Community Health Needs Assessment
2018 - 2021

Owensboro Health Regional Hospital

1201 Pleasant Valley Road | Owensboro, KY 42303 | (270) 417-2000

https://www.owensborohealth.org

Table of Contents

Listing of Figures and Tables........ 3
Executive Summary........ 4
Acknowledgments........ 6
Letter from Owensboro Health Regional Hospital CEO........ 7
1. Introduction........ 8
1.1 CHNA Report Objective........ 8
1.2 Owensboro Health Regional Hospital........ 8
1.3 CHNA Defined Community........ 8
2. Evaluation of Progress Since Prior CHNA........ 9
3. CHNA Process........ 26
3.1 CHNA Process Overview........ 26
3.2 Collection of Daviess County Data........ 26
4. Daviess County Secondary Data........ 27
5. Community Feedback........ 29
5.1 Community Survey........ 29
5.2 Focus Groups........ 32
5.3 Key Informant Interviews........ 35
6. Selected Priority Areas........ 39
7. Conclusion........ 40
Appendix........ 41

Listing of Figures

Figure 1. CHNA Process Overview.. 26
Figure 2. Vision of What Would be Included in a Healthy Daviess County................ 32

Listing of Tables

Table 1. Demographics.. 27
Table 2. Social and Economic Factors... 27
Table 3. Health Behaviors... 28
Table 4. Health Outcomes.. 28
Table 5. Access to Care.. 28

Executive Summary

Owensboro Health Inc. (OHI) owns and operates Owensboro Health Regional Hospital, a 477 bed hospital in Daviess County, Kentucky. Owensboro Health Regional Hospital (OHRH) is pleased to present its 2018-2021 Community Health Needs Assessment (CHNA). This CHNA report includes health assessment data collected by the Green River District Health Department. OHRH contracted with the Community and Economic Development Initiative of Kentucky (CEDIK) to conduct a CHNA in accordance with the Affordable Care Act (ACA) and section 501(r) of the Internal Revenue Code for nonprofit tax-exempt hospitals. This CHNA is the first report prepared by CEDIK for OHRH. This report will be used to create an implementation plan with wide community input to address the identified health needs for the community served by OHRH over the next three years. The Owensboro Health, Inc. Board of Directors approved this CHNA on May 28, 2019.

Summary of Findings

Methodology

CEDIK facilitated the process of primary data collection through focus groups and key informant interviews to support OHRH in their creation of an implementation plan to address identified health needs. In addition, county specific secondary data was gathered to help examine the social determinants of health. Throughout the process, CEDIK, as did the Green River District Health Department, made it a priority to get input from populations that are often not engaged in conversations about their health needs or gaps in service. CEDIK conducted thirteen key informant interviews to probe more deeply into health and quality of life themes within the county. Potential barriers to accessing community resources were also identified in these interviews.

This CHNA report synthesizes community health needs survey data, focus groups with vulnerable populations, and key informant interview data with social and economic data as well as health outcomes data collected from secondary sources to help provide context for the community. Below are identified themes collected from the primary data collection:

Focus Group Visioning

Residents describe their vision of a vibrant, healthy Daviess County: access to health care and healthy foods; dental care; transportation; inclusive services and programs; parks and physical activity; quality mental health care; strong education system; walkable community; tobacco free policies; air quality; decrease in substance abuse; jobs; services for seniors – home assistance.

Focus Groups – Unmet Needs

CEDIK conducted focus groups in Daviess County to discuss health needs of populations with unmet health needs and to deepen the understanding of the health challenges they face. Focus group discussions revealed unmet needs across the low-income and senior populations. Common concerns across these populations include: diabetes; obesity – in children and adults; smoking; poor diet and lack of exercise; substance use – drugs, alcohol; homelessness; affordability – high cost of health care, low income, housing; mental health – depression, stress, access to care; safety – particularly for elderly; transportation; caregiver support; medication management; transitional services; pain management specialists; dental care – not enough providers who will accept Medicaid; aging population health care – residential treatment for dementia and Alzheimer's, weight loss, nutrition; food insecurity and hunger; cancer; having to travel outside of county

for care; and lack of inclusion in health care discussion for those with disabilities (provider speaks to caregiver instead of the patient).

Key Informant - Community Themes and Strengths

OHRH and CEDIK obtained additional primary data through thirteen supplemental interviews with individuals knowledgeable about health and quality of life needs in Daviess County. CEDIK organized the data into strengths, barriers and opportunities for change for Daviess County. Strengths included collaborative partners; a supportive corporate community that promotes health care and wellness; generous hospital that provides community grants; support of local government; and excellent at coordinating services. Challenges faced by residents include: the health care system does not always understand patient's circumstances – how they choose to access healthcare; transportation needs; not enough mental health and primary care providers; need for more communication of hospital services; and a lack of knowledge about what the hospital is doing in the community. A number of opportunities were highlighted, including new partnerships and collaborations, community openness to prioritizing health and changing mindset; routine care addressing tobacco use and obesity; adult day care and expanded transportation access for rural areas.

Prioritized Areas

Based on survey results, focus group and key informant interview results, as well as key secondary health data, there were five priority areas identified. Existing local, state and national priorities were considered. This information can assist the hospital as implementation plans are developed to address the prioritized health needs. The following priorities were identified as areas of need to address in the next three years:

- **Healthy behaviors – poor eating habits, access to healthy foods, lack of exercise**
- **Obesity and obesity-related diseases**
- **Mental health – depression, counseling and testing for mental health disorders**
- **Substance use – prescription, illegal and illicit substances**
- **Tobacco use and smoking**

A plan for addressing these priority areas will be described in the OHRH Implementation Strategy.

Acknowledgements

This Community Health Needs Assessment is a joint effort by the Owensboro Health Regional Hospital and the Community and Economic Initiative of Kentucky (CEDIK), and builds on the community health improvement efforts of the prior CHNA.

Thirteen key informants shared their time and expertise to provide additional insights on strengths and needs in Daviess County:

- Beth Cecil, Manager of Community Wellness, Owensboro Health
- Bill Bryant, Geriatrician, Owensboro Health
- Brandon Harley, Deputy CEO, Audubon Area Community Services
- Bridget Burshears, Medical Director of Neonatal Intensive Care Unit, Owensboro Health
- Clay Horton, Public Health Director, Green River District Health Department
- Colleen Brey, Oncology Nurse Navigator, Owensboro Health
- Dana Peveler, Executive Director, Senior Community Center of Owensboro Daviess County
- Eric Sharf, CEO, Wendell Foster
- Jennifer Williams, Associate Director for Aging and Social Services, Green River Area Development District
- Mike Flaherty, Mental Health Provider and Owensboro Area Suicide Prevention Coalition
- Rosemary Conder, Executive Director, CASA of Ohio Valley
- Wanda Figueroa, President and CEO, RiverValley Behavioral Health
- Wendi Kozel, District Health Coordinator, Daviess County Public Schools

CEDIK at the University of Kentucky provided assistance with the collection and analysis of primary key informant data and compilation of this analysis. CEDIK works with stakeholders to build engaged communities and vibrant economies. If you have questions about CEDIK's assessment process, contact Melody Nall, CEDIK Extension Specialist: melody.nall@uky.edu or (859) 218-5949.

Owensboro Health Regional Hospital would like to thank CEDIK, Green River District Health Department, all community partners and key informants for their contributions to the information compiled in this document.

May 28, 2019

Owensboro Health Regional Hospital is pleased to present its 2018-2021 Community Health Needs Assessment (CHNA). In partnership with the Green River District Health Department and the Community and Economic Development Initiative in Kentucky (CEDIK), we share with you compilation of efforts to identify and prioritize our collective community health needs. Through collaborative partnerships, grant investments, and strategic efforts, Owensboro Health Regional Hospital and our 4,300 team members will work to address these health needs as we strive to meet the Owensboro Health mission, “To heal the sick and improve the health of the communities we serve.”

The information and findings presented in this report were assembled from an analysis of data, surveys, focus groups, and interviews with key community, social service and health care leaders. The findings reveal that the health issues our communities face mirror many of the same issues faced across our state. Unfortunately, Kentucky is not a healthy state as is evidenced by poor rankings in nearly all health outcomes. Owensboro Health desires to change the trajectory of those outcomes and to be a leader in addressing the difficult health issues and social determinants of health which present barriers to better health and quality of life for the individuals, families and communities we serve.

We want to thank all our partners and participants who assisted us with this Community Health Needs Assessment and look forward to working together to address health issues and disparities together.

Sincerely,

Greg R. Strahan, MHA

President and CEO

1. Introduction

1.1 CHNA Report Objective

The purpose of a Community Health Needs Assessment (CHNA) is to understand health needs and priorities in a given community, with the goal of addressing those needs through the development of an implementation strategy. Owensboro Health Regional Hospital (OHRH) has produced this CHNA in accordance with the Affordable Care Act (ACA) and section 501(r) of the Internal Revenue Service tax code for nonprofit tax exempt hospitals. The results are meant to guide OHRH in the development of an implementation strategy and to help direct overall efforts to impact priority health needs. The Owensboro Health, Inc. Board of Directors approved this CHNA on May 28, 2019.

1.2 Owensboro Health Regional Hospital

Owensboro Health is a nonprofit health system with a mission to heal the sick and to improve the health of the communities it serves in Kentucky and Indiana. The system includes Owensboro Health Regional Hospital. OHRH is nationally recognized for design, architecture and engineering, and is the only hospital in the world to be designated a Signature Sanctuary by Audubon International. OHRH is affiliated with Owensboro Health Muhlenberg Community Hospital, the Owensboro Health Medical Group comprising over 180 providers in 25 locations, a certified medical fitness facility and the Mitchell Memorial Cancer Center. Owensboro Health has been recognized for outstanding care, safety and clinical excellence by The Joint Commission, Healthgrades, U.S. News & World Report and Becker's Hospital Review. For more information, visit owensborohealth.org.

1.3 CHNA Defined Community

For the purposes of this CHNA, OHRH has defined its primary service area as Daviess County, Kentucky. Daviess County will serve as the unit of analysis for this CHNA, and health needs discussed will pertain to residents of Daviess County.

OWENSBORO HEALTH PROGRESS & EVALUATION ON IDENTIFIED PRIORITY HEALTH NEEDS & IMPLEMENTATATION STRATEGY ty 2015-2018

An important additional component of the CHNA is to evaluate the impact of the actions taken to address the significant health needs from your previous CHNA report. In the last report, Daviess County selected the priority areas for action:

1. Substance Abuse
2. Obesity
3. Access to Care

In addition, mental health and dental health were identified as growing concerns. The community decided to incorporate methods of addressing these two areas into ongoing initiatives, rather than focus on them separately. Provided in this update are strategies of which Owensboro Health is utilizing to address these areas.

The following table represents progress made since the approval of the 2015-2018 CHNA. This update represents a summary of initiatives, investments, programs and/or specific outcomes beginning June 1, 2015 to May 20, 2019.

DEFINED COMMUNITY: DAVIESS COUNTY

Significant Health Need Identified in Preceding CHNA	Planned Activities to Address Health Needs Identified in Preceding Implementation Strategy	Was Activity Implemented (Yes/No/other action)	Results, Impact & Data Sources
Obesity Nutrition, weight management, fitness and obesity related diseases.	• Continue to conduct and evaluate school health assessments. Utilize assessment data to make decisions on partnerships and financial support of school efforts to address childhood obesity.	Discontinued in Daviess Co.	**<u>School Health Assessments:</u>** The Healthpark staff has provided school health assessments for local and regional schools. Historically assessments were conducted in Owensboro City Schools, Daviess County Public Schools and Owensboro Catholic Schools. Muhlenberg and McLean County school systems were added in FY 16. The assessments provided a look at student's flexibility, strength, and cardiovascular fitness. In addition the assessment included nutrition questions regarding eating fruits and vegetables, helmet use and exposure to second hand smoke. Determination was made to end conducting the school health assessments in Daviess County and work to determine how assessments could be revised to strengthen the ability to assess the health of students and evaluate findings in order to tailor appropriate programming. Each school system is utilizing its own school and nutrition reports cards to assess their nutritional needs, food insecurity and need to dedicated time and resources to increasing physical fitness for all students. (Assessments for FY 19 took place in McLean and Muhlenberg County schools) One school system has implemented Cross Fit for all freshman and work with students to develop a plan for a lifetime commitment to staying physically fit. Multiple schools have been recognized for their outcomes achieved through the Alliance for a Healthier Generation.

	• Continue to support Owensboro Health Healthpark and its scholarship program providing financial assistance, Healthpark educational programming, outreach and targeted evidence based programming	Yes	Owensboro Health continues to support and operate a medical based fitness facility certified through the Medical Fitness Association. As part of the continuum of care for the organization and those it serves, the Healthpark provides services focused on body, mind and spirit to keep people well and restore health to others. The facility provided community benefit through membership scholarships, educational events, provision of screenings, transportation and provides additional programming and services which directly impact the priority areas of the community. For Fiscal Year 19 the Healthpark health and fitness center provided \$598,740 in discounted fees and charity care memberships for those with documented health risks that can benefit from exercise. In addition, the facility contributed \$130,492 in the form of services, donations and facility rentals (swim lanes/facility rental for swim teams and donations/giveaways to fundraisers and civic groups) to the community. Total contribution is \$729, 232. Contribution per year: FY18 - \$687,725 FY17 - \$ 700,449 FY 16 - \$ 736,212 FY 15- \$1,097,455 Additional examples Support groups /community group meeting space -\$10,800 Transportation with Golden Partners van service –total benefit \$41,272.20 Camp Wheeze Away - \$4354 with staff time and space We currently do not have Power up kids classes going but hope to get that program started back up in the next 6 months to a year. Working to manage childhood obesity, from the nutrition side, we still offer individual nutrition counseling (with a referral from a provider) and see a good number of kids (and their families). **Exercise is Medicine**- Exercise Is Medicine is an eight week supervised exercise program at the Owensboro Healthpark. The program was developed in conjunction with the initiative created by the American College of Sports Medicine to create collaborations between exercise professionals and healthcare providers in the care of their patients. Providers may refer appropriate patients who meet criteria for participation. All participants are assigned to a fitness coach who performs an initial fitness assessment and exercise prescription that is unique for each

		Yes	patient's needs. During the eight weeks, patients must follow the exercise prescription at least three times a week at the Healthpark. Participants also receive weekly contact from their fitness coach to advise, encourage, teach, and support through the program. • Over 1,300 participants have completed the Exercise Is Medicine program with a compliance rate of 81%. • Currently we have 312 referring providers. • Average weight loss over the 8 week program is 5.84 lbs. and a waist circumference decrease of -1.94 inches. • Over 60% of participants see improvement in better blood pressure, decreased waist circumference (heart disease risk), and weight loss. **Lifesteps**- **Lifesteps®**: Lifesteps® is a comprehensive weight management program that offers proven techniques to help participants lose weight and keep it off. The key components of the program are nutrition, physical activity, behavior modification, small group support and personal lifestyle change. Participants meet one time a week for 16 weeks. We also offer the Lifesteps® Reboot program, which is open to anyone who has completed the Lifesteps® program and would like to renew their health goals, recharge their motivation and refresh the skills they learned in Lifesteps®. The Healthpark has 5 people on the education and wellness team who are certified to teach the Lifesteps program. In 2018, 38 people started the Lifesteps program and 19 completed this program. Participants saw an average loss of 8.3 pounds of weight and 7 inches, 1.5% decrease in body fat, and improvement in their blood pressures, some 10-20 point improvement. Currently in 2019, we have 32 people enrolled and active in LIfesteps. See also: **Diabetes Prevention Program**- **Diabetes Prevention Program/ Prevent T2 under Access to Care**

	• Financially support and advocate for community projects and programs which focus on working collaboratively to improve healthy food options; appropriate time for play and exercise, art and music opportunities among others.	Yes	Since the adoption of the last CHNA, OH invested over $212,000 in specific grant funding to community organizations which sought to target obesity through youth and adult programs, policy changes, partnerships with universities, and special populations. OH continued its commitment to having employees serve and participate on local projects, initiatives and other efforts. During this same time period, over $560,000 was allocated to the Arts and Cultural organizations in Daviess County which many, through its programming, promoted better nutrition, participation and engagement in music, increased movement through dance and other art forms and walking tours in our city to view placement of sculpture.
	• Utilize community data to target specific areas of community which could most benefit by changes of policy, structural improvement, and community assets and work in partnership to develop improvement plans.	Yes	Owensboro Health utilized, as did community organizations, the Healthy Communities Institute, a.k.a. Conduent, a community dashboard of indicators to guide programmatic efforts and investments to impact priority health areas during this cycle. Targeting rates of adult obesity, childhood obesity, diabetes and other obesity related diseases allowed for a keener eye and tactics with prioritized population(s). Partnerships with UK and the CDC have resulted in targeted programming for those community members with cognitive or physical disadvantages. Partnerships with NIH, CDC, Western Ky University and other community partners has expanded the scope of work and numbers of persons impacted through what has now been named an evidence based practice, Bingocize® Owensboro Health Healthpark worked to develop a local program specific to older African American adults to address specific health needs they experience. Owensboro Health is continuing to look for opportunities to address social determinants of health, disparate health needs and those who experience them.
	• Serve on local and state task forces related to community development, health and chambers of commerce, workplace health, economic development, health and wellness and the Arts to provide voice for community health improvement.	Yes	Owensboro Health has a number of employees serving on local, state and national task forces, coalitions, Boards and committees to ensure that health planning is and remains a targeted strategic effort. We provide technical assistance, expertise, data, connectivity, and additional resources in our role to serve.
	• Provide expertise from staff to the community for		In November 2016, Owensboro Health launched the Community Requests Portal to provide communities with easier access to needed expertise,

	education and program guidance. • **ADDITIONAL**		knowledge and support to the system to help them impact the health of the communities we serve. This online tool has been refined during this CHNA cycle to allow for greater partnerships, awareness, and engagement between the health system and community. **Bariatric program opening** In early 2018, Owensboro Health began offering surgical weight loss services (formally known as bariatric surgery), at Owensboro Health Regional Hospital. The Surgical Weight Loss Program at Owensboro Health is led by Dr. Ravi Alapati, a board-certified general and bariatric surgeon. The program is comprehensive, offering the full range of needed care and expertise, including dietitian guidance, mental health consultation, an insurance specialist, and more. The program also interfaces with several different areas of Owensboro Health, including primary care and specialist services.

Significant Health Need Identified in Preceding CHNA	Planned Activities to Address Health Needs Identified in Preceding Implementation Strategy	Was Activity Implemented (Yes/No/other action)	Results, Impact & Data Sources
Substance Abuse Tobacco, Alcohol and other Drugs	**Tobacco Cessation:** • Continue to advocate use of the Quit Now Kentucky line through financial support of the Green River District Health Department's Tobacco Control coalition's marketing and media messages to increase number of persons utilizing the quit line.	Yes	Owensboro Health has invested over $89,485 since the approval of the last CHNA to increase access to Nicotine Replacement Therapy through the Green River District Health Department and marketing of the Ky Quit Now coaching line; over $113,000 has been invested since the first project proposal was requested. In addition, Owensboro Health invested in programmatic efforts to assist organizations in assisting those they serve with tobacco cessation programming.
	• Financially support and assist in efforts to have additional persons trained in American Lung Association's Freedom from Smoking evidence based tobacco cessation program.	Yes	Owensboro Health Community Wellness team members received training and are the sole providers of Freedom from Smoking classes in Daviess County. Owensboro Health started offering Freedom from Smoking in 2016 Initially 3 classes were done that year and 2 were conducted in the workplace. 2017- 2 classes, 18 participants, 4 people quit smoking 2018- 4 classes, 30 participants, 10 quit OHRH instituted an electronic referral process for providers to refer to FFS in EPIC, the hospital's EMR.
	• Continue to provide patient, employee, and community education on these resources.	Yes	There is a need to track better outcomes and there are challenges by long term outcome measurement. Currently OH has 3 staff in Community Wellness certified to teach FFS which presents great opportunity. The opportunity also exists to consider the potential for trained tobacco treatment specialists to work with patients and community members. Freedom From Smoking cessation class information and information about Nicotine Replacement therapy is provided to employees, patients, providers, and community members year round.
	• Maintain advocacy of local, regional and state efforts for appropriate policies for tobacco use and second hand smoke reduction.	Yes	Owensboro Health has actively advocated for smoke free laws including passage of an increased tax on cigarettes, 100% tobacco free school districts both of which have now been passed (2018, 2019 respectively) by the Kentucky legislature.

	• Maintain commitment to campus tobacco free policies.	Yes	Owensboro Health is represented on local tobacco control coalitions, the Kentucky Health Collaborative Smoke Free Committee and partners with the Kentucky Cancer Program, Kentucky Lung Cancer Consortium, Kentucky Center for Smoke Free Policy, Markey Community Advisory Board, Foundation for a Healthy Kentucky, Healthy Horizons, and the Owensboro Daviess County Drug Free Steering committee in an effort to maintain its knowledge of tobacco prevention and education, evidence based practices and advocacy needs. Owensboro Health maintains as a requirement of the Community Health Investments Grant Program, that any applicant to this program must show evidence of a 100% tobacco free policy. 37 policies were developed, strengthened, or amended the first full year of implementation.
	• Explore potential to expand early lung cancer screening and provide support o individuals at risk for lung disease.	Yes	In 2012, Owensboro Health was one of the first hospitals in Kentucky to participate in a statewide trial investigating the use of low-dose CT scans for early detection of lung cancer. Today, low-dose CT screenings are covered by most insurance plans and Owensboro Health has worked to increase awareness and participation in screenings for eligible individuals. In 2018, Owensboro Health conducted more than 1,000 low-dose CT screenings at in Daviess and Muhlenberg counties. Of the cancers found, the overwhelming majority were detected early, in Stage I or II. Owensboro Health has invested in research to gain a greater awareness of what messaging resonates with community members and working to assist the University of Kentucky College of Nursing as they train Community Health Workers (CHWs) to work with minority populations in an effort to educate on lung cancer, lung cancer screening, and encouraging those who are eligible to be screened as early as possible. Four CHWs have been trained and all of the four identified the sites where they will teach; 2 African American churches; HL Neblett Center; and with the Burmese population. Six more individuals are scheduled to be trained.

	Alcohol and other drugs:		
	• Continue work with local substance abuse coalitions and community efforts to provide education specific to opiate abuse and heroin use.	Yes	Since the adoption of the last CHNA, OHRH has partnered with local partners to host or participate in multiple community and provider forums as we gained a greater understanding of the scope of this issue, impact on prescribing and magnitude of issues.
	• Support internal policy and processes to educate physicians and other providers on prevention efforts.	Yes	Kentucky's All Schedule Prescription Electronic Reporting system (KASPER) and Owensboro Health are piloting a program that integrates the health system's electronic record system with KASPER data. It dramatically expedites the time it takes to access a KASPER report and enables simplifies access to prescription reporting data. OHI in conjunction with community partners desires to develop and support a comprehensive plan to impact substance abuse and opioid addiction. Owensboro health has committed to the Kentucky Hospital Association's Kentucky Statewide Opioid Stewardship Program which is focused on reducing opioid overprescribing, improving safe opioid use, and will provide a mechanism for hospitals to demonstrate their actions and commitments to their patients and communities to combat the state's opioid epidemic.
	• Continue to use angel Visitation program bringing persons in recovery from community into hospital setting to share recovery options for those in need.	Yes	OHRH partners with members of the local recovery community to conduct angel visits with patients who request someone to come and talk to them about options and resources to get help. Over 219 angel visits have taken place since the last CHNA.
	• Continue to financially support organizations whose missions and abilities and projects are specific to providing substance abuse prevention, treatment and recovery services, housing, education and assistance to address substance abuse through our grant programs.	Yes	OHRH has made over $452,700 in investments to support substance abuse prevention, intervention, treatment and recovery in our communities since the adoption of the last CHNA. Support has been given for programmatic efforts, targeted populations including pregnant mothers and youth, building of transitional living, curriculum, and incentives for tobacco cessation. Owensboro Health provides team members to serve on area substance abuse alliances and coalitions. Advocacy for clean needle exchange program was successful by the local health department.

	• Explore potential collaborative partnerships and projects between Mother Baby/and Neonatal services and community organizations focused on prevention of substance use during pregnancy.		OHRH Mother Baby and Neonatal teams work on ongoing efforts with community partners, organizations and initiatives to address substance abuse. It is a reportable disease in the state of KY when a newborn is exposed to opiates, benzodiazepines, heroin, suboxone/subutex, or methadone during the pregnancy. OHRH keeps these babies for extended lengths of stay. (OHRH statistics are on the rise- we had 19 patients with inutero drug exposure in April, 2019)
			Since 2015 a multidisciplinary internal team has been meeting- Nursing leadership, frontline nursing staff, neonatologist, case management are all consistent attendees.
			• KY START (Sobriety Treatment and Recovery Team previously provided a representative for this team as OHRH has patients that are enrolled in the START program but there is not currently a START or DCBS representative on our team) OH has greater awareness about the program; we hosted a 4 hour Neonatal Abstinence Syndrome (NAS) conference event in 2017 where the START representative was a speaker.
			• In 2019 OHRH has shared the KY Moms program information with our OB physicians and nursing staff which includes information about local workshops.
			  ○ Potential exists to increase our referral practices to the program.
			• Additional opportunities:
			  ○ to improve maternal substance testing as an organization.
			  ○ working on a process to store umbilical cords for all newborns
			  ○ provide information to pain clinic physicians in Muhlenberg County regarding newborn withdrawal.
			  ○ Potential work with U of L research project to assess and manage neonatal abstinence syndrome

Significant Health Need Identified in Preceding CHNA	**Planned Activities to Address Health Needs Identified in Preceding Implementation Strategy**	**Was Activity Implemented (Yes/No/other action)**	**Results, Impact & Data Sources**
Access to Care Primary care, access points, transportation, language, and cultural barriers, financial support for prescriptions, equipment and supplies, care coordination, education regarding benefit enrollment, staff engagement with community team to address access to care.	• As a system continue with present building and construction and future building projects to address shortage of primary care physicians and access points to primary and specialty care.	Yes	**Healthplexes (brief overview)** In January 2019, Owensboro Health opened three new Healthplexes, which were built in Henderson, Hopkins and Muhlenberg counties. Through the addition of these facilities, Owensboro Health was able to expand services and bring new providers and specialists closer to people living in these communities. In addition to primary care and specialist services, the Healthplexes are also home to on-site lab services, urgent care, occupational medicine and diagnostic radiology – including walk-in availability of x-rays and 3-D mammography, as well as scheduled CT scans, bone density scans and ultrasound

	• Continue to pursue primary care residency program.	Yes	In 2018, Owensboro Health announced a new partnership with the University of Louisville to bring a family medicine residency program to Owensboro. Medical residents, who are recently graduated doctors completing required postgraduate clinical experience, will begin practicing in 2020. With six residents per class, there will be a total of 18 new providers by 2023. According to data from the American Medical Association, nearly half of the physicians who complete a residency program end up practicing within 50 miles of the program's location. This will further encourage family medicine physicians to come to and remain in this area, further increasing regional access to primary care in the years to come. The Family Medicine Residency Program has earned accreditation from the Accreditation Council for Graduate Medical Education.
	• Work to provide opportunities for service learning projects and professional educational opportunities which can work in tandem with efforts of community outreach to underserved populations with highest risk of chronic health disease.	Yes	Owensboro Health developed a process to use approved Stoplight Tools for COPD, Diabetes, Heart Failure, Depression, and Signs of infection and sepsis. Simple and brief talking points for COPD, CHF, and Sepsis were made available for nurses to use to educate patients on how to manage their chronic disease. The talking points were also made available through EPIC to be added to the AVS. It is evidence based that the Stoplight Tools are effective in helping patients with chronic conditions to improve their quality of life by better managing their health at home. The Stoplight tools contain a list of up to 7 questions the patient should ask him or herself daily to see if in a green, yellow, or red zone and when to seek medical assistance. Other helpful information, as well, is listed on the back of each Stoplight Tool. The SEPSIS team trained employees to provide community presentations to educate community members on SEPSIS, a significant health issue specifically to vulnerable populations: Matthew 25 (specializes in the treatment of AIDS/HIV); Senior Center of Owensboro-Daviess County and Hancock County; Mental Health and Aging committee; Grand Rounds and Senior Day at the mall. Internal teams are tracking incidence of SEPSIS and will look for and develop strategies to continue our community education outreach. Owensboro Health's Nursing Professional Advancement Program was launched in August of 2018. Its purpose is to achieve excellent patient outcomes through recruiting, developing, and retaining professional nurses in direct care positions. As the program develops, we expect to see an increase in the percentage of nurses with advanced degrees and specialty certifications. The program will also provide opportunities for nurses to develop leadership skills and to support evidence-based practice. As nurses

			get involved in the program, they must complete clinical, educational, and professional projects. One of the professional activities includes a commitment to volunteering in the community. The nurse will volunteer for at least three hours in a health-related activity, i.e. health fair, camp nurse, teaching CPR, providing education, health screening, and many more. The activity organizer is asked to sign an Activity Agreement Form to validate the applicant's work. To date, 48 nurses have achieved professional advancement levels through this program, and an additional 28 nurses have applied for the June review sessions. We are thrilled to see nurses excited about professional development. The anticipated increase in nurse satisfaction and decrease in nursing turnover will have a positive impact on the organization and the communities we serve. **(Also see description for the Community Requests portal under Obesity strategy "provide expertise to the community".)**
	• Target populations and areas of community with highest incidence of diabetes and work in collaboration to provide education and resources.	Yes	**Diabetes Prevention Program**- **Diabetes Prevention Program/ Prevent T2.** Owensboro Health currently has one of only a few of the diabetes prevention programs in Western Kentucky that has received full recognition from the CDC. Our Prevent T2 program is offered at the Owensboro Health Healthpark by trained lifestyle coaches who will help support and encourage you. Prevent T2 is a year-long series of classes geared toward teaching participants simple changes to lower their risk of developing diabetes while promoting healthy weight loss . The course covers topics such as finding healthy foods you enjoy, tracking your food intake, physical activity, eating well away from home, coping with triggers, staying motivated, stress management, and much more. The DPP program itself has not changed but the name of it and the curriculum we use changed from DPP to Prevent T2. We started using Prevent T2 in January of this year (2019). We still often use these names interchangeably. Full CDC DPP recognition achieved in 2017 *Became a Medicare DPP supplier in 2018 *4 cohorts completed to date *40 people have started DPP, 26 have completed it * In January 2019, 70 people joined Prevent T2 and we are offering 4 classes 64 still enrolled and regularly attending class Significant increases in physical activity noted We have recently been hearing from participants that they are

			seeing their A1C levels improve significantly- we won't have an exact number though until the end of this year **Weight loss:** Current weight loss at 4.2% 14 people have exceeded 7% weight loss 10 of those have exceeded a 10% weight loss Current weight loss at 14 weeks = 564.8#
	• Financially support community organizations that provide assistance in easing language, cultural, educational transportation or other barriers to health care services and health improvement.	Yes	Owensboro Health has multiple policies in place to ensure that timely, appropriate care can be delivered to patients who speak other languages. Printed materials are available with brief descriptions in more than 15 languages, telling patients about the service. By pointing to the relevant line on the sheet, they can indicate to staff which language they speak, which then allows staff to access interpreting services. These services, which are always provided free of charge, can be delivered using online interpreting services (informally known as "language line"). The list of languages is also available on Owensboro Health's primary website, increasing online accessibility as well. Managing the health of the population requires the understanding and attention to social determinants of health which can include language barriers but also cultural, educational, financial, and access barriers such as transportation. OH Foundation and OHRH Community Health Grant investments work to address those barriers by partnering respectively with internal departments in supporting unmet needs and external partners to help meet barriers to access. Financial support has been provide to grantees to support and ensure prescription assistance, community transportation for seniors and the refugee population through the International Center, equipment, housing and health literacy.
	• Work with community partnerships to continually seek areas for improvement in care coordination and coordination of community support systems to keep citizens healthy and improve quality of life.	Yes	OHRH facilitates a monthly meeting with community long term care and home health agency providers not only to assist with the transitions of care between hospitals and facilities but to provide educational opportunities, grant opportunities, and partnerships to sustain best practice efforts to streamline transitions of care for all persons ensuring one achieves the highest and optimal quality of life.
	• Ensure financial counselors, navigators, and case	Yes	Owensboro Health ensures financial counselors are in place to provide patients and community members with information about signing up for

Significant Health Need Identified in Preceding CHNA	Planned Activities to Address Health Needs Identified in Preceding Implementation Strategy	Was Activity Implemented (Yes/No/other action)	Results, Impact & Data Sources
	managers are available to work with patients and community members in understanding financial assistance; benefit enrollment; available community resources to prevent barriers to access; and understanding of the healthcare system and how to access care.		insurance through the exchange and other access points; works with other entities to provide that assistance. This is important as multiple access points for many services across the continuum are then opened up inside and outside the walls of the hospital. Counselors provide resource information. OHRH invests over $100,000 annually for counselors to provide this assistance to community members, patients and families.
Mental health	Provide support to community regarding named priority health issue.		As part of the commitment to implement strategies to address Mental Health and Access in our communities, an identified priority health-need, Owensboro Health Regional Hospital partnered with Signet Health in June of 2018. Signet's Leadership Team has a combined average of 28 years of experience in Mental Health in hospitals across the nation and brings the highest level of operational expertise and experience in this field. The scope of services with this partnership include; Community Education and Internal Educational Programming, Physician Recruitment, Strategic and Business Planning. OHRH began telemedicine at the Healthplexes which further expands access to care, especially to specialty services like mental health care, which might not otherwise be available. OHRH has made over $287,620 in grants to community partners to address mental health. Great emphasis has been placed on building a trauma informed community based on the Adverse Childhood Experiences research, hosting suicide prevention training (ZERO Suicide), partnering to support expansion of Mental Health First Aid throughout the region, support of suicide prevention educational conferences, DBT, EMDR,PEARLS program for older adults, provision of support for mental health staff in school settings, programs to reduce stigmas attached to mental health issues.

Dental health	Provide support to community regarding named priority health issue.		Owensboro Health has invested the Community Dental Clinic since 2013. Since that time they have served over 14,000 low income individuals, adults and children who may be eligible for Medicaid but have no dental insurance or regular dental provider. The clinic provides education and screenings in the schools and fills a significant gap in the community. Since the last CHNA, OHRH has invested over $245,000 for the community dental clinic and in additional oral health education and outreach efforts.

Owensboro Health has named a Vice-President of Population Health as a part of its strategic effort to strive to meet its mission: to heal the sick and improve the health of the communities we serve.

Owensboro Health has also named priority areas of focus developed to further target specific populations and/or specific strategies related to the community priority health needs. Cross-organizational teams have been created to complement, expand, develop new and partner to create strategies to impact these areas. Those areas are:

Older Adults and Aging- Our aim is to change the culture of care for the aging adult in our region that enables each individual to attain optimal life expectancy with maximal quality of life. OH should strive to become a center for excellence for the aging population.

- Effective Sept. 2018, OHRH is a member of NICHE (Nurses Improving Care for Healthsystem Elders). Training modules are currently being completed. NICHE Goal statement: Implementation of NICHE Geriatric Resource Nurse Model in 10 patient care areas.

  OHRH Nurse Executive committee approved a plan requiring nursing leaders to complete GRN program so that 9 additional patient care areas will have access to a GRN (total of 11)
- OHRH is one of about 100 hospitals/health systems participating in the Institute for Healthcare Improvement's (IHI) Action Community Age-Friendly Health Systems initiative; Two NICHE units and three additional units are participating; focus is implementing changes directed at "4M's"- what Matters to the patient, Medications, Mobility and Mentation.
- Owensboro Daviess County has formed a team to pursue the AARP Age Friendly Community designation. City of Owensboro is submitting Livable Communities application. OHRH serves on that team.
- Owensboro Health serving on multiple community boards serving older adults to better understand efforts and areas for potential partnerships to address this population.
- Senior Center of Owensboro Daviess County developing plans and funding for new building with adjacent affordable housing for seniors. Their desire would be to have an on-site clinic and space for health programming.
- Owensboro Health Director of Trauma Services working with Green River Area Development District Area Agency on Aging (GRADD) to develop Safe Aging Coalition based on OHRH Trauma data indicating significance of falls among older adults 65+

- OHRH Trauma Services will co-chair and develop Safe Aging Coalition under the GRADD Aging Council.
- The Morrisons / OHRH / Owensboro Daviess County Senior Center (formerly the Munday Activity Center) partnership continues to provide weekend meals to seniors in need. (https://www.facebook.com/owensborohealth/videos/stop-the-waste/10156888615999410/) Over 8,900 meals have been provided since the inception of this program to seniors who do not have access to meals on the weekends.
- OHRH is providing technical assistance to the state Department for Aging and Independent Living as they write a federal grant to replicate this program in Kentucky.

- **Tobacco and Related Diseases-** OHI seeks to develop and support a comprehensive plan to impact tobacco use and its related respiratory diseases including lung cancer and COPD.
    - Owensboro Health serves on the Kentucky Health Collaborative (KHC) Tobacco Subcommittee. Advocated for tobacco free legislation, looking at best practices across 10 hospital system; currently reviewing materials which could be used across all 10 hospitals to promote tobacco cessation and lung cancer screening for those eligible. Discussion on Radon as second leading cause of lung cancer has taken place and opportunities for the KHC to play a role in awareness are on the table.
    - KHC is forming an additional subcommittee on Lung Cancer Screening programs on which representatives from Owensboro Health will serve.
    - Owensboro Health hosted in partnership with the University of Kentucky an expert panel presentation for community organizations on addressing tobacco use among vulnerable populations.
    - Better Breathers Support Group launched in May 2019. Developed from COPD subcommittee.
    - Kentucky Community Cancer Awareness Research and Education (K-CARE) Community Health Worker Project has now completed Owensboro focus groups and trained individuals to be Community Health Workers to work with minority populations educating them on lung cancer, lung cancer screening, eligibility and access to lung cancer screening. Tracking protocol will be established to determine the success of this community intervention.
    - Health maintenance and registry up and running.
    - Multiple EPIC / electronic medical record projects supporting our lung cancer screening program have been completed, including a Best Practice Alert (BPA) and Referrals / Tracking Work Queue. Work continues on Lung Nodule / Incidental Findings program.
    - Smoking Cessation / Freedom from Smoking classes are currently being offered by the Owensboro Health community wellness team.
    - COPD materials were reviewed by pulmonary physicians in an effort to achieve consistent, system-wide, patient education materials. As previously noted, OHRH has now adopted the "Stop Light Tool" from Sutter Health and rolled this out in December 2018 to provide for patients with COPD; additional tools were developed for Diabetes, Depression, CHF, Sepsis and Pneumonia.

- UK Research Foundation (FY18 grantee) recently completed a lung cancer screening awareness campaign and research study. Researchers provided results of this study on November 26 2018.Additional time will be given to do additional analysis on the measures.
- Ongoing discussions are taking place regarding the need for additional Tobacco Treatment Specialists at multiple points throughout the system.
- AVS successfully changed regarding harms of tobacco use and tobacco cessation for patients at the point of discharge. The group is also working to develop an updated tobacco cessation resource communication plan (re: Nicotine Replacement Therapy / NRT access. Need to update this status.)
- This team consistently exploring need for additional lung cancer screening education both internally and externally.

- **Children and School Health-** Our aim is to improve health outcomes for children and students while initiating a proactive, comprehensive, and replicable program that includes health education, wellness activities and direct health services.

  - Owensboro Health hosted SPARK-ODC ACES Summit on March 27th, 2019. Over 200 people attended. Dominic Cappello presented at the Summit and the following day at the Owensboro Chamber of Commerce Rooster Booster meeting. There are 10 focus areas for this trauma and resilience initiatives.(1.Mental Health Care, 2.Medical and Dental Care, 3.Housing, 4.Food, 5.Transportation, 6.Parent Supports, 7.Youth Members, 8.Early Childhood Learning, 9.Family Centered Schools, and 10.Job training. Several members of the Owensboro Health team have been playing a key role in this initiative. There are some very exciting projects that will have a direct impact on our patients and the communities we serve.
  - Owensboro Health is participating in the SPARK-ODC (Social Partners Advocating for a Resilient Kentucky – Owensboro-Daviess County) Resilience Leaders initiative, as the first community in the nation to participate in this pilot project. This is a data-driven, cross-sector effort to reduce trauma and increase resilience for the children of our community.
  - Owensboro Health has also been a part of the Public Life Foundation of Owensboro's Early Childhood Education Initiative, working with leaders from across the community.

  - Owensboro Health recognizes the importance of health and wellbeing of our community's youth and role it plays to providing an optimal environment for children to learn. Teaching good health choices and habits is important for children to establish while they are young in order to develop a healthy lifestyle they can take into adulthood. Owensboro Health Medical Group is proud to support local school health efforts for Owensboro City Schools and Daviess County Public Schools through a yearly financial subsidy. OHMG provides a RN and two medical technicians for the Owensboro Catholic School System. For fy19 ytd, the total contribution to school health programs is $377,865.Contributions per year: fy 18- $370,413;fy 17-$375,180; fy 15- $323,630; fy 16- $336,329

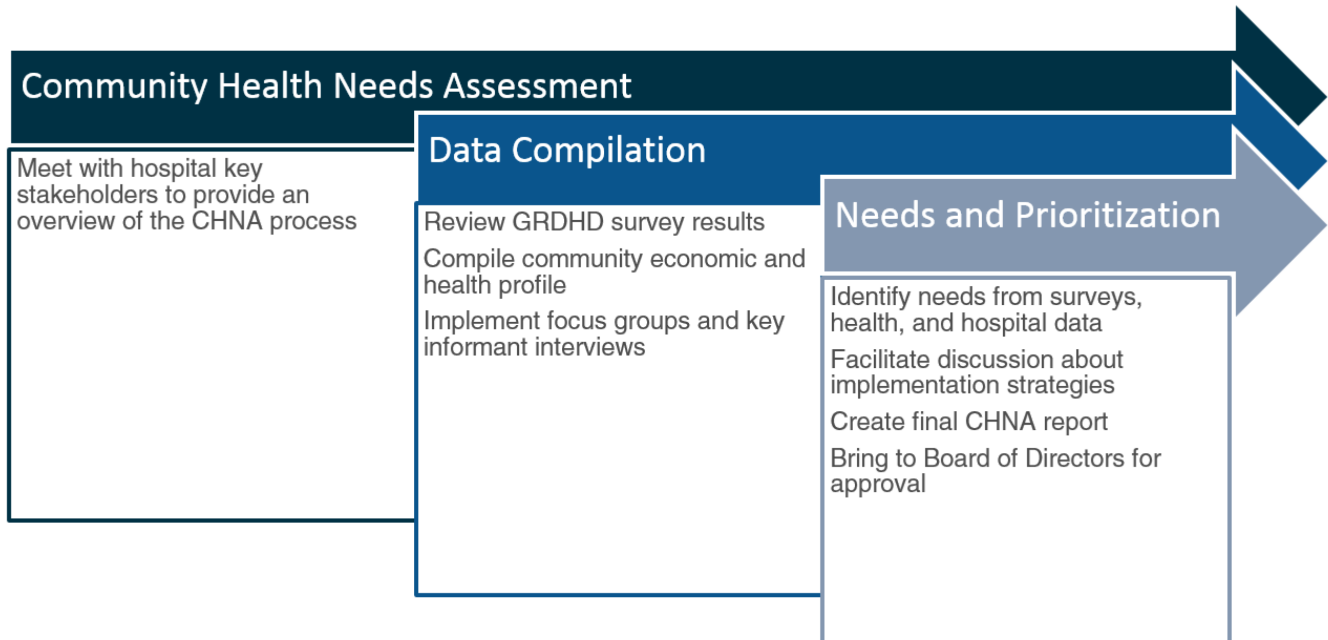
- **<u>Arts in Healing</u>-** Art can play a positive role in the treatment and healing process of those in our care as well as to their caregivers. The vision for this work is to create a healing environment by incorporating various art forms at OH locations and ultimately, to the patient at bedside.
  - OHRH has invested over $560,100 since fy15 in the local arts community as Owensboro Health recognizes the significant role these organizations have on the economic and health outcomes of a community.
  - Two work groups have been created under the Arts in Healing program, Arts at the Bedside and Signature Events.
  - Staff team members have joined the National Organization for Arts in HealthCare.
    - Team members have been invited to participate in the Kentucky Urban Rural Exchange.
  - OHRH hosted statewide conference on Food+Art+Health bringing artists and health professionals together to explore the impact the Arts can have on health, wellness and healing.
  - An Art Cart was developed and launched to provide patients with art experiences while in the hospital. This will be expanded to the ambulatory settings.
  - The Signature Events series continues to take place the first Thursday of each month in the lobby or other designated special space as needed for staff, patients and guests. The team is currently developing strategies to engage employees, physicians and in the patient rooms began featuring live-stream performances from the first floor as we host the Owensboro Symphony Orchestra's Music On Call program, as well as performances by special guests, like the Owensboro Health choir.
  - Bi-directional microphones have been ordered to allow for better recording of signature events so that those offerings can be placed on the Arts Channel in patient rooms. providers as performers for future events.
  - OHRH created an Arts channel in in the patient rooms began featuring live-stream performances from the first floor as we host the Owensboro Symphony Orchestra's Music On Call program, as well as performances by special guests, like the Owensboro Health choir.
  - Signature events are now being recorded so that those offerings can be placed on the Arts Channel in patient rooms.

3. CHNA Process

3.1 CHNA Process Overview

Here is an overview of the CHNA process that CEDIK uses based on the IRS guidelines:

Figure 1. CHNA Process Overview.



3.2 Collection of Daviess County Data

The assessment process included collecting secondary data related to the health of the community. Social and economic data as well as health outcomes data were collected from secondary sources to help provide context for the community. Data sources are listed next to the tables and further information (when available) is in the Appendix.

4. Daviess County Secondary Data

Below is the demographic, social, economic and health data that were compiled for Daviess County. The secondary data in this section were retrieved from the *Owensboro Health Community and Demographic Dashboards* in November 2018.

Table 1. Demographics.

Indicator	Daviess County	Kentucky
Total Population	100,379	4,456,503
Percent of Population under 18 years	24.0%	22.6%
Percent of Population 65 years and older	17.2%	16.3%
Percent of Population Non-Hispanic White	91.3%	87.6%
Percent of Population Non-Hispanic African American	5.1%	8.5%
Percent of Population Hispanic	3.1%	3.7%
Percent of Population Other Race	1.5%	1.5%
Percent of the Population that are Female	51.4%	50.8%

Table 2. Social and Economic Factors.

Indicator	Daviess County	Kentucky	National Level
Median Household Income	$46,675	$44,811	$55,322
High School Graduation Rate	90.2%	89.7%	84.1%
People 25 and Older with a Bachelor's Degree or Higher	21.2%	22.7%	30.3%
Violent Crime Rate (per 100,000 population)	193.3	240.4	163.2
Percent of Population with Severe Housing Problems	12.2%	14.4%	18.80%
Unemployed Workers in Civilian Labor Force	3.8%	4.1%	n/a
Child Food Insecurity Rate	17.7%	19.2%	n/a
Percent of Children Eligible for Free Lunch Program	51.7%	54.5%	42.6%
Children Living Below Poverty Level	22.9%	25.7%	21.2%
Single Parent Households	34.5%	34.6%	33.6%

Table 3. Health Behaviors.

Indicator	Daviess County	Kentucky	National Level
Percent of Adults who Smoke Regularly	25.0%	25.2%	17.1%
Percent of Adults who are Obese (BMI>=30)	29.5%	33.4%	29.9%
Access to Exercise Opportunities	76.5%	72.4%	83.1%
Adults who Binge Drink	10.4%	14.2%	16.9%
Percent of Alcohol-Impaired Driving Deaths	25.4%	27.6%	29.3%
STDs: Chlamydia Rate (per 100,000 population)	494.7	413.2	497.3
Teen Birth Rate (per 1,000 females ages 15-19)	42.7	37.4	24.3

Table 4. Health Outcomes.

Indicator	Daviess County	Kentucky	National Level
Infant Mortality Rate	6.1	6.7	51
Self-Reported General Health Assessment: Poor to Fair	22.5%	23.0%	16.4%
Percent of Adults who Report Frequent Physical Distress	13.9%	15.6%	15.0%
Percent of Adults who Report Frequent Mental Distress	13.3%	15.4%	15.0%
Percent of Adults with Diabetes	13.0%	13.0%	10.5%
HIV Prevalent Cases	85	n/a	n/a
Death Rate Due to Drug Poisoning	12.5	28.4	16.9
Age-Adjusted Death Rate due to Motor Vehicle Traffic Collisions	15.6	17.1	11

Table 5. Access to Care.

Indicator	Daviess County	Kentucky	National Level
Primary Care Provider Rate (per 100,000 population)	56	66	75
Dentist Rate (per 100,000 population)	58	64	67
Preventable Hospital Stays: Medicare Population (per 100,000 population)	53.3	76.6	49.4

5. Community Feedback

To gather Daviess County resident feedback, OHRH received results from the community health survey the Green River District Health Department (GRDHD) conducted in 2017. CEDIK facilitated other primary data collections with focus groups and key informant interviews. Throughout the process, CEDIK made it a priority to get input from populations that are often not engaged in conversations about their health needs or gaps in service. This CHNA report synthesizes community health needs survey data, focus groups with those representing vulnerable populations and community experts through key informant interviews.

5.1 Community Survey

The GRDHD conducted a community health needs assessment survey in 2017. GRDHD used the CASPER methodology to select respondents for the survey. The methodology applies a multistage cluster sampling to select a “random and representative sample of the population” and has been approved by the CDC as a sampling method for health needs assessment studies. For more details on the selection method please visit http://healthdepartment.org/wp-content/uploads/2016/06/CASPER-Final-Report-2017.pdf

The survey was implemented in all seven counties part of the Green River District, including Daviess County. There were a total of 109 representative surveys for the county. The survey results for Daviess County are consistent with those for the GRDHD overall (see Appendix) and are supported by the feedback received from focus groups and key informant interviews. A summary of the Daviess County survey results can be found on the next page.

2017 Community Survey Results

Daviess County

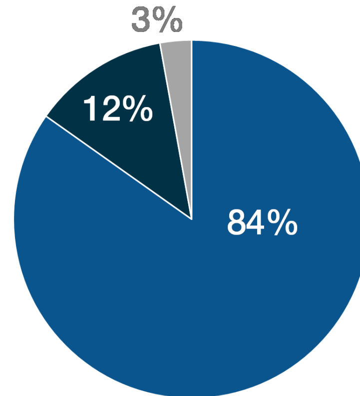
Data collected by the Green River District Health Department
https://healthdepartment.org/

109 Respondents

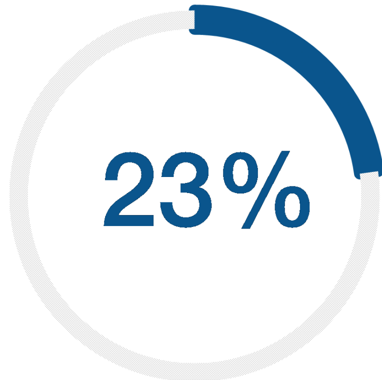
75% of responding households have **easy access to needed medical specialists**.

67% of responding households are **satisfied with the health care system in our community.**

84% of responding households **have a healthcare provider** they see on at least an annual basis, while **12%** of households have some members who see a provider annually, and **3%** do not.

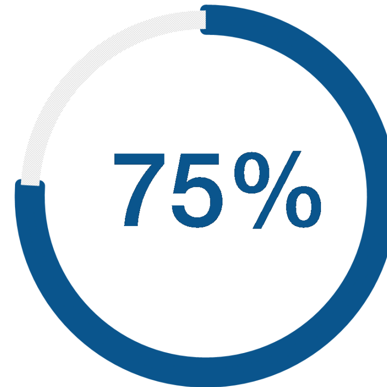


23% of responding households have **delayed needed medical care**.



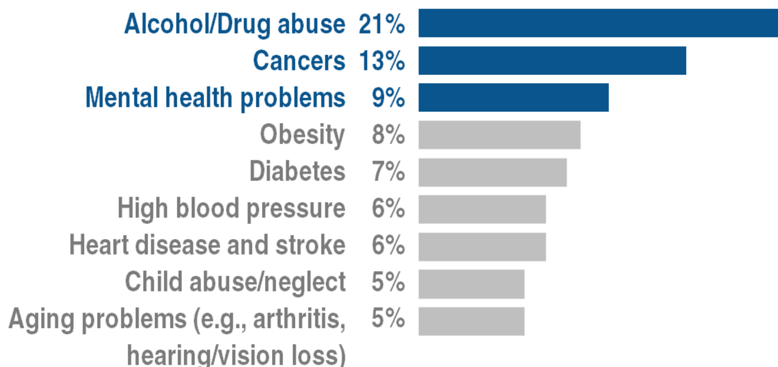
Reasons for delaying care include: Cost (13%), Was not an urgent need (4%), Unable to get off work (1%), Unable to get appointment (1%).

75% of responding households **receive regular dental care**.

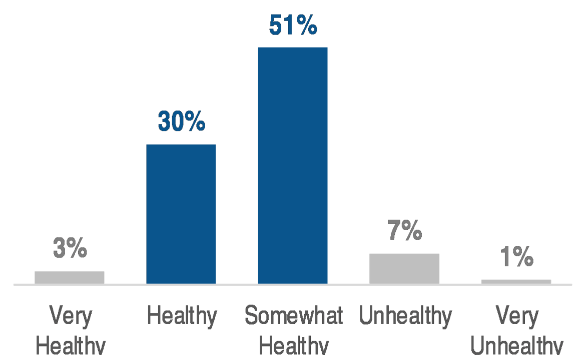


Reasons for not receiving regular dental care include: Cost/insurance (24%), No need for care/ not necessary (4%), Fear of dental treatment (3%).

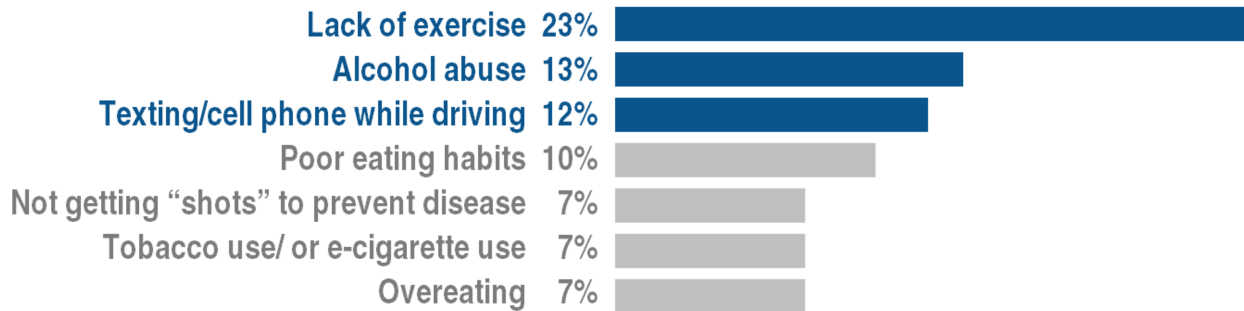
The top 3 most pressing health problems in our community include:



81% of respondents rated the **community's health as healthy or somewhat healthy.**

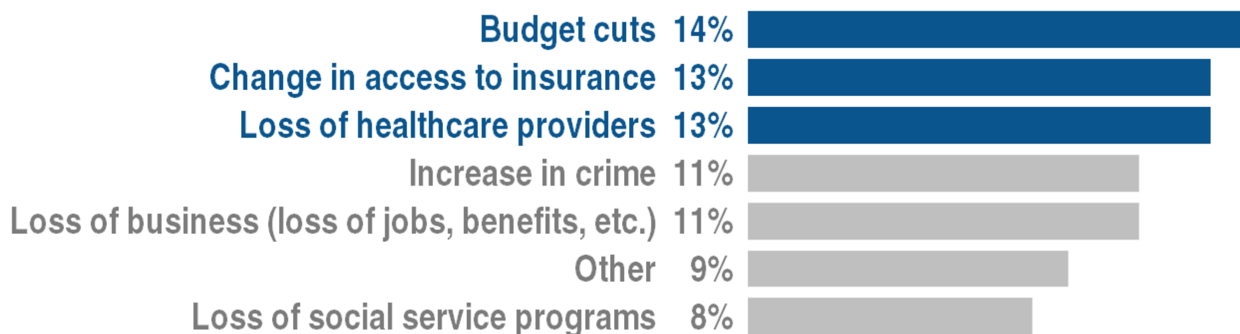


The top 3 behaviors that threaten the health of our community include:

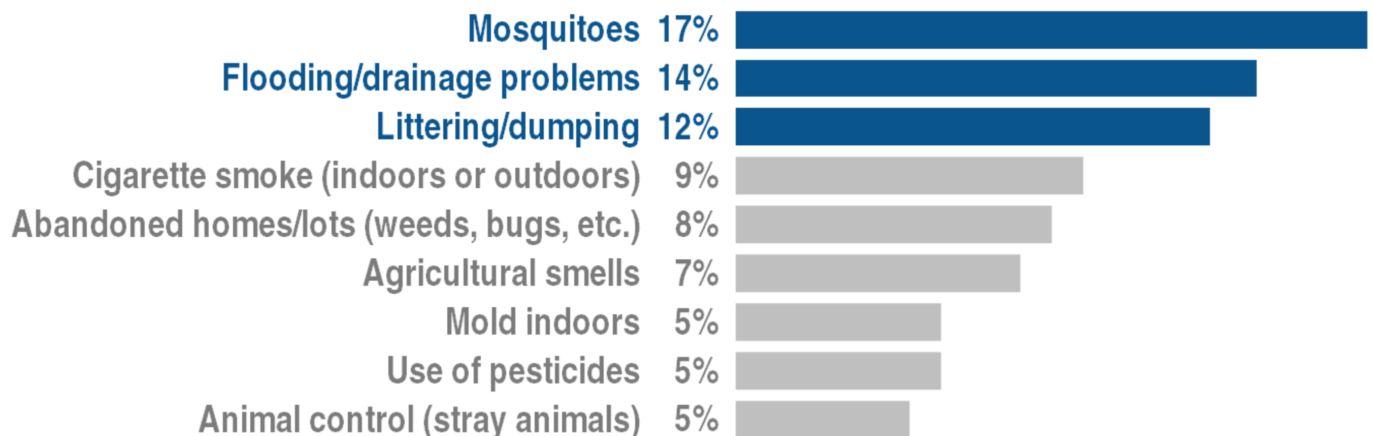


Occurrences that **positively impacted the health** of our community include:

Occurrences that **negatively impacted the health** of our community include:



The following have a **negative effect on the community's environment:**



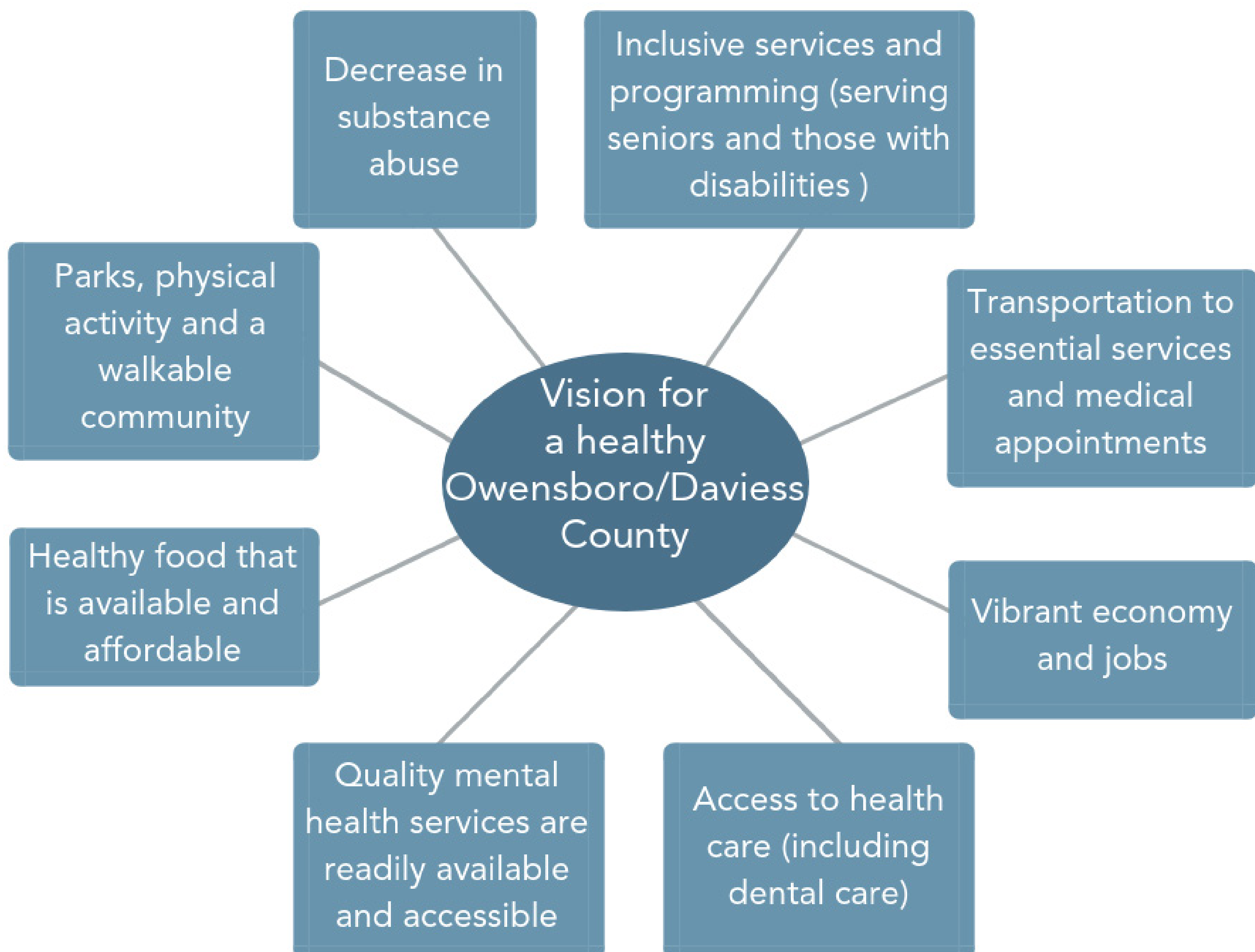
5.2 Focus Groups

Two focus groups, with a total of thirty-one participants, were conducted in the area where Owensboro Health patients reside. The Senior Community Center of Owensboro/Daviess County hosted a senior focused focus group with representatives from eleven organizations including assisted living facilities, social services, transportation services, area development district and others. In addition, the Healthy Horizons coalition, a community health coalition that is celebrating its 20th anniversary in Daviess County this year and comprised of representatives from local government, public health, law enforcement, mental health, health care and others representing underserved populations that include children, families and seniors participated in the focus group. The focus groups were conducted in March of 2019.

Below is a list of questions and topics discussed within the groups as participants shared their thoughts, opinions and healthcare needs.

Each focus group began with asking participants to describe their vision for a healthy Owensboro/ Daviess County. The graphic below illustrates the themes that emerged.

Figure 2. Vision of What Would be Included in a Healthy Daviess County.



What are the most significant health problems in Daviess County?

- Diabetes
- Obesity – in children and adults
- Smoking
- Poor diet and lack of exercise
- Substance use – drugs, alcohol
- Homelessness
- Affordability – high cost of care, low income, housing
- Mental health – depression, stress, access to care
- Safety – particularly for elderly
- Transportation
- Caregiver support
- Medication management
- Transitional services
- Pain management specialists
- Dental care – not enough providers who will accept Medicaid
- Aging population health care – residential treatment for dementia and Alzheimer's, weight loss, nutrition
- Food insecurity and hunger
- Cancer
- Having to travel outside of county for care
- Lack of inclusion in health care discussion for those with disabilities – provider speaks to caregiver instead of the patient

What is your perception of the current healthcare system including the hospital, health department, physicians, EMT, and other essential services in Daviess County?*
*(*Essential services include public utilities, access to healthy food, access to housing, etc.)*

Responses sorted into strengths and opportunities for improvement in the health care system.

Strengths of the health care system in Owensboro/Daviess County:

- Collaborative partners
- Supportive corporate community that promotes health care and wellness
- Generous hospital- community grants
- Support of local government
- Excellent at coordinating services

Opportunities for improving the health care system in Owensboro/Daviess County:

- Perception that the health care system is confusing and intimidating, time consuming and costly
- Health care system does not always understand patient's circumstances- how they choose to access healthcare
- Mistrust of doctors by some patients
- Transportation – more public transportation, more assistance for seniors who need transport to grocery, pharmacy, physician appointments
- Reduce ER use as primary care
- Lack of knowledge of current community resources for residents
- Long wait times to see specialists
- Not enough mental health and primary care providers
- No affordable assisted living
- Community has perception that some services that Owensboro Health offers are not available – need for more communication of hospital services
- Some resources/health care services are out of network making it difficult for patients to see their preferred physician
- Need for a community health focus in Owensboro/Daviess County
- Lack of knowledge about what the hospital is doing in the community

What can be done to better meet health needs of residents in Owensboro/Daviess County?

- Collaboration without duplication – engaging new partners, finding overlap
- Community buy in and making health a priority
- Learning to navigate the health care system
- Culture of health – changing the current mindset
- Health literacy
- Better communication
- Holistic health
- Lessening adverse childhood experiences (ACE's) and trauma
- Addressing obesity during physician appointments
- Physicians recommend that patient stop smoking during routine visits
- Universal and inclusive approach to health care
- Policies related to health – tobacco policy
- Accessibility to transportation in rural areas
- Adult day care options

5.3 Key Informant Interviews

Owensboro Health leadership provided a list of potential community stakeholders or health care providers considered potential contacts for key informant interviews to provide a deeper understanding of health needs in the community. The list of interviews to complete was prioritized based on data from the Green River District Health Department community health needs assessment and the availability of the contact. In total, thirteen key informant interviews were completed representing specialists or providers in the identified need areas. Responses are summarized into four areas that cross cut across populations and age groups throughout the thirteen key informant interviews. Additionally, responses not captured in the summary or easily categorized are listed below each question. Finally, a summary of their responses highlighting the strengths of the community, challenges/barriers in the broader healthcare system and opportunities for improving the community's health.

Participants:

- Beth Cecil, Manager of Community Wellness, Owensboro Health
- Bill Bryant, Geriatrician, Owensboro Health
- Brandon Harley, Deputy CEO, Audubon Area Community Services
- Bridget Burshears, Medical Director of Neonatal Intensive Care Unit, Owensboro Health
- Clay Horton, Public Health Director, Green River District Health Department
- Colleen Brey, Oncology Nurse Navigator, Owensboro Health
- Dana Peveler, Executive Director, Senior Community Center of Owensboro Daviess County
- Eric Sharf, CEO, Wendell Foster
- Jennifer Williams, Associate Director for Aging and Social Services, Green River Area Development District
- Mike Flaherty, Mental Health Provider and Owensboro Area Suicide Prevention Coalition
- Rosemary Conder, Executive Director, CASA of Ohio Valley
- Wanda Figueroa, President and CEO, RiverValley Behavioral Health
- Wendi Kozel, District Health Coordinator, Daviess County Public Schools

Substance Abuse

When asked about significant health issues in Owensboro/Daviess County, almost all interviewees mentioned substance abuse. Alcohol, opioids, methamphetamine, marijuana and tobacco were all discussed. Key informants also identified issues that are effects of substance abuse, such as the increase in grandparents raising grandchildren, adverse childhood experiences, and health issues that arise from secondhand smoke. While speaking with a specialist in the area, she mentioned that co-occurring disorders, such as mental health issues, could be a real barrier for those seeking help from substance abuse. Interviewees repeatedly referenced the lack of substance abuse treatment facilities in the county. In addition, they suggested resources to address substance abuse can take many forms, highlighting drug court as one example.

Mental Health
One key informant noted the high quality of mental health providers in Owensboro, but also stated that there is a high need for providers, such as psychiatrists, in the area. The lack of mental health providers, the stigma surrounding mental health, and the need for behavioral health access were all identified as needs in the community. Case management for those suffering from mental health issues is a real barrier, as it is difficult to stay in contact with providers, maintain medication, while also attending regular appointments. Patients with lower incomes or those on Medicaid may suffer long wait times. There are some support groups, but one key informant hoped to have those services expanded. Providing mental health care to elementary, middle and high school students emerged as a high need.

Obesity and Obesity Related Diseases
Nearly every key informant mentioned obesity, diabetes, or both. Childhood obesity was an identified issue, and many cited poor diet as a cause. Though there are many resources for obesity and obesity related diseases, connecting patients with the resources can serve as a barrier. In many cases, an appointment with a dietician is not covered by a patient's health insurance. Another key informant mentioned that chronic health management, for diseases like diabetes, is a real struggle for vulnerable populations. Obesity creates a higher risk for many other health issues, such as pregnancy.

Healthy Behaviors
The desire for a "culture of health" and more of a "wellness mindset" in the community stood out in the key informant interviews. Participants identified poor diet, lack of access to healthy and affordable foods, the need for nutrition education and wish for more physical activities as health issues within Owensboro-Daviess County. A key informant observed that one of the most significant or common health needs in the community is for public policy that promotes health lifestyles and healthy behavior. Another key informant discussed that many people do not understand wellness in general, and that there are opportunities for education and ways to raise medical and health literacy.

Most significant or common health needs in Owensboro/Daviess County

- Affordable health care
- Access to healthy foods
- Asthma
- Cancer
- Diabetes
- Respiratory illness
- Mental health – trauma informed care, need for behavioral health access, transitional housing
- Chronic health management issues – hard for vulnerable populations
- Heart disease
- COPD
- Transportation
- Lack of health education
- Access to care

- Services and resources for the aging population – many have not been trained in the unique needs of seniors
- Dental care
- Homelessness

Challenges and/or barriers to health in Owensboro/Daviess County

- Dental care that accepts Medicaid
- Lack of mental health providers and care – psychiatric services
- Mental health stigma
- Uninsured patients, what is and is not covered
- Children being raised by guardians without medical authority
- Language barriers
- Need for more primary care providers
- High cost of care
- People traveling outside of Owensboro/ Daviess County for care – and people forgoing care if they cannot travel
- Mistrust of hospital and system
- Need for greater access to behavioral health care
- Specialty care for seniors
- Social barriers
- Long wait times for specialists
- Service gap – those with limited resources but do not qualify for assistance
- Difficult to navigate system
- Education on patient compliance and public health
- Connecting patients to resources
- Poor housing

Identified strengths

- Many services available – community is rich in resources
- Variety of health care facilities
- Raising awareness of the needs for aging population
- Positive collaborations – strong health coalitions in the community
- Health Department is well utilized and has effective programming
- Strong hospital and staff
- Quality care available
- Wendell Foster is a unique resource for community
- Compassionate care
- Progressive community with those willing to work towards solutions for issues
- Healthpark
- Urgent care centers and after hours care
- Support groups
- Community benefit grants are well used within community

Identified opportunities

- More health education – public health, nutrition
- Communication between providers and organizations
- Manage barriers
- Advocate for access to health care coverage
- Be creative in finding solutions to community's needs
- More resources for those facing eating disorders
- Continue to reach and locate more resources for refugee population
- Community health workers
- Utilize telehealth for appointments
- Improving access to transportation
- Medication management
- Increased access to care for minority/ underserved groups
- Free or more affordable dietician – not usually covered by insurance
- More communication about resources offered by system
- Partnership for case management
- More support groups
- Coordinating services

6. Selected Priority Areas

CEDIK reviewed findings from the community surveys, focus groups, key informant interviews and county specific secondary health data.

The process of priority selection followed the Catholic Health Association of the United States recommendations to consider:

- The magnitude of the problem (i.e., the number of people or the percentage of a population impacted).
- The severity of the problem (i.e., the degree to which health status is worse than the national norm).
- A high need among vulnerable populations.
- The community's capacity/willingness to act on the issue.
- The ability to have a measurable impact on the issue.
- Community resources already focused on the issue.
- Whether the issue is a root cause of other problems.

Taking into consideration the survey results, secondary data and community's feedback through focus groups and key informant interviews, the following priorities were identified as areas of need to address in the next three years:

- Healthy behaviors – poor eating habits, access to healthy foods, lack of exercise
- Obesity and obesity related diseases
- Mental health – depression, counseling and testing for mental health disorders
- Substance use – prescription, illegal and illicit substances
- Tobacco use and smoking

7. Conclusion

Daviess County is a community with many assets, with a caring community spirit being an important driver in the approach to community health improvements through collaborative efforts. While there are many areas of need in the county, this report identifies priority areas that Owensboro Health Regional Hospital will use for guidance in planning its community benefit efforts and strategic direction for addressing community health needs. Further investigation may be necessary for determining and implementing the most effective interventions.

An implementation strategy will be developed and rolled out over the next three years; periodic evaluation of goals/objectives for each identified priority will be conducted to assure that progress is on track per the implementation plan.

Community feedback to the report is an important step in the process of improving community health. Please send your comments to Debbie Zuerner Johnson, Director of Community Engagement. Email: debbie.johnson@owensborohealth.org

Appendix

Green River District Health Department Community Survey

Date: ________________ Interviewer Name: ________________________ Household Code:__________

Hello, I am with Green River District Health Department. We are doing a survey on the health of our community and your household was randomly chosen to be a part of the survey. The survey is voluntary and all the information you give will be confidential and will not be linked to you in any way. It should take ___ minutes to complete.

	YES	NO
1. Are you 18 years or older?	❍	❍ Ask if there is someone 18 years or older in the house. Otherwise, do not complete the survey.
2. Would you be willing to participate in the survey?	❍	NO – Thank them for their time. ❍

	Daviess	Hancock	Henderson	McLean	Ohio	Union	Webster
3. Which county do you live in?	❍	❍	❍	❍	❍	❍	❍

	Very Unhealthy	Unhealthy	Somewhat Healthy	Healthy	Very Healthy	Don'tKnow /Refuse
4. How would you rate your community's level of health?	❍	❍	❍	❍	❍	❍

Please indicate your level of agreement with each of the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don'tKnow /Refuse
5. My household is satisfied with the quality of life in our community (consider your sense of safety, well-being, involvement in community life).	❍	❍	❍	❍	❍	❍
6. The community has adequate health and wellness activities	❍	❍	❍	❍	❍	❍
7. My household is satisfied with the health care system in our community.	❍	❍	❍	❍	❍	❍
8. My household has easy access to the medical specialists we need.	❍	❍	❍	❍	❍	❍
9. This community is a good place to grow old (considering elder-friendly housing, transportation to medical services, elder day care, social support for elderly living alone, meals on wheels, etc.)	❍	❍	❍	❍	❍	❍
10. There are networks of support for the elderly living alone in our community.	❍	❍	❍	❍	❍	❍
11. There are jobs available in our community.	❍	❍	❍	❍	❍	❍
12. Businesses, agencies, and organizations contribute to improve and strengthen our community.	❍	❍	❍	❍	❍	❍
13. Our community is a safe place to live. Neighbors know and trust one another and look out for one another.	❍	❍	❍	❍	❍	❍
14. There are support networks for individuals and families (neighbors, support groups, faith community, agencies, and organizations) during times of stress and need.	❍	❍	❍	❍	❍	❍

Date: ____________ Interviewer Name: ____________ Household Code: ____________

15. Does everyone in your household have a healthcare provider they see on at least an annual basis (for check-ups)?	❍ Yes, everyone does	❍ Some household members do	❍ No, no one does	❍ Don't know/Refused
16. Has anyone in your household ever delayed needed medical care?	❍ Yes	❍ No	❍ Don't know/refused	
17. If yes, what was the reason for delaying care?	❍Cost ❍Unable to get appointment ❍Unsure what doctor to see ❍Never delayed care	❍No Transportation ❍Unable to get off work ❍Unable to get childcare		
18. Do all members of your household receive regular dental care (cleanings, checkups)?	❍ Yes	❍ No	❍ Don't know/refused	
19. If no, what is getting in the way of your household receiving regular dental care?	❍Cost/Insurance ❍Unable to get appointment ❍Fear of dental treatment ❍Have access to dental care	❍No Transportation ❍No dentist available ❍ Unable to get childcare ❍Unable to get off work		

20. In the following list, what do you think are the **3 most pressing "health problems"** in our community? **Check only 3.**

☐	Aging problems (e.g., arthritis, hearing/vision loss)	☐	Homicide
☐	Alcohol/Drug abuse	☐	Infant death
☐	Bullying	☐	Infectious diseases (e.g., hepatitis, TB)
☐	Cancers	☐	Mental health problems
☐	Child abuse/neglect	☐	Motor vehicle crash injuries
☐	Dental problems	☐	Obesity
☐	Diabetes	☐	Rape/sexual assault
☐	Domestic Violence	☐	Respiratory/lung disease
☐	Firearm-related injuries	☐	Sexually transmitted diseases
☐	Heart disease and stroke	☐	Suicide
☐	High blood pressure	☐	Teenage pregnancy
☐	HIV/AIDS	☐	Other:
☐	Not Enough Safe Housing		

21. In the following list, which **3 behaviors** are currently a threat to the health of your community? (those behaviors that have the greatest impact on overall community health) **Check only 3.**

☐	Alcohol abuse	☐	Racism
☐	Dropping out of school	☐	Texting/cell phone while driving
☐	Drug abuse	☐	Tobacco use/ or electronic cigarette use
☐	Lack of exercise	☐	Not using birth control
☐	Overeating	☐	Not using seat belts and/or child safety seats
☐	Poor eating habits	☐	Unsafe sex
☐	Poor parenting	☐	Pollution (littering, burning, etc.)
☐	Not getting "shots" to prevent disease	☐	Other:

Date: ____________ Interviewer Name: ____________ Household Code: ____________

22. Have you recently observed or expect any of the following occurrences to impact the health of our community in a positive way?			
☐	Change in Leadership (local government, schools, etc.)	☐	New Businesses/Job Opportunities
☐	Transportation	☐	Money coming into the community (grants, etc.)
☐	New Assistance Program (HELP Office, FRYSC, etc.)	☐	Increase in healthcare providers (primary care, dental, mental, etc.)
☐	Availability of Wellness Programs	☐	New Social Service Programs
☐	Educational Opportunities	☐	Change in access to insurance
☐	Revitalization of City/Area	☐	Change of Laws/Policies/Ordinances
☐	Availability of Youth Activities/Services	☐	Other:

23. Have you recently observed or expect any of the following occurrences to impact the health of our community in a negative way?			
☐	Loss of business (loss of jobs, benefits, etc.)	☐	Budget cuts
☐	Change in Leadership (local government, schools, etc.)	☐	Change in recreational opportunities (closing gyms, unsafe parks, etc.)
☐	Transportation	☐	New Social Service Programs
☐	Loss of healthcare providers (primary care, dental, mental, etc.)	☐	Change in availability of youth activities/services
☐	Loss of Social Service Programs	☐	Change in access to insurance
☐	Decline of community areas (parks, buildings, etc.)	☐	Environmental concerns (pollution, air quality, water quality, etc.)
☐	Increase in Crime	☐	Change of Laws/Policies/Ordinances
☐	Loss of Wellness Programs	☐	Other:

24. Which of the follow have you noted having a negative effect on the environment in your community?			
☐	Drinking Water Issues	☐	Use of pesticides
☐	Sewage Issues	☐	Child Lead Exposure
☐	Flooding/Drainage Problems	☐	Mosquitoes
☐	Abandoned homes/lots (weeds, bugs, etc.)	☐	Animal Control (stray animals)
☐	Littering/Dumping	☐	Rodent Control (mice, rats, etc.)
☐	Transportation Pollution (cars exhaust, etc.)	☐	Unsafe disposal of needles or medical waste
☐	Industrial Air Pollution	☐	Cigarette smoke (indoors or outdoors)
☐	Agricultural Smells ☺ ?????	☐	Radon
☐	Mold indoors	☐	Other:

Thank you very much for your response!

Approval

This Community Health Needs Assessment was approved by the Owensboro Health, Inc. Board of Directors on May 28th, 2019. The CHNA may be accessed on the Owensboro Health website: https://www.owensborohealth.org/health-resources/health-needs-assessment/