2025 Community Health Implementation Strategy and Plan

Adopted September 2025

CHI Saint Joseph Health
Saint Joseph East

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At-a-Glance Summary

Community Served 	Saint Joseph East serves residents in Clark, Fayette, Jessamine, Laurel, Madison, Montgomery, and Scott counties, Kentucky.
Significant Community Health Needs Being Addressed 	The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). • **Diabetes** • **Heart Disease and Stroke** • **Nutrition, Physical Activity and Weight**
Strategies and Programs to Address Needs 	The hospital intends to take actions and to dedicate resources to address these needs, including: • **Health screenings and efforts to prevent disease and better manage chronic health conditions** • **Partnerships with diverse organizations to provide education and outreach to populations most at risk for health disparities** • **Collaborate with community partners to provide education that addresses Social Determinants of Health and encourages healthy behaviors**

Planned resources and collaborators to help address these needs, as well as anticipated impacts of the strategies and programs, are described in the "Strategies and Program Activities by Health Need" section of the document.

This document is publicly available on the hospital's website. Written comments on this strategy and plan can be submitted to the Community Health Department, Saint Joseph East, 150 N. Eagle Creek Drive, Lexington, Kentucky, 40509 or by e-mail to sherri.craig@commonspirit.org.

Our Hospital and the Community Served

About the Hospital

CHI Saint Joseph Health is one of the largest and most comprehensive health systems in the Commonwealth of Kentucky. It consists of 100 locations in 20 counties, including hospitals, physician groups, clinics, primary care centers, specialty institutes and home health agencies. In total, the health system serves patients in 43 Kentucky counties.

Saint Joseph East is a 217-bed full-service community hospital located in the southeastern section of Lexington, Kentucky. Established in 1983, the facility serves residents of central and eastern Kentucky. At Saint Joseph East, ambulatory surgery, 24-hour emergency care and women's health services are supported through a vast array of inpatient and outpatient programs.

CHI Saint Joseph Health is dedicated to building healthier communities by elevating patient care. The health system is guided by its strong mission, faith-based heritage and its work through local partnerships to expand access to care in the communities it serves.

CHI Saint Joseph Health is a member of CommonSpirit Health, one of the largest nonprofit health systems in the U.S., with more than 2,200 care sites in 24 states coast to coast, serving patients in big cities and small towns across America.

Our Mission

The hospital's dedication to assessing significant community health needs and helping to address them in conjunction with the community is in keeping with its mission. As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Financial Assistance for Medically Necessary Care

It is the policy of CommonSpirit Health to provide, without discrimination, emergency medical care and medically necessary care in CommonSpirit hospital facilities to all patients, without regard to a patient's financial ability to pay.

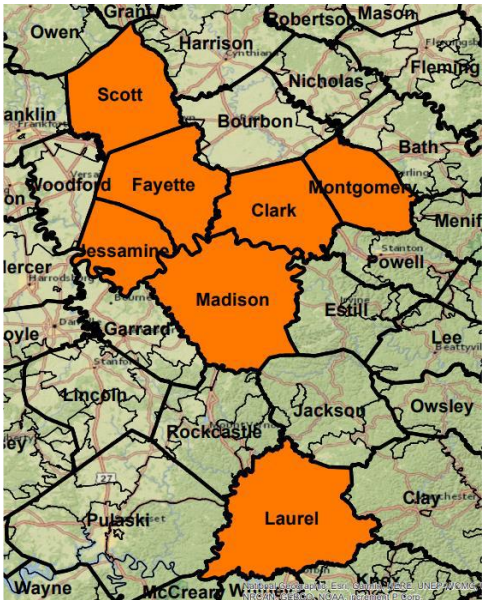
This hospital has a financial assistance policy that describes the assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for such care, and who meet the eligibility criteria for such assistance. The financial assistance policy, a plain language summary and related materials are available in multiple languages on the hospital's website.

Description of the Community Served

The study area for Saint Joseph East for the 2025 CHNA was determined based on the ZIP Codes of residence of recent patients of Saint Joseph East.

The hospital's primary service area is comprised of 52 ZIP Codes in these Kentucky counties: Clark, Fayette, Jessamine, Laurel, Madison, Montgomery, and Scott.

Service Area ZIP Codes:
40004, 40012, 40013, 40020, 40048, 40051, 40107, 40385, 40403, 40404, 40405, 40475, 40334, 40337, 40353, 40358, 40701, 40702, 40729, 40737, 40740, 40741, 40744, 40745, 40769, 40324, 40340, 40356, 40370, 40379, 40390, 40391, 40502, 40503, 40504, 40505, 40506, 40507, 40508, 40509, 40510, 40511, 40512, 40513, 40514, 40515, 40516, 40517, 40575, 40312, 40348, 40456



Service Area Snapshot

Urbanization	74.6% Urban
Total Population Size	655,253
Race & Ethnicity Hispanic	6.4%
White	78.5%
Black	8.7%
Asian	2.5%
American Indian or Alaska Native	0.1%
Native Hawaiian/Pacific Islander	0.1%
Average Household Income	$93,898
Percent of Population Living in Poverty (Below 100% FPL)	15.22%
Unemployment Rate (December 2024)	4.3%
Percent of People Age 5 and Older Who are Non-English Speaking	2.3%
Percent of People Without Health Insurance	6.9%
Percent of People with Medicaid	25.3%
Health Professional Shortage Area	Yes
Medically Underserved Areas/Populations	Yes
Medically Underserved, Low Income, or Minority Populations	Multiple
Number of Other Hospitals Serving the Community	11

Community Assessment and Significant Needs

The health issues that form the basis of the hospital's community health implementation strategy and plan were identified in the most recent CHNA report, which was adopted in May 2025. The CHNA report includes:

- description of the community assessed that is consistent with the hospital's service area;
- description of the assessment process and methods;
- data, information and findings, including significant community health needs;
- community resources potentially available to help address identified needs; and
- impacts of actions taken by the hospital since the preceding CHNA.

Additional details about the needs assessment can be found in the CHNA report, which is publicly available on the hospital's website or upon request from the hospital, using the contact information in the At-a-Glance Summary.

Significant Health Needs

The CHNA identified the significant needs in the table below, which also indicates which needs the hospital intends to address. Identified needs may include specific health conditions, behaviors or health care services, and also health-related social and community needs that have an impact on health and well-being.

Significant Health Need	Description	Intend to Address?
DIABETES	• Increasing diabetes prevalence • Earlier onset of disease and co-morbidities • Health disparities among African American and Hispanic communities • Impact of social drivers of health	•
HEART DISEASE AND STROKE	• Leading cause of death • Risk factors: high blood pressure, cholesterol • Health disparities • Impact of social drivers of health	•
NUTRITION, PHYSICAL ACTIVITY AND WEIGHT	• Increased obesity and overweight • Decreased physical activity • Food insecurity and access to healthy foods • Impact of social drivers of health	•
MENTAL HEALTH	• Residents rating their mental health as "poor" • Increased depression • Increased need for mental health treatment	
SUBSTANCE USE	• Unintentional drug-induced deaths • Higher use of prescription opioids • Residents impacted by substance use	

Significant Needs the Hospital Does Not Intend to Address

Saint Joseph East recognizes the increasing behavioral health needs of our patients and community members. We continue to screen patients for signs of depression and related mental health needs. When appropriate, we help patients connect with specialty care for advanced care. We will continue our commitment to providing care and support for mental health and substance use needs, and we acknowledge that these are not areas where Saint Joseph East has free or low cost services or other community benefit initiatives. However, we will continue to support the many organizations and providers that bring this distinct experience, expertise, and services to our community. In working to advance mental and physical wellbeing for all residents, we will focus our community benefit efforts in the areas where we can best lend expertise and leadership.

2025 Implementation Strategy and Plan

This section presents strategies and program activities the hospital intends to deliver, fund or collaborate with others to address significant community health needs over the next three years, including resources for and anticipated impacts of these activities.

Planned activities are consistent with current significant needs and the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant, such as changes in community needs or resources to address them.

Creating the Implementation Strategy

Saint Joseph East is dedicated to improving community health and delivering community benefit with the engagement of its staff, clinicians and board, and in collaboration with community partners. Saint Joseph East leadership convened a team of multidisciplinary staff to lead the development of the Implementation Strategy. Hospital and health system participants included representation of the following departments:

- Hospital Administration
- Advocacy and Community Health
- Providers, Clinicians, Nurses
- Care Coordination
- Social Work
- Mission and Community Benefit
- Communications
- Strategy and Planning
- Quality

Community input or contributions to this implementation strategy included responses from health and human service experts that participated in the CHNA Key Informant Survey.

The programs and initiatives described here were selected on the basis of:

- demonstrated success or impact in addressing community needs
- programs, services, and strategies that reduce health disparities
- programs, services, and strategies aimed at advancing health equity
- promising practices and expanding or adapting a partner's program
- increasing access to existing care and services
- expansion of proven programs to new communities

Community Health Core Strategies

Saint Joseph East believes that program activities to help address significant community health needs should reflect a strategic use of resources. CommonSpirit Health has established three core strategies for community health improvement activities. These strategies help to ensure that program activities overall address strategic aims while meeting locally identified needs.

- **Core Strategy 1**: Extend the care continuum by aligning and integrating clinical and community-based interventions.
- **Core Strategy 2**: Implement and sustain evidence-informed health improvement strategies and programs.
- **Core Strategy 3**: Strengthen community capacity to achieve equitable health and well-being.

Saint Joseph Health Systemwide Strategies and Resources

Programs, Services, Partnerships	Description
Community Health Improvement Grants	Grants to CBOs to address significant health issues identified in community health needs assessments to improve the health and well-being of underserved populations
Food is Medicine statewide initiative	Grant funding for local initiatives; partnerships with CBOs and schools; Pilot CSA in Lexington
Total Health Roadmap	Universal screening for social needs and embedding community health workers (CHWs) in interdisciplinary teams in family medicine, pediatrics, behavioral health, high-risk OB/GYN, and rural health clinics to help patients with social needs that compromise their health
Communications and Health Literacy	Education and information distributed systemwide via print, electronic, social media communications, and at interactions
Advocacy and Education	Share information with community stakeholders and policy makers to affect changes in health policies and address significant needs identified through the CHNAs
Health Equity Strategies	Medication access; violence prevention efforts include behavioral health and healthy behaviors (nutrition, exercise, etc.)
Telehealth Technology	Investments in telehealth platforms and technical support to increase access to care for primary and specialty care
Patient and Family as Partners	Engage and support activity and input to improve patient care and equitable service delivery; Ensure representatives reflect community served by health system

Vital Conditions and the Well-Being Portfolio

Community health initiatives at CommonSpirit Health use the Vital Conditions framework and the Well-Being Portfolio[1] to help plan and communicate about strategies and programs. Investments of time, resources, expertise and collaboration to improve health and well-being can take different approaches. And usually, no single approach can fully improve or resolve a given need on its own.

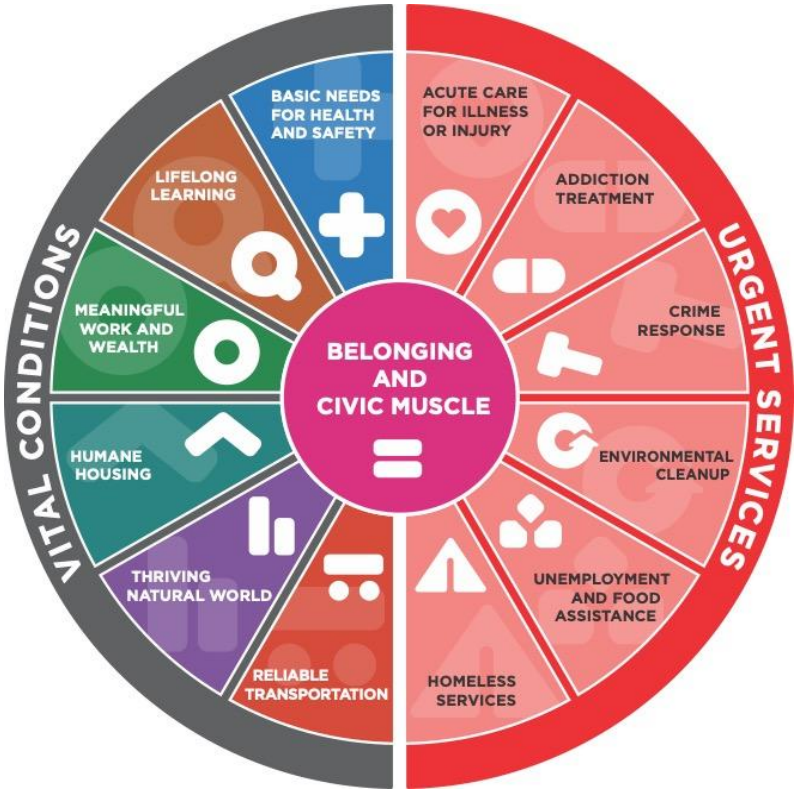
One way to think about any approach is that it may strengthen "vital conditions" or provide "urgent services," both of which are valuable to support thriving people and communities. A set of program activities may seek to do one or both. Taken together, vital conditions and urgent services compose a well-being portfolio.

What are Vital Conditions?
These are characteristics of places and institutions that all people need all the time to be healthy and well. The vital conditions are related to social determinants or drivers of health, and they are inclusive of health care, multi-sector partnerships and the conditions of communities. They help create a community environment that supports health.

What are Urgent Services?
These are services that anyone under adversity may need temporarily to regain or restore health and well-being. Urgent services address the immediate needs of individuals and communities, say, during illness.

What is Belonging and Civic Muscle?
This is a sense of belonging and power to help shape the world. Belonging is feeling part of a community and valued for what you bring. Civic muscle is the power of people in a society to work across differences for a thriving future.

Well-Being Portfolio in this Strategy and Plan
The hospital's planned strategies and program activities that follow are each identified as aligning with one of the vital conditions or urgent services in this figure.



This helps to identify the range of approaches taken to address community needs and also acknowledges that the hospital is one community resource and stakeholder among many that are dedicated to and equipped for helping to address these needs and improve health.

[1] The Vital Conditions framework and the Well-Being Portfolio were created by the Rippel Foundation, and are being used with permission. Visit https://rippel.org/vital-conditions/ to learn more.

Strategies and Program Activities by Health Need

Health Need:	**Diabetes**				
Population(s) of Focus:	Residents that are underserved, experience disparities that contribute to health outcomes, and those at increased risk to develop these conditions or experience premature death due to these conditions.				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	Vital Condition (VC) or Urgent Service (US)
Increase access to primary care	Help residents enroll in appropriate insurance programs and secure a medical home	•	•	•	VC, US
Health screenings	Free health screenings and education; partner with CBOs; emphasize efforts with underserved communities and high-risk populations	•	•	•	VC
Health education	Communications and presentations via print, electronic, and social media; Food is Medicine and other education programs	•	•	•	VC
Engagement with historically underserved communities	Partner with diverse CBOs to provide education and screenings; emphasize efforts to engage underserved communities and higher risk residents, older adults	•	•	•	VC
Community Health Workers (CHW)	Embed CHWs in primary and specialty care teams to improve outcomes, support needs with social drivers of health and reduce health disparities	•	•	•	VC, US
Community Paramedicine Initiative	Partner with local EMS for in-home visits to address SDoH, care coordination, etc.	•	•	•	VC, US

Health Need:	**Diabetes**
Planned Resources:	Clinically Integrated Network; community benefit team; doctors, clinicians, and educators; population health data team; foundation; volunteers
Planned Collaborators:	CBOs that serve historically marginalized communities: faith communities, neighborhood groups, schools, YMCA and rec centers, senior centers, homeless shelters, food banks, farm markets; municipalities; employers and local businesses; community influencers, Lexington-Fayette Community Health Improvement Partnership (Lex-CHIP)

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Increased people with a medical home; Increased access to primary and specialty care among underserved populations	Self-report, EHR analysis, next appt, referrals	EHR, BRFSS, CHNA participant feedback
Increased knowledge of risk factors, signs/symptoms, current screening levels	Self-report, clinical screening results	Screening results, participant feedback
Reduced risk factors for Diabetes, especially among underserved, high risk populations	Blood pressure, cholesterol, other risk factors	Screening results, EMR, BRFSS, CDC, CHNA, participant feedback
Decreased prevalence of Diabetes, especially among underserved, high risk populations	Rates/percentage of disease	EHR, BRFSS, CDC, CHNA
Reduced disparities among racial and ethnic communities experiencing higher disease burden	EHR analysis	EHR, BRFSS, CDC, CHNA
Increased partnerships with CBOs; increased trust and relationships with underserved and/or vulnerable communities	# of partnerships, community engagement	Participant feedback
Increased connections to existing community social resources to improve food insecurity, housing, and other SDoH factors	Screenings and referrals	Tracked referrals, CBO data and reporting

Health Need:	**Heart Disease and Stroke**				
Population(s) of Focus:	Older adults; residents that are underserved, experience disparities that contribute to health outcomes, and those at increased risk or experience premature death due to these conditions.				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Increase access to primary care	Help residents enroll in appropriate insurance programs and secure a medical home	•	•	•	VC, US
Health screenings	Free health screenings and education with CBOs; emphasize efforts with underserved communities and high-risk populations	•	•	•	VC
Health education	Communications and presentations via print, electronic, social media, and onsite	•	•	•	VC
Engagement with historically underserved communities	Partner with diverse CBOs to provide education and screenings; emphasize efforts to engage underserved communities and higher risk residents, older adults	•	•	•	VC
Community Health Workers (CHW)	Embed CHWs in primary and specialty care teams to improve outcomes, support needs with social drivers of health and reduce health disparities	•	•	•	VC, US
Community Paramedicine Initiative	Partner with local EMS for in-home visits to address SDoH, care coordination, etc.	•	•	•	VC, US

Health Need:	**Heart Disease and Stroke**
Planned Resources:	Clinically Integrated Network; community benefit team; doctors, clinicians, and educators; population health data team; foundation; volunteers
Planned Collaborators:	CBOs that serve historically marginalized communities: faith communities, neighborhood groups, schools, YMCA and rec centers, senior centers, homeless shelters, food banks, farm markets; municipalities; employers and local businesses; community influencers, Lexington-Fayette Community Health Improvement Partnership (Lex-CHIP)

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Increased people with a medical home; Increased access to primary and specialty care among underserved populations	Self-report, EHR analysis, next appt, referrals	EHR, BRFSS, CHNA, participant feedback
Increased knowledge of risk factors, signs/symptoms, current screening levels	Self-report, clinical screening results	Screening results, participant feedback
Reduced risk factors for HD and stroke, especially among underserved, high risk populations	Blood pressure, cholesterol, other risk factors	Screening results; EMR; BRFSS, CDC, CHNA, participant feedback
Decreased prevalence of HD and stroke, especially among underserved, high risk populations	Rates/percentage of disease	EHR, BRFSS, CDC, CHNA
Reduced disparities among racial and ethnic communities experiencing higher disease burden	EHR analysis	EHR, BRFSS, CDC, CHNA
Increased partnerships with CBOs; increased trust and relationships with underserved and/or vulnerable communities	# of partnerships, community engagement	Participant feedback
Increased connections to existing community social resources to improve food insecurity, housing, and other SDoH factors	Screenings and referrals	Tracked referrals; CBO data and reporting

Health Need:	**Nutrition, Physical Activity and Weight**				
Population(s) of Focus:	Youth; adult residents that are underserved, those that experience disparities that contribute to health outcomes, and those at increased risk to develop these conditions or experience premature death due to these conditions.				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	Vital Condition (VC) or Urgent Service (US)
Provide free and low cost nutrition and exercise programs	Partner with CBOs to augment existing programs or develop new offerings; emphasize efforts with underserved communities and high-risk populations	•	•	•	VC
Health education	Communications in print, electronic, and social media	•	•	•	VC
School based nutrition	Increase nutrition options and consumption of fruits and vegetables in the school setting	•	•	•	VC
Increase physical activity among youth	Work with partners to determine assets and barriers for youth activities; identify opportunities; support programs and funding to address needs	•	•	•	VC

Health Need:	**Nutrition, Physical Activity and Weight**
Planned Resources:	Clinically Integrated Network; community benefit team; doctors, clinicians, and educators; population health data team; foundation; volunteers
Planned Collaborators:	CBOs that serve historically marginalized communities: faith communities, neighborhood groups, schools, YMCA and rec centers, senior centers, homeless shelters, food banks, farm markets; municipalities; employers and local businesses; community influencers; Lexington-Fayette Community Health Improvement Partnership (Lex-CHIP)

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Increased knowledge of risk factors, signs/symptoms, current screening levels	Self-report	Screening results, participant feedback
Increased rates of physical activity among residents, patients, and program participants	Rates/percentage of activity	EHR, BRFSS, CDC, CHNA
Reduced food insecurity; Increased access and consumption of healthy foods	Rates/percentage of food security	CBO data and reporting, BRFSS, CHNA, participant feedback
Reduced risk factors and prevalence of preventable chronic disease, especially among youth, underserved, and high risk populations	Screenings, self-report, rates/percentage of disease	Screening results; EHR, BRFSS, CDC, CHNA, participant feedback

Abbreviation Key:

BRFSS: Behavioral Risk Factor Surveillance System
CBO: Community Based Organization
CDC: Centers for Disease Control and Prevention
EHR: Electronic Health Record
CHNA: Community Health Needs Assessment
CHW: Community Health Worker