FY2023-2025

Community Health Needs Assessment
Implementation Strategies

UofL Health | Jewish Hospital

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Organization Description

UofL Health – Jewish Hospital, is an internationally renowned, high-tech tertiary referral center, developing leading-edge advancements in hand and microsurgery, heart and lung care, orthopedics, and sports medicine, neuroscience, organ transplantation and outpatient care. The hospital is the site of the world's first successful hand transplant and AbioCor® implantable replacement heart procedures, in addition to the first trial of adult cardiac stem cells in chronic heart failure. Jewish Hospital offers the most advanced technology for minimally invasive, robotic surgery including the da Vinci Xi, used for cardiac, general surgery, urologic, head and neck, and colorectal procedures, the Monarch Platform, a fully integrated bronchoscope for early detection of lung cancer, and Stryker's MAKO roboticarm for total joint replacement of the knee and hip. Part of Jewish Hospital, the UofL Health – Trager Transplant Center is a nationally recognized transplant center offering heart, lung, liver, kidney, living donor, pancreas, and vascularized composite allografts (hand only) transplantation. As an advanced organ disease center, our multidisciplinary team of physicians and experts treat complex organ failure with life-saving procedures like the implantation of ventricular assist devices (VAD) and transcatheter aortic valve replacement (TAVR) as well as organ transplantation.

Jewish Hospital is part of UofL Health, a fully integrated regional academic health system with more than 12,000 team members, six hospitals, four medical centers, 200+ physician practice locations, 700+ providers, Frazier Rehab Institute, Brown Cancer Center, and the Eye Institute. The mission of UofL Health is to transform the health of the communities we serve through compassionate, innovative, patient-centered care.

Community Served

Jewish Hospital primarily serves Jefferson County through both inpatient and outpatient services. Services are also provided to surrounding counties, with a significant number of patients residing in Bullitt, Hardin, Nelson, Oldham, and Shelby Counties. Jefferson County was the focus of this CHNA and Implementation Strategy. The US Census Bureau July 2021 population estimate for Jefferson County is 777,874. The map included provides a visualization of the community served.

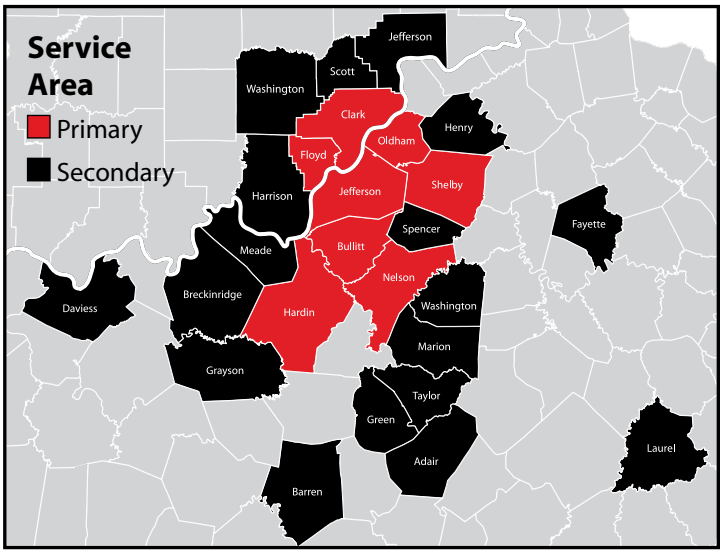

Figure 1 - Map of Service Area

According to the July 2021 Census estimates, Jefferson County has a racial demographic makeup of 65.1% White, 22.8% Black or African American, 6.6% Hispanic or Latino, 3.3% Asian, 2.8% Two or More Races, 0.2% American Indian and Alaska Native, and 0.1% Native Hawaiian and Other Pacific Islander. Approximately 90.8% of the population are a high school graduate or higher, and the median household income is $58,196.

Community Health Needs Assessment Process

During the Spring of 2022, UofL Health contracted with Blue and Co., LLC to conduct the community health needs assessment for each of its six hospital facilities to identify needs within the local service areas. The Community Health Needs Assessment and the subsequent Implementation Strategies meet the requirements set forth by the Patient Protection and Affordable Care Act (2010) and IRS Section 501(r).

Blue and Co. compiled secondary data and collected primary data from the community to highlight themes of prevalent health needs. Primary data collection included an online survey and interviews with community leaders and stakeholders. Themes were developed from all information compiled and priorities were set by hospital leadership. The full CHNA and included priorities were approved by the Board of Directors on June 20, 2022. The CHNA document can be found on the UofL Health website at: **https://uoflhealth.org/about/community-engagement/reports/**.

The Implementation Strategy was developed in conjunction with the Community Health Needs Assessment (CHNA) completed for the 2023-2025 fiscal years. The Implementation Strategy Plan provides actions steps for the hospital to enact that will assist the community in addressing some of its most serious and prevalent health needs. The plan was developed by the Community Engagement Office and an advisory committee of hospital and community stakeholders.

Significant Health Needs

Blue and Co. highlighted themes that emerged from both primary and secondary data. The following overall needs were identified for the Jewish Hospital service area: Access to Health Care, Mental Health, Substance Use, Obesity/Inactivity/Unhealthy Food, Violence, Social Isolation of Seniors, and Health Equity and Disparities. To have the most wide-spread impact within the realm of health equity, the UofL Health System will work toward addressing health disparities as a system-wide goal.

Once major themes were identified in the CHNA data collection process, they were prioritized by each hospital within the UofL Health system. Leadership of Jewish Hospital met with Community Engagement and Quality leaders to set the priority health needs. Priorities were selected based on the impact the hospital could have within the area of need, the resources and capacity of the hospital to address the need, and current plans and priorities in place.

Priorities

During the prioritization process, Jewish Hospital selected the following needs as a focus of this three-year CHNA cycle. Goals for each need are also included below.

1. **Health Equity and Disparities** (priority for UofL Health system)
   Goal: Increase UofL Health's focus on and understanding of health equity through data analysis, planning, and policy/procedure changes to address health disparities

2. **Access to Care**
   Goal: Increase access to high quality, equitable health care and community resources for underserved individuals and communities

3. **Obesity/Inactivity/Unhealthy Food**
   Goal: Strategically involve the hospital in helping to address food insecurity and work toward food justice in the community

4. **Violence**
   Goal: Ensure the safety of patients and staff through enhancing the safety of hospital facilities

Needs Not Addressed

The Community Health Needs Assessment identified the themes of social isolation, substance use, and mental health as major health needs in the Jefferson County community. However, these needs will not be a focus of Jewish Hospital's implementation strategies. These were not areas where the hospital had service lines in place to address it comprehensively, nor could they make a significant impact with available resources.

Implementation Plan

The newly formed Community Engagement Office at UofL Health led the creation of the implementation strategies. They formed an advisory committee of hospital stakeholders and representatives from the community. The CE Office and Advisory Committee developed goals and action steps that corresponded to local needs and resources and current hospital strategic plans. The committee began meeting in July 2022 and completed the development of the plan in August of 2022. The full implementation strategy plan was approved by the UofL Health-Louisville Board of Directors on October 17, 2022. Strategies for fiscal years 2023-2025 are outlined in the following tables.

Approval and Adoption

The Community Health Needs Assessment for FY 2023-2025 was approved by the UofL Health-Louisville Board of Directors on June 20, 2022. The Implementation Strategy was approved by the Board on October 17, 2022.

Questions

Questions concerning the Community Health Needs Assessment and Implementation Strategies may be directed to the UofL Health Community Engagement Office at **502-587-4447** or **Tabitha.underwood@uoflhealth.org**. Questions may also be submitted online through the comment form at: **https://uoflhealth.org/about/community-engagement/community-health-needs-assessment-feedback/**

Implementation Strategies

Jewish Hospital

ACCESS TO CARE

Goal: Increase access to high quality, equitable health care and community resources for underserved individuals and communities

CATEGORY: Connect to resources		
Strategies	**Possible Collaborations***	**Resources Dedicated/Needed**
1. Assist patients with connecting to resources available through Medicaid insurance plans such as non-emergency medical transport (e.g. Kynect online resource) 2. Partner with the provider practices to create an ED discharge navigator program that will connect ED patients to primary and specialty care post-discharge 3. Partner with nursing and care management to create a standardized discharge process from hospital-to-home and hospital-to-home with home health. This will include the addition of the Cerner Readmissions Risk Assessment	UofL Physicians, Community Engagement, Care Management, Kynect, Nursing, Quality Management	1. Staff time – part of SDOH screening and intervention 2. $500,000, Includes 6 FTEs
POTENTIAL IMPACT: Patients will be connected to resources and have an established system of support and continuum of care **MONITORING: Referral and discharge tracking in Cerner, readmission rates**		

CATEGORY: Focus on underserved populations		
Strategies	**Possible Collaborations***	**Resources Dedicated/Needed**
1. Develop a program to standardize and manage the care of medically compromised patients with a substance use disorder (SUD) 2. Determine gaps and opportunities for alternative model of delivery for homeless population through outreach	Community Engagement, various CBOs	Staff time
POTENTIAL IMPACT: Residents in underserved areas and those with limited access to care will be reached to improve health and wellbeing **MONITORING: Outreach tracked in CBISA, patients tracked in Cerner**		

**Potential collaborators, partnerships may not be formed*

OBESITY/INACTIVITY/UNHEALTHY FOOD

GOAL: Strategically involve the hospital in helping to address food insecurity and work toward food justice in the community

CATEGORY: Assess and connect		
Strategies	**Possible Collaborations***	**Resources Dedicated/Needed**
1. Implement screening tool to identify food insecurities through the Social Determinants of Health Screening 2. Develop a model for a Food as Medicine Program that includes a food pharmacy and fresh food vouchers connected to Cardiology and Diabetes Management. The program will include partnerships with community fresh food resources such as Kroger Mobile Market, Hope Bus, New Roots, and local farmers markets	Care Management, Kroger, local food justice and food access community groups	1. $385,000 5 additional social workers (University and JH) 2. TBD- funding for vouchers and food
POTENTIAL IMPACT: Providers will have a better understanding of patient food insecurity and patients will have enhanced access to fresh, healthy food **MONITORING: Screenings and referrals tracked in Cerner, partnerships tracked in CBISA**		

CATEGORY: Enhance local capacity		
Strategies	**Possible Collaborations***	**Resources Dedicated/Needed**
1. Set up Chestnut Café as a food rescue site by working with Metz to donate leftover food to Feed Louisville and other food rescue groups 2. Assist with building the capacity of local organizations focused on food justice through sponsorships and involvement of hospital leadership	Feed Louisville, Metz, Marketing, various CBOs	Staff time to volunteer with organization, current sponsorships
POTENTIAL IMPACT: Increase the capacity of local community groups to address food insecurity and work toward food justice **MONITORING: Sponsorships and partnerships tracked in CBISA**		

**Potential collaborators, partnerships may not be formed*

VIOLENCE

GOAL: Ensure the safety of patients and staff through enhancing the safety of hospital facilities

CATEGORY: Ensure the safety of buildings		
Strategies	**Possible Collaborations***	**Resources Dedicated/Needed**
1. Partner with Louisville Central Area for safety ambassadors 2. Implement security plan for Jewish and UofL Hospital	Lou ED/MED district (to be formed)	Staff time to develop
POTENTIAL IMPACT: The areas in and around Jewish Hospital will be perceived as safe by patients and staff **MONITORING: Strategic plan monitoring**		

CATEGORY: Build internal systems		
Strategies	**Possible Collaborations***	**Resources Dedicated/Needed**
1. Partner with Human Resources and create a Just Culture Steering Team that will guide the implementation of Just Culture throughout the system 2. Partner with Human Resources and Education to revise the New Employee Orientation process 3. Develop Patient & Family Advisory Councils at each facility	Human Resources, Quality, Patient Experience, Education	Staff time to coordinate
POTENTIAL IMPACT: Internal systems will be in place to be proactive concerning the safety of patients **MONITORING: Strategic plan monitoring**		

**Potential collaborators, partnerships may not be formed*

HEALTH EQUITY AND DISPARITIES

GOAL: Increase UofL Health's focus on and understanding of health equity through data analysis, planning, and policy/procedure changes to address health disparities

CATEGORY: Utilizing data

Strategies	Possible Collaborations*	Resources Dedicated/Needed
1. Develop dashboards from quality databases (Vizient & Press Ganey) with outcomes based on socioeconomic and demographic data. Begin with organ transplant, maternity care, and diabetes management. 2. Develop a plan to address patient health disparities identified by stratifying quality and safety data using sociodemographic characteristics 3. Collaborate with Envirome Institute, Center for Health Equity, and UofL Innovation Hub to share data and better understand avenues of intervention for addressing health disparities 4. Utilize Vizient Neighborhood Vulnerability reports to target outreach and relationship building to specific neighborhoods when appropriate 5. Utilize toolkits and indices to map progress toward equity within each hospital (e.g. Health Equity Transformation Assessment-AHA, Healthcare Equality Index-Human Rights Campaign, and Disability Equality Index-Disability:IN)	Data Analytics, Transplant, Maternal Fetal Medicine, Diabetes Prevention/Education, Community Engagement, Envirome Institute, Innovation Hub, Center for Health Equity, Organizational Development, KY Division of Epidemiology and Health Planning, Metro Public Health and Wellness, IT, Quality	Current contract with Vizient and Press Ganey Staff time for coordination

POTENTIAL IMPACT: The UofL Health system will have a better understanding of health equity and opportunities for improvement and enhancement of internal practices
MONITORING: Disparity dashboards, health equity plan monitoring, equity toolkits, Vizient reports

CATEGORY: Building internal systems

Strategies	Possible Collaborations*	Resources Dedicated/Needed
1. Continue implementation of DEI curriculum and modules (cultural competence, emotional intelligence, implicit bias, and DEI)	Org Dev, Engagement and Inclusion, KY Equal Justice Ctr., JCPS DEI Dept, HR, UofL LGBT Center, Patient Experience, Community Engagement, DEI Committee, Central High School, UofL School of Medicine	1 FTE staff Current staff time for trainings and coordination

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**Potential collaborators, partnerships may not be formed*

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2. Utilize professional development opportunities through UofL LGBT Center to train front line staff in affirming health care practice 3. Create LGBTQ+ work group to determine gaps in care, policy and procedure changes, and improvements in patient experience 4. Partner with Women's Services to implement California Maternal Quality Care Collaborative model and decrease racial disparities in maternal health		

POTENTIAL IMPACT: UofL Health will have internal systems in place to decrease implicit bias and increase cultural competence for addressing health equity within the hospital facilities and services
MONITORING: Professional development evaluations, disparity dashboards

CATEGORY: Connection to resources

Strategies	Possible Collaborations*	Resources Dedicated/Needed
1. Train and implement program for social workers to complete social needs and SDOH assessment for all patients 2. Create a referral pipeline for SDOH through Unite Us, MyKY, Aunt Bertha, Kynect, 211, direct partnerships (when necessary), and health plan case managers/navigators 3. Implement the Kentucky Prescription Assistance Program to support underserved populations, including a program to aid with co-pays for transplant medications 4. Explore opportunities to train/employ/utilize community health workers and peer support specialists in outreach work to connect underserved populations to resources and monitor wellbeing 5. Pilot Adverse Childhood Experiences (ACE) screenings for new mothers in the high-risk demographics and connect to community resources for home visits and a continuum of care	Care Management, Patient Experience, ULP, Data Analytics, Community Engagement, Center for Health Equity, MUW, LHAB, Innovation Hub, KHA, Neighborhood Place, Community Ministries, Health Plans, State of KY, Metro Public Health and Wellness, KY Voices for Health, Community Health Worker Associations, BOUNCE Coalition, HANDS	1. $385,000 5 additional social workers 2. Cost of referral software

POTENTIAL IMPACT: Patients will be connected to resources that affect the social factors impacting their health and access to care
MONITORING: SDOH and referral tracking in Cerner, screenings tracked in EPIC

**Potential collaborators, partnerships may not be formed*

CATEGORY: Focus on underserved populations		
Strategies	**Possible Collaborations***	**Resources Dedicated/Needed**
1. Increase access to care and health education for medically underserved populations and under-resourced communities through outreach activities • Build pool of community outreach volunteers and Community Engagement Clinical Outreach team • Develop community partnerships in underserved areas for regular, consistent community outreach • Assess supports and barriers to outreach participation by staff • Develop avenues for listening sessions through outreach to inform future practice 2. Expand Ambulatory Services to underserved areas in West and South Jefferson County and Bullitt County 3. Explore feasibility of adding a mobile clinic to outreach efforts through the Community Engagement Office 4. Communicate with local LGBTQ+ advocacy and social service organizations to better understand gaps and opportunities in health care and health literacy for LGBTQ+ populations 5. Explore partnerships to develop a refugee patient navigator program through Maternal Fetal Medicine 6. Continue Allied Health Academy across the state and the partnership with Central High School pre-med program to enhance the pipeline for secondary students in underserved areas to pursue health sciences careers	Community Engagement, various CBOs (currently doing outreach), Metro Resilience & Community Services, FHC, Seven Counties, LGBTQ+ advocacy organizations, Metro Health and Wellness, ULP, UofL LGBT Center, Maternal Fetal Medicine, agencies serving refugee and immigrant populations, faith-based organizations	1. 3 FTE and new Community Engagement Office 2. $9 M Dixie $500,000 West Jefferson Staff time for coordination
POTENTIAL IMPACT: Residents in underserved areas and those with limited access to care will be reached to improve health and wellbeing **MONITORING: CBISA outreach tracking, strategic plan monitoring, partnerships tracked in CBISA, high school partnerships evaluation**		

**Potential collaborators, partnerships may not be formed*