KING'S DAUGHTERS

Community Health Needs Assessment

Implementation Plan

2016

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

Adopted September 26, 2016

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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 more than 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 September 2015 and March 2016. 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
3. Access to Care
4. Poverty/Unemployment
5. Diabetes
6. Hypertension

King's Daughters will work in partnership with the Healthy Choices, Healthy Communities Coalition 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

KDMC's primary service area encompasses four counties in two states: Boyd, Carter and Greenup Counties in KY and Lawrence County in OH.

Summary of Community Health Improvement Plan Process

The purpose of the Community Health Needs Assessment (CHNA) is to document compliance with the Affordable Care Act, section 501(r) that requires not-for-profit hospitals to conduct a CHNA every three years and adopt an implementation strategy to meet the identified community health needs. The information from these assessments is used to guide the strategic and annual planning process of the organization.

King's Daughters conducted a CHNA in partnership with Bon Secours Kentucky, Our Lady of Bellefonte Hospital and the Healthy Choices, Healthy Communities Coalition. The assessment was conducted from September 2015-March 2016. In addition, KDMC contracted with Dr. Angela Carman, assistant professor at the University of Kentucky College Of Public Health, to facilitate the community forums, provide analysis of the survey results and to guide the prioritization process. Dr. Carman is also a trained facilitator with the Kentucky and Appalachia Public Health Training Center.

The goals of the assessment process were to:

- Determine what various agencies are doing to meet and/or improve healthcare needs in the communities King's Daughters serves
- Learn more about what healthcare needs are not being met and why
- Determine strengths and weakness of current resources
- 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 2016 Community Health Needs Assessment companion document. The findings discussed in the assessment serve as the basis for this implementation plan.

2016 CHNA Identified Needs:

Based on the results of the primary and secondary data collection for the Community Health Need Assessment, the following broad issues were identified:

1. Alcohol/Substance Abuse/Mental Health
2. Unemployment
3. Crime
4. Child and Adult Obesity
5. Access to Care
6. Cancer
7. Homelessness
8. Child Abuse/Neglect
9. Lack of Recreational Opportunities
10. Poverty
11. Diabetes
12. Prenatal Care/Moms who smoke during pregnancy

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

Dr. Angela Carman, UK School of Public Health, presented the secondary data and the results of the survey and focus groups to the Healthy Choices, Healthy Communities coalition that encompasses representatives from all four counties. The health needs were also 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/Tobacco
- Obesity
- Access to Care
- Poverty/Unemployment
- Diabetes
- Hypertension

Health needs unable to meet and why:

While King's Daughters recognizes that child abuse, crime and homelessness are issues for our service area, King's Daughters neither has the expertise or resources to significantly impact these issues. King's Daughters is supportive of other organizations in the community working on crime, homelessness and child abuse and will continue to support them through partnerships, events and sponsorships.

Implementation plan goals, objectives and strategies:

Priority Area #1: Substance Abuse/Tobacco

Rationale: The substance abuse epidemic is growing increasingly worse in Appalachia. The results from the focus groups and surveys placed substance abuse as the top health issue identified by the community. Substance abuse can be defined as alcohol, illicit drugs, prescription drugs and/or tobacco.

The National Institute of Health (NIH) has shown that tobacco use can increase the likelihood of a person using harder, illicit drugs. Some even call tobacco a gateway drug as users have reported using tobacco products or alcohol, prior to illicit drug use. According to the Center for

Disease Control (CDC), nearly all tobacco use begins during youth and progresses into adulthood. The CDC also stated that 9 out of 10 smokers start before the age of 18 and if smoking continues at current rates, 5.6 million—or one out of every 13—of today's children will ultimately die prematurely from a smoking-related illness. Tobacco use, especially smoking, leads to a number of chronic illnesses including cancer, heart disease, stroke, asthma, emphysema and COPD. Tobacco use, primarily cigarette smoking, continues to be the leading cause of preventable disease, disability, and death in the United States.

The abuse of harder drugs such as heroin, pharmaceutical opioids and others were also of great concern to the community. A greater proportion of people in Appalachia abuse prescription drugs and report mental health problems than the nation as a whole, according to a report by the Appalachian Regional Commission. The area's growing drug addiction problems put these individuals at risk for depression, suicides and health problems.

Goal 1: Reduce illness, disability and death related to tobacco/substance abuse.

Objective	Strategies	Resources Needed	Measures
Tobacco Cessation 1. Increase smoking cessation attempts by adults through smoking cessation programs	Offer smoking cessation activities	• Educational materials • Marketing materials • Wellness educator certified in tobacco cessation	Evaluate # of participants in cessation activities; establish baseline in 2017; increase in 2018 and 2019 by 10%.
	Research non-traditional alternatives for smoking cessation support (chat rooms, skype, social media, etc.)	• Information on the alternative methods available	Implement 2 alternate (non-traditional) methods for smoking cessation support in 2017; reevaluate resources and set new goals for 2018-2019

Schools 2. Increase school-based initiatives focused on the harmful effects of tobacco/substance abuse using King's Daughters Wellness Educators	Provide substance abuse education in school districts including tobacco and vaping	• Education materials • Wellness educators • Partnership with Schools	Develop and implement programming among adolescents in 3 school districts 2017-2019.
Partnerships 3. Increase substance abuse community initiatives and partnerships	Place team member on substance abuse work group for Healthy Choices, Healthy Communities coalition	• Team member to actively participate • Work group times and location	Partner with Pathways and/or Healthy Choices, Healthy Communities coalition at least once annually on substance abuse events/activities;
	Partnership with Pathways on Lunch and Learn series (including case managers and social workers) to learn about services offered and the referral process	• Representatives from Pathways • Time/Date/Location/Food • Invitations to potential participants	Host Lunch and Learn with Pathways in 2017
	Provide support to Celebrating Families local initiative	• Staff	Participate in one 12 week Celebrating Families session; reevaluate future

			opportunities after first session
Inpatient Care 4. Provide primary substance abuse detoxification in King's Daughters Behavior Medicine Unit	Provide beds for substance abuse users that request detox	• Beds • Education among staff	Classify 4 inpatient beds as primary detox in 2017; Serve 75 substance abuse users in FY17; increase 2% in 2018 & 2019
	Create linkages and referrals to community addiction services including Pathways, Alcoholics Anonymous & other long term support systems	• Knowledge of community addiction services available • Staff	Refer 100% of successful detox candidates for further treatment

Priority Area #2: Obesity

Rationale: Obesity was a common health need identified through the focus groups, survey and secondary data. Obesity is a contributing factor to many other health issues including cancer, diabetes, high blood pressure and heart disease. By focusing efforts on obesity, it is possible to also impact these other conditions. When considering obesity, it is important to look at the factors that contribute to people becoming overweight or obese. These include poor diet and exercise. Unfortunately, our Appalachian region fares far worse in both states and the nation in most categories. The obesity percentages for the four counties are Boyd (35%), Carter (34%),

Greenup (38%), and Lawrence (36%) all higher than the states KY (31%), OH (29.6%) and the nation (30.4%). These areas also have higher rates for physical inactivity and diabetes.

Goal 1: Promote health and reduce chronic disease risk by providing the knowledge and skills to increase the consumption of fruits and vegetables and other healthy foods for healthful diets and achievement and maintenance of healthy body weight.

Objective	Strategies	Resources needed	Measures
Schools 5. Increase school-based initiatives focused on healthy living (good nutrition and physical activity)	Provide MyPlate, Portion Distortion and other nutrition and/or physical activity programs	• Education materials • Wellness educators	Establish effective school-based programming plan in 2017; increase # of students reached; baseline in FY2016 and target 5% in increase 2017-2019;
	Develop Sustainable Community Healthy Living Challenge	• Education materials • School leaders • Wellness educators/ staff	Implement Community Healthy Living Challenge in 3 schools 2017-2019;
Community Education 6. Improve access to healthy living education at fairs, festivals, schools, screenings and other events	Provide healthy community cooking classes	• Cooking supplies • Location • Education • Recipes • Dietician/Staff • Marketing materials	Evaluate # of people educated about healthy living; establish baseline 2017; target increase by 5% in 2018 and 2019.
	Provide education at health related community events	• Education materials	

	Partner with others in the community to provide nutrition/physical activity education; place a team member on Healthy Choices, Healthy Communities coalition obesity workgroup	• Information about what other community agencies are doing • Workgroup meeting times & location	
Community Access 7. Increase access to healthy foods for vulnerable population	Develop a plan for partnering with food programs such as River Cities Harvest, summer food programs or back pack programs for low cost healthy food options	• Dietician/Staff • List of healthy items	Work with River Cities Harvest & Community Kitchen to serve low cost healthy food options & education in 2017; add 2 additional food programs 2018-2019
Physical Activity 8. Support opportunities for individuals to be physically active	Sponsor or promote events that include physical activity-runs, walks, etc.	• Financial support • Advertising	Sponsor at least 4 events reaching at least 1500 people annually

Goal 2: Improve patient knowledge about the relationship between height and weight through screening, counseling and education in healthcare setting.

Objective	Strategies	Resources Needed	Measure
Inpatient/Outpatient 9. Increase the number of patient contacts that include assessment of BMI	Weight and BMI screening done during office visit	• Educational materials • EPIC build • Provider	Establish benchmark 2017; increase by 2% annually 2018-2019

(HP 2020)		education	

Priority Area #3: Access to Care

Rationale: Lack of access to care can be caused by several factors such as low-income, inadequate health insurance, no health insurance, geographic isolation, poor education and lack of transportation. Due to lack of access to care, people may often go long periods of time without visiting a healthcare professional. Access to quality preventative care and disease management education is critical in minimizing future hospitalizations as well as the seriousness of these diseases. Kentucky participated in the Medicaid expansion providing health care to approximately 700,000 additional individuals. This expansion has been very beneficial for uninsured individuals across the state. Health insurance coverage is also a factor in determining whether patients will seek preventative care or wait for symptoms to become more severe, thus requiring extensive treatments, including hospitalization.

Community status reveals there are significant barriers in access to health care such as poverty, unemployment, low-educational attainment and social barriers. For example, the Center for Healthy Living at King's Daughters stresses the importance of medicine to their diabetic patients. Many can't afford the medicine but luckily have access to a medication assistance program through their providers. However, many can't afford the office visit in order to get the medication assistance.

Access to health care services is a key factor in the health of our community and was identified by the community for inclusion in the implementation plan

Goal 1: To improve access to comprehensive, quality health care services for the achievement of health equity (HP 2020)

Objective	Strategies	Resources Needed	Measure
Schools 10. Increase access to medical care for school students and staff in our school-based clinics	Partner with schools to evaluate absentee rate for both students and teachers; review annual wellness visit data	• Nurse Practitioner • School Nurse/Staff	Evaluate # of annual wellness visits; baseline in FY17; increase by 2% annually

Hospital Setting 11. Improve access to primary care providers	Increase the # of successfully scheduled same day appointments requested by patients in Primary Care setting	• Additional capacity • Additional providers • Extended hours	Improve the primary care same day appointment rates by 1% annually; FY16 baseline 1.4%
12. Increase community access to medical advice/services through 24/7 Care line	Promote that 24/7 Care has free access to nurses to answer medical questions, get advice about needed services, refill prescriptions, etc. (not just for King's Daughters patients)	• Marketing materials • Educational materials	Establish baseline of people served by 24/7 Care line in FY17; increase by 5% annually 2018-2019

Priority Area #4: Poverty/Unemployment

Rationale: Research shows that poverty is linked to poor health outcomes. The U.S. Department of Health and Human Services conducted an analysis and found that

- low-income individuals are especially sensitive to even nominal increases in medical out-of-pocket costs, and modest copayments can have the effect of reducing access to necessary medical care.
- Medical fees, premiums, and copayments could contribute to the financial burden on poor adults who need to visit medical providers.
- The problem is even more pronounced for families living in the deepest levels of poverty, who effectively have no money available to cover out-of-pocket medical expenses including copays for medical visits.

According to the U.S. Census Bureau, approximately 2.86% of the households in our service area receive public assistance income, not including Social Security Income or noncash benefits such as food stamps, compared to Kentucky- 2.53%, Ohio- 3.33% and the United States-2.82%. More than 18% of households receive Supplemental Nutrition Assistance Program (SNAP) benefits, compared to KY- 17.28% and Ohio-14.95% and United States- 12.98%. Within the four county service area 56.81% students are eligible for Free/Reduced Price lunch out of 28,211 total students enrolled.

Goal 1: Improve opportunities for employment among residents in an effort to build the economy and improve overall health

Objective	Strategies	Resources Needed	Measure
13. Promote clinical and non-clinical health careers in the community	Communicate with high schools/colleges about in demand careers Partner with others interested in job promotion (schools, colleges, Ashland Alliance)	• Staff • Education materials	Participate in 4 initiatives annually 2017-2019 Partner with 3 area schools to add the medical assistance and/or certified nursing aid program; 1 or both of programs in 3 schools by 2019

Priority Area #5: Diabetes

Rationale: Diabetes mellitus (DM) is the seventh 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 financial cost of DM in the United States in 2007 was $174 billion, which includes the costs of medical care, disability and premature death.

Our service area of Boyd, Carter, Greenup Counties in Kentucky and Lawrence County in Ohio have a higher percentage of the population diagnosed with diabetes than that of the national average and above Healthy People 2020 targets. Diabetes is also more prevalent as people age. Therefore with an aging population Kentucky and Ohio (like the rest of the nation) can expect to continue seeing high rates of Diabetes.

Goal 1: Reduce the disease and economic burden of diabetes mellitus (DM) and improve the quality of life for all persons who have, or are at risk for, DM. (HP2020)

Objective	Strategies	Resources Needed	Measure
School-based 15. Provide diabetic education and/or testing in schools	Education in schools via King's Daughters school-based health program	• School Nurses • King's Daughters Nurse Practitioner • Education Materials	Evaluate (youth and adult) diabetic needs in schools 2017; implementation plan for 2018-2019
16. Provide a fun, educational environment for diabetic youth	Develop diabetic initiative	• Staff • Financial support • Programming plan	Develop 1 new diabetic youth initiative by FY18

Priority Area #6: Hypertension

Rationale: According to the World Heart Federation, hypertension is the single biggest risk factor for stroke. It also plays a significant role in heart attacks. Our service area and the tristate region as a whole has a 56% higher mortality rate from cardiovascular disease than any other territory in the United States. This is caused by a number of risk factors all related to extraneous variables including lower socioeconomic status, smoking, obesity, lack of exercise and hypertension. The same lifestyle leads to other chronic diseases and comorbidities. According to the CDC's Behavioral Risk Factor Surveillance System (2006-2010), 17.8% of adults in our service area, or 24,287 adults, self-reported that they are not taking medication for their high blood pressure.

<u>Goal 1:</u> Improve cardiovascular health and quality of life through prevention, detection, and treatment of hypertension

Objective	Strategies	Resources Needed	Measure
17. Increase hypertension education among community members	Provide community education at events, screenings, fairs, senior centers, low-income, etc. on one or more of the following: • Risk factors • What high blood pressure means; the result; stroke • Importance of treatment (medicine and follow-up) • How to take a blood pressure • Lifestyle Changes (less sodium)	• Education materials • Marketing materials (social media) • Staff	Evaluate # of people educated; establish baseline 2016; increase by 2% in 2018 and 2019.

		• Education materials • Marketing materials • Staff	Provide 2 hypertension activities in each county annually 2017-2019
18. Increase blood pressure screenings in the community to identify those at risk for hypertension earlier	Include blood pressure screenings in appropriate community events		Provide BP screenings at 2 health events in each county in 2017; 3 events in 2018; 4 events in 2019

King's Daughters Medical Center

The health and wellbeing of the communities it serves has always been a priority for King's Daughters Medical Center. Recognizing the diverse and pressing health needs of the people living in this largely rural service area is the driving force behind everything we do.

KDMC regularly collects surveys and feedback from patients to enhance the healthcare it provides. The medical center also regularly reviews local, regional and national healthcare data to ensure its strategic direction matches the community's needs and any projected state or national changes/trends.

Adoption of Implementation Strategy

On September 26, 2016, the King's Daughters board met to discuss the Fiscal Years 2016-2018 Implementation Strategy for addressing the community health needs identified in the 2015-16 Community Health Needs Assessment. Upon review, the board approved this implementation strategy.

Communication and Distribution Plan

The King's Daughters Community Health Needs Assessment and Implementation Plan will be posted on our 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.