Clinch Memorial HOSPITAL

# 2025 COMMUNITY HEALTH NEEDS ASSESSMENT

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Clinch Memorial HOSPITAL

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To Whom It May Concern:

The Clinch Memorial Hospital Board of Directors approved the 2025 Community Health Needs Assessment and Implementation Plan at their meeting on May 22, 2025. The Community Health Needs Assessments (CHNA) Report is widely available to the public and interested parties can view and download it on the Clinch Memorial Hospital website. Hard copies are available upon request as well as website location, please contact: Lily Blitch, Director of Organizational Development, lblitch@clinchmh.org and (912) 470-2401 for copies or web location.

Courtney Tolle

Courtney Tolle, Board Vice Chairman

Clinch Memorial Hospital

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# Executive Summary

Using a mixed-methods approach described below for this assessment, the Georgia Southern University CPHPR team utilized community input and data from secondary sources to **identify health needs of the defined community that the hospital serves – the hospital's primary service area of Clinch County, Georgia, which is the home to the majority of the patients utilizing Clinch Memorial Hospital.** Community input was obtained from hospital stakeholders and the general community through community surveys and focus group discussions. Recruitment efforts for community surveys and focus groups were designed to obtain feedback from diverse population groups, including minority and underserved populations. Secondary data sources, used in assessing the community's needs, included a broad list of community health-related databases. No written comments have been received since the previous assessment.

The results from the secondary data analyses identified:

- A slightly contracting, aging county population with a slight increase in racial and ethnic diversity
- Higher rates of unhealthy behaviors (including obesity, smoking, alcohol-related motor vehicle deaths, physical inactivity, and teen pregnancy rates) compared to the state
- Poorer health outcomes, compared to the rest of the state (except for a lower HIV and STD infection rate in Clinch); high heart disease and cancer rates, and lower average life expectancy in the county by 6.3 years, compared to the state
- Limited supply of dental and mental health providers
- Limited access to both digital connectivity (particularly in the northwest corner of the county) and recreational opportunities – important health-promoting resources

Input from the community, through the survey and focus groups, was generally consistent with findings from the secondary data analysis. Community members and key stakeholders described Clinch County as a tight-knit, safe, and family-oriented community with availability of good jobs as the biggest challenge. Other themes from these data sources included:

- Obesity and inactivity – related issues – were noted as key detractors from good health
- Inadequate nutrition was the top negative influencer of child health.
- Limited access to specialty providers, women's health, drug/alcohol rehab, and mental health services impacts health.
- High demand for, and low supply of, mental health services.
- Lack of medical transportation and health insurance can negatively affect health.
- Pediatrics and cardiology specialties are perceived to be the most in demand.

Secondary data, survey and focus group findings aligned in several areas of community health. The table that follows highlights where alignment exists in the data by area of concern. **The first three areas of concern, in addition to overall community health systems strengthening initiative, were determined to be priorities for the next 3 years.**

| AREA OF CONCERN | SECONDARY DATA | SURVEY | KEY STAKEHOLDER FOCUS GROUPS |
|---|---|---|---|
| Access | -Per capita supply of providers of all provider types lower than state<br>-Preventable Medicare hospital stays higher than state | -Access issues noted in: insurance, transportation, mental health, drug/alcohol addiction, women's health<br>-Top specialist shortages: pediatrics, cardiology, orthopedics | -Medical transportation noted as a key need.<br>-Insurance seen as a contributor to insufficient healthcare access.<br>-Pediatrics, cardiology and dialysis noted as needs |
| Cancer | -Similar prevalence to state<br>-Lung cancer #4 cause of death<br>-Low mammography rates | -Prostate-Specific Antigen screening rates show room for improvement<br>-Cost was a key screening barrier, yet screening is usually covered by insurance | -Hospital-offered screening services were noted |
| Mental Health | -Very low mental health provider ratio<br>-Days of poor mental health in last 30 days lower than state | -Poor mental health rated 5th highest negative influencer of health<br>-Low availability of mental health services | -Mental health's fundamental role in overall health and its very high demand in the area for services were noted |
| Health Literacy | -Low high school graduation rate | -Ranked 6h highest negative influencer of health | -Noted as an issue, especially for nutrition |
| Nutrition | -High rate of obesity<br>-Food insecurity higher than state<br>-Diabetes and heart disease higher than state | -Obesity #2 and cholesterol #3 chronic conditions<br>-Nutrition identified as top adolescent health issue<br>-62% don't eat enough fruits and vegetables | -Inadequate access to healthy food in grocery stores and in restaurants frequently mentioned in focus groups |
| Lack of Adequate Physical Activity | -Obesity and inactivity worse than state<br>-Low access to exercise opportunities<br>-High heart disease rates | -Obesity 1st and physical activity 4th highest negative influencers of health<br>-44% don't get recommended level of physical activity | -Inadequacy of fitness venues, especially for women, and lack of group classes were concerns |
| Tobacco, Alcohol, Drug Abuse | -Higher tobacco usage than state<br>-Alcohol related Motor Vehicle Accidents higher than state | -Tobacco, alcohol, and substance abuse highly ranked as factors affecting health and quality of life<br>-Low availability of addiction treatment services | -Abuse of recreational drugs and prescription medicines noted as an issue, especially in conjunction with mental health. |
| Adolescent Behavior | -High teen pregnancy rates<br>-Low high school graduation rates<br>-Low rate of 3–4-year-old children in school | -Nutrition, early sexual activity, and dental care identified as top 3 health needs for children | Nutrition education seen as lacking in school |

# Previous Needs Assessment (2022)

## *Brief Summary of 2022 CHNA*

The 2022 Community Health Needs Assessment (CHNA) results from the secondary data analyses noted Clinch had a contracting and aging county population, with high poverty rates, lower educational attainment and limited access to health-promoting amenities including healthcare and recreational opportunities. Higher rates of poor mental and physical health outcomes, compared to the state, were also present.

A synthesis of primary data, collected from resident survey data, and focus group findings portrays Clinch County as a tight-knit community where residents can rely on one another, but highlighted some problems, including poverty (lack of employment options), a lack of computer and internet access, healthy foods, and transportation, and a high prevalence of unhealthy behaviors (including smoking, physical inactivity and poor nutrition).

***Link: 2022 CHNA Report***

## Previous Health Priorities

Top Concerns based on Primary & Secondary Data

- Obesity & Physical Inactivity
- Low Preventive Screenings
- Teen Risky Sexual Behavior
- Drug/Alcohol Abuse
- High Cancer Rates
- Mental Health
- Healthy Food Access
- Chronic Conditions (Diabetes, Hypertension, Heart disease)

## Prior Implementation Plan

Previous Goals

The steering committee established the following goals after prioritizing identified needs:

1. To improve the diet of Clinch County residents
2. Create a more active Clinch County population
3. Improve health behavior of teens
4. Improve rates of preventive screenings
5. Enhance services available for mental health, including drug and alcohol counseling

# Report Methodology

The Center for Public Health Practice & Research (CPHPR) project team worked with the hospital CHNA steering committee throughout the project **to identify the health needs of Clinch County, Georgia - the primary community served by Clinch Memorial Hospital**. The steering committee facilitated the completion of a community survey, recruited community members for focus group discussions, and provided information about the hospital's activities to address community health needs since the 2022 CHNA.

### Primary Data Collection

*Community Survey*

The online community survey, available from December 2024 to February 2025, assessed the general quality of life, health priorities and health care needs of the people residing in the primary service area of Clinch Memorial Hospital - Clinch County, Georgia. The community survey link was disseminated via the hospital's website, its social media webpages, at in-person community meetings, and through networks of various community organizations.

*Focus Groups*

Focus group participants represented key stakeholder groups in maintaining the overall health of Clinch County residents and *included representation from the local health department*. Their perspectives provided a well-rounded view of life in the community.

### Secondary Data Collection

Secondary data on the community's profile, health care access, and utilization were obtained from multiple publicly available sources including the US Census Bureau, the Area Resource File, Centers for Disease Control (CDC) disease and mortality data, Georgia Department of Public Health, Office of Health Indicators for Planning's OASIS (Online Analytical Statistical Information System), County Health Rankings, PolicyMap, and the National Cancer Institute. The most current available data for each source were obtained at the time of analysis.

Findings from all the above-described data collection efforts informed the identification of community health needs in preparation for development of an implementation plan.

### Data Analysis and Visualization

Quantitative data from the community survey and secondary data sources were analyzed using descriptive statistics, including frequencies, means, and standard deviations. Analyses were completed, and charts and graphs were created using Microsoft Excel version 16 software and Datawrapper data visualization application. Spatial variations in selected community health indicators estimates are also presented using data and maps from PolicyMap. Qualitative data from the focus groups were analyzed using the NVIVO14 qualitative analysis software.

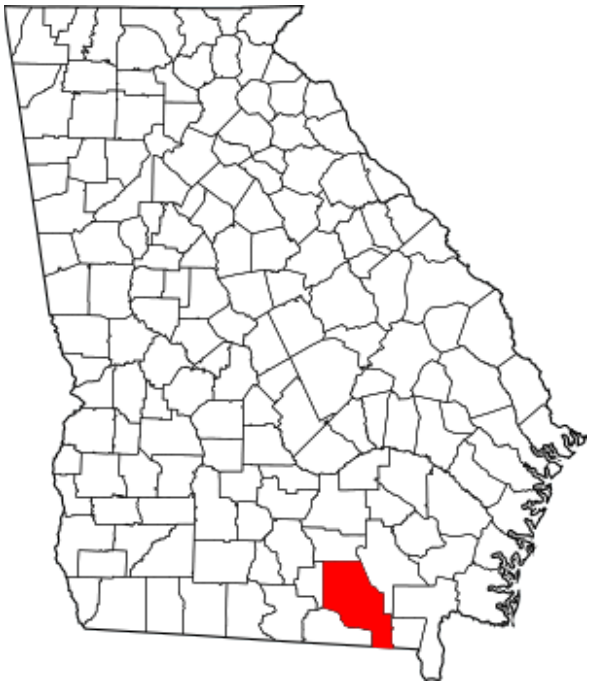
Clinch Memorial values your input. If you would like to provide input/feedback on this report, please do so here.

# Hospital and Service Area

Clinch Memorial Hospital is in Clinch County, Georgia in the county seat of Homerville, Georgia. By land mass, Clinch is the second largest county in Georgia and is in the most southeast part of the state. Clinch shares its southern border with Florida.

**Clinch County is the community served by the hospital**. Clinch County's seat is Homerville, Georgia, with a population of 2,324.

Within the county, there are several fishing, hiking, and hunting opportunities. Stephen C. Foster State Park as well as Okefenokee Swamp are nearby. According to the Clinch County government website, Clinch County's primary employment sectors are blueberry and honeybee farming industries.



Clinch Memorial Hospital was founded in 1957 as a 48-bed rural community hospital. In 2007 it moved to a new facility in Homerville, GA as a 25-bed critical access hospital. The hospital's mission is "Integrity and Excellence Always", its vision is "Inspire Hope, Invest in Others, Promote Wellness" and it core values are: "Compassion, Curiosity, Collaboration". Clinch Memorial provides the following services: 24/7 Emergency Care, Telehealth, Radiology, Rehabilitation, Swing bed, Nursing, Pulmonary, Respiratory, Gastroenterology, Clinch Family Practice, Dietary, and Pharmacy Services.

### CHNA Report Organization

This report presents the findings of the CHNA, beginning with the results of secondary data analysis. Community input from the survey and focus group interviews are presented next. Implementation planning to address the community's health needs, including a discussion of results from the previous CHNA and the implementation plan for the next three years that was developed by the CHNA Steering Committee, follows. Finally, a community health care resource listing is provided.

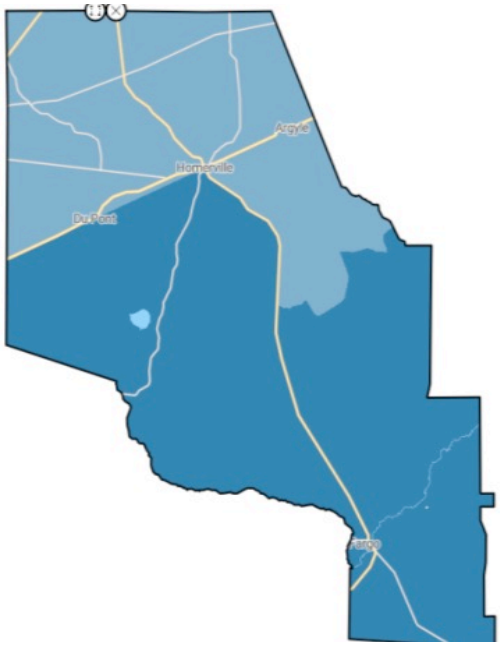
# Secondary Data

## CLINCH COUNTY DEMOGRAPHICS

As of 2023, there were an estimated 6,746 residents in Clinch County. Compared to Georgia overall, the population of Clinch has more residents both over 65 (18%) and under 18 (25%). Compared to Georgia overall, Clinch also has fewer veterans (3%) and more disabled residents (13%).

Figure 1 was generated with Data from the Census using an online mapping platform (PolicyMap, 2024), illustrates that the southern tract of the county has a slightly higher percentage of 65+ adults (19%) compared to the northern tract (15%).

*Figure 1. Estimated percent of people 65+ (2018-2022)*



| | Clinch | GA |
|---|---|---|
| Total Number of Residents | 6,746 | 11,029,227 |
| Female | 52% | 51% |
| Male | 48% | 49% |
| **Age Distribution** | | |
| Population Under 5 years | 7% | 6% |
| Population Under 18 years | 25% | 23% |
| Population 65 years and older | 18%* | 15% |
| **Race & Ethnicity** | | |
| Non-Hispanic White | 68%* | 59% |
| Non-Hispanic Black/AA | 28% | 33% |
| Other Races/Multiracial | 4% | 8% |
| Hispanic | 5%* | 11% |
| **Other Demographics** | | |
| Foreign Born | 4%* | 10% |
| Non-English Language Spoken at Home | 6.5%* | 15% |
| Veterans | 3% | 6% |
| Population under 65 years disabled | 13%* | 9% |

*Significantly different from state average, Data Source: US Census Bureau, County Health Rankings

# POPULATION CHANGE

The population of Clinch County decreased by 0.7% between 2013 and 2023 whereas Georgia's overall population increased by 10%. Over that period, both Clinch and Georgia saw an increase in the proportion of Asian, American Indian/Native Alaskan and Hispanic residents. Although the proportions have increased, the number of Asian and Native American/Alaskan, Native Hawaiian, Multiracial and Hispanic residents remain small. The proportion of residents 65 and older increased by 18.8% in the county and 41.8% in the state (Figure 2).

The overall population of Clinch County is projected to continue to decrease by 1.2% by 2028, while Georgia's population is expected to increase by 5.3%. Over the next five years, the county is projected to maintain its aging population with decreases across under-20 and working-age adults. The only projected growth by category for Clinch is anticipated to be the Hispanic population by 8% (Figure 3).

*Figure 2. Clinch County Population Change, 2013-2023*

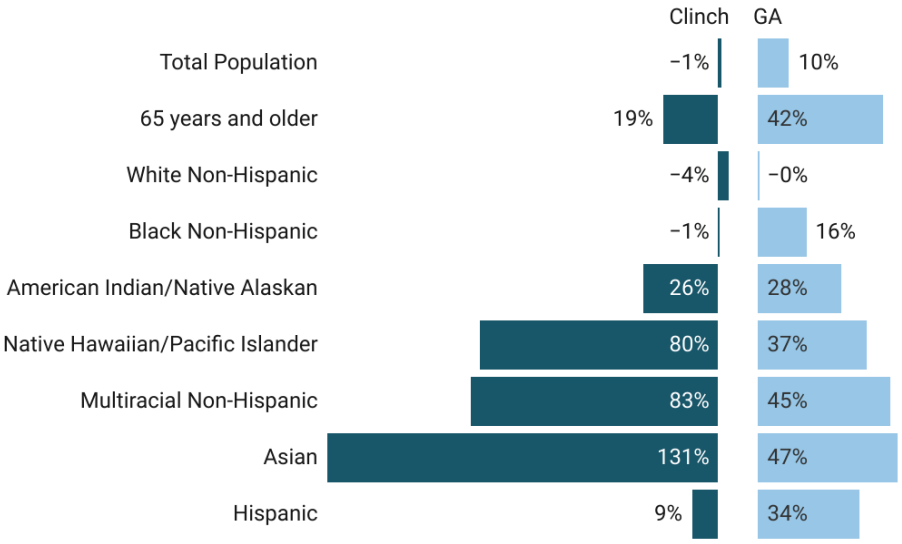
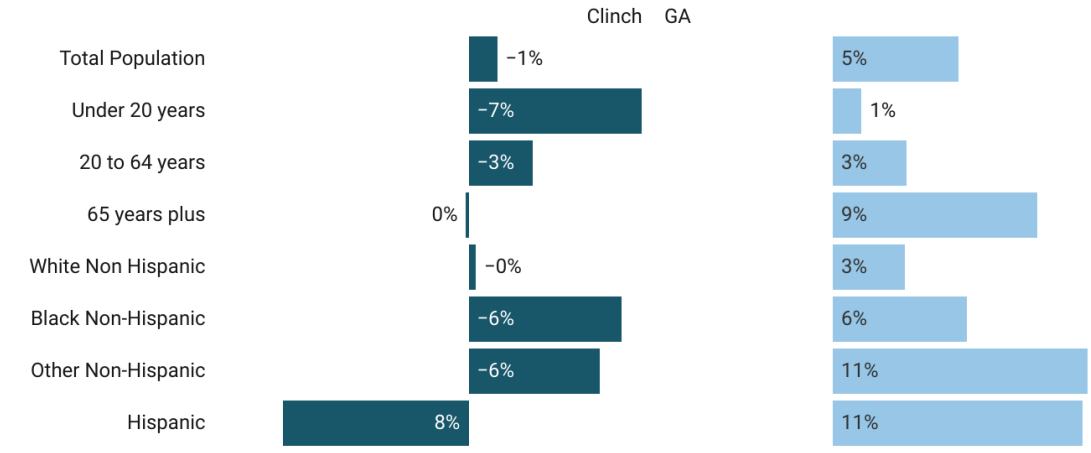



*Figure 3. Projected Clinch County Population Change, 2023-2028*




*Data Source: Census.gov, & Georgia Governor's Office of Planning and Budget. Graphs created with Datawrapper.*

## *CENSUS TRACT DEMOGRAPHIC VARIATIONS*

The maps below display demographics within Clinch County by census tract. Maps are from PolicyMap, with darker colors representing greater proportions.

*Figure 4. Median Income by Census Tract (2019-2023)*

Figure generated with data from the Census using an online mapping platform (PolicyMap, 2024).

Figure 4 illustrates Median household income varies little across the county. The highest median household income is found in the northern tract ($55,750), compared to the southern tract ($53,750).

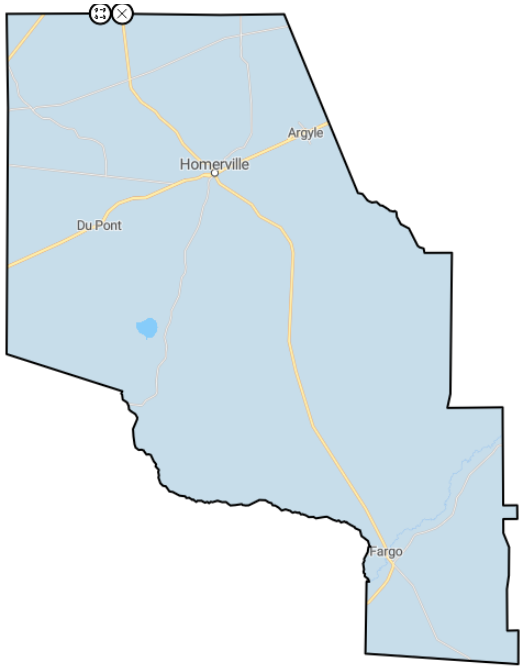
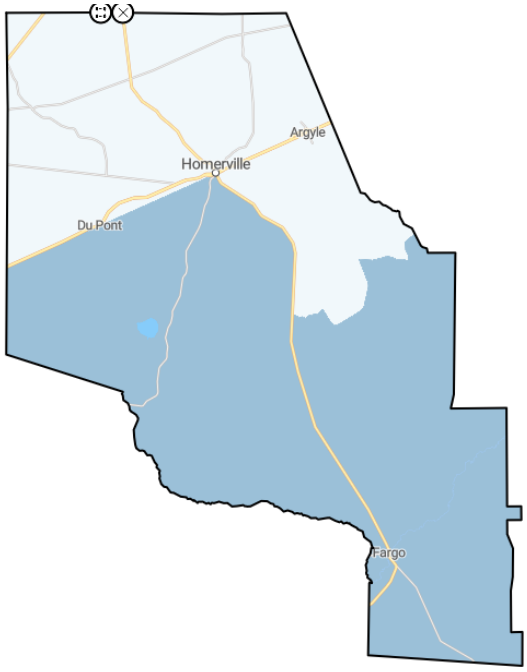



*Figure 5. Estimated percent of all people 65 or older who live in poverty as of 2019-2023.*

Figure generated with data from the Census using an online mapping platform (PolicyMap, 2024).

The southern tract in the county has a higher proportion of population aged 65 or older in poverty (34% vs 20%).



# ECONOMIC PROFILE

In 2023, Clinch's GDP was ranked 128 out of 159 counties in Georgia. Workforce representation is lower in Clinch, with 57% of residents participating compared to 76% in Georgia.

The median household income for Clinch County is significantly below the state median ($53K vs $71K). Poverty is greater in the county than in the state. About 22% of the population and 27% of children live in poverty. Furthermore, three quarters of school-aged children (75%) in the County are eligible for free or reduced lunches.

Housing costs are comparatively favorable: 73% of residents report homeownership versus 65% in Georgia, and 9% of Clinch families spend over 50% of their income on housing compared to 14% in Georgia. Severe housing problems are comparable to the state (14% vs 15%). Median gross rent in Clinch is $574, much lower than Georgia's $1,221.

*Figure 6. Workforce Representation (2013-17)*

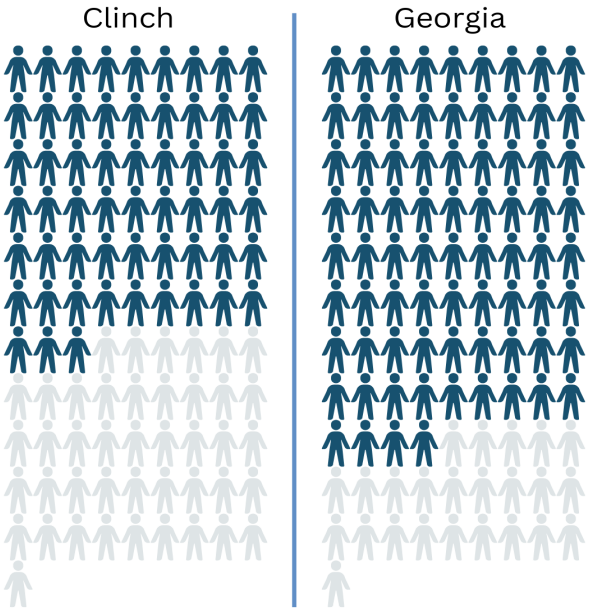



Figure 6 compares Clinch to Georgia in terms of percent of workforce representation with the missing workforce in light grey.

| | Clinch | GA |
|---|---|---|
| Real GDP Growth Rate (2022-2023) | -0.9 | 1.9 |
| Real GDP Rate (2013-2023) | -0.2 | 3.1 |
| **Poverty** | | |
| Median Household Income (2018-2022) | $53,350* | $71,355 |
| Population in Poverty (2023) | 22%* | 14% |
| Children in Poverty (2022) | 27%* | 17% |
| Children eligible for reduced lunch (2020-2021) | 75%* | 56% |
| **Employment** | | |
| 16+ work seekers unemployed | 3.6% | 3.6% |
| Work Force Representation (20–64) (2013-17) | 57%* | 76% |
| **Housing** | | |
| Home ownership | 73%* | 65% |
| Families spending > 50% of income on housing | 9%* | 14% |
| Severe housing problems | 14% | 15% |
| Median gross rent | $547* | $1,221 |
| Median selected monthly owner costs, includes mortgage | $1,053* | $1,640 |

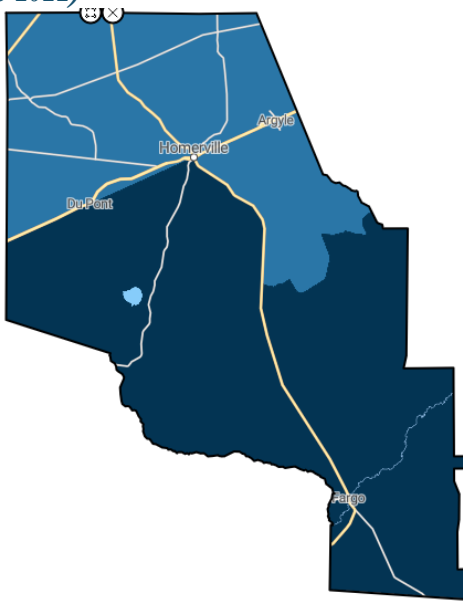
*Significantly different from state average, Data Sources: US Census Bureau, County Health Rankings

# EDUCATION

Educational attainment in Clinch County is lower than Georgia overall. With Clinch's high school graduation rate at 74%, it's considerably lower compared to 89% statewide. Additionally, only 13% of Clinch's population has a bachelor's degree, far below Georgia's 34%. Additionally, Clinch is underspending per-pupil based on the amount needed for average US test scores, (by $7,472) - below the compared to Georgia's $6,772 deficit.

Figure 7 on the right from www.policymap.com displays census data for residents with only a high school diploma and no college. 51% of the southern census tract population has a high school diploma and no college, whereas 33% of the northern census tract had this level of education.

*Figure 1. High School Diploma and no college (2018-2022)*




| | Clinch | GA |
|---|---|---|
| High school graduation rate | 74%* | 89% |
| Population with at least a bachelor's degree | 13%* | 34% |
| 3–4-year-old children in school (2021) | 32%* | 48% |
| Average grade level score for 3rd graders in English (2019) | 2.7 | 3 |
| Average grade level score for 3rd graders in math (2019) | 2.4 | 2.9 |
| School Funding Adequacy (2021) | -$7,472 | -$6,772 |

# SOCIAL CONTEXT

Clinch County has more social associations (17.8 per 10,000) compared to Georgia (8.9), indicating a better social environment. The suicide rate is not available for Clinch, while Georgia's rate is 14 per 100,000. Clinch also has slightly fewer persons per household compared to the state overall (2.51 vs. 2.64).

| | Clinch | GA |
|---|---|---|
| Average persons per household | 2.51 | 2.64 |
| Social Associations per 10,000 (2021) | 17.8 | 8.9 |
| Suicide rates per 100,000 (2017-2021) | N/A | 14 |

*Significantly different from the state. Data Sources: County Health Rankings, US Census Bureau

# NEIGHBORHOOD AND ENVIRONMENT

Accessing resources is a challenge for some Clinch residents: 84% have a computer, but only 66% have internet access. Clinch residents do not have adequate access to exercise opportunities (within a half mile of a park, or within three miles of a recreational facility). *However, actual counts of local exercise opportunities include one fitness center, one "Local Loop" walking trail, a park with exercise equipment, and recreation park.*

Deaths from motor vehicle accidents are 30 per 100,000 in Clinch, double Georgia's rate of 15 per 100,000.

Food insecurity is a mixed issue in Clinch, with 16% of the population experiencing food insecurity, compared to 11% in Georgia. Yet only 5% of low-income residents in Clinch face limited access to healthy foods, and in Clinch the food environment index (7), is slightly better than Georgia's 6.4.

*Figure 8. Child Food Insecurity rate (2022)*

Figure 8 was generated with Data from Feeding America using a mapping platform (PolicyMap, 2024). Displays Clinch's child food insecurity rate (27.3%), significantly higher than Georgia overall (18.4%). As of 2022, the only full-service grocery store was located in Homerville.

| | Clinch | GA |
|---|---|---|
| **Access** | | |
| Households with computer % | 84%* | 94% |
| Households with Internet Access | 66%* | 88% |
| Access to exercise opportunities | 0%* | 74% |
| Households with no motor vehicle | 11%* | 6% |
| Number of childcare centers per 1,000 | 7* | 10 |
| Median Income spent on childcare | 26% | 24% |
| **Safety** | | |
| Firearm deaths per 100,000 | N/A | 17 |
| Alcohol-related Deaths from MVA, per 100,000 | 30* | 15 |
| Injury Deaths per 100,000 | 90* | 73 |
| **Food Insecurity** | | |
| Low-income with limited access to healthy foods | 5%* | 10% |
| Food environment index (1 worst; 10 best) | 7 | 6.4 |
| Food insecurity | 16%* | 11% |
| **Pollution** | | |
| Air pollution (PM2.5) | 8.3 | 9.4 |
| Drinking Water Violations | No | Yes |

*Significantly different from state. Data Sources: County Health Rankings, US Census Bureau, Sparkmap

## *DIFFERENCES IN ENVIRONMENT*

The maps below display demographics within Clinch County by Census block group or tract. Maps are from PolicyMap, with darker colors representing greater proportions.

*Figure 9. National Walkability Index (2021)*

Figure generated with data from the EPA Smart Location Database displayed by 2010 block group (PolicyMap, 2024).

The National Walkability Index (2021) is ranked on a 0-10 scale. The walkability of the Clinch varies with the highest index located near Homerville (7.5 & 6.5), followed by the northeast part of the county (4.7). The lowest walkability is the southern portion of the county (3.2).

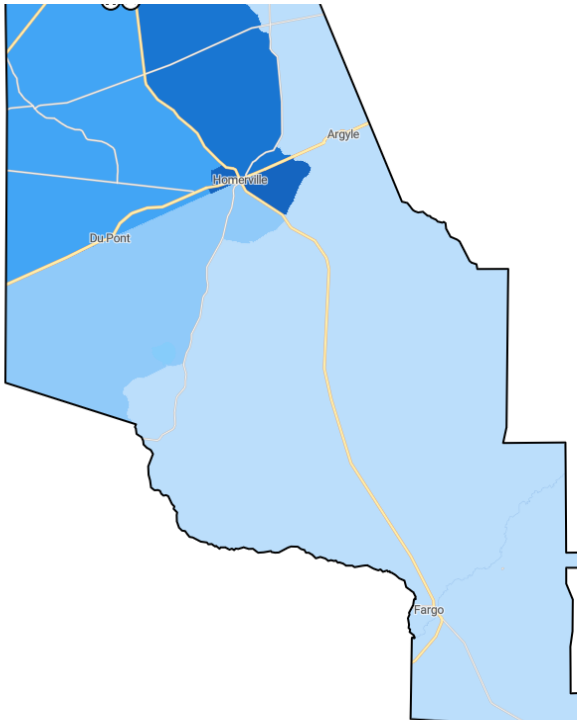



*Figure 10. Household Internet Access by Census Tract (2017-2021)*

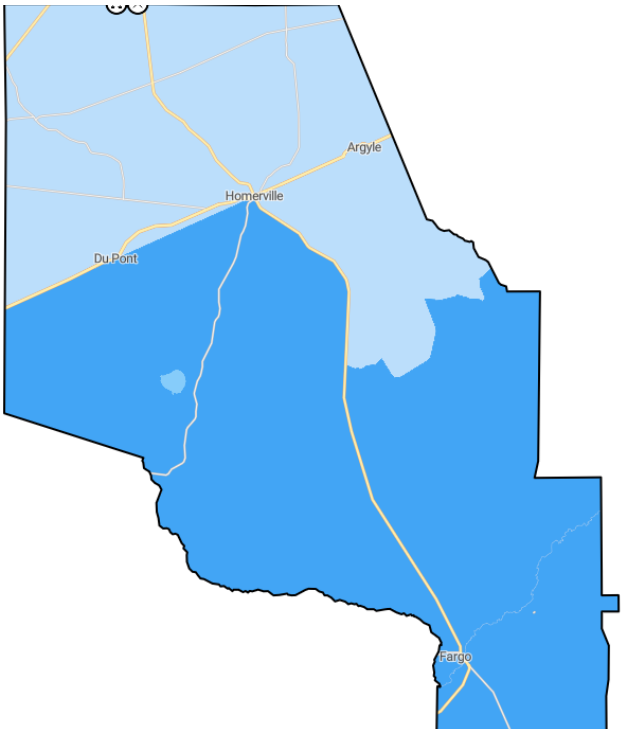



Figure generated with data from the Census Smart Location Database 2018-2022 data displayed by census tracts (PolicyMap, 2024).

The proportion of households without internet access is relatively high throughout the county, ranging from 29%% in the northern tract to 51% in the southern tract.

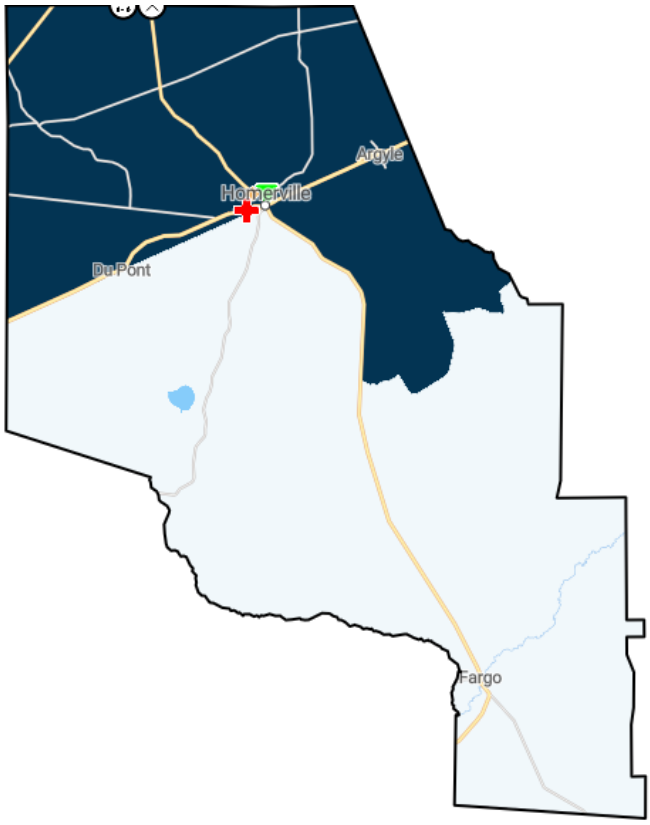
# HEALTHCARE ACCESS

Clinch County, Georgia has one hospital, Clinch Memorial Hospital. There is one nursing facility, Riverbrook Healthcare Center in the county. Additionally, Clinch County has one mental health treatment facility, Unison Behavioral Health (Figure 11, PolicyMap.com). Currently, approximately 23% of Clinch County residents are uninsured, which is higher than the Georgia state average of 18%.

Nationally collected data shows that the county faces shortages of primary care physicians, dentists, and mental health providers compared to the state overall. *(However, actual counts of providers indicate there are 6 full-time providers in the county.)*

Additionally, the rate of Medicare preventable hospital stays per 100,000 residents in Clinch County is higher than the state overall, indicating a need for more preventive care.

*Figure 11. Location of Health Facilities*




**Legend:** Census tracts are shaded based on total population in 2020, with darker colors representing greater population counts. Red cross=Medicare Certified Hospital, green triangle = nursing facility (Rehabilitation Center), yellow square= community health center, pink triangles = drug and alcohol treatment facilities, orange diamond=mental health treatment facilities.

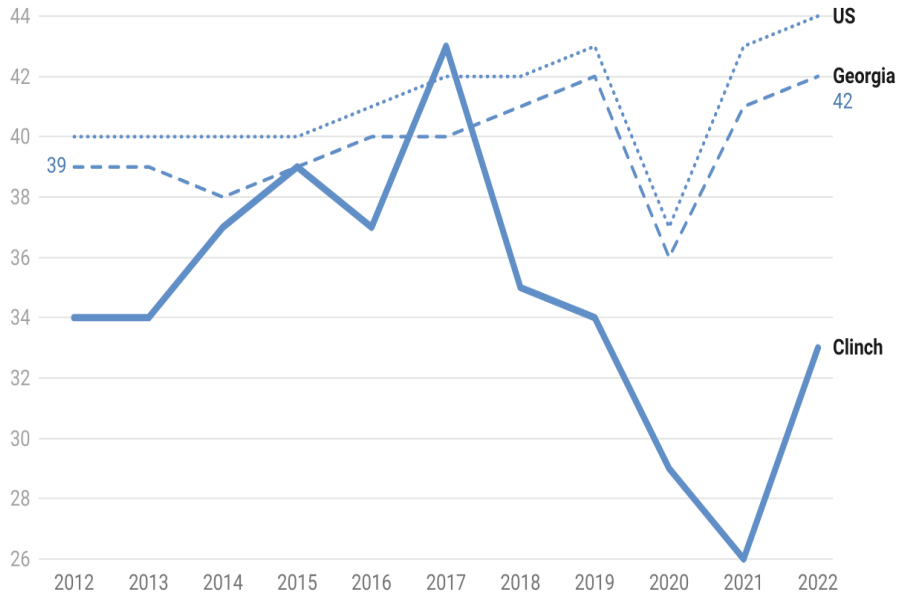
| | Clinch | GA |
|---|---|---|
| **Health Insurance Coverage** | | |
| Percent under 65 years Uninsured | 23%* | 18% |
| **Provider Supply** | | |
| Population to One Primary Care Physician | 6,730* | 1,520 |
| Population to One Dentist | 6,660* | 1,860 |
| Population to One Mental Health Provider | 6,660* | 560 |
| **Primary Care** | | |
| Medicare Preventable Hospital Stays per 100,000 | 4,747* | 3,076 |

*Significantly different from state. Data Sources: County Health Rankings, US Census Bureau

# LIFESTYLE AND HEALTH BEHAVIOR

Clinch residents receive fewer vaccinations, compared to the state. Screening rates for mammograms of Medicare-aged women are lower in Clinch than Georgia while PAP screening rates are comparable. An overall decreasing trend in mammogram screening for Clinch has occurred since 2017 (Figure 12).

*Figure 12. Mammogram Screening (2012-2022)*




In terms of lifestyle behaviors, the proportion of Clinch County residents who smoke (27%), are physically inactive (37%), or are obese (42%) is higher compared to the state. Rates of excessive drinking and insufficient sleep are comparable to the state.

Clinch County's teen pregnancy rate and sexually transmitted diseases are higher than the state. yet the HIV prevalence in Clinch is lower than the state.

| | Clinch | GA |
|---|---|---|
| **Disease Prevention and Screening Behaviors** | | |
| Flu Vaccination Rates among Medicare | 36%* | 43% |
| Fully Vaccinated for COVID | 57%* | 89% |
| Mammogram Screening Rates (2022) | 33%* | 42% |
| PAP Smear Screening Rates | 74% | 77% |
| **Suboptimal Lifestyle Behaviors** | | |
| Adult smoking rate | 27%* | 16% |
| Adult excessive drinking rate | 13% | 17% |
| Adult obesity rate | 42%* | 34% |
| Adult physical inactivity rate | 37%* | 23% |
| Adults report insufficient sleep (<7 hours) (2020) | 40%* | 36% |
| **Sexual Risk Behaviors** | | |
| HIV prevalence rate per 100,000 | 452* | 657 |
| STD infection rates per 100,000 | 744* | 629 |
| Teen pregnancy rates per 1000 female teens | 43* | 20 |

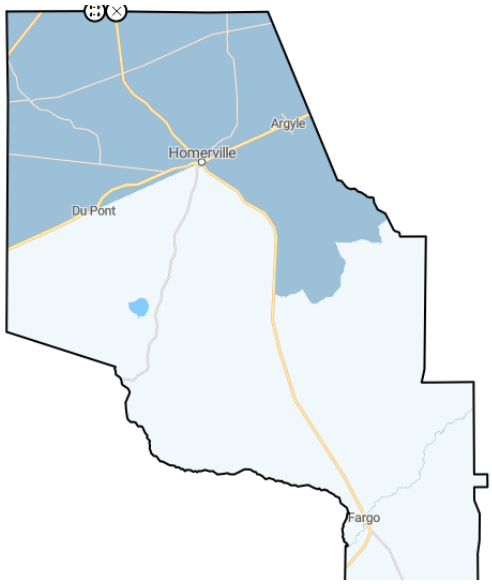
*Significantly different from state. Data Sources: County Health Rankings

# HEALTH OUTCOMES

Overall, health outcomes for Clinch County residents are comparatively worse than those for Georgia. Life expectancy at birth as of 2021 in the county (69.8) is over six years shorter than in the state (76.1). Within Clinch County, the incidence of both cancer and diabetes are higher compared to the state. Clinch County had more cardiovascular disease deaths than Georgia (757 vs 357 per 100,000). More Clinch residents also reported poor physical and mental health compared to the state.

Figure 13, generated with data from the CDC HUD using a mapping platform (PolicyMap, 2024), illustrates CDC data on life expectancy from birth. The northern census tract has a life expectancy of 74.7 compared to the southern tract 71.3 years.

*Figure 13. Life Expectancy at Birth, 2010-15*




| | Clinch | GA |
|---|---|---|
| **Disease Burden & Health Outcomes** | | |
| Cancer incidence rate per 100,000 (2021) | 475 | 472 |
| Adult diabetes prevalence rate | 16% | 11% |
| Cardiovascular disease deaths per 100,000 35+(2019-2021) | 757* | 357 |
| Low birth weight rate | 12% | 10% |
| Life expectancy | 69.8* | 76.1 |
| Premature (under 75yrs) death rate per 100,000 | 790* | 440 |
| Adults reporting poor health | 28%* | 18% |
| Adults reporting frequent mental distress | 21%* | 15% |

## *Top 10 Causes of Death 2019-2023*

| Cause | Clinch | GA |
|---|---|---|
| Ischemic Heart Disease | 1 | 1 |
| COVID-19 | 2 | 2 |
| COPD | 3 | 5 |
| Lung Cancer | 4 | 7 |
| Alzheimer's | 5 | 6 |
| Cerebrovascular Disease | 6 | 3 |
| Nervous System Diseases | 7 | 8 |
| Kidney Disease | 8 | 11 |
| Motor Vehicle Crashes | 9 | 14 |
| Hypertensive Heart Disease | 10 | 4 |

Georgia Department of Public Health's Online Analytical Statistical Information system reports the top three causes of death from 2019-2023 for Clinch as ischemic heart disease, COVID-19, and COPD. For Georgia overall, cerebrovascular disease replaced COPD as the 3rd leading cause. COPD, lung cancer and motor vehicle crashes ranked relatively higher in Clinch compared to Georgia overall, cerebrovascular disease and hypertensive heart disease ranked higher for Georgia than Clinch. The toll of COVID-19 for both the county and state is evident.

*Significantly different from state. Data sources: CDC Atlas of Heart Disease and Stroke, County Health Rankings, GA Dept. Of Health, NIH State Cancer Profile.

# PROGRESS ON SELECTED INDICATORS

| | Prior CHNA (2022) | Current CHNA (2025) | Progress |
|---|---|---|---|
| **Social and Economic Context** | | | |
| Percent children in poverty | 31% | 27% | → |
| Unemployment rate | 4% | 3.6% | → |
| High school graduation rate | 69% | 74% | → |
| Social associations per 10,000 | 16.5 | 17.8 | → |
| **Environment** | | | |
| Percent population with access to exercise opportunities | 5% | 0% | ← |
| Percent population food insecure | 21% | 16% | → |
| **Health Care Access** | | | |
| Uninsured adults | 18% | 23% | ← |
| Proportion of people to primary care providers | 6,650 | 6,730 | – |
| Proportion of people to Dentists | 6,620 | 6,660 | – |
| Proportion of people to mental health to providers | 6,620 | 6,660 | – |
| **Health Behaviors** | | | |
| Obesity rate | 46% | 42% | → |
| Physical inactivity rate | 22% | 37% | ← |
| Smoking rate | 28% | 27% | → |
| Teen pregnancy rate (per 1000 teen females) | 52 | 43 | → |
| **Health Outcomes** | | | |
| Percent reporting poor or fair health | 31% | 28% | → |
| Low birth weight rate | 12% | 12% | – |
| Diabetes prevalence | 18% | 16% | → |
| Premature (under 75yrs) death rate per 100,000 | 670 | 790 | ← |

← worsened – stable → improved

Data source: Previous CHNA and 2024 County Health Rankings.

# Primary Data

## COMMUNITY SURVEY

The survey was shared on the hospital's website, at various community group meetings, through social media accounts, and with the school board for further dissemination. There were 135 community members who provided complete or partial responses to the online survey. Demographics of survey respondents are provided in Table 1.

## *RESPONDENT DEMOGRAPHIC CHARACTERISTICS*

Most survey respondents were female (79%), White (78%), aged under 65 years (79%), married or partnered (58%), and employed (78%), with at least some college or associate degree (75%). Of those responding, 59% reported annual household income above $60,000. Compared to census statistics, survey respondents were significantly more likely to be female (79% vs 52%). Respondents had more years of formal education: 20% (vs 13%) had a bachelor's degree. Similarly, nearly 6 in 10 respondents reported household earnings greater than the county median household income of $56K. Survey respondents were also more likely to own a home than the actual population (90% vs 70%). The percentage of participants over 65 was comparable to census data (21% vs 23% (of adult residents). Non-Hispanic White participants were overrepresented in the survey (78% vs 68%).

Census Data Source: U.S. Census Bureau (2024). Quick Facts. Retrieved from: https://www.census.gov/quickfacts/fact/table/clinchcountygeorgia,US/PST045223

*Table 1: Demographic Characteristics of Survey Respondents*

| | Frequency (N) | Percentage (%) |
|---|---|---|
| Gender (n=108) | | |
| Female | 85 | 79% |
| Male | 23 | 21% |
| Other | 0 | 0 |
| Age (n=108) | | |
| 18-24 | 3 | 3% |
| 25-34 | 12 | 11% |
| 35-44 | 20 | 19% |
| 45-56 | 25 | 23% |
| 55-64 | 25 | 23% |
| 65-74 | 16 | 15% |
| 75+ | 7 | 6% |
| Race (n=106) | | |
| White | 83 | 78% |
| Black or African American | 21 | 20% |
| American Indian or Native Alaskan | 5 | 5% |
| Asian | 3 | 3% |

| | Frequency (N) | Percentage (%) |
|---|---|---|
| Native Hawaiian or Pacific Islander | 2 | 2% |
| Hispanic or Latino | 2 | 2% |
| Education (n=108) | | |
| Less than high school | 4 | 4% |
| High school graduate or GED | 23 | 21% |
| Some college or associate degree | 41 | 38% |
| Bachelor degree | 22 | 20% |
| Graduate or advanced degree | 18 | 17% |
| Marital Status (n=108) | | |
| Married/Partnered | 63 | 58% |
| Divorced | 14 | 13% |
| Widowed | 14 | 13% |
| Single/Never Married | 17 | 16% |
| Household Income (n=107) | | |
| Below $20,000 | 5 | 5% |
| $20,001-$40,000 | 24 | 22% |
| $40,001-$60,000 | 14 | 13% |
| $60,001-$80,000 | 11 | 10% |
| $80,001-$100,000 | 11 | 10% |
| Above $100,000 | 25 | 23% |
| Don't know/Prefer not to say | 17 | 16% |
| Employment Status (n=108) | | |
| Unemployed | 4 | 4% |
| Part-time | 8 | 7% |
| Full-time | 77 | 71% |
| Retired | 19 | 18% |
| Home Ownership (n=106) | | |
| Yes | 90 | 85% |
| No | 16 | 15% |
| Access to Reliable Transportation (n=100) | | |
| Yes | 97 | 97% |
| No | 3 | 3% |

## *HEALTH STATUS*

Just under half of respondents (43%) reported their health status as excellent or very good (Figure 14). Conversely, one-fourth of respondents perceive their community as healthy / very healthy (Figure 15). The most common chronic conditions that participants reported having were high blood pressure (56%), obesity (51%), and high cholesterol (39%) (Figure 16).

*Figure 14. Self-Reported Health Status*

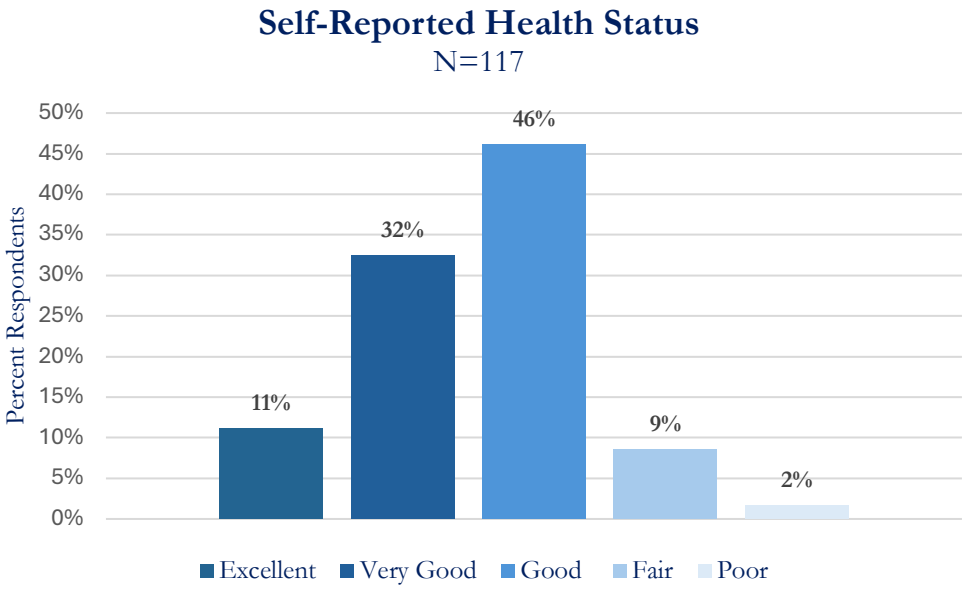



*Figure 15. Rating of Community Health Status*

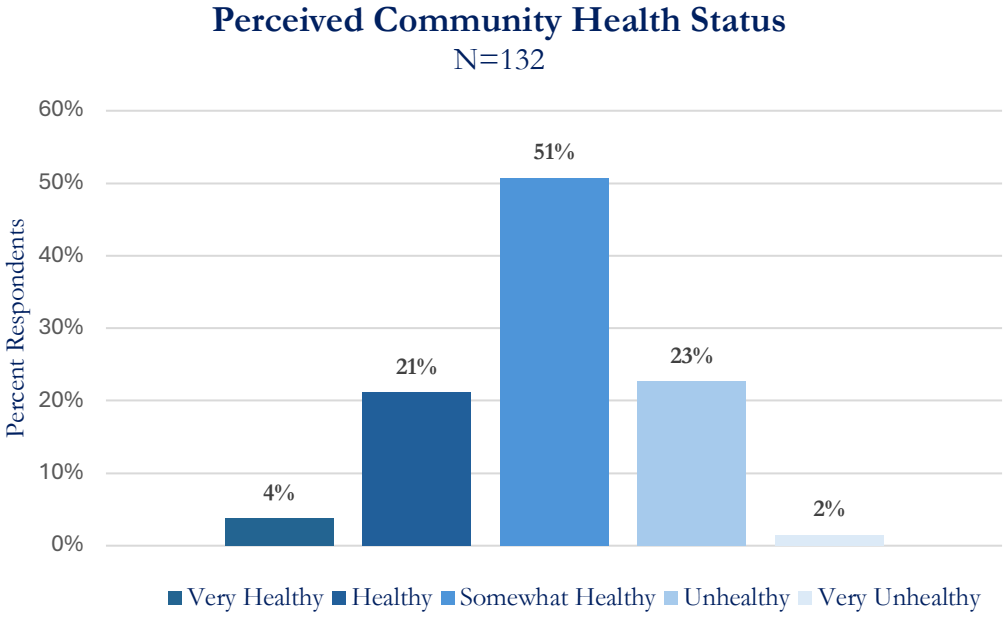
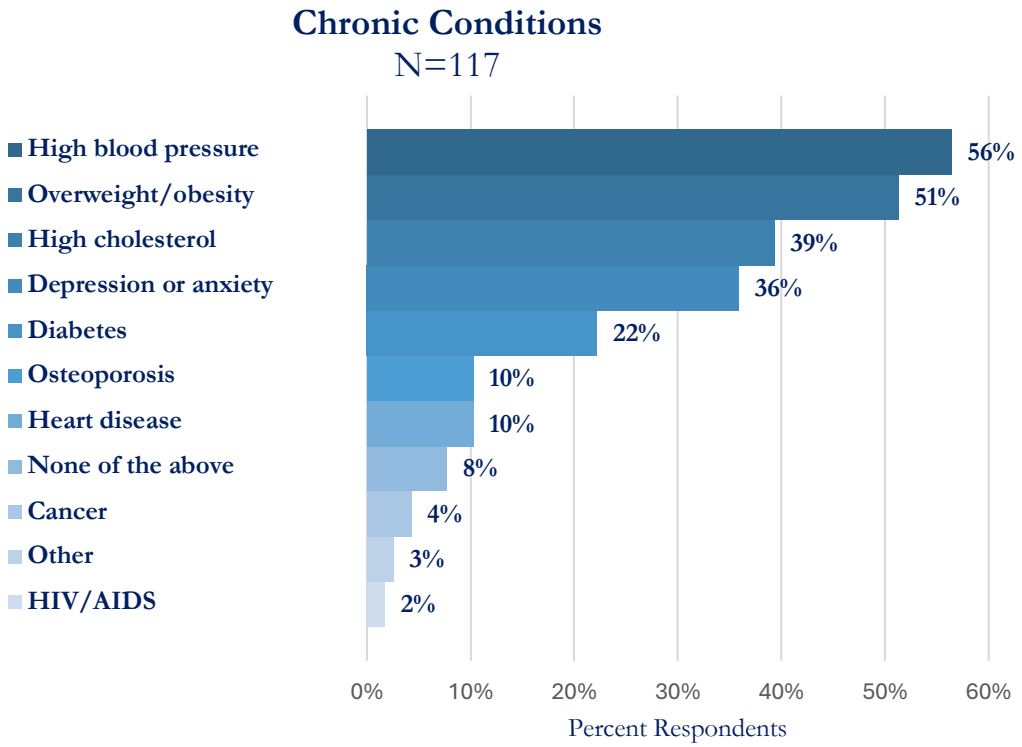


*Figure 16. Most Common Chronic Conditions*




*Note: Participants could choose more than one response option. Hence, percentages do not add up to 100.*

# *HEALTH BEHAVIORS*

## *Smoking, Nutrition, and Physical Activity*

Approximately one in ten (11%) of respondents reported currently smoking tobacco products (Figure 17).

Also, about two in five (38%) reported eating the recommended five servings of fruits and vegetables daily (Figure 18). Of those not meeting the recommended amounts, about 45% indicated that they could not adhere to this nutrition guideline because they don't think about it, and 42% attributed their non-adherence to the cost of fruits and vegetables. Similarly, 40% stated they go bad before they eat them (Figure 19).

Regarding physical activity, over half of the respondents (56%) stated that they met daily recommended physical activity guidelines of 30 minutes per day, five times per week (Figure 20). Among those who do not meet the recommended amount, nearly one-half of respondents reported being too tired to exercise (46%). About one out of four (42%) participants reported not having enough time to exercise. Just a little above three out of ten (32%) said they did not have access to a place to exercise (Figure 21).

*Figure 17. Smoking Behavior*

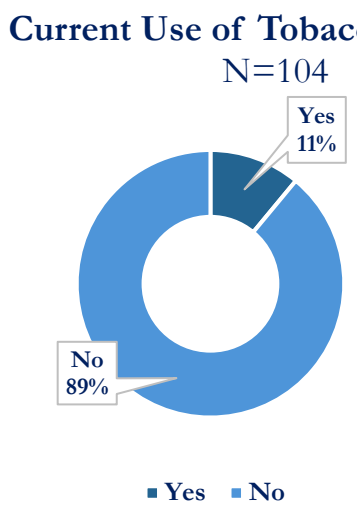



*Figure 18. Fruit and Vegetable Consumption*

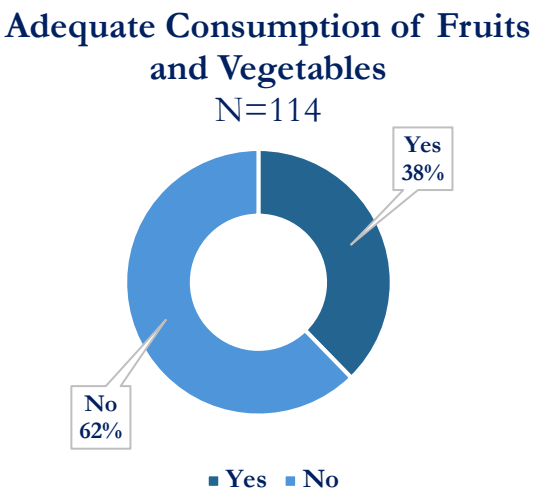
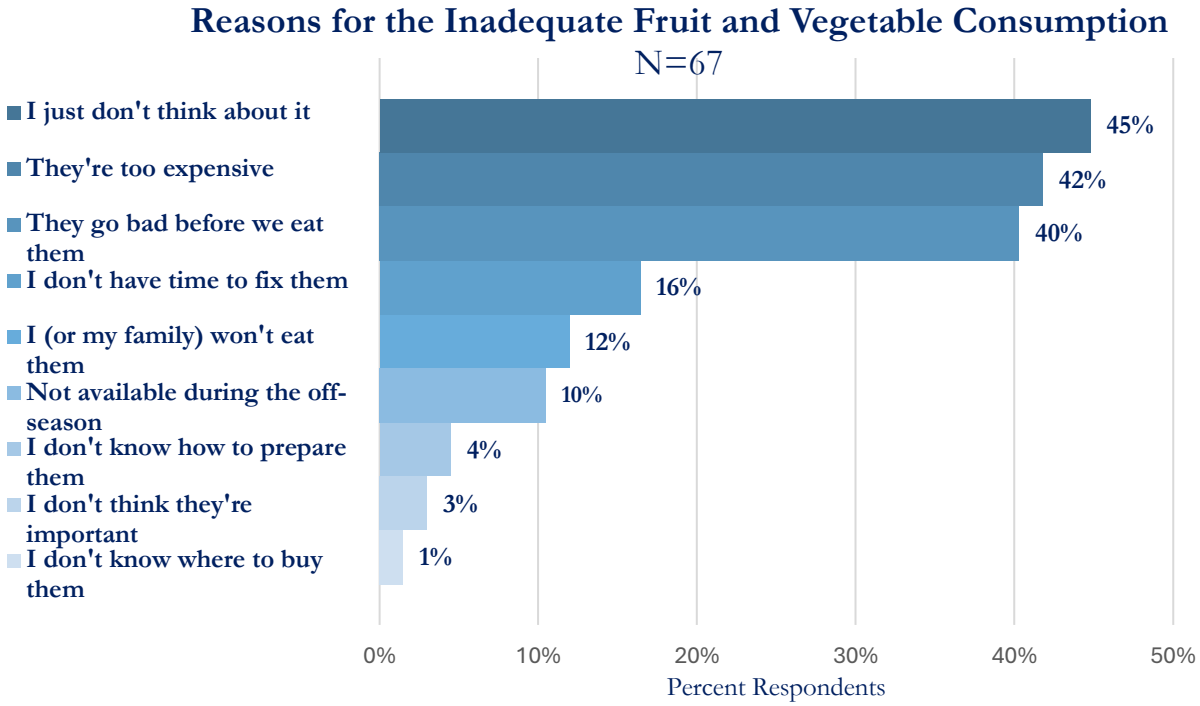
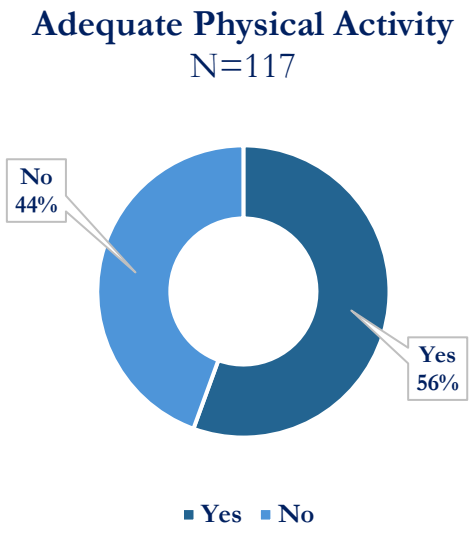



*Figure 19. Reasons for Inadequate Vegetables and Fruits Consumption*



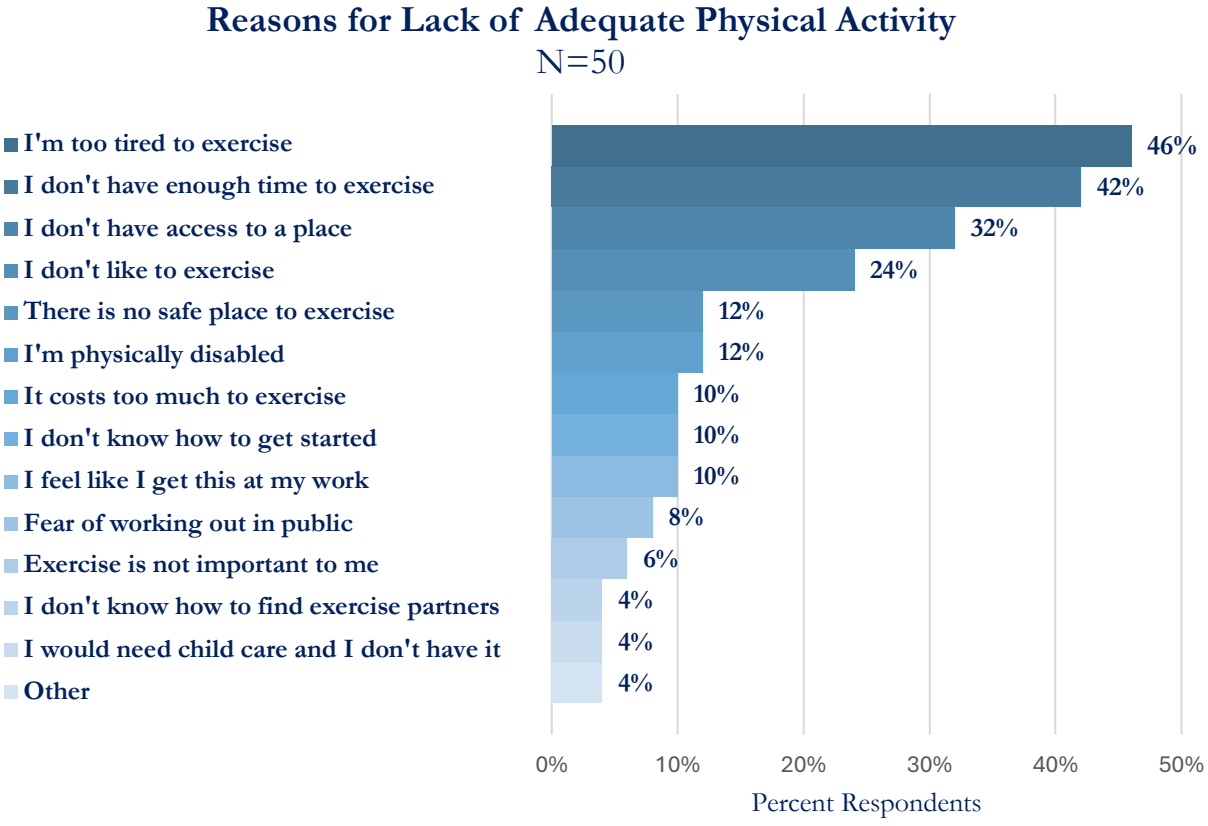

*Note: Participants could choose more than one response option. Hence, percentages may not add up to 100.*

*Figure 20. Physical Activity*




*Note: Participants could choose more than one response option. Hence, percentages may not add up to 100.*

*Figure 21. Inadequate Physical Activity*




*Note: Participants could choose more than one response option. Hence, percentages may not add up to 100.*

## *Preventive Screening*

Respondents were also asked about their utilization of preventive and screening services and their adherence to recommended screening guidelines.

Nearly three-quarters (73%) of respondents 50 years and older reported having ever received a colonoscopy (Figure 22). About one out of five (18%) reported having barriers to obtaining a colonoscopy (Figure 23), with fear of pain (36%), high cost (29%), and limited availability (14%) as the most cited barriers (Figure 24).

*Figure 22. Colon Cancer Screening*

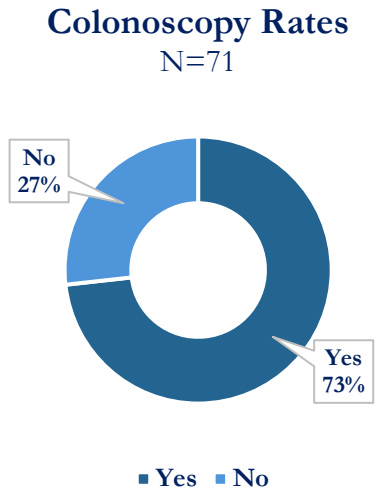



*Figure 23. Any Barriers to Colon Cancer Screening*

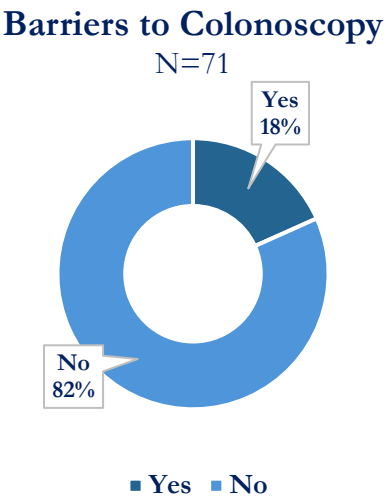
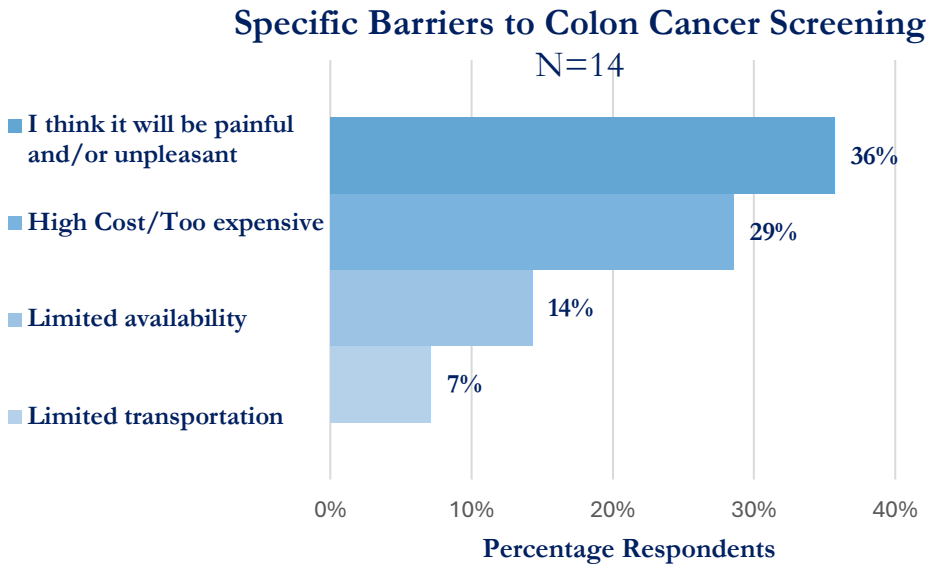



*Figure 24. Specific Barriers to Colon Cancer Screening*




*Note: Participants could choose more than one response option. Hence, percentages may not add up to 100.*

Nearly three out of five (59%) of male respondents over 40 years had discussed prostate cancer screening with their healthcare provider (Figure 25). Twenty-one percent reported barriers to prostate cancer screening (Figure 26), with high cost, limited availability, pain/discomfort, lack of transportation, lack of childcare, and worry of pain having equal response rates (Figure 27).

*Figure 25. Prostate Cancer Screening*

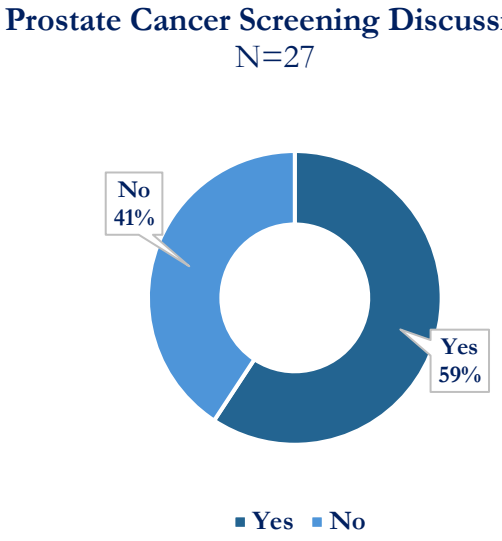



*Figure 26. Any Barriers to Prostate Cancer Screening*

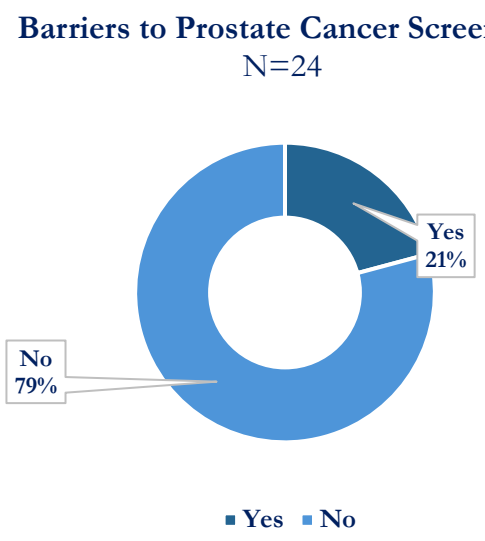
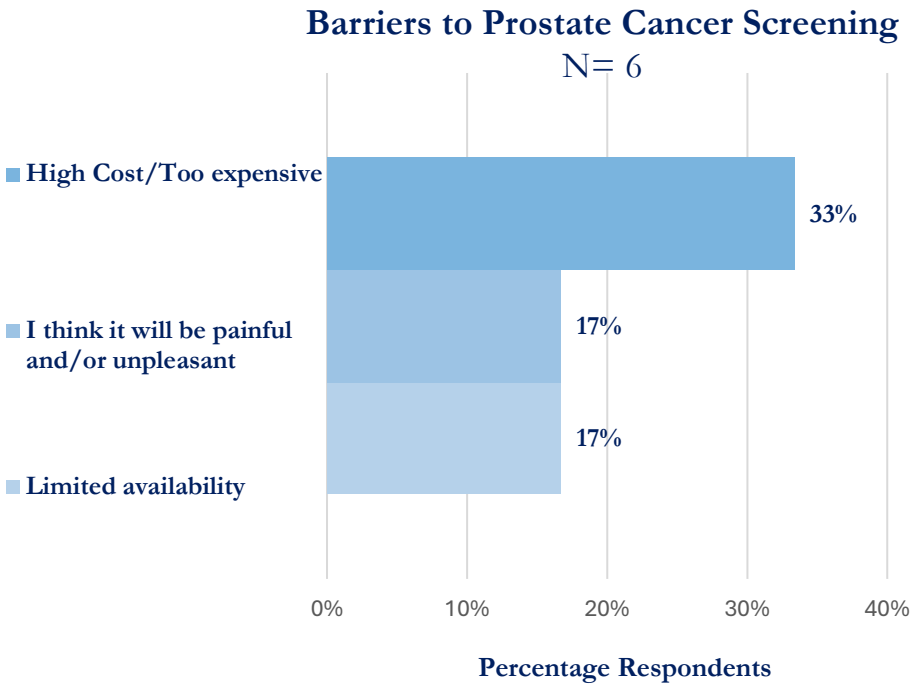



*Figure 27. Specific Barriers to Prostate Cancer Screening*




*Note: Participants could choose more than one response option. Hence, percentages may not add up to 100.*

More than eight out of ten (84%) female respondents 50 years or older reported receiving an annual mammogram (Figure 28). Eleven percent of those respondents reported experiencing barriers to receiving mammography (Figure 29), with an equal percentage response of 29% each for high cost, pain/discomfort, lack of childcare, and limited availability as the top four main barriers (Figure 30).

*Figure 28. Breast Cancer Screening*

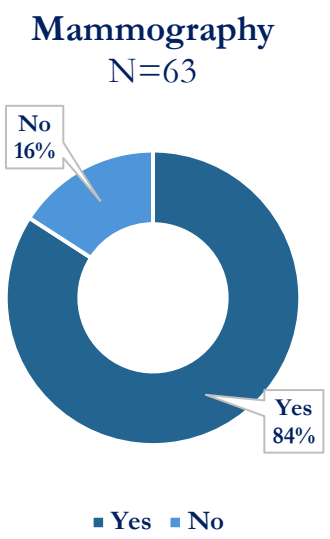



*Figure 29. Any Barriers to Breast Cancer Screening*

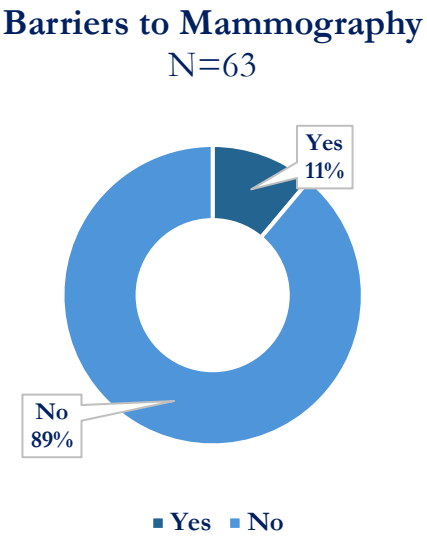
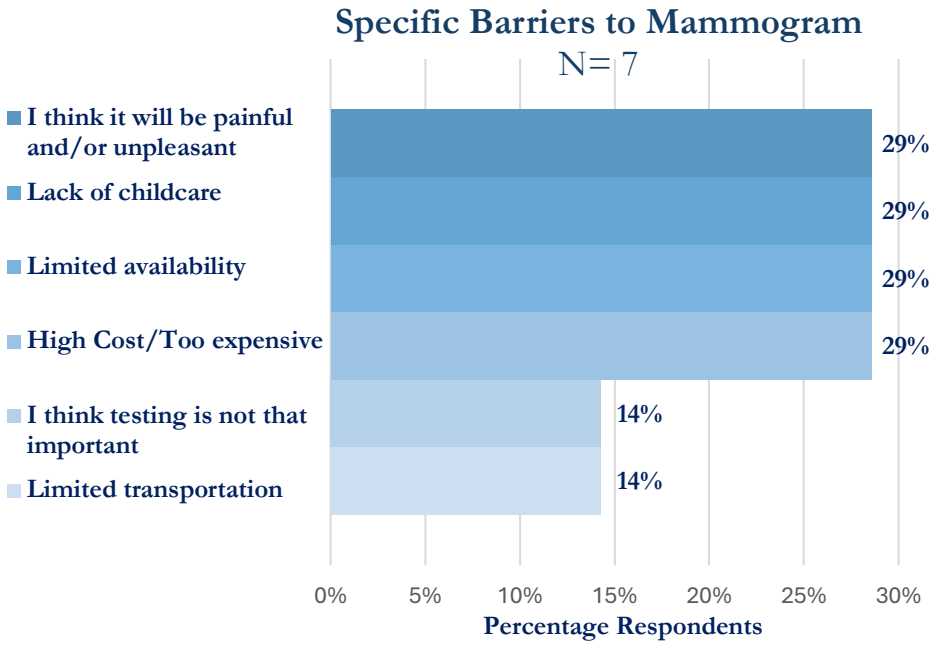



*Figure 30. Specific Barriers to Mammogram Screening*




*Note: Participants could choose more than one response option. Hence, percentages may not add up to 100.*

Over four out of five (83%) females over the age of 21 reported having received a pap smear in the last five years (Figure 31).

About one out of ten respondents (12%) reported facing barriers to getting a pap smear (Figure 32), with high cost (42%), limited availability (25%), and other reasons (25%) listed as the top three barriers (Figure 33).

*Figure 31. Cervical Cancer Screening*

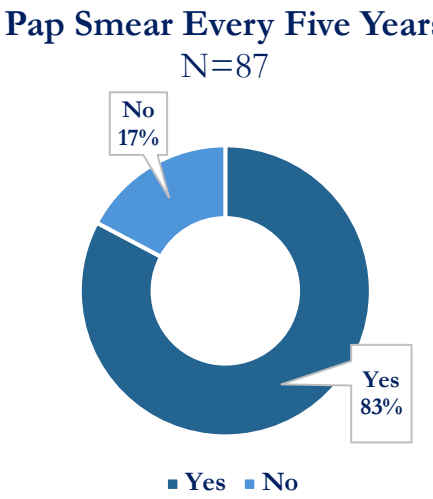



*Figure 32. Any Barriers to Cervical Cancer Screening*

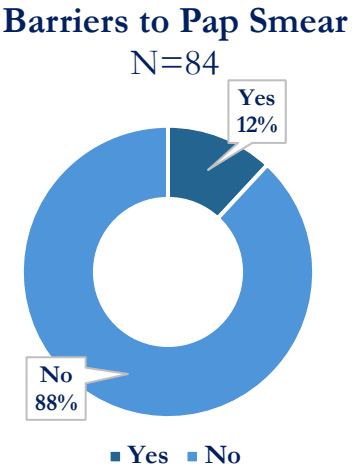
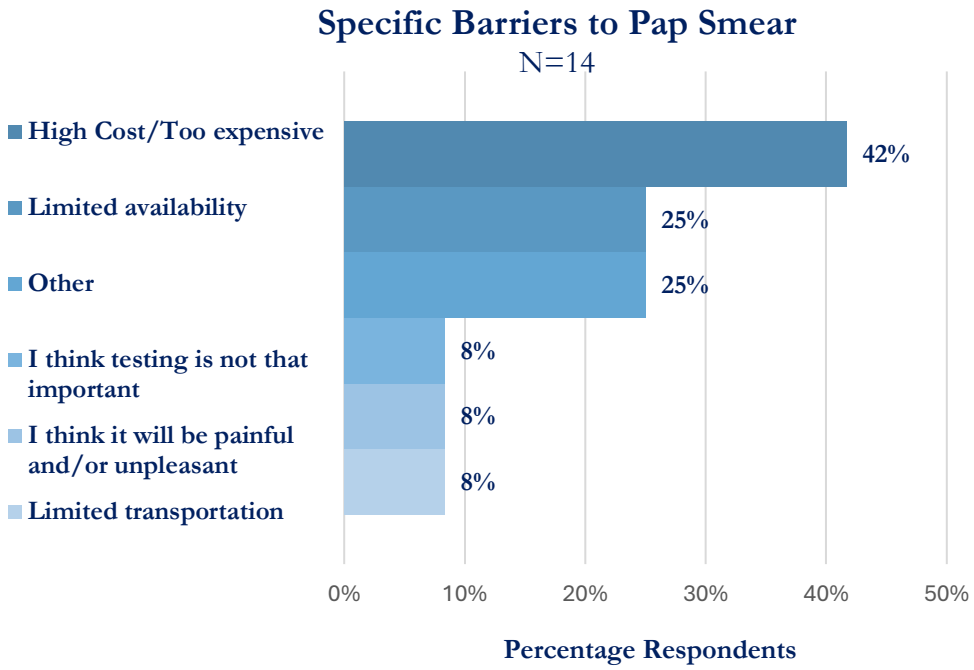



*Figure 33. Specific Barriers to Pap Smear*




*Note: Participants could choose more than one response option. Hence, percentages may not add up to 100.*

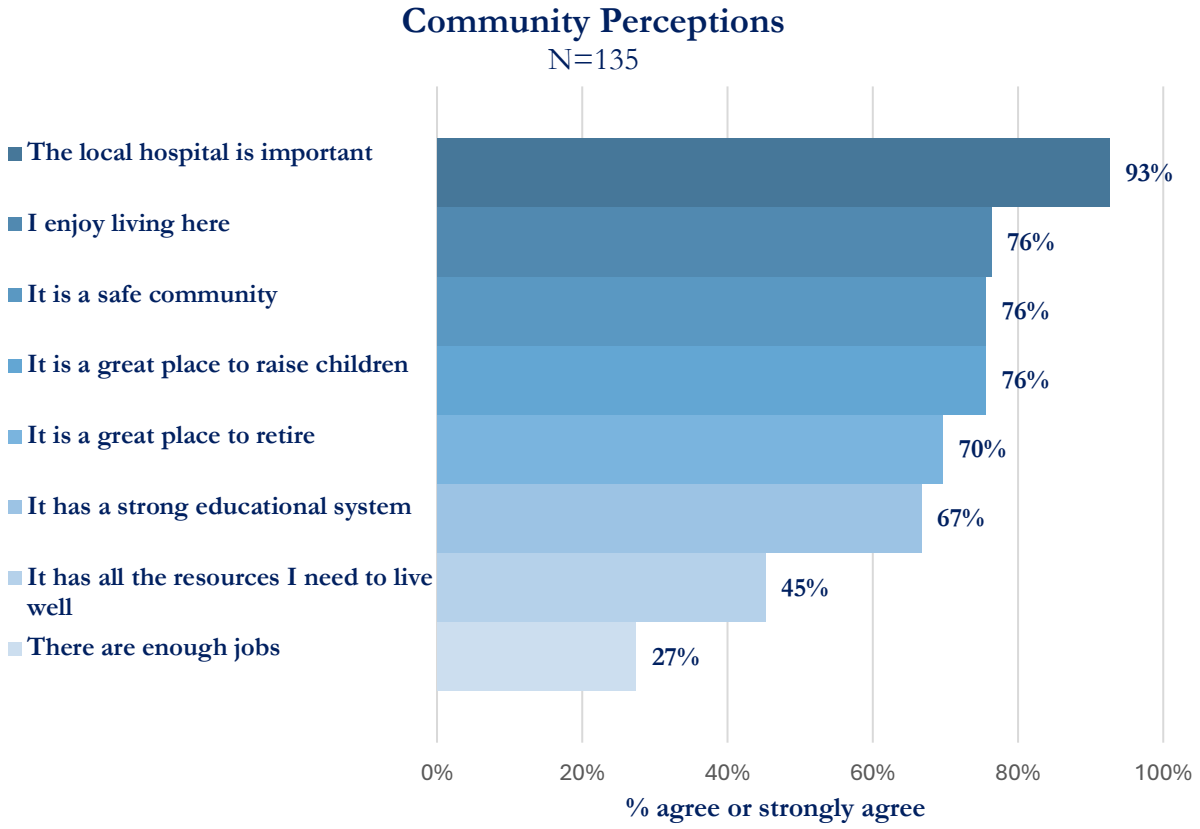
# *COMMUNITY PERCEPTION*

## *General Community Perception*

Respondents generally had a favorable view of the community, with the exception of availability of jobs and adequacy of resources.

Almost all (93%) of respondents agreed or strongly agreed that the local hospital is essential. More than seven out of ten respondents (76%) strongly agreed or agreed that they enjoy living in Clinch County, that the community is safe, and that it is a great place to raise children. Seven out of ten respondents agreed that the community is a great place to retire, and 67% felt the educational system was strong, but only 27% felt there were enough jobs (Figure 34).

*Figure 34. General Community Perceptions*



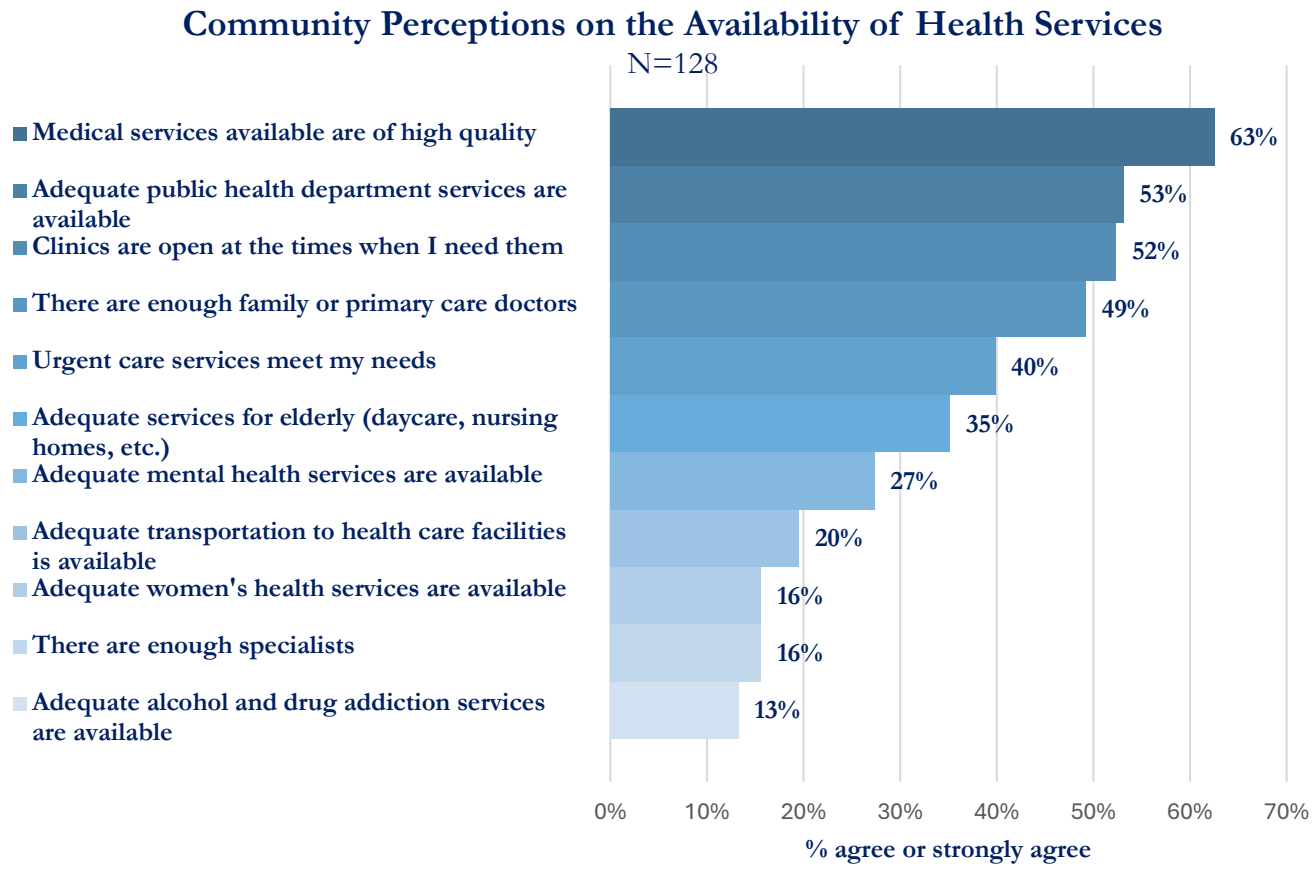

*Note: Participants could choose more than one response option. Hence, percentages may not add up to 100*.

## *Community Perception Concerning Health Care Services*

Sixty-three percent of respondents felt medical services were of high quality, as were public health services (53%). More than half of respondents (52%) felt that clinics were open when needed.

Adequacy of services for the elderly (35%), for mental health (27%), for transportation to medical appointments (20%), for women's health (16%), for specialists (16%), and for drug and alcohol addiction (13%) were viewed most unfavorably. (Figure 35).

*Figure 35. Community Perceptions Concerning Health Care Services*




*Note: Participants could choose more than one response option. Hence, percentages may not add up to 100.*

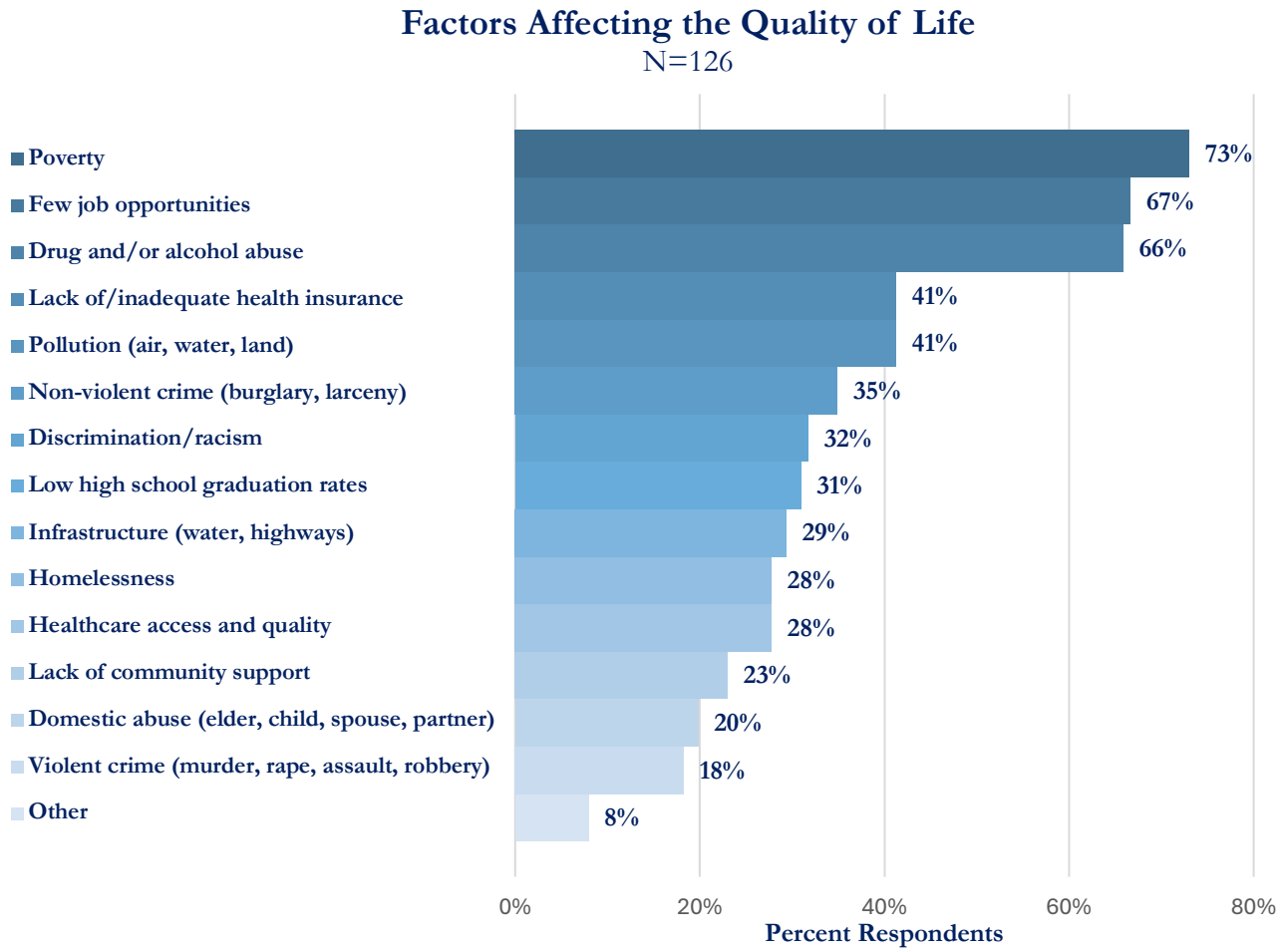
## *Community Perceptions Concerning Health and Quality of Life*

Seven out of ten of the respondents (73%) identified poverty as the most significant factor affecting the quality of life in the community, followed by inadequate job opportunities (67%) and drug and /or alcohol abuse (66%).

Lack of or inadequate health insurance (41%), pollution (41%), and non-violent crime (35%) formed a second tier of factors impacting community life (Figure 36).

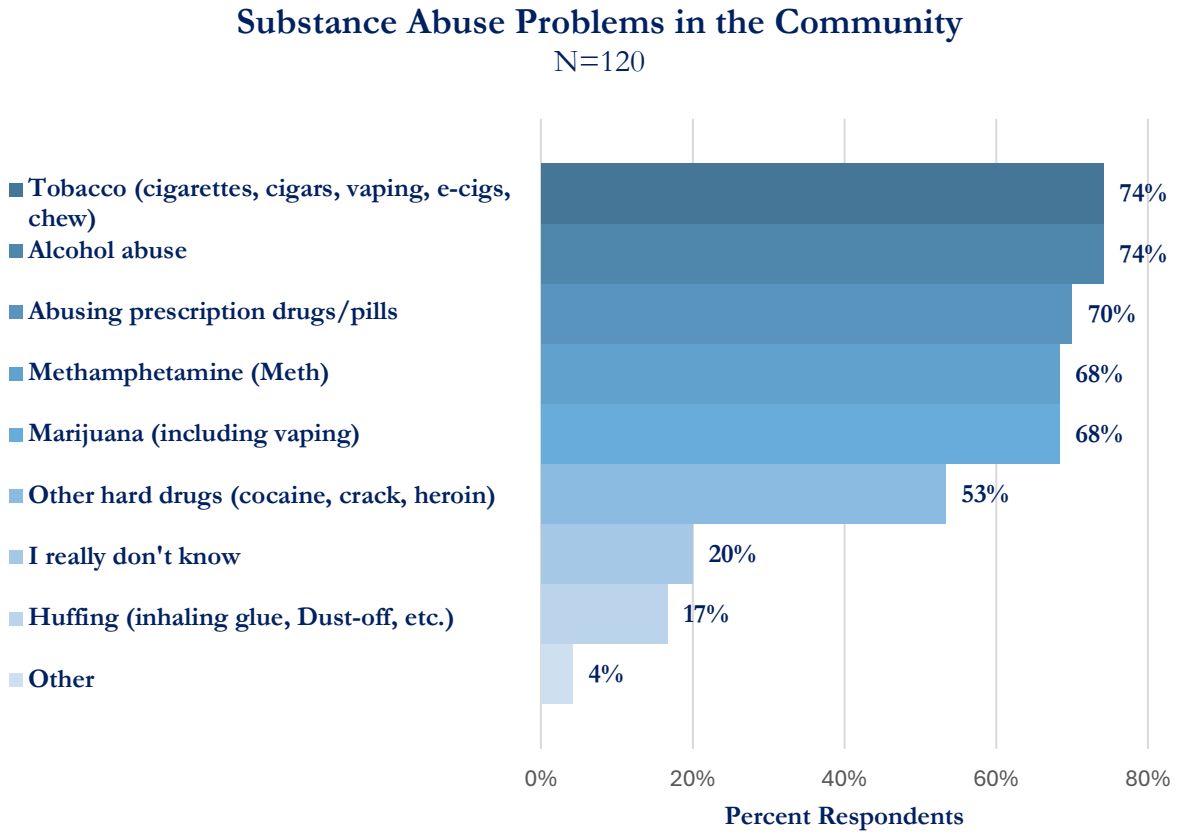
Concerning substance abuse in the community, tobacco and alcohol each (74%) were identified as the most commonly abused substance, followed by prescription drugs/pills (70%), with methamphetamine and marijuana (68%) also being identified as issues for the community (Figure 37).

*Figure 36. Perceptions Concerning Factors Affecting the Quality of Life in the Community*




*Note: Participants could choose more than one response option. Hence, percentages may not add up to 100.*

*Figure 37. Substance Abuse Problems*



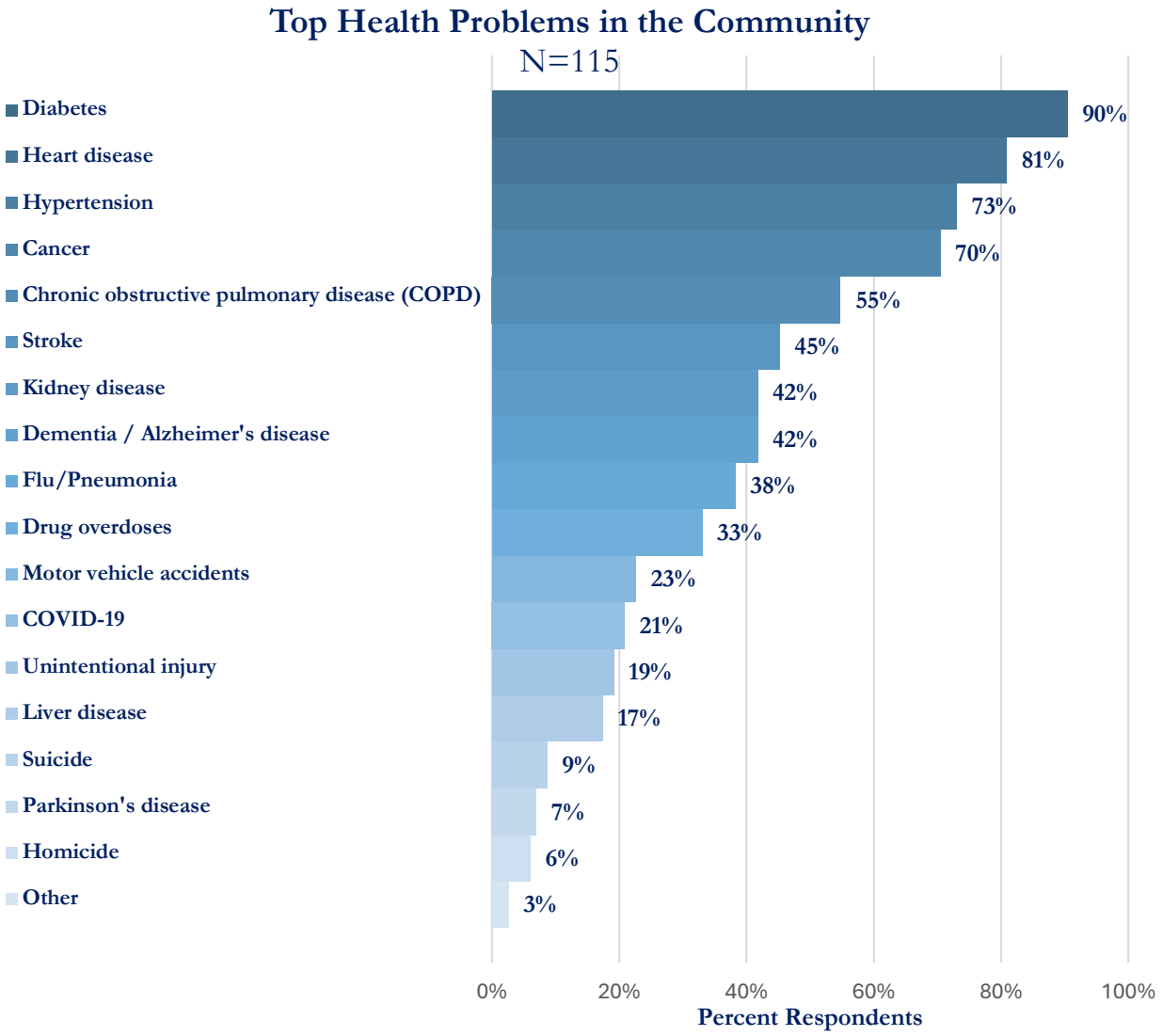

*Note: Participants could choose more than one response option. Hence, percentages may not add up to 100.*

## *Community Perceptions Concerning Mortality & Morbidity*

Diabetes (90%), heart disease (81%), hypertension (73%), and cancer (70%) were identified by the survey respondents as the top causes of poor health in the community.

Chronic obstructive pulmonary disease (COPD) (55%), stroke (45%), kidney disease (42%), and dementia/Alzheimer's (42%) formed a second tier of reported factors (Figure 38).

*Figure 38.Main Health Problems in the Community*



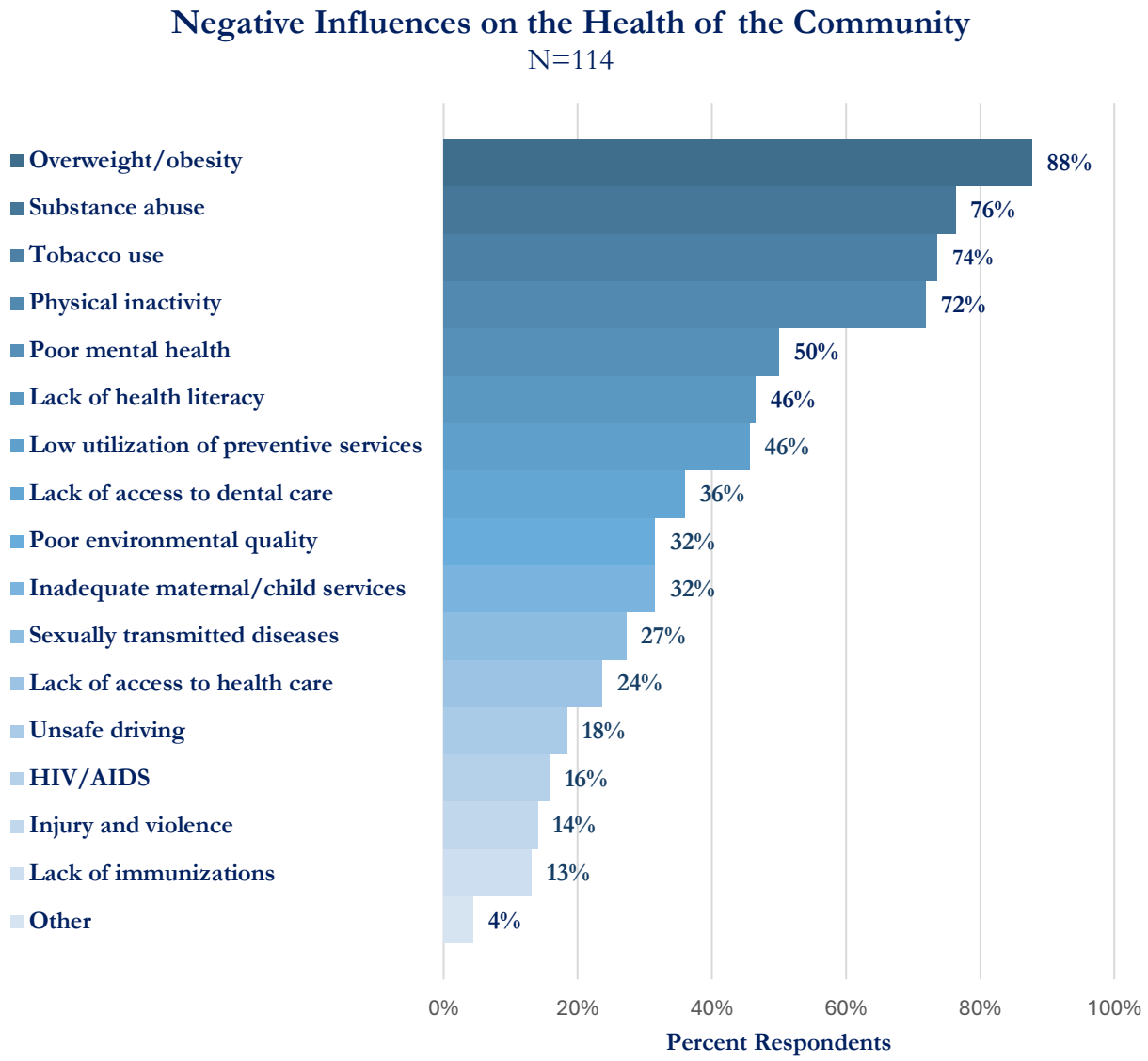

*Note: Participants could choose more than one response option. Hence, percentages do not add up to 100.*

## *Negative Influencers of Health*

Obesity/overweight (88%), substance abuse (76%), tobacco use (74%), and physical inactivity (72%) were identified as the top negative influences on health in the community for adults. Poor mental health (50%), and lack of health literacy (46%), and low utilization of preventive services (46%) formed a second tier of significant negative factors on the health of community members. (Figure 39).

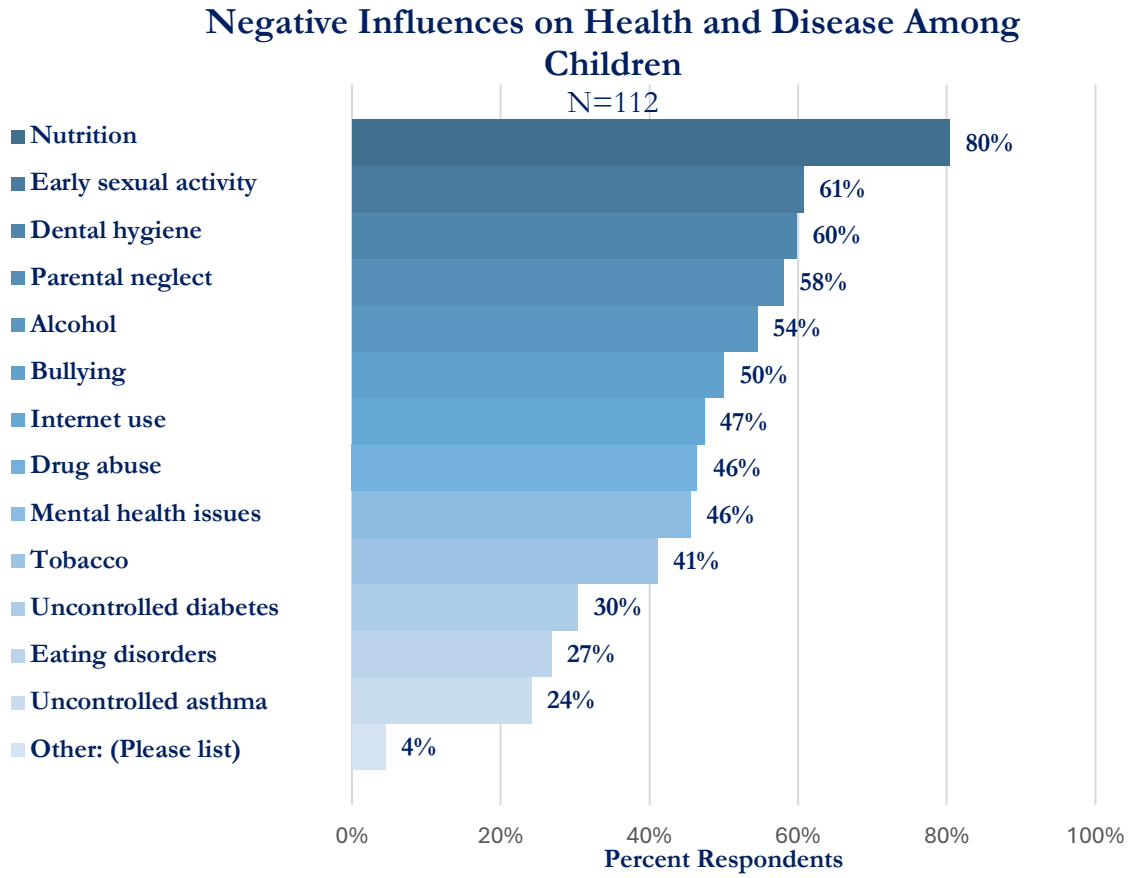
Nutrition (80%), early sexual activity (61%), dental hygiene (60%), and parental neglect (58%) were identified as the top negative influences on children's health (Figure 40).

*Figure 39. Negative Influencers of Community Health*




*Note: Participants could choose more than one response option. Hence, percentages do not add up to 100.*

*Figure 40. Negative Influencers of Children's Health*




*Note: Participants could choose more than one response option. Hence, percentages do not add up to 100.*

# *HEALTH CARE ACCESS*

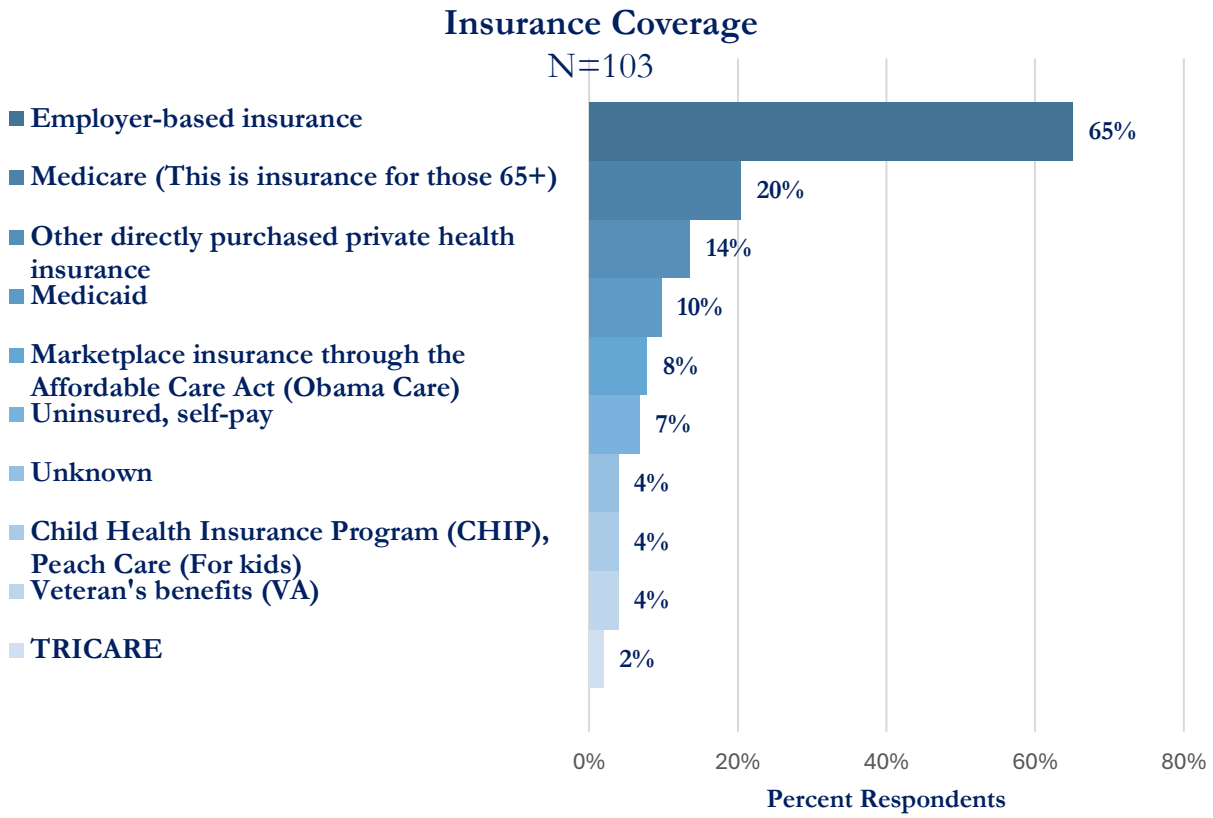
***Insurance Coverage and Usual Source of Care***

Nearly two-thirds of respondents (65%) reported that they had employer-based insurance. One-fifth of respondents (20%) were covered by Medicaid, and fourteen percent were covered through other directly purchased private health insurance. Only 10% reported having Medicare, reflecting the younger survey population (Figure 41).

Most respondents (79%) reported that their usual source of care was a provider in a doctor's office setting. A significantly lower percentage of respondents (6%) identified that they do not receive health care when sick. Similar responses were received as sources of care from the local emergency room, local urgent care center, and non-local hospital. (Figure 42).

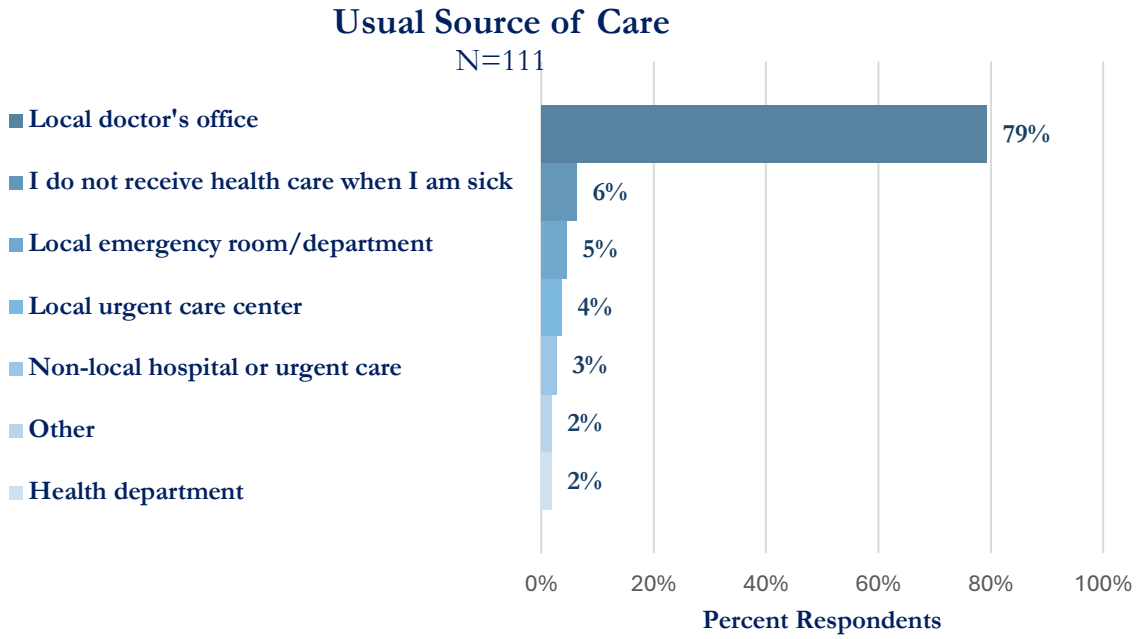
Respondents most frequently identified their health care provider (doctor/nurse) as their source of health information (93%), followed by the hospital (49%), pharmacist (44%), internet (36%), and friends and family (34%). (Figure 43).

*Figure 41. Insurance Coverage*



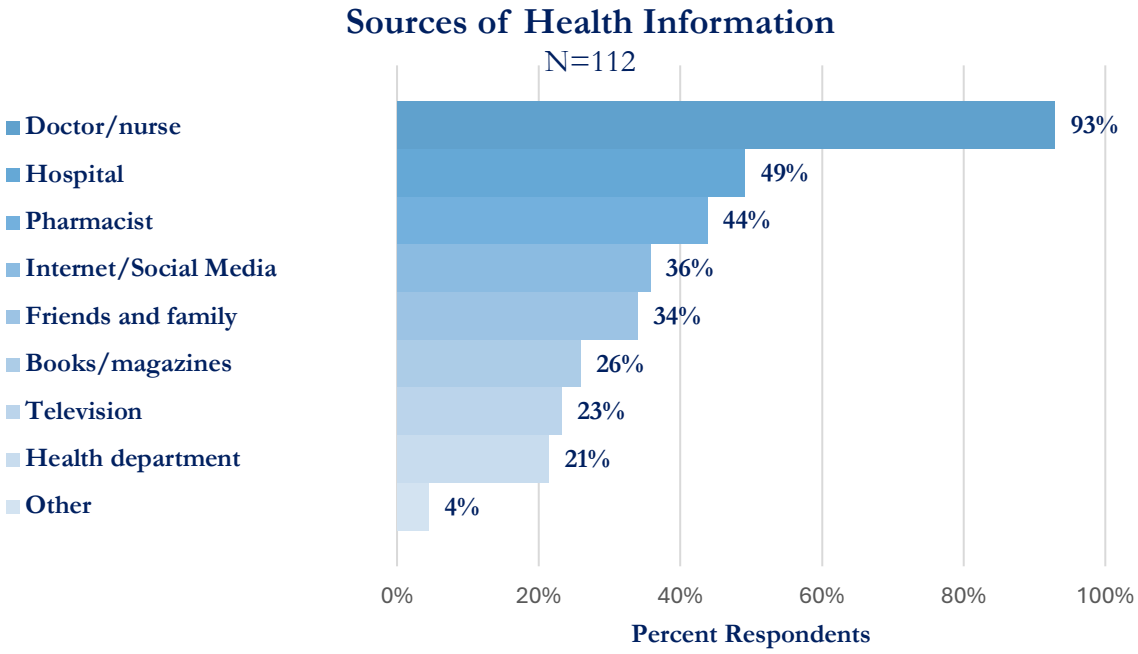

*Note: Participants could choose more than one response option. Hence, percentages do not add up to 100.*

*Figure 42. Usual Source of Care*




*Note: Participants could choose more than one response option. Hence, percentages do not add up to 100.*

*Figure 43. Sources of Health Information*




*Note: Participants could choose more than one response option. Hence, percentages do not add up to 100.*

## *Barriers to Healthcare Access*

Only 15% of respondents reported experiencing barriers to accessing healthcare in the past 12 months (Figure 44). Barriers most frequently mentioned were predominantly cost-related: high deductibles/copays (68%), limited insurance coverage (58%), and either no insurance or Medicaid not taken by a healthcare provider (37%) (Figure 45).

*Figure 44. Barriers to Healthcare Access*

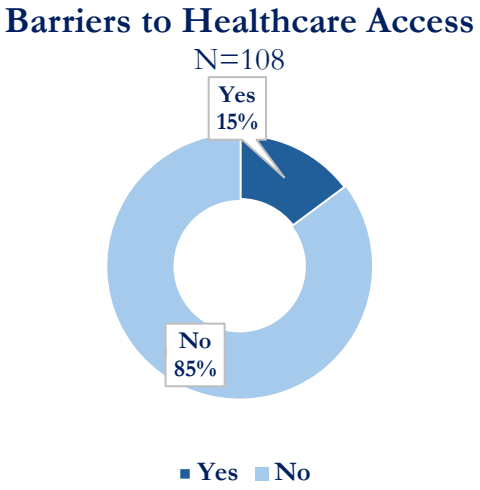
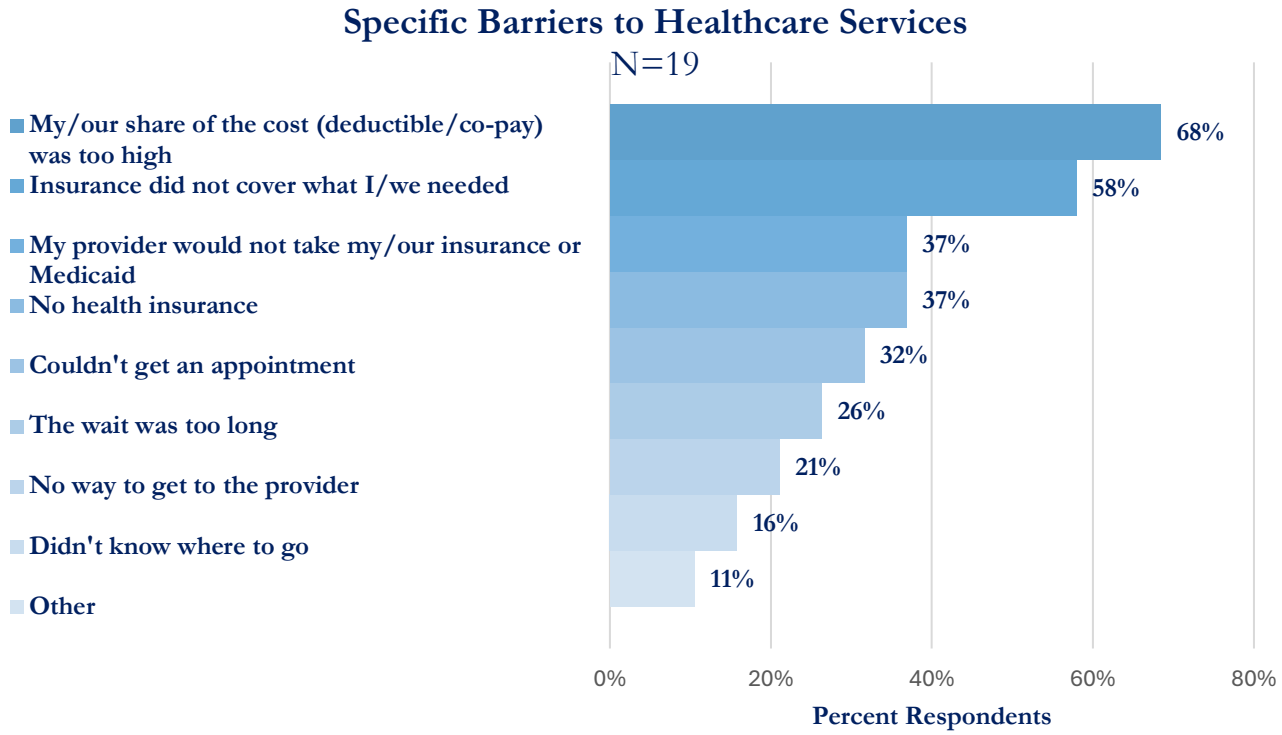



*Figure 45. Specific Barriers to Healthcare Access*




*Note: Participants could choose more than one response option. Hence, percentages do not add up to 100.*

## *Health Specialists*

Over three-fourths of the respondents (77%) felt that there are not enough health specialists in Clinch County (Figure 46). Pediatrics was reported as the most needed health specialty (84%), followed by cardiology (78%) and orthopedics (61%) (Figure 47).

*Figure 46. Shortage of Health Specialists*

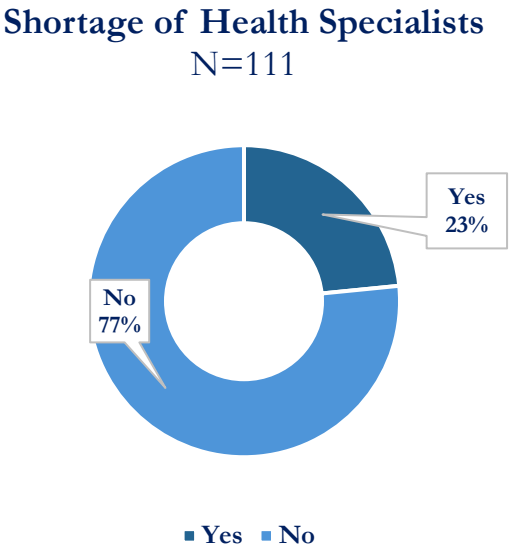
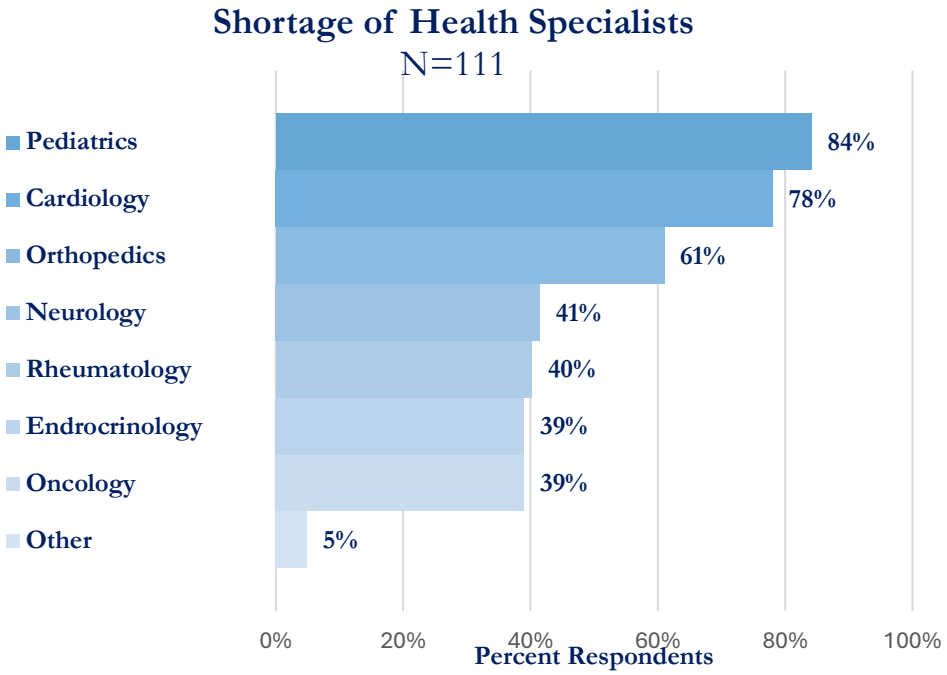



*Figure 47. Most Needed Specialties*




*Note: Participants could choose more than one response option. Hence, percentages do not add up to 100.*

## *SUMMARY POINTS FROM THE COMMUNITY SURVEY*

Survey respondents were more likely to be female, white, young, and have more years of education than the general population of Clinch County.

### Health Status and Behavior

- The most common chronic conditions that the participants reported having include high blood pressure, obesity, and high cholesterol.
- Reported adherence to nutrition and physical activity guidelines was limited among respondents.
- Reported adherence to cancer screening guidelines was generally high among participants, except for prostate cancer screening.

### Perceptions about the Community and Community Health

- Respondents had a very favorable view of the community but perceived some shortfalls in availability of transportation to healthcare appointments, services for the elderly, mental health services, women's health services, and drug and alcohol addiction treatment.
- Respondents identified poverty, insufficient job opportunities, and drug/alcohol abuse as the most significant factors affecting the quality of life in the community.
- Diabetes, heart disease, hypertension, and cancer were perceived to be the top causes of illness and death in the community.
- Overweight/obesity, substance abuse, tobacco use, and physical inactivity were identified as the top negative influences on adult health.
- Nutrition, early sexual activity, and dental hygiene emerged as the top three negative health influences among children.
- Pediatrics, cardiology, and orthopedics were viewed as the specialties with the most significant provider shortages.

# FOCUS GROUPS

## *PARTICIPANT CHARACTERISTICS*

Four focus groups of key stakeholders were held in February 2025, with a total of fifteen participants representing various vital aspects of the community. Participants included community stakeholders with roles such as emergency services providers, healthcare providers, public health professionals, and hospital board members.

## *EMERGING THEMES*

Focus group discussions are summarized below, organized by emerging themes.

**Community Perception Overall**

Overall, participants described their community as caring, close-knit, and safe. The participants also expressed that residents are community-oriented and hard-working. The county's strong health system was also emphasized.

*"I would say that it's a small community, which I prefer. Most people know each other or know somebody who knows somebody, and people tend to care about each other, seem to have some hardworking people here and people that want to make the community stronger and better."*

*"I love the small-town feel. We're a very close-knit community. We love each other and take care of each other, especially in times of tragedy and crisis. Just the feel of the small town is wonderful."*

*"There's two traffic signals in the town. If you count flashing lights, that might be three or four. It's the speed I'm looking for. I would emphasize folks coming to check on you. That is a guarantee that's going to happen. It's an all-volunteer fire department. Folks want to know you're okay. Now, they'll talk about you at church…"*

**STRENGTHS: Strong Education System, Hospital as a Great Resource, Cost of Living**

The participants highlighted several favorable conditions that speak of the benefits of living in Clinch County, including a **strong school system** and **overall low cost of living in the community**. The **multitude of services** offered by the hospital and healthcare providers were also commended by participants.

*"We do have a good **school system**, and we have a good hospital system."*

*"I think for our size **hospital**, we have really good resources and we use them. It's not like there's an issue of "I wouldn't go to this hospital. We use the hospital."*

*"In my position, it also has been a huge help that we have a **local hospital** to be able to attract folks to come here and start even small business, but especially for industry, it's been enormous to have that as an asset where they would not necessarily look at Clinch County if we did not have that resource available to us. They added value to other economic drivers as well."*

## CHALLENGES: Poverty, Transportation, Limited Housing

In addition to the positive aspects of the community, participants also commented on challenges within the community. **Poverty** was a key area of concern, as highlighted by low household incomes and limited job opportunities in the community. A consistent theme within all focus groups was **the lack of emergency services and lack of transportation.**

*"Being a rural county, and I do think there's quite a bit of **economic need** for people in our county. We do have several manufacturing businesses, but I still think there's probably a need for more jobs. I know that there's a need for more housing. That's a disadvantage that we have right now is there not a lot of housing opportunities for people to move into our community. For not only our hospital, but the two manufacturing businesses, a lot of people commute to Homerville to work, and I feel like if we had more housing and maybe some additional opportunities for their spouse to work, that perhaps more people would live here. We do have a good school system, and we have a good hospital system."*

*"Our median income is around $26,000 to $27,000 per household. It is quite difficult. We have lots of people who are on social programs that helps make that be met, whether that be through SNAP, through Medicaid, Medicare. Because we have an elderly population, it is a **economically depressed area**, just for sense of the population that lives here. That sounds depressing. It really is a great town. That's just the nature of where we live."*

*"We're a very **highly impoverished community**. I think our economic basis really stems from industry. Then in our county seat in Homerville, that's where you see a little bit more economic development going on. In our sister cities, they're further spread out. Also, we're the third-largest county in the state. We're so rural because of the swamp and because of the timber. It's very impoverished. We're well below what the minimum standard would be for the state in economic development."*

*There's no **public transportation**."*

*"We have GPs, and we live in a poor community. If you need glasses, if you need to go see …any orthodontist, anything specialized, you're going to have to leave the community. If you don't have **transportation**, that's going to be a really big problem."*

**Health Related Community Characteristics**

**Themes: Chronic Conditions, Unhealthy Nutrition, Limited Opportunities for Physical Activity, Health Literacy**

Participants emphasized the **high burden of chronic conditions** in their community, mainly due to a **lack of healthy nutrition and physical inactivity**. Healthy nutrition is challenging due to limited options to buy fresh food, a lack of healthy dining spaces, and overall preferences for fried food. Furthermore, the county has **limited resources** and access for residents to engage in physical activity. Focus group participants also pointed out a struggle regarding **health education/literacy** and how to educate the community enough to prioritize their health. Similarly, they highlighted the need for more health education overall and community interventions to address these health needs, with a particular focus on introducing healthy food options to children.

*"There's no **healthy options for lunch** like if you needed to go.*

*"We live in the stroke belt …It goes through the state. High rate **of type two diabetes**, which is caused probably from lack of fresh fruits and vegetables that they don't have access to. We have one grocery store and one Dollar General market, so if either one of those were to close, we would become a food desert. That can definitely affect your health."*

*"Also in Homerville, we have one grocery store. Going back to the economic side, **healthy food** is expensive…For people trying to eat a little healthier, and with the economic status of our community, it's hard for people to afford to be able to eat healthy that stay in our community."*

*"In looking at our health outcomes through the years, we have, as a county, always rated high in obesity and poor health care. I recently taught a **nutrition** course at the high school and I was amazed at a room full of kids and talking about what do you consider a healthy diet, they didn't have a clue. When you think of we live in South Georgia, where fried food is the number one food choice. If you even think of what we have available in our community, it's mostly fried food."*

*"… If you ask a kid, "Do you eat squash?" They're going to say, "No, I don't like squash." "Have you ever eaten it?" "No." "Why haven't you?" "My mama doesn't cook it," or carrots or apples or whatever. You fill in the blank. Sometimes kids say they don't like things because their parents don't buy it or they just don't like it."*

*"… We do have the **WIC program** that's offered through the health department. I think y'all would be surprised at the numbers that the local health department serves from birth up to five years of age. It is like a well-child visit every time they come.*

*"We have seen children that we're concerned about even weekly. There is home visits that are done as many times as needed. There's lots of nutrition education, making sure that by the time these children are ready to go to school, that they are healthier children."*

***"…**if you want to go to a nicer **gym**, you have to drive at least 40 minutes, I'd say, which can be difficult."*

*"That's where I think it's important that for older adults that we have **activities,** which I think we're really lacking in. Zumba and some of those-- what's the-- silver sneakers, those kind of activities for 60 and above."*

*"At some point, you have to **take ownership of your own health** and your own well-being. There's that fine line thereof, I think for us to have an adult healthy lifestyle, it starts as how we were raised, how we ate as children. Those create habits. This is how my mama cooked..."*

**Healthcare Related Community Characteristics**

**Themes: Lack of Specialty Health Services, Mental Health, Health Insurance, Shortage of Health Professionals, Transportation**

Key healthcare needs discussed were **access to specialists, dialysis services and mental health**. Participants also mentioned lack of (or inadequate) **health insurance** as contributing to poorer health outcomes within the community. Despite feeling that the hospital and access to general practitioners were strengths, these items, along with difficulties with medical transportation, were thought to be issues negatively impacting the county's healthcare.

*"… while we have general practitioners in our community, we do not have **specialists** that can really pinpoint these types of health issues that we've talked about with relationship to more internists, with those types of issues with endocrinologists, things like that."*

*"Even if there could be **dialysis** one or two days a week, that might help people. I don't know. I think there are more people on dialysis probably than I realize.*

***"**I think there's 20-something [in dialysis in the county]. [ ] gets up at 4:30 in the morning and drives up there. If you could just get like one day a week, like you say, just to give her that little bit of time to rest in between, would be great because she's so weak when she needs **dialysis**. She just can't drive, and sometimes she has to sit there forever before she gets to come home."*

*"I think we would be remiss not to talk about **mental health**. There is a very strong mental health crisis in this community and it is what really pushes other factors. Whether it's obesity or drug use, or not wanting to better yourself from whatever, we definitely are not hitting the mark with mental health resources here. We do have Unison, but they're only able to do as much as they're able to do. There's a ton of stuff, I think, that stems specifically from that."*

*Yes, physical health is absolutely important, but if your mind has got holes like Swiss cheese, then we have bigger fish to fry than whether or not you're overweight because we can't get to the root of whatever. It would be nice to see more in mental health resources here. Certainly, just like I said, we have a huge epidemic with-- the opioid crisis, I think, is getting more and more limited, but we do have a lot of people who use **recreational drugs** on the regular, that **abuse prescription medications**."*

*"…We've tried to implement some different things. I think there has to be better networking amongst the medical community and the behavioral health side, mental health side to make those resources available... Sadly, I didn't even think about the mental health side because we've been focused on the physical side for much of the conversation…**Mental health** plays a role in the physical health…"*

*"…One thing that I think that I see that's a huge struggle in Clinch County is the lack of awareness, the lack of understanding of what Unison really does. People just associate **mental health** with being crazy. I'm being serious when I say that. They don't want that stigma attached to them. Mental health is more than that label. Parents don't want their children associated with that."*

*"…There's a segment of the population who probably don't have [insurance]. We're not able to offer it. I think the cost of it, one of the things that I would see for the small business we have, I would love to be able to offer-- I'd love to be able to offer **insurance** to my employees. To get involved in, a group policy for all of us, it's just outrageous. I wish there were a way that we could sort of find a middle ground, because I think that's important for employee retention and stuff, in a small community is to have small businesses be able to offer that. It's just really hard."*

*"That is a big problem with getting to healthcare. Once you get there, the healthcare's fine. You just got to get there.*

*"Because a lot of people are worried about their vital signs, and they'll come up to the ER to have them check or call 911. We only had one ambulance here with a 911 crew. That's something that we all like to see is a **second ambulance**, but it wouldn't be needed much. When it's needed, it's really needed."*

### Hospital's Role in Improving Community Health

**Themes: Ancillary Services, Screenings, Education, Swing Bed, Health Education**

Availability of **labs, screenings, radiology, swing bed, education**, and other services at the hospital was noted as a strength, and vital for the community.

*"We do have **physical therapy**, and we have **pulmonary therapy** or **respiratory therapy**. The **radiology** department does some scans and mammograms and things of that nature…"*

*"It is nice to have **primary care** physician here in Homerville, and then it's very nice to have the hospital. We're able to have blood tests and mammograms and other radiology needs met there. Then, if need[ed], we can go to the ER, and they will evaluate the situation and stabilize and then transport us, help us get, if we need to be at a larger hospital."*

*"I love the swing bed, the **swing bed** is wonderful for people who need to, that can't go home after having some type of like shoulder surgery or knee surgery or just need some transition help before they return home from complete hospital care to that. I think that's wonderful."*

*"Another service that the hospital provides is **community education sessions**. At least once a month, they'll have a session on some health-related topic, and the community is invited to come and listen and have a light supper, and that works very well."*

*"I think **education** could be another level of help. I know that the hospital has been doing some educational nights where they're doing different things, but maybe, I don't know. You can lead a horse to water, but you can't make him drink. I would also talk about healthy food choices, but they are more expensive, and they do take time."*

*"…they're planning on having like a… **health fair** where you come by, you can get blood pressure checks and things like that. There's already things in place that we're discussing where people can come and get some informal screenings and checks, and pick up some information. I think something like that is good. They're interested in doing stuff like that. Those, the little health fairs, because a lot of times I think people just don't-- I'm aware of my blood pressure, because my people have high blood pressure. I don't take any medication for it. Stuff like that, where people have an opportunity just to get free screenings for things like that would be, that's a good thing."*

*"Offhand, just off the top of my mind, they do a pretty good job. We have a CNA class here at the school where, we're partnered with a college, but, they'll come in every now and then. They'll do some rounds at the hospitals as far as just observing and just helping out with some things later on. There's some tie-in there with school that creates a great relationship between the school and the hospital."*

**Health-Specific Wishlist Items and Strategies for Improvement**

**Themes: Specialty services, Medical Transportation, Fitness Opportunities**

Focus group participants talked about the need to **expand on specialty services** such as dialysis, pediatrics, and cardiology. Furthermore, due to its impact on health outcomes, there is a need to improve **public transportation**, as many community residents may use it to get access to healthcare services. Finally, participants mentioned the need to add more resources to engage in physical activity.

*"I would like to be able to see in our community at least a **cardiologist**. I think once again, I'd like to see a **dialysis center** in this area. I would like to have access to a cardiologist here at the hospital. We have so many patients with cardiovascular disease and maybe an orthopedic or pulmonary rehabilitation. We've got that now. Just trying to think of the-- because that I go to on the ambulance the most. It's mostly just people with pain like orthopedic specialists. Then dialysis is another. Then… the ER. Maybe having a provider in there that's a doctor as well."*

*"I've made a note to really begin to explore the **dialysis**, and I'm sure that's expensive. Even if there could be dialysis one or two days a week, that might help people. I don't know. I think there are more people on dialysis probably than I realize."*

*"We don't have a **pediatrician**. I think that's a top need and a top issue that could be maybe be addressed in three years."*

*"I see some sort of **transportation**, maybe some little shuttle type deal that will get patients around here to the dentist or to the hospital for their labs and then take them back over to our long-term health care places. That would free up the 911 ambulance once again. We really need that ambulance to be on emergency calls only, and if we could have some sort of non-emergency transportation to get those and take them from the hospital back over to that place and maybe possibly go get them because there's no need in calling 911 and making the ambulance run lapses and sirens for critical labs that they drew two or three days ago and they just got the results and they used the ambulance for that. I'd just like to see that ambulance really doing what it's supposed to do."*

*"Some sort of **exercise gym** that would be open to the public, maybe, or some kind of a monthly fee. Just have a real nice gym here so people can exercise. That's just for me and my family. We wouldn't have to travel so far to exercise. It would help the overall health of the community."*

## *SUMMARY POINTS FROM THE FOCUS GROUPS*

Fifteen community stakeholders participated in the community focus groups. Participants discussed barriers and facilitators to health and well-being within the Clinch County community.

### Perceptions about Community and Community Health

- Clinch County is caring and close-knit, where the community members feel safe and support each other, and faith plays a strong role.
- Clinch County residents are community-oriented and hard-working.
- The health system is strong, with multiple services offered by the hospital and healthcare providers. However, emergency services and availability of medical transportation were noted as shortfalls.
- A strong school system and overall low cost of living in the community are key points of strength for the community.
- Low household income and limited job opportunities are challenges for the community.

### Perceptions about Health and Healthcare

- A burden of chronic conditions exists, mainly due to a lack of healthy nutrition and physical inactivity further exacerbated by limited fresh food and a lack of healthy dining options.
- Health literacy and lack of knowledge of services, as well as lack of good insurance, contribute to worsened health outcomes within the community.
- Despite the strong health system and general practitioners, a lack of services, combined with health insurance and affordability issues and transportation challenges for the large area served, create healthcare access challenges.
- There is a need for more specialty services in the community.
- Main health needs pointed out were dialysis and mental health.

### Hospital's Role in Advancing Community Health and Wellness

- Mental health needs outweigh available resources to meet those needs.
- Dialysis within the county is a real necessity.
- Substance use and the impact of unhealthy nutrition on chronic conditions are key concerns.

### Health-Specific Wish List Priorities

The following items stood out as services that focus group participants would wish for to improve the health of the community:

- Expansion of specialty services such as dialysis, pediatric care and cardiology
- Improved public transportation, as many community residents may use it to get access to healthcare services
- Additional resources that encourage increased physical activity.

# Summary of Data

The table below highlights areas of alignment in the findings by data source.

| AREA OF CONCERN | SECONDARY DATA | SURVEY | KEY STAKEHOLDER FOCUS GROUPS |
|---|---|---|---|
| Access | -Per capita supply of providers of all provider types lower than state<br>-Preventable Medicare hospital stays higher than state | -Access issues noted in: insurance, transportation, mental health, drug/alcohol addiction, women's health<br>-Top specialist shortages: pediatrics, cardiology, orthopedics | -Medical transportation noted as a key need.<br>-Insurance seen as a contributor to insufficient healthcare access.<br>-Pediatrics, cardiology and dialysis noted as needs |
| Cancer | -Similar prevalence to state<br>-Lung cancer #4 cause of death<br>-Low mammography rates | -Prostate-Specific Antigen screening rates show room for improvement<br>-Cost was a key screening barrier, yet screening is usually covered by insurance | -Hospital-offered screening services were noted |
| Mental Health | -Very low mental health provider ratio<br>-Days of poor mental health in last 30 days lower than state | -Poor mental health rated 5th highest negative influencer of health<br>-Low availability of mental health services | -Mental health's fundamental role in overall health and its very high demand in the area for services were noted |
| Health Literacy | -Low high school graduation rate | -Ranked 6h highest negative influencer of health | -Noted as an issue, especially for nutrition |
| Nutrition | -High rate of obesity<br>-Food insecurity higher than state<br>-Diabetes and heart disease higher than state | -Obesity #2 and cholesterol #3 chronic conditions<br>-Nutrition identified as top adolescent health issue<br>-62% don't eat enough fruits and vegetables | -Inadequate access to healthy food in grocery stores and in restaurants frequently mentioned in focus groups |
| Lack of Adequate Physical Activity | -Obesity and inactivity worse than state<br>-Low access to exercise opportunities<br>-High heart disease rates | -Obesity 1st and physical activity 4th highest negative influencers of health<br>-44% don't get recommended level of physical activity | -Inadequacy of fitness venues, especially for women, and lack of group classes were concerns |
| Tobacco, Alcohol, Drug Abuse | -Higher tobacco usage than state<br>-Alcohol related Motor Vehicle Accidents higher than state | -Tobacco, alcohol, and substance abuse highly ranked as factors affecting health and quality of life<br>-Low availability of addiction treatment services | -Abuse of recreational drugs and prescription medicines noted as an issue, especially in conjunction with mental health |
| Adolescent Behavior | -High teen pregnancy rates<br>-Low high school graduation rates<br>-Low rate of 3–4-year-old children in school | -Nutrition, early sexual activity, and dental care identified as top 3 health needs for children | Nutrition education seen as lacking in school |

# Issue Prioritization

## PREVIOUS IMPLEMENTATION PLAN

Clinch Memorial Hospital's 2022 Implementation Plan centered on four community-centered Initiatives that were prioritized as significant issues where the hospital could have a meaningful impact: 1. Health Behaviors; 2. Teen Health; 3. Preventive Screenings; and 4. Mental Health.

**Health Behaviors:**
In the spring of 2023, Clinch Memorial launched a Mobile Food Market, funded by a Healthy Food Financing Initiative grant. This market traveled quarterly to Clinch County's most food-insecure communities, including Fargo, Georgia, Pea Ridge, DuPont, and Argyle, which are miles away from the nearest grocery store. Over 120 mobile food market stops occurred, offering products from 20 Georgia farmers. The grant ended in the winter of 2023. Analysis of community feedback and of the Mobile Market's operating margins, led Clinch Memorial Hospital to stop its operations. Clinch Memorial Hospital continues to sell farm produce to employees and to the community in its cafeteria when possible, and the hospital operates a community pantry for citizens in need of food or essential supplies.

In the summer of 2024, Clinch Memorial Hospital launched the "BeFit" Program, selecting ten employees for a healthy eating and weight loss initiative. This program included one free healthy meal for participants. Additionally, all employees could purchase clean, healthy meals. In the fall of 2023, Clinch Memorial Family Practice launched a social media campaign featuring healthy recipes, reaching a total of 538 users. Fifteen social media announcements were posted pertaining to healthy eating. Additionally, Clinch Memorial Hospital hosted 3 Tuesday Night Talks that focused on diabetes and nutrition, with attendance of 10-15 per session. Weekly exercise sessions occurred from June 3 to Aug 19, 2024.

**Teen Health:**
Following discussions with the school administration, Clinch Memorial Hospital was informed that safe sex education is already provided to the students.

**Preventive Screenings**:
In the summer and fall of 2024, Clinch Memorial Hospital extended its hours for mammograms. The hospital also established a Mammogram Fund to provide free mammograms to community members. This opportunity was advertised at events including a 2023 Breast Cancer Awareness Tuesday Night Talk. Since 2022, Clinch Memorial has funded 41 mammograms with this fund. Clinch Memorial Hospital purchased a new x-ray system with Rural Hospital Stabilization Funds. Promoting this enhanced system has increased trust from the community and referral partners, leading to greater use of radiology services, including cancer screenings.

**Mental Health:**
Clinch Memorial Family Practice expanded its Medication Assisted Treatment (MAT) Program to help patients recover from certain substance abuse disorders. Recognizing that those struggling with addiction often face mental health crises, the practice provides a list of mental health resources to MAT Program patients and any patient in need. This resource list is available on the family practice website and in physical copies at the clinic.

# 2025 PRIORITIZATION OF INITIATIVES

The 2025 Implementation Plan prioritization session occurred remotely on May 7, 2025. A steering committee including hospital employees, board members, business representation, and a health department representative participated in the planning session. The session was facilitated by members of the CPHPR of Georgia Southern University. Jennifer McDonald, Nurse Manager at Clinch County Health Department, participated. The following priorities were developed in this session after reviewing the secondary data, survey results, and focus group findings in this report, after considering feasibility and impact of initiatives.

PRIORITY AREA ONE: ACCESS

GOAL 1: To decrease the proportion of uninsured residents in Clinch County

OBJECTIVES:

- Increase awareness of affordable insurance options for the currently uninsured

GOAL 2: Improve ability of residents to attain needed healthcare

OBJECTIVES:

- Provide transportation to healthcare appointments for those in need
- Explore options to increase telehealth to reduce residents' need for traveling

PRIORITY AREA TWO: Preventive Screenings

GOAL: Improve Rates of Preventive Screenings

OBJECTIVES:

- Promote Prostate, Colorectal, and Breast Cancer Screening

PRIORITY AREA THREE: Mental Health

GOAL: Enhance area mental health services, including drug and alcohol counseling

OBJECTIVES:

- Increase awareness of existing mental health services by 2027
- Offer new mental health and addiction resources to the community

PRIORITY AREA FOUR: Community Health Systems Strengthening

GOAL: Assess and address root causes of the county's most pressing health problems

OBJECTIVES:

- Initiate a "Healthy Clinch Collaborative"

# Implementation Plan

## PRIORITY AREA 1: Access

| Goal 1: To decrease the proportion of uninsured residents in Clinch County | | | | |
|---|---|---|---|---|
| Action Steps | Timeline | Person Responsible | Measure | Community Partners Involved |
| Objective 1: Increase awareness of affordable health insurance options through Madison St. | | | | |
| Collaborate with Madison St. Agency to develop a marketing campaign | Fall 2025 | Madison Pope<br>Kim Ratliff<br>Lily Blitch<br>Shalonda Lowe | # Ads<br># New Policies | Madison Street Agency<br>Local primary care practices |

| Goal 2: Connect residents to needed healthcare through transportation and telehealth | | | | |
|---|---|---|---|---|
| Action Steps | Timeline | Person Responsible | Measure | Community Partners Involved |
| Objective 1: Van Medical Transportation Services | | | | |
| Develop feasible operating policies | Fall 2025 | Angela Handley<br>Lily Blitch<br>Tony Walsh<br>George Johnson | Approval of policies | Clinch Senior Center<br>Goldstar EMS<br>Clinch County Government |
| Advertise van services | Fall 2025 | Lily Blitch<br>Patrick Anderson<br>Kylie Hatton | # Ads | Clinch County News<br>Local primary care practices<br>Local churches |
| Begin service | Fall 2025 | Lily Blitch<br>Tony Walsh | Track trips/miles | Clinch Senior Center<br>Goldstar EMS |
| Objective 2: Telehealth | | | | |
| Research regional telehealth partnerships to expand capabilities | Winter 2025 | Kellie Register<br>Christine Smith<br>Lily Blitch<br>Jami Lee Smith | Research findings complete | Southeastern Telehealth Center |
| Develop policies for use of telehealth equipment for Children's Healthcare of Atlanta | Spring 2026 | Kellie Register<br>Christine Smith<br>Billy Inman<br>Cheryl Lee<br>Lily Blitch | Policies in place<br>Usage (visits/hours) | Georgia Rural Health & Innovation Center<br>Mercer University School of Medicine<br>Children's Healthcare of Atlanta<br>Specialist Providers |

## PRIORITY AREA 2: Preventive Screenings

| Goal 1: Improve Rates of Preventive Screenings | | | | |
|---|---|---|---|---|
| Action Steps | Timeline | Person Responsible | Measure | Community Partners Involved |
| Objective 1: Promote Prostate, Colorectal, and Breast Cancer Screening beginning Fall 2025 | | | | |
| Revamp and continue social media campaigns | Fall 2025 | Lily Blitch<br>Patrick Anderson<br>Kylie Hatton<br>Rebecca Latham<br>Marsha Nelson | # impressions for each post (weekly posts) - three month campaign<br><br># of scheduled screenings in a three month period, if successful we will continue campaign and measurements | - CMH Radiology Dept & Staff<br>- CMH Laboratory Dept & Staff<br>- Clinch Senior Citizen Center |
| Promote Existing Men's Health Day – Free Lunch promotion for Men during the month of June on day of screening (TSA and Colorectal Screenings) | Summer 2026 | Lily Blitch<br>Patrick Anderson | # of screenings | - CMH Laboratory Department<br>- Clinch Senior Center<br>- Clinch Family Practice & local primary care practices |
| Create & Promote Women's Health Month Mammogram and Colorectal Screening Promotion – Free lunch for those who receive a screening | Fall 2025 | Lily Blitch<br>Patrick Anderson<br>Rebecca Latham | # of screenings | - CMH Radiology Dept & Staff<br>- CMH Laboratory Department |
| Host a Tuesday Night Talk regarding Mammogram and Colorectal Screenings – Offer screenings before and after the seminar | Fall 2025 | Lily Blitch<br>Patrick Anderson<br>Rebecca Latham | # of attendees | - CMH Radiology Dept & Staff<br>- CMH Laboratory Department |
| Inform/educate/encourage providers to build awareness | Fall 2025 | Lily Blitch<br>Patrick Anderson | # of providers contacted<br># of providers who attend health days | - Clinch Memorial Family Practice & local family medical practices |

## PRIORITY AREA 3: Mental Health

| Goal 1: Enhance services in the area for mental health, including drug and alcohol counseling | | | | |
|---|---|---|---|---|
| Action Steps | Timeline | Person Responsible | Measure | Community Partners Involved |
| Objective 1: Increase awareness of existing mental health services by 2027 | | | | |
| Offer Tuesday Night Talks focusing on Mental Health | Winter 2026 | Lily Blitch<br>Patrick Anderson | # of attendees | - Unison Behavioral Health<br>- Bridges of Hope |
| Host weekly Narcotics Anonymous meetings and ensure local resources are provided | Fall 2025 | Lily Blitch<br>Patrick Anderson | Brochures/printed resources given out | - Bridges of Hope |
| Objective 2: Offer new mental health and addiction resources to the community | | | | |
| Offer psychiatry as part of Medically Assisted Treatment Program at Clinch Memorial Family Practice | Fall 2025 | Angela Handley<br>Lily Blitch<br>Jami Lee Smith | # of patients utilizing psychiatry | - Bridges of Hope |

## PRIORITY AREA 4: COMMUNITY SYSTEMS STRENGTHENING

| Goal 1: Assess and address root causes of the county's most pressing health problems | | | | |
|---|---|---|---|---|
| Action Steps | Timeline | Person Responsible | Measure | Community Partners Involved |
| Objective 1: Build functioning coalition of community partners to systematically tackle health issues | | | | |
| Determine membership | Fall 2025 | Angela Handley<br>Lily Blitch<br>Tony Walsh | Membership Roster | County Commission<br>City Council<br>Chamber of Commerce/Development Authority<br>Public Health Dept<br>Gold Star EMS<br>Clinch EMA<br>Clinch Fire Department |
| Hold exploratory meeting | Winter 2026 | Angela Handley<br>Lily Blitch<br>Tony Walsh | Number of Participants | |
| Determine two health topics to prioritize each calendar year | Winter 2026 | Angela Handley<br>Lily Blitch<br>Tony Walsh | Written List of Priorities | |
| Create community asset & resource list for top health issues | Winter 2026 | Angela Handley<br>Lily Blitch<br>Tony Walsh | List of Resources | |

# Community Resource Listing

| ORGANIZATION NAME | ADDRESS | PHONE/CONTACT INFO |
|---|---|---|
| **ALCOHOL ABUSE, ADDICTION, & TREATMENT FOR DEVELOPMENTALLY DISABLED** | | |
| Unison Behavioral Health | 1007 Mary Street<br>Waycross, GA 31503 | (912) 449-7100 |
| Treatment Center of Waycross | 1766 Memorial Drive, Suite 3<br>Waycross, Ga. 31501 | (912) 285-2658 |
| Saint Illa Center | 3455 Harris Road<br>Waycross, GA 31503 | (912) 449-7200 |
| Satilla Community Services Unison Behavioral Health | 1005 Shirley Avenue<br>Douglas, GA 31533 | (800) 342-8168 |
| Greenleaf Behavioral Health Hospital | 2209 Pineview Drive<br>Valdosta, GA 31602 | (877) 978-1698 |
| Greenleaf Counseling Center | 2217 Pineview Drive<br>Valdosta, GA 31602 | (229) 671-6700 |
| Dr. Joel Morgan | 3541 North Crossing Circle<br>Valdosta, GA 31603 | (229) 244-4200 |
| Unison Behavioral Health Bacon BHS | 108 East 5th Street<br>Alma, GA. 31510 | (912) 632-1111 |
| Unison Behavioral Health Brantley | 434 Bryan Street<br>Nahunta, GA 31553 | (912) 462-5849 |
| Unison Behavioral Health Clinch | 551 Old Pearson Road<br>Homerville, GA | (912 487-5234 |
| **ASSISTED LIVING FACILITIES** | | |
| ResCare Normal Life | 104 Peach Street<br>Homerville, GA 31634 | (912) 487-5292 |
| River Brook Healthcare Center | 390 N. Sweat Street<br>Homerville, GA | (912) 487-5328 |
| **CANCER SUPPORT SERVICES** | | |
| Pearlman Cancer Center<br>Best Buddies: Support group for breast cancer survivors<br>Look Good…Feel Better for Ladies: Support group for female cancer patients | 209 Pendleton Dr<br>Valdosta, GA 31602 | (229) 259-4600 |

| ORGANIZATION NAME | ADDRESS | PHONE/CONTACT INFO |
|---|---|---|
| **CHILDREN'S SERVICES** | | |
| Clinch County Family Connections | 478 West Dame Avenue<br>Homerville, GA 31634 | (912) 483-0475 |
| Babies Can't Wait | Georgia Dept of Public Health (South Health District) Locations in Echols, Ware, & Lowndes County | 1-800-429-6307<br>(912) 284-2552<br>(229) 245-6565 |
| Clinch County DFACs | 17 Shirley Rd<br>Homerville, GA 31634 | (229) 219-1282 |
| Children's 1st | 401 Reed St W.<br>Waycross, GA 31501 | (912) 584-3271 |
| Clinch County Head Start | 282 Carswell Street<br>Homerville, GA 31634 | (912) 487-5304 |
| Children's Medical Services | 206 South Patterson<br>Valdosta, GA 31601 | (229) 245-4310 |
| **HEALTH CLINICS** | | |
| Clinch County Health Dept. | 285 Sweat Street<br>Homerville, GA 31634 | (855) 473-4374 |
| **DIALYSIS** | | |
| DaVita Satilla River Dialysis | 308 Carswell Ave<br>Waycross, GA 31501 | (866) 544-6741 |
| **DENTISTS** | | |
| Dr. Benjamin Tanner (Clinch Dental Care) | 114 Huxford Street<br>Homerville, GA 31634 | (912) 487-5271 |
| Dr. Varnedoe & Jackson | 2009 Tabeau St<br>Waycross, GA | (912) 283-1340 |
| McKinney Health Center | 218 Quarterman Street<br>Waycross, GA 31501 | (912) 287-9140 |
| Morrison Dental Clinic | Waycross, GA 31501 | (912) 232-2779 |
| Morton & Peavey, D.D.S. | 408 Lister Street<br>Waycross, GA 31501 | (912) 285-1212 |
| **FOOD PANTRY & FREE MEALS** | | |
| Hope Ministries | 94 E Dame Avenue<br>Homerville, GA 31634 | (912) 487-5153 |
| Clinch County Concerted Services | 101 South College Street<br>Homerville, GA 31634 | (912 487-2445 |
| Jesus and Jam of Clinch County Inc | 75 Hampton Street<br>Homerville, GA 31634 | (912) 337-5342 |