



20 AdventHealth 23 Redmond

Community Health Needs Assessment

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■ Letter From Leadership

At AdventHealth, our mission of Extending the Healing Ministry of Christ goes beyond our walls. We are committed to addressing the needs of the communities we serve with a holistic focus – one that strives to heal and restore the body, mind and spirit.

Every three years, AdventHealth hospitals complete a Community Health Needs Assessment. We collaborate with community organizations, public health experts and people like you: those who understand our communities best. This in-depth look at the overall health of the community as well as barriers to care helps us better understand each area's unique needs, so we can address the issues that matter most.

AdventHealth is blessed to serve communities across the United States. In big cities and small towns, our promise of wholeness is constant. We believe all people deserve to feel whole, and we are committed to meeting them wherever they are on that journey and supporting them along the way.

Work of this magnitude is not possible without the incredible partnership of public health experts, community health organizations and countless community members. It is through open dialogue and constant collaboration with these key partners that AdventHealth will bring wholeness to all communities we serve.

In His Service,

Isaac Sendros
President and CEO
AdventHealth Redmond



Executive Summary

Redmond Park Hospital, LLC d/b/a AdventHealth Redmond will be referred to in this document as AdventHealth Redmond or “the Hospital”. The Hospital conducted a community health needs assessment from September 2022 to April 2023. The goals of the assessment were to:

- Engage public health and community stakeholders including low-income, minority and other underserved populations.
- Assess and understand the community’s health issues and needs.
- Understand the health behaviors, risk factors and social determinants that impact health.
- Identify community resources and collaborate with community partners.
- Publish the Community Health Needs Assessment.
- Use assessment findings to develop and implement a 2023-2025 Community Health Plan based on the needs prioritized in the assessment process.

Community Health Needs Assessment Committee

In order to ensure broad community input, AdventHealth Redmond created a Community Health Needs Assessment Committee (CHNAC) to help guide the Hospital through the assessment process. The CHNAC included representation from the Hospitals, public health experts and the broad community. This included intentional representation from low-income, minority and other underserved populations.

The CHNAC met two times in 2022 - 2023. They reviewed the primary and secondary data and helped to identify the top priority needs in the community.

See the Prioritization Process section for a list of CHNAC members.

Hospital Health Needs Assessment Committee

AdventHealth Redmond also convened a Hospital Health Needs Assessment Committee (HHNAC). The purpose of the HHNAC was to select the needs the Hospital would address as a result of the findings in the assessment. The HHNAC made this decision by reviewing the priority needs selected by the CHNAC and the internal Hospital resources available. With this information the HHNAC was able to determine where the Hospital could most effectively support the community.

See the Prioritization Process section for a list of HHNAC members.

Data

AdventHealth Redmond in collaboration with the AdventHealth Corporate team collected both primary and secondary data. The primary data included community surveys and stakeholder interviews. Secondary data included publicly available data from state and national data sources. Primary and secondary data was compiled and analyzed to identify the top 11 aggregate issues.

See the Process and Methods section for Primary and Secondary Data Sources.

Community Asset Inventory

The next step was to create a Community Asset Inventory. This inventory was designed to help the CHNAC and the HHNAC understand existing community efforts to address the 11 identified issues from aggregate primary and secondary data and to prevent duplication of efforts.

See Available Community Resources for more.

Selection Criteria

The CHNAC participated in a prioritization process after data review and discussion through which the needs were ranked based on established criteria.

See the Priorities Selection for more.

The HHNAC reviewed and discussed the needs that had been identified by the CHNAC and the available resources to address them in the community. The HHNAC also considered the Hospital's current resources and strategies which could most effectively address the needs having the biggest short term and long-term impact on the community. Through these discussions the Hospital selected the needs it is best positioned to impact.



The priority selection criteria included:

- A. Impact on Community:** What are the consequences to the health of the community of not addressing this issue now?
- B. Resources:** Are there existing, effective interventions and opportunities to partner with the community to address this issue?
- C. Outcome Opportunities:** Do interventions addressing this issue have an impact on other health and social issues in the community?



Priority Issues to be Addressed

The priority issues to be addressed are:

1. Mental Health
2. Heart Disease
3. Cancer

See Priorities Selection for more.

Approval

On May 11, 2023, the AdventHealth Redmond Board approved the Community Health Needs Assessment findings, priority issues and final report. A link to the 2023 Community Health Needs Assessment was posted on the Hospital's website prior to December 31, 2023.

Next Steps

AdventHealth Redmond will work with the CHNAC and the HHNAC to develop a measurable implementation strategy called the 2023-2025 Community Health Plan to address the priority issues. The plan will be completed and posted on the Hospital's website prior to May 15, 2024.

About AdventHealth

AdventHealth Redmond is part of AdventHealth. With a sacred mission of Extending the Healing Ministry of Christ, AdventHealth strives to heal and restore the body, mind and spirit through our connected system of care. More than 80,000 skilled and compassionate caregivers serve 4.7 million patients annually. From physician practices, hospitals, outpatient clinics, skilled nursing facilities, home health agencies and hospice centers, AdventHealth provides individualized, wholistic care at nearly 50 hospital campuses and hundreds of care sites throughout nine states.

Committed to your care today and tomorrow, AdventHealth is investing in research, new technologies and the people behind them to redefine medicine and create healthier communities.

In a 2020 study by Stanford University, physicians and researchers from AdventHealth were featured in the ranking of the world's top 2% of scientists. These critical thinkers are changing medicine and shaping the future of health care.

Amwell, a national telehealth leader, named AdventHealth the winner of its Innovation Integration Award. This telemedicine accreditation recognizes organizations that have identified connection points within digital health care to improve clinical outcomes and user experiences. AdventHealth was recognized for its innovative digital front door strategy, which

is making it possible for patients to seamlessly navigate their health care journey. From checking health documentations and paying a bill, to conducting a virtual urgent care visit with a provider, we are making health care easier by creating pathways to wholistic care no matter where your health journey starts.

AdventHealth is also an award-winning workplace aiming to promote personal, professional and spiritual growth with its workplace culture having been recognized by Becker's Hospital Review on its "150 Top Places to Work in Healthcare" three years straight. This recognition is given annually to health care organizations that promote workplace diversity, employee engagement and professional growth.



AdventHealth Redmond

AdventHealth Redmond is a 230-bed medical, surgical and rehab facility serving Rome, Floyd County and surrounding counties. Built in 1972, the hospital has expanded and evolved over the following decades to become a flagship health care institution in Northwest Georgia and Northeast Alabama. AdventHealth Redmond opened the region's first diagnostic cardiac catheterization lab in 1975, and doctors performed the region's first open-heart surgery in 1986. Since 2016, its Structural Heart Program has overseen over 400 transcatheter aortic valve replacement procedures and now offers MitraClip. Today, the hospital offers minimally invasive robotic-assisted surgery.

Serving as the heart hospital for Northwest Georgia, AdventHealth Redmond offers cardiac services and is the only dedicated chest pain center in the region. AdventHealth Redmond was named as one of the nation's 50 top performing cardiovascular hospitals, top teaching hospital and top 100 hospitals by Fortune/Merative.

AdventHealth Redmond offers many services including emergency care, cancer care, orthopedics, vascular care, surgical care, women's care and inpatient and outpatient rehabilitation services. Some of the surgeries the hospital offers includes coronary artery bypass surgery, heart attack care, knee surgery, total and partial hip joint replacement, metabolic and bariatric surgery and hip fracture surgery.

COMMUNITY OVERVIEW



Community Description

AdventHealth Redmond is located in Floyd County, Georgia. The Hospital defines its community as the Primary Service Area (PSA), the area in which over 75-80% of its patient population lives. This includes 18 zip codes across five counties: Bartow, Chattooga, Floyd, Gordon, and Polk.

According to the 2020 Census, the population in the Hospital's Primary Service Area has grown 4.3% in the last ten years to 276,002 people. This is forty percent the amount of growth seen in Georgia since the last Census.

Demographic and community profile data in this report are from publicly available data sources such as the U.S. Census Bureau and the Center for Disease Control and Prevention, unless indicated otherwise. Data are reported for the PSA unless listed differently. Data are also provided to show how the community compares locally, in the state and at a national level for some indicators.



Community Profile

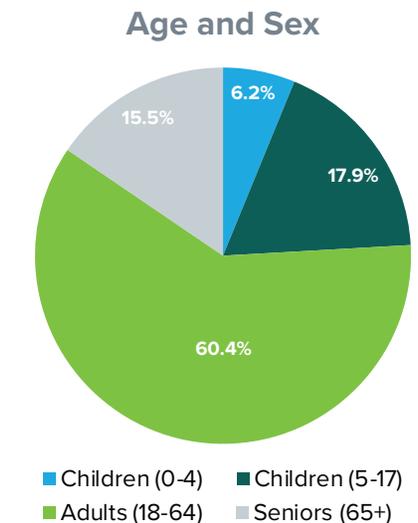
Age and Sex

The median age in the Hospital's community is 38.6, higher than that of the state which is 37.5 but lower than the US, 38.8.

Females are the majority, representing 51% of the population. Middle-aged women, 40-64 are the largest demographic in the community at 16.4%

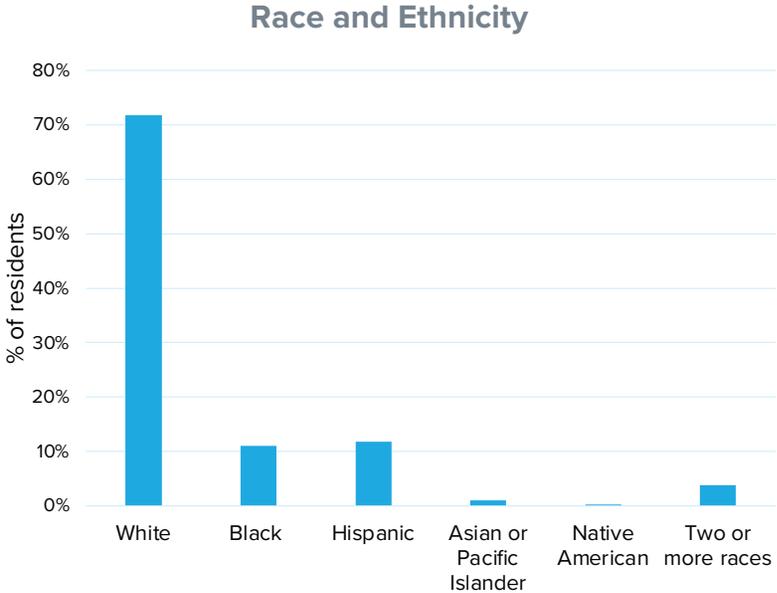
Children are 24% of the total population in the community. Infants, those zero to four, are 6% of that number. The community birth rate is 57.6 births per 1,000 women aged 15-50, this is higher than the U.S. average of 51.5 and then that of the state, 50.4. In the Hospital's community, 26.2% of children aged 0-4 and 23.3% of children aged 5-17 are in poverty.

Seniors, those 65 and older, represent 15.3% of the total population in the community. Females are 56% of the total senior population.



Race and Ethnicity

In the Hospital’s community, 71.7% of the residents are non-Hispanic White, 11% are non-Hispanic Black and 11.8% are Hispanic or Latino. Residents that are of Asian or Pacific Islander descent represent 1% of the total population, while less than 1% are Native American and 3.9% are two or more races.



Social Determinants of Health

According to the CDC, social determinants of health (SDOH) are the conditions in the places where people live, learn, work and play that affect a wide range of health risks and outcomes. Social determinants of health are increasingly seen as the largest contributing factor to health inequities in communities throughout the country.

The Hospital categorized and analyzed SDOH data following the Healthy People 2030 model. This approach was chosen so, when possible, the Hospital could align its work with national efforts when addressing social determinants of health. For the purposes of CHNA the Hospital will follow this model for reporting any related data.



The Healthy People 2030 place-based framework outlines five areas of SDOH:



Economic Stability: This includes areas such as income, cost of living, food security and housing stability.



Education Access and Quality: This focuses on topics such as high school graduation rates, enrollment in higher education, literacy and early childhood education and development.



Health Care Access and Quality: This includes topics such as access to health care, access to primary care and health insurance coverage.



Neighborhood and Built Environment: This includes areas for example like quality of housing, access to transportation, availability of healthy foods, and neighborhood crime and violence.

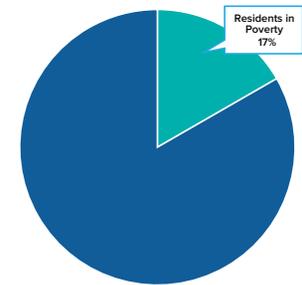


Social and Community Context: This focuses on topics such as community cohesion, civic participation, discrimination and incarceration.

Economic Stability

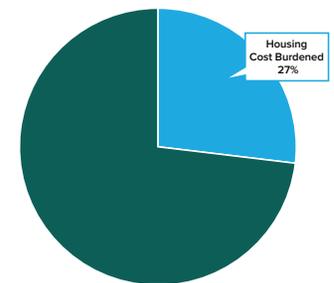
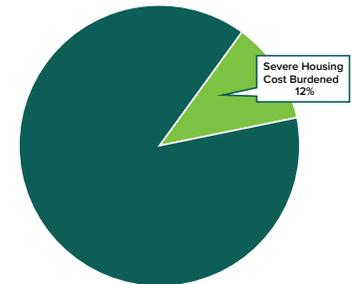
Income

The median household income in the Hospital's community is \$55,130. This is below the median for both the state and the US. In the community, 16.7% of residents live in poverty, this is higher than the poverty rate of the state, 14.3% and U.S., 12.8%.



Food Insecurity and Housing Stability

People who are food insecure, having reduced quality and/or amount of food intake, may be at an increased risk of negative health outcomes. Studies have shown an increased risk of obesity and chronic disease in adults who are food insecure. Children who are food insecure have been found to have an increased risk of obesity and developmental problems compared to children who are not¹. Feeding America estimates for 2020², showed the food insecurity rate in the Hospital's community as 16.7%.



Increased evidence is showing a connection between stable and affordable housing and health³. When households are cost burdened or severely cost burdened, they have less money to spend on food, health care and other necessities. Having less access can result in more negative health outcomes. Households are considered cost burdened if they spend more than 30% of their income on housing and severely cost burdened if they spend more than 50%.

¹ Food Insecurity - Healthy People 2030 | health.gov

² Map the Meal Gap 2020 Combined Modules.pdf (feedingamerica.org)

³ Severe housing cost burden* | County Health Rankings & Roadmaps

Education Access and Quality

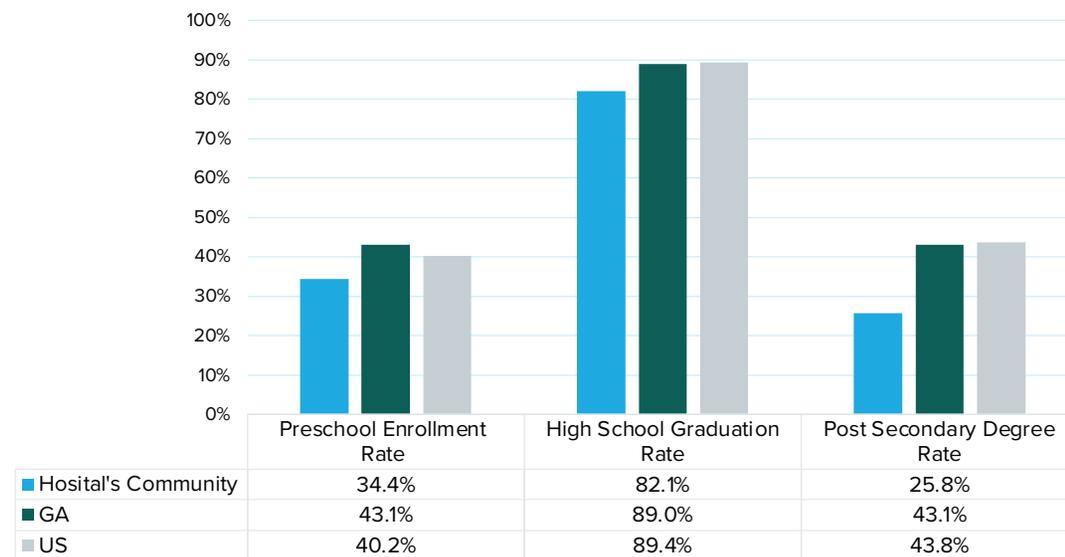
Research shows education can be a predictor of health outcomes, as well a path to address inequality in communities⁴. Better education can lead to people having an increased understanding of their personal health and health needs. Higher education can also lead to better jobs, which can result in increased wages and access to health insurance.

In the Hospital's community, there is a 82.1% high school graduation rate, which is lower than both the state and national average. The rate of people with a post-secondary degree is 25.8%, which is lower than in both the state and nation.

Early childhood education is uniquely important and can improve the cognitive and social development of children. This helps provide the foundation for long term academic success, as well as improved health outcomes. Research on early childhood education programs show that long-term benefits include improved health outcomes, savings in health care costs and increased lifetime earnings⁵.

In the Hospital's community, 34.4% of 3–4-year-olds were enrolled in preschool. This is lower than both the state (43.1%) and the national (40.2%) average, which means there may be a large percentage of children in the community who may not be receiving these early foundational learnings.

Educational Attainment



⁴ The influence of education on health: an empirical assessment of OECD countries for the period 1995–2015 | Archives of Public Health | Full Text (biomedcentral.com)

⁵ Early Childhood Education | Health Impact in 5 Years | Health System Transformation | AD for Policy | CDC



Health Care Access and Quality

In 2020, 24% of community members aged 18-64 were found to not have health insurance. A lack of health insurance can lead to delayed care, resulting in more serious health conditions and increased treatment costs. Although health insurance coverage levels can be a strong indicator of a person's ability to access care, there are other potential barriers that can delay care for many people⁶.

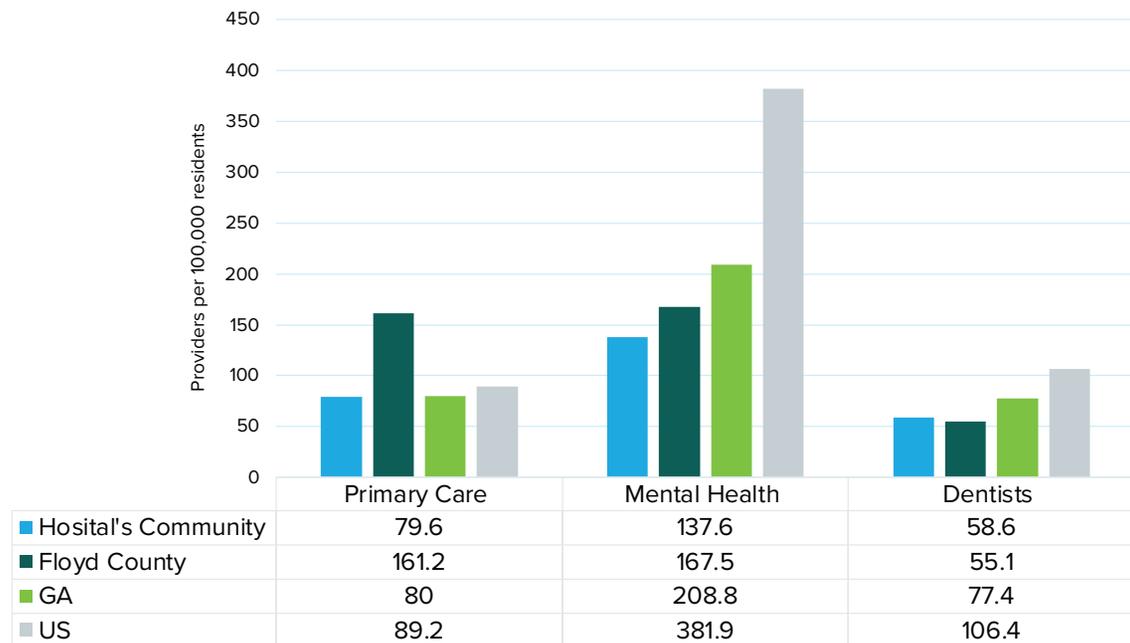
Accessing health care requires more than just insurance, there also needs to be health care professionals available to provide care. When more providers are available in a community access can be easier, particularly for those experiencing transportation challenges. In the counties that the Hospital serves, Floyd County has the most mental health and primary care providers available.

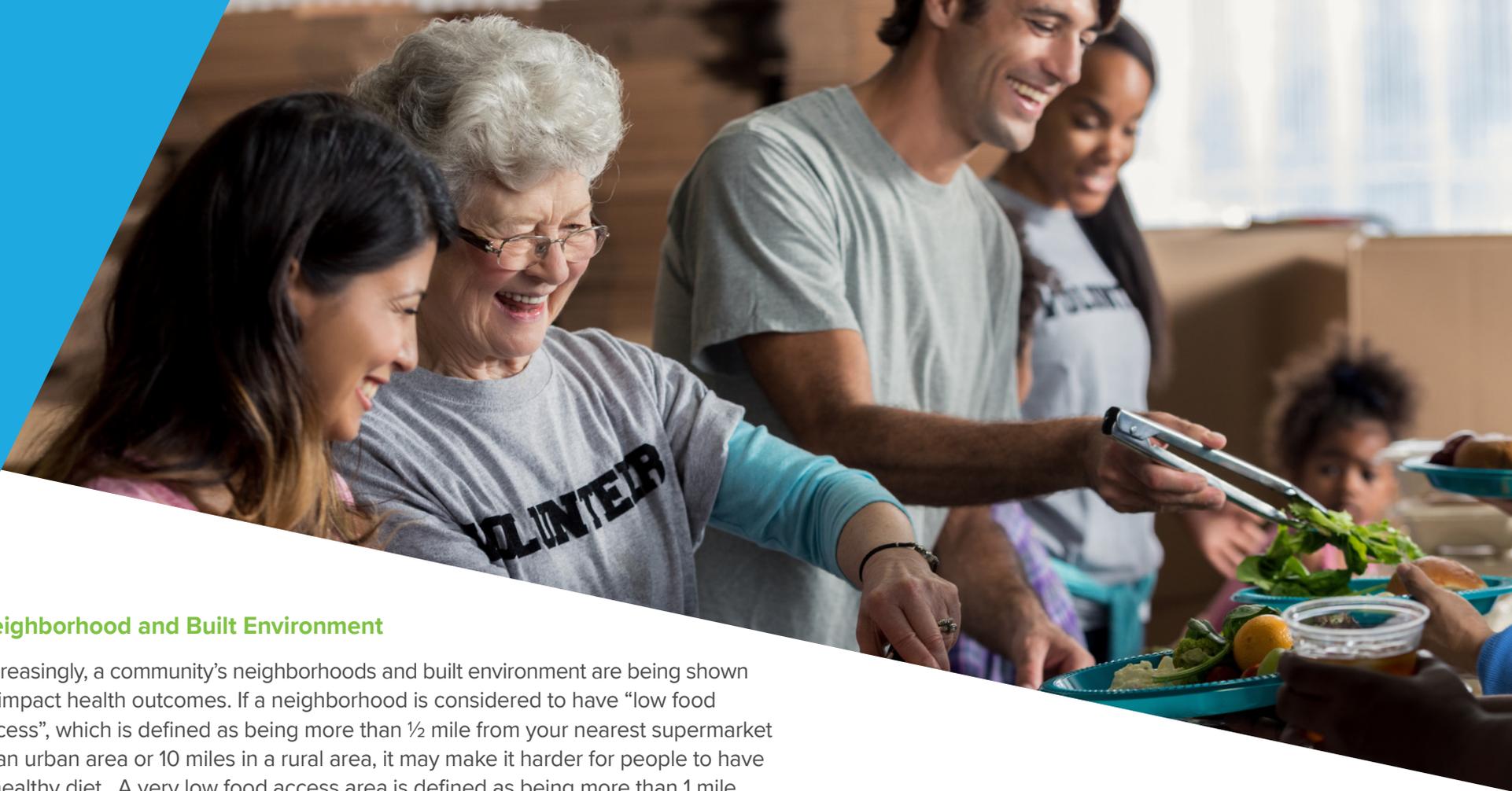
Routine checkups can provide an opportunity to identify potential health issues and, when needed, develop care plans. In the Hospital's community, 74% of people report visiting their doctor for routine care.

⁶ Health Insurance and Access to Care (cdc.gov)



Providers Per Capita





Neighborhood and Built Environment

Increasingly, a community's neighborhoods and built environment are being shown to impact health outcomes. If a neighborhood is considered to have “low food access”, which is defined as being more than ½ mile from your nearest supermarket in an urban area or 10 miles in a rural area, it may make it harder for people to have a healthy diet. A very low food access area is defined as being more than 1 mile from your nearest supermarket in an urban area or 20 miles in a rural area.

A person's diet can have a significant impact on health, so access to healthy food is important. For example, the largest contributors to cardiovascular disease are obesity and type 2 diabetes, both of which can be impacted by diet⁷. In the Hospital's community, 45% of the community lives in a low food access area, while 30.7% live in a very low food access area.

Access to public transportation is also an important part of a built environment. For people who do not have cars, reliable public transportation can be essential to access health care, healthy food and maintaining employment. In the community, 6.5% of the households do not have an available vehicle.

⁷ A Neighborhood's Built Environment May Have Numerous Effects on Its Residents' Health - RWJF

Social and Community Context

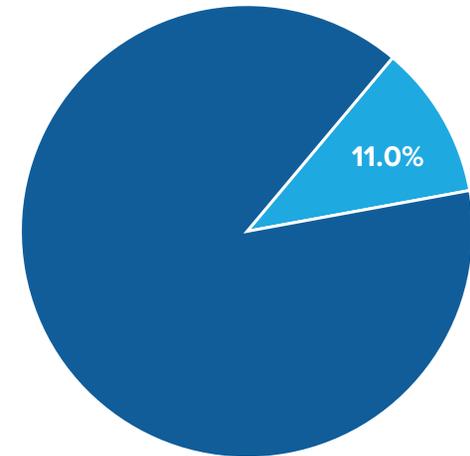
People's relationships and interactions with family, friends, co-workers and community members can have a major impact on their health and well-being⁸. When faced with challenges outside of their control, positive relationships with others can help reduce negative impacts. People can connect through work, community clubs or others to build their own relationships and social supports. There can be challenges to building these relationships when people don't have connections to create them or there are barriers like language between groups.

In the community, 11% of youth aged 16-19 were reported as disconnected, this means they were neither enrolled in school nor working at the time.

Also, in the community 26.8% of seniors (age 65 and older) report living alone and 2.9% of residents report having limited English proficiency. All these factors can create barriers to feeling connected in the community.

⁸ Social and Community Context - Healthy People 2030 | health.gov

Disconnected Youth



Process, Methods and Findings



■ Process and Methods

The Process

The health of people living in the same community can be very different, because there are so many influencing factors. To understand and assess the most important health needs of its unique community and the people in it, the Hospital, in collaboration with the AdventHealth Corporate team, solicited input directly from the community and from individuals who represent the broad interests of the community. A real effort was made to reach out to all members of the community to obtain perspectives across age, race/ethnicity, gender, profession, household income, education level and geographic location. The Hospital, aided by the AdventHealth Corporate team, also collected publicly available data for review.

The Hospital partnered with local community organizations and stakeholders, including those in public health and those who represent the interests of medically underserved, low-income and minority community members, to form a Community Health Needs Assessment Committee (CHNAC) to guide the assessment process. During data review sessions, community members of the CHNAC provided insight on how health conditions and areas of need were impacting those they represented. The CHNAC used the data review and discussion sessions to understand the most important health needs and barriers to health the community was facing and to guide the selection of needs to be addressed in the 2023 CHNA.

Community Input

The Hospital collected input directly from the community and from community stakeholders, individuals working in organizations addressing the needs and interests of the community. Input was collected through two different surveys: the community health survey and the stakeholder survey.

Community Health Survey

- Provided in both English and Spanish to anyone in the community and accessible through web links and QR codes.
- Links and QR codes shared through targeted social media posts and with community partners including public health organizations. Partners were provided links to the survey, with the request that it be sent to listservs, electronic mailing lists, they maintained and when possible shared on their own social media channels.

Stakeholder Interviews

- Participants were asked to provide input on health and barriers to health that they were seeing in the community.
- Surveys were sent to individuals working at community organizations, including public health organizations, that work to improve the health and wellbeing of the community.
- A focus was on hearing from stakeholders who represent or serve communities that are underserved, underrepresented, lower income, and/or who are more likely to be impacted by the social determinants of health.

Public and Community Health Experts Consulted

A total of nine stakeholders provided their expertise and knowledge regarding their community including:

Name	Organization	Services Provided	Populations Served
Rhonda Wallace, Floyd County Commissioner	Floyd County Government	Health care/public health; Domestic Violence; Mental/behavioral health care	Low income; Homeless; Women; General public
Tannika King, Board Member	Sexual Assault Center of Northwest Georgia	Sexual assault advocacy, medical services, and prevention	Low income; Children; Women; Homeless, Elderly, Veterans, LGBTQIA+, General public
Tim Blevins, Corps Officer	The Salvation Army of Rome, Georgia	Housing; Food assistance; Financial support; Church services and spiritual wellness	Low income; Children; Women; Homeless, Elderly, Veterans, LGBTQIA+, General public
Gary Voccio, District Health Director	Georgia Public Health District 1-1	Health care/public health;	Low income; Children; Women; Homeless, Elderly, Veterans, LGBTQIA+, General public
Melissa Hunter, Epidemiologist	Northwest Georgia Public Health	Health care/public health; Education/youth services	Low income; Children; Women; Homeless, Elderly, Veterans, LGBTQIA+, General public
LaDonna Collins, Executive Director	Rome Floyd County Commission on Children and Youth	Collaborative	Children; General public; Family
Pam Powers-Smith, President	Rome Floyd Chamber of Commerce	Education, advocacy, networking, connecting	Businesses and nonprofits
Lynn Green, President	PFLAG Rome	Education/youth services	LGBTQIA+; Families of LGBTQIA+
Jim Moore, Board Member	National Alliance on Mental Illness (NAMI) Rome	Education/youth services; Mental/behavioral health care	Low income; General public

Secondary Data

To inform the assessment process, the Hospital collected existing health related and demographic data about the community from publicly available sources and Metopio, a web-based data platform. This included data on health conditions, social determinants of health and health behaviors.

The most current public data for the assessment was compiled and sourced from government and public health organizations including:

- US Census Bureau
- Centers for Disease Control and Prevention
- Feeding America
- County Health Rankings
- The State Health Department



■ The Findings

Throughout the assessment process there were several themes from community input that rose to the top, which were mentioned across numerous issues and health needs, including:



Access: A need for more affordable and accessible entry points to care in the community, including for primary, dental and mental health care.



Mental Health: An awareness of increasing mental health needs in the community and the resources to support the growing need.

When reviewing the data for prioritization, the CHNAC considered the identified themes and their impact on the communities whose interests they represented.

The significant needs identified in the assessment process included:



Asthma: Asthma is a disease that affects your lungs. It causes repeated episodes of wheezing, breathlessness, chest tightness, and nighttime or early morning coughing. Asthma can be controlled by taking medicine and avoiding the triggers that can cause an attack.



Cancer: Cancer is a disease in which some of the body's cells grow uncontrollably and spread to other parts of the body. Cancer can start almost anywhere in the human body, which is made up of trillions of cells. Normally, human cells grow and multiply (through a process called cell division) to form new cells as the body needs them. When cells grow old or become damaged, they die, and new cells take their place. Sometimes this orderly process breaks down, and abnormal or damaged cells grow and multiply when they shouldn't. These cells may form tumors, which are lumps of tissue. Tumors can be cancerous or not cancerous (benign).



Cardiovascular Heart Disease: Cardiovascular disease generally refers to conditions that involve narrowed or blocked blood vessels that can lead to a heart attack, chest pain (angina) or stroke. Other heart conditions, such as those that affect your heart's muscle, valves or rhythm, also are considered forms of heart disease.



Diabetes: Diabetes is a group of diseases characterized by high blood sugar. When a person has diabetes, the body either does not make enough insulin (type 1) or is unable to properly use insulin (type 2). When the body does not have enough insulin or cannot use it properly, blood sugar (glucose) builds up in the blood. Prediabetes is a condition in which blood sugar is higher than normal but not high enough to be classified as diabetes.

People with diabetes can develop high blood pressure, high cholesterol, and high triglycerides (a type of fat in the blood). High blood sugar, particularly when combined with high blood pressure and high triglycerides, can lead to heart disease, stroke, blindness, kidney failure, amputations of the legs and feet, and even early death. Diabetes is also associated with increased risk of certain types of cancer, such as liver, pancreas, uterine, colon, breast, and bladder cancer. High blood sugar also increases a person's chance of developing dementia and Alzheimer's disease.

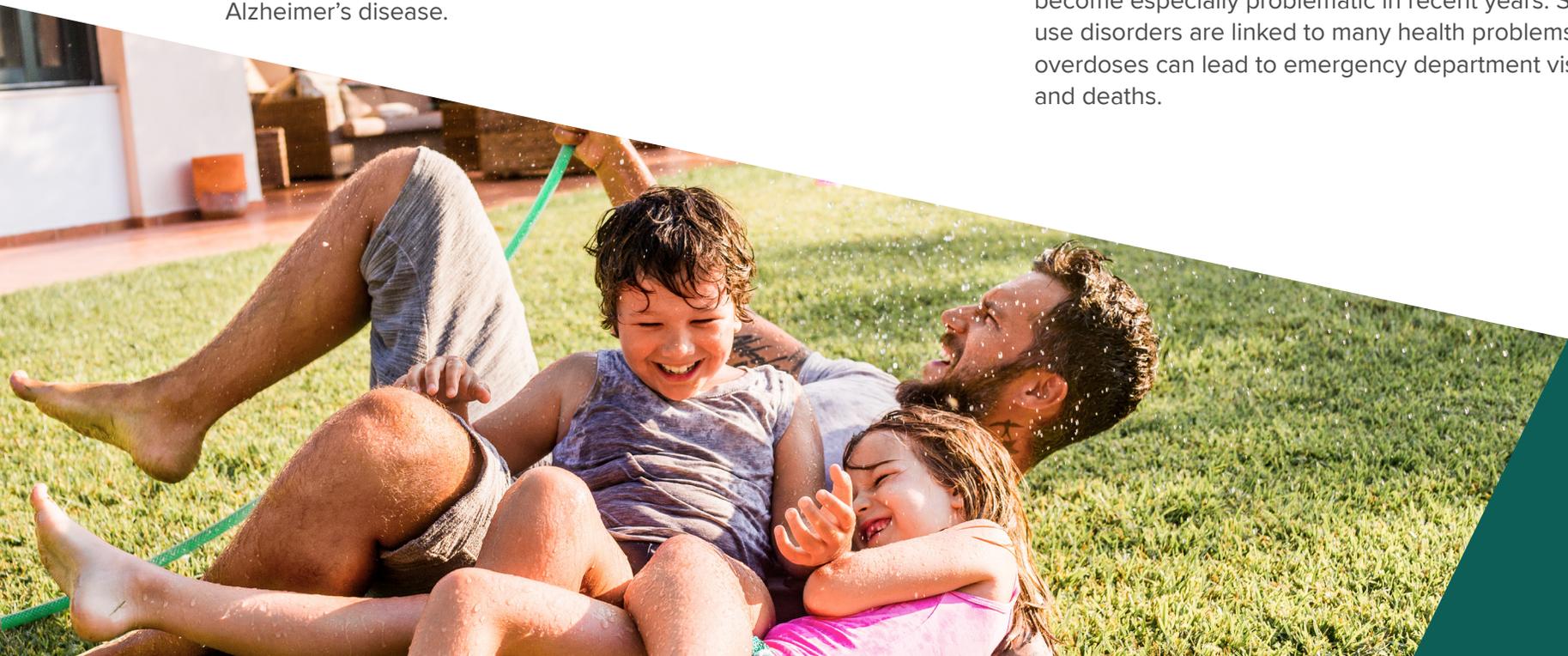


Mental Health: Mental illnesses are conditions that affect a person's thinking, feeling, mood or behavior, such as depression, anxiety, bipolar disorder, or schizophrenia. Such conditions may be occasional or long-lasting (chronic) and affect someone's ability to relate to others and function each day.

Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make healthy choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.



Drug Misuse: Healthy People 2030 focuses on preventing drug and alcohol misuse and helping people with substance use disorders get the treatment they need. Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.





Tobacco: Tobacco smoking is the practice of burning tobacco and ingesting the smoke produced. Smoking leads to disease and disability and harms nearly every organ of the body. Additionally, smoking causes cancer, heart disease, stroke, lung diseases, diabetes, and chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis. Smoking also increases risk for tuberculosis, certain eye diseases, and problems of the immune system, including rheumatoid arthritis. Secondhand smoke causes stroke, lung cancer, and coronary heart disease in adults. Children who are exposed to secondhand smoke are at increased risk for sudden infant death syndrome, acute respiratory infections, middle ear disease, more severe asthma, respiratory symptoms, and slowed lung growth.

Needs that are social determinants of health are grouped accordingly.



Education Access & Quality: People with higher levels of education are more likely to be healthier and live longer. Healthy People 2030 focuses on providing high-quality educational opportunities for children and adolescents — and on helping them do well in school. Children from low-income families, children with disabilities, and children who routinely experience forms of social discrimination — like bullying — are more likely to struggle with math and reading. They're also less likely to graduate from high school or go to college. This means they're less likely to get safe, high-paying jobs and more likely to have health problems like heart disease, diabetes, and depression.



Economic Stability: People with steady employment are less likely to live in poverty and more likely to be healthy, but many people have trouble finding and keeping a job. People with disabilities, injuries, or conditions like arthritis may be especially limited in their ability to work. In addition, many people with steady work still don't earn enough to afford the things they need to stay healthy.



Neighborhood & Built Environment: Food Security: Food security exists when all people, at all times, have physical and economic access to sufficient safe and nutritious food that meets their dietary needs and food preferences. A lack of food security has been linked to negative health outcomes in children and adult, as well as potentially causing trouble for children in schools.



Health Care Access and Quality: Many people in the United States don't get the health care services they need. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.





PRIORITIES SELECTION

■ Prioritization Process

The Community Health Needs Assessment Committee through data review and discussion, narrowed the health needs of the community to a list of 11. Community partners on the CHNAC were looked to represent the broad range of interests and needs, from public health to the economic, of underserved, low-income and minority people in the community. During the Spring of 2023 the CHNAC met to review and discuss the collected data and select the top community needs.

Members of the CHNAC included:

Community Members

- Captain Tim Blevins, Corps Officer, The Salvation Army of Rome, Georgia
- Tannika King, Director of Communications, Darlington School
- Lindsey Jacobs Howerton, Director, Floyd County Georgia Division of Family & Children Services
- Jamie Youngblood, Community Care Services Program Coordinator, Area Agency on Aging and Northwest Georgia Regional Commission
- Mitchell Jolly, Global Impact/Restoration Rome
- Cathy Hart, Community Case Manager, United Way of Floyd County
- Jeannie King, Unity Christian School
- Rebekah Butler, Admissions Director, Unity Christian School
- Renee Blackburn, Executive Director, Free Clinic of Rome
- LaDonna Collins, Executive Director, Rome Floyd County Commission on Children and Youth

AdventHealth Team Members

- Isaac Sendros, President and CEO
- Juleun Johnson, Vice President, Mission & Ministry, Southeast Region
- Garrett Nudd, Vice President, Marketing & Brand Strategy
- Edma Diller, Director, Regulatory Affairs
- Scotty Hancock, Director, Outreach & Business Development
- Rika Meyer, Manager, Marketing & Communications
- Logan Yerbey, Project Manager
- Paul Samuel, Chaplain
- Jake Hager, Director, Foundation

Public Health Experts

- Dr. Gary Voccio, Medical Director, District 1-1, Northwest Georgia Public Health



To identify the top needs the CHNAC took part in a prioritization activity. During the activity, the data behind each need was reviewed, followed by a discussion of the need, the impact it had on the community and the resources available to address it. CHNAC members then voted through an online survey.



CHNAC members were asked to select the top three issues they believed the Hospital should address using the criteria below:

- **Impact on Community:** What are the consequences to the health of the community of not addressing this issue now?
- **Resources:** Are there existing, effective interventions and opportunities to partner with the community to address this issue?
- **Outcome Opportunities:** Do interventions addressing this issue have an impact on other health and social issues in the community?

The following needs rose to the top during the CHNAC's discussion and prioritization activity:

Top Need Identified	# of Votes	% Responses
Asthma	0	0%
Cancer	4	24%
Heart Disease	9	53%
Diabetes	1	6%
Mental Health	12	71%
Drug Misuse	4	24%
Tobacco Use	3	18%
Education Access & Quality	3	18%
Economic Stability	4	24%
Neighborhood & Built Environment: Food Security	6	35%
Health Care Access & Quality	5	29%

After a list of 11 of the top health needs of the community had been selected by the CHNAC, a Hospital Health Needs Assessment Committee (HHNAC) met to review the top needs that had been chosen. The HHNAC reviewed and discussed the needs that had been identified by the CHNAC and the available resources to address them in the community. The HHNAC also considered the Hospital's current resources and strategies which could most effectively address the needs having the biggest short term and long-term impacts on the community. Through these discussions the Hospital selected the needs it is best positioned to impact.

Members of the HHNAC included:

- Isaac Sendros,
President and CEO
- Dr. Julie Barnes,
Chief Medical Officer
- Juleun Johnson,
Vice President, Mission And Ministry, Southeast Region
- Garrett Nudd,
Associate Vice President, Marketing And Brand Strategy
- Scotty Hancock,
Business Development
- Edma Diller,
Director, Regulatory Affairs
- Rika Meyer,
Manager, Marketing and Communications
- Paul Samuel,
Chaplain
- Jake Hager,
Foundation

The HHNAC followed the same process as the CHNAC for prioritization, narrowing down the list to three priority needs:

- **Heart Disease**
- **Mental Health**
- **Cancer**



Available Community Resources

When evaluating the top issues in the community a review of the available organizations and resources addressing these issues was conducted to understand where the greatest impact could be made.

Top Issues	Current Community Programs	Current Hospital Programs
Asthma	<ul style="list-style-type: none"> Georgia Department of Public Health provides referrals to free asthma self-management education for children and teens. 	
Cancer	<ul style="list-style-type: none"> West Rome United Methodist Church provides a food pantry for cancer patients who are undergoing cancer treatment Summit Quest provides resources, emotional support, transportation and programs for patients and families facing cancer Northwest Georgia Cancer Coalition, Inc. provides cancer-related education, communications, prevention, early detection and screening treatment and research 	<ul style="list-style-type: none"> In partnership with Northwest Georgia Cancer Coalition, Inc., provide cancer screenings to uninsured and underinsured populations Distribution events where cancer patients and families affected by cancer receive seasonal produce Grant-funded transportation program for qualifying oncology patients (funded by Northwest Georgia Cancer Coalition, Inc.) Health Initiative for Men and Women: Prevention Event includes a health fair, food distribution event, cooking demonstrations and health screenings Distribute cancer awareness and education resources
Heart Disease	<ul style="list-style-type: none"> Free Clinic of Rome provides healthcare services to uninsured residents 	<ul style="list-style-type: none"> The Community Outreach team conducts blood pressure and health screenings at community events “Strike Out Stroke” is hosted in May each year to share information and education about stroke response
Diabetes	<ul style="list-style-type: none"> Free Clinic of Rome provides healthcare services to uninsured residents Veterans Clinic of Rome provides diabetes classes and nutrition counseling 	
Mental Health	<ul style="list-style-type: none"> Highland Rivers Behavioral Health provides mental health treatment, support and recovery services for all ages The National Alliance on Mental Health (NAMI) Rome provides a variety of support groups for individuals as well as family and friends of individuals who are dealing with mental health struggles Restoration Rome is a hub for trauma-informed services in Northwest Georgia 	
Drug Misuse	<ul style="list-style-type: none"> Floyd Against Drugs provides drug education to reduce the use of drugs, tobacco and underage drinking Freedom Counseling Services provides addiction rehabilitation with Christian discipleship 	<ul style="list-style-type: none"> Partners with Floyd Against Drugs for a “Drug Takeback” day to reduce prescription drug abuse

Top Issues	Current Community Programs	Current Hospital Programs
Tobacco Use	<ul style="list-style-type: none"> Northwest Georgia Regional Cancer Coalition provides tobacco/e-cigarette prevention and education programs, cessation classes and support to local school systems and community organizations 	<ul style="list-style-type: none"> Lung Clinic offers smoking cessation classes High risk patients without funding may be eligible for lung screenings in conjunction with the Northwest Georgia Cancer Coalition
Education Access & Quality	<ul style="list-style-type: none"> Blue Ridge Area Health Education works to grow and sustain a diverse healthcare workforce Etowah Employment helps individuals gain employment 	
Economic Stability	<ul style="list-style-type: none"> Good Neighbor Ministries provides rent and utility assistance Tallatoona Community Action Partnership helps individuals acquire knowledge and skills to achieve economic self-sufficiency The United Way of Rome & Floyd County provides case management for individuals and families facing economic, family or housing instability 	
Neighborhood & Built Environment: Food Security	<ul style="list-style-type: none"> Bagwell Food Pantry provides food assistance Good Neighbor Ministries provides food assistance to individuals in Rome and Floyd County Helping Hands Food Bank provides an emergency food pantry for Polk County Journey Community Food Pantry provides food to Floyd County residents Rome-Floyd County Community Kitchen offers a soup kitchen The Salvation Army of Rome provides food, shelter, as well as family and social services to people in need. Rome-Floyd County Commission on Children & Youth empower children and youth to reach their full potential through collaboration, advocacy and visibility Northwest Georgia Hunger Ministries serves families in need through sourcing and delivering food 	
Health Care Access & Quality	<ul style="list-style-type: none"> Floyd County Health Department Baptist Mobile Health Ministry Bethany Christian Clinical Services Free Clinic of Rome 	<ul style="list-style-type: none"> Partners with the Free Clinic of Rome to provide translation technology care to uninsured and underinsured residents



■ Priorities Addressed



Priority 1: Heart Disease

According to secondary data, individuals in the Hospital's community have higher rates of coronary heart disease and of heart disease mortality per 100,00 than elsewhere in Georgia and the nation. Almost 13.5% of community survey respondents report having coronary heart disease. Also, 34% of individuals living in the community have been told they have high cholesterol which

can be a contributing factor to heart disease as well. There are several heart disease and heart related health indicators where the community is faring more poorly than others in the state and the nation. Recognizing that healthy lifestyle habits can be an important preventative approach and treatment to addressing this priority, the Hospital will consider strategies that can be both proactive and reactive.



Priority 2: Mental Health

In the Hospital's community, 22.3% of residents have a prevalence of depression, while 19% of the residents report poor mental health. According to community survey respondents 20.7% have been diagnosed with a depressive order and more than 23.1% have been diagnosed with an anxiety disorder. Awareness and the need to address mental health disorders has been growing in the country. Including mental health as a priority, the Hospital can align to local, state and national efforts for resources to create better outcome opportunities over the next three years.



Priority 3: Cancer

In the Hospital's community 6.86% of the residents have had cancer according to secondary data which is higher than the state rate of 6.16%. All counties except Floyd have new cancer diagnosis rates slightly higher than the state average. According to the community survey, 17% of residents had been diagnosed with cancer. When addressing cancer as a priority, the Hospital can look to align to local, state and national efforts to impact this issue over the next three years.



■ Priorities Not Addressed

The priorities not addressed include:



Asthma

According to secondary data, asthma impacts almost 10% of residents. Community survey data included a higher rate of 36% residents diagnosed with asthma. While survey respondents reported a higher rate of asthma than secondary data, the priority was not selected as an overall focus area based on potential to impact and resources available.



Neighborhood & Build Environment: Food Security

Approximately 16.7% of the residents in the Hospital's community are food insecure according to Feeding America and 45% live in a low food access area. According to community survey respondents, 13.75% received SNAP benefits last year, while 42% felt they ate less than they should have due to cost. The Hospital believes that other organizations are better positioned in the community to address this need directly and will support those efforts when able.



Diabetes

Diabetes is shown to impact 12.4% of residents in the Hospital's community according to public data, while 23.3% of community survey respondents report having diabetes. Stakeholders also identified diabetes as a top health condition. The Hospital did not select diabetes as a priority, as it is not positioned to directly address this in the community at large.



Drug Misuse

All counties except Gordon are above the State average for drug overdose mortality. Of community survey respondents, 38.2% reported taking prescription medication for non-medical reasons. The rate was found to be 49% for minority groups. The Hospital believes that other organizations are better positioned in the community to address this need directly and will support those efforts when able.



Tobacco Use

According to secondary data, 22% of residents currently smoke cigarettes which is higher than the state average of 17%. Community survey respondents shared higher rates of smoking with 62% overall, and 73% of Hispanic residents. The Hospital did not select tobacco use as a priority as it is not resourced to directly address this in the community but will support other community partners where possible in their efforts.



Education Access & Quality

According to secondary data, pre-school enrollment, high school graduation rates and higher degree graduation rates are all lower than the state averages. The high school graduation rate, in particular, is in the bottom quartile for the nation. Community survey respondents identified education access and quality as an important issue, along with stakeholders. While the importance of education was recognized, prioritization results confirmed the need to prioritize other issues.



Economic Stability

The Redmond PSA and all counties within are worse than the state average for income, poverty rate, and evictions. The eviction rate and low-income jobs lost due to COVID were amongst the top 5 nationally. While economic stability is an important issue and integral to health, the Hospital did not select this priority as it is not resourced to directly address this issue.



Health Care Access & Quality

The Redmond PSA and all counties within are worse than the state average for health insurance coverage, as well as mental health providers per capital. While insurance coverage and sufficient providers are important issues, the Hospital did not feel resourced to directly address this issue.





COMMUNITY HEALTH PLAN

Next Steps

The Hospital will work with the CHNAC and other community partners to develop a measurable Community Health Plan for 2023-2025 to address the priority issues. For each priority, specific goals will be developed including measurable outcomes, intervention strategies and the resources necessary for successful implementation.

Evidence based strategies will be reviewed to determine the most impactful and effective interventions. For each goal, a review of policies that can support or deter progress will be completed with consideration of opportunities to make an impact. The plan will be reviewed quarterly with an annual assessment of progress. A presentation of progress on the plan will also be presented to the hospital board annually.

A link to the Community Health Plan will be posted on [AdventHealth.com](https://www.adventhealth.com) prior to May 15, 2024.



■ Community Health Needs Assessment Comments

This is the first Community Health Needs Assessment completed for AdventHealth Redmond, so no written comments have been received.





**Redmond Park Hospital, LLC d/b/a
AdventHealth Redmond**

CNHA Approved by the Hospital Board on: May 11, 2023

For questions or comments please contact:
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