

KING'S DAUGHTERS

Community Health Needs Assessment Implementation Plan 2020-21

Serving Boyd, Greenup, Carter Counties in Kentucky
and Lawrence County, Ohio

Adopted: November 25, 2019

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EXECUTIVE SUMMARY

King's Daughters Medical Center is a locally controlled, not-for-profit, 465 bed regional referral center, covering a 150-mile radius that includes southern Ohio and eastern Kentucky. With nearly 3,000 team members, King's Daughters offers comprehensive cardiac, medical, surgical, maternity, pediatric, rehabilitative, bariatric, psychiatric, cancer, neurological, pain care, wound care and home care services. KDMC operates more than 50 offices in eastern Kentucky and southern Ohio.

King's Daughters conducted a Community Health Needs Assessment (CHNA) with Bon Secours Kentucky, Our Lady of Bellefonte Hospital between November 2018 and May 2019. The CHNA included both primary data analysis and secondary data analysis. The primary data encompassed surveys and focus groups with key individuals in the community including those representatives of our community with knowledge of public health, the broad interests of the communities we serve, as well as individuals with special knowledge of the medically underserved, low-income and vulnerable populations and people with chronic diseases. The following were needs identified through the assessment process and will be areas of focus for King's Daughters moving forward.

1. Substance Abuse
2. Obesity/Diabetes
3. Cancer Prevention
4. COPD/Lung Disease
5. Heart Disease/Hypertension

King's Daughters will work in partnership with the Healthy Choices, Healthy Communities Coalition (HCHC) and its members; other healthcare providers; educational institutions; government agencies, businesses and internal departments and service lines to help provide services and resources to improve the health of Boyd, Carter and Greenup Counties in KY and Lawrence County in Ohio.

Service Area Description

The assessed counties (Boyd, Carter and Greenup in Kentucky and Lawrence in Ohio) lay in the foothills of the Appalachian Mountains, situated at the border between Ohio, Kentucky and West Virginia. This area is known for unhealthy behaviors and poor health outcomes.

- Investigate what else can be done to improve the health of the community
- Create a community health improvement plan

The following methods were used to gather information for the assessment:

- Community forums in all counties identified in the assessment
- Web/print survey
- Review of local, state and national data

The findings from the primary and secondary data collection can be reviewed in the 2019 Community Health Needs Assessment companion document. The findings discussed in the assessment serve as the basis for this implementation plan.

2019 CHNA Identified Needs:

Based on the results of the primary and secondary data collection for the Community Health Need Assessment, the top issues across all data points included:

1. Substance Abuse/Smoking
2. Cancer
3. Obesity
4. Mental Health/Suicide/Depression
5. Diabetes
6. Heart Disease/High Blood Pressure

Disparities

KDMC recognized that disparities exist in the service area due to multiply factors. The areas rural nature makes seeking healthcare harder, especially for those that do not have resources like transportation and health insurance. The area also suffers from a high level of poverty and low level of educational attainment, both factors create problems with individuals living healthy lives and accessing preventive services. In addition, there are gender disparities with both heart and lung disease, with males having higher rates of mortality. Overdose deaths are more prevalent among young males compared to other demographic groups.

Criteria for Determining Needs to be Addressed

In assessing and prioritizing the health needs of the community, King's Daughters took a broad, societal view that incorporated public health goals into the planning

process. The following criteria were used to determine the top health needs upon which this implementation is built.

1. Institution's ability to address the social determinants of health
2. Staff and volunteer resources
3. Organizational capacity to leverage existing programs, services and resources
4. The organization's mission and strategic initiatives

The health needs were shared with the hospital's internal leadership team. King's Daughters evaluated each of the priority health needs identified and concluded that key issues could be reduced to the following priorities which could have overlapping strategies and are within King's Daughters ability to address.

Health Needs to be met

The priorities identified by the CHNA and ratified by the KDMC leadership team are:

- Substance Abuse
- Obesity/Diabetes
- Cancer Prevention
- Heart Disease/Hypertension
- COPD/Lung Disease

Health needs unable to meet and why:

While King's Daughters recognizes that mental health and depression are issues for our service area, King's Daughters neither has the expertise or resources to significantly impact these issues. King's Daughters does recognize that these issues may be somewhat impacted through targeting other issues like substance abuse.

Implementation plan goals, objectives and strategies:

Priority Area: Substance Misuse/Abuse

Rationale: Substance misuse is growing problem across Appalachia. The results from the focus groups and surveys placed substance misuse as the top health issue identified by the community. Substance misuse can be defined as an addiction to alcohol, illicit drugs, prescription drugs and/or tobacco.

Prescription *drug misuse*, especially opioids, is a huge problem in eastern Kentucky. While steps have been taken to reduce the number of prescriptions, individuals already addicted need assistance to become healthy, contributing members of society. Drug poisoning/overdose deaths continue to rise in the area. In 2017, the number of drug overdose deaths in the service area was nearly three times higher than in 2012. Heroin and prescription opioids account for the greatest number of fatal overdoses. Hydrocodone and naloxone account for the highest number of deaths from controlled substances. Drug overdose is a growing problem for the area. The death rate from drug overdose is higher in Boyd County (32.6), Greenup County (27.4), and Lawrence County, Ohio (28.1), than Kentucky (27.4), Ohio (2.7) and the United States (15.6). While Carter County’s rate (24.9) is better than both states, it is still much higher than the nation.

Goal 1: Increase the number of justice system involved individuals that are established with a primary care provider and receiving individualized mental health, physical health, MAT and social services.

Expected Impact: Fewer justice involved individuals testing positive for illicit drugs

Target Population: Justice involved individuals in drug court or other judicial programs

Collaborators: Greenup County Drug and other courts, Pathways, health departments, education institutions,

Objective	Strategies	Existing Resources	Measures
1. Increase the number of justice-involved individuals that receive individualized services, including mental health, physical health, hepatitis and HIV testing, MAT, housing, job placement, trauma-based services, etc. by 30%, by September 30, 2021.	Partner with judicial system for referrals Train providers in MAT Hire LCSW and Case Manager to provide care or referral, case management, counseling and referral to needed resources. Mental health, depression, suicide prevention,	Inpatient and outpatient behavioral services Drug Court Family practice physicians Advanced Practice Nurses KORE grant	Number of individuals served, tracked through OP behavioral health

	etc. training		
2. Increase the number of justice-involved individuals that are established with a primary care provider by 25%, by September 30, 2021.	Referrals to primary care from judicial system, outpatient and inpatient behavioral medicine.	KDMC primary care physicians Outpatient behavioral health NPs Collaboration with court system	Individuals referred from the judicial system and established with PCC, tracked through OP behavioral health

Goal 2: Reduce the impact of substance use disorder (SUD)

Expected Impact: Increased support for individuals with SUD; reduced number of individuals with SUD

Target Population: Community at large

Collaborators: Faith community; HCHC Coalition; OLBH; Pathways; ASAP

Objective	Strategies	Existing Resources	Measures
1. Increase community knowledge of substance use disorder and its impact	Educational summits for faith community	Collaboration with faith community	Number of individuals educated, tracked through the Community Benefit tracking system (CBISA)

Goal 3: Reduce initiation into substance use through medication safety education

Expected Impact: reduce accidental use of prescription medications, improve medication safety in the home; increase knowledge of protective factors

Target Population: Children, youth and adults, parents and other caregivers

Collaborators: HCHC Coalition; Pathways; Tri-County Prevention Board; Schools

Objective	Strategies	Existing Resources	Measures
1. Increase knowledge of safe medication practice	<p>School programs that include medication safety and other protective factors</p> <p>Community programs that provide medication safety education</p> <p>Community prescription medication take back efforts</p>	<p>Generation Rx materials</p> <p>Trained staff</p> <p>Existing take back bins in KD OP pharmacy</p>	<p>Number of individuals educated, tracked through the Community Benefit tracking system (CBISA)</p>

Priority Area: Obesity and Diabetes Mellitus

Rationale: Obesity and diabetes have been grouped together because many strategies that impact one may also impact the other. By focusing efforts on obesity and diabetes, it is possible to impact these and other conditions. When considering obesity and diabetes mellitus, it is important to look at the factors that contribute to these conditions, which include poor diet and exercise. In the service area, all four counties are worse than the nation and Ohio for consuming five or more servings of fruits and vegetables. In addition, all counties are significantly worse than the nation in leisure time activity with as much as one-third of adults physically inactive.

Obesity is a contributing factor to many other health issues including cancer, diabetes, high blood pressure and heart disease. Poor diet and physical inactivity are contributing factors to obesity and overweight, which is high in all four counties: Boyd (38.9%), Carter (38.9%), Greenup (39.9%), and Lawrence (38.9%) all higher than the states KY (32.7%), OH (30.9%) and the nation (27.5%). All four counties have seen increases in obesity since the last CHNA in 2016.

Diabetes mellitus (DM) is the eighth leading cause of death in the United States. It has devastating impact on a person’s quality of life. Diabetes mellitus lowers life expectancy by 15 years, increase the risk of heart disease by two to four times and is the leading cause of kidney failure, lower limb amputations and adult onset blindness. According to the Centers for Disease Control, in addition to these human costs, the estimated total economic cost of diagnosed diabetes in 2017 was \$327 billion, which includes the costs of medical care, disability and premature death. The service area has a higher percentage of the population diagnosed with diabetes than the national average, with rates ranging from 12.1% to 13.5%, compared to the nation at 9.2%. The high

prevalence of diabetes may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.

Goal 1: Increase access to healthy foods for healthful diets, and achievement and maintenance of healthy body weight.

Expected Impact: Increase healthy eating; reduce food insecurity

Target Population: Individuals living in food deserts, low-income,

Collaborators: Schools, farmers, Cooperative Extension, faith community, KDMC team members, Second Harvest, Community Kitchen, HCHC Coalition, OLBH

Objective	Strategies	Existing Resources	Measure
1. Increase opportunities to obtain fruits and vegetables in food deserts.	Place farmer's markets in designated food desert areas	Partnerships with farmers, Extension and area food banks	Farmers market days in food desert areas, tracked through days open and sales
2. Increase access to healthy foods through food banks and feeding programs	Collect healthy foods for distribution through local food banks Meals on Wheels	Current efforts for food collection Collaboration with area food banks Collaboration with OLBH (Food Feud)	Number of pounds of food donated

Goal 2: Reduce household food insecurity and in doing so reduce hunger (HP2030 proposed – NWS2030-01)

Expected Impact: Improved diet, reduced hunger

Target Population: Low income; children

Collaborators: Farmer's markets, Cooperative Extension, grocers, faith community, food banks

Objective	Strategies	Existing Resources	Measure
1. Reduce food insecurity among children through food provision programs	Food distribution programs like backpack buddies, food drives, summer feeding, etc.	Current partnerships with farmers, Extension service, schools	Number of programs implemented to support food programs

Goal 3: Reduce the proportion of children and adolescents aged 2 to 19 years who have obesity (HP2030 proposed objective NWS-2030-03)

Expected Impact: fewer children and adolescents that are obese

Target Population: Low income; children; adolescents

Collaborators: Local organizations promoting physical activity

Objective	Strategies	Existing Resources	Measure
1. Increase opportunities for physical activity in the area	Support for runs and walks School-based programs encouraging physical activity (i.e. Heart Challenge)	Collaborations with local non-profits Partnerships with schools	Number of programs implemented to support physical activity; number of participants; number of entry fee scholarships

Goal 4: Reduce the proportion of adults with undiagnosed prediabetes (HP2030 proposed objective D-2030-09)

Expected Impact: increased number of individuals receiving blood sugar screening; increased number of prediabetics referred to healthcare provider

Target Population: adults;

Collaborators: HCHC Coalition; schools, businesses;

Objective	Strategies	Existing Resources	Measures
1. Increase the number of adults receiving blood sugar screening	Free community screenings for non-fasting blood sugar Low cost A1c blood sugar screenings	Equipment and trained staff to do screenings Partnerships with area schools and businesses	Number of individuals served as tracked through CBISA

Priority Area: Cancer Prevention

Rationale: Cancer imposes a heavy societal burden worldwide, in terms of both human and financial costs. The introduction of more sophisticated imaging and diagnostic techniques and advanced drugs that specifically target tumor cells is leading to increasingly expensive treatments, which may be affordable only for few patients. Prevention is an effective way of addressing the challenging issue of cancer, since between one-third and one-half of cancers could be prevented on the basis of current knowledge of risk factors. In the service area, all counties except Carter (129.6) fare much better than the nation (123.5) when it comes to breast cancer incidence. All of the service area counties are worse than the United States when it comes to incidence of colon/rectal cancer (Boyd-52.4, Carter-56.9, Greenup-50.4, Lawrence, OH-44.3, US-39.8) and lung cancer (Boyd-90.4, Carter-101.9, Greenup-105.6, Lawrence, OH-79.1, US-61.2).

Goal 1: Reduce the overall cancer death rate (HP2030 proposed – C-2030-01)

Expected Impact: fewer deaths from breast, colon/rectal, and lung cancers

Target Population: adults with cancer, at-risk for cancer or within age of current screening guidelines

Collaborators: healthcare providers

Objective	Strategies	Existing Resources	Measure
1. Increase the proportion of adults who receive a lung cancer screening based on the most recent guidelines (HP2030 proposed)	Promote low-dose CT (LDCT) scans HealthAware Risk Assessment Letters to patients that qualify for	EPIC build complete to generate data for letters and to track patients Low-dose CT program in place	The number of adults receiving lung cancer screening, tracked through EPIC

<p>– C-2030-03)</p>	<p>LDCT</p> <p>Reminder letters for LDCT patients for annual test</p> <p>Collaborate with PCP to educate them on early lung cancer detection and improve communication with patients regarding stigma of smoking and improving patient care</p>		
<p>2. Increase the proportion of adults who receive a colon/rectal cancer screening based on the most recent guidelines (HP2030 proposed – C-2030-07)</p>	<p>Fecal immunochemical test (FIT)</p> <p>Colonoscopy/ Sigmoidoscopy</p> <p>HealthAware Risk Assessment</p>	<p>Colon cancer education programs</p> <p>Giant colon display</p>	<p>Number of individuals receiving any type of colon/rectal screening – tracked through EPIC</p>
<p>3. Increase the proportion of women in Carter County who receive a breast cancer screening based on the most recent guidelines (HP2030 proposed – C-2030-05)</p>	<p>Mobile mammography-increase number of visits</p> <p>Komen grant</p> <p>BCTF grant</p> <p>KCWSP grant/program</p> <p>Genetic testing</p>	<p>Mobile mammography unit newly equipped with 3-D imaging</p> <p>Grant funds to assist women without insurance or other resources</p>	<p>Number of women in Carter County receiving mammography services through mobile unit – tracked through the Breast Care Center data collection</p>

Priority Area: Chronic Lower Respiratory Disease (COPD & other lung/breathing issues)

Rationale: Chronic obstructed pulmonary disease (COPD), emphysema, chronic bronchitis and other respiratory illnesses are all grouped together under the name chronic lower respiratory disease. Chronic lower respiratory disease is the third leading cause of death in the United States. *Lung disease*, other than cancer, refers to many disorders affecting the lungs, such as asthma, COPD, infections like influenza, pneumonia and tuberculosis and many other breathing problems. The lung disease mortality rate per 100,000 people, in the service area, is higher than the nation: Boyd - 57.4, Carter - 76.7, Greenup – 65.4, Lawrence, OH – 71.4, United States – 41.3. In addition, the prevalence of asthma in the area is high with all four counties higher than the nation: Boyd – 19.1%, Carter – 13.6%, Greenup – 14.9%, Lawrence, OH – 23.8%, United States – 13.4%.

According to the Center for Disease Control (CDC), tobacco use is the leading cause of preventable disease, disability, and death in the United States. Nearly all tobacco use begins during youth and progresses into adulthood, with nine out of 10 smokers starting before the age of 18. Tobacco use, especially smoking, leads to a number of chronic illnesses including cancer, heart disease, stroke, asthma, emphysema and COPD. In the service area, an estimated 36,057, or 26.4% of adults age 18 or older self-report currently smoking cigarettes some days or every day. Tobacco use among former and current smokers is near or greater than 50% in three of the four counties: Boyd – 49.8%, Carter – 61.6%, Greenup – 57.5%, Lawrence, OH – 44.5%, compared to the nation at 44.2%. Current smokers are considerably higher than the nation (18.1%), with Boyd at 28%, Carter at 33.6%, Greenup at 23.9% and Lawrence at 26.2%.

Goal 1. Improve lung health by reducing illness, disability and death related to tobacco use.

Expected Impact: Reduction in number of youth initiating tobacco or e-cigarette use; increased number of quit attempts among current tobacco users

Target Population: Children, adolescents, young adults and current tobacco users

Collaborators: Schools, health departments, healthcare providers

Objective	Strategies	Existing Resources	Measures
1. Reduce the initiation of cigarettes and e-cigarettes among adolescents and young adults (HP 2030 proposed – TU2030-08 & TU2030-04)	<p>Conduct nicotine education programs in local schools</p> <p>Include nicotine education at screening events.</p> <p>Provide nicotine education throughout the service area to reduce initiation of tobacco use.</p>	<p>Staff trained to deliver the programs</p> <p>Collaboration with schools</p>	Number of individuals served, collected and reported through CBISA
2. Increase use of smoking cessation counseling and/or medication among adult smokers (HP 2030 proposed – TU2030-11)	<p>Physician referrals to smoking cessation programs</p> <p>Include information about smoking cessation programs at screening events.</p>	Smoking cessation educator	Number participating in the smoking cessation courses, tracked through CBISA

Goal 2. Reduce lung illness and death due to vaping among adolescents

Expected Impact: Reduction in number of youth initiating use or currently using e-cigarettes or other vaping products.

Target Population: Children, adolescents, young adults and parents or caregivers

Collaborators: Schools, health departments, healthcare providers; youth organizations; faith community

Objective	Strategies	Existing Resources	Measures
1. Increase knowledge of the hazards of e-cigarette use and vaping	<p>Conduct nicotine education programs in local schools</p> <p>Include nicotine education at screening</p>	<p>Staff trained to deliver the programs</p> <p>Collaboration with schools</p>	Number of individuals served, collected and reported through CBISA

	events.		
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Goal 3. Reduce morbidity and mortality due to respiratory disease (other than cancer)

Expected Impact: Early identification of respiratory issues like asthma, emphysema and COPD; increased management of respiratory diseases that improve quality of life

Target Population: Community at large; individuals living in rural areas with breathing issues

Collaborators: Healthcare providers

Objective	Strategies	Existing Resources	Measures
1. Increase the number of individuals in rural areas receiving PFT screening for breathing issues	Mobile unit visits for PFT screening	Mobile health unit Trained staff	Number of individuals served, collected and reported through CBISA

Priority Area: Heart Disease and High Blood Pressure

Rationale: According to the American Heart Association, there is a relationship between high blood pressure and heart disease. The excess strain and resulting damage from high blood pressure (HBP) causes the coronary arteries serving the heart to slowly become narrowed from a buildup of fat, cholesterol and other substances that together are called plaque, increasing the risk for atherosclerosis which can lead to a heart attack. In addition, HBP can increase the risk for heart failure and stroke. Heart disease and high blood pressure are grouped together because many strategies can be shared that impact both issues.

Heart disease is the number one killer of adults in the service area. Among adults, 4.8%-8.9% of the population has heart disease, above the national average of 4.4%. Heart disease among the Medicare population is much higher ranging from 30-34%, which is much higher than the national average of 26.5%. The cardiovascular disease rate, per 100,000 population, is also higher than the nation, with Boyd at 158.0, Carter at 145.0, Greenup at 133.6 and Lawrence at 129.9, compared to the United States at

99.6. Mortality from heart disease is also high, with Boyd at 241.6, Carter at 221.8, Greenup at 213.9 and Lawrence at 213.3, compared to the nation at 168.2.

High blood pressure is a contributing factor to many diseases including heart disease, stroke, kidney failure, and vision loss among others. The community survey showed that more than half of respondents felt that high blood pressure was a concern, ranking it at number eight among issues they recommended be addressed. The secondary data showed that HBP was higher than the nation among adults in three of the four counties: Boyd - 33.4%; Carter – 40.3%; Greenup – 32.7%. Lawrence County (26.5%) showed lower than the nation (28.2%).

Goal 1: Reduce coronary heart disease deaths (HP2030 proposed – HDS2030-02)

Expected Impact: increased number of adults with controlled high cholesterol

Target Population: adults, adults with undiagnosed/untreated hypertension

Collaborators: healthcare providers, schools, businesses, etc.

Objective	Strategies	Existing Resources	Measure
1. Improve early detection and treatment of high total cholesterol	Healthy Heart and general health free community screenings Low-cost blood profiles, includes lipids HealthAware risk assessments	Mobile health unit Existing capabilities for blood profiles	Number of persons participating in screenings, blood profiles and cardiac risk assessment tracked through CBISA
2. Increase community education about the prevention of coronary heart disease	Community education through schools and community events	Existing materials Trained staff as volunteers Community collaborations	Number of persons educated about the prevention of coronary heart disease, tracked through CBISA

Goal 2. Reduce the proportion of adults with hypertension (HP2030 proposed – HDS 2030-04)

Expected Impact: increased number of adults with hypertension whose blood pressure is under control

Target Population: adults, adults with hypertension

Collaborators: healthcare providers, schools, businesses, etc.

Objective	Strategies	Existing Resources	Measure
1. Improve early detection and treatment of hypertension	Free community screenings HealthAware risk assessment	Mobile health units Existing capabilities for blood profiles	Number of persons participating in the screenings
2. Increase community education about risk factors and prevention of hypertension	Community education through schools, businesses and at community events		Number of individuals educated/ counseled regarding high blood pressure

Adoption of Implementation Strategy

On November 25, 2019, the King's Daughters board met to discuss the Fiscal Years 2020-2021 Implementation Strategy for addressing the community health needs identified in the 2019 Community Health Needs Assessment. Upon review, the board approved the Implementation Plan strategies.

Communication and Distribution Plan

The King's Daughters Community Health Needs Assessment and Implementation Plan will be posted on the hospital website (kdmc.com) for community review. Upon request, the document will also be distributed, electronically, to all participating community partners, internally to hospital staff and to the King's Daughters Board of Directors.