Our Commitment to the Commonwealth

As one of the largest and most comprehensive health systems in the Commonwealth, KentuckyOne Health acutely understands our responsibility to listen to the needs of our communities and turn issues into action. Some needs are identified through our community health needs assessment or our community-based board of directors; others come from community leaders, patients, our own physicians and employees.

As health care providers, we can offer our communities a unique perspective and partnership, as no one is immune to illness and medical emergencies. That means that at some point during our lives, our providers will interact with nearly everyone.

During 2018, Jewish Hospital in Louisville took a leadership position to develop procedures to identify and help victims of human trafficking. Through the resources of KentuckyOne and Catholic Health Initiatives, the impact was broadened to hospitals across the nation that are now implementing similar procedures.

In Laurel County, Saint Joseph London partnered with the health department to prevent child fatalities by reducing the number of parents co-sleeping with children. The hospital also partnered with the detention center to help children stay emotionally connected to their incarcerated mothers. To empower the next generation of difference-makers, Saint Joseph Berea is working with local schools to educate high school students on ways to identify potentially violent situations and intervene to prevent bullying, dating violence and sexual assault.

The ability to make positive change often happens one person at a time, and personal health can be impacted by other life barriers. Recognizing this fact, the Total Health Roadmap is the idea behind an initiative to connect the dots between our patients’ medical needs and basic life needs.

You can read more about these success stories in the following pages; we are just as proud of the hundreds more initiatives that occur on a smaller scale at every one of our facilities. Collectively, they deliver major, life-changing results. Over the past six years, since the formation of our combined organization, KentuckyOne Health has returned more than $1 billion in community benefits back to those we serve.

Together we bring wellness, healing and hope to all, including the underserved.

Jane Chiles    Martha Jones

Benefits Provided for the Poor

<table>
<thead>
<tr>
<th>Description</th>
<th>FY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of charity care</td>
<td>34,413,300</td>
</tr>
<tr>
<td>Unpaid cost of Medicaid</td>
<td>72,776,436</td>
</tr>
<tr>
<td>Unpaid cost of indigent programs</td>
<td>9,719</td>
</tr>
<tr>
<td>Non-billed services for the poor</td>
<td>2,556,251</td>
</tr>
<tr>
<td>Cash and in-kind donations for the poor</td>
<td>529,363</td>
</tr>
<tr>
<td><strong>Total cost of community benefit provided to the poor</strong></td>
<td><strong>110,285,069</strong></td>
</tr>
</tbody>
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Benefits Provided for the Broader Community

<table>
<thead>
<tr>
<th>Description</th>
<th>FY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-billed services for the community</td>
<td>4,331,940</td>
</tr>
<tr>
<td>Education/research provided to the community</td>
<td>5,707,317</td>
</tr>
<tr>
<td>Other benefits provided to the community</td>
<td>1,602,795</td>
</tr>
<tr>
<td><strong>Total cost of community benefit provided to the broader community</strong></td>
<td><strong>11,642,052</strong></td>
</tr>
</tbody>
</table>

**Total Cost of Community Benefit** $121,927,121

KentuckyOne Health follows the guidelines set forth in the Catholic Health Association’s A Guide for Planning and Reporting Community Health Benefit as the basis for developing its financial statement for community benefit.
A community needs assessment that focused on diet and exercise has evolved into a double benefit for the community. Rita Taylor and Tina Jones, employees of Saint Joseph London, took the information from those surveys and suggested helping local people by giving them some vegetables to offset both areas.

That suggestion was widely received by her co-workers and hospital officials and has now become a one-acre garden on the hilltop that once housed Marymount Hospital and the former Saint Joseph Hospital.

“We do the community needs assessment every three years and pick out the top three,” Taylor said. “We wanted to do something to address those needs and when I suggested a garden, everybody loved it.”

The first plant was set on May 25 and has entailed many volunteer hours. The City of London installed water lines so the garden can be watered when needed, and Taylor said Saint Joseph London President Terry Deis has been instrumental in encouraging the effort.

Although a community garden, this venture requires volunteers to come help with the maintenance of the produce now reaching its maturity.

“We need people to volunteer and then they can take home some of the produce,” Taylor added. “Then we take the extra and take it to our patients who are unable to get out and help.”

Taylor said the garden produce has helped 20 local families with their food costs by supplying them with healthy vegetables. The garden hosts cucumbers, leaf lettuce, okra, three varieties of peppers, pink and white half-runner beans, greasy beans, onions, radishes, corn, zucchini, squash and watermelon. Another area offers pumpkins and gourds, which Taylor and co-coordinator Tina Jones hope to use at another community event in the fall.

“This is a community garden but it’s for people who come and help work,” Taylor said. “We do have the area fenced off and locked up except at work times. We really want to keep doing this and help the community who come and help us.”

That help comes through the Saint Joseph London community garden’s Facebook page, which lists the times the area will be open for volunteer work. Taylor said that usually is done in the mornings and late afternoons.

For more information, visit their Facebook page at SJL Community Garden and ask to join the group to see postings.

Reprinted with permission from the Sentinel-Echo of London.
Jewish Hospital has always taken seriously its commitment to be a learning center, and among the many students and future medical professionals that it helps to train are social work students who pursue their practicum with Rabbi Dr. Nadia Siritsky, MSSW, BCC. They provide emotional support to patients and families, and also work on special projects. One such project was community outreach and advocacy for victims of human trafficking, where a former student connected with CHI to help advocate for the ICD-10 codes for services rendered to victims of human trafficking.

In November 2017, one of these students was speaking with a patient who confessed that she was a victim of human trafficking. This student was able to reach out to the rest of the unit and together they were able to help her escape her perpetrator to reach safety, reuniting her with a family member in the West, who took her in and helped her to get back on her feet.

The American Hospital Association, Catholic Health Initiatives and Massachusetts General Hospital worked collaboratively to secure recognition for diagnostic codes that will allow health care providers to identify victims of human trafficking that seek health care. Twenty-nine ICD-10 codes took effect Oct. 1, 2018.

Violence is an epidemic in our country and no sector is spared. It is prevalent with the wealthy as well as the poor, the old and the very young; males and females are both perpetrators; and, the abused and abusers cross all ethnic groups.

To continue the legacy of the founding congregations, Catholic Health Initiatives (CHI) launched United Against Violence, a national violence prevention initiative, in 2008. CHI has committed millions of dollars in mission and ministry funds to develop and implement violence prevention programs that will address the most prominent issues of violence in local communities. KentuckyOne Health is also committed to the prevention of violence, foundational to its purpose: To bring wellness, healing and hope to all, including the underserved.

All KentuckyOne Health facilities embraced the commitment to violence prevention for their communities and have completed amazing work. Whether it is Green Dot, Shaken Baby Syndrome, PACT in Action, Safe Ambassadors or another initiative – each has a success story to share. Below is a snippet from a few of the communities:

**Louisville Market**

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**Central/East Market**

**Violence Prevention | Green Dot**

Saint Joseph Berea’s Violence Prevention program implemented the Green Dot bystander intervention program at Berea Community and Madison Southern high schools. This program focuses on empowering high school students to recognize and intervene in situations of power-based personal violence like bullying, dating violence and sexual assault. With this program, we encourage students to intervene when they see acts of violence in their school or community. The students were provided tools and knowledge so that they can directly handle the situation, distract the individuals involved to diffuse the situation, or delegate to friends or responsible adults who are more equipped to handle the specific situations. Our ultimate goal and focus is to raise awareness and create a school culture that lets people know that violence of any kind is not OK and will not be tolerated.

The Green Dot program at both schools has been very successful and has had a great impact. We have heard several stories of students intervening to stop potentially harmful situations. We’ve had students come together and help another student who was having suicidal thoughts to get help; we have helped students understand that their relationships were not healthy; and we have empowered students to stand up to bullies on many occasions. The Green Dot program has given our students the ability to create a much safer and inclusive environment. We have had significant success with other students encouraging others to sign up and be involved with our program. Between the two schools, we have had more than 500 students trained.
The violence prevention coordinator at Saint Joseph London implemented the Nurturing Children Program in the Laurel County Detention Center. One of the women delivered her child while incarcerated and, due to barriers with family who has the child, has not had any contact with the child since birth. Working inside the correctional system, we are seeing how the women who are separated from their children continue to have a strong desire to see their children and make healthier life choices. Bonding and attachment are crucial to a child’s development. Regardless of the reason for separation of a child and his/her parent, it is critical to gain and maintain positive communication if legally permitted. Women in the jail don’t smile when discussing their children. They seem hopeless and feel their children will have a better life without communication from the displaced parent. Seeing the negative effects of the lack of communication led the violence prevention coordinator to find a creative way for the parents to gain contact and keep the young child’s interest, but also follow the rules of the correctional facility. The coordinator found books that record the mother reading the pages aloud. We found books entitled “Now I Lay Me Down to Sleep – A Bedtime Prayer,” “All the Ways I Love You” and “My Wish For You.” These books were purchased with Mission and Ministry funds. This method allows the mother to help children feel a connection to their absent parent; at the same time, this is educational and helps increase the children’s brain development and increase vocabulary. Members of the first class of incarcerated women have successfully graduated parenting classes. Recordable books were mailed to their children. We have heard feedback from families about how excited the children were to hear their mother’s voice anytime they wanted. Not only were the children excited, but we also saw hope from the mothers. The mothers became very emotional while recording reading to their children. They felt empowered and seemed to have a boost of confidence. The women related these emotions to having a tool to help maintain bonds and attachment with their children.

Child fatality review meetings in Laurel County revealed that an alarming number of child fatalities in Laurel County are due to parents co-sleeping with their children. In most cases, the parents have been impaired by an illegal substance. Through collaborative efforts of Saint Joseph London Nurturing Children Program and the Laurel County Health Department, we were able to purchase cribs through the Cribs for Kids Foundation. The Saint Joseph London Violence Prevention coordinator and assistant have been able to offer safe sleep education and 34 cribs to families in need of a safe place to sleep since January 2018. The families are identified through London Women’s Care, Saint Joseph London Birthing Center, Department for Community Based Services and parenting education groups.
KentuckyOne Health is part of the Catholic Health Initiatives (CHI) Total Health Roadmap implementation initiative funded by a $1,124,240 grant through The Robert Wood Johnson Foundation and Catholic Health Initiatives’ Mission & Ministry Fund.

The purpose of this work is to implement and evaluate a scalable and sustainable approach for addressing total health through integration into our systems of care, effective partnership with community-based organizations and expansion of leadership competencies and accountabilities. A critical component of this work is our commitment to “learn as we go” to ensure that we are continually improving our approach through collaborative work with community partners, thus fostering a sustained culture of shared learning and ownership both within CHI and across the communities we serve.

The strategic aims are as follows:

- CHI will transform its role as a health care provider by integrating universal screening for basic human needs in primary care
- CHI will strengthen its role as a community organization by participating in local/regional cross-sector partnerships
- CHI will strengthen leadership commitment by integrating the total health framework into required leadership competencies and composition of governing bodies at the local/regional system and national system levels

Aligned efforts across these three priority areas are necessary to foster a learning health care organization and to make an impact on total health of our communities. It is critical to expand the concept of care for the patients we serve in order to help them achieve optimal health. As anchor health care organizations, we must also work with others to move upstream and address the drivers of health in our communities, advocating for total health and health equity. This requires leaders and board members who understand these complex drivers.

Three clinics are part of this work in Kentucky – Berea Family Medicine, Premier Family Health Center in London, and Pediatric and Adolescent Medicine of London. Each of these clinics has integrated a full-time community health worker to assist clinic staff in universal screening for and addressing basic human needs (social determinants of health) for clinic patients. All patients, regardless of insurance source/lack of insurance, are asked to complete the screening during visits to the clinic and, if the patient does indicate need and wishes to receive help, the clinic’s community health worker meets with the patient to develop a plan of referrals. The community health worker will then follow up with the patient on referrals to see if needs were met.

Allie is a 16-year-old teen mother who is working toward getting her high school diploma. Allie didn’t want food stamps – she wanted a job. We worked with her to write her resume and post it on the Indeed.com website. Because of the posting, she was called to an interview with Kroger.

Allie got the job and has begun computer training.

The stories shared here are about real people, but names have been changed out of respect for those we serve.
Although clinicians may choose variations, depending on their relationship with their patients (i.e., the clinician may do a ‘warm handoff’ to the community health worker at the end of a visit), the working model for integration of universal screening for basic needs is as follows:

- Patients are given the screening form for basic needs as part of the rooming process.
- If the patient indicates needs, the clinician notes that a community health worker is available and will be following up to assist the patient in addressing those needs.
- The community health worker reviews the screening form with the patient and asks additional questions to learn about the depth of need and what resources with which the patient may be familiar. Referrals to community agencies are made.
- Within a reasonable time period (one-two weeks), the community health worker follows up with the patient by telephone to assess whether resources have been accessed and needs have been met. This may occur during a follow-up visit if the timeframe is reasonable.

The community health workers are part of the clinical team. The results of the screening and the initial referrals made are scanned and uploaded into the clinic EMR. The community health workers at each of the pilot clinics are primarily responsible for addressing social determinants of health in collaboration with other clinic staff and maintaining an up-to-date database of community resources to which they can refer patients.

During the first six months of 2018, 1,332 patients have been screened at the three participating clinics; 571 patients screened positive for one or more needs; and 446 were provided contact information for resources.

One community health worker described the work this way: A life with many needs and few resources can be overwhelming and we have no idea what that life is like, but we have the honor and privilege of walking beside people in these situations during this part of their life’s journey.

Sharon is 59 years old, low functioning, and unable to read or write. With the help of Hospice, she is taking care of her husband who has dementia. One of our physicians brought her to our attention. Sharon identified needs for food security and was immediately set up with food banks in the area. She also had outstanding medical bills and we have helped her process financial aid applications through our hospital. She also needed assistance with managing funds so that she could afford the co-pays on her prescriptions. One of Sharon’s other needs was new dentures because what she had no longer fit, and she had problems when eating. We helped her fill out an application for new dentures and she has just been approved through a local foundation for ongoing dental care.

Sharon also heats her trailer with chopped wood. We have helped her to reach out to Habitat for Humanity to aid in upgrading her heat source from chopped wood and to do a home inspection for improved insulation and door and window repairs. Sharon was not able to do any of the work with the applications, nor did she know where to get the help that was needed. This is an ongoing process with her and we will continue to keep in touch.

The Smiths

Just a few weeks after we had integrated community health workers, we met with the Smiths, a family of six who lost their home in a house fire. They came to the clinic to check for smoke inhalation. Because of the situation, we were able to connect the Smiths with Community Co-Operative Care (CCC). Through CCC, they were provided with clothes (three sets per family member), food and, when they find a home, CCC will furnish their home for free with used furniture.

We also asked the mother if she received WIC and explained the benefits of the program. Mrs. Smith was able to connect with the county health department to get set up. For housing, we immediately called the local housing authority and was faxed a list of homes that were available for rent.

The next week, Mrs. Smith followed up by signing up for HUD benefits and getting on a waiting list. The Red Cross provided $300 for a security deposit. We also connected the Smiths with the county school resource department.

By the end of the day, the Smiths had clothing and school supplies for their two school-age daughters. We kept in touch for another three weeks to be sure that the Smith family was able to secure the resources they need.

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Together we will create an integrated, comprehensive health system known for:

- Efficiently providing the highest quality care and services
- Reducing the incidence of disease
- Eliminating inequities in access in the communities it serves

**Our Facilities**
- Flaget Memorial Hospital
- Frazier Rehab Institute
- Jewish Hospital
- Medical Center Jewish East
- Medical Center Jewish South
- Medical Center Jewish Southwest
- Medical Center Jewish Northeast
- Jewish Hospital Shelbyville
- Our Lady of Peace
- Saint Joseph Berea
- Saint Joseph East
- Saint Joseph Hospital
- Saint Joseph Jessamine
- Saint Joseph London

**Saint Joseph Martin**
- Saint Joseph Martin transitioned to Appalachian Regional Healthcare July 1, 2018
- Saint Joseph Mount Sterling
- Sts. Mary & Elizabeth Hospital
- The Women’s Hospital at Saint Joseph East

**Long-Term Acute Care**
- Continuing Care Hospital within Saint Joseph Hospital

**Our Affiliates**
- Southern Indiana Rehab Hospital
- Southern Indiana Rehab Hospital transitioned to Vibra Healthcare June 18, 2018
- Taylor Regional Hospital