AdventHealth Manchester 2025 Community Health Needs Assessment

Extending the Healing Ministry of Christ

AdventHealth

Table of Contents

3 Introduction

3 Letter from Leadership
4 Executive Summary
6 About AdventHealth

9 Community Overview

9 Community Description
9 Community Profile

17 Process, Methods and Findings

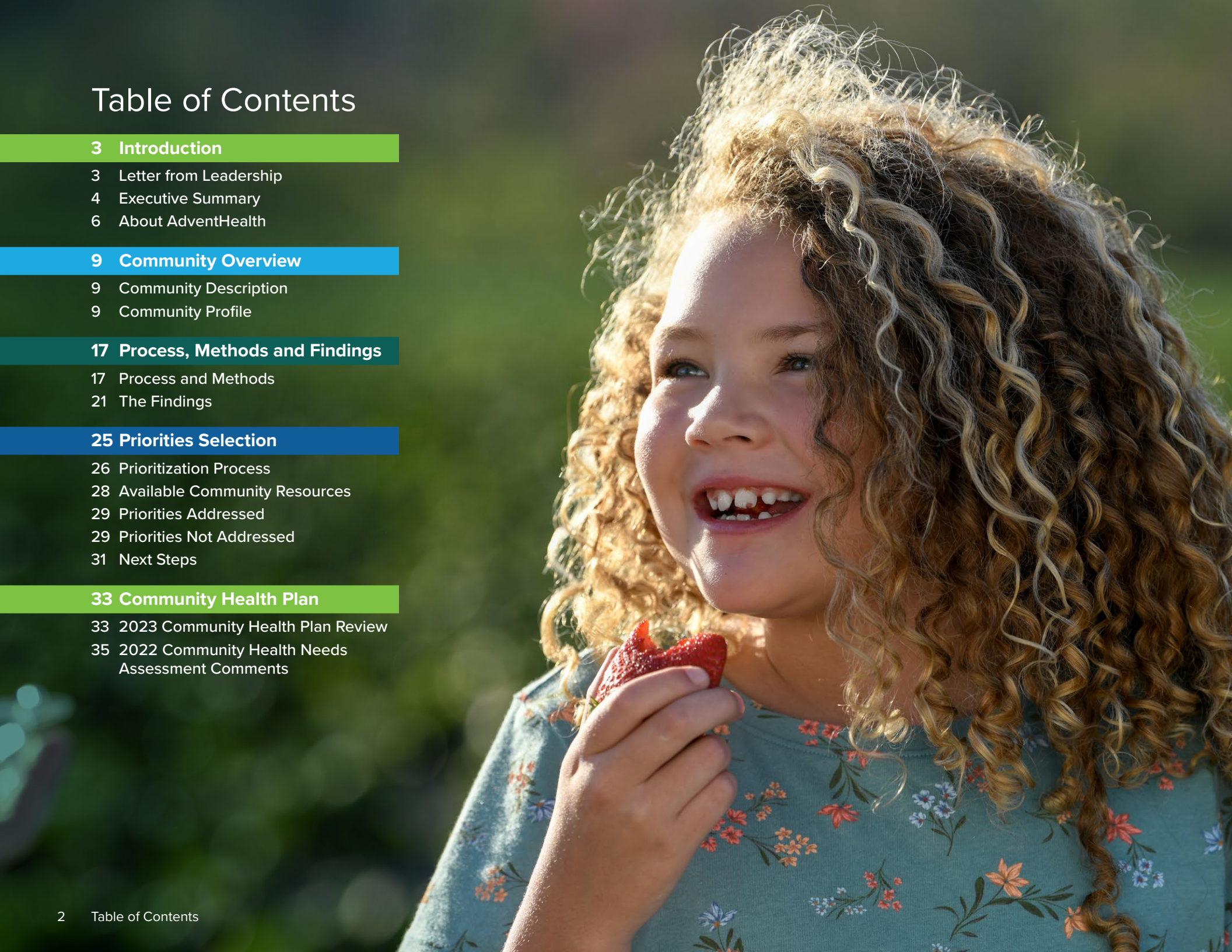
17 Process and Methods
21 The Findings

25 Priorities Selection

26 Prioritization Process
28 Available Community Resources
29 Priorities Addressed
29 Priorities Not Addressed
31 Next Steps

33 Community Health Plan

33 2023 Community Health Plan Review
35 2022 Community Health Needs Assessment Comments



Letter from Leadership

At AdventHealth, we have a sacred mission of Extending the Healing Ministry of Christ. That obligation goes beyond our hospital walls and permeates into our communities. Our commitment is to address the health care needs of our community with a wholistic focus, one that strives to heal and restore the body, mind and spirit. We want to help our communities get well and stay well.

Every three years, AdventHealth hospitals across the nation complete a Community Health Needs Assessment. During this assessment, we talk and work with community organizations, public health experts and people like you who understand our communities best. This in-depth look at the overall health of our communities and the barriers to care they experience helps AdventHealth better understand the unique needs in the various communities we serve.

We use this information to create strategic plans that address the issues that impact our communities most. At AdventHealth, we know that a healthy community is not a “one size fits all” proposition—everyone deserves a whole health approach that meets them where they are and supports their individual health journey.

This work would not be possible without the partnership of public health experts, community organizations and countless community members who helped inform this report. Through these ongoing partnerships and collaborative efforts, AdventHealth will continue to create opportunities for better health in all the communities we serve.

In His service,

Terry Shaw

Our commitment is to address the health care needs of our community with a wholistic focus, one that strives to heal and restore the body, mind and spirit.

Executive Summary

Memorial Hospital, Inc dba AdventHealth Manchester will be referred to in this document as AdventHealth Manchester or "The Hospital." AdventHealth Manchester in Manchester, Kentucky conducted a community health needs assessment from February 2024 to December 2024. The goals of the assessment were to:

- Engage public health and community stakeholders, including low-income, minority and other underserved populations.
- Assess and understand the community's health issues and needs.
- Understand the health behaviors, risk factors and social determinants that impact health.
- Identify community resources and collaborate with community partners.
- Publish the Community Health Needs Assessment.
- Use the assessment findings to develop and implement a 2026–2028 Community Health Plan based on the needs prioritized in the assessment process.

Community Health Needs Assessment Committee

To ensure broad community input, AdventHealth 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 community members. This included intentional representation from low-income, minority and other underserved populations.

The CHNAC met two times in 2024. They reviewed primary and secondary data and helped to identify the top priority needs in the community.

See Prioritization Process for a list of CHNAC members.

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 due to the findings in the assessment. The HHNAC made this decision by reviewing the priority needs that were selected by the CHNAC and by the internal hospital resources available. With this information, the HHNAC was able to determine where the Hospital could most effectively support the community.

See Prioritization Process for a list of HHNAC members.

Data

AdventHealth Manchester collected both primary and secondary data. The primary data included community surveys and stakeholder interviews. Secondary data included internal hospital utilization data (inpatient, outpatient and emergency department). This utilization data showed the top diagnoses for visits to the Hospital from 2022–2024. In addition, publicly available data from state and nationally recognized sources were used. Primary and secondary data was compiled and analyzed to identify the top 13 needs.

See Process, Methods and Findings for data sources.

Community Asset Inventory

The next step was to create a community asset inventory. This inventory was designed to help the CHNAC and the HHNAC understand the existing community efforts being used to address the 13 needs identified from the aggregate primary and secondary data. This inventory was also designed to prevent duplication of efforts.

See Available Community Resources for more.

Selection Criteria

The CHNAC participated in a prioritization process after a data review and facilitated discussion session. The identified needs were then ranked based on clearly defined criteria. The HHNAC reviewed and discussed the needs identified by the CHNAC and the available resources to address them in the community. The HHNAC also considered the Hospital's current resources and strategies. Through these discussions the Hospital selected the needs it is best positioned to impact.

See Prioritization Process for more.

The following criteria were considered during the prioritization process:

A. Impact on Community

What are the consequences to the health of the community of not addressing this issue now?

B. Resources

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

C. Outcome Opportunities

Do interventions addressing this issue have an impact on other health and social issues in the community?

Priorities to Be Addressed

The priorities to be addressed are:

1. Heart Disease and Stroke
2. Mental Health
3. Neighborhood and Built Environment—Food Security

See Priorities Addressed for more.

Approval

On May 12, 2025, the AdventHealth Manchester board approved the Community Health Needs Assessment findings, priority needs and final report. A link to the 2025 Community Health Needs Assessment was posted on the Hospital's website prior to December 31, 2025.

Next Steps

AdventHealth Manchester will work with the CHNAC and the HHNAC to develop a measurable implementation strategy called the 2026–2028 Community Health Plan to address the priority needs. The plan will be completed, board approved and posted on the Hospital's website prior to May 15, 2026.

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 100,000 talented and compassionate team members serve over 8 million patients annually. From physician practices, hospitals and outpatient clinics to skilled nursing facilities, home health agencies and hospice centers, AdventHealth provides individualized, whole-person care at more than 50 hospital campuses and hundreds of care sites throughout nine states.

Committed to your care today and tomorrow, AdventHealth is investing in new technologies, research and the brightest minds to redefine wellness, advance medicine and create healthier communities.

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

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

AdventHealth is also an award-winning workplace aiming to promote personal, professional and spiritual growth with its team culture. Recognized by Becker's Hospital Review on its "150 Top Places to Work in Healthcare" several years in a row, this recognition is given annually to health care organizations that promote workplace diversity, employee engagement and professional growth. In 2024, the organization was named by Newsweek as one of the Greatest Workplaces for Diversity and a Most Trustworthy Company in America.

AdventHealth Manchester

Our facility has a rich history of providing exceptional healthcare services to the community. Established in 1973, our Hospital has grown and evolved to meet the changing needs of our patients. We trace our roots back to 1866, when a team of Seventh-day Adventist medical pioneers in Battle Creek, Michigan, laid the foundation for our mission of whole-person care. With over 600 team members, we have remained committed to this mission, focusing on the health of the body, mind, and spirit.

Today, our Hospital is equipped with state-of-the-art technology and modern facilities to ensure the highest quality of care. We have a total of 49 beds. Our dedicated team of healthcare professionals is committed to delivering compassionate and personalized care to each patient.

We also engage with the community through health education programs, wellness screenings, and other outreach activities to promote a healthier lifestyle. Our goal is to enhance the overall well-being of our community by providing comprehensive healthcare services and fostering a culture of wellness and prevention.

In 2022, AdventHealth Manchester achieved the bronze standard—Level 3 Geriatric Emergency Department Accreditation (GEDA) from the American College of Emergency Physicians (ACEP). In 2022, AdventHealth Manchester received an "A" rating for safety from the Leapfrog Group. In 2024, AdventHealth Manchester earned The Joint Commission's Gold Seal of Approval® for hospital Accreditation by demonstrating continuous compliance with its performance standards.

Awards received in 2024:

1. **2024 Patient Experience Awards—** AdventHealth Manchester was honored with the 2024 Patient Experience Awards for their exceptional patient experience and unwavering commitment to healthcare excellence. They were recognized for their top quartile performance from July 2023 to June 2024.

2. **Clinical Distinction Award —** This award was presented by RestorixHealth to AdventHealth Manchester's wound center for meeting or exceeding national healing benchmarks, including a median of 32 days to heal and a 90% healing percentage.
3. **Excellence in Patient Satisfaction Award —** Also presented by RestorixHealth, this award recognized the wound center for achieving a national patient satisfaction benchmark of 96%.
4. **Leapfrog Grade A Hospital Safety Grade —** AdventHealth Manchester earned an "A" Hospital Safety Grade from The Leapfrog Group for fall 2024. This national recognition reflects their commitment to patient safety, with the grade based on over 30 performance measures including errors, accidents, injuries, and infections.
5. **Safe Sleep Hospital Certification —** AdventHealth Manchester achieved certification as a Bronze Cribs for Kids® National Safe Sleep Hospital. This certification recognizes their commitment to best practices in infant safe sleep, ensuring the highest standards of care for their youngest patients.
6. **Pathway to Excellence Designation —** AdventHealth Manchester earned the prestigious Pathway to Excellence® designation from the American Nurses Credentialing Center. This achievement recognizes their commitment to creating a healthy, empowering work environment for nurses, leading to higher job satisfaction, improved safety, and better patient outcomes.
7. **Recognizing Excellence in Achieving Turnover Targets —** Culture of a company can be expressed in many ways. Once a healthy culture is achieved, hiring and retaining the right talent to fit that culture is so important to continued sustainability. In 2024 AdventHealth Manchester set out to become a standout in retention with a turnover goal below top quartile. We are happy to report not only did we achieve that goal but we surpassed it and ended the year with a turnover percentage of 13.8%.

Community Overview

Community Description

Located in Clay County, Kentucky, AdventHealth Manchester defines its community as the Primary Service Area (PSA), the area in which 75–80% of its patient population lives. This includes eight zip codes across Clay and Owsley Counties.

Demographic and community profile data in this report are from publicly available data sources such as the U.S. Census Bureau and the Center for Disease Control and Prevention (CDC), unless indicated otherwise. Data are reported for PSA, unless listed differently. Data are also provided to show how the community compares locally, in the state, and at a national level for some indicators.

Community Profile

Age and Sex

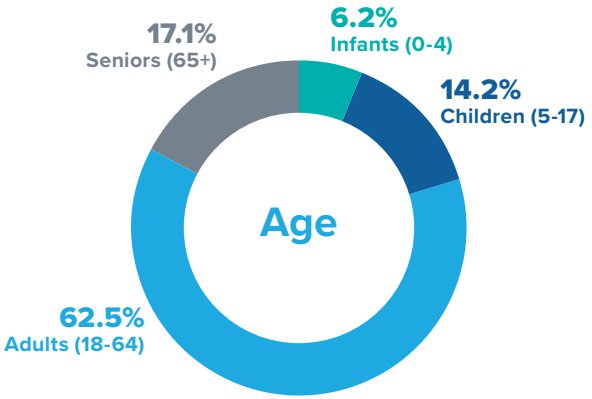
The median age in the Hospital's community is 41.9, slightly higher than that of state which is 39.4 and the US, 39.

Males are the majority, representing 51.8% of the population. Middle-aged men, 40–64 are the largest demographic in the community at 18.4%.

Children make up 20.4% of the total population in the community. Infants, those zero to four, are 6.2% of that number. The community birth rate is 46.8 births per 1,000 women aged 15–50. This is lower than the U.S. average of 52.1, and lower than that of the state, 55. In the Hospital's community, 52% of children aged 0–4 and 39.1% of children aged 5–17 are in poverty.

AdventHealth Manchester defines its community as... the area in which 75–80% of its patient population lives. This includes eight zip codes across Clay and Owsley Counties.

Seniors, those 65 and older, represent 17.1% of the total population in the community. Females are 53% of the total senior population.



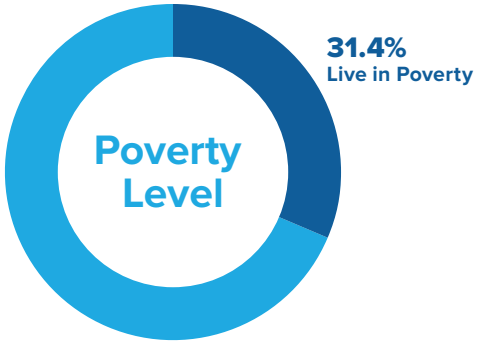
Race and Ethnicity

In the Hospital's community, 91.8% of the residents are non-Hispanic White, 3.5% are non-Hispanic Black and 1.1% are Hispanic or Latino. Residents who are of Asian or Pacific Islander descent represent .01% of the total population, while .01% are Native American and 3.4% are two or more races.

Economic Stability

Income

The median household income in the Hospital's community is $33,852. This is below the median for both the state ($54,411), and the US ($68,545). Although below the median, 31.4% of residents live in poverty, the majority of whom are under the age of 18.



Housing Stability

Increasingly, evidence is showing a connection between stable and affordable housing and health.[1] When households are cost burdened or severely cost burdened, they have less money to spend on food, health care and other necessities. Having less access can result in more negative health outcomes. Households are considered cost burdened if they spend more than 30% of their income on housing and severely cost burdened if they spend more the 50%.

1 Severe housing cost burden* | County Health Rankings & Roadmaps

Education Access and Quality

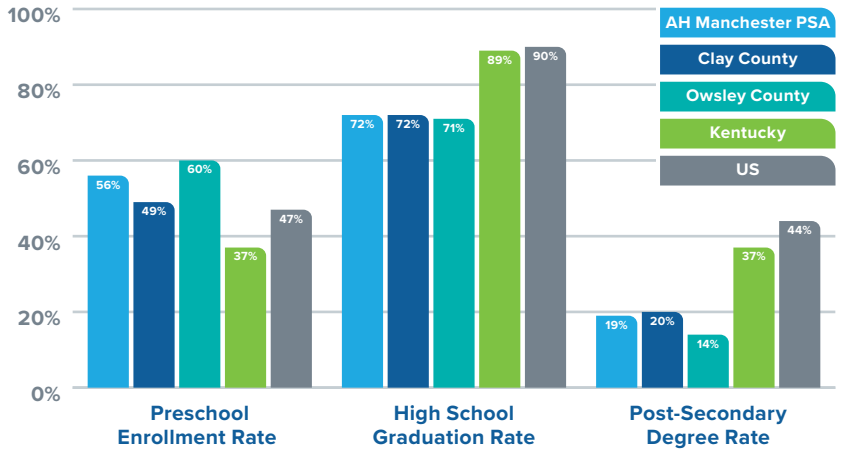
Research shows that education can be a predictor of health outcomes, as well a path to address inequality in communities.[2] Better education can lead to people having an increased understanding of their personal health and health needs. Higher education can also lead to better jobs, which can result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

In the Hospital's community, there is a 71.9% high school graduation rate, which is lower than both the state, (89%) and national average (89.6%). The rate of people with a post-secondary degree is or lower in the Hospital's PSA than in both the state and nation.

Early childhood education is uniquely important and can improve children's cognitive and social development. It helps provide the foundation for long-term academic success, as well as improved health outcomes. Research on early childhood education programs shows that long-term benefits include improved health outcomes, savings in health care costs and increased lifetime earnings.[3]

In the Hospital's community, 56.2% of three- and four-year olds were enrolled in preschool. Although higher than both the state (36.9%) and the national (46.6%) average, there is still a large percentage of children in the community who may not be receiving these early foundational learnings.

Educational Attainment



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

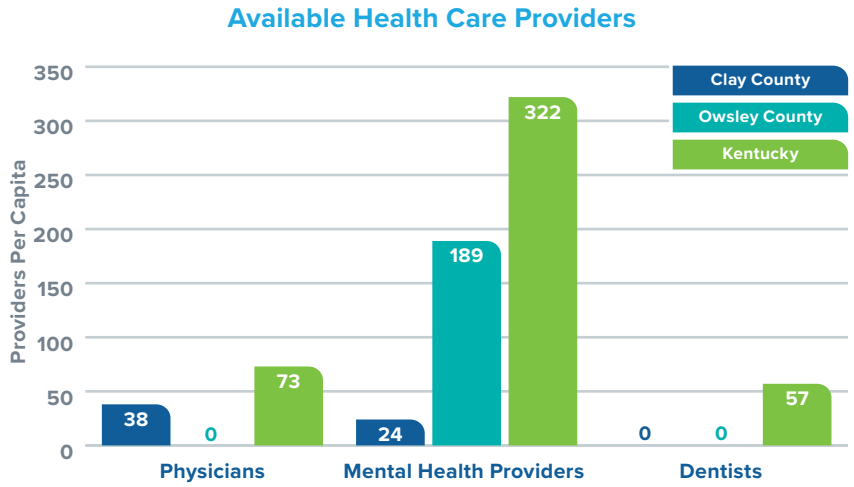
3 Early Childhood Education | U.S. Department of Health and Human Services

Health Care Access and Quality

In 2022, 15.7% of community members aged 18–64 were found to lack health insurance. Without access to health insurance, these individuals may experience delayed care, resulting in more serious health conditions and increased treatment costs. Although health insurance coverage levels can be a strong indicator of a person's ability to access care, there are other potential barriers that can delay care for many people.[4]

Accessing health care requires more than just insurance. There must also be health care professionals available to provide care. When more providers are available in a community access can be easier, particularly for those experiencing transportation challenges. In the counties that the Hospital serves, Clay County has the most care providers available, lower than the state average.

Routine checkups can provide an opportunity to identify potential health issues and when needed develop care plans. In the Hospital's community, 78% of people report visiting their doctor for routine care.



4 Health Insurance and Access to Care | CDC

Neighborhood and Built Environment

Increasingly, a community's neighborhoods and built environment are shown to impact health outcomes. If a neighborhood is considered to have low food access, which is defined as being more than ½ mile from the nearest supermarket in an urban area or ten miles in a rural area, it may make it harder for people to have a healthy diet. A very low food access area is defined as being more than one mile from your nearest supermarket in an urban area or 20 miles in a rural area.

A person's diet can have a significant impact on health, so access to healthy food is important. For example, the largest contributors to cardiovascular disease are obesity and type 2 diabetes, both of which can be impacted by diet.[5] In the Hospital's community, 27% of the community lives in a low food access area, while 11.3% live in a very low food access area.

People who are food insecure, who have reduced quality or food intake, may be at an increased risk of negative health outcomes. Studies have shown an increased risk of obesity and chronic disease in adults who are food insecure. Children who are food insecure have been found to have an increased risk of obesity and developmental problems compared to children who are not.[6] Feeding America estimates for 2022[7], showed the food insecurity rate in Clay County, where the Hospital is located as 23.7%

Access to public transportation is also an important part of a built environment. For people who do not have cars, reliable public transportation can be essential to access health care, healthy food and steady employment. In the community, 11.8% of the households do not have an available vehicle.

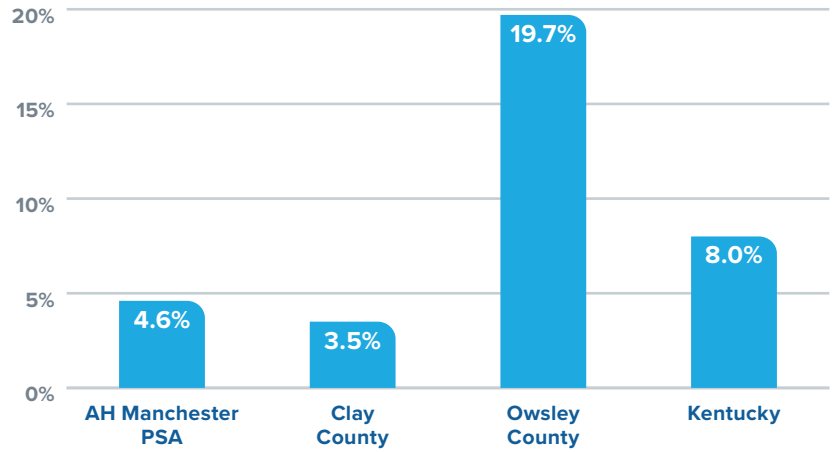
5 Heart Disease Risk Factors | CDC
6 Facts About Child Hunger | Feeding America
7 Map the Meal Gap 2022 | Feeding America

Social and Community Context

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

In the community, 4.6% of youth aged 16–19 were reported as disconnected, meaning they were neither enrolled in school nor working at the time. Disconnected youth are also referred to as opportunity youth, marginalized youth, disengaged youth, and NEET (Not in Education, Employment, or Training). The percentage of disconnected youth was highest in Owsley County at 19.7%.

Disconnected Youth



Also, in the community 27.3% of seniors (age 65 and older) report living alone and <1% of residents report having limited English proficiency. All these factors can create barriers to feeling connected in the community.

8 Social and Community Context - Healthy People 2030 | U.S. Department of Health and Human Services

Social Determinants of Health

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

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

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

Economic Stability

Includes areas such as income, cost of living and housing stability.

Education Access and Quality

This framework focuses on topics such as high school graduation rates, enrollment in higher education, literacy and early childhood education and development.

Health Care Access and Quality

Covers topics such as access to health care, access to primary care and health insurance coverage.

Neighborhood and Built Environment

Includes quality of housing, access to transportation, food security, and neighborhood crime and violence.

Social and Community Context

Focuses on topics such as community cohesion, civic participation, discrimination and incarceration.

Social determinants of health are increasingly seen as the largest contributing factor to health outcomes in communities throughout the country.

Process, Methods and Findings

Process and Methods

The Process

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

The Hospital partnered with local community organizations and stakeholders, including those in public health and those who represent the interests of medically underserved, low-income and minority community members, to form a Community Health Needs Assessment Committee (CHNAC) to guide the assessment process.

During data review sessions, community members of the CHNAC provided insight on how health conditions and areas of need were impacting those they represented. The CHNAC used the data review and discussion sessions to understand the most important health needs and barriers to health the community was facing and to guide the selection of needs to be addressed in the 2025 CHNA.

A real effort was made to reach out to all members of the community to obtain perspectives across age, race and ethnicity, gender, profession, household income, education level and geographic location.

Community Input

The Hospital collected input directly from the community and from community stakeholders, including individuals working in organizations addressing the needs and interests of the community.

Input was collected through two different surveys: the community health survey and the stakeholder survey.

Community Health Survey

- The survey was provided in both English and Spanish to anyone in the community and accessible through weblinks and QR codes.
- Links and QR codes were shared through targeted social media posts and with community partners, including public health organizations. Partners were provided links to the survey, with the request that it be sent to electronic mailing lists they maintained, and, when possible, shared on their own social media channels.
- Paper surveys were given to partners to place at their organizations with the goal of reaching those who might not have access otherwise and who experience barriers to responding electronically. Responses from paper surveys were recorded using survey weblinks.

Stakeholder Survey

- Participants were asked to provide input on health, and barriers to health, that they saw in the community.
- Surveys were sent to individuals working at community organizations, including public health organizations, that work to improve the health and well-being of the community.
- Efforts were focused on stakeholders who represent or serve underserved, underrepresented communities that are lower income, and are more likely to be impacted by the social determinants of health.

Public and Community Health Experts Consulted

A total of six stakeholders provided their expertise and knowledge regarding their communities, including:

Name	Organization	Services Provided	Populations Served
Tammy Pennington, Health Educator	Clay County Health Department	Health Care/Public Health	Infant/Children/Adolescents, LGBTQIA+, Elderly, Parents or Caregivers, People with Disabilities, Women, Homeless, Low Income, Veterans, General Public
David Watson, Executive Director	AdventHealth Manchester	Health Care/Public Health, Behavioral Health	Infant/Children/Adolescents, LGBTQIA+, Elderly, Parents or Caregivers, People with Disabilities, Women, Homeless, Low Income, Veterans, General Public
Tracy Nolan, Community Outreach and Housing Director	Red Bird Mission, Red Bird Clinic, Red Bird Mission Housing	Health Care/Public Health, Transportation, Education/Youth Services, Housing, Mental Health, Behavioral Health, Food Assistance, Employment Assistance	Infant/Children/Adolescents, LGBTQIA+, Elderly, Parents or Caregivers, People with Disabilities, Women, Homeless, Low Income, Veterans, General Public
Vickie Butler, Case Management/ Discharge Planning	AdventHealth Manchester	Health Care/Public Health, Transportation, Behavioral Health	Infant/Children/Adolescents, LGBTQIA+, Elderly, Parents or Caregivers, People with Disabilities, Women, Homeless, Low Income, Veterans, General Public
Christina Couch, Marketing and Wellness Lead	AdventHealth Manchester	Health Care/Public Health, Education/ Youth Services, Behavioral Health	General Public
Crystal Day, Marketing Director	AdventHealth Manchester	Health Care/Public Health, Education/ Youth Services, Transportation, Mental Health, Behavioral Health, Food Assistance	Infant/Children/Adolescents, LGBTQIA+, Elderly, Parents or Caregivers, People with Disabilities, Women, Homeless, Low Income, Veterans, General Public

Secondary Data

To inform the assessment process, the Hospital collected existing health-related and demographic data about the community from public sources. This included data on health conditions, social determinants of health and health behaviors.

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

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

Hospital utilization data for uninsured or self-pay patients who visited the Hospital for emergency department, inpatient or outpatient services in 2022 – 2024 was also used in the assessment. The top ten diagnosis codes were provided by the AdventHealth Information Technology team.

The Findings

To identify the top needs, the Hospital analyzed the data collected across all sources. At the conclusion of the data analysis, there were 13 needs that rose to the top. These needs were identified as being the most prevalent in the community and frequently mentioned among community members and stakeholders.

The significant needs identified in the assessment process included:

Asthma

Asthma is a disease that affects your lungs. It causes repeated episodes of wheezing, breathlessness, chest tightness, and nighttime or early morning coughing. Asthma can be controlled by taking medicine and avoiding the triggers that can cause an attack.

Cancer

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

Heart Disease and Stroke

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

Diabetes

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

Mental Health

Mental illnesses are conditions that affect a person's thinking, feeling, mood or behavior, such as depression, anxiety, bipolar disorder or schizophrenia. Such conditions may be occasional or long-lasting (chronic) and affect someone's ability to relate to others and function each day. Mental health includes our emotional, psychological and social well-being. It affects how we think, feel and act. It also helps determine how we handle stress, relate to others and make healthy choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.

Obesity

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

Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Some racial/ethnic groups are more likely to have obesity, which increases their risk of chronic diseases.

Drug and Alcohol Use

Healthy People 2030 focuses on preventing drug and alcohol misuse and helping people with substance use disorders get the treatment they need. Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

Physical 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.

Tobacco Use

Tobacco smoking is the practice of burning tobacco and ingesting the smoke produced. Smoking leads to disease and disability and harms nearly every organ of the body. Additionally, smoking causes cancer, heart disease, stroke, lung diseases, diabetes, and chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis. Smoking also increases risk for tuberculosis, certain eye diseases, and problems of the immune system, including rheumatoid arthritis.

Economic Stability

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

Education Access and Quality

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

Health Care Access and Quality

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

Neighborhood and Built Environment—Food Security

Food security exists when all people, at all times, have physical and economic access to sufficient safe and nutritious food that meets their dietary needs and food preferences. A lack of food security has been linked to negative health outcomes in children and adult, as well as potentially causing trouble for children in schools.

Priorities Selection

The CHNAC through data review and discussion, narrowed the health needs of the community to a list of 13. Community partners on the CHNAC represented the broad range of interests and needs, from public health to the economic, of underserved, low-income and minority people in the community. During the Fall of 2024, the CHNAC met to review and discuss the collected data and select the top community needs.

Members of the CHNAC included:

Community Members

- Tracy Nolan, Red Bird Mission, Community Outreach Coordinator
- Bailey Lewis, Clay County Senior Citizens, Assistant Director
- Stephanie Hoskins, Volunteers of America, Director of Freedom House
- Edith Crawford, Save the Children, Community Engagement Coordinator—Clay County Schools
- Danielle Collins, Stay in Clay, President
- Genia Lewis, Thompson Scholars, Director of Operations
- Marsha Garrison, Healthy Clay Coalition, Community Health Educator
- Sandy Eversole, Daniel Boone, Business Services Representative

AdventHealth Team Members

- James Couch, AdventHealth Manchester, VP of Operations
- David Watson, AdventHealth Manchester, Executive Director of Engineering
- Maria Ball, AdventHealth Manchester, Educator
- Vickie Butler, AdventHealth Manchester, Case Management
- Robin Hensley, AdventHealth Primary Care Clinic, Manager
- Christina Couch AdventHealth Manchester, Community Benefits Lead

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.

- Crystal Day, AdventHealth Manchester, Marketing Director
- Kellie Gray, AdventHealth Manchester, Dietitian
- Sheila Asher, AdventHealth Primary Care Clinic, Assistant Director
- Randeana Collett, AdventHealth Primary Care Clinic, Behavioral Health Manager

Public Health Experts

- Tammy Pennington, Clay County Health Department, Health Educator

Prioritization Process

To identify the top needs the CHNAC participated in a prioritization session. During the session, the data behind each need was reviewed, followed by a discussion of the need, the impact it had on the community and the resources available to address it. CHNAC members then ranked the needs via an online survey.

The CHNAC (n=12) were asked to select the three needs they thought the Hospital should address in the community.

The following criteria were considered during the prioritization process:

A. Impact on Community

What are the consequences to the health of the community of not addressing this issue now?

B. Resources

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

C. Outcome Opportunities

Do interventions addressing this issue have an impact on other health and social issues in the community?

The following needs rose to the top during the CHNAC's discussion and prioritization session. The needs receiving the most votes were considered the highest priority by the CHNAC.

Top Identified Needs	# of Votes	% of Responses
Mental Health	7	19%
Diabetes	6	17%
Physical Activity	5	14%
Neighborhood and Built Environment—Food Security	5	14%
Heart Disease and Stroke	3	8%
Tobacco Use	3	8%
Economic Stability	3	8%
Obesity	2	6%
Cancer	1	3%
Drug and Alcohol Use	1	3%
Asthma	0	0%
Education Access and Quality	0	0%
Health Care Access and Quality	0	0%

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

Members of the HHNAC included:

- James Couch, AdventHealth Manchester Interim Administrator/VP of Operations
- Jesse Kleven, AdventHealth Manchester, Chief Financial Officer
- David Watson, AdventHealth Manchester Executive Director
- Christina Couch AdventHealth Manchester Community Benefits Lead
- Crystal Day, AdventHealth Manchester, Marketing Director
- Anita Cornett, AdventHealth Manchester, Chief Medical Office
- James Nelson, AdventHealth Manchester Chief Nursing Officer

The HHNAC narrowed down the list to three priority needs:

- Heart Disease and Stroke
- Mental Health
- Neighborhood and Built Environment—Food Security

Available Community Resources

As part of the assessment process, a list of resources or organizations addressing the top needs in the community was created. Although not a complete list, it helped to show where there were gaps in support and opportunities for partnership in the community when the CHNAC chose which priorities to address.

Top Needs	Current Community Programs	Current Hospital Programs
Cancer	• Cancer Coalition • Cumberland Valley District Health Department	• Preventative Cancer Screenings
Diabetes	None	• Endocrinology • Pharmacy
Heart Disease and Stroke	None	• UK Heart Gill Affiliation
Mental Health	None	• AdventHealth Primary Care Clinic — Behavioral Health
Drug and Alcohol Use	• Volunteers of America	• AdventHealth Primary Care Clinic — Behavioral Health
Physical Activity	• Clay County Fitness Center • Big Hickory Golf Course	• Summer Fitness
Tobacco Use	• Freedom From Smoking Cessation — Red Bird Mission	• Freedom From Smoking Cessation
Economic Stability	• Daniel Boone Community Action Agency • KCEOC Community Action Partnership	• Job Fairs
Education Access and Quality	• Daniel Boone Community Action Agency — Career Workshops • Save the Children • Clay County Adult Education	• Bert T. Combs Scholarships — 5/$1000 • Live Life Scholarships — 5/$1000
Health Care Access and Quality	• Daniel Boone Community Action Agency • Cumberland Valley District Health Department • KYNECT • Shriners Children's	• CREATION Life Transportation Program • Home Health • Global Missions
Neighborhood and Built Environment — Food Security	• Daniel Boone Community Action Agency • Cumberland Valley Domestic Violence Program • Face It — A movement to end child abuse • Thompson Scholars Foundation	• Adventist Community Food Pantry • Red Bird Food Pantry

Priorities Addressed

The priorities to be addressed include:

Heart Disease and Stroke

According to secondary data, 41% of residents in Clay county and 39% in Owsley county reported higher rates of hypertension than the state average of 35.5%. In addition, 48% of community survey respondents reported having hypertension. The Hospital believes that a focus on cardiovascular disease, in particular hypertension, can improve outcomes across multiple health conditions.

Mental Health

In the Hospital's community, 29.2.% of residents have depression, while 20.7% of resident self-reported poor mental health. According to the community survey, more than 37% of respondents have been diagnosed with a depressive order and more than 47% have been diagnosed with an anxiety disorder.

Awareness and the need to address mental health disorders has been growing in the country. The Hospital selected mental health as a priority in the 2022 needs assessment and will continue their efforts to address this issue in the community.

Neighborhood and Built Environment—Food Security

Approximately 32.5% of households in the Hospital's community receive SNAP benefits. A higher percent of community survey respondents, 59.8% received SNAP benefits in the past 12 months. Secondary data also showed 37.2% of households in poverty do not receive SNAP benefits despite being financially eligible. One in four community survey respondents are food insecure, reporting they eat less than should in the past 12 months because they did not have enough money for food. According to Feeding America 24.6% of the residents in the Hospital's community are food insecure. The Hospital will work with community partners to improve access to healthy and affordable food to address the issue of food security.

Priorities Not Addressed

The priorities not to be addressed include:

Asthma

According to secondary data, asthma impacts 12.3% of residents. Community survey data included a higher rate of residents, 17%, diagnosed with asthma. The Hospital did not select asthma as a priority as it is not positioned to directly address this issue. The Hospital will support other efforts addressing this through advocacy, community partnerships and public health collaborations as needed.

Cancer

In the Hospital's community 8.7% of the residents have had cancer which is higher than the state rate of 7.3%. According to the community survey respondents, 12% of residents had been diagnosed with cancer. The Hospital believes that other organizations are better positioned in the community to address this need directly and will support those efforts when able.

Diabetes

Diabetes is shown to impact 17.2% of residents in the Hospital's community according to public data. According to the community survey respondents, 28% of residents reported being diagnosed with diabetes. The Hospital did not select diabetes as a priority because the Hospital did not perceive the ability to have a measurable impact on the issue within the three years allotted for the Community Health Plan with the current resources available.

Obesity

In the Hospital's community, 43.7% of residents are overweight or obese, which is higher than the state average of 38.5%. Although health complications from obesity are 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.

Drug and Alcohol Use

When asked about drug use, 14% of community survey respondents reported taking prescription medication for non-medical reasons, and 13% reported taking prescription pain medication without a doctor's prescription. The Hospital did not select drug and alcohol use as a priority as it is not positioned to directly address this issue. The Hospital will support other efforts addressing this through advocacy, community partnerships and public health collaborations.

Physical Activity

In the Hospital's community, 35.9% of residents report not exercising in the past 30 days which is higher than the state average of 26%. This was lower among community survey respondents, with only 21% reporting zero exercise in the past 30 days. Although a significant need, the Hospital believes other organizations are better suited to address this issue and will support their efforts.

Tobacco Use

According to secondary data, 27.4% of residents currently smoke cigarettes which is higher than the state average of 19.1%. Community survey respondents shared slightly lower rates of smoking with 26% overall, and 23% of respondents reporting they vape as well. Although a significant need, the Hospital no longer has the resources available to address this issue and will support other organizations efforts to address tobacco use.

Economic Stability

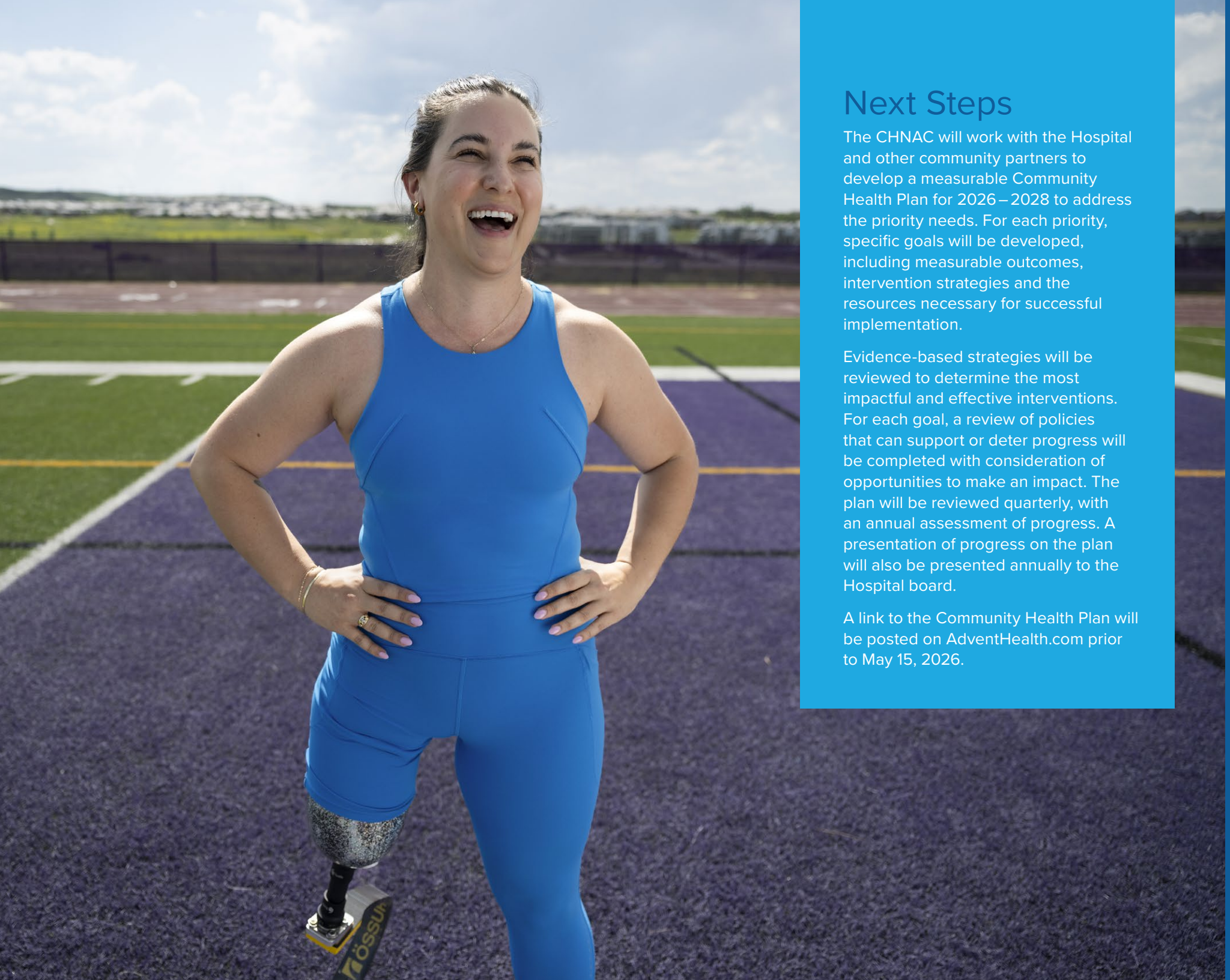
In the Hospital's community, 31.4% of residents are currently living in poverty. When asked about housing, 17% of community survey respondents said they were worried about stable housing. Stakeholders also ranked living wage, poverty, and affordable housing as top community conditions impacting the health of people in the community. Although economic stability is an important need, the Hospital is not positioned to directly address this issue. The Hospital will support other efforts addressing this through advocacy, community partnerships and public health collaborations.

Education Access and Quality

According to secondary data, 71.9% of residents have at least a high school degree and 13.8% of residents have a college degree, although both are lower than the state averages. While this is an identified need, due to existing resources and scope, the Hospital did not perceive the ability to have a measurable impact on this need within the three years allotted for the for the Community Health Plan, therefore this need was not selected as a priority.

Health Care Access and Quality

According to secondary data, 10.4% of residents in the Hospital's PSA do not have health insurance which is higher than the state average of 7.2%. This is even higher in Clay County where the Hospital is located, with 13.8% of resident adults without health insurance. About 15% of community survey respondents indicated they needed to see a doctor in the past 12 months but could not due to cost. The Hospital did not perceive the ability to have a measurable impact on this need within the three years allotted for the for the Community Health Plan, therefore this need was not selected as a priority.



Next Steps

The CHNAC will work with the Hospital and other community partners to develop a measurable Community Health Plan for 2026 – 2028 to address the priority needs. For each priority, specific goals will be developed, including measurable outcomes, intervention strategies and the resources necessary for successful implementation.

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

A link to the Community Health Plan will be posted on AdventHealth.com prior to May 15, 2026.

Community Health Plan

2023 Community Health Plan Review

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

Priority 1: Cardiovascular Issues

In the 2022 assessment, the Hospital selected cardiovascular disease as a priority to address. 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.

One of the key strategies to combat cardiovascular disease is by improving access to nutritious food in food deserts. The Hospital pinpointed community locations within these areas to host food pantry distributions. Marlon Robinson, Chaplain, leads a team of AdventHealth volunteers who dedicate their time to distribute food from the pantry twice a month. This initiative, in collaboration with the Seventh Day Adventist Church, ensures that the Hospital reaches those in need and provide them with healthy food options. In 2023, the Hospital served 6,942 individuals.

In 2023, the Hospital offered smoking cessation classes. Two nursing team members completed their instructor certification and will host their first community class in September 2024. Additionally, the Hospital provided an 8-week Summer Fitness & Nutrition program, which educated participants on how to adopt a healthier lifestyle. In 2024, there were 36 unique participants who collectively lost

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

24.99% of their weight as a group. The Hospital partnered with the Clay County School System and the Family Resource and Youth Center (FRYSC) to make this program a success. Participants were given initial screenings and tests to gauge their nutrition and wellness knowledge, and the program included a variety of physical exercises and health lessons.

Priority 2: Transportation

Transportation was identified as a significant barrier to healthcare access in our community. 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%) felt the same. Community members also shared that a lack of transportation is a barrier to employment and impacts everything from food to healthcare access, especially in rural areas. Transportation barriers can impact every facet of life and be a significant contributing factor to an individual's health outcomes. In 2023, the Hospital provided 464 transports through the CREATION Life transportation program. This program aims to provide reliable transportation for individuals in need, ensuring they have access to essential services, including healthcare.

Priority 3: Mental Health

The 2022 assessment found 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. The Hospital remains committed to addressing mental health.

The Live It Up program, a cornerstone of the mental health strategy, is offered at the local county middle school. The program teaches CREATION Life principles and their impact on a healthy lifestyle. In 2023, 416 students participated in the Live It Up program, learning valuable skills and habits to maintain both mental and physical health. The program aims to instill healthy habits early in life, helping students develop resilience and coping strategies that will benefit them throughout their lives.

Priority 4: Preventative Care — Screenings

Preventative care, specifically screenings, was identified as a significant need in the community. During the 2022 assessment, the Hospital learned 27.8% of community survey respondents were not aware of what preventative screenings are needed. Among those that were aware, 47.7% reported not getting regular screenings. Public data showed that 80.4% of community members were up to date on routine checkups.

The Hospital is prioritizing efforts to increase awareness and education about the importance of preventative care screenings. This includes distributing educational materials, hosting informational sessions, and leveraging social media to reach a broader audience. The Hospital will provide free biometric screenings to adults in the community. These screenings include checks for blood pressure, cholesterol levels, blood sugar, and body mass index (BMI). By offering these services at no cost, the Hospital aims to encourage more individuals to participate in regular health checkups.

The Hospital will create targeted marketing materials to advertise our screening events. This includes flyers, posters, and digital advertisements to ensure that community members are informed about the availability and benefits of these screenings. The Hospital will also collaborate with local health organizations, schools, and community groups to extend our reach and impact. These partnerships will help provide comprehensive care and support to individuals in need of preventative screenings.

2022 Community Health Needs Assessment Comments

We posted a link to the most recently-conducted CHNA and the most recently adopted implementation strategy, 2023 Community Health Plan on our hospital website as well as on AdventHealth.com prior to May 15, 2023 and have not received any written comments.

AdventHealth

Memorial Hospital, Inc. dba AdventHealth Manchester

CHNA Approved by the Hospital board on: May 12, 2025

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

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