2022

**AdventHealth Murray**

Community Health Needs Assessment

Extending the Healing Ministry of Christ

**AdventHealth**

# Table of Contents

## ▮ 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 wholistic 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,

Terry Shaw
President and CEO
AdventHealth

# ▊ Executive Summary

Adventist Health System Georgia, Inc. d/b/a AdventHealth Murray will be referred to in this document as AdventHealth Murray or "the Hospital". The Hospital conducted a community health needs assessment from August 2021 to June 2022. 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 Murray created a Community Health Needs Assessment Committee (CHNAC) to help guide the Hospital through the assessment process. The CHNAC included representation from the Hospital, public health experts and the broad community. This included intentional representation from low-income, minority and other underserved populations.

The CHNAC met three times in 2021 - 2022. 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 Murray 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 Murray 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 internal Hospital utilization data (inpatient, outpatient and emergency department). This utilization data showed the top diagnoses for visits to the Hospital from 2019-2021. In addition, publicly available data was utilized from state and national data sources. Primary and secondary data was compiled and analyzed to identify the top 12 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 12 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 CHNAC and the HHNAC also considered four factors during prioritization:

**A. Alignment:** Does this issue align with our mission, strategy, public-health or community goals?

**B. Impact on Community:** What is the scope, size and seriousness of this issue? What are the consequences to the health of the community of not addressing this issue now?

**C. Resources:** Are there existing, effective interventions and opportunities to partner with the community to address this issue?

**D. Outcome Opportunities:** Can an impact on this issue be made in a demonstrable way, and will interventions 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. Heart Disease and Heart-Related Issues
   *Focusing on seniors and low-income individuals residing in the 30705 zip code*

2. Cancer
   *Focusing on low-income individuals residing in the 30705 zip code*

3. Vaping
   *Focusing on adults and youth residing in the 30705 zip code*

*See Priorities Selection for more.*

## Approval

On September 28, 2022, the AdventHealth Murray Board approved the Community Health Needs Assessment findings, priority issues and final report. A link to the 2022 Community Health Needs Assessment was posted on the Hospital's website prior to December 31, 2022.

## Next Steps

AdventHealth Murray 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, 2023.

# ▌ About AdventHealth

AdventHealth Murray 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 Murray

AdventHealth Murray is a comprehensive, 42-bed community hospital located in Murray County, Georgia. Built originally in 1949 as Murray County Memorial Hospital, the Hospital moved to its current location in the 1970's to meet the growing needs in the community. In 2015, the name was changed to Murray Medical Center and Adventist Health System partnered with the Murray County Hospital Authority Board to assume the Hospital operations. The Hospital became AdventHealth Murray in 2019 but officially become part of the Adventist Health System in 2020.

AdventHealth Murray offers many services including allergy care, emergency and urgent care, imaging services, lab services orthopedic care, physical therapy, primary care, sports medicine, surgical care, urology and women's care.

# COMMUNITY OVERVIEW

## Community Description

AdventHealth Murray is located in Murray County, Georgia. The Hospital defines its community as the Total Service Area (TSA), the area in which over 90% of its patient population lives. This includes five zip codes across three counties: Murray, Gilmer and Whitfield.

According to the 2020 Census, the population in the Hospital's Total Service Area has grown 1.7% in the last ten years to 109,689 people. This is a quarter the amount of growth seen in the United States since the last Census.

Demographic and community profile data in this report are from publicly available data sources such as the US Census Bureau and the Center for Disease Control and Prevention, unless indicated otherwise. Data are reported for the TSA 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.



AdventHealth Murray
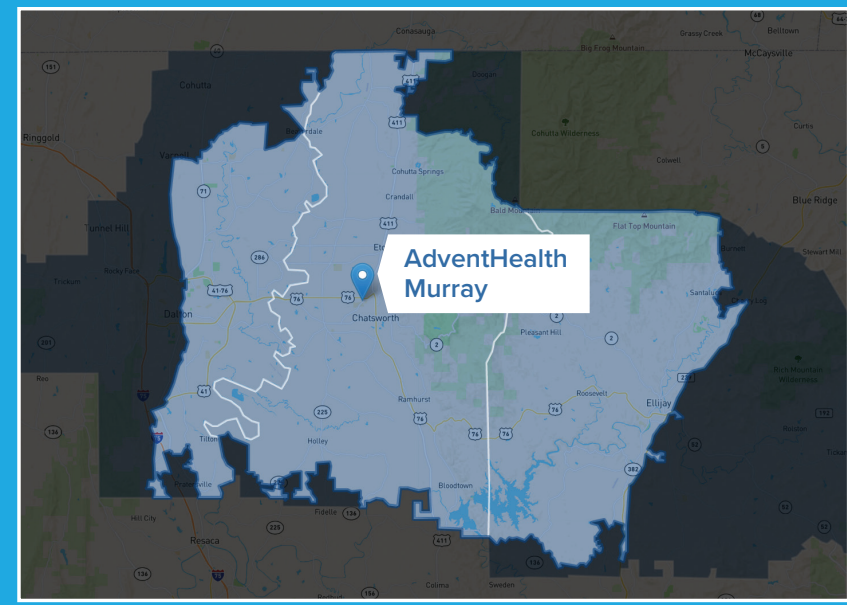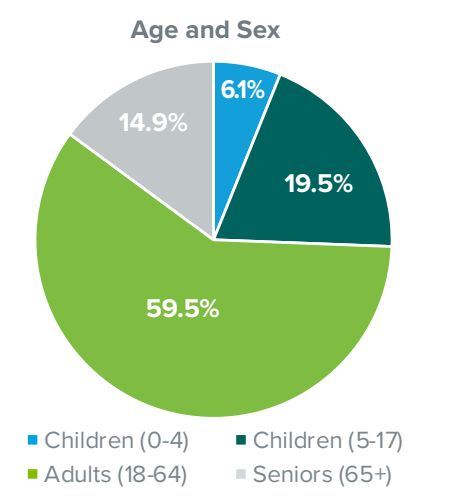
## Community Profile

### Age and Sex

The median age in the Hospital's community is 38.2, higher than that of state which is 36.9 and the same of the US.

Females are a slight majority, representing 50.1% of the population. Middle-aged men and women, 40-64 are the largest demographic groups in the community each at 16.2%.

Children are 25.6% of the total population in the community. Infants, those zero to four, are 6.1% of that number. The community birth rate is 44.9 births per 1,000 women aged 15-50, this is lower than the US average of 51.9 and than that of the state, 51.6. In the Hospital's community, 30.9% of children aged 0-4 and 26.9% of children aged 5-17 live in poverty.

Seniors, those 65 and older, represent 14.9% of the total population in the community. Females are 56.2% of the total senior population.

**Age and Sex**



| | |
|---|---|
| 6.1% | |
| 14.9% | |
| 19.5% | |
| 59.5% | |

- Children (0-4)
- Children (5-17)
- Adults (18-64)
- Seniors (65+)

## Race and Ethnicity

In the Hospital's community, 63.5% of the residents are non-Hispanic White, 2% are non-Hispanic Black and 30.9% are Hispanic or Latino. Residents that are of Asian or Pacific Islander descent represent .5% of the total population, while .2% are Native American and 2.7% are two or more races.

**Race and Ethnicity**
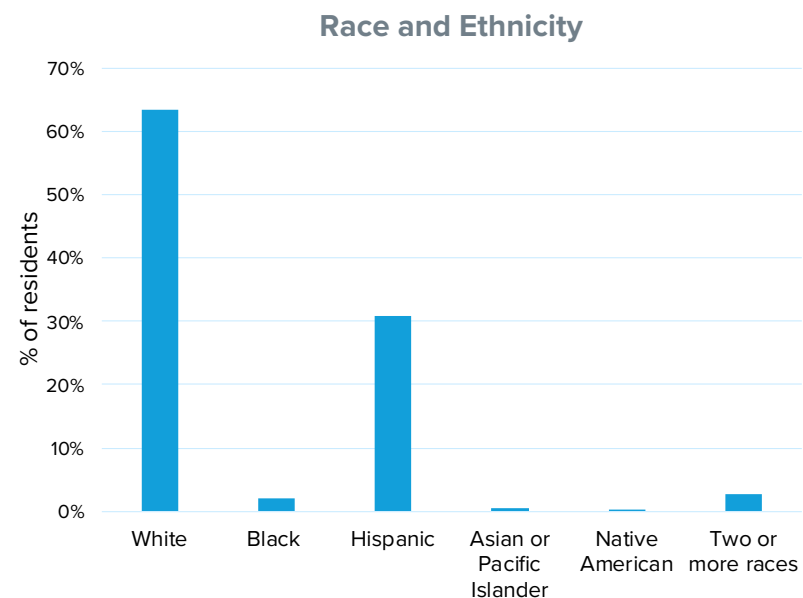


## Social Determinants of Health

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 the 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 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 $51,176. This is below the median for both the state and the US. In the community, 16.9% of residents live in poverty, this is higher than the poverty rate of the state, 14.3% and US, 12.8%.
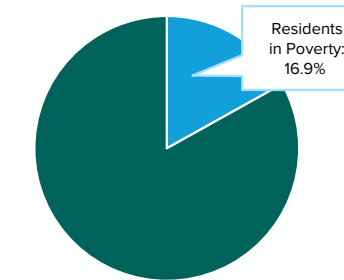
### Food Insecurity and Housing Stability

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 not.[1] Feeding America estimates for 2020[2], showed the food insecurity rate in the Hospital's community as 16.1%.
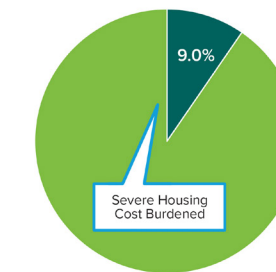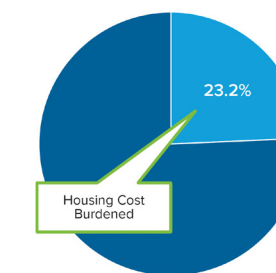
Increased evidence is showing a connection between stable and affordable housing and health.[3] When households are cost burdened or severely cost burdened, they have less money to spend on food, health care and other necessities. Having less access can result in more negative health outcomes. Households are considered cost burdened if they spend more than 30% of their income on housing and severely cost burdened if they spend more the 50%.



Residents in Poverty: 16.9%

23.2%

Housing Cost Burdened

9.0%

Severe Housing Cost Burdened

## Education Access and Quality

Research shows education can be a predictor of health outcomes, as well as a path to address inequality in communities.[4] 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 69.7% high school graduation rate, which is lower than both the state and national average. The rate of people with a post-secondary degree is 17.2%, which is also 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 shows that long-term benefits include improved health outcomes, savings in health care costs and increased lifetime earnings.[5]

In the Hospital's community, 34% of 3–4-year-olds were enrolled in preschool. This is lower than both the state (49.1%) and the national (47.3%) average, which leaves a large percentage of children in the community who may not be receiving these early foundational learnings.
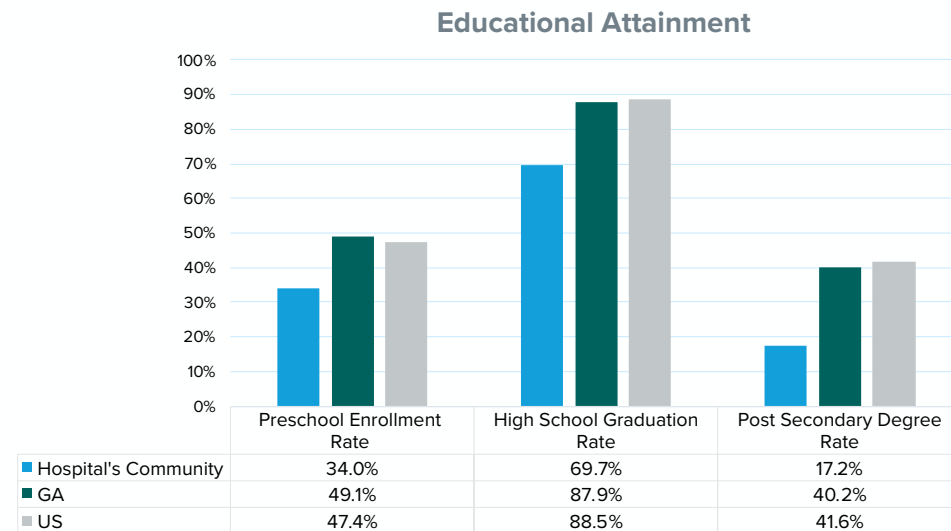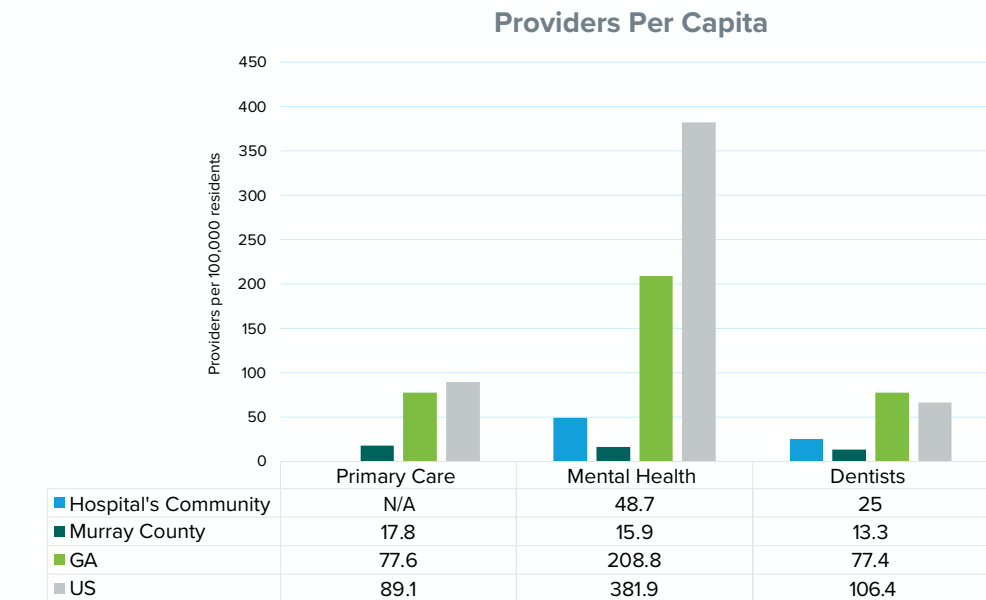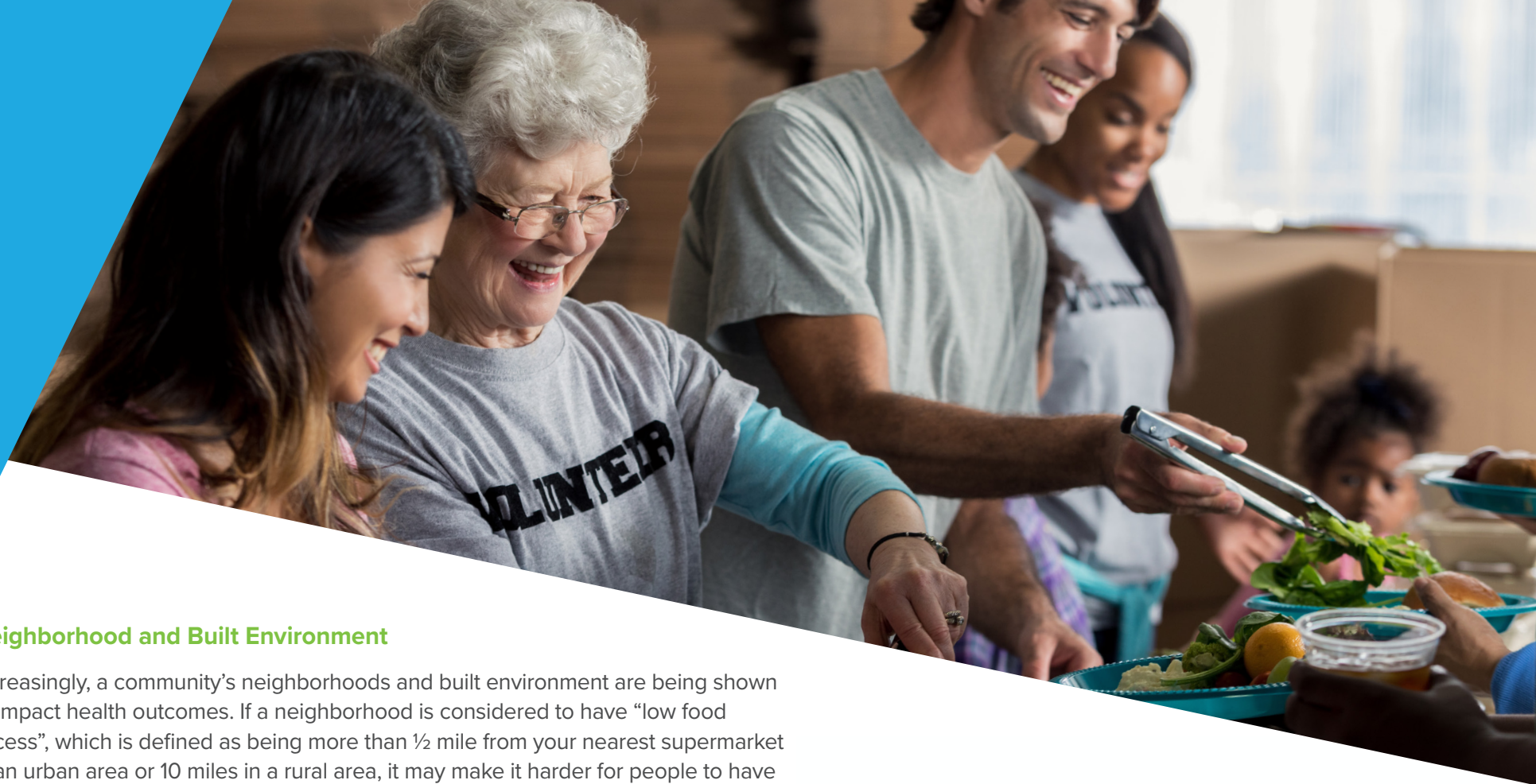
## Health Care Access and Quality

In 2020, 17.2% 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 people.[6]

Accessing health care requires more than just insurance, there also need to be available health care professionals 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, Gilmer County has the most primary care providers available and Whitfield has the most mental health providers.

Routine checkups can provide an opportunity to identify potential health issues and when needed develop care plans. In the Hospital's community, 73.4% of people report visiting their doctor for routine care.

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

### Educational Attainment

| | Preschool Enrollment Rate | High School Graduation Rate | Post Secondary Degree Rate |
|---|---|---|---|
| Hospital's Community | 34.0% | 69.7% | 17.2% |
| GA | 49.1% | 87.9% | 40.2% |
| US | 47.4% | 88.5% | 41.6% |

### Providers Per Capita

Providers per 100,000 residents

| | Primary Care | Mental Health | Dentists |
|---|---|---|---|
| Hospital's Community | N/A | 48.7 | 25 |
| Murray County | 17.8 | 15.9 | 13.3 |
| GA | 77.6 | 208.8 | 77.4 |
| US | 89.1 | 381.9 | 106.4 |

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

## 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 diet.[7] In the Hospital's community, 40.2% of the community lives in a low food access area, while 28.1% 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, 5.5% of the households do not have an available vehicle.

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

### Food Access



Low Food Accesss Area 40.2%

Very Low Food Accesss Area 28.1%
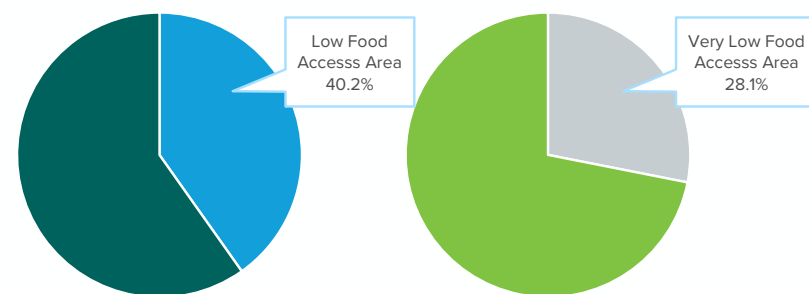
### Social and Community Context

People's relationships and interactions with family, friends, co-workers and community members can have a major impact on their health and well-being.[8] 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, 7.2% of youth aged 16-19 were reported as disconnected, which means they were neither enrolled in school nor working at the time. Also, in the community 26.5% of seniors (age 65 and older) report living alone and 7% 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



Disconnected Youth Reported 7.2%
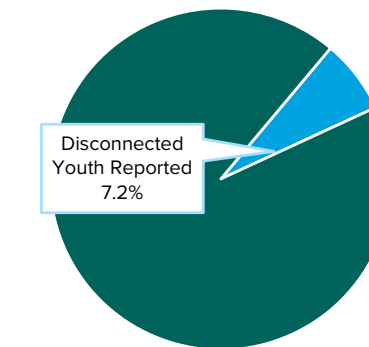
# Process, Methods and Findings

## ▌ 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 and internal Hospital utilization 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 2022 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 weblinks 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 Survey

- 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 seven stakeholders provided their expertise and knowledge regarding their community including:

| Name | Organization | Services Provided | Populations Served |
|---|---|---|---|
| Karen Penland,<br>Nurse Manager | Murray County Health Department | Health care/public health | General public; Low income; Children; Women; Families |
| Barry Gentry,<br>C.O.O. | Murray County Chamber of Commerce | Economic Development, Business Recruitment, Retention and Professional Development | General public |
| Roger Rainey,<br>Principal | Murray County Schools | Education/youth services | Children; Youth; Families; General public |
| Annette Peden,<br>Administrative Assistant and Medical Staff Coordinator | AdventHealth Murray | Health care/public health | Homeless; Low income; Elderly; Children; Women; Veterans; LGBTQIA+; General public |
| T Bond,<br>Community Member | North Murray Booster Club/ Parent | Education/youth services; Spiritual Development | Children; General public |
| Doug Douthitt,<br>Deputy Director of EMS | AdventHealth Murray | Health care/public health; Education/youth services; Transportation; Mental/behavioral health care | Homeless; Low income; Elderly; Children; Women; Veterans; LGBTQIA+; General public |
| Robin Green,<br>Nurse Manager | AdventHealth Murray | Health care/public health | Homeless; Low income; Children; Women; Veterans; LGBTQIA+; 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,[9] 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

Hospital utilization data for 2019-2021 was also used in the assessment. Data was for uninsured or self-pay patients who visited the Hospital for emergency department, inpatient or outpatient services. The top ten diagnosis codes were provided by the AdventHealth finance team for emergency room, inpatient and outpatient visits.

9 Metopio – Ridiculously easy data tools to understand places and populations.

## ▍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:

**Awareness:** A lack of understanding in the community about the services that are available and how to access them.

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

**Transportation:** The barrier that a lack of transportation presents to accessing services in community.

**Lifestyle:** A need to increase understanding on the importance of lifestyle choices on health and health outcomes.

**Seniors:** A growing senior population and the need to increase resources and support services to create a healthy and safe community for residents to grow old in.

**Cost:** The increasing barrier that cost creates in accessing necessities, care, transportation and other resources.

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:

**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 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.

**Health Insurance and Health Care Access:** Inadequate health insurance coverage is one of the largest barriers to health care access, and the unequal distribution of coverage contributes to disparities in health. Out-of-pocket medical care costs may lead individuals to delay or forgo needed care (such as doctor visits, dental care and medications) and medical debt is common among both insured and uninsured individuals.

**Mental Health and Mental Health Disorders:** 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.

**Nutrition & Healthy Eating:** Nutrition is considered something that is taken into the body as food, influencing health, while healthy eating means eating a variety of foods that give you the nutrients you need to maintain your good health. Many people in the United States do not eat a healthy diet, which could be because some people do not have the information needed to choose healthy foods or do not have access to healthy foods or cannot afford to buy enough food. People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes and other health problems.

**Obesity:** Obesity is a medical condition in which excess body fat has accumulated to an extent that it may have a negative effect on health. Obesity is measured by an individual's body mass index (BMI). The prevalence of obesity continues to increase in the United States. Obesity is common, serious and costly. This epidemic is putting a strain on American families, affecting overall health, health care costs, productivity and military readiness. Moreover, obesity can have negative health outcomes since obesity can lead to type 2 diabetes, heart disease and some cancers.

**Physical Health & Activity:** Being physically active means movement of the body to get to and from places, for work or for leisure. Regular physical activity is proven to help prevent and manage noncommunicable diseases such as heart disease, stroke, diabetes and several cancers. It also helps prevent hypertension, maintain healthy body weight and can improve mental health, quality of life and well-being.

**Preventative Care – Screenings:** Prevention means intervening before health effects occur, through measures such as screenings, vaccinations, altering risky behaviors (poor eating habits, tobacco use) and banning substances known to be associated with a disease or health condition.

**Tobacco and Vaping:** 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. Vaping is an alternative way to consume tobacco and has been growing in popularity.

# 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 12. Community partners on the CHNAC represented 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 2022, the CHNAC met three times to review and discuss the collected data and select the top community needs.

### Members of the CHNAC included:

**Community Members**

- Barbie Kenderick, Assistant Superintendent, Murray County Schools, providing education and strategies which connect families with resources to strengthen education outcomes for students

- Barry Gentry, COO, Murray County Chamber of Commerce, creating educational and economic opportunities for youth in the area through workforce development programs from 9th and beyond

- Tony Causby, Director, Murray County Boys & Girls Club, providing a space for students to grow, the club provides financial assistance for those in need

**AdventHealth Team Members**

- Donny Abraham, Vice President, Administrator

- Garrett Nudd, Associate Vice President, Marketing and Brand Strategy

- Juleun Johnson, Vice President, Mission and Ministry, Southeast Region

- Wendy Taylor, Office Manager, Marketing and Foundation Office

- Alexa Hernandez, Chaplain

**Public Health Experts**

- Karen Penland, Public Health Nursing Supervisor, Murray County Health Department, providing services to all community members with a focus on those that are underserved

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 scored the need through an online survey.

The needs found in the assessment were evaluated and ranked by the CHNAC and the HHNAC on a scale of 1 to 5 (1=lowest, 2=low, 3=moderate, 4=high, 5=highest) using the criteria below:

- **Alignment:** Does this issue align with our mission, strategy, public health or community goals? (15%)

- **Impact on Community:** What is the scope, size and seriousness of this issue? What are the consequences to the health of the community of not addressing this issue now? (25%)

- **Resources:** Are there existing, effective interventions and opportunities to partner with the community to address this issue? (30%)

- **Outcome Opportunities:** Can an impact on this issue be made in a demonstrable way and will interventions have an impact on other health and social issues in the community? (30%)

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

| Identified Issues | Alignment (15%) | Impact on Community (25%) | Resources (30%) | Outcome Opportunities (30%) | Total Ranking |
|---|---|---|---|---|---|
| Diabetes | 4.17 | 4.33 | 3.33 | 4.50 | 4.06 |
| Tobacco and Vaping Use | 4.50 | 4.67 | 2.67 | 4.50 | 3.99 |
| Preventative Care - Screenings | 4.33 | 4.33 | 3.00 | 4.50 | 3.98 |
| Cancer | 4.17 | 4.33 | 3.17 | 4.33 | 3.96 |
| Cardiovascular Disease: Heart Disease | 4.00 | 4.17 | 3.17 | 4.33 | 3.89 |
| Physical Health | 4.50 | 4.50 | 2.67 | 4.17 | 3.85 |
| Cardiovascular Disease: Hypertension | 3.83 | 4.00 | 3.17 | 4.33 | 3.83 |
| Cardiovascular Disease: High Cholesterol | 3.83 | 4.17 | 2.83 | 4.33 | 3.77 |
| Health Insurance and Access | 3.67 | 4.00 | 3.50 | 3.83 | 3.75 |
| Obesity | 4.00 | 3.67 | 3.00 | 4.33 | 3.72 |
| Mental Health | 4.17 | 4.83 | 2.17 | 3.83 | 3.63 |
| Nutrition and Healthy Eating | 4.67 | 4.50 | 2.33 | 3.67 | 3.63 |

After a list of 12 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:**

- Chris Self,
  President and CEO,
  AdventHealth Gordon and AdventHealth Murray

- Donny Abraham,
  Vice President,
  Administrator

- Juleun Johnson,
  Vice President, Mission and Ministry,
  Southeast Region

- Garrett Nudd,
  Associate Vice President,
  Marketing and Brand Strategy

- Tracy Farriba,
  Director, Community Relations

- Erika Meyer,
  Manager, Marketing

- Wendy Taylor,
  Office Manager, Marketing and
  Foundation Office

The HHNAC narrowed down the list to three priority needs:

- **Heart Disease and Heart-Related Issues**
  Focusing on seniors and low-income individuals residing in the 30705 zip code

- **Cancer**
  Focusing on low-income individuals residing in the 30705 zip code

- **Vaping**
  Focusing on adults and youth residing in the 30705 zip code

## ▌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 |
|---|---|
| **Mental Health** | • Georgia Mountains Health, provides services to children, adolescents and adults who are facing depression, anxiety or other mental health concerns on an income-based sliding fee scale<br>• Highland River Center, provides comprehensive treatment, support and recovery services for adults, children, families and veterans affected by mental health disorders, substance use disorders and intellectual and developmental disabilities on an income-based sliding fee scale |
| **Preventative Care - Screenings** | • PeachCare for Kids/GA Department of Health, providing a comprehensive health care program for uninsured children living in Georgia; the health benefits include primary, preventive, specialist, dental care and vision care<br>• Multiple Head Start locations, providing services to aid with nutrition, health & safety, mental health, pregnancy and child development including disease and disability screenings<br>• Georgia Mountains Health Services, providing a variety of primary care and other medical services to individuals and families in the community on an income-based sliding fee scale |
| **Diabetes** | • AdventHealth Murray, providing clinical care to all community members regardless of ability to pay<br>• Georgia Mountains Health Services, providing a variety of primary care and other medical services to individuals and families in the community on an income-based sliding fee scale |
| **Health Insurance and Access** | • PeachCare for Kids/GA Department of Health, providing a comprehensive health care program for uninsured children living in Georgia; the health benefits include primary, preventive, specialist, dental care and vision care<br>• Georgia Department of Human Services/GA Medicaid, providing health care services to individuals who meet the requirements for income, resources and citizenship |
| **Physical Health & Activity** | • Senior Citizens Center: providing resources, support and reactional opportunities for community connectedness for seniors in need |

| Top Issues | Current Community Programs |
|---|---|
| **Tobacco and Vaping Usage** | • Georgia Department of Health/Tobacco Quit Line, providing effective, evidence-based interventions to help Georgians quit smoking and using any other smokeless tobacco products (i.e., dip or snuff, available to all Georgians<br>• AdventHealth Murray provides vaping education classes at local schools and Boys and Girls Clubs |
| **Cardiovascular Disease: Hypertension, High Cholesterol, Heart Disease** | • AdventHealth Murray, providing clinical care to all community members regardless of ability to pay<br>• Georgia Mountains Health Services, providing a variety of primary care and other medical services to individuals and families in the community on an income-based sliding fee scale |
| **Nutrition and Healthy Eating** | • Multiple Head Start locations, providing services to aid with nutrition, health & safety, mental health, pregnancy and child development. Head Start programs serve infants, children, low-income parents with children<br>• Women, Infants and Children (WIC), provides low-income families with children under five and pregnant women with vouchers to purchase healthy food |
| **Cancer** | • AdventHealth Murray, providing clinical care to all community members regardless of ability to pay<br>• Georgia Mountains Health Services, providing a variety of primary care and other medical services to individuals and families in the community on an income-based sliding fee scale<br>• The Northwest Georgia Regional Cancer Coalition, Inc. is a collaboration of fifteen counties in Northwest Georgia whose vision is to build a model of comprehensive rural cancer control. Our mission is to develop programs of excellence in cancer-related education, communications, prevention, early detection and screening, treatment and research in this region. |
| **Obesity** | • AdventHealth Murray, providing clinical care to all community members regardless of ability to pay<br>• Georgia Mountains Health Services, providing a variety of primary care and other medical services to individuals and families in the community on an income-based sliding fee scale |

## ▌Priorities Addressed

### Heart Disease and Heart-Related Issues[10]
*Focusing on seniors and low-income individuals residing in the 30705 zip code*

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 a third of community survey respondents (30.1%) report having hypertension, which can be a major contributing factor to heart disease and hypertension is shown to be one of the top ten codes in Hospital visits by uninsured patients. Also, more than 1/3 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.

10 These conditions were referred to as "cardiovascular" related during data review and discussion.

### Cancer
*Focusing on low-income individuals residing in the 30705 zip code*

In the Hospital's community 6.5% of the residents have had cancer according to secondary data. There is also a higher mortality rate per 100,000 than in both the state and the nation for colorectal cancer, breast cancer and lung, trachea and bronchus cancer in Murray County. When addressing cancer as a priority, the Hospital can look to align to local, state and national efforts when developing resources to create better outcome opportunities over the next three years.

### Vaping
*Focusing on adults and youth residing in the 30705 zip code*

According to community survey respondents, 30.8% are vaping every day or some days. Stakeholders also consider vaping to be a top health behavior risk factor, particularly among youth. Nationally, the prevalence of vaping and e-cigarette usage has been rising among youth and although vaping is considered to be less than harmful than smoking tobacco, there is still much unknown about its long-term effects. In addressing the priority, the Hospital will look at both proactive strategies to keep people from starting and reactive strategies to help them quit.

# ▌ Priorities Not Addressed

The priorities not addressed include:

## 🧪 Diabetes

Diabetes is shown to impact 12.6% of residents in the Hospital's community according to public data, while 22.4% of community survey respondents report having diabetes. Diabetes related conditions are also shown to be one of the top ten codes in Hospital visits by uninsured patients.

The Hospital did not select diabetes as a priority, as it is not positioned to directly address this in the community at large and will focus its available resources where there is the greatest opportunity for positive impact.

## 📋 Preventative Care and Screenings

According to community survey respondents, 33.3% are not aware of what preventative screenings are needed. Among those that are aware, 9.6% report not getting regular screenings. While public data shows that only 73.4% of community members are up to date on routine checkups. The Hospital did not select preventative care and screenings as a priority due to a lack of resources. However, the Hospital did select heart disease and heart related issues as a priority, which is disproportionately impacting the community and may use preventative care strategies in addressing it.

## 📋 Health Insurance and Health Care Access

In the Hospital's community, secondary data shows 17.2% of residents are uninsured, this is higher than the both the state and national rate. There are also fewer primary care, mental health and dental care providers in the counties served by the Hospital than the rates both in the state and nationally. While slightly over a quarter, 25.6%, of community survey respondents reported not having a primary care provider. The Hospital did not select this as a priority as it is not resourced to directly address this in the community outside of existing efforts but will support other community partners where possible in their efforts.

## 📦 Obesity

In the Hospital's community 35.1% of the residents are obese according to secondary data. While almost a quarter, 23.1%, of community survey respondents report being overweight. Individuals with obesity have a higher risk of developing heart disease, type 2 diabetes and some types of cancer. The Hospital did not choose obesity as a priority, instead focusing its efforts and resources on heart disease through which it may indirectly impact obesity in the community.

## 🍎 Nutrition and Healthy Eating

According to community survey respondents, 36.5% eat fruits and vegetables less than two days a week. Secondary data shows 40.2% of residents in the Hospital's community live in a low food access area and more than a quarter (28.1%) live in a very low food access area. The Hospital believes that other organizations are better positioned in the community to address this need directly and will support those efforts when able.

## 👟 Physical Health and Activity

In the Hospital's community, 34.6% of residents report not engaging in physical activities outside of their jobs according to secondary data. The community also has a higher percentage, 17.5%, than both the state and the nation of residents who report 14 or more days in the last 30 during which their physical health was not good. Community members in the assessment cited a need for more low-cost fitness centers and accessible community spaces for recreation. The Hospital believes that other organizations are better positioned in the community to address this need directly and will support those efforts when able.

## 🧠 Mental Health and Mental Health Disorders

In the Hospital's community, 22.5% of residents have a prevalence of depression, while 19.5% of the residents report poor mental health. According to community survey respondents 14.7% have been diagnosed with a depressive order and more than 18% have been diagnosed with an anxiety disorder. Although the mental health needs of the community are significant, the HHNAC did not perceive the ability to impact the issue with existing Hospital resources at this time and did not select it as a priority.

# 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 prior to May 15, 2023.

# 2020 Community Health Plan Review

The Hospital evaluates the progress made on the implementation strategies from the Community Health Plan annually. The following is a summary of progress made on our most recently adopted plan. The full evaluation is available upon request.

## Priority 1: Cancer

In the 2019 CHNA, the Hospital addressed cancer as a priority. The assessment showed the cancer mortality rate per 100,00 in the Hospital's community (181.3) was higher than in the state (162.1). The rates for lung cancer were also higher than the state rate. The community's rate of individuals receiving cancer screenings, sigmoidoscopy or colonoscopy and PAP tests, was lower than in the state.

Since adopting the plan, the Hospital has focused its efforts on increasing education on the importance of early diagnosis and treatment. To support this, the Hospital has created custom educational materials which include information on the importance of early detection, diagnosis and treatment, as well as identify local care options for individuals in need. Through participation in several community events the Hospital has connected almost 200 individuals with education and care options in the local community.

## Priority 2: Diabetes

The Hospital chose diabetes as a priority in the 2019 assessment as the percentage of individuals reporting diabetes was over one and a half times higher in the community than the state average, 19.1% compared to 11.2%. Inpatient admission data also indicated endocrinology as one of the most frequent diagnoses at the Hospital.

As part of their efforts to address the need in the community, the Hospital has provided free education to raise awareness about diabetes and how to manage it. This has led to more than 130 community members attending classes on diabetes education, weight management and learning strategies on how to manage their chronic disease.

## Priority 3: Smoking/Vaping

The Hospital also chose vaping as a priority. During the 2019 assessment, community stakeholders vocalized concern over the growing number of children who had begun vaping. The use of e-cigarettes is particularly unsafe for children, teens and young adults as it is not only highly addictive but harmful to adolescent brain development.

As part of the effort to address this, the Hospital partnered with local schools to provide educational seminars on the impacts of vaping. The Hospital has provided lectures on the dangers of vaping to more than 3,000 students since adopting the plan.

## Priority 4: Nutrition

In the 2019 CHNA, the Hospital also prioritized nutrition. During the assessment, the need to focus on nutrition was reflected in consistently higher than state incidence of preventable, chronic disease. The Community Health Needs Assessment Committee agreed that increasing the community's ability to access and incorporate a more balanced diet would help with the prevention and maintenance of many issues identified throughout the needs assessment process.

Since adopting the plan, the Hospital has focused on increasing awareness around the importance of good nutrition and its impact on health. Through participation in several community events the Hospital has connected with almost 300 community members to provide nutrition education.

# 2019 Community Health Needs Assessment Comments

We posted a link to the most recently conducted CHNA and most recently adopted 2020 Community Health Plan on our Hospital website as well as AdventHealth.com prior to May 15, 2020 and have not received any written comments.

**AdventHealth**

**Adventist Health System Georgia, Inc. d/b/a
AdventHealth Murray**

CHNA Approved by the Hospital Board on: September 28, 2022

For questions or comments please contact:
CORP.CommunityBenefitSupport@AdventHealth.com

22-COMIMP-08540