2023-2025
AdventHealth Manchester
Community Health Plan
Executive Summary

About AdventHealth

Priorities Addressed
Cardiovascular Diseases
Transportation
Mental Health
Preventative Care and Screenings

Priorities Not Addressed

Acknowledgements
This community health plan was prepared by Christina Couch with contributions from members of AdventHealth Manchester Community Health Needs Assessment Committee and Hospital Health Needs Assessment Committee both representing health leaders in the community and hospital leaders.

We are especially grateful for the internal and external partners who helped guide the development of the community health plan which will enable our teams to continue fulfilling our mission of Extending the Healing Ministry of Christ.
Executive Summary

Memorial Hospital, Inc. d/b/a AdventHealth Manchester will be referred to in this document as AdventHealth Manchester or the “Hospital”.

Community Health Needs Assessment Process
AdventHealth Manchester in Manchester, Kentucky conducted a community health needs assessment in 2022. The assessment identified the health-related needs of the community including low-income, minority and other underserved populations. This assessment process was the most comprehensive to date and included survey questions related to diversity, equity and inclusion. In addition, the priorities were defined, when possible, in alignment with Healthy People 2030, national public health priorities to improve health and well-being.

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 Hospital, public health experts and the broad community. This included intentional representation from low-income, minority and other underserved populations. The prioritization process sought to balance our ability to impact the greatest number of people who are facing the greatest disparities.

AdventHealth Manchester also convened a Hospital Health Needs Assessment Committee (HHNAC) to help select the needs the Hospital could most effectively address to support the community. The HHNAC made decisions by reviewing the priorities selected by the CHNAC and the internal Hospital resources available.

The CHNAC and HHNAC met throughout 2021-2022. The members reviewed the primary and secondary data, helped define the priorities to be addressed and helped develop the Community Health Plan to address those priorities. Learn more about Healthy People 2030 at https://health.gov/healthypeople.

Community Health Plan Process
The Community Health Plan (CHP), or implementation strategy, is the Hospital’s action plan to address the priorities identified from the CHNA. The plan was developed by the CHNAC, HHNAC and input received from stakeholders across sectors including public health, faith-based, business and individuals directly impacted.

The CHP outlines targeted interventions and measurable outcomes for each priority noted below. It includes resources the Hospital will commit and notes any planned collaborations between the Hospital and other community organizations and hospitals.

The identified goals and objectives were carefully crafted, considering evidence-based interventions and AdventHealth’s Diversity, Equity, and Inclusion and Faith Accountability strategies. AdventHealth Manchester is committed to addressing the needs of the community, especially the most vulnerable populations, to bring wholeness to all we serve.
Executive Summary

Priorities Addressed
The priorities addressed include:
1. Cardiovascular Diseases
2. Transportation
3. Mental Health
4. Preventative Care and Screenings

See page 9 for goals, objectives and next steps for each priority selected to be addressed.

Priorities Not Addressed
The priorities not addressed include:
1. Diabetes
2. Food Insecurity
3. Health Insurance and Health Care Access
4. Drug Misuse
5. Obesity
6. Housing
7. Cancer

See page 15 for an explanation of why the Hospital is not addressing these issues.

The Community Health Plan is a three-year strategic plan and may be updated during implementation based on changing community needs or availability of resources. AdventHealth recognizes community health is not static and high priority needs can arise or existing needs can become less pressing. The Hospital may pivot and refocus efforts and resources to best serve the community.
Executive Summary

Board Approval
On May 8, 2023, the AdventHealth Manchester Board approved the Community Health Plan goals, objectives and next steps. A link to the 2023 Community Health Plan was posted on the Hospital’s website prior to May 15, 2023.

Ongoing Evaluation
AdventHealth Manchester’s fiscal year is January – December. For 2023, the Community Health Plan will be deployed beginning May 15, 2023, and evaluated at the end of the calendar year. In 2024 and beyond, the CHP will be evaluated annually for the 12-month period beginning January 1st and ending December 31st. Evaluation results will be attached to the Hospital’s IRS Form 990, Schedule H. The collective monitoring and reporting will ensure the plan remains relevant and effective.

For More Information
Learn more about the Community Health Needs Assessment and Community Health Plan for AdventHealth Manchester at https://www.adventhealth.com/community-health-needs-assessments.
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.

About 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
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 100,000 than elsewhere in Kentucky 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.

**Goal 1:** Improve cardiovascular health by providing health education programs and increasing access to healthy foods

**Objective 1.1:** By December 31, 2025, increase access to healthy foods through community food pantries among low-income families in Clay County from 4,800 persons served to 7,200.

**Objective 1.2:** By December 31, 2025, continue to offer the Freedom from Smoking Cessation program to decrease cardiovascular disease among smokers in the Hospital’s service area from 15 participants to 25 over the next three years.

**Target Population:** Adults living in low-income area and food deserts

<table>
<thead>
<tr>
<th>Activities/Strategies</th>
<th>Outputs</th>
<th>Hospital Contributions</th>
<th>Community Partnerships</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify community location in food desert to host food pantry distribution</td>
<td>Community location in food desert to host pantry</td>
<td>Marlon Robinson, Chaplain, coordinates team members from AdventHealth who volunteer time to distribute food from food pantry twice a month</td>
<td>Seventh Day Adventist Church</td>
<td>Y1 X Y2 X Y3</td>
</tr>
<tr>
<td>Provide 8-week Freedom from Smoking Cessation program to adults interested in quitting tobacco products</td>
<td># of participants in Smoking Cessation Program</td>
<td>Community Outreach Coordinator, Randy Craft, will plan and teach the Freedom from Smoking Cessation classes to smokers</td>
<td>Volunteers of America, Agency for Substance Abuse</td>
<td>Y1 X Y2 X Y3</td>
</tr>
</tbody>
</table>
Goal 1 continued: Improve cardiovascular health by providing health education programs and increasing access to healthy foods

Objective 1.3: By December 31, 2025, increase the number of participants in the Summer Fitness program to decrease cardiovascular disease in the Hospital’s service area from 15 participants to 18.

Target Population: Adults living in low-income area and food deserts

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Provide 8-week Summer Fitness &amp; Nutrition Program which educates participants on how to adopt a healthier lifestyle</td>
<td># of participants attending summer fitness and nutrition program</td>
<td>Community Outreach Coordinator, Randy Craft, and Marketing, Christina Couch, to plan, find trainers, and schedule nutritionist for the 8-week program</td>
<td>Family Resource and Youth Center (FRYSC)</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Clay County School System</td>
<td>X</td>
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<td>X</td>
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</table>
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 transportation options are needed. Transportation barriers can impact every facet of life and be a significant contributing factor to an individual's health outcomes.

**Goal 1:** Increase availability of transport services for low-income community members

**Objective 1.1:** By December 31, 2025, increase the number of free transports provided to patients who need to access medical services from 720 transports to 800. The transports are offered via the CREATION Life Transportation service to populations living below the poverty line.

**Target Population:** Adults living in low-income area with no vehicle access

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</tr>
</thead>
<tbody>
<tr>
<td>Provide free transportation to and from healthcare provider appointments</td>
<td># of transports through CREATION Life Transportation Program</td>
<td>Transportation Coordinators time to schedule and transport patients</td>
<td>Daniel Boone Community action Agency (provides transit)</td>
<td>X</td>
</tr>
</tbody>
</table>
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.

**Goal 1:** Improve the mental health and well-being of adolescents through education

**Objective 1.1:** By December 31, 2025, increase the number of middle school students participating in the Live It Up Program from a baseline of 1,200 to 1,300 over three years. The Live It Up Program teaches middle school aged children how to live a healthy lifestyle both mentally and physically. Middle school aged children learn early in life to adopt healthy habits to maintain a healthy lifestyle.

**Target Population:** Middle school aged children in service area

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>The Live It Up program is offered at local county middle schools and teaches CREATION Life principles—Choice, Rest, Environment, Activity, Trust, Interpersonal Relationships, Outlook and Nutrition—and their impact on a healthy lifestyle</td>
<td># of students participating in the Live It Up Program</td>
<td>Provide instructors for the Live It Up Program</td>
<td>Clay County School System</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provide equipment as needed</td>
<td>Oneida Baptist Institute</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community Benefit staff time for program management and deployment</td>
<td>Red Bird Mission</td>
<td>X</td>
</tr>
</tbody>
</table>

2023-2025 | Community Health Plan
Preventative Care-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.

**Goal 1:** Increase the proportion of adults who receive preventative screenings.

**Objective 1.1:** By December 31, 2025, increase the number of adults who receive free screenings in the Hospital’s service area from 20 to 50 over three years.

**Target Population:** Adults screening age appropriate

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</tr>
</thead>
<tbody>
<tr>
<td>Provide free biometric screenings to adults</td>
<td># of adults receiving biometric screenings</td>
<td>Randy Craft, Community Outreach Coordinator- staff time for event management and deployment</td>
<td>Volunteers of America</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Cover the cost of supplies and equipment</td>
<td>Eastern Kentucky University (host)</td>
<td>Y1 X Y3</td>
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<td></td>
<td></td>
<td></td>
<td>Clay County Public Library</td>
<td></td>
</tr>
<tr>
<td>Create marketing materials to advertise screening events</td>
<td>Flyers, social media, etc.</td>
<td>Tina Couch, staff time to design flyer</td>
<td>Local gas stations- distribute flyers to customers</td>
<td></td>
</tr>
</tbody>
</table>

- Volunteers of America
- Eastern Kentucky University (host)
- Clay County Public Library
- Local gas stations- distribute flyers to customers

Y1 Y2 Y3
PRIORITIES NOT ADDRESSED
Priorities Not Addressed

AdventHealth Manchester also identified the following priorities during the CHNA process. In reviewing the CHNA data, available resources, and ability to impact the specific identified health need, the Hospital determined these priorities will not be addressed.

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.
Priorities Not Addressed

**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 Community Health Plan with the current resources available to the community and the Hospital at this time.

**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 Community Health Plan with the current resources available to the community and the Hospitals 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.

**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.