FY2023-2025

Community Health Needs Assessment
Implementation Strategies

UofL Health | Shelbyville Hospital

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Organization Description

For more than a century, UofL Health – Shelbyville Hospital has served the people of Shelby and surrounding counties with high-quality health care. Founded in 1906 as Kings Daughter's Hospital, the hospital continued to expand care and services at its Henry Clay Street location until 1954 when it opened a new, state of the art 70-bed facility on Hospital Drive. From its start, physicians and staff have focused on providing the best possible care close to home. Briefly managed and later owned by the for-profit United Medical Corp., of Orlando, Fla., the hospital was purchased in 1992 by Jewish Hospital HealthCare Services Inc. and renamed Jewish Hospital Shelbyville. In 2012, the hospital became part of a Catholic Health Initiative's KentuckyOne Health. The hospital joined the newly formed UofL Health becoming UofL Health – Shelbyville Hospital in 2019. Colonel Harland Sanders stands tall at the front entrance to greet guests. In appreciation for a generous gift from the Canadian-based Colonel Harland Sanders Charitable Foundation, the hospital gave honor by naming the campus Harland D. Sanders Medical Campus.

Shelbyville 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. As an academic health care system, our mission is to transform the health of the communities we serve through compassionate, innovative, patient-centered care.

Community Served

Shelbyville Hospital primarily serves Shelby County through both inpatient and outpatient services. Services are also provided to surrounding counties, with a significant number of patients residing in Spencer and Henry Counties. Shelby County was the focus of this CHNA and Implementation Strategy. The US Census Bureau July 2021 population estimate for Shelby County is 48,461. The map included provides a visualization of the community served.

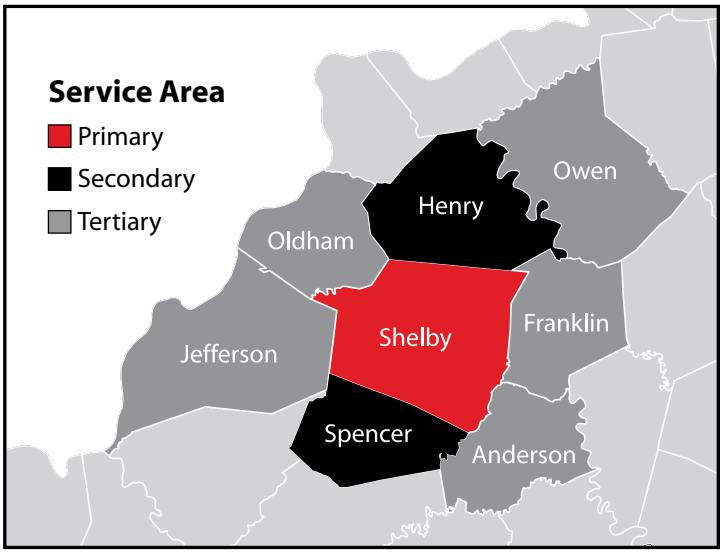

Figure 1 - Map of Service Area

According to the July 2021 Census estimates, Shelby County has a racial demographic makeup of 80% White, 9.7% Hispanic or Latino, 7.2% Black or African American, 2.6% Two or More Races, 1.1% Asian, 0.6% American Indian and Alaska Native and 0.3% Native Hawaiian and Other Pacific Islander. Approximately 87% of the population are a high school graduate or higher, and the median household income is $72,564.

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 28, 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 Shelbyville Hospital service area: Access to Health Care, Mental Health, Smoking, Obesity/Inactivity/Unhealthy Food, 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 Shelbyville 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, Shelbyville 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 programming and services that focus on the treatment & safety of individuals living with mental illness and substance use disorder

4. **Smoking**
   Goal: Increase the connection to services and resources for smoking, vaping, and ecigarette cessation and prevention

Needs Not Addressed

The Community Health Needs Assessment identified the theme of Obesity/Inactivity/Unhealthy Food as a major health need in the Shelby County community. However, this need will not be a focus of Shelbyville Hospital's implementation strategies. This was not an area where the hospital had service lines in place to address it, 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 including public health, government, nonprofit, and local businesses. 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 Shelbyville Hospital Board of Directors on September 22, 2022. Strategies for fiscal years 2023-2025 are outlined in the following table.

Approval and Adoption

The Community Health Needs Assessment for FY 2023-2025 was approved by the Shelbyville Hospital Board of Directors on June 28, 2022. The Implementation Strategy was approved by the Board on September 22, 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

Shelbyville 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. Primary Care Provider Recruitment/Onboarding in Eminence & Taylorsville 2. Create Urgent Care Plus/ Occ Med/ Specialty Satellite Clinic in Taylorsville 3. Create Urgent Care Plus/Occ Med/Telehealth Clinic in Shelbyville 4. Expand specialty providers 5. Complete feasibility study for new hospital that will expand services available in Shelby County- if recommended, move forward with capital planning 6. Expand telehealth specialty consult offerings	Ambulatory Services, UofL Physicians, Carnahan Group	1. Currently in budget 2. $1M 3. $1M 4. $600,000 for current plans 5. $100,000 6. Cost of software Staff time currently budgeted
POTENTIAL IMPACT: The patient provider ratio will decrease, and more services will be available to underserved areas and individuals **MONITORING: Strategic plan monitoring, patient-provider ratio, availability of services**		

CATEGORY: Build sustainable, mutually beneficial partnerships		
Strategies	**Possible Collaborations***	**Resources Dedicated/Needed**
1. Explore opportunities for partnership with local school corporations, NCDHD, and Mercy Medical to improve community knowledge of local health resources and access to care 2. Work with partners in Shelby County to develop Health Equity report 3. Implement quarterly long-term care meeting with area resources to improve services 4. Serve on Advisory Board for new senior living with memory care center and Jefferson Community and Technical College Advisory Board	Community Engagement Office, School Systems (Shelby, Henry, Spencer), North Central District Health Department, Mercy Medical, various CBOs, UofL Physicians, long-term care facilities, social service resources	Staff time for community collaboration and coordination
POTENTIAL IMPACT: The capacity of the community will be enhanced, and partners will work together to address health needs through sharing of resources and regular communication **MONITORING: Partnerships tracked in CBISA, meeting minutes**		

**Potential collaborators, partnerships may not be formed*

CATEGORY: Elimination of barriers to care		
Strategies	**Possible Collaborations***	**Resources Dedicated/Needed**
1. Work with UofL Network to establish a more reliable ambulance transport option 2. Create community coalition from DEI committee to focus on health/wellbeing, access to care, DEI, and health equity. Committee will also assess barriers to care for Hispanic and African American populations in Shelby County 3. Explore new transportation options with community stakeholders to reduce no-shows and cancelled appointments	Community Engagement, Centro Latino, local churches, Mercy Medical, local farmers, KIPDA, North Central District Health Department, Ride Health, Private transport providers	Staff time for coordination
POTENTIAL IMPACT: Patients will be connected to resources that affect the social factors impacting their health and access to care **MONITORING: Available transportation, meeting minutes**		

CATEGORY: Connection 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	Staff time for discharge planning and resource coordination $500,000 – Includes 6 FTEs (discharge navigators)-system-wide
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**		

**Potential collaborators, partnerships may not be formed*

MENTAL HEALTH

GOAL: Increase programming and services that focus on the treatment & safety of individuals living with mental illness and substance use disorder

CATEGORY: Enhance behavioral health services		
Strategies	**Possible Collaborations***	**Resources Dedicated/Needed**
1. PeaceNow/Telehealth clinic included in Urgent Care and Primary Care 2. Partner within UofL Health and with community agencies to expand outpatient behavioral health services available in the area 3. Work with Peace Hospital to explore building an internal transportation system for voluntary behavioral health patients from Shelby County to the Adult Outpatient Center in Louisville	UofL Physicians, Peace Hospital, other behavioral health providers	PeaceNow currently budgeted Staff time for coordination
POTENTIAL IMPACT: Residents will have greater access to behavioral health services **MONITORING: Available services, strategic plan monitoring, referrals tracked in Cerner**		

CATEGORY: Safety for patients living with substance use disorder		
Strategies	**Possible Collaborations***	**Resources Dedicated/Needed**
1. Partner with KY Harm Reduction Coalition and Health Dept. for community-wide Naloxone trainings and distribution 2. Work with community resources to implement needle exchanges in Shelby County 3. Work with regional health department to increase availability of fentanyl testing strips in the community	Kentucky Harm Reduction Coalition, North Central District Health Department	Funding for Naloxone and Fentanyl test strips
POTENTIAL IMPACT: Overdose rate, disease transmission, and injury will decrease among individuals living with substance use disorder **MONITORING: Overdose rate, Naloxone training and distribution quanities, NCDHD tracking fentanyl test strips and needle exchanged, ED visits tracked in Cerner**		

**Potential collaborators, partnerships may not be formed*

SMOKING

GOAL: Increase the connection to services and resources for smoking, vaping, and e-cigarette cessation and prevention

CATEGORY: Utilize existing resources		
Strategies	**Possible Collaborations***	**Resources Dedicated/Needed**
1. Directly connect patients to Health Dept and other agencies for smoking cessation resources including nicotine replacement, insurance coverage, education 2. Utilize sponsorship funding to support multi-media marketing efforts of cessation and prevention in the community 3. Enhance availability of information on smoking cessation for patients and employees	North Central District Health Department, CHFS-KY, American Cancer Society, Foundation for a Healthy KY, health plans, Marketing	Staff time for collaboration and coordination
POTENTIAL IMPACT: Participation in cessation programs will increase through utilization of existing resources **MONITORING: Referrals tracked in Cerner and by NCDHD**		

CATEGORY: Build sustainable, mutually beneficial partnerships		
Strategies	**Possible Collaborations***	**Resources Dedicated/Needed**
1. Work with community partners and local businesses to change policies and practices around smoking 2. Partner with regional health department on their smoking cessation efforts 3. Partner with UofL Envirome Institute to develop interventions for e-cigarettes and vaping	North Central District Health Department, Judge Executives, Chamber of Commerce, UofL Health Envirome Institute	Staff time for collaboration and coordination
POTENTIAL IMPACT: Smoking, vaping, and e-cigarette use will decrease **MONITORING: Partnerships tracked in CBISA, smoking-vaping-e-cigarette rates**		

**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*