KentuckyOne Health®
Saint Joseph London

Implementation Strategy
FY 2017-19

Contents

Introduction

Forward

During 2015-2016, Saint Joseph London (SJL) conducted its FY2017-19 community health needs assessment (CHNA) to support its mission to enhance the health of people in the communities it serves by identifying health needs in these communities and prioritizing the allocation of hospital resources to meet those needs. This Implementation Strategies document, developed from June-October 2016, serves as an accompaniment to that report by identifying the strategies which Saint Joseph London will employ from FY2017-19 to address the needs identified in the most recent CHNA. Additionally, the completion of this report and subsequent approval and adoption by the KentuckyOne Health Board of Directors complies with requirements mandated by the *Patient Protection and Affordable Care Act of 2010* and federal tax-exemption requirements.

Executive Summary

The implementation strategies process involved the following steps:

- The KentuckyOne Health Healthy Communities department created an inventory of hospital-level and system-level strategies that were already in place to address the applicable health needs.
- Saint Joseph London leaders reviewed the inventory, evaluated continuation of current strategies, and added additional strategies where appropriate.
- The Healthy Communities department consulted with KentuckyOne Health system-level leaders to include in the inventory applicable strategies occurring on behalf of all KentuckyOne Health hospital communities, including that of Saint Joseph London.
- A final list of appropriate strategies was prepared.
- The goals for addressing each identified health need are listed below. The strategies applicable to each goal are detailed in the body of the Implementation Strategies report.
- Tobacco Use
    1. Address tobacco use from a KentuckyOne Health system-wide approach; this is a primary prevention to tobacco use.
    2. Support local groups and events that have a mission to address tobacco prevention; this is a primary prevention to tobacco use.
    3. Improve tobacco cessation efforts through community education and advocacy; this is a secondary prevention to tobacco use.
    4. Align efforts with Commission on Cancer triennial community health assessment (completed by KentuckyOne Health Cancer Care) to address the impact of cancer; this is a tertiary response to tobacco use.
- Diet and Exercise
    1. Promote healthy options for diet and exercise from a KentuckyOne Health system-wide approach; this is a primary prevention related to diet and exercise.
    2. Support local groups and events that have a mission to promote healthy diet and exercise to prevent negative health outcomes; this is a primary prevention related to diet and exercise.
    3. Increase available resources to address consequences of negative health outcomes related to poor diet and lack of exercise; this is a secondary response related to diet and exercise.

4. Provide support for programs addressing condition management and survivorship through diet and exercise; this is a tertiary response related to diet and exercise.

- Alcohol and Drug Use
    1. Address alcohol and drug use from a KentuckyOne Health system-wide approach, including working upstream to address the mental health issues that can underlie substance abuse. This is a primary prevention to alcohol and drug use.
    2. Support local groups and events that have a mission to prevent alcohol and drug use; this is a primary prevention to alcohol and drug use.
    3. Increase available resources to address consequences of negative health outcomes related to alcohol and drug use; this is a secondary response related to alcohol and drug use.
    4. Provide support for programs addressing long-term condition management for individuals affected by alcohol and drug use; this is a tertiary response related to alcohol and drug use.
- This process for creating the Implementation Strategies was presented to the KentuckyOne Health Board of Directors for approval and adoption on October 26, 2016 as the active Implementation Strategies report through June 30, 2019 (FY 2017-19).
- This report was made public and widely-available on or before November 15, 2016.

Organization Description

In July of 1946, the Sisters of Charity of Nazareth, Kentucky purchased what was then called Pennington General Hospital in London, Kentucky and assumed its leadership. Renamed Marymount – Our Lady of the Mountain, the mission of the sisters was to extend the healing ministry of Christ bringing quality health care to the poor and underserved of rural Kentucky. In 1997, Marymount, along with seven other Kentucky facilities, became part of Catholic Health Initiatives (CHI) and in 2008 those same eight facilities formed Saint Joseph Health System. At that time the hospital name was changed to Saint Joseph – London.

In January 2012, Saint Joseph London became 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 Saint Joseph London, with this purpose:

- **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.

Community Served

Geographic Area

For the purposes of our community health needs assessment, the community served by Saint Joseph London is defined as the geographic area from which a significant number of the patients utilizing hospital services reside. Inpatient discharge data for Saint Joseph London from July 1, 2014-June 30, 2015 (the latest fiscal year available as of data collection for this writing) shows that Laurel County was the county of residence for the largest concentration of patients, with 48.3% of patients living in Laurel County. Therefore, the service area for this community health needs assessment and accompanying implementation strategies is defined as Laurel County.

London is a relatively small rural community in Kentucky and is the county seat for Laurel County. Laurel County is located in southeastern Kentucky and is bordered by Clay, Jackson, Know, McCreary, Pulaski, Rockcastle and Whitley counties.

Populations

Understanding the population demographics of the community served by Saint Joseph London helped the hospital team understand characteristics unique to their community and can impact the identification of health needs. Laurel County demographics indicate that Laurel County is largely representative of Kentucky averages but does represent less ethnic and racial diversity than the state does. Detailed community demographic information can be found in Saint Joseph London's 2017-2019 CHNA.

Target Populations for Implementation Strategies

The target populations in the IS plan are described as applying to either the "Broader Community" or those "Living in Poverty" to correspond with federal community benefit reporting requirements. Additionally included is a "Vulnerable Populations" description for strategies targeting persons with disabilities; racial, cultural, and ethnic minorities; and the uninsured/underinsured. When only a certain age bracket is directly impacted by the strategy, we have specified teens, adults, children, infants, or seniors as the strategy's target population. Each strategy has at least one descriptor of its target population.

Significant Health Needs Identified in CHNA

Criteria Used to Identify Priorities

To achieve consistency across the KentuckyOne Health system and to identify opportunities for cross-hospital collaboration, we chose to identify our priorities as named in the Robert Wood Johnson County Health Rankings health factors.

The vast majority of health outcomes—measured by both length of life and quality of life—are determined by the health factors in these categories: social and economic factors, health behaviors, clinical care and the physical environment. These health factors represent what is commonly referred to as social determinants of health. The Robert Wood Johnson Foundation's County Health Rankings model illustrates the following:

- Social and economic factors account for 40% of a person's health outcomes and include these health factors:
  - Education
  - Employment
  - Income
  - Family and Social Support
  - Community Safety
- Health behaviors account for 30% of health outcomes and include these health factors:
  - Tobacco Use
  - Diet and Exercise
  - Alcohol and Drug Use
  - Sexual Activity
- Clinical care accounts for 20% of health outcomes and includes these health factors:
  - Access to Care
  - Quality of Care
- The physical environment accounts for 10% of health outcomes and includes these health factors:
  - Air and Water Quality
  - Housing and Transit

Each of the 13 health factors listed above was assessed on eight prioritization factors: magnitude, impact on mortality, impact on morbidity, trends, community input, strategic alignment, comparison to peer communities and common identification. Each health factor received a score of zero to four, with a four indicating the greatest need possible for that particular factor. The total score was the sum of all prioritization factors for that particular health factor, and the possible total score is 32.

In our efforts to address the health needs that heavily influence health outcomes, we created a system for ranking community health needs using a weighted scale to account for the measure of influence. The measure of influence is the percentage of effect that this category of health factors has on health outcomes. The weighted score was created by multiplying the total score for each health measure by the percentage of their influence on overall health. For example, tobacco use is a health behavior. If all eight prioritization factors added up to a total score of 21, we then multiplied this total score by 30%—the measure of influence for a health behavior according the *County Health Rankings* model. This

weighted score was compared against the other categories. The factors with the highest weighted scores were identified as community health needs for the community served.
This ranking system illustrates KentuckyOne's commitment to bringing wellness, healing and hope to all as we recognize the disproportionately negative impact of these social determinants on the health of the poor, vulnerable and underserved in our communities.

Final Priority Health Needs

In March 2016, the leadership team at Saint Joseph London gathered to review the Laurel County data and the aforementioned prioritization chart. The team discussed each of the health measures in the chart and where they believed the hospital had the greatest capacity to make the most marked improvement. The areas below were chosen as the FY2017-2019 community health needs assessment priority areas with the consideration of a linking chronic disease education and disease management:

- **Tobacco Use**
  - The data in the health needs prioritization chart showed tobacco use to have the highest total score and the second highest weighted score of all health measures assessed. The leadership teams concluded that this issue continues to present itself as a major concern in the community and that the hospital had the capacity to address this health need.
- **Diet and Exercise**
  - The data in the health needs prioritization chart showed diet and exercise to have the second highest total score and the third highest weighted score of all the measures assessed. The leadership teams concluded that there were many opportunities to address this health need at various levels in the community and in the hospital.
- **Alcohol and Drug Use**
  - The data in the health needs prioritization chart showed alcohol and drug use to have third highest total score and fourth highest weighted score of all health measures assessed. As this issue continues to have increasing impact in Laurel County, the leadership team discussed the need to respond.

Significant Health Need(s) Not Addressed

One health need appeared in the data analysis which the Saint Joseph London leadership team chose not to select as a priority area for this community health needs assessment:

- Income
  - The data in the health needs prioritization chart showed income to have the highest weighted score of all the health measures assessed. The leadership team chose not to address this area specifically in the Implementation Strategies report due to the lack of ability to impact this area beyond the hospital employees in the community.

CHNA Infographic

This infographic was developed for use in explaining the CHNA process and final priority needs to community members, stakeholders, and hospital personnel. A PDF of this infographic can be found here: http://www.kentuckyonehealth.org/documents/CHNAs%20and%20Implementation%20Strategies/SJL_CHNA_Infographic_8.5x11_TP.pdf.

Implementation Strategy Process

Development of Implementation Strategies

During the development of the CHNA, there were many conversations at the hospital-level and at the KentuckyOne Health system-level about recognizing the many strategies already in place to address community need. It was vital to develop a thorough understanding of current strategies and determine where additional strategies were needed to respond to community need. Therefore, the first step in the implementation strategies report was for the KentuckyOne Health Healthy Communities (Population Health) team to create an inventory of hospital-level strategies that were already in place address the applicable health needs. This involved researching current strategies reported in CBISA (Community Benefit Inventory for Social Accountability—the community benefit reporting system used by KentuckyOne Health) and by garnering information from the hospital leadership team.

In August-September 2016, Saint Joseph London leaders met to review this inventory and evaluated it for their commitment to continuation of these strategies. Strategies that proved to be ineffective, inefficient, or did not demonstrate best practices were discussed to ensure resources were linked with proven strategies. Additional strategies were added per the leadership brainstorming session.

The next step in the implementation strategy process was reviewing system-level strategies that were occurring on behalf of Saint Joseph London. The KentuckyOne Health Healthy Communities team consulted with KentuckyOne Health system-level leaders to include in the inventory applicable strategies occurring on behalf of all KentuckyOne Health hospital communities, including that of Saint Joseph London. The system-level strategies were shared by leaders representing these KentuckyOne Health departments:

- Cancer Care
- Diversity and Inclusion
- Food and Nutrition Services
- KentuckyOne Health Foundations/KentuckyOne Health Grants Office
- Public Policy and Advocacy
- Strategy and Business Development
- WorkPlace Care

Related strategies from both the hospital-level and the system-level were grouped and overall goals were developed around the intended outcomes of the strategies. At least one goal is attached to each identified health need, with multiple strategies linked to each goal.

Each strategy is listed with a target population, action plan, committed resources, evaluation plan, and applicable external partners. The target population descriptors are listed earlier in this document. The action plan describes the goal of the strategy. The hospital resources detail what Saint Joseph London, and/or KentuckyOne Health on behalf of Saint Joseph London, will commit to the execution of the strategy. The evaluation plan is an outcomes-focused description of how the strategy will be evaluated for impact on the health need it addresses. Any external partners involved in the strategy are also listed.

A final list of appropriate strategies was prepared for final review by hospital leaders. The KentuckyOne Health Board of Directors reviewed the Implementation Strategies process on October 26, 2016. Adoption and approval details are described at the end of this document.

New Features of 2017-19 Reports

To respond to the final 501(r) rules around CHNA and the IS reports and to further the transparency in our response to our community's health needs, we have descriptors included in the 2017-2019 reports additional to what was included in the 2013-2016 reports.

- We have included system-level initiatives that are a response to the community health needs, which has encouraged an increased alignment with strategy and with accreditation guidelines. This also demonstrates KentuckyOne Health's unique position to respond to community health needs by leveraging our state-wide health system's resources.
- We have listed more detailed and transparent resources committed to addressing the strategies in place.
- We have created evaluation metrics for determining the success of our strategies, including linking community benefit as a component of evaluation.
- We increased the rigor and validity of our chosen strategic objectives, measurements, and evaluation plans. Strategies and accompanying metrics were developed based on evidence-based gold standard practices identified through extensive literature review. Citations documenting studies supporting these evidence based, gold-standard strategic approaches are included to increase transparency and document the validity of these approaches.
- Finally, we have included a widely-used public health resource (the community health improvement matrix) to display how our strategies are designed to work together. This is discussed later in this document.

Strategies to Address Significant Health Needs

The charts below detail Saint Joseph London's identified community needs, the goals it has set as a means of addressing those needs, and the strategies that will forward each goal.

Tobacco Use

Goal 1: Address tobacco use from a KentuckyOne Health system-wide approach; this is a primary prevention to tobacco use.

Strategy	*Target Population*	*Action Plan with Objective*	*Committed Resources*	*Evaluation Plan*	*External Partner(s)*
1.1. State-wide smoke-free law	Broader Community	Advocate for legislation that would prohibit smoking in indoor workplaces and public places, including restaurants, bars, and hotels.	The KentuckyOne Health Advocacy and Public Policy department is committed to leading this effort.	Update any progress towards this strategy in annual legislative priorities report.	Kentucky State Government
1.2. Advocate for Increasing Cigarette Tax	Broader Community	Include advocacy for increasing the cigarette tax on 2017 legislative priorities agenda.	The KentuckyOne Health Advocacy and Public Policy department is committed to leading this effort.	Update any progress towards this strategy in annual legislative priorities report.	Kentucky State Government
1.3. Insurance Coverage for Tobacco Cessation	Broader Community	Advocate requiring insurance companies to pay for evidence-based smoking cessation treatments.	The KentuckyOne Health Advocacy and Public Policy department is committed to leading this effort.	Update any progress towards this strategy in annual legislative priorities report.	Kentucky State Government
1.4. Health in All Policies and Practices	Broader Community	Create Health in All Policies and Practices (HiAPP) document for guidance on the health implications of organizational decisions in order to improve population health and health equity.	The KentuckyOne Health SVP of Population Health is drafting this document for the organization.	Improve accountability for health impacts at all levels of decision-making within the organization.	N/A

Goal 2: Support local groups and events that have a mission to address tobacco prevention; this is a primary prevention to tobacco use.

Strategy	*Target Population*	*Action Plan with Objective*	*Committed Resources*	*Evaluation Plan*	*External Partner(s)*
2.1. Laurel County Health Department	Broader Community	Continue to collaborate on the Tri-County Cancer Coalition to address tobacco prevention in Laurel County.	Mission Leader (Lisa Rutherford) will lead this effort.	Annually, identify a minimum of one opportunity to collaborate with the health department on tobacco prevention efforts.	Laurel County Health Department
2.2. Tri-County Cancer Coalition	Broader Community	Continue to collaborate on the Tri-County Cancer Coalition to address tobacco prevention in Laurel County.	Mission Services and Healthy Communities will lead this effort. Attendance of KOH employee at 80% of coalition meetings.	Annually, ensure at least one KOH employee sits on this coalition and is counted toward community benefit.	• Laurel County Health Depart. • Tri-County Cancer Coalition • KCP • American Cancer Society • Baptist Health • Whitley County Health Dept. • Hospice of the Bluegrass
2.3. Clean Air Ordinance for Workplaces	Broader Community	Support clean-air ordinance expansion for Laurel County to include e-cigarettes. Annually, identify a minimum of one opportunity to advocate for legislation that would prohibit smoking and e-cigarette use in indoor workplaces.	Healthy Communities will lead this effort.	Annually, identify at least three efforts undertaken.	• Laurel County Health Depart. • Health in Motion Coalition

Strategy	*Target Population*	*Action Plan with Objective*	*Committed Resources*	*Evaluation Plan*	*External Partner(s)*
2.4. Education and Health Fairs	Broader Community	Offer education, screenings, and information on tobacco use to inform prevention efforts. Annually, identify a minimum of three opportunities (i.e. health fairs, lunch and learn, seminars, workshops, news articles or interviews, presentations) to provide education or screening to community members on all forms of tobacco use and e-cigarettes, consequences of smoking, (i.e. prenatal, heart disease, cancer, diabetes) to promote tobacco prevention.	Healthy Communities will lead this effort.	Annually, identify at least three efforts undertaken.	• KCP • American Cancer Society • Laurel and East Bernstadt Schools Family Resource and Service Center

Goal 3: Improve tobacco cessation efforts through community education and advocacy; this is a secondary prevention to tobacco use.

Strategy	*Target Population*	*Action Plan with Objective*	*Committed Resources*	*Evaluation Plan*	*External Partner(s)*
3.1. Smoke-Free Campus Policy. Enforce smoke-free policy on hospital grounds by developing appropriate response/ policy for those smoking on hospital grounds.	Broader Community (Patients and Employees)	By 2nd quarter FY17, educate and equip managers to enforce tobacco-free policy. (employees, patients, visitors)	Human Resources Department will lead education and training, Human Resources and Security will enforce policy for this effort.	Education and training by end of 1st quarter FY17.	N/A
		By 2nd quarter, tobacco-free signage updated on SJL grounds/facilities.	HR Dept. will lead education/training and implementation of new signage with Plant Ops.	Tobacco-free signage updated by 2nd quarter FY17.	N/A
		By end of FY18 and FY19, evaluate for effectiveness and identify areas of potential improvement.	HR monitoring in conjunction with review of Iris Reports, Patient Satisfaction Surveys, security incidents, maintenance staff observations of parking lots/walkways.	Review incidents, comments, and complaints regarding smoke-free policy and discuss with facility leadership.	N/A
		By end of FY17, evaluate the feasibility of developing a tobacco cessation program aimed at employees and their families (i.e. cessation classes, support groups, provision of cessation aids, and healthcare premium reductions for non-smokers. Healthy Spirit Workshop) to facilitate smoking cessation among employees to promote community smoking cessation.	Human Resources and Employee Health and Wellness will lead this effort.	Feasibility evaluation completed by end of FY17. If feasible, implement program in FY18 and FY19.	Laurel County Health Depart.

Strategy	*Target Population*	*Action Plan with Objective*	*Committed Resources*	*Evaluation Plan*	*External Partner(s)*
3.2. Tobacco cessation education and services. Offer education, screenings, and information to support tobacco cessation ion efforts.	Broader Community	Annually, identify a minimum of three opportunities (i.e. support groups, seminars, workshops, presentations, Great American Smoke-Out) to provide education, screening or support services to community members on all forms of tobacco use cessation.	Healthy Communities will lead this effort.	Annually, identify at least three efforts undertaken.	• Laurel County Health Depart. • Tri-County Cancer Coalition • KCP • American Cancer Society • Baptist Health • Whitley County Health Dept. • Hospice of the Bluegrass
		By end of FY17, evaluate the feasibility of developing a tobacco cessation program aimed at youth under 18 to facilitate smoking cessation at an earlier age.	Healthy Communities will lead this effort.	Feasibility evaluation completed by end of FY17. If feasible, implement program in FY 18 and FY19.	• UK Extension Office • KCP • American Cancer Society
	Broader Community (Patients)	By end of FY17, develop and implement a cessation plan for patients (i.e. pregnancy, cancer, at discharge) who are current smokers.	Nursing Administration and Physicians will lead this effort.	Development and implementation of smoking cessation planning by end of FY17.	N/A
		By end of FY18 and FY19, evaluate for effectiveness and identify areas of potential improvement.	Nursing Administration and Physicians will lead this effort.	Smoking cessation planning in place for 75% of patients as part of treatment phase and confirmed at discharge.	N/A

Goal 4: Align efforts with Commission on Cancer triennial community health assessment (completed by KentuckyOne Health Cancer Care) to address the impact of cancer; this is a tertiary response to tobacco use.

Strategy	*Target Population*	*Action Plan with Objective*	*Committed Resources*	*Evaluation Plan*	*External Partner(s)*
4.1. Tobacco Cessation Strategy Partnerships. Establish partnerships with Kentucky Cancer Program on Plan to Be Tobacco Free and American Cancer Society Quit Line as tobacco cessation strategies.	Broader Community (Patients)	Partner with Kentucky Cancer Program on Plan to Be Tobacco Free as a tobacco cessation strategy. Establish partnership by end of FY 2017. Continuation of partnership in FY18 and FY19.	KentuckyOne Health Cancer Care will lead this effort.	Annual review at end of FY17.	Kentucky Cancer Program
	Broader Community (Patients)	Partner with American Cancer Society on Quit Line referrals as a tobacco cessation strategy. Establish partnership by end of FY 2017. Continuation of partnership in FY18 and FY19.	KentuckyOne Health Cancer Care will lead this effort.	Annual review at end of FY17.	American Cancer Society
	Broader Community (Patients)	Evaluate use of Mayo Clinic smoking cessation program. Evaluate program by end of FY 2017. If indicated, begin program offering in FY18 and FY19.	KentuckyOne Health Cancer Care will lead this effort.	Annual review at end of FY17.	Mayo Clinic
4.2. Tobacco Cessation Support. Expand behavioral and pharmacological counseling for cancer patients who continue to smoke.	Broader Community (Patients)	Annually, evaluate number of behavioral and pharmacological services offered to patients. Establish baseline measures at end of FY 2017. Increase of services each year for FY18 and FY19.	KentuckyOne Health Cancer Care will lead this effort.	Annual review at end of fiscal year.	Identify annually based on efforts undertaken.

Strategy	*Target Population*	*Action Plan with Objective*	*Committed Resources*	*Evaluation Plan*	*External Partner(s)*
4.3. Automated Process for Lung Screenings.	Broader Community (Patients)	Develop and implement an automated process for lung screening to ease the ordering and patient follow-up. Annually, evaluate number of All Scripts automated screening metrics for automated lung screening process. Develop automated process for lung screening by end of FY17. Increase of services each year for FY18 and FY19.	The KentuckyOne Health Oncology Service Line will lead this effort.	Annual review at end of fiscal year.	All Scripts
4.4. Lung Accreditation Program (LAP)	Broader Community (Patients)	Develop and implement a lung accreditation program to address gaps in care and strengthen access to screening, prevention, and treatment. During FY17, evaluate existing systems, identify gaps in care, and develop program to strengthen access to care. During FY18, implement LAP.	The KentuckyOne Health Oncology Service Line will lead this effort.	Successful evaluation of existing programs for LAP by end of FY17. Review at end of FY17. Successful implementation of LAP by end of FY18.	(Not Applicable)

Diet and Exercise

Goal 1: Promote healthy options for diet and exercise from a KentuckyOne Health system-wide approach; this is a primary prevention related to diet and exercise.

Strategy	*Target Population*	*Action Plan with Objective*	*Committed Resources*	*Evaluation Plan*	*External Partner(s)*
1.1. Kentucky Proud products	Broader Community	Begin discussions with Commissioner of Agriculture to discuss feasibility of having hospitals participate in Kentucky Proud Program to have local food used in hospital foodservice and available for resale in hospitals.	The KentuckyOne Health Advocacy and Public Policy department is committed to leading this effort with guidance from Food and Nutrition Services.	Update progress on Kentucky Proud eligibility in annual legislative priorities report.	Kentucky State Department of Agriculture
1.2. Encourage healthy lifestyles as a cost-control measure.	Broader Community	Support legislation to provide tax and other incentives for the creation of wellness programs enabling businesses to educate and encourage employees to engage in healthy lifestyles and obtain preventative care.	The KentuckyOne Health Advocacy and Public Policy department is committed to leading this effort.	Update progress in annual legislative priorities report.	• Kentucky State Govern-ment • Kentucky Chamber
1.3. Keep Children Healthy	Broader Community (Youth)	Advocate for initiatives that address the risk factors that lead to obesity and chronic diseases in children.	The KentuckyOne Health Advocacy and Public Policy department is committed to leading this effort.	Update progress in annual legislative priorities report.	Kentucky State Government
1.4. CHI Healthy Food and Wellness Initiative	Broader Community	Annually, identify a minimum of one opportunity to support and implement initiatives to support the CHI healthy food and wellness initiative.	Food and Nutrition Services (Amanda Goldman) is committed to leading this effort.	Annually, identify at least one effort undertaken.	Catholic Health Initiatives

Goal 2: Support local groups and events that have a mission to promote healthy diet and exercise to prevent negative health outcomes; this is a primary prevention related to diet and exercise.

Strategy	*Target Population*	*Action Plan with Objective*	*Committed Resources*	*Evaluation Plan*	*External Partner(s)*
2.1. Farmer's Market	Broader Community	Collaborate with the local farmer's Market to promote healthy diet options for Laurel County. Annually, identify a minimum of one opportunity to promote the local Farmer's Market (i.e. double dollars program, new site expansion) to promote healthy diet in Laurel County.	Healthy Communities and Diabetes and Nutrition Care will lead this effort.	Annually, identify at least one effort undertaken.	• Farmer's Market • UK Extension Office • London Downtown (Brittany Cradic)
2.2. Education and Health Fairs	Broader Community	Offer education, screenings, and information on diet and exercise to inform prevention efforts. Annually, identify a minimum of three opportunities (i.e. health fairs, lunch and learn, seminars, workshops, news articles or interviews, presentations, community cooking classes) to provide education or screening to community members on diet and exercise (i.e. prenatal, heart disease, cancer, diabetes) to aid in prevention of negative health outcomes.	Healthy Communities (Rita Taylor) will lead this effort.	Annually, identify at least three efforts undertaken.	Partnership with local community and agencies. Varies year to year.

Goal 3: Increase available resources to address consequences of negative health outcomes related to poor diet and lack of exercise; this is a secondary response related to diet and exercise.

Strategy	*Target Population*	*Action Plan with Objective*	*Committed Resources*	*Evaluation Plan*	*External Partner(s)*
3.1. Improve KOH Accessibility to Healthy Diet and Exercise. Establish opportunities for improved diet and exercise to address barriers to access.	Broader Community (Patients and Families)	By end of FY 18 establish a Saint Joseph London wellness committee.	Dietary and Nutrition Services (Sodexo), Healthy Spirit Committee, and Healthy Communities will lead this effort.	In FY18 identify committee establishment. Continuation of committee in FY19.	UK Extension Office
	Broader Community (Employees)	Annually, identify a minimum of three opportunities implemented to promote healthy diet and exercise within KOH facilities for employees and their families (i.e. free pre-diabetes or diabetes education class, more exercise classes at employee gym, personal trainer in employee gym, ease into exercise programs, desk exercise education (LFCHD), weekly Weight Watcher's meetings, more activities at change of shift, group walking, annual employee wellness program, Healthy Spirit Workshops).	Healthy Spirit (Sharon Hershberger, Contact) and Dietary (Sodexo) will lead this effort.	Annually, identify at least three efforts undertaken.	Power House Gym
	Broader Community (Patients and Families)	Annually, identify a minimum of three opportunities implemented to promote healthy diet and exercise within KOH facilities (i.e. healthy choices in vending machines, meal planning through dietitians, healthy recipes on website, outdoor walking track).	Healthy Spirit (Sharon Hershberger, Contact) and Dietary (Sodexo) will lead this effort.	Annually, identify at least three efforts undertaken.	N/A
	Broader Community (Patients)	Annually, promote at least three programs to provide diet and exercise promotion to the community through marketing efforts.	Marketing will lead this effort.	Annually, identify at least three efforts undertaken.	• Local newspaper • PSA's

Strategy	*Target Population*	*Action Plan with Objective*	*Committed Resources*	*Evaluation Plan*	*External Partner(s)*
3.2. Walk with a Doc.	Broader Community	Provide Walk With a Doc opportunities to promote exercise and education opportunities to the community. Offer Walk with a doc monthly in FY17-19.	The Healthy Communities staff will lead this effort.	Annually, offer WWAD at least 6 months of the year.	• Laurel County Health Dept. • Walk with a Doc
3.3. Expand diet and exercise partnerships. Pursue opportunities to develop or expand on partnerships to increase access to resource related to diet and exercise.	Broader Community	Annually, promote at least one collaboration with the police department to promote physical activity and wellness education in Laurel County (i.e. National Night Out).	Healthy Communities (Rita Taylor) will lead this effort.	Annually, identify at least one effort undertaken.	London City Police
		Annually, identify at least one opportunities to collaborate with the Cooperative Extension Office to educate or teach healthy diet and exercise options to community members to address diabetes or chronic disease management.	Healthy Communities (Rita Taylor) and Dietitian (Melinda Hinkle) will lead this effort.	Feasibility evaluation completed by end of FY17. If feasible, implement program in FY18 and FY19.	• UK Extension Office • Laurel County Health Dept.

Strategy	*Target Population*	*Action Plan with Objective*	*Committed Resources*	*Evaluation Plan*	*External Partner(s)*
3.4. Identify opportunities for new program development to address positive impact of diet and exercise for existing conditions. Pursue opportunities to develop or expand services to utilize diet and exercise to impact existing health conditions.	Broader Community	By end of FY17, evaluate the feasibility of establishing an urban farm/community garden at the prior hospital site. This could be a Mission and Ministry grant proposal.	Healthy Communities (Rita Taylor) will lead this effort.	Feasibility evaluation completed by end of FY17. If feasible, implement program in FY18 and FY19.	• Laurel County Health Dept. • Walk with a Doc
		By end of FY17, evaluate the feasibility of collaborating with the African American Heritage Center to develop a garden.	Healthy Communities (Rita Taylor) will lead this effort.	Feasibility evaluation completed by end of FY17. If feasible, implement program in FY18 and FY19.	• African American Heritage Center • Grow Appalachia
		By end of FY 17, evaluate the feasibility of a telehealth initiative for nutrition education pilot project.	Telehealth (Deb Burton), Community Outreach, and Healthy Communities will lead this effort.	Feasibility evaluation completed by end of FY17. If feasible, implement program in FY18 and FY19.	N/A
	Broader Community (Patients)	Support hospital dietitian efforts in becoming a certified diabetes educator.	Diabetes and Nutrition Service will lead this effort.	Implement process in FY18 and FY19.	N/A

Goal 4: Provide support for programs addressing condition management and survivorship through diet and exercise; this is a tertiary response related to diet and exercise.

Strategy	*Target Population*	*Action Plan with Objective*	*Committed Resources*	*Evaluation Plan*	*External Partner(s)*
4.1. Promote Community Events for Disease Research and Survivorship	Broader Community	Promote community walks and runs to support survivorship, research, and assist in fundraising for treatment of diseases. Annually, identify at least three community walks or runs; promote participation and support of disease management, treatment, research, and survivorship (i.e. March of Dimes, Relay for Life, Go Red for Women, and Ride for ALA).	The KentuckyOne Health Oncology Program will lead this effort.	Annually, identify at least three efforts undertaken.	Identify annually based on efforts undertaken.

Alcohol and Drug Use

Goal 1: Address alcohol and drug use from a KentuckyOne Health system-wide approach, including working upstream to address the mental health issues that can underlie substance abuse. This is a primary prevention to alcohol and drug use.

Strategy	*Target Population*	*Action Plan with Objective*	*Committed Resources*	*Evaluation Plan*	*External Partner(s)*
1.1. Availability of Naloxone	Broader Community	Continue to support legislation allowing the Kentucky Harm Reduction Coalition to dispense Naloxone.	The KentuckyOne Health Advocacy and Public Policy department is committed to leading this effort on behalf of KentuckyOne Health hospitals.	Update progress in annual legislative priorities report	• Kentucky State Government • Kentucky Harm Reduction Coalition
1.2. Increase access to mental health services.	Broader Community	Leverage expertise in mental health to increase access to mental health services via telehealth programs that allow KentuckyOne Health staff to operate programs in communities that do not have sufficient mental health services to serve need.	The KentuckyOne Health Strategy department is leading this effort with expertise from Our Lady of Peace.	Evaluate for progress on expanding access to mental health programs.	Potentially other health care organizations
1.3. Seek grant opportunities to address mental health needs.	Broader Community (Vulnerable Populations)	Pursue various private, state, and federal funding for programs to address mental health needs that can underlie substance abuse.	The KentuckyOne Health Grant Office is pursuing this funding on behalf of KentuckyOne Health hospitals.	Report funding in annual hospital Foundation reports.	Can Include: • SAMHSA • Kentucky Dept. for Behavioral Health

Goal 2: Support local groups and events that have a mission to prevent alcohol and drug use; this is a primary prevention to alcohol and drug use.

Strategy	*Target Population*	*Action Plan with Objective*	*Committed Resources*	*Evaluation Plan*	*External Partner(s)*
2.1. Support Laurel County Alcohol and Drug Prevention Initiatives.	Broader Community	Continue to collaborate with Laurel Health Department to address issues surrounding alcohol and drug use. Annually, identify a minimum of three opportunities to support Laurel County drug and alcohol prevention efforts (i.e. drug take back program, local and regional substance abuse coalitions, Hooked on Fish not on Drugs event, Old time Cruise In for Prevention).	Healthy Communities and Mission Leader (Lisa Rutherford) will lead this effort.	Annually, identify at least three efforts undertaken.	• Laurel County Health Dept. • Operation Unite
2.2. Clean Needle Exchange	Broader Community	Collaborate with the Laurel County Health Department to support clean needle exchange program to prevent spread of HIV, Hepatitis C, etc. through use of contaminated needles. Annually, identify a minimum of three opportunities to support Laurel County drug and alcohol prevention efforts (i.e. drug take back program, local and regional substance abuse coalitions, Hooked on Fish not on Drugs event, Old time Cruise In for Prevention).	Healthy Communities (Rita Taylor) will lead this effort.	Annually, identify at least one effort undertaken.	• Laurel County Health Dept. • Operation Unite

Strategy	*Target Population*	*Action Plan with Objective*	*Committed Resources*	*Evaluation Plan*	*External Partner(s)*
2.3. Behavioral Health Coalition	Broader Community	Reestablish Behavioral Health coalition. Align substance abuse prevention efforts with statewide efforts. Third quarter of 2017: re-establishment of SJL Behavioral l Health Coalition. Fourth quarter of 2017: work with EKU to implement student lead support group in second quarter of 2018. By fourth quarter of2018, work to align substance abuse prevention efforts with statewide efforts.	Healthy Communities (Rita Taylor) will lead this effort.	Reestablishment of Behavioral Health monthly Coalition (monthly student led support groups).	Identify annually based on efforts undertaken.

Goal 3: Increase available resources to address consequences of negative health outcomes related to alcohol and drug use; this is a secondary response related to alcohol and drug use.

Strategy	*Target Population*	*Action Plan with Objective*	*Committed Resources*	*Evaluation Plan*	*External Partner(s)*
3.1. Develop KOH staff protocols for addiction response. Develop protocols to address staff addiction issues.	Broader Community (Patients)	By the end of FY18, develop a protocol at screen and address alcohol or drug addiction for patients to begin during treatment process, not only on day of discharge (i.e. behavioral health referrals to OLOP for assessment/treatment).	Nursing and Senior Leadership will lead this effort.	Protocol development completed by end of FY18. Implement program in FY19. Annual review at end of fiscal year.	N/A
	Broader Community (Employees)	Annually, provide education to employees on how to handle alcohol and substance use in patients (i.e. who to inform, possible medication concerns, and safety).	Women's Health and Clinical Education will lead this effort.	Annually, identify at least one effort undertaken.	N/A
	Broader Community (Patients)	By end of FY17, develop a program or protocol to address drug seeking/drug affected patients in the ED.	ED leadership will lead this effort.	Program or protocol development completed by end of FY17. Implement program or protocol in FY18 and FY19.	N/A

Strategy	*Target Population*	*Action Plan with Objective*	*Committed Resources*	*Evaluation Plan*	*External Partner(s)*
3.2. Identify opportunities for new program development to address alcohol and drug use. Pursue opportunities to develop or expand services to address alcohol and drug use.	Broader Community (Employees)	By end of FY17, explore the feasibility of providing 100% covered alcohol or drug treatment for employees who seek help.	Human Resources will lead this effort.	Feasibility evaluation completed by end of FY17. If feasible, implement program in FY 18 and FY19.	N/A
	Broader Community	By end of FY17, explore the feasibility of developing a clean and sober hiring program for prior offenders to offer a second chance.	Human Resources will lead this effort.		N/A
	Broader Community	By end of FY18, explore the feasibility of developing a Neonatal Abstinence Program to address pregnancy among drug using women.	Women's Health and Perinatal education will lead this effort.	Annual review at end of fiscal year. If feasible, implement program in FY 18 and FY19.	London Women's
	Broader Community	By end of FY18, explore the feasibility of expanding telehealth opportunities for alcohol and drug counseling.	Telehealth (Deb Burton) and Healthy Communities will lead this effort.	Feasibility evaluation completed by end 2nd Q FY18. If feasible, implement program in FY 18 and FY19.	Our Lady of Peace
	Broader Community	Annually, explore the feasibility of establishing a drug rehabilitation program (i.e. inpatient, outpatient, community detox program for patients with comorbidities complicating detox, 30-day sliding scale program, regional behavioral health services) to address the growing addiction epidemic.	Chief Medical Officer will lead this effort.	Annual review at end of fiscal year. Annual review at end of fiscal year.	Our Lady of Peace
	Broader Community (Teens)	Annually, explore the feasibility of establishing a program to address alcohol and drug use in youth (i.e. school programs, Student Ambassador Campaign, recidivism, intensive outpatient substance abuse program).	Healthy Communities (Rita Taylor) will lead this effort.		• Operation Unite • Health in Motion Coalition • Local School Systems

Goal 4: Provide support for programs addressing long-term condition management for individuals affected by alcohol and drug use; this is a tertiary response related to alcohol and drug use.

Strategy	*Target Population*	*Action Plan with Objective*	*Committed Resources*	*Evaluation Plan*	*External Partner(s)*
4.1. Community Support Groups. Promote community support groups for alcohol and drug use.	Broader Community (Patients)	Annually, identify at least three opportunities to collaborate with existing addiction programs (i.e. alcoholics anonymous, narcotics anonymous, teens anonymous, Celebrate recovery, Drug Court Walk) within the community through strengthening partnerships with organizations offering these programs.	Healthy Communities (Rita Taylor) will lead this effort.	Annually, identify at least three efforts undertaken.	Identify annually based on efforts undertaken.
		By end of FY17, develop a protocol for referring patients to support groups within their community as part of discharge planning.	Nursing Leadership will lead this effort.	Protocol development completed by end of FY18. Implement program in FY19.	Identify annually based on efforts undertaken.
	Broader Community (Employees)	By end of FY17, develop a protocol for referring employees to support groups as needed.	Human resources (EAP program) will lead this effort.	Protocol development completed by end of FY18. Implement program in FY19.	Identify annually based on efforts undertaken.

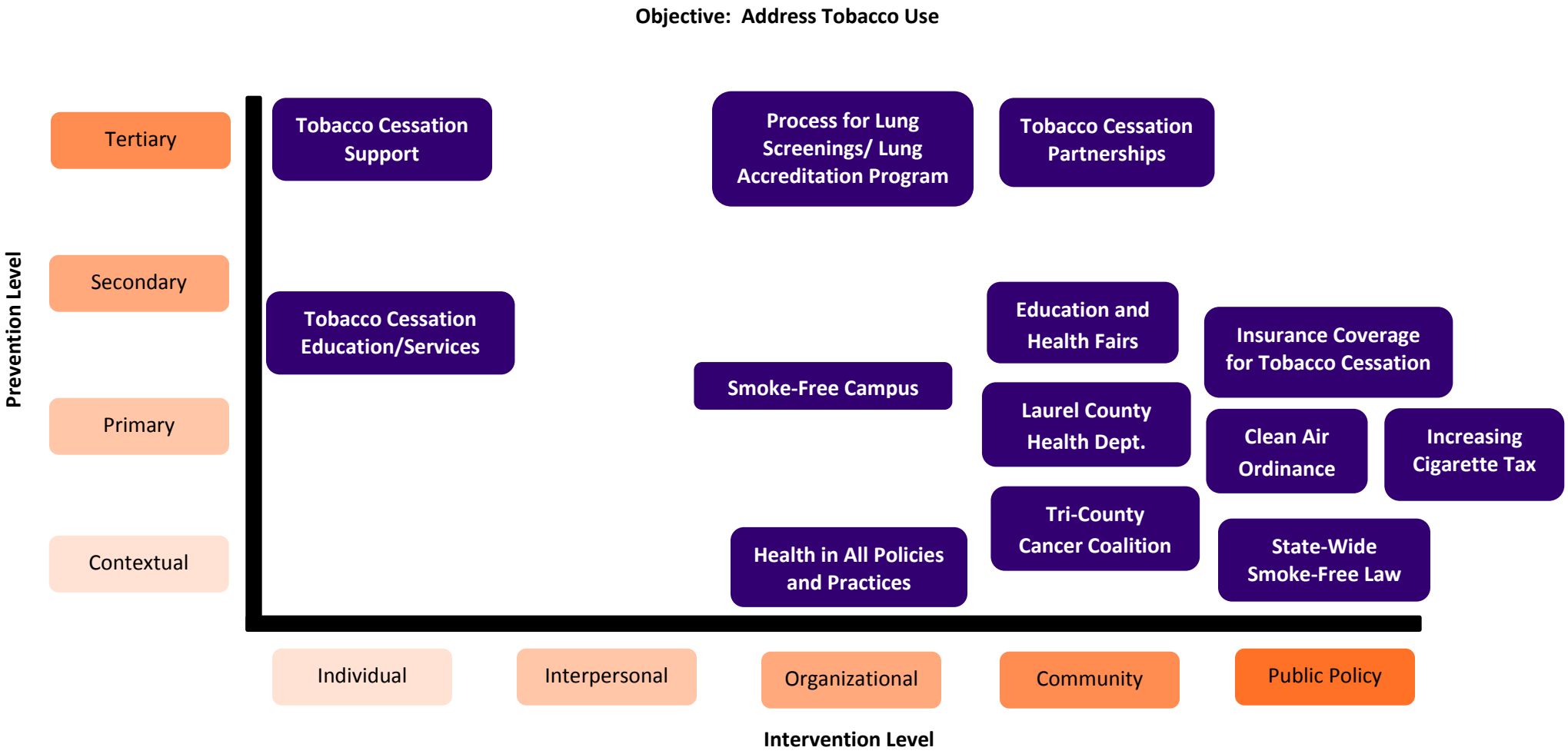
Graphic Representation of Implementation Strategies

The National Association of County & City Health Officials (NAACHO) provided the outline for a community health improvement matrix that allowed us to graphically represent the depth and breadth of the strategies we implemented to address the health needs identified. The matrix shows each strategy's place on an intervention level and a prevention level. Per NAACHO, these levels are defined below.

- **Prevention Levels:** Prevention aims to minimize the occurrence of disease or its consequences. The levels include:
  - **Contextual:** Prevent the emergence of predisposing social and environmental conditions that can lead to causation of disease.
  - **Primary:** Reduce susceptibility or exposure to health threats.
  - **Secondary:** Detect and treat disease in early stages.
  - **Tertiary:** Alleviate the effects of disease and injury.
- **Intervention Levels:** Intervention levels are built on a socio-ecological model that recognizes different factors affecting health.
  - **Individual:** Characteristics of the individual such as knowledge, attitudes, behavior, self-concept, skills, etc. Includes the individual's developmental history.
  - **Interpersonal:** Formal and informal social network and social support systems, including family, work group, and friendship networks.
  - **Organizational:** Social institutions with organizational characteristics and formal (and informal) rules and regulations for operation.
  - **Community:** Relationships among organizations, institutions, and informal networks within defined boundaries.
  - **Public Policy:** Local, state, and national laws and policies.

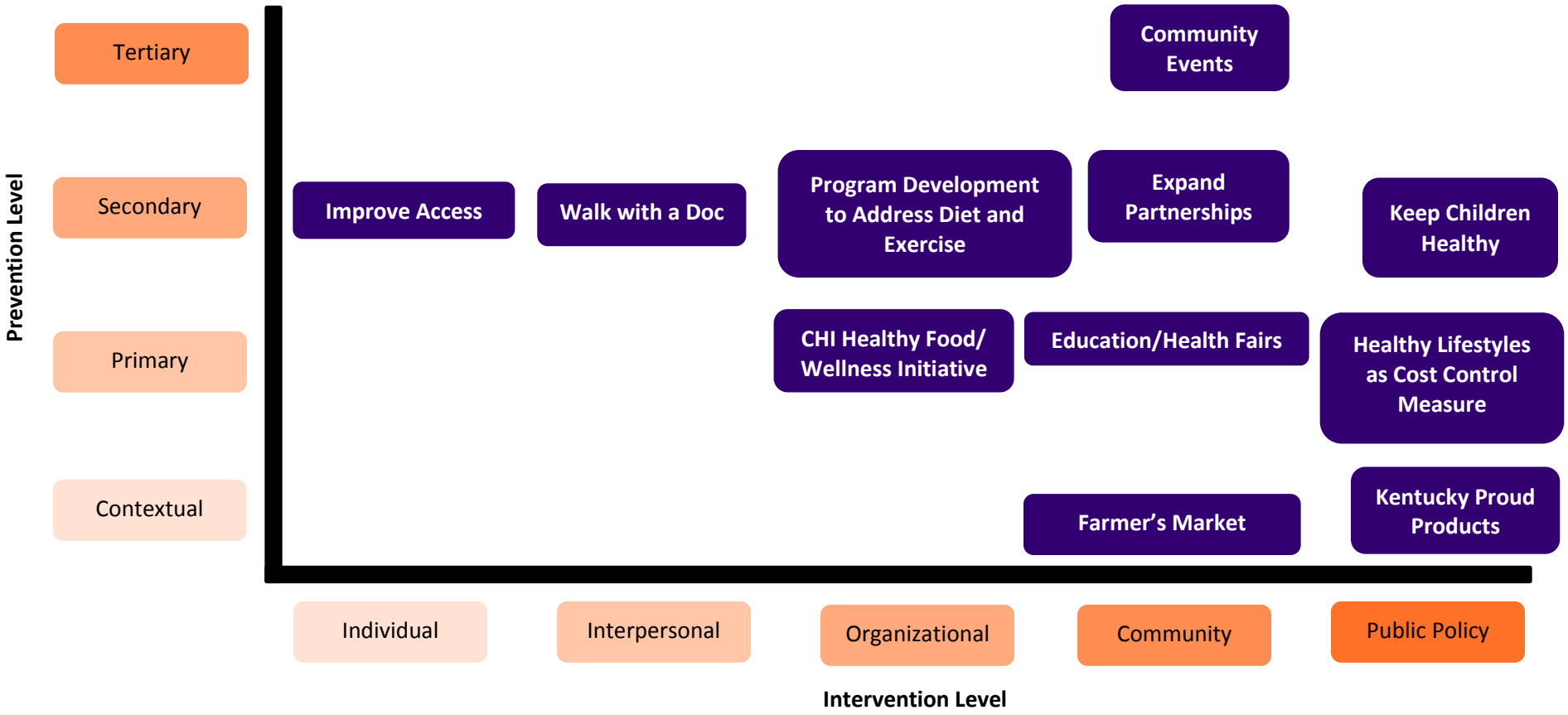
For more information about NAACHO's community health improvement matrix, please see the "References" section of this document.

Strategies According to Community Health Improvement Matrix: Tobacco Use

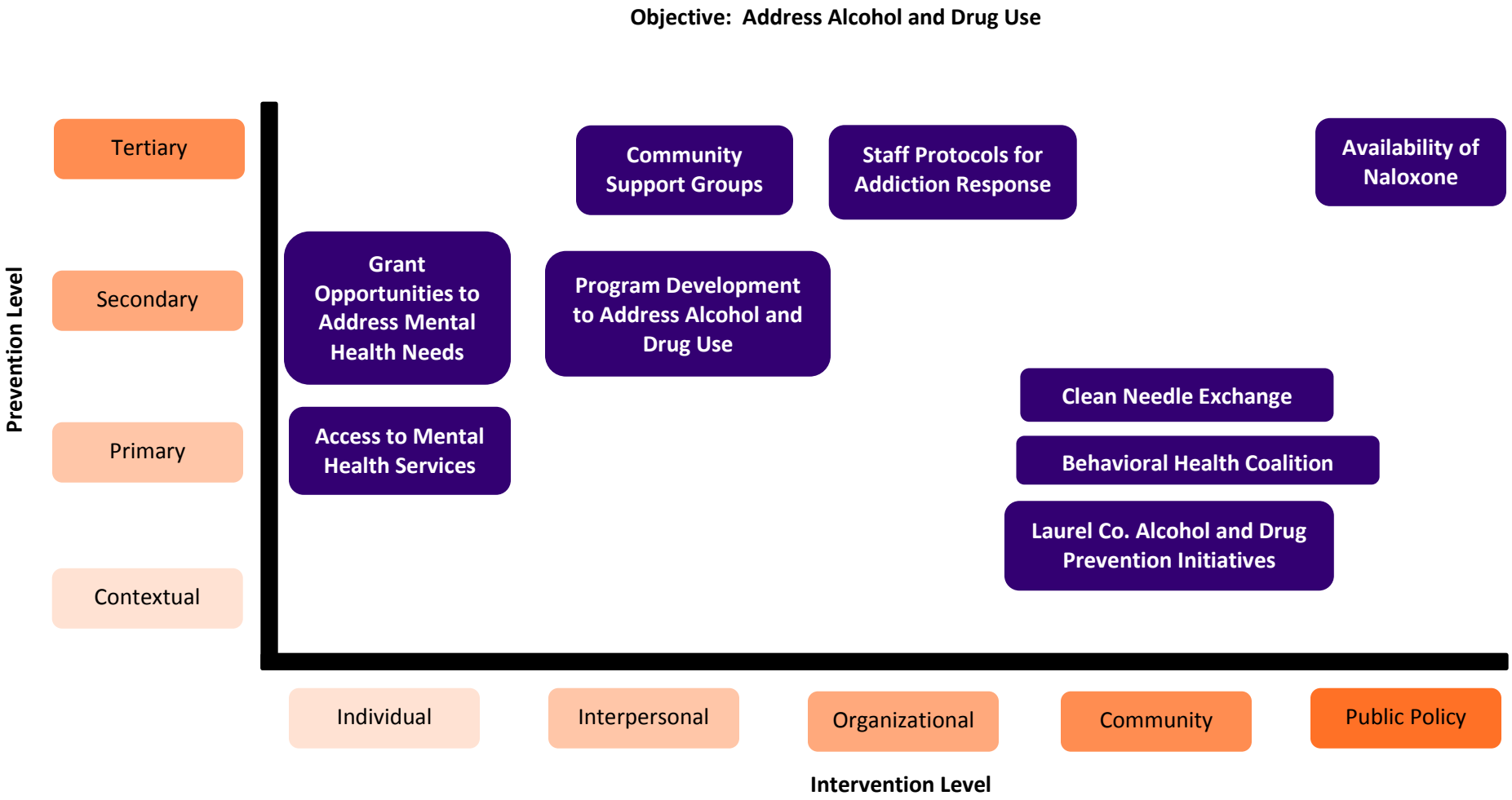


Strategies According to Community Health Improvement Matrix: Diet and Exercise

Objective: Address Diet and Exercise



Strategies According to Community Health Improvement Matrix: Alcohol and Drug Use

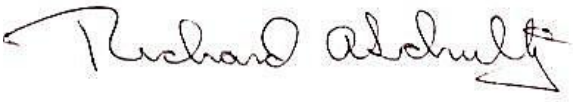


Next Steps

Saint Joseph London's Implementation Strategy report will outline the response to the community's health needs through June 20, 2019. This document will be made public and widely available no later than November 15, 2016. Saint Joseph London is committed to conducting another community health needs assessment and implementation strategy within three years.

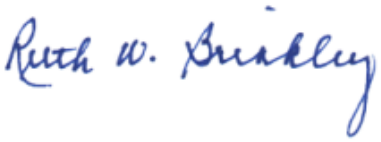
Adoption/Approval

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 Saint Joseph London's Implementation Strategy that has been developed to address the priorities of the most recent Community Health Needs Assessment.



10/26/2016

Chair, KentuckyOne Health Board of Directors — Date



10/26/2016

President & Chief Executive Officer, KentuckyOne Health — Date

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