AdventHealth Gordon 2025 Community Health Needs Assessment

Extending the Healing Ministry of Christ

AdventHealth

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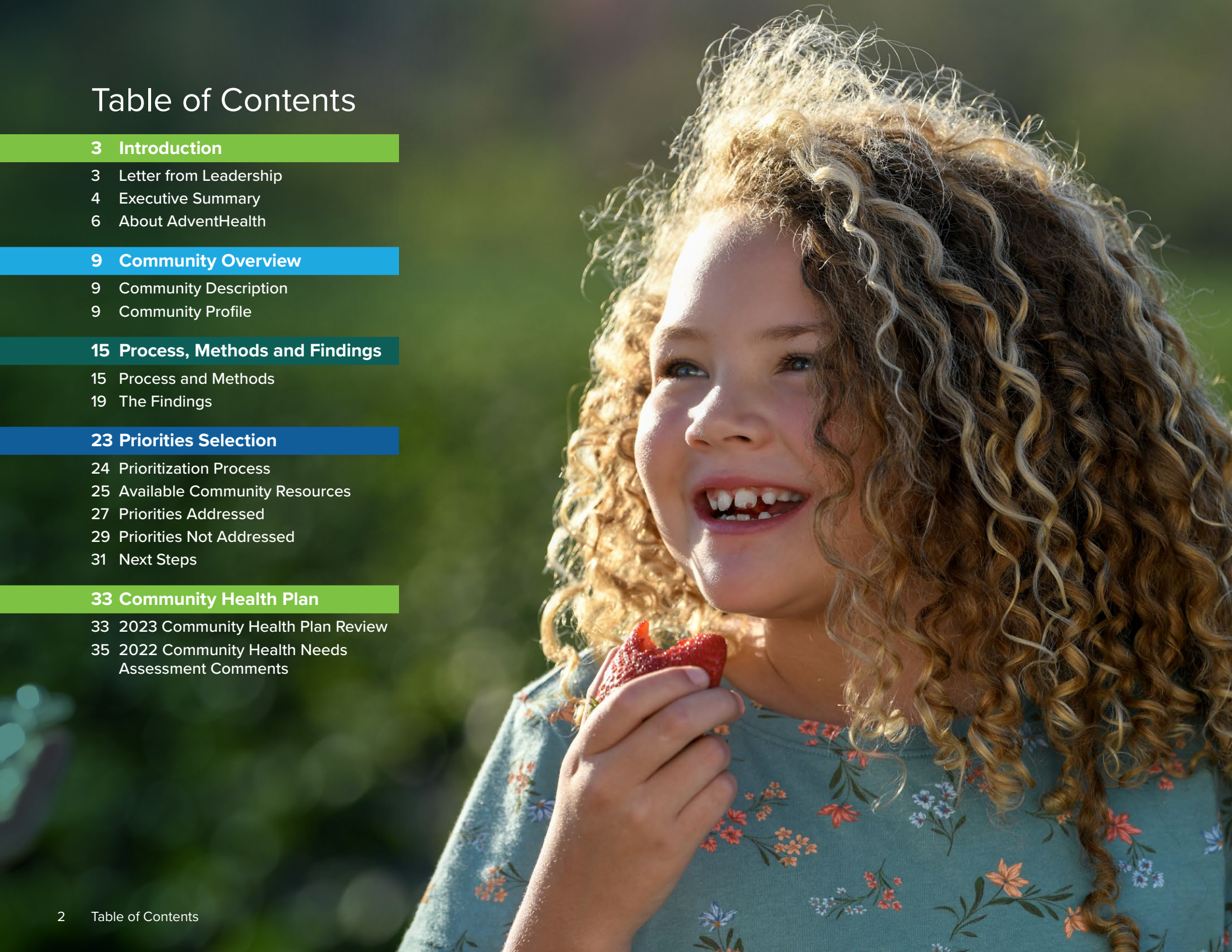


Letter from Leadership

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 Gordon will be referred to in this document as AdventHealth Gordon or "The Hospital." AdventHealth Gordon in Calhoun, 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 Gordon 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 Gordon 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 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. Diabetes
2. Heart Disease and Stroke
3. Mental Health

See Priorities Addressed for more.

Approval

On May 1, 2025, the AdventHealth Gordon 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 Gordon 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 and posted on the Hospital's website prior to May 15, 2026.

About AdventHealth

AdventHealth Gordon 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 Gordon

AdventHealth Gordon is a comprehensive, 69-bed community hospital located in Gordon County, Georgia. Built originally in 1953 as Gordon County Hospital, the Hospital moved to its current location in the 1970s to meet the growing needs in the community. The Hospital become part of the Adventist Health System in 1994 and officially became AdventHealth Gordon in 2019. In 2020, AdventHealth Gordon completed a project to enhance its services offered to the community. The project included the construction of the Edna Owens Breast Center, relocation and expansion of The Baby Place, expansion and renovation of the operating room and construction of a new cardiac catheterization lab. AdventHealth Gordon offers many services including allergy care, cancer care, diabetes, education, emergency and urgent care, endocrinology, heart and vascular care, home care, imaging services, lab services, lifestyle medicine, mother and baby care, ophthalmology, orthopedic care, pain medicine, pediatrics, physical therapy, primary care, sleep medicine, sports medicine, surgical care, urology, women's care and wound care.

AdventHealth Gordon's caring team of experts specializes in everything from emergency care to robotic surgery. Our whole-person approach to care is designed to help you take your health — and your life — back into your own hands.

Considered a Primary Stroke Center by The Joint Commission, AdventHealth Gordon provides access to expert care across a wide range of medical services. AdventHealth Gordon also has a PCI Accreditation from Corazon, and the facility's emergency department

AdventHealth Gordon is a comprehensive, 69-bed community hospital located in Gordon County, Georgia

has achieved Level 3 Geriatric Emergency Department Accreditation (GEDA) by the American College of Emergency Physicians.

At AdventHealth Gordon, our goal is to walk beside you through all of life's many stages. Our special blend of faith-based whole-person care is offered throughout a connected care network that starts from pre-birth to babies, pediatrics to adult and family medicine, a variety of specialties, rehabilitation, home care and everything in between. Through it all, we are right here beside you at every age and every stage.

Community Overview

Community Description

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

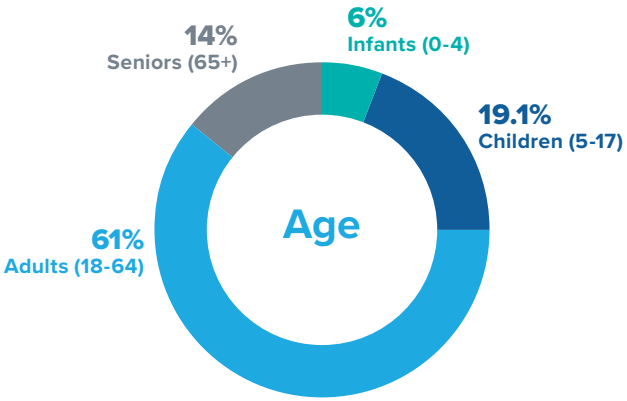
The median age in the Hospital's community is 37.3, slightly lower than that of state which is 37.6 and the US, 39.

Males are the majority, representing 50.5% of the population. Middle-aged females 40–64, are the largest demographic in the community at 16.7%.

Children make up 25.1% of the total population in the community. Infants, those zero to four, are 6% of that number. The community birth rate is 53.6 births per 1,000 women aged 15–50. This is higher than the U.S. average of 51.6, and higher than that of the state, 50.9. In the Hospital's community, 17.9% of children aged 0–4 and 19.7% of children aged 5–17 are in poverty.

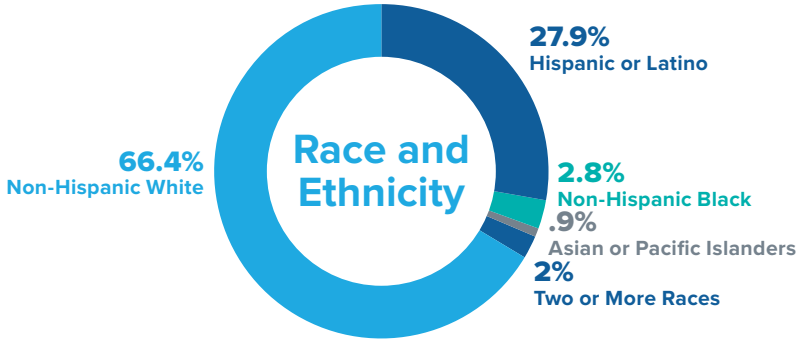
AdventHealth Gordon defines its community as seven zip codes across Gordon County, Murray County, Whitfield County and Bartow County.

Seniors, those 65 and older, represent 14% of the total population in the community. Females are 53.6% of the total senior population.



Race and Ethnicity

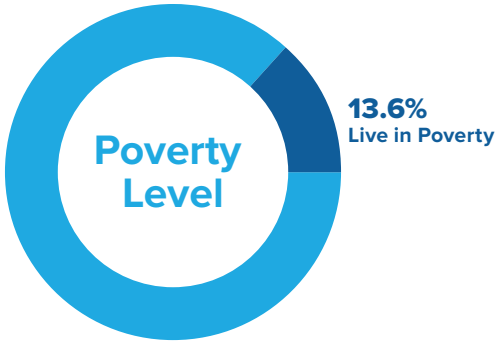
In the Hospital's community, 66.4% of the residents are non-Hispanic White, 2.8% are non-Hispanic Black and 27.9% are Hispanic or Latino. Residents who are Asian represent 0.9% of the population, and 2.0% are two or more races.



Economic Stability

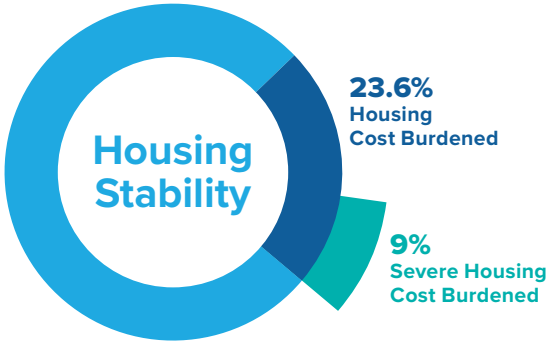
Income

The median household income in the Hospital's community is $53,405. This is below the median for both the state, $65,427, and the US, $68,906. Being below the median, 13.6% of residents live in poverty, the majority of whom are under the age of 18.



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

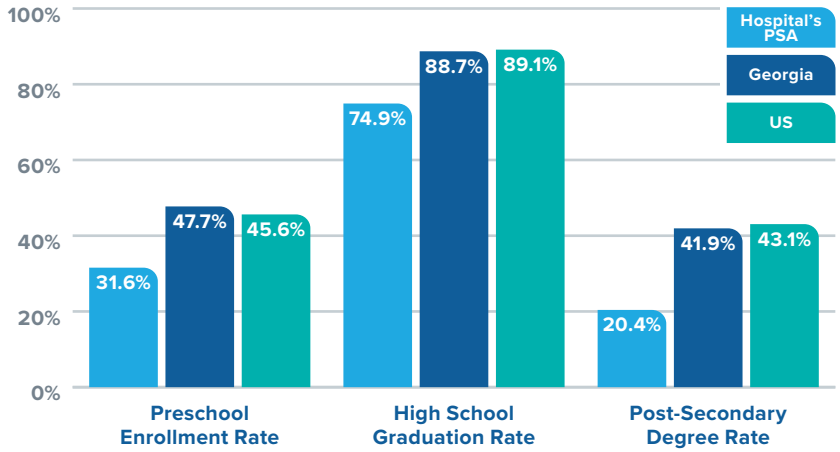
Research shows that education can be a predictor of health outcomes, as well a path to address inequality in communities.[2] Better education can lead to people having an increased understanding of their personal health and health needs. Higher education can also lead to better jobs, which can result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

In the Hospital's community, there is a 74.9% high school graduation rate, which is higher than both the state (89.5%) and national averages (89.6%). The rate of people with a post-secondary degree is lower (20.4%) in the Hospital's PSA than in both the state (43.4%) and nation (44.6%).

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, 31.6% of three- and four-year olds were enrolled in preschool. This rate is lower than both the state (49.4%) and the national (46.7%) averages. 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

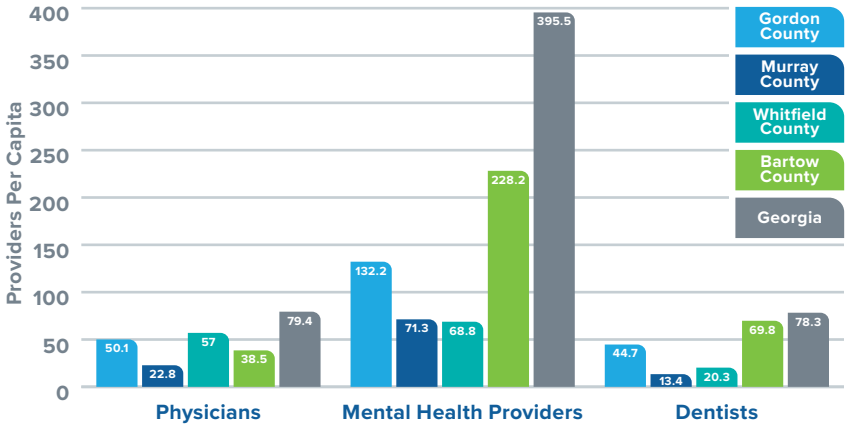
Health Care Access and Quality

In 2022, 22.4% 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.

Routine checkups can provide an opportunity to identify potential health issues and when needed develop care plans. In the Hospital's community, 73.9% of people report visiting their doctor for routine care.

Available Health Care Providers

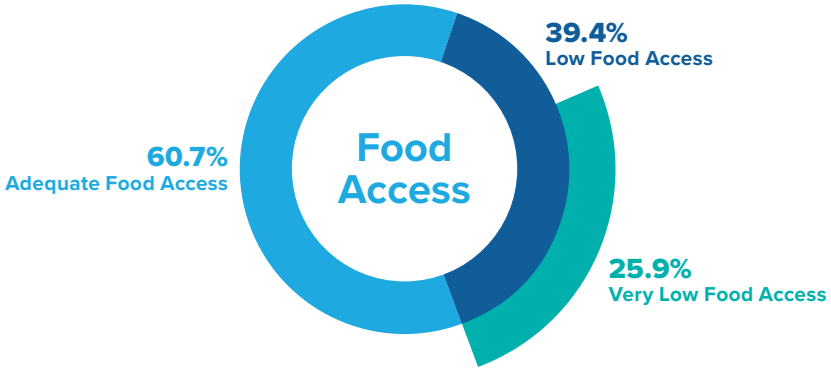


4 Health Insurance and Access to Care | CDC

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.

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.[5] In the Hospital's community, 39.4% of the community lives in a low food access area, while 25.9% live in a very low food access 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.[6] Feeding America estimates for 2022,[7] showed the food insecurity rate in Gordon County, where the Hospital is located, as 15.2%.

Access to public transportation is also an important part of a built environment. For people who do not have cars, reliable public

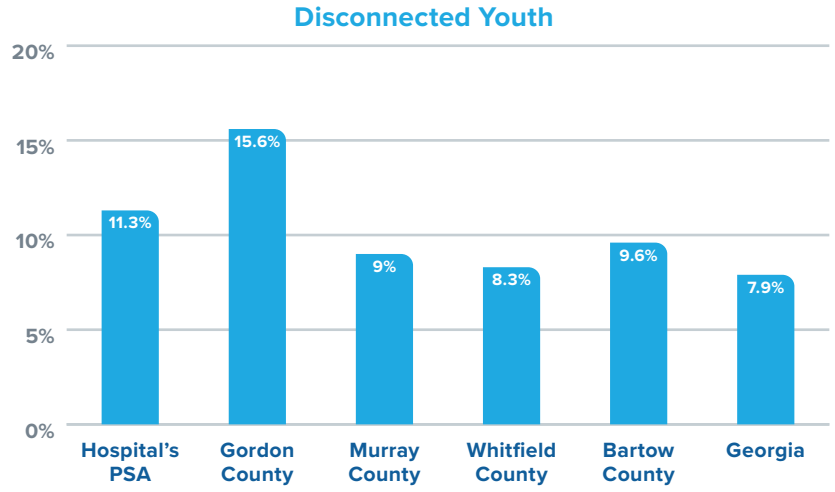
5 Heart Disease Risk Factors | CDC
6 Facts About Child Hunger | Feeding America
7 Map the Meal Gap 2022 | Feeding America

transportation can be essential to access health care, healthy food and steady employment. In the community, 4.6% 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, 11.3% of youth aged 16 – 19 were reported as disconnected, meaning they were neither enrolled in school nor working at the time. The percentage of disconnected youth was highest in Gordon County at 15.6%.



Also, in the community 27.1% of seniors (age 65 and older) report living alone and 3.5% 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.

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 14 stakeholders provided their expertise and knowledge regarding their communities, including:

Name	Organization	Services Provided	Populations Served
Amanda Schutz, Director of Student Services	Calhoun City Schools	Education/Youth Services	Infant, Children, Adolescents
Stacy Long, Executive Director	United Way of Gordon County	Financial Support	Non-Profit Organizations
Marie Funes, Family Engagement Coordinator	Other Education	Education/Youth Services	Infant, Children, Adolescents, People with Disabilities, Parents or Caregivers, Women, Homeless, Low Income, General Public
Nicole Errickson, School Social Worker	Calhoun City Schools	Education/Youth Services	Infant, Children, Adolescents, General Public, Low Income, Homeless
Dorothy Self, Nurse Practitioner	Georgia-Cumberland Academy	Education/Youth Services; Health Care/Public Health	Infant, Children, Adolescents
Cynthia, FEC	Calhoun City Schools	Housing, Mental Health, Behavioral Health, Food Assistance, Transportation, Education/Youth Services	Parents or Caregivers, Homeless, General Public, People with Disabilities, School-Age Children
Rick Claus, Associate Treasurer	Georgia-Cumberland Conference	Church Headquarters	Infant, Children, Adolescents, Elderly, Parents or Caregivers, People with Disabilities, Women
Ilsia Bonilla, School Social Worker	Calhoun City Schools	Education/Youth Services	Infant, Children, Adolescents, Homeless, Low Income, People with Disabilities, LGBTQIA+, Parents or Caregivers
Cindy Gregg, School Counselor	Gordon Central High School	Education/Youth Services	Infant, Children, Adolescents
Tracy Farriba, Director of Physician and Community Outreach	AdventHealth	Health Care/Public Health	Infant, 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	Infant, 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	Infant, Children, Adolescents, LGBTQIA+, Elderly, Parents or Caregivers, People with Disabilities, Women, Low income, Veterans, General Public
Glenn Aguirre, Senior Pastor	Calhoun SDA	Education/Youth Services, Food Assistance	Infant, Children, Adolescents, Elderly, LGBTQIA+, Parents or Caregivers, People with Disabilities, Women, Homeless, Low income, Veterans, General Public
Rebekah Helbley, Principal	Coble Elementary School	Education/Youth Services	Infant, Children, Adolescents, Parents or Caregivers, 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 (AIT) 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 13 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 disease that affects your lungs. It causes repeated episodes of wheezing, breathlessness, chest tightness, and nighttime or early morning coughing. Asthma can be controlled by taking medicine and avoiding the triggers that can cause an attack.

Cancer

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

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.

Heart Disease and Stroke

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.

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

About 2 in 5 adults and 1 in 5 children and adolescents in the United States have obesity and many others are overweight. Healthy People 2030 focuses on helping people eat healthy and get enough physical activity to reach and maintain a healthy weight.

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.

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

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.

Economic Stability

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

Education Access and Quality

People with higher levels of education are more likely to be healthier and live longer. Healthy People 2030 focuses on providing high-quality educational opportunities for children and adolescents—and on helping them do well in school. Children from low-income families, children with disabilities, and children who routinely experience forms of social discrimination—like bullying—are more likely to struggle with math and reading.

Health Care Access and Quality

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

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.

Priorities Selection

The CHNAC through data review and discussion, prioritized the health needs of the community to a list of three. 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

- Benji Parker, Assistant Director, Highland Rivers Behavioral Health
- Ty Bonner, Social Worker, Gordon County
- Amanda Schutz, Social Worker, Calhoun City
- Stacy Long, Director, Voluntary Action Center
- Whytnie Martin-Sackett, Child Advocacy Center
- Cristal Anguiano, Child Advocacy Center
- Wendy Shedd, Director, Gordon Family Resource Center
- Ann Bradford, Director, Gordon Senior Center

AdventHealth Team Members

- Chris Self, CEO, AdventHealth Gordon and AdventHealth Murray
- Juleun Johnson, VP Mission Integration, AdventHealth Southeast Region
- Garrett Nudd, Director of Communications and 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
- Denise Rustad, Community Benefit, AdventHealth Gordon and AdventHealth Murray
- James Keaton, Director of Nursing, AdventHealth Gordon
- Kevin Rodman, Director of ED, AdventHealth Gordon

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.

- Karen Hughes, Director of Case Management, AdventHealth Gordon
- Scotty Hancock, Director of Market Relations, AdventHealth Georgia Market
- Reeve Wall, Executive Director of Revenue Cycle, AdventHealth Georgia Market

Public Health Experts

- Lisa Crowder, Director, Gordon Health Department
- Marsha Vanwert, Gordon 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=14) 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
Diabetes	10	71.4%
Mental Health	9	64.3%
Heart Disease and Stroke	7	50%
Obesity	4	28.6%
Health Care Access and Quality	3	21.4%
Neighborhood and Built Environment—Food Security	3	21.4%
Cancer	2	14.3%
Tobacco Use	2	14.3%
Economic Stability	2	14.3%
Asthma	0	0%
Drug and Alcohol Use	0	0%
Physical Activity	0	0%
Education Access and Quality	0	0%

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	None
Cancer	• North Georgia Cancer Coalition	• Edna Owens Breast Center • Cancer and Infusion Center • Harris Radiation Therapy Center
Diabetes	None	• Monthly Diabetes Education Classes
Heart Disease and Stroke	None	• Cardiology • Cardiac Rehab
Mental Health	• Highland Rivers Behavioral Health — Mental Health Services • Georgia HOPE — Community-Based Mental Health Services • ACE (Achieving Community Enrichment) — Counseling Services	• Grief Recovery Support
Obesity	• Boys & Girls Club — Georgia — SMART Moves	None
Drug and Alcohol Use	None	None
Physical Activity	None	None
Tobacco Use	None	• Breathe Free Program
Economic Stability	• Society of St. Vincent De Paul — Georgia — Financial Assistance • Voluntary Action Center (VAC) — Financial Assistance • Housing Authority of Calhoun — HUD Public Housing Program • Georgia DCA Housing Authority — Housing Choice Vouchers • Tallatoona Community Action Partnership, Inc. (CAP) — Low-Income Home Energy Assistance Program (LIHEAP) • Northwest Georgia Area Agency on Aging — Nursing Home Transitions • Providence Men's Shelter	None

Top Needs	Current Community Programs	Current Hospital Programs
Education Access and Quality	• Family Resource Center Of Gordon County — Parents as Teachers (PAT) • Tallatoona Community Action Partnership, Inc. (CAP) — Head Start • Valley Point — Head Start	None
Health Care Access and Quality	• Kindred at Home — Georgia — Home Health Services • AdventHealth — Home Health Care • Amedisys — Georgia — Home Health Care • Northwest Health District — Women, Infants and Children (WIC) • Gordon County Health Department — Women, Infants and Children (WIC) • Georgia Mountains Hospice — Hospice Care • Legacy Link — Community Care Services Program (CCSP) • Northwest Georgia Area Agency on Aging — Personal Support • Northwest Georgia Area Agency on Aging — Nursing Home Transitions • Verida — Non-Emergency Medical Transportation (NEMT) North Georgia	None
Neighborhood and Built Environment — Food Security	None	None

Priorities Addressed

The priorities to be addressed include:

Diabetes

In the Hospital's community, 13.3% of residents have diabetes, which is higher than the state average of 11.6%. According to the community survey, more than 18% of respondents reported being diagnosed with diabetes. Stakeholder survey respondents chose diabetes as a top health condition due to its' increased prevalence in the community. When addressing diabetes as a priority in the community, the Hospital can align to local, state and national efforts for resources and to create better outcomes opportunities over the next three years.

Heart Disease and Stroke

In the Hospital's community, 7.5% of residents have coronary heart disease, which is higher than the state average of 5.8%. According to the community survey, more than 10% of respondents have been diagnosed with coronary heart disease, 8% have been diagnosed with stroke, and 32% have been diagnosed with hypertension. There are several cardiovascular disease indicators where the Hospital's community is faring worse in comparison to the state and nation. The Hospital will work collaboratively with community partners to leverage existing strategies to address this priority.

Mental Health

In the Hospital's community, 23.6% of residents have depression, while 18.8% of the residents self-reported poor mental health. According to the community survey, more than 24% of respondents have been diagnosed with a depressive disorder and more than 29% have been diagnosed with an anxiety disorder. Stakeholder survey respondents also ranked mental health as a top health condition. Awareness and the need to address mental health disorders has been growing in the country. Including mental health as a priority, the Hospital can align to local, state and national efforts for resources and to create better outcomes opportunities over the next three years.

Priorities Not Addressed

The priorities not to be addressed include:

Asthma

In the Hospital's community, 10.8% of residents have asthma, which is slightly higher than the state average of 10.6%. According to the community survey, more than 15% of respondents have been diagnosed with asthma. The Hospital did not select asthma 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.

Cancer

In the Hospital's community, 7.8% of residents have a prevalence of cancer, which is exactly aligned with the state average of 7.8%. According to the community survey, more than 11% of respondents have been diagnosed with cancer. Although cancer is an issue that needs to be addressed, the Hospital did not select it as a priority due to a lack of resources. The Hospital will support other organizations in the community addressing this issue.

Obesity

In the Hospital's community, 38.5% of residents are obese, which is higher than the state average of 36.8%. The obesity treatment need in the community is significant, however, 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.

Drug and Alcohol Use

In the Hospital's community, 15.6% of residents binge drink, which is slightly below the state average of 15.8%. Bing drinking is having five or more drinks (men) or four or more drinks (women) on an occasion in the past 30 days. According to the community survey, more than 33% of respondents have reported taking prescription medication for non-medical reasons, and more than 24% have reported using prescription pain medication without a doctor's prescription. The drug and alcohol use needs in the community are significant. However, the Hospital believes other organizations are better positioned in the community to address this need directly and will support those efforts.

Physical Activity

In the Hospital's community, 31.1% of residents reported zero exercise within the past thirty days, which is higher than the state average of 25.2%. According to the community survey, more than 6% of respondents reported zero exercise within the past thirty days. Although lack of physical activity is a concern in the community, the Hospital did not perceive the ability to have a measurable impact on the issue with the current resources available at this time.

Tobacco Use

In the Hospital's community, 18% of residents smoke cigarettes, which is higher than both the state (14.8%) and national (14.6%) averages. According to the community survey, more than 41% of respondents reported smoking, and more than 22% reported vaping. The need to address tobacco use in the community is significant, however, the Hospital did not perceive the ability to impact the issue with existing resources. The Hospital will support other organizations addressing this issue in the community.

Economic Stability

In the Hospital's community, 4.8% of residents are unemployed. The percent of residents living in poverty was highest in the Hospital's community, 16.6%, compared to the state, 13.5% and national, 12.5% averages. According to the community survey, more than 26% of respondents reported being worried about stable housing. Stakeholders indicated poverty and a livable wage were top community concerns. Although economic stability is a need in the community, the Hospital believes other organizations are better positioned to address this need directly and will support those efforts when able.

Education Access and Quality

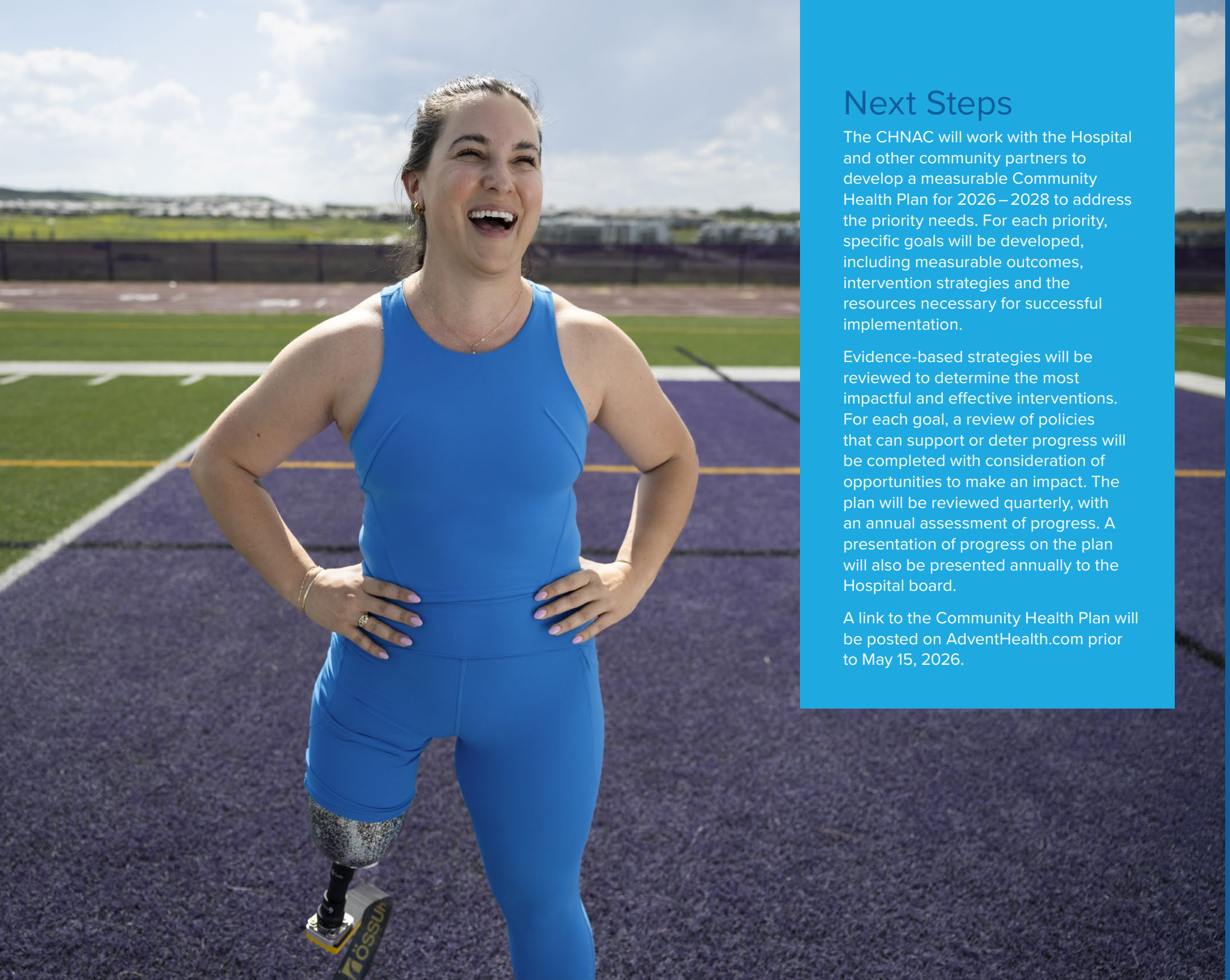
In the Hospital's community, high school graduation and preschool enrollment were below the state and nation averages. In the Hospital's community, 74.9% of residents have at least a high school degree and 31.6% of three- to four-year olds were enrolled in preschool. Although education access is a need in the community, the Hospital believes other organizations are better positioned to address this need directly and will support those efforts when able.

Health Care Access and Quality

In the Hospital's community, 22.4% of resident adults (18–64 years old) do not have health insurance, which is significantly higher than the state average of 15.2%. Stakeholders also expressed frustration with provider availability and timely appointments for community members needing health care. The Hospital did not select health care access and quality as a priority because it did not perceive the ability to have a measurable impact on the issue with the current resources available at this time.

Neighborhood and Built Environment—Food Security

According to the community survey, 33% of respondents reported receiving SNAP benefits in the past 12 months. When asked if they ate less than they should because they didn't have enough money for food, 32% of community survey respondents said yes. Food insecurity was also one of the most common social determinants of health needs when screening in-patients. The Hospital did not select neighborhood and environment (food security) as a need because it believes other organizations are better positioned to address this issue in the community.



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

In the 2023 CHNA, the Hospital identified heart disease and heart-related issues as a top priority to address in our community. 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 40% of community survey respondents 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, 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.

The Hospital set a goal to increase the number of individuals receiving preventative, early diagnosis and treatment of heart disease by providing free heart-disease screenings including blood pressure and calcium screenings through multiple community partnerships and targeting low-income adults. Since adopting the plan, the Hospital partnered with several local churches, the Voluntary Action Center, Gordon Senior Center, and local schools to offer these free blood pressure and calcium screenings along with education and awareness information on the dangers and risks of heart disease.

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

Priority 2: Cancer

In the Hospital's community 6.4% 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 and lung, trachea and bronchus cancer in Gordon County. Our goal was to decrease the prevalence of life-threatening cancer in Gordon County.

The Hospital has focused on preventative measures by offering more free screenings for lung and skin cancers and partnered with public safety personnel, public school staff and faculty, Chamber of Commerce, local businesses and dermatologists to offer free skin checks on Melanoma Monday. The Hospital's Cancer Center also offers free lung cancer screenings every November to the community at large that register in advance. The Hospital has committed to increasing breast cancer awareness by investing in and expanding their breast cancer Pink Porch Campaign throughout the month of October, and highlighting $30 out of pocket Mammograms during the entire month of May to make it affordable to seek early detection for those who are uninsured or underinsured. Lastly, they offer cancer screening surveys on lung, colorectal, and skin at all our community health fairs and clinics to bring more awareness to the benefits of early detection through screening.

Priority 3: Vaping

According to community survey respondents, 19.7% 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 harmful than smoking tobacco, there is still much unknown about its long-term effects. Our local schools have seen a particularly high rise in underage students vaping, largely in the high schools, but a growing number in middle schools.

The Hospital created lectures and educational materials to educate teenagers about the dangers of vaping. The lectures have been offered at four different schools in Gordon County. The Hospital also partnered with the Cancer Coalition of Northwest Georgia, Live Drug Free, Gordon County Schools, Calhoun City Schools to conduct vaping education lectures, providing information and resources in the community to adults, and meet quarterly with The Drug and Vaping Task Force to ensure resources, education and access to help are available to local youth and adults struggling with a vaping and tobacco addiction.

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 Gordon

CHNA Approved by the Hospital board on: May 1, 2025

For questions or comments, please contact
AdventHealth Corporate Community Benefit
corp.communitybenefit@adventhealth.com

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