



20 AdventHealth 22 Ottawa

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, our facilities complete a Community Health Needs Assessment. We collaborate with community organizations, public health experts and people like you: those who understand our community best. This in-depth look at the area’s overall health and barriers to care helps us understand the community’s unique needs, so we can address what matters most.

Work of this magnitude is not possible without the incredible partnership of public health experts, community health organizations and countless community members. Through open dialogue and continued collaboration, AdventHealth will bring wholeness to all the communities we are so blessed to serve.

Thank you for your partnership,

Dallas Purkeypile
CEO, AdventHealth Ottawa



Executive Summary

AdventHealth Ransom Memorial, Inc. d/b/a AdventHealth Ottawa will be referred to in this document as AdventHealth Ottawa 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.

The Collaborative

In order to ensure broad community input, AdventHealth Ottawa partnered with the Live Healthy Franklin County Coalition to form “the Collaborative”, to help guide the Hospital through the assessment process. The Collaborative 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 Collaborative met seven times in 2021 - 2022. They reviewed the primary and secondary data and helped to identify the top priority needs in the community.

See the Prioritization Process section for a list of Collaborative members.

Hospital Health Needs Assessment Committee

AdventHealth Ottawa 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 Collaborative and the internal Hospital resources available. With this information the HHNAC was able to determine where the Hospital could most effectively support the community.

See the Prioritization Process section for a list of HHNAC members.

Data

AdventHealth Ottawa and the Collaborative in partnership with the AdventHealth Corporate team collected both primary and secondary data. The primary data included community and stakeholder surveys. 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 13 aggregate issues.

See the Process and Methods section for Primary and Secondary Data Sources.

Community Asset Inventory

The next step was to create a Community Asset Inventory. This inventory was designed to help the Collaborative and the HHNAC understand existing community efforts to address the 13 identified issues from aggregate primary and secondary data and to prevent duplication of efforts.

See Available Community Resources for more.

Selection Criteria

The Collaborative and the HHNAC 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 Collaborative and the HHNAC also considered four factors during prioritization:

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

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

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

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



Priority Issues to be Addressed

The priority issues to be addressed are:

1. **Mental Health**
Focusing on teens and adults
2. **Preventative Care and Screenings**
Focusing on all ages
3. **Nutrition and Healthy Eating**
Focusing on low-income populations, youth and those with or at greater risk for chronic disease

See *Priorities Selection* for more.

Approval

On October 27, 2022, the AdventHealth Ottawa 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 Ottawa will work with the Collaborative 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 Ottawa 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.

About AdventHealth Ottawa

As the only full-service hospital in the rural community of Franklin County, AdventHealth Ottawa has a 90-year tradition of providing compassionate, competent care to residents in and around the city of Ottawa. Located about 40 miles southwest of metropolitan Kansas City, the 44-bed, full-service hospital and outpatient care clinics employ almost 400 team members. Formerly known as Ransom Memorial Health, the well-established hospital joined the AdventHealth network in 2019 and became AdventHealth Ottawa.

- Currently an "A" Hospital Safety Grade for achieving the highest national standards in patient safety. The Leapfrog Group assigns an "A", "B", "C", "D" or "F" grade to all general hospitals across the country.
- Cancer Care – AdventHealth Cancer Center Ottawa is the first and only comprehensive outpatient cancer care program in Ottawa.
- Orthopedics, PT and Rehab – A growing team of orthopedic surgeons, sports medicine specialists, physical therapists and rehab clinicians provides comprehensive, coordinated care.
- Heart Care – Our Board-certified cardiology team provides complete diagnostic and interventional cardiology and vascular services, including full-time cardiologist coverage.
- Emergency Care – After expanding in 2017, our state-of-the-art ER and Trauma Center includes 12 treatment rooms, two trauma bays, two critical care rooms and an enclosed and heated ambulance bay.
- Birth Center – Our Family Birth Place has earned the highly prestigious Baby-Friendly® designation from the World Health Organization and UNICEF.





COMMUNITY OVERVIEW

Community Description

AdventHealth Ottawa is located in Franklin County, Kansas. The Hospital defines its community as 12 zip codes encompassing parts of six counties: Franklin, Miami, Anderson, Douglas, Osage and Linn. The Hospital's community does include the entirety of Franklin County.

According to the 2020 Census, the population in the Hospital's community has grown .13% in the last ten years to 42,041 people. This reflects a decrease in population in Anderson County of 3.3% 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 community 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

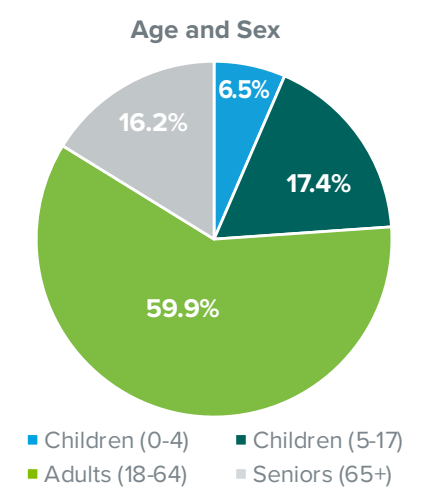
Age and Sex

The median age in the Hospital's community is 39.2, higher than that of the state which is 36.9 and the US, 38.2.

Females are the majority, representing 50.2% of the population. Middle-aged women, 40-64 are the largest demographic in the community at 16.5%. Middle-aged men, 40-64 are second at 15.9%.

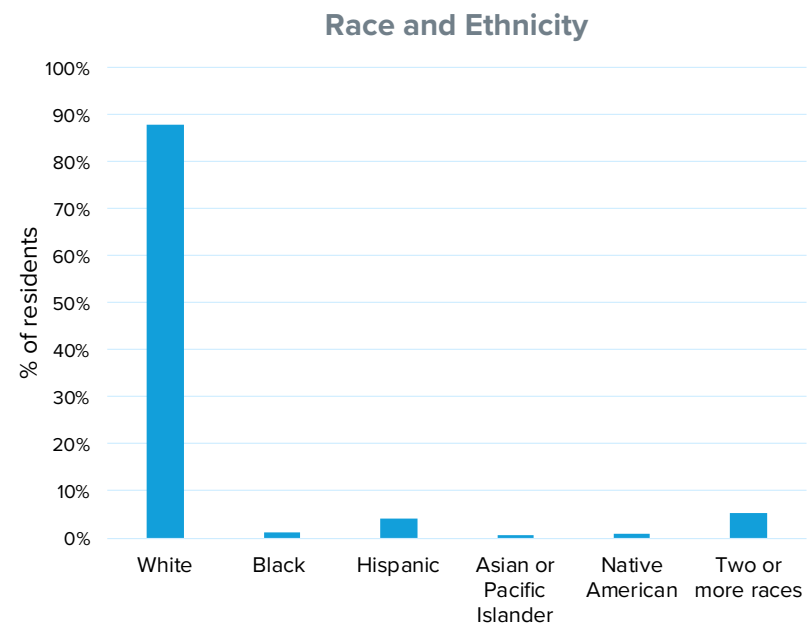
Children are 23.9% of the total population in the community. Infants, those zero to four, are 6.5% of that number. The community birth rate is 63 births per 1,000 women aged 15-50; this is higher than the US average of 51.9 and than that of the state, 58.8. In the Hospital's community, 14.1% of children aged 0-4 and 13.3% of children aged 5-17 live in poverty.

Seniors, those 65 and older, represent 16.2% of the total population in the community. Females are 52% of the total senior population.



Race and Ethnicity

In the Hospital's community, 87.9% of the residents are non-Hispanic White, 1.3% are non-Hispanic Black and 4% are Hispanic or Latino. Residents that are of Asian or Pacific Islander descent represent .5% of the total population, while .8% are Native American and 5.2% 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.

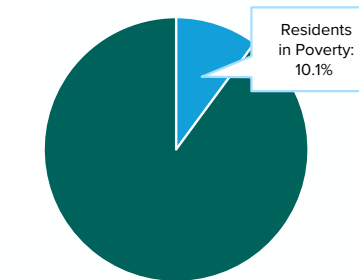


Social and Community Context: This focuses on topics such as community cohesion, civic participation, discrimination and incarceration.

Economic Stability

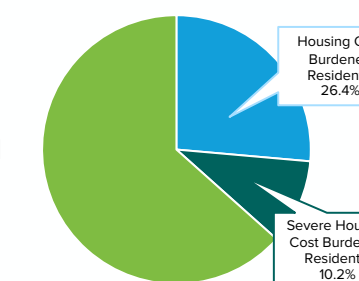
Income

The median household income in the Hospital's community is \$62,979. This is below the median for both the state and the US. In the community, 10.1% of residents live in poverty, this is lower than the poverty rate of the state, 11.4% and US, 12.8%.



Food Insecurity and Housing Stability

People who are food insecure, having reduced quality and/or amount of food intake, may be at an increased risk of negative health outcomes. Studies have shown an increased risk of obesity and chronic disease in adults who are food insecure. Children who are food insecure have been found to have an increased risk of obesity and developmental problems compared to children who are not.¹ Feeding America estimates for 2020², showed the food insecurity rate in the Hospital's community as 13.5%.



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

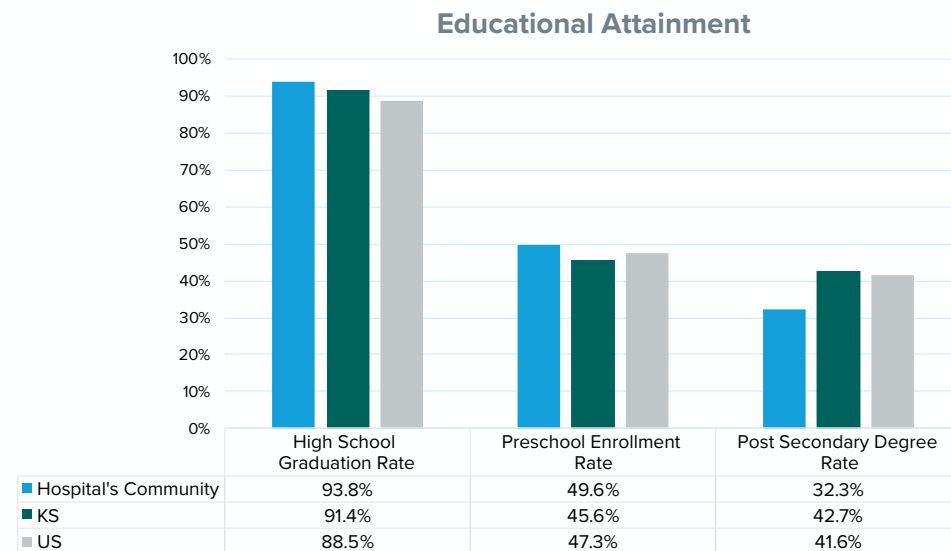
Education Access and Quality

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 a 93.8% high school graduation rate, which is higher than both the state and national average. The rate of people with a post-secondary degree is 32.3%, which is lower than in both the state and nation.

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

In the Hospital's community, 49.6% of 3–4-year-olds were enrolled in preschool. This is higher than both the state (45.6%) and the national (47.3%) average, but that still leaves 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

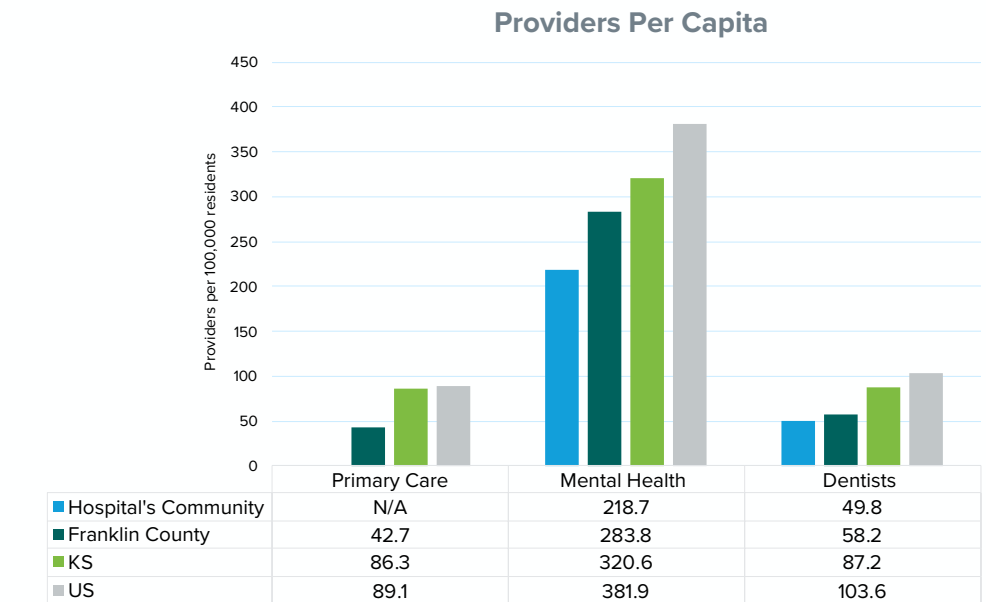
Health Care Access and Quality

In 2020, 6.9% of community members aged 18-64 were found to not have health insurance. A lack of health insurance can lead to delayed care, resulting in more serious health conditions and increased treatment costs. Although health insurance coverage levels can be a strong indicator of a person's ability to access care, there are other potential barriers that can delay care for many people.⁶

Accessing health care requires more than just insurance, there also need to be available health care professionals to provide care. When more providers are available in a community access can be easier, particularly for those experiencing transportation challenges. In the counties that the Hospital serves, Douglas County has the most mental health and primary care providers available.

Routine checkups can provide an opportunity to identify potential health issues and when needed develop care plans. In the Hospital's community, 73.1% of people report visiting their doctor for routine care.

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





Neighborhood and Built Environment

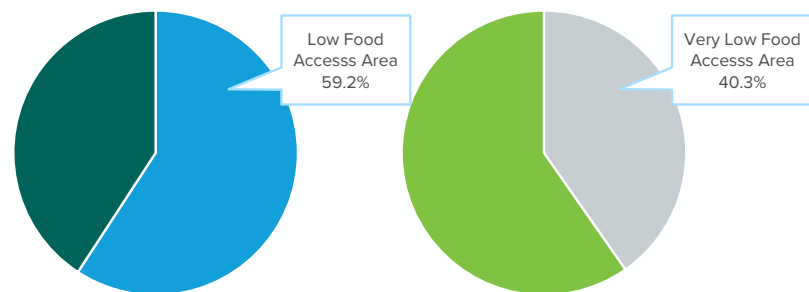
Increasingly, a community's neighborhoods and built environment are being shown to impact health outcomes. If a neighborhood is considered to have "low food access", which is defined as being more than 1/2 mile from your nearest supermarket in an urban area or 10 miles in a rural area, it may make it 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, 59.2% of the community lives in a low food access area, while 40.3% live in a very low food access area.

Access to public transportation is also an important part of a built environment. For people who do not have cars, reliable public transportation can be essential to access health care, healthy food and maintaining employment. In the community, 4.3% 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



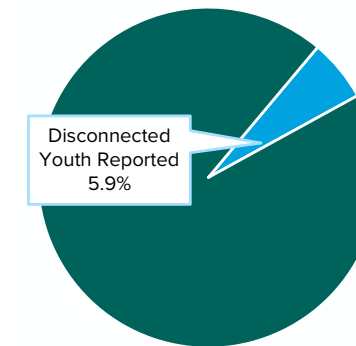
Social and Community Context

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, 5.9% of youth aged 16-19 were reported as disconnected; this means they were neither enrolled in school nor working at the time. Also, in the community 24.7% of seniors (age 65 and older) report living alone. These factors 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 Collaborative 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 Collaborative, 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 guide the assessment process. The Collaboration included the Live Healthy Franklin County Coalition, part of a statewide effort to make long lasting health impacts through community collaboration. During data review sessions, community members of the Collaborative provided insight on how health conditions and areas of need were impacting those they represented. The Collaborative 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 Collaborative 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 26 stakeholders provided their expertise and knowledge regarding their community including:

Name	Organization	Services Provided	Populations Served
Brandi Lopez, Assistant Director of CSBG Operations	ECKAN	Financial support; Food assistance; Housing	Low income
Jenna Williams, Health Specialist	ECKAN Head Start	Education/youth services	Homeless; Low income; Children Women
Teresia Templeton, Human Service Coordinator	ECKAN	Health care/public health; Housing; Food assistance; Financial support; Employment assistance; Transportation	Homeless; Low income; Elderly; Children; Women; Veterans; LGBTQIA+; General public
Levi Meyer, Executive Director	Ottawa Recreation Commission	Education/youth services; Financial support; Health care/public health; Recreation	Low income; Children; Elderly; Women; General public
Crystal Anderson, CEO	ECKAN	Food assistance; Employment assistance; Housing; Transportation; Education/youth services; Weatherization, case management, etc.	Homeless; Low income; Elderly; Children; Women; Veterans; LGBTQIA+; General public; any low-income folks mtg our program guidelines
Sheila Robertson, Grant Coordinator	Franklin County Health Department	Health care/public health; Education/youth services; Food assistance; Financial support	General public
Michelle Graf, Interim Director	Hope House	Food assistance; Financial support; Clothing	Homeless; Low income; General public
Erin Laurie, Assistant Director	Franklin County Health Department	Health care/public health; Education/youth services	Homeless; Low income; Elderly; Children; Women; Veterans; LGBTQIA+; General public
Tammy Moore, Medical Account Manager	Franklin County Health Department	Health care/public health	General public
Paul Bean, Executive Director	Franklin County Development Council	Employment assistance; Education/youth services; Housing; Financial support	General public
Terry Chartier, Executive Director	Ottawa Library	Education/youth services; Food assistance; Employment assistance; We refer patrons for help in many areas	Homeless; Low income; Elderly; Children; Women; Veterans; LGBTQIA+; General public
Bernie Smith, Director of Recreation	Wellsville Joint Recreation Commission	Health care/public health; Education/youth services; Youth sports; Food assistance	General public; LGBTQIA+; Veterans; Women; Children; Elderly; Low income
Donald Anderson, Dean of Student Life	Ottawa University	Education/youth services; Housing; Mental/behavioral health care; Food assistance	LGBTQIA+; General public; Women; Veterans; Low income
Julie Riggins, Director	Blessing Box Foundation	Food assistance; Transportation	Homeless; Low income; Elderly; Children; Women; Veterans; LGBTQIA+; General public

Name	Organization	Services Provided	Populations Served
Melissa Reed, City Clerk	City of Ottawa	City service including licenses, utility billing and emergency services	General public; Low income; Homeless; Elderly; Children; Women
Bryan W. Mann, Chaplain	AdventHealth	Mental/behavioral health care; Health care/public health	Homeless; Low income; Elderly; Children; Women; Veterans; LGBTQIA+; General public
Donald Stottlemire, County Commissioner	Franklin County	Health care/public health; Food assistance	General public
Dorothy Rice, Director of Quality, Patient Safety, Risk & Care Management	AdventHealth Ottawa	Health care/public health	General public
Jerod Yancey, Senior Pastor	Hope Anthem Church	Education/youth services; Mental/behavioral health care ;Financial support; Food assistance; Housing; Everything the church provides around the world.;	Homeless; Low income; Elderly; Children; Women; Veterans; LGBTQIA+; General public
Maiyee Lor, City Clerk	City of Pomona	Utilities	Families
Nicole Vicek, Chiropractor/owner	Wellsville Chiropractic	Health care/public health	Low income; Elderly; Children; Women; Veterans; LGBTQIA+; General public
Kelly Whittaker, Principal	USD 290, Ottawa High School	Education/youth services	Children; General public
Ryan Bradbury, Superintendent	USD 289	Education/youth services; Food assistance	Homeless; Low income; Children; General public
Leslie Bjork, Executive Director	Elizabeth Layton Center, Inc.	Mental/behavioral health care; Employment assistance; Primary services have been checked. ELC also offers transportation to Medicaid members, as well as housing, food assistance and financial support for qualifying individuals who meet State criteria and are enrolled in our community-based programming for those with serious mental illness.	Homeless; Low income; Elderly; Children; Women; Veterans; LGBTQIA+; General public; All residents of Franklin and/or Miami County
JoAnna Bishop, Marketing Manager	AdventHealth Ottawa	Health care/public health; Education/youth services	Homeless; Low income; Elderly; Children; Women; Veterans; LGBTQIA+; General public
Ianne Dickinson, County Commissioner	Franklin County	Health care/public health; Government services	General public

Secondary Data

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

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

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







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

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







The Findings

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

-  **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.
-  **Economic Barriers:** An increasing cost barrier to accessing care, products and services regardless of insurance and employment status.
-  **Childcare Subsidies:** The rising cost of childcare and the impact on standard of living for individuals who are low-income.
-  **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 Collaborative 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. This includes heart disease, high cholesterol and hypertension. 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.
-  **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 diseases.



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.



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.



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.



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




Physical Health & Activity: Being physically active means movement of the body to get to and from places, for work or for leisure. Regular physical activity is proven to help prevent and manage noncommunicable diseases such as heart disease, stroke, diabetes and several cancers. It



also helps prevent hypertension, maintain healthy body weight and can improve mental health, quality of life and well-being.

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 Collaborative through data review and discussion, narrowed the health needs of the community to a list of 13. Community partners in the Collaborative 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 2021 and the Spring of 2022, the Collaborative met seven times to review and discuss the collected data and select the top community needs.

Members of the Collaborative included:

Community Members

- Leslie Bjork, Executive Director, Elizabeth Layton Center, providing outpatient community based behavioral health services for low income, minority or underserved populations
- Rebecca McFarland, Director, K-State Research and Extension, a statewide network of educators working to address the five grand challenges facing the state: global food systems, water, health, developing tomorrow's leaders and community vitality
- John Coen, President / CEO, Ottawa Chamber of Commerce, working to improve economic opportunities in and for Franklin County
- Catherine Rice, Vice President, Health Partnership Clinic, providing medical, dental, behavioral health, substance abuse, MAT and assistance in insurance enrollment for low income, minority or underserved populations
- Amy Falk, President / CEO, Health Partnership Clinic, providing medical, dental, behavioral health, substance abuse, MAT and assistance in insurance enrollment for low income, minority or underserved populations
- Levi Meyer, Director, Ottawa Recreation Commission, focusing on creating community recreation and health and wellness opportunities for all Franklin County residents

- Crystal Anderson, CEO, ECKAN, providing community services from Head Start, weatherization, housing, food pantries and emergency distribution payments for low income, minority or underserved populations
- Korrie Snell, Director of Operations, ECKAN, providing community services from Head Start, weatherization, housing, food pantries and emergency distribution payments for low income, minority or underserved populations
- Kyle Bures, Director, Teaching and Learning Center at Neosho County Community College, providing educational opportunities for all community members at a community college level
- Dustin Browning, Director, Community Corrections at Franklin County, focusing on creating safer communities and opportunities for rehabilitation for community members who have been part of the legal system

AdventHealth Team Members

- Dallas Purkepile, CEO, AdventHealth Ottawa
- Sheila Robertson, Community Benefit Contractor



Public Health Experts

- Brenda Pfizenmaier, Director, Franklin County Health Department, providing services to all community members with a focus on those that are underserved
- Erin Laurie, Assistant Director, Franklin County Health Department, providing services to all community members with a focus on those that are underserved

To identify the top needs the Collaborative 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. Collaborative members then ranked the need through an online survey.



The needs found in the assessment were evaluated and scored by the Collaborative 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
Physical Health and Activity	3.78	3.67	3.67	4.00	3.78
Cancer	4.00	3.67	3.67	3.89	3.78
Nutrition and Healthy Eating	4.22	3.67	3.67	3.78	3.78
Mental Health	3.78	4.11	3.33	3.89	3.76
Diabetes	4.11	4.00	3.33	3.78	3.75
Obesity	4.11	3.89	3.22	3.89	3.72
Food Insecurity	4.11	3.78	3.33	3.56	3.63
Cardiovascular Disease: Hypertension	3.89	3.56	3.33	3.78	3.61
Pregnancy and Maternal Health	3.89	3.56	3.00	3.67	3.47
Cardiovascular Disease: Heart Disease	3.89	3.44	3.11	3.56	3.44
Housing	3.56	4.00	2.67	3.67	3.43
Health Insurance and Access	3.89	3.78	2.89	3.44	3.43
Tobacco and Vaping Use	3.67	3.44	3.00	3.44	3.34

After a list of 13 of the top health needs of the community had been selected by the Collaborative, 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 Collaborative 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.

Members of the HHNAC included:

- Dallas Purkeypile, CEO, AdventHealth Ottawa
- Stacy Steiner, CNO, AdventHealth Ottawa
- Sheila Robertson, Community Benefit Contractor
- Joanna Bishop, Marketing Manager
- Dorothy Rice, Director of Quality
- Mitzie Eddins, Director of Emergency Department
- Bryan Mann, Senior Chaplain
- Lora O'Connor, Director of Customer Service
- Becki Carl, Senior Director Physician Enterprise
- Cait St. John, Clinical Mission Integration Specialist
- Wenceslita Mendez, Lead Medical Technologist

The HHNAC followed the same process as the Collaborative for prioritization, narrowing down the list to three priority needs:

Topic Averages	Alignment	Impact on Community	Resources	Outcome Opportunities	Weighted Averages
Nutrition and Healthy Eating <i>Focusing on low-income populations, youth and those with or at greater risk for chronic disease</i>	4.57	4.43	2.86	4.00	3.85
Mental Health <i>Focusing on teens and adults</i>	4.00	3.86	2.86	3.86	3.58
Preventative Care and Screenings <i>Focusing on all ages</i>	4.14	3.86	2.86	3.71	3.56



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
Diabetes	<ul style="list-style-type: none"> KSU Extension - Dining with Diabetes Health Department: Diabetes Management and Prevention sessions 	
Food Insecurity	<ul style="list-style-type: none"> East Central Kansas Economic Opportunity Corporation (ECKAN): Harvesters, food pantries and distributions providing food pantries and emergency distribution payments for low income, minority or underserved populations FrCo Food Policy Council: CONNECT, a mobile pantry for residents in need who lack transportation Health Department: Women, Infants and Children supplemental nutrition program Hope House food pantry, providing food support to residents living in Franklin County Blessing Boxes Ottawa University food pantry (BCBSKS Pathways project to enhance) Ministerial Alliance, Churches: meals, food Ottawa Library: Read & Feed meals for kids East Central Kansas Area Agency on Aging: senior meals, delivery, Farmers Market Vouchers 	<ul style="list-style-type: none"> Food drives for community programs
Nutrition and Healthy Eating	<ul style="list-style-type: none"> FrCo Food Policy Council: Harvest to Home (BCBSKS Pathways project offering low-cost produce bundles to residents in low food access areas) KSU Extension - SnapEd Farmers Markets 	<ul style="list-style-type: none"> Plantwise (AH, promotes plant-centered eating)
Pregnancy and Maternal Health	<ul style="list-style-type: none"> Health Department: Women, Infants and Children program LifeCare 	<ul style="list-style-type: none"> Prenatal care
Chronic Disease – Hypertension, Heart Disease	<ul style="list-style-type: none"> Health clinics and physician groups (screening and treating) Stand-alone blood pressure stations (pharmacies) 	

Top Issues	Current Community Programs	Current Hospital Programs
Health Insurance and Health Care Access	<ul style="list-style-type: none"> Health Partnership Clinic, providing free and reduced cost care to all eligible community members Health Department Churches sometimes assist with financial assistance for treatment Franklin County Cancer Foundation Transportation- Fr County Public Transport, Churches, Retirement homes 	<ul style="list-style-type: none"> Advocacy to expand Medicaid in KS FirstSource Financial Assistance (charity care) AH auto deduction for private pay patients Nurse line Transportation vouchers
Preventive Care – Screenings	<ul style="list-style-type: none"> Health clinics listed above Internal Medicine and Family Practice clinics 	<ul style="list-style-type: none"> AH medical group Employer wellness screenings
Housing	<ul style="list-style-type: none"> East Central Kansas Economic Opportunity Corporation (ECKAN): vouchers, Weatherization Assistance Program providing weatherization, housing and emergency distribution payments for low income, minority or underserved populations Homeless Coalition through Hope House – providing free care for community members, including clothing, housing, food and financial Willow Domestic Violence Center Fr Co Development Council Housing Study and Recommendations 	
Mental Health	<ul style="list-style-type: none"> Elizabeth Layton Center: crisis response line, hospitalization assessments, co-responding with Ottawa Police Department, outreach/trainings/education and behavioral health services at a sliding scale fee to clients who are uninsured and residents of Franklin or Miami County Health Partnership Clinic behavioral health services Farm Bureau farmer stress programming KSU Extension Question-Persuade-Refer suicide prevention trainings BCBSKS Pathways Worksite wellbeing 	<ul style="list-style-type: none"> All Emergency Department patients have mental health screenings and a second screening is done when admitted
Drug Misuse	<ul style="list-style-type: none"> Health Department: Substance Use Prevention Coalition providing universal support services for all expectant parents and families with children Elizabeth Layton Center – behavioral health services at a sliding scale fee to clients who are uninsured and residents of Franklin or Miami County Drug Take Back Events 	<ul style="list-style-type: none"> Access to the K-tracks system, which identifies opioid prescriptions for possible identification of opioid misuse



■ Priorities Addressed



Mental Health

Focusing on teens and adults

In the Hospital's community, 20.6% of residents have a prevalence of depression, while 14.9% of the residents report poor mental health. According to community survey respondents, 22.8% have been diagnosed with a depressive order and 27.6% 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

Focusing on all ages

According to community survey respondents, 29.7% are not aware of what preventative screenings are needed. Among those that are aware, 23.9% report not getting regular screenings. Public data shows that only 73.1% 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.

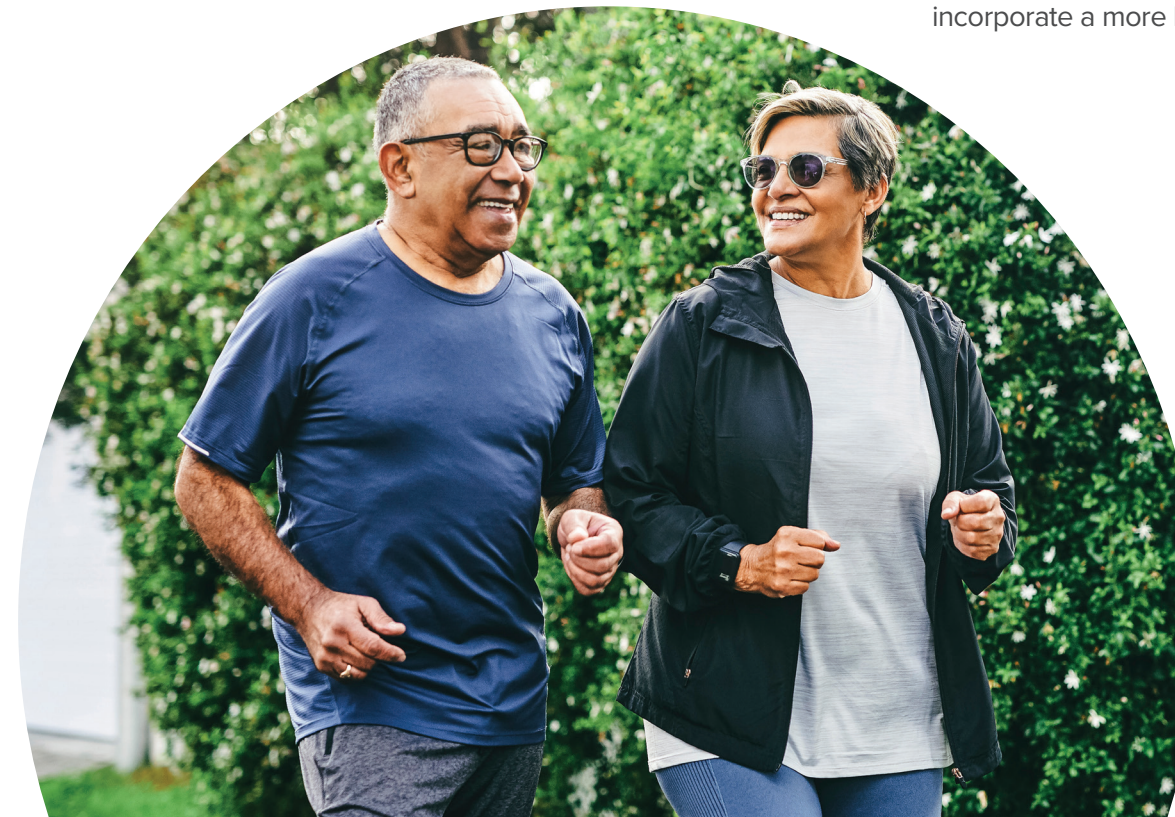


Nutrition and Healthy Eating

Focusing on low-income populations, youth and those with or at greater risk for chronic disease

Almost 60% of residents in the Hospital's community live in a low food access area and 42% of community survey respondents reported eating fruits and vegetables less than two days a week. Stakeholder survey respondents also considered poor nutrition and low food access to be top factors in the community impacting health.

Nutrition is known to be a critical influencer of health. Healthier eating improves maternal health and health at every stage of life. It builds stronger immune systems, lowers the risk of chronic diseases like diabetes and cardiovascular disease, while increasing longevity. By addressing nutrition and healthy eating, the Hospitals hope to improve the overall health of the community. This will impact multiple health conditions identified in the assessment process, as well as food security challenges, by increasing the community's ability to access and incorporate a more balanced diet.



Priorities Not Addressed

The priorities not addressed include:



Diabetes

Diabetes is shown to impact 9.7% of residents in the Hospital's community according to public data, while 22.8% 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 and nutrition and healthy eating, however, and hopes to have an indirect impact on diabetes through these efforts.



Food Insecurity

In the Hospital's community, 13.5% of the residents are food insecure according to Feeding America and 59.2% live in a low food access area. According to community survey respondents, 33% received SNAP benefits last year, while 25.5% 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.



Pregnancy and Maternal Health

In Franklin County, the primary county served by the Hospital, 10.8% of births are premature and 80.4% of births receive prenatal care in the first trimester. Pregnancy related diagnosis codes are also shown to be among the top ten codes in Hospital visits by uninsured patients.

The Hospital did not select pregnancy and maternal health as a priority as it is not resourced to directly address this in the community but will support other community partners where possible in their efforts. The Hospital did choose preventative care and screenings, however, knowing that preventive care is an important factor in maternal health and maternal health outcomes and hopes to have an indirect impact through these efforts.



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 breast cancer and lung, trachea and bronchus cancer in Franklin 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.



Housing

In the Hospital's community, 26.4% of residents are housing cost burdened or paying over 30% of their income to housing costs per public data. According to community survey respondents 21.9% report being worried they would not have stable housing in the next two months. More than 70% of the community and public health experts surveyed do not consider housing in the area affordable. The Hospital did not select housing as a priority, as it is not positioned to directly address this in the community at large.



Physical Health and Activity

In the Hospital's community, 27.4% of residents report not engaging in physical activities outside of their jobs according to secondary data and stakeholder survey respondents consider lack of exercise to be a top health behavior concern. Community members in the assessment however cited a need for more low-cost fitness centers and accessible community spaces for recreation, which may be a factor in activity level. The Hospital believes that other organizations are better positioned in the community to address this need directly and will support those efforts when able.



Obesity

More than one third of residents in the Hospital's community have been told they are obese according to public data and stakeholders consider obesity to be a top health risk factor. Obesity related codes also appear in the top ten codes in Hospital visits by uninsured patients. The Hospital did not select obesity as a priority, as it is not positioned to directly address this in the community at large. The Hospital did choose Nutrition And Healthy Eating, however, and hopes to have an indirect impact on obesity through these efforts.



Cardiovascular Disease: Hypertension

Almost one third of residents in the Hospital's community have been told they have hypertension per public data. The number of community survey respondents reporting hypertension is even higher at 38.4% and hypertension related conditions are shown to be one of the top ten codes in Hospital visits by uninsured patients.

The Hospital did not select hypertension as a priority, as it is not positioned to directly address this in the community at large. The Hospital did choose nutrition and healthy eating however knowing that how individual eats is an integral step in treating hypertension and hopes to have an indirect impact through these efforts.



Cardiovascular Disease: Heart Disease

According to secondary data, individuals in the Hospital's community have higher rates of coronary heart disease and in Franklin County the heart disease mortality rate per 100,000 is higher than elsewhere in Kansas and the nation.

The Hospital did not choose heart disease 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 cardiovascular needs.



Health Insurance and Health Care Access

In the Hospital's community, 6.9% of residents had no health insurance, according to public data. Of community survey respondents, 3.6% 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.



COMMUNITY HEALTH PLAN

Next Steps

The Hospital will work with the Collaborative 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: Chronic Disease Prevention and Management

The Hospital chose chronic disease and prevention management as a priority in the 2020 assessment due to the direct and indirectly related chronic health indicators found in the data. For example, in the Hospital's community heart disease is the leading cause of death and when adjusted for age, the mortality rate is higher than the state's. The assessment also found that nearly a third (32%) of the adults in the community have high blood pressure and 42% have high cholesterol. More than 60% of individuals in the service area are overweight and/or obese and the age adjusted rate of diabetes in the population over the age of 18 is 8.4%.

Since adopting the plan the Hospital has focused on healthy eating, education and the impact of lifestyle as an avenue to addressing chronic disease in the community. This has led to participating in the Franklin County Food Policy Council, a multistakeholder county collaborative focusing on increasing access to healthy food countywide. Through the Council, the Hospital has supported food collection drives, the coordination of a mobile food pantry and other initiatives focused on increasing food access. The Hospital also implemented a Whole-Person health promotion and disease prevention campaign reaching over 13,000 households in the community through the distribution of the MyHealth magazine.

Priority 2: Mental Health

In the 2020 CHNA, the Hospital also prioritized mental health. During the assessment, 13.7% of community survey respondents reported that their mental health was not good in the past month, and the Hospital admission rate for mental health needs in Franklin County was 73.8 per 10,000. It was also reported eleven percent of the Hospital's community survey respondents were unable to receive mental health or substance abuse treatment.

As part of its efforts to address the need, the Hospital has focused on increasing the knowledge and skills of community members to effectively respond to those who may be contemplating suicide with the evidence-based program QPR (Question-Persuade-Refer). The program launched in 2022 with an expected 50 people completing by the end of 2022.



■ 2020 Community Health Needs Assessment Comments

We posted a link to the most recently conducted CHNA and most recently adopted 2021 Community Health Plan on our Hospital website as well as AdventHealth.com prior to May 15, 2021, and have not received any written comments.





**AdventHealth Ransom Memorial, Inc. d/b/a
AdventHealth Ottawa**

CHNA Approved by the Hospital Board on: October 27, 2022

For questions or comments please contact:
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