Owensboro Health Regional Hospital

COMMUNITY HEALTH NEEDS ASSESSMENT

2021 - 2024

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Owensboro, KY 42303
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https://www.owensborohealth.org

Owensboro Health

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Executive Summary

Owensboro Health Inc. (OHI) owns and operates Owensboro Health Regional Hospital, a 477 bed hospital in Daviess County, Kentucky. Owensboro Health Regional Hospital (OHRH) is pleased to present its 2021-2024 Community Health Needs Assessment (CHNA). OHRH contracted with the Community and Economic Development Initiative of Kentucky (CEDIK) to conduct a CHNA in accordance with the Affordable Care Act (ACA) and section 501(r) of the Internal Revenue Code for nonprofit tax-exempt hospitals. This CHNA is the second report prepared by CEDIK for OHRH. This report will be used to create an implementation plan with wide community input to address the identified health needs for the community served by OHRH over the next three years. The Owensboro Health, Inc. Board of Directors approved this CHNA on May 23, 2022.

Summary of Findings

Methodology

CEDIK facilitated the process of primary data collection through focus groups and key informant interviews to support OHRH in their creation of an implementation plan to address identified health needs. In addition, county specific secondary data was gathered to help examine the social determinants of health. Throughout the process, CEDIK made it a priority to get input from populations that are often not engaged in conversations about their health needs or gaps in service. CEDIK conducted seven key informant interviews to probe more deeply into health and quality of life themes within the county. Potential barriers to accessing community resources were also identified in these interviews.

This CHNA report synthesizes community health needs survey data, focus groups with vulnerable populations, and key informant interview data with social and economic data as well as health outcomes data collected from secondary sources to help provide context for the community. Below are identified themes collected from the primary data collection:

Focus Group Visioning

Residents describe their vision of a vibrant, healthy Daviess County: access to healthy foods and shelter; access to health care and dental care; transportation; inclusive services and programs; safe parks, bike and walking paths, accessible green spaces for physical activity; quality mental health care; strong education system; tobacco free policies; air quality; decrease in substance abuse, child abuse and domestic violence; jobs; safe environment for seniors.

Focus Groups – Unmet Needs

Focus groups were conducted by CEDIK in Daviess County to discuss health needs of populations with unmet health needs and to deepen the understanding of the health challenges they face. Focus group discussions revealed unmet needs across the low-income and senior populations. Common concerns across these populations include: obesity and obesity related diseases in children and adults; tobacco use and vaping; food insecurity, poor diet and lack of exercise; substance use and addiction – drugs, alcohol and illegal substances; substandard or limited housing and homelessness; affordability – high cost of health care; mental health – depression, stress, lack of providers and long wait times; recent increase in gun violence;

community safety, particularly for elderly; transportation; caregiver support; transitional services; dental care – not enough providers who will accept Medicaid; aging population health care – residential treatment for dementia and Alzheimer's; cancer; having to travel outside of county for care; and providers' lack of communication skills with individuals with disabilities.

Key Informant - Community Themes and Strengths

OHRH and CEDIK obtained additional primary data through seven key informant interviews with individuals knowledgeable about health and quality of life needs in Daviess County. CEDIK organized the data into strengths, barriers, and opportunities for change for Daviess County. Strengths included expansion of telehealth for services; collaborative partners; a growing community in industry, service, and retail sectors; expansion of bus routes; corporate community embraces wellness and partners with hospital; generous hospital that provides community grants and responsive to emerging needs. Challenges faced by residents include: the health care system does not always understand patient's circumstances – how they choose to access healthcare; transportation needs; not enough mental health and primary care providers; need for more communication of hospital services; and a lack of knowledge about what the hospital is doing in the community. Several opportunities were highlighted, including an increased understanding of the impact of trauma; understanding cultural differences in patients and communication; community openness to prioritizing health and changing culture of health; routine care addressing mental health, tobacco use and obesity; mobile crisis units and expanded transportation assistance to health care appointments.

Prioritized Areas

Based on survey results, focus group and key informant interview results, as well as key secondary health data, there were five priority areas identified. Existing local, state and national priorities were considered. This information can assist the hospital as implementation plans are developed to address the prioritized health needs. The following priorities were identified as areas of need to address in the next three years:

- **Obesity and related diseases**
- **Tobacco use**
- **Substance use**
- **Mental health**
- **Housing**

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

Acknowledgments

This Community Health Needs Assessment is a joint effort by the Owensboro Health Regional Hospital and the Community and Economic Initiative of Kentucky (CEDIK), and builds on the community health improvement efforts of the prior CHNA.

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

- Sarah Adkins, Owensboro Regional Recovery
- Anna Allen, International Center
- Shauna Boom, Owensboro Housing Authority
- Brandon Harley, Audubon Area Community Services
- Clay Horton, Green River District Health Department
- Dr. Lionel Phelps, RiverValley Behavioral Health
- Brian Short, AMR Emergency Medical Response

CEDIK at the University of Kentucky provided assistance with the collection and analysis of primary key informant data and compilation of this analysis. CEDIK works with stakeholders to build engaged communities and vibrant economies. If you have questions about CEDIK's assessment process, contact Melody Nall, CEDIK Extension Specialist Administrator: melody.nall@uky.edu or (859) 218-5949.

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

Owensboro Health

May 23, 2022

It is with great pleasure Owensboro Health Regional Hospital presents its 2021-2024 Community Health Needs Assessment. In partnership with Community and Economic Development Initiative in Kentucky (CEDIK) we share with you a compilation of work which sought to identify and prioritize community health needs of which together, through collaborative partnerships, grant investments, and strategic efforts we will work to address as we strive to meet the Owensboro Health mission, "To heal the sick and improve the health of the communities we serve."

The data reflected in this report was collected from an analysis of secondary data, community surveys, focus groups, and key informant interviews. This information was reviewed by the Owensboro Health Community Health committee and based on those findings the committee has selected priority health issues and social determinants of health which will be focused upon in the next three years. Owensboro Health will strive to work collaboratively to improve health outcomes and be a leader in addressing the health issues and social determinants of health which present barriers to better health and quality of life for the individuals, families and communities we serve.

The past two years in battling the pandemic we have faced many challenges together. Owensboro Health, its team members and community partners have not wavered in our efforts to meet our mission and in fact, intensified efforts to reach our most vulnerable populations.

We want to thank all our partners and participants who assisted us with this community health needs assessment and look forward to working together to address priority health issues, disparities, and the social determinants of health together.

Sincerely,

Mark Marsh, President and CEO
Owensboro Health

Beth Steele, MSN, RN, FACHE
Chief Operating Officer
Owensboro Health Regional Hospital

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1. Introduction

1.1 CHNA Report Objective

The purpose of a Community Health Needs Assessment (CHNA) is to understand health needs and priorities in a given community, with the goal of addressing those needs through the development of an implementation strategy. Owensboro Health Regional Hospital (OHRH) has produced this CHNA in accordance with the Affordable Care Act (ACA) and section 501(r) of the Internal Revenue Service tax code for nonprofit tax exempt hospitals. The results are meant to guide OHRH in the development of an implementation strategy and to help direct overall efforts to impact priority health needs. The Owensboro Health, Inc. Board of Directors approved this CHNA on May 23, 2022.

1.2 Owensboro Health Regional Hospital

Owensboro Health is a nonprofit health system with a mission to heal the sick and to improve the health of the communities it serves in Kentucky and Indiana. The system includes Owensboro Health Regional Hospital. OHRH is nationally recognized for design, architecture and engineering, and is the only hospital in the world to be designated a Signature Sanctuary by Audubon International. Owensboro Health Medical Group comprises over 180 providers in 25 locations, a certified medical fitness facility and the Mitchell Memorial Cancer Center. Owensboro Health has been recognized for outstanding care, safety and clinical excellence by The Joint Commission, Healthgrades, U.S. News & World Report and Becker's Hospital Review. For more information, visit owensborohealth.org.

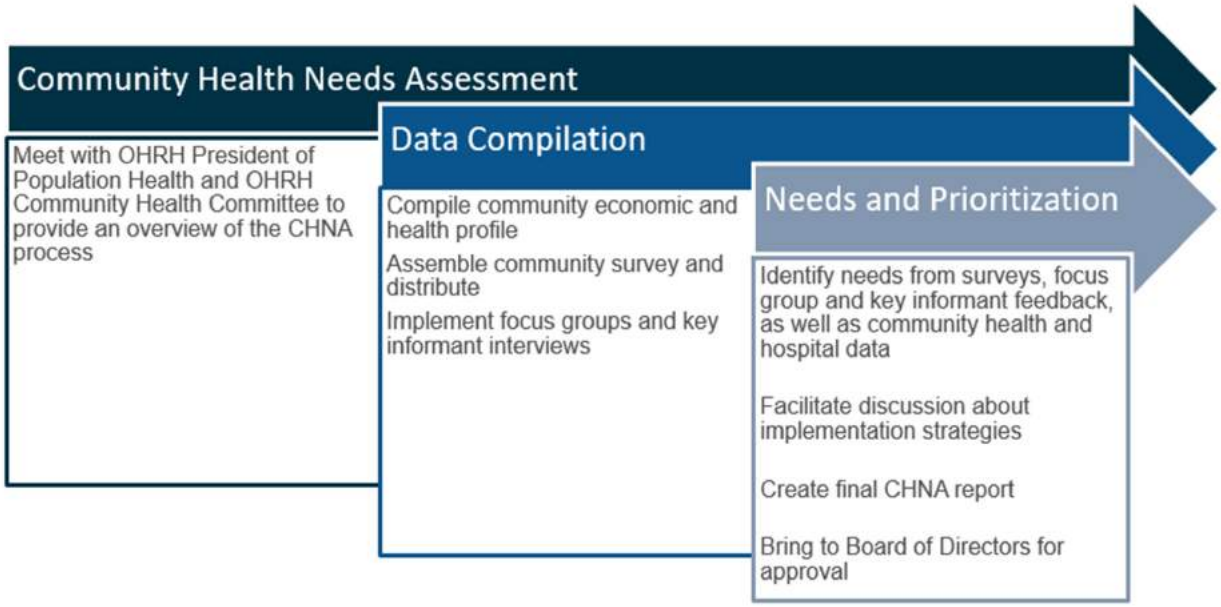
1.3 CHNA Defined Community

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

1.4 CHNA Process

Here is an overview of the CHNA process that CEDIK uses, based on the IRS guidelines:

Figure 1. CHNA Process



2. CHNA Reported Successes 2018-2021

OWENSBORO HEALTH PROGRESS ON IDENTIFIED PRIORITY HEALTH NEEDS & IMPLEMENTATATION STRATEGY ty 2018-2021

An important additional component of the CHNA is to evaluate the impact of the actions taken to address the significant health needs from your previous CHNA report. In the last report, Daviess County selected the priority areas for action:

1. Healthy Behaviors
2. Obesity and obesity related diseases
3. Substance use
4. Tobacco Use and smoking
5. Mental Health

The following table represents progress made since the approval of the tax year 2018-2021 CHNA. This update represents a summary of initiatives, investments, programs and/or specific outcomes beginning June 1, 2019 to May 31, 2022.

DEFINED COMMUNITY: DAVIESS COUNTY

Significant Health Need Identified in Preceding CHNA	Planned Activities to Address Health Needs Identified in Preceding Implementation Strategy	Was Activity Implemented (Yes/No/other action)	Results, Impact & Data Sources
Healthy Behaviors, Obesity and Obesity Related Diseases	• Continue financial and in-kind support to address senior hunger via partnership with Morrison's Food Services and Owensboro Senior Community Center.	Yes	Continued financial support has been ongoing for the Senior Weekend Frozen Meal Project, a partnership between Morrison's Food Services, the Department for Aging and Independent Living, and the Senior Community Center of Owensboro – Daviess County. In addition, data from this project is being captured and analyzed in order to establish evidence based practices, develop a manual for replication. Partnerships were initiated with the Tri-State Food Bank to continue mobile food units.
	• Establish internal nursing pods and no less than one community nursing pod to promote breastfeeding as the optimal source of nutrition for babies reducing barriers to breastfeeding while visiting OH campuses and in community settings.	Yes/No	Two nursing areas have been created to provide an additional layer of support for Owensboro Health team members who may need to breastfeed or pump. Visitors may also use these pods. Discussions have taken place to plan to create a community nursing pod where nursing mothers can access privacy while either on Owensboro Health property or in the community however this work has been delayed to the pandemic.
	• Conduct annual holiday food drive for area food pantries.	Yes	Each year during the holiday season, Owensboro Health conducts a food drive to benefit food – insecure individuals residing in the OH catchment

	• Assist community partner(s) in facilitation of regional meeting to discuss food insecurity as a significant social determinant of health. • Continue to support Owensboro Health Healthpark and its scholarship program providing financial assistance, the Healthpark educational programming, and outreach and targeted evidenced based programming.	Yes	service area. Thousands of pounds of food and hygiene items are collected each year. Owensboro Health has a presence on several boards and community groups where one of the main topics discussed is food insecurity, including representation on the Hunger Steering Committee in Daviess County. This steering committee was established in order to coordinate a community – wide effort to address food insecurity. The Healthpark provides significant benefits to the community, including scholarship programs through financial assistance, educational programing, outreach, and targeted, evidence – based programming. Support for these programmatic efforts will continue. **Exercise is Medicine**- Exercise is Medicine is an eight week supervised exercise program at the Owensboro Healthpark. The program was developed in conjunction with the initiative created by the American College of Sports Medicine to create collaborations between exercise professionals and healthcare providers in the care of their patients. Providers may refer appropriate patients who meet criteria for participation. All participants are assigned to a fitness coach who performs an initial fitness assessment and exercise prescription that is unique for each patient's needs. During the eight weeks, patients must follow the exercise prescription at least three times a week at the Healthpark. Participants also receive weekly contact from their fitness coach to advise, encourage, teach, and support through the program. **Lifesteps**- **Lifesteps®**: Lifesteps® is a comprehensive weight management program that offers proven techniques to help participants lose weight and keep it off. The key components of the program are nutrition, physical activity, behavior modification, small group support and personal lifestyle change. Participants meet one time a week for 16 weeks. We also offer the Lifesteps® Reboot program, which is open to anyone who has completed the Lifesteps® program and would like to renew their health goals, recharge their motivation and refresh the skills they learned in Lifesteps®. The Healthpark has 5 people on the education and wellness team who are trained to provide this program.

	• Financially support and advocate for community projects and programs which focus on working collaboratively to improve healthy food options; appropriate time for play and exercise; art and music opportunities among others	Yes	Since the adoption of the last CHNA, OH has continued to invest in specific grant funding to community organizations which sought to target obesity through youth and adult programs, policy changes, partnerships with universities, and special populations. OH continued its commitment to having employees serve and participate on local projects, initiatives and other efforts. During this same time period, funds were allocated to the Arts and Cultural organizations in Daviess County which many, through its programming, promoted better nutrition, participation and engagement in music, increased movement through dance and other art forms and walking tours in our city to view placement of sculpture. Targeting rates of adult obesity, childhood obesity, diabetes and other obesity related diseases allowed for a keener eye and tactics with prioritized population(s). Partnerships with UK and the CDC have resulted in targeted programming for those community members with cognitive or physical disadvantages. Partnerships with NIH, CDC, Western Ky University and other community partners have expanded the scope of work and numbers of persons impacted through what has now been named an evidence based practice, Bingocize® Owensboro Health Healthpark worked to develop a local program specific to older African American adults to address specific health needs they experience. Owensboro Health is continuing to look for opportunities to address social determinants of health, disparate health needs and those who experience disparities. The COVID pandemic highlighted significant disparities among many populations which will prompt future strategies at local and national levels.
	• Utilize community data to target specific areas of community which could most benefit by changes of policy, structural improvement, and community assets and work in partnership to develop improvement plans.	Yes	Owensboro Health has a number of employees serving on local, state and national task forces, coalitions, Boards and committees to ensure that health planning is and remains a targeted strategic effort. We provide technical assistance, expertise, data, connectivity, and additional resources in our role to serve.

	• Serve on local and state task forces related to community development, chambers of commerce, workplace health, economic development, health and wellness and the Arts to provide voice for community health improvement. • Provide expertise from staff to the community for education and program guidance • Continue the Diabetes Prevention Program T2	Yes Yes Yes	Owensboro Health has hired Dr. Scott Black as a Primary Care and Sports Medicine Physician. Dr. Black has specialized training in the prevention and treatment of illnesses and injury by providing comprehensive care for both patients who are already physically active and for patients looking to improve their health through exercise and better nutrition, which can lead to better health outcomes. The Community Request Portal was developed to provide communities with easier access to needed expertise, knowledge and support to the system to help them impact the health of the communities we serve. This online tool has been refined during this CHNA cycle to allow for greater partnerships, awareness, and engagement between the health system and community. Continued facilitation will occur for a support group for patients who have participated in surgical weight loss. Owensboro Health understands a path towards healthier living is a lifelong commitment and this group can help identify and reduce barriers to participants when social determinants of health are factors. Owensboro Health is continuing and expanding its focus on diabetes through the Diabetes Prevention Program T2, Inbalance Diabetes Education Program, and Medicare Diabetes Prevention Program. Due to the amount of increased referrals, an additional full – time staff member was hired to the department in 2019. To alleviate or diminish some barriers face by patients, additional telehealth services are now offered. A state pilot project has been developed, centering around diabetes prevention. Owensboro Health is an active member of this project.
Significant Health Need Identified in Preceding CHNA	**Planned Activities to Address Health Needs Identified in Preceding Implementation Strategy**	**Was Activity Implemented (Yes/No/other action)**	**Results, Impact & Data Sources**
Substance Abuse Prescription, Illegal, and Illicit Substances	• The National Institute on Drug Abuse ranks Kentucky among the top 10 states with the highest opioid-related overdose deaths,		As a participant in this initiative, our organization agrees to: Work to improve patient safety in the area of Opioid Stewardship including a specific focus on:

	and Kentucky's hospitals are on the frontline in the fight to help the state recover. To assist the state's hospitals in this battle, the Kentucky Hospital Association (KHA) is partnering with the Cabinet for Health and Family Services as part of the Kentucky Opioid Response Effort (KORE) to launch the Kentucky Statewide Opioid Stewardship (KY SOS) program.		• Development and implementation of policies and procedures to promote opioid stewardship including: • Increasing community outreach and education regarding pain management and safe opioid use; • Providing non-pharmacologic analgesics options to patients; • Development of an opioid stewardship committee (this has been done and is led by Dr. Fran DuFrayne, Chief Medical Officer for Owensboro Health); • Tracking and reporting of metrics regarding opioid stewardship (dashboards are available in EPIC for individual providers and leaders; • Developing guidelines for opioid use in the inpatient, ambulatory, perioperative, and emergency department settings; and • Educating providers, staff, patients, and families to ensure success.
	• Pilot program integrating the health system's electronic record system with KASPER data dramatically expedites the time it takes to access a KASPER report and enables simplifies access to prescription reporting data	Yes	
	• Continue work with local substance abuse coalitions and community efforts to provide education specific to opiate, heroin, methamphetamine, alcohol, and marijuana use and abuse.	Yes	Meth continues to ravage individuals, families, and our community. Owensboro Health is an advocate for federal dollars to also be used to treat methamphetamine addiction.
	• Support internal policy and processes to educate physicians and other providers on prevention efforts.	Ongoing	

	• Continue to use Angel Visitation program bringing persons in recovery from community into hospital setting to share recovery options for those in need.	Put on hold during Pandemic due to visitation restrictions.	
	• Continue to financially support organizations whose missions and abilities and projects are specific to providing substance abuse prevention, treatment and recovery services, housing, education and assistance to address substance abuse through our grant programs.	Yes	
	• Installed a permanent drug take – back bin located in the Owensboro Health Outpatient Pharmacy.	Yes	
	• Explore potential collaborative partnerships and projects between Mother/Baby and Neonatal services and community organizations focused on prevention of substance use during pregnancy.	Yes	Work has been ongoing despite the pandemic with community stakeholders to consider programs for pregnant mothers and their children. OH has had physician and team member leadership in working to secure understanding and support to establish a VOA Freedom House in Daviess County. One of the hospitals in the Owensboro Health system has a program for pregnant moms with substance use disorders and as we learn more about this program and its patient outcomes, could be a program of consideration for replication. Owensboro Health is embarking on a research study to understand the differences in current treatment and outcomes for infants with neonatal Opioid Withdrawal Syndrome admitted to regional verses urban medical centers in western Kentucky.

Significant Health Need Identified in Preceding CHNA	Planned Activities to Address Health Needs Identified in Preceding Implementation Strategy	Was Activity Implemented (Yes/No/other action)	Results, Impact & Data Sources
Tobacco Use and Smoking Primary care, access points, transportation, language, and cultural barriers, financial support for prescriptions, equipment and supplies, care coordination, education regarding benefit enrollment, staff engagement with community team to address access to care.	• Continue to advocate use of the Quit Now Kentucky line through financial support of Green River District Health Department's Tobacco Control Coalition's marketing and media messages to increase number of persons utilizing the quit line.	Yes	
	• 10 OH team members will be trained as Tobacco Treatment Specialists.		Owensboro Health Regional Hospital now has over 10 TTSs, and two additional anticipated TTSs will undergo training in the next year. TTS will be available at all OH hospitals and outpatient settings. • A referral process was built in EPIC on both the inpatient and outpatient sides to refer patients to a TTS and is now live. • TTS interventions are now requested from patients and community members. Community members have utilized TTS interventions in a one-on-one setting in person, by phone and was increased via telehealth during the pandemic, rather than Freedom from Smoking classes, which occur in a group setting, are also still available.
	• OHRH Outpatient Pharmacy to provide Nicotine Replacement Therapies (NRT)	Yes	• OHRH Outpatient Pharmacy is now providing accessibility to Nicotine Replacement Therapies (NRT) prior to patients leaving the hospital. If financial barriers exist, the pharmacy has acquired a grant from the Owensboro Health Foundation to address that barrier. No one who meets the criteria and desires to quit tobacco products and wants / needs NRT will leave OHRH without it.
	• Financially support Nicotine Replacement Therapy products through the Green River District Health Department, National Jewish and Quit Now Kentucky.	Yes	

	• Financially support and assist in efforts to have additional persons trained in American Lung Association's Freedom from Smoking evidenced based smoking cessation program.	Yes	
	• There is the potential to partner with a local college campus to support cessation efforts.	Yes	OH invested in and is a partner with a local college campus, Kentucky Wesleyan College, in developing a tobacco cessation program including training for trained tobacco specialists to be on campus for students and faculty and access NRT when needed.
	• Continue to provide patient, employee, and community education on these resources.	Yes	
	• Maintain advocacy of local, regional and state efforts for appropriate policies for tobacco use, nicotine use, vaping and second hand smoke reduction.	Yes	
	• Strengthen current campus tobacco free policies and develop new signage for clarity related to electronic cigarettes and vaping.	Not complete	Policy revision needs to take place. Signage replacement has not taken place at all campuses due to the pandemic.
	• Maintain comprehensive tobacco policy requirement for all applicants in the OH Community Health Investments Grant Program.	Yes	
	• Continue to expand early lung cancer screening and provide support to individuals at risk for lung disease.	Yes	

	• Evaluate to determine impact of University of Kentucky College of Nursing K-CARE Project, training Community Health Workers (CHWs) to work with minority populations in an effort to educate on lung cancer, lung cancer screening, and encouraging those who are eligible to be screened as early as possible.	Ongoing	Owensboro Health is currently setting goals to establish a CHW program.
	• Develop educational initiative to understand the synergistic effects of radon and smoking and radon's impact on lung disease.	Yes	Work has begun by the Lung Cancer Screening program and other partners to provide education to patients and community, integrate screening questions, provide for testing kits and resource information to those persons with positive responses to possible radon exposure. Radon kits are provided to patents and communities in partnership with the Green River District Health Department.
	• Develop community outreach event to bring about awareness of COPD and the newly launched Better Breathers Club.	Yes and ongoing	Face to face meetings were ceased, restarted, and then ceased again due to the COVID pandemic and the risks to this vulnerable population. Communication with members continued. While the pandemic eliminated face to face Better Breather's Club meetings, as of this writing those meetings have resumed. Prior to the pandemic within this reporting cycle, multiple outreach events including local media educated our community on the club. Owensboro Health hosts the largest Better Breathers Club in Kentucky.
	• Educate OH team members on vaping, JUULs and impact of electronic cigarettes and other non FDA approved tobacco and/or nicotine products in accordance with correlating community plan to educate schools, parents and community.	Ongoing	OH invested in external community organizations to continue this education during the pandemic. Medical providers participated in a community forum to address the danger of Juuls and electronic cigarettes. Further consideration must be given to continue to address this strategy in the next cycle.

Significant Health Need Identified in Preceding CHNA	Planned Activities to Address Health Needs Identified in Preceding Implementation Strategy	Was Activity Implemented (Yes/No/other action)	Results, Impact & Data Sources
Mental health	According to primary interview data collected in the 2018-2021 CHNA, there is a lack of providers for those facing mental health issues; a stigma in seeking this type of care; and, a significant increase in the rate of suicide.		
	• Owensboro Health will launch an Intensive Outpatient Program using an evidence based curriculum focusing on mental health problems. Each IOP group will have a maximum of 10 participants. Groups will be 3 days a week, for 3 hours per day. As the program grows, we hope to add an additional group for mental health court participants, and another group with a focus on co-occurring mental health and substance use disorders.	Yes	Owensboro Health has launched an outpatient program using an evidence – based curriculum to address mental health. Two groups are currently being conducted – one morning group and one afternoon group. In order to adhere to COVID restrictions, only five participants are included in each group. In addition, 10 participants may attend by telehealth if they wish to do so. A co-occurring disorder group was also started (for those experiencing mental health and substance use issues).
	• We will initiate the IOP by hiring one therapist and adding an additional part or full-time therapist as the program grows.	Yes	One licensed practical nurse has been added to assist with this program.
	• Owensboro Health will serve on the Board and Clinical	Yes	

	Care team for the new mental Health Court in Owensboro Daviess County.		
	• We have and will continue to have representation on each of the three community health action teams as they seek to establish and implement strategies to address priority areas	Yes	
	• Owensboro Health Regional hospital will continue to financially support through our grant program projects and proposals which seek to impact education and barriers to access to mental health.	Yes	In spring 2021, many organizations came together to develop programs for which formal applications for financial support to address mental health in a coordinated manner would be later submitted. Allocations to support projects and programs to address mental health and well-being were one of the two largest areas of focus in grant funding.
	• We will continue to provide educational opportunities with expertise and knowledge in this area and seek to advocate for policy where most beneficial to meet the identified needs. • We will maintain our partnerships and outreach with the Arts community as a strategy to impact mental health and wellness as supported by research and literature.	Yes	Owensboro Health is now providing telehealth behavioral health services. In spring 2020, Owensboro Health informed the community of the development of a partnership to offer a free online mental health resource called CredibleMind. Funding was sought through the Owensboro Health Foundation and a partnership has ensued with RiverValley Behavioral Health. A summer 2021 launch for this resource was planned and executed. Over 5,000 users have been noted thus far with use of online assessments significant. Anxiety, Depression, Burnout, Substance Use are the top areas of interest searched. OH was asked to present this collaborative partnership at a national conference. Mental Health First Aid training has been piloted and provided to two units within the inpatient OHRH setting with a goal to train all team members. Owensboro Health has an internal committee focused on mental health and the provision of mental health services across the system. Team members from Owensboro Health and technical assistance is provided to a community – based mental health provider group.

Owensboro Health has named a Vice-President of Population Health as a part of its strategic effort to strive to meet its mission: to heal the sick and improve the health of the communities we serve.

Owensboro Health has also named priority areas of focus developed to further target specific populations and/or specific strategies related to the community priority health needs. Cross-organizational teams have been created to complement, expand, develop new and partner to create strategies to impact these areas. Those areas are:

Older Adults and Aging- Our aim is to change the culture of care for the aging adult in our region that enables each individual to attain optimal life expectancy with maximal quality of life. OH should strive to become a center for excellence for the aging population.

- Effective Sept. 2018, OHRH became a member of NICHE (Nurses Improving Care for Healthsystem Elders). Training modules were developed. NICHE Goal statement: Implementation of NICHE Geriatric Resource Nurse Model in 10 patient care areas.
- Our NICHE Mission Statement: "Our mission is to create meaningful improvements in the outcomes that matter to older adults and their families. We will do this by strengthening nursing and interdisciplinary expertise in geriatric sensitive care as we heal the sick and improve the health of the communities we serve."
- OHRH Nurse Executive committee initially approved a plan requiring nursing leaders to complete GRN program so that 9 additional patient care areas will have access to a GRN (total of 11)
    - As of 5-16-2022, OH currently has **104 GRNs and 12 GCNAs**.

- OHRH is one of about 100 hospitals/health systems participating in the Institute for Healthcare Improvement's (IHI) Action Community Age-Friendly Health Systems initiative; Two NICHE units and three additional units are participating; focus is implementing changes directed at "4M's"- what Matters to the patient, Medications, Mobility and Mentation.
- Owensboro Daviess County achieved the AARP Age Friendly Community designation. City of Owensboro submitted the Livable Communities application. The COVID pandemic slowed this team but meetings have resumed. OH serves on this committee.
- Owensboro Health serving on multiple community boards serving older adults to better understand efforts and areas for potential partnerships to address this population.
- Senior Center of Owensboro Daviess County developing plans and funding for new building with adjacent affordable housing for seniors. Their desire would be to have an on-site clinic and space for health programming.
- Owensboro Health has rebranded its Golden Partners Group to Connections with a focus on healthy aging.
- The Owensboro Health Healthpark Fall Prevention Program has a new name: BASE (BALANCE, AWARENESS, STABILITY, EVERYWHERE) Falls are the number one reason for admission in hospital emergency rooms annually for the 65+ population. Balance and our walking gait are components of overall fitness that can diminish as we get older. The program seeks to improve strength, stability, balance, coordination, walking gait and alleviate fears of falling and build confidence.

- Owensboro Health Director of Trauma Services worked with Green River Area Development District Area Agency on Aging (GRADD) to develop Safe Aging Coalition based on OHRH Trauma data indicating significance of falls among older adults 65+; this work ceased during the pandemic.

- The Morrisons / OHRH / Owensboro Daviess County Senior Center (formerly the Munday Activity Center) partnership continues to provide weekend meals to seniors in need. (https://www.facebook.com/owensborohealth/videos/stop-the-waste/1015688861599941O/) Over 10,000 meals have been provided since the inception of this program to seniors who do not have access to meals on the weekends. Meal delivery continued and expanded during the pandemic.
- The Owensboro Daviess County Senior Center is currently working, as part of their grant funding from OHRH, with WKU to evaluate the weekend meal program, create a standard operating procedural manual, and assessing and evaluating the impact to 45 seniors in the program. Two nutrition assessments are being utilized in addition to primary data collection from in-home visits with the seniors to measure strength, social status and living conditions.

- **Tobacco and Related Diseases-** OHI seeks to develop and support a comprehensive plan to impact tobacco use and its related respiratory diseases including lung cancer and COPD.

    - Owensboro Health serves on the Kentucky Health Collaborative (KHC) Tobacco Subcommittee. OH has advocated for tobacco free legislation, looking at best practices across 10 hospital system; reviewed materials which could be used across all 10 hospitals to promote tobacco cessation and lung cancer screening for those eligible. Discussion on Radon as second leading cause of lung cancer has taken place and opportunities for the KHC to play a role in awareness are priority. OH has initiated a radon screening program to be further developed.
        - Representatives from Owensboro Health have been asked to serve and have now become leaders on this team and in this area, receiving multiple awards, asked to serve as technical advisors and speak to other audiences regarding the lung cancer screening program.

        - Lung Cancer Screening over the past three years has taken an amazing turn. OH screened a total of 2,420 patients in 2021, finding a total of 14 early stage lung cancers. So far in 2022, we are screening anywhere from 200-250 patients a month. OH has evolved from having only 1 LDCT location to now having a total of 6- 4 of which are ACR accredited and deemed a center of excellence in lung cancer screening by the GO2 Foundation. We are now also a continuum of care center of excellence by the GO2 foundation for our prevention-survivorship efforts. We now have the lowest self-pay rate within the Kentucky Health Collaborative at $99, and have recently received a grant that will help to fund the lung cancer screening for our patients who are under/un-insured. OH lung cancer screening program also has one of the top adherence rates in the state, which was the rationale behind us leading the KHC initiative of adherence.

- Owensboro Health hosted in partnership with the University of Kentucky an expert panel presentation for community organizations on addressing tobacco use among vulnerable populations.
- Better Breathers Support Group launched in May 2019. Developed from COPD subcommittee.
- Kentucky Community Cancer Awareness Research and Education (K-CARE) Community Health Worker Project was completed; Owensboro focus groups and trained individuals to be Community Health Workers to work with minority populations educating them on lung cancer, lung cancer screening, eligibility and access to lung cancer screening. Tracking protocol will be established to determine the success of this community intervention.
- Health maintenance and registry up and running.
- Multiple EPIC / electronic medical record projects supporting our lung cancer screening program have been completed, including a Best Practice Alert (BPA) and Referrals / Tracking Work Queue. The Lung Nodule / Incidental Findings program launched and is detecting cancers early.
- Smoking Cessation / Freedom from Smoking classes are currently being offered by the Owensboro Health community wellness team.
- COPD materials were reviewed by pulmonary physicians in an effort to achieve consistent, system-wide, patient education materials. As previously noted, OHRH has now adopted the "Stop Light Tool" from Sutter Health and rolled this out in December 2018 to provide for patients with COPD; additional tools were developed for Diabetes, Depression, CHF, Sepsis and Pneumonia.
- UK Research Foundation (FY18 grantee) recently completed a lung cancer screening awareness campaign and research study. Researchers provided results of this study on November 26 2018.Additional time will be given to do additional analysis on the measures.
- Ongoing assessments are taking place to determine where additional Tobacco Treatment Specialists are needed throughout the system.
- AVS successfully changed regarding harms of tobacco use and tobacco cessation for patients at the point of discharge.
- This team consistently exploring need for additional lung cancer screening education both internally and externally as well as referrals to Cardiac and Lung rehab.

- **Children and School Health-** Our aim is to improve health outcomes for children and students while initiating a proactive, comprehensive, and replicable program that includes health education, wellness activities and direct health services.

  - This focus team is currently undergoing reorganization however work continues to build a foundation for addressing this area of focus.
  - Owensboro Health is collaborating with the cardiology experts of Cincinnati Children's and Kentucky Children's Hospital to bring the most advanced congenital heart care closer to the communities we serve as part of the Joint Heart Program.
  - Owensboro Health Children's Clinic continues its Reach Out and Read Program to encourage reading with children by providing free books, promoting both bonding and literacy.
  - Owensboro Health hosted SPARK-ODC ACES Summit on March 27th, 2019. Over 200 people attended. Dominic Cappello presented at the Summit and the following day at the Owensboro Chamber of Commerce Rooster Booster meeting. There are 10 focus areas for this trauma

and resilience initiatives. A focus on building a trauma informed community continues and OH continues to invest in these projects and programs across the region.

- Owensboro Health participated in the SPARK-ODC (Social Partners Advocating for a Resilient Kentucky – Owensboro-Daviess County) Resilience Leaders initiative, as the first community in the nation to participate in this pilot project. This is a data-driven, cross-sector effort to reduce trauma and increase resilience for the children of our community.
- OH partners with The Center of Owensboro - Daviess County and can now make direct referrals in EPIC for patients needing access to resource information.
- Owensboro Health has also been a part of the Public Life Foundation of Owensboro's Early Childhood Education Initiative, working with leaders from across the community. A strategic plan was developed and launched in December 2021. OH continues to serve on this committee, now named the Greater Owensboro Partnership for Early Development.

- Owensboro Health recognizes the importance of health and wellbeing of our community's youth and role it plays to providing an optimal environment for children to learn. Teaching good health choices and habits is important for children to establish while they are young in order to develop a healthy lifestyle they can take into adulthood. Owensboro Health Medical Group is proud to support local school health efforts for Owensboro City Schools and Daviess County Public Schools through a yearly financial subsidy. OHMG provides a RN and two medical technicians for the Owensboro Catholic School System.

- **Arts in Healing-** Art can play a positive role in the treatment and healing process of those in our care as well as to their caregivers. The vision for this work is to create a healing environment by incorporating various art forms at OH locations and ultimately, to the patient at bedside.
    - OHRH has invested in the local arts community as Owensboro Health recognizes the significant role these organizations have on the economic and health outcomes of a community.
    - Two work groups have been created under the Arts in Healing program, Arts at the Bedside and Signature Events.
    - Staff team members have joined the National Organization for Arts in HealthCare.
        - Team members have participated in the Kentucky Urban Rural Exchange.
    - OHRH hosted statewide conference on Food+Art+Health bringing artists and health professionals together to explore the impact the Arts can have on health, wellness and healing.
    - Art Carts have been built and launched to provide patients with art experiences while in the hospital. This will be expanded to the ambulatory settings. While the carts could not be taken to patient halls during COVID the materials were available upon request.
    - Art was established in the OH nursing rooms and in Labor and Delivery areas of the hospital where walls were previously bare and unwelcoming. Community members assisted in this effort. OH continues to use the expertise of artists who understand the specific research behind placing art in the healthcare setting.

- The Signature Events series ceased during COVID pandemic and will soon resume to take place the first Thursday of each month in the lobby or other designated special space as needed for staff, patients and guests. The team is currently developing strategies to engage employees, physicians and in the patient rooms began featuring live-stream performances from the first floor as we host the Owensboro Symphony's Music On Call program, as well as performances by special guests, like the Owensboro Health choir.
- Bi-directional microphones were ordered to allow for better recording of signature events so that those offerings can be placed on the Arts Channel in patient rooms. providers as performers for future events.
- With funding from the OH Foundation, a piano was purchased and now permanently resides in the OH Lobby for use and programming.

- OHRH created an Arts channel in in the patient rooms began featuring live-stream performances from the first floor as we host the Owensboro Symphony's Music On Call program, as well as performances by special guests.
- Signature events are now being recorded so that those offerings can be placed on the Arts channel in patient rooms.
- The OH Foundation is working on a project developing a virtual Arts tour of Owensboro Health.
- A pilot project will be launched on of the units under guidance of the Patient Experience Director, nursing management, the VP of Population Health and a local musician. The pilot project, funded by the OH Foundation, will include the use of banjoleles. Specific targeted metrics have been developed to measure project impact.
- OH Food+Art+ Health Signature event continues at the Owensboro Regional Farmer's market to demonstrate the intersection of these key components to a healthy vibrant community. The event has taken place since 2016.

3. Daviess County Data

3.1 2021 County Health Rankings Data

In this section, publicly available data are presented for Daviess County. These data come from County Health Rankings & Roadmaps, The Kentucky Injury Prevention and Research Center, and the Kentucky Cancer Registry. These sites provide social, economic, and health data that is intended for use by communities to understand the multiple factors that influence a population's health. These data were accessed in March and April 2022. See appendix for County Health Rankings data sources and years.

Table 1. Population Characteristics

	Daviess County	Kentucky	US Overall
2019 Population	101,511	4,467,673	328,239,523
Percent of Population under 18 years	24.3%	22.4%	22.3%
Percent of Population 65 year and older	17.3%	16.8%	16.5%
Percent of Population Non-Hispanic Black	4.9%	8.2%	13.4%
Percent of Population American Indian & Alaska Native	0.2%	0.3%	1.3%
Percent of Population Asian	1.9%	1.6%	5.9%
Percent of Population Native Hawaiian/Other Pacific Islander	0.1%	0.1%	0.2%
Percent of Population Hispanic	3.3%	3.9%	18.5%
Percent of Population Non-Hispanic White	87.6%	84.1%	60.1%
Percent of Population not Proficient in English	1%	1.0%	8.3%
Percent of Population Female	51.2%	50.7%	50.8%
Percent of Population Rural	27.0%	41.6%	14%

Table 2. Health Outcomes

Years of Potential Life Lost Rate	8266	9505	6900
Percent Fair or Poor Health	21%	22%	17%
Average Number of Physically Unhealthy Days	5.0	4.6	3.7
Average Number of Mentally Unhealthy Days	5.4	5.0	4.1
Percent Low Birthweight	8%	9%	8%

Table 3. Health Behaviors	Daviess County	Kentucky	US Overall
Percent Smokers	22%	24%	17%
Percent Adults with Obesity	30%	35%	30%
Food Environment Index	7.8	6.9	7.8
Percent Physically Inactive	28%	29%	23%
Percent with Access to Exercise Opportunities	79%	71%	84%
Percent Excessive Drinking	19%	17%	19%
Percent Driving Deaths with Alcohol Involvement	25%	25%	27%
Fatal overdose (any drug)*	20.6	43.9	-
Non-fatal overdose – ED visits*	193.2	288.0	-
SUD diagnosis – ED visit*	755.1	1020.1	-
Chlamydia Rate	500.1	436.4	539.9
Teen Birth Rate	36	31	21

Table 4. Access to Care

Percent Uninsured	6%	7%	10%
Number of Primary Care Physicians	54	2,895	-
Primary Care Physicians Rate	53	65	-
Primary Care Physicians Ratio	1872:1	1543:1	1320:1
Number of Dentists	62	2,996	-
Dentist Rate	61	67	-
Dentist Ratio	1637:1	1491:1	1400:1
Number of Mental Health Providers	297	10,733	-
Mental Health Provider Rate	293	240	-
Mental Health Provider Ratio	342:1	416:1	380:1

**Data from the Kentucky Injury Prevention and Research Center – data are reported as rate per 100,000 population.*

Table 5. Social & Economic Factors	Daviess County	Kentucky	US Overall
Percent Completed High School	90%	86%	88%
Percent with Some College Education	66%	62%	66%
Number Unemployed	1,837	89,014	-
Number in Labor Force	47,567	2,072,597	-
Percent Unemployed	3.9%	4.3%	3.7%
80th Percentile Income	$99,621	$101,776	-
20th Percentile Income	$22,045	$20,248	-
Percent of Children in Poverty	20%	21%	17%
Number of Children in Single-Parent Households	6,543	265,296	-
Number of Children in Households	24,426	1,005,667	-
Percent of Children in Single-Parent Households	27%	26%	26%
Number of Associations	128	4,732	-
Social Association Rate	12.7	10.6	9.3
Annual Average Violent Crimes	176	9,824	-
Violent Crime Rate	177	222	386
Number of Injury Deaths	371	21,274	-
Injury Death Rate	74	96	72

Table 6. Physical Environment			
Average Daily PM2.5	8.6	8.7	7.2
Presence of Water Violation	No	n/a	n/a
Percent with Severe Housing Problems	13%	14%	18%
Percent with Severe Housing Cost Burden	11%	11%	14%
Percent with Overcrowding	2%	2%	-
Percent with Inadequate Facilities	1%	1%	-
Percent that Drive Alone to Work	86%	82%	76%
Number of Workers who Drive Alone	45,180	1,949,184	-
Percent with Long Commute - Drives Alone	19%	31%	37%

Table 7. Top 10 Invasive Cancer Incidence Rates

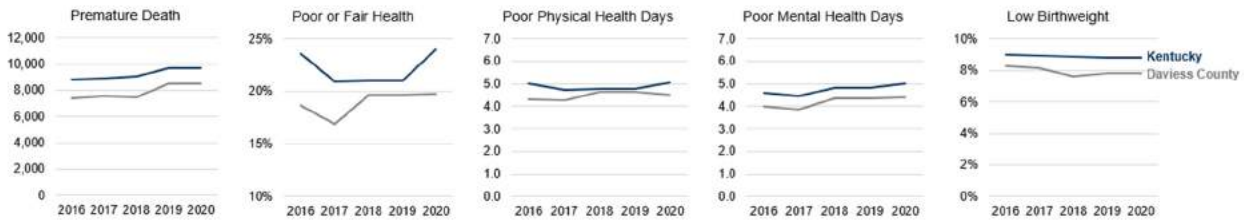
All Genders, All Races	Daviess County	Crude Rate	Age-adjusted Rate
Total all sites over 5 years (2014-2018)	**3306**	**661.6**	**531.4**
Prostate (males only)	356	146.3	116.1
Lung and Bronchus	586	117.3	90
Breast	445	89.1	74.1
Colon & Rectum	246	49.2	39.5
Melanoma of the Skin	210	42	35.2
Urinary Bladder, invasive & in situ	173	34.6	26.9
Kidney and Renal Pelvis	148	29.6	23.9
Non-Hodgkin Lymphoma	121	24.2	19.6
In situ Breast	120	24	19.5
Miscellaneous	98	19.6	15.2

Note: All rates are per 100,000 population. All rates are age-adjusted to 2000 US Standard Million Population.

3.2 2016-2020 County Health Rankings Data Trends

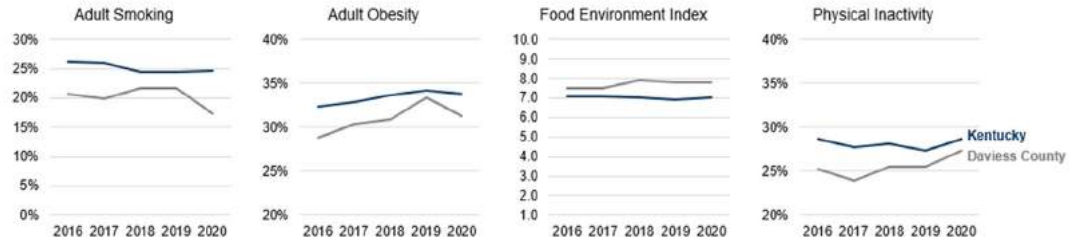
Next, to provide more context to the ongoing health of the community, we present five year data trends (2016-2020) for Daviess County alongside the state average. These data come from the *County Health Rankings & Roadmaps* website and include selected health outcomes, health behaviors, and access to care as well as social, economic, and environmental factors that impact the health of Daviess County residents.

Figure 2. Health Outcomes, 2016-2020



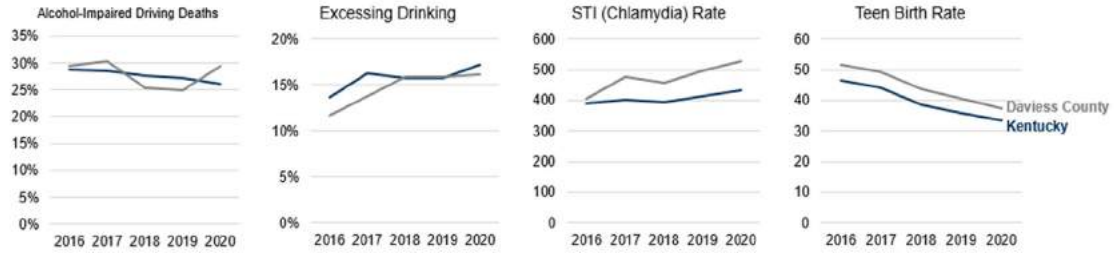
- The middle three variables are based on self-reported data from BRFSS (Behavioral Risk Factor Surveillance System). All three are on an overall upward trend for the County.
- The County's low birthweight is on an overall downward trend.

Figure 3. Health Behaviors, 2016-2020



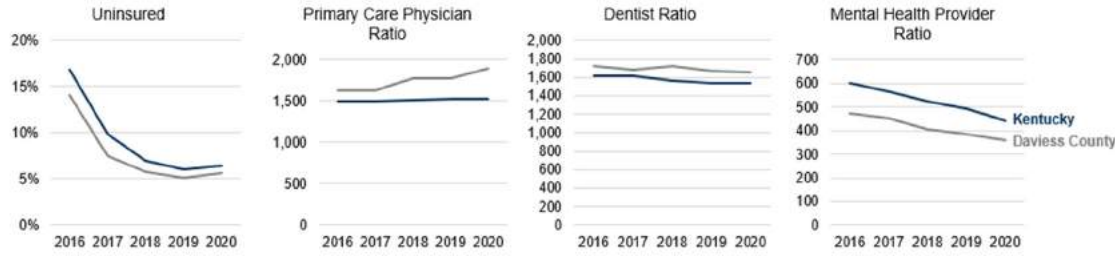
- Adult smoking in the County is lower than the state and has an unclear trend.
- Adult obesity in the County is trending upward overall.
- The higher the number on the USDA Food Environment Index (1-10) the better the Food Environment. The County has an improved score on the index over the five year trend.
- The County's rate of physical inactivity is lower than the state, however the overall upward trend is closing that gap.

Figure 4. Health Behaviors, continued, 2016-2020



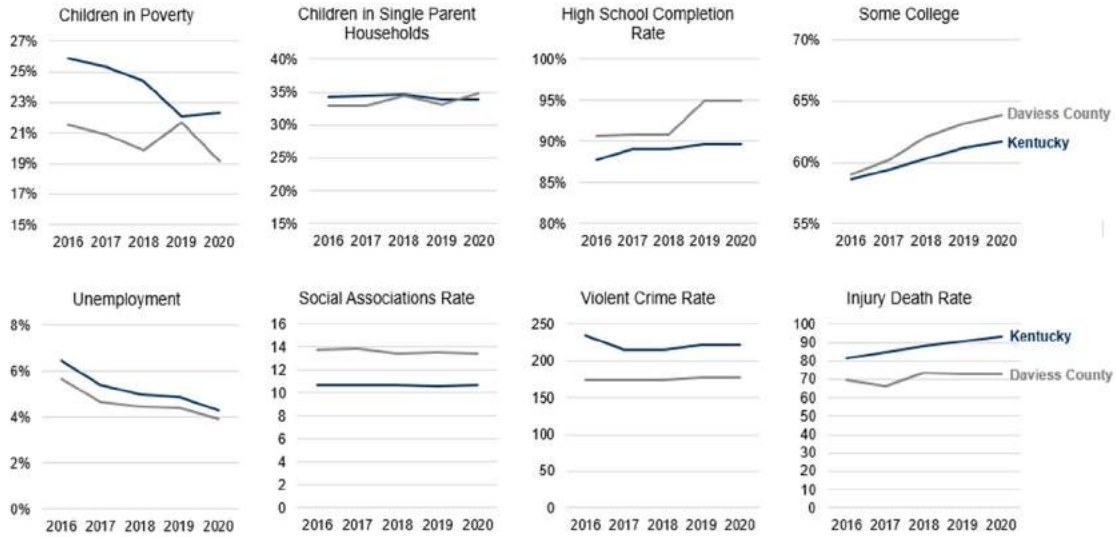
- There is an unclear trend in alcohol-impaired driving deaths in the County.
- The data for excessive drinking in the County are trending upward overall.
- STI infections in the County are on an overall upward trend.
- The County's teen birth rates are trending downward and following the state trend.

Figure 5. Access to Care, 2016-2020



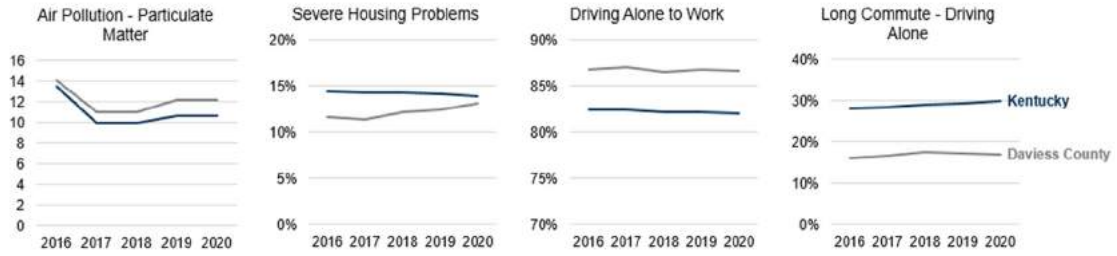
- The County's ratio of primary care physicians and dentists is higher (less providers for population) compared to the state average. The County has a lower ratio of mental health providers compared to the state average.
- County uninsurance rate trend is on par with the state.

Figure 6. Social & Economic Factors, 2016-2020



- Children in poverty appears to be trending downward for the County.
- The County year-to-year shifts in children in single parent households makes it difficult to pinpoint an overall trend.
- County high school completion rates are above the state average, and percent of the County population with some college education is on a steady upward trend.
- The County unemployment rate is lower than the state and is on a downward trend (pre-pandemic).
- The County's rate of social associations is higher than the state and has an overall slow downward trend.
- The County's violent crime rate is lower than the state average and has a steady trend.
- The County's injury death rate is lower than the state average and has a slow upward trend.

Figure 7. Physical Environment, 2016-2020



- Air pollution in the County is higher than the state and follows the state trend.
- The County's percentage of population with severe housing problems has an upward trend.
- The County population driving alone to work and making long commutes have an overall steady trend.

4. Hospital Utilization Data

The Tables below provide an overview of Owensboro Health Regional Hospital's patients and in particular how they pay, and why they visited.

Table 8. Hospital Usage, 1/1/2020 - 12/31/2020

Patient Status	Total
Inpatient Discharges	16,616
Outpatient Visits	271,951

Table 9. Hospital Inpatient Payer Mix, 1/1/2020 - 12/31/2020

Payer	Discharges
Medicare (Excluding Medicare Managed Care)	5297
Commercial - Anthem Health Plans of KY PPO Plan	2405
WellCare of Kentucky Medicaid Managed Care	2289
Medicare Managed Care	2222
Commercial - Other	737
Aetna Better Health of KY Medicaid Managed Care	595
Humana Medicaid Managed Care	494
In State Medicaid	469
Passport Medicaid Managed Care	467
Commercial - United Healthcare PPO Plan	341
Self Pay	292
VA	247
Anthem Medicaid Managed Care	183
Commercial - Humana PPO Plan	111
Out of State Medicaid	109
Tricare (Champus)	78
Commercial - Cigna Health & Life PPO Plan	73
Commercial - Humana POS Plan	49
Auto Insurance	44

Table 10. Hospital Outpatient Payer Mix, 1/1/2020 - 12/31/2020

Payer	Visits
Medicare (Excluding Medicare Managed Care)	64610
Commercial - Anthem Health Plans of KY PPO Plan	64295
Medicare Managed Care	37358
WellCare of Kentucky Medicaid Managed Care	30544
Commercial - Other	21497
Aetna Better Health of KY Medicaid Managed Care	8720
Commercial - United Healthcare PPO Plan	7464
Humana Medicaid Managed Care	6595
Self Pay	6302
Passport Medicaid Managed Care	5456
In State Medicaid	4585
Commercial - Humana PPO Plan	2660
Commercial - Cigna Health & Life PPO Plan	2186
VA	1457
Anthem Medicaid Managed Care	1368
Tricare (Champus)	1287
Commercial - Humana POS Plan	1094
Workers Compensation	1027
Out of State Medicaid	970
Auto Insurance	801
Commercial - PPO	801
Commercial - Indemnity	330
ChampVA	162
Commercial - Aetna Health PPO Plan	131
Medicaid MCO Pending	120
Other	99
Pending Insurance	27
Commercial - Nippon Life Insurance Company of America	5

Table 11. Hospital Inpatient Diagnosis Related Group, 1/1/2020 - 12/31/2020

DRG Description	Discharges
Vaginal delivery	1267
Normal newborn	1183
Cesarean section	786
Septicemia	747
Respiratory infections & inflammations	552
Heart failure & shock	551
Neonate with other significant problems	508
Psychoses	447
Renal failure	360
Alcohol/drug abuse or dependence	358

5. Community Health Committee

The Community Health Committee plays a vital role to the CHNA process. These committee members represent organizations and agencies that serve the Daviess County population in a variety of areas that relate to the health of the population. By volunteering their time, the committee members enable the hospital to acquire input from residents that are often not engaged in conversations about their health needs. This committee provides both an expert view of the needs they see while working with the people and clients they serve and in extensive distribution of the community survey. Conducting this assessment during the COVID-19 pandemic added new challenges in accessing community input, however the community health committee committed to the process both with promoting the survey through social media and encouraging organizations to share through email channels.

Owensboro Health Regional Hospital Vice President for Population Health and additional hospital leadership strategically recruited members of the community and the hospital to serve on the newly formed Community Health Committee to lead the 2021-2024 CHNA process. CEDIK representatives introduced the format for the CHNA process and proposed community survey February 18, 2022, at the inaugural meeting. Committee members provided final input on the survey and were encouraged to share the survey link widely with community groups, employers, and patients. At the April 22, 2022, Community Health Committee meeting, CEDIK staff presented results of the survey, focus group and key informant interview results along with selected secondary health data to inform and guide the prioritization process of the identified health needs. An additional meeting held April 29, 2022, was dedicated to prioritizing identified health needs resulting in recommendations for to OHRH to address over the next three years.

Table 12. Owensboro Health Regional Hospital Community Health Committee

Name	Representing Organization
Tom Watson	City of Owensboro, Mayor
Al Mattingly	Daviess County Fiscal Court, Judge Executive
Clayton Horton	Green River District Health Department, Public Health Director
Rebecca Horn	Green River District Health Department, Accreditation Coordinator and Public Health Services Manager
Brandon Harley	Audubon Area Community Services, Deputy Chief Executive Officer
Dr. Wanda Figueroa	RiverValley Behavioral Health, President and CEO
Joanna Shake	Green River Area Development District, Executive Director
Paula Yevincy	United Way of the Ohio Valley, President and CEO
Pattie Martin	Healthy Horizons, Chairperson
Beth Steele	Owensboro Health Regional Hospital, Chief Operating Officer
Dr. Michael Kelley	Owensboro Health, Vice President of Medical Affairs
Dr. Jim Tidwell	Owensboro Health, Vice President of Population Health
Steve Johnson	Owensboro Health, Vice President of Government and Community Affairs
Debbie Zuerner	Owensboro Health, Director of Community Engagement
Brian Hamby	Owensboro Health, Director of Marketing
Kelly Armour	Owensboro Health, Director of Employee Engagement
Nicole Leach	Owensboro Health, Community Outreach Specialist

6. Community Feedback Overview

To gather Daviess County resident feedback, OHRH distributed a paper and digital survey throughout the community in early 2022. CEDIK facilitated other primary data collection with focus groups and key informant interviews. Throughout the process, CEDIK made it a priority to get input from populations that are often not engaged in conversations about their health needs or gaps in service. This CHNA report synthesizes community health needs survey data, focus groups with those representing vulnerable populations and community experts through key informant interviews.

Seven focus groups, with a total of fifty-nine participants were conducted virtually. There was representation from a health coalition, healthcare providers, and vulnerable populations/ providers for vulnerable populations. The focus groups were conducted in March of 2022. The following groups participated/were represented:

- Healthy Horizons Coalition
- OHRH Nursing/Ancillary Staff
- Older Adults & Aging
- Individuals with Disabilities
- Housing and Homelessness
- Education
- After School & Mentoring Programs for Children and Youth

Qualitative analysis of focus group responses revealed overarching themes across the focus groups. Findings across all groups consistently underscored challenging experiences that not only hindered community ability to access services, but also the need for expanded services.

The key findings from each of the 5 questions posed to the focus groups are listed below:

- The community's vision for a healthy Daviess County involves community vitality, healthy lifestyles, and access to care.
- The greatest health needs in Daviess County involve chronic diseases and co-morbidities, food access, communication, education and support, mental health and substance use and access to care. Social determinants of health particular to Daviess County heavily impact the community's view of the greatest health needs.
- The current greater healthcare system (including hospital, health department, clinics, behavioral health, EMS, housing, and food access), is described as a system rich with resources and providers and many collaborate often, but there continues to be a need for expanded access.
- To better meet health needs in Daviess County, there should be a healthcare approach and a community approach.
- There were positive and negative lasting impacts of COVID-19 on the community.

7. Focus Group Findings

Finding 1: The community's vision for a healthy Daviess County involves community vitality, healthy lifestyles, and access to healthcare.

Focus group responses that contributed to this finding are listed below.

Community vitality

- Accessible green spaces for individuals and family to enjoy
  - Parks and equipment
  - Biking and walking paths
- Inclusivity and respect for diversity
- Easy access to necessities for all areas of community
- Food
- Shelter
- Transportation
- Community free of substance use
  - Reduction of drugs coming into community
- Safe environment for seniors

Healthy lifestyles

- No domestic or child abuse
- Good nutrition and access to healthy foods
- Safe water, sewage, air
- Safe spaces, sidewalks, lighting
- Family caregiver support for those working and caring for seniors and children
- More people engaged in physical activity
- Disease free

Access to health care

- Everyone (aging, special needs, healthy and unhealthy people) can have access to good healthcare
- Parental engagement, awareness, and understanding regarding healthcare
- Transportation
- SUD Treatment, including gender specific options for care
- Long term recovery services
- Family caregiver support for those working and caring for seniors and children

Finding 2: The greatest health needs in Daviess County involve chronic diseases and co-morbidities, food access, communication, education and support, mental health and substance use, violence in the community, and access to care. Social determinants of health particular to Daviess County heavily impact the community's view of the greatest health needs.

Focus group responses that contributed to this finding are listed below.

Chronic Diseases and Co-morbidities

- Obesity and behaviors that can lead to obesity including physical inactivity and poor eating habits/diet
- Diabetes
- Lung cancer, COPD & diseases related to smoking
- Heart disease
- High blood pressure
- Post COVID-19 health needs
- Issues impacting the aging population include falls, hearing and vision loss

Food Access

- Food Insecurity
  - Children taking food home from school
  - Children overeating at schools/programming because they're unsure where their next meal will come from
- Limited access to healthy foods
  - Families living in food deserts suffer from the costs of healthy foods

Communication, Education, and Support

- Health literacy
- Information to current services
- Nutrition education for community
- Lack of second chance employment
- Education for parents to promote healthy lifestyles for their children
- Employment education and job readiness
- Youth need education surrounding topics like gender identity, leadership, and life skills
- Safe built environment in community

Mental Health and Substance Use

- Substance Use/Addiction
  - Meth, Heroin, Opioids
  - Tobacco use in both middle and high school students, including vaping, adults still smoking
  - Alcohol abuse in people high school aged and up
  - Co-occurrences of substance abuse, alcoholism, depression and suicide
  - Misuse of prescription medications
- Mental health
  - Eating disorders and lack of treatments
  - Suicide
  - PTSD
  - Limited access to mental health care
  - Social isolation
  - Lack of community connection
  - Stigma associated with mental health

Violence in the Community

- Child abuse and neglect
- Domestic violence
- Gun violence
- Social media bullying
- Creating trauma in children and youth
- The sense of connection provided by phones is sometimes a lifeline for youth

Access to Care

- Lack of access to primary care providers
  - Long wait times for appointments and follow up care
  - Leads some patients to use Urgent Care or ER as primary care
- Patients unable to be discharged because follow up treatment is not available/lack of providers in other facilities, which lengthens hospital stays
- Financial barriers to care
- Issues facing people with disabilities
  - Equal access to transportation
  - Standardized public parking
  - Standardization of paint colors for ramps
  - Communication barriers and acceptance of differing communication styles
    - Not all facilities are prepared to work with and have a flexible communication style with people with disabilities

Access to Care - Issues facing people with disabilities, continued

- Struggle to encourage older caregivers to transition patients into new living situations
- No options for long term care
- Limitations on facilities lead to many displaced people with disabilities
- Long wait lists for care
- Caregivers struggle with depression, stress, isolation, and exhaustion, all of which have been exacerbated by the global pandemic
- Neglect

- Lack of specialty care
- Transportation
  - People having to travel outside of the community for care
- Access to healthcare providers that accept Medicaid and Medicare
  - Dentists that accept Medicaid
- Uninsured community members
- Housing and homelessness
- Access to childcare
- Need for case managers and patient navigators

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

Housing

Lack of safe and affordable housing, in addition to homelessness is an issue. There is a need for quality, safe, and affordable housing for all populations of people in Daviess County: Seniors, people living with disabilities, children, long term recovery and transitional housing were all mentioned in focus group discussions.

Transportation

Transportation to and from essential services, including healthcare, recreation opportunities and healthy foods is a barrier for people.

Food Insecurity

Children struggle with hunger when out of school. Access to healthy affordable foods is limited for residents.

Access to Quality Care

Individuals in Daviess County are struggling with mental health challenges, accessing dental/vision/hearing care, persons with Substance Use Disorder/or persons in recovery, or those who are in need of home care have difficulty finding providers in the area.

Economic Needs

The community needs economic development regarding workforce training for health care workers as well as childcare for working parents, and especially after hours childcare.

Finding 3: The current greater healthcare system (including hospital, health department, clinics, behavioral health, EMS, housing, and food access), is described as a system rich with resources and providers and many collaborate often, but there continues to be a need for expanded access.

Focus group responses that contributed to this finding are listed below.

Opportunities for System

- Expand primary care
  - Difficult to get appointment with primary care physician
  - Office will refer to urgent care or emergency room
- Transportation
- Mental Health Providers
- Mobile health unit
- One stop shop for needs for youth, including health needs
- Safe and adequate housing
  - Students couch surfing
  - Refugee population impacted as well
  - Limited affordable rental housing
  - Collaboration between groups to address issue
- Providing comfortable experiences for patients while with provider
  - Refugee population
  - Mental health urgent care – one stop shop evaluation for people suffering with mental health issues
- Extended hours at Help Office (food pantry that can assist with other services)
  - Limited hours is a barrier
- Innovation solutions and treatments for youth living with the impacts of the opioid epidemic
  - Trauma therapy
  - Support for children whose families are struggling
  - Interventions for bullying and support for children who are bullied
- Awareness/education of issues that the aging population might be facing
  - Understanding aging
  - e.g. Hearing – speaking loudly and slowly
- Dental services that accept Medicaid
  - Orthodontists
  - Oral surgery
  - Transportation to services in Bowling Green
- EMS – some services not covered by insurance

- Poverty
  - Lack of knowledge on how to access help due to new situation
  - Stress can keep people from being able to access help
- Duplication of services
- More healthcare education
- More careers in healthcare
  - Severe workforce shortage
  - Across the board in healthcare
- Need more mental health providers
  - Long (4-6 week) wait time
- Breaking down silos, continuing to collaborate

Strengths of System

- Past two years have demonstrated partnership, communication, and collaboration between health organizations, facilities, schools, and communities
- More healthcare services that are neighborhood based and able to meet needs across community
- Telehealth helpful to community
- Unbelievable amount of communication between hospital and health department to give community organizations a voice and allowed their needs to be noted and considered when developing solutions
- Hospital has specialized in recruitment of doctors
- Technology advances in hospital is commendable and exciting
- Hospital CEO is engaged in community and that is evident to community
- Expanded mental health services
- Expanded footprint into more rural communities through access to more clinics and facilities
- Trained Tobacco Specialists and provision of NRT (inpatient and outpatient)
- Audubon Area Community Care clinic has been incredibly helpful during COVID
- Health Department does a great job with services and putting information out into the community
- Lion’s Club collaboration to provide glasses
- Owensboro/Daviess County is well known as a place supportive of those in long-term recovery
- Homeless shelters and spaces for people in need
- Rich history of coalitions and collaborative community work

Finding 4: To better meet health needs in Daviess County, there should be a healthcare approach and a community approach.

Focus group responses that contributed to this finding are listed below.

Healthcare Approach

- Outpatient social workers to assist with follow up care
- Care navigators for all specialties
- Address communication barriers such as language and culture
- Education on services available
- Healthcare system asking community members about issues and then working together to develop solutions
- Expanded access
    - Facilities for people with disabilities
    - Supportive services for homeless population
    - Affordable medications for Medicare patients
    - More providers to limit long wait times
        - Mental health
            - On-site mental healthcare for students
        - Primary care
    - Cancer resources, including screening for individuals with low income
    - Scholarships to Healthpark to limit barriers
    - Pop up clinics and mobile care
    - After hours care and extended hours

Community Approach

- More jobs with a living wage
- More healthcare career education
- Promote nutrition education and physical activity
- Collaboration
    - Breaking down silos to continue collaboration between organizations
    - Cooperation
    - Sharing of services
- Community events to promote social connection
- Community gardens
- Transportation to services
- Awareness campaigns to reduce stigma
    - Mental health
    - Elderly and aging population
    - Homelessness

- Community that embraces aging population
- Community policies that address built environment including safe sidewalks, lighting, and bike paths
- Community conversations about issues that people with disabilities face
- Advocacy for patients, including families and children
- Programming for people in transitional housing
- Education for healthy living, including financial skills, life skills, and healthy behaviors
- Interventions for children affected by bullying

Finding 5: There were positive and negative lasting impacts of COVID-19 on the community.

Focus group responses that contributed to this finding are listed below.

Positives

- Telehealth opportunities
- Robust community response
  - Health department, healthcare community, community organizations
- Education did an amazing job transitioning to the new reality with COVID
- School districts did an excellent job collaborating
- Students, faculty, and staff had a positive attitude and moved forward
- Community has learned and is better prepared
- Healthcare workers protected community
- Technology and Zoom
- The way we do business has improved
- Community and families learned to value services more
  - Showed us how essential we actually are
- Realizing how important being together is
  - Emphasis on mental health
- People more aware of their health
  - Senior population led vaccination efforts in community
- Ability to adapt to deliver care
  - Telemedicine
  - Reassessing programming
  - New collaborations (Senior Center and YMCA)
  - Arts programming also was adapted to meet people at home
- Ability to mass vaccinate
  - Hospital and community agencies that worked together on vaccination campaign

- Some seniors more tech savvy
- Senior Center stepped up to provide care to community
    - Creative ways to work with seniors
- The health department has been a real leader in the community regarding sharing information and being responsive
- Creativity in delivering services
    - Openness to possibilities on different ways to reach others
- Raising awareness of mental health
    - Reduced stigma, but not enough
    - Younger generations have less of a stigma around mental health compared to the older generations
- Workforce shortage has led to collaboration between education and healthcare to meet healthcare employment needs

Negatives

- Social issues
    - Lack of respect
    - Social isolation has led to misbehavior
    - Impact of social isolation on elderly
        - Decline in mental and cognitive ability
- Workforce shortage
    - People to fill positions
        - Want to work in an office everyday
        - Employees who can work through trauma
- Guilt of burnout
    - “If we stopped, everything stopped”
    - Own health has taken a fall
- Length of pandemic has created burnout in front line staff
- Lack of people looking into healthcare careers
    - Staffing shortages
- Long COVID syndrome
- COVID pneumonia has affected several patients in the community
    - Especially after some patients have experienced multiple times over the past 2 years
- Students negatively impacted by disruption in learning over multiple school years
- Mental health of community
    - Caregivers of people with disabilities
    - Weight is too heavy
    - Impacts people with disabilities

- Workforce shortages
  - Impacted every aspect of aging population healthcare
- Impacts of lack of socialization
  - Lack of computer skills can be isolating
  - Social isolation and lack of family access to elderly caused extensive physical and mental decline
- Reengaging with others
- Loss of social skills
- Mental health for kids

8. Key Informant Interviews

Owensboro Health leadership provided a list of community stakeholders or healthcare providers considered potential contacts for key informant interviews to provide a deeper understanding of health needs in the community. In total, seven key informant interviews were completed representing specialists or providers in the identified need areas. Responses are summarized below. Key informants were asked to discuss the quality of life in their community, identify explain their understanding of the most common health needs, give their perception of the current healthcare system, and provide suggestions on how to better meet the health needs in the community.

Participants:

- Sarah Adkins, Owensboro Regional Recovery
- Anna Allen, International Center
- Shauna Boom, Owensboro Housing Authority
- Brandon Harley, Audubon Area Community Services
- Clay Horton, Green River District Health Department
- Dr. Lionel Phelps, RiverValley Behavioral Health
- Brian Short, AMR Emergency Medical Response

Quality of Life

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

Most Common Health Needs

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

- Chronic diseases
- Basic needs
- Substance use
- Mental health
- Barriers to care

Three populations were identified as being particularly vulnerable:

- Children
- Elderly
- Refugees

Basic Needs

Access and affordability of basic needs including housing and food insecurity are barriers some residents of Owensboro and Daviess County face.

Concerning homelessness, there is a lack in currently available safe and affordable housing for all income brackets. A key informant recommended case management and supportive services for individuals facing homelessness. This was echoed by another key informant who noted that government housing is able to provide supportive services, such as scheduling follow up appointments, which is helpful to residents. A key informant noted that the lack of ADA compliant housing keeps many people with disabilities precariously housed.

Food insecurity impacts some in Owensboro/Daviess County. Some areas in the community are food deserts, which limits access to healthy foods. Many organizations work to address food insecurity but not everyone knows how to access those resources. Children are particularly vulnerable to food insecurity when not in a school setting. The rising cost of food is a barrier to many.

Substance Use

Most key informants referenced substance use as a health issues in Owensboro/Daviess County. Alcohol, opioids, methamphetamine, heroin and tobacco were all discussed. One key informant referenced meth as the substance that most facilities see patients seeking treatment for, but also noted the rise in use of opioids in the area and attributed a higher number of overdoses to that rise. Nearly all key informants related other social issues, such as grandparents raising grandchildren and mental health problems, to the rise of substance use in the community. Most key informants agreed that Owensboro/Daviess County has many treatment options, but that expanded access is always needed.

Tobacco usage, such as vaping, which is prevalent in both adults and youth in middle and high school, was cited as a health need. Key informants that identified chronic diseases like COPD as an issue in the community referred tobacco use in behaviors like smoking and vaping to be leading causes. One key informant that tobacco usage is a health need that has the most to be gained from reduction.

Chronic Diseases

Many residents of Owensboro/Daviess County suffer from chronic diseases. Obesity and obesity related diseases such as diabetes was mentioned by all key informants. Obesity and diabetes impacts both children and adults, and is a co-morbidity for many other health issues. Lack of access to healthy foods, opportunities for recreation, and nutrition education, including information on how to prepare healthy meals, were all mentioned as possible causes for the high rates of obesity and diabetes in the community.

Other chronic diseases such as COPD, hypertension, asthma, and heart disease were named by key informants as health needs. Many of these diseases can be attributed to unhealthy lifestyles, but key informants referenced that many vulnerable populations do not have as many opportunities to make healthy choices.

Mental Health

There is a high need for mental health providers in Owensboro/Daviess County. Key informants noted that there are not enough providers for the population, including providers for youth. The current provider shortage makes it difficult to receive care, there are long wait times and other barriers that keep patients from timely care. One key informant said that many patients "suffer while waiting." Certain medications require a psychiatrist's evaluation, and with no psychiatrists available, that can create a real issue for patients needing treatment. Many individuals suffering a mental health crisis end up in the emergency room or in the crisis stabilization unit because they were not able to access care. The stigma associated with mental health keeps many people from accessing care.

Access to mental/behavioral health services are also limited. Many individuals needing this care also witness other barriers, such as transportation. Ambulance services in the area are being asked to transport patients to behavioral healthcare outside of the community.

Barriers to Care

There are a number of barriers to care in Owensboro/Daviess County. Some of these barriers nearly all residents face, but others are specific to vulnerable populations. There is a lack in knowledge of resources available in the community. Insurance type dictates the type/quality of care many patients receive. For example, there is a severe deficit in the number of dentists that will accept Medicaid patients. Another example given by a key informant concerned psychological testing and how it is not covered by Medicaid, which can make it difficult to diagnose patients. A key informant noted that many of the primary care providers are focused on Medicare patients, which negatively impacts Medicaid patients.

Quite a few key informants mentioned that access to primary care can be difficult. Due to the shortage of primary care providers in the area, there can be long wait times to get into a physician's office, which causes people to use the emergency room or Urgent Care facilities as primary care.

Other barriers include language and cultural understanding of patients. Understanding and navigating the healthcare system is difficult for many, and added language and cultural barriers only furthers the gap in care. Health literacy and understanding how to ask questions and advocate for healthcare can be an issue for patients as well.

Transportation to essential services including healthcare impacts the community. One key informant reported that some travel anywhere from 45 minutes to 2 hours for specialty care they cannot access in Owensboro/Daviess County. Another key informant said that bus routes are expanded, but some still struggle to access even public transportation.

The high cost of healthcare is a barrier to many in Owensboro/Daviess County. High copays and deductibles, along with prescribed medications cause patients to struggle between paying for their healthcare or other essentials.

Vulnerable Populations

Two populations were particularly identified as being vulnerable. The health issues specifically mentioned in reference to these communities are listed below.

Issues facing Children – When referencing children in Owensboro/Daviess County, key informants mentioned food insecurity, child abuse and neglect, homelessness, vaping, and mental health issues as health needs.

Issues facing the Elderly – Key informants said a lack of care and services for the aging population such as at home care and nursing home care, the cost of healthcare, and limitations on mental health care due to insurance as issues that significantly impact the elderly.

Perception of Healthcare System

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

Identified Strengths

- Owensboro Health Regional Hospital
    - “Largest healthcare system on this side of the state”
    - Partnership with community
    - Mitchell Memorial Cancer Center is helpful
    - Specialists available to patients
    - Health Department has taken good care of the community through COVID
- People who care
- Many community organizations collaborating
- Telehealth opened up many services
- Significant amount of providers who take Medicaid (excluding dentists)
- Bus routes are expanding

Identified Opportunities

- Bridge barriers to care
    - Language and culture
        - Interpreters, patient advocates
    - Transportation
    - Stigma
    - Costs
    - Health literacy and understanding the healthcare system
        - Knowing what’s happening at appointments and knowing what questions to ask

- Educating community on services that are available
- Expanding access to care
  - Long wait time for primary care providers
  - Many travel outside of Owensboro for pediatric care
  - Shortage of mental health providers in surrounding rural areas
- Long wait times for ER
- Dentists who accept Medicaid patients

How to Better Meet Health Needs

Key informants shared ways to meet the health needs in Owensboro/Daviess County. Their suggestions on how to meet the health needs discussed above are listed here:

- Assistance with scheduling transportation to care
- Cultural understanding of differences in clients
  - Creating an atmosphere where patients feel comfortable asking questions
  - Understanding how trauma might impact a patient's response
- Expanded services for mental health, behavioral health, substance use, dental care, and specialty care
- Ongoing community advisory board to advise on community needs to Owensboro Health
  - "Real patients talking about their real needs"
- Health education
  - Understanding the healthcare system and understanding how to make healthy choices
- Mobile services
  - Mobile crisis services
  - Mobile clinics
- Communication between doctors, patients, and insurance companies to make sure patients can afford medications they're being prescribed
- Case management
  - Healthcare
    - Healthcare navigators for patients
  - Homeless
- Connections between health systems
  - Communication and coordination between providers at differing facilities

8. Community Survey Results

CEDIK assisted OHRH in developing a survey to gather health information and opinions of Daviess County residents 18 and older. The survey was conducted in February and March 2022 using an online survey tool and by distributing printed copies in various locations throughout the community. The online survey was promoted through newspaper ads and stories, radio, emails, and on the OHRH Facebook page. Emails with a link to the survey were sent to Chamber of Commerce members, local industries, and employees of the school system and the hospital.

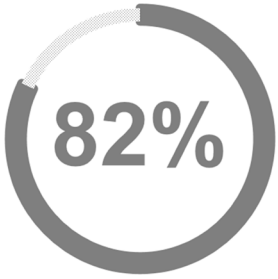
2,313 Daviess County residents participated in the survey. The were three primary categories of questions on the survey; demographics, personal health information, and perceived health needs of the community.

Owensboro Health Regional Hospital Survey Results

WINTER 2022

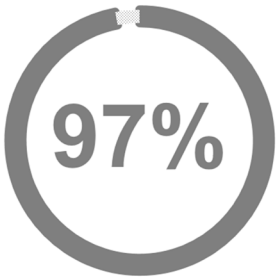
Respondent Demographics

2,313 Respondents



Respondents are female.

Additional responses: Male (17%), Other (0.4%)



Respondents are white.

Additional responses: African American/Black (1%), Asian/Pacific Islander (1%), Native American (1%).

Age group of respondents

18-24	3%
25-39	32%
40-54	39%
55-64	19%
65-69	3%
70 or older	3%

Educational attainment of respondents

College or above	77%
High School	15%
Technical school	6%
Other	2%

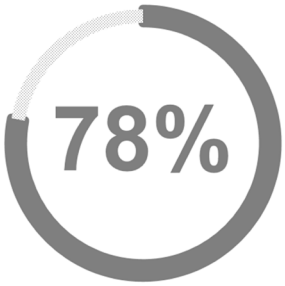
Income level of respondents

$0-$24,999	4%
$25,000-$49,999	16%
$50,000-$74,999	17%
$75,000-$99,999	18%
$100,000 or more	36%
Prefer not to answer	9%

Employment status of respondents

Employed full-time	82%
Retired	5%
Unemployed	2%
Employed part-time	7%
Student	0%
Other	4%

Where respondents go for routine healthcare:



Go to a provider's office for their routine healthcare.

Respondents also use these options:

Emergency Room	2%
Urgent Care	12%
Health Department	1%
Do not receive routine healthcare	5%
Other	2%

Reasons why respondents do not receive routine healthcare:

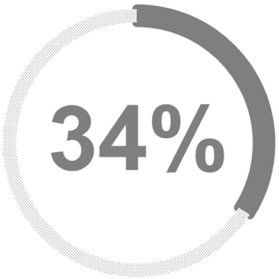
Respondents that said they did not receive routine healthcare in the question above, 25% cannot afford it.

Respondents identified the following:

No appointment available	9%
Lack of providers in my community	13%
No transportation	3%
Cannot take off from work	13%
Cannot afford it	25%
Other	37%

Other responses: do not need it/healthy, lack of trust in providers, not knowledgeable about what insurance covers

Transportation to healthcare:



Travel 20 miles or more to see a specialist.

Respondents chose from these options:

Less than 20 miles	58%
20-49 miles	19%
50-100 miles	7%
More than 100 miles	8%
I do not see any specialists	8%

98% of respondents use their own vehicle, while 1% travel in a friend/family vehicle.

The top three health challenges respondent households face:

Overweight/obesity	**21%**
High blood pressure	**19%**
Mental health issues	**16%**
Diabetes	9%
Dental health	9%
Heart disease and stroke	6%
Respiratory/lung disease	5%
Cancer	4%
Substance use	1%
HIV/AIDS/Sexually Transmitted Infections	0%
Autism	0%
Other	10%

Hypothyroidism, Kidney disease, Rheumatoid arthritis, Orthopedic needs, Neurological illness, Lupus, High cholesterol, Autoimmune disease, Epilepsy, Allergies, ADHD

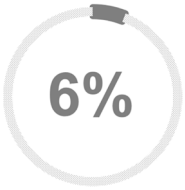
Respondent household eligibility:

Medicare	18%
Medicaid	17%
Public Housing Assistance	2%
SNAP (Food stamp program)	5%
VA	6%
Commercial/private insurance	52%

The top three risky behaviors seen most in the community:

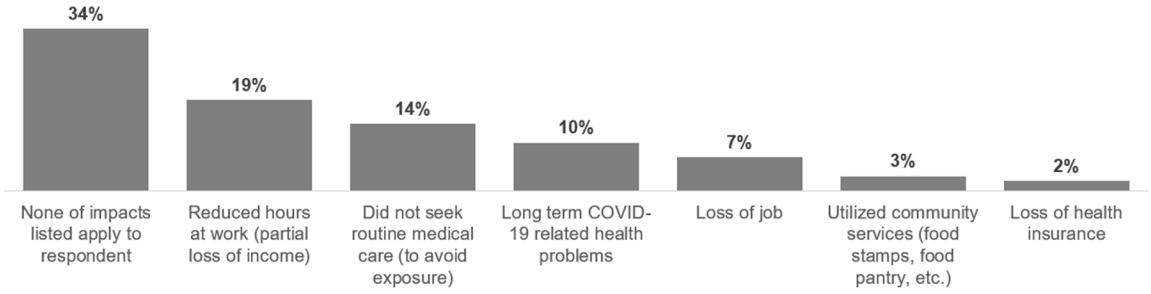
Overweight	**19%**
Drug abuse	**19%**
Alcohol abuse	**13%**
Poor eating habits	12%
Tobacco use	11%
Lack of exercise	9%
Prescription drug misuse	8%
Lack of access to healthy food	4%
Unsafe sex	2%
Dropping out of school	1%

Respondent households have delayed healthcare because of lack of money and/or insurance.



Respondent households currently without health insurance.

Respondent household impacts due to COVID-19 pandemic:



Respondents identified another 11% of impacts due to COVID-19: Isolation/depression and stress, Loss of loved ones, Overworked/ healthcare professional, Delayed doctor visits, Childcare issues, Financial strain

The top three most important factors for a healthy community:

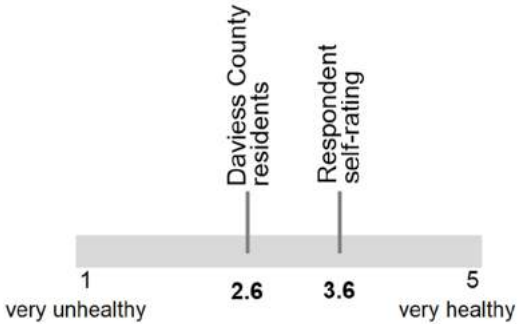
Low crime/safe neighborhood	**18%**
Good jobs/healthy economy	**17%**
Easy access to healthcare	**14%**
Good school systems	11%
Good place to raise children	10%
Affordable housing	7%
Personal responsibility	5%
Religious or spiritual values	5%
Community activities and events	3%
Low disease rate	2%
Diverse community	2%
Parks and recreation	2%
Dental health	2%
Transportation	1%
Excellent race relations	1%

Respondents think Daviess County has the above factors for a healthy community.

Places respondents purchase fruits and vegetables:

Farmer's Market/local grower	34%
Small convenience store/gas station	1%
Small retail stores (e.g. Dollar General)	3%
Large retail stores (e.g. Walmart)	59%
Other *(grow own, other stores not listed)*	3%

Respondents rate their own health, and the overall health of their community:

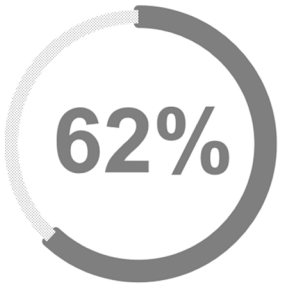


Respondents are satisfied with the ability to access healthcare services in Daviess County.

Reasons why respondents do not eat AMA daily recommended minimum fruits and vegetables:

Cost	41%
Limited options available	14%
Do not like taste of fruits and vegetables	11%
Lack of knowledge on how to prepare fruits and vegetables	10%
Lack of access to fruits and vegetables	8%
Other *Lack of time and planning, Bad habits/ convenience of other choices, Allergies, Preferences, Specific diet due to health issues*	17%

Where respondents go for routine healthcare:



Respondent households that struggle with mental health issues. *81% have sought treatment.*

Respondent reasons for not seeking treatment:

Treatment not covered by insurance	28%
Embarrassed to ask for help	26%
Not sure where to access treatment	26%
Unable to get an appointment	17%
Lack of transportation to services	3%

What types of treatment/support have you used for substance use disorders in the past 12 months?

Primary care provider	8%
Counselor/therapist	5%
Psychologist/Psychiatrist	2%
Medication Assisted Therapy (MAT)	1%
Faith based leader/program	1%
Alcoholics Anonymous/Narcotics Anonymous	0%
Emergency department	0%
Certified peer support specialist	0%
Support group	0%
I have not needed to use treatment or support for substance use disorder	78%
Other	4%
Long term treatment, Therapy and psychiatry, No treatment available	

What could be done in Daviess County to better meet your health needs?

Better and more affordable healthcare
More specialists
More affordable dental care
24/7 or free clinic
Address the violence/crime issues
Affordable housing
Affordable childcare

Selected Priority Areas

CEDIK reviewed findings from the community surveys, focus groups, key informant interviews and county specific secondary health data.

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

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

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

CEDIK staff led a facilitated discussion with members of the steering committee after the data presentation and completed the process of prioritizing the identified health needs. The following represent the recommendations of the community health committee to Owensboro Health Regional Hospital for addressing health needs in Daviess County and the hospital service area for the next three years.

Prioritized Needs

1. Obesity and related diseases
2. Tobacco use
3. Substance use
4. Mental health
5. Housing

Conclusion

Daviess County is a community with many assets, with a caring community spirit being an important driver in the approach to community health improvements through collaborative efforts. While there are many areas of need in the county, this report identifies priority areas that Owensboro Health Regional Hospital will use for guidance in planning its community benefit efforts and strategic direction for addressing community health needs. Further investigation may be necessary for determining and implementing the most effective interventions.

An implementation strategy will be developed within five months of the approval of the CHNA; periodic evaluation of goals/objectives for each identified priority will be conducted to assure that progress is on track per the implementation plan.

Community feedback to the report is an important step in the process of improving community health. Please send your comments to Debbie Zuerner, Director of Community Engagement.

Email: debbie.zuerner@owensborohealth.org

Appendix

A. Secondary Data Sources

B. Owensboro Health Regional Hospital CHNA Survey

C. Owensboro-Daviess County Community Resources

2021 Secondary Data Sources

Population		Source	Years of Data
2019 Population	Total Population	Census Population Estimates	2019
Under 18 years	Percent of Population 18 years of age	Census Population Estimates	2019
65 years and older	Percent of Population 65 and older	Census Population Estimates	2019
Non-Hispanic Black	Percent of Population Non-Hispanic Black	Census Population Estimates	2019
American Indian & Alaska Native	Percent of Population American Indian & Alaska Native	Census Population Estimates	2019
Asian	Percent of Population Asian	Census Population Estimates	2019
Native Hawaiian/Other Pacific Islander	Percent of Population Native Hawaiian/Other Pacific Islander	Census Population Estimates	2019
Hispanic	Percent of Population Hispanic	Census Population Estimates	2019
Non-Hispanic White	Percent of Population Non-Hispanic White	Census Population Estimates	2019
Not Proficient in English	Percent of Population not Proficient in English	American Community Survey, 5-year estimates	2015-2019
Female	Percent of Population Female	Census Population Estimates	2019
Rural	Percent of Population Rural	Census Population Estimates	2010

Health Outcomes			
Premature death	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	National Center for Health Statistics - Mortality Files	2017-2019
Poor or fair health	Percentage of adults reporting fair or poor health (age-adjusted).	Behavioral Risk Factor Surveillance System	2018
Poor physical health days	Average number of physically unhealthy days reported in past 30 days (age-adjusted).	Behavioral Risk Factor Surveillance System	2018
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted).	Behavioral Risk Factor Surveillance System	2018
Low birthweight	Percentage of live births with low birthweight (< 2,500 grams).	National Center for Health Statistics - Natality files	2013-2019

2021 Secondary Data Sources, continued

Health Behaviors		Source	Years of Data
Adult smoking	Percentage of adults who are current smokers (age-adjusted).	Behavioral Risk Factor Surveillance System	2018
Adult obesity	Percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2.	United States Diabetes Surveillance System	2017
Food environment index	Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best).	USDA Food Environment Atlas, Map the Meal Gap from Feeding America	2015 & 2018
Physical inactivity	Percentage of adults age 20 and over reporting no leisure-time physical activity.	United States Diabetes Surveillance System	2017
Percent with Access to Exercise Opportunities	Percentage of population with access to exercise opportunities.	Business Analyst, Delorme map data, ESRI, & US Census Tigerline Files	2010 & 2019
Excessive drinking	Percentage of adults reporting binge or heavy drinking (age-adjusted).	Behavioral Risk Factor Surveillance System	2018
Alcohol-impaired driving deaths	Percentage of driving deaths with alcohol involvement.	Fatality Analysis Reporting System	2015-2019
Fatal overdoses	Fatal overdoses from any drug, rate per 100,000 population.	Kentucky Injury Prevention and Research Center	2020
Non-fatal overdoses	Non-fatal overdoses - ED visits, rate per 100,000 population.	Kentucky Injury Prevention and Research Center	2020
SUD diagnoses	SUD diagnosis - ED visits, rate per 100,000 population.	Kentucky Injury Prevention and Research Center	2020
Sexually transmitted infections	Number of newly diagnosed chlamydia cases per 100,000 population.	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2018
Teen births	Number of births per 1,000 female population ages 15-19.	National Center for Health Statistics - Natality files	2013-2019
Access to Care			
Access to Care	Uninsured	Small Area Health Insurance Estimates	2018
	Primary care physicians	Area Health Resource File/American Medical Association	2018
	Dentists	Area Health Resource File/National Provider Identification file	2019
Mental health providers	Mental health providers	CMS, National Provider Identification	2020

2021 Secondary Data Sources, continued

Social & Economic Factors		Source	Years of Data
Education	High school completion	American Community Survey, 5-year estimates	2015-2019
	Some college	American Community Survey, 5-year estimates	2015-2019
Employment	Unemployment	Bureau of Labor Statistics	2019
Income	Children in poverty	Small Area Income and Poverty Estimates	2019
	Income inequality	American Community Survey, 5-year estimates	2015-2019
Family and Social Support	Children in single-parent households	American Community Survey, 5-year estimates	2015-2019
	Social associations	County Business Patterns	2018
Community Safety	Violent crime	Uniform Crime Reporting - FBI	2014 & 2016
	Injury deaths	National Center for Health Statistics - Mortality Files	2015-2019
Physical Environment			
Environmental Quality	Air pollution - particulate matter	Environmental Public Health Tracking Network	2016
	Drinking water violations	Safe Drinking Water Information System	2019
Housing and Transit	Severe housing problems	Comprehensive Housing Affordability Strategy (CHAS) data	2013-2017
	Driving alone to work	American Community Survey, 5-year estimates	2015-2019
	Long commute - driving alone	American Community Survey, 5-year estimates	2015-2019

2016-2020 County Health Rankings Data Sources

Health Outcomes		Source	2016 Data	2020 Data
Premature death	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	National Center for Health Statistics - Mortality Files	2011-2013	2016-2018
Poor or fair health	Percentage of adults reporting fair or poor health (age-adjusted).	Behavioral Risk Factor Surveillance System	2014	2017
Poor physical health days	Average number of physically unhealthy days reported in past 30 days (age-adjusted).	Behavioral Risk Factor Surveillance System	2014	2017
Poor mental health days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted).	Behavioral Risk Factor Surveillance System	2014	2017
Low birthweight	Percentage of live births with low birthweight (< 2,500 grams).	National Center for Health Statistics - Natality files	2007-2013	2012-2018
Health Behaviors				
Adult smoking	Percentage of adults who are current smokers (age-adjusted).	Behavioral Risk Factor Surveillance System	2014	2017
Adult obesity	Percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2.	CDC Diabetes Interactive Atlas, United States Diabetes Surveillance System	2012	2016
Food environment index	Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best).	USDA Food Environment Atlas, Map the Meal Gap from Feeding America	2013	2015 & 2017
Physical inactivity	Percentage of adults age 20 and over reporting no leisure-time physical activity.	CDC Diabetes Interactive Atlas, United States Diabetes Surveillance System	2012	2016
Excessive drinking	Percentage of adults reporting binge or heavy drinking (age-adjusted).	Behavioral Risk Factor Surveillance System	2014	2017
Alcohol-impaired driving deaths	Percentage of driving deaths with alcohol involvement.	Fatality Analysis Reporting System	2010-2014	2014-2018
Sexually transmitted infections	Number of newly diagnosed chlamydia cases per 100,000 population.	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2013	2017
Teen births	Number of births per 1,000 female population ages 15-19.	National Center for Health Statistics - Natality files	2007-2013	2012-2018

2016-2020 County Health Rankings Data Sources, continued

Access to Care		Source	2016 Data	2020 Data
Access to Care	Uninsured	Small Area Health Insurance Estimates	2013	2017
	Primary care physicians	Area Health Resource File/American Medical Association	2013	2017
	Dentists	Area Health Resource File/National Provider Identification file	2014	2018
Mental health providers	Mental health providers	CMS, National Provider Identification	2015	2019
Social & Economic Factors				
Education	High school completion	EDFacts, KY & WV Departments of Education	2012-2013	2016-2017
	Some college	American Community Survey, 5-year estimates	2010-2014	2014-2018
Employment	Unemployment	Bureau of Labor Statistics	2014	2018
Income	Children in poverty	Small Area Income and Poverty Estimates	2014	2018
Family and Social Support	Children in single-parent households	American Community Survey, 5-year estimates	2010-2014	2014-2018
	Social associations	County Business Patterns	2013	2017
Community Safety	Violent crime	Uniform Crime Reporting - FBI	2010 & 2012	2014 & 2016
	Injury deaths	CDC WONDER Mortality data, National Center for Health Statistics - Mortality Files	2009-2013	2014-2018
Physical Environment				
Environmental Quality	Air pollution - particulate matter	CDC WONDER Environmental data, Environmental Public Health Tracking Network	2011	2014
Housing and Transit	Severe housing problems	Comprehensive Housing Affordability Strategy (CHAS) data	2008-2012	2012-2016
	Driving alone to work	American Community Survey, 5-year estimates	2010-2014	2014-2018
	Long commute - driving alone	American Community Survey, 5-year estimates	2010-2014	2014-2018

OH Regional Hospital 2022 CHNA Survey

We want to better understand your health needs and how the hospital and its partners can better meet those needs. Please take 5-10 minutes to fill out this survey. Please do not include your name anywhere. All responses will remain anonymous.

Q1. Please tell us your zip code:

_____

Q2. Are you or anyone in your household satisfied with the ability to access health care services in Daviess County?

- ○ Yes
- ○ No

Q3. Where do you or anyone in your household go for routine healthcare such as annual checkups and wellness exams? Select all that apply.

- ○ Provider's office
- ○ Emergency room
- ○ Health department
- ○ Urgent care center
- ○ I do not receive routine healthcare
- ○ Other. Please specify:

_____

Q4. If you answered ***I do not receive routine healthcare*** to the previous question, please select all that apply as to why:

- ○ No appointment available
- ○ Lack of providers in my community
- ○ No transportation
- ○ Cannot take off work
- ○ Cannot afford it
- ○ Other. Please specify:

_____

Q5. How far do you or anyone in your household travel to see a healthcare specialist?

- ○ Less than 20 miles
- ○ 20 - 49 miles
- ○ 50 - 100 miles
- ○ More than 100 miles
- ○ I do not see any specialists

Q6. What do you or anyone in your household use for transportation?

- ○ My own vehicle
- ○ Family/friend vehicle
- ○ GRITS/other transportation service
- ○ Taxi/cab
- ○ Other. Please specify:

_____

Q7. Please select the TOP THREE **health challenges** you or anyone in your household face. Select only three.

- ○ Cancer
- ○ Diabetes
- ○ Mental health issues
- ○ Dental health
- ○ Heart disease and stroke
- ○ High blood pressure
- ○ Substance use
- ○ HIV/AIDS/Sexually Transmitted Infections
- ○ Overweight/obesity
- ○ Respiratory/lung disease
- ○ Autism
- ○ Other. Please specify:

_____

Q8. Please select the TOP THREE **risky behaviors** you see <u>most</u> in your community. Select only three.

- ○ Alcohol abuse
- ○ Tobacco use
- ○ Unsafe sex
- ○ Prescription drug misuse
- ○ Overweight
- ○ Poor eating habits
- ○ Lack of exercise
- ○ Lack of access to healthy food
- ○ Dropping out of school
- ○ Drug abuse
- ○ Other. Please specify:

_____

Q9. Are you or anyone in your household without health insurance currently?

- ○ Yes
- ○ No

Q10. Have you or anyone in your household delayed healthcare due to lack of money and/or insurance?

- ○ Yes
- ○ No

Q11. Are you or anyone in your household currently eligible for any of the following? Select all that apply.

- ○ Medicare
- ○ Medicaid
- ○ Public housing assistance
- ○ SNAP (Food stamp program)
- ○ Veteran Affairs
- ○ Commercial/private insurance

Q12. How would you rate your **own personal health**?

- ○ Very healthy
- ○ Healthy
- ○ Neither healthy nor unhealthy
- ○ Unhealthy
- ○ Very unhealthy

Q13. How would you rate the overall **health of Daviess County**?

- ○ Very healthy
- ○ Healthy
- ○ Neither healthy nor unhealthy
- ○ Unhealthy
- ○ Very unhealthy

Q14. Please select what you would consider the TOP THREE most important factors for a **healthy community**.Select only three:

- ○ Good place to raise children
- ○ Low crime/safe neighborhood
- ○ Good school systems
- ○ Easy to access healthcare
- ○ Dental health
- ○ Community activities and events
- ○ Affordable housing
- ○ Low disease rate
- ○ Personal responsibility
- ○ Excellent race relations
- ○ Diverse community
- ○ Good jobs/healthy economy
- ○ Religious or spiritual values
- ○ Transportation
- ○ Parks and recreation
- ○ Other. Please specify:

_____

Q15. Do you think Daviess County has the things you selected in question 14?

- ○ Yes
- ○ No

Q16. What could be done in Daviess County to better meet your health needs?

_____

_____

_____

_____

Q17. According to American Heart Association, a person should eat a minimum of 5 servings of fruits and vegetables (2 fruit and 3 vegetables) daily. If you do not eat the minimum recommended servings of fruits and vegetables daily, what are the reasons? Select all that apply.

- ○ Lack of access to fruits and vegetables
- ○ Cost
- ○ Lack of knowledge on how to prepare fruits and vegetables
- ○ Limited options available
- ○ Do not like taste of fruits and vegetables
- ○ Other. Please specify:

_____

Q18. Where do you or others in the community purchase fruits and vegetables? Select all that apply.

- ○ Farmer's market/local grower
- ○ Small convenience store/gas station
- ○ Small retail stores (ex. Dollar General)
- ○ Large retail stores (ex. Walmart, Meijer, IGA, Save-a-lot, etc.)
- ○ Other. Please specify:

_____

Q19. Do you or anyone in your household struggle with mental health issues such as anxiety, depression, bipolar disorder, schizophrenia, multiple personality disorder, PTSD, substance use disorder, etc.?

- ○ Yes
- ○ No (skip to question 22)

Q20. If you answered yes to question 19, did you or your householder seek treatment?

- ○ Yes (skip to question 22)
- ○ No

Q21. If you answered no to question 20, what was the reason? Select all that apply.

- ○ Unable to get an appointment
- ○ Treatment not covered by insurance
- ○ Embarrassed to ask for help
- ○ Not sure where to access treatment
- ○ Lack of transportation to services

Q22. What type of treatment and/or support have you used for substance use disorders in the past 12 months? Select all that apply.

- ○ Alcoholics/Narcotics Anonymous
- ○ Counselor/therapist
- ○ Emergency department
- ○ Medication Assisted Treatment (MAT)
- ○ Certified peer support specialist
- ○ Primary care provider
- ○ Psychiatrist/Psychologist
- ○ Faith based leader/program
- ○ Support group
- ○ I have not needed to use treatment or support for substance use disorder
- ○ Other. Please specify:

_____

Q23. In what ways were you or your family affected by the COVID-19 pandemic? Select all that apply.

- ○ Loss of job
- ○ Loss of health insurance
- ○ Reduced hours at work (partial loss of income)
- ○ Utilized community services (food stamps, food pantry, etc.)
- ○ Did not seek routine medical care (to avoid exposure)
- ○ Long term COVID-19 related health problems
- ○ Other. Please specify:

_____

- ○ None of the above

Q24. What is your age?

- ○ 18 - 24
- ○ 25 - 39
- ○ 40 - 54
- ○ 55 - 64
- ○ 65 - 69
- ○ 70 or older

Q25. What is your gender?

- ○ Male
- ○ Female
- ○ Other _____
- ○ Prefer not to answer

Q26. What ethnic group do you identify with?

- ○ African American/Black
- ○ Asian/Pacific Islander
- ○ Hispanic/Latino
- ○ Native American
- ○ White/Caucasian
- ○ Other. Please specify:

_____

Q27. What is the highest level of education you have completed?

- ○ High School/GED
- ○ Technical school
- ○ College or above
- ○ Other. Please specify:

_____

Q28. What is your annual household income?

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

Q29. What is your current employment status?

- ○ Unemployed
- ○ Employed part-time
- ○ Employed full-time
- ○ Retired
- ○ Student
- ○ Other. Please specify:

_____

Owensboro-Daviess County Community Resources

1. The Center of Owensboro – Daviess County Community Service Directory: https://thecenterodc.org/info/
2. RiverValley Behavioral Health Social Services Directory: https://www.rvbh.com/download/social-services-directory/
3. Credible Mind, Owensboro Health and RiverValley Behavioral Health Community Resources and Platform App: https://healthymind.crediblemind.com/user-resources

Approval

This Community Health Needs Assessment was approved by the Owensboro Health, Inc. Board of Trustees on May 23, 2022.