FY2023-2025

Community Health Needs Assessment
Implementation Strategies

UofL Health | Peace Hospital

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Organization Description

UofL Health – Peace Hospital, is a private, non-profit behavioral health hospital. One of the largest behavioral health facilities in the nation, Peace Hospital is known for providing care for children, adolescents, and adults. It's Kosair Charities Children's Peace Center is the largest and most comprehensive private provider of youth inpatient behavioral health services in the country. The hospital was the nation's first behavioral health care center to open a retail pharmacist operated, longacting injection clinic. The clinic was established to help people adhere to prescribed medications for behavioral health conditions, such as substance use and psychotic disorders.

Peace 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

Peace 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.

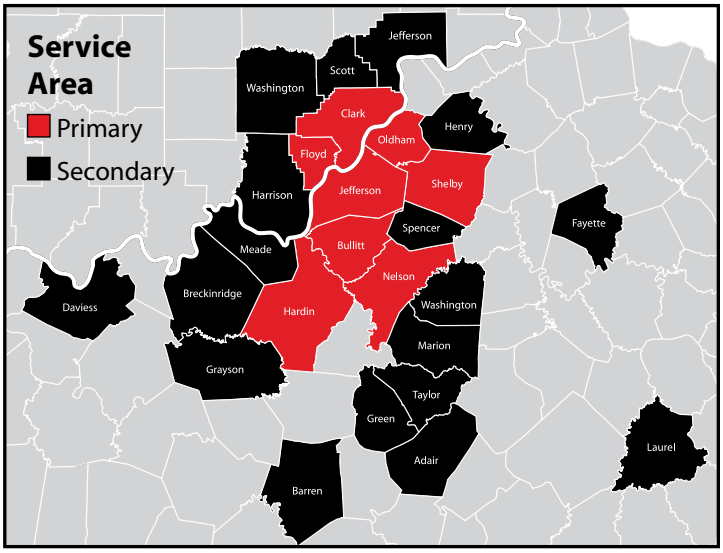

Figure 1 - Map of Service Area

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 Peace 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 Peace 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, Peace 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. **Mental Health**
   Goal: Increase access to behavioral health services and other systems of support for individuals living with mental illness

4. **Social Isolation of Seniors**
   Goal: Decrease social isolation through care coordination and community resources focused on building connections among older adults

Needs Not Addressed

The Community Health Needs Assessment identified the themes of Substance Use, Obesity/Inactivity/Unhealthy Food, and Violence as major health needs in the Jefferson County community. However, these needs will not be a focus of Peace 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

Peace Hospital

ACCESS TO CARE

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

CATEGORY: Increase physicians, facilities, and services		
Strategies	**Possible Collaborations***	**Resources Dedicated/Needed**
1. Integrate telebehavioral health into UofL Physicians including brief, episodic evidence-based treatment with coordinated referrals 2. Embed social workers/mental health therapists in primary care practices beginning with Virginia Avenue to meet the full needs of our patients 3. Increase psych beds for adolescents 4. Increase available beds for geropsych unit by adding RNs 5. Recruit additional specialty behavioral health providers 6. Explore expanding Long Acting Injectable (LAI) Clinic	ULP	1. 2 telebehavioral health providers 2. 1 new social worker 3. Capital request $10.5M 4. 4.2 new agency RNs 5. 2 new academic providers 6. Staff time
POTENTIAL IMPACT: The patient provider ratio will decrease, and more services will be available to underserved areas and individuals **MONITORING: Strategic plan monitoring, available services, patient census**		

CATEGORY: Eliminate barriers to care		
Strategies	**Possible Collaborations***	**Resources Dedicated/Needed**
1. Explore offering transportation to Adult OP in Louisville for patients in Shelby and Bullitt County 2. Increase transportation to Peace from within the UofL Health system 3. Assist patients with connecting to resources available through Medicaid insurance plans such as non-emergency medical transport (e.g. Kynect online resource)	UofL Health hospitals, Kynect	1. Staff time 2. 2 FTE, 2 PT, and 1 vehicle 3. Staff time
POTENTIAL IMPACT: Patients will be connected to resources that affect the social factors impacting their health and access to care **MONITORING: Patients utilizing transportation, transportation expenses, referrals tracked in Cerner**		

**Potential collaborators, partnerships may not be formed*

CATEGORY: Focus on underserved populations		
Strategies	**Possible Collaborations***	**Resources Dedicated/Needed**
1. Determine gaps and opportunities for alternative model of delivery for homeless population through outreach and work with Care Continuum for Homeless Medical Respite to plan and advocate for medical respite in Louisville Community 2. Provide services to underserved areas (Shepherdsville South & Sun Valley) via telehealth integration 3. Assess current workforce, train all employees, and ensure access to services in underserved areas	Community Engagement, various CBOs, Norton, Seven Counties, Coalition for the Homeless, various CBOs (currently doing outreach), ULP, HR, Organizational Development	1. Staff time 2. TBD – based on staffing needs 3. 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, DEI professional development evaluation, patient-provider ratio in underserved areas**		

**Potential collaborators, partnerships may not be formed*

MENTAL HEALTH

GOAL: Increase access to behavioral health services and other systems of support for individuals living with mental illness

CATEGORY: Outreach and education		
Strategies	**Possible Collaborations***	**Resources Dedicated/Needed**
1. Provide suicide prevention training in the community 2. Provide mental health first aid training in the community 3. Increase health literacy related to mental health through outreach and community partnerships 4. Education of primary care providers and hospital front-line staff on symptoms, medications, referrals, ACEs, and trauma informed care 5. Continue partnership with JCPS to train school staff, parents, nurses, FRYSC, and counselors on topics such as mental illness, treatment options, suicide prevention. Continue partnership for suicide prevention screenings and school-based level of care assessments	ULP, various CBOs, Jefferson County Public Schools	Staff time
POTENTIAL IMPACT: Resources will be readily available in the community to break down the stigma of mental illness and provide compassionate care **MONITORING: Outreach and trainings tracked in CBISA**		

CATEGORY: Connection to resources		
Strategies	**Possible Collaborations***	**Resources Dedicated/Needed**
1. Connect patients to Peer Recovery Programs and Community Health Workers in the community through enhanced discharge planning	Community agencies providing peer recovery/support specialists	Staff time for discharge planning
POTENTIAL IMPACT: Patients will be connected to resources and have an established system of support and continuum of care **MONITORING: Referrals tracked in Cerner, readmission rates**		

**Potential collaborators, partnerships may not be formed*

SOCIAL ISOLATION OF SENIORS

GOAL: Decrease social isolation through care coordination and community resources focused on building connections among older adults

CATEGORY: Direct service		
Strategies	**Possible Collaborations***	**Resources Dedicated/Needed**
1. Continue to build out new GeroPsych Unit 2. Provide support and training for caregivers 3. Implement support groups specifically for seniors with mental illness and/or substance use disorder 4. Facilitate walking club at the hospital 5. Investigate implementing a loneliness screening tool in conjunction with SDOH screening for older adults such as UCLA Loneliness Scale		Staff time 1. 4.2 FTE's
POTENTIAL IMPACT: Patients will have services available at the hospital that address social isolation and loneliness **MONITORING: Patient outcomes tracked in Cerner, caregiver training and support group evaluations and participant tracking**		

CATEGORY: Build sustainable, mutually beneficial partnerships		
Strategies	**Possible Collaborations***	**Resources Dedicated/Needed**
1. Explore partnership with EMS, and Fire Dept, and Police on identifying and referring for social isolation 2. Develop direct referrals to programs that encourage social interaction such as day centers, Senior Companion Program, RSVP, AARP Connect2Affect, etc. 3. Join TRIAD and Age Friendly Louisville 4. Explore opportunities to partner with UofL to pair students with patients for intergenerational phone calls	EMS, Fire Departments, LMPD, various community coalitions, UofL	Staff time to coordinate and collaborate
POTENTIAL IMPACT: The capacity of the community will be enhanced, and partners will work together to address social needs through sharing of resources and regular communication **MONITORING: Partnerships tracked in CBISA, referrals tracked in Cerner**		

**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*