COMMUNITY HEALTH NEEDS ASSESSMENT
Tax Year 2024

Owensboro Health
Twin Lakes Medical Center

910 Wallace Ave.
Leitchfield, KY 42754
(270) 259-9400
https://www.owensborohealth.org

Table of Contents

Listing of Figures

Listing of Tables

Executive Summary

Owensboro Health Inc. (OHI) owns and operates Owensboro Health Twin Lakes Medical Center, a 75 bed acute-care hospital in Grayson County, Kentucky. Owensboro Health Twin Lakes Medical Center (OHTLMC) is pleased to present its 2024-2027 Community Health Needs Assessment (CHNA). OHTLMC 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 second report prepared by Blueprint Kentucky for OHTLMC. This report will be used to create an implementation plan to address the identified health needs for the community served by OHTLMC over the next three years. The OHTLMC Board of Directors approved this CHNA on May 22nd, 2025 and The 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 seven 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 their representatives, 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

Grayson 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 quality health care, opportunities for community members through education and outdoor recreation, and strong community and social support organizations and groups that are collaborative and strengthen the sense of community in Grayson County. 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 and recreation.

Focus Groups – Unmet Needs

Blueprint Kentucky conducted specific focus groups with representatives of organizations in Grayson 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, and aging populations. The needs most often mentioned include mental health concerns for youth and adults noting that substance use is a common co-occurring disorder for mental health, obesity and nutrition needs related to access to healthy foods and lack of

nutrition education, and access to care. Supporting family needs, such as parenting classes or support for grandparents raising grandchildren was mentioned many times as an area for growth. The shortage of affordable and safe housing for a variety of groups (families, individuals in recovery, seniors, and the homeless) was mentioned.

Key Informant - Community Themes and Strengths

OHTLMC and Blueprint Kentucky obtained additional primary data through seven supplemental interviews with individuals knowledgeable about health and quality of life needs in Grayson County. Blueprint Kentucky organized the data into strengths, barriers and opportunities for change in Grayson County. Strengths include local health care assets (rural clinic, hospital, specialty care, health department, substance use treatment) and community assets (strong community collaboration through organizations with innovative programming and involved local leadership.) 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 Grayson County residents including public transportation or mobile units, preventative care and education, expanding access to care, and continued collaboration within the community.

Prioritized Areas

The OHTLMC 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.

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

- Mental health
- Addiction
    - Substance or behavior
    - Legal or illegal
- Nutrition
- Physical inactivity

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

Acknowledgments

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

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

- Debbie Childress, Director of Grayson County Alliance
- Manuel Galaviz, Emergency Department Director at OHTLMC
- Bethany Hinton, Community Education Coordinator of Geriatric Psychiatry Unit at OHTLMC
- Adam Cox, Assistant Superintendent of Grayson County Schools
- Josh Horton, Director of Grayson County Health Department
- Jennifer Hughes DNP, APRN, FNP-C, CWS, Wound Care at OHMG
- Wayne Meriwether, Grayson County Health Care Foundation Board Member & retired OHTLMC CEO

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 Engagement Director: melody.nall@uky.edu.

Owensboro Health Twin Lakes Medical Center 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 Twin Lakes Medical Center (OHTLMC) 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 OHTLMC in the development of an implementation strategy and to help direct overall efforts to impact priority health needs. The Owensboro Health Board of Directors approved this CHNA on May 29th, 2025.

1.2 Owensboro Health Twin Lakes Medical Center

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. The system includes Owensboro Health Twin Lakes Medical Center. OHTLMC is affiliated with the Owensboro Health Medical Group, comprising over 180 providers in 25 locations, a certified medical fitness facility and the Mitchell Memorial Cancer Center. Owensboro Health has been recognized for outstanding care, safety and clinical excellence by The Joint Commission, Healthgrades, U.S. News & World Report and Becker's Hospital Review. For more information, visit owensborohealth.org.

1.3 CHNA Defined Community

Owensboro Health Twin Lakes Medical Center defined its service area for this Community Health Needs Assessment in accordance with the guidance in section 501(r) as Grayson County, Kentucky.

Owensboro Health
Twin Lakes Medical Center

910 Wallace Avenue
Leitchfield, KY 42754
Phone (270) 259-9400 • Fax (270) 259-9524

April 28th, 2025

It is with great pleasure Owensboro Health Twin Lakes Medical Center 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 Twin Lakes Medical Center 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 Twin Lakes Medical Center 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 Twin Lakes Medical Center 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
Owensboro Health

Ashley Herrington
CEO
Owensboro Health Twin Lakes Regional Medical Center

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/ Physical Inactivity			
	Develop partnerships with community walking trails to encourage youth and adults to get outside and get moving.	Yes	OHTLMC partnered with Leitchfield Parks and Recreation to place 20 signs throughout the walking trails at James D Beville Park. The signage includes health facts related to physical activity. The second phase of this project will include adding 10 park maps to the park to display the lengths of all the walking trails and encourage community members and visitors to utilize the trails.
	Create a community walking program to encourage local businesses to all gather at a certain time each Wednesday and walk in different areas of the city.	Yes	The OHTLMC Community Health Committee developed the Fitt Fiddle program. This program exists as a creative way to encourage the community to become active by tying fitness to strong community roots based in bluegrass music.*Fitt Fiddle* is a mascot in the shape of a violin who was designed by a Grayson County High School senior. *Fitt Fiddle* has his own catchy jingle that is often heard throughout the community called *Fitt as a Fiddle*, which was written and produced by a Grayson County native Jimmy Mattingly, fiddle player for Garth Brooks.*Fitt,* Grayson County's fitness pal, attends community events, health fairs, and local schools to encourage community members to get active through education, fun activities and friendly competition.
	Feature monthly recipes for the community through social media.	Progressing	Recipes were not regularly highlighted on social media, but recipe cards were distributed at community events.
	Feature monthly at home exercises for the community through social media.	Progressing	OHTLMC has shared general exercise tips through social media platforms.
	Explore potential partnership with Leitchfield Aquatic Center.	Yes	OHTLMC Community Health Committee has partnered with Leitchfield Aquatic Center to offer free day passes as prizes at community events encouraging physical activity.
	Explore a partnership with the Grayson County School System to get middle and high school students who don't receive recess outside and walking.	Yes	The OHTLMC Community Health Committe has partnered with the Grayson County School System to provide "Fitt Fiddle on Tour", which is available to all local elementary schools. Education on physical activity and nutrition were proivded to elementary and middle school students. For example, OHTLMC provided pedometors and participated in the Grayson County Middle School walk-a-thon.
	Partner with the Grayson County Extension Office to offer health education classes.	Yes	OHTLMC partnered with the Grayson County Extension Office to participate in their Seniors in the Park program. This free program was held through the warmer months and encouraged older adults to come together monthly and engage in age appropriate physical activity. OHTLMC partnered with Extension to host "Fittober" in the month of October.
	Create a get active wellness campaign to feature monthly activities to engage in physical activity.	Yes	**2022-** OHTLMC Community Health Committee completed the background work to build a community fitness program. **2023-** The Fitt Fiddle Program was launched in July at the Twin Lakes National Fiddler's Championship followed up with presence at the Grayson County Fair, Clarkson Honeyfest Festival and 5K, and the Hometown Christmas Parade. **2024-** The Fitt Fiddle Program conducted activities at Grayson County elementary schools, Grayson County Middle School, Clarkson Honeyfest 5K, Think Pink 5K, Fittober, Fitt Fiddle Pumpkin Walk, The Hometown Christmas Parade, Logsdon Valley Park ribbon cutting, Grayson County Fair, Twin Lakes National Fiddler's Championship, Art in the Park, & Fitt Friday community walks.
	OHTLMC will assist and participate in the development of a focus team with OHRH regarding obesity.	Yes	OHTLMC actively participates in the monthly OH Obesity and Related Diseases Team meeting, allows OHTLMC to stay updated on system services.

	Begin promoting “Walk with a Doc” to encourage community members to come out and walk with their physicians.	Ongoing	OHTLMC was unable to continue the Walk with a Doc program. An alternative program, walks with Fitt Fiddle, was implemented.
	Increase employee participation in wellness activities at OHTLMC.	Progressing	Employee participation is tracked through the OH wellness platform. Education on this platform is provided at new employee orientation to encourage participation. 2022- 60% enrolled 59% engaged 2023- 54% enrolled 47% engaged 2024- 72% enrolled 34 % engaged
	Develop a process to refer appropriate patients to OHRH weight loss center.	Yes	Weight loss management providers regularly educate OHTLMC on weight management services and referral processes.
	Develop and promote a referral process for lifestyle medicine visits.	Ongoing	Lifestyle medicine vists are no longer available at OHTLMC. Patients are referred to health coaches and diabetes education services.
Substance Abuse			
	Team members actively participate on the Grayson County Substance Abuse Focused Education (SAFE) Coalition.	Yes	OHTLMC participates in these meetings monthly. Successful initiatives included: billboards to advertise Narcan boxes, banners to advertise RX drop-off locations, support to our local law enforcement agencies, community Red Ribbon Week activities, scholarships and much more.
	Pharmacy team to continue education of Narcan dosing to local Police Departments.	No	Currently being provided to local law enforcement agencies through a partnership with the Grayson County Health Department.
	Team members will continue to host monthly “Taking Back Kentucky” meetings, bringing substance abuse providers across the region together for collaboration.	Yes	OHTLMC facilitates quarterly Taking Back Kentucky meetings. Presentation topics include: Casey's Law, House Bill 248, Opioid Abatement funding, Office of Drug Control Policy, and the Kentucky State Police Angel Initiative.
	Assist in marketing National Drug Takeback Days (in coordination with the Grayson County Sheriff’s Office and Leitchfield Police Department).	Yes	OHTLMC assists local law enforcement agencies by creating graphic design materials for National Drug Takeback Days and shares this information with patients.
	Team members actively participate on the Grayson Hardin Meade Agency for Substance Abuse Policy (GHM ASAP).	Yes	Representatives from OHTLMC regularly attend these meetings to stay current on funding available for local projects.
	OHTLMC will host a free annual Community Mental Health and Addiction Resource Awareness Fair to bring resources together for educating community members.	Yes	OHTLMC has hosted a Community Mental Health and Addiction Resource Fair annually.
	Commit to providing an evidence based substance abuse education program within the Grayson County school system.	Yes	2024 was spent researching evidence-based programs, building relationships within the school system and exploring possible financial aid opportunities. In 2025 OHTLMC and several other community partners launched "Too Good for Drugs" education to all 6th graders at Grayson County Middle School. Plans are in place to expand this education to grades 6th-8th for the 2025-2026 school year.
	Medical staff at OHTLMC participate in a system wide opioid stewardship committee whose charge is to ensure safe opioid prescribing and assist in the decrease of opioid abuse and misuse by patients in our care.	Yes	Since April 2019, OH has continued to be a member of the Kentucky Opioid Response Effort’s Kentucky Statewide Opioid Stewardship Program (KY-SOS) to address inappropriate or excess opioid prescribing. The Opioid stewardship team at OH meets regularly and participates in data collection and reporting as required by KY-SOS. il 2019, OH has continued to be a member of the Kentucky Opioid Response Effort’s Kentucky Statewide Opioid Stewardship Program (KY-SOS) to address inappropriate or excess opioid prescribing. The Opioid stewardship team at OH meets regularly as a system and participates in data collection and reporting as required by KY-SOS. Some outcomes of the system opioid stewardship committee meeting include: placement of Narcan dispensing boxes accessible by the communities across the region and a substance use resource guide available on the OH website and rack cards being distributed throughout the community.

	OHTLMC will assist and participate in the development of a focus team on Substance Use for the Owensboro Health system.	Yes	OHTLMC facilitates this system priority health meeting monthly since April of 2023 Team vision: OHI develops and supports a comprehensive plan to change the culture of care surrounding substance abuse disorder through our commitment across the system providing education, prevention and treatment to the communities we serve.
	Explore the development of a Narcan kit distribution for the appropriate identified patients in the emergency department and inpatient addiction services patients.	Yes	OH has developed an OPA (Our Practice Advisories) that fires a notification when a patient is prescribed medication with a 50 mme of morphine equivalent or more) to advise the provider to prescribe Narcan to the patient.
	Continue to assist and refer community members and patients to appropriate Mental Health and Substance Use services (OHRH intensive outpatient program and/or OHTLMC addiction service lines).	Yes	OHTLMC continues to refer patients to needed mental health and substance use resources both internally and externally. The addition of an in-house behavioral health provider in conjunction with our line of addiction services have ensured we have adequate referral options to serve the needs of our patients internally.
	Train three Certified Tobacco Treatment Specialists (TTS) to provide effective, evidence-based treatments and education about dependence treatments. OHTLMC may also consider using these TTS for inpatient referrals to have intervention prior to a patient's discharge.	Ongoing	OHTLMC currently has 1 TTS that has completed certification and another team member that is nearing completion. Currently all appropriate inpatient admissions receive a consult and are referred to an outpatient TTS at OHRH for virtual follow up.
	OHTLMC will continue to offer 4 addiction service lines to our community: Maternal Opioid Medical Stabilization (MOMS), Medication Assisted Treatment (MAT), Medical Stabilization (Detox) and Hepatitis C Treatment.	Yes	OHTLMC started tracking inpatient consults for medical stabilization and inpatient MAT admission in 2023. **2023**-39 **2024**-68 Our outpatient MAT visits were as follows: **2022**-841 **2023**-1537 **2024**-1811
	Develop an awareness campaign for the MOMS-Maternal Opioid Medical Stabilization program at OHTLMC to ensure the population in need of this service are reached.	On Hold	This project is currently on hold due to legislative changes to prescribing Buprenorphine and changes in OB providers at OHTLMC.
	Establish a physician managed non opioid surgical post op recovery plan.	Progressing	OHTLMC has been working with providers to include Exparel (non-opioid) injection for intra op and post op pain. This non opioid option started with just certain procedures, but has recently expanded to inlcude all surgical procedures.
	Develop an alternative to opioid order set for use in the emergency department.	Yes	OH has developed ALTO ordersets for providers to use. Once these order sets were created and approved, education was conducted with all providers. Monthly usage of these order sets continue to increase.
	Provide self-help addiction recovery workbooks to all patients admitted for addiction services.	Yes	OHTLMC received a grant from the OH Foundation in 2023 for 50 self-help recovery workbooks. To date, 43 books have been given to patients.
	Develop substance abuse materials to incorporate into our pediatric readiness program.	Ongoing	OHTLMC received the pediatric readiness certification in late 2024. A review of evidence based practices before including substance use materials.
Mental Health			
	Promote the availability of a population based new mental health virtual resource, CredibleMind, through traditional/social media channels and local community organizations.	Yes	Promoted at Mental Health and Addiction Awareness Fair in 2023 and 2024 and GC Thrive Summer Resource Fair by placing info QR cards in 150 giveaway bags. This resource has also been promoted through the OHTLMC social media channels.
	OHTLMC will host a free annual Community Mental Health and Addiction Resource Awareness Fair to bring resources together for educating community members.	Yes	OHTLMC has hosted a Community Mental Health and Addiction Resource Fair annually.

	Participate in The Grayson County Poverty Coalition's Summer Resource Fair. This event provides community and basic need resources to patients to help bridge the gap.	Yes	OHTLMC has significant annual representation at this event.
	Increase mental health treatment services available in Grayson County through a recently hired Behavioral Health physician who is available for both telehealth and outpatient appointments at OHTLMC.	Yes	Provider started at OHTLMC in August of 2022. Below are the number of visits conducted at OHTLMC. **2022**-567 **2023-**1231 **2024-**1503
	Increase the use of telehealth psychiatric consultations available through Owensboro Health for patients at OHTLMC (Emergency Department and Inpatient Units).	Yes	OHTLMC began using an OH behavioral health physician to conduct telehealth psychiatric consults in August 2022 for all inpatient units. OHTLMC ED is still utilizing telehealth consults with OHRH and those numbers are as follows: **2022-**22 **2023**-55 **2024**-84
	OHTLMC will have at least one pharmacist board certified in geriatrics by the end of 2023.	No	This remains a goal at OHTLMC, however due to pharmacy staffing issues this has not occurred.
	Increase access for aging community in Grayson County with the addition of Geriatric Psychiatry in-patient 12 bed unit at Owensboro Health Twin Lakes Medical Center with an anticipated start date of summer of 2023.	Yes	The geriatric psychiatry unit opened in May of 2023. Total number of admissions for fiscal year 2024 was 149. Currently capping at 5-6 patients while preparing to open all 12 beds.
	Continue to assist and refer community and patients to appropriate Behavioral Health services including the intensive outpatient program at OHRH.	Yes	Dr. Smith, behavioral health provider at OHTLMC provided the following referrals to outpatient services at OHRH. **2022**-213 **2023**-269 **2024**-339
	Begin using an approved assessment tool to screen for the social determinants of health in both the inpatient and outpatient identified settings.	Yes	Since January 2023, all inpatients admissions are screened for social determinants of health. Forthcoming SDOH screenings for the ambulatory setting is in development.
	Provide onsite behavioral health services and wellbeing assessments to team members.	Ongoing	**2022:** 100 visits over 5 dates **2023:** 56 visits over 4 dates **2024:** 45 visits over 4 dates
	Offer and provide Mental Health First Aid training to team members.	Ongoing	OHTLMC began offering classes in February of 2024 and 7 team members became certified. OH is looking into innovative solutions to get more team members trained such as: opening the classes to the community and splitting the class into two 4 hour sessions.
Chronic Disease			
	OHTLMC to host diabetes support groups/classes.	Ongoing	Identified patients are referred to a diabetes educator. Additional resources are given to these patients when necessary.
	OHTLMC to host diabetes prevention classes.	Ongoing	Identified patients are referred to a diabetes educator. Additional resources are given to this patient when necessary.
	Develop a community chronic disease prevalence information sheet.	Yes	OHTLMC began utilizing the Sutter Health Stoplight tools to educate patients and the community on chronic disease. This education is distributed in the form of magnets and educational booklets.
	Host a community health fair.	Ongoing	OHTLMC utilizes the opportunity to participate in the GC Thrive Summer Resource Fair. This event already has an established high attendance rate and activities to entice community members to come. This allows us to provide all our services that would be present at a community health fair to a large audience.
	Offer chronic disease education days at OHTLMC.	Ongoing	Rather than hosting specific disease education days, OHTLMC changed directions and offered chronic disease education at community events.

	Explore using OHTLMC smoking cessation certified pharmacists for patient consults.	No	After researching the possibility of utilizing OHTLMC pharmacists in this way, it was discovered that best practice is to utilize tobacco treatment specialists for inpatient consults.
	Train three Certified Tobacco Treatment Specialists (TTS) to provide effective, evidence-based treatments and education about dependence treatments. OHTLMC may also consider using these TTS for inpatient referrals to have intervention prior to a patient's discharge.	Progressing	OHTLMC currently has 1 TTS that has completed certification and another team member that is nearing completion. Currently all appropriate inpatient admissions receive a consult and are referred to an outpatient TTS at OHRH for virtual follow up.
	Work with OH preventative service lines to determine appropriate screening events and promote screening awareness campaigns.	Yes	Screening events throughout the community have significantly increased. Provider Open Houses- BMI, Height & Weight, Glucose, Ultrasound, EKG, Blood pressure screenings. June 2023/2024 GC Thrive Summer Resource Fair- preventive services represented. Blood pressure checks performed. Provided mammogram information at Think Pink 5k. Love your lung event-November 6 2023/2024. Incredible Colon Event March 2023/2024. Grayson County Fair August 2024- Blood pressure checks and A1C's. Chamber of Commerce Luncheon October 2024- Free Flu Shots. August 2024 Teacher Open House- several screening options.
	Focus efforts on COPD education, treatment and prevention by partnering with OHRH COPD specialist, implementing the use of standardized COPD order sets, utilizing COPD patient education booklets and Sutter Health COPD stoplight tools, providing standardized nursing education, providing community education on proper inhaler use and increasing referrals to smoking cessation resources.	Yes	A multidisciplinary team from OHTLMC and OMHG came together to focus on COPD. The work group focused on improving care for patients by identifying and implementing the most effective interventions in both inpatient and outpatient settings. The workgroup completed extensive research to determine needs for best practice interventions to ensure positive patient outcomes. They selected a structured approach by using a driver diagram to identify the following primary drivers: staff education, patient education, emergency & inpatient disease management, discharge follow up from emergency & acute care and connecting with community resources. A few interventions included: •Enhanced staff skills and knowledge thru targeted education programs, ensuring they were well-equipped to provide excellent care. This training included standardized patient teaching methods to improve patient understanding. •Housed patient teaching tools outside each nursing alcove for quick availability. •Provided take home stoplight tools for symptom management and disease specific patient education booklets. •Reviewed and encouraged the use of disease specific order sets to drive evidence based care in the acute setting. •Collaborated with OHMG providers and complex care navigators to ensure smooth transitions and continued care after discharge. •Increased referrals to the Tobacco Treatment Specialist to assist patients with smoking cessation and provided take home nicotine replacement therapy. •Increased referrals to cardiac rehab at OHTLMC to improve heart health. •Raised awareness at community events by sharing resource guides. •Received grant to provide scales, blood pressure cuffs and oxygen monitoring equipment for patients to monitor their health status at home.
	Increase the number of patients who receive discharge follow up referrals to PCP or specialist within 7 days of discharge.	Yes	Number of patients who received follow up within 7 days of discharge **2022**-462 **2023**-767 **2024**-1563
	Apply for grant funding to assist in providing scales for weight monitoring after discharge.	Yes	Grant funding was received. OHMG has received scales, BP cuffs, O2 monitors, pill calendars, and thermometers. These are given to patients who meet chronic disease criteria and tracked to ensure no duplication.

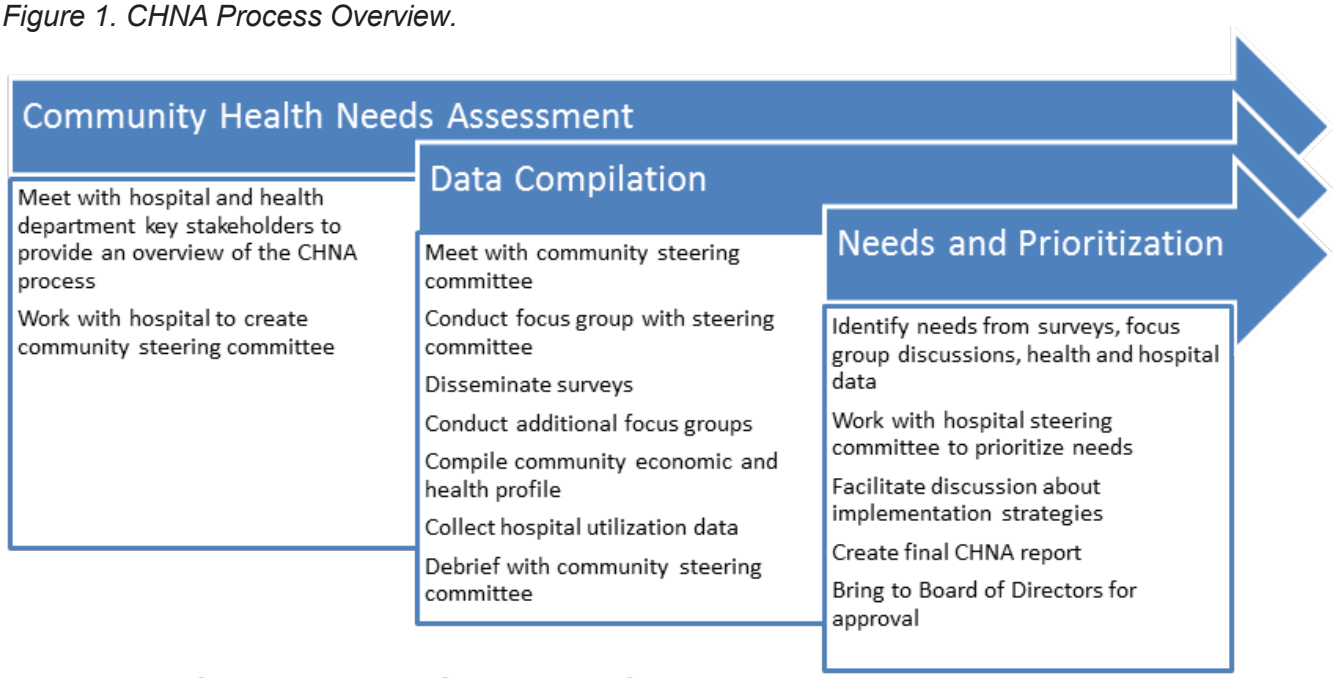
	Focus efforts on CHF education, treatment and prevention by implementing the use of standardized CHF order sets, utilizing CHF patient education booklets and Sutter Health CHF stoplight tools, and providing standardized nursing education.	Yes	A multidisciplinary team from OHTLMC and OMHG came together to focus on CHF. The work group focused on improving care for patients by identifying and implementing the most effective interventions in both inpatient and outpatient settings. The workgroup completed extensive research to determine needs for best practice interventions to ensure positive patient outcomes. They selected a structured approach by using a driver diagram to identify the following primary drivers: staff education, patient education, emergency & inpatient disease management, discharge follow up from emergency & acute care and connecting with community resources. A few interventions included: •Enhanced staff skills and knowledge thru targeted education programs, ensuring they were well-equipped to provide excellent care. This training included standardized patient teaching methods to improve patient understanding. •Housed patient teaching tools outside each nursing alcove for quick availability. •Provided take home stoplight tools for symptom management and disease specific patient education booklets. •Reviewed and encouraged the use of disease specific order sets to drive evidence based care in the acute setting. •Collaborated with OHMG providers and complex care navigators to ensure smooth transitions and continued care after discharge. •Increased referrals to the Tobacco Treatment Specialist to assist patients with smoking cessation and provided take home nicotine replacement therapy. •Increased referrals to cardiac rehab at OHTLMC to improve heart health. •Raised awareness at community events by sharing resource guides. •Received grant to provide scales, blood pressure cuffs and oxygen monitoring equipment for patients to monitor their health status at home.

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. OHTLMC 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 Grayson 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 in the extensive distribution of the community survey.

Owensboro Health Twin Lakes Medical Center scheduled the first steering committee meeting where Blueprint Kentucky representatives introduced the assessment process, the role and duties of 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
Ashley Herrington	Chief Executive Officer, Owensboro Health Twin Lakes Medical Center
Jessica Embry	Community Engagement Coordinator, Owensboro Health Twin Lakes Medical Center
Manuel Galaviz	Director of Nursing, ED, Owensboro Health Twin Lakes Medical Center
Heather Smith	Care Navigator, Owensboro Health Medical Group
Angela Gibson	Director of Pharmacy, Owensboro Health Twin Lakes Medical Center
Stacey Wilt	Director of Clinic Operations, Owensboro Health Medical Group
Debbie Zuerner	Director of Community Engagement, Owensboro Health
James Tidwell	VP of Population Health Services, Owensboro Health
Nicole Leach	Community Engagement Supervisor, Owensboro Health
Brittany Clemons	Executive Director, Grayson County Healthcare Foundation
Josh Horton	Public Health Director, Grayson County Health Department
Jessica Rusher	Tobacco Cessation Coordinator, Grayson County Health Department
Jessica Hughes	Accreditation Coordinator, Grayson County Health Department
Natalie Taul	Extension Agent for Family & Consumer Sciences, University of Kentucky Cooperative Extension Service
Debbie Childress	Executive Director, Grayson County Alliance
Brandi Lee	Transition Coordinator, Grayson County Schools
Tammee Saltsman	Director, Leitchfield Parks & Recreation
Ilsa Johnson	Director of Tourism, City of Leitchfield Tourism
Michael Anderson	Commissioner, City of Clarkson
Anthony Smith	Managing Partner, Leitchfield Pediatric Clinic, P.S.C.
Samantha Taylor-Kaii	Clinic Program Director, Audubon Area Community Care Clinic
Deana Wilson	Health Education Supervisor, Grayson County Health Department

3.3 Collection of Grayson 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. Grayson 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	Grayson County	Kentucky	National Level
2022 Population Estimate	26,631	4,512,310	333,271,411
Percent of Population under 18 years	23.2%	22.3%	21.7%
Percent of Population 65 year and older	18.5%	17.6%	17.3%
Percent of Population Non-Hispanic White	95.2%	83.2%	58.9%
Percent of Population Non-Hispanic Black	1.3%	8.4%	14.1%
Percent of Population Hispanic	0.0%	4.3%	19.1%
Percent of Population Asian	0.3%	1.8%	6.3%
Percent of Population American Indian & Alaska Native	1.6%	0.3%	1.3%
Percent Native Hawaiian/Other Pacific Islander	0.3%	0.1%	0.3%
Percent of the Population not Proficient in English	0.3%	1%	8.2%
Percent of the Population Female	49.4%	50.3%	50.4%
Percent of the Population Rural	75.4%	41.3%	13.8%

Indicator	Grayson County	Kentucky	Top US Performers
Table 3. Physical Environment			
Average daily density of air pollution - PM 2.5	8.5	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	14.4%	13%	8%
Percentage of workforce driving alone to work	80.6%	73%	70%
Percentage of workforce commuting alone for more than 30 minutes	32.2%	31%	17%
Table 4. Social and Economic Environment			
Percentage of adults ages 25 and over with a high school diploma or equivalent	83.6%	88%	96%
Percentage of ages 25-44 with some post-secondary college	45.3%	63%	73%
Percent of unemployed job-seeking population 16 years and older	4.6%	3.9%	2.6%
Percent of children in poverty	22.4%	21%	11%
Income inequality ratio	5.5	4.9	3.7
Percent of children in single-parent households	23.9%	25%	13%
Median household income	$52,130	$59,246	-
Social association rate per 10,000 population	6.0	10.2	18
Injury death rate per 100,000 population	123	106	64
Table 5. Food Access			
Percentage of population who lack adequate access to food	16.1%	12.9%	-
Percentage of population who are low-income and do not live close to a grocery store	9.6%	6.4%	-
Percentage of children enrolled in public schools that are eligible for free or reduced-price lunch	61.5%	56.9%	-

Indicator	Grayson County	Kentucky	Top US Performers
Table 6. Clinical Care			
Percent uninsured adults	8.3%	7.9%	-
Percent uninsured children	3.9%	3.8%	-
Primary care provider ratio	1,658:1	1,601:1	1,030:1
Dentist ratio	2,959:1	1,502:1	1,180:1
Mental health provider ratio	832:1	342:1	230:1
Preventable hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees	3737	3,457	1,558
Percent of population FFS Medicare enrollees receiving flu vaccinations	38%	44%	53%
Percent of female Medicare enrollees ages 65-74 receiving mammography screening	35%	42%	52%
Table 7. Health Behaviors			
Percent adult smokers	26.7%	20%	14%
Percent obese adults with BMI >=30	40.8%	41%	32%
Percent physically inactive adults	34.3%	30%	20%
Percent of population with access to exercise opp.	21.0%	70%	90%
Percent of adults excessively/binge drinking	13.5%	15%	13%
Percent of driving deaths due to alcohol impairment	20.5%	26%	10%
Chlamydia rate (newly diagnosed) per 100,000 pop.	199.8	410.3	151.7
Teen birth rate (ages 15-19) per 100,000 pop.	39	26	9
Drug overdose mortality rate per 100,000 pop.	25	43	-
Motor vehicle crash deaths per 100,000 pop.	35	18	-
Table 8. Health Outcomes			
Premature death rate (under age 75) per 100,000 pop.	12,286	11,055	6,000
Child mortality rate (under age 18) per 100,000 pop.	67	59	-
Percent of live births with low birth weight	8.3%	8.9%	6%
Percent of population in fair/poor health	24.7%	21.1%	13%
Physically unhealthy days	5.4	4.5	3.1
Percent of population in frequent physical distress	16.2%	14.0%	-
Mentally unhealthy days	6.3	5.5	4.4
Percent of population who are diabetic	12.1%	12.4%	-
HIV prevalence rate	45	214.5	-

	2019	2023

Table 9. Substance Use Rates, Grayson County

Any Drug-Involved Fatal Overdose, rate per 100K population	*Suppressed*	*Suppressed*
Any Drug-Involved Non-Fatal Overdose, rate per 100K population	408.5	480.9
ED Visit with a SUD Diagnosis, rate per 100K population	1,437.5	1,480

**Rates based on counts less than 10 are suppressed*

Table 10. Top 10 Invasive Cancer Incidence Rates

All Genders, All Races, 2018-2022	Grayson County	Crude Rate	Age-adjusted Rate
Total all sites over five years ('18-'22)	**993**	**750.6**	**565.7**
Prostate (males only)	122	181.9	131.7
Lung and Bronchus	210	158.8	113
Breast	115	86.9	66.8
Colon & Rectum	92	69.5	52.3
Urinary Bladder, invasive and in situ	58	43.8	33.7
Melanoma of the Skin	42	31.8	25.3
Kidney and Renal Pelvis	40	30.2	24.1
Miscellaneous	34	25.7	21.7
Corpus Uteri (females only)	17	26.1	21
Non-Hodgkin Lymphoma	33	24.9	19.7

Next, we present data trends from 2019-2024 for several of the County Health Rankings variables in the prior tables. The blue lines represent Grayson 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: Grayson County is in **blue**, the Kentucky average is in gray.

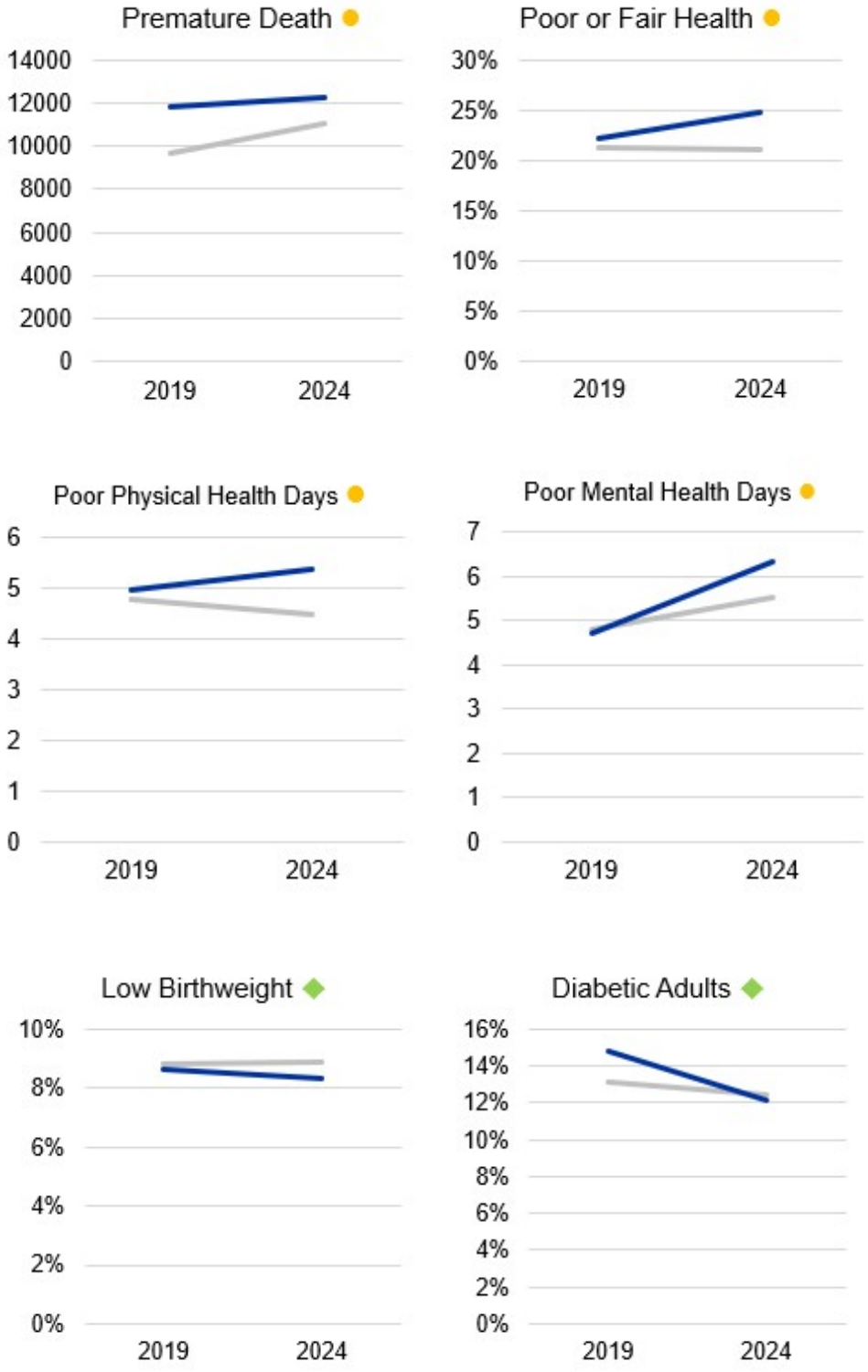


Figure 3. Health Behaviors
Note: Grayson County is in **blue**, the Kentucky average is in **gray**.

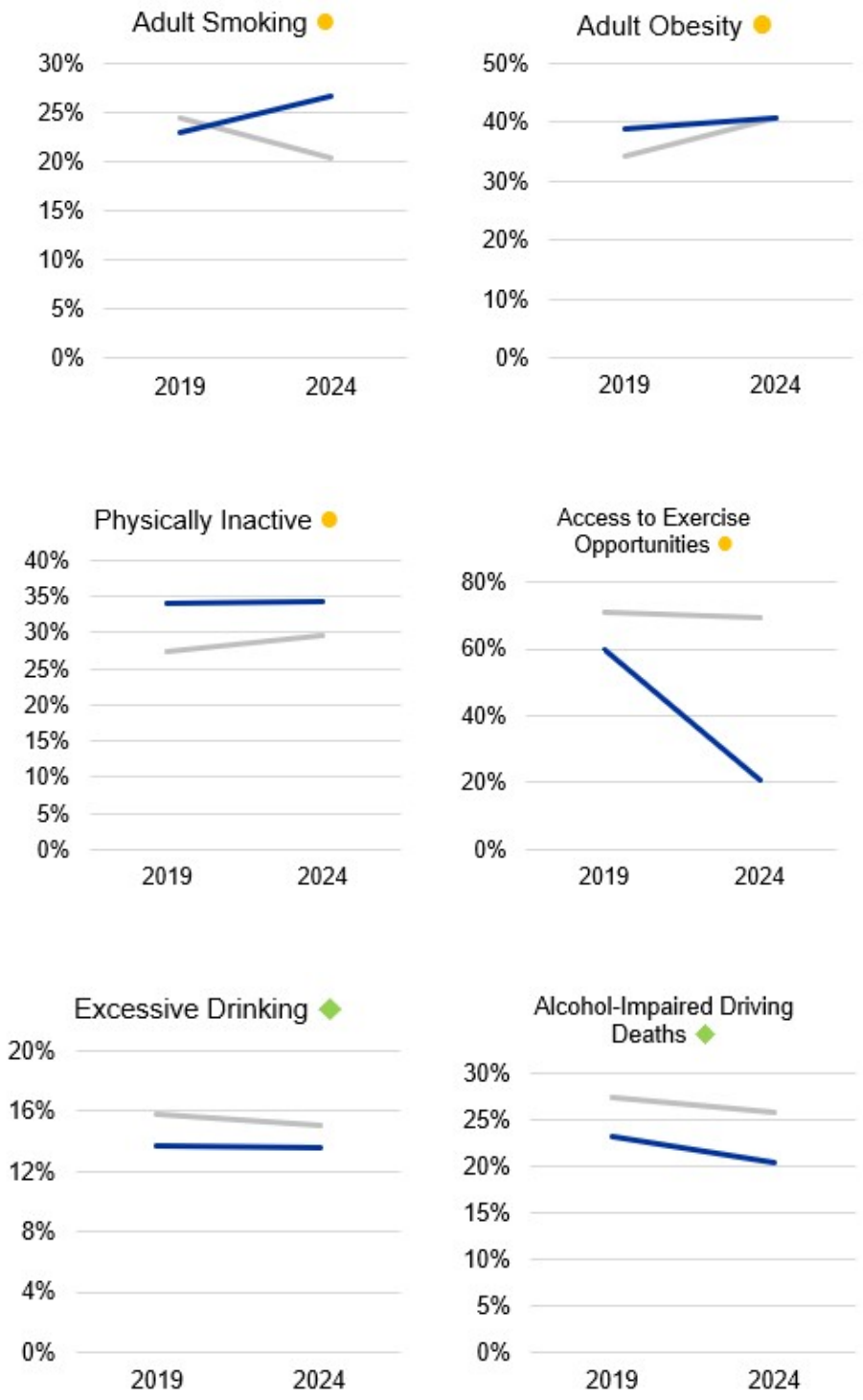


Figure 3. Health Behaviors, continued

Note: Grayson County is in **blue**, the Kentucky average is in **gray**.

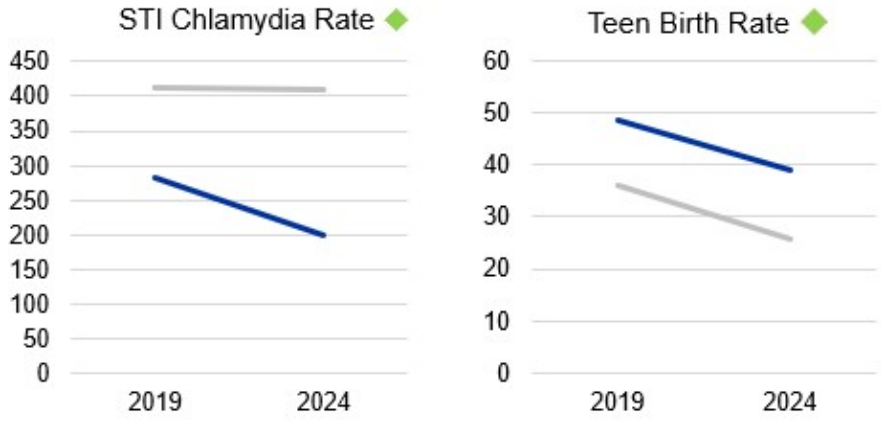


Figure 4. Access to Care

Note: Grayson County is in **blue**, the Kentucky average is in **gray**.

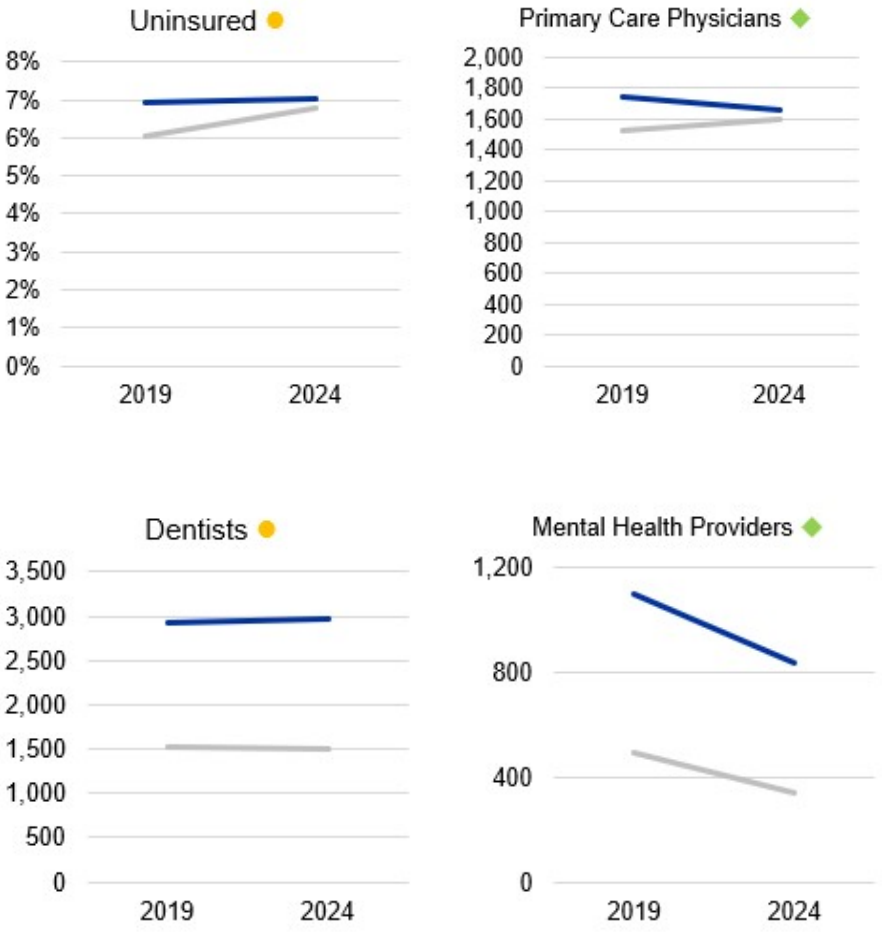


Figure 5. Social and Economic Factors
Note: Grayson County is in **blue**, the Kentucky average is in **gray**.

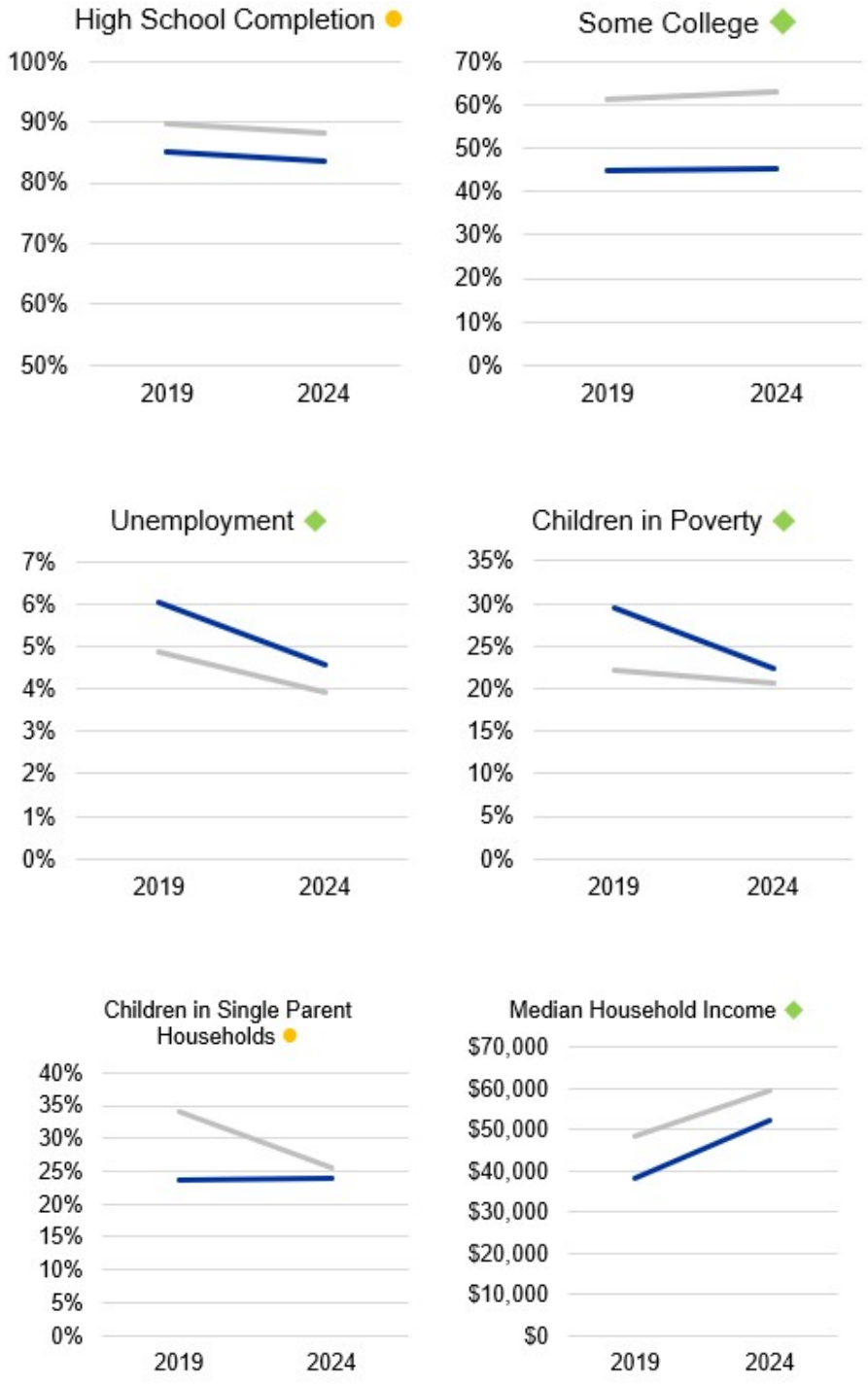


Figure 5. Social and Economic Factors, continued
Note: Grayson County is in **blue**, the Kentucky average is in **gray**.

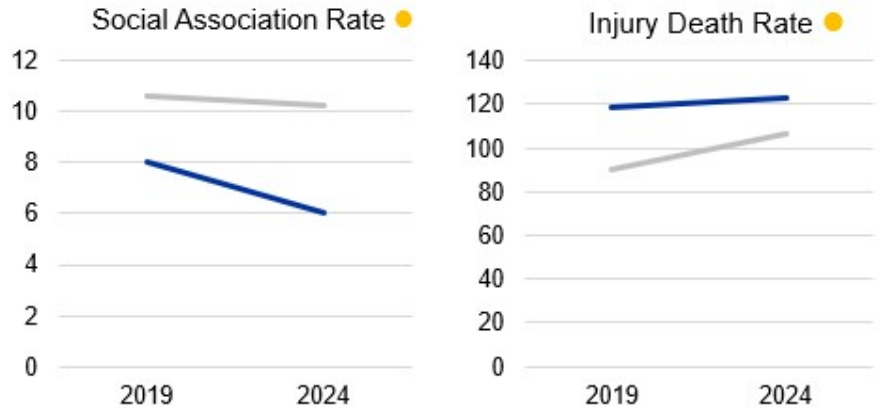


Figure 6. Physical Environment
Note: Grayson County is in **blue**, the Kentucky average is in **gray**.

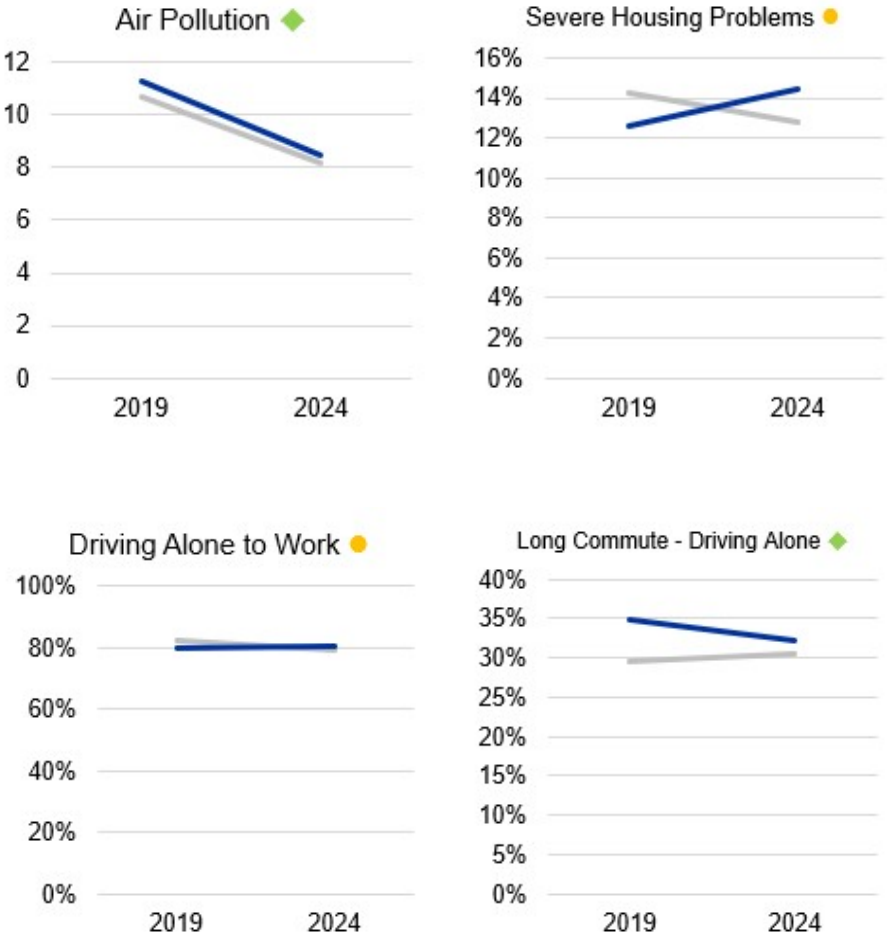
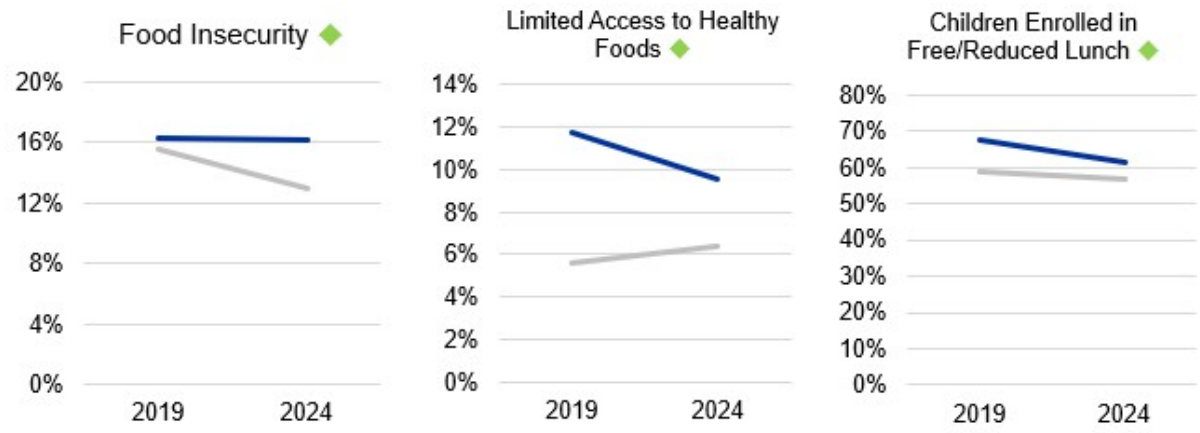


Figure 7. Food Access
Note: Grayson County is in **blue**, the Kentucky average is in **gray**.



5. Community Feedback

To gather Grayson 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 and those that represent them and key informant interviews with identified community stakeholders.

5.1 Community Survey

631 Respondents completed the “Owensboro Health Twin Lakes Medical Center 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 Twin Lakes Medical Center Survey Results

WINTER 2024

Respondent Demographics

631 Respondents

Respondents by age group:

	Percent responses	Number of responses
18–29	17%	91
30–39	18%	96
40–49	25%	132
50–59	19%	103
60–69	16%	86
70–79	5%	26
80 or older	0.4%	2

Respondents by sex listed on birth certificate:

	Percent responses	Number of responses
Male	16%	86
Female	82%	456
Prefer not to answer	2%	11

How respondents identify:

	Percent responses	Number of responses
Female	15%	85
Male	80%	439
Other*	3%	15
Prefer not to answer	2%	12

** Other includes non-binary/ non-conforming (2%), transgender female/male (0.4%)*

Respondents by primary caretaker of children:

	Percent responses	Number of responses
Parent	58%	310
Grandparent	3%	18
Other family or non-family member	2%	8
No children in the home	37%	197

Respondents by race:

	Percent responses	Number of responses
White/ Caucasian	95%	526
African American/ Black	1%	4
Hispanic/ Latino	1%	4
Other*	2%	10
Prefer not to answer	2%	11

** Other includes American Indian/ Alaskan Native (0.2%), Asian (0.4%), Mixed-race (1%)*

Respondents by education level:

	Percent responses	Number of responses
High school graduate/GED or less	28%	157
Technical school	5%	29
Some college/ Currently in college	16%	87
Associate's degree	19%	104
Bachelor's degree	16%	90
Master's degree	14%	77
Doctoral degree	1%	7

Respondents by employment status:

	Percent responses	Number of responses
Employed full time	62%	342
Employed part time	12%	66
Disabled	6%	35
Retired	10%	57
Full / part time student	2%	9
Stay at home parent / caregiver	3%	19
Unemployed	5%	25

Respondents by annual household income:

	Percent responses	Number of responses
$0 - $24,999	12%	69
$25,000 - $49,999	20%	111
$50,000 - $74,999	19%	106
$75,000 - $99,999	16%	86
$100,000 or more	20%	111
Prefer not to answer	13%	70

Respondents by primary source of income:

	Percent responses	Number of responses
Wages from employer	69%	380
Social security / disability social security	13%	69
Self-employment	5%	27
Pension / retirement plan	4%	23
Support from family members	2%	13
Unemployment benefits	0%	0
Other	2%	9
Prefer not to answer	5%	30

Respondents by living situation:

	Percent responses	Number of responses
I have a steady place to live	94%	513
I have a steady place to live today but I worry about losing it in the future	6%	31
I do not have a steady place to live	0%	0

Social Determinants of Health

Respondents by access to reliable/ affordable transportation:

	Percent responses	Number of responses
Yes, I have a reliable vehicle when needed	93%	590
Yes, I use CATS or other public transportation	1%	4
No but a family or friend can take me	3%	20
No, I have a vehicle but it breaks down often	2%	12
No, I have a vehicle but at times cannot afford gas	2%	10

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	84%	533
1-2 times	9%	55
3-4 times	5%	30
5 or more times	2%	13

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

	Percent responses	Number of responses
Family	37%	49
Cash advance/loans	18%	24
Community resource	16%	22
Friends	12%	16
Church	7%	9
Employer	1%	2
Other	9%	12

Problems with the place where residents live:

	Percent responses	Number of responses
Pests such as bugs or mice	35%	57
Mold	20%	32
Smoke detectors not working/missing	10%	16
None of the above	8%	13
Holes in the flooring	5%	9
Lack of heat	5%	8
Lack of air conditioning	4%	7
Lead paint or pipes	1%	2
Lack of oven/does not work	1%	1
Lack of refrigerator/does not work	1%	1
Other*	35%	57

** Other includes Ceiling/ roof (4%), Windows/ Insulation (4%), Foundation (3%), Neighbors/ neighborhood (2%)*

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

	Percent responses	Number of responses
Often true (more than 5 times)	4%	20
Sometimes true (1-5 times)	13%	69
Never true	84%	451

Respondent Perspective

How respondents rate their personal health:

Weighted average: 2.8

	Percent responses	Number of responses
Excellent	13%	75
Good	59%	336
Fair	24%	134
Poor	4%	20

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

Weighted average: 2.0

	Percent responses	Number of responses
Excellent	2%	9
Good	18%	101
Fair	59%	329
Poor	22%	122

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

Weighted average: 2.0

	Percent responses	Number of responses
Excellent	3%	15
Good	18%	99
Fair	58%	321
Poor	22%	123

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

	Percent responses	Number of responses
Good school systems	12%	350
Low crime/safe neighborhoods	11%	341
Access to primary care	11%	333
Positive place to raise children	11%	329
Healthy economy	9%	268
Affordable/safe housing	8%	254
Access to behavioral/mental health care	5%	150
Access to medical specialists	5%	143
Access to nutritious foods	5%	142
Religious/spiritual values	5%	137
Access to quality affordable childcare	4%	112
Access to dental services	3%	98
Access to parks and recreation	3%	87
Availability of care for senior citizens	3%	80
Access to eye care	2%	68
Transportation	2%	60
Low disease rates	2%	46
Excellent race relations	1%	19
Other	0.3%	9

The frequency with which Grayson County meets these factors:

	Percent responses	Number of responses
Frequently	6%	35
Somewhat frequently	20%	111
Sometimes	46%	256
Somewhat infrequently	24%	136
Never	4%	20

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

	Percent responses	Number of responses
Illegal drug abuse	18%	495
Tobacco/nicotine use	15%	417
Alcohol abuse	14%	393
Prescription drug abuse	13%	349
Poor eating habits	12%	337
Lack of exercise	10%	266
Lack of financial literacy	9%	244
Unsafe sex behaviors	6%	163
Lack of proper sleep	3%	70

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

	Percent responses	Number of responses
Attract, Hire, & Retain More Primary Care Doctors	14%	36
Community Outreach Education for Healthy Behaviors/Raising a Family/Financial Responsibility	12%	31
Access to Affordable/Quality Health Care Services	11%	30
Recreation Center & Build Outdoor Options (Exercise equipment, Sports Courts)	11%	29
Alcohol & SUD Rehab Facility/Counseling/Programs	8%	20
Better Health/Sex/Drug/Financial Programs in School	6%	17
Access to Dental Care/Accept Medicare & Medicaid	6%	15
Access to Healthy Food (Grocery, Restaurant, School Lunch)	5%	14
Better Economy/More Jobs/Higher Pay	5%	13
More Specialists/Specialty Services (Orthodontist, pulmonologist, cardiologist, etc.)	5%	12
Age-appropriate Activities/Entertainment (Youth, Family, Adult, Senior)	4%	11
Public Transportation System	4%	10
Mental Health Services	3%	9
Affordable Housing/Shelters/Helping Homeless	3%	8
Smoking ban/Cessation Programming/Prohibit Nicotine, Tobacco, Vape sales	3%	7
Less Public Assistance & Make People Work	2%	4
Better/Different Community Leaders	2%	4

Health Status and Access

Where respondents go for routine health care:

	Percent responses	Number of responses
Primary care office	73%	573
Emergency room	1%	6
Health department	2%	15
Urgent care	18%	143
Other*	2%	16
I do not receive routine health care	4%	32

** Other includes VA (0.6%), Specialist (0.5%), VA (0.2%)*

Reasons for not receiving routine health care:

	Percent responses	Number of responses
No appointment available	19%	11
No specialist in my community	5%	3
No transportation	0%	0
Cannot take off work	14%	8
Cannot afford it	24%	14
No health care insurance	16%	9
Other*	22%	13

** Other includes No need/ not sick (9%), no PCP (3%)*

Respondents by type of medical insurance:

	Percent responses	Number of responses
Private insurance through an employer	61%	383
Private insurance paid by me/family member	8%	50
Medicare/Medicaid	25%	160
I do not have insurance	2%	14
Other	4%	26

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

	Percent responses	Number of responses
Yes	26%	163
No	74%	468

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

	Percent responses	Number of responses
Primary care	17%	168
Dental care	21%	216
Eye care	11%	109
Behavioral / mental health care	5%	55
Substance / alcohol use or treatment	1%	11
Gynecological / obstetrical / pregnancy related care	15%	153
Heart care	7%	70
Cancer care	4%	38
Chronic condition care	9%	86
Other	10%	100

** Other includes Orthopedic (1%), Neuro (1%), Rheumatologist (0.8%), Pulmonary (0.7%), Imaging/Diagnostics (0.5%)*

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

	Percent responses	Number of responses
Very satisfied	24%	128
Somewhat satisfied	38%	208
Neither satisfied nor dissatisfied	16%	87
Somewhat dissatisfied	15%	81
Very dissatisfied	7%	40

Health challenges faced by respondents or household members:

	Percent responses	Number of responses
High blood pressure	23%	265
Overweight/obesity	22%	250
Diabetes	13%	154
Mental health challenges	13%	151
Heart disease	7%	86
Respiratory/lung disease	7%	75
Cancer	4%	45
Substance use disorder	1%	17
Stroke	1%	13
Sexually transmitted infections	0.3%	3
Other*	8%	90

** Other includes Arthritis/ Auto-immune (1%), Thyroid (0.7%), Kidney (0.7%), (Neurological (0.7%), Gastrological (0.6%), High Cholesterol (0.5%)*

5.2 Focus Groups

Six focus groups, with a total of forty-five 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
- Social Determinants of Health
- Youth
- Economic Development
- Individuals with Special Needs
- Seniors

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 well-resourced, works collaboratively, and is dedicated to offering comprehensive health, education, and recreation services to its members.
2. The greatest health needs in Grayson County involve mental and behavioral health, obesity and nutrition, and access to care. Social determinants of health particular to Grayson 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 supportive, dedicated, and rich with resources. Partnerships 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 equitable access to health and resources. Addressing these barriers may require cross-sector efforts.
5. To better address health needs in Grayson County both health system and community approaches are needed.

Finding 1: The community is well-resourced, works collaboratively, and is dedicated to offering comprehensive health, education, and recreation services to its members.

Responses that contributed to this finding are listed below.

Health Care

- Access to Quality Care
  - Strong health department (mentioned multiple times)
  - Hospital (mentioned multiple times)
  - Specialty clinics
  - Telehealth
  - Geriatric behavioral health unit
  - Access to medical facilities (hospitals, clinics, physician offices, health department, dental, specialists, recovery, mental health)
  - Seniors have proximity to care
  - Strong health care system

Empowering Opportunities

- Education
  - Local community college (mentioned multiple times)
  - Vocational Technology School
  - Early Intervention and Consultation Services (EICS)
  - Stellar library
- Recreation
  - Several parks, including city park, where families can gather
  - Recreational areas like the aquatic center and theater
  - Baseball fields
  - Lakes

Community and Social Support

- Collaboration
  - Ability for agencies to collaborate and deliver quality programming
  - Services work well together
  - Strong community partnerships
  - Community is willing to grow and look for areas of improvement
  - A sense of community
  - Community is generous and big-hearted, impacts the ability to do good things
  - “A community full of helpers”
  - Local government focused on health and wellness
- Community Programs
  - Community support organizations
  - Matured as a community to embrace recovery programs, working against stigma
  - Involved churches
  - GC Thrive
  - Grayson County Alliance Food Pantry

Finding 2: The greatest health needs in Grayson County are mental and behavioral health, obesity and nutrition, and access to care. Social determinants of health particular to Grayson 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
  - Lack of providers
  - Long wait times/providers booked for months
- Co-occurring Disorders
  - Substance use
    - Tobacco use (including vaping)
    - Alcohol
    - Drugs
- Family Dynamics
  - Parenting
  - Grandparents raining grandchildren
  - Generational poverty
  - Foster care crisis

Obesity and Nutrition

- Obesity
  - Related to access to healthy foods and nutrition education
  - Rising rates of childhood obesity
  - Unhealthy eating habits driven by convenience and cost
- Food insecurity
  - High cost of food
- Education
  - Lack of nutrition and healthy food preparation education
  - Generational poverty at play

Access to Care

- Barriers
  - Dental care for Medicaid patients
  - Lack of providers can lead to long wait times
  - Traveling outside of the community for care
  - High cost of "healthy lifestyle"
  - Mistrust of health care systems
  - Affordable childcare
  - Shortage of providers, especially for Medicaid patients.
  - Gaps in primary care, pediatrics, vision, dental, and specialty care.
  - Lack of services for special needs individuals
  - Transportation is a huge issue
  - Shortage of affordable and safe housing

    - Need for services to the homeless population
    - Providers are not trained to work with patients who have special needs and their caregivers
- Health Education
    - Lack of education on available resources
    - Need for preventative education
    - Difficulty navigating complex health care system

Social determinants of health particular to Grayson 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 of 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 supportive, dedicated, and rich with resources. Partnerships 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

- Patient Barriers
  - Transportation
  - Housing issues
  - Homelessness and the need for a homeless shelter
  - Insurance issues
  - Dental care
    - Acceptance of Medicaid patients, children and adults
    - Having to travel out of county
    - Long wait times can lead to more severe issues
  - Negative perception of hospitals
    - Stories of past experiences
    - Distrust of providers and system
  - Education
    - Patients unaware of resources
    - Importance of follow up care
    - Education and preventive care for healthier lifestyles
- Support for Vulnerable Populations
  - Services for elderly
  - Services for individuals with disabilities
  - Respite care
- Mental Health Support
  - Need for increase in number of providers
  - Placement for geriatric psychiatry patients

Strengths of health care system

- Collaboration
  - Community Health Committee
  - "Connections between groups lead to quick access or answers"
- Local Access
  - Rural clinic
  - Hospital
  - Health Department
  - Specialty care available at hospital
- Innovative Programs
  - Fitt Fiddle
  - Grayson County Alliance Food Pantry
  - Here's Looking at You elementary intervention program
  - Recovery care

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
  - Stigma of accessing certain resources
  - Cost of living
- Perception of Medical System
  - Fear and distrust of system
  - Providers not trained on working with special needs population
  - Providers not making timely referrals
  - Long wait times
- Lack of Education
  - Health literacy
  - Understanding how to navigate health care systems
  - Information about resources available when in crisis
  - Prevention
  - Lack of personal accountability for health decisions, apathy
- Insufficient Infrastructure
  - Transportation
  - Housing
    - Increase in homelessness
  - High costs of basic needs
- Lack of Support
  - Caregiver
  - Parent
  - Respite care

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

Responses that contributed to this finding are listed below.

Health Care Approach

- Improving Access to Services
  - Transportation
  - Health Care Navigators or Community Health Workers
    - Assist with coordination of services and case management
- Education
  - Education to reduce stigma of accessing services
    - Mental health
    - Behavioral health
    - Substance use
  - Education on available resources in the community
  - Preventative education
  - Training for health care providers on best practices for working with individuals

with special needs

Community-based approach

- Improving Infrastructure
  - Transportation
  - Housing
    - Safe and affordable
    - For vulnerable populations such as elderly, individuals with special needs, recovery community
  - Health Care Navigators or Community Health Workers
    - Assist with coordination of services and case management
- Education
  - Education on available community resources
  - Advocacy on issues that impact community such as mental health to reduce stigma
  - Engaging local leadership
- Collaborations
  - Continue collaborations, including work with health care system
  - Maintain communication to increase impact and to ensure there is no duplication of 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:

- Debbie Childress, Director of Grayson County Alliance
- Manuel Galaviz, Emergency Department Director at OHTLMC
- Bethany Hinton, Community Education Coordinator of Geriatric Psychiatry Unit at OHTLMC
- Adam Cox, Assistant Superintendent of Grayson County Schools
- Josh Horton, Director of Grayson County Health Department
- Jennifer Hughes DNP, APRN, FNP-C, CWS, Wound Care at OHMG
- Wayne Meriwether, Grayson County Health Care Foundation Board Member & retired OHTLMC CEO

Quality of Life

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

Most Common Health Needs

The most common health needs in Grayson County can be sorted into four categories:

1. Barriers to care
2. Risky behaviors
3. Community support
4. Chronic issues

The following populations were identified as being particularly vulnerable:

- Children
- Elderly
- Low income
- Individuals with disabilities
- Homeless

Barriers to Care

Accessing care is a significant challenge for many residents, with cost emerging as a primary barrier. Key informants list that high costs impacts access to prescriptions, health care, healthy foods, hearing aids, childcare, and housing.

Transportation keeps many from accessing care in Grayson County. The lack of a robust public transportation system keeps community members from accessing health care, food, work, recreation opportunities, and community engagement activities. One key informant said, "If they aren't getting to us, they're not getting to medical care, dental care, supportive relationships,

mental health, etc." The idea of embedding services to reduce barriers was listed by many key informants as a way to better meet health needs. Key informants also listed addressing transportation as a way to increase the health of the community.

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. Expanding access to dental care regardless of insurance status is vital for improving the overall health and well-being of residents in Grayson County. Respite care was also noted as an area with a need for expanding services.

Risky Behaviors

Substance use was mentioned multiple times by key informants as a common health need in Grayson County. Tobacco use, specifically vaping, was mentioned as an issue affecting young people in the community. It was noted that alcohol use causes a high number of accidents in the area.

The lack of safe practices also causes health problems in the community. Safety measures like not wearing life jackets while boating or failing to wear helmets while using ATVs were listed as reasons for many ER visits. Burns and agricultural hazards are also common in the community.

Community support

Community support plays a vital role in addressing the unique needs of residents across different age groups. Families, youth, and the elderly face distinct challenges, but strengthening community networks and providing targeted resources can improve their quality of life.

For families, poverty is a significant obstacle. Many parents lack access to parenting resources or support groups, which could provide guidance on raising healthy and resilient children. Additionally, ensuring children have access to nutritious meals remains a pressing concern. Community programs that offer parenting classes and meal support can help create a more stable foundation for families.

Youth in the community face challenges in maintaining a healthy lifestyle, with many lacking opportunities for physical activity or engagement in educational activities. Without these outlets, young people are at greater risk of health and behavioral issues. Programs that focus on youth engagement, such as recreational sports, educational workshops, and wellness initiatives are critical to fostering healthier habits and keeping children active and involved.

Elderly residents often struggle with isolation, which can lead to feelings of loneliness and depression. Opportunities for engagement, such as social events or volunteer programs, can help seniors stay connected and active. Additionally, housing remains a challenge for many older adults, with limited options for affordable or accessible homes. Expanding senior housing and providing resources to reduce isolation would greatly enhance the well-being of this population.

Chronic Issues

Chronic health issues remain a concern for the community, with mental health, diabetes, and obesity standing out as critical areas requiring attention.

Mental health, particularly the lack of providers available in the community, was noted as an issue. Reducing the stigma surrounding mental health care is equally important, as it often prevents individuals from seeking the help they need.

Diabetes continues to affect a large portion of the population, often as a result of limited access to education about prevention and management. Expanding diabetes education programs, offering nutritional counseling, and providing access to affordable medications and screenings can significantly improve outcomes for those living with this chronic condition.

Obesity is another widespread issue, contributing to numerous other health problems, including diabetes and heart disease. Limited opportunities for physical activity and poor access to nutritious foods contribute to the problem. Initiatives such as community fitness programs, healthier school meal options, and education on portion control and cooking skills can play a key role in reducing obesity rates.

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 Grayson County. Responses are categorized below as identified strengths of the system and identified opportunities for the system.

Identified Strengths

- Strong providers
    - Owensboro Health Twin Lakes Medical Center
    - OHTLMC brought in services like behavioral health and substance use treatment
    - Grayson County Health Department
    - Individual offices
    - Many services available within county
- Collaborative community
    - People working Together
    - Local leadership

Identified Opportunities

- Increasing access to services
    - Lymphedema
    - Orthopedics
    - Diabetes management
    - Physical trainers at student athletics to teach them how to take care of their bodies
    - More mental health and family practice physicians
    - Long wait times are an issue for many
    - Dental care for Medicaid patients
    - Transportation

- Community Education and Outreach
    - Health education offered at community spaces like schools and Extension Office
    - Education on resources available within community
    - Positive community interactions might build community trust and foster a positive perception of hospital

How to Better Meet Health Needs

Key informants identified two approaches to meet the health needs in Grayson County. Their suggestions on how to meet the health needs are outlined below:

Health Care Approach

- Transportation
    - Mobile units to take services to population
    - Transportation to appointments for those who are not eligible for CATS
    - Embed health care into other common locations
- Preventative Care and Education
    - Preventative care and next steps
    - Nutrition education
    - Raise awareness of issues
    - Education on available services
- Continued collaboration
    - Between schools and health systems
    - To understand patient barriers and address those barriers
- Expanding access
    - Rural access
    - Specialty services

Community Approach

- Transportation
    - Public transportation
- Continued collaboration
    - Between schools and health systems
    - Physical recreation in schools

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 February 5th, 2025.

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

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

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 Twin Lakes Medical Center Community Health Committee. After one month of review the committee met on March 5th, 2025, to complete the process of prioritizing the identified health needs. Consensus was drawn and the following represents the recommendations of the Community Health Committee to Owensboro Health Twin Lakes Medical Center for addressing health needs in Grayson County for the next three years.

- Mental health
- Addiction
    - Substance and behavior
    - Legal or illegal
- Nutrition
- Physical inactivity

7. Conclusion

Grayson 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 Twin Lakes Medical Center 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.

Community feedback to the report is an important step in the process of improving community health. Please send your comments to Jessica Embry, Owensboro Health Twin Lakes Medical Center Community Engagement Coordinator.

Email: jessica.embry@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 Twin Lakes Medical Center, in collaboration with Blueprint Kentucky, with the University of Kentucky, is conducting the Community Health Needs Assessment (CHNA) for Grayson 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.

1. Please tell us your zip code.

   _____

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)*

     _____

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)*

     _____

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 CATS 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)*

      _____

11. Is everyone in your household satisfied with your ability to access health care services in Grayson 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? *Please 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)*

_____

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

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

14. How would you rate the overall **mental health** of residents of Grayson 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)*

_____

16. Do you think Grayson 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 five** most common unhealthy behaviors in Grayson County. *Choose up to five 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 Grayson County to better meet the community's health needs?

_____

_____

_____

_____

_____

_____

_____

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

26. What is your annual household income?

- 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!

Grayson County Community Resources

Grayson County Alliance Resource Guide - https://gc-alliance.com/resource-guide

Approval

This Community Health Needs Assessment was approved by Owensboro Health Twin Lakes Medical Center Board of Directors on May 22nd, 2025 and was approved by the Owensboro Health Board of Directors on May 29th, 2025.