# Community Health Needs Assessment & Implementation Plan

2016-2018

St. Elizabeth
FT. THOMAS

# St. Elizabeth Ft. Thomas

## Community Health Needs Assessment & Community Benefits Implementation Plan

**November 2, 2015**

**CONDUCTED ON BEHALF OF:**
St. Elizabeth Healthcare

**FOR**:
St. Elizabeth Edgewood
St. Elizabeth Florence
St. Elizabeth Ft. Thomas
St. Elizabeth Grant

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# EXECUTIVE SUMMARY

St. Elizabeth Healthcare has a long history dedicated to strengthening the health of the community it serves. Every three years, St. Elizabeth Healthcare conducts a comprehensive Community Health Needs Assessment (CHNA). The process incorporates a systematic approach to identifying and analyzing the community health needs, prioritizing those needs, and develops an action plan to address the prioritized needs. This assessment meets the IRS Requirements governing Charitable 501(c)(3) Hospitals as defined by the Affordable Care Act.

St. Elizabeth Healthcare conducted a Community Health Needs Assessment in 2015 that included a combination of quantitative and qualitative information based on available national, state, regional and local health data. Incorporated in the assessment was input from public health agencies, social service agencies, educational institutions, healthcare providers, and civic services. Statistics for the St. Elizabeth Healthcare system were also reviewed in this assessment.

The service area considered for this assessment was determined by identifying where 90% of St. Elizabeth Healthcare patient population originates. The data revealed that, 93% of the patient population resides in the eight counties that make up the Northern Kentucky Area Development District (NKADD). The NKADD encompasses the counties of Boone, Campbell, Carroll, Gallatin, Grant, Kenton, Owen and Pendleton, with a population over 447,896 residents. All hospitals in the St. Elizabeth Healthcare system are located in this same geographical region.

Dearborn County, Indiana, is also included in this analysis since St. Elizabeth has begun offering healthcare services in this region.

The health needs identified by the community and health reporting resources were summarized and tabulated into a prioritized listing. This list was reviewed by the Community Benefits Steering Committee, composed of St. Elizabeth Healthcare executive leaders, who engaged in additional dialogue, taking into consideration what resources are available that when redirected would have the most positive impact on health outcomes. The Committee then, by vote, narrowed the list to the top three priorities. Next, the prioritized list was forwarded to the Strategic Planning Committee of the Board of Trustees to review, discuss, and approve the top issues that the system will concentrate on that will have the greatest possible impact on community health status**.**

**The top three priorities identified that will be address for years 2016, 2017, and 2018: Mental Health, Drug Addiction/Treatment, and Heart Disease.**

An Implementation Plan was developed to address prioritized health needs. The Board of Trustees reviewed and approved the Community Health Needs Assessment and Implementation Plan on November 2, 2015. The progress toward achieving the goals identified in the plan will be monitored and reported to the St. Elizabeth Healthcare Board of Trustees on a regular basis. The CHNA Plan is made widely available to the public.

## ACKNOWLEDGMENTS

Conducting a large-scale community health needs assessment would not be possible without the contributions of many members of our community. The Community Benefits Steering Committee wishes to express its gratitude for the contributions made by those who participated in the development of this assessment.

# Organization Description

## St. Elizabeth Healthcare

St. Elizabeth Healthcare operates four hospital facilities throughout Northern Kentucky: St. Elizabeth Edgewood, St. Elizabeth Florence, St. Elizabeth Ft. Thomas and St. Elizabeth Grant for a combined total of 1,153 patient beds. In addition, St. Elizabeth Healthcare operates an Ambulatory Care Center, an Alcohol and Drug Treatment Center, Hospice Center, three freestanding imaging centers and a physician organization which includes over 314 physicians and 71 mid-level providers (over 100 primary care and specialty office locations in Kentucky, Indiana, and Ohio), more than 1,200 physicians with admitting privileges and more than 7,300 associates. St. Elizabeth Healthcare is sponsored by the Diocese of Covington and provided more than $111 million in uncompensated care and benefit to the community in 2014. For more information, visit www.stelizabeth.com.

St. Elizabeth Healthcare provides a broad range of programs and services to address the needs identified by its patients and community to improve the health of Northern Kentucky. When and where appropriate, "Centers of Excellence" have been developed at specific facilities that are best suited to provide those services, thereby reducing the duplication and costs in providing services.

## Mission | Vision | Values

**Mission Statement**

As a Catholic healthcare ministry, we provide comprehensive and compassionate care that improves the health of the people we serve.

**Our Vision**

St. Elizabeth is the preferred destination for healthcare, where innovative professionals deliver the highest quality of care.

**Our Values**

**INNOVATION** - I seek better ways to perform my work, find creative solutions, and embrace change.
**COLLABORATION** - I understand that mutual respect and teamwork are critical to accomplishing goals. I work with others to achieve the best individual and collective outcomes.
**ACCOUNTABILITY** - I use resources efficiently, respond to others promptly, face challenges in a timely manner, and accept responsibility for my actions and decisions.
**RESPECT** - I respect the dignity and diversity of our associates, physicians, patients, family, and community members. I promote trust, fairness, and inclusiveness through honest and open communication.
**EXCELLENCE** - I believe in serving others by pursuing excellence in healthcare. I compassionately care for the mind, body, and spirit of each patient.

**Ethical & Religious Directives**

As a Catholic health system, St. Elizabeth Healthcare strictly follows the national Ethical and Religious Directives for Catholic Health Care Services.

The link below will take you to the directives published on the website for the United State Catholic Conference of Bishops:
http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/

# COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS

## Community Needs Assessment Purpose

A Community Health Needs Assessment (CHNA) serves an essential role in supporting hospitals, practitioners and policy-makers in identifying the greatest health needs in their communities. Recognizing that most needs are complex and require collaboration and various solutions, needs assessments establish the essential foundation for planning that can focus healthcare and community benefits resources to address healthcare disparities and enhance community health.

The CHNA evaluates the existing health needs of the community and the resources currently in place to meet those needs and then identifies any major gaps between the two. A prioritization process revealed the top three health needs. Data collected in the process informed development of an implementation plan to bridge the gap and better meet the identified health needs of the community.

## Community Health Needs Assessment Requirements

As part of the federal requirements included in the Affordable Care Act (ACA), nonprofit hospital systems under 501(c)(3) status, are required to conduct a broad-based Community Health Needs Assessment (CHNA) at least once every three years, beginning with tax year 2013.

The ACA requires that the hospital's CHNA include in a written report the following:

- A definition of the community served by the hospital and a description of how the community was determined;
- A description of the process and methods used to conduct the CHNA;
- A description of how the hospital took into account input from persons who represent the broad interests of the community it serves;
- A prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing such significant health needs; and
- A description of the potential measures and resources identified through the CHNA to address the significant health needs.

CHNA must be made available to the public online, and must be filed with the IRS.

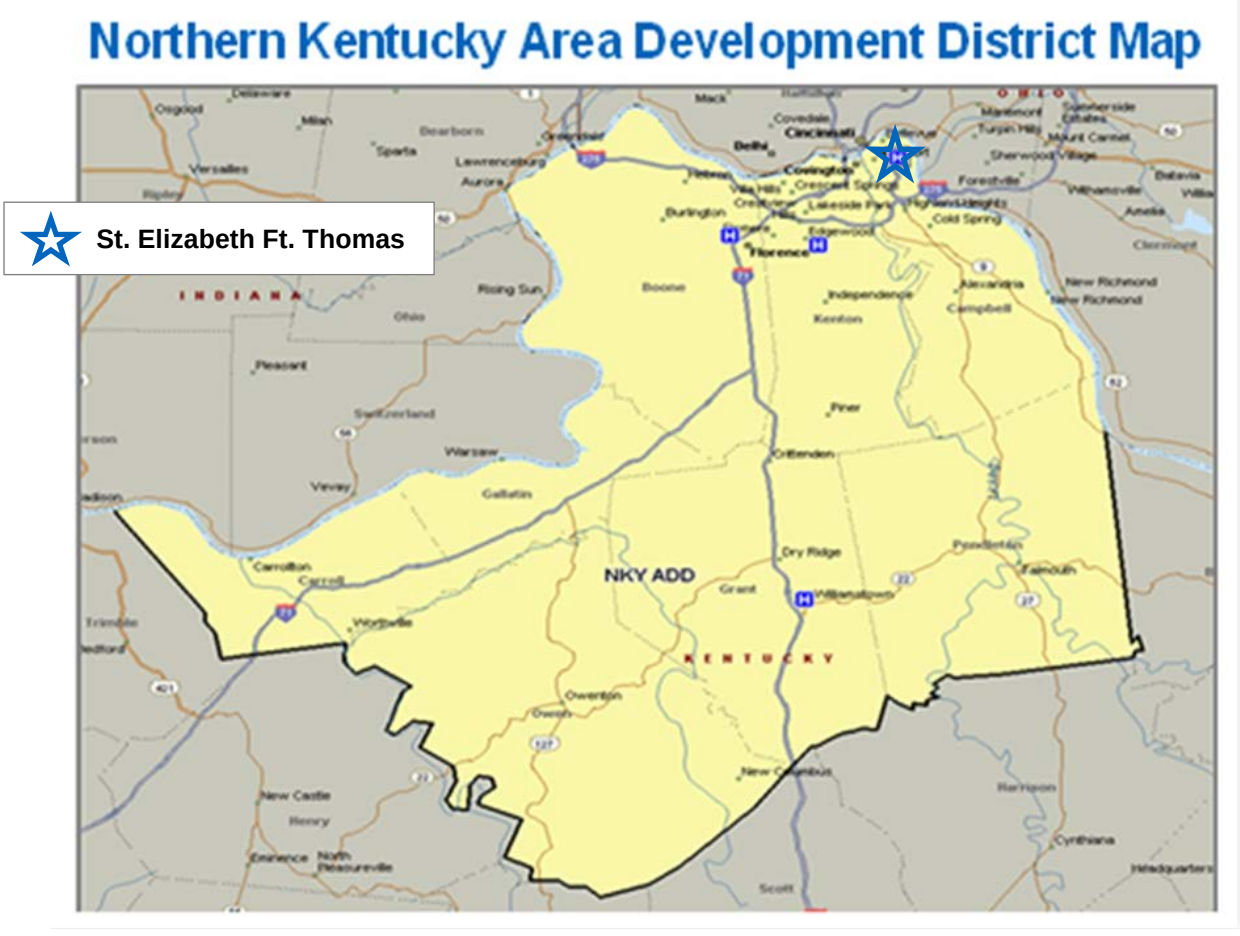
**St. Elizabeth Ft. Thomas**

This document is the Community Health Needs Assessment and Strategic Implementation Plan for St. Elizabeth Ft. Thomas, located in Ft. Thomas, Kentucky.

St. Elizabeth Ft. Thomas is a 332 bed full-service hospital featuring 24/7 emergency care, a center for breast health and cancer treatment center, a diabetes center, and cardiac rehabilitation services.

St. Elizabeth Ft. Thomas
85 N. Grand Avenue, Ft. Thomas
Campbell County, Kentucky 41075

| Fiscal Year 2011 — Operating Status | |
|---|---|
| Licensed Beds | 332 |
| Inpatients | 7,418 |
| Patients days | 35,956 |
| Births | - |
| Outpatient visits | 62,502 |
| Emergency room visits | 35,845 |



## The Community Benefits Steering Committee

The Community Benefits Steering Committee (CBSC) is an internal multi-disciplinary team that oversees the Community Health Needs Assessment (CHNA), the development of CHNA Plan, monitors the systems' activities to ensure it is achieving the objectives identified in the CHNA Plan, and provides periodic reports to the Strategic Planning Committee of the Board and the community. The Community Benefits Steering Committee makes recommendations to the Strategic Planning Committee of the Board, which recommends community benefits initially to the full SEH Board of Trustees. The Board of Trustees approves the CHNA.

The committee also has oversight of Community Benefits reporting to ensure that St. Elizabeth Healthcare is fulfilling its mission to improve the health of the community, and assure that the programs are in compliance with IRS 990 H requirements. (See Appendix: 1)

## Defining the Service Area

St. Elizabeth Healthcare's primary service areas considered in this assessment were determined by identifying where 90% of its patient population originates. This approach ensures that the assessment was not limited to a certain geographic areas but included the majority of the population served. The data revealed that 93% of the patient population resides in the counties that make up the Northern Kentucky Area Development District (NKADD). The NKADD encompasses the counties of Boone, Campbell, Carroll, Gallatin, Grant, Kenton, Owen and Pendleton, and represents over 447,896 residents. All hospitals in the St. Elizabeth Healthcare system are located in this region. This also simplified the acquisition and standardization of data since the state of Kentucky and other resources report out their data at the NKADD level. (See map on previous page).

Dearborn County, Indiana, was also included in this analysis since St. Elizabeth has begun offering healthcare services in this area.

| St. Elizabeth Edgewood — Total Discharges for 2014 | | | | |
|---|---|---|---|---|
| **County** | **Inpatients** | **Outpatients** | **Total** | **% of Total** |
| Kenton | 17,095 | 284,066 | 301,161 | 34.45% |
| Boone | 11,920 | 222,225 | 234,145 | 26.79% |
| Campbell | 9,324 | 155,890 | 165,214 | 18.90% |
| Grant | 3,171 | 64,927 | 68,098 | 7.79% |
| Pendleton | 1,476 | 24,233 | 25,709 | 2.94% |
| Gallatin | 895 | 12,488 | 13,383 | 1.53% |
| Owen | 336 | 4,097 | 4,433 | 0.51% |
| Carroll | 265 | 2,144 | 2,409 | 0.28% |
| NKADD Total | 44,482 | 770,070 | 814,552 | 93.19% |
| Other Counties | 3,387 | 56,164 | 59,551 | 6.81% |
| **Total** | **47,869** | **826,234** | **874,103** | **100.00%** |

## COLLECTING AND ANALYZING DATA

The CHNA process and plan development was conducted over a course of five months (February to July). St. Elizabeth Healthcare's four hospitals worked collaboratively on this CHNA since they are located in the same geographical region and have established cross coverage of services.

### Prior CHNA Plan

The assessment began with reviewing the existing Community Health Plan for the years 2013 through 2015 for any pertinent information that may have an impact on the current assessment. The area of concentration included Heart Disease, Diabetes and Obesity.

Over the course of two and half years, all areas were actively working towards their intended goals. Activities were tracked and quarterly dashboards were presented to the Board of Trustees for review and input. (See Appendix: 2)

- Regional Diabetes Center:
  - Using the American Diabetes Association guidelines developed a curriculum for a Prevent Diabetes Class that is presented at community events.
  - Has and will continue to participate at health fairs and provide screening opportunities.
  - Established community support groups.
  - Began a Nurse Practitioner Outreach Program in Primary Care Physician (PCP) Offices.
- Weight Management Center:
  - Provided wellness in-services in the schools.
  - St. Elizabeth Physicians implemented an action plan to identify and educate patients.
  - Internally developed and promoted a corporate-based wellness services.
  - Established best practice alert for medical & surgical pathways as obesity treatment choices for PCPs.
  - Developed Weight Management educational content for exam room screen savers.
- Heart & Vascular Institute:
  - Increased the number of vascular screenings.
  - Increased the number of physician lead educational events.
  - Participated in new hospital-based research studies.
  - Provided educational programs to the community and in area schools.
  - Offered programs cover issues that also addressed the other chronic diseases of obesity and diabetes.

These departments will continue providing these enhanced services.

### Secondary Data - Collection

Multiple secondary data sources were used to gather data on population demographics, including:

- U.S. Census Bureau (Quick Facts, http://quickfacts.census.gov/qfd/index.html ) (See Appendix: 3)
- Health status indicators, social and behavioral indicators; health outcomes; prevalence of chronic diseases; access to care; and maternal and child health, (source: Kentucky Health Facts.org, http://kentuckyhealthfacts.org/
- County Health Rankings.org, http://www.countyhealthrankings.org
- America's Health Rankings, http://www.americashealthrankings.org/

The secondary data were summarized and tabulated in order of importance. The chart on the following page illustrates the top 10 health issues identified by the reporting sources.

The timeliness of the source data was a consideration in the prioritization process, as dated information may not accurately reflect current healthcare needs that are reported in the Primary Data.

**2015 CHNA Listing of Secondary Data Prioritized**

| CHSI** | KY Health Rankings | KyHealthNow | Skyward (Formerly Vision 2020) | Health Collaborative | Ranking |
|---|---|---|---|---|---|
| | | | | | |
| Wellness - Overall Health | Cancer Deaths | Reduce uninsured | Live Well NKY | Health Behaviors | **Smoking** |
| Cancer | Poor Mental Health Days | Smoking | Smoke free | Care Delivery | **Mental Health** |
| Mental Health | Preventable Hospitalizations | Obesity | Drug | Payment & Financing | **Obesity** |
| Chronic | High Cholesterol | Cancer | Mental health | | **Cancer** |
| Smoking | Smoking | Cardiovascular deaths | | | **Heart** |
| Teen Births & Preterm | Drug Deaths | Dental | | | **Drug** |
| Diabetes | Health attack & Heart Disease | Drug | | | **Wellness** |
| Obesity | Stroke | Mental Health | | | Stroke |
| Motor Vehicle | High Blood Pressure | | | | **Diabetes** |
| Coronary Heart Disease Deaths | Obesity | | | | **Dental** |
| Stroke Deaths | | | | | |
| Unintentional injury (including Motor Vehicle) | | | | | |

** Community Health Status Indicators by the Center for Disease Control and Prevention
(See Appendix: 4 for additional information on the secondary data sources)

## Primary Data - Gathering Community Input

Primary data was collected from persons who represent the broad interests of the community, including those with expertise in public health. Representation included area Health Departments, local governmental/civic agencies, healthcare providers, community based social service agencies and area school districts. (See Appendix 5)

The methodology used to collect the data included one-on-one meetings, presentations to groups, phone calls, and an on-line survey. The process included an explanation of the CHNA requirements and how the data garnered will be used to develop the CHNA Plan. Participants were then asked to list in order from most important to least important what they believe are the top five community health needs that need to be addressed and/or considered in this assessment. (See Appendix 6) Primary data was summarized and tabulated.

Concentrating on social service agencies, school districts and civic services ensured that the CHNA identified and received data on the most pressing health needs within the community served. Two local community organizations that work in collaboration with like community providers are the Safety Net Alliance and the Northern Kentucky Education Council. They permitted St. Elizabeth to use their membership email listing to send information about the CHNA and the request for input.

Safety Net Alliance http://nkysafetynet.org

Formed in June 2007, the Safety Net Alliance is a collaboration of social service agencies and other entities committed to providing effective and efficient emergency assistance to Northern Kentucky residents in need. The Alliance currently consists of 120 Partner Agencies including non-profit organizations, government groups and education and faith-based initiatives.

Northern Kentucky Education Council – http://nkyec.org/

The Northern Kentucky Education Council is the backbone organization for the alignment of educational initiatives in Northern Kentucky. The Council serves as a catalyst for collaboration, change and progress toward regional educational goals. Membership includes area schools and various community partners.

## Summary of Primary Data:

Throughout the primary data collection process, when participants were asked "What do you think are the five most significant health problems in your community?" the common themes that emerged were mental health and drug addiction/treatment. Heroin was mentioned as the most serious substance abuse problem in NKY.

**2015 CHNA Listing of Primary Data Prioritized**

| Community At Large | Health Department | Civic Services | SEH Frontline | St. Elizabeth Physicians | Ranking |
|---|---|---|---|---|---|
| | | | | | |
| Drug Addiction Treatment | Tobacco | Drug Addiction Treatment | Heart Disease | Drug Addiction Treatment | **Drug** |
| Dental | Drug Addiction Treatment | Mental Health-Behavior Health | Mental Health-Behavior Health | Wellness Overall Health | **Mental Health** |
| Wellness Overall Health | Obesity | Heart Disease | Drug Addiction Treatment | Mental Health-Behavior Health | **Obesity** |
| Obesity | Access to Care | Dental | Dental | Obesity | **Dental** |
| Mental Health-Behavior Health | Chronic Disease | Obesity | Tobacco | Diabetes | **Tobacco** |
| Tobacco | Dental | Wellness Overall Health | Diabetes | Financial Assistance | **Heart** |
| Access to Care | Medical Care for uninsured | Cancer | Transportation | Tobacco | **Wellness** |
| Chronic Diseases | Address disparities in health outcomes | Transportation | Transition of Care | Med Compliance | **Diabetes** |
| Diabetes | Breaking the cycle - unhealthy across generations | Urgent Care Centers for area of Major Growth | Emergency Shelters | Access to Care | **Access** |
| Care Coordination | | Easily accessible and coordinated resources | Geriatric Care and placement | PainManagement | **Cancer** |
| Heart Disease | | | Avoidable ED Visits/ admissions | Transportation | **Transportation** |
| Cancer | | | Cancer | More Physicians | |
| Preventive Health and Wellness for the poor | | | Medication Access - compliance, cost | | |
| Maternity Care of Undocumented / Low income and non-resident families | | | | | |

(For additional information on mental health and drug addiction, see Appendix 7)

## Prioritization of Identified Health Needs

Like many communities in Kentucky, heart disease, cancer, stroke, obesity, diabetes, mental health and substance abuse, are prevalent in all of the NKADD counties.

After the assessment data was gathered, it was summarized into categories and tabulated. The findings were presented to the CBSC for review and thoroughly discussed. The committee was tasked with ranking the community's most important health needs and providing suggestions for hospital priorities. The majority of the needs listed are currently being addressed by St. Elizabeth Healthcare or community providers. A vote taken to determine which of the needs identified should be addressed in the new Plan. **The three top needs identified to be addressed were Mental Health, Drug Addiction/Treatment and Heart Disease.**

The prioritized list along with the assessment findings were presented to the Strategic Planning Committee of the Board for review, discussion and a combination of the identified priorities. This step in the CHNA process is significant because the priorities identified drive the development of an implementation strategy and the related goals.

| Community Benefits Steering Committee | | | | |
|---|---|---|---|---|
| **Secondary Data** | **Primary Data** | **Combined** | | **Steering Committee** |
| **Ranking** | **Ranking** | **Ranking** | | **Ranking** |
| | | | | |
| Smoking | Drug | Drug | | **Mental Health** |
| Mental Health | Mental Health | Mental Health | | **Drug** |
| Obesity | Obesity | Tobacco | | **Heart** |
| Cancer | Dental | Obesity | | **Diabetes** |
| Heart | Tobacco | Heart | | **Tobacco** |
| Drug | Heart | Wellness | | **Obesity** |
| Wellness | Wellness | Cancer | | **Cancer** |
| Diabetes | Diabetes | Dental | | **Wellness** |
| Stroke | Access | Diabetes | | **Dental** |
| Dental | Cancer | Access | | **Access** |
| | Transportation | Transportation | | |
| | | Stroke | | |

The summary below highlights the prioritized health improvement needs that will be addressed for the years 2016 through 2018.

- **Mental Health --** To collaborate with community partners to develop programs/services to diagnosis, treat, educate, prevent and assist residents of Northern Kentucky, with mental health issues.
- **Drug Addiction/Treatment --** To collaborate with community partners to develop treatment programs for those who need assistance.
- **Heart Disease --** Develop a comprehensive integrated approach to the prevention, diagnosis and treatment of heart disease with a focus on research.

The healthcare needs identified by the community that were not chosen as top priorities are currently being addressed by St. Elizabeth Healthcare through existing programs and other providers (see Appendix 9).

Next the CBSC identified content experts to across the system to assist in developing the program/activities to address the needs.

## COMMUNITY HEALTH IMPLEMENTATION PLAN, 2016–2018

Staff with expertise in the areas of identified needs were involved in the development of strategies to be incorporated into the CHNA Implementation plan to address the prioritized focus areas. This plan was reviewed and revised by the Community Benefits Steering Committee. The revised plan was then taken to the Strategic Planning committee of the St. Elizabeth Healthcare Board for review and approval. Once approved, the plan was taken to the Board of Trustees and approved on November 2, 2015.

### The following is a summary of the strategies to address the prioritized needs identified in the CHNA Plan for 2016 through 2018.

# Mental Health:

**Goal**

- Collaborate with community partners to develop programs/services to educate, treat, prevent and assist residents of Northern Kentucky, with mental health issues.
- Develop comprehensive behavioral health care services based on proven best practice models.

**Measure:**

- Increase treatment capacity both inpatient and outpatient services.

**Strategies/Tactics:**

- Add 5-7 new providers.
- Develop a child\teen program.
- Integrate behavioral health services within primary care physician offices.
- Improve coordination with community partners such as social services, schools, and county officials to extend the continuum of care.
- Improve access to education in the community.

**Already in Process:**

To adequately meet the needs of the community, St. Elizabeth Healthcare entered into a joint venture partnership with SUN Behavioral Health to build and operate a 197 bed freestanding Behavior Health (BH) hospital in Northern Kentucky. This will be completed in 2017. Services include specialized inpatient and partial hospitalization services across a spectrum of behavioral disorders and chemical dependencies, including a BH Emergency Room for non-medical BH patients. The dedicated BH facility will serve both adolescents and adults.

# Drug Addiction/Treatment:

**Goal:**

- Reduce substance abuse to protect the health, safety and quality of life for all.
- Take a leadership role in education and data distribution.

**Measure:**

- Increase treatment capacity for inpatient and outpatient services.
- Reduce overdoses in Northern Kentucky. (2014 Treated at SEH: 745)
- Reduce drug induced deaths. (2014 NKY: 188)

**Strategies/Tactics**:

- Work with community partners to educate residents on the dangers of the use/addiction of heroin and prescription opioid painkillers.
- Increase access to substance abuse treatment services, including Medication-Assisted Treatment (MAT), for opioid addiction.
- Expand access to and training for administering naloxone to reduce opioid overdose deaths.
- Help local jurisdictions to put these effective practices to work in communities where drug addiction is common, e.g., local detention centers.
- Work collaboratively with community partners in the continuity of care and wraparound services.
- Recruit additional addictionologists.
- Develop support services for addicted mother and babies born with neonatal abstinence syndrome.

**Already in Process:**

St. Elizabeth participated on the Northern Kentucky's Collective Response To the Heroin Epidemic coalition. Using the group's findings and recommendations, St. Elizabeth conducted its own gap analysis comparing SEH's and SEP's available services. This analysis serves as the basis for determining potential services that could be developed to address this community issue.

St. Elizabeth is among the first health organizations in the United States to partner with the Hazelden Betty Ford Foundation to address the nationwide heroin and prescription painkiller crisis. This partnership includes training for St. Elizabeth staff and community members in Hazelden's Comprehensive Opioid response 12 (COR 12 program), which combines Hazelden's traditional 12-step recovery method with medication-assisted treatment.

St. Elizabeth has also opened an addiction clinic, recruited addictionologists, and pledged $250,000 to purchase naloxone for first responders.

St. Elizabeth Healthcare entered into a joint venture partnership with SUN Behavioral Health to build and operate a 197-bed freestanding Behavior Health hospital in Northern Kentucky. This is to be completed in 2017. Services include specialized inpatient and partial hospitalization services across a spectrum of behavioral disorders and chemical dependencies, including a BH Emergency Room for non-medical BH patients.

## Heart Disease:

**Goal:**

- To develop a Heart & Vascular Institute which encompasses a comprehensive integrated approach to the prevention, diagnosis and treatment of heart disease with a focus on research.

**Measure**

- Reduce heart-related deaths in Northern Kentucky by 25 percent by the end of 2025.
- Work collaboratively with physicians, community stakeholders and industry to identify new treatments and technology through initiation of research activities.

**All Heart Disease Mortality Rate 2011- 2013**

Average yearly rate per 100,000

| County | Rate | County | Rate |
|---|---|---|---|
| Boone | 164.5 | Grant | 258.0 |
| Campbell | 180.8 | Kenton | 191.9 |
| Carroll | 227.2 | Owen | 344.2 |
| Gallatin | 421.1 | Pendleton | 212.7 |
| Northern Kentucky Area Development District | | | 193.8 |

Source: Claritas; CDC (http://nccd.cdc.gov/DHDSPAtlas); Based on All Heart Disease Mortality, All Ages, 2011-2013, Smoothed.

**Strategies/Tactics:**

- Provide prevention and wellness services to the community with the goal of catching heart and vascular disease early or preventing it all together.
- Support ongoing research for the community.
- Implement strategies identified by St. Elizabeth Physicians.
- Improve information received from EMS prior to arrival at the hospital.
- Increase community education on heart attack symptoms, the importance of timely response to symptoms and the importance of calling 911.
- Promote development of walkable and active communities.

**Already in Process:**

The St. Elizabeth Heart & Vascular Institute serves as a resource for community.

- Opened in 2015
- Participated in several clinical trials (Leadership Saves Lives, Tailor Percutaneous Coronary Intervention)
- Hired HVI educators to provide outreach

## Community Healthcare Resources

St. Elizabeth Healthcare has and will continue to work collaboratively with the various healthcare resources that are accessible to the residents of Northern Kentucky when applicable to address the needs identified in the Community Health Needs Assessment.

### Hospital Facilities in the Northern Kentucky Area Development District

| Name | County | Type | # Beds |
|---|---|---|---|
| Carroll County Memorial Hospital | Carroll | Critical Access | 25 |
| Gateway Rehabilitation Hospital | Boone | Physical Rehabilitation | 40 |
| Healthsouth Northern KY Rehabilitation | Kenton | Physical Rehabilitation | 40 |
| NorthKey Community Care Intensive Services | Kenton | Acute Care<br>Psychiatric | 6<br>51 |
| New Horizons Medical Center | Owen | Critical Access | 25 |
| St. Elizabeth Edgewood | Kenton | Acute Care<br>General Psychiatric<br>Neonatal II<br>Neonatal III | 515<br>52<br>18<br>12 |
| St. Elizabeth Falmouth | Pendleton | Chemical Dependency | 28 |
| St. Elizabeth Ft. Thomas | Campbell | Acute Care | 284 |
| St. Elizabeth Florence | Boone | Acute Care<br>Psychiatric | 139<br>22 |
| St. Elizabeth Grant | Grant | Acute Critical Access | 25 |

Source: Kentucky Cabinet for Health and Family Services, Inventory of Kentucky Health Facilities; May 2015

### Health Departments

- Northern Kentucky Independent Health District
  *(Serves Boone, Kenton, Campbell and Grant Counties http://www.nkyhealth.org )*
- Three Rivers District Health Department
  *(Serves Carroll, Gallatin, Owen and Pendleton Counties*
  *http://www.trdhd.com/mx/hm.asp?id=home)*
- Dearborn County Health Department
  (Serves Dearborn County, Indiana
  http://www.dearborncounty.org/egov/apps/locations/facilities.egov?view=detail&id=45

### Other Health Needs Identified by the Assessment

The remaining healthcare needs that were identified in this assessment that were not chosen as the top priorities are currently being addressed by St. Elizabeth Healthcare through existing programs and services or other providers (See Appendix 8).

# APPENDIX

# Appendix 1:

## Community Benefits Steering Committee

The Community Benefits Steering Committee is a multi-disciplinary team to oversee the Community Health Needs Assessment (CHNA), the development of CHNA Plan, monitors the system's activities to ensure it is achieving the objectives identified in the CHNA Plan and provide periodic reports to the Strategic Planning Committee of the Board and the community. **The Community Benefits committee makes recommendations to the Strategic Planning Committee of the Board who will serve as the approving body.**

**Committee composition**:
The committee will consist of the following representatives who will meet annually or as needed:

- Lori Ritchey-Baldwin, SVP Finance/Chief Financial Officer
- Sarah Giolando, SVP and Chief Strategy Officer
- Gary Blank, Exec VP & Chief Operating Officer
- Rosanne Nields, VP, Planning and Government Relations
- Anthony Helton, VP, Revenue Cycle, Patient Finance
- David Bailey, Dir. Community Benefits, Planning & Government Relations
- Director of Public Relations and Marketing Communications (Open Position)
- Mary Jindra Koch, Dir. Service & Communication, St. Elizabeth Physicians
- Duke Osborne, Manager Tax, General Accounting
- Brent Harvey, Manager of Planning & Program Development

**Tasks of the Committee**:

The following tasks/decisions will be the primary functions:

- Review the existing 2013 - 2015 Community Health Needs Assessment (CHNA) Plan regularly and report the progress towards its goals to the system's Board.
- Oversee implementation of the CHNA and update the Community Benefit Plan accordingly every 3 years (required by ACA). Next assessment and plan update needs to be completed in 2015.
- Review the Community Benefits activities and annual report to assure compliance with IRS 990 H requirements. Make recommendations regarding communication efforts and public reporting.

# Appendix 2:

## St. Elizabeth Healthcare

### Community Health Needs Assessment 2013 -- 2015 2014 Update 4th Qtr.

**Obesity: Reduce obesity rate of 33.3% for the PSA towards 2020 Healthy People 2020 goal of 30%.**

| Strategies/Tactics | Measures/Action Plans - 2014 | Baseline | Status | | | |
|---|---|---|---|---|---|---|
| | | | 1st | 2nd | 3rd | 4th |
| Partnership with area schools to provide wellness education and other initiatives. | Provide education programs in 10 schools | 10 | 1 | 4 | 2 | 4 |
| | Work with Boone County School and NKU College of Informatics to develop health education program (gamification) | 1 | 1 | 1 | 1 | 1 |
| Offer services through SEP that will provide the tools, education resources, to those in our community who struggle with obesity and co-morbidities | Reduce patient population with BMI >30. Current SEP patient population is 41.01% to 39.84% by 2015. | 41% | | | 41.48% | 42.61% |
| | Increase weight management referrals from SEP in 2014 from a base of 1,100 | 1,100 | 451 | 566 | 538 | 426 |
| Work through Business Health to increase focus with area employers on nutrition and fitness programs for their associates and encourage incentives e.g. insurance discounts for healthy behaviors | Continue to strategically develop and promote corporate based Wellness Services. Goal – Meet with 10 corporate accounts per quarter. | 10 | 17 | 18 | 9 | 11 |
| Leverage and explore partnerships with community organizations and legislators to support efforts to reduce obesity | Identify and implement three partnerships to develop activities or initiatives to address obesity | 3 | 1 | 1 | 0 | 1 |
| Support/enhance efforts for SEH's & SEP's employees such as Target Health, insurance incentives, fitness centers, etc. | Set goals through Human Resources/Benefits and Comp. Goal- to have 20 activities per quarter within SEH/SEP | 20 | 20 | 30 | 45 | 32 |
| Develop promotional efforts to educate public on strategies to reduce obesity. | Encourage associates and promote to public to participate in 14 programs in 2014 and promote the events | 13 | 7 | 5 | 7 | 3 |

**Heart: Reduce the current incidence of mortality from heart disease by 25% over 20 years as targeted by the Heart and Vascular Institute Campaign (Currently at 230+ for the Northern Kentucky counties).**

| Strategies/Tactics | Measures/Action Plans - 2014 | Baseline | Status | | | |
|---|---|---|---|---|---|---|
| | | | 1st | 2nd | 3rd | 4th |
| Heart and Vascular strategic plan initiatives | Increase average encounter at mobile sites — Dates | 182 | 45 | 58 | 58 | 50 |
| | Patien | 1449 | 442 | 518 | 602 | 567 |
| | Screenings | 3933 | 1017 | 1224 | 1260 | 1448 |
| Increase outreach efforts for prevention, education, and screenings | Increase the number of physician lead educational events | 10 | 3 | 4 | 3 | 2 |
| Increased research efforts to increase quality of care and innovative approaches to care | Participate in at least 2 new hospital based research studies | 2 | 0 | 0 | 2 | 0 |
| Heart & Vascular Institute as a resource for community e.g. CHF clinics, stroke clinic, etc. | Establish two new outreach locations (focus on EP) | 0 | 0 | 1 | 0 | 1 |

**Diabetes: Increase the screening of residents who are at risk for diabetes. Enhance the percentage of SEP practices that meet all 5 standards for diabetes care.**

| Strategies/Tactics | Measures/Action Plans - 2014 | Baseline | Status | | | |
|---|---|---|---|---|---|---|
| | | | 1st | 2nd | 3rd | 4th |
| Continue to provide and enhance the Regional Diabetes Center for the community including education, support, screenings, and treatment | Provide New Education on Prevention of Diabetes Program provided by the RDC. | 4 | | | 5 | 6 |
| Expand diabetes educational services affecting patients who are interested in utilizing an insulin pump to new locations, i.e. Grant County, schools, churches | Offer new open to public monthly insulin pump/sensor informational programs | 12 | 1 | 3 | 6 | 5 |
| SEP to enhance diabetes treatment and performance on five (5) community wide standards as indicated on the Your Health Matters website. | Provide health screening services to the community through community events and in office screenings to exceed 66 individual screenings as reported in 2013. | 67 | 0 | 102 | 145 | 203 |
| | Increase to 50% of SEP physicians meeting the 5 standards on diabetes and participate in the annual audit for public reporting through "Your Health Matters.org". Provide ongoing monthly reporting to providers through EPIC quality reporting | 38% | | 31% | 44.5% | 44.5% |

Legend: On Target — Work in progress — meeting goal

# Appendix 3:

| Population Demographics (US Census 2013 Estimates) ** | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Population totals 2013 estimates | White alone, not Hispanic or Latino | Black or African American | Hispanic or Latino | American Indian & Alaska Native | Asian | Native Hawaiian & other Pacific Islander | Two or More Races | Persons Below Poverty Level, Percent 2009-2013 All Ages | Uninsured ++ |
| **USA** | 316 Mil | 62.5% | 13.2% | 17.1% | 1.2% | 5.3% | 0.2% | 2.4% | 15.4% | 17% |
| **Kentucky** | 4,399,583 | 85.6% | 8.2% | 3.3% | 0.3% | 1.3% | 0.1% | 1.7% | 18.8% | 17% |
| **Indiana** | 6,570.713 | 80.7% | 9.5% | 6.4% | 0.4% | 1.9% | 0.1% | 1.8% | 15.4% | 17% |
| | | | | | | | | | | |
| **Counties** | | | | | | | | | | |
| **Boone** | 124,442 | 88.9% | 3.0% | 3.9% | 0.2% | 2.6% | 0.1% | 1.7% | 9.0% | 12% |
| **Campbell** | 90,988 | 92.9% | 2.9% | 1.8% | 0.2% | 0.9% | Z | 1.6% | 13.0% | 13% |
| **Carroll** | 10,953 | 88.7% | 2.0% | 6.8% | 0.4% | 0.5% | 0.1% | 1.9% | 29.9% | 19% |
| **Gallatin** | 8,474 | 91.5% | 1.6% | 5.2% | 0.2% | 0.3% | 0.1% | 1.8% | 20.7% | 20% |
| **Grant** | 24,662 | 94.8% | 0.9% | 2.4% | 0.3% | 0.4% | 0.2% | 2.4% | 18.0% | 17% |
| **Kenton** | 163,145 | 89.3% | 4.9% | 2.8% | 0.3% | 1.2% | 0.2% | 2.8% | 13.7% | 15% |
| **Owen** | 10,662 | 95.1% | 1.0% | 2.6% | 0.3% | 0.2% | Z | 1.0% | 16.2% | 16% |
| **Pendleton** | 14,570 | 97.1% | 0.6% | 1.1% | 0.3% | 0.3% | Z | 0.9% | 15.6% | 17% |
| | | | | | | | | | | |
| **Dearborn IN** | 49,904 | 96.5% | 0.7% | 1.2% | 0.2% | 0.5% | 0.1% | 1.0% | 9.1% | 13% |
| | | | | | | | | | | |

**Source: Quick Facts from US Census Bureau; quickfacts.census.gov February 24, 2015
Z: Value greater than zero but less than half unit of measure shown
++ County Health Rankings 2015 www.countyhealthrankings.org

| Age Groups | State | Counties | | | | | | | | State | County | USA |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| As percent of 2013 totals | Kentucky | Boone | Campbell | Carroll | Gallatin | Grant | Kenton | Owen | Pendleton | Indiana | Dearborn | |
| Persons under 5 years | 6.30% | 7.10% | 6.20% | 8.30% | 6.50% | 7.50% | 7.10% | 5.30% | 5.30% | 6.40% | 5.60% | 6.30% |
| Persons under 18 years | 23.10% | 27.60% | 22.40% | 25.70% | 25.90% | 27.60% | 24.60% | 23.40% | 23.40% | 24.10% | 24.00% | 23.30% |
| Persons 65 years and over | 14.40% | 10.70% | 13.50% | 14.20% | 12.30% | 12.10% | 12.30% | 16.00% | 16.00% | 13.90% | 14.60% | 14.10% |

Source: Quick Facts from US Census Bureau; quickfacts.census.gov February 24, 2015

# Appendix 4:

## Secondary data sources and additional information

**The Community Health Status Indicators (CHSI) 2015** is an online web application produced by the Center for Disease Control and Prevention, which produces health status profiles for each of the 3,143 counties in the United States and the District of Columbia.

Each county profile contains indicators of health outcomes (mortality and morbidity); indicators on factors selected based on evidence that they potentially have an important influence on population health status (e.g., health care access and quality, health behaviors, social factors, physical environment); health outcome indicators stratified by subpopulations (e.g., race and ethnicity); important demographic characteristics; and HP 2020 targets. http://wwwn.cdc.gov/communityhealth 4/24/2015

Quartile Headings Summarized: Mortality, Morbidity, and Health Behaviors. Items were ranked by most often mentioned to least mentioned. Counties Included: Boone, Campbell, Carroll, Gallatin, Grant, Kenton, Owen, Pendleton in KY & Dearborn, Indiana

Kentucky Health Rankings

Kentucky continues to rank at the bottom in most national health rankings. (Overall Rank: 47th per America's Health Ranking 2014) http://www.americashealthrankings.org/KY

| | |
|---|---|
| 50th Cancer Deaths | 48th Drug Deaths |
| 50th Poor Mental Health Days | 48th Health attack & Heart Disease |
| 50th Preventable Hospitalizations | 47th Stroke |
| 49th High Cholesterol | 46th High Blook Pressure |
| 49th Smoking | 46th Obesity |

**Kentucky Health Initiative**
**kyhealthnow 2019 (Initiative of Governor Steve Beshear)**

**Goals:**

Reduce Kentucky's rate of uninsured individuals to less than 5%.
Reduce Kentucky's smoking rate by 10%.
Reduce the rate of obesity among Kentuckians by 10%.
Reduce Kentucky cancer deaths by 10%.
Reduce cardiovascular deaths by 10%.
Reduce the percentage of children with untreated dental decay by 25% and increase adult dental visits by 10%.
Reduce deaths from drug overdose by 25%.
Reduce by 25% the average number of poor mental health days of Kentuckians.

***Kentucky Health Facts*** is sponsored by the Foundation for a Healthy Kentucky. The aim of this website, begun as part of the Foundation's *Local Data for Local Action* initiative, is to provide ready access to key health data for Kentucky communities. Our hope is that communities will use this data to identify local needs, to motivate change, to guide planning efforts, and to take meaningful, positive action toward improved health. http://kentuckyhealthfacts.org/

**Skyward (Formerly Vision 2020)** Health is the foundation for Northern Kentucky's future growth and vitality. Currently ranked 47th out of 50 states in overall health, it is critical for Kentucky to promote healthy behaviors such as active lifestyles, proper nutrition, and smoking cessation. With the help of the myNKY vision, we're determined to make the healthiest choice the easiest choice for everyone in Northern Kentucky. Our goal is to have 20,000 more adults rating their health status as very good or excellent. **www.mynky.org**

Transformational tactics to realize this goal include:

- Implement LiveWell NKY, a program designating local residents, organizations, and communities as "LiveWell" ambassadors by achieving health goals in exercise, nutrition, and smoking cessation.
- Implement SmokeFree NKY, a program dedicated to reducing the number of smokers, as well as eliminating second-hand smoke exposure in public places.
- Invest in and support education, training, and applied research programs designed to improve population health.
- Increase regional access to mental health and substance abuse services.

**United Way "Bold Goals For Our Region"**

Bold Goals….by 2020

- At least 70% of the community will report having excellent or very good health: Metric -- went from 50% to 52% in 2013.
- At least 95% of the community will report having a usual and appropriate place to go for health care: Metric -- went from 80% to 82% in 2013.
- http://www.uwgc.org/community-impact/bold-goals-for-our-region

**The Health Collaborative:**
http://the-collaborative.org/home/what-we-do/collective-impact-on-health/

## Appendix 5:

**Community Health Needs Assessment**
**Community Participants**

### SOCIAL SERVICE AGENCIES

**AHEC Hispanic Health Edu Survey**
- Juliana McGuinn

**Apprisen**
- David Johnsoe

**Be Concerned**
- Andy Brunsman

**Brighton Center, Inc.**
- Wonda Winkler

**Campbell Cty Fiscal Court - Assistance Program**
- Lisa Haines

**Catholic Charities**
- Shannon Braun

**Children Home of NKY**
- Rick W. Wuth

**Children Inc.**
- Gayle Drexter

**Children's Law Center**
- John Vissman

**Cincinnati VA**
- Emily Hunt

**City Heights Health Center**
- Lynn Brown

**Faith Community Pharmacy**
- Rosana Aydt

**Hosea Hous**
- Karen Yates

**Interact For Health**
- Jennifer Chubinski

**ITN Greater Cincinnati**
- Kathy Nafus

**Jacc, Inc.**
- Chuck Heilman

**KY Office for the Blind**
- Larry McNabb

**Life Learning Center**
- Leah Janssen

**Life Point Solutions**
- Anna Stark

**NKU NACU Ctr City Heights,**
- Cindy Foster, RN, Site Director

**Rosedale Green**
- Londa Knollmay

**The Butler Foundation**
- Barbara Schaefer

**Transitions, Inc.**
- Robert Schrage

**Welcomed House of NKY Inc.**
- Linda Young

### BUSINESSES

**Anthem Medicaid**
- Mendy Ruby

**CareSource & Humana**
- Mary Robinson

**NKY Chamber of Commerce**
- Adam Casewell

**Business Benefits**
- Jim Beatrice

### SCHOOLS

**Bellevue Independent Schools**
- Tara Wittrock

**Boone Cty Schools- North Pointe**
- Chris Deel

**Campbell County Schools**
- Diana Taylor

**Campbell County Schools**
- Connie Pohlgeers

**Caywood Elementary**
- Kelly Fagin

**Collins Elementary School**
- Jennifer Neace

**Covington Independent Public Schools**
- Elaine Bolte

**Covington Independent Schools**
- Joy Collins/Janice Wilkerson

**Dayton High School**
- Sherri Chan

**Erlanger-Elsmere Independent Schools**
- Mary Burch

**Grant County Middle School**
- Lynn Bailey

**Grant County Schools**
- Rhonda Schlueter

**Kenton County School District**
- Paula Rust/Nicole Dirks

**Larry A. Ryle High School**
- Erik Arkenberg

**Lawrenceburg Community School**
- Karl Galey

**Lloyd Memorial High School**
- Shawn Lehman

**Northern Kentucky University**
- Joseph Winn

**Ockerman Middle School**
- Marcella Coomer

**Pendleton County High School**
- Chad Simms

**Piner Elementary**
- Christi Jefferds

**Reiley Elementary**
- Susan Rath

### HEALTH DEPARTMENTS

**NKY Independent Health Department**
- Lynne Saddler, MD, MPH

**Three Rivers District Health Dept.**
- April Harris

**Dearborn County Health Department**
- Kelly McDaniel

### CIVIC SERVICES

**Kenton County Detention Center**
- Shawnee Thoman

**Boone County Detention Center**
- Rachael Montgomery

**Campbell County Detention Center**
- Jim Daley

**NKY Area Development District**
- Anne Wildman/Marianne Scott

**Kenton County Fiscal Court**
- Scott Gunning

**Campbell County Fiscal Court**
- Allyn Reineck

### CITIES

**Edgewood**
- Belinda Nitschke

**Fort Wright**
- Adam Feinauer

**Independence**
- Chris Moriconi

### HEALTHCARE

**HealthPoint Family Care (FQHC)**
- Chris Goddard

**St. Elizabeth Healthcare**

**SEH Care Coordination**
- Sara Briggs

**SEH Covington Emergency Department**
- Elizabeth Jackson

**SEH Edgewood Emergency Department**
- Theresa Vietor

**SEH Family Medical Residency Program**
- John Stewart

**SEH Grant Emergency Department**
- Pat Mill, RN

**SEH Health Ministries Program**
- Marlene Feagan

**St. Elizabeth Physicians (73 Respondents multiple office locations)**

# Appendix 6:

## Community Health Needs Assessment and Implementation Strategy

St. Elizabeth Healthcare – David.Bailey@stelizabeth.com

| ORGANIZATION INFORMATION | | |
|---|---|---|
| Organization Name: | | |
| Organization Address: | | |
| City: | State: | Zip Code |
| Organization Web Address: | | |
| Contact: | Phone: | E-mail: |
| Services: | | |
| Counties Served: | | |

**Defining Purpose and Scope**
The purpose of this assessment is to evaluate the current health needs of the community, to review the resources currently in place to meet those needs and to identify major gaps between the two. Data from this assessment will be used to develop an implementation plan to bridge the gap and better meet the health needs of the community.

The goal is to identify the top five to ten of the most pressing health needs in the area.

Please list in order of most to least importance, which community needs that need to be addressed and/or considered in this assessment.

| | COMMUNITY HEALTH NEEDS |
|---|---|
| 1 | |
| 2 | |
| 3 | |
| 4 | |
| 5 | |

| **Comments:** |
|---|
| |

**Contact:**
David Bailey
Community Relations & External Affairs
St. Elizabeth Healthcare
1360 Dolwick Drive
Erlanger, KY 41018
David.Bailey@stelizabeth.com
859-301-6337 fax: 859-301-6340

Our Mission: As a Catholic healthcare ministry, we provide comprehensive and compassionate care that improves the health of the people we serve.

# Appendix 7:
## Additional Information on Mental Health and Drug Addiction

**Mental Health and Mental Disorders (Healthy People 2020);**
http://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders
July 10, 2015.

**Mental health** is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Mental health is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society.

**Mental disorders** are health conditions that are characterized by alterations in thinking, mood, and/or behavior that are associated with distress and/or impaired functioning. Mental disorders contribute to a host of problems that may include disability, pain, or death.

Mental illness is the term that refers collectively to all diagnosable mental disorders.

**Why Is Mental Health Important?**
Mental disorders are among the most common causes of disability. The resulting disease burden of mental illness is among the highest of all diseases. According to the National Institute of Mental Health (NIMH), in any given year, an estimated 13 million American adults (approximately 1 in 17) have a seriously debilitating mental illness. Mental health disorders are the leading cause of disability in the United States and Canada, accounting for 25 percent of all years of life lost to disability and premature mortality. Moreover, suicide is the 11th leading cause of death in the United States, accounting for the deaths of approximately 30,000 Americans each year.

Suicidal Ideation Diagnosis (common medical term for thoughts about suicide) was the third leading cause for admitting inpatients.

| St. Elizabeth TOP 10 Admitting Inpatient Diagnosis for 2014 | |
|---|---|
| **ICD-9-CM Admit Diag Code** | **Cases** |
| V30.00 Single live born in hospital delivered without cesarean section | 3242 |
| 786.50 Chest pain, unspecified | 1598 |
| V62.84 Suicidal Ideation (common medical term for thoughts about suicide) | 1179 |
| V30.01 Single liveborn infant, delivered by cesarean | 1136 |
| 486 Pneumonia, unspecified organism | 1046 |
| V22.1 Encounter for supervision of other normal pregnancy | 946 |
| 650 Normal Delivery | 910 |
| 786.05 Shortness of Breath | 890 |
| 276.51 Dehydration | 879 |
| V57.89 Care involving other specified rehabilitation procedure | 876 |

Mental health and physical health are closely connected. Mental health plays a major role in people's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery.

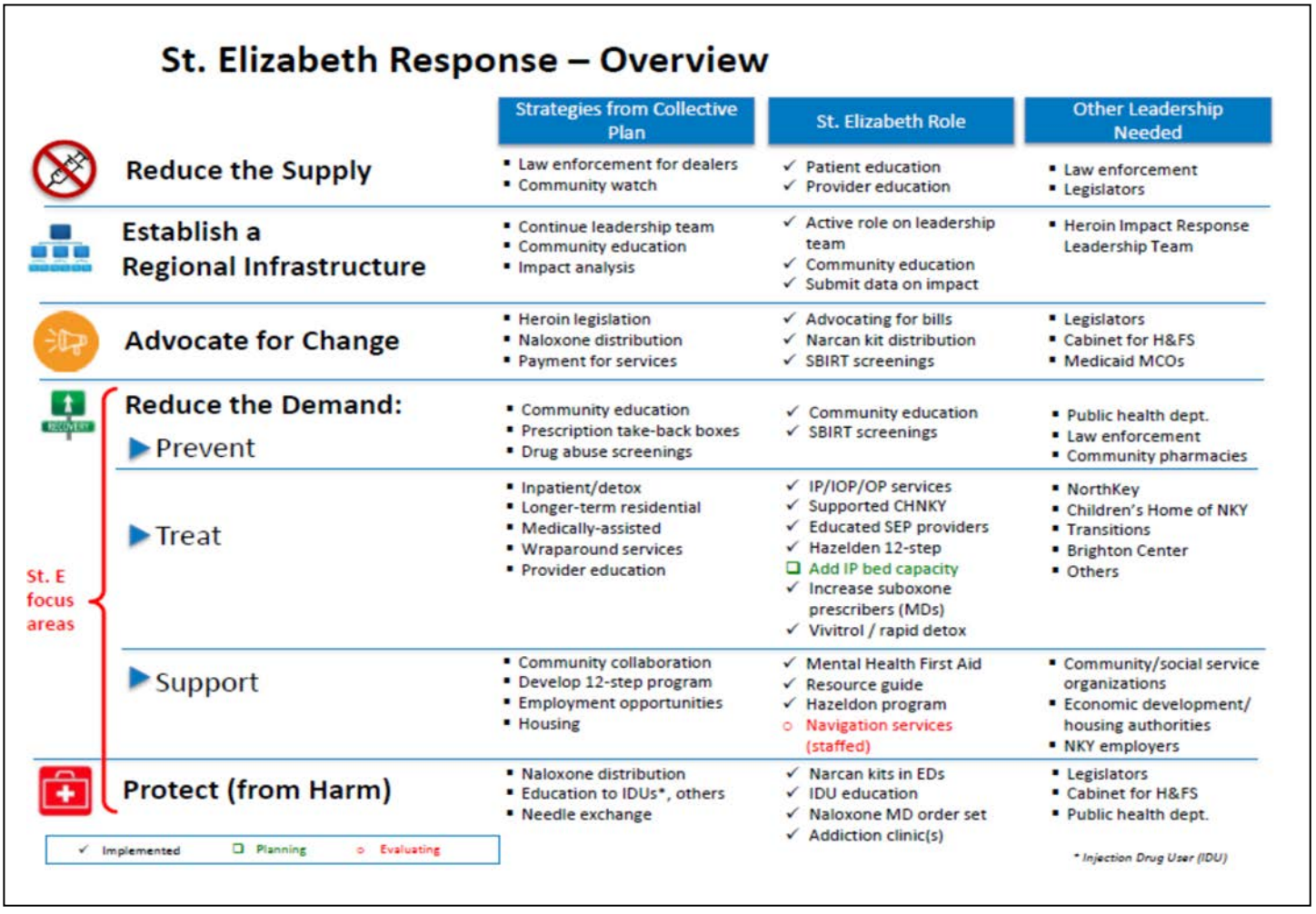
**Today's Heroin Epidemic: Centers for Disease Control and Prevention**
http://www.cdc.gov/vitalsigns/heroin/index.html July 9, 2015

Heroin use has increased across the US among men and women, most age groups, and all income levels. Some of the greatest increases occurred in demographic groups with historically low rates of heroin use: women, the privately insured, and people with higher incomes. Not only are people using heroin, they are also abusing multiple other substances, especially cocaine and prescription opioid painkillers. As heroin use has increased, so have heroin-related overdose deaths. Between 2002 and 2013, the rate of heroin-related overdose deaths nearly quadrupled, and more than 8,200 people died in 2013.

**Heroin in Northern Kentucky**
The heroin epidemic has overwhelmed the Northern Kentucky region. St. Elizabeth Healthcare has seen a 195% increase in the number of heroin overdoses from 2011 to 2014. The number rose from 252 cases in 2011 to 745 cases in 2014. In the first six months of 2015 there have been 565 overdose cases treated.

The number of infants admitted to St. Elizabeth NICU for Neonatal Abstinence Syndrome has increased 392% since 2011. The number of babies with this complication born at St. Elizabeth in 2011 was 26. This number has climbed to 128 in 2014. The average cost of treating an infant with this syndrome was $18,714 and the total cost in 2014 was $2,395,367.

In 2014, St. Elizabeth formed its own internal Heroin Response Committee to begin researching and developing a system strategy to address the Heroin epidemic. The initiative not only concentrated on in-house services being offered, but also how to align with community partners also attempting to address this problem. Activities and services developed and implemented aligned with the strategies developed by the community group.



**Northern Kentucky Heroin Impact Response Task Force**
Community members came together to address the Heroin problem and produce a plan: Northern Kentucky's Collective Response To the Heroin Epidemic. http://drugfreenky.org/wp-content/uploads/2013/11/Northern-Kentuckys-Collective-Response-Final.pdf . Several St. Elizabeth associate participated on this team and on the plan development.

**NKY Health Department report,** Presented by Lynne Saddler, MD, MPH, District Director of Health, June 18, 2015.
Patients suffering from complications of long term IV Drug Use (IVDU) are on the rise as well. Rates of acute infections of Hepatitis C in NKY double the states rate and are 24 times the national rate.

The Hepatitis C rates in Northern Kentucky are among the highest in the nation with a rate 2.7 times that of the state of Kentucky and 19.5 times that of the United States. Northern Kentucky comprises 9% of Kentucky's population, yet we have 24% of the Hepatitis C cases in the state.
The Northern Kentucky Health Department's Hepatitis C testing program from 2012-2014 tested 2,704 residents for Hepatitis C and 304 (11%) tested positive, with 80% of those testing positive reporting a history of injection drug use.

The cost for the medication for one course of treatment for Hepatitis C is approximately $84,000 and left untreated, may progress to cirrhosis, liver cancer or liver failure requiring a liver transplant at a cost of $600,000.

Sharing needles, syringes, and other drug injection equipment is the second highest cause of HIV infection in the United States. The cost of treating HIV infection, a lifelong chronic disease, is $600,000.

# Appendix 8:

**Health Needs Identified by the Assessment but Not Selected as One of the Top 3**

St. Elizabeth Healthcare (SEH) will continue providing services to support these important community health needs. The following is a summary of many of the programs and community partners that are already providing services for each of the issues identified.

- **Access to Care**
  - Medicaid expansion has address most of the uninsured population.
  - St. Elizabeth Healthcare provides a variety of community in-services to educate residents on care and access.
- **Address Disparities in Health Outcomes**
  - St. Elizabeth participates in Health Collaborative Data gathering.
- **Avoidable ED Visits/Access to Primary Care:**
  - Established 100% of eligible St. Elizabeth Physician practices as Level III Patient Centered Medical Home.
  - Developed walk-in clinics and urgent care options through St. Elizabeth Physicians.
  - Provide training and care through the Family Practice Residency program.
  - Continue to offer the Parish Nursing/Health Ministry program.
  - Recruit St. Elizabeth Healthcare medical specialists as identified.
  - Treating Dental patients needing emergent care in the Emergency Department.
  - Providing cab and bus vouchers for patients.
  - Launched e-visits, piloting video-visits, piloting shared medical appoints to increase access.
- **Breaking the Cycle – Unhealthy Across Generations**
  - SEH provides and support community education on improving one's health.
- **Cancer:**
  - Providing cancer screenings, support groups and Breast Cancer Navigators.
  - Providing Drug Replacement Services — chemotherapy provided to those who are uninsured.
  - Providing mobile mammography van — no cost mammograms.
  - Offering the Cooper Clayton Smoking Cessation program.

    - Donating financial / operational support to several community health improvement organizations.
- **Care Coordination / Care Delivery:**
    - St. Elizabeth Healthcare's Care Coordination takes a proactive multi-disciplinary approach to identifying high risk patient populations and implementing best practices to improve quality, smooth care transitions tp post-hospital care and prevent avoidable readmissions.
- **Chronic Diseases:**
    - Chronic diseases and conditions—such as heart disease, stroke, cancer, diabetes, obesity, and arthritis—are among the most common, costly, and preventable of all health problems. St. Elizabeth Physicians offers a complete spectrum of healthcare services, including primary care and specialty care services.
- **Dental:**
    - Patients seen in the SEH's Emergency Departments for dental reasons that do not have a family dentist are provided a Dental Referral Listing for follow-up care.
- **Diabetes:**
    - The St. Elizabeth Physicians Regional Diabetes Center is the only one of its kind in the Greater Cincinnati region, offering patients the medical expertise and care of the single greatest number of diabetes specialists and auxiliary services in one.
- **Easily Accessible & Coordinated Resources:**
    - St. Elizabeth Healthcare operates four hospitals geographically distributed across its service area, operates over 100 primary care and specialty office locations in Kentucky, Indiana and Ohio.
- **Emergency Shelters:**
    - Not the primary business of St. Elizabeth, support is provided.
- **Financial Assistance for the Uninsured and Underinsured:**
    - Medicaid Expansion has addressed many of those in needs.
    - Sponsoring a Financial Assistance Program.
    - Assisting patients eligible for government programs to register for those programs, plus providing charity care when appropriate.
    - Providing medications upon discharge from the Emergency Department or Inpatient and referral to Faith Community Pharmacy. Provided financial support to Faith Community Pharmacy.
- **Geriatric Care and Placement**
    - The family medicine providers at St. Elizabeth are board certified and medically trained in practicing a full spectrum of wellness-related healthcare for patients of all ages.
    - A Palliative Care program.
- **Maternity Care of Undocumented / Low income & non-resident Families:**
    - Medicaid Expansion addresses the low income families.
    - St. Elizabeth offers maternal child programs: First Steps Point of Entry and Nurse-Family Partnerships.
    - Providing Obstetricians to Healthpoint (FQHC) for prenatal care.
    - Administering immunizations for whooping cough to family members — Cocooning Project.
    - Offering Pre-Admission Education.
- **Medication Access – Compliance, Cost**
    - Medicaid Expansion has addressed many of those in need.
    - Patient Advocates work with patients to understand the importance of taking their medications.
    - Providing medications upon discharge from the Emergency Department or Inpatient and referral to Faith Community Pharmacy.
- **More Physicians, Midlevel Providers, and Allied Health Professionals**
    - St. Elizabeth Healthcare offers a three-year residency program in Family Medicine that is fully accredited by the Accreditation Council for Graduate Medical Education and designed to prepare physicians for board certification.

- St. Elizabeth Healthcare has affiliation agreements with multiple educational institutions to provide clinical training sites for healthcare students.
- St. Elizabeth Physicians employs several recruiting agencies to assist in recruitment of additional primary care physicians.

- **Obesity**
  - St. Elizabeth Physicians provides a physician-supervised programs that incorporates an entire team of health care professionals that specialize in weight management to give each patient the support, education and lifelong tools they need to not just lose weight, but maintain that weight loss long-term.
  - St. Elizabeth participates in educational events in the community and schools.
  - Kentucky has seen a decrease in its adult obesity rate, to 31.6 percent in 2014 from 33.2 percent in 2013, causing it to drop to 12th in the nation for adult obesity from fifth, according to the latest State of Obesity Report. http://www.nkytribune.com/2015/11/kentucky-drops-to-12th-from-fifth-in-adult-obesity-state-official-says-many-programs-have-contributed/
- **Pain Management:** SEH's website 'Find A Physician' lists physicians that specializes in pain management.
  - Pain Management integrated in Spine Center.
- **Payment & Financing:**
  - St. Elizabeth Healthcare offers Financial Assistance Programs for those requiring assistance.
- **Preventable Hospitalizations**
  - St. Elizabeth Healthcare and physicians work to direct patients to non-emergent clinics.
- **Preventive Health & Wellness for the poor**
  - Provide to the community and schools many programs on various health topics and screenings.
  - St. Elizabeth's free Health Ministries and Faith Community Nursing program is helping congregations of all denominations throughout the Tri-state to become "healthplaces."
- **Smoking Cessation:**
  - Assuring all of St. Elizabeth Healthcare campuses are smoke free.
  - Offering Cooper Clayton Smoking Cessation Classes throughout the year.
  - Providing advocacy support for smoking ban ordinances.
  - Support organizations advocating for smoke-free Kentucky (i.e. NKY Health Department).
- **Transition of Care**
  - St. Elizabeth Healthcare Care Coordination Department coordinates the Discharge Planning**:** Arranging and planning for appropriate post-hospital care.
- **Transportation**
  - Northern Kentucky Area Development District ("NKADD"), leads the coordination between area service providers and agencies to address the transportation needs of the NKY residents.
  - St. Elizabeth Healthcare does provide some transportation via bus or taxi voucher on and as needed basis.
- **Urgent Care Centers for area of Major Growth**
  - St. Elizabeth Healthcare and other healthcare organizations have opened centers in several locations.
- **Wellness – Overall Health**
  - St. Elizabeth Healthcare provides a variety of community in-services to educate residents on care and access.