



20 AdventHealth 22 Manchester

Community Health Needs Assessment

Extending the Healing
Ministry of Christ

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Letter From Leadership

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

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

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

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

In His Service,

Terry Shaw
President and CEO
AdventHealth



Executive Summary

Memorial Hospital, Inc. d/b/a AdventHealth Manchester will be referred to in this document as AdventHealth Manchester or “the Hospital”. The Hospital conducted a community health needs assessment from August 2021 to June 2022. The goals of the assessment were to:

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

Community Health Needs Assessment Committee

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

The CHNAC met three times in 2021 - 2022. They reviewed the 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 Manchester also convened a Hospital Health Needs Assessment Committee (HHNAC). The purpose of the HHNAC was to select the needs the Hospital would address as a result of the findings in the assessment. The HHNAC made this decision by reviewing the priority needs selected by the CHNAC and the internal Hospital resources available. With this information the HHNAC was able to determine where the Hospital could most effectively support the community.

See Prioritization Process for a list of HHNAC members.

Data

AdventHealth Manchester in collaboration with the AdventHealth Corporate team collected both primary and secondary data. The primary data included community surveys and stakeholder interviews. Secondary data included internal Hospital utilization data (inpatient, outpatient and emergency department). This utilization data showed the top diagnoses for visits to the Hospital from 2019-2021. In addition, publicly available data was utilized from state and national data sources. Primary and secondary data was compiled and analyzed to identify the top 12 aggregate issues.

See the Process, Methods and Findings for Primary and Secondary Data Sources.

Community Asset Inventory

The next step was to create a Community Asset Inventory. This inventory was designed to help the CHNAC and the HHNAC understand existing community efforts to address the 12 identified issues from aggregate primary and secondary data and to prevent duplication of efforts.

See Available Community Resources for more.

Selection Criteria

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

See the Priorities Selection for more.

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

See the Priorities Selection for more.



The CHNAC and the HHNAC considered four factors during prioritization:

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

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

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

D. Outcome Opportunities: Can an impact on this issue be made in a demonstrable way, and will interventions have an impact on other health and social issues in the community?



Priority Issues to be Addressed

The priority issues to be addressed are:

1. Cardiovascular Issues
2. Transportation
3. Mental Health
4. Preventative Care – Screenings
See Priorities Selection for more.

Approval

On December 12, 2022, the AdventHealth Manchester Board approved the Community Health Needs Assessment findings, priority issues and final report. A link to the 2022 Community Health Needs Assessment was posted on the Hospital's website prior to December 31, 2022.

Next Steps

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

About AdventHealth

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

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

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

Amwell, a national telehealth leader, named AdventHealth the winner of its Innovation Integration Award. This telemedicine accreditation recognizes organizations that have identified connection points within digital health care to improve clinical outcomes and user experiences. AdventHealth was recognized for its innovative digital front door strategy, which is making it possible for patients to seamlessly navigate their health care journey. From checking health documentations and paying a bill, to conducting a virtual urgent care visit with a provider, we are making health care easier by creating pathways to wholistic care no matter where your health journey starts.

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

AdventHealth Manchester

AdventHealth Manchester in Clay County has provided care in Kentucky since 1917. Today, the Hospital serves more than 60,000 patients every year, while staying true to AdventHealth's community-focused, patient-centric model of care. Guided by the principles of CREATION Life — Choice, Rest, Environment, Activity, Trust, Interpersonal Relationships, Outlook and Nutrition—staff go above and beyond to make every patient's stay feel like home.

Available services include the following: Addiction Medicine • Behavioral Care • Home Care • Imaging Services • Infusion Care • Emergency Care • Lab Services • Men's Care • Mother and Baby Care • Pediatrics • Psychiatry • Psychology • Orthopedic and Spine Care • Senior Care • Sports Med and Rehab Care • Surgical Care • Weekend Care • Women's Care

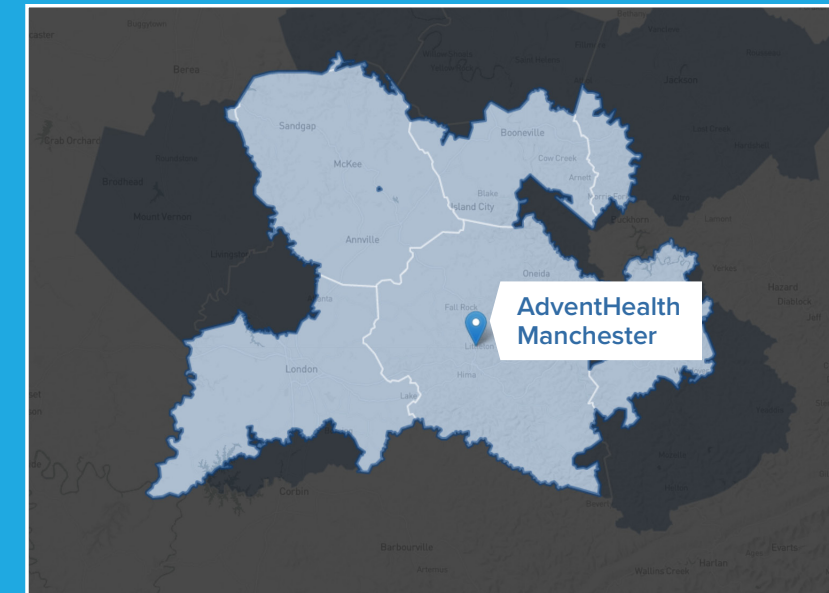


COMMUNITY OVERVIEW

Community Description

Located in Clay County, Kentucky, AdventHealth Manchester defines its community as the Primary Service Area (PSA), the area in which 90-95% of its patient population lives. This includes 13 zip codes across mainly Clay, Jackson, Owsley, Laurel, Leslie and Breathitt Counties.

According to the 2020 Census, the population in the AdventHealth Manchester community has grown 1.1% in the last ten years to 84,101 people. This is less than the percentage of growth seen in the United States and the State of Kentucky since the last Census. Demographic and community profile data in this report are from publicly available data sources such as the US Census Bureau and the Center for Disease Control and Prevention unless indicated otherwise. Data are reported for the Hospital's PSA, also referred to as the community, unless listed for a specific county. Data are also provided to show how the community compares locally, in the state and at a national level for some indicators.



Community Profile

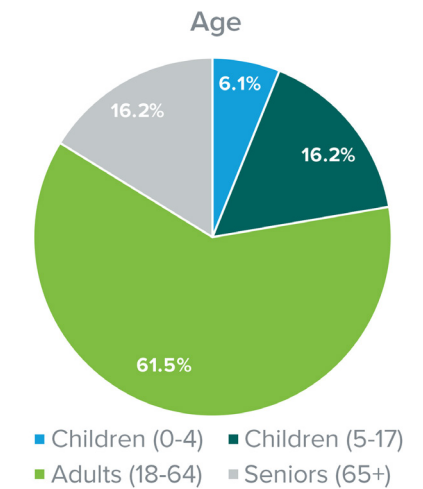
Age and Sex

The median age in the Hospital's community is 40.8, higher than that of state which is 39 and that of the US, 38.2.

Females are the majority, representing 50.6% of the population. Middle aged women, 40-64, are the largest demographic group at 17%. Middle aged men, 40-64, are the second largest demographic in the community at 16.3%.

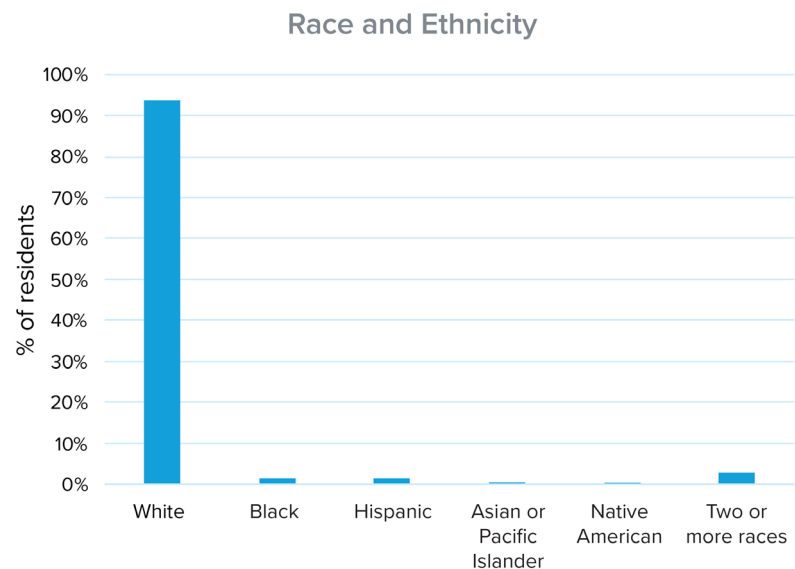
Children are 22.3% of the total population in the community. Infants, those zero to four, are 6.1% of that number. The community birth rate is 54.7 births per 1,000 women aged 15-50, this is higher than the US average of 51.9 and that of the state, 52.4. In the Hospital's community, 38.3% of children aged 0-4 and 33.9% of children aged 5-17 live in poverty.

Seniors, those 65 and older, represent 17.2% of the total population in the community. Females are 53.9% of the total senior population.



Race and Ethnicity

In the Hospital's community, 93.7% of the residents are non-Hispanic white, 1.4% are non-Hispanic Black and 1.5% are Hispanic or Latino. Residents that are of Asian or Pacific Islander descent represent .5% of the total population, while .2% are Native American and 2.7% are two or more races.



Social Determinants of Health

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

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



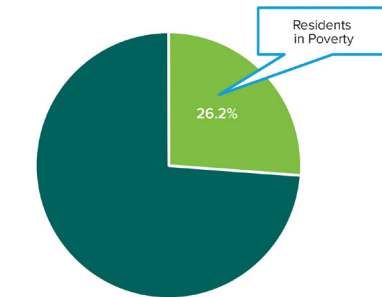
The Healthy People 2030 place-based framework outlines five areas of SDOH:

- 
Economic Stability: This includes areas such as income, cost of living, food security and housing stability.
- 
Education Access and Quality: This focuses on topics such as high school graduation rates, enrollment in higher education, literacy and early childhood education and development.
- 
Health Care Access and Quality: This includes topics such as access to health care, access to primary care and health insurance coverage.
- 
Neighborhood and Built Environment: This includes areas like quality of housing, access to transportation, availability of healthy foods and neighborhood crime and violence.
- 
Social and Community Context: This focuses on topics such as community cohesion, civic participation, discrimination and incarceration.

Economic Stability

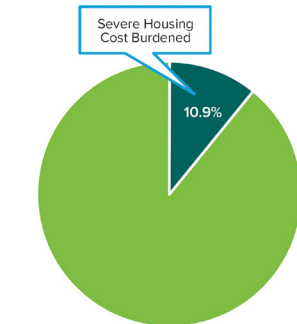
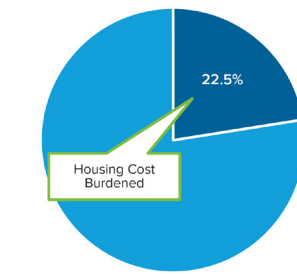
Income

The median household income in the Hospital's community is \$40,568. This is below the median for the state and significantly lower than that of the US. The poverty rate in the community is 26.2%, which is higher than the state's by 10% and more than twice the national rate.



Food Insecurity and Housing Stability

People who are food insecure, having reduced quality and/or amount of food intake, may be at an increased risk of negative health outcomes. Studies have shown an increased risk of obesity and chronic disease in adults who are food insecure. Children who are food insecure have been found to have an increased risk of obesity and developmental problems compared to children who are not.¹ Feeding America estimates for 2020,² showed the food insecurity rate in the Hospital's community as 21.7%.



Increased evidence is showing a connection between stable and affordable housing and health.³ When households are cost burdened or severely cost burdened, they have less money to spend on food, health care and other necessities. Having less access can result in more negative health outcomes. Households are considered cost burdened if they spend more than 30% of their income on housing and severely cost burdened if they spend more the 50%.

¹ Food Insecurity - Healthy People 2030 | health.gov
² Map the Meal Gap 2020 Combined Modules.pdf (feedingamerica.org)
³ Severe housing cost burden* | County Health Rankings & Roadmaps

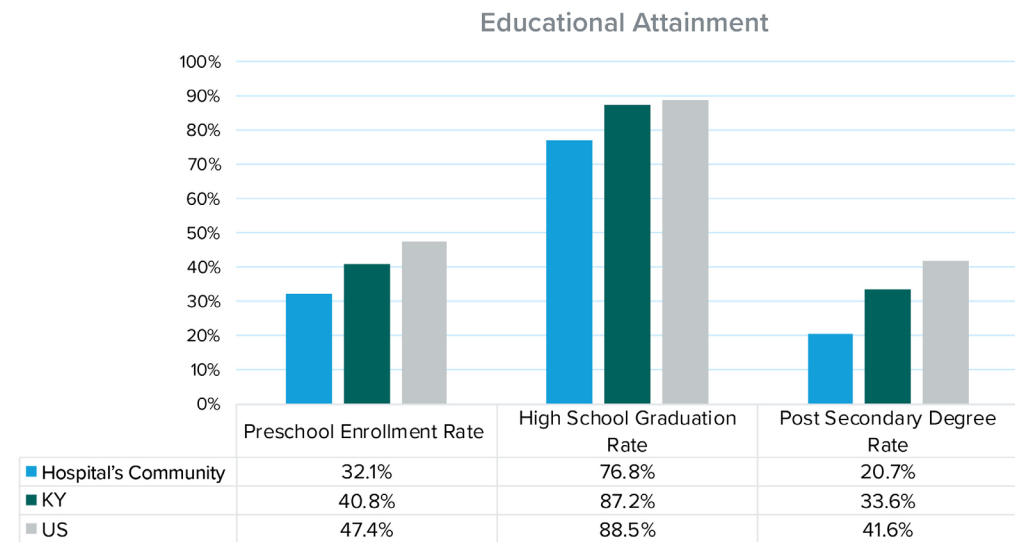
Education Access and Quality

Research shows education can be a predictor of health outcomes, as well as a path to address inequality in communities.⁴ Better education can lead to people having an increased understanding of their personal health and health needs. Higher education can also lead to better jobs, which can result in increased wages and access to health insurance.

In the Hospital's community, there is an 76.8% high school graduation rate, which is lower than the state and national rate. The rate of people with a post-secondary degree is also lower in the Hospital's community than both that of the state and the nation.

Early childhood education is uniquely important and can improve the cognitive and social development of children. This helps provide the foundation for long term academic success, as well as improved health outcomes. Research on early childhood education programs show that long-term benefits include improved health outcomes, savings in health care costs and increased lifetime earnings.⁵

In the Hospital's community, 32.1% of 3-4-year-olds were enrolled in preschool. This is lower than the state rate and the national rate. There is a large percentage of children in the community who may not be receiving these early foundational learnings.



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

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

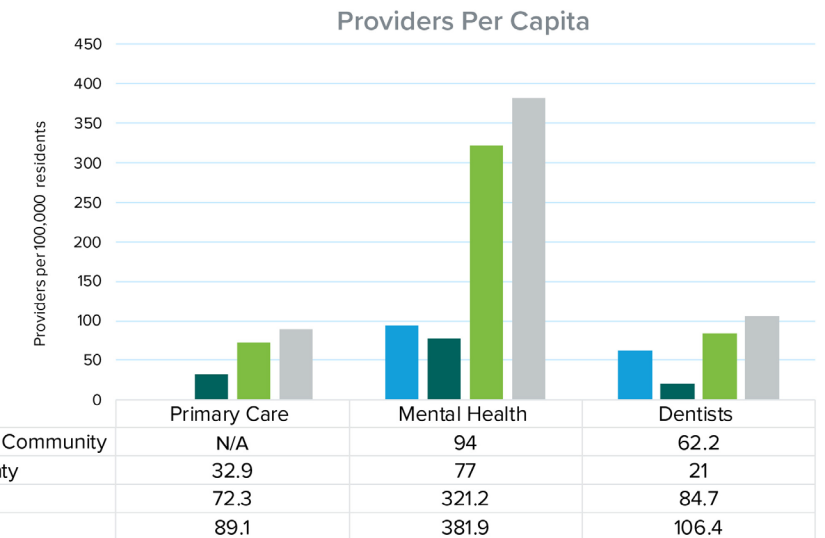
Health Care Access and Quality

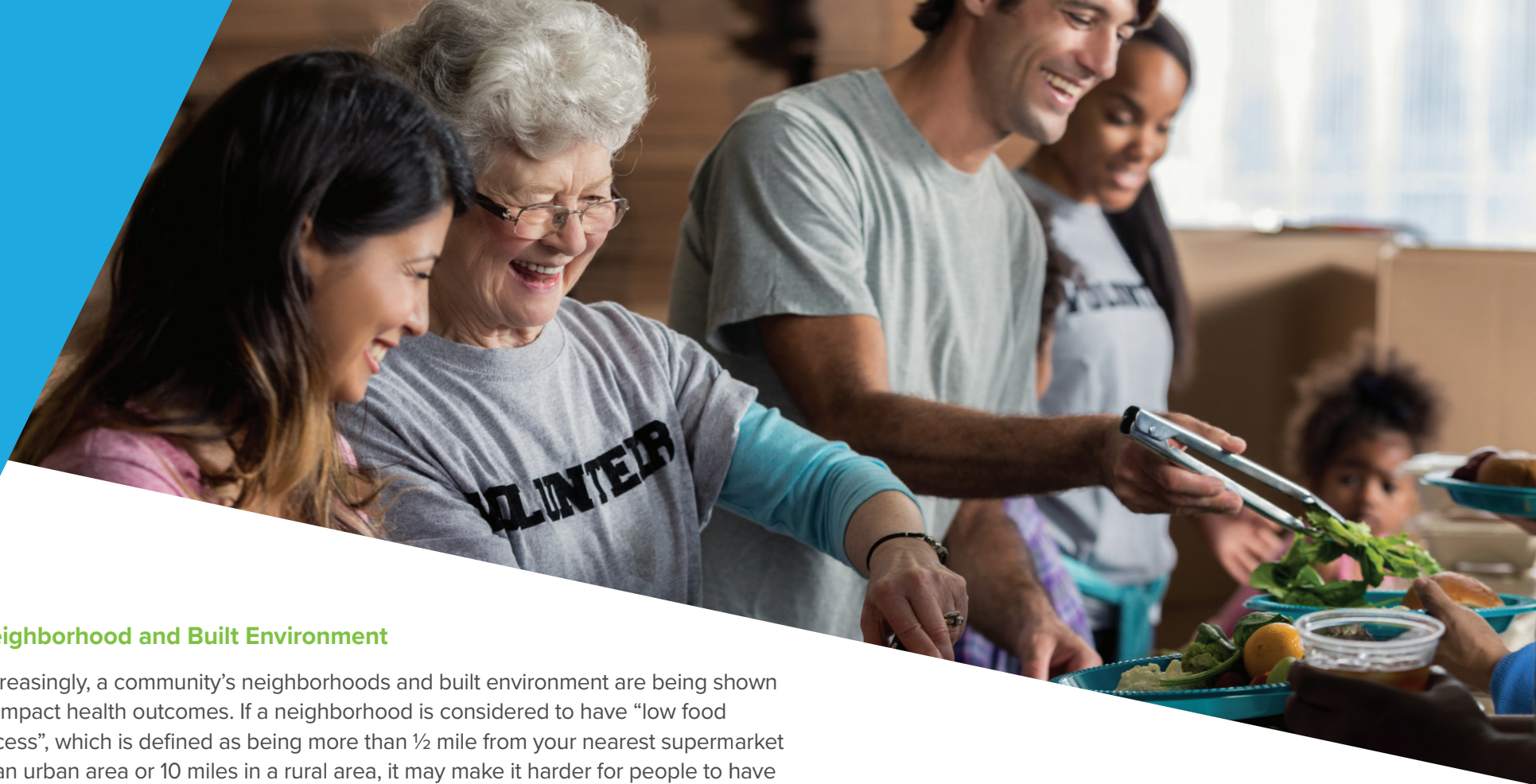
In 2020, 5.8% of community members aged 18-64 were found to not have health insurance. A lack of health insurance can lead to delayed care, resulting in more serious health conditions and increased treatment costs. Although health insurance coverage levels can be a strong indicator of a person's ability to access care, there are other potential barriers that can delay care for many people.⁶

Accessing health care requires more than just insurance, there also need to be available health care professionals to provide care. When more providers are available in a community access can be easier, particularly for those experiencing transportation challenges.

Routine checkups can provide an opportunity to identify potential health issues and when needed develop care plans. In the Hospital's community, 80.4% of people report visiting their doctor for routine care.

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





Neighborhood and Built Environment

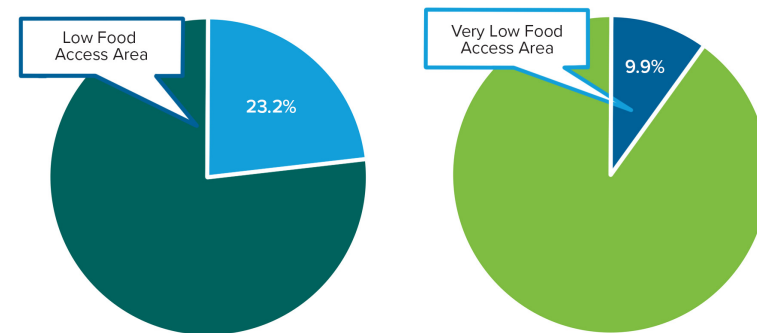
Increasingly, a community's neighborhoods and built environment are being shown to impact health outcomes. If a neighborhood is considered to have "low food access", which is defined as being more than 1/2 mile from your nearest supermarket in an urban area or 10 miles in a rural area, it may make it harder for people to have a healthy diet. A very low food access area is defined as being more than 1 mile from your nearest supermarket in an urban area or 20 miles in a rural area.

A person's diet can have a significant impact on health, so access to healthy food is important. For example, the largest contributors to cardiovascular disease are obesity and type 2 diabetes, both of which can be impacted by diet.⁷ In the Hospital's community, 23.2% of the community lives in a low food access area, while 9.9% live in a very low food access area.

Access to public transportation is also an important part of a built environment. For people who do not have cars, reliable public transportation can be essential to access health care, healthy food and maintaining employment. In the community, 8.6% of the households do not have an available vehicle.

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

Food Access



Social and Community Context

People's relationships and interactions with family, friends, co-workers and community members can have a major impact on their health and well-being.⁸ When faced with challenges outside of their control, positive relationships with others can help reduce negative impacts. People can connect through work, community clubs or others to build their own relationships and social supports. There can be challenges to building these relationships when people don't have connections to create them or there are barriers like language between groups.

In the community, 7.1% of youth aged 16-19 were reported as disconnected, which means they were neither enrolled in school nor working at the time. Also, in the community 27.2% of seniors (age 65 and older) report living alone. Factors like these can create barriers to feeling connected in the community.

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

Disconnected Youth





Process, Methods and Findings

■ Process and Methods

The Process

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

The Hospital partnered with local community organizations and stakeholders, including those in public health and those who represent the interests of medically underserved, low-income and minority community members, to form a Community Health Needs Assessment Committee (CHNAC) to guide the assessment process. During data review sessions, community members of the CHNAC provided insight on how health conditions and areas of need were impacting those they represented. The CHNAC used the data review and discussion sessions to understand the most important health needs and barriers to health the community was facing and to guide the selection of needs to be addressed in the 2022 CHNA.

Community Input

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

Community Health Survey

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

Stakeholder Survey

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

Public and Community Health Experts Consulted

A total of 11 stakeholders provided their expertise and knowledge regarding their community including:

Name	Organization	Services Provided	Populations Served
Helen Baker, DCBS	DCBS Protection and Permanency	Health care/public health; Education/youth services; Domestic violence; Mental/behavioral health care; Food assistance; Child protection	Homeless; Low income; Elderly; Children; Veterans; Women; LGBTQIA+; General public
Jeff Russell, Cancer Control Specialist	University of Kentucky	Health care/public health; Education/youth services	Low Income; General public
Tim Crawford, Development Director	Red Bird Mission, Inc., Red Bird Clinic, Inc. and Red Bird Mission Housing, Inc.	Health care/public health; Education/youth services; Transportation; Housing; Food assistance	Homeless; Low income; Elderly; Children; Women; General public
Lisa Sester, Senator Stivers Secretary	Senator Stivers Office	All public services	General public
Kelly Minton, Adult & Family Peer Support Coordinator	Ky Partnership for Families and Children, Inc.	Health care/public health; Education/youth services; Transportation; Housing; Domestic violence; Mental/behavioral health care; Food assistance; Employment assistance; Financial support	Low income; Children; Homeless; General public; Elderly; Women; Veterans; LGBTQIA+
James Caudill, Project Manager	Fahe	Housing; Employment assistance; Recovery Workforce Support	Homeless; Low income; Elderly; Children; Women; Veterans; LGBTQIA+; General public
Sandi Curd, Promise Zone Coordinator	Kentucky Highlands Investment Corporation	Financial support	Businesses which create jobs particularly for low income
Walter Mullins, Program Manager	VOA Mid-States	Recovery Support; Health care/public health; Mental/behavioral health care; Transportation; Employment assistance	Homeless; Low income; Elderly; Children; Women; Veterans; LGBTQIA+; General public
Tammy Pennington, Health Educator	Clay County Health Department	Health care/public health; Education/youth services	Homeless; Low income; Elderly; Children; Women; Veterans; LGBTQIA+; General public
Stephanie Hoskins, Director of rural ARS	Volunteers of America Mid-States	Health care/public health; Mental/behavioral health care	Homeless; Low income; Children; Women; LGBTQIA+
Tracy Nolan, Community Outreach Director	Red Bird Mission	Health care/public health; Education/youth services; Transportation; Housing; Mental/behavioral health care; Food assistance; Employment assistance; agriculture; baby pantry	Homeless; Low income; Elderly; Children; Women; Veterans; LGBTQIA+; General public

Secondary Data

To inform the assessment process, the Hospital collected existing health related and demographic data about the community from publicly available sources and Metopio,⁹ a web-based data platform. This included data on health conditions, social determinants of health and health behaviors.

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

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

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

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



The Findings

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



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



Availability: A community need for more available social support services for everyone and recreational facilities for youth and seniors.



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



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



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

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

The significant needs identified in the assessment process included:



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



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



Food Insecurity: Food insecurity exists when people do not have physical and economic access to sufficient safe and nutritious food that always meets their dietary needs and food preferences. Food insecurity has been linked to negative health outcomes in children and adults, as well as potentially causing trouble for children in schools.



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



Housing: Where people live and how people live directly affects their well-being. Research shows that individuals experiencing housing instability have limited access to preventive care and are more likely to have infectious diseases and chronic health conditions like diabetes, cardiovascular disease and chronic obstructive pulmonary disease. Homeless individuals also have a shorter lifespan.

Housing stability is another factor of housing, where housing instability can mean having housing with poor sanitation, heating and cooling; exposure to allergens or pests; and substandard housing structures.



Transportation: Each year, 3.6 million people in the United States do not obtain medical care due to transportation issues. These issues may result in missed or delayed health care appointments, increased health expenditures and overall poorer health outcomes. Transportation issues include lack of vehicle access, inadequate infrastructure, long distances and lengthy times to reach needed services, transportation costs and adverse policies that affect travel. Transportation challenges affect rural and urban communities. Because transportation touches many aspects of a person's life, adequate and reliable transportation services are fundamental to healthy communities.



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

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



Substance Misuse: Substance Misuse – Alcohol & Drug: Substance use disorders can involve illicit drugs, prescription drugs or alcohol. Opioid use disorders, which stem from the improper use of prescription drugs, 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 and Vaping: Tobacco smoking is the practice of burning tobacco and ingesting the smoke produced. Smoking leads to disease and disability and harms nearly every organ of the body. Additionally, smoking causes cancer, heart disease, stroke, lung diseases, diabetes and chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis. Smoking also increases risk for tuberculosis, certain eye diseases and problems of the immune system, including rheumatoid arthritis. Secondhand smoke causes stroke, lung cancer and coronary heart disease in adults. Children who are exposed to secondhand smoke are at increased risk for sudden infant death syndrome, acute respiratory infections, middle ear disease, more severe asthma, respiratory symptoms and slowed lung growth. Vaping is an alternative way to consume tobacco and has been growing in popularity.



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. You must also remove the triggers in your environment that can make your asthma worse.



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



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



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



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

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



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



Pregnancy and Maternal Health: Women in the United States are more likely to die from childbirth than women living in other developed countries. Some women have health problems that start during pregnancy, and others have health problems before they get pregnant that could lead to complications during pregnancy. Strategies to help women adopt healthy habits and get health care before and during pregnancy can help prevent pregnancy complications. In addition, interventions to prevent unintended pregnancies can help reduce negative outcomes for women.



PRIORITIES SELECTION

■ Prioritization Process

The Community Health Needs Assessment Committee through data review and discussion, narrowed the health needs of the community to a list of 12. Community partners on the CHNAC represented the broad range of interests and needs, from public health to the economic, of underserved, low-income and minority people in the community. During the Spring of 2022, the CHNAC met three times to review and discuss the collected data and select the top community needs.

Members of the CHNAC included:

Community Members

- Tracy Nolan, Community Outreach Coordinator, Red Bird Mission, a community organization providing a food pantry and emergency financial assistance for those that are homeless, low income or in need
- Bailey Lewis, Assistant Director, Clay County Senior Citizens, providing seniors a variety of services including lunches, homemaking services, respite support for caregivers and a Meals on Wheels option for home bound seniors
- Stephanie Hoskins, Director of Freedom House, Volunteers of America, providing recovery and holistic, family-centered treatment, addressing the cycle of addiction with children while simultaneously treating their mothers
- Edith Crawford, STC Community Engagement Coordinator, Clay County Schools, providing education and connecting families with resources to strengthen education outcomes for students
- Tess Lipps, Vice President, Cancer Coalition, providing financial and educational support for cancer patients
- Jackie Collins, Medical Assistant, AdventHealth Primary Care Clinic, providing a space for community members to get the health care they need regardless of insurance status and ability to pay

- Marsha Garrison, Community Health Educator, Healthy Clay Coalition, providing a space for organizations and individuals working together to encourage healthy lifestyle choices for those living and working in Clay County through policy and community change
- Ruthie Sizemore, Clay and Jackson Coordinator, Agencies for Substance Abuse Policy focusing on developing a strategic plan to reduce the prevalence of alcohol, tobacco and other drug use among youth and adult populations in Kentucky and coordinate efforts among state and local agencies in the area of substance misuse prevention to improve outcomes for all community members

AdventHealth Team Members

- James Couch, Vice President, AdventHealth Manchester
- David Watson, Executive Director, Engineering
- Randy Craft, Community Outreach Coordinator, Community Education
- Crystal Day, Director, Marketing
- Christina Couch, Marketing and Wellness Lead, Marketing Public Relations

Public Health Experts

- Tammy Pennington, Health Educator, Clay County Health Department, providing services to all community members with a focus on those that are underserved.



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



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

- **Alignment:** Does this issue align with our mission, strategy, public health or community goals? (15%)
- **Impact on Community:** What is the scope, size and seriousness of this issue? What are the consequences to the health of the community of not addressing this issue now? (25%)
- **Resources:** Are there existing, effective interventions and opportunities to partner with the community to address this issue? (30%)
- **Outcome Opportunities:** Can an impact on this issue be made in a demonstrable way and will interventions have an impact on other health and social issues in the community? (30%)

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

Topic Averages	Alignment	Impact on Community	Resources	Outcome Opportunities	Weighted Averages
Preventative Care - Screenings	4.63	4.63	3.88	4.25	4.29
Mental Health	4.38	4.63	3.50	4.13	4.10
Diabetes	4.50	4.38	3.38	4.13	4.02
Health Insurance and Access	4.13	4.38	3.75	3.88	4.00
Drug Misuse	4.00	4.75	3.25	4.00	3.96
Obesity	4.38	4.25	3.25	4.00	3.89
Food Insecurity	4.25	4.13	3.25	4.13	3.88
Cancer	4.38	4.50	3.00	4.00	3.88
Cardiovascular Disease: Hypertension	4.25	4.38	3.38	3.63	3.83
Cardiovascular Disease: High Cholesterol	4.25	3.75	3.63	3.88	3.83
Cardiovascular Disease: Heart Disease	4.38	3.88	3.63	3.62	3.80
Transportation	4.00	4.38	2.88	4.00	3.76

After a list of 12 of the top health needs of the community had been selected by the CHNAC, a Hospital Health Needs Assessment Committee (HHNAC) met to review the top needs that had been chosen. The HHNAC reviewed and discussed the needs that had been identified by the CHNAC and the available resources to address them in the community. The HHNAC also considered the Hospital's current resources and strategies which could most effectively address the needs having the biggest short term and long-term impacts on the community. Through these discussions the Hospital selected the needs it is best positioned to impact.

Members of the HHNAC included:

- Sissel Jacob, CEO, AdventHealth Manchester
- James Nelson, CNO, AdventHealth Manchester
- Daniel Camacho, CFO, AdventHealth Manchester
- David Watson, Executive Director, Global Missions
- Crystal Day, Director, Marketing
- Randy Craft, Community Outreach, Community Education
- Christina Couch, Marketing and Wellness Lead, Marketing Public Relations

The HHNAC narrowed down the list to four priority needs:

- **Cardiovascular Issues**
- **Transportation**
- **Mental Health**
- **Preventative Care – Screenings**



Available Community Resources

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

Top Issues	Current Community Programs	Current Hospital Programs
Mental Health	<ul style="list-style-type: none"> Grace Health in Corbin Cumberland River Comp Care Center in McKee Appalachian Regional Healthcare Medical Center Inpatient Behavioral Healthcare in Hazard Dayspring Williamsburg (FQHC) in Williamsburg 	AdventHealth Primary Care
Preventative Care — Screenings	<ul style="list-style-type: none"> Grace Health in Corbin Dayspring Williamsburg (FQHC) in Williamsburg 	Screening Program
Food Insecurity	<ul style="list-style-type: none"> Red Bird Mission (rbmission.org) Manchester Adventist Community Services The Remnant Bread of Life Oneida Community Church Fed by Grace Calvary Baptist Come-Unity Cooperative Care 	
Health Insurance & Access	<ul style="list-style-type: none"> Kentucky Children’s Health Insurance Program (KCHIP) office in Manchester 	
Drug Misuse	<ul style="list-style-type: none"> Cumberland River Comp Care Center in McKee Groups Recover Together Medication Assisted Treatment (virtual group therapy) 	AdventHealth Primary Care – Behavioral Health

Top Issues	Current Community Programs	Current Hospital Programs
Health Care Services for Chronic Disease (Cardiovascular Disease, Diabetes, Cancer)	<ul style="list-style-type: none"> Grace Health in Corbin Cumberland River Comp Care Center in McKee Landmark of Laurel Creek Rehab and Nursing Center in Manchester Dayspring Williamsburg (FQHC) in Williamsburg 	Live It Up Program Screening Program
Transportation	<ul style="list-style-type: none"> Grace Health in Corbin Cumberland Family Medical Center Dayspring Williamsburg (FQHC) in Williamsburg 	CREATION Life Transportation
Obesity	<ul style="list-style-type: none"> No local resources found 	Summer Fitness Live It Up Program
Housing	<ul style="list-style-type: none"> No local resources found 	Global Mission Projects



Priorities Addressed



Cardiovascular Diseases

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. More than 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, 38% of individuals living in the community have been told they have high cholesterol which can be a contributing factor to heart disease as well.

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



Transportation

Public data in the assessment found that 8.6% of households in the community do not have available vehicles. Transportation was also a concern cited by both community and stakeholder survey respondents. More than 40% of community survey respondents do not believe that people of all ages and mobility in the community have needed transportation, while more than one-third of stakeholder survey respondents (37.5%) also felt the same. Community members also shared that a lack of transportation is also a barrier to employment and for those in rural communities impacts everything from food to health care access and more rural options are needed.

Transportation barriers can impact every facet of life and be a significant contributing factor to an individual's health outcomes. The Hospital will address transportation through efforts that will hopefully have impacts on other issues identified in the assessment process including food security and health care access.



Mental Health

In the Hospital's community, 29% of residents have a prevalence of depression, while 20.4% of the residents report poor mental health. According to community survey respondents 37.2% have been diagnosed with a depressive order and more than 42% have been diagnosed with an anxiety disorder.

Awareness and the need to address mental health disorders has been growing in the country. Including mental health as a priority, the Hospital can align to local, state and national efforts for resources to create better outcome opportunities over the next three years.



Preventative Care and Screenings

According to community survey respondents, 27.8% are not aware of what preventative screenings are needed. Among those that are aware, 47.7% report not getting regular screenings. Public data shows that 80.4% of community members are up to date on routine checkups. Preventative care has been shown to reduce the risk of disease, disabilities and death. Preventative care also improves health outcomes, quality of life and can decrease an individual's cost of care over time through early detection.

The Hospital will address preventative care and screenings through efforts that will have impacts on other issues identified in the assessment process including diabetes, obesity and various types of cardiovascular disease.



Priorities Not Addressed

The priorities not addressed include:



Diabetes

Diabetes is shown to impact 14.2% of residents in the Hospital's community according to public data, while 17.5% of community survey respondents report having diabetes. Diabetes related conditions are also shown to be one of the top ten codes in Hospital visits by uninsured patients.

The Hospital did not select diabetes as a priority, as it is not positioned to directly address this in the community at large. The Hospital did choose preventative care and screenings however and hopes to have an indirect impact on diabetes through these efforts.



Food Insecurity

More than 21.7% of the residents in the Hospital's community are food insecure according to Feeding America and 23.2% live in a low food access area. According to community survey respondents, 29% received SNAP benefits last year, while 9.7% felt they ate less than they should have due to cost. The Hospital believes that other organizations are better positioned in the community to address this need directly and will support those efforts when able.



Health Insurance and Health Care Access

In the Hospital's community, 13.2% of residents had no health insurance, according to public data. Of community survey respondents, 1.7% were uninsured. A need for increasing access to available services was heard from community and stakeholder survey respondents as well. The Hospital believes that other organizations are better positioned in the community to address this and will support those efforts when able in the Community Health Plan through the preventative care and screenings priority.



Drug Misuse

According to the Hospital's community survey, more than half of respondents believe that people in the community are addicted to prescription or street drugs. Community feedback also included a need for an expansion of substance abuse/rehabilitation programs, more drug education programs in schools and better communication and education on the dangers of prescription drugs. Although there is a lack of resources in the area for substance and drug misuse, the Hospital did not perceive the ability to have a measurable impact on the issue within the three years allotted for the for the Community Health Plan with the current resources available to the community and the Hospital at this time.



Obesity

More than one third of residents in the Hospital's community (38.5%) have been told they are obese according to public data. While one fifth of community stakeholders consider obesity a top health risk factor in the community, citing the health complications from obesity as a concern. The Hospital did not select obesity as a priority, as it is not positioned to directly address this in the community at large.



Housing

In the Hospital's community, 22.5% of residents are housing cost burdened or paying over 30% of their income to housing costs per public data. According to community survey respondents 7.4% report being worried they would not have stable housing in the next two months. More than 90% of the community and public health experts surveyed do not consider housing in the area affordable.

The need for safe and affordable housing in the community is significant, however the Hospitals did not perceive the ability to have a measurable impact on the issue within the three years allotted for the for the Community Health Plan with the current resources available to the community and the Hospitals at this time.



Cancer

In the Hospital's community 7.4% of the residents have had cancer according to secondary data. There is also a higher mortality rate per 100,000 than both state and the nation for colorectal cancer and breast cancer in Manchester County. The Hospital did not choose cancer as a priority, instead focusing its efforts and resources on preventative care and screenings, where there is an opportunity to indirectly impact several of the needs identified in the assessment, including cancer.





COMMUNITY HEALTH PLAN

Next Steps

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

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

A link to the Community Health Plan will be posted on [AdventHealth.com](https://www.adventhealth.com) prior to May 15, 2023.



2020 Community Health Plan Review

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

Priority 1: Obesity

In the 2019 assessment, obesity was identified as a priority. Obesity is a complex health issue to address. Influenced by both health behaviors and genetics, obesity can increase the risk for reduced quality of life and poor mental health when left untreated. Obesity can also contribute to many of the leading causes of death such as heart disease, stroke and some types of cancer. In the Hospital's community 35.9% of adults are obese, while 34% of adults are overweight. In addition, 30.9% of adults aged 20 and older self-report no leisure time for activity, which is a determinant of future health.

As part of its efforts to address the priority, the Hospital has developed and launched the Summer Fitness program. This 8-week summer fitness and nutrition program offers a curriculum to help community members an path to lose weight and adopt a healthier lifestyle. The program includes eight nutrition classes with a registered dietician and weekly guided fitness classes. Open at no cost to all members of the Hospital's community, the program had 20 participants in the 2021 session.

Priority 2: Tobacco Usage

Tobacco use was also identified as a priority during the assessment. Smoking leads to disease and is harmful to nearly every organ in the body according to the Center for Disease Control. Smoking related illnesses are among leading causes of death in the United States including cancer, heart disease, stroke, lung diseases, diabetes and chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis. Data from the assessment found that 25.8% of adults age 18 or older in the Hospital's community self-report smoking cigarettes some days or every day.

Since adopting the plan, the Hospital has focused on increasing education and access to tobacco cessation classes to address the priority. This includes building a network of community partners where free tobacco cessation classes and intervention therapies to quit smoking are available at the neighborhood level. The Hospital offers the Freedom from Smoking Cessation program which provides all the tools necessary to educate individuals about the impacts of smoking and how to quit to all partners in the network. Through building and expanding the network where the program is available the Hospital hopes to increase participation and reach a greater proportion of smokers in the area. The Hospital has progressed on building the network out and intends to have classes deployed throughout the network by the end of 2022.

Priority 3: Behavioral Health

The Hospital selected behavioral health as a result of the data found in the assessment. Behavioral health focuses on promoting well-being by preventing or intervening in mental illnesses such as depression or anxiety, as well as an aim of preventing or intervening in substance abuse or other addictions. Mental health needs and support were cited as issues in community surveys and interviews. The community has also been designated as a Health Professional Shortage Area for Mental Health Care Facilities, with only seven identified in the primary service area compared to the

state average of 68. Lack of access to the proper treatment contributes to the incidence of drug and substance abuse in the area. There has been a steady increase in the percentage of Medicare population with depression in Kentucky between 2010 and 2015.

In addressing this priority, the Hospital has focused on creating a network of social support service organizations for patient referrals. The Hospital offers the Whole Person Clinic, which provides behavioral health care to address an individual's mental and physical well-being. Recognizing the impact of social determinant of needs on health and that these are not always something which can be addressed through clinical care, the Hospital is working to create a network to provide wrap around services for patients upon discharge. By the end of 2021, the Hospital had established partnerships with six new community organizations and intends to deploy classes starting in 2022.

Priority 4: Diabetes

Diabetes was also a priority identified in the assessment. Chronic diseases were highlighted by community members as a high area of concern. Secondary data identified diabetes as an increasing problem in the Hospital's community. Trends in the community data demonstrate a steady increase in percent the of adults diagnosed with diabetes from 2004 to 2015 as well as a higher prevalence than the United States.

As part of its work to address the priority, the Hospital has focused on creating a network of community partners through which it can expand its diabetes education efforts. The Hospital provides diabetes management classes at no cost to any interested community members. The classes provide all the tools necessary to educate individuals on how to manage diabetes through lifestyle choices to live a healthier, happier life. The Hospital is working to create a robust community network to offer classes more broadly in the community. By the end of 2021, the Hospital had established partnerships with three new community organizations and intends to deploy classes starting in 2022.

Priority 5: Lack of Access

The Hospital also chose to focus on lack of access as a result of the findings in the assessment. The majority of Clay County residents lack access to clean water, proper nutrition and proper living conditions or necessary infrastructure for handicap accessibility. The average population living below 100% of the federal poverty level in the Hospital community is 22.9% compared to 18.8% for the State of Kentucky. The community also has a higher than state average of adults and children who are uninsured. One in four community members lack a consistent source of primary care compared to the state average of 19.2%. During the assessment, transportation was consistently cited as a barrier to accessing care for many community members.

The Hospital chose to focus its efforts on the barrier to care that transportation presents in the community. The Hospital established a program, The CREATION Life Transportation service. The program provides free transportation for patients who lack access to transportation to doctor visits, to ensure necessary care is received. In 2021, the Hospital provided 730 rides and is on track to complete 2,000 by the end of 2022.

■ 2019 Community Health Needs Assessment Comments

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





**Memorial Hospital, Inc.
d/b/a AdventHealth Manchester**

CHNA Approved by the Hospital Board on: December 12, 2022

For questions or comments please contact:
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