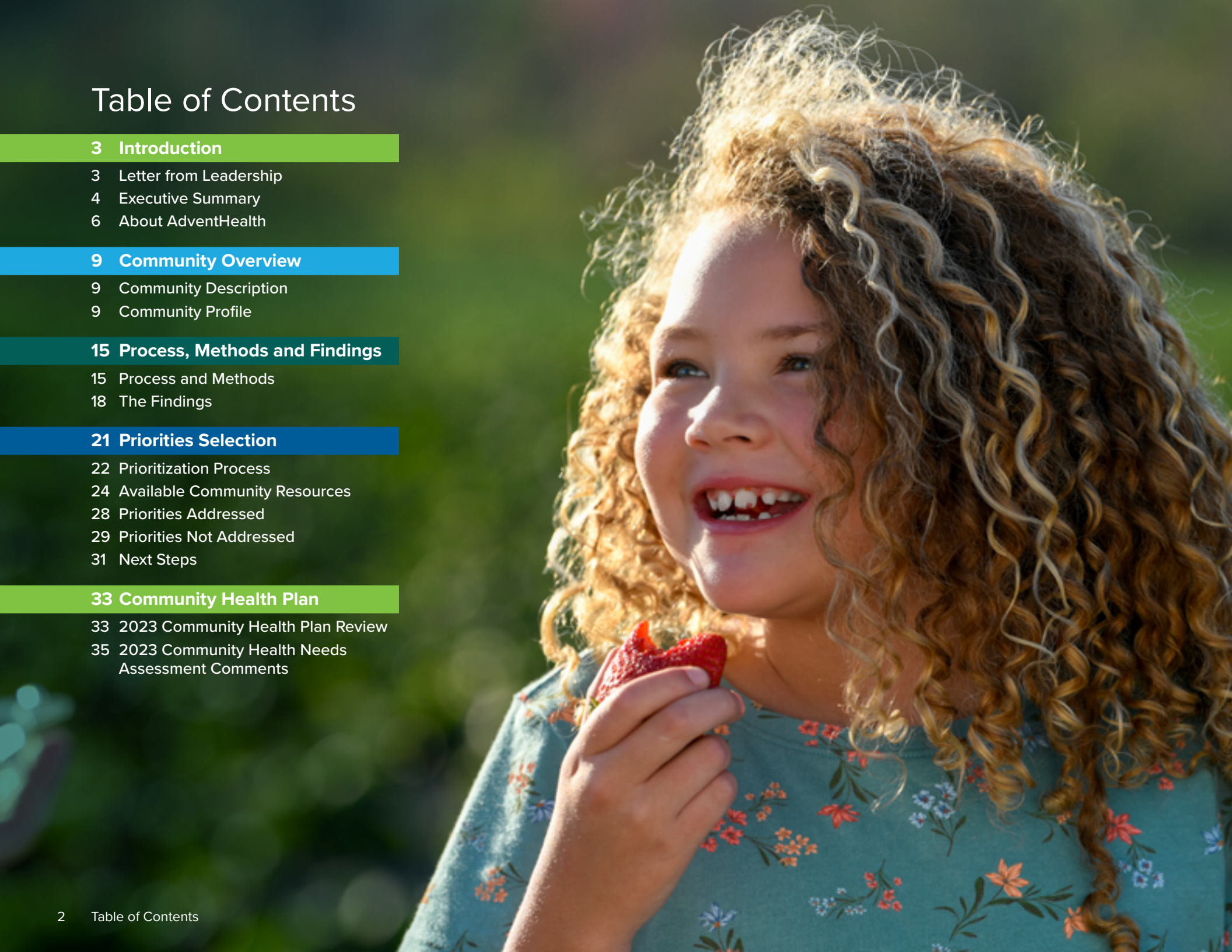
AdventHealth Redmond 2025 Community Health Needs Assessment

Extending the Healing Ministry of Christ

AdventHealth

Table of Contents



Letter from Leadership

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

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

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

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

In His Service,

Isaac Sendros, President and CEO
AdventHealth Redmond

We are committed to addressing the needs of the communities we serve with a wholistic focus — one that strives to heal and restore the body, mind and spirit.

Executive Summary

Redmond Park Hospital, LLC dba AdventHealth Redmond will be referred to in this document as AdventHealth Redmond or "The Hospital." AdventHealth Redmond in Rome, Georgia conducted a community health needs assessment from February 2024 to December 2024. 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 Redmond created a Community Health Needs Assessment Committee (CHNAC) to help guide the Hospital through the assessment process. The CHNAC included representation from the Hospital, public health experts and the broad community. This included intentional representation from low-income, minority and other underserved populations.

The CHNAC met 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.

Hospital Health Needs Assessment Committee

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

See Prioritization Process for a list of HHNAC members.

Data

AdventHealth Redmond in collaboration with the AdventHealth Corporate team collected both primary and secondary data. The primary data included community surveys and stakeholder interviews. Secondary data included 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 12 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 and the HHNAC understand the existing community efforts being used to address the 12 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. The HHNAC reviewed and discussed the needs identified by the CHNAC and the available resources to address them in the community. The HHNAC also considered the Hospital's current resources and strategies. Through these discussions the Hospital selected the needs it is best positioned to impact.

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. Heart Disease and Stroke
2. Mental Health
3. Health Care Access and Quality

See Priorities Addressed for more.

Approval

On April 29, 2025, the AdventHealth Redmond 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 Redmond will work with the CHNAC and the HHNAC 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 Redmond is part of AdventHealth. With a sacred mission of Extending the Healing Ministry of Christ, AdventHealth strives to heal and restore the body, mind and spirit through our connected system of care. More than 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 Redmond

AdventHealth Redmond is a 230-bed medical, surgical and rehab facility serving Floyd County and surrounding counties. Built in 1972, the Hospital has expanded and evolved over the following decades to become a flagship health care institution in Northwest Georgia and Northeast Alabama.

AdventHealth Redmond opened the region's first diagnostic cardiac catheterization lab in 1975, and doctors performed the region's first open-heart surgery in 1986. Continuing the legacy as the region's heart care center, AdventHealth Redmond now provides true comprehensive heart care across the full spectrum of cardiovascular disease, including preventative cardiac care, diagnostics, heart catheterization procedures, electrophysiology, open-heart surgery, a heart failure program and intensive cardiac rehabilitation.

Since 2016, The Structural Heart Program has performed over 1,000 structural heart procedures including Transcatheter Aortic Valve Replacement, transcatheter mitral valve replacement, left atrial appendage (LAA) occlusion and MitraClip procedures. Serving as the heart hospital for Northwest Georgia, AdventHealth Redmond offers cardiac services and is designated as a Level 1 Emergency Cardiac Care Center by the Georgia Department of Health.

Today, the Hospital offers minimally invasive robotic-assisted surgery and advanced rehab to get patients feeling better, faster. In 2024, AdventHealth Redmond launched the first neurointerventional program to provide advanced treatment for complex cases of stroke.

AdventHealth Redmond was named as one of the nation's 50 top performing cardiovascular hospitals, top teaching hospital and top 100 hospitals by PINC AI and ranks in the top 5% of the nation for critical care.

AdventHealth Redmond and its surrounding AdventHealth Medical Group practices offer many services including emergency care, cancer care, orthopedics, vascular care, surgical care, women's care, primary care, pediatrics and inpatient and outpatient rehabilitation services.

Built in 1972, the hospital has expanded and evolved over the following decades to become a flagship health care institution in Northwest Georgia and Northeast Alabama.

Community Overview

Community Description

Located in Floyd County, Georgia, AdventHealth Redmond defines its community as the Primary Service Area (PSA), the area in which 75–80% of its patient population lives. This includes 18 zip codes across Floyd County, Bartow County, Chattooga County, and Polk 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 Primary Service Area (PSA) unless listed differently. Data are also provided to show how the community compares locally, in the state, and at a national level for some indicators.

Community Profile

Age and Sex

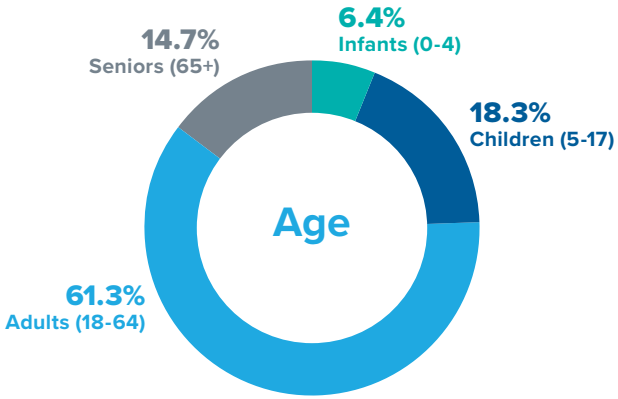
The median age in the Hospital's community is 38.3, slightly higher than that of state which is 37.6 and slightly lower than the US, 39.

Females are the majority, representing 51% of the population. Middle-aged women, 40–64 are the largest demographic in the community at 16.2%.

Children make up 24.7% of the total population in the community. Infants, those zero to four, are 6.4% of that number. The community birth rate is 65.6 births per 1,000 women aged 15–50. This is higher than the U.S. average of 51.6, and the state, 50.9. In the Hospital's community, 22.1% of children aged 0–4 and 20.9% of children aged 5–17 are in poverty.

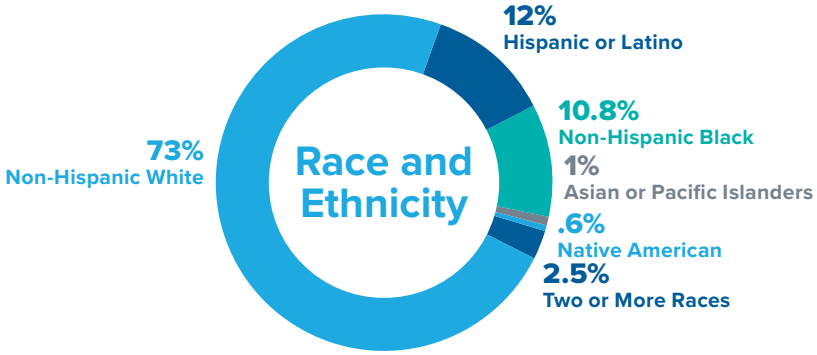
AdventHealth Redmond defines its community as... the area in which 75–80% of its patient population lives. This includes 18 zip codes across Floyd County, Bartow County, Chattooga County, and Polk County.

Seniors, those 65 and older, represent 14.7% of the total population in the community. Females are 56.6% of the total senior population.



Race and Ethnicity

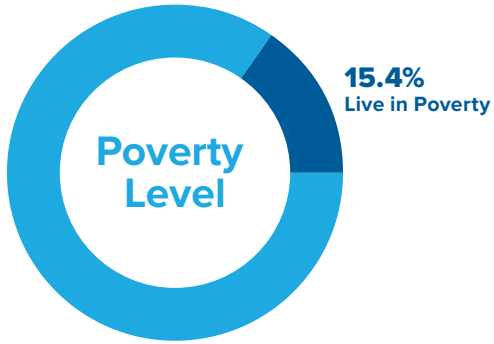
In the Hospital's community, 73.3% of the residents are non-Hispanic White, 10.8% are non-Hispanic Black and 12.3% are Hispanic or Latino. Residents who are of Asian or Pacific Islander descent represent 1% of the total population, while 0.6% are Native American and 2.5% are two or more races.



Economic Stability

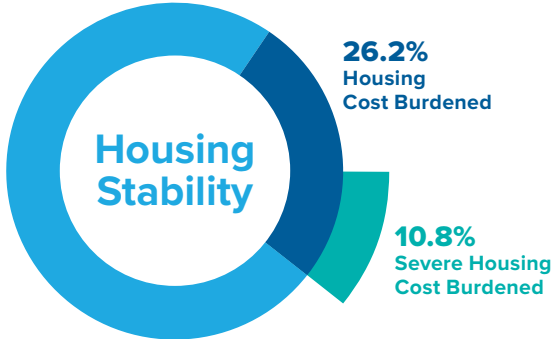
Income

The median household income in the Hospital's community is $55,675. This is below the median for both the state and the US. Although below the median, 15.4% 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.

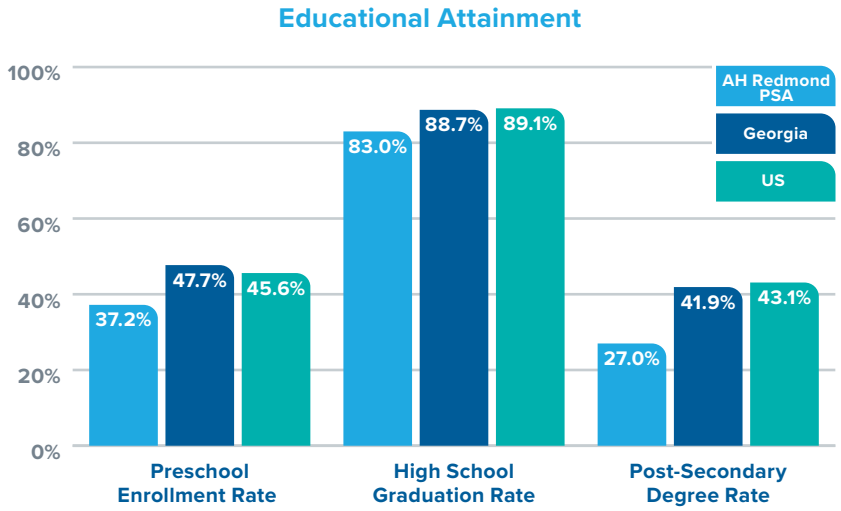
In the Hospital's community, there is an 82.9% high school graduation rate, which is lower than both the state, (88.7%) and national average (89.1%). The rate of people with a post-secondary degree is also lower in the Hospital's PSA than in both the state and nation.

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]

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 Service

In the Hospital's community, 37.2% of three- and four-year olds were enrolled in preschool. Although lower than both the state (47.7%) and the national (45.6%) average, there is still a large percentage of children in the community who may not be receiving these early foundational learnings.



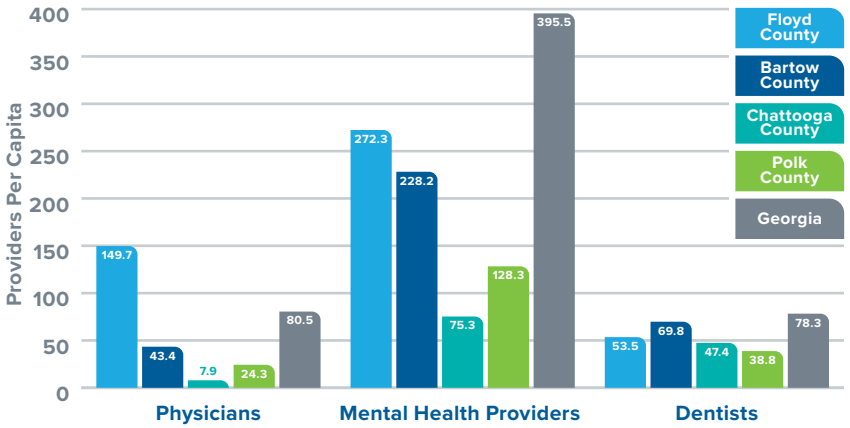
Health Care Access and Quality

In 2022, 14.1% 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, Floyd County has the most physicians and mental health providers per capita, and Bartow County has the most dentists available.

Routine checkups can provide an opportunity to identify potential health issues and when needed develop care plans. In the Hospital's community, 75.4% of people report visiting their doctor for routine care.

Available Health Care Providers

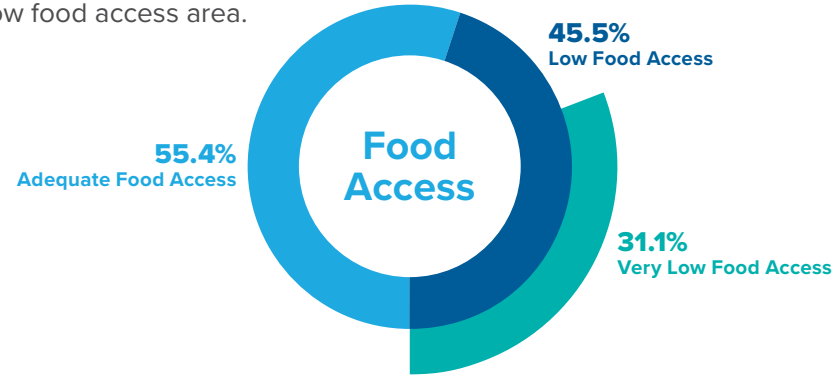


4 Health Insurance and Access to Care | CDC

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, 45.5% of the community lives in a low food access area, while 31.1% 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 Floyd County, where the Hospital is located, as 14.4%

Access to public transportation is also an important part of a built environment. For people who do not have cars, reliable public transportation can be essential to access health care, healthy food and steady employment. In the community, 5.9% of the households do not have an available vehicle.

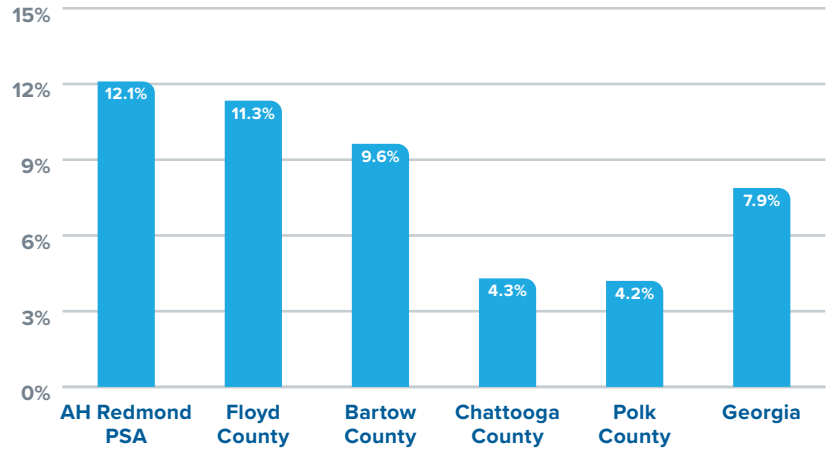
5 Heart Disease Risk Factors | CDC
6 Facts About Child Hunger | Feeding America
7 Map the Meal Gap 2022 | Feeding America

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, 12.1% 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 Floyd County at 11.3%.

Disconnected Youth



Also, in the community 26.8% of seniors (age 65 and older) report living alone and 1.2% 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 ten stakeholders provided their expertise and knowledge regarding their communities, including:

Name	Organization	Services Provided	Populations Served
Emily Matson, Director of Advancement	Unity Christian School	Education/Youth Services, Faith Formation	Infant/Children/ Adolescents
Becky McCoy, Executive Director of Student Services	Floyd County Schools	Education/Youth Services	Infant/Children/Adolescents, LGBTQIA+, Parents/ Caregivers, People with Disabilities, Homeless, Low Income
Jamie Youngblood, CCSP Program Coordinator	NWGA Area Agency on Aging	Health Care/Public Health, Transportation, Food Assistance	Elderly
Bonnie Moore, Educate Chair	NAMI Rome	Education/Youth Services, Mental Health	LGBTQIA+, Elderly, Parents or Caregivers, People with Disabilities, Women, Homeless, Low Income, Veterans, General Public, Anyone living with Mental Illness
Tina Bartleson, Executive Director	Exchange Club Family Resource Center	Education/Youth Services, Transportation, Food Assistance, Home Visits, Parent Education, Child Development	Infant/Children, Adolescents, LGBTQIA+, Parents or Caregivers, Women, Low Income, Veterans, Parents with children 12 years or younger
Jennifer Patrick, Board Member	NAMI	Mental Health	People with Disabilities, General Public
Dondra Crawford, Community Outreach Manager	AdventHealth Redmond	Health Care/Public Health	General Public
Jessica Dempsey, Physician Liaison	AdventHealth Redmond	Health Care/Public Health, Transportation	General Public
Juleun Johnson, VP Mission and Ministry	AdventHealth	Health Care/Public Health, Domestic Violence,	LGBTQIA+, Elderly, Parents or Caregivers, People with Disabilities, Women, Homeless, Low Income, Veterans, General Public
Terrence Hight, Sr., CEO	Hight for Sight, Inc.	Education/Youth Services, Financial Support	Infant/Children/Adolescents, LGBTQIA+, People with Disabilities, Low Income

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

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 12 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).

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.

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.

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.

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, narrowed the health needs of the community to a list of 1 – 5. 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

- Jeannie King, Marketing Director, Unity Christian School
- Tannika King, Marketing Director, Darlington School
- Jeff Mauer, Founder, Restoration Rome
- Jennifer Jolly, Director, Rome Floyd County Commission on Children and Youth
- Jamie Youngblood, Assistant Director, Northwest Georgia Regional Council Agency on Aging
- Erin Elrod, Chair, Community Services Division Director
- Kelly Ledford, Mayor, Assistant to City Manager
- Jim Moore, Director, NAMI Rome
- Bonnie Moore, Director, NAMI Rome
- Renee Blackburn, Executive Director, Free Clinic of Rome

AdventHealth Team Members

- Isaac Sendros, President and CEO
- Dr. Dave Tomey, Chief Medical Officer
- Amy Jordan, Chief Nursing Officer
- Cindy Hoggard, Director, Emergency Services
- Lindsey Smollar, Supervisor, Care Management

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.

- Noah Johnson, Director of Finance
- Scotty Hancock, Director Business and Industry Development/ Government Relations
- Rika Meyer, Marketing Director
- Stephanie Whitley-Ferguson, Chaplain
- Dondra Crawford, Community Outreach Manager

Public Health Expert

- Dr. Gary Voccio, Director, Northwest Ga Public Health

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=17) 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
Mental Health	12	25%
Health Care Access and Quality	8	17%
Heart Disease and Stroke	6	13%
Obesity	6	13%
Economic Stability	5	10%
Drug and Alcohol Use	3	6%
Diabetes	3	6%
Cancer	3	6%
Neighborhood and Built Environment—Food Security	2	4%
Education Access and Quality	0	0%
Tobacco Use	0	0%
Asthma	0	0%

After a list of the top 12 health needs of the community had been voted on by the CHNAC, they were presented to the Hospital Health Needs Assessment Committee (HHNAC). The HHNAC met and reviewed the data behind the selected needs and the available resources to address them in the community. The HHNAC also considered the Hospital's current resources and strategies to find ways to most effectively address the needs. Through these discussions the Hospital selected the needs it is best positioned to impact.

Members of the HHNAC included:

- Isaac Sendros, President and CEO
- Dr. Dave Tomey, Chief Medical Officer
- Amy Jordan, Chief Nursing Officer
- Jeff Prusia, Chief Financial Officer
- Juleun Johnson, VP Mission and Ministry
- Scotty Hancock, Business and Industry Development/Government Relations
- Rika Meyer, Marketing Director
- Stephanie Whitley-Ferguson, Chaplain
- Jake Hager, Foundation Director
- Dondra Crawford, Community Outreach Manager

The HHNAC narrowed down the list to three priority needs:

- Heart Disease and Stroke
- Mental Health
- Health Care Access and Quality

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	• Georgia Department of Public Health provides referrals to free asthma self-management education for children and teens	• Area Agency on Aging Chronic Disease Management class	None
Cancer	• Cancer Navigators of Rome — Cancer Navigators • Loving Arms Cancer Outreach, Inc. — Patient Financial Assistance Program • West Rome United Methodist Church provides a food pantry for cancer patients who are undergoing cancer treatment	• Summit Quest provides resources, emotional support, transportation and programs for patients and families facing cancer • Northwest Georgia Cancer Coalition, Inc. provides cancer-related education, communications, prevention, early detection and screening treatment and research	• In partnership with Northwest Georgia Cancer Coalition, Inc., provide cancer screenings to uninsured and underinsured populations • Distribution events where cancer patients and families affected by cancer receive seasonal produce • Health Initiative for Men and Women: Prevention Event includes a health fair, food distribution event, cooking demonstrations and health screenings • Distribute cancer awareness and education resource • Grant-funded transportation program for qualifying oncology patients (funded by Northwest Georgia Cancer Coalition, Inc.)
Heart Disease and Stroke	• Area Agency on Aging Chronic Disease Management class	• Free Clinic of Rome provides healthcare services to uninsured residents	• The Community Outreach team conducts blood pressure and health screenings at community events • “Strike Out Stroke” is hosted in May each year to share information and education about stroke response

Top Needs	Current Community Programs		Current Hospital Programs
Diabetes	• Area Agency on Aging Chronic Disease Management class • Free Clinic of Rome provides healthcare services to uninsured residents	• Veterans Clinic of Rome provides diabetes classes and nutrition counseling	None
Mental Health	• Highland Rivers Behavioral Health provides mental health treatment, support and recovery services for all ages • Highland Rivers Crisis Stabilization Units — Floyd and Polk • Georgia HOPE — Community-Based Mental Health Services • Elevation House — Clubhouse • Highland Rivers Behavioral Health — Floyd Assertive Community Treatment (ACT) Program • Highland Rivers Behavioral Health — Child and Adolescent Outpatient Services • ACE (Achieving Community Enrichment) — Counseling Services	• Bridge Health — Adult Outpatient Services • LivingProof Recovery — Peer Coaching • Sexual Assault Center of Northwest Georgia — Support Groups and Counseling • The National Alliance on Mental Health (NAMI) Rome provides a variety of support groups for individuals as well as family and friends of individuals who are dealing with mental health struggles • Restoration Rome is a hub for trauma-informed services in Northwest Georgia • Atrium Floyd Day Treatment	None
Obesity	None		None
Drug and Alcohol Use	• Highland Rivers Behavioral Health — Residential Substance Use Treatment for Women and Mothers • Living Proof Recovery — Peer Coaching • Highland Rivers Behavioral Health — Women's Outpatient Substance Abuse Treatment • Bridge Health — Children and Adolescents Addictive Disease Services • Bridge Health — Adult Addictive Disease Services	• Highland Rivers Behavioral Health — Floyd Substance Abuse Outpatient Services • Highland Rivers Behavioral Health — Floyd Substance Abuse Outpatient Services • Floyd Against Drugs provides drug education to reduce the use of drugs, tobacco and underage drinking • Freedom Counseling Services provides addiction rehabilitation with Christian discipleship • Highland Rivers Behavioral Health Crisis Stabilization Units Floyd and Polk	• Partners with Floyd Against Drugs for a "Drug Takeback" day to reduce prescription drug abuse

Top Needs	Current Community Programs		Current Hospital Programs
Tobacco Use	• Northwest Georgia Regional Cancer Coalition provides tobacco/e cigarette prevention and education programs, cessation classes and support to local school systems and community organizations		• Lung Clinic offers smoking cessation classes • High risk patients without funding may be eligible for lung screenings in conjunction with the Northwest Georgia Cancer Coalition
Economic Stability	• Noonday Association — Storehouse Ministries Food Pantries • Northwest Georgia Family Crisis Center — Emergency Shelter • Salvation Army Georgia Division — Rome — Emergency Shelter • William S. Davies Homeless Shelters — Ruth and Naomi House — Women and Children's Shelter • Hospitality House For Women, Inc. — Emergency Temporary Shelter • William S. Davies Homeless Shelters — Davies Men's Shelter • Society of St. Vincent De Paul — Georgia — Financial Assistance	• Salvation Army Georgia Division — Rome — Project SHARE • Fork Spoon & Plate — Food and Goods Distribution • University of Georgia — Bartow County Extension Office — Food Talk SNAP-Ed • Good Neighbor Ministries provides rent and utility assistance • Tallatoona Community Action Partnership helps individuals acquire knowledge and skills to achieve economic self-sufficiency • The United Way of Rome & Floyd County provides case management for individuals and families facing economic, family or housing instability	None
Education Access and Quality	• Family Resource Center Of Gordon County — Parents as Teachers (PAT) • House Of The Children Academy — Early Head Start • Floyd County Schools — McKinney-Vento Homeless Assistance • Chattooga County School District — McKinney-Vento Federal Grant	• Tallatoona Community Action Partnership, Inc. (CAP) — Head Start • Advocates for Children — CARES Act Assistance • Blue Ridge Area Health Education works to grow and sustain a diverse healthcare workforce • Etowah Employment helps individuals gain employment	None

Top Needs	Current Community Programs		Current Hospital Programs
Health Care Access and Quality	• Women of W.O.R.T.H., Inc. — Affordable Health Services • Kindred at Home — Georgia — Home Health Services • Northwest Georgia Center for Independent Living — Assistive Technology and Durable Medical Equipment Re-use • Floyd County Health Department — Women, Infants and Children (WIC) • Polk County Health Department — Cedartown — Women, Infants and Children (WIC) • Gordon County Health Department — Women, Infants and Children (WIC) • Northwest Health District — Women, Infants and Children (WIC)	• Floyd Medical Center — Floyd Polk Medical Center • AdventHealth — Home Health Care • NWGA Specialty Care Clinic — HIV and Primary Health Services • Area Agency on Aging in Home Services (60+) Chronic Disease Mgmt. Classes — Assistive Technology • Public Health CMS (all Health Departments) • Floyd County Health Department • Baptist Mobile Health Ministry • Bethany Christian Clinical Services • Free Clinic of Rome	• Partners with the Free Clinic of Rome to provide medical care which includes access to translation technology
Neighborhood and Built Environment — Food Security	• Tallatoona Community Action Partnership, Inc. (CAP) — Weatherization • Bagwell Food Pantry provides food assistance • Good Neighbor Ministries provides food assistance to individuals in Rome and Floyd County • Helping Hands Food Bank provides an emergency food pantry for Polk County • Journey Community Food Pantry provides food to Floyd County residents • Rome-Floyd County Community Kitchen offers a soup kitchen	• The Salvation Army of Rome provides food, shelter, as well as family and social services to people in need. • Rome-Floyd County Commission on Children & Youth empower children and youth to reach their full potential through collaboration, advocacy and visibility • Northwest Georgia Hunger Ministries serves families in need through sourcing and delivering food including over 2000 backpack buddy bags per month • YMCA monthly “Mobile food markets” at multiple locations in community with higher frequency during summer break	None

Priorities Addressed

The priorities to be addressed include:

Heart Disease and Stroke

Secondary data showed 7.8% of adults in the Hospital's PSA have coronary heart disease which is above the state average of 5.8%. All surrounding counties were also above the state average for coronary heart disease. In the Hospital's community, 37% of residents have a prevalence of high cholesterol, while 40.3% of residents have high blood pressure. According to the community survey, 36% of respondents reported having high blood pressure, and 9% of respondents reported having coronary heart disease. The need to address this need in the community is significant as the data has shown. The Hospital also prioritized heart disease in the previous needs assessment. By including heart disease and stroke as a priority, the Hospital can continue their work in the community to address this issue and increase their collaboration with community partners.

Mental Health

In the Hospital's community, 23.2% of residents have depression, while 18.5% of adults self-reported poor mental health. Chattooga County had the highest rate of depression at 24.9%. According to the community survey, 33% of respondents have been diagnosed with a depressive order and 34% have been diagnosed with an anxiety disorder. Awareness and the need to address mental health disorders has been growing in the country. The Hospital prioritized mental health in the previous needs assessment and will continue to partner with organizations already addressing this issue to create better outcomes opportunities over the next three years.

Health Care Access and Quality

In the Hospital's community, per 100,000 residents, 223.2 have a prevalence of mental health providers, while 17.5% of residents report being without health insurance. According to the community survey, 32% of respondents said they needed to see a doctor in the past 12 months but weren't able to due to cost. Awareness and the need to address healthcare access and quality has been growing in the country. Including healthcare access and quality 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

According to secondary data, asthma impacts 10.9% of residents which is slightly below the state average of 10.6%. Community survey data showed a higher rate with 34% of respondents diagnosed with asthma. The Hospital did not select asthma as a priority as it is not positioned to directly address this issue. The Hospital will support other efforts addressing this through advocacy, community partnerships and public health collaborations as needed.

Cancer

In the Hospital's community, 8.4% of residents have had cancer according to secondary data which is higher than the state rate of 6.6%. According to the community survey, 10% of residents had been diagnosed with cancer. Patient data also showed high utilization of mammogram screenings in the outpatient setting. The Hospital prioritized cancer in the previous needs assessment and was able to offer education and screenings to help community members with early detection. The Hospital decided it was best to pivot to address health care access and quality which can indirectly impact cancer and other needs found in the assessment.

Diabetes

Diabetes is shown to impact 13.2% of residents in the Hospital's community according to public data. This is above the state average of 11.6%. Among community survey respondents, 17% reported being diagnosed with diabetes. The Hospital did not select diabetes as a priority because 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.

Obesity

In the Hospital's community, 39.7% of residents are overweight or obese, which is higher than the state (36.8%) and higher than the national average (33.8%). Polk County had the highest rate of obesity with 41.7% of adults. Secondary data also showed 29.4% of adults in the Hospital's community reported zero exercise in the past 30 days. The need to address obesity 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

Stakeholders chose drug and alcohol use as a top health condition affecting the community. All counties are above the Hospital's PSA (15.1%) for residents who report binge drinking. According to the community survey, 14% of respondents reported taking prescription medication for non-medical reasons and 11% reported taking prescription pain medication without a doctor's prescription. Drug and alcohol use has been a growing concern across the country, however, the Hospital believes other organizations are better positioned to address this issue in the community. The Hospital will support those organization and their work to address drug and alcohol use.

Tobacco Use

According to secondary data, 18% of residents currently smoke cigarettes which is higher than the state average of 14.8%. Chattooga County had the highest percentage of adult smokers at 21%. Community survey respondents shared higher rates of smoking with 25% overall, and 20% of respondents reporting they vape as well. The tobacco use 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.

Economic Stability

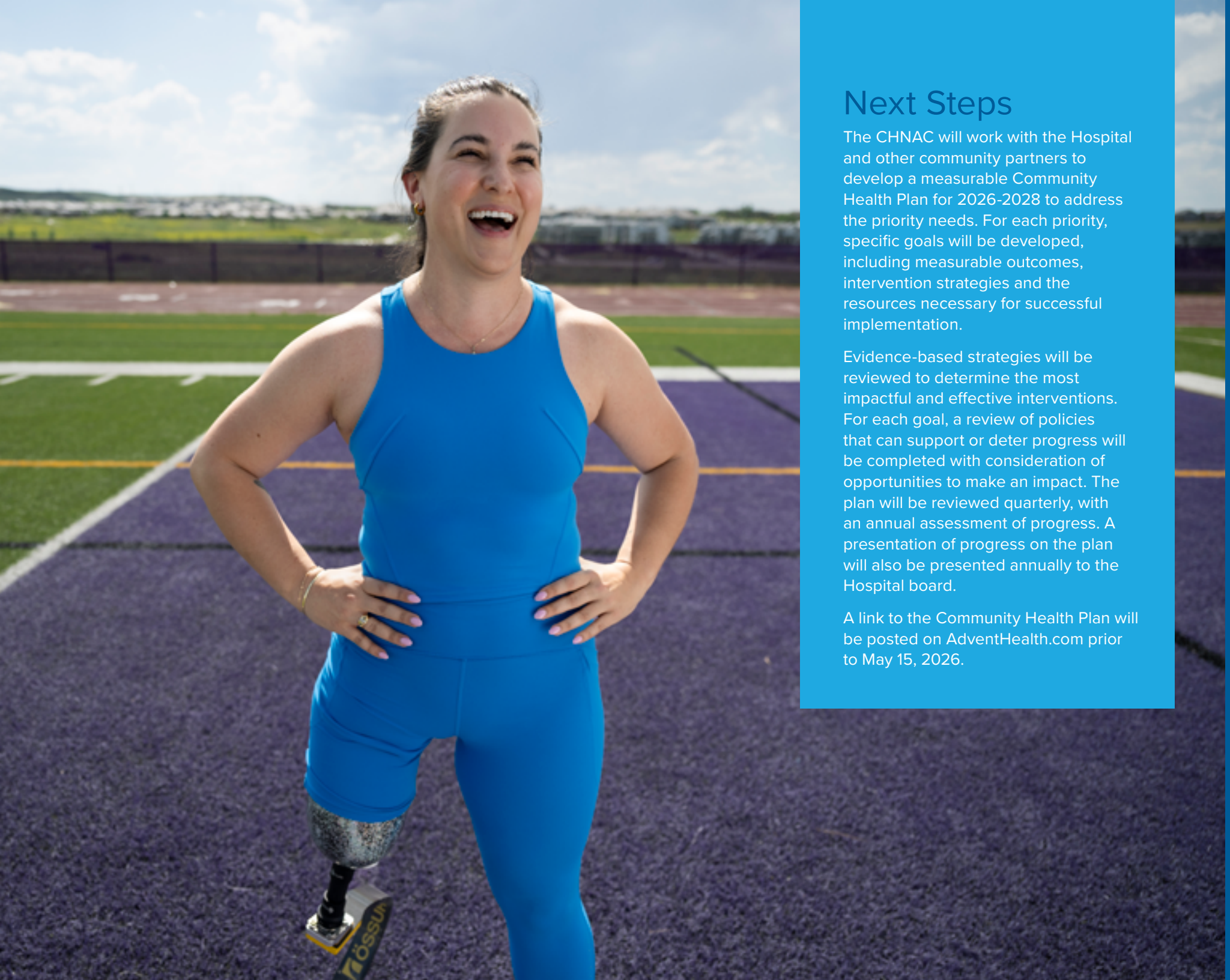
In the Hospital's community, 26.2% of residents are housing cost-burdened, while 10.8% of residents are severely housing cost-burdened. According to the community survey, 17% of respondents reported being worried they would not have stable housing in the next two months. Secondary data also showed 15.4% of residents in the Hospital's community are in poverty which is higher than the state average (13.5%). Chattooga County had the highest percent of residents in poverty (19.9%) followed by Floyd County (17.5%). The economic stability need in the community is significant, however, the Hospital did not perceive the ability to have a measurable impact on the issue with the current resources available to the community and the Hospital at this time.

Education Access and Quality

In the Hospital's community, 82.9% of adult residents have a high school degree which is below the state average of 88.7%. Additionally, 26.9% have an advanced degree, while 37.2% of residents aged three-four are enrolled in preschool. The Hospital agreed there is room to improve education outcomes in the community but ultimately did not select this need as a priority due to a lack of resources. The Hospital will support external partners to address these issues whenever possible.

Neighborhood and Built Environment—Food Security

Approximately 12.6% of the households in the Hospital's community reported receiving SNAP Benefits in the past 12 months according to secondary data. In Chattooga County, 19.1% of households, and in Floyd County, 13/4% of households receive SNAP benefits. Among community survey respondents, 24.6% reported eating less than they should in the past 12 months due to cost which indicates they are food insecure. Also, 25.2% of community survey respondents received SNAP benefits in the past 12 months. The Hospital decided not to address this need and 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

In the 2023 CHNA, the Hospital addressed heart disease as a priority. According to secondary data, individuals in the Hospital's community had higher rates of coronary heart disease and of heart disease mortality per 100,00 than elsewhere in Georgia and the nation. Almost 13.5% of community survey respondents report having coronary heart disease. Also, 34% of individuals living in the community had been told they have high cholesterol which can be a contributing factor to heart disease as well.

The Hospital has focused on community outreach to provide education and services related to prevention and screenings. AdventHealth Redmond provided 200 heart disease screenings (including blood pressure checks and calcium screenings) to low-income adults in Floyd County, and physicals to 80 special Olympic athletes. Over 1,200 community members in Floyd County of all ages were educated about heart disease prevention through awareness, health education programming and free information from community partnerships such as Rome Braves Strike out Stroke, Heart of the Community's Awards and Heart Walk, HeartSaver training and the YMCA.

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

Priority 2: Mental Health

During the 2023 needs assessment, secondary data showed 22.3% of residents had a prevalence of depression, while 19% of the residents reported poor mental health. According to community survey respondents 20.7% had been diagnosed with a depressive order and more than 23.1% had been diagnosed with an anxiety disorder.

The Hospital set out to host monthly support groups for individuals with cancer where they can discuss their experiences with similar individuals. Additionally, the Hospital established a partnership with the Rome chapter of the National Alliance on Mental Illness (NAMI). NAMI Rome is an advocacy organization consisting of families, friends, and individuals whose lives have been affected by mental illness. Through the partnership, they have increased communication and accessibility of mental health programs and other support resources

Priority 3: Cancer

The Hospital selected cancer as a priority during the 2023 CHNA. During the assessment, data showed 6.86% of the residents have had cancer according to secondary data which is higher than the state rate of 6.16%. All counties except Floyd had new cancer diagnosis rates slightly higher than the state average. According to the community survey, 17% of residents had been diagnosed with cancer.

Since adopting the plan, AdventHealth Redmond provided free screenings for colon cancer for early detection to 40 community members. Increasing cancer awareness was also a top goal for the Hospital and, thus far, six educational events were hosted in the community. The Hospital also provided leadership and financial support through partnerships and educational events such as Skin Cancer Awareness, Pink Out the Park, Kellogg's Health Fair, the Health Initiative for Men + Women and the Pink Porch breast cancer awareness campaign to help reduce the risk of cancer through healthy lifestyle practices and early detection..

2023 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, 2024 and have not received any written comments.

AdventHealth

Redmond Park Hospital, LLC dba AdventHealth Redmond

CHNA Approved by the Hospital board on: April 29 2025

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

25-CORP-1666163854