AdventHealth Murray 2025 Community Health Needs Assessment

Extending the Healing Ministry of Christ

AdventHealth

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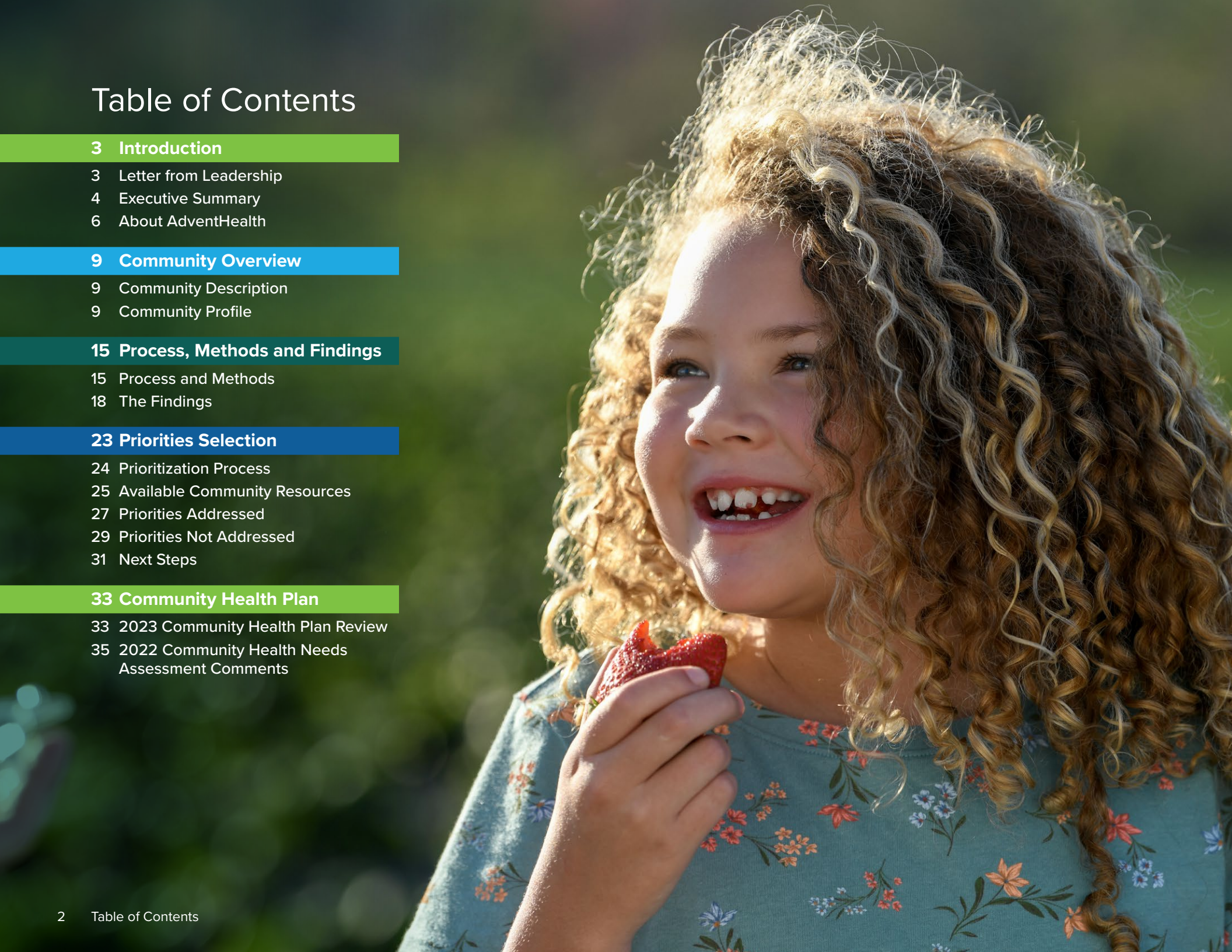


Letter from Leadership

At AdventHealth, we have a sacred mission of Extending the Healing Ministry of Christ. That obligation goes beyond our hospital walls and permeates into our communities. Our commitment is to address the health care needs of our community with a wholistic focus, one that strives to heal and restore the body, mind and spirit. We want to help our communities get well and stay well.

Every three years, AdventHealth hospitals across the nation complete a Community Health Needs Assessment. During this assessment, we talk and work with community organizations, public health experts and people like you who understand our communities best. This in-depth look at the overall health of our communities and the barriers to care they experience helps AdventHealth better understand the unique needs in the various communities we serve.

We use this information to create strategic plans that address the issues that impact our communities most. At AdventHealth, we know that a healthy community is not a “one size fits all” proposition—everyone deserves a whole health approach that meets them where they are and supports their individual health journey.

This work would not be possible without the partnership of public health experts, community organizations and countless community members who helped inform this report. Through these ongoing partnerships and collaborative efforts, AdventHealth will continue to create opportunities for better health in all the communities we serve.

In His service,

Terry Shaw

Our commitment is to address the health care needs of our community with a wholistic focus, one that strives to heal and restore the body, mind and spirit.

Executive Summary

Adventist Health System Georgia, Inc. dba AdventHealth Murray will be referred to in this document as AdventHealth Murray or "The Hospital." AdventHealth Murray in Chatsworth, Georgia conducted a community health needs assessment from February 2024 to June 2025. 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 the assessment findings to develop and implement a 2026–2028 Community Health Plan based on the needs prioritized in the assessment process.

Community Health Needs Assessment Committee

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 community members. This included intentional representation from low-income, minority and other underserved populations.

The CHNAC met two times in 2024. They reviewed primary and secondary data and helped to identify the top priority needs in the community.

See Prioritization Process for a list of CHNAC members.

Data

AdventHealth Murray 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 2022–2024. In addition, publicly available data from state and nationally recognized sources were used. Primary and secondary data was compiled and analyzed to identify the top 13 needs.

See Process, Methods and Findings for data sources.

Community Asset Inventory

The next step was to create a community asset inventory. This inventory was designed to help the CHNAC understand the existing community efforts being used to address the 13 needs identified from the aggregate primary and secondary data. This inventory was also designed to prevent duplication of efforts.

See Available Community Resources for more.

Selection Criteria

The CHNAC participated in a prioritization process after a data review and facilitated discussion session. The identified needs were then ranked based on clearly defined criteria.

See Prioritization Process for more.

The following criteria were considered during the prioritization process:

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?

Priorities to Be Addressed

The priorities to be addressed are:

1. Cancer
2. Diabetes
3. Neighborhood and Built Environment—Food Security

See Priorities Addressed for more.

Approval

On April 30, 2025, the AdventHealth Murray board approved the Community Health Needs Assessment findings, priority needs and final report. A link to the 2025 Community Health Needs Assessment was posted on the Hospital's website prior to December 31, 2025.

Next Steps

AdventHealth Murray will work with the CHNAC to develop a measurable implementation strategy called the 2026–2028 Community Health Plan to address the priority needs. The plan will be completed, board approved and posted on the Hospital's website prior to May 15, 2026.

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 100,000 talented and compassionate team members serve over 8 million patients annually. From physician practices, hospitals and outpatient clinics to skilled nursing facilities, home health agencies and hospice centers, AdventHealth provides individualized, whole-person care at more than 50 hospital campuses and hundreds of care sites throughout nine states.

Committed to your care today and tomorrow, AdventHealth is investing in new technologies, research and the brightest minds to redefine wellness, advance 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 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 documentation and paying bills to conducting a virtual urgent care visit with a provider, we're making health care easier—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 team culture. Recognized by Becker's Hospital Review on its "150 Top Places to Work in Healthcare" several years in a row, this recognition is given annually to health care organizations that promote workplace diversity, employee engagement and professional growth. In 2024, the organization was named by Newsweek as one of the Greatest Workplaces for Diversity and a Most Trustworthy Company in America.

About 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 1970s 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. As a part of our aim to provide comprehensive care to our community, AdventHealth Medical Group has clinic locations in cardiology, allergy care, general surgery, orthopedics and sports medicine, physical therapy, primary care, urology, women's care, and emergency and urgent care services right in the heart of Chatsworth.

At this small rural hospital, highly trained specialists deliver award-winning care for residents of Murray County as well as guests visiting Fort Mountain and other nearby areas. Our dedicated physicians offer warm, compassionate care at your bedside and beyond. Considered an Acute Stroke Ready Hospital by The Joint Commission, AdventHealth Murray provides access to expert care across a wide range of medical services. From emergency care and inpatient care to imaging and home care, we're here to help you live a fuller, happier life.

At AdventHealth Murray, Extending the Healing Ministry of Christ is our mission. It calls us to be His hands and feet in helping people feel whole. We strive to provide whole-person care to heal and restore the body, mind and spirit.

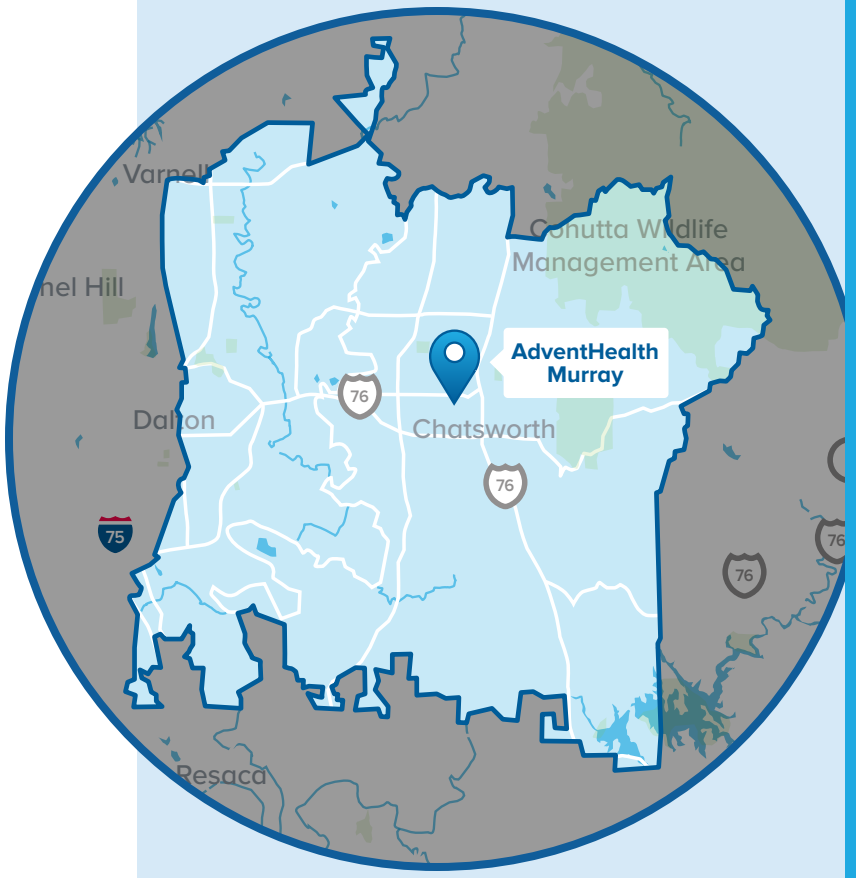
AdventHealth Murray is a comprehensive, 42-bed community hospital located in Murray County, Georgia.

Community Overview

Community Description

Located in Murray County, Georgia, AdventHealth Murray defines its community as the Primary Service Area (PSA), the area in which 75–80% of its patient population lives. This includes two zip codes across Murray County and Whitfield County.

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 (CDC), unless indicated otherwise. Data are reported for the Hospital's PSA and counties within 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

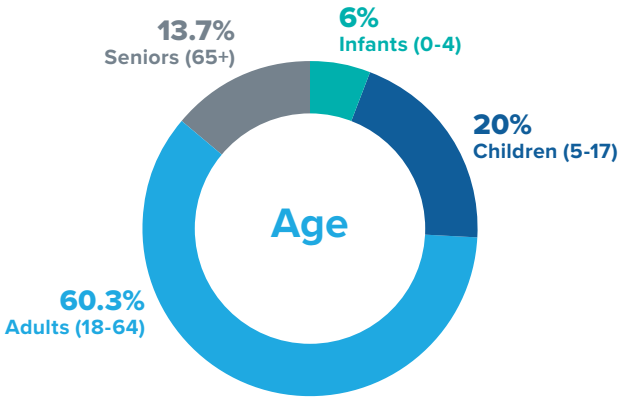
The median age in the Hospital's community is 36.6, lower than that of state which is 37.2 and the US, 38.2.

Males are the majority, representing 50.7% of the population. Young adult women, 25-39 are the largest demographic in the community at 29%.

Children make up 26% of the total population in the community. Infants, those zero to four, are 5.9% of that number. The community birth rate is 41.6 births per 1,000 women aged 15–50. This is lower than the U.S. average of 51.6, and lower than that of the state, 50.9. In the Hospital's community, 24.3% of children aged 0–4 and 22.3% of children aged 5–17 are in poverty.

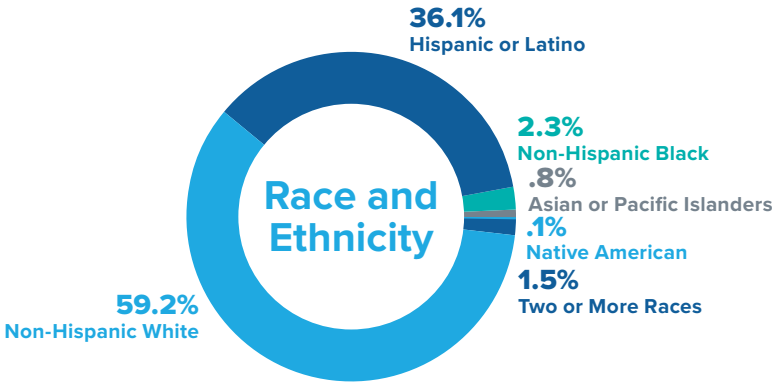
AdventHealth Murray defines its community two zip codes across Murray County and Whitfield County.

Seniors, those 65 and older, represent 13.7% of the total population in the community. Females are 52.7% of the total senior population.



Race and Ethnicity

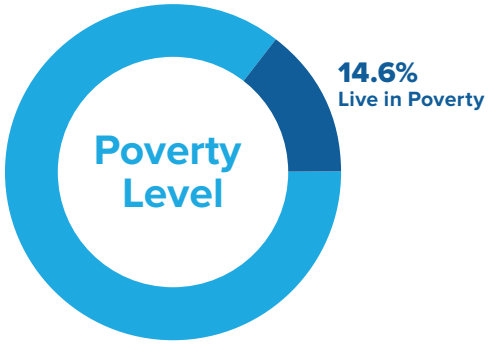
In the Hospital's community, 59.2% of the residents are non-Hispanic White, 2.3% are non-Hispanic Black and 36.1% are Hispanic or Latino. Residents who are of Native American descent represent less than 1% of the total population, while 1.5% are two or more races.



Economic Stability

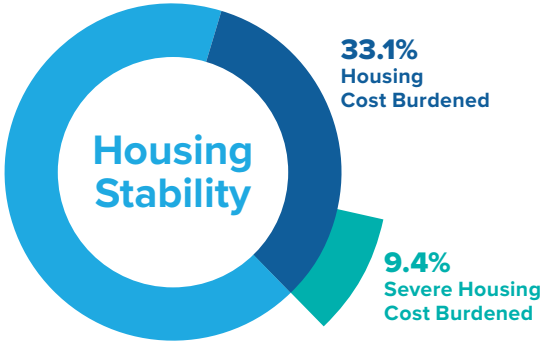
Income

The median household income in the Hospital's community is $51,086. This is below the median for both the state ($65,427) and the US ($68,906). In the Hospital's community, 14.6% of residents live in poverty, the majority of whom are children under the age of 5.



Housing Stability

Increasingly, evidence is showing a connection between stable and affordable housing and health.[1] 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%.



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

Education Access and Quality

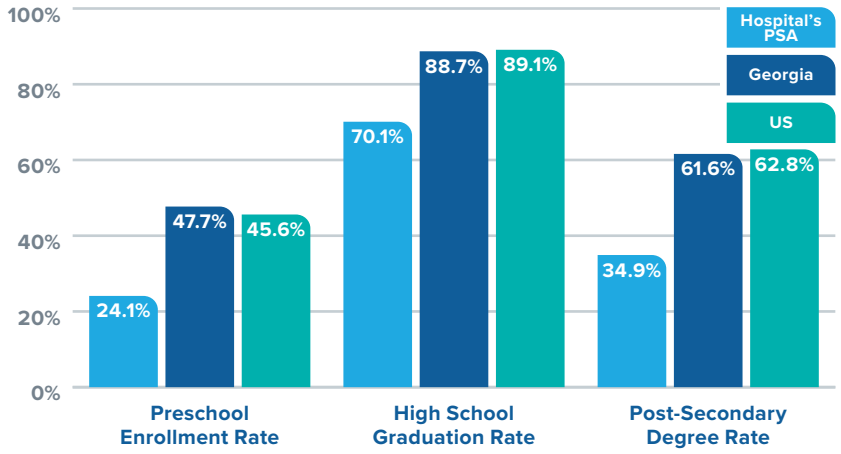
Research shows that education can be a predictor of health outcomes, as well a path to address inequality in communities.[2] Better education can lead to people having an increased understanding of their personal health and health needs. Higher education can also lead to better jobs, which can result in increased wages and access to health insurance.

In the Hospital's community, there is a 70.6% high school graduation rate, which is lower than both the state (88.7%), and national average (89.1%). The rate of people with a post-secondary degree is lower in the Hospital's PSA than in both the state (41.9%) and nation (43.1%).

Early childhood education is uniquely important and can improve children's cognitive and social development. It 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.[3]

In the Hospital's community, 24.1% of three- and four-year olds were enrolled in preschool. This rate is lower than the state (47.7%) and the national (45.6%) average. There is a large percentage of children in the community who may not be receiving these early foundational learnings.

Educational Attainment



2 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)

3 Early Childhood Education | U.S. Department of Health and Human Services

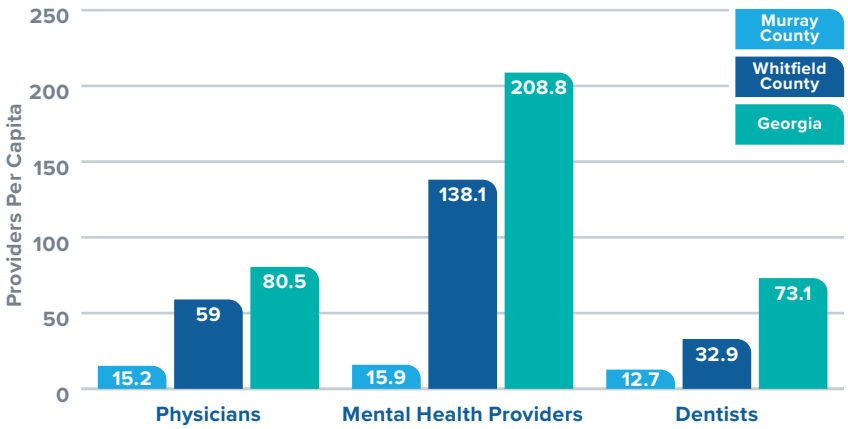
Health Care Access and Quality

In 2022, 15.6% of community members aged 18–64 were found to lack health insurance. Without access to health insurance, these individuals may experience 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.[4]

Accessing health care requires more than just insurance. There must also 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, Murray County has the least care providers available, lower than the state average and all counties within the PSA.

Routine checkups can provide an opportunity to identify potential health issues and when needed develop care plans. In the Hospital's community, 73.8% of people report visiting their doctor for routine care.

Available Health Care Providers



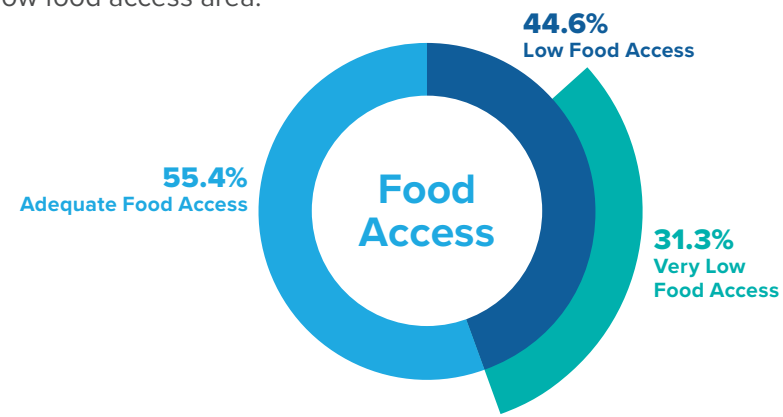
4 Health Insurance and Access to Care | CDC

Neighborhood and Built Environment

Increasingly, a community's neighborhoods and built environment are 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 the nearest supermarket in an urban area or ten 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 one mile from your nearest supermarket in an urban area or 20 miles in a rural area.

People who are food insecure, who have reduced quality or 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.[5] Feeding America estimates for 2022,[6] showed the food insecurity rate in Murray County, where the Hospital is located, as 15.5%.

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, 44.6% of the community lives in a low food access area, while 31.3% 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

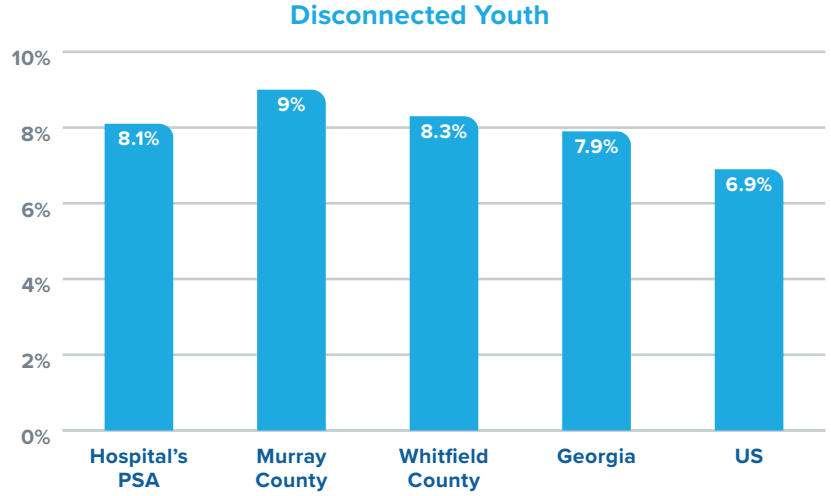
5 Facts About Child Hunger | Feeding America
6 Map the Meal Gap 2022 | Feeding America
7 Heart Disease Risk Factors | CDC

transportation can be essential to access health care, healthy food and steady employment. In the community, 4.9% of the households do not have an available vehicle.

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.

In the community, 8.1% of youth aged 16–19 were reported as disconnected, meaning they were neither enrolled in school nor working at the time. Disconnected youth are also referred to as opportunity youth, marginalized youth, disengaged youth, and NEET (Not in Education, Employment, or Training). The percentage of disconnected youth was highest in Murray County at 9%.



Also, in the community 28.7% of seniors (age 65 and older) report living alone and 5.5% 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 | U.S. Department of Health and Human Services

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 outcomes in communities throughout the country.

The Hospital categorized and analyzed SDOH data following the Healthy People 2030 model. This approach was chosen so the Hospital could align its work with national efforts when addressing social determinants of health when possible. 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

Includes areas such as income, cost of living and housing stability.

Education Access and Quality

This framework 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

Covers topics such as access to health care, access to primary care and health insurance coverage.

Neighborhood and Built Environment

Includes quality of housing, access to transportation, food security, and neighborhood crime and violence.

Social and Community Context

Focuses on topics such as community cohesion, civic participation, discrimination and incarceration.

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, 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 and ethnicity, gender, profession, household income, education level and geographic location. The Hospital also collected publicly available 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. Removed rest of paragraph.

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 2025 CHNA.

A real effort was made to reach out to all members of the community to obtain perspectives across age, race and ethnicity, gender, profession, household income, education level and geographic location.

Community Input

The Hospital collected input directly from the community and from community stakeholders, including 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

- The survey was provided in both English and Spanish to anyone in the community and accessible through weblinks and QR codes.
- Links and QR codes were 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 electronic mailing lists they maintained, and, when possible, shared on their own social media channels.
- Paper surveys were given to partners to place at their organizations with the goal of reaching those who might not have access otherwise and who experience barriers to responding electronically. Responses from paper surveys were recorded using survey weblinks.

Stakeholder Survey

- Participants were asked to provide input on health, and barriers to health, that they saw in the community.
- Surveys were sent to individuals working at community organizations, including public health organizations, that work to improve the health and well-being of the community.
- Efforts were focused on stakeholders who represent or serve underserved, underrepresented communities that are lower income, and are more likely to be impacted by the social determinants of health.

Public and Community Health Experts Consulted

A total of 12 stakeholders provided their expertise and knowledge regarding their communities, including:

Name	Organization	Services Provided	Populations Served
Donny Abraham, VP and Administrator	AdventHealth Murray	Health Care, Public Health, Behavioral Health	General Public
Ashley Johnson, School Social Worker	Murray County Schools	Education, Youth Services	School-Age Children and Families
Pam Bishop, Director	Murray County Family Connection	Social Services Resources	General Public
Alexa Hernandez, Chaplain	AdventHealth Murray	Church Headquarters	Parents or Caregivers, People with Disabilities, Elderly, LGBTQIA+, Infants, Children Adolescents, Women, Homeless, Low Income, Veterans, General Public
Barry Gentry, President and CEO	Murray County Chamber of Commerce	Health Care, Public Health, Education, Youth Services, Mental Health, Faith-Based Support	Focus on Business
Karen Penland, County Nurse Manager	Murray County Health Department	Business Development	General Public
Tracy Farriba, Director of Physician and Community Outreach	AdventHealth	Health Care, Public Health	Infants, Children, Adolescents, LGBTQIA+, Elderly, Parents or Caregivers, People with Disabilities, Women, Homeless, Low Income, Veterans, General Public
Josefer Montes, Executive Director	AdventHealth	Health Care, Public Health	Infants, Children, Adolescents, Lgbtqia+, Elderly, People with Disabilities, Parents or Caregivers, Women, Homeless, Low Income, Veterans, General Public
Denise Rustad, Wellness Coordinator	AdventHealth	Health Care, Public Health	Infants, Children, Adolescents, LGBTQIA+, Elderly, Parents or Caregivers, People with Disabilities, Women, Low Income, Veterans, General Public
Sandra Webb, ACNO	AdventHealth Murray	Health Care, Public Health	General Public
Wendy Hunt, Director	Murray County Senior Center	Food Assistance, Health Care, Public Health, Transportation, Housing, Mental Health, Employment Assistance, Aging Resource Liaison	Elderly, Low Income, Veterans
Tommy Parker, County Manager	Murray County Government	Transportation, Domestic Violence, Mental Health	General Public

Secondary Data

To inform the assessment process, the Hospital collected existing health-related and demographic data about the community from public sources. This included data on health conditions, social determinants of health and health behaviors.

The most current publicly available 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
- National Cancer Institute

Hospital utilization data for uninsured or self-pay patients who visited the Hospital for emergency department, inpatient or outpatient services in 2022 – 2024 was also used in the assessment. The top ten diagnosis codes were provided by the AdventHealth Information Technology team.

The Findings

To identify the top needs, the Hospital analyzed the data collected across all sources. At the conclusion of the data analysis, there were eleven needs that rose to the top. These needs were identified as being the most prevalent in the community and frequently mentioned among community members and stakeholders.

The significant needs identified in the assessment process included:

Asthma

Asthma is a chronic (long-term) condition that affects the airways in the lungs. The airways are tubes that carry air in and out of your lungs. With asthma, the airways can become inflamed and narrowed at times. This makes it harder for air to flow out of the airways when breathing out. Asthma attacks can lead to emergency department visits and even death. Reducing environmental triggers and making sure people get the right medications can help reduce asthma attacks.

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).

Diabetes

Diabetes is a serious disease when the body doesn't make enough insulin or can't use it well. Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases.

Heart Disease and Stroke

Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

In addition, making sure people who experience a cardiovascular emergency—like stroke, heart attack, or cardiac arrest—get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need.

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.

Obesity

Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Some racial/ethnic groups are more likely to have obesity, which increases their risk of chronic diseases. Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce overweight and obesity. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight.

Drug and Alcohol Use

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.

Physical Activity

Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active—like providing access to community facilities and programs—can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

Tobacco Use

Most deaths and diseases from tobacco use in the United States are caused by cigarettes.1 Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

Economic Stability

When families have to spend a large part of their income on housing, they may not have enough money to pay for things like healthy food or health care. This is linked to increased stress, mental health problems, and an increased risk of disease. Expanding policies that make housing more affordable can help reduce the proportion of families that spend more than 30 percent of their income on housing.

Education Access and Quality

People with higher levels of education are likely to be healthier and live longer. Interventions to increase high school graduation rates and ensure that students are proficient in math and reading can help boost overall achievement. To promote physical health and well-being for children and adolescents, schools can provide safe and supportive environments, healthy foods, health education, and physical education. They can also offer access to health care and mental health services and help students manage chronic conditions.

Health Care Access and Quality

About 1 in 10 people in the United States don't have health insurance.1 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. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from healthcare providers who offer them. Interventions to increase access to health care professionals and improve communication—in person or remotely—can help more people get the care they need.

Neighborhood and 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. Giving more people benefits through nutrition assistance programs, increasing benefit amounts, and addressing unemployment may help reduce food insecurity and hunger.

Additionally, many people in the United States live in neighborhoods with high rates of violence, unsafe air or water, and other health and safety risks. Racial/ethnic minorities and people with low incomes are more likely to live in places with these risks. In addition, some people are exposed to things at work that can harm their health, like secondhand smoke or loud noises.

Interventions and policy changes at the local, state, and federal level can help reduce these health and safety risks and promote health. For example, providing opportunities for people to walk and bike in their communities—like by adding sidewalks and bike lanes—can increase safety and help improve health and quality of life.

Priorities Selection

The CHNAC through data review and discussion, narrowed the health needs of the community to a list of thirteen. 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 fall of 2024, the CHNAC met to review and discuss the collected data and select the top community needs.

Members of the CHNAC included:

Community Members

- Gracie Parrish, Director, Boys and Girls Club
- Pam Bishop, Director, Murray Family Connections
- Josh Etheridge, Chief, Chatsworth Police Department
- Danielle Jones, Lead Social Worker, Murray County School District
- Megan Callahan, Social Worker, Murray County School District
- Ashley Johnson, Social Worker, Murray County School District
- Wendy Hunt, Director, Murray Senior Center

AdventHealth Team Members

- Chris Self, CEO, AdventHealth Gordon and AdventHealth Murray
- Denise Rustad, Coordinator, Community Benefits and Community Wellness
- Juleun Johnson, VP Mission Integration, AdventHealth Southeast Region
- Garrett Nudd, Director of Communications & Foundation, AdventHealth Georgia Market
- Tracy Farriba, Director of Outreach and Physician Liaison, AdventHealth Gordon and AdventHealth Murray
- Wendy Taylor, Coordinator of Community Outreach and Foundation
- Alexa Hernandez, Chaplain, AdventHealth Murray
- Vanessa Crawford, Director of Case Management, AdventHealth Murray
- Sandra Webb, Assistant Chief Nursing Officer, AdventHealth Gordon and AdventHealth Murray
- Scotty Hancock, Director of Market Relations, AdventHealth Georgia Market
- Reeve Wall, Executive Director of Revenue Cycle, AdventHealth Georgia Market

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.

Public Health Experts

- Karen Penland, Director, Murray Health Department

Prioritization Process

To identify the top needs the CHNAC participated in a prioritization session. During the session, 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 ranked the needs via an online survey.

The CHNAC (n=9) were asked to select the three needs they thought the Hospital should address in the community.

The following criteria were considered during the prioritization process:

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?

The following needs rose to the top during the CHNAC's discussion and prioritization session. The needs receiving the most votes were considered the highest priority by the CHNAC.

Top Identified Needs	# of Votes	% of Responses
Neighborhood and Built Environment—Food Security	6	22%
Diabetes	5	19%
Cancer	4	15%
Health Care Access & Quality	4	15%
Heart Disease and Stroke	2	7%
Mental Health	2	7%
Drug and Alcohol Use	2	7%
Physical Activity	1	4%
Economic Stability	1	4%
Tobacco Use	0	0%
Asthma	0	0%
Obesity	0	0%
Education Access and Quality	0	0%

Based on the voting results, the two prioritized needs were Neighborhood and Built Environment—Food Security and Diabetes. There was a tie for third with Cancer and Health Care Access and Quality receiving four votes. To break the tie, Hospital leaders reviewed the data behind each need and the available resources to address. The Hospital decided to prioritize Cancer instead of Health Care Access and Quality.

The Hospital leaders who helped break the tie included:

- Chris Self, CEO, AdventHealth Gordon and AdventHealth Murray
- Josefer Montes, Executive Director of Marketing and Brand
- Tracy Farriba, Director of Outreach and Physician Liaison, AdventHealth Gordon and AdventHealth Murray
- Denise Rustad, Coordinator, Community Benefits and Community Wellness

Available Community Resources

As part of the assessment process, a list of resources or organizations addressing the top needs in the community was created. Although not a complete list, it helped to show where there were gaps in support and opportunities for partnership in the community when the CHNAC chose which priorities to address.

Top Needs	Current Community Programs	Current Hospital Programs
Asthma	None	• Dr. Smalley, ENT • Cynthia Cox, NP • Melissa Carter, AuD
Cancer	• Team Buddy Forever Foundation — Financial Support for Families Battling Pediatric Brain Cancer • Infinite Strength — Metastatic Breast Cancer Human Needs Grant • Living Beyond Breast Cancer — Living Beyond Breast Cancer Fund • Luke Neuhedel Foundation — Assistance for Pediatric Cancer Patients • American Cancer Society — Road to Recovery • Lindsay's Legacy Fund — Financial Assistance • Hailey Bankhead Foundation (HBF) — General Support for Children with Cancer • Parker Project — Financial Assistance • Ovarcome — OvarCare Patient Assistance Program • Remember Betty Foundation — Breast Cancer Financial Assistance Grant • North Georgia Cancer Coalition	• Edna Owens Breast Cancer Center and Infusion Center • Harris Radiation Therapy Center
Diabetes	None	• Diabetes Education Classes — monthly at Gordon
Heart Disease and Stroke	• Heartfelt Dreams Foundation — Heart Within A Heart Caring — Financial Assistance	• Cardiac Rehab • Cardiology
Mental Health	• Highland Rivers Behavioral Health — Mental Health Outpatient Services • Highland Rivers Behavioral Health — Mental Health Services • Georgia HOPE — Community-Based Mental Health Services • Georgia Mountains Health Services, Inc. — Behavioral Health Care • Project HEAL — Eating Disorder Navigation and Assistance	• Grief Recovery Support • Elizabeth Dial, Oncology Psychotherapist • Kim Robertson, Oncology Social Worker
Obesity	None	None

Top Needs	Current Community Programs	Current Hospital Programs
Drug and Alcohol Use	• BayMark Health Services — Opioid Treatment Programs (OTPs)	None
Physical Activity	• Boys & Girls Club — Georgia — SMART Moves	None
Tobacco Use	• Murray County Health Department	• Breathe Free — at Gordon
Economic Stability	• Giving Kitchen (GK) — Financial Assistance • Parker Project — Financial Assistance • Guidance Medical — Financial Assistance Funds • North Georgia Community Action, Inc. (NGCA) — Murray County Meals on Wheels • Goodwill Industries of the Greater Chattanooga Area — Thrift Store • Green Path Financial Wellness — Financial Counseling Services • Wounded Warriors Family Support (WWFS) — Mobility is Freedom — Mobility Equipped Vehicles • Sugar Bear Foundation — Financial Assistance Program • Team Buddy Forever Foundation — Financial Support for Families Battling Pediatric Brain Cancer • Guidance Medical — Financial Assistance Funds	None
Education Access and Quality	• NID Housing Counseling Agency — Homebuyer Education	None
Health Care Access and Quality	• Georgia Mountains Health Services, Inc. — Medical Services • The DEO Clinic, Inc. — Medical Clinic • US Department of Veterans Affairs — Veteran's Affairs Housing Assistance • Verida — Non-Emergency Medical Transportation (NEMT) • Elevated Access — Flights for Abortion and Gender-Affirming Care • Murray County Health Department	None
Neighborhood and Built Environment — Food Security	• American Red Cross Georgia Regional Headquarters — Georgia Home Fire Campaign • Northwest Georgia Family Crisis Center — Emergency Shelter • North Georgia Community Action, Inc. (NGCA) — Weatherization Program • Georgia Department of Community Affairs — Pandemic Assistance • Northwest Georgia Area Agency on Aging — Minor Home Repair Program • North Georgia Community Action, Inc. (NGCA) — Murray County Meals on Wheels • Northwest Georgia Area Agency on Aging — Farmer's Market • Salvation Army — Chatsworth — Food Pantry	None

Priorities Addressed

The priorities to be addressed include:

Cancer

In the Hospital's community, 7.4% of residents reported being diagnosed with cancer, which is higher than both the state (6.6%) and national (6.9%) averages. According to the community survey, 11% of respondents reported having cancer with breast cancer being the most common cancer diagnosis, accounting for 36% of diagnoses. Meanwhile, 30% of survey respondents are not up to date on preventative cancer screenings. The Hospital selected cancer as a priority in the previous needs assessment and decided to continue to address this need in the community. Interventions to promote evidence-based cancer screenings—such as screenings for lung, breast, cervical, and colorectal cancer—can help reduce cancer deaths.

Diabetes

In the Hospital's community, 13.6% of residents have diabetes, which is higher than the state average of 11.6%. According to the community survey, 20% of respondents have reported having diabetes. When addressing diabetes as a priority, the Hospital can work collaboratively with organizations already addressing this issue to promote prevention activities over the next three years.

Neighborhood and Built Environment—Food Security

Approximately 11.1% of households in the Hospital's community receive SNAP benefits. A higher percent of community survey respondents, 32.9%, received SNAP benefits in the past 12 months. Secondary data also showed 64.4% of households in poverty do not receive SNAP benefits despite being financially eligible. 32% of survey respondents are food insecure, reporting they eat less than should in the past 12 months because they did not have enough money for food. The Hospital will work with community partners to improve access to healthy and affordable food to address the issue of food security.

Priorities Not Addressed

The priorities not to be addressed include:

Asthma

Individuals in the Hospital's PSA have asthma at rate of 10.8%, higher than both the state (10.4%) and national rates (10.4%). Community survey respondents report having asthma at a rate of 17%. The Hospital did not perceive the ability to have a measurable impact on the issue within the three years allotted for the Community Health Plan with the current resources available to the community and the Hospital at this time. The Hospital may continue to support other efforts addressing this through advocacy, community partnerships and public health collaborations as needed.

Heart Disease and Stroke

According to secondary data, 7.4% of adults in the Hospital's PSA have coronary heart disease which is higher than the state average of 5.8%. Stakeholder chose heart disease as one of the top health conditions impacting community members. Among community survey respondents, 12% reported having coronary heart disease and 9% reported having a stroke. Additionally, 32% of survey respondents reported having high blood pressure. In the Hospital's PSA, 37.3% of adults have high blood pressure.

The Hospital prioritized heart disease in the previous needs assessment but chose not to address this time. It will continue to offer heart disease screenings in the community but focus their resources on diabetes and food security.

Mental Health

Stakeholders ranked mental health as the number one health condition affecting community members. According to secondary data, 23.7% of adults in the Hospital's PSA have depression and 19.1% of adults reported having poor mental health. Primary data from the community survey shows 24% of adults as having depression, and 29% report having anxiety. The Hospital did not select this as a priority as there are already several other community organizations actively addressing this need in the community who are better positioned to make an impact.

Obesity

In the Hospital's community, 38.2% of adults are obese, which surpasses the state average of 36.8%. Obesity is linked to type 2 diabetes, heart disease, stroke and some cancer types. Certain health behaviors, including a lack of physical activity and unhealthy eating patterns are risk factors for obesity. The Hospital did not select obesity as a priority as it believes that other organizations are better positioned in the community to address this need directly and will support those efforts.

Drug and Alcohol Use

Stakeholders chose drug and alcohol use as the number one health behavior of concern among community members. Community survey respondents reported using prescription medication for non-medical use at a rate of 40%. Additionally, 27% report having used prescription pain medication without a prescription. Secondary data showed, 15.3% of adults binge drink which is slightly below the state average (15.8%). While this is an identified need, due to existing resources and scope, the Hospital did not perceive the ability to have a measurable impact on these needs within the three years allotted for the for the Community Health Plan, therefore this need was not selected as a priority.

Physical Activity

In the Hospital's PSA, 31.6% of adults reported no exercise in the last thirty days which is above the state average of 25.2%. According to community survey data, 6% of adults report no exercise in the last thirty days. The Hospital did not select this need as it believes that other organizations are better positioned in the community to address this need directly and will support those

Tobacco Use

According to the secondary data, 18.1% of adults in the Hospital's PSA smoke cigarettes. This is above the state average of 14.8%. Murray County and Whitfield County also had smoking rates above the state average. Among community survey respondents, 43% said they smoke and 27% said they vape. The Hospital prioritized vaping the previous needs assessment and successfully implemented vaping education for middle and high school students. The Hospital did not select this need as a priority and instead will shift focus to address other need. The Hospital will continue their vaping work with schools and support community efforts to address.

Economic Stability

Stakeholders chose living wage, poverty and affordable housing as top community conditions impacting the health of community members. The median household income in the Hospital's community is $51,086. This is below the median for both the state ($65,427) and the US ($68,906). In the Hospital's community, 16.3% of residents live in poverty which is higher than the state (13.9%) and national averages (12.6%). On the community survey, 34% of respondents said they were worried about stable housing in the next two months. The Hospital did not select economic stability as a priority as it is not resourced to directly address this in the community but will support other community partners in their efforts.

Education Access and Quality

In the Hospital's PSA, 70.6% of students graduated high school which is lower than both the state (88.7%) and national graduation rates (89.1%). The college graduation rates in the Hospital's PSA (11.6%), Murray County (11.4%) and Whitfield County (18.6%) were all below the state average (33.6%). The Hospital decided that although an identified need for a multitude of reasons, education access is already being addressed countywide by other organizations better positioned to address it. Additionally, the Hospital did not anticipate being able to make meaningful change in the time allotted for the next community health plan.

Health Care Access and Quality

One the community survey, 41.2% of respondents said they needed to see a doctor in the past 12 months but could not due to cost. Secondary data showed 25.4% of adults aged 18-64 in the Hospital's PSA do not have health insurance. Whitfield County had the highest rate with 26.7% of adults without insurance. The Hospital's PSA and all counties were above the state average of 15.2%. Provider availability was also lower in the Hospital's PSA and the surrounding counties compared to the state averages. The Hospital decided not to address this need as it believes that other organizations are better positioned in the community to address this need directly and will support those efforts when able.

Next Steps

The CHNAC will work with the Hospital and other community partners to develop a measurable Community Health Plan for 2026 – 2028 to address the priority needs. 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 annually to the Hospital board.

A link to the Community Health Plan will be posted on AdventHealth.com prior to May 15, 2026.

Community Health Plan

2023 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: Heart Disease and Heart Related Issues

During the 2022 needs assessment, the Hospital chose heart disease and heart related issues as a top priority to address. 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. Our goal has been to increase the number of individuals receiving preventative, early diagnosis and treatment of heart disease.

The Hospital aimed to accomplish this by providing a minimum of 100 free heart-disease screenings (including blood pressure and calcium screenings) to low-income adults in Murray County. The Hospital created partnerships with at least three local churches, the senior center, local library and various businesses and industries in the form of employee health fairs to bring these free screenings, educational resources and greater awareness to the general public as to the risks and preventative measures available to reduce their risk of dying from heart related issues.

The Hospital evaluates the progress made on the implementation strategies from the Community Health Plan annually.

Priority 2: Cancer

Cancer was the other chronic health issue that rose to the top of the survey results during the 2022 needs assessment. 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. Our goal was to decrease the prevalence of life-threatening cancer in Murray County. The Hospital chose to start by creating more awareness for the threat, early detection and treatment of cancer available in the area and providing education and lifestyle prevention resources at local events and health fairs. The Hospital also created cancer surveys for lung, skin and colorectal awareness that would encourage early screening for those at highest risk.

Priority 3: Vaping

AdventHealth Murray also chose to prioritize vaping based on the data found in the 2022 needs assessment. According to community survey respondents, 30.8% were vaping every day or some days. Stakeholders also considered vaping to be a top health behavior risk factor, particularly among youth. Nationally, the prevalence of vaping and e-cigarette usage had 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. Our goal was to decrease the usage of vaping in Murray County among adolescents by increasing education to teenagers about the dangers of vaping from one school (2021–2022) to four public middle and high schools in AdventHealth Murray's PSA.

As part of the effort to address this issue the Hospital aimed to reach every 6th–12th grader in Murray County with a vaping lecture at their school, create partnerships with the Cancer Coalition of Northwest Georgia, Live Drug Free, Murray County Schools and meet quarterly with a Drug and Vaping Task Force that will serve to provide information and resources on cessation and dangers of vaping targeted toward youth and their parents (adults) in the community, and engages students in healthy behavior choices.

2022 Community Health Needs Assessment Comments

We posted a link to the most recently-conducted CHNA and the most recently adopted implementation strategy, 2023 Community Health Plan on our hospital website as well as on AdventHealth.com prior to May 15, 2023 and have not received any written comments.

AdventHealth

Adventist Health System Georgia, Inc. dba AdventHealth Murray

CHNA Approved by the Hospital board on: April 30, 2025

For questions or comments, please contact
AdventHealth Corporate Community Benefit
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