COMMUNITY HEALTH NEEDS ASSESSMENT
Tax Year 2024

Owensboro Health Regional Hospital

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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 2024-2027 Community Health Needs Assessment (CHNA). OHRH contracted with Blueprint Kentucky, formerly known as 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 third report prepared by Blueprint Kentucky 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. Owensboro Health Board of Directors approved this CHNA on May 29th, 2025.

Summary of Findings

Methodology

Blueprint Kentucky facilitated the process of primary data collection through community surveys, focus groups and key informant interviews to identify and prioritize health needs. In addition, county specific secondary data was gathered to help examine the social determinants of health. Throughout the process, Blueprint Kentucky and the community steering committee intentionally sought input from populations that are often not engaged in conversations about their health needs or gaps in service. Blueprint Kentucky conducted thirteen key informant interviews to probe more deeply into health and quality of life themes within the county. Current community resources and potential barriers to accessing 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.

Focus Groups – Community Assets

Daviess County residents identified community assets and strengths that contribute to their continued vision for a healthy and vibrant community that encompasses all who live, work and play here. These assets include access to health care, including specialty care, substance use and mental health treatment, educational opportunities for youth, robust collaborations, and partnerships between community organizations, and infrastructure that encourages healthy living. This well-resourced county continues to work together to build a community where youth feel safe and protected, can live drug, tobacco and vape free and can enjoy access to trails, recreation and wellness centers.

Focus Groups – Unmet Needs

Blueprint Kentucky conducted specific focus groups with representatives of organizations in Daviess County that provide services to vulnerable populations that are under resourced or experience unmet health needs. The participants provided a view of health challenges and gaps in health care or essential services. The discussions revealed needs among children/youth, low-income, English as a second language, and senior populations. The needs most often mentioned include lack of affordable housing/homelessness, mental health concerns for adults and youth, substance use disorder, chronic health issues, tobacco use and vaping, barriers to care, and generational poverty. Additional commonly noted health issues discussed include Chronic Obstructive Pulmonary Disorder (COPD), cancer, high blood pressure, obesity and

diabetes. Parenting was mentioned many times as an area for growth. While the county has multiple clinics for primary care some residents have difficulty scheduling appointments or navigating the health care system in general.

Key Informant - Community Themes and Strengths

OHRH and Blueprint Kentucky obtained additional primary data through thirteen supplemental interviews with individuals knowledgeable about health and quality of life needs in Daviess County. Blueprint Kentucky organized the data into strengths, barriers and opportunities for change in Daviess County. Strengths include both health care assets (hospital, health department, federally qualified health center (FQHC), access to specialty care and behavioral health services) and community assets (a strong commitment to collaboration among community organizations, strong relationships through schools, families, and churches that hold the community together.) Barriers to health care include lack of public transportation, low health literacy, stigma related to mental health conditions, dental care access for Medicaid patients, and support for caregivers. The interviews identified several opportunities that could improve the health and well-being of Daviess County residents including public transportation or mobile units, translation services, health literacy and education on navigating the complex health care system, and continued collaboration within the community.

Prioritized Areas

The OHRH Community Health Committee reviewed survey results, focus group and key informant interview results as well as key secondary health data. Members identified current resources and possible barriers to resources that residents may experience. The committee considered existing local and state priorities, conducted an open discussion and voted on prioritized health areas for the county. This information can assist both the hospital and the health department, as implementation plans are developed to address the prioritized health needs.

OHRH Community Health Committee selected the following priority areas for action:

- Lifestyle behaviors (associated with obesity, chronic disease, cancer)
- Mental health
- Addiction (legal and illegal substance use, electronics, gambling)
- Housing
- Food insecurity

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

Acknowledgements

This Community Health Needs Assessment is a joint effort by the Owensboro Health Regional Hospital and the Blueprint Kentucky and builds on the community health improvement efforts of the 2021 CHNA.

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

- Amanda Owen, Puzzle Pieces
- Dr. Andrew Collins, Geriatrician at Owensboro Health
- Beth Benjamin, Owensboro Public Schools
- Brandon Harley, Audubon Area Community Services
- Brittani Roberts, Licensed Professional Counselor Associate
- Claude Bacon, Greater Owensboro Economic Development Cooperation
- Clay Horton, Green River District Health Department
- Jenny Young, Diabetes Educator at Owensboro Health
- Martiza Meeks, H. L. Neblett Center
- Mindy Jones, Mother and Baby Unit Manager at Owensboro Health
- Samantha Taylor Kaii, Audubon Area Community Care Clinic
- Steve Innes, Green River Community Food Warehouse
- Suzanne Craig, Green River Health District Health Department, Daviess County Community Access Project (DC-CAP)

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

Owensboro Health Regional Hospital would like to thank Blueprint Kentucky, all community partners, and key informants for their contributions to the information compiled in this document.

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. Owensboro Health Board of Directors approved this report on May 29th, 2025.

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 Southern Indiana. 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. Owensboro Health Medical Group comprises 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

Owensboro Health Regional Hospital defined its service area for this Community Health Needs Assessment in accordance with the guidance in section 501(r) as Daviess County, Kentucky.

Owensboro Health

April 28, 2025

It is with great pleasure Owensboro Health Regional Hospital presents its tax year 2024-2027 Community Health Needs Assessment. In partnership with Community and Economic Development Initiative in Kentucky (CEDIK) we share with you a compilation of work which sought to identify and prioritize community health needs of which together, through collaborative partnerships, grant investments, and strategic efforts we will work to address as we strive to meet the Owensboro Health mission, "To heal the sick and improve the health of the communities we serve."

The data reflected in this report was collected from an analysis of secondary data, community surveys, focus groups, and key informant interviews. This information was reviewed by the Owensboro Health Community Health Committee, which is comprised of internal hospital and community representatives, and based on those findings the committee has selected priority health issues and social determinants of health which will be focused on over the next three years. Owensboro Health will strive to work collaboratively to improve health outcomes and be a leader in addressing the 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 citizens who assisted us with this community health needs assessment and look forward to working together to address priority health issues, disparities, and the social determinants of health together.

Sincerely,

Mark Marsh
President and CEO

Beth Steele, MSN, RN, FACHE
Chief Operating Officer
Chief Nursing Officer

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2. Evaluation of Progress Since Prior CHNA

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, and Data Sources
Obesity and Related Diseases			
	Establish an OH Obesity and Related Diseases cross-organizational priority team	Yes	OH Obesity team started in November of 2022; is lead by two physician champions and meets monthly. Two subcommittees have been developed, Childhood Obesity and Healthy Choices.
	Offer weight management and nutrition programs both to identified employer groups and community populations.	Ongoing	The Diabetes Prevention Program transitioned to Prediabetes Education and Exercise Program (PEEP). Lifesteps, Exercise is Medicine, and OH Weight Management programs are now offered. Classes are also offered to Connections and employer services. Bariatric support groups are hosted at the OH Healthpark. Outpatient Nutrition visits totaled over 3000.
	Reinstate Kids Weight Management Program	No	Outreach and marketing for this program resulted in little to no interest, therefore the program was not able to continue.
	Explore potential to expand Medical Fitness Programming	Ongoing	Average referrals are 195 a month. Healthpark was able to expand capacity for testing to accommodate increases in volumes. From 2021 – 2024 the number of people joining the Exercise is Medicine increased by 5% and those completing the program increased by 28.8%. Consideration to expand to other locations not possible due to staffing but will continue to be considered for future.
	Expand Outpatient Nutrition Program	Ongoing	Healthpark outpatient dietitians and diabetes educators provide services in Daviess, Henderson, Ohio, Muhlenberg, and Hopkins counties. Both in person and virtual services offered.
	Increase number of cooking classes	Yes	Nutrition 101 and educational videos are online and available within OHRH hospital Sonifi system. Classes offered quarterly and dietitians partnering with Daviess County Extension and Owensboro Regional Farmers Market to offer programs.
	Work with local groceries to conduct store/food tours	Ongoing	Healthpark team members partnered with Healthy Head to Toe and the local Help Office to conduct assessments of available food items to create healthy low cost recipes. In addition a tour of the local Family Dollar resulted in a mapping of healthy low cost food items and how various items could be combined for healthy menus in both English and Spanish.
	Promote healthy food options for Owensboro Health employees	Ongoing	Healthy Choice, a subcommittee of the Obesity and other related diseases, worked with Morrisons to implement feedback survey. From survey healthier menus implemented, healthier food choices offered and education/increased awareness of choices provided. Work at OHRH expanded to Parrish and Healthpark campus sites and implemented with Virgin Pulse (now Personify), Owensboro Health's wellness platform for team members. This work also taken into Physicians Lounge with feedback from Provider well-being survey. Cooking demos and sampling events also scheduled.
	Identify communities within Daviess County with limited resources to participate in physical activity and partner to provide exercise classes facilitated by Healthpark team members.	No	OH is working with Owensboro Parks and Recreation and RiverValley Behavioral Health to develop potential programming.

	Host classes off-site within neighborhoods and communities when feasible.	No	Participation in neighborhood alliance events with education as scheduled. Healthpark hosted Walk with a Doc at local parks. Dogwood Neighborhood Alliance events hosted at Healthpark.
	Host children's relay/obstacle course fun days for children.	No	Continuing to explore events with local Parks and Recreation.
	Establish library of online education topics and tips for community.	Yes	Nutrition 101 and Healthy Tips are available online and in the OHRH Sonifi
	Explore potential to partner in establishment of additional community gardens in Owensboro-Daviess County.	No	Discussion will continue to determine the feasibility of this objective.
	Explore partnerships with community organizations to teach food preservation, canning, freezing to community members and non-profit organizations addressing food insecurity.	Yes	We have explored and initiated a partnership with the local Owensboro Regional Farmers Market and the Daviess County Extension. OHRH has made significant financial investments for the development of a commercial kitchen at the ORFM and in Extension programming for children teaching them about fresh produce and affording them market tokens.
	Continue to support Owensboro Health Healthpark and its scholarship program providing financial assistance.	Yes	Over $1.5 million offered in scholarships to those with documented health need in the last three years. Application process and access changed to allow referred patients to choose two options with medical exercise programs. The two options are Exercise is Medicine or scholarship for member access to fitness center.
	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	OHRH has made financial commitments through its Community Health Investments Grant Program to multiple organizations promoting healthy food options and expansion of programming to address food insecurity, the arts, and physical fitness. OH has made a financial investment in a community food warehouse, which includes cold storage for available food items, including proteins, for area agencies focused on addressing food insecurity.
	Utilize community data to target specific areas of the community which could most benefit by changes of policy, structural improvement, and community assets and work in partnership to develop improvement plans.	Ongoing	OH is working with City of Owensboro Parks and Recreation; OH has formed a housing collaborative that is also taking this objective into consideration.
	Continue financial and in-kind support to address senior hunger via partnership with Morrison's Food Services and Owensboro Senior Community Center.	Yes	This partnership continues and has been enhanced by research from Western Kentucky University. In the future, this partners will seek to develop a replicable "playbook", enhance nutritional intake and physical activity among the recipients.
	Establish no less than one community nursing pod to promote breastfeeding as the optimal source of nutrition for babies reducing barriers to breastfeeding while visiting OH campuses and in community settings.	Yes	Provided financial support to Kentucky Wesleyan College to assist in their efforts to obtain a nursing pod on campus.
	Conduct annual holiday food drive for area food pantries.	Yes	In addition we have added a Spring food and toiletry drive.

	Explore collection of specialty items for specific population needs.	Ongoing	The Mitchell Memorial Cancer Center and the Emergency Department works with both patients and schools respectively to ensure needed specialty items and items of need are obtained and distributed. The annual holiday food drive and spring food drive are now including special requests in the needs list.
	Partner with local school systems to complement holiday/summer food distribution efforts.	Ongoing	Funding has been provided to local community colleges to support student food insecurity.
	Serve with community partner(s) in facilitation of regional meeting to discuss food insecurity as a significant social determinant of health.	Yes	Worked with Neighborhood Alliances to form the NW Neighborhood Food Alliance; ongoing work to support efforts to build a frozen food storage facility; serving on a State committee with the KY Dept of Agriculture Food is Medicine initiative and hosted the Commissioner's Roundtable event working with local farmers, Extension, food distributors and others.
	Serve on local and state task forces related to community development, chambers of commerce, workplace health, economic development, health and wellness and the Arts to provide voice for community health improvement.	Yes	Ongoing and expanded participation from OH Leadership and team members. OH is playing a significant role allowing its team members to be involved with the Harwood Institute Civic Engagement work.
	Provide expertise from staff to the community for education and program guidance.	Ongoing	Healthpark offers regular programming to community with Right Stuff, Doc Is in, and cooking classes. Presentation on health topics and demonstrations are provided with participation in community events and featured at local organizational meetings (i.e. Cooking program for Rotary). Continued partnerships are being secured to expand reach to more targeted groups.
	Continue the Diabetes Prevention Program/Medicare Diabetes Prevention Program and explore expansion opportunities.	Yes	In June 2024, the DPP transitioned to the PEEP. The PEEP program is shorter than the DPP. Cohorts of DPP took place through 2024. Due to challenges of year long program, DPP transition to PEEP, a 12-week program incorporating nutrition, diabetes management education with exercise. Support group for Type 1 Diabetes established through needs identified with local school system. Type 2 Diabetes support group continues to be offered monthly along with a Type 2 Diabetes Essentials class. A system Diabetes Advisory Committee is being established.
Substance Use			
	Develop and initiate a Substance Abuse Priority cross-organizational priority focus team.	Yes	The cross-system Substance Use Priority Team was developed and meets monthly. As a result the After Visit Summary (AVS) and OH website has been updated to provide substance use resource information. Additionally a QR code was developed with like resource information and is provided to all contracted employers and HR to use at their discretion.

	The National Institute on Drug Abuse ranks Kentucky among the top 10 states with the highest opioid-related overdose deaths, and Kentucky's hospitals are on the frontline in the fight to help the state recover. To assist the state's hospitals in this battle, the Kentucky Hospital Association (KHA) is partnering with the Cabinet for Health and Family Services as part of the Kentucky Opioid Response Effort (KORE) to launch the Kentucky Statewide Opioid Stewardship (KY SOS) program.	Yes	Owensboro Health has been an active participant with KYSOS since its implementation. OH reports monthly, monitor and educate based on this data. OH also participates with the opioid measures for HRIP and have been extremely successful in improving those measures.
	As a participant in this initiative, our organization agrees to: Work to improve patient safety in the area of Opioid Stewardship including a specific focus on: the development and implementation of policies and procedures to promote opioid stewardship including:	Yes	OH has policies on pain management and opioid prescribing.
	Increasing community outreach and educating regarding pain management and safe opioid use	Yes	OH has presented at numerous city and county leaders meetings in Daviess County, Henderson County, Grayson County, and Muhlenberg County. OH has also participated in community events educating on Narcan and distribution of Narcan.
	Providing-pharmacologic analgesics options to patients	Yes	OH has created "alternative to opioids" order sets for inpatients at Owensboro Health or patients having outpatient procedures. These order sets allow our providers easily to order those alternatives. Owensboro Health has recently joined the KYSOS program for primary care physicians. OH has a meeting in the coming weeks to discuss further discuss the **outpatient** version of our "alternative to opioids" order set to encourage it's use. These orders sets provide options for non-pharmacological options such as heat, ice, etc. and non-opioid options such as Motrin, acetaminophen, etc.
	Continue opioid stewardship committee	Yes	This committee meets monthly. It is a multidisciplinary team of physicians, pharmacist, nurses/nurse leaders, quality and administration. We also include the health departments in our region and well as River Valley Behavioral Health. Each of them have a standing spot on our agenda each month. This allows us to coordinate efforts to maximum the benefits and work in collaboration.
	Tracking and reporting as required metrics regarding opioid stewardship	Yes	OH reports metrics each month on the Kentucky Quality Counts website. All three of our facilities reports our data each month allowing us to track our progress compared to the state.
	Developing guidelines for opioid use in the inpatient, ambulatory, perioperative, and emergency department settings	Yes	Many of the OH guidelines are based on the KYSOS standards. For example, concurrent e-prescribing, 3 days or less for appendectomies, prostatectomies; zero days for uncomplicated vaginal deliveries, cardiac caths, etc.

	Educating providers, staff, patients, and families to ensure success.	Yes	OH has attended department and physicians meetings to educate on opioid stewardship and the measures we are focusing on. OH also meets in real time with providers. When data reveals a provider failing a measure more than once, Pharmacy meets with these providers to have a one-on-one conversation. This has been very successful andimprovements occur after those meetings. The pharmacy director and pharmacy resident recently presented a one hour Grand Rounds presentation to any staff who wanted to attend. Education is also provided on discharge if going home on pain medications.
	Commitment to collaboration, alignment and coordination	Yes	The state of Kentucky Recovery Ready designation was provided to Daviess County. Nicotine Replacement Therapy (NRT) (grant through OH Foundation), community education on opioid stewardship and NRT availability. Pharmacy works with provider order sets at all 3 hospitals to reduce opioid prescriptions; Narcan availability in partnership with GRDHD, RVBH, Grayson County Health Department and others; KY SOS being rolled out in the clinics, alternative order sets for providers for inpatient and outpatient. Worked with Owensboro Marketing and a 3rd part marketing firm to get out education to our community and team members on the topic of medicinal marijuana.
	Share success stories and lessons learned with other KY SOS hospitals via the KY SOS listserv, webinars, and in-person meetings.	Yes	The OH system has three hospitals in the system who participate in the Pain Management and Opioid Stewardship Steering Committee. Hospitals in the system have been able to learn from each other ways to guide providers to improve in different measures. For example, OHMCH was doing very well in coprescribing. OHRH worked with them and implemented changes at OHRH to improve our data and improve our prescribing.
	Participate in site visits with the KY SOS Advisory Team as requested, which should include the appropriate representative(s) from our hospital's senior leadership.	Ongoing	While a site visit has not been requested, OHRH would be happy to participate in the future.
	Pilot program integrating the health system's electronic record system with KASPER data dramatically expedites the time it takes to access a KASPER report and enables and simplifies access to prescription reporting data.	Yes	Owensboro Health uses EPIC for our EHR and it integrates with Kasper improving our ability to appropriately monitor opioid prescribing to our patients and community.
	Continue work with local substance abuse coalitions and community efforts to provide education specific to opiate abuse and heroin use.	Yes	Updated AVS and OH website to provide resources info; creation of a substance use resource QR code - Medical Review Officer using this for anyone who needs access to these needed resources; Partnered with River Valley Behavioral Health (RVBH), Green River Health Department (GRHD) and Grayson County Health Department (GCHD) to provide services to our communities. They are all active members of our Opioid Stewardship Steering Committee. OH has also participated in local neighborhood alliance events in Owensboro to provide information on opioids and Narcan.

	Support internal policy and processes to educate physicians and other providers on prevention efforts.	Yes	Owensboro Health has held Grand Rounds on the topic, attended PEC meetings and worked 1:1 with providers Pharmacy identified as needed coaching through our data evaluation for KYSOS.
	Continue to use Angel Visitation program bringing persons in recovery from community into hospital setting to share recovery options for those in need.	No	This program ended during COVID and was not resumed.
	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	Investments have been made to support housing specific to pregnant and postpartum women with SUD. Sponsorships have been provided to support recovery programs' efforts to raise funds to maintain and or expand their services. OH has multiple team members serving on community alliances, boards, and committees to address SUD, indicating a commitment of human capital investment.
	Expand collaborative community partnerships and programming between Mother/Baby and Neonatal services and community organizations focused on prevention of substance use during pregnancy.	Yes	There has been significant work initiated in this area. Mother Baby began the 4th Trimester Support group to support post partum women, the I Just Delivered wristband program was begun to provide identification to women who who have just delivered to remind family and health care professionals about the risks of post partum complications. OH has representation on state councils and the regional Maternal Health Council from which additional projects and partnerships are under development to address the needs of pregnant and post-partum women.
	Participate in the development of a Drug Endangered Children Coalition.		OH team members participated in the development of a DEC alliance. The DEC alliance is restructuring and OH will determine what its next participatory level will be.
Tobacco Use and Smoking			
	Review plan for training team members as Tobacco Treatment Specialists to include all OH sites	Yes	Over 10 team members have been trained as TTSs, which includes TTSs at all 3 hospital sites, the Mitchell Memorial Cancer Center, and the Healthpark.
	Financially support Nicotine Replacement Therapy (NRT) program with OH Outpatient Pharmacy to provide NRT products to reduce all barriers to cessation resources.	Yes	Outpatient Pharmacy, through a grant provided by the Owensboro Health Foundation, has provided over $68,000 worth of NRT to patients where cost is a barrier.
	Continue to provide patient, employee, and community education on these resources. Provide information to schools, neighborhood alliances, etc.	Yes	Owensboro Health has representation on the Regional Tobacco Control Coalition. Healthpark team members have met with representatives of Owensboro Catholic Schools to discuss possible cessation efforts for youth. One team member has been NOT on Tobacco certified and is working with youth who have self identified nicotine or tobacco usage. Physician liaisons take TTS and NRT information to all OH and non OH physician practices in the region. AVS was updated to include these resources. Referral processes were put in place for patients and community at large.

	Maintain advocacy of local, regional and state efforts for appropriate policies for tobacco use, nicotine use, vaping and second hand smoke reduction.	Yes	Owensboro Health was instrumental in supporting the City of Owensboro's tobacco free ordinance when a gaming facility was proposed within city limits. Director of Government Affairs provides updates in this area to senior leadership and Population Health.
	Strengthen current campus tobacco free policies and develop new signage for clarity related to electronic cigarettes and vaping.	Ongoing	Signage regarding medical marijuana has been posted at Owensboro Health sites. Signage including verbiage for tobacco free policies has not been strengthen.
	Continue to advocate use of the Quit Now Kentucky line and Public Health's Tobacco Control marketing and media messages to increase number of persons utilizing the quit line and available resources.	Yes	Referrals to the Quit Line are still made when appropriate, but with the successes of the Tobacco Treatment Specialists in combination with Nicotine Replacement Therapies, these are the primary services used.
	Maintain comprehensive tobacco policy requirement for all applicants in the OH Community Health Investments Grant Program.	Yes	The tobacco policy requirements are still in existence for applicants through the large and mini grant programs. As a result, several agencies, including the local community mental health center (RiverValley Behavioral Health) adopted a comprehensive tobacco free policy.
	Continue to expand early lung cancer screening and provide support to individuals at risk for lung disease.	Yes	As of November 2024, 20,000 lung cancer screenings have taken place across the Owensboro Health system. The Love Your Lungs events take place annually at all system hospitals and Healthplexes. A lung tumor board was initiated in October 2024 and meets biweekly. The EON software has been instituted to assist in the process of identifying incidental findings. In September 2023, the Ion robot was purchased, which allows for bronchoscopies to be conducted, which helps to diagnose and treat lung cancer in a less invasive manner.
	Expand educational initiative to understand the synergistic effects of radon and smoking and radon's impact on lung disease.	Yes	For a trial period of time, patients who experienced a cancer diagnosis, radon test kits were available if desired. Depending on the patient's county of residence, testing kits could be acquired either through OH Prevention Services or the Green River District Health Department.
	Continue and expand Better Breathers Clubs.	Yes	The Better Breathers Club at OHRH continues to be one of the most well attended clubs of its its kind across the state. A Better Breathers Club has now been started at Owensboro Health Muhlenberg Community Hospital.
	Continue educational outreach to educate community to reduce stigma of tobacco related diseases.	Yes	The Prevention Services department was created, which has a heavy focus on community and educational outreach centered around tobacco and its related diseases. Outpatient Pharmacy works closely in this area as well with their distribution of Nicotine Replacement Therapies.
	Continue to partner with public health and other organizations to educate OH team members on vaping, JUULs and impact of electronic cigarettes and other non FDA approved tobacco and/or nicotine products in accordance with correlating with a community plan to educate schools, parents and community.	Yes	The NOT program has been created to help youth with tobacco/nicotine dependence. During open enrollment of OH team members, resources are provided related to tobacco and substance use.

	Develop plan and pilot youth tobacco cessation program.	Ongoing	One of the Tobacco Treatment Specialists in the system has been trained in the NOT program. However, a full youth program has not been created.
	Continue to provide Freedom from Smoking classes for community members and identified groups, businesses and industry clients.	Other	Freedom From Smoking classes were offered, but due to low participation, classes were eliminated to provide additional resources for one on one Tobacco Treatment Specialist appointments. TTS option now is a referral option through EPIC. Health Coach referrals have also been added to EPIC to assist with client navigation to programs including smoking cessation. Cessation resource information is included in biometric screening results and individualized resources are provided.
Housing			
	Owensboro Health will develop a screening tool and an implementation Social Determinants of Health screening process.	Yes	The SDOH screening tool was adopted for use in the inpatient setting and launched January 23, 2024. A dashboard has been built and a team dedicated to this work. It is ongoing.
	Owensboro Health will meet with community organizations and entities to gain understanding of affordable housing challenges, homelessness, current resources, current financial need and costs, grant programs, investments, government plans and vision to address housing issues in the community.	Yes	OHRH has helped to form and facilitate a Housing Collaborative which has developed a goal to work together to increase the number of affordable housing units in Owensboro-Daviess County. It is the hope that this model can be replicated in other counties.
	Owensboro Health will use the Community Health Investment Grant Program to provide financial support to programs with sustainable and creative plans to systemically address housing and related issues to housing.	Yes	Targeted investments have been made to support the Housing Collaborative's initiative to meet this goal. Investments have been made to support pregnant moms with SUD, Habitat for Humanity, and precariously housed youth. A significant land donation and partnership with Habitat for Humanity will serve to increase the number of affordable housing units.
	Explore team member engagement opportunities for improving existing housing issues related to maintenance and repair issues.	Ongoing	Ongoing dialogue with community organizations is taking place to ensure their volunteer opportunities are posted on the OH digital bulletin board for team members to review. There are OH team members actively involved and will pursue additional opportunities to meet this objective.
Mental Health			
	Owensboro Health, RiverValley Behavioral Health and the Owensboro Health Foundation will partner to continue utilizing CredibleMind as a population level intervention.	Yes	The OH Foundation assisted in year one of funding the CredibleMind platform. Thereafter it has been a partnership with OHRH and RiverValley Behavioral Health to fund the platform and work to expand the reach of its use. Data has been excellent month after month since launch in use, time used, referrals sources utilized, and # of assessments taken. Will continue to expand plan using CredibleMind as a population level intervention to address mental health. The Healthpark provides CredibleMind information to members, patients and includes at all community events. Posters and cards are provided to all employer client groups for awareness at their worksites. CredibleMind is included in wellness promotion and resources for Owensboro Team members.

	Owensboro Health, RiverValley Behavioral Health and the Green River District Health Department will participate in the American Hospital Association's Hospital Community Learning Collaborative in fy 22 cohort to focus on community mental health.	Yes	The three organizations completed the Learning Collaborative. Made the decision to re-work the steps learned. OHRH developed and initiated a Mental Health Collaborative. The three organizations' efforts was an American Hospital Association Case study has been published in 2025. Work will continue under RVBH leadership. Integration of mental health services is also a priority of the Collaborative's.
	Develop no less than one actionable goal from learning collaborative.	Yes	OH has partnered with RVBH to invest in a multimedia outreach plan to maximize the use of CredibleMind. The American Hospital Association feature a case study with OH, RVBH, and the GRDHD on its joint efforts to address mental health.
	Explore a mental health "community assessment center"	Ongoing	Being explored with CredibleMind, who has developed the capability of such a center.
	Owensboro Health will continue in its partnership with RiverValley Behavioral Health to provide monthly Mental Health First Aid training to all OH team members.	Ongoing	Owensboro Health Employee Assistance Program counselors were trained to offer Mental Health First Aid trainings at OH sites and additional rural areas. 150 team members have been trained thus far.
	Explore potential for embedding mental health professionals in Primary Care offices.	Ongoing	Discussions have taken place and explored but action has not been established.
	Explore potential for embedding a case manager/community health worker or other in Primary Care offices.	Ongoing	An LCSW has been added to the OH Geriatric Service Line, which falls under Primary Care. Discussions will continue.
	Expand partnership with One Mind at Work.	No	Now using CredibleMind as the community / mental health platform.
	Owensboro Health will continue Intensive Outpatient Program using an evidence based curriculum focusing on mental health problems.	Ongoing	This program is budgeted for and expected to address of the community for FY26.
	We will initiate the IOP by hiring one therapist and adding an additional part or full-time therapist as the program grows.	No	Expansion of this program has been a challenge due to spacing constraints provided for the IOP.
	Owensboro Health will serve on the Board and Clinical Care team for the Mental Health Court in Owensboro Daviess County.	Ongoing	Jenni Smith serves on the Mental Health Court Board and the Clinical Care Team for Daviess County.
	We have and will continue to have representation on each of the three community health action teams as they seek to establish and implement strategies to address priority areas.	Yes	Healthy Horizons has restructured it's Community Health Action Teams and OH continues to have representation on them all.
	Owensboro Health Regional Hospital will continue to financially support through our grant program projects and proposals which seek to impact education and barriers to access to mental health.	Yes	OHRH has allocated over $1.3 million dollars through its Community Health Investments Grant Program in the past three years. Mental Health has been a priority for investments during this time with just shy of $750,000. allocated specifically to projects focused on mental health.
	Continue to provide educational opportunities with expertise and knowledge in this area and seek to advocate for policy where most beneficial to meet the identified needs.	Ongoing	OH developed the Mental Health Collaborative and will continue to serve as a partner to this work. OH is currently working toward developing strategies to address pregnant and post-partum moms and their mental health and wellbeing. OH director of Government Affairs informs senior leadership of legislation and policy impacting mental health.

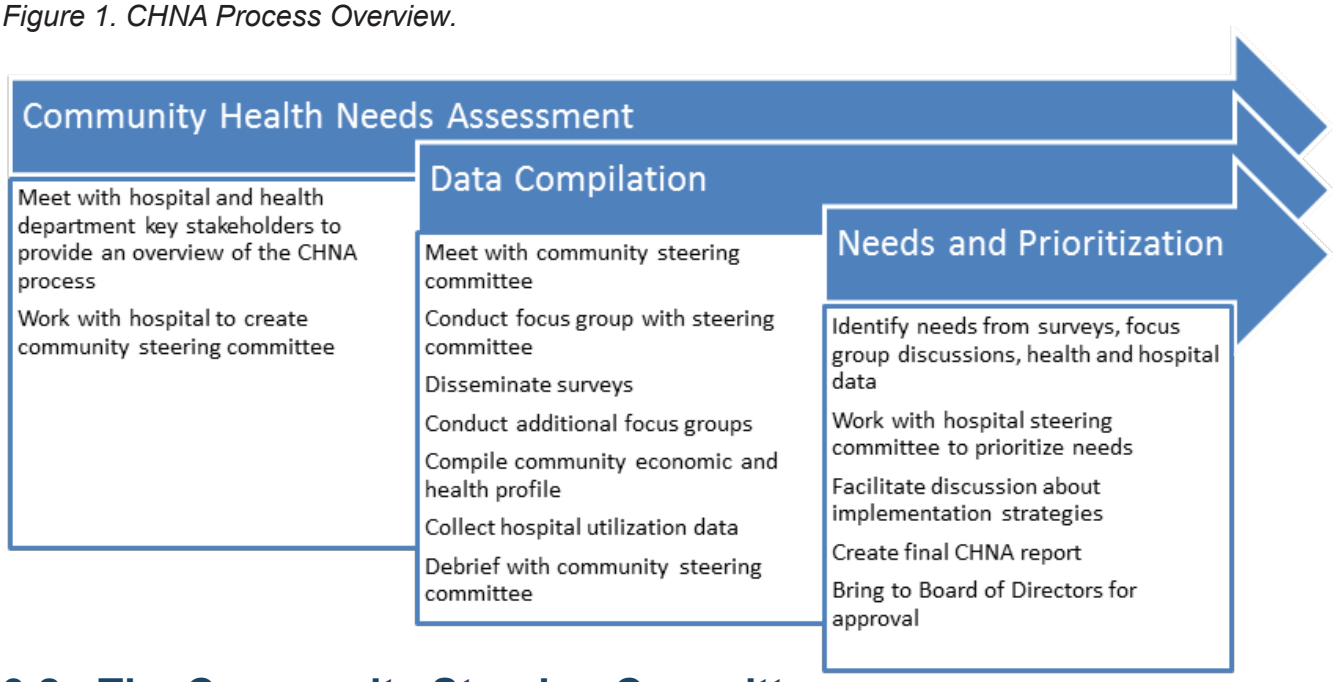
	Strengthen partnerships and outreach with the Arts community as a strategy to impact mental health and wellness as supported by research and literature.	Yes	The Arts in Healing program at OHRH is now under the leadership of the Pastoral Care Director. Signature Series continues. Work began to bring musicians to the bedside at request of a patient and family. Partnerships with local Arts organizations have made this possible. OHRH continues its annual Food+Art+Health event in the summer to build upon the community's awareness of the intersection of each.

3. CHNA Process

3.1 CHNA Process Overview

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

Figure 1. CHNA Process Overview.



3.2 The Community Steering Committee

The Community Steering Committee plays a vital role in the CHNA process. Blueprint Kentucky provides a list of suggested community leaders, agencies and organizations to the hospital and health department to assist them in the recruitment of members that would facilitate broad community input. OHRH chose to have the active Community Health Committee serve as the Community Steering Committee for this CHNA process.

These committee members represent organizations and agencies that serve the Daviess County population in a variety of areas that relate to the health of the residents. By volunteering their time, the committee members enable the hospital to acquire input from residents that are often not engaged in conversations about their health needs. The steering committee provides both an expert view of the needs they see while working with clients they serve and the extensive distribution of the community survey.

Owensboro Health Regional Hospital scheduled the first steering committee meeting where Blueprint Kentucky representatives introduced the assessment process, the role and duties of a committee members and conducted a focus group. Another steering committee meeting was held for the reporting of primary data collected from surveys, focus groups and key informant interviews. After the primary data and secondary health data was presented, the steering committee met to complete a prioritization process of the identified health needs resulting in recommendations for the hospital, health department and community to address over the next three years.

Table 1. 2024 CHNA Community Steering Committee.

Name	Organization
Tom Watson	City of Owensboro, Mayor
Charlie Castlen	Daviess County Fiscal Court, Judge Executive
Clayton Horton	Green River District Health Department, Public Health Director
Rebecca Horn	Green River District Health Department, Accreditation Coordinator and Public Health Services Manager
Brandon Harley	Audubon Area Community Services, CEO
Dr. Wanda Figueroa	RiverValley Behavioral Health, President and CEO
Joanna Shake	Green River Area Development District, Executive Director
Paula Yevincy	United Way of the Ohio Valley, President and CEO
Pattie Martin	Healthy Horizons, Chairperson
Beth Steele	Owensboro Health, Chief Operating Officer and Chief Nursing Officer
Debbie Zuerner	Owensboro Health, Director of Community Engagement
Brian Hambry	Owensboro Health, Director of Marketing
Kelly Armour	Owensboro Health, Director of Employee Engagement
Nicole Leach	Owensboro Health, Community Engagement Supervisor
Seth Sharp	Owensboro Health, Wellness Coordinator
Dr. Jim Tidwell	Owensboro Health, Vice President of Population Health

3.3 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

The assessment process included collecting secondary data related to the health of the community. Social and economic data as well as health outcomes and providers data were collected from secondary sources to help provide context for the community (see below). Finally, with the assistance of the Community Steering Committee, input from the community was collected through focus groups, key informant interviews and surveys.

First, we present the demographic, social, economic and health outcomes data that were compiled through secondary sources. Tables 2 through 8 contain data retrieved from the County Health Rankings website. Table 9 provides data from KIPRC, and Table 10 includes data from the Kentucky Cancer Registry. For more information on data sources, please see the Appendix.

Table 2. Demographics.

Indicator	Daviess County	Kentucky	National Level
2022 Population Estimate	103,222	4,512,310	333,271,411
Percent of Population under 18 years	24.1%	22.3%	21.7%
Percent of Population 65 year and older	18.1%	17.6%	17.3%
Percent of Population Non-Hispanic White	86.8%	83.2%	58.9%
Percent of Population Non-Hispanic Black	4.9%	8.4%	14.1%
Percent of Population Hispanic	0.1%	4.3%	19.1%
Percent of Population Asian	2.3%	1.8%	6.3%
Percent of Population American Indian & Alaska Native	3.6%	0.3%	1.3%
Percent Native Hawaiian/Other Pacific Islander	0.2%	0.1%	0.3%
Percent of the Population not Proficient in English	1.3%	1%	8.2%
Percent of the Population Female	50.9%	50.3%	50.4%
Percent of the Population Rural	26.0%	41.3%	13.8%

Indicator	Daviess County	Kentucky	Top US Performers
Table 3. Physical Environment			
Average daily density of air pollution - PM 2.5	8.7	8.2	5
Presence of drinking water violations	No	n/a	n/a
Percentage of severe housing problems with at least one of the following; Overcrowding, high housing costs, or lack of kitchen or plumbing facilities	14.0%	13%	8%
Percentage of workforce driving alone to work	84.8%	73%	70%
Percentage of workforce commuting alone for more than 30 minutes	20.0%	31%	17%
Table 4. Social and Economic Environment			
Percentage of adults ages 25 and over with a high school diploma or equivalent	91.2%	88%	96%
Percentage of ages 25-44 with some post-secondary college	64.0%	63%	73%
Percent of unemployed job-seeking population 16 years and older	3.9%	3.9%	2.6%
Percent of children in poverty	14.6%	21%	11%
Income inequality ratio	4.6	4.9	3.7
Percent of children in single-parent households	22.8%	25%	13%
Median household income	$65,949	$59,246	-
Social association rate per 10,000 population	12.6	10.2	18
Injury death rate per 100,000 population	75	106	64
Table 5. Food Access			
Percentage of population who lack adequate access to food	11.5%	12.9%	-
Percentage of population who are low-income and do not live close to a grocery store	5.6%	6.4%	-
Percentage of children enrolled in public schools that are eligible for free or reduced-price lunch	57.0%	56.9%	-

Indicator	Daviess County	Kentucky	Top US Performers
Table 6. Clinical Care			
Percent uninsured adults	7.3%	7.9%	-
Percent uninsured children	4.0%	3.8%	-
Primary care provider ratio	1,808:1	1,601:1	1,030:1
Dentist ratio	1,518:1	1,502:1	1,180:1
Mental health provider ratio	314:1	342:1	230:1
Preventable hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees	2,840	3,457	1,558
Percent of population FFS Medicare enrollees receiving flu vaccinations	51%	44%	53%
Percent of female Medicare enrollees ages 65-74 receiving mammography screening	50%	42%	52%
Table 7. Health Behaviors			
Percent adult smokers	21.0%	20%	14%
Percent obese adults with BMI >=30	41.9%	41%	32%
Percent physically inactive adults	29.1%	30%	20%
Percent of population with access to exercise opp.	87.1%	70%	90%
Percent of adults excessively/binge drinking	15.1%	15%	13%
Percent of driving deaths due to alcohol impairment	33.3%	26%	10%
Chlamydia rate (newly diagnosed) per 100,000 pop.	487.1	410.3	151.7
Teen birth rate (ages 15-19) per 100,000 pop.	28	26	9
Drug overdose mortality rate per 100,000 pop.	17	43	-
Motor vehicle crash deaths per 100,000 pop.	14	18	-
Table 8. Health Outcomes			
Premature death rate (under age 75) per 100,000 pop.	9,463	11,055	6,000
Child mortality rate (under age 18) per 100,000 pop.	54	59	-
Percent of live births with low birth weight	8.5%	8.9%	6%
Percent of population in fair/poor health	19.5%	21.1%	13%
Physically unhealthy days	4.5	4.5	3.1
Percent of population in frequent physical distress	13.2%	14.0%	-
Mentally unhealthy days	5.4	5.5	4.4
Percent of population who are diabetic	10.3%	12.4%	-
HIV prevalence rate	115	214.5	-

	2019	2023
Table 9. Substance Use Rates, Daviess County		
Any Drug-Involved Fatal Overdose, rate per 100K population	9.8	22.2
Any Drug-Involved Non-Fatal Overdose, rate per 100K population	302.3	304.5
ED Visit with a SUD Diagnosis, rate per 100K population	1478.0	1849.1

Table 10. Top 10 Invasive Cancer Incidence Rates

All Genders, All Races, 2018-2022	Daviess County	Crude Rate	Age-adjusted Rate
Total all sites over five years ('18-'22)	**3,249**	**631.5**	**504.6**
Prostate (males only)	368	145.5	113
Lung and Bronchus	562	109.2	82.6
Breast	409	79.5	65.6
Colon & Rectum	260	50.5	41.7
Melanoma of the Skin	244	47.4	40
Kidney and Renal Pelvis	181	35.2	29.6
Urinary Bladder, invasive and in situ	151	29.4	22.5
Non-Hodgkin Lymphoma	132	25.7	20.8
Corpus Uteri (females only)	59	22.6	17
Pancreas	102	19.8	15.6

Next, we present data trends from 2019-2024 for several of the County Health Rankings variables in the prior tables. The blue lines represent Daviess County's data, and the gray lines are the Kentucky average for comparison. Further, each graph includes a title of the data, and either a yellow circle or green diamond that helps the reader quickly determine if the data indicate an improving trend (green), or a worsening trend (yellow). Note that food insecurity is a measure that has an inverse effect. For more information on data sources, please see the Appendix.

Figure 2. Health Outcomes
Note: Daviess County is in **blue**, the Kentucky average is in **gray**.

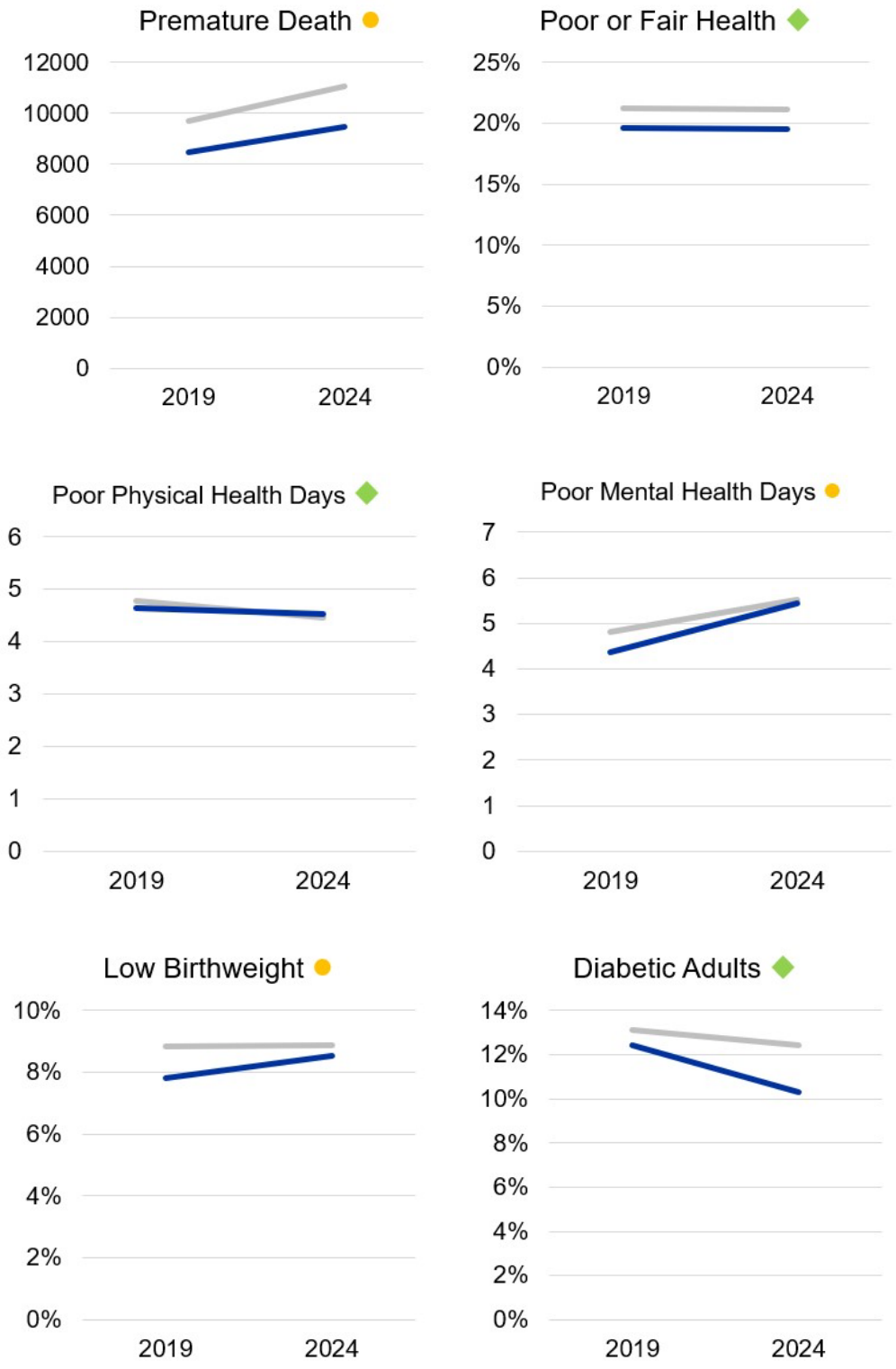


Figure 3. Health Behaviors
Note: Daviess County is in **blue**, the Kentucky average is in **gray**.

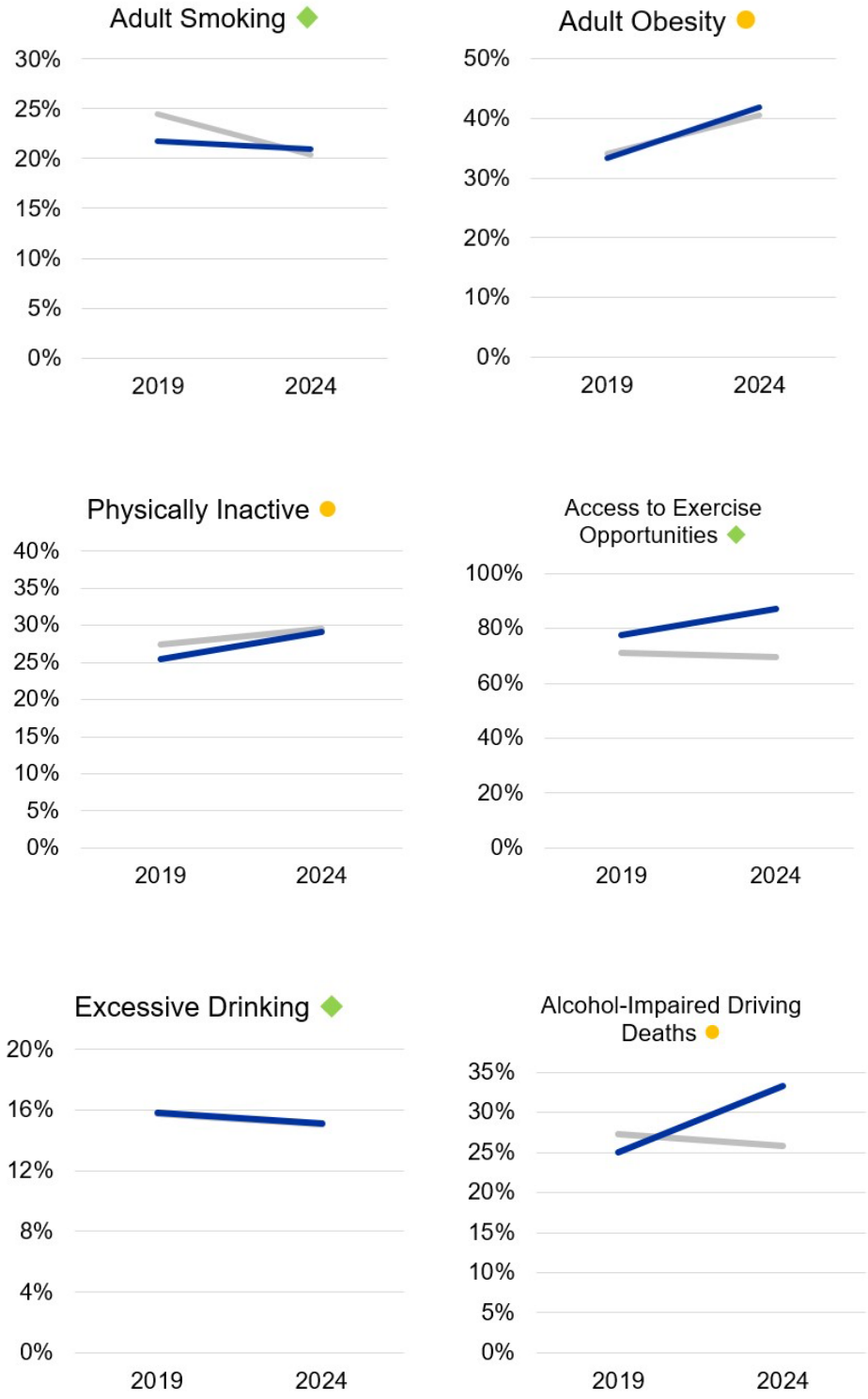


Figure 3. Health Behaviors, continued
Note: Daviess County is in **blue**, the Kentucky average is in **gray**.

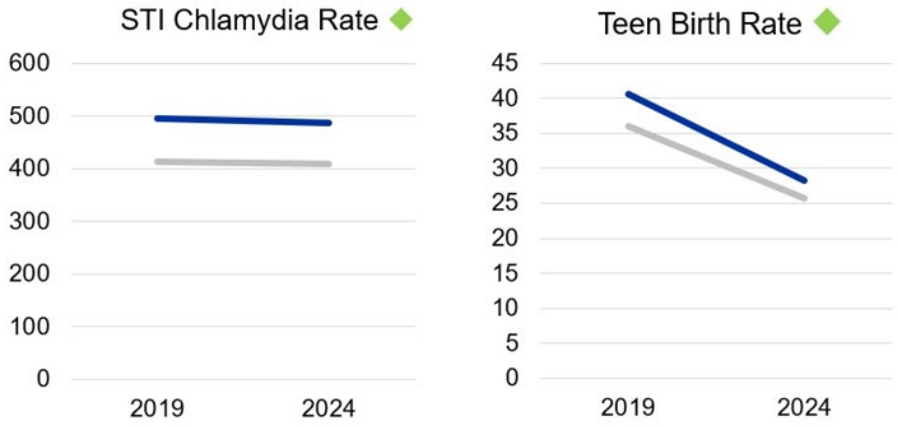


Figure 4. Access to Care
Note: Daviess County is in **blue**, the Kentucky average is in **gray**.

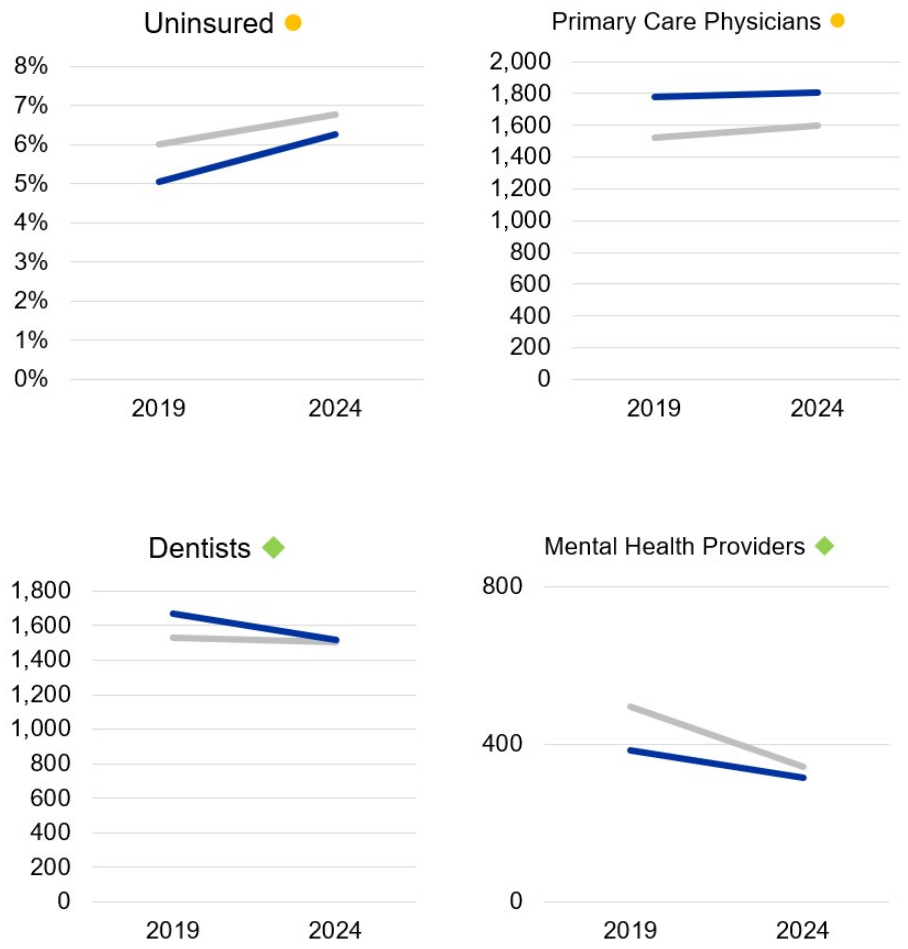


Figure 5. Social and Economic Factors
Note: Daviess County is in **blue**, the Kentucky average is in **gray**.

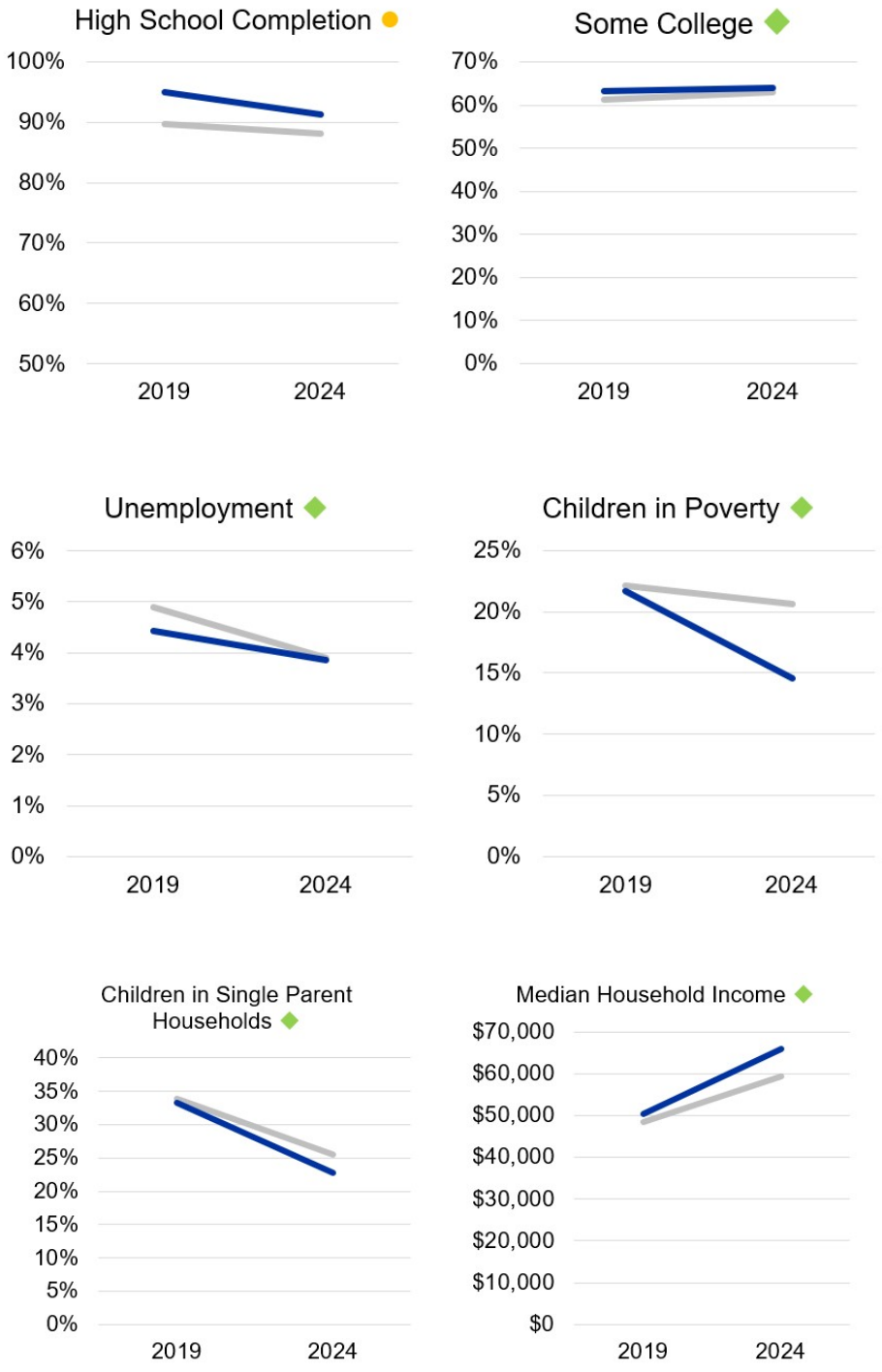


Figure 5. Social and Economic Factors, continued
Note: Daviess County is in **blue**, the Kentucky average is in **gray**.

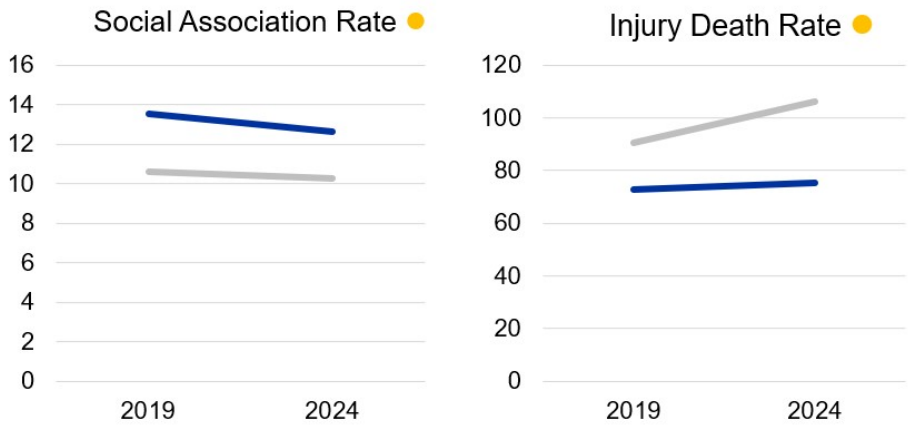


Figure 6. Physical Environment
Note: Daviess County is in **blue**, the Kentucky average is in **gray**.

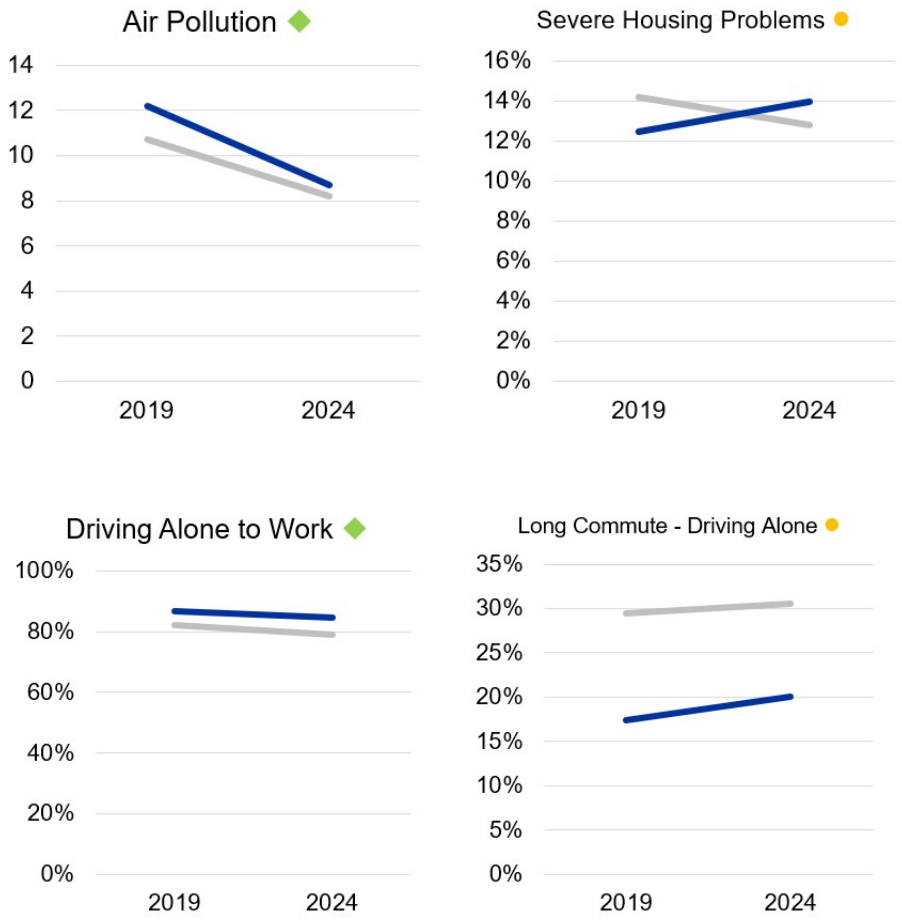
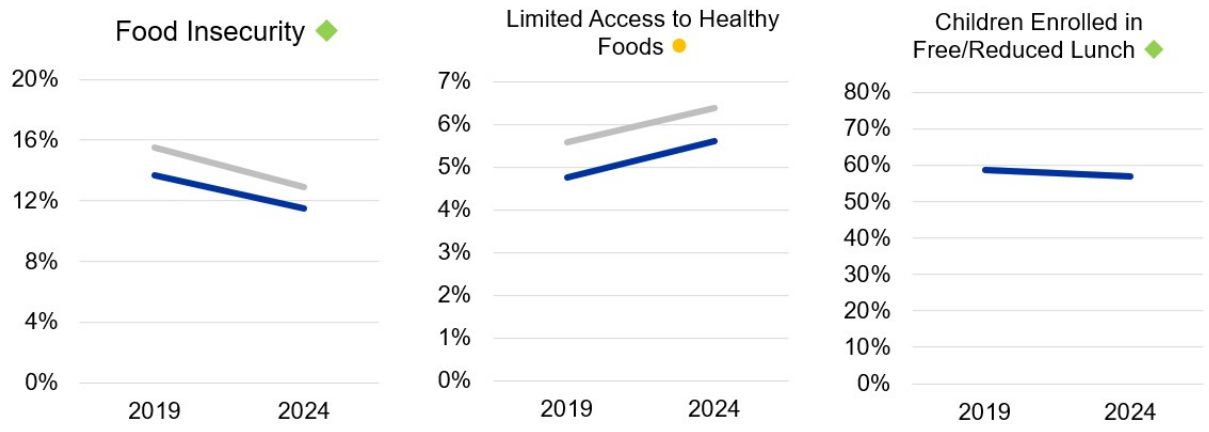


Figure 7. Food Access
Note: Daviess County is in **blue**, the Kentucky average is in **gray**.



5. Community Feedback

To gather Daviess County resident feedback, Blueprint Kentucky facilitated the process of primary data collection through community surveys, focus groups and key informant interviews. Throughout the process, Blueprint Kentucky and the community steering committee made it a priority to intentionally seek 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 vulnerable populations.

5.1 Community Survey

924 Respondents completed the “Owensboro Health Regional Hospital Community Health Needs Assessment Survey” in late 2024. The survey is included in the Appendix. A summary of the survey results can be found on the next page.

Owensboro Health Regional Hospital Survey Results

WINTER 2024

Respondent Demographics

924 Respondents

Respondents by age group:

	Percent responses	Number of responses
18–29	9%	77
30–39	19%	156
40–49	25%	207
50–59	24%	205
60–69	16%	137
70–79	6%	49
80 or older	1%	10

Respondents by sex listed on birth certificate:

	Percent responses	Number of responses
Male	24%	200
Female	74%	623
Prefer not to answer	2%	17

How respondents identify:

	Percent responses	Number of responses
Female	73%	614
Male	23%	195
Other*	2%	14
Prefer not to answer	2%	15

** Other includes non-binary/ non-conforming (0.5%), transgender female/male (0.3%)*

Respondents by primary caretaker of children:

	Percent responses	Number of responses
Parent	45%	379
Grandparent	3%	22
Other family or non-family member	1%	6
No children in the home	51%	428

Respondents by race:

	Percent responses	Number of responses
White/ Caucasian	92%	774
African American/ Black	3%	22
Hispanic/ Latino	1%	9
Other*	1%	10
Prefer not to answer	3%	25

** Other includes American Indian/ Alaskan Native (0.2%), Asian (0.2%), Native Hawaiian/ Pacific Islander (0.1%)*

Respondents by education level:

	Percent responses	Number of responses
High school graduate/GED or less	10%	81
Technical school	2%	19
Some college/ Currently in college	15%	123
Associate's degree	13%	107
Bachelor's degree	29%	244
Master's degree	28%	232
Doctoral degree	4%	33

Respondents by employment status:

	Percent responses	Number of responses
Employed full time	79%	661
Retired	10%	87
Employed part time	7%	55
Stay at home parent / caregiver	2%	15
Disabled	2%	13
Unemployed	1%	7
Full / part time student	0.4%	3

Respondents by annual household income:

	Percent responses	Number of responses
$0 - $24.999	5%	43
$25.000 - $49.999	18%	152
$50.000 - $74.999	16%	132
$75.000 - $99.999	15%	126
$100.000 or more	35%	294
Prefer not to answer	11%	92

Respondents by primary source of income:

	Percent responses	Number of responses
Wages from employer	81%	678
Pension/retirement plan	6%	52
Social security/disability social security	5%	40
Self-employment	3%	25
Support from family members	0.5%	4
Other	1%	8
Prefer not to answer	4%	35

Respondents by living situation:

	Percent responses	Number of responses
I have a steady place to live	92%	769
I have a steady place to live today but I worry about losing it in the future	7%	60
I do not have a steady place to live	1%	5

Social Determinants of Health

Respondents by access to reliable/ affordable transportation:

	Percent responses	Number of responses
Yes I have a reliable vehicle when needed	94%	885
No but a family or friend can take me	2%	18
No I have a vehicle but it breaks down often	2%	17
No I have a vehicle but at times cannot afford gas	2%	15
Yes I use GRITS or other public transportation	1%	7

Number of times respondents were unable to pay the electric, water, or heating bills in the past 12 months:

	Percent responses	Number of responses
Never	85%	788
1-2 times	8%	74
3-4 times	4%	39
5 or more times	2%	21

Resources used if unable to pay the electric, water, or heating bills:

	Percent responses	Number of responses
Family	42%	52
Community resource	16%	20
Cash advance / loans	14%	17
Friends	6%	7
Church	6%	7
Employer	1%	1
Other	15%	19

Problems with the place where residents live:

	Percent responses	Number of responses
Pests such as bugs or mice	31%	71
Mold	22%	51
Smoke detectors not working/missing	14%	31
Holes in the flooring	7%	15
Lack of heat	4%	8
Lack of oven/does not work	4%	8
Lead paint or pipes	3%	7
Lack of air conditioning	3%	7
Lack of refrigerator/does not work	1%	3
Other*	11%	26

** Other includes Maintenance/ landlord (5%), Expenses/ costs (3%), Neighbors/ neighborhood (3%)*

Worry about running out of food in the past 12 months:

	Percent responses	Number of responses
Often true (more than 5 times)	4%	36
Sometimes true (1-5 times)	12%	97
Never true	84%	699

Respondent Perspective

How respondents rate their personal health:

Weighted average: 3.8

	Percent responses	Number of responses
Excellent	15%	132
Good	62%	531
Fair	19%	163
Poor	3%	26

How respondents rate the overall physical health of Daviess County residents:

Weighted average: 2.1

	Percent responses	Number of responses
Excellent	2%	13
Good	25%	210
Fair	59%	500
Poor	14%	120

How respondents rate the overall mental health of Daviess County residents:

Weighted average: 2.1

	Percent responses	Number of responses
Excellent	1%	12
Good	23%	192
Fair	57%	484
Poor	18%	155

Most important **factors for a healthy community**:

	Percent responses	Number of responses
Low crime/safe neighborhoods	11%	509
Affordable/safe housing	10%	457
Access to primary care	10%	456
Healthy economy	10%	437
Good school systems	9%	421
Positive place to raise children	9%	402
Access to behavioral/mental health care	7%	331
Access to medical specialists	5%	232
Access to nutritious foods	5%	210
Religious/spiritual values	4%	179
Access to dental services	3%	155
Access to quality affordable childcare	3%	153
Transportation	3%	115
Availability of care for senior citizens	2%	106
Access to parks and recreation	2%	91
Access to eye care	2%	77
Excellent race relations	1%	63
Low disease rates	1%	54
Other	0.4%	16

The frequency with which Daviess County meets these factors:

	Percent responses	Number of responses
Frequently	8%	71
Somewhat frequently	27%	228
Sometimes	43%	365
Somewhat infrequently	19%	162
Never	2%	20

Most common **unhealthy behaviors in Daviess County**:

	Percent responses	Number of responses
Illegal drug use	23%	595
Poor eating habits	17%	450
Tobacco/nicotine use	16%	425
Alcohol abuse	14%	374
Lack of exercise	11%	278
Prescription drug misuse	8%	210
Lack of financial literacy	7%	183
Unsafe sex behaviors	2%	52
Lack of proper sleep	1%	38

What respondents believe Daviess County could do to better meet the community's health needs:

	Percent responses	Number of responses
Access to Free/Affordable & Timely Health Care	22%	93
Access to Behavioral/Mental Health & Education	15%	62
Housing Programs/Homeless Aid	10%	43
Access to Affordable Healthy Foods & Education	10%	41
Attract & Retain skilled HCP/physicians/specialists	8%	35
Healthy Behavior Education Incentives & Modeled by leaders	8%	32
Economy & Better wages/jobs	5%	23
Health Care System Communication, Navigation Help & Education with Community	5%	20
Transportation	4%	18
Access to Drug Rehab & Education	4%	17
More Police/Stricter Penalties	3%	13
Access to Affordable/Free Exercise	2%	10
Childcare	2%	8
Collaborative Health Care Among Providers	1%	5
Holistic Medicine	1%	4
New Leadership	0.5%	2

Health Status and Access

Where respondents go for routine health care:

	Percent responses	Number of responses
Primary care office	66%	847
Urgent care center	24%	305
Emergency room	5%	58
Health department	0.5%	6
Other*	3%	33
I do not receive routine health care	2%	26

** Other includes Specialist (1%), VA (0.2%), Deaconess (0.2%)*

Reasons for not receiving routine health care:

	Percent responses	Number of responses
Cannot afford it	36%	12
No health care insurance	18%	6
Cannot take off work	9%	3
No specialist in my community	3%	1
No transportation	3%	1
No appointment available	0%	0
Other*	30%	10

** Other includes Have not found/taken the time to find PCP (18%)*

Respondents by type of medical insurance:

	Percent responses	Number of responses
Private insurance through an employer	70%	643
Private insurance paid by me/family member	7%	62
Medicare/Medicaid	20%	184
I do not have insurance	2%	16
Other	2%	16

Delays in health care due to cost or lack of insurance in the past year:

	Percent responses	Number of responses
Yes	30%	272
No	70%	649

Types of care for which respondents traveled more than 20 miles:

	Percent responses	Number of responses
Primary care	10%	80
Dental care	17%	134
Eye care	10%	80
Behavioral / mental health care	8%	66
Substance / alcohol use or treatment	2%	18
Gynecological / obstetrical / pregnancy related care	8%	66
Heart care	9%	67
Cancer care	5%	40
Chronic condition care	8%	66
Other*	22%	170

** Other includes Orthopedic (3%), Neuro (2%), Pediatric Specialist (1%), Surgery (1%), Gastro (0.9%), Kidney/Stones (0.8%), Fertility (0.6%)*

Respondents' satisfaction with the ability to access health care services in Daviess County:

	Percent responses	Number of responses
Very satisfied	34%	287
Somewhat satisfied	36%	310
Neither satisfied nor dissatisfied	10%	85
Somewhat dissatisfied	14%	122
Very dissatisfied	5%	46

Health challenges faced by respondents or household members:

	Percent responses	Number of responses
Overweight/obesity	21%	384
High blood pressure	21%	383
Mental health challenges	17%	297
Diabetes	11%	194
Heart disease	9%	153
Respiratory/lung disease	6%	105
Cancer	4%	69
Substance use disorder	3%	46
Stroke	1%	21
Sexually transmitted infections	1%	12
Other*	7%	128

** Other includes Neurological (0.9%), Autoimmune (0.8%), Gastrointestinal (0.7%), Pain (0.7%), Allergy/Asthma (0.6%), Rheumatoid Arthritis (0.5%)*

5.2 Focus Groups

Eight focus groups, with a total of sixty-six participants, were conducted virtually and in person. There was representation from a health coalition, health care providers, and vulnerable populations, as well as providers for vulnerable populations. The focus groups were categorized accordingly:

- Community Health Committee
- Healthy Horizons Coalition
- Addiction and Recovery
- Housing
- Immigrant, Refugee, and English as a Second Language
- Mental Health
- Social Determinants of Health
- Youth

Qualitative analysis of focus group and key informant responses revealed overarching themes. Findings consistently underscored challenging experiences that not only hindered community ability to access services, but also the need for expanded services. The key findings from each of the 5 questions posed to those who participated in the focus groups and key informant interviews:

1. The community is resource rich, collaborative, and focused on providing extensive health, education, and recreation resources to community members.
2. The greatest health needs in Daviess County involve mental health, chronic illnesses, and access to care. Social determinants of health particular to Daviess County heavily impact the community’s view of the greatest health needs.
3. Concerning the community’s perception of the current health care system, the current greater health care system is described as a system rich with resources. Partnerships, diverse providers, and community-focused initiatives have strengthened the system's ability to meet needs. Continuing to address gaps in provider capacity, accessibility, and public awareness of services is essential.
4. There are a variety of barriers that prevent access to health and resources. Addressing these barriers may require cross-sector efforts.
5. To better address health needs in Daviess County, both health system and community approaches are needed.

Finding 1: The community is resource rich, collaborative, and focused on providing extensive health, education, and recreation resources to community members.

Responses that contributed to this finding are listed below.

Health Resources

- Strong health care access
  - Accredited and strong health department
  - Size and scope of the hospital is quite an asset
  - Audubon Area Community Services
- Specialty services
  - Health system provides a number of specialty services
- Substance use treatment
  - Great resources for substance abuse treatment
  - People coming to county for recovery community
  - Community has embraced treatment for substance use and behavioral health
- Mental health resources
  - RiverValley Behavioral Health is a strong community mental health center

Youth Opportunities

- Strong education systems
  - Amazing city and county schools
  - Can receive college credits and attend college classes
  - Community college and local colleges are an amazing opportunity
  - Easier to extend education here
- Organizations for youth
  - Opportunities for children and youth (athletics to academics, theater, etc.)

Infrastructure that Encourages Health Living

- Access
  - Access to walks and trails to encourage healthy lifestyles
  - Access to fresh foods
  - Some public transit options
  - Walkable community
  - Public parks
- Public policy
  - City ordinances that address smoking indoors
  - Community leaders interested in issues

Collaboration & Community Spirit

- Community support
  - Supportive community, businesses that want to contribute
  - Family oriented
  - Community supportive of refugees
  - Non-profits in community are very giving
  - Faith based supports
- Partnerships
  - Health system provides a number of specialty services
  - Health care agencies work to fufill their missions, and are looking for ways to

be better community partners
    - Health care system is adaptable and partners to meet community needs
- Leadership
    - Strong collaboratives and excellent communication
    - Engaged local leadership

Finding 2: The greatest health needs in Daviess County are mental health, chronic illnesses, and access to care. Social determinants of health particular to Daviess County heavily impact the community's view of the greatest health needs.

Responses that contributed to this finding are listed below.

Mental Health

- Stigma
    - Misunderstanding of mental health
    - Generational
    - Social media contributing to mental health issues
- Access
    - "Mental health at crisis level"
    - Lack of providers
    - Long wait times/providers booked for months
- Suicide
- Co-occurring disorders
    - Substance use
        - Not enough support for youth facing addiction
    - Tobacco use (including vaping)
    - Alcohol
    - Drugs
    - "Mental health may be a root cause of other health issues, like substance use"

Chronic Illnesses

- Obesity
    - Related to access to healthy foods and nutrition education
- Diabetes
    - Rise in juvenile diabetes
- Heart disease
    - High blood pressure
- Respiratory illness
    - COPD

Access to Care

- Barriers
    - Dental care for Medicaid patients
    - High cost of care
    - Lack of providers can lead to long wait times
    - Traveling outside of the community for care
    - Transportation
    - High cost of healthy food

    - Mistrust of health care systems
    - Affordable childcare
    - Shortage of affordable and safe housing
- Education
    - Lack of education on available resources
    - Nutrition education
    - Utilizing preventative and primary care to catch problems early
    - Misinformation
- Lifestyle
    - Generational poverty
    - Poor health choices
    - Diet
    - Substance use
    - Lack of physical activity

Social determinants of health particular to Daviess County that impact the greatest health needs in the community are:

Physical Environment/Transportation
Transportation to and from essential services, including health care is a barrier for people. This includes the need for safe walking paths for community members to use. There are programs that are unavailable to some community members because transportation is not provided and serves as a barrier to access.

Quality & Access to Health Education
Community members need health education to live healthier lives, which includes understanding a healthy diet and coping skills to combat mental health issues. There are some resources available, but many people do not know about them or how to access them.

Housing
The high cost of housing impacts many community members, and the impact of the housing shortage is more significant to vulnerable populations

Finding 3: Concerning the community's perception of the current health care system, the current greater health care system is described as a system rich with resources. Partnerships, diverse providers, and community-focused initiatives have strengthened the system's ability to meet needs. Continuing to address gaps in provider capacity, accessibility, and public awareness of services is essential.

Responses that contributed to this finding are listed below.

Opportunities for health care system

- Access
  - Specialists (chronic conditions), can be long wait times
  - Nephrologists
  - Rheumatology
  - Transportation
  - Many counseling centers, but we need more medical mental health care to reduce wait time for appointments
  - Streamlining services at touchpoints for patients
  - Dental care
  - Acceptance of Medicaid patients
  - Having to travel out of county
  - Long wait times can lead to more severe issues
- Cultural competencies
  - Providers willing to work with diverse populations
  - Diversity in hiring
  - Addressing the language barrier
- Communication
  - With patients about available services
  - Between providers about resources available within system
  - Some policies seem outdated, need to be inclusive for entire population

Strengths of health care system

- Collaboration
  - Connecting patients to resources
  - "Trickle down success" from partnerships
  - Bridging gaps between preventative primary care and social determinants of health
- Expansion of services
  - Mobile units
  - More urgent cares to alleviate ER visits
  - Increase in recovery services
  - Telehealth
- Innovative programs
  - Hospital community grants
  - Owensboro Health Healthpark is an asset
  - Law enforcement trained in crisis intervention
  - CredibleMind, an evidence-based, population digital mental health platform scales screening, prevention, referral, and early intervention

- Owensboro Regional Farmers' Market programming
- Outreach to homeless population

Finding 4: There are a variety of barriers that prevent equitable access to health and resources. Addressing these barriers may require cross-sector efforts.

Responses that contributed to this finding are listed below.

Barriers

- Poverty
  - Competing priorities can make access difficult
  - "Putting band-aids on gaping wounds that come from trauma"
  - Stigma of accessing certain resources
  - Food deserts, need for access to healthy foods
  - Competing needs can cause individuals to make unhealthy choices
  - High costs of health care
- Education
  - Literacy
  - Misinformation
  - Distrust of systems
  - Understanding how to navigate health care systems
  - Information about resources available when in crisis
  - Connection of resources for patients
  - Prevention
  - Lack of personal accountability for health decisions
- Infrastructure
  - Transportation
  - Housing
  - Increase in homelessness
  - High living costs
- Language and culture
  - Understanding system
  - ER vs. Urgent Care vs. Primary Care visits
  - Language
  - Cultural competencies

Finding 5: To better address health needs in Daviess County, both health system and community approaches are needed.

Responses that contributed to this finding are listed below.

Health Care Approach

- Community Health Workers
  - To address gaps in care
  - Connect clients to resources
  - Case management
  - Build trust in system and providers
- Education
  - "Empower patients through education to manage and understand their health"

    - Targeted marketing for specific populations addressing the barriers that affect them
    - Broad initiative that addresses insurance and related topics
    - Health literacy

- Accessibility
    - Embed services in frequently used locations for patients

Community-based approach

- Accessibility
    - Housing
    - Transportation
    - Expanded access
    - Language barriers
    - Expanded hours
    - Mobile units
    - Rural access
    - Healthy foods
    - Opportunities to build community
    - Walkable community
- Education
    - Available community resources
    - Advocacy on issues that impact community
    - Engaging local leadership
- Collaborations
    - Continue collaborations, including work with health care providers
    - Prioritizing needs based on collaborative efforts

5.3 Key Informant Interviews

As a mechanism to examine needs that surfaced in focus group discussions, Owensboro Health leadership provided contact information for potential key informant interviews to be conducted. Below is the list of interviewees and a summary of their responses highlighting comments, identifying the strengths of the community, challenges/barriers in broader health care system and opportunities for improving the community's health.

Participants:

- Amanda Owen, Puzzle Pieces
- Dr. Andrew Collins, Geriatrician at Owensboro Health
- Beth Benjamin, Owensboro Public Schools
- Brandon Harley, Audubon Area Community Services
- Brittani Roberts, Licensed Professional Counselor Associate
- Claude Bacon, Greater Owensboro Economic Development Cooperation
- Clay Horton, Green River District Health Department
- Jenny Young, Diabetes Educator at Owensboro Health
- Martiza Meeks, H. L. Neblett Center
- Mindy Jones, Mother and Baby Unit Manager at Owensboro Health
- Samantha Taylor Kaii, Audubon Area Community Care Clinic
- Steve Innes, Green River Community Food Warehouse
- Suzanne Craig, Green River Health District Health Department, Daviess County Community Access Program (DC-CAP)

Quality of Life

Key informants reported that the quality of life in Owensboro/Daviess County is high for "average" community members, but can be very low for vulnerable populations, such as children, elderly, lower income, people with disabilities, and the homeless.

Most Common Health Needs

The most common health needs in Owensboro can be sorted into three categories:

1. Basic Needs
2. Chronic Diseases
3. Barriers to Care

The following populations were identified as being particularly vulnerable:

- Children
- Elderly
- Homeless
- Individuals with disabilities
- Refugees and individuals who speak English as a second language

Basic Needs

Access to basic needs, such as housing and food, remains a challenge for some residents of Owensboro and Daviess County, with affordability and availability serving as significant barriers.

Lack of affordable housing is directly linked with homelessness in the community. Key Informants noted there are struggles with mental health and substance use issues within the homeless population. Many Key Informants cited the need for case management and well-funded follow-up care to reduce barriers, such as transportation. The idea of embedded services to reduce barriers was listed by numerous Key Informants for many issues related and not related to homelessness.

Children are greatly impacted by food insecurity in Owensboro-Daviess County. Key Informants note there is access, but barriers include cost, nutrition education, and preparing healthy meals. It was also noted that nutrition and diet impact mental and physical health, and that generational poverty may contribute to issues surrounding food insecurity and later impacts on health.

Chronic Disease

Chronic diseases are prevalent among residents of Owensboro-Daviess County, with obesity and related conditions, such as diabetes, highlighted by all key informants. These conditions affect both children and adults often serving as co-morbidities for other health issues. Contributing factors cited include limited access to healthy foods, insufficient opportunities for recreation, and a lack of nutrition education, including guidance on preparing healthy meals.

Key informants also identified other chronic diseases, such as COPD, hypertension, asthma, and heart disease, as significant health concerns. While many of these conditions are linked to unhealthy lifestyles, vulnerable populations often face limited opportunities to make healthier choices, further exacerbating these challenges.

Mental health was referenced by many Key Informants as an issue in the community, and while most agreed that there has been significant increase in the amount of mental health care available within Owensboro-Daviess County, there are still not enough providers. Opportunities are needed to address mental health issues for pregnant and postpartum women. Many new and expecting mothers face challenges such as postpartum depression and anxiety but lack adequate resources or support systems. Training health care providers to identify and address mental health concerns is essential.

Barriers to Care

Accessing care is a significant challenge for many residents, with cost emerging as a primary barrier. High prescription prices and the overall expense of health care make it difficult for individuals to prioritize their health needs. Beyond medical care, the affordability of healthy foods adds another layer of complexity, as does the cost of essential services like hearing aids and childcare. These financial burdens disproportionately affect vulnerable populations, limiting their ability to maintain overall well-being.

Transportation is a critical obstacle, particularly for patients requiring specialized care such as orthopedics, neurology, labor and delivery, or mental health services. The lack of public transportation in the area exacerbates the problem, forcing some patients to rely on ambulances or drive long distances—sometimes over two hours—for necessary care. Although some services are available locally, barriers like long wait times or ineligibility often push residents to seek help outside the community or not receive care at all.

Specialty care remains a pressing need for residents, particularly in areas such as geriatric care, dementia, and psychiatric care. Services like memory care, rheumatology, neurology, and

urology are either limited or unavailable locally, forcing patients to travel long distances to receive treatment. Additionally, caregivers in the community face significant challenges, including limited resources and support systems. There is a need for more diabetes education and management, and the current gap leaves many residents without the comprehensive support they need for chronic conditions.

Another area of concern is dental care, particularly for Medicaid patients who often struggle to find providers willing to accept their insurance. All Key Informants cited this as a significant issue. This lack of access contributes to worsening oral health, which can exacerbate other medical conditions. Expanding access to dental care regardless of insurance status is vital for improving the overall health and well-being of residents in Owensboro and Daviess County.

Perception of Health Care System

When asked about their perception of the current health care system (described as hospital, health department, clinics, behavioral health, EMS, housing, and food access), key informants were positive and realistic about the system available to residents in Owensboro/Daviess County. Responses are categorized below as identified strengths of the system and identified opportunities for the system.

Identified Strengths

- Strong providers
    - Owensboro Health
    - Green River District Health Department
    - RiverValley Behavioral Health
    - Individual physician offices
- Collaboration
    - Broad network
    - Medical community works together
    - People care
    - Groups working together to increase access

Identified Opportunities

- Increasing access to services
    - Maternal fetal medicine patients
    - Specialty care
        - Pediatrics
        - Psychiatry
        - Rheumatologists
        - Neurologists
        - Endocrinologists
        - Staff retention/recruitment for specialty areas
    - Dental care
        - Patients with Medicaid
        - Orthodontics
    - Transportation
    - Housing
    - Expanded access to services for individuals with disabilities and their caregivers
    - Marketing of services/resources

    - Education to combat distrust of system
    - Addressing language barriers

How to Better Meet Health Needs

Key Informants identified two approaches to meet the health needs in Owensboro-Daviess County. Their suggestions on how to meet the health needs are outlined below:

Health Care Approach

- Transportation
    - Mobile units to take services to population
    - Embedding/centralizing services so patients only need to travel to one location
- Addressing barriers for refugees
    - Translation services
    - Navigating health care system
    - Working to build trust
- Expanding services
    - Dental care for lower resource groups
    - Home services
    - Services for caregivers and respite care
- Continued collaboration

Community Approach

- Transportation
    - Public transportation
- Education
    - Educating government officials and community members about issues to:
        - Influence policy change
        - Offer perspective of patients and providers
    - Address stigma associated with receiving certain kinds of care
    - Resource guides on services available
- Continued collaboration

6. Selected Priority Areas

Blueprint Kentucky reviewed findings from the community survey, focus groups, key informant interviews, and county specific secondary health data with the steering committee on January 16th, 2025.

The process of priority selection followed the Association for Community Health Improvement (ACHI) recommendations to consider:

- Magnitude and severity of the problem
- Need among vulnerable populations
- Community's capacity and willingness to act on the issue
- Ability to have a measurable impact on the issue
- Availability of hospital and community resources
- Existing interventions focused on the issue
- Whether the issue is a root cause of other problems
- Trending health concerns in the community

Additional prioritization criteria can include: the importance of each problem to community members, evidence that an intervention can change the problem, and alignment with an organization.

Blueprint Kentucky staff led the data presentation and facilitated discussion with members of the Owensboro Health Regional Hospital Community Health Committee. After one month of review, the committee met on February 19th, 2025 to complete the process of prioritizing the identified health needs. Consensus was drawn and the following represent the recommendations of the Community Health Committee to Owensboro Health Regional Hospital for addressing health needs in Daviess County for the next three years.

- Lifestyle behaviors (associated with obesity, chronic disease, cancer)
- Mental health
- Addiction (legal and illegal substance use, electronics, gambling)
- Housing
- Food insecurity

7. Conclusion

Daviess County is a community rich in assets, with a strong sense of care and collaboration driving efforts to improve community health. This report highlights priority areas Owensboro Health Regional Hospital will use to guide its development of an implementation strategy to address prioritized needs. Further investigation may be needed to identify and implement the most effective solutions.

Within five months of approving the Community Health Needs Assessment (CHNA), an implementation strategy will be developed. This strategy will include regular evaluations to ensure progress toward the goals and objectives for each priority area. Community feedback is essential in this process, as it helps shape and refine strategies aimed at improving health outcomes.

Please share your comments with Debbie Zuerner, Director of Community Engagement, at debbie.zuerner@owensborohealth.org.

Appendix

Source listing for secondary data used in this report.

Social and Economic Environment

Indicator	Original Source	Year
Percentage of adults ages 25 and over with a high school diploma or equivalent.	American Community Survey, 5-year estimates	2015-2019
Percentage of ages 25-44 with some post-secondary college	American Community Survey, 5-year estimates	2015-2019
Percent of unemployed job-seeking population 16 years and older	Bureau of Labor Statistics	2019
Percent of children in poverty	Small Area Income and Poverty Estimates	2019
Percent of children qualifying for free or reduced lunch	National Center for Education Statistics	2018-2019
Disconnected Youth	American Community Survey, 5-year estimates	2015-2019
Income inequality ratio	American Community Survey, 5-year estimates	2015-2019
Percent of single-parent households	American Community Survey, 5-year estimates	2015-2019
Median Household Income	Small Area Income and Poverty Estimates	2019
Social Association Rate per 10,000 population	County Business Patterns	2018
Violent crime rate per 100,000 population	Uniform Crime Reporting - FBI	2014 & 2016
Injury death rate per 100,000 population	National Center for Health Statistics - Mortality Files	2015-2019

Clinical Care

Indicator	Original Source	Year
Percent uninsured adults	Small Area Health Insurance Estimates	2018
Percent uninsured children	Small Area Health Insurance Estimates	2018
Primary care provider ratio	Area Health Resource File/American Medical Association	2018
Dentist ratio	Area Health Resource File/National Provider Identification file	2019
Mental health provider ratio	CMS, National Provider Identification	2020
Other primary care provider ratio	CMS, National Provider Identification	2020
Preventable hospital stays	Mapping Medicare Disparities Tool	2018
Percent of population receiving flu vaccinations	Mapping Medicare Disparities Tool	2018
Percent of population receiving mammography screening	Mapping Medicare Disparities Tool	2018

Health Behaviors

Indicator	Original Source	Year
Percent adult smokers	Behavioral Risk Factor Surveillance System	2018
Percent obese adults with BMI >=30	United States Diabetes Surveillance System	2017
Percent physically inactive adults	United States Diabetes Surveillance System	2017
Percent of population with access to exercise opportunities	Business Analyst, Delorme map data, ESRI, & US Census Tigerline Files	2010 & 2019
Percent of adult excessive drinking	Behavioral Risk Factor Surveillance System	2018
Percent alcohol-impaired driving deaths	Fatality Analysis Reporting System	2018
Chlamydia rate newly diagnosed per 100,000 population	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2018
Teen birth rate ages 15-19 per 1,000 population	National Center for Health Statistics - Natality files	2013-2019
Percent of population food insecure	Map the Meal Gap	2018
Percent of population limited access to healthy foods	USDA Food Environment Atlas	2015
Drug overdose mortality rate per 100,000 population	National Center for Health Statistics - Mortality Files	2017-2019

Motor vehicle mortality rate per 100,000 population	National Center for Health Statistics - Mortality Files	2013-2019

Health Outcomes

Indicator	Original Source	Year
Premature death rate	National Center for Health Statistics - Mortality Files	2017-2019
Child mortality rate	National Center for Health Statistics - Mortality Files	2017-2019
Percent of live births with low birth weight	National Center for Health Statistics - Natality files	2013-2019
Percent of population in fair/poor health	Behavioral Risk Factor Surveillance System	2018
Physically unhealthy days	Behavioral Risk Factor Surveillance System	2018
Percent of population in frequent physical distress	Behavioral Risk Factor Surveillance System	2018
Mentally unhealthy days	Behavioral Risk Factor Surveillance System	2018
Percent of population in frequent mental distress	Behavioral Risk Factor Surveillance System	2018
Percent of population who are diabetic	United States Diabetes Surveillance System	2017
HIV prevalence rate	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2018

Secondary Data Sources, 2024 County Health Rankings

Population		Source	Years of Data
2022 Population Estimate	Total Population	Census Population Estimates	2022
Under 18 years	Percent of Population 18 years of age	Census Population Estimates	2022
65 years and older	Percent of Population 65 and older	Census Population Estimates	2022
Non-Hispanic Black	Percent of Population Non-Hispanic Black	Census Population Estimates	2022
American Indian & Alaska Native	Percent of Population American Indian & Alaska Native	Census Population Estimates	2022
Asian	Percent of Population Asian	Census Population Estimates	2022
Native Hawaiian or Other Pacific Islander	Percent of Population Native Hawaiian or Other Pacific Islander	Census Population Estimates	2022
Hispanic	Percent of Population Hispanic	Census Population Estimates	2022
Non-Hispanic White	Percent of Population Non-Hispanic White	Census Population Estimates	2022
Not Proficient in English	Percentage of population aged 5 & over who reported speaking English less than well.	American Community Survey, 5-year estimates	2018-2022
Female	Percent of Population Female	Census Population Estimates	2022
Rural	Percent of Population Rural	Census Population Estimates	2020

Health Outcomes			
Premature death rate	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	National Center for Health Statistics - Mortality Files	2019-2021
Child mortality rate	Number of deaths among residents under age 18 per 100,000 population.	National Center for Health Statistics - Mortality Files; Census Population Estimates Program	2018-2021
Poor or fair health	Percentage of adults reporting fair or poor health (age-adjusted).	Behavioral Risk Factor Surveillance System	2021
Poor physical health days	Average number of physically unhealthy days reported in past 30 days (age-adjusted).	Behavioral Risk Factor Surveillance System	2021
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted).	Behavioral Risk Factor Surveillance System	2021
Low birthweight	Percentage of live births with low birthweight (< 2,500 grams).	National Center for Health Statistics - Natality files	2016-2022
Frequent physical distress	Percentage of adults reporting 14 or more days of poor physical health per month (age-adjusted).	Behavioral Risk Factor Surveillance System	2021
Diabetic adults	Percentage of adults aged 20 and above with diagnosed diabetes (age-adjusted).	Behavioral Risk Factor Surveillance System	2021
HIV prevalence rate	Number of people aged 13 years and older living with a diagnosis of human immunodeficiency virus (HIV) infection per 100,000 population.	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2021

Secondary Data Sources, 2024 County Health Rankings, continued

Health Behaviors		Source	Years of Data
Adult smoking	Percentage of adults who are current smokers (age-adjusted).	Behavioral Risk Factor Surveillance System	2021
Adult obesity	Percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2.	United States Diabetes Surveillance System	2021
Physical inactivity	Percentage of adults age 20 and over reporting no leisure-time physical activity.	United States Diabetes Surveillance System	2021
Percent with Access to Exercise Opportunities	Access to exercise opportunities	ArcGIS Business Analyst and ArcGIS Online; YMCA; US Census TIGER/Line Shapefiles	2023, 2022 & 2020
Excessive drinking	Percentage of adults reporting binge or heavy drinking (age-adjusted).	Behavioral Risk Factor Surveillance System	2021
Alcohol-impaired driving deaths	Percentage of driving deaths with alcohol involvement.	Fatality Analysis Reporting System	2017-2021
Sexually transmitted infections	Number of newly diagnosed chlamydia cases per 100,000 population.	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2021
Teen births	Number of births per 1,000 female population ages 15-19.	National Center for Health Statistics - Natality files	2016-2022
Drug overdose mortality rate	Number of drug poisoning deaths per 100,000 population.	National Center for Health Statistics - Mortality Files; Census Population Estimates Program	2019-2021
Motor vehicle crash deaths	Number of motor vehicle crash deaths per 100,000 population.	National Center for Health Statistics - Mortality Files; Census Population Estimates Program	2015-2021

Access to Care			
Uninsured adults	Percentage of population under age 65 without health insurance.	Small Area Health Insurance Estimates	2021
Uninsured children	Percentage of children under age 19 without health insurance.	Small Area Health Insurance Estimates	2021
Primary care physicians	Ratio of population to primary care physicians.	Area Health Resource File/American Medical Association	2021
Dentists	Ratio of population to dentists.	Area Health Resource File/National Provider Identification file	2022
Mental health providers	Ratio of population to mental health providers.	CMS, National Provider Identification	2023
Preventable Hospital Stays	Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees.	Mapping Medicare Disparities Tool	2021
Mammography Screening	Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening.	Mapping Medicare Disparities Tool	2021
Flu Vaccinations	Percentage of fee-for-service (FFS) Medicare enrollees who had an annual flu vaccination.	Mapping Medicare Disparities Tool	2021

Secondary Data Sources, 2024 County Health Rankings, continued

Social & Economic Factors		Source	Years of Data
High school completion	Percentage of adults ages 25 and over with a high school diploma or equivalent.	American Community Survey, 5-year estimates	2018-2022
Some college	Percentage of adults ages 25-44 with some post-secondary education.	American Community Survey, 5-year estimates	2018-2022
Unemployment	Percentage of population ages 16 and older unemployed but seeking work.	Bureau of Labor Statistics	2022
Children in poverty	Percentage of people under age 18 in poverty.	Small Area Income and Poverty Estimates; American Community Survey, 5-year estimates	2022 & 2018-2022
Income inequality	Ratio of household income at the 80th percentile to income at the 20th percentile.	American Community Survey, 5-year estimates	2018-2022
Children in single-parent households	Percentage of children that live in a household headed by a single parent.	American Community Survey, 5-year estimates	2018-2022
Social associations	Number of membership associations per 10,000 population.	County Business Patterns	2021
Median household income	The income where half of households in a county earn more and half of households earn less.	Small Area Income and Poverty Estimates; American Community Survey, 5-year estimates	2022 & 2018-2022
Injury deaths	Number of deaths due to injury per 100,000 population.	National Center for Health Statistics - Mortality Files	2017-2021
Physical Environment			
Air pollution - particulate matter	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5).	Environmental Public Health Tracking Network	2019
Drinking water violations	Indicator of the presence of health-related drinking water violations. 'Yes' indicates the presence of a violation, 'No' indicates no violation.	Safe Drinking Water Information System	2022
Severe housing problems	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.	Comprehensive Housing Affordability Strategy (CHAS) data	2016-2020
Driving alone to work	Percentage of the workforce that drives alone to work.	American Community Survey, 5-year estimates	2018-2022
Long commute - driving alone	Among workers who commute in their car alone, the percentage that commute more than 30 minutes.	American Community Survey, 5-year estimates	2018-2022
Food Access			
Food insecurity	Percentage of population who lack adequate access to food.	Map the Meal Gap	2021
Limited access to healthy foods	Percentage of population who are low-income and do not live close to a grocery store.	USDA Food Environment Atlas	2019
Children eligible for free or reduced price lunch	Percentage of children enrolled in public schools that are eligible for free or reduced price lunch.	National Center for Education Statistics	2021-2022

Secondary Data Source Links

US Census, American Community Survey, 5-year estimates	https://data.census.gov/advanced
Bureau of Labor Statistics	https://www.bls.gov/
US Census, Small Area Income and Poverty Estimates	https://data.census.gov/advanced
National Center for Education Statistics	https://nces.ed.gov/
US Census, County Business Patterns	https://data.census.gov/advanced
FBI, Uniform Crime Reporting	https://www.fbi.gov/how-we-can-help-you/more-fbi-services-and-information/ucr
US Census, Small Area Health Insurance Estimates	https://www.census.gov/programs-surveys/sahie.html
HRSA, Area Health Resources File	https://data.hrsa.gov/topics/health-workforce/ahrf
CMS, National Provider Identification	https://www.cms.gov/regulations-and-guidance/administrative-simplification/nationalprovidentstand
CDC, Mapping Medicare Disparities Tool	https://www.cms.gov/priorities/health-equity/minority-health/research-data/mapping-medicare-disparities-tool-mmd
CDC, Behavioral Risk Factor Surveillance System	https://www.cdc.gov/brfss/index.html
CDC, United States Diabetes Surveillance System	https://gis.cdc.gov/grasp/diabetes/diabetesatlas-surveillance.html
NHTSA, Fatality Analysis Reporting System	https://www.nhtsa.gov/research-data/fatality-analysis-reporting-system-fars
CDC, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	https://www.cdc.gov/nchhstp/index.html
CDC, National Center for Health Statistics	https://www.cdc.gov/nchs/index.html
Feeding America, Map the Meal Gap	https://map.feedingamerica.org/
USDA Food Environment Atlas	https://www.ers.usda.gov/data-products/food-environment-atlas
US Census, Population Estimates	https://data.census.gov/advanced
CDC, National Environmental Public Health Tracking Network	https://ephtracking.cdc.gov/
EPA, Safe Drinking Water Information System	https://www.epa.gov/ground-water-and-drinking-water/safe-drinking-water-information-system-sdwis-federal-reporting
HUD, Comprehensive Housing Affordability Strategy (CHAS)	https://socds.huduser.gov/chas/index.html

2024 Community Health Needs Assessment Survey

Owensboro Health Regional Hospital, in collaboration with Blueprint Kentucky, with the University of Kentucky, is conducting the Community Health Needs Assessment (CHNA) for Daviess County. We want to better understand your health needs and how the hospital and its partners can better meet those needs. Please take 10-15 minutes to fill out this survey. Please do not include your name anywhere. All responses will remain anonymous.

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1. Please tell us your zip code.

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2. Where do you or anyone in your household go for routine health care? *Choose all that apply.*

   - O Primary care office
   - O Emergency room
   - O Health department
   - O Urgent care center
   - O I do not receive routine health care *
   - O Other *(please specify)*

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3. * If you answered "I do not receive routine health care" to the above question, please specify why. *Choose all that apply.*

   - O No appointment available
   - O No specialist in my community
   - O No transportation
   - O Cannot take off work
   - O Cannot afford it
   - O No health care insurance
   - O Other *(please specify)*

     _____

4. Do you have medical insurance?

   - O Private insurance, through an employer
   - O Private insurance, paid by me / family member
   - O Medicare / Medicaid
   - O I do not have insurance
   - O Other *(please specify)*

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5. Within the last year, has anyone in the household ever delayed initial health care or a follow up due to lack of money or insurance?

   - O Yes
   - O No

6. Do you have reliable / affordable transportation? *Choose all that apply.*

   - O Yes, I have a reliable vehicle when needed
   - O Yes, I use GRITS or other public transportation
   - O No, but a family or friend can take me
   - O No, I have a vehicle, but it breaks down often.
   - O No, I have a vehicle, but at times cannot afford gas.

7. In the past 12 months, have you experienced a time when you were personally unable to pay your electric, water, or heating bills?

   - O Yes, 5 or more times
   - O Yes, 3-4 times
   - O Yes, 1-2 times
   - O No, never

8. What resources did you use to assist you if you answered "yes" for the previous question? *Choose all that apply.*

   - O Family
   - O Friends
   - O Church
   - O Community resource
   - O Cash advance / loans
   - O Employer
   - O Other *(please specify)*

     _____

9. How would you rate your own personal health?

   - O Excellent
   - O Good
   - O Fair
   - O Poor

10. For what type(s) of care have you had to travel more than 20 miles? *Choose all that apply.*

    - O Primary care
    - O Dental care
    - O Eye care
    - O Behavioral / mental health care
    - O Substance / alcohol use or treatment
    - O Gynecological / obstetrical / pregnancy related care
    - O Heart care
    - O Cancer care
    - O Chronic condition care (COPD, diabetes, high blood pressure, etc.) *Please specify which condition you must travel for.*

      _____

    - O Other *(please specify)*

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11. Is everyone in your household satisfied with your ability to access health care services in Daviess County?

    - O Yes, very satisfied
    - O Yes, somewhat satisfied
    - O Neither satisfied nor dissatisfied
    - O No, somewhat dissatisfied
    - O No, very dissatisfied

12. Which of the following health challenges do you or anyone in your household face? *Choose all that apply.*

- O Cancer
- O Diabetes
- O Mental health challenges
- O Heart disease
- O Stroke
- O High blood pressure
- O Sexually transmitted infections
- O Overweight / obesity
- O Respiratory / lung disease
- O Substance use disorder
- O Other *(please specify)*

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13. How would you rate the overall **physical health** of residents of Daviess County?

- O Excellent
- O Good
- O Fair
- O Poor

14. How would you rate the overall **mental health** of residents of Daviess County?

- O Excellent
- O Good
- O Fair
- O Poor

15. What are the **top five** most important factors for a healthy community? *Choose up to five options.*

- O Positive place to raise children
- O Low crime / safe neighborhoods
- O Good school systems
- O Access to primary care
- O Access to medical specialists
- O Access to behavioral / mental health care
- O Access to dental services
- O Access to eye care
- O Access to parks and recreation
- O Affordable / safe housing
- O Access to quality, affordable childcare
- O Low disease rates
- O Excellent race relations
- O Religious / spiritual values
- O Availability of care for senior citizens (assisted care, long-term care, etc.)
- O Healthy economy (job opportunities, low poverty rate, etc.)
- O Access to nutritious foods
- O Transportation
- O Other *(please specify)*

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16. Do you think Daviess County meets these factors?

- O Yes, frequently
- O Yes, somewhat frequently
- O Sometimes
- O No, somewhat infrequently
- O No, never

17. Please select the **top three** most common unhealthy behaviors in Daviess County. *Choose up to three options.*

- O Alcohol abuse
- O Tobacco / nicotine use (cigarettes, vaping, chew tobacco, etc.)
- O Unsafe sex behaviors
- O Prescription drug misuse
- O Illegal drug use (methamphetamine, cocaine, etc.)
- O Poor eating habits
- O Lack of exercise
- O Lack of proper sleep
- O Lack of financial literacy

18. What could be done in Daviess County to better meet the community's health needs?

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19. What is your age group?

- O 18 – 29
- O 30 – 39
- O 40 – 49
- O 50 – 59
- O 60 – 69
- O 70 – 79
- O 80 – 89
- O 90 or older

20. What sex was listed on your birth certificate?

- O Male
- O Female
- O Prefer not to answer

21. How do you best identify?

- O Male
- O Female
- O Transgender male
- O Transgender female
- O Non-binary / non-conforming
- O Prefer not to answer
- O Other *(please specify)*

_____

22. Who is the primary caretaker of any children in the home?

- O Parent
- O Grandparent
- O Other family member
- O No children in the home
- O Other *(please specify)*

_____

23. Which race do you most closely identify with?

- O African American / Black
- O American Indian / Alaskan Native
- O Hispanic / Latino
- O Native Hawaiian or other Pacific Islander
- O Asian
- O White / Caucasian
- O Prefer not to answer
- O Other *(please specify)*

  _____

24. What is your highest level of education?

- O Less than 12 years
- O High school graduate / GED
- O Technical school
- O Some college, no degree
- O Associate's degree
- O Bachelor's degree
- O Master's degree
- O Doctoral degree

25. What is your current employment status? *Please choose all that apply.*

- O Employed full time
- O Employed part time
- O Disabled
- O Retired
- O Full / part time student
- O Stay at home parent / caregiver
- O Unemployed

- O $0 - $24,999
- O $25,000 - $49,999
- O $50,000 - $74,999
- O $75,000 - $99,999
- O $100,000 or more
- O Prefer not to answer

27. What is your primary source of income?

- O Wages from employer
- O Self-employment
- O Pension / retirement plan
- O Unemployment benefits
- O Social security / disability social security
- O Support from family members
- O Prefer not to answer
- O Other *(please specify)*

  _____

28. What is your living situation today?

- O I have a steady place to live.
- O I have a steady place to live today, but I worry about losing it in the future.
- O I do not have a steady place to live. (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, in a car, in an abandoned building, at a bus or train station, or at a park.)

29. Think about the place you live. Do you have problems with any of the following? *Choose all that apply.*

- O Pests, such as bugs or mice
- O Mold
- O Lead paint or pipes
- O Lack of heat
- O Lack of air conditioning
- O Holes in the flooring
- O Lack of oven / oven does not work
- O Lack of refrigerator / refrigerator does not work
- O Smoke detectors not working / missing
- O Other *(please specify)*

  _____

- O None of the above

30. Within the past 12 months, my household worried whether our food would run out before we had money to buy more.

- O Often true (more than 5 times)
- O Sometimes true (1-5 times)
- O Never true

Thank you for your time spent taking this survey!

Owensboro – Daviess County Community Resources

1. https://thecenterodc.org/resource-directory
2. https://www.rvbh.com/community-resources/community-resource-guide/
3. https://healthymind.crediblemind.com/user-resources

Approval

This Community Health Needs Assessment was approved by the Owensboro Health Board of Directors on May 29th, 2025.