Community Health Implementation Strategy FY 2014-16

Jewish Hospital
KentuckyOne Health™

A service of Jewish Hospital & St. Mary's HealthCare

Introduction

Jewish Hospital opened in 1905 with a mission to provide all patients with the highest quality care and a strong emphasis on research and education. Today, it is a 462-bed, internationally renowned, high-tech tertiary referral center located in downtown Louisville, developing leading-edge advancements in hand and microsurgery, heart and lung care, cancer care, home care, rehab medicine, sports medicine, orthopedics, neuroscience, occupational health, organ transplantation, and outpatient and primary care. Jewish Hospital is at the vanguard of medical science. It is among a select group of hospitals performing heart, lung, liver, kidney, and pancreas transplantation. It was the site of the world's first successful hand transplant, the world's first and second successful AbioCor® Implantable Replacement Heart procedures, and world's first trial of cardiac stem cells in chronic heart failure.

Jewish Hospital is part of KentuckyOne Health, one of the largest health systems in Kentucky with more than 200 locations including hospitals, outpatient facilities and physician offices, and more than 3,100 licensed beds. An 18-member volunteer board of directors governs KentuckyOne Health, its facilities and operations, including Jewish Hospital, with this mission:

Our Purpose

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

Our Future

To transform the health of communities, care delivery and health care professions so that individuals and families can enjoy the best of health and wellbeing.

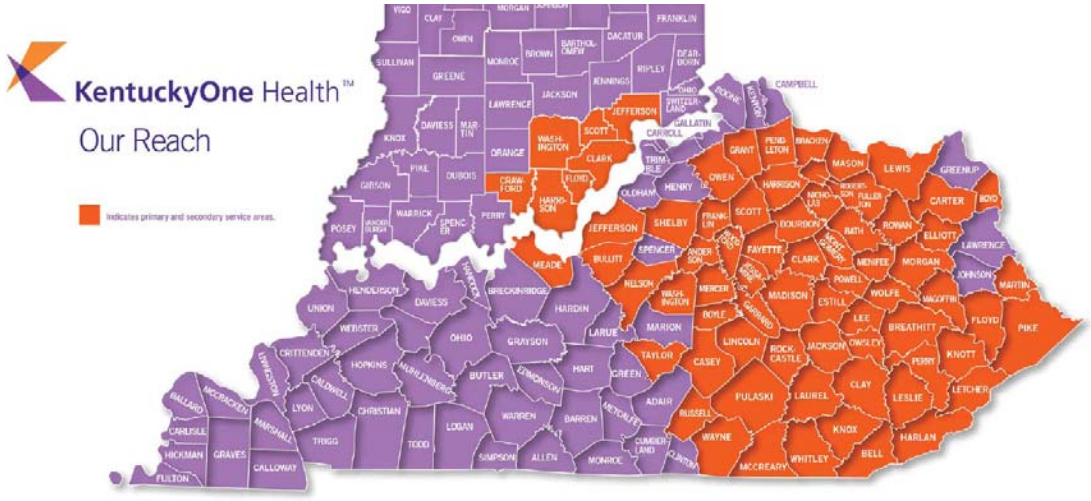
Our Values

Reverence: Respecting those we serve and those who serve.

Integrity: Doing the right things in the right way for the right reason.

Compassion: Sharing in others' joys and sorrows.

Excellence: Living up to the highest standards.



Jewish Hospital is located in Louisville, the largest city in the state of Kentucky and the county seat of Jefferson County. The hospital serves a population of roughly 1.5 million people residing in the Louisville metropolitan area which includes Louisville-Jefferson County and 12 surrounding counties, eight in Kentucky and four in Southern Indiana. The majority (approximately 60 percent) of its discharges originate from Jefferson County.

This document provides a summary of Jewish Hospital's plan to develop new and enhance established community benefit programs and services from FY2014-16. This plan is focused on addressing the top community health priorities identified in the community health needs assessment conducted by Jewish Hospital in FY2012.

Identifying Health Needs

Jewish Hospital identified community health needs by undergoing an assessment process in collaboration with the Louisville Metro Department of Public Health and Wellness (LMPHW), the Kentucky Hospital Association and other Louisville area health systems (Baptist Hospital East, Norton Healthcare and University of Louisville Hospital). More than 1,800 residents provided input via community forums conducted in all four quadrants of Jefferson County and through an on-line survey (available in both English and Spanish). Another 40 community leaders, physicians, and other health professionals shared their expertise at a special community forum. In addition, secondary data was compiled from demographic and socioeconomic sources as well as national, state and local sources of information on disease prevalence, health indicators, health equity and mortality.

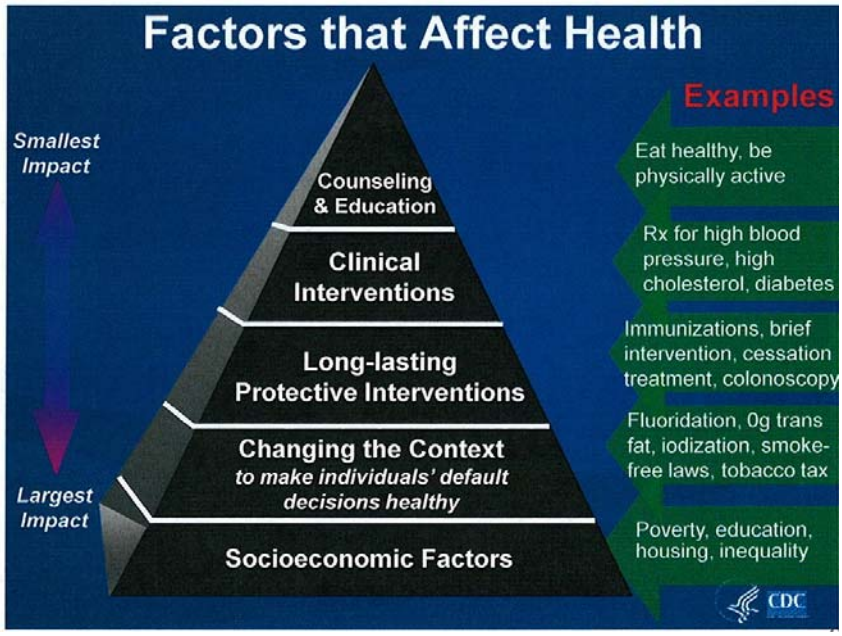
This was analyzed and reviewed to identify health issues of uninsured persons, low-income persons and minority groups, and the community as a whole. Health needs were prioritized utilizing a method that weighs: 1) the impact on vulnerable populations; 2) the importance to the community; 3) the size of the problem; 4) the seriousness of the problem; 5) prevalence of common themes; 6) how closely the need aligns with the strategies and strengths of the hospital and KentuckyOne Health; and 7) an evaluation of existing hospital programs responding to the identified need. The hospital engaged **BKD, LLP** to assist with compiling secondary data and prioritizing identified health needs.

Subsequently, Jewish Hospital leadership entered into a dialogue with other key community partners, including representatives of LMPHW, to discuss the results of the evaluation and select health priorities. Participants were given the opportunity to revise rankings and debate issues until a consensus was reached on a composite ranking of health issues. The process identified the following issues with scores of 14 or more (on a scale of 28):

Stroke/cerebrovascular disease
Chronic diseases in vulnerable neighborhoods (defined by health outcomes, race and socioeconomic status)
Chronic lower respiratory disease (COPD)
Cancer
Adult obesity
Heart disease
Physical inactivity
Access to care
Brain disorders (mental/emotional health)
Shortage of primary care physicians
Violent crime
Limited access to healthy foods
Addiction/substance abuse
Adult smoking
Limited health knowledge and health education

With an understanding that collaborative efforts have the greatest opportunity for measurable, collective impact, Jewish Hospital has chosen to align its community health improvement efforts around the Mayor's Healthy Hometown Movement. Led by the LMPHW, it envisions a community-wide culture where healthy eating and active living are the norm and fosters an environment that promotes increased physical activity, better nutrition, healthy public policy and access to needed resources.

Mayor's Health Hometown Priority	Correlated Community Health Need
 **Tobacco Control and Prevention**	Adult Smoking
 **Healthy Eating and Active Living**	Chronic Diseases in Vulnerable Neighborhoods Adult Obesity Heart Disease Physical Inactivity Limited Health Knowledge/Health Education Limited Access to Healthy Foods
 **Chronic Disease Prevention and Management**	Stroke/Cerebrovascular Disease Chronic Lower Respiratory Disease Cancer Heart Disease Mental or Emotional Health Addiction/Substance Abuse
 **Access to Services (Addressing Health Disparities)**	Chronic Diseases in Vulnerable Neighborhoods Access to Care Shortage of Primary Care Physicians Violent Crime



Furthermore, the goals and strategies outlined in this implementation plan span the range of factors affecting health as outlined by the Centers for Disease Control.

PRIORITY: Tobacco Control and Prevention

Community Health Needs: Adult smoking

Goal: Enhance community education about the risks of smoking to promote early identification and intervention and ultimately improve outcomes and survival rates.

Strategies:

A. Continue to partner with LMPHW to offer free Cooper Clayton Method smoking cessation classes to include the provision of lozenges/patches for participants.

B. Increase the number of KentuckyOne employees trained in the Cooper Clayton Method to enable expanded class offerings throughout the community, with a particular focus in southwest Jefferson County.

C. Increase the number of participants in smoking cessation classes by registering residents at health fairs, the Kentucky State Fair, and other community outreach events.

D. Evaluate the effectiveness of the intervention of a nurse navigator in improving the outcomes of participants completing the smoking cessation courses offered by KentuckyOne Health.

PRIORITY: Healthy Eating and Active Living

Community Health Needs: Chronic diseases in vulnerable neighborhoods, adult obesity, heart disease, physical inactivity, limited health knowledge, and limited access to healthy foods

Goal 1: Improve opportunities for Louisville residents to participate in physical activities, particularly within at-risk neighborhoods.

Strategies:

A. Establish Walk With a Doc events at west and south Louisville public parks to provide free monthly opportunities for residents to exercise with the support of a physician and supportive walking community.

B. Continue established Walk With a Doc event monthly at the Parklands of Floyds Fork in eastern Jefferson County.

C. Inventory existing walking clubs, running groups, and other community-based entities that encourage physical activity and create a resource list to post on the web and distribute at health fairs and other events.

Goal 2: Increase youth knowledge of the importance of healthy lifestyles and promote interest in science and health careers.

Strategies:

A. Continue participation in Pulse of Surgery, a partnership with the Kentucky Science Center and Greater Louisville Medical Society that allows students to view live heart surgeries at Jewish Hospital via videoconferencing technology.

B. Explore the feasibility of expanding Pulse of Surgery to students in rural sites across Kentucky that are proximal to KentuckyOne Health facilities by using teleconferencing technology to link schools with the Kentucky Science Center.

Goal 3: Support collaborative initiatives to address Louisville's food deserts, to raise the "food IQ" of residents, and promote access to nutrition education/counseling and exercise programs.

Strategies:

A. Participate in local collaborative efforts to include the 2013 Bingham Fellows (developing long-term strategies to foster a smart food culture) and the Mayors' Healthy Hometown Movement committees on healthy eating and active living.
B. Develop a partnership with the YMCA to expand exercise opportunities for cancer patients.
C. Create new opportunities for patients with diabetes and cancer to obtain nutrition counseling in an outpatient setting through the KentuckyOne physician enterprise.
D. Explore the feasibility of facilitating patient referrals to community-based resources to include exercise programs, community gardens, Fresh Stop markets, and community supported agriculture programs (CSAs).

PRIORITY: Chronic Diseases Among Vulnerable Populations

Community Health Needs: Stroke/cerebrovascular disease, COPD, cancer, heart disease, mental/emotional health, and addiction/substance abuse

Goal 1: Provide stroke and heart attack education, screenings, and support to residents and emergency responders with the goal of effecting measurable improvement in health outcomes.

Strategies:

A. Stroke and STEMI Program staff (STEMI stands for ST Segment Elevation Myocardial Infarction—a severe heart attack) will continue to provide screenings at community events (e.g. National Stroke Association health fair, Senior Day Out at the Louisville International Convention Center) to include glucose checks, cholesterol checks, blood pressure and body fat analysis.
B. Provide KentuckyOne Health primary care physician offices with educational materials on stroke and STEMI prevention to increase awareness where modifiable risk factors exist.
C. Host an annual symposium for statewide emergency responders to educate on time-critical diagnosis of stroke and STEMI and to better define the role of EMS; host a stroke-specific rapid response training twice a year for EMS employees; and provide on-going clinical training opportunities for Louisville EMS employees at Jewish Hospital.
D. Send stroke and STEMI outcome tools to referring facilities and EMS to provide feedback on acute cases, to celebrate successes, and to collaboratively address opportunities for improving patient outcomes.
E. Develop and implement a Stroke Check Program in collaboration with VNA Nazareth Home Care to improve the care continuum for stroke survivors. This program will provide the needed support in the critical few weeks post discharge to ensure compliance with treatment plan, ensure environment safety and reinforce education.
F. Collaborate with health professionals throughout the state to develop a statewide stroke and cardiac chronic disease management plan.

Goal 2: In partnership with residents of challenged neighborhoods in Louisville's urban core, LMPHW and its Center for Healthy Equity, continue implementation of an action plan to promote improved health status and to reduce disparities.

Strategies:

A. Continue the Transitions of Care Program to provide support to patients with Medicaid or no insurance who live in neighborhoods within zip codes 40203, 40211 and 40212 who are discharged from Jewish Hospital in an effort to improve their ability to self-manage their condition at home. This free program includes the coaching support of a nurse navigator by phone, home visits from peer advisors (aka community health workers) trained to link residents with community resources, and a visit from a dietitian when nutritional counseling is needed.

B. Implement the addition of a peer specialist to the Transitions of Care Program to provide residents identified with substance use disorders, depression or mental illness with a specially trained community member who is in recovery.

C. Explore the feasibility of expanding the Transitions of Care Program to serve more Louisville residents.

D. Continue implementation of educational training in culturally competent care at the Louisville WIC clinics and at Jewish Hospital.

E. Continue to engage clients of Louisville's WIC clinics in implementing health equity practice changes that improve satisfaction.

F. Support the Family Health Center in Butchertown, a free clinic serving predominantly Hispanic residents from across Louisville, and the Volunteers of America primary care clinic.

Goal 3: Working in partnership with the Network Center for Community Change, continue striving to improve the health status of residents in Louisville's urban core neighborhoods with a particular focus on Shelby Park, Smoketown, Phoneix Hill, and California.

Strategies:

A. Improve the civic engagement of residents through the implementation of public policy initiatives designed and championed by residents.

B. Improve educational achievement of students through training, education and development initiatives designed to reduce dropout rates for engaged youth.

C. Increase enrollment in WIC among eligible families.

Goal 4: Research, develop and test innovative, evidence-based practices in collaboration with community partners to reduce unnecessary hospital readmissions and emergency department visits while improving patient experience and health outcomes.

Strategies:

A. In partnership with UofL Hospital and Family Health Centers (federally qualified health centers), explore the feasibility of implementing a collaborative case management program to identify vulnerable populations and better serve their needs—physical, emotional and social—in the appropriate community-based setting.

B. Explore the feasibility of implementing congregation-based health programs in partnership with area churches and synagogues.

C. Provide leadership to the Louisville coalition addressing the causes of chronic disease in children (pending funding support from the Foundation for a Healthy Kentucky).

D. Explore the feasibility of partnering with UofL faculty on research projects to address the needs of people with chronic diseases to include both high-tech (technology) and high-touch (community health workers) approaches.

E. Continue participating in "Changing this Generation through Unbridled Care" State Task Force and continue collaboration throughout the state with a goal of implementing a statewide improvements in chronic disease management.

PRIORITY: Access to Services (Addressing Health Disparities)

Community Health Needs: Chronic diseases in vulnerable neighborhoods, access to care, shortage of primary care physicians, and violent crime

Goal 1: Enhance community education about early identification and intervention for breast, colon and lung cancer with a goal of reducing late-stage diagnoses and improving outcomes and survival rates.

Strategies:

A. Gather KentuckyOne Health system and registry data for **mammograms** with a particular focus on residents living in zip codes 40258 and 40272 to develop a baseline for measurable improvement; actively recruit women for screening mammograms at health fairs, churches, and through media.

B. Reduce the number of late-stage diagnoses of **lung cancer** by collaborating with primary care physicians to refer patients meeting screening criteria; through public awareness campaigns (web, news media, paid advertising) to heighten public awareness and celebrate success stories; by actively recruiting eligible screening participants at community events; and by measuring, reporting and publishing incidental findings to include evaluating at what stage the cancer is diagnosed and how many screenings are completed.

C. Increase the number of screenings for **colon cancer** among low-income residents by participating as a lead partner in the Kentucky Cancer Foundation's Colon Cancer Prevention Project in metro Louisville. In FY 2014, the program's goal is to provide more than 700 free FIT screenings and close to 250 free screening colonoscopies for those screened at the highest risk

Goal 2: Continue working to achieve a 10% reduction in the incidence of domestic violence involving adults and youth in the 40210 zip code by 2020 as measured by Louisville Metro Police Department data.

Strategies:

A. In partnership with the Center for Women and Families, mobilize teens in the Parkhill, Algonquin and California neighborhoods through PACT in Action, a youth-led initiative focused on building community capacity to develop teen dating violence prevention programming to their peers.

B. Through PACT in Action: 1) strengthen individual knowledge and skills; 2) promote community education; 3) educate providers; 4) foster coalitions and networks; 5) change organizational practices; and 6) influence policy and legislation, all as it pertains to teen dating and intimate partner violence.

Goal 3: Enhance access to primary care providers.

Strategies:

A. Through collaborative partnerships with other hospitals and physician networks, the Health Department, and federally qualified health centers, facilitate improved care navigation services to assist vulnerable patients in establishing a medical home.

B. Support the on-going implementation of patient-centered medical homes in the KentuckyOne Health physician enterprise.

C. Continue to implement and evaluate innovative methods of improving patient access to providers to include evaluating a nurse call center, use of community health work-

ers, and deployment of community-based interventions for patients who are identified as most vulnerable through evidence-based risk assessment tools.

Goal 4: Improve the health status of patients with diabetes.

Strategies:

A. Facilitate patient access to the myriad financial resources available to them through Metro United Way's 211 service; and explore the feasibility of building on the Transitions of Care resource directory for distribution in community settings and physician offices.

B. In partnership with LMPHW, continue diabetes outreach/education/prevention to include: 1) Transitions of Care Peer Advisors continue recommending LMPHW Diabetes Education classes; 2) Partnering with YMCA Diabetes Prevention Program for diabetes prevention for persons with pre-diabetes; and 3) Collaborating with Bellarmine University to promote Active Steps at Park Duvall.

Needs Not Addressed

Some issues identified through the community health needs assessment have not been addressed in this plan. In initial discussion and subsequent prioritization, Jewish Hospital's Community Needs Assessment Team considered the levels to which some needs were already being addressed in the service area. Additionally, some community needs fall out of the scope of expertise and resources of Jewish Hospital. The following chart outlines how some of the needs identified in the assessment are addressed by others or in different ways:

Community Need	How Need is Addressed
Mental or Emotional Health Addiction/Substance Abuse Excessive Drinking	Jewish Hospital has adopted numerous strategies in this plan to integrate mental health and substance use disorders with physical health. Within KentuckyOne Health, the primary resource for this area of focus is Our Lady of Peace which has developed an implementation plan to address these needs comprehensively. In addition, Seven Counties Services, the area's community mental health service, has the expertise and resources to focus in these areas.

Next Steps

Jewish Hospital's Community Needs Assessment Team initiated the development of implementation strategies for each health priority identified through the assessment process. This Implementation Plan will be rolled out over the next three years, from FY2014 through the end of FY2016. The Team will work with community partners and health issue experts on the following for each of the approaches to addressing the identified health needs:

- Develop work plans to support effective implementation
- Create mechanisms to monitor and measure outcomes
- Develop a report card to provide on-going status and results of these efforts to improve community health

Jewish Hospital is committed to conducting another health needs assessment within three years.

Adoption/Approval

KentuckyOne Health's Board of Directors includes representation across the state and support the work that each facility completes to improve the health of their community. The Board of Directors approves Jewish Hospital's Implementation Strategy that has been developed to address the priorities of the recent Community Health Needs Assessment.

Harmonious with the mission of KentuckyOne Health, Jewish Hospital will utilize this Implementation Strategy as a roadmap to collaborate with their community to address the priorities, particularly for the most vulnerable. KentuckyOne Health approves Jewish Hospital's Implementation Strategy and is a champion for a healthier Kentucky.

Robert M Hewett
Chair, KentuckyOne Health Board of Directors

4/10/13
Date

Ruth W. Brinkley
President & Chief Executive Officer, KentuckyOne Health

4/10/13
Date