ST. ELIZABETH FT. THOMAS

COMMUNITY HEALTH NEEDS ASSESSMENT & COMMUNITY BENEFITS IMPLEMENTATION PLAN

St. Elizabeth HEALTHCARE

ST. ELIZABETH FT. THOMAS

COMMUNITY HEALTH NEEDS ASSESSMENT & COMMUNITY BENEFITS IMPLEMENTATION PLAN

NOVEMBER 29, 2021

Conducted on behalf of:

St. Elizabeth Healthcare

For:

St. Elizabeth Dearborn

St. Elizabeth Edgewood

St. Elizabeth Florence

St. Elizabeth Ft. Thomas

St. Elizabeth Grant

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St. Elizabeth Community Benefits Steering Committee

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EXECUTIVE SUMMARY

For more than 160 years, St. Elizabeth Healthcare has been committed to providing the highest level of care and best experience to those who come to us. Our vision is to lead the communities we serve to become the healthiest in America. The needs of our communities guide our work, which we evaluate every three years through a comprehensive community health needs assessment* (CHNA).

St. Elizabeth Healthcare conducted our latest CHNA in 2021. Through this process, we identified, analyzed and prioritized community health needs and developed a three-year (2022–2024) action plan to address top priorities.

Top priorities identified that will be addressed for years 2022, 2023, and 2024:

1. **Chronic Disease**
2. **Equitable Access to Care**
3. **Healthy Behaviors**
4. **Social Determinants of Health**

Plans to address these priorities include, but are not limited to, focused efforts around food security, addressing homelessness and affordable housing, closing transportation gaps to healthcare resources, increasing access to both primary care and mental health, increasing public health education, particularly around exercise and nutrition, expanding assistance with substance abuse, and increasing cancer screenings.

The health needs identified by the community and health reporting resources were summarized and tabulated into a prioritized list. The Community Benefits Steering Committee (CBSC), which includes St. Elizabeth Healthcare executive leaders, reviewed this list. This committee engaged in additional communication and considered available resources that, when redirected, would have the most significant positive impact on health outcomes.

A community benefits implementation plan (CBIP) was then developed to address these top priority health needs.

Our Inclusive Methodology

St. Elizabeth Healthcare's 2021 CHNA relied on a combination of qualitative and quantitative information based on available national, state, regional and local health data. Also included in the assessment was input from public health agencies, social service agencies, educational institutions, healthcare providers and civic services. Statistics from the St. Elizabeth Healthcare system were also reviewed within the assessment.

The service area for this assessment was determined by identifying the geographical area in which at least 90% of St. Elizabeth Healthcare patients live. The data revealed that 94% of our patients reside within the eight counties comprising the Northern Kentucky Area Development District (NKADD) and five counties in Southeast Indiana. The NKADD includes Boone, Campbell, Carroll, Gallatin, Grant, Kenton, Owen and Pendleton counties. Southeast Indiana includes Dearborn, Franklin, Ohio, Ripley and Switzerland counties. The 2020 estimated population of these combined areas was over 575,000. All hospitals in the St. Elizabeth Healthcare system are located in the NKADD and Southeast Indiana geographical regions.

Review, Approval and Next Steps

The top St. Elizabeth Healthcare CHNA priorities, along with the CBIP, were first reviewed and approved by the Strategic Planning Committee of the St. Elizabeth Healthcare Board of Trustees. The full Board of Trustees was responsible for the final review and approval of the plan, which they gave on Dec. 7, 2021.

Progress toward achieving the goals identified in the CBIP will be monitored and reported to the St. Elizabeth Healthcare Board of Trustees regularly. The CHNA will be made widely available to the public.

Acknowledgments

This large-scale CHNA would not be possible without the contributions of many members of our community. The CBSC wishes to express its gratitude for the contributions made by those who participated in the development of this assessment.

* St. Elizabeth Healthcare's CHNA meets IRS Requirements governing charitable 501(c)(3) hospitals as defined by the Patient Protection and Affordable Care Act (the ACA).

ORGANIZATION DESCRIPTION

ST. ELIZABETH HEALTHCARE

St. Elizabeth Healthcare operates five hospital facilities throughout Northern Kentucky and Southeast Indiana: St. Elizabeth Dearborn, St. Elizabeth Edgewood, St. Elizabeth Florence, St. Elizabeth Ft. Thomas, and St. Elizabeth Grant, for a combined total of 1,191 patient beds. In addition, St. Elizabeth Healthcare operates an Ambulatory Care Center, Hospice Center, three freestanding imaging centers, and is in partnership with St. Elizabeth Physicians (SEP). SEP is the multi-specialty physician organization of St. Elizabeth Healthcare, with more than 460 physicians, 245 advanced practice providers, and nearly 1,500 non-provider associates. SEP delivers care to residents of Northern Kentucky, Southwest Ohio and Southeast Indiana, with a network of 172 physician offices located in Kentucky, Indiana and Ohio.

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 the communities we serve. 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.

St. Elizabeth Healthcare is sponsored by the Diocese of Covington and provided more than $120 million in uncompensated care and benefit to the community in 2019. For more information, please visit www.stelizabeth.com.

Ethical & Religious Directives

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

For more information, please view the directives published by the United States Conference of Catholic Bishops: http://www.usccb.org/

OUR MISSION

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

OUR VISION

St. Elizabeth will lead the communities we serve to become the healthiest in America.

OUR VALUES

I — INNOVATION
I seek better ways to perform my work, find creative solutions, and embrace change.

C — 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.

A — ACCOUNTABILITY
I use resources efficiently, respond to others promptly, face challenges in a timely manner, and accept responsibility for my actions and decisions.

R — 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.

E — EXCELLENCE
I believe in serving others by pursuing excellence in healthcare. I compassionately care for the mind, body, and spirit of each patient.

COMMUNITY HEALTH ASSESSMENT NEEDS PROCESS

COMMUNITY HEALTH NEEDS ASSESSMENT PURPOSE

Our diverse community has unique and complex health needs — and we believe it's our responsibility to understand those needs and address them.

Our triennial community health needs assessment (CHNA) is an essential first step in our short- and long-term planning process. Information we gather from our CHNA process is foundational to our understanding of healthcare disparities and the many ways we can collaborate with others to enhance community health.

Our CHNA also reveals resources currently in place and, equally importantly, exposes gaps that exist. This information helps us develop action plans and processes that support those we serve and the hospitals, practitioners and policymakers working directly with them or on their behalf.

COMMUNITY HEALTH NEEDS ASSESSMENT REQUIREMENTS

St. Elizabeth Healthcare's commitment to the community is strengthened by our CHNA process.

Guided by Section 501(r)(3) the U.S. Patient Protection and Affordable Care Act (the ACA), St. Elizabeth Healthcare — considered a nonprofit hospital organization under 501(c)(3) status — is required to conduct a CHNA every three years and to adopt an implementation strategy to meet the community health needs identified through our CHNA.

ACA Section 501(r)(3)(B) says CHNAs must:

- Take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and
- Be made widely available to the public.

DOCUMENTATION REQUIREMENTS

Per the IRS, which enforces Section 501(r)(3) of the ACA, a hospital facility must document its CHNA in a report that is adopted by an authorized body of the hospital facility.

The CHNA report must include the following items:

- A definition of the community served by the hospital facility 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 facility solicited and took into account input received 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. This includes a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs.
- A description of resources potentially available to address the significant health needs identified through the CHNA.
- An evaluation of the impact of any actions that were taken to address the significant health needs identified in the immediately preceding CHNA.

IMPLEMENTATION STRATEGY REQUIREMENTS

Per the IRS, a hospital facility's implementation strategy must be a written plan (herein identified as the community benefits implementation plan, or CBIP) that, for each significant health need identified, either:

- Describes how the hospital facility plans to address the health need, or
- Identifies the health need as one that the hospital facility does not intend to address and explains why it does not intend to address the health need.

For more detailed information, please visit the IRS page on ACA Section 501(r)(3).

COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS

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.

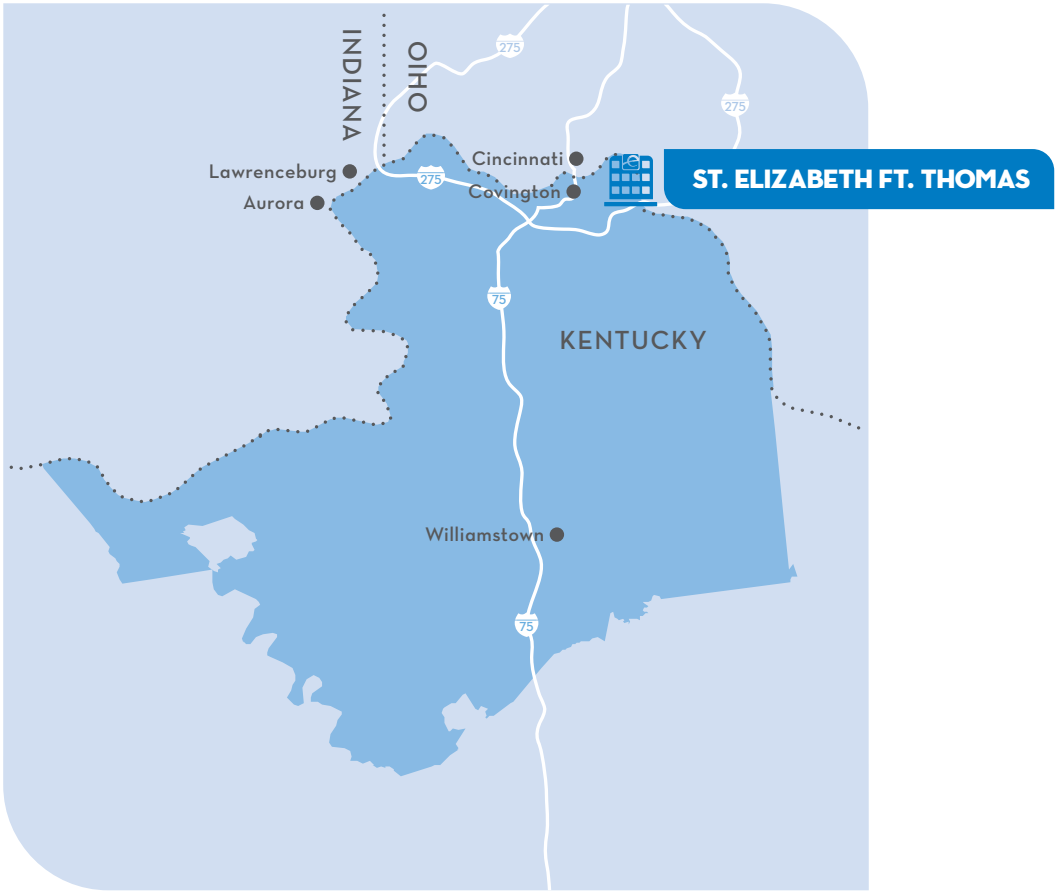
St. Elizabeth Ft. Thomas is a 220-bed full-service hospital featuring 24/7 emergency care, a center for breast health and cancer treatment center, diagnostic cardiac catheterization, and cardiac rehabilitation services. This facility receives patients from throughout the Northern Kentucky Area Development District (NKADD) and Southeast Indiana, which is being used as the defined service area.

St. Elizabeth Ft. Thomas

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

2020 OPERATING STATISTICS	
Licensed Beds	220
Inpatient Discharges	6,033
Patients Days	34,051
Births	-
Outpatient Registrations	52,365
Emergency Room Visits	23,518

Northern Kentucky Area Development District Map



COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS

COMMUNITY BENEFITS STEERING COMMITTEE

The Community Benefits Steering Committee (CBSC) is an internal multi-disciplinary team that oversees the CHNA, development of the CBIP, monitors the systems' activities to ensure it is achieving the objectives identified in the CBIP, and provides periodic reports to the Strategic Planning Committee of the Board. The CBSC makes initial recommendations to the Strategic Planning Committee of the Board of Trustees, which then recommends to the Board of Trustees. The Board of Trustees provides the final CHNA approval.

The CBSC 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 compliant 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 at least 90% of its patient population originates. This approach ensures that the assessment was not limited to a certain geographical area, but included the majority of the population served. The data revealed that 94% of the patient population resides in the eight counties that comprise the Northern Kentucky Area Development District (NKADD) and five counties of Southeast Indiana. The NKADD encompasses the counties of Boone, Campbell, Carroll, Gallatin, Grant, Kenton, Owen, and Pendleton. Southeast Indiana includes the counties of Dearborn, Franklin, Ohio, Ripley, and Switzerland. The 2020 estimated population of these combined areas was over 575,000. All hospitals in the St. Elizabeth Healthcare system are located in these two geographical regions.

ST. ELIZABETH HEALTHCARE — TOTAL DISCHARGES 2020

County	Inpatients	Outpatients	Total	% of Grand Total
Kenton	14,830	298,634	313,464	32.6%
Boone	11,363	254,844	266,207	27.7%
Campbell	7,182	161,420	168,602	17.6%
Grant	3,035	67,005	70,040	7.3%
Pendleton	1,326	28,445	29,771	3.1%
Gallatin	871	13,257	14,128	1.5%
Owen	294	6,925	7,219	0.8%
Carroll	205	3,042	3,247	0.3%
NKYADD Total	39,106	833,572	872,678	90.9%
Dearborn	525	21,009	21,534	2.2%
Franklin	14	447	461	0.0%
Ohio	100	2,764	2,864	0.3%
Ripley	84	2,855	2,939	0.3%
Switzerland	75	2,158	2,233	0.2%
SE IN Total	798	29,233	30,031	3.1%
Other Counties	2,555	55,148	57,703	6.0%
Grand Total	**42,459**	**917,953**	**960,412**	**100.0%**

COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS

COLLECTING AND ANALYZING DATA

The CHNA process and CBIP development were conducted over a course of 10 months (January to October). St. Elizabeth Healthcare's five hospitals worked collaboratively on this CHNA since they are in the same geographical region and have established cross coverage of services.

PRIOR CHNA & CBIP

The assessment began with reviewing the existing CHNA for years 2019 through 2021 for any pertinent information that may impact the current assessment. The previous areas of concentration included: mental health, substance use disorders, cancer care and heart disease.

Over the course of nearly three years, all areas were actively working toward their intended goals. For example:

Mental Health

- Supported community agencies participating in the Activating Hope Collaborative.
- Developed a comprehensive telemedicine system for therapy.
- Increased Behavioral Health staff by 18 providers to deliver greater access to BH services.

Substance Use Disorders (SUD)

- Implemented a comprehensive opioid prescribing policy for all St. Elizabeth Physicians' prescribers.
- Developed primary SUD prevention/education modules for K-12 students and posted to the Activating Hope website.
- Strengthened our recovery model by partnering with Life Learning Center (LLC) and planning to offer Journey Recover Center (JRC) services at the LLC location.

Heart Disease

- Achieved accreditation by the American Heart Association as a Cardiovascular Center of Excellence.
- Provided screenings and educational events throughout the community.
- Launched the "Freedom from Smoking" tobacco cessation program.

Cancer

- Opened the 250,000 square foot, state-of-the-art St. Elizabeth Cancer Center on our Edgewood campus.
- Participated in multiple clinical trials for cancer treatment.

COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS

SECONDARY DATA COLLECTION

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

- U.S. Census Bureau QuickFacts for Kentucky and Indiana, https://www.census.gov/quickfacts/ (see Appendix 3).
- Health status indicators, social and behavioral indicators; health outcomes; prevalence of chronic diseases; access to care; and maternal and child health, http://kentuckyhealthfacts.org/.
- County Health Rankings, http://www.countyhealthrankings.org/app/kentucky/2021/overview and https://www.countyhealthrankings.org/app/indiana/2021/overview.
- America's Health Rankings for Kentucky and Indiana, http://www.americashealthrankings.org.
- Interact for Health's 2020 Kentucky Health Issues Poll, released January 2020 https://www.healthy-ky.org/projects/category/4/kentucky-health-issues-polls/article/122/2020-kentucky-health-issues-poll?order_by=latest.
- American Cancer Society, Cancer Facts & Figures 2021 | American Cancer Society.
- The Health Collaborative's Community Health Needs Assessment 2019 Report, 2019-CHNA-Report-2-7-19.pdf (healthcollab.org).
- See Appendix 4 for additional data sources.

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.

KHIP (Not ranked)	Health Collaborative 2019 NKY Counties	Health Collaborative 2019 SE IN Counties
Substance Use	Mental Health	Substance Use
Vaping/Smoking	Substance Use	Healthy Behaviors
Firearms	Healthy Behaviors	Mental Health
Delayed Care	Chronic Disease	Child Care
	Access to Care	Parenting Education

America's Health Rankings: KY	
Exercise: % of Adults	50
Fruit & Vegetable Consumption: % of Adults	50
Nutrition & Physical Activity	49
Tobacco Use — Annual	49
Smoking: % of Adults	49
Depression: % of Adults	49
Multiple Chronic Conditions: % of Adults	49
Arthritis: % of Adults	49
COPD: % of Adults	49
High Cholesterol: % of Adults	49

America's Health Rankings: IN	
HPV Vaccination: % of Adolescents 13–17	49
Immunizations: Annual	48
Public Health Funding: $/Person	48
Air Pollution: Micrograms of fine particles/cubit meters	46
Childhood Immunizations: % of Children <35 months	44
Social Support & Engagement: Annual	44
Physical Inactivity: % of Adults	43
Preventative Care Services: Annual	43
Mental Health Providers per 100,000 population	43
High Cholesterol: % of Adults	49

COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS

2019 Report on the Unsheltered Homeless in Northern Kentucky Top Physical & Mental Health Conditions at Program Entry:	
53%	Mental Health
42%	Drug Abuse
36%	Alcohol Abuse
29%	Physical Disability
28%	Chronic Health Condition

Xavier's 2020 SDOH Study
Transportation
Food insecurity
Housing

St. Elizabeth Leading Causes of Hospitalizations Based on 2020 discharges
General Medicine
Cardiac Services
Obstetrics
Neonatology
General Surgery
Orthopedics
Neurology
Oncology/Hematology (Medical)
Vascular Services
Urology

American Cancer Society
Breast
Lung and bronchus
Prostate
Colorectum
Melanoma of the skin
Kidney and renal pelvis
Urinary bladder
Non-Hodgkin lymphona
Uterine corpus
Leukemia

KY Overdose Fatality Report	
KY	1,316
PSA	165
Boone	34
Campbell	36
Grant	17
Kenton	78

COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS

PRIMARY DATA COLLECTION: 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, other healthcare providers, community-based social service agencies and area school districts (see Appendix 5 for full listing).

The methodology used to collect the data included presentations to groups, phone calls and an online survey. The process included an explanation of the CHNA requirements and how the data garnered would be used to develop the CBIP. Participants were then asked to list in order from most important to least important what they believed were the top five community health needs that should be addressed and/or considered in the assessment (see Appendix 6 for full survey).

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.

SUMMARY OF PRIMARY DATA

Primary data were summarized and tabulated in order of importance. The last column in the below chart illustrates the top health issues identified by the reporting sources.

Public	SEH / SEP	Agencies	Overall Ranking
Affordability	Mental Health	Mental Health	Mental Health
Translation Services	Substance Use	Substance Use	Substance Use
COVID	Vaping/Smoking	Obesity	Vaping/Smoking
Cancer	COVID	Access	COVID
Heart	Cancer	COVID	Obesity
Transportation	Obesity	Vaping/Smoking	Cancer
Insurance Coverage	Heart	COVID Vaccinations	Heart
Medication Assistance	Access	Cancer	Access
Mental Health	COVID Vaccinations	Heart	COVID Vaccinations
Substance Use	Diabetes	Exercise	Transportation
Vaping/Smoking	Transportation	Geriatrics	Diabetes
Access	Food Insecurities	Nutrition	Preventative Care
COVID Vaccinations	Preventative Care	Vaccinations	Affordability
Obesity	Nutrition	Preventative Care	Food Insecurities
Exercise	Homelessness	Diabetes	Geriatrics


St. Elizabeth
Brent Ganther
Physician

COMMUNITY BENEFITS IMPLEMENTATION PLAN (CBIP), 2022–2024

PRIORITIZATION OF IDENTIFIED HEALTH NEEDS

Findings from the Primary and Secondary data sources were presented to the CBSC for review and thorough discussion. The committee was tasked with ranking the community's most important health needs and providing suggestions for hospital priorities. A vote was taken to determine which of the needs identified should be addressed in the new CHNA. Those needs were then grouped into four categories: Address Social Determinants of Health, Provide Equitable Access to Care, Enhance/Educate for Health Behaviors, and Manage/Reduce Chronic Diseases (see below chart).

ADDRESS SOCIAL DETERMINANTS OF HEALTH

Food Security
Homelessness / Affordable Housing
Transportation
Education
Economic Deprivation

PROVIDE EQUITABLE ACCESS TO CARE

Primary Care
Insurance Coverage
Community-Based Care
Public Health Issues (e.g., COVID)

ENHANCE & EDUCATE FOR HEALTHY BEHAVIORS

Exercise / Nutrition
Tobacco / Vaping

MANAGE & REDUCE CHRONIC DISEASES

Cancer
Heart
Mental Health
Substance Use

COMMUNITY BENEFITS IMPLEMENTATION PLAN, 2022–2024

Once the top health needs were identified, the CBIP was developed, identifying strategies, action items, and targets. The CBIP was developed in collaboration with St. Elizabeth associates who have expertise in the prioritized health needs. The top priorities, along with the CBIP, were first reviewed and approved by the Strategic Planning Committee of the Board of Trustees, then by the Board of Trustees for final review and approval. The Board of Trustees approved the plan on December 7, 2021.

The following is a summary of strategies from the CBIP to address the prioritized needs identified in the CHNA for 2022 through 2024 (see Appendix 7 for more detail).

ADDRESSING SOCIAL DETERMINANTS OF HEALTH

Focus Area	Goal	Target
Food Security	SEH IP: Follow up with 100% of patients who identify a Food Security need	100%
	SEH OP: Follow up with 100% of patients who identify a Food Security need	100%
Homelessness / Affordable Housing	Evaluate development of or identify a partner to provide medical respite services	1
	Connect with community partners to address housing for specific vulnerable populations (e.g. pregnant women with SUD)	2
Transportation	Explore 3 new partnerships to fill transportation gaps for patients and others to get healthcare resources and partner with at least 1	3/1
Education	Expand support for after school programming with emphasis on vulnerable populations in urban areas	2
	Seek new investments into scholarships to connect vulnerable households with postsecondary educational opportunities	2
Economic Deprivation	Achieve Lift-Up reentry goal each year	350

ENHANCING & EDUCATING FOR HEALTHY BEHAVIORS

Focus Area	Goal	Target
Exercise/Nutrition	Host community education events annually on importance of exercise and nutrition to youth in schools	8
Tobacco/Vaping	Host community education events annually on the dangers of vaping to youth in schools	10
	Offer tobacco cessation education programs anually	12

COMMUNITY BENEFITS IMPLEMENTATION PLAN, 2022–2024

PROVIDING EQUITABLE ACCESS TO CARE

Focus Area	Goal	Target
Primary Care	Expand PCP access for all of NKY and SE IN (e.g. Free Clinic, partnership with Healthpoint, mobile health)	1
Insurance Coverage	Convert 50% of self-pay patients to Federal/State coverage	50%
Community-Based Care	Provide education to vulnerable/minority populations around Lung/Colon/Breast/ Diabetes screenings in English and Spanish	6 Total (3 English, 3 Spanish
	Increase % of completed telemedicine encounters in underutilized zipcodes	TBD
Public Health Issues	Launch campaign to educate public on dangers of secondhand smoke	1

MANAGING & REDUCING CHRONIC DISEASES

Focus Area	Goal	Target
Heart Disease	Decrease heart-related deaths by 25% by 2025 (2019: 13.83%)	25%
	Host 2 heart-related education events per month in the community	24
Cancer	Identify cancer earlier through increased screenings for Lung (46% of targeted population), Colon (80% of target patient population), and Breast (83% of target patient population)	46% 80% 83%
Mental Health	Expand telehealth offerings for BH to increase access (connect with community partners to increase tele-psychiatric services)	46% 80% 83%
Substance Use	Increase % of JRC patients who are sober/abstinent at 6 and 12 months (baseline 21%)	2

COMMUNITY HEALTHCARE RESOURCES

To address the needs identified in the CHNA, St. Elizabeth Healthcare continues to work collaboratively with various healthcare resources accessible to the residents of Northern Kentucky and Southeast Indiana.

Healthcare Resources in the Northern Kentucky Area Development District

Name	County	Type	# Beds
Carroll County Memorial Hospital	Carroll	Acute Critical Access	25
Gateway Rehabilitation Hospital	Boone	Physical Rehabilitation	40
Encompass Health Rehabilitation Hospital of Northern Kentucky	Kenton	Physical Rehabilitation	71
SUN Behavioral Health	Kenton	Acute Care Psychiatric Chemical Dependency	6 105 86
St. Elizabeth Edgewood	Kenton	Acute Care Neonatal II Neonatal III	604* 13 12
St. Elizabeth Ft. Thomas	Campbell	Acute Care	234**
St. Elizabeth Florence	Boone	Acute Care General Psychiatric	204*** 20
St. Elizabeth Grant	Grant	Acute Critical Access	25
St. Elizabeth Medical Center North (Acute beds to be transferred to St. Elizabeth Edgewood; Psych and Chemical Dependency beds to be transferred to SUN Behavioral Health)	Kenton	Acute Psychiatric Chemical Dependency	37 8 58

Source: Kentucky Cabinet for Health and Family Services, Inventory of Health Facilities and Services; September 2021

* Alleviation of emergency circumstances due to COVID 19 emergency through the temporary conversion of up to 20 psych beds** to acute care beds, conversion of up to 16 hospice beds to acute care beds and through the addition of 15 acute care beds for a total bed complement of up to 561 acute care beds effective 4/20/20 **the 20 psych beds have not yet been relocated to St. Elizabeth Florence per CON #008-07-5314(2)

** Alleviation of emergency circumstances due to COVID 19 emergency through the temporary conversion of up to 26 NF bed to acute care beds and the addition of 30 acute care beds for a total bed complement of 234 acute care beds effective 4/20/20

*** Alleviation of emergency circumstances due to COVID 19 emergency through the temporary conversion of up to 16 NF bed to acute care beds for a total bed complement of 204 acute care beds effective 4/20/20

Healthcare Resources in Southeast Indiana

Name	County	# Staffed Inpatient Beds
Community Mental Health Center	Dearborn	16
St. Elizabeth Dearborn	Dearborn	64
Margaret Mary Health	Ripley	25

Health Departments

- Northern Kentucky Health Department: Serves Boone, Campbell, Grant, and Kenton Counties www.nkyhealth.org
- Three Rivers District Health Department: Serves Carroll, Gallatin, Owen, and Pendleton Counties www.trdhd.com
- Dearborn County Health Department, www.dearborncounty.org/department/index.php?structureid=23
- Franklin County Health Department, www.franklincounty.in.gov/countyoffices/health-department
- Ohio County Health Department, ohiocountyhealthdept.com/
- Ripley County Health Department, www.ripleyhealth.com/
- Switzerland County Health Department, www.switzerland-county.com/health.html

OTHER HEALTH NEEDS IDENTIFIED BY THE ASSESSMENT

Healthcare needs identified in the assessment that were not chosen as top priorities are currently being addressed by St. Elizabeth Healthcare through existing programs and services, or other providers (see Appendix 7).


St. Elizabeth
Michael M
Registered Nurse
REGISTERED
NURSE

APPENDIX


St. Elizabeth
Lisa Lankheit
NURSE MANAGER
REGISTERED NURSE
CareFusion
Alaris PC

APPENDIX 1

COMMUNITY BENEFITS STEERING COMMITTEE

The Community Benefits Steering Committee (CBSC) is a multi-disciplinary team to oversee the community health needs assessment (CHNA), the development of the community benefits implementation plan (CBIP), and monitor the system's activities to ensure it is achieving the objectives identified in the CBIP and provide periodic reports to the Strategic Planning Committee of the Board of Trustees and the community. The CBSC makes recommendations to the Strategic Planning Committee, who recommend to the Board of Trustees, who serve as the approving body.

CBSC Composition

The committee consists of the following representatives who meet annually, or as needed:

- Sarah Giolando, Senior Vice President and Chief Strategy Officer
- Rosanne Nields, Vice President, Planning and Government Relations
- Pam Deeter, Vice President, Finance
- Dan Cole, Assistant Vice President, Operations, St. Elizabeth Physicians
- Laurie Conkright, Vice President and Chief Nursing Officer – Edgewood, Covington, Grant
- Matt Hollenkamp, Vice President, Marketing and Public Relations
- Sandra Broerman, System Director, Treasury and Tax
- David Bailey, Director, Community Benefits and, Inclusion Reporting
- Sara Hamilton, Director, Planning and Program Development
- David Meier, Manager, Tax
- Edward Brush, Manager, Rehabilitation Services
- Brent Harvey, Manger, Consumer and Market Knowledge
- Scott Sedmak, Director, Community Relations
- Chad Bowman, Assistant Controller, St. Elizabeth Physicians
- Mark Wilson, Analyst, Planning and Program Development

Tasks of the Committee

The following tasks/decisions are their primary functions:

- Review the existing 2019–2021 CBIP regularly and report the progress toward its goals to the Board of Trustees.
- Oversee implementation of the CHNA and update the CBIP accordingly every three years (required by the ACA). The next assessment and plan update will need to be completed in 2024.
- Review the Community Benefits activities and annual report to ensure compliance with IRS 990 H requirements. Make recommendations regarding communication efforts and public reporting.

APPENDIX 2

COMMUNITY HEALTH NEEDS ASSESSMENT 2019 TO 2021: 3RD QUARTER 2021 UPDATE

SUBSTANCE USE DISORDERS

Offer programs and services to prevent SUD and harm associated with it and offer evidence-based treatment and recovery support for patients with SUC. Increase by 25% the number of referrals to Journey Recovery Center.

Overall Progress of Strategy: Baseline: Baseline: 2018 – 952; 2019 – 1,236; 2020 – 1,345; 2021 Q3 – 1,289

Strategies/Tactics	Measures/Action Plans	Target	Status				
			1st	2nd	3rd	4th	YTD
	Review and revise existing pain management education and post to Get-Well Network	1	-	-	-		-
Prevent new users of illicit drugs, including youth use of alcohol, tobacco, marijuana, and prescription drugs, and adult use of pain medication	Develop and post a minimum of 4 digital primary SUD prevention/ education modules per quarter on the Activating Hope website for K–12 students	16	-	-	12		12
	Finalize and deploy the Common Assessment tool to track outcomes for continuous improvement	1	-	-	-		-
Treat people's substance use disorders	Increase number of IP chemical dependency consults throughout hospital system by 15%. 2020 Baseline - 1,800	2,070	409	596	615		1,620
	Improve recovery outcomes for patients with SUD by expanding JRC services through community partnerships via Workforce Development Grant	233	66	110	105		281
	Increase number of women served by Baby Steps. 2020 Baseline - 243	279	111	116	260		487
	Integrate GPRA recovery outcome assessment tool into EPIC to measure recovery outcomes on all JRC patients	1	1	-	-		1

Legend: Meeting/ exceeding goal; On track to meet goal; Forecasted to miss goal

APPENDIX 2

MENTAL HEALTH

Decrease the number of behavioral health patients presenting at St. Elizabeth Emergency Department (relates to severity of disease) by 3%.

Overall Progress of Strategy: 2018 – 5,149; 2019 – 4,818; 2020 – 3,320; 2021 Q3 - 3,046

Strategies/Tactics	Measures/Action Plans	Target	Status				
			1st	2nd	3rd	4th	YTD
Ensure SEP patients have access to mental health providers	Maintain and foster the existing relationship with community agencies to assist in the treatment plan of SEP patients (e.g., residential treatment facilities with no provider on staff along with community partners providing education and support) including increasing access to care by 10% based on the total number of 138 unique patients treated at Brighton Recovery Center in 2020.	152	39	24	31		94
	Create an algorithm for direct referrals from Women's Health agencies in the community to Behavioral Health, targeting perinatal and postnatal women who are identified to be high risk with depression and anxiety	1	1	-	-		1
Support suicide and depression awareness to the community	Provide financial support to community agencies participating in the Activating Hope Collaborative as they implement community education programs	8	1	-	8		9
	Develop and post a minimum of 4 mental health education modules on the Activating Hope website for youth 7–12 grade, parents, and general consumers	4	-	-	4		4

Legend: Meeting/ exceeding goal | On track to meet goal | Forecasted to miss goal

APPENDIX 2

HEART DISEASE

Work with the community to reduce the incidence of heart-related deaths by 25 percent in the Northern Kentucky region by 2025. (Baseline 193.8 per 100,000)

Overall Progress of Strategy: 13.83% cumulative reduction as of 2019 (168.2)

Strategies/Tactics	Measures/Action Plans	Target	Status				
			1st	2nd	3rd	4th	YTD
Provide prevention and wellness services to the community with the goal of detecting heart and vascular disease early or preventing it all together	Provide monthly cardiovascular screenings in our Primary Service Area	12	42	53	55		150
	Provide education quarterly in the community in both virtual and in-person formats regarding prevention and early recognition of cardiovascular disease	4	9	6	7		22
	Provide blood pressure education to all patients screened on CMHU following AHA guidelines and report all abnormal results to primary care providers	100%	100%	100%	100%		100%
	Offer a quarterly Take Time for Your Heart prevention and wellness series	4	4	6	2		12
Transition to the Freedom from Smoking Tobacco Cessation program and offer individualized support for Tobacco Cessation	Conduct training for existing Fresh Start associates into Freedom from Smoking in 1st quarter	1	1	-	-		1
	Offer a Freedom from Smoking session in 2nd quarter	1	-	2	3		5
	Fully transition to Freedom from Smoking program in 3rd quarter	1	-	-	1		1
	Explore one virtual option for Tobacco Cessation in 4th quarter	1	-	-	-		-
Education the community on the youth vaping crisis	Develop a series of six 60-second videos regarding the danger of vaping for use on social media platforms	6	1	-	13		14
Improve access to and treatment for patients seeking weight-loss programs (medical & surgical)	Increase volume of new patients to Medical Weight Management program by 15% of 2019 volumes (1,073)	1,234	223	261	242		726
	Increase bariatric surgery case volumes by 10% over 2019 volumes (304)	334	88	103	95		286

Legend: Meeting/ exceeding goal | On track to meet goal | Forecasted to miss goal

APPENDIX 2

ONCOLOGY

Identify cancer earlier through increased screenings for Lung (40% of targeted population), Colon (70% of target patient population), and Breast (70% of target patient population)

Overall Progress of Strategy: 2019 - Lung 35.91%; Colon 72.58%; Breast 77.62%
2020 - Lung 28.25%; Colon 74.23%; Breast 72.37%
2021 - Lung 30.39%; Colon 71.42%; Breast 61.86%

Strategies/Tactics	Measures/Action Plans	Target	Status				
			1st	2nd	3rd	4th	YTD
Evaluate future expansion needs	Develop strategic growth plans for Grant County, Fort Thomas, and Dearborn County locations	3	-	-	-		-
Deliver highest level of care to our patients by attracting the best providers	Develop a strategic provider hiring plan to support strategic growth initiatives	1	-	-	1		1
Expand Lung Screening program into Dearborn County	Incorporate Dearborn lung screening workflow into existing Lung Screening program by end of Q3	1	-	1	-		1
Continue to grow our Integrative Oncology offerings to provide the best care for our patients	Develop 2 new Integrative Oncology programs by end of Q2	2	-	2	1		3

Legend: Meeting/ exceeding goal | On track to meet goal | Forecasted to miss goal

APPENDIX 3

NORTHERN KENTUCKY & SOUTHEAST INDIANA POPULATION DEMOGRAPHICS

Population Demographics (US Census 2017 Estimates)**

	Population Census 2020	Hispanic or Latino	White alone, not Hispanic or Latino	Black or African American alone	American Indian and Alaska Native alone	Asian alone	Native Hawaiian and Other Pacific Islander alone	Two or More Races	Persons under 5 years	Persons under 18 years	Persons 65 years and over	Persons in poverty
USA	331,449,281	18.5%	60.1%	13.4%	1.3%	5.9%	0.2%	2.8%	6.0%	22.3%	16.5%	11.4%
Kentucky	**4,505,836**	**3.9%**	**84.1%**	**8.5%**	**0.3%**	**1.6%**	**0.1%**	**2.0%**	**6.1%**	**22.4%**	**16.8%**	**16.3%**
Counties												
Boone	135,968	4.4%	87.3%	3.8%	0.2%	2.4%	0.2%	2.2%	6.5%	25.8%	14.1%	7.1%
Campbell	93,076	2.2%	92.2%	3.0%	0.2%	1.1%	Z	1.7%	5.8%	20.8%	16.1%	10.9%
Carroll	10,810	7.0%	88.2%	2.1%	0.4%	0.6%	0.1%	2.5%	7.3%	25.8%	15.7%	15.2%
Gallatin	8,690	5.2%	91.0%	1.7%	0.3%	0.5%	0.1%	2.0%	6.3%	23.9%	14.2%	13.3%
Grant	24,941	2.9%	94.3%	1.0%	0.3%	0.5%	0.2%	1.2%	7.3%	26.2%	14.0%	13.3%
Kenton	169,064	3.4%	88.2%	4.9%	0.2%	1.3%	0.1%	2.2%	6.5%	23.6%	14.9%	11.2%
Owen	11,278	2.7%	94.8%	1.2%	0.3%	0.2%	Z	1.1%	5.1%	21.9%	19.1%	15.7%
Pendleton	14,644	1.5%	95.7%	1.0%	0.4%	0.3%	Z	1.3%	6.3%	22.8%	16.5%	12.4%
Indiana	**6,785,528**	**7.3%**	**78.4%**	**9.9%**	**0.4%**	**2.6%**	**0.1%**	**2.2%**	**6.2%**	**23.3%**	**16.1%**	**11.9%**
Counties												
Dearborn	50,679	1.4%	96.1%	0.7%	0.2%	0.5%	0.1%	1.3%	5.2%	21.9%	18.3%	9.3%
Franklin	22,785	1.3%	96.6%	0.3%	0.3%	0.8%	Z	0.9%	6.2%	23.0%	19.0%	9.2%
Ohio	5,940	1.7%	96.1%	0.6%	0.3%	0.4%	Z	1.1%	5.3%	19.7%	22.4%	9.6%
Ripley	28,995	1.9%	95.5%	0.5%	0.4%	0.9%	Z	1.2%	6.0%	23.4%	18.3%	9.1%
Switzerland	9,737	1.9%	95.2%	1.4%	0.3%	0.4%	Z	1.1%	6.0%	24.6%	17.4%	14.5%

APPENDIX 4

SECONDARY DATA SOURCES AND ADDITIONAL INFORMATION

America's Health Rankings analysis of America's Health Rankings composite measure, United Health Foundation, AmericasHealthRankings.org, Accessed 2021

https://www.americashealthrankings.org/explore/annual/measure/Overall/state/KY

Kentucky's overall health ranking in 2019 was 43 out of 50, and continues to rank at the bottom in most traditional health measures:

Measure Name	2019 Rank	2018 Rank	2017 Rank
Cancer Deaths	50	50	50
Physical Inactivity	50	50	46
Smoking	49	49	49
Frequent Mental Distress	49	48	48
Premature Death	47	47	47
Drug Deaths	46	47	49
Obesity	46	43	44
Frequent Physical Distress	45	49	48
Diabetes	44	44	46
Children in Poverty	44	43	38
Cardiovascular Deaths	42	44	44
KENTUCKY OVERALL	**43**	**45**	**42**

Interact for Health's 2020 Kentucky Health Issues Poll (KHIP):
2020 Kentucky Health Issues Poll | Foundation for a Healthy Kentucky (healthy-ky.org)

The Health Collaborative, Community Health Needs Assessment:
2019-CHNA-Report-2-7-19.pdf (healthcollab.org)

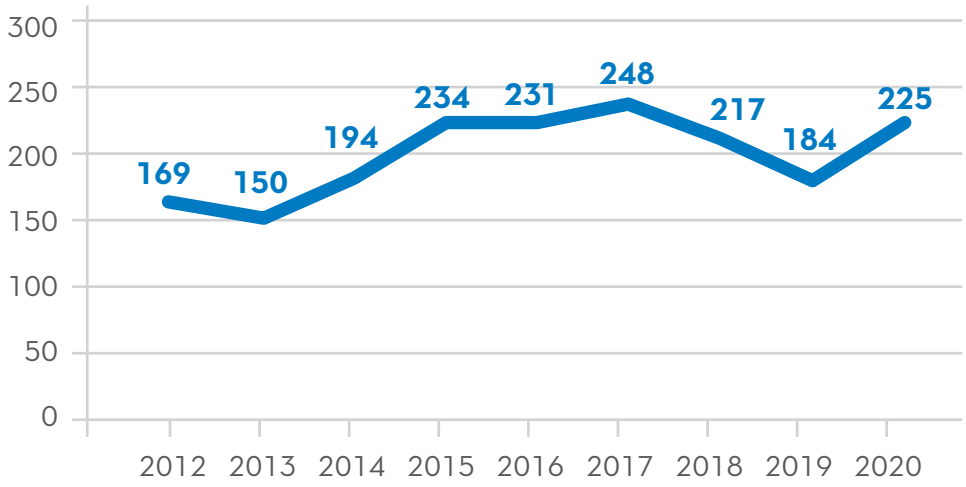
Kentucky Office of Drug Control Policy 2020 Overdose Fatality Report:
2020 KY ODCP Fatality Report (final).pdf

APPENDIX 4

OPIOID MORTALITY AND MORBIDITY IN NORTHERN KENTUCKY 2012–2020

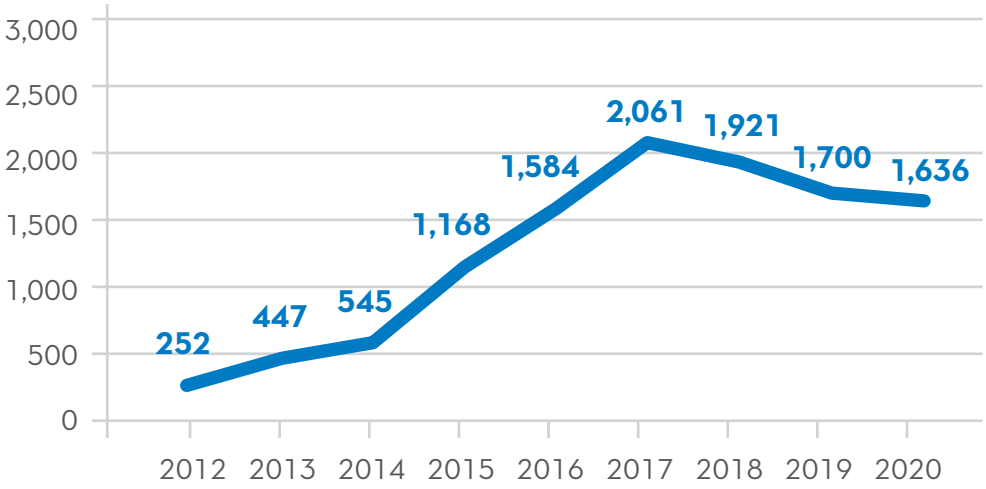
Mortality

1,852 people died from opioid overdoses



Morbidity

Over 11,000 people were treated for overdose in the EDs



Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. American Society of Addiction Medicine: Retrieved from: https://www.asam.org/Quality-Science/definition-of-addiction

APPENDIX 5

COMMUNITY PARTICIPANTS IN SURVEY

Organization	Contact Person
Social Service Agencies	
Batesville Food Pantry	Anne Baran
Brighton Center	Jennifer Wiley
Butler Foundation (Corporex)	Barbara Schaefer
Catholic Charities	Alan Pickett
Center for Great Neighborhoods	Tom DiBello
Children's Home of NKY	Rick Wurth
Clearinghouse	Karry Hollan
Community Foundation of Switzerland County	Pam Acton
Community Mental Health Center	Kevin Kennedy
Dearborn Community Foundation	Fred McCarter
Faith Community Pharmacy	Aaron Broomall
Franklin County Community Foundation	Shelly Lunsford
Henry Hosea House	Bruce Stelzer
Hispanic Community Advisory Committee	Mark Stenger
Ida Spence Mission	Regina Cornelius
Life Learning Center	Alecia Dawn Webb-Edgington
LifeTime Resources	Amber Walker
New Horizons Rehabilitation, Inc.	Marie Dausch
NKU NACU	Jennifer Hunter
NKY Community Action Commission	Rhonda Chisenhall
Pregnancy Care Center	Karla Raab
Rosedale Green	Londa Knollman
Transitions	Jim Beiting
United Way Greater Cincinnati Southeast Indiana	Karen Snyder
Businesses	
Absolute Web Design	Bebe Kinnett
African American Chamber of Commerce	Eric H Kearney
Covington Business Council	Pat Frew
Maxwell Construction Company	Randy Maxwell
NKY Chamber of Commerce	Kristin Baldwin
Northern Kentucky Area Development District	Anne Wildman

APPENDIX 5

Organization	Contact Person
Schools	
Batesville Community Schools	Gayla Vonderheide
Bishop Brossart	Dan Ridder
Campbell County Schools	David Rust
Community Christian Academy	Tara Bates
Covington Schools	Jennifer Fowee
Erlanger-Elsmere Schools	Melanie Dowdy
Franklin County Schools	Tammy Chavis
Grant County Schools	Matt Morgan
Jac-Cen-Del Community Schools	Ryan Middleton
Kenton County Schools	Paula Rust
Ludlow Schools	Mike Borchers
Milan Community Schools	Jane Rogers
Rising Sun - Ohio County Schools	Brenden Roeder
South Dearborn Community Schools	Jessica Peak
South Ripley Community Schools	Rob Moorhead
St. Lawrence Catholic School	Robert Detzel
St. Nicholas School	Sherri Kirschner
Sunman Dearborn Schools	Kelly Roth
Switzerland County Schools	Rodney Hite
Walton Verona Schools	Matt Baker
Health Depts	
Dearborn County Health Dept	Mary Calhoun
NKY Health Dept	Stephanie Vogel
Ripley County Health Dept	Lois Franklin
Switzerland County Health Dept	Mark Reed
Three Rivers District Health Dept	Christina Perkins
Civic Services	
Boone County Detention Center	Jason Maydak
Campbell County Detention Center	James A Daley
Campbell County Fiscal Court	Matt Elberfeld
Dearborn Circuit Clerk	Gayle Pennington
Dearborn County Commissioner	Rick Probst
Kenton County Detention Center	Marc Fields
NKY Area Development District	Anne Wildman
Pendleton County Fiscal Court	David Fields

APPENDIX 5

Organization	Contact Person
Cities	
Batesville	Mike Bettice, Mayor
Bellevue	Charles Cleves
Covington	David Johnston
Crestview Hills	Paul Meier
Dillsboro	Doug Rump, Town Mgr
Edgewood	Brian Dehner
Fort Wright	Jill Bailey
Greendale	Alan Weiss, Mayor
Southgate	Jim Hamberg
Union	Melissa Hinkle
Williamstown	Rick Skinner
First Responders	
Alexandria	Natalie Selby
Batesville Fire	Todd Schutte, Chief
Bellevue/Dayton Fire	William Brent Schafer
Brookville Fire	Aaron Leffingwell, Chief
Covington Fire	David J Geiger
Dillsboro Police	Josh Cady, Chief
Dry Ridge Fire	Kevin Stave
Edgewood	Brian Zurborg
Erlanger Fire/EMS	Rhonda Wolfe
Florence	Tom Grau
Florence Fire	Chris Miller
Franklin County Sheriff	Peter Cates, Sheriff
Gallatin Fire	Bud Webster
Grant County Sheriff	Brian Maines
Greendale Police	Shane Slack, Chief
Independence	Tony Lucas
Kentucky State Police	Isaiah Hill
Kentucky State Police	Cory Elliott
Kentucky State Police	Evan Guilfoyle
Lawrenceburg Police	David Schneider, Chief
Ludlow Fire	David Hodge
Pendleton County Fire	Jody Dunhoft
Switzerland County Sheriff	Brian Morton, Sheriff
Villa Hills	Bryan Allen
Walton Fire	Steve Maselli
Wilder	Chad Martin

APPENDIX 6

EXPLANATION AND DATA GATHERING DOCUMENT

CHNA SURVEY 2021

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.

***1. Please tell us about your organization:**

Organization Name	
Department	
City	
State	
Your Name (optional)	
Your Title (optional)	

***2. Please list the top community health needs that should be addressed and/or considered in this assessment, in order of most to least importance:**

1.	
2.	
3.	
4.	
5.	

3. Please share any comments for consideration:

APPENDIX 7

HEALTH NEEDS IDENTIFIED, BUT NOT SELECTED AS A TOP PRIORITY

The following items ranked in the top 10 of the Primary data and/or Secondary data. While they were not chosen as a top priority, St. Elizabeth Healthcare will continue providing services to support these important community health needs. The following is a summary of the many programs and community partners that are already providing services for each of the identified issues.

Affordability

The St. Elizabeth Financial Assistance Program (FAP) is available for uninsured patients and patients with self-pay balances after insurance. FAP is a charity program based on the patient's family income. Patients with family incomes at or below 200% of the Federal Poverty Guidelines (FPG) are eligible for 100% charity or "free" care. Individuals with an income level from 201% to 300% FPG are eligible for a 50% adjustment and individuals with an income level from 301% to 400% FPG are eligible for a 25% adjustment. Patients with family income exceeding 400% of the Federal Poverty Guidelines may still be eligible for hardship financial assistance or catastrophic discount on an individual basis. For those uninsured patients who do not qualify for any of the aforementioned discounts, we extend an automatic discount to their hospital bills.

Diabetes

The St. Elizabeth Physicians Regional Diabetes Center is the only comprehensive center of its kind in Greater Cincinnati, offering patients access to many diabetes and endocrinology services in one location.

Disease Management

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 to address these issues.

Geriatrics

St. Elizabeth Healthcare created a Geriatrics service line, responsible for assisting patients 65+ years old navigate our system into post-acute care options to improve their health outcomes. Goals of this service line include:

- Actively engaging and educating this population and their family members of the benefits of staying as active and healthy as possible for as long as possible; their options and choices for accessing care in various settings; the options and choices for end-of-life decisions; and resources available to assist in the decision-making processes.
- Creating interaction and collaboration of internal and external partners in the Greater Cincinnati/Northern Kentucky region resulting in a quality patient care experience.
- Create multiple patient access points for education and the provision of healthcare services that are delivered according to patient's wishes and assist patients through the various access points, healthcare settings, facilities and providers in the Greater Cincinnati/ Northern Kentucky Health Care community.
- Coordinating the delivery of Acute Care, Post-Acute Care, and Home Care services with the goal of providing care and "aging in-place" as much as possible.
- St. Elizabeth Healthcare offers the PrimeWise membership program (age 50+) with over 32,000 members.

Healthcare Coverage

The St. Elizabeth Healthcare Finance Department has financial counselors to assist patients with finding eligible coverage. The focus of the financial counselor is to secure Federal and State funding (i.e., Social Security, Disability, Medicaid, Kentucky DSH) for uninsured patients. The financial counselor utilizes a social services approach to help uninsured patients secure such funding. These efforts include face-to-face interviews with patients (even visiting patients at their homes to assist them with the application process), filing necessary paperwork on their behalf, and acting as a patient advocate.


St. Elizabeth
HEALTHCARE
Heart & Vascular Institute
St. Elizabeth
Jeanne S
Registered Nurse Team Leader
REGISTERED

COMMITTED TO PROVIDING THE HIGHEST QUALITY CARE IN THE REGION.

St. Elizabeth HEALTHCARE