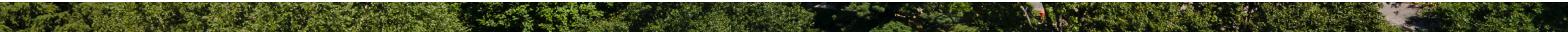
2022 Community Health Needs Assessment

2023-2025 Community Health Implementation Plan

Approved October 27, 2022



King's Daughters Mission

"To care. To serve. To heal." King's Daughters fulfills its mission through its commitment toward addressing the health needs in the community by conducting a Community Health Needs Assessment (CHNA) and developing an Implementation Strategy every three years.

Purpose of a Hospital's Implementation Strategy

A Community Health Implementation Plan (CHIP) outlines how a hospital plans to address community health needs and is intended to satisfy the requirements set forth by state law and the Internal Revenue Code Section 501(c)(3) regarding Community Health Needs Assessments and Implementation Strategy. The CHIP process is meant to align King's Daughters initiatives and programs with goals, objectives and indicators that address significant community health needs described in the CHNA.

Community Definition

KDMC's patients collectively come from a large geographic area. For purposes of this report, the community served by King's Daughters includes Boyd, Carter and Greenup counties in Kentucky, and Lawrence County, Ohio.

About King's Daughters

King's Daughters Medical Center is a locally controlled, not-for-profit, 455-bed regional referral center covering a 150-mile radius that includes southern Ohio and eastern Kentucky. King's Daughters offers comprehensive cardiac, medical, surgical, maternity, pediatric, rehabilitative, bariatric, psychiatric, cancer, neurological, pain care, wound care and home care services. KDMC operates more than 50 offices in eastern Kentucky and southern Ohio. KDMC's primary service area encompasses four counties in two states, Boyd, Carter and Greenup counties in Kentucky, and Lawrence County, Ohio. The organization serves a population of approximately 175,000 and is the largest employer in the region with more than 4,900 employees.

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How the Community Health Implementation Plan was Developed

The Community Health Implementation Plan (CHIP) was developed after the comprehensive Community Health Needs Assessment (CHNA) was completed. Please refer to the complete CHNA for the full report. Strategies and action plans were developed based on a consensus among steering committee members taking into account input from various disciplines.

The organization intends to focus on the priority areas below and undertake strategies to meet the identified community health needs. Most of the strategies and initiatives will be coordinated and advanced through teams comprised of representatives from KDMC and other community organizations. This CHIP will be reviewed annually during the three-year lifespan of the 2022 CHNA to determine if changes should be made to better address the dynamic healthcare needs of the community.

Access to Care

- Remove barriers to care
- Educate about access to primary care

Holistic Health

- Physical
- Mental
- Social
- Spiritual

Social Determinants of Health

- Partner with existing community organizations who focus on issues surrounding Social Determinants of Health

King's Daughters Steering Committee Members

Kristie Whitlatch, President/CEO

Sara Marks, Vice President/Chief Operating Officer

Mark Detherage, M.D., Vice President/Chief Medical Officer

Elaine Corbitt, Executive Director, Communications/Community Engagement

Julie Hall, Director, Quality Programs

Scott Hill, Executive Director, Community Engagement

Diva Justice, Director, Community Health

Trish Lewis, Director, Behavioral Health

Kerry Tague, Director, Business Development/Strategic Planning

Access To Care

ACTIONS KDMC PLANS TO TAKE TO ADDRESS THE HEALTH NEED

Priority Area	Initiatives/Programs	Reportable Goals/Anticipated Impact	Collaborations
Improve access to care	1. Provide transportation for patients through the Van Ministry to medical visits (Monday – Friday) 2. Provide Mammography and Healthy Heart with EKG services through our mobile health programs. 3. Educate the community on availability of PCP providers. 4. Educate the 45+ community on colorectal cancer screenings (Colonoscopy, FIT & Cologuard). 5. Educate providers and patients on the importance of statin therapy for patients with cardiovascular disease and diabetes.	1. Increase number of patients transported by 2% in FY 2023. FY 2022 baseline 1,296 patient served. Reevaluate goals for FY 2024-2025. 2. Mammography and Healthy Heart at least four new locations added per year 2023-2025. 3. Increase new patient PCP office visits by 3% per year. FY 2022 baseline 6,780. Revaluate goals for FY 2024. 4. At least 58% of Medicaid patients will receive a colorectal screening by 9/30/2025. 5. Increase Medicaid statin usage by 20% by 9/30/2025. FY 2022 baseline 64.3%. Revaluate goal for FY 2024-25.	Primary Care providers Health departments Businesses Service organizations Senior centers Schools Faith-based organizations Federally qualified health centers

Access to Care

ACTIONS KDMC PLANS TO TAKE TO ADDRESS THE HEALTH NEED

Priority Area	Initiatives/Programs	Reportable Goals/Anticipated Impact	Collaborations
Primary Care	1. Promote well care visits first 15 months and 3-6 years. 2. Increase childhood immunizations status. 3. Educate the community on when to use Primary Care, Urgent Care and Emergency Department.	1. Increase in well visits for Medicaid patients by 3% per year for each age group. FY 2022 baseline: 0-15 months 49.6% 3-6 years 67.8%. Reevaluate goal for FY 2025. 2. Increase in immunization status for Medicaid patients by 3% per year. FY 2022 baseline 23.2%. Reevaluate goal for FY 2025. 3. Number of people reached through education: Set baseline at end of FY 2023. Set goals for FY 2024-2025.	Primary care providers and office staff Schools Childcare centers After-school programs Fairs/festivals

Holistic Health

ACTIONS KDMC PLANS TO TAKE TO ADDRESS THE HEALTH NEED

Priority Area	Initiatives/Programs	Reportable Goals/Anticipated Impact	Collaborations
Physical Health	1. Identify, promote and/or expand walking or other physical activity opportunities. 2. Identify individuals with food insecurities; partner with local food sources to provide healthy food to those in need including those with specific medical conditions.	1. At least twelve events annually. 2. Identify and implement a food box program for patients facing food insecurity for deliver/pickup. 100 boxes FY 2023. Set new matrix for 2024-25.	Faith-based organizations Businesses Schools Fairs and festivals Physician offices Senior centers Malls River Cities Harvest Ashland Community Kitchen
Mental Health	1. Promote Suicide Prevention Hotline. 2. Educate and provide NARCAN to Behavioral Health Patients at discharge as appropriate. 3. Collaborate on two mental health awareness activities: (1) for the community and (2) for networking among providers. 4. Increase number of Certified Peer Support Specialists. 5. Promote mental health awareness at community events. 6. Reduce the number of high dose Opioid prescriptions from KD prescribers.	1. Promote hotline number through at least six events and social media each year. 2. Number of patients served. Establish benchmark 2023, metrics for FY 2024. 3. At least two events. Attendance at programs, establish benchmark 2023. Set metrics FY 2024-25. 4. Establish additional peer support in FY 2023, set patient benchmark and set metrics to increase number of patients served in FY 2024-25. 5. Promote through at least six events each year, 2023-2025. Track attendance at events. 6. Decrease prescribing of high dose opioids to 3% overall by 9/302025.	Faith-based organizations Businesses Schools Fairs and festivals Physician offices Senior centers Malls Mental health providers Drug courts Social service agencies

Holistic Health continued

ACTIONS KDMC PLANS TO TAKE TO ADDRESS THE HEALTH NEED

Priority Area	Initiatives/Programs	Reportable Goal/Anticipated Impact	Collaborations
Social Health	1. Provide free, interactive learning for children and adults. Topics may include, bullying, nicotine/vaping, SUD, suicide prevention, grief, depression etc. 2. Provide social health programming for adults. Topics may include dealing with depression, active living, staying socially active, grief, diet & mental health, etc. 3. Implement Social Determinants of Health screening protocol in Epic.	1. At least eight programs per year. Set goal at end of FY 2023. 2. At least eight programs per year. Set goal at end of FY 2023. 3. Implement SDH screening by end of FY 2023.	Faith-based organizations Businesses Schools Fairs and festivals Physician offices Senior centers Malls Mental health providers Social service agencies
Faith-Based Health	1. Rebuild the FaithWorks collaborative program to support community health initiatives.	1. Recruit at least six churches to provide health programming. Establish a FaithWorks phone number for questions, and appointments in FY 2023. Set goals for establishing new programs at in of FY 23.	Faith community

Social Determinants of Health

ACTIONS KDMC PLANS TO TAKE TO ADDRESS THE HEALTH NEED

Priority Area	Initiatives/Programs	Reportable Goals/Anticipated Impact	Collaborations
Reduce the Impact of Social Determinants of Health	1. Support organizations focused on assisting individuals facing issues associated with social determinants of health by supporting them to expand their services. Focus organizations are those providing, but not limited to food, clothing, shelter, housing, dental and social services.	a. Develop grant application by December 2022. b. Track number of organizations supported. c. Number of individuals served by the funding.	Neighbors Helping Neighbors City of Ashland Homeless Coalition Hillcrest-Bruce Mission Salvation Army Schools Other non-profits

Significant Health Needs Not Addressed

IRS regulations require that the CHNA Implementation Strategy include a brief explanation of why a hospital facility does not intend to address any significant health needs identified through the CHNA.

As described in detail in the CHNA, KDMC prioritized three significant health needs during the CHNA process, including:

- Access to Care
- Holistic Health (Body, Mind, Spirit)
- Poverty

Other identified health needs have not been specifically addressed through the development of this Implementation Strategy. However, many of these needs are covered through KDMC's provision of comprehensive services or through the three above-mentioned priority areas to be focused on over the next three years. Specific reasons are outlined below.

Identified Need	Reason for Not Addressing
• Chronic Health Conditions • Lack of Healthcare Providers • Mental Health • Obesity • Physical Inactivity • Preventive Care • Smoking/Vaping • Substance Use Disorders	Addressed through Access to Care, Holistic Health and Poverty.
• Cancer • Heart Disease • Lack of Prenatal Care	Addressed through KDMC's comprehensive services and/or educational outreach. Relatively low priority per community input obtained through key stakeholder interviews and community survey.
• Lack of Affordable Housing • Teenage Pregnancy • Unintentional Injury	Outside the scope of services provided by KDMC, but opportunities may exist for KDMC to support organizations addressing these needs.

Conclusion

KDMC believes that the new programs to be developed and expanded will respond to the significant health needs of the community. Through the resources identified and collaboration with the community, the impact of these new programs will be significant.

Comments regarding the Community Health Needs Assessment and/or Implementation Strategy can be submitted to the organization by contacting:

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