing access to care through several sites.
- WellStar’s 4-1 Care Network was established and will increase medical volunteerism in Cobb and Douglas Counties.

**Cobb**

- Between 2011-2015, Cobb saw a slight decrease in the number of deaths due to heart disease as compared to the previous five-year period, even with a marked increase in the population during that time.
- Cobb2020 launched the seasonal Farm Fresh Markets to improve access to low cost, fresh produce with positive outcomes.
- Cobb2020 launched the Breathe Easy Coalition and implemented numerous indoor/outdoor tobacco-free policies, including those for the Kennesaw State University Campus, City of Kennesaw, City of Smyrna, the Atlanta Braves SunTrust Park and The Battery Atlanta.
- We merged the Cobb2020 Worksite Wellness Team with the Cobb Chamber Health & Wellness Committee to improve efficiencies and resources to support worksite wellness policies.
- We helped Good Samaritan Health Center of Cobb achieve Federally Qualified Health Center (FQHC) status bringing more resources to our community, allowing us to serve more patients.
- We completed the Kaiser/CDPH/Good Samaritan Prescription Assistance Pilot to determine the most effective way to make chronic disease medications affordable for our residents.

**Douglas**

- Between 2011-2015, Douglas saw a decrease in the number of deaths due to heart disease as compared to the previous five-year period.
- Douglas school age children showed an improvement in Cardiovascular Endurance as measured by the Georgia Fitnessgram Tests over the past five years.
- Though we are still above the Georgia and U.S levels, Douglas County saw a slight decrease in the number of Emergency Room visits over the past five years.
- Live Healthy Douglas’ Power in Truth youth leadership conference, now in its 17th year, received national recognition as a Model Practice from the National Association for County and City Health Officials (NACCHO).
- We launched The CarePlace – Douglas County’s first non-profit, volunteer-based primary care center generously supported by Kaiser Permanente, WellStar and CDPH.
- We helped launch The Family Health Center’s first school-based Federally Qualified Health Center in Douglas County, now making primary care more affordable and accessible to thousands of school children and their families.
Everyone should have an opportunity to access available resources that can help them live a long and healthy life. Healthy People 2020 defines health equity as *the attainment of the highest level of health for all people*. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities. For each strategic priority being addressed, our goal is to focus on the related social and economic conditions, in the places where people work, live, learn or play, effecting health risks and outcomes. These social determinants of health have the power to positively or negatively affect an individual or family’s ability to achieve health. The CHIP’s approach recognizes that all Americans should have the opportunity to make the choices that allow them to live a long, healthy life, regardless of their income, education or background. It seeks to raise the bar for everyone, especially those who face significant barriers to better health.
The 2017-2021 CHIP Continues to Focus on the Impact of Policy, Systems and Environmental Change

For many years, most health programs focused on teaching behavioral changes that could help individuals live healthier lives. Realizing that it is not enough for one to know how to be healthy, policy, systems and environmental (PSE) changes help to modify the environment to make healthy choices practical and available to all members of the community.

- **Policy Change** – includes the passing of laws, ordinances, resolutions, mandates, regulations, or rules that will greatly influence the decisions individuals make about health (e.g., a tobacco prevention policy on a school campus).
- **Systems Change** – made to the rules within an organization and will often focus on changing infrastructure within a school, park, worksite or health setting (e.g., establishing a school-based health center to increase access and decrease absenteeism).
- **Environmental Change** – made to the physical environment to help promote healthy behaviors (e.g., assuring sidewalks are built to link a neighborhood to a nearby park).

The Health Impact Pyramid, developed by previous CDC Director, Dr. Thomas Frieden, displays the smallest to largest impact of factors affecting health. The CHIP strategies and objectives (to be established in the action planning phase) reflect all tiers of this pyramid, but will prioritize PSE changes as interventions with the potential for high impact for the total population. For example, building adequate sidewalks to connect neighborhoods to local parks may be more important in parts of the county with fewer choices for physical activity. This approach would also apply the health equity lens towards environmental changes in a community with less resources. In addition, by committing to the Health in All Policies approach (HiAP), we can proactively account for potential health impacts during all stages of the policymaking process. This ensures the avoidance of harmful health impacts and supports positive health outcomes.

Category of Interventions

<table>
<thead>
<tr>
<th>Intervention Type</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling and Education</td>
<td>Eat Healthy and Exercise</td>
</tr>
<tr>
<td>Clinical Interventions</td>
<td>Medicine for High Blood Pressure, Diabetes</td>
</tr>
<tr>
<td>Long-lasting, Protective Interventions</td>
<td>Vaccines, Smoking Cessation, Colonoscopy</td>
</tr>
<tr>
<td>Changing the Context to Make...</td>
<td>Flouridation, Smoke-Free Laws, Tobacco Tax</td>
</tr>
<tr>
<td>Socioeconomic Factors</td>
<td>Poverty, Education, Housing, Inequality</td>
</tr>
</tbody>
</table>

Our CHIP: Next Steps - Action Planning

Appendix 1 provides a template for the annual action plans that will be developed in support of CHIP goals and strategies. Led by Cobb2020 and Live Healthy Douglas Implementation Teams (I-Teams), the Action Cycle of the MAPP framework engages the community in a continuous process of planning, implementation and evaluation of programs, activities and interventions to achieve CHIP goals. Community ownership and commitment during this phase will be fundamental to achieving the goals being set forth. Diverse participation in the coalitions are desired. No matter who you are, there is an opportunity to partner to improve the community in which you work, live, learn or play.
Strategic Priority 1: Healthy Lifestyles
How can we prevent chronic disease by creating a community that supports healthy lifestyle choices for all?

The County Health Rankings model tells us that when we think about improvements that can create a healthier community, increasing healthy behaviors will impact about 30% of our outcomes, which is very significant. The Healthy Lifestyles priority focuses on ways that we as a community can change our behaviors and improve negative health outcomes such as heart disease, stroke, obesity and lung cancer. Knowing that social determinants have a big role in the choices we make, we will attempt to make living healthy an easier choice for all residents.

Strategic Priority 2: Access to Health Services
How do we improve access to quality health services to meet the needs of a diverse community?

Access to clinical care and other important health services will account for about 20% of our health outcomes. The Access to Health Services priority acknowledges that a large portion of our residents continue to live without the insurance or adequate access to providers, facilities or resources to help them maintain health, have healthy children or manage existing health issues. Our community improvements in this area must acknowledge our growing diversity and the challenges being faced by all groups.
Cobb County CHIP Overview

The 2017 Cobb County Community Health Improvement Plan (CHIP) was developed in partnership with Cobb2020 – A Partnership for a Healthier Cobb County. Cobb2020 was established in 2011 and has a mission of creating a community that works together to achieve optimal health for all those who live, learn, work, and play in Cobb County.

Following the Mobilizing for Action through Planning and Partnerships (MAPP) framework, the Cobb2020 Steering Committee has analyzed data from the 2016 Community Health Assessment (CHA) to identify and prioritize the underlying themes or strategic priorities affecting health outcomes. Figure 1 summarizes the CHIP strategy which emphasizes commitment to applying a place-based health equity approach to our strategic priorities. This means that we will purposefully target certain efforts within the schools, churches, workplaces and neighborhoods of communities at greatest risk for negative health outcomes.

Appendix 2 (pp. 53-54) contains additional details on the MAPP process and Cobb2020 Partnership.
The following Cobb2020 partners contributed to the development of the CHIP:

- American Cancer Society, Inc. - Southeast Region
- American Heart Association/American Stroke Association
- Austell Community Task Force Inc.
- Chattahoochee Technical College
- Children's Healthcare of Atlanta
- City of Marietta
- Cobb & Douglas Community Services Board
- Cobb & Douglas Public Health
- Cobb Chamber of Commerce
- Cobb County Community Members
- Cobb County Government
- Cobb County School District
- Cobb County Sheriff’s Office
- Eaton Chiropractic
- Good Samaritan Health Center of Cobb
- Kaiser Permanente
- Kennesaw State University
- Kiwanis Club of Marietta
- Leading Public Health
- Marietta City Schools
- McCleskey-East Cobb YMCA
- Morehouse School of Medicine/Satcher Health Leadership Institute
- Ser Familia, Inc.
- The Atlanta Regional Commission
- The Breakthrough Fellowship
- UGA Extension Cobb County
- WellStar Health System
Cobb County CHIP

The comprehensive Cobb and Douglas Community Health Assessments (CHA) are conducted every five years. The 2016-2017 CHA utilized the Mobilizing Action through Partnerships & Planning (MAPP) process and was led by Cobb & Douglas Public Health and Kennesaw State University in partnership with our Cobb2020 and Live Healthy Douglas Steering Teams. Results of the CHA guided the development and implementation of the Cobb County Community Health Improvement Plan (CHIP).

The CHA report includes both primary and secondary statistics on county demographics and characteristics, leading causes of death and injury, chronic and infectious diseases, maternal and child health, behavioral health, environmental health, all with a focus on existing disparities and social determinants of health.

Technical and community-level CHA reports may be accessed at: cobbanddouglaspublichealth.org/publications/.

Highlights of the CHA follow:

Leading Causes of Death in Cobb County, 2011-2015

1. Ischemic Heart & Vascular Disease (e.g., Heart Attack) 1,528
2. All Other Mental & Behavioral Disorders* 1,328
3. Malignant Neoplasms of the Trachea, Bronchus and Lung (e.g., Lung Cancer) 1,114
4. Cerebrovascular Disease (e.g., Stroke) 967
5. All COPD Except Asthma 862
6. Alzheimers Disease 646
7. Accidental Poisoning and Exposure to Noxious Substances 439
8. Malignant Neoplasms of Colon, Rectum and Anus (e.g., Colon Cancer) 422
9. Septicemia (e.g., Blood Poisoning) 413
10. Pneumonia 411

Heart and Vascular Diseases continue to be the leading causes of death in adults in both Cobb County and the state of Georgia.

Multiple factors contribute to an individual’s (and community’s) health outcomes. These include health behaviors, clinical care, social and economic factors, and physical environment. Key CHA findings in each of these are highlighted on pages 15-17.

*All Other Mental and Behavioral Disorders includes Dementia, Schizophrenia, and Bipolar Disorder.
HEALTH BEHAVIORS
Risk factors for heart disease include obesity, high blood pressure, high cholesterol and tobacco use.

**OBESE:** 23.4% of adults in Cobb and Douglas Counties

**OVERWEIGHT:** 37.9% of adults in Cobb and Douglas Counties

**BREAKDOWNS:**
- **Black:**
  - Males: 36.4%
  - Females: 21.8%
- **White:**
  - Males: 26.5%
  - Females: 19.7%
- **Hispanic:**
  - Males: 39.4%
  - Females: 37.2%
- **Males:**
  - Black: 39.6%
  - White: 35.9%

(Note: 2014 BRFSS, only district-level data available)

TOBACCO

**CIGARETTE SMOKING**
13.4% of adults in Cobb and Douglas Counties.

There is a disturbing trend of increased vaping (e-cigarettes) among young people.

(Note: 2014 BRFSS, only district-level data available)

SEXUAL ACTIVITY

**SYPHILLIS**
Syphilis remains a major and increasing health problem in Cobb County, causing significant complications if left untreated and aiding in the transmission of HIV infection.

**RACIAL DIFFERENCES**
- Black: 23.0%
- White: 4.3%
- Hispanic: 3.7%

(Note: Rate per 100,000; 2011-2015 aggregate data for all)

**GENDER DIFFERENCES**
- Male: 18.5%
- Female: 1.0%

(Note: 2014 BRFSS, only district-level data available)

**HIV**
Georgia is currently ranked 5th IN THE NATION for number of new HIV diagnoses.

In 2014, Black/Non-Hispanics accounted for 65% of new HIV infection diagnoses in Georgia.

(Note: 2014 BRFSS, only district-level data available)

- **2011:** 11,235 newly diagnosed HIV infections in Georgia.
- **2012:** 771 newly diagnosed HIV infections in Cobb and Douglas Counties (combined).
MENTAL/BEHAVIORAL HEALTH ISSUES: DRUG ABUSE AND SUICIDE

#1 leading cause of premature death in Cobb County
Accidental poisoning and exposure to noxious substances, including accidental overdoses of legal and illegal drugs, (2011-2015).

DRUG ABUSE

At both a national and local level, the opioid crisis is sky-rocketing. In Cobb County from 2011 to 2015, the age-adjusted death rate of all opioids (includes both prescription opioid pain relievers and heroin) increased from a death rate of 1.7 (2011) to 11.4 (2015) per 100,000 residents.

OPIOID ABUSE

2015 11.4
2014
2013
2012 1.7
2011

SUICIDE

2015
2014
2013
2012
2011

Suicide was the third leading cause of premature death in Cobb County between 2011-2015.

White males in particular comprised 61% (215 deaths) of the 354 suicides in Cobb County between 2011-2015, with 43% of those between the ages of 35-55 years old.

HEALTH INSURANCE COVERAGE

13.3% of Cobb County residents had no form of health insurance coverage in 2015 (decrease from 18.7% in 2011). However, among unemployed adults in 2015, nearly half (43.5%) had no health insurance coverage.

2011

2015

11.4

NO INSURANCE

2011 18.7%
2015 13.3%
2015 among unemployed adults 43.5%

PER SURVEY RESPONDENT:
“KIDS = MEDICAID; ADULTS = EMERGENCY KIDS = PREVENTATIVE; ADULTS = REACTIONARY”

16.1% delaying medical care due to cost

16.1% of Cobb County respondents to the CHA survey reported delaying medical care in the past 12 months due to cost.
**SOCIAL & ECONOMIC FACTORS**

**POVERTY**
Percentage of individuals in Cobb County living below poverty level (between 2010-2014)

- 2011: 11.1%
- 2015: 5.9%

**UNEMPLOYMENT**

- 2011: 11.1%
- 2015: 5.9%

The unemployment rate in Cobb County was 5.9% in 2015, down from 11.1% unemployment in 2011.

**EDUCATION**

Correlations exist between both education and income, and education and health. Between 2011-2015, Cobb County saw a 20.5% increase in high school graduation rates.

**RACIAL DISPARITY**

Cobb County residents living below poverty level (between 2010-2014)

- White, non-Hispanic: 7.3%
- African American: 17.6%
- Hispanic: 25.5%

**TRANSPORTATION**

With 741,334 residents, over 560,000 of which are between the ages of 15-74 (potential drivers) and the close proximity to Atlanta, traffic congestion is a significant problem in Cobb County.

**Mean travel time to work**: 31.8 minutes. 79.2% of workers drove alone to work.

**Housing**

Cobb County’s Fair Market Rent (FMR) for a 2 bedroom apartment is $949. In order to afford this level of rent and utilities - without paying more than 30% of income on housing - a household must earn $32,960 annual income - 2.5 jobs at minimum wage.

**Family & Social Support**

In 2015

44,513 (24.5%) children less than 18 years of age in Cobb County lived in a “female head of household (no husband)” home.

**Physical Environment**
Tobacco Product Use

Although there has been a significant decline in the number of people who smoke, tobacco use remains the leading cause of preventable death in the United States, with nearly 1 in 5 deaths, at more than 480,000 deaths each year.

- Smoking increases the risk of coronary heart disease, stroke and lung cancer, 3 of the top 5 leading causes of death in Cobb.*

- There is no risk-free level of exposure to secondhand smoke, so friends and family impacted are at risk for more frequent and severe asthma attacks, respiratory infections, ear infections and sudden infant death syndrome (SIDS).1,2

- Almost 9 out of 10 cigarette smokers first tried smoking by the age of 18, and 99% by the age of 26.1,3 While cigarette smoking has declined among U.S. youth, there has been an increase in use of products such as electronic cigarettes and hookahs, which carry similar health risks as cigarettes, but are in some cases more accessible.4,5

We aim to prevent initiation of tobacco use among youth and young adults as we continue to promote cessation programs to assist all smokers to quit. In addition, comprehensive smoke-free/tobacco-free policies will not only help protect our residents from secondhand smoke exposure, but will help limit the youth’s exposure to behaviors that encourage tobacco use.

*See Technical CHA Report for more detail.
GOAL 1.1: Tobacco Product Use  
Reduce illness, disability and death related to tobacco product use and secondhand smoke exposure.

Strategy 1.1.1: Identify and reduce tobacco-related disparities among population groups.  
Strategy 1.1.2: Promote access to information and support systems for cessation services.  
Strategy 1.1.3: Reduce the initiation of tobacco product use among children, adolescents, and young adults.  
Strategy 1.1.4: Reduce exposure to tobacco related products and secondhand smoke.

Local, State and National Alignment**

<table>
<thead>
<tr>
<th>10 Essential Public Health Services</th>
<th>1-7, 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy People 2020</td>
<td>TU - Tobacco Use</td>
</tr>
<tr>
<td>CDC HI-5</td>
<td>Tobacco Control Interventions</td>
</tr>
<tr>
<td>GA DPH SHIP</td>
<td>3.5 - Tobacco Use Prevention</td>
</tr>
</tbody>
</table>

**This chart contains hyper-links to the aligned state and national health improvement priorities.

Applying a Health Equity Lens

Per the CDC, “health equity can be achieved in tobacco prevention and control by eliminating differences in tobacco use and exposure to secondhand smoke between certain groups.” By identifying the Cobb communities and groups with the highest rate of use and secondhand smoke exposure, we can take a targeted approach to policy building and address the factors that contribute to these differences.

Social Determinants

<table>
<thead>
<tr>
<th>Gender</th>
<th>Educational Attainment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race and ethnicity</td>
<td>Geographic Location</td>
</tr>
<tr>
<td>Age</td>
<td>Disability</td>
</tr>
<tr>
<td>Income Level</td>
<td>Social Environment</td>
</tr>
</tbody>
</table>

Policy Changes to Consider to Alleviate Health Inequity

- Create smoke-free workplaces, school campuses, multi-unit housing and outdoor spaces to eliminate secondhand exposure (i.e., the new Atlanta Braves SunTrust Park and The Battery Atlanta in Cobb County opened in 2017 tobacco-free).
- Incentivize the development of healthy retail outlets in all neighborhoods as an alternative to tobacco vendors.
- Enact local licensing ordinances to control location and operations of tobacco retailers.
- Enforce laws regulating storefront and window signage.
Physical Activity

Obesity due to lack of physical activity is a major factor in the leading causes of illness and death in Cobb County.

- In 2015, only 141,255 (71.0%) children in Cobb were in the Healthy Fitness Zone for Aerobic Capacity.*
- Most recent Behavioral Risk Factor Surveillance Systems Data (2014) reports 147,390 (23.4%) of adults were obese, and 238,721 (37.9%) of adults were overweight in the Cobb and Douglas County district.*
- Additionally, 109,598 (17.4%) of adults reported they had not participated in any physical activity during the past month.*

Regular physical activity is important to health and the quality of life. For adults, it can lower the risk of early death and most chronic diseases including coronary heart disease, stroke, high blood pressure, Type 2 diabetes and breast and colon cancer. In children, following recommendations for physical activity can improve bone health, cognitive skills and the ability to concentrate. By strengthening school, early learning and workplace policies aimed at increasing physical activity, we will have a far-reaching impact on those who choose Cobb County to work, live, learn and play.

*See Technical CHA Report for more detail.
GOAL 1.2: Physical Activity

Improve health and the quality of life through daily physical activity.

Strategy 1.2.1: Increase physical activity among at-risk populations through community design and access.
Strategy 1.2.2: Promote and strengthen school and early learning policies and programs that increase physical activity.
Strategy 1.2.3: Promote and strengthen workplace policies and programs that increase physical activity.

Local, State and National Alignment

<table>
<thead>
<tr>
<th>10 Essential Public Health Services</th>
<th>Healthy People 2020</th>
<th>CDC HI-5</th>
<th>GA DPH SHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA – Physical Activity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School-Based Programs to Increase Physical Activity</td>
<td></td>
<td>Safe Routes to School</td>
<td>3.2 – Cancer Prevention and Control</td>
</tr>
<tr>
<td>Multi-Component Worksite Obesity Prevention</td>
<td></td>
<td>Public Transportation System Introduction or Expansion</td>
<td>3.3 – Diabetes and Hypertension</td>
</tr>
<tr>
<td>or Expansion</td>
<td></td>
<td></td>
<td>3.4 – Childhood Obesity</td>
</tr>
</tbody>
</table>

Applying a Health Equity Lens

A national study by Gordon-Larsen, et al. found that non-white and lower-income neighborhoods are twice as likely to lack at least one facility for physical activity when compared to higher-income white neighborhoods. Through built environment changes and community design, we can strategically target improvements in neighborhoods comprising the gap.

Social Determinants

<table>
<thead>
<tr>
<th>Age</th>
<th>Income Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Social Cohesion</td>
</tr>
<tr>
<td>Employment</td>
<td>Safe Neighborhoods</td>
</tr>
<tr>
<td>Disability Status</td>
<td>Social Environment</td>
</tr>
<tr>
<td>Educational Attainment</td>
<td>Built Environment</td>
</tr>
</tbody>
</table>

Policy Changes to Consider to Alleviate Health Inequity

- Plan for and invest in pedestrian and bicycling infrastructure and transit-oriented development.
- Expand Safe Routes to Schools programs (e.g., improved sidewalks, crosswalks and bike areas were installed on Floyd Road near the middle school in the past 5 years in Cobb County).
- Ensure access to safe, well-maintained parks and recreation facilities.
- Pursue joint use agreements to share facilities with schools.
- Increase the amount of time students spend in moderate or vigorous-intensity physical activity during PE class (i.e., Cobb County and Marietta City schools were the first in Georgia to adopt Power Up for 30 - adding 30 minutes of physical activity outside of PE and recess during the elementary school day).
Healthy Eating

There is strong scientific support for the benefits of eating healthy foods, which typically includes consuming the recommended portions across the food groups and limiting certain types of food elements (e.g., saturated and trans-fat, cholesterol, added sugars, sodium/salt and alcohol).13

- Between 2011-2015, heart disease was the leading cause of death and the fourth leading cause of hospital visits in Cobb County. Consuming healthy foods and maintaining a healthy body weight will reduce the risk of heart disease as well as other major health issues such as overweight and obesity, high blood pressure, Type 2 diabetes and some cancers.*

- People at a healthy weight are also less likely to experience complications during pregnancy and are less likely to die at an earlier age.

By increasing our county’s knowledge on how to consume healthy portions and make better decisions based on ingredients, we will begin the work of enabling healthy choices. We will also advocate for organizational changes in regards to the types of food offered to our residents whether it be in a school vending machine, a park’s concession stand, or during an employee celebration at work.

*See Technical CHA Report for more detail.
GOAL 1.3: Healthy Eating
Promote health and reduce overweight and obesity through the consumption of healthy foods.

Strategy 1.3.1: Increase access to healthy and affordable foods in food desert communities.
Strategy 1.3.2: Increase community knowledge on recognizing appropriate portions and making healthy food and beverage choices.
Strategy 1.3.3: Increase organizational and programmatic changes focused on healthy eating.

Local, State and National Alignment

| 10 Essential Public Health Services | 1, 3-5, 9-10 |
| Healthy People 2020 | NWS – Nutrition and Weight Status |
| CDC HI-5 | Multi-Component Worksite Obesity Prevention |
| GA DPH SHIP | Public Transportation System Introduction or Expansion |
| | 3.2 – Cancer Prevention and Control | 3.3 – Diabetes and Hypertension | 3.4 – Childhood Obesity |

Applying a Health Equity Lens

Food deserts are areas that lack access to affordable fruits, vegetables, whole grains, low-fat milk, and other foods that make up the full-range of a healthy diet. Families living in food deserts are often limited in their ability to access these foods because they live far from a supermarket or grocery store and do not have access to transportation to get them there. It is very difficult to make healthy choices if there is limited access to healthy foods, so we aim to take a targeted approach to increasing the availability of foods within these neighborhoods.

Social Determinants

| Gender | Income Level |
| Age | Disability Status |
| Race and Ethnicity | Transportation |
| Educational Level | Built Environment |

Policy Changes to Consider to Alleviate Health Inequity

- Provide fast-track permitting for grocery stores in underserved areas.
- Identify sites for farmers’ markets and community gardens.
- Encourage farmers’ markets and other healthy food retailers to accept federal nutrition programs such as WIC and SNAP (food stamps) (i.e., CDPH and the YMCA partnered to host numerous Farm Fresh Markets in South Cobb and Marietta food desert areas over the past 3 years).
- Adopt pedestrian-friendly design codes to improve non-motorized access to healthy foods.
- Offer bus service from underserved neighborhoods to healthy food retail stores.
Access to Primary Care

The lack of access to primary care providers is a major challenge of the entire U.S. health care system. Primary care providers are typically a patient’s first point of contact and provide critical preventative care, disease management and referrals.

- Increased access to primary care results in fewer low birthweight babies and lower mortality due to chronic disease.\textsuperscript{16}

- In 2014, top U.S. performers reported 1,041:1 as the ratio of the population to total primary care physicians; Cobb County’s ratio was 1,440:1.\textsuperscript{17}

- Cobb County is currently served by only five safety net providers, including two Federally Qualified Health Centers (FQHCs), providing increased access to care for the low-income population who are uninsured/underinsured. Safety net providers include public hospitals, community health centers, local health departments, free clinics, special service providers, and in some cases, physician networks and school-based clinics that deliver care to low-income, at-risk patients.*

- Uninsured adults often use the local hospital’s Emergency Department (ED) in the absence of accessible primary care providers. This decreases the ED’s service capabilities and increases health care costs.

We aim to combat the lack of access to primary care providers by reducing barriers among those at greatest risk, and by increasing the capacity of our safety net providers to serve a growing population of individuals that are uninsured or underinsured.

*See Technical CHA Report for more detail.
GOAL 2.1: Access to Primary Care

Improve access to quality primary health services for the underserved community.

Strategy 2.1.1: Reduce barriers to accessing clinical and community preventive services, especially among populations at greatest risk.

Strategy 2.1.2: Increase the care capacity of safety net providers.

Local, State and National Alignment

<table>
<thead>
<tr>
<th>10 Essential Public Health Services</th>
<th>4-5, 7, 9, 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy People 2020</td>
<td>AHS – Access to Health Services</td>
</tr>
<tr>
<td>CDC HI-5</td>
<td>N/A</td>
</tr>
<tr>
<td>GA DPH SHIP</td>
<td>1.1 – Healthcare Workforce</td>
</tr>
</tbody>
</table>

Applying a Health Equity Lens

The high-cost of care, lack of insurance coverage and lack of available primary care providers impact some communities more than others. By systematically reducing the barriers to accessing preventive services in at-risk populations, we can improve overall health outcomes for the county.

Social Determinants

<table>
<thead>
<tr>
<th>Gender</th>
<th>Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Access to Providers</td>
</tr>
<tr>
<td>Race and Ethnicity</td>
<td>Transportation</td>
</tr>
<tr>
<td>Origin of Birth</td>
<td>High Cost</td>
</tr>
<tr>
<td>Income</td>
<td></td>
</tr>
</tbody>
</table>

Policy Changes to Consider to Alleviate Health Inequity

- Streamline implementation of school-based health centers in low-income communities.
- Incentivize implementation of school and childcare center-based vaccination programs.
- Provide technical assistance to improve the quality and efficacy of the safety net providers (i.e., Good Samaritan Health Center of Cobb achieved FQHC status in the past five years, greatly increasing their ability to serve more residents).
- Integrate Community Health Workers (CHWs) into the healthcare workforce.
Chronic Disease Management

The successful management of prevalent chronic diseases (e.g., asthma, high blood pressure and diabetes) relies on early screening, education and access to the appropriate care to prevent increased sickness or death.

• Between 2011-2015, asthma was the leading cause of hospitalizations in Cobb County children ages 1-9 years old and the ninth leading cause of Emergency Department (ED) visits across all ages.*

• In addition to high medical costs, poorly controlled asthma leads to missed school days, decreased academic performance and causes parents/guardians to miss work.

• Heart disease and stroke are the first and fourth leading cause of death in Cobb County respectively. High blood pressure and high cholesterol are the two main contributors to these conditions.*

• There has been a significant increase in hospitalizations due to diabetes, which was the 11th leading cause of death in Cobb County between 2011-2015. 23

In alignment with the CDC’s 6/18 initiative, we aim to better manage the chronic diseases within our county through control of asthma, diabetes and high blood pressure for communities at greatest risk.

*See Technical CHA Report for more detail.
GOAL 2.2: Chronic Disease Management

Increase access to local services that screen for and help control chronic conditions.

Strategy 2.2.1: Increase chronic disease screenings, education and care management among populations at greatest risk.

Local, State and National Alignment

| 10 Essential Public Health Services | 1-5, 7, 9, 10 |
| Healthy People 2020 | D – Diabetes | HDS – Heart Disease and Stroke |
| | RD – Respiratory Diseases |
| CDC HI-5 | N/A |
| GA DPH SHIP | 1.2 – School-based Health Centers | 1.3 – Healthcare Partnerships |
| | 1.5 - Telehealth | 3.1 – Pediatric Asthma | 3.2 – Cancer |
| | Prevention and Control | 3.3 – Diabetes and Hypertension |

Applying a Health Equity Lens

It is known that poor medication access and adherence is a significant barrier to achieving positive health outcomes for the underinsured and uninsured populations. Their economic vulnerability makes them more likely to suffer from chronic diseases, but less likely to have access to the appropriate education, medications and other management solutions. Increasing access to chronic disease screening and management services within the communities of greatest need will help to reduce our county’s overall death, disability and hospitalization rates. It will also create a higher quality of life for the individuals and families experiencing the most risk.

Social Determinants

| Educational Attainment | Social Environment |
| Employment | Transportation |
| Safe Neighborhoods | Access to Provider |

Policy Changes to Consider to Alleviate Health Inequity

- Create interoperable systems to exchange clinical, public health and community data, streamline eligibility requirements, and expedite enrollment processes to facilitate access to clinical preventive services.
- Expand the use of community health workers and home visiting programs.
- Give employees time off to access clinical preventive services.
- Establish patient and clinical reminder systems for preventive services.

Source: DPH OASIS - https://oasis.state.ga.us/gis/mappingtool/agsMort.aspx
Infant Mortality
Infant Mortality is the death of an infant immediately after birth up to his or her first birthday. The infant mortality rate (IMR) is the number of infant deaths occurring per every 1,000 live births. These deaths are generally caused by birth defects, preterm birth, maternal complications during pregnancy, Sudden Infant Death Syndrome (SIDS), or injuries.

- Between 2011-2015, Cobb County had a total of 280 infant deaths, which equates to an IMR of 5.9; there was also an increase of 30% from the 2011 to 2015 rates.*

- There are great disparities in infant mortality within Cobb. Between 2011-2015, Black, non-Hispanic infants had the highest rates of dying in their first year of life with an overall IMR of 10.8 (142 deaths).*

While infant mortality may be caused by a variety of unavoidable factors, including genetics and birth defects, studies show that early and adequate prenatal/postnatal care can have positive outcomes on an infant’s risk level. Thus, we will work to identify the high-risk pregnant women within the county and create interventions to increase their likelihood of receiving the level of care needed within the recommended time frames.

*See Technical CHA Report for more detail.
GOAL 2.3: Infant Mortality
Reduce infant mortality disparities through access to prenatal care.

Strategy 2.3.1: Increase the proportion of at-risk pregnant women who receive early and adequate prenatal/postnatal care.

Local, State and National Alignment

<table>
<thead>
<tr>
<th>10 Essential Public Health Services</th>
<th>1, 3-5, 7, 9-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy People 2020</td>
<td>AHS – Access to Health Services</td>
</tr>
<tr>
<td>CDC HI-5</td>
<td>MICH – Maternal, Infant, and Child Health</td>
</tr>
<tr>
<td>GA DPH SHIP</td>
<td>Earned Income Tax Credits</td>
</tr>
<tr>
<td></td>
<td>1.3 – Healthcare Partnerships</td>
</tr>
</tbody>
</table>

Applying a Health Equity Lens

Due to the overwhelming disparities in infant mortality, it will be important for Cobb County’s health leaders to engage the at-risk communities at a higher level to better understand the social and economic factors leading to the outcomes being seen. This may require partnerships for advanced research and pilots for evidence-based interventions to sufficiently reduce barriers to care.

Social Determinants

<table>
<thead>
<tr>
<th>Race</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnicity</td>
<td>Income</td>
</tr>
<tr>
<td>Age</td>
<td>Access to Providers</td>
</tr>
<tr>
<td>Location</td>
<td></td>
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</tbody>
</table>

Policy Changes to Consider to Alleviate Health Inequity

- Encourage birthing hospitals to have policies and education that adhere to the American Academy of Pediatrics (AAP) safe sleep guidelines.
- Increase funding for perinatal case management (PCM) services within at-risk populations.
- Increase funding to comprehensive preconception and prenatal care, especially for low-income and at-risk women (i.e., Kaiser Permanente and WellStar have helped fund better access to prenatal care in the past five years in our district, however the need still outweighs the resources).
- Implement policies and procedures to ensure culturally competent and confidential reproductive and sexual health services.

Source: DPH OASIS - https://oasis.state.ga.us/gis/mappingtool/agsInfantMort.aspx
Behavioral Health
The terms “mental health” and “behavioral health” are often used interchangeably, but behavioral health officially refers to the state of mental/emotional being and/or choices and actions that affect wellness. Prevention efforts are proactive, occurring prior to the onset of a disorder, and are generally centered around substance abuse prevention, suicide prevention and the promotion of mental health.29

- Per the CDC, depression is the most common type of mental illness affecting more than 26% of the adult population and is estimated to become the leading cause of disability throughout the world by year 2020.30

- Premature death refers to someone dying at a younger age than expected. Accidental poisoning by exposure to noxious substances was Cobb County's leading cause of premature death between 2011-2015. Overdose from prescription/non-prescription drug use is known to be the main cause of death in this category.*

- In 2014, Cobb County saw a 200% increase in opioid-related deaths when compared to 1999; Emergency Department (ED) visit rates more than doubled from 2014 to 2015 for disorders related to all drug use.*

To address the growing behavioral health concerns, we aim to increase access to services through cultural humility (willingness to suspend what you know, or what you think you know, about a person based on generalizations about their culture). In addition, acknowledgment of cultural/individual barriers and development of partnerships will enable the community’s ability to quickly identify needs and link individuals to the available services.

*See Technical CHA Report for more detail.
GOAL 2.4: Behavioral Health

Improve access to appropriate, quality behavioral health services.

Strategy 2.4.1: Increase cultural humility among service providers to enhance awareness.
Strategy 2.4.2: Enhance partnerships to improve access to behavioral health services.
Strategy 2.4.3: Promote early identification of behavioral health needs and services available to the community.

Local, State and National Alignment

<table>
<thead>
<tr>
<th>10 Essential Public Health Services</th>
<th>1-5, 7-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHS – Access to Health Services</td>
<td></td>
</tr>
<tr>
<td>HRQOL/WB – Health-Related Quality of Life &amp; Well-Being</td>
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<tr>
<td>IVP – Injury and Violence Prevention</td>
<td>SA – Substance Abuse</td>
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<tr>
<td>School-Based Violence Prevention</td>
<td>Pricing Strategies for</td>
</tr>
<tr>
<td>Alcohol Products</td>
<td>Early Childhood Education</td>
</tr>
<tr>
<td>Earned Income Tax Credits</td>
<td></td>
</tr>
<tr>
<td>1.3 – Healthcare Partnerships; 1.5 – Telehealth; 2.4 – Children with Special Health Care Needs</td>
<td></td>
</tr>
</tbody>
</table>

Applying a Health Equity Lens

While behavioral health is a concern for people of all ages, like any other public health issue, there are social and economic factors that may place individuals at a greater risk for developing a disorder, or failing to receive adequate behavioral health care.

Social Determinants

<table>
<thead>
<tr>
<th>Gender</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Sexual Orientation</td>
</tr>
<tr>
<td>Race and Ethnicity</td>
<td>Geographic Location</td>
</tr>
<tr>
<td>Income</td>
<td>Social Environment</td>
</tr>
<tr>
<td>Employment</td>
<td>Housing Conditions</td>
</tr>
</tbody>
</table>

Policy Changes to Consider to Alleviate Health Inequity

- Increase affordable and reliable transit options to essential services.
- Restrict approvals of new retailers selling alcohol for off-site consumption near high crime areas, schools, and parks.
- Create requirements for the development of a culturally and linguistic competent workforce.
- Strengthen diversity among health and behavioral health providers.
Douglas County CHIP Overview

The 2017 Douglas County Community Health Improvement Plan (CHIP) was developed in partnership with the Live Healthy Douglas coalition. In 2004, the Live Healthy Douglas County Coalition was developed to lead Douglas County toward becoming a Tobacco-Free community. In 2011, CDPH leadership championed the Mobilizing for Action through Planning and Partnerships (MAPP) framework in Douglas County to engage residents in a meaningful community health improvement process. In the summer of 2014, Douglas MAPP merged with the Live Healthy Douglas County Coalition to better align resources and now operates as Live Healthy Douglas (LHD) with a mission to create an environment of wellness through community collaboration, advocacy and education.

Following the MAPP framework, the Live Healthy Douglas Steering Committee analyzed data from the 2016 Community Health Assessment (CHA) to identify and prioritize the underlying themes affecting health outcomes. These themes have been termed as the strategic priorities for the 2017 CHIP. Figure 2 summarizes the CHIP strategy and focus areas. The map in the middle emphasizes our commitment to applying a place-based health equity approach to our strategic priorities. This means that we will purposefully target certain efforts within the schools, churches, workplaces and neighborhoods of communities at greatest risk for negative health outcomes. Appendix 2 (pp. 53-54) contains additional details on the MAPP process and Live Healthy Douglas.
The following Live Healthy Douglas partners contributed to the development of the CHIP:

- City of Douglasville
- Cobb & Douglas Public Health
- DeNyse Companies
- Douglas Chamber of Commerce
- Douglas C.O.R.E.
- Douglas County Government
- Douglas County School System
- Douglas County Senior Services
- Douglas County Sheriff’s Office
- Faith Educational & Employability Services
- GreyStone Power Corporation

- Harvester Christian Academy
- High Caliber Realty
- Junior League of Douglas County
- Kaiser Permanente
- Leading Public Health
- The Church at Chapel Hill
- The CarePlace
- UGA Extension Douglas County
- United Way of Greater Atlanta
- WellStar Health System

Figure 2
The comprehensive Cobb and Douglas Community Health Assessments (CHA) are conducted every five years. The 2016-2017 CHA utilized the Mobilizing Action through Partnerships & Planning (MAPP) process and was led by Cobb & Douglas Public Health and Kennesaw State University in partnership with our Cobb2020 and Live Healthy Douglas Steering Teams. Results of the CHA guided the development and implementation of the Douglas County Community Health Improvement Plan (CHIP).

The CHA report includes both primary and secondary statistics on county demographics and characteristics, leading causes of death and injury, chronic and infectious diseases, maternal and child health, behavioral health, environmental health, all with a focus on existing disparities and social determinants of health.

Technical and community-level CHA reports may be accessed at: cobbanddouglaspublichealth.org/publications/.

Highlights of the CHA follow:


1. **Malignant Neoplasms of the Trachea, Bronchus and Lung (e.g., Lung Cancer)**
   - Number: 289

2. **All Other Mental & Behavioral Disorders**
   - Number: 265

3. **Ischemic Heart & Vascular Disease (e.g., Heart Attack)**
   - Number: 260

4. **All COPD Except Asthma**
   - Number: 239

5. **Cerebrovascular Disease (e.g., Stroke)**
   - Number: 223

6. **Diabetes Mellitus**
   - Number: 136

7. **Alzheimers Disease**
   - Number: 121

8. **Nephritis, Nephrotic Syndrome and Nephrosis (e.g., Kidney Disease)**
   - Number: 121

9. **Motor Vehicle Crashes**
   - Number: 97

10. **Malignant Neoplasms of Colon, Rectum and Anus (e.g., Colon Cancer)**
    - Number: 91

Lung Cancer is the leading cause of death in adults in Douglas County.

Multiple factors contribute to an individual’s (and community’s) health outcomes. These include health behaviors, clinical care, social and economic factors, and physical environment. Key CHA findings in each of these are highlighted on pages 35-37.

*All Other Mental and Behavioral Disorders includes Dementia, Schizophrenia, and Bipolar Disorder.
**HEALTH BEHAVIORS**
Risk factors for heart disease include obesity, high blood pressure, high cholesterol and tobacco use.

**OBESITY:**
- **23.4%** of adults in Cobb and Douglas Counties

**BREAKDOWN:**
- **36.4%** Black
- **21.8%** White
- **26.5%** Males
- **19.7%** Females

**OVERWEIGHT:**
- **37.9%** of adults in Cobb and Douglas Counties

**BREAKDOWN:**
- **39.4%** Black
- **37.2%** White
- **39.6%** Males
- **35.9%** Females

(Note: 2014 BRFSS, only district-level data available)

**TOBACCO**

**CIGARETTE SMOKING**
- **13.4%** of adults in Cobb and Douglas Counties.

There is a disturbing trend of increased vaping (e-cigarettes) among young people.

(Note: 2014 BRFSS, only district-level data available)

**SEXUAL ACTIVITY**

**SYPHILLIS**
Syphilis remains a major and increasing health problem in Douglas County, causing significant complications if left untreated and aiding in the transmission of HIV infection.

**RACIAL DIFFERENCES**
- **Black:** 10.3
- **White:** 2.9
- **Hispanic:** TOO LOW TO CALCULATE

**GENDER DIFFERENCES**
- **Male:** 12.5
- **Female:** TOO LOW TO CALCULATE

(Note: Rate per 100,000; 2011-2015 aggregate data for all)

**HIV**
- Georgia is currently ranked **5th IN THE NATION** for number of new HIV diagnoses.
- In 2014, Black/Non-Hispanics accounted for 65% of new HIV infection diagnoses in Georgia.

- **2011:** 11,235 newly diagnosed HIV infections in Georgia.
- **2012:**
- **2013:**
- **2014:** 771 newly diagnosed HIV infections in Cobb and Douglas Counties (combined).
MENTAL/BEHAVIORAL HEALTH ISSUES: DRUG ABUSE AND SUICIDE

DRUG ABUSE

At both a national and local level, the opioid crisis is sky-rocketing. In Douglas County from 2011 to 2015, the age-adjusted death rate from all opioids (includes both prescription opioid pain relievers and heroin) increased from a death rate of 5.2 (2011) to 11.4 (2015) per 100,000.

#2 leading cause of premature death in Douglas County
Accidental poisoning and exposure to noxious substances, including accidental overdoses of legal and illegal drugs, (2011-2015).

SUICIDE

Suicide was the third leading cause of premature death in Douglas County between 2011-2015.

Males (all races) comprised 82% of the 78 suicides, with white males making up 84% of male total.

HEALTH INSURANCE COVERAGE

14.5% of Douglas County residents had no health insurance coverage in 2015 (decrease from 17.7% in 2011). However, among unemployed adults in 2015, over half (57.1%) had no health insurance coverage.

NO INSURANCE

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>17.7%</td>
</tr>
<tr>
<td>2015</td>
<td>14.5%</td>
</tr>
</tbody>
</table>

2015 among unemployed adults: 57.1%

DELAYING MEDICAL CARE

18.6% of Douglas County respondents to the CHA survey reported delaying medical care in the past 12 months due to cost.

18.6% delaying medical care due to cost

PER SURVEY RESPONDENT:
“KIDS = MEDICAID;
ADULTS = EMERGENCY
KIDS = PREVENTATIVE;
ADULTS = REACTIONARY”
Douglas County CHIP

SOCIAL & ECONOMIC FACTORS

POVERTY
Percentage of individuals in Douglas County living below poverty level (between 2010-2014)

2011
2012
2013
2014
2015

16.4% Residents
22.0% Children under the age of 18

15.6% 2011
8.8% 2015

The unemployment rate in Douglas was 8.8% in 2015, down from 15.6% unemployment in 2011.

UNEMPLOYMENT

EDUCATION
Correlations exist between both education and income, and education and health. Between 2011-2015, Douglas County saw a 22.5% increase in high school graduation rates.

High school graduation rates in Douglas County by race/ethnicity/SES:

- Black, Non-Hispanic: 74.0%
- Hispanic: 67.5%
- White, Non-Hispanic: 79.1%
- Asian, Pacific Islander: 86.6%
- Economically Disadvantaged: 71.8%

FAMILY & SOCIAL SUPPORT
In 2015

10,824 (28.9%) children less than 18 years of age in Douglas County lived in a “female head of household (no husband)” home.

PHYSICAL ENVIRONMENT

HOUSING
Douglas County’s Fair Market Rent (FMR) for a 2 bedroom apartment is $949. In order to afford this level of rent and utilities - without paying more than 30% of income on housing - a household must earn $37,960 annual income - 2.5 jobs at minimum wage.

TRANSPORTATION
With 140,733 residents, over 105,000 of which are between the ages of 15-74 (potential drivers) and the close proximity to Atlanta, traffic congestion is a significant problem in Douglas County. Mean travel time to work: 33.5 minutes. 78.1% of workers drove alone to work.

2011
2012
2013
2014
2015

39
Tobacco Product Use

Although there has been a significant decline in the number of people who smoke, tobacco use remains the leading cause of preventable death in the United States, with nearly 1 in 5 deaths, at more than 480,000 deaths each year.

- Smoking is known to increase the risk of lung cancer, the leading cause of death in Douglas County. It also increases the risk of coronary heart disease and stroke, the County’s third and fifth leading causes of death.*

- There is no risk-free level of exposure to secondhand smoke, so friends and family impacted are at risk for more frequent and severe asthma attacks, respiratory infections, ear infections and sudden infant death syndrome (SIDS).1,2

- Almost 9 out of 10 cigarette smokers first tried smoking by the age of 18, and 99% by the age of 26.1,3 While cigarette smoking has declined among U.S. youth, there has been an increase in use of products such as electronic cigarettes and hookahs, which carry similar health risks as cigarettes, but are in some cases more accessible.4,5

We aim to prevent initiation of tobacco use among youth and young adults as we continue to promote cessation programs to assist all smokers to quit. Douglas County was among the first communities in the State of Georgia to adopt a smoke-free/tobacco-free ordinance through Parks & Recreation. We look to build on this success and seek other opportunities for policies that will protect our residents from secondhand smoke exposure and limit the youth’s contact with behaviors that encourage tobacco use.

*See Technical CHA Report for more detail.
GOAL 1.1: Tobacco Product Use
Reduce illness, disability and death related to tobacco product use and secondhand smoke exposure.

Strategy 1.1.1: Identify and reduce tobacco-related disparities among population groups.
Strategy 1.1.2: Promote access to information and support systems for cessation services.
Strategy 1.1.3: Reduce the initiation of tobacco product use among children, adolescents, and young adults.
Strategy 1.1.4: Reduce exposure to tobacco product use and secondhand smoke.

Local, State and National Alignment**

<table>
<thead>
<tr>
<th>10 Essential Public Health Services</th>
<th>1-7, 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy People 2020</td>
<td>TU-Tobacco Use</td>
</tr>
<tr>
<td>CDC HI-5</td>
<td>Tobacco Control Interventions</td>
</tr>
<tr>
<td>GA DPH SHIP</td>
<td>3.5 - Tobacco Use Prevention</td>
</tr>
</tbody>
</table>

**This chart contains hyper-links to the aligned state and national health improvement priorities.

Applying a Health Equity Lens

Per the CDC “health equity can be achieved in tobacco prevention and control by eliminating differences in tobacco use and exposure to secondhand smoke between certain groups.”6 By identifying the Douglas County communities and groups with the highest rate of use and secondhand smoke exposure, we can take a targeted approach to policy building and address the factors that contribute to these differences.

Social Determinants

<table>
<thead>
<tr>
<th>Gender</th>
<th>Educational Attainment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race and Ethnicity</td>
<td>Geographic Location</td>
</tr>
<tr>
<td>Age</td>
<td>Disability</td>
</tr>
<tr>
<td>Income Level</td>
<td>Social Environment</td>
</tr>
</tbody>
</table>

Policy Changes to Consider to Alleviate Health Inequity

- Create smoke-free workplaces, school campuses, multi-unit housing, and outdoor spaces to eliminate secondhand exposure.
- Incentivize the development of healthy retail outlets in all neighborhoods as an alternative to tobacco vendors.
- Enact local licensing ordinances to control location and operations of tobacco retailers.
- Enforce laws regulating storefront and window signage.
Healthy Eating
There is strong scientific support for the benefits of eating healthy foods, which typically includes consuming the recommended portions across the food groups and limiting certain types of food elements (e.g., saturated and trans-fat, cholesterol, added sugars, sodium/salt and alcohol).  

- Between 2011-2015, heart disease was the third leading cause of death and the fourth leading cause of hospital visits in Douglas County. Consuming healthy foods and maintaining a healthy body weight will reduce the risk of heart disease as well as other major health issues such as overweight and obesity, high blood pressure, Type 2 diabetes and some cancers.*

- People at a healthy weight are also less likely to experience complications during pregnancy and are less likely to die at an earlier age.

By increasing our county’s knowledge on how to consume healthy portions and make better decisions based on ingredients, we will begin the work of enabling healthy choices. We will also advocate for organizational changes in regards to the types of food offered to our residents whether it be in a school vending machine, a park’s concession stand, or during an employee celebration at work.

*See Technical CHA Report for more detail.
GOAL 1.2: Healthy Eating
Promote health through portion control and the consumption of healthy foods to reduce overweight and obesity.

Strategy 1.2.1: Increase access to healthy and affordable foods in food desert communities.
Strategy 1.2.2: Increase community knowledge on recognizing portion control and making healthy food and beverage choices.
Strategy 1.2.3: Increase organizational and programmatic changes focused on healthy eating.

Local, State and National Alignment

| 10 Essential Public Health Services | 1, 3-5, 9-10 |
| Healthy People 2020 | NWS – Nutrition and Weight Status |
| CDC HI-5 | Multi-Component Worksite Obesity Prevention | Public Transportation System Introduced or Expansion |
| GA DPH SHIP | 3.2 – Cancer Prevention and Control | 3.3 – Diabetes and Hypertension | 3.4 – Childhood Obesity |

Applying a Health Equity Lens

Food deserts are areas that lack access to affordable fruits, vegetables, whole grains, low-fat milk, and other foods that make up the full-range of a healthy diet. Families living in food deserts are often limited in their ability to access these foods because they live far from a supermarket or grocery store and do not have access to transportation to get them there.\(^\text{14}\) It is very difficult to make healthy choices if there is limited access to healthy foods, so we aim to take a targeted approach to increasing the availability foods within these neighborhoods.

Social Determinants\(^\text{15}\)

| Gender | Income |
| Age | Disability Status |
| Race and Ethnicity | Transportation |
| Education Level | Built Environment |

Policy Changes to Consider to Alleviate Health Inequity\(^\text{8}\)

- Provide fast-track permitting for grocery stores in underserved areas.
- Identify sites for farmers’ markets and community gardens.
- Encourage farmers’ markets and other healthy food retailers to accept federal nutrition programs such as WIC and SNAP (food stamps).
- Adopt pedestrian-friendly design codes to improve non-motorized access to healthy foods.
- Offer bus service from underserved neighborhoods to healthy food retail (e.g., in 2017, Douglas County will pilot two bus service routes to allow residents better access to many critical services).
Youth Behavior
Improving the health, safety, well-being and mental/emotional development of youth is a comprehensive approach to address factors impacting risky youth behavior.

- In Douglas County, motor vehicle crashes are the #1 cause of premature death, accounting for 30% of deaths among youth aged 1-19 years.  

- While tobacco use has declined over the past 15 years, the 2013 Georgia High School Youth Risk Behavior Survey reported alarming rates of substance abuse related to marijuana, alcohol, cocaine and prescription drugs.*  

- Nationally in 2013, 19.6% of high school students reported being bullied on school property and 14.8% reported being bullied electronically.  

Given these statistics and the need for improvement, we are committed to prevention practices that “meet the youth where they are” particularly for those who encounter peer pressure and media manipulation when it comes to risky behaviors.

*See Technical CHA Report for more detail.
GOAL 1.3: Youth Behavior

Improve the health, safety, well-being and mental and emotional development of youth (<10), adolescents (10-19) and young adults (20-24).

Strategy 1.3.1: Promote access to information and resources to maintain or improve mental and emotional well-being in at-risk communities.

Strategy 1.3.2: Create environments that inform and empower youth, adolescents and young adults to make positive choices related to alcohol, tobacco, and other drugs.

Strategy 1.3.3: Provide individuals and families with the knowledge, life skills, and tools to prevent violence and injuries.

Local, State and National Alignment

<table>
<thead>
<tr>
<th>10 Essential Public Health Services</th>
<th>1-5, 7-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy People 2020</td>
<td>AH - Adolescent Health</td>
</tr>
<tr>
<td>CDC HI-5</td>
<td>School-Based Violence Prevention</td>
</tr>
<tr>
<td>GA DPH SHIP</td>
<td>1.2 - School Based Health Centers</td>
</tr>
</tbody>
</table>

Applying a Health Equity Lens

Youth behavior in at-risk populations is largely influenced by the social environment and level of access to resources that improve mental/emotional well-being. A lack of these resources leads to higher dropout rates, substance abuse rates and higher levels of violence. Preventive efforts will require approaches that target families and communities, as well as the individual.

Social Determinants\textsuperscript{15,34,35}

<table>
<thead>
<tr>
<th>Social Environment</th>
<th>Parental Involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>Disability Status</td>
</tr>
<tr>
<td>Education Level</td>
<td>Media</td>
</tr>
<tr>
<td>(parents/youth)</td>
<td></td>
</tr>
</tbody>
</table>

Policy Changes to Consider to Alleviate Health Inequity\textsuperscript{36}

- Encourage center-based early childhood education to reduce educational achievement gaps.
- Fast track the implementation of comprehensive school-based health centers in at-risk populations (e.g., In 2016, Douglas County Schools launched the first school-based health center with The Family Health Centers of Georgia which greatly increased health services access for many children and their families).
- Fund the development of high school completion programs for students at higher risk for non-completion.
- Provide tenant-based rental assistance programs to reduce exposure to negative social environments.
Access to Primary Care
The lack of access to primary care providers is a major challenge of the entire U.S. health care system. Primary care providers are typically a patient’s first point of contact and provide critical preventative care, disease management and referrals.

- Increased access to primary care results in lower rates of low birthweight babies and lower mortality due to chronic disease.\textsuperscript{16}

- In 2014, top U.S. performers reported 1,041:1 as the ratio of the population to total primary care physicians; Douglas County’s ratio was 2,350:1.\textsuperscript{37}

- Douglas County is currently served by only three safety net providers dedicated to increasing access to care for the low-income population who are uninsured/underinsured. Safety net providers include public hospitals, community health centers, local health departments, free clinics, special service providers, and in some cases, physician networks and school-based clinics that deliver care to low-income, at-risk patients.*

- Uninsured adults often use the local hospital’s Emergency Department (ED) in the absence of accessible primary care providers. This decreases the ED’s service capabilities and increases health care costs.

We aim to combat the lack of access to primary care providers by reducing barriers among those at greatest risk, and by increasing the capacity of our safety net providers to serve a growing population of individuals that are uninsured or underinsured.

*See Technical CHA Report for more detail.
GOAL 2.1: Access to Primary Care

*Improve access to quality primary health services for the underserved community.*

**Strategy 2.1.1:** Reduce access barriers to clinical and community preventive services among populations at greatest risk.

**Strategy 2.2.2:** Increase the care capacity of safety net providers.

**Strategy 2.2.3:** Increase the number of comprehensive school-based health centers.

The high-cost of care, lack of insurance coverage and lack of available primary care providers impact some communities more than others. By systematically reducing the barriers to accessing preventive services in at-risk populations, we can improve overall health outcomes for the county.

### Local, State and National Alignment

<table>
<thead>
<tr>
<th>10 Essential Public Health Services</th>
<th>4-5, 7, 9, 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy People 2020</td>
<td>AHS – Access to Health Services</td>
</tr>
<tr>
<td>CDC HI-5</td>
<td>N/A</td>
</tr>
<tr>
<td>GA DPH SHIP</td>
<td>1.1 – Healthcare Workforce</td>
</tr>
</tbody>
</table>

### Applying a Health Equity Lens

The high-cost of care, lack of insurance coverage and lack of available primary care providers impact some communities more than others. By systematically reducing the barriers to accessing preventive services in at-risk populations, we can improve overall health outcomes for the county.

### Social Determinants\(^{18}\)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Access to Providers</td>
</tr>
<tr>
<td>Race and Ethnicity</td>
<td>Transportation</td>
</tr>
<tr>
<td>Origin of Birth</td>
<td>High Costs</td>
</tr>
<tr>
<td>Income</td>
<td></td>
</tr>
</tbody>
</table>

### Policy Changes to Consider to Alleviate Health Inequity \(^{19,20,21,22}\)

- Streamline implementation of school-based health centers in low-income communities.
- Incentivize implementation of school and childcare center-based vaccination programs.
- Provide technical assistance to improve the quality and efficacy of the safety net providers (i.e., over the past 5 years, Live Healthy Douglas partners helped launch and expand The CarePlace – Douglas' first non-profit, volunteer-based primary care clinic).
- Integrate Community Health Workers (CHWs) into the healthcare workforce.
Chronic Disease Management

The successful management of prevalent chronic diseases (e.g., asthma, high blood pressure and diabetes) relies on early screening, education and access to the appropriate care to prevent increased sickness or death.

• Between 2011-2015, asthma was the leading cause of hospitalizations in Douglas County children, ages 1-9 years old, and the ninth leading cause of ED visits across all ages.*

• In addition to high medical costs, poorly controlled asthma leads to missed school days, decreased academic performance and causes parents/guardians to miss work.

• Heart disease and stroke are the third and fifth leading causes of death in Douglas County respectively. High blood pressure and high cholesterol are the two main contributors to these conditions.*

• Between 2011-2015, diabetes was the sixth leading cause of death and the tenth leading cause of hospitalizations.*

In alignment with the CDC’s 6/18 initiative, we aim to better manage the chronic diseases within our county through control of asthma, diabetes and high blood pressure for communities at greatest risk.

*See Technical CHA Report for more detail.
GOAL 2.2: Chronic Disease Management

Increase access to local services that screen for and help control chronic conditions.

Strategy 2.2.1: Increase chronic disease education, screenings and care management among populations at greatest risk.

Strategy 2.2.2: Reduce the number of people who are unable to obtain or delay in obtaining necessary prescription medicines for the management of chronic diseases.

Local, State and National Alignment

<table>
<thead>
<tr>
<th>10 Essential Public Health Services</th>
<th>1-5, 7, 9-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy People 2020</td>
<td>D – Diabetes; HDS – Heart Disease and Stroke</td>
</tr>
<tr>
<td></td>
<td>RD – Respiratory Diseases</td>
</tr>
<tr>
<td>CDC HI-5</td>
<td>N/A</td>
</tr>
<tr>
<td>GA DPH SHIP</td>
<td>1.2 – School-based Health Centers</td>
</tr>
</tbody>
</table>

Applying a Health Equity Lens

It is known that poor medication access and adherence is a significant barrier to achieving positive health outcomes for the underinsured and uninsured populations. Their economic vulnerability makes them more likely to suffer from chronic diseases, but less likely to have access to the appropriate education, medications and other management solutions. Increasing access to chronic disease screening and management services within the communities of greatest need will help to reduce our county’s overall death, disability and hospitalization rates. It will also create a higher quality of life for the individuals and families experiencing the most risk.

Social Determinants

<table>
<thead>
<tr>
<th>Educational Attainment</th>
<th>Social Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>Access to Providers</td>
</tr>
<tr>
<td>Safe Neighborhoods</td>
<td>Transportation</td>
</tr>
</tbody>
</table>

Policy Changes to Consider to Alleviate Health Inequity

- Create interoperable systems to exchange clinical, public health and community data, streamline eligibility requirements, and expedite enrollment processes to facilitate access to clinical preventive services.
- Expand the use of community health workers and home visiting programs.
- Give employees time off to access clinical preventive services.
- Establish patient and clinical reminder systems for preventive services.

Source: DPH OASIS - https://basis.state.ga.us/gis/mappingtool/agsMort.aspx
Mental/Behavioral Health
The terms “mental health” and “behavioral health” are often used interchangeably, but behavioral health officially refers to the state of mental/emotional being and/or choices and actions that affect wellness. Prevention efforts are proactive, occurring prior to the onset of a disorder, and are generally centered around substance abuse prevention, suicide prevention and the promotion of mental health.  

- Per the CDC, depression is the most common type of mental illness affecting more than 26% of the adult population and is estimated to become the leading cause of disability throughout the world by year 2020.  

- Premature death refers to someone dying at a younger age than expected. Accidental poisoning by exposure to noxious substances was Douglas County’s second leading cause of premature death between 2011-2015. Overdose from prescription/non-prescription drug use is known to be the main cause of death in this category.* 

- In 2014, Douglas County saw a 1300% increase in opioid-related deaths when compared to 1999; Emergency Department (ED) visit rates more than doubled from 2014 to 2015 for disorders related to all drug use.* 

To address the growing behavioral health concerns, development of partnerships will enable the community’s ability to quickly identify needs and link individuals to the available services.

*See Technical CHA Report for more detail.
GOAL 2.3: Mental/Behavioral Health

_Improve access to appropriate and quality mental/behavioral health services._

Strategy 2.3.1: Explore partnerships to improve access to mental/behavioral health services.

### Local, State and National Alignment

<table>
<thead>
<tr>
<th>10 Essential Public Health Services</th>
<th>1-5, 7-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy People 2020</td>
<td>AHS – Access to Health Services</td>
</tr>
<tr>
<td>CDC HI-5</td>
<td>School-Based Violence Prevention</td>
</tr>
<tr>
<td>GA DPH SHIP</td>
<td>1.3 – Healthcare Partnerships</td>
</tr>
</tbody>
</table>

### Applying a Health Equity Lens

While behavioral health is a concern for people of all ages, like any other public health issue, there are social and economic factors that may place individuals at a greater risk for developing a disorder, or failing to receive adequate behavioral health care.

#### Social Determinants

<table>
<thead>
<tr>
<th>Gender</th>
<th>Education</th>
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</thead>
<tbody>
<tr>
<td>Age</td>
<td>Sexual Orientation</td>
</tr>
<tr>
<td>Race and Ethnicity</td>
<td>Geographic Location</td>
</tr>
<tr>
<td>Income</td>
<td>Social Environment</td>
</tr>
<tr>
<td>Employment</td>
<td>Housing Conditions</td>
</tr>
</tbody>
</table>

#### Policy Changes to Consider to Alleviate Health Inequity

- Increase affordable and reliable transit options to essential services.
- Restrict approvals of new retailers selling alcohol for off-site consumption near high crime areas, schools, and parks.
- Create requirements for the development of a culturally and linguistic competent workforce.
- Strengthen diversity among health and behavioral health providers.
The Action Cycle is the next step in our CHIP process and involves three activities: Planning, Implementation, and Evaluation, each building on the previous in a continuous and interactive manner. During the CHIP Development Process, Cobb2020 and Live Healthy Douglas Steering Committee members received two broad recommendations on how to increase the impact of the coalitions’ work in the community. One of the recommendations involved the prioritization of policy, systems and environmental changes as a way to produce far reaching effects on the factors that contribute to health outcomes. The other recommendation involved consideration of the way we mobilize the community to action; “Strategize on how to create traction and sustainability through community engagement, outreach and communications.” A Community Health Improvement Plan is just a document. One cannot expect sustainable change without the participation of a diverse network of stakeholders (e.g., residents, businesses, health systems, non-profit organizations, public health, schools, government). As mentioned earlier, the CHIP is a guide for the next level of planning and is designed to organize, inspire and activate community members who value creating a healthy community for all residents.

How to Get Involved
Cobb2020 and Live Healthy Douglas are building Implementation Teams (I-Teams) to develop the first action plans in response to the 2017-2021 CHIP goals and strategies (see Appendix 1, p. 52). Please contact us at info@cobb2020.com or info@healthydouglas.org if you would like to get engaged in the Action Cycle for either Cobb or Douglas County. No matter who you are, there are opportunities to partner for a healthier community!

A Step-by-Step Overview of the Action Cycle

**Evaluation**
Engage stakeholders and prepare for evaluations by describing each activity.

Focus on the evaluation design by selecting evaluation questions, the process for answering these questions, the methodology and plan for carrying out the evaluation, and a strategy for reporting results.

Gather credible evidence that answers the evaluation questions.

Ensure that the results of the evaluation are used and shared with others.

**Planning**
Recruit participants and develop implementation activities for Action Cycle

Develop realistic and measurable objectives related to each strategic goal and establish accountability by identifying responsible committee members

Develop action plans aimed at achieving the outcome objectives and addressing the selected strategies.

**Implementation**
Review action plans for opportunities, coordination and combine resources for maximum efficiency and effectiveness.

Implement and monitor the progress of the action plans.
Part 3: Appendices/Resources/References
This appendix will be updated with annual action plans corresponding to each strategy set forth within the 2017-2021 CHIP. Cobb2020 and Live Healthy Douglas Implementation Teams (I-Teams) are responsible for leading the action planning phase for the development of SMART objectives, measures, targets and actions (programs, activities and interventions) to achieve CHIP goals.

**Template Example: Goal 1.1 (Tobacco Product Use)**

<table>
<thead>
<tr>
<th>1. Healthy Lifestyles</th>
</tr>
</thead>
</table>

**Goal 1.1: Tobacco Product Use**  
Reduce illness, disability and death related to tobacco product use and secondhand smoke exposure.

**Strategy 1.1.1: Identify and reduce tobacco-related disparities among population groups.**

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Measures</th>
<th>Targets</th>
<th>Data Source</th>
<th>Actions</th>
<th>Individuals/Organizations Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1.1.1: TBD</td>
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<tr>
<td>1.1.1.2: TBD</td>
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</tbody>
</table>
Since April 2011, Cobb & Douglas Public Health has championed and facilitated the Mobilizing for Action through Planning and Partnerships (MAPP) framework to organize partners, collect comprehensive community data and implement a health improvement plan. Developed by the National Association of County and City Health Officials (NACCHO) and the federal Centers for Disease Control and Prevention (CDC), MAPP is a community-driven strategic planning tool for improving community health. The MAPP Academic Model illustrates the six phases of the MAPP Process that have been followed with the guidance and advisement of Steering Committees local to both Cobb and Douglas Counties.

The Six MAPP Phases

- **Phase 1**: Organize for Success & Partnership Development – to structure a planning process that builds commitment, engages participants as active partners, uses participants’ time well, and results in a plan that can be realistically implemented.
- **Phase 2**: Visioning – guides the community through a collaborative, creative process that leads to a shared community vision and common values. (see Appendix 3, p. 54)
- **Phase 3**: The Four Assessments – conducted to gain a comprehensive understanding to yield information for community health improvement (see Appendix 3, p. 55).
- **Phase 4**: Identify Strategic Issues – explores the convergence of the results of the four MAPP Assessments to create an ordered list of the most important issues facing the community.
- **Phase 5**: Formulate Goals & Strategies – to take the strategic issues identified in the previous phase and formulate goal statements related to those issues, then identify broad strategies for addressing issues and achieving goals related to the community’s vision.
- **Phase 6**: Action Cycle – involves the participation of the local public health system in developing and implementing an action plan for addressing priority goals and objectives. (see Appendix 1, p. 52)

Comprised of a diverse group of representatives from public, private, and volunteer entities, the original community teams have evolved through the MAPP process and have taken on the names Cobb2020 - A Partnership for a Healthier Cobb County (Cobb2020) and Live Healthy Douglas (LHD). Each coalition accomplishes its work through several groups, teams, and committees.

- **Steering Committees** – A cross-sector group of community leaders overseeing the strategic planning process within each county. Steering committee members are responsible for guiding, advising and bringing resources to both the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP).
- **Implementation Teams** – Organizations and community members engaged in planning, facilitating and evaluating the initiatives of the partnership.
- **Workgroups** – Individual teams dedicated to implementing the evidence-based initiatives highlighted within the county’s Community Health Improvement Plan. Workgroup members have community knowledge and a desire to advocate for a healthier county. The workgroups provide a space for partners to network and collaborate on shared goals and objectives.
**Cobb2020 Overview**

**Mission:** Creating a community that works together to achieve optimal health for all those who live, learn, work, and play in Cobb County.

**Vision:** Cobb County will reach its full potential in health and well-being.

**Values:** Collaboration, Education, Access, Prevention and Equity

Cobb2020 was formed in April 2011 as a result of the Cobb County MAPP process. It is a partnership of community organizations dedicated to promoting healthy lifestyles and improving the delivery of essential health services in Cobb County. This is accomplished through several groups, teams, and committees.

Cobb2020 is currently led by Rebecca Shipley, Multi-Branch Executive Director for Metro Atlanta YMCA, and Lisa Crossman, Deputy Director for Cobb & Douglas Public Health. It has a Steering Committee with a diverse membership of 22 key community leaders who are dedicated to making significant changes to the health status of Cobb County.

Contact us at info@cobb2020.com for more information on our initiatives and how to get involved.

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**Live Healthy Douglas Overview**

**Mission:** To create an environment of wellness through community collaboration, advocacy and education.

**Vision:** Healthy People, Safe Environment, Engaged Community

**Values:** Comprehensiveness, Accessibility, Sustainability & Empowerment – “CASE”

In 2004, the Live Healthy Douglas County Coalition developed to lead Douglas County toward becoming a Tobacco-Free community. In partnership with the Douglas C.O.R.E. (Community Organizing Resources for Excellence) Family Connections Collaborative, they helped enact some of the most forward-thinking Smoke Free Air policies in the state prior to the 2005 Georgia Law. After that success, the group turned their attention to hosting the Power in Truth conference for youth and introducing the community to other healthy behaviors such as drug use prevention, the youth alcohol prevention initiative, physical activity and proper nutrition. In the summer of 2014, Douglas MAPP (created in 2011) merged with the Live Healthy Douglas County Coalition to better align resources and now operates as Live Healthy Douglas (LHD).

Live Healthy Douglas is currently led by Carol Lindstrom, a real estate agent with High Caliber Realty, and former Vice-Chair of the Douglas County Board of Education (District 1). Its 15-member Steering Committee is equally dedicated to realizing a healthier Douglas County and represents key local public health system partners.

Contact us at info@healthydouglas.org for more information on our initiatives and how to get involved.

Please refer to Appendix 5 (p. 57) for a complete list of Steering Committee members associated with each partnership.
Appendix 3: Community Health Assessments

2016 Community Health Assessments
To address the current situation of the conditions that currently exist in the community, four assessments are implemented. The four MAPP assessments provide a comprehensive understanding to yield information for community health improvement. The four MAPP assessments are as follows:

**Community Health Status Assessment (CHSA)**
This assessment supplies the MAPP participants and the community members with data about health factors, issues, health outcomes and quality of life. Possible approaches for data collection include: using state and local databases, accessing previously conducted health assessments or reports, identifying participants who have access to data through their organization, and primary data collection through randomized community surveys. This assessment answers the questions:
1. “How healthy are our residents?”
2. “What does the health status of our community look like?”

The results of the CHSA provide an understanding of the community’s health status and ensure that the community’s priorities consider specific health status issues.

**Community Themes and Strengths Assessment (CTSA)**
This assessment provides insight from the community members concerning what health issues are important to them. These results guide the MAPP participants to identify key issues and prioritize them to ensure that the community health improvement reflects the community needs and concerns. Possible approaches for data collection include: community meetings, focus groups, windshield surveys, key informant interviews, surveys and town hall meetings. The CTSA provides a deep understanding of the issues residents feel are important by answering the questions:
1. “What is important to our community?”
2. “How is quality of life perceived in our community?”
3. “What assets do we have that can be used to improve community health?”

**Local Public Health System Assessment (LPHSA)**
This assessment evaluates how well the public health system delivers the “Ten Essential Services of Public Health” to the community. To assess the local public health system, the National Public Health Performance Standards Program is employed. The LPHSA answers the questions:
1. “What are the components, activities, competencies, and capacities of our local public health systems?”
2. “How are the 10 Essential Public Health Services being provided to our community?”

**Forces of Change Assessment (FCA)**
This assessment focuses on identifying factors such as events, trends, legislation, technology and other impending changes that affect health care and quality of life within the community. The FCA answers the questions:
1. “What is occurring or might occur that affects the health of our community or the local public health system?”
2. “What specific threats or opportunities are generated by these occurrences?”

Technical and community-level CHA reports may be accessed at cobbanddouglaspublichealth.org/publications/.
Appendix 4: Development Process

2017-2021 Community Healthy Improvement Plan Development Process

The CHIP development process took place over nine months, from October 2016 through June 2017, and involved the input and feedback of over 1,700 individuals who work, live, learn or play in Cobb and/or Douglas County.

In December 2016, following the completion of the four MAPP Assessments, CDPH staff presented a summary of key findings to the Cobb2020 and Live Healthy Douglas Steering Committees. The presentations highlighted data from all four MAPP Assessments, including quantitative and qualitative elements, as well as the use of geographical mapping to identify health disparities at the local level. The Committees reviewed the results and participated in a facilitated discussion to create a list of strategic issues using the following questions as criteria:

- Is the issue related to our community’s vision?
- Will the issue affect our entire community?
- Is the issue something that will affect us now and in the future?
- Will the issue require us to change the way we function?
- Is the solution to this issue not obvious?
- Are there long-term consequences of us not addressing this issue?
- Does the issue require the involvement of more than one organization?
- Does the issue create tensions in the community?

Using a ‘dotocracy’ method, each participant identified their top two issues of priority. The resultant ranking formed a basis for the strategy options to be considered. In a later meeting, two broad recommendations were made, as Steering Committee members weighed strategy options to adopt. Both recommendations were based on results from the Local Public Health System Assessment (LPHSA) and reflected ways to build on successes to increase the impact of the coalition’s work in the community. With the help of a public health strategist, CDPH staff presented the strategy options along with a discussion on the pros, cons and additional factors to consider. Steering Committee members then voted on their preferred strategy (the selected strategic priorities) and provided initial guidance on focus areas for goal setting.

The formulation of goals and strategies took place at the Implementation Team level and leveraged subject matter expertise to ensure alignment with national and state priorities. The proposed goals and strategies were later reviewed, revised and confirmed by Steering Committee members. The following questions were considered during this step of the process:

- Are the goals and strategies feasible?
- Are they important?
- Are we the right people to solve the problem?
- Are there any gaps?

In the effort to receive broad community participation in the development process, initial drafts of the CHA Executive Summary and CHIP report were shared with major stakeholders and community residents during a two-week public comment period. This enabled a wide array of interested parties to provide feedback on the formulated goals and strategies. The accompanying survey also provided an opportunity for each participant to identify organizational linkages and personal areas of interest (future opportunities for partnership). Community feedback was processed in the finalization of this report and will help inform the action planning process.
Appendix 5: Partner Acknowledgments

Cobb2020 – A Partnership for a Healthier Cobb County

Chair: Rebecca Shipley – Metro Atlanta YMCA
Vice-Chair: Lisa Crossman – Cobb & Douglas Public Health

Steering Committee Members
Mark Anderson – Cobb County School District
Dr. Betty Ann Cook – Chattahoochee Technical College
Dr. Kevin Daniel – Cobb County School District
Kelly Durden – American Cancer Society, Inc. – Southeast Region
Jennifer Haines-Pruitt – Cobb & Douglas Community Services Board
Dr. Jennifer Hernandez – Marietta City Schools
Dr. Kisha Holden – Morehouse School of Medicine/Satcher Health Leadership Institute
DeBorah Johnson – Austell Community Task Force
Sabrina Mallett – Cobb & Douglas Public Health

Emily Markette – Kaiser Permanente
Rev. Jennifer Maxell – The Breakthrough Fellowship
Dr. Janet Memark – WellStar Health System
Mark Mooney – American Heart Association/American Stroke Association
Dr. Monica Nandan – Kennesaw State University
Dr. Chirag Patel – WellStar Health System
Joyce Reid – Cobb County Community Member
Rosalind Tucker – The Atlanta Regional Commission
Belisa Urbina – Ser Familia, Inc.
Hope Warren – UGA Extension Cobb County
Lindsey Wiles – City of Marietta
Pamela Younker – Children’s Healthcare of Atlanta

Live Healthy Douglas

Chair: Carol Lindstrom – High Caliber Realty
Special thanks to GreyStone Power’s Tim Williams who served as Chair during the 2016 CHA process.
Vice-Chair: Vacant

Steering Committee Members
Bianca Ash – United Way of Greater Atlanta
Amy Baillie – DeNyse Companies
Amanda Bryant – Douglas C.O.R.E.
Lisa Crossman – Cobb & Douglas Public Health
Susan Culpepper – UGA Extension Douglas County
Delores Franklin – Faith Education & Employability Services
C. Shane Greene – WellStar Health System
Sgt. Jesse Hambrick – Douglas County Sheriff’s Office

Kellie Hunter – City of Douglasville
Sabrina Mallett – Cobb & Douglas Public Health
Emily Markette – Kaiser Permanente
Jermal McCoy – Harvester Christian Academy
Trent North – Superintendent, Douglas County School System
Dr. Gordon Pritz – Douglas County School System
Rev. Frank Smith – The Church at Chapel Hill/The CarePlace

Prior Steering Committee Members
Comm. Lisa Cupid – Cobb County Government
Jay Dillon – Education Planners
Jody Drum – Marietta City Schools
Dr. cris Eaton-Welsh – Eaton Chiropractic
Dr. Kristyn Greifer – WellStar Health System
Dr. Angela Huff – Cobb County School District
Eric Klein – Shire Pharmaceuticals
Sue Leithead – Cobb Chamber of Commerce

Kacie McDonnell – Good Samaritan Health Center of Cobb
Dr. Jackie McMorris – Cobb County Government
Micheal Murphy – Austell Community Task Force
Wende Parker – Cobb & Douglas Public Health
Col. Janet Prince – Cobb County Sheriff’s Office
Beth Spinning – Kaiser Permanente
Debbie Strotz – Cobb & Douglas Community Services Board

Additional Contributors
Dr. Ross Brakeville – Woodstock Physical Therapy
Alison Curtis – Cobb & Douglas Public Health
Teresa Hale – WellStar Health System
Maggie Lloyd – Family Health Centers of Georgia

Dr. Steven Mirtschink – Life University
Jazmyn McCloud – Cobb & Douglas Public Health
Catharine Smythe – Cobb & Douglas Public Health
Appendix 5: Partner Acknowledgements

Live Healthy Douglas, continued

Prior Steering Committee Members
Kali Boatright - Douglas Chamber of Commerce
Richard Hagan - Douglas County Senior Services
Chairman Dr. Ramona Jackson-Jones -
   Douglas County Government
Helen McCoy - City of Douglasville

Catherine Owens - United Way of Greater Atlanta
Kathy Patman - Junior League of Douglas County
Dr. Gordon Pritz - Douglas County School System
Tim Williams - GreyStone Power Corporation
(Chair from 2011-2016)

Valerie Crow - Director of Communications
Alison Curtis - Planning & Policy Development
Specialist, Nutrition & Physical Activity
Rachel Franklin - Director of Epidemiology &
   Health Assessment
Jan Heidrich-Rice - District Development Director
Melissa Hester - Health Communications Intern

Special Recognition
The following agencies contributed significantly to both the CHA and CHIP process in 2016-2017 and we
give our sincere thanks.

WellStar Health System
Cobb EMC
GreyStone Power Corporation
Ron Chapman - Leading Public Health,
   Facilitator/Strategist
Emily Frantz – Accreditation Consultant
524 Creative

Community Health Status Assessment Participants
Local Public Health System Assessment Participants
Community Themes & Strengths Participants
   (key informant interviews/focus groups)
Forces of Change Assessment Participants
Public Comment Participants

Additional Contributors
Karla Ayers – Cobb & Douglas Public Health
Shonna Frazier – Cobb & Douglas Public Health
Viva Price – Cobb & Douglas Public Health
DePriest Waddy – United Way of Greater Atlanta

Cobb & Douglas Public Health Staff
Lisa Crossman - Deputy Director
Valerie Crow - Director of Communications
Alison Curtis - Planning & Policy Development
   Specialist, Nutrition & Physical Activity
Rachel Franklin - Director of Epidemiology &
   Health Assessment
Jan Heidrich-Rice - District Development Director
Melissa Hester - Health Communications Intern

Cobb & Douglas Public Health Staff
Dr. John D. Kennedy - District Health Director
Sabrina Mallett - Planning & Partnerships Director
Jazmyn McCloud - Planning & Policy Development
   Specialist - Tobacco and Asthma
Lynnette McLeod - Administrative Assistant
Viva Price - Children & Youth Program Manager
Gurleen Roberts - Director of Quality Management

Kennesaw State University Faculty & Staff
Dr. Jonathan Arnett - Assistant Professor of Technical Communication
Dr. Carol Holtz - Distinguished Lecturer and Professor of Nursing; Cobb County Board of Health Chair
Dr. Monica Nandan - Chair of the Department of Social Work and Human Services

Special thanks to numerous Kennesaw State University staff and students who worked tirelessly with
CDPH staff over the past 18 months to design and complete the thorough CHA for both counties.

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Public Comment Participants
## Local Resources in Cobb and Douglas Counties

### Medical Behavioral Health Safety Net Programs

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<td>The Family Health Centers of Georgia (previously known as West End Medical Center)</td>
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### Online Prescription Assistance Programs

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<td>RxOutreach</td>
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Additional Resources

- 2016 Cobb and Douglas Community Health Assessment (CHA)
  http://www.cobbanddouglaspublichealth.org/publications/
- BARHII Healthy Planning Guide
  http://barhii.org/resources/healthy-planning-guide/
- Centers for Disease Control and Prevention
  https://www.cdc.gov/
- Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System
  http://www.cdc.gov/brfss/annual_data/annual_2011.htm
- Centers for Disease Control and Prevention Health Impact in 5 Years (HI-5)
- Centers for Disease Control and Prevention 10 Essential Public Health Services
  http://www.cdc.gov/nphpsp/essentialservices.html
- Children’s Healthcare of Atlanta 2016 CHNA
- Department of Health and Human Services Community Preventive Services Task Force
  http://www.thecommunityguide.org/healthequity/healthcare/ccc.html
- Georgia Department of Public Health
  http://dph.georgia.gov/
- Georgia Department of Public Health State Health Improvement Plan
  https://dph.georgia.gov/sites/dph.georgia.gov/files/GADPH%20SHIP%202017%20FINAL.PDF
- Georgia Department of Public Health Online Analytical Statistical Information System
  https://oasis.state.ga.us/
- Healthy People 2020
  http://www.healthypeople.gov
- Kaiser Permanente 2016 CHNA
- Mobilizing for Action through Planning and Partnerships (MAPP)
  http://www.naccho.org/topics/infrastructure/mapp/index.cfm
- National Association of County and City Health Officials
  http://naccho.org/
- National Prevention Strategy
- Public Health 3.0
- WellStar Health System 2016 CHNA
References


References

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