CHI Saint Joseph Health
Continuing Care Hospital

Community Health Needs Assessment

FY 2023-2025

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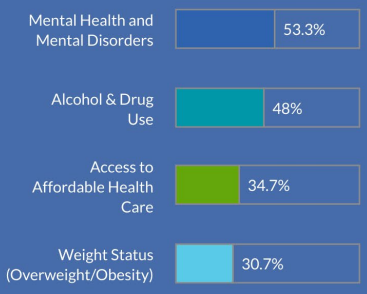
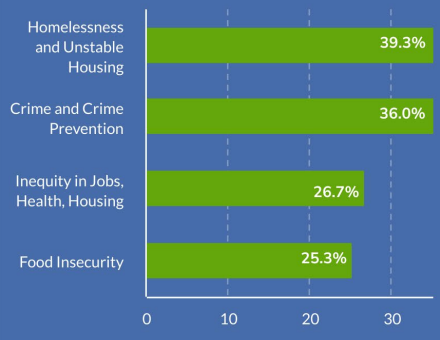


Quality of Life Factors:



Health Equity

Health equity focuses on the fair and just distribution of health determinants, outcomes, and resources across communities.

Systemic racism
Poverty
Gender discrimination

Poorer health outcomes for groups such as Black persons, Hispanic or Latino persons, indigenous communities, people experiencing poverty and LGBTQ+ communities.

PRIORITY HEALTH NEEDS

Fayette County

Alcohol, Tobacco & Drug Use

Themes from Community Input:

- Ranked by survey respondents as the second most pressing health problem (48.0%)
- Lack of education, financial concerns and family dynamics cited as major factors for substance use
- Need for free counseling services and harm reduction strategies

Warning Indicators:

- Death Rate due to Drug Poisoning
- Liquor Store Density
- Alcohol-Impaired Driving Deaths
- Adults who Binge Drink

Mental Health & Mental Disorders

Themes from Community Input:

- Ranked by survey respondents as the most pressing health problem (53.3%)
- Stress, anxiety, family dynamics, and domestic violence cited as contributing factors to poor mental health
- Need for more mental health services

Warning Indicators:

- Alzheimer's Disease or Dementia: Medicare Population
- Depression: Medicare Population
- Poor Mental Health: 14+ Days

Weight Status, Physical Activity & Nutrition

Themes from Community Input:

- Ranked by survey respondents as the fourth most pressing health problem (30.7%)
- Healthy eating options at restaurants, stores, and markets a top quality of life issue among survey respondents (15.3%)
- Lack of exercise, busy lifestyles, lack of nutritional foods and learned behaviors through multiple generations cited as key contributors to obesity

Warning Indicators:

- Fast Food Restaurant Density
- SNAP Certified Stores
- Farmers Market Density
- Low-Income and Low Access to a Grocery Store
- Adult Fruit and Vegetable Consumption

Executive Summary

Introduction & Purpose

The purpose of this Community Health Needs Assessment (CHNA) is to identify and prioritize significant health needs of the community served by Continuing Care Hospital (CCH). The priorities identified in this report help to guide the hospital's community health improvement programs and community benefit activities, as well as its collaborative efforts with other organizations that share a mission to improve health. This CHNA report meets requirements of the Patient Protection and Affordable Care Act that nonprofit hospitals conduct a community health needs assessment at least once every three years.

CommonSpirit Health Commitment and Mission Statement

The hospital's dedication to engaging with the community, assessing priority needs, and helping to address them with community health program activities 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."

CHNA Collaborators

CHI Saint Joseph Health commissioned Conduent Healthy Communities Institute (HCI) to conduct the 2023-2025 Community Health Needs Assessment for Continuing Care Hospital.

Community Definition

The community served by Continuing Care Hospital, also known as the hospital's primary service area (PSA), was defined based on zip codes representing 75% of all inpatient discharges. The primary service area consists of 33 zip codes and spans 21 counties in Kentucky, with the largest portion of the hospital's patients residing in Fayette County.

Methods for Identifying Community Needs

Secondary data used in this assessment consisted of community health indicators, while primary data consisted of key informant interviews, focus group discussions, and an online community survey. Findings from all these data sources were analyzed to identify the significant health needs for the community served by Continuing Care Hospital.

Secondary Data

The secondary data used in this assessment were obtained and analyzed from a community indicator database developed by Conduent Healthy Communities Institute. The database includes over 150 community health and quality of life indicators, spanning at least 24 topics, that are primarily derived from state and national public data sources. Indicator values for Fayette County were compared to other

counties in Kentucky and the U.S., trends over time and Healthy People 2030 targets to assess relative areas of need. HCI's Data Scoring Tool systematically summarizes these comparisons, ranking indicators based on highest need. Each indicator is assigned a score from 0 to 3, where 0 indicates the best outcome and 3 indicates the worst outcome. Indicators are grouped into broader topic areas for a higher-level ranking of community health needs. Topic scores also range from 0 to 3, with 0 indicating the best outcome and 3 indicating the worst outcome. Topics receiving a secondary data score of 1.50 or higher were identified as a significant health need.

Primary Data

The primary data used in this assessment included an online community survey and qualitative data in the form of key informant interviews and focus group discussions. Key informants invited to participate in these interviews were recognized as having expertise in public health, special knowledge of community health needs, representing the broad interests of the community served by the hospital, and/or being able to speak to the needs of medically underserved or vulnerable populations.

Summary of Findings

Health needs were determined to be significant if they met the following criteria:

- Secondary data analysis: topic score of 1.50 or higher
- Survey analysis: identified by 20% or more of respondents as a priority issue
- Qualitative analysis: frequency topic was discussed within/across interviews and focus groups

Through this criteria, thirteen needs emerged as significant. Figure 1 illustrates the final 13 significant health needs, listed in alphabetical order, that were included for prioritization based on the findings of all forms of data collected for the Continuing Care Hospital 2023-2025 CHNA.

FIGURE 1. SIGNIFICANT HEALTH NEEDS

Prioritization

Continuing Care Hospital convened a group of community leaders to participate in a presentation of data on the 13 significant health needs. Following the presentation, participants engaged in a discussion and were asked to complete an online prioritization activity.

Process and Criteria

The online prioritization activity included two criteria for prioritization:

- Magnitude of the Issue

- Ability to Impact

Participants assigned a score of 1-3 to each health topic and criterion, with a higher score indicating a greater likelihood for that topic to be prioritized. Numerical scores for the two criteria were then combined and averaged to produce an aggregate score and ranking for each health topic.

FIGURE 2. RANKED ORDER OF HEALTH NEEDS

1. **Alcohol & Drug Use** (2.47)
2. **Diabetes** (2.47)
3. **Weight Status, Physical Activity & Nutrition** (2.47)
4. **Immunizations & Infectious Diseases** (2.44)
5. **Mental Health & Mental Disorders** (2.41)
6. **Health Care Access & Quality** (2.38)
7. **Food Insecurity** (1.97)
8. **Homelessness & Unstable Housing** (1.94)
9. **Crime & Crime Prevention** (1.85)
10. **Inequity (in jobs, health, housing)** (1.85)
11. **Sexually Transmitted Infections** (1.85)
12. **Tobacco Use** (1.85)
13. **Prevention & Safety** (1.68)

Prioritization Results

The list of significant health needs in Figure 2 is provided in the rank order that resulted from the prioritization process, alongside the average score assigned to each topic. The needs are listed in order of highest priority to lowest priority. For those topics with identical scores, the health needs are listed in alphabetical order.

Prioritized Areas

The prioritized list of significant health needs was presented to hospital leadership. The hospital's Healthy Communities / Community Benefit Committee reviewed the scoring results of the online prioritization activity in conjunction with the full list of health needs that were identified as significant across all seven hospitals in the CHI Saint Joseph Health system. A decision was made to combine the prioritized health areas of Alcohol & Drug Use and Tobacco Use and move forward with the significant health needs that were trending across all seven hospitals. This process resulted in a final selection of three priority health areas that will be considered for subsequent implementation planning. The three priority health needs are shown in Table 1.

TABLE 1. PRIORITIZED HEALTH NEEDS

Alcohol, Tobacco & Drug Use
Mental Health & Mental Disorders
Weight Status, Physical Activity & Nutrition

Report Adoption, Availability and Comments

This CHNA report was adopted by the CHI Saint Joseph Health Board of Directors in May 2022. The report is widely available to the public on the hospital's website: https://www.chisaintjosephhealth.org/healthycommunities. Paper copies are also available for inspection upon request at Continuing Care Hospital. Written comments on this report can be submitted through the online Assessment Feedback form: https://www.chisaintjosephhealth.org/healthy-community-chna-feedback.

Conclusion

This report describes the process and findings of a comprehensive Community Health Needs Assessment (CHNA) for the community served by Continuing Care Hospital. The prioritization of the identified significant health needs will guide the community health improvement efforts of the hospital. Following this process, Continuing Care Hospital will outline how it plans to address the prioritized health needs.

Introduction & Purpose

Continuing Care Hospital is pleased to present its fiscal year 2023-2025 Community Health Needs Assessment (CHNA).

CHNA Purpose

The purpose of this CHNA report is to identify and prioritize significant health needs of the community served by Continuing Care Hospital (CCH). The priorities identified in this report help to guide the hospital's community health improvement programs and community benefit activities, as well as its collaborative efforts with other organizations that share a mission to improve health. This CHNA report meets requirements of the Patient Protection and Affordable Care Act that nonprofit hospitals conduct a community health needs assessment at least once every three years.

This report includes a description of:

- **The community demographics and population served;**
- **The process and methods used to obtain, analyze and synthesize primary and secondary data;**
- **The significant health needs in the community, taking into account the needs of uninsured, low-income, and marginalized groups;**
- **The process and criteria used in identifying certain health needs as significant and prioritizing those significant community needs.**

CHI Saint Joseph Health

CHI Saint Joseph Health is one of the largest and most comprehensive health systems in the Commonwealth of Kentucky. We consist 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 35 Kentucky counties.

At CHI Saint Joseph Health, we are dedicated to building healthier communities by elevating patient care. We are guided by our strong mission and faith-based heritage and work through local partnerships to expand access to care in the communities we serve.

CHI Saint Joseph Health is part of CommonSpirit Health, a nonprofit, Catholic health system dedicated to advancing health for all people. It was created in February 2019 through the alignment of Catholic Health Initiatives and Dignity Health. CommonSpirit Health is committed to creating healthier communities, delivering exceptional patient care, and ensuring every person has access to quality health care. With its national office in Chicago and a team of approximately 150,000 employees and 25,000 physicians and advanced practice clinicians, CommonSpirit Health operates 142 hospitals and more than 700 care sites across 21 states.

Continuing Care Hospital

Continuing Care Hospital (CCH), a part of CHI Saint Joseph Health, is a long-term acute care hospital with 25 beds located within Saint Joseph Hospital, so it acts as a "hospital within a hospital." Long-term acute care hospitals are a special classification of hospitals recognized by the federal government for facilities that meet the required specifications, including maintenance of an average length of stay of at least 25 days. Continuing Care Hospital provides a highly focused environment of care to meet the needs of its patients. Continuing Care Hospital has multiple resources available to assist in the management of complex medical needs.

Community Benefit Leadership and Team

The Healthy Communities / Community Benefit Committee at CHI Saint Joseph Health plays a vital role in the CHNA process. The committee includes representation from community health, mission services, nursing services, violence prevention, and other hospital leadership. Committee members were invited to participate in several meetings throughout the CHNA process, including multiple presentations of data findings, virtual discussions, and an online prioritization activity. The members participating in this committee, including names, titles, and associated facilities, are provided in Appendix H.

Resources Potentially Available to Address Needs

The availability of health care resources is critical to the health of a county's residents and addressing health needs, including those identified in this assessment. A limited supply of health resources, especially providers, results in poorer health status of the community. Appendix I provides a list and description of potentially available resources to address the health needs of Continuing Care Hospital's community. The Kentucky Cabinet for Health and Family Services updates the list of these resources monthly in their report "Inventory of Health Facilities and Services" at this link: https://chfs.ky.gov/agencies/os/oig/dcn/Pages/inventory.aspx.

Acknowledgements

CHI Saint Joseph Health commissioned Conduent Healthy Communities Institute (HCI) to support report development for Continuing Care Hospital's 2023-2025 Community Health Needs Assessment. HCI works with clients across the nation to drive community health outcomes by assessing needs, developing focused strategies, identifying appropriate intervention programs, establishing monitoring systems, and implementing performance evaluation processes. Report authors from HCI include Cassandra Miller, MPH, Public Health Consultant; Era Chaudhry, MBA, MPH, Public Health Senior Analyst; and George Nguyen, Research Assistant. To learn more about Conduent Healthy Communities Institute, please visit https://www.conduent.com/community-health/.

Continuing Care Hospital gratefully acknowledges the participation of a dedicated group of external stakeholders that gave generously of their time and expertise to help guide this CHNA report (Table 2).

TABLE 2. EXTERNAL STAKEHOLDERS

American Heart Association
Bluegrass Area Development District
Catholic Action Center
Consolidated Baptist Church
Croswell-Schulte
Fayette County Public Schools
Food Chain
God's Pantry Food Bank
Humana CareSource
Kentucky House of Representatives
Lexington-Fayette County Health Department
Lexington-Fayette Urban County Government
Lexington Public Library
New Vista
Partners for Youth
Refuge Clinic
The Lexington Education and Partnership (LEAP) Academy
The Nest

Look Back: Evaluation of Progress Since Prior CHNA

Continuing Care Hospital completes its CHNA every three years. An important piece of this three-year cycle includes the ongoing review of progress made on priority health topics set forth in the preceding CHNA and Implementation Strategy (Figure 3). By reviewing the actions taken to address priority health issues and evaluating the impact those actions have made in the community, it is possible to better target resources and efforts during the next assessment.

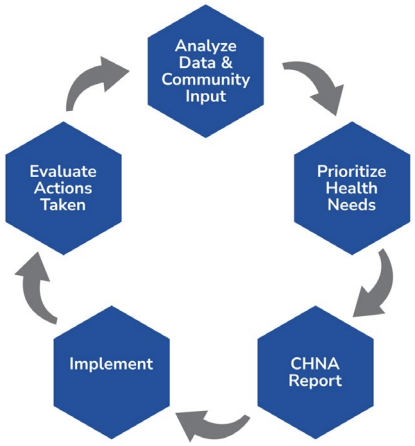
Priority Health Needs from Preceding CHNA

Continuing Care Hospital's priority health areas for fiscal year 2020-2022 were:

- Substance Abuse, including Tobacco and Vaping
- Obesity and Diabetes, including Wellness & Exercise
- Mental Health Support

A detailed impact report outlining the goals, objectives and status of each strategy is provided in Appendix G.

FIGURE 3. THE CHNA CYCLE



Community Feedback

The 2020-2022 Community Health Needs Assessment and Implementation Strategy were made available to the public via the website https://www.chisaintjosephhealth.org/healthycommunities. Continuing Care Hospital invited written comments on the most recent CHNA and Implementation Strategy on the website where they are widely available to the public: https://www.chisaintjosephhealth.org/healthy-community-chna-feedback. No written comments had been received on the preceding CHNA at the time this report was written.

Defining the Community

Defining the community is a key component of the CHNA process as it determines the scope of the assessment and implementation strategy.

Process for Identifying the Community

For the 2023-2025 Community Health Needs Assessment, the community served by Continuing Care Hospital, also known as the hospital's primary service area (PSA), was defined based on zip codes representing 75% of all inpatient discharges. To identify those zip codes, inpatient discharge data from July 2020 – June 2021 (fiscal year 2021) were obtained and analyzed by the patient's zip code of residence. This process identified 33 zip codes that define Continuing Care Hospital's Primary Service Area.

Continuing Care Hospital Primary Service Area

Continuing Care Hospital is located in Lexington, Kentucky. The geographical boundary of the hospital's primary service area is defined by 33 zip codes and is home to an estimated 796,901 residents. While the largest portion of the hospital's patients reside in Fayette County, the hospital's service area includes 21 counties, stretching from Anderson County in the west to Rowan County in the east and Harrison County in the north to Knox County in the south. The 33 zip codes that define the Continuing Care Hospital Primary Service Area (PSA) are colored in blue in the map below (Figure 4). The zip codes and corresponding city/county names that comprise the hospital's PSA are listed in Table 3.

FIGURE 4. CONTINUING CARE HOSPITAL PRIMARY SERVICE AREA

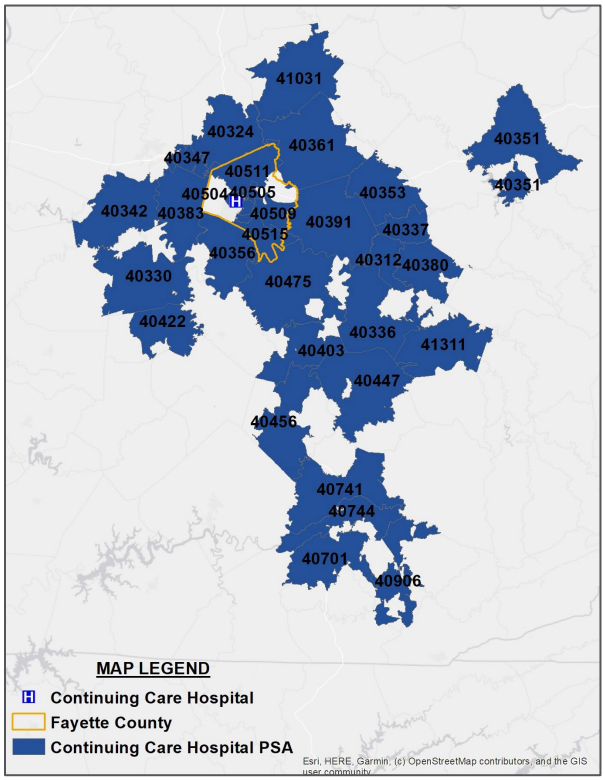


TABLE 3. ZIP CODES COMPRISING CCH PRIMARY SERVICE AREA, BY INPATIENT DISCHARGES

Zip Code	City	County	State	Inpatient Discharges	Percent of Total
40511	Lexington	Fayette	KY	15	6.0%
40356	Nicholasville	Jessamine	KY	14	5.6%
40505	Lexington	Fayette	KY	12	4.8%
40504	Lexington	Fayette	KY	10	4.0%
40391	Winchester	Clark	KY	10	4.0%
40324	Georgetown	Scott	KY	8	3.2%
40353	Mount Sterling	Montgomery	KY	8	3.2%
40361	Paris	Bourbon	KY	8	3.2%
40475	Richmond	Madison	KY	7	2.8%
40508	Lexington	Fayette	KY	7	2.8%
40515	Lexington	Fayette	KY	6	2.4%
40517	Lexington	Fayette	KY	6	2.4%
40403	Berea	Madison	KY	6	2.4%
40336	Irvine	Estill	KY	5	2.0%
40741	London	Laurel	KY	5	2.0%
40502	Lexington	Fayette	KY	4	1.6%
40456	Mount Vernon	Rockcastle	KY	4	1.6%
41031	Cynthiana	Harrison	KY	4	1.6%
40422	Danville	Boyle	KY	4	1.6%
40509	Lexington	Fayette	KY	4	1.6%
40312	Clay City	Powell	KY	3	1.2%
40906	Barbourville	Knox	KY	3	1.2%
40383	Versailles	Woodford	KY	3	1.2%
40337	Jeffersonville	Montgomery	KY	3	1.2%
41311	Beattyville	Lee	KY	3	1.2%
40342	Lawrenceburg	Anderson	KY	3	1.2%
40701	Corbin	Whitley	KY	3	1.2%
40347	Midway	Woodford	KY	3	1.2%
40744	London	Laurel	KY	3	1.2%
40447	Mc Kee	Jackson	KY	3	1.2%
40380	Stanton	Powell	KY	3	1.2%
40351	Morehead	Rowan	KY	3	1.2%
40330	Harrodsburg	Mercer	KY	3	1.2%
Other				62	25.0%
Fiscal Year 2021 Total Discharges				**248**	**100%**

Health Professional Shortage Areas & Medically Underserved Areas

Twelve medically underserved communities have been designated within the hospital's primary service area by the Health Resources and Services Administration (HRSA), including Berry Service Area (MUA/P: 01317), Estill County (MUA/P: 1211038356), Fayette Service Area (MUA/P: 01314), Jackson County (MUA/P: 1211126189), Knox County (MUA/P: 1212550713), Lee County (MUA/P: 1212723153), Madison Service Area (MUA/P: 01268), Mercer County (MUA/P: 1216771018), Montgomery Service Area (MUA/P: 01277), Powell County (MUA/P: 1212442088), Rockcastle County (MUA/P: 01291), and Scott Service Area (MUA/P: 01293). Within Fayette County, HRSA has also designated Federal Medical Center-Lexington, Bluegrass Primary Health Care Center, Inc., Healthfirst Bluegrass, Inc., and University of Kentucky as health professional shortage areas for primary care, dental health, and mental health discipline professionals.

Geographic Levels of Data

Due to variability in the geographic level in which public health data sets are available, data within this report may be presented at various geographic levels:

- Continuing Care Hospital Primary Service Area (CCH PSA) – an aggregate of the 33 zip codes defined in Table 3
- Fayette County – the county representing the greatest proportion of inpatient discharges at Continuing Care Hospital

Demographic Profile

The demographics of a community significantly impact its health profile. Different racial, ethnic, age and socioeconomic groups may have unique needs and require varied approaches to health improvement efforts. The following section explores the demographic profile of the community served by Continuing Care Hospital.

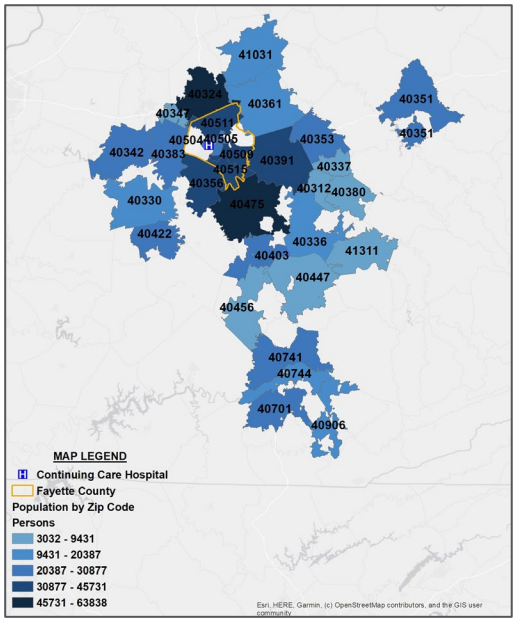
Geography and Data Sources

Data are presented in this section at the geographic level of the hospital's primary service area, an aggregate of the 33 zip codes defined earlier in this report (see Continuing Care Hospital Primary Service Area, Table 3). Comparisons to the county, state, and national value are also provided when available. All demographic estimates are sourced from Claritas Pop-Facts® (2021 population estimates) and American Community Survey one-year (2019) or five-year (2015-2019) estimates unless otherwise indicated.

Population

According to the 2021 Claritas Pop-Facts® population estimates, Continuing Care Hospital's Primary Service Area has an estimated population of 796,901 persons. Figure 5 shows the population size by each zip code, with the darkest blue representing the zip codes with the largest population. Table 4 provides the actual population estimates for each zip code. The most populated zip code within the hospital's primary service area is 40475 (Richmond, in Madison County) with a population of 63,838 (Table 4). The second most populated zip code is 40324 (Georgetown, in Scott County), with a population of 52,122 (Table 4). According to the Federal Office of Rural Health Policy, 24 of the 33 zip codes in the hospital's primary service area (72.7%) have been designated rural. This designation is important for government functions related to policymaking, regulation, and program administration.[1]

FIGURE 5. POPULATION BY ZIP CODE*



*Map shows all zip codes in the hospital's primary service area and Fayette County

[1] Rural Health Information Hub https://www.ruralhealthinfo.org/

TABLE 4. POPULATION BY ZIP CODE

Zip Code	City	Population
40475	Richmond	63,838
40324	Georgetown	52,122
40356	Nicholasville	45,731
40509	Lexington	41,799
40515	Lexington	38,326
40511	Lexington	37,232
40517	Lexington	36,805
40391	Winchester	35,771
40701	Corbin	30,877
40504	Lexington	28,141
40403	Berea	27,651
40505	Lexington	26,570
40502	Lexington	25,982
40422	Danville	25,355
40383	Versailles	24,859
40508	Lexington	23,270
40741	London	23,210
40353	Mount Sterling	22,721
40342	Lawrenceburg	22,438
40351	Morehead	22,082
40330	Harrodsburg	20,387
40744	London	18,964
40361	Paris	17,820
41031	Cynthiana	16,356
40336	Irvine	12,649
40906	Barbourville	11,392
40456	Mount Vernon	9,431
40447	Mc Kee	7,481
41311	Beattyville	6,804
40380	Stanton	6,688
40337	Jeffersonville	5,635
40312	Clay City	5,482
40347	Midway	3,032

Age

Figure 6 shows the population of the hospital's primary service area by age group.

The age distribution of the population in the CCH PSA is relatively similar to the age distribution of the population in Kentucky and the U.S. (Figure 7).

FIGURE 6. POPULATION BY AGE, CCH PRIMARY SERVICE AREA

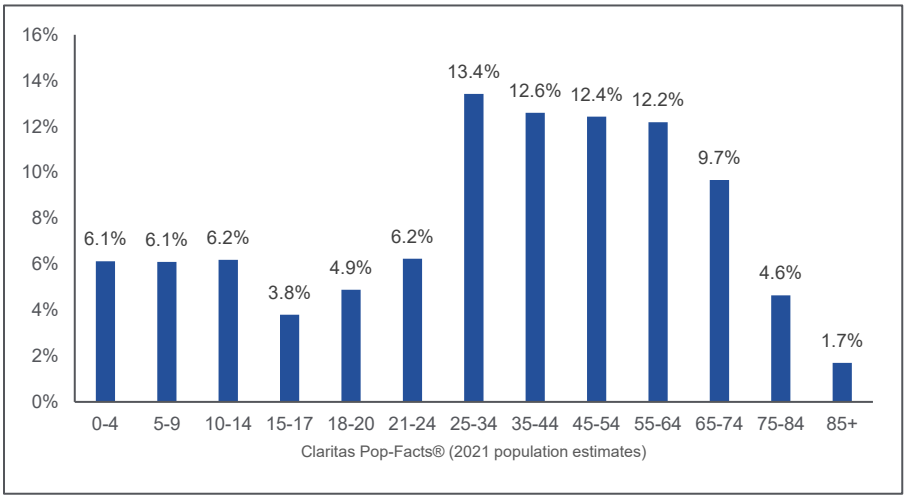


FIGURE 7. POPULATION BY AGE: COUNTY, STATE AND U.S. COMPARISONS

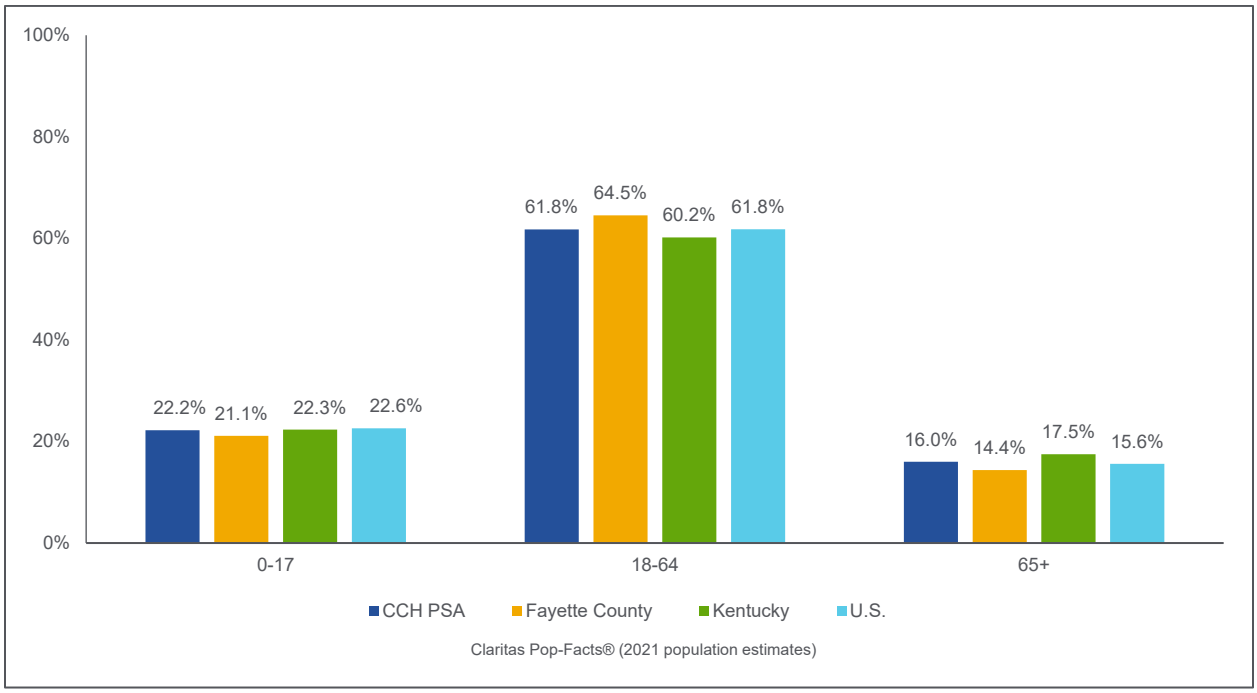
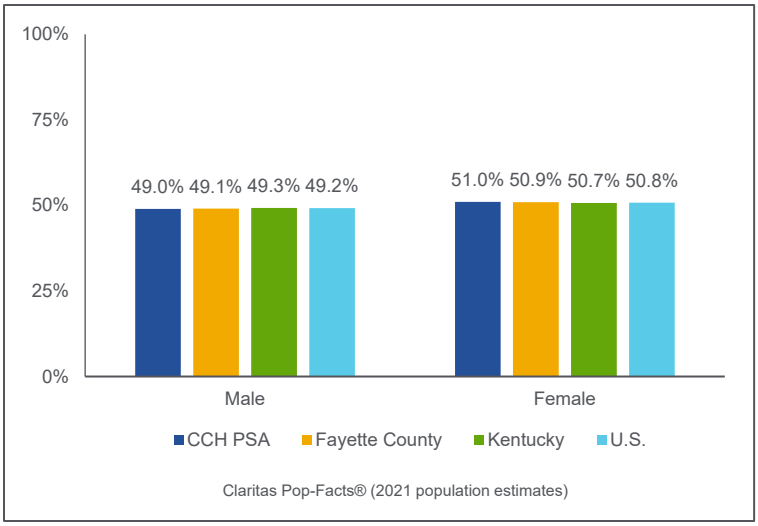


FIGURE 8. POPULATION BY SEX: COUNTY, STATE AND U.S. COMPARISONS



Sex

Figure 8 shows the population of the hospital's primary service area by sex. Males comprise 49.0% of the population, whereas females comprise 51.0% of the population in the CCH PSA.

Race and Ethnicity

The racial and ethnic composition of a population is important in planning for future community needs, particularly for schools, businesses, community centers, health care, and childcare. Analysis of health and social determinants of health data by race/ethnicity can also help identify disparities in housing, employment, income, and poverty.

The racial makeup of the hospital's primary service area shows 84.9% of the population identifying as White, as indicated in Figure 9. The proportion of Black/African American community members is the second largest of all races in the CCH PSA at 8.2% and is the only other race that makes up more than 5% of the population.

FIGURE 9. POPULATION BY RACE, CCH PRIMARY SERVICE AREA

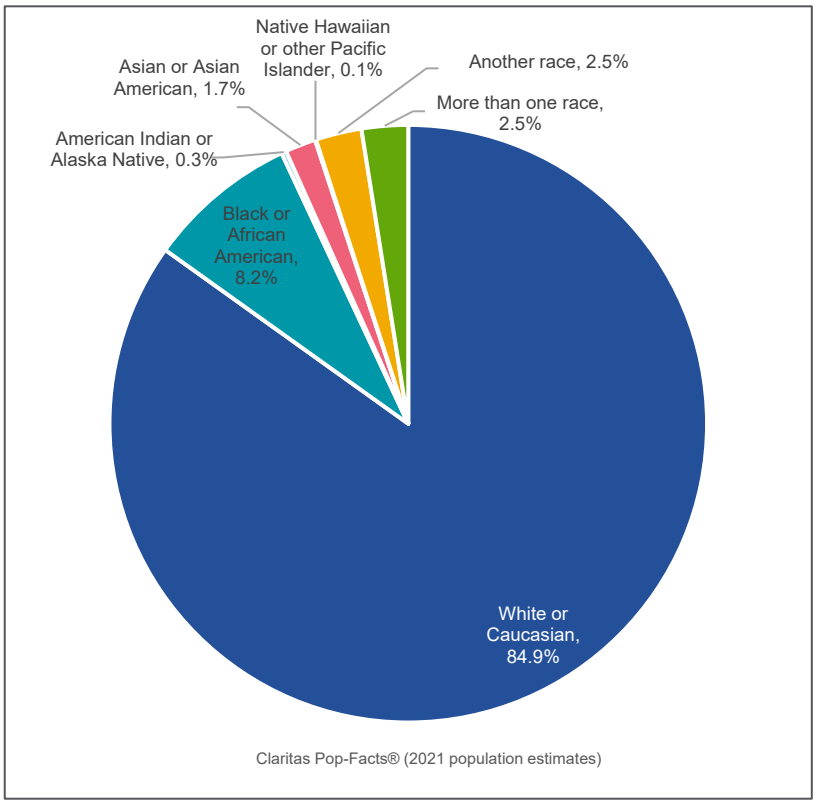


FIGURE 10. POPULATION BY RACE: COUNTY, STATE AND U.S. COMPARISONS

White community members represent a higher proportion of the population in the CCH PSA when compared to Fayette County and the U.S., while Black/African American community members represent a lower proportion of the population when compared to Fayette County and the U.S. (Figure 10).

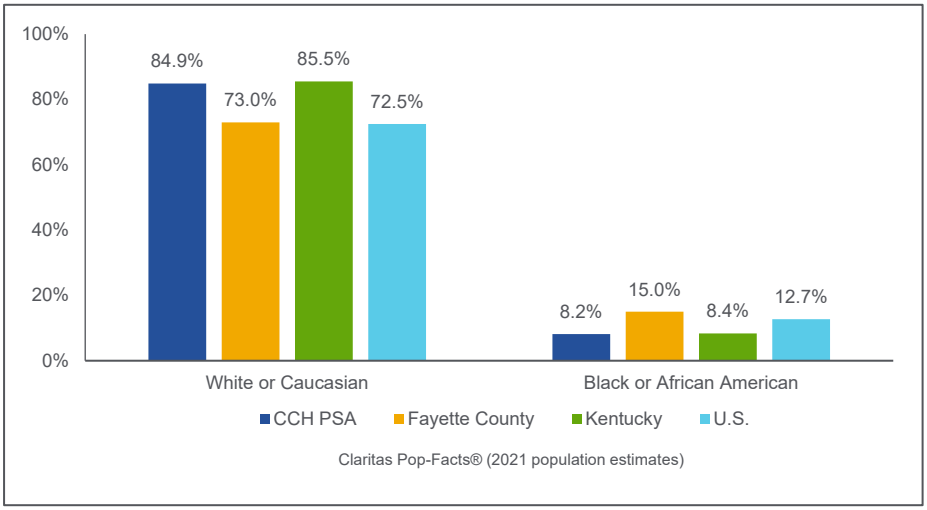
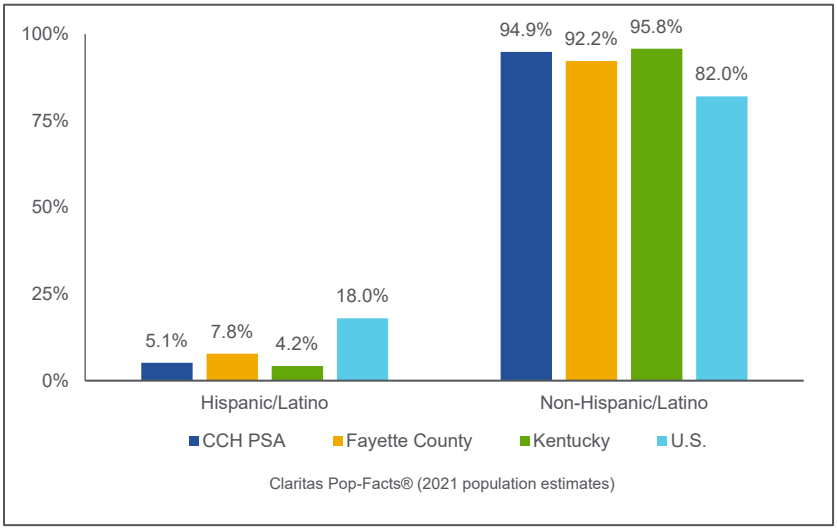


FIGURE 11. POPULATION BY ETHNICITY: COUNTY, STATE AND U.S. COMPARISONS



As shown in Figure 11, 5.1% of the population in the CCH PSA identify as Hispanic/Latino. This is a smaller proportion of the population when compared to Fayette County and the U.S., but a slightly higher proportion of the population when compared to Kentucky.

Language and Immigration

Understanding countries of origin and language spoken at home can help inform the cultural and linguistic context for the health and public health system. According to the American Community Survey, 9.7% of residents in Fayette County are born outside the U.S., which is higher than the Kentucky value of 3.9% but lower than the U.S. value of 13.6%.[2]

More than 91% of the population age five and older in the hospital's primary service area speak only English at home, which is slightly lower than the state value of 91.9% and higher than the national value of 78.4% (Figure 12). This data indicates that nearly 9% of the population in the hospital's primary service area speak a language other than English at home.

FIGURE 12. POPULATION 5+ BY LANGUAGE SPOKEN AT HOME: COUNTY, STATE AND U.S. COMPARISONS

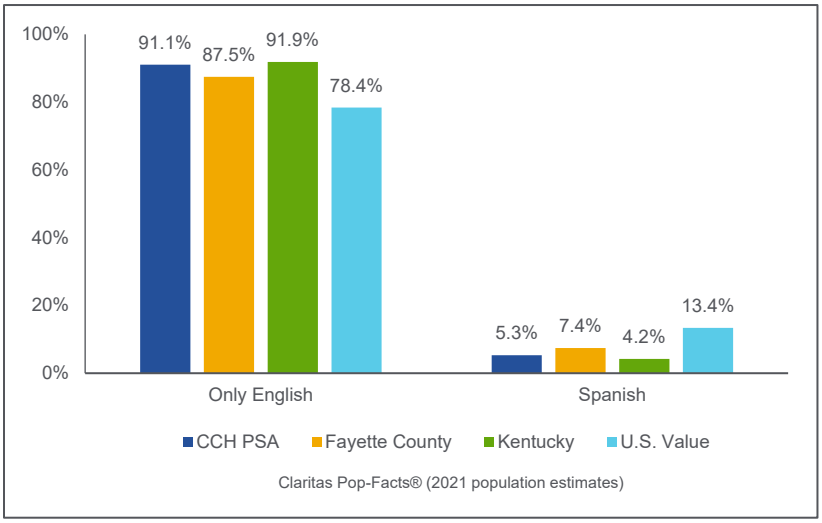
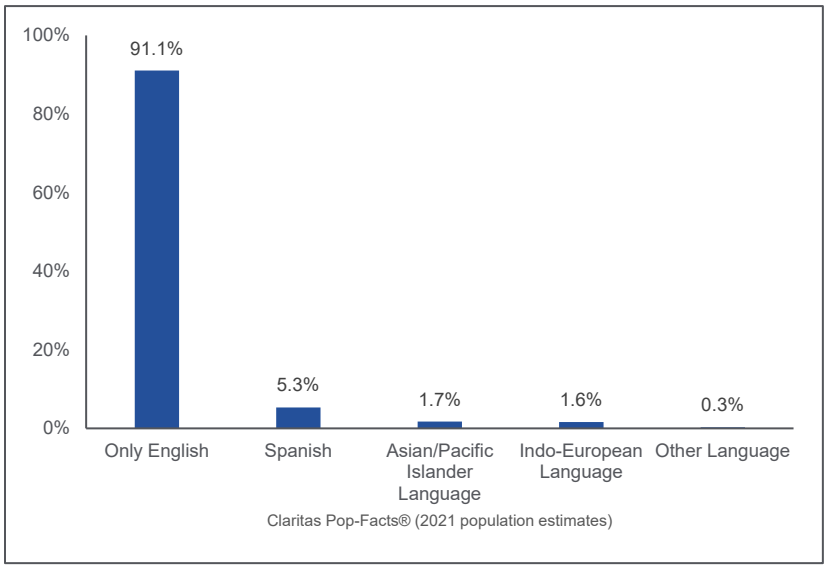


FIGURE 13. POPULATION AGE 5+ BY LANGUAGE SPOKEN AT HOME, CCH PRIMARY SERVICE AREA



The most common languages spoken at home among residents in the hospital's primary service area are English (91.1%) and Spanish (5.3%) (Figure 13).

[2] American Community Survey, 2015-2019

Social & Economic Determinants of Health

This section explores the economic, environmental, and social determinants of health impacting the community served by Continuing Care Hospital. Social determinants are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.

Geography and Data Sources

Data in this section are presented at various geographic levels (zip code, primary service area, and/or county) depending on data availability. When available, comparisons to county, state and/or national values are provided. It should be noted that hospital service area or county level data can sometimes mask what could be going on at the zip code level in many communities. While indicators may be strong when examined at a higher level, zip code level analysis can reveal disparities.

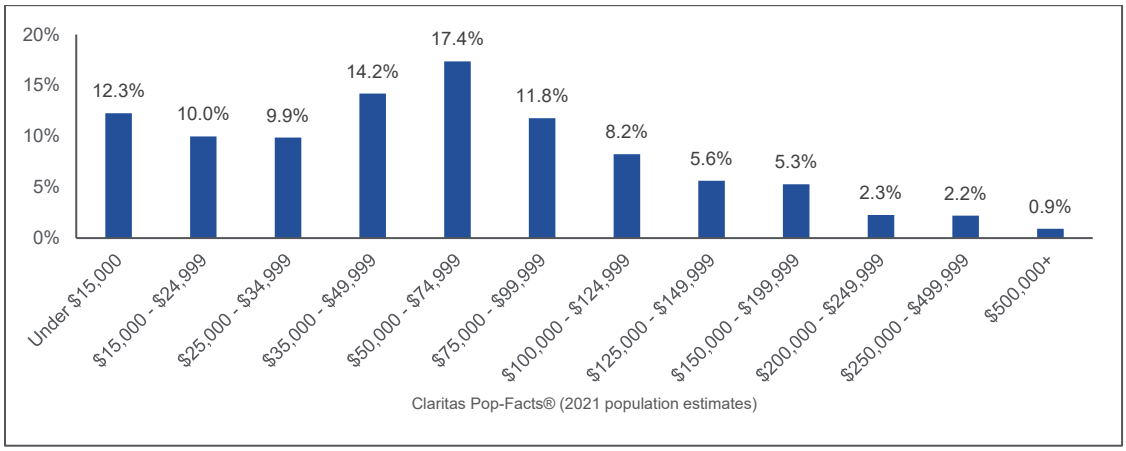
All demographic estimates are sourced from Claritas Pop-Facts® (2021 population estimates) and American Community Survey one-year (2019) or five-year (2015-2019) estimates unless otherwise indicated.

Income

Income has been shown to be strongly associated with morbidity and mortality, influencing health through various clinical, behavioral, social, and environmental factors. Those with greater wealth are more likely to have higher life expectancy and reduced risk of a range of health conditions including heart disease, diabetes, obesity, and stroke. Poor health can also contribute to reduced income by limiting one's ability to work.[3]

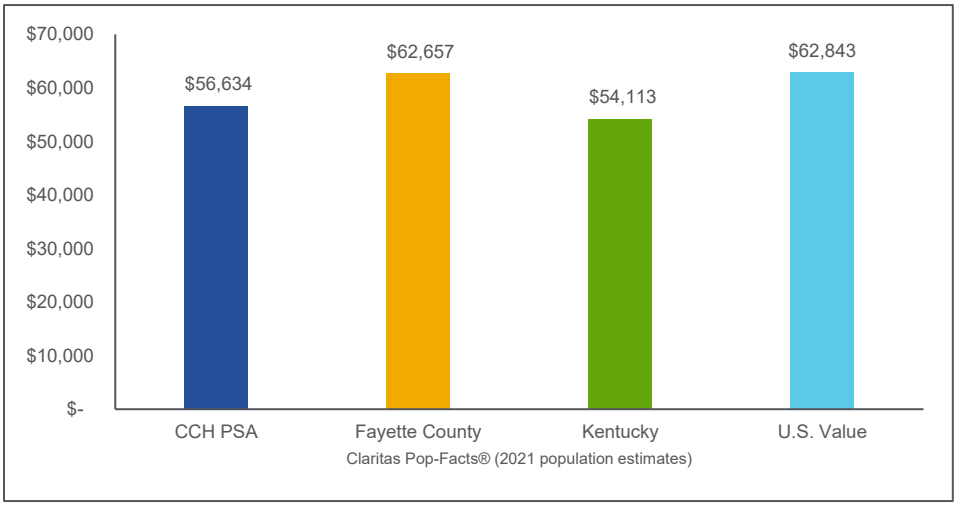
Figure 14 provides a breakdown of households by income in the hospital's primary service area. A household income of $50,000 - $74,999 is shared by the largest proportion of households in the CCH PSA (17.4%), followed by a household income of $35,000 - $49,999 (14.2% of households). Households with an income of less than $15,000 make up 12.3% of households in the CCH PSA.

FIGURE 14. HOUSEHOLDS BY INCOME, CCH PRIMARY SERVICE AREA



[3] Robert Wood Johnson Foundation. Health, Income, and Poverty. https://www.rwjf.org/en/library/research/2018/10/health--income-and-poverty-where-we-are-and-what-could-help.html

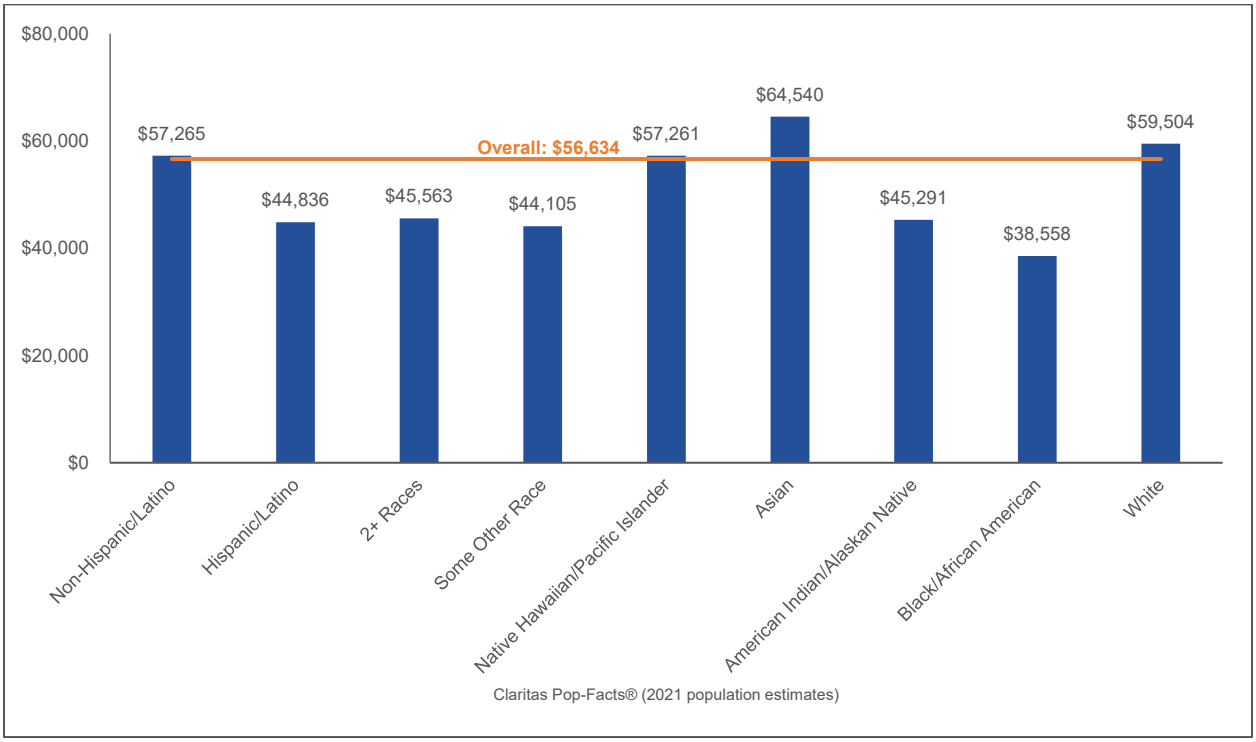
FIGURE 15. MEDIAN HOUSEHOLD INCOME: COUNTY, STATE AND U.S. COMPARISONS



The median household income for the CCH PSA is $56,634, which is slightly higher than the Kentucky value ($54,113) but lower than both the Fayette County value ($62,657) and national value ($62,843) (Figure 15).

Figure 16 shows the median household income by race and ethnicity. Four racial/ethnic groups – Asian, White, Native Hawaiian/Pacific Islander and Non-Hispanic/Latino – have median household incomes above the overall median value. All other races have incomes below the overall value, with the Black/African American population having the lowest median household income at $38,558, which is about $18,000 lower than the overall median household income.

FIGURE 16. MEDIAN HOUSEHOLD INCOME BY RACE/ETHNICITY, CCH PRIMARY SERVICE AREA

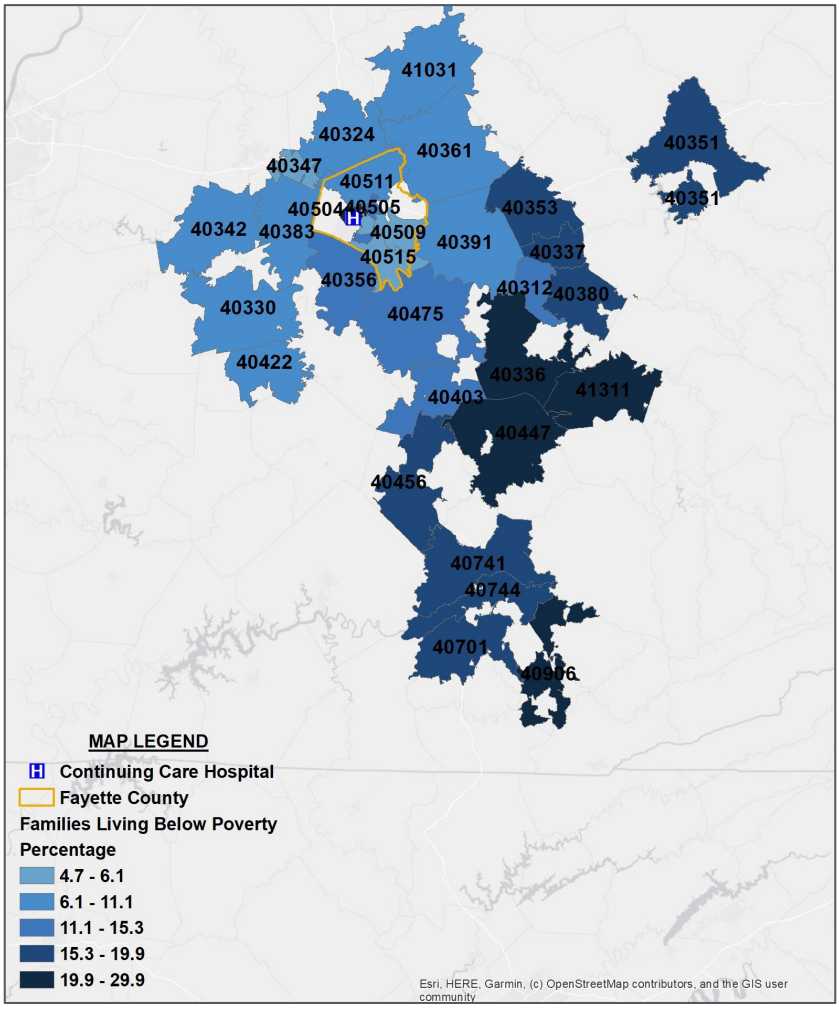


Poverty

Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. People living in poverty are less likely to have access to health care, healthy food, stable housing, and opportunities for physical activity. These disparities mean people living in poverty are more likely to experience poorer health outcomes and premature death from preventable diseases.[4]

Figure 17 shows the percentage of families living below the poverty level by zip code, with the darker blue colors representing a higher percentage of families living below the poverty level. The southeastern portion of the hospital's primary service area has the highest rates of poverty, with zip codes 40336 (Irvine, in Estill County), 41311 (Beattyville, in Lee County), and 40447 (Mc Kee, in Jackson County) having the highest percentages at 30.0%, 28.0% and 26.5%, respectively. Overall, 13.3% of families in the CCH PSA live below the poverty level, which is higher than the Fayette County value of 9.2%, the state value of 12.9% and the national value of 9.5%. The percentage of families living below poverty for each zip code in the CCH PSA is provided in Table 5.

FIGURE 17. FAMILIES LIVING BELOW POVERTY LEVEL BY ZIP CODE*



*Map shows all zip codes in the hospital's primary service area and Fayette County

[4] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/economic-stability/reduce-proportion-people-living-poverty-sdoh-01

TABLE 5. FAMILIES LIVING BELOW POVERTY LEVEL BY ZIP CODE

Zip Code	City	Families Below Poverty Level (%)
40336	Irvine	30.0%
41311	Beattyville	28.0%
40447	Mc Kee	26.5%
40906	Barbourville	25.6%
40508	Lexington	24.4%
40504	Lexington	23.0%
40741	London	20.0%
40701	Corbin	19.1%
40456	Mount Vernon	18.2%
40351	Morehead	17.8%
40337	Jeffersonville	17.7%
40744	London	16.4%
40380	Stanton	16.3%
40353	Mount Sterling	16.3%
40312	Clay City	15.3%
40517	Lexington	14.9%
40356	Nicholasville	13.9%
40505	Lexington	13.4%
40403	Berea	13.2%
40475	Richmond	12.4%
40361	Paris	11.2%
40391	Winchester	11.1%
41031	Cynthiana	10.9%
40342	Lawrenceburg	10.8%
40330	Harrodsburg	10.5%
40383	Versailles	9.9%
40422	Danville	9.5%
40324	Georgetown	9.2%
40511	Lexington	9.1%
40509	Lexington	6.1%
40502	Lexington	5.9%
40347	Midway	5.0%
40515	Lexington	4.7%
--	**CCH PSA**	**13.3%**
--	**Fayette County**	**9.2%**
--	**Kentucky**	**12.9%**
--	**U.S.**	**9.5%**

Employment

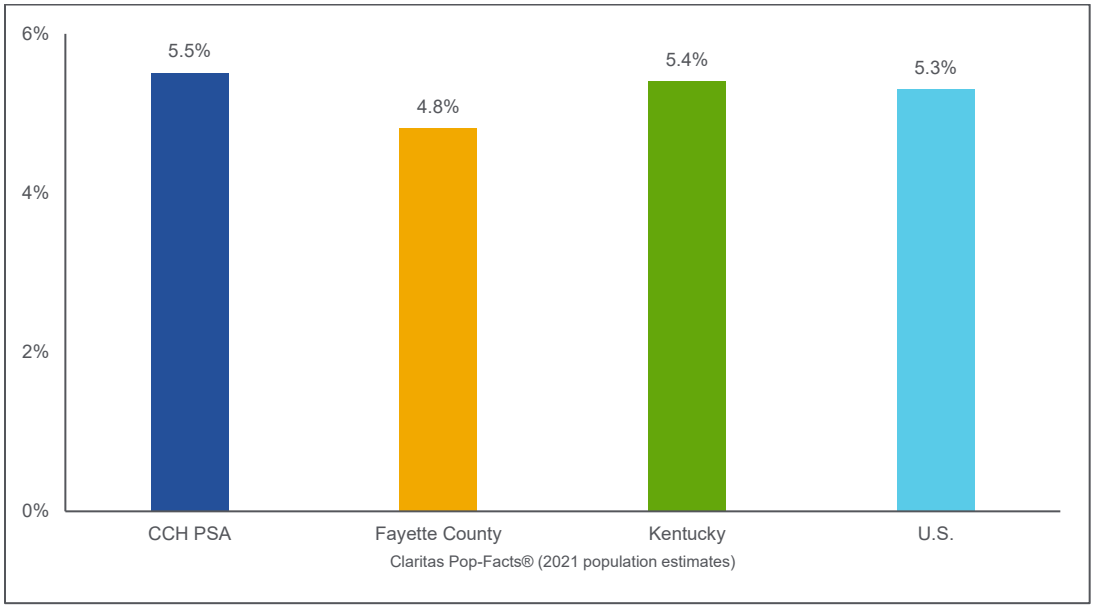
A community's employment rate is a key indicator of the local economy. An individual's type and level of employment impacts access to health care, work environment, health behaviors and health outcomes. Stable employment can help provide benefits and conditions for maintaining good health. In contrast, poor or unstable work and working conditions are linked to poor physical and mental health outcomes. [5]

Unemployment and underemployment can limit access to health insurance coverage and preventive care services. Underemployment is described as involuntary part-time employment, poverty-wage employment, and insecure employment.[5]

Type of employment and working conditions can also have significant impacts on health. Work-related stress, injury, and exposure to harmful chemicals are examples of ways employment can lead to poorer health.[5]

Figure 18 shows the population aged 16 and over who are unemployed. The unemployment rate for the hospital's primary service area is 5.5%, which is higher than the Fayette County value of 4.8%, the state value of 5.4% and the national value of 5.3%.

FIGURE 18. POPULATION 16+ UNEMPLOYED



[5] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/social-determinants-health/literature-summaries/employment

Education

Education is an important indicator for health and wellbeing across the lifespan. Education can lead to improved health by increasing health knowledge, providing better job opportunities and higher income, and improving social and psychological factors linked to health. People with higher levels of education are likely to live longer, to experience better health outcomes, and practice health-promoting behaviors.[6]

FIGURE 19. POPULATION 25+ BY EDUCATIONAL ATTAINMENT, CCH PRIMARY SERVICE AREA

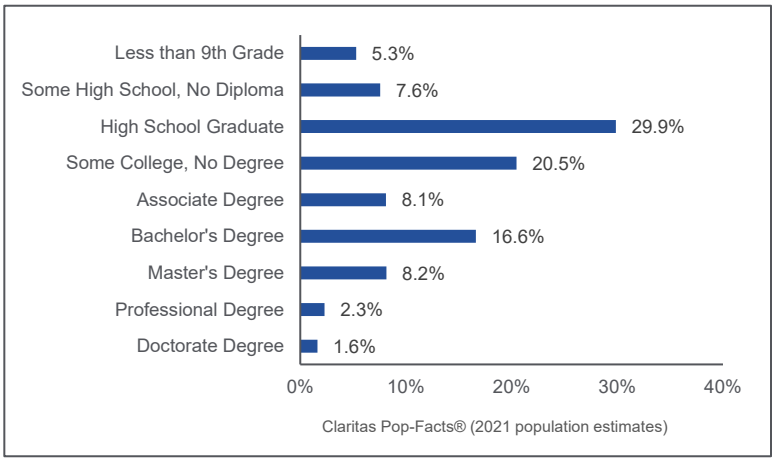
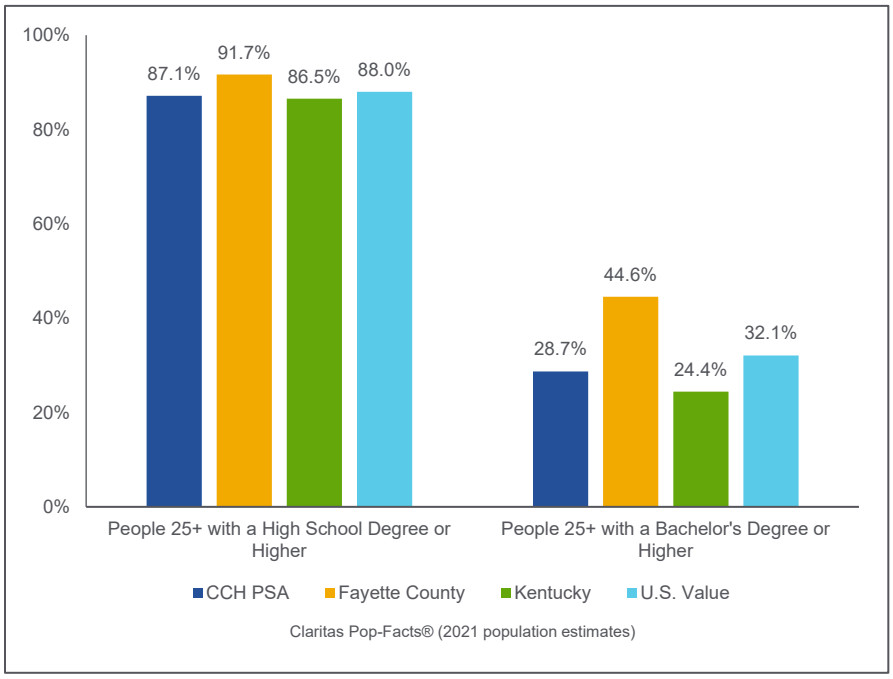


Figure 19 shows the percentage of the population 25 years or older by educational attainment.

FIGURE 20. POPULATION 25+ BY EDUCATIONAL ATTAINMENT: COUNTY, STATE AND U.S. COMPARISONS



Another indicator related to education is on-time high school graduation. A high school diploma is a requirement for many employment opportunities and for higher education. Not graduating high school is linked to a variety of negative health impacts, including limited employment prospects, low wages, and poverty.[7]

Figure 20 shows that the hospital's primary service area has a lower percentage of residents with a high school degree than in Fayette County and the U.S. The percentage of residents with a bachelor's degree is markedly lower in the hospital's primary service area when compared to Fayette County and the U.S., but higher when compared to Kentucky.

[6] Robert Wood Johnson Foundation, Education and Health. https://www.rwjf.org/en/library/research/2011/05/education-matters-for-health.html

[7] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/social-determinants-health/literature-summaries/high-school-graduation

Housing

Safe, stable, and affordable housing provides a critical foundation for health and wellbeing. Exposure to health hazards and toxins in the home can cause significant damage to an individual or family's health.[8]

Figure 21 shows the percentage of houses with severe housing problems. This indicator measures the percentage of households with at least one of the following problems: overcrowding, high housing costs, lack of kitchen, or lack of plumbing facilities. In Fayette County, 16.7% of households were found to have at least one of those problems, which is higher than the state value (13.7%) and national value (16.0%).

FIGURE 21. HOUSEHOLDS WITH SEVERE HOUSING PROBLEMS

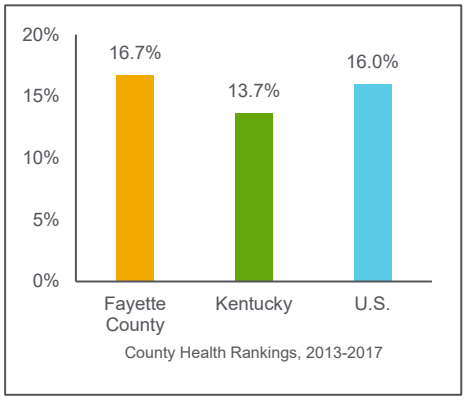
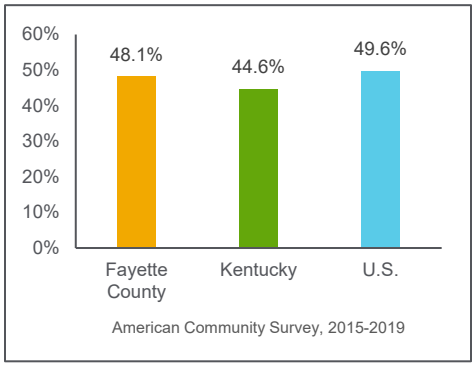


FIGURE 22. RENTERS SPENDING 30% OR MORE OF HOUSEHOLD INCOME ON RENT



When families must spend a large portion of their income on housing, they may not have enough money to pay for things like healthy foods or health care. This is linked to increased stress, mental health problems, and an increased risk of disease.[9]

Figure 22 shows the percentage of renters who are spending 30% or more of their household income on rent. The value in Fayette County, 48.1%, is higher than the Kentucky value (44.6%) but lower than the national value (49.6%).

Neighborhood and Built Environment

Access to the internet is an important indicator for health and wellbeing. Internet access is essential for basic health care access, including making appointments with providers, getting test results, and accessing medical records. Access to the internet is also increasingly essential for obtaining home-based telemedicine services.[10]

Internet access may also help individuals seek employment opportunities, conduct remote work, and participate in online educational activities.[10]

FIGURE 23. HOUSEHOLDS WITH AN INTERNET SUBSCRIPTION

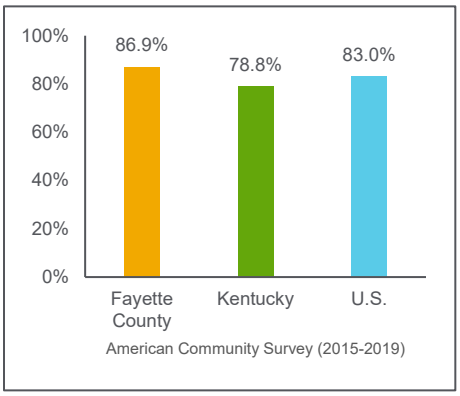


Figure 23 shows the percentage of households that have an internet subscription. The rate in Fayette County, 86.9%, is higher than both the state value (78.8%) and national value (83.0%).

[8] County Health Rankings, Housing and Transit. https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/physical-environment/housing-and-transit

[9] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/housing-and-homes/reduce-proportion-families-spend-more-30-percent-income-housing-sdoh-04

[10] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/neighborhood-and-built-environment/increase-proportion-adults-broadband-internet-hchit-05

Disparities and Health Equity

Identifying disparities by population groups and geography helps to inform and focus priorities and strategies. Understanding disparities also helps us better understand root causes that impact health in a community and inform action towards health equity.

Health Equity

Health equity focuses on the fair distribution of health determinants, outcomes, and resources across communities.[11] National trends have shown that systemic racism, poverty, and gender discrimination have led to poorer health outcomes for groups such as Black/African American persons, Hispanic/Latino persons, indigenous communities, people with incomes below the federal poverty level, and LGBTQ+ communities.

Race, Ethnicity, Age & Gender Disparities

Primary and secondary data revealed significant community health disparities by race, ethnicity, gender, and age. It is important to note that while much of the data is presented to show differences and disparities of data by population groups, differences within each population group can be as great as differences between different groups. For instance, Asian or Asian and Pacific Islander persons encompasses individuals from over 40 different countries with very different languages, cultures, and histories in the U.S. Information and themes captured through key informant interviews, focus group discussions, and an online community survey have been shared to provide a more comprehensive and nuanced understanding of each community's experiences.

Secondary Data

Community health disparities were assessed in the secondary data using the Index of Disparity[12] analysis, which identifies disparities based on how far each subgroup (by race, ethnicity, or gender) is from the overall county value. For more detailed methodology related to the Index of Disparity, see Appendix B.

Table 6 below identifies secondary data indicators with a statistically significant race, ethnicity, or gender disparity for Fayette County, based on the Index of Disparity.

[11] Klein R, Huang D. Defining and measuring disparities, inequities, and inequalities in the Healthy People initiative. National Center for Health Statistics. Center for Disease Control and Prevention. https://www.cdc.gov/nchs/ppt/nchs2010/41_klein.pdf

[12] Pearcy, J. & Keppel, K. (2002). A Summary Measure of Health Disparity. Public Health Reports, 117, 273-280.

TABLE 6. INDICATORS WITH SIGNIFICANT RACE, ETHNICITY OR GENDER DISPARITIES

Health Indicator	Group Negatively Impacted
Age-Adjusted Death Rate due to Colorectal Cancer	Black/African American, Male
Age-Adjusted Death Rate due to Coronary Heart Disease	Male
Age-Adjusted Death Rate due to Diabetes	Black/African American, Male
Age-Adjusted Death Rate due to Suicide	Male
Age-Adjusted Death Rate due to Unintentional Injuries	Male
Children Living Below Poverty Level	Black/African American, American Indian/Alaska Native, Multiple Races, Other Race, Hispanic/Latino
Families Living Below Poverty Level	Black/African American, American Indian/Alaska Native, Multiple Races, Other Race, Hispanic/Latino
Oral Cavity and Pharynx Cancer Incidence Rate	Male
People 65+ Living Below Poverty Level	Black/African American, Asian, Multiple Races, Hispanic/Latino
People Living Below Poverty Level	Black/African American, American Indian/Alaska Native, Multiple Races, Other Race, Hispanic/Latino
Workers Commuting by Public Transportation	White, American Indian/Alaska Native, Other Race, Hispanic/Latino
Youth not in School or Working	Male

The Index of Disparity analysis for Fayette County reveals that the Black/African American and male populations are disproportionately impacted for many chronic diseases, including colorectal cancer and diabetes. Further, the male population is disproportionately impacted for indicators related to suicide and unintentional injuries. Multiple racial and ethnic groups are disproportionately impacted across various measures of poverty, which is often associated with poorer health outcomes. These groups include the Black/African American and Hispanic/Latino population, among others (Table 6).

Primary Data

Key informants and focus group participants mentioned that the Black/African American and Hispanic/Latino communities are more likely to be negatively impacted by poverty, which contributes to poor health outcomes. Key informants pointed out that diabetes and obesity are prevalent within the Hispanic/Latino and Black/African American populations and described an imbalance in the rate in which these groups receive regular health check-ups through a primary care physician. Distrust and fear were also mentioned as concerns within the Hispanic/Latino community, and several key informants pointed to language and culture as barriers impacting both the Hispanic/Latino community and foreign-born residents, including migrants and refugees. Another key informant described an active LGBTQ+ community, emphasizing that members of this community often struggle more than others, particularly with mental health issues. Additionally, key informants emphasized that older adults experience more barriers to accessing health care and services when compared to younger populations. Primary concerns affecting the older adult population include high rates of chronic disease and financial instability. Lower-income families and those with lower educational attainment were also cited as

struggling more than others when it comes to accessing services. Many of these challenges are documented further in Barriers to Care.

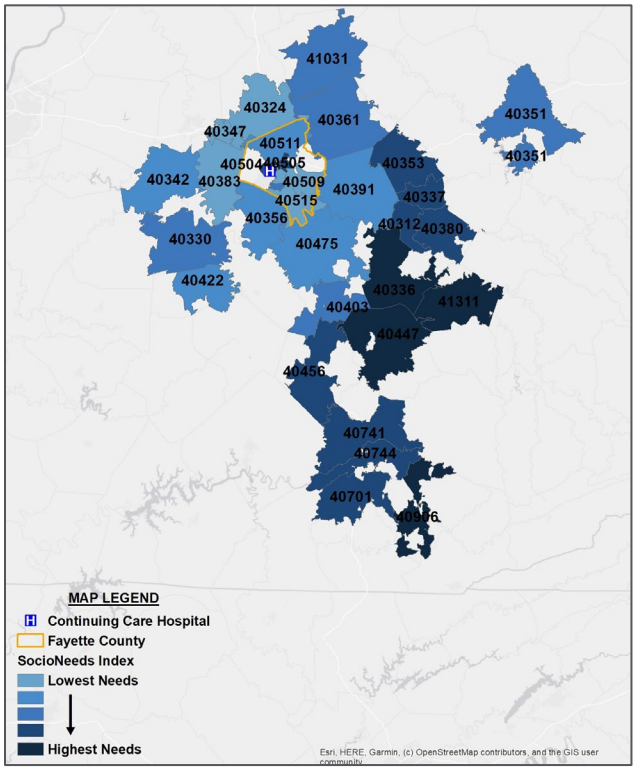
Geographic Disparities

In addition to disparities by race, ethnicity, gender, and age, this assessment also identified specific zip codes/municipalities with differences in outcomes related to health and social determinants of health. Geographic disparities were identified using the SocioNeeds Index and Food Insecurity Index. These indices have been developed by Conduent Healthy Communities Institute to easily identify areas of high socioeconomic need or food insecurity. Conduent's SocioNeeds Index estimates areas of highest socioeconomic need correlated with poor health outcomes. Conduent's Food Insecurity Index estimates areas of low food accessibility correlated with social and economic hardship. For both indices, counties, zip codes, and census tracts with a population over 300 are assigned index values ranging from 0 to 100, with higher values indicating greater need. Understanding where there are communities with higher need is critical to targeting prevention and outreach activities.

SocioNeeds Index

Conduent's SocioNeeds Index (SNI) estimates areas of high socioeconomic need, which are correlated with poor health outcomes. Zip codes are ranked based on their index value to identify relative levels of need, as illustrated by the map in Figure 24. The following zip codes in the CCH PSA had the highest level of socioeconomic need (as indicated by the darkest shades of blue): 40447 (Mc Kee, in Jackson County), 40336 (Irvine, in Estill County) and 41311 (Beattyville, in Lee County) with index values of 97.2, 97.0 and 96.2, respectively. In Fayette County, the zip codes with the highest socioeconomic need include 40508, 40504 and 40505 (all in Lexington) with index values of 90.8, 86.8 and 81.7, respectively. Table 7 provides the index values for each zip code.

FIGURE 24. SOCIONEEDS INDEX*



*Map shows all zip codes in the hospital's primary service area and Fayette County

TABLE 7. SOCIONEEDS INDEX VALUES BY ZIP CODE

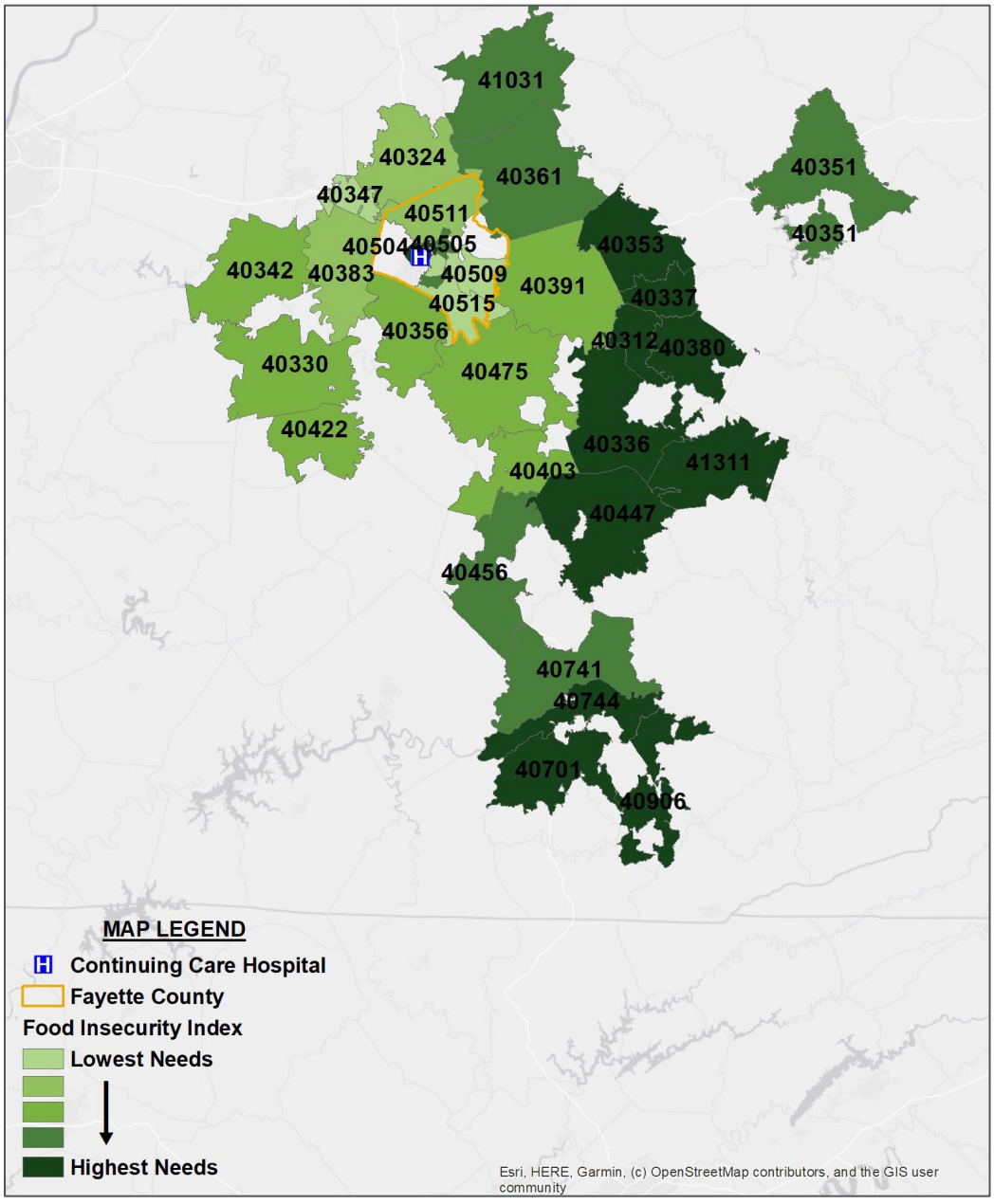
Zip Code	City	Index Value
40447	Mc Kee	97.2
40336	Irvine	97 .0
41311	Beattyville	96.2
40906	Barbourville	94.2
40508	Lexington	90.8
40337	Jeffersonville	87.4
40701	Corbin	87.0
40504	Lexington	86.8
40456	Mount Vernon	86.0
40380	Stanton	85.8
40312	Clay City	82.2
40505	Lexington	81.7
40741	London	81.6
40744	London	78.0
40353	Mount Sterling	77.1
40351	Morehead	73.9
40330	Harrodsburg	73.5
41031	Cynthiana	69.4
40403	Berea	65.5
40361	Paris	65.3
40517	Lexington	64.1
40356	Nicholasville	62.4
40391	Winchester	61.9
40342	Lawrenceburg	60.7
40475	Richmond	54.7
40422	Danville	54.4
40511	Lexington	51.1
40324	Georgetown	37.8
40383	Versailles	36.6
40347	Midway	21.8
40509	Lexington	14.7
40515	Lexington	12.7
40502	Lexington	11.9
--	**Fayette County**	**16.5***

*County index values are calculated separately from zip code index values, and the two should not be compared to each other. While index values range from 0-100 at both the county and zip code level, zip code index values represent the percentile of each zip code among all U.S. zip codes, while county index values represent the percentile of each county among all U.S. counties.

Food Insecurity Index

Conduent's Food Insecurity Index estimates areas of low food accessibility correlated with social and economic hardship. Zip codes are ranked based on their index value to identify relative levels of need, as illustrated by the map in Figure 25. The following zip codes had the highest level of food insecurity (as indicated by the darkest shades of green): 40906 (Barbourville, in Knox County), 41311 (Beattyville, in Lee County), and 40447 (Mc Kee, in Jackson County). In Fayette County, the zip codes with the highest estimated food insecurity include 40504, 40508, and 40517 with index values of 91.0, 88.2 and 82.9, respectively. Table 8 provides the index values for each zip code.

FIGURE 25. FOOD INSECURITY INDEX*



*Map shows all zip codes in the hospital's primary service area and Fayette County

TABLE 8. FOOD INSECURITY INDEX VALUES BY ZIP CODE

Zip Code	City	Index Value
40906	Barbourville	95.5
41311	Beattyville	94.6
40447	Mc Kee	94.2
40701	Corbin	92.9
40336	Irvine	91.4
40504	Lexington	91.0
40312	Clay City	90.6
40380	Stanton	89.5
40337	Jeffersonville	88.3
40508	Lexington	88.2
40353	Mount Sterling	87.4
40744	London	87.0
40741	London	85.7
40456	Mount Vernon	84.8
40517	Lexington	82.9
40505	Lexington	81.8
41031	Cynthiana	79.8
40361	Paris	79.1
40351	Morehead	78.3
40403	Berea	76.1
40422	Danville	75.5
40391	Winchester	73.3
40342	Lawrenceburg	71.6
40330	Harrodsburg	69.5
40475	Richmond	65.3
40356	Nicholasville	63.9
40511	Lexington	49.3
40383	Versailles	48.4
40324	Georgetown	41.4
40509	Lexington	30.5
40515	Lexington	26.8
40502	Lexington	19.8
40347	Midway	15.5
--	**Fayette County**	**27.1***

*County index values are calculated separately from zip code index values, and the two should not be compared to each other. While index values range from 0-100 at both the county and zip code level, zip code index values represent the percentile of each zip code among all U.S. zip codes, while county index values represent the percentile of each county among all U.S. counties.

Primary Data

Within Lexington and Fayette County, key informants and focus group participants pointed to several geographic areas of greater need. One key informant described the southern part of Fayette County as more affluent, with more access to treatment centers and grocery stores, while the northern part of the county lacks resources and services. Zip codes 40504 and 40508 – the inner-city areas – were described as some of the areas of greatest need. Due to their proximity to the downtown area and the geographical focus of many nonprofit organizations that offer services in the city center, however, one key informant mentioned that residents living in these zip code areas now have access to more services. Key informants and focus group participants also named specific neighborhoods as areas of greater need, including Cardinal Valley, Winburn, Tates Creek, Woodhill, and Eastland. Informants described many of these neighborhoods as areas that lack access to fresh and healthy foods, include many residents experiencing poverty and have sizeable refugee/immigrant populations, leading to cultural and language barriers.

Future Considerations

While disparities in health outcomes by race, ethnicity, gender, age, and geography are critical components in assessing the needs of a community, it is equally important to understand the social determinants of health and other upstream factors that influence a community's health. The challenges and barriers faced by a community must be balanced by identifying practical, community-driven solutions. Together, these factors come together to inform and focus strategies to positively impact a community's health and mitigate the disparities faced along gender, racial, ethnic, or geographic lines in the community served by Continuing Care Hospital.

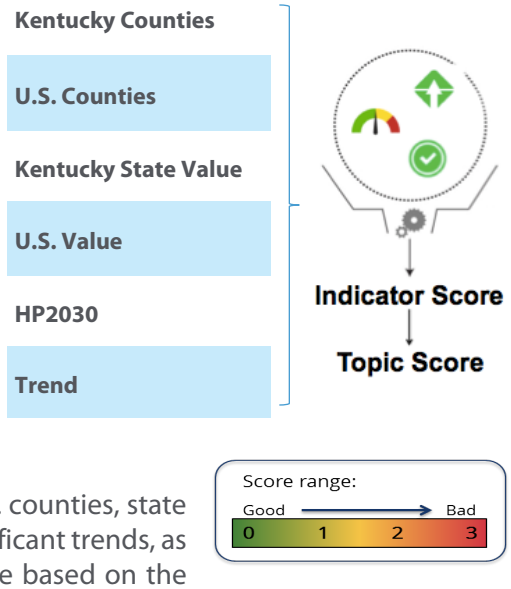
Primary and Secondary Data Methodology and Key Findings

Overview

Multiple types of data were collected and analyzed to inform this Community Health Needs Assessment. Primary data consisted of key informant interviews, focus group discussions and a community survey, while secondary data included indicators spanning health outcomes, health behaviors and social determinants of health. The methods used to analyze each type of data are outlined below. The findings from each data source were then synthesized and organized by health topic to present a comprehensive overview of the health needs in Fayette County.

Secondary Data Sources & Analysis

FIGURE 26. SECONDARY DATA SCORING



Secondary data used for this assessment were collected and analyzed from a community indicator database developed by Conduent Healthy Communities Institute (HCI). The database, maintained by researchers and analysts at HCI, includes over 150 community indicators, spanning at least 24 topics in the areas of health, determinants of health, and quality of life. The data are primarily derived from state and national public secondary data sources. The value for each of these indicators is compared to other communities, national targets, and to previous time periods.

HCI's Data Scoring Tool systematically summarizes multiple comparisons and ranks indicators based on highest need. For each indicator, the Fayette County value was compared to a distribution of Kentucky and U.S. counties, state and national values, Healthy People 2030 targets, and significant trends, as shown in Figure 26. Each indicator was then given a score based on the available comparisons. These scores range from 0 to 3, where 0 indicates the best outcome and 3 indicates the worst outcome. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected from other communities, and changes in methodology over time. These indicators were grouped into topic areas for a higher-level ranking of community health needs.

Due to the limited availability of zip code, census tract, or other sub-county health data, the data scoring technique is only available at the county level. The data scoring results for Continuing Care Hospital are therefore presented in the context of Fayette County.

Table 9 shows the health and quality of life topic scoring results for Fayette County, with Sexually Transmitted Infections as the poorest performing topic area with a score of 2.73, followed by Prevention & Safety with a score of 2.04. Topics that received a score of 1.50 or higher were considered a significant health need. Four topics scored at or above the threshold. Topic areas with fewer than three indicators were considered a data gap.

TABLE 9. TOPIC SCORING RESULTS

Topic Area	Score
Sexually Transmitted Infections	2.73
Prevention & Safety	2.04
Alcohol & Drug Use	1.80
Immunizations & Infectious Diseases	1.74

Table 9 shows only those topic areas that met the threshold of 1.50 to be considered a significant health need. Please see Appendix A for the full list of health and quality of life topics, including the list of national and state indicators that are categorized into and included in the secondary data analysis for each topic area. Further details on the quantitative data scoring methodology are also available in Appendix A.

Primary Data Collection & Analysis

To ensure the perspectives of community members were considered, input was collected from residents of the community served by Continuing Care Hospital. Primary data used in this assessment consisted of key informant interviews, focus group discussions, and an online community survey. These findings expanded upon information gathered from the secondary data analysis to inform this Community Health Needs Assessment.

Community Survey

Continuing Care Hospital gathered community input from an online survey to inform its Community Health Needs Assessment. The survey was promoted across the five primary counties served by the seven CHI Saint Joseph Health hospital facilities: Fayette, Laurel, Madison, Montgomery, and Nelson counties in Kentucky. Responses were collected from September 2, 2021, to October 20, 2021. Both an English and Spanish version of the survey were made available. A paper survey was also developed, but its distribution was limited due to health concerns and the challenge of many distribution sites operating at limited capacity during the COVID-19 pandemic. The survey consisted of 47 questions related to top health needs in the community, individuals' perception of their overall health, individuals' access to health care services, as well as social and economic determinants of health. The list of survey questions is available in Appendix E.

Survey marketing and outreach efforts included email invitations, social media and other marketing efforts through CHI Saint Joseph Health and its partner organizations. A total of 870 responses were collected for the entire survey target area, which included all seven hospital facilities spanning Fayette, Laurel, Madison, Montgomery and Nelson counties in Kentucky. Out of those survey responses, 169 (19.4%) were from community members residing in Fayette County. For purposes of this CHNA, the survey data that follows is based on an analysis of responses from community members residing in Fayette County.

Demographic Profile of Survey Respondents

Fayette County survey respondents were more likely to be educated, have a higher income, identify as female, identify as White, identify as Non-Hispanic/Latino, and skew older when compared to the actual

population estimates reflected in the demographic data for Fayette County. See Appendix C for additional details on the demographic profile of survey respondents.

Community Survey Analysis Results

Survey participants were asked about the most important health issues and which quality of life issues they would most like to see addressed in the community. The top responses for these questions are shown in Figures 27 and 28 below.

FIGURE 27. MOST IMPORTANT COMMUNITY HEALTH ISSUES AMONG SURVEY RESPONDENTS

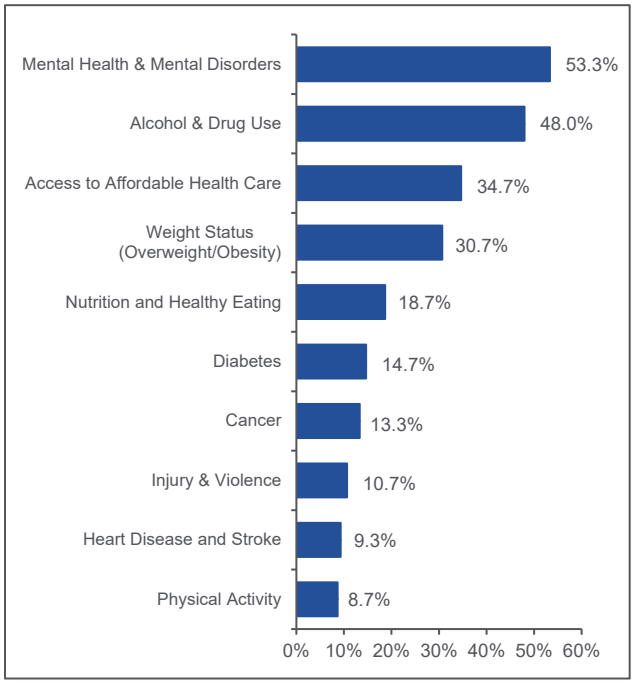
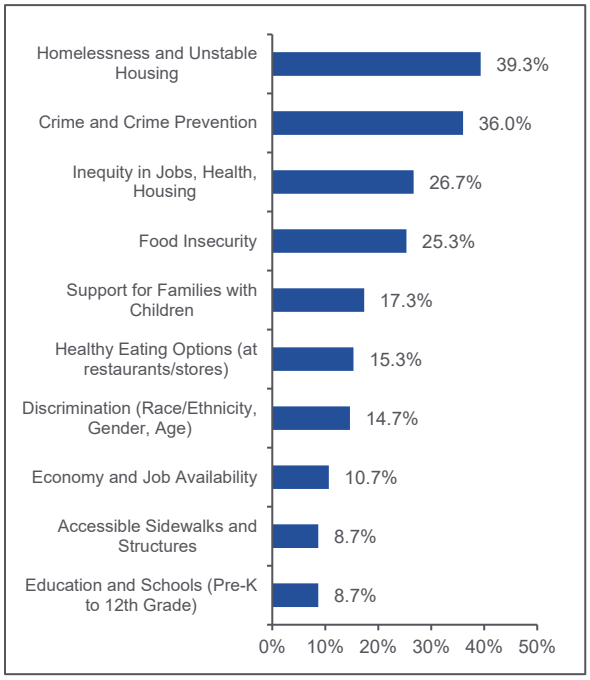


FIGURE 28. MOST IMPORTANT QUALITY OF LIFE ISSUES AMONG SURVEY RESPONDENTS



As shown in Figure 27, the most important community health issues identified by survey respondents were Mental Health & Mental Disorders (53.3% of respondents), Alcohol & Drug Use (48.0% of respondents), Access to Affordable Health Care (34.7%), and Weight Status (30.7%). A health topic was considered to be a significant need if at least 20% of survey respondents identified it as a top health issue.

As shown in Figure 28, Homelessness & Unstable Housing was identified by survey respondents as the most pressing quality of life issue (39.3% of respondents), followed by Crime and Crime Prevention (36.0%), Inequity in Jobs, Health, Housing (26.7%), and Food Insecurity (25.3%). Similar to the health topics, a quality of life topic was considered to be a significant need if at least 20% of survey respondents identified it as a pressing issue.

Qualitative Data: Key Informant Interviews & Focus Group Discussions

Ten key informant interviews and two focus group discussions were conducted to gain deeper understanding of health issues impacting the residents of the community served by Continuing Care Hospital. Community members invited to participate were recognized as having expertise in public health, special knowledge of community health needs, representing the broad interests of the community served by the hospital, and/or being able to speak to the needs of medically underserved or vulnerable populations.

A total of 22 organizations participated in the process, including the local health department, social service organizations, local businesses, and representatives from the education sector. Table 10 lists the organizations that participated in these discussions.

These discussions took place between August 2021 and October 2021. Due to the ongoing COVID-19 pandemic, each discussion was conducted virtually by phone and/or webinar. A questionnaire was developed to guide each interview and focus group discussion. Discussion topics included (1) biggest perceived health needs in the community, (2) barriers of concern, and (3) the impact of health issues on vulnerable populations. Interviewees were also asked about their knowledge around health topics where there were data gaps in the secondary data. Additionally, questions were included to get feedback about the impact of COVID-19 on the community (see COVID-19 Impact Snapshot in Appendix D). The list of questions included in the key informant interviews and focus group discussions can be found in Appendix E.

TABLE 10. ORGANIZATIONS PARTICIPATING IN INTERVIEWS & DISCUSSIONS

American Heart Association
Bluegrass Area Development District
Catholic Action Center
CHI Saint Joseph Health
Continuing Care Hospital
Consolidated Baptist Church
Croswell-Schulte
Fayette County Public Schools
Food Chain
God's Pantry Food Bank
Humana CareSource
Kentucky House of Representatives
Lexington-Fayette County Health Department
Lexington-Fayette Urban County Government
Lexington Public Library
New Vista
Partners for Youth
Refuge Clinic
Saint Joseph East
Saint Joseph Hospital
The Lexington Education and Partnership (LEAP) Academy
The Nest

Key Informant & Focus Group Analysis Results

The project team captured detailed transcripts of the key informant interviews and focus group discussions. The text from these transcripts were analyzed using the qualitative analysis tool Dedoose® [13]. Text was coded using a pre-designed codebook, organized by themes and analyzed for significant observations. Figure 29 summarizes the main themes and topics that emerged from these discussions.

[13] Dedoose Version 8.0.35, web application for managing, analyzing, and presenting qualitative and mixed method research data (2018). Los Angeles, CA: Sociocultural Research Consultants, LLC www.dedoose.com

FIGURE 29. KEY THEMES FROM QUALITATIVE DATA

Top Health Concerns/Issues	Barriers to Care	Most Negatively Impacted Populations
• Alcohol & Drug Use • Diabetes • Food Insecurity • Health Care Access & Quality • Mental Health & Mental Disorders • Obesity • Tobacco Use	• Awareness • Cost / Lack of Insurance / Underinsurance • Fear or stigma • Lack of primary care physician • Language barriers • Navigating the health care system • Office hours • Transportation	• Low Income • Minorities • Undocumented • Older Adults • Geographic: Downtown (40504 and 40508), East End, North End, Winburn, Cardinal Valley, Millcreek, Tates Creek, Eastland, Woodhill

The findings from the qualitative analysis were combined with findings from the secondary data and survey analysis, and are incorporated throughout this report in more detail (see Prioritized Health Needs, Barriers to Care and Appendix D: COVID-19 Impact Snapshot sections of this report).

Data Considerations

A key part of any data collection and analysis process is recognizing potential limitations within the data considered. Each data source used in this assessment was evaluated based on its strengths and limitations during data synthesis and should be kept in mind when reviewing this report.

For both primary and secondary data, immense efforts were made to include as wide a range of community health indicators, key informant experts, focus group participants and survey respondents as possible. Although the topics by which data are organized cover a wide range of health and quality of life areas, within each topic there is a varying scope and depth of secondary data indicators and primary data findings.

Secondary data were limited by the availability of data, with some health topics having a robust set of indicators, while others were more limited. Population health and demographic data are often delayed in their release, so data is presented for the most recent years available for any given data source. There is also variability in the geographic level at which data sets are available, ranging from census tract or zip code to statewide or national geographies. Whenever possible, the most relevant localized data is reported. Due to variations in geographic boundaries, population sizes, and data collection techniques for different locations (hospital service areas, zip codes, and counties), some datasets are not available for the same time spans or at the same level of localization. The Index of Disparity[14], used to analyze disparities for the secondary data, is also limited by data availability – some secondary data sources do not include subpopulation data and others only display values for a select number of race/ethnic groups. Finally, persistent gaps in data systems exist for certain community health issues.

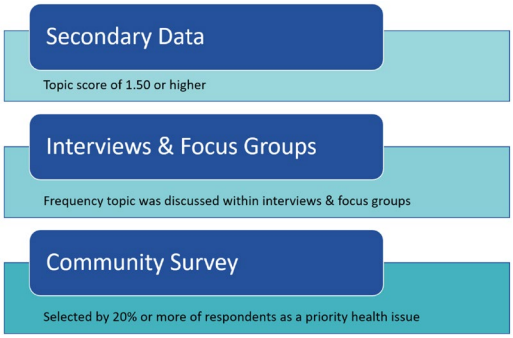
For the primary data, the breadth of findings is dependent upon who was selected to be a key informant or who self-selected to participate in the focus group discussions. Additionally, the community survey was a convenience sample, which means results may be vulnerable to selection bias and make the findings less generalizable.

[14] Pearcy, J. & Keppel, K. (2002). A Summary Measure of Health Disparity. Public Health Reports, 117, 273-280.

Identification of Significant Health Needs

Secondary data used in this assessment consisted of community health indicators, while primary data consisted of key informant interviews, focus group discussions, and an online community survey. Findings from all these data sources were analyzed and combined to identify the significant health needs for the community served by Continuing Care Hospital.

FIGURE 30. CRITERIA USED TO DETERMINE SIGNIFICANT HEALTH NEEDS



Criteria for Significant Health Needs

Health needs were determined to be significant if they met certain criteria in at least one of the three data sources: a secondary data score of 1.50 or higher, frequency by which the topic was discussed within/across interviews and focus groups, and identification as a priority issue by 20% or more of survey respondents. Figure 30 summarizes these criteria.

Significant Health Needs

Based on the criteria shown in Figure 30, thirteen needs emerged as significant. Figure 31 illustrates the final 13 significant health needs, listed in alphabetical order, that were included for prioritization based on the findings of all forms of data collected for the Continuing Care Hospital 2023-2025 CHNA.

FIGURE 31. SIGNIFICANT HEALTH NEEDS

Data Synthesis

To gain a comprehensive understanding of the significant health needs, the findings from all three data sources were analyzed for areas of overlap.

Overlapping Evidence of Need

Table 11 outlines the 13 significant health needs (in alphabetical order) alongside the corresponding data sets that identified the need as significant. Secondary data identified four needs as significant. Discussions with key informants and focus group participants identified seven topic areas of greater need, and the community survey identified eight needs as significant.

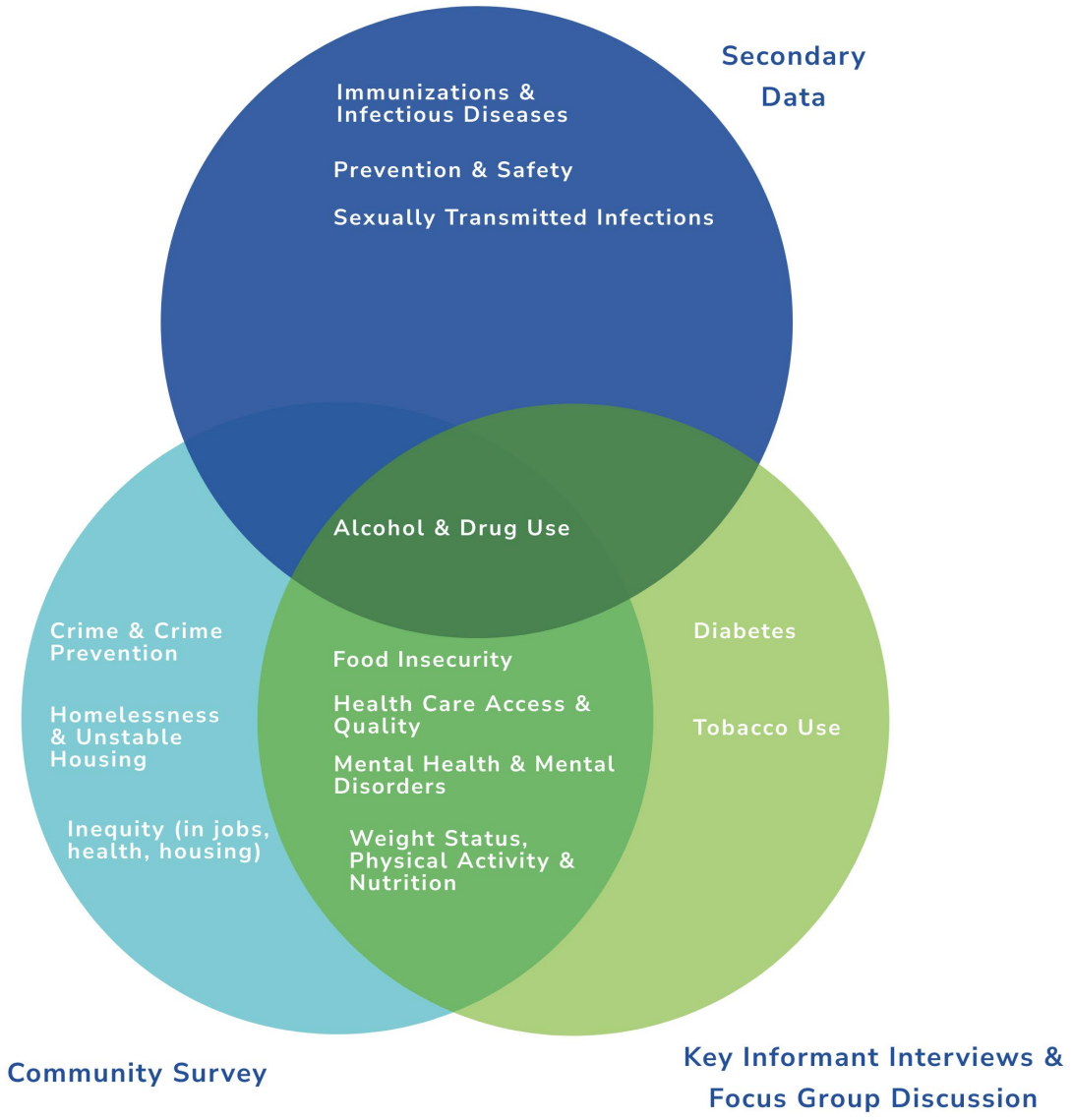
TABLE 11. OVERLAPPING EVIDENCE OF NEED

Topic	Data Source(s)
Alcohol & Drug Use	Community Survey, Secondary Data, Qualitative Data
Crime & Crime Prevention	Community Survey
Diabetes	Qualitative Data
Food Insecurity	Community Survey, Qualitative Data
Health Care Access & Quality	Community Survey, Qualitative Data
Homelessness & Unstable Housing	Community Survey
Immunizations & Infectious Diseases	Secondary Data
Inequity (in jobs, health, housing)	Community Survey
Mental Health & Mental Disorders	Community Survey, Qualitative Data
Prevention & Safety	Secondary Data
Sexually Transmitted Infections	Secondary Data
Tobacco Use	Qualitative Data
Weight Status, Physical Activity & Nutrition	Community Survey, Qualitative Data

Venn Diagram

The Venn Diagram in Figure 32 visually displays the results of the primary and secondary data synthesis. One topic was considered significant across all three data sources – Alcohol & Drug Use. An additional four topics were considered significant across two data sources. These topics include Food Insecurity, Health Care Access & Quality, Mental Health & Mental Disorders and Weight Status, Physical Activity & Nutrition, all of which were identified as significant needs through both the community survey and qualitative data. For all other topic areas, the evidence was present in just one source of data. It should be noted, however, that this may be reflective of the strength and limitations of each type of data that was considered in this process.

FIGURE 32. DATA SYNTHESIS RESULTS



Significant Needs Identified Across CHI Saint Joseph Health

In reviewing the significant health needs identified for the community served by Continuing Care Hospital, it's also important to consider the significant health needs identified systemwide. While each facility has the authority to prioritize and select which health areas it will ultimately consider for subsequent implementation planning, there are obvious benefits to prioritizing those health areas that overlap with other hospitals in the system, including consistency, resource sharing and most importantly, the ability to have a larger impact.

The seven facilities that make up CHI Saint Joseph Health and are required to conduct a CHNA include Saint Joseph Hospital, Saint Joseph East, Continuing Care Hospital, Saint Joseph Berea, Saint Joseph London, Saint Joseph Mount Sterling, and Flaget Memorial Hospital. These seven facilities are primarily based in Fayette, Laurel, Madison, Montgomery, and Nelson counties in Kentucky.

Across all seven facilities, a total of 24 needs emerged as significant. Figure 33 shows how the 13 significant health topics that were identified for Continuing Care Hospital and Fayette County overlap with the other four counties and six facilities comprising the CHI Saint Joseph Health system.

FIGURE 33. SIGNIFICANT HEALTH NEEDS IDENTIFIED ACROSS CHI SAINT JOSEPH HEALTH SYSTEM

Fayette County (Saint Joseph Hospital, Saint Joseph East, Continuing Care Hospital)	**Laurel County** (Saint Joseph London)	**Madison County** (Saint Joseph Berea)	**Montgomery County** (Saint Joseph Mount Sterling)	**Nelson County** (Flaget Memorial Hospital)
Alcohol & Drug Use	Alcohol & Drug Use	Alcohol & Drug Use	Alcohol & Drug Use	Alcohol & Drug Use
Crime & Crime Prevention	Crime & Crime Prevention	Crime & Crime Prevention		Crime & Crime Prevention
Diabetes	Diabetes	Diabetes	Diabetes	
Food Insecurity			Food Insecurity	
Health Care Access & Quality			Health Care Access & Quality	Health Care Access & Quality
Homelessness & Unstable Housing		Homelessness & Unstable Housing		
Immunizations & Infectious Diseases				Immunizations & Infectious Diseases
Inequity (in jobs, health, housing)				
Mental Health & Mental Disorders	Mental Health & Mental Disorders	Mental Health & Mental Disorders	Mental Health & Mental Disorders	Mental Health & Mental Disorders
Prevention & Safety		Prevention & Safety	Prevention & Safety	
Sexually Transmitted Infections		Sexually Transmitted Infections	Sexually Transmitted Infections	Sexually Transmitted Infections
Tobacco Use	Tobacco Use	Tobacco Use	Tobacco Use	Tobacco Use
Weight Status, Physical Activity & Nutrition	Weight Status, Physical Activity & Nutrition	Weight Status, Physical Activity & Nutrition	Weight Status, Physical Activity & Nutrition	Weight Status, Physical Activity & Nutrition

As seen in Figure 33, four topics emerged as a significant need across all five counties: (1) Alcohol & Drug Use (2) Mental Health & Mental Disorders (3) Tobacco Use and (4) Weight Status, Physical Activity & Nutrition.

Prioritization

To better target activities to address the most pressing health needs in the community, Continuing Care Hospital convened a group of community leaders to participate in a presentation of data on significant health needs facilitated by HCI. Following the presentation and question session, participants were given access to an online link to complete a scoring exercise to assign a score to each significant health need based on a set of criteria. The process was conducted virtually to maintain social distancing and safety guidelines related to the COVID-19 pandemic.

Leadership at CHI Saint Joseph Health and Continuing Care Hospital, including the hospital's Healthy Communities / Community Benefit Committee, reviewed the scoring results of the significant community needs alongside additional supporting evidence and identified three priority areas to be considered for subsequent implementation planning.

Process

An invitation to participate in the Continuing Care Hospital CHNA data synthesis presentation and virtual prioritization activity was sent out in the weeks preceding the meeting held on November 16, 2021. A total of 26 individuals representing local hospital systems, the health department, educational institutions as well as community-based organizations and nonprofits attended the virtual presentation and of these, 17 completed the online prioritization activity.

During the November 16th meeting, the group reviewed and discussed the results of HCI's primary and secondary data analyses leading to the significant health needs shown in Figure 31. A one-page handout called a "Prioritization Cheat Sheet" (see Appendix F) was provided to participants to support the virtual prioritization activity. From there, participants were given one day to access an online link and assign a score to each of the significant health needs based on how well they met the criteria set forth by the hospital. The group also agreed that root causes, disparities, and social determinants of health would be considered for all prioritized health topics resulting from the online prioritization activity.

The criteria for prioritization included:

1. Magnitude of the Issue
    - How many people in the community are or will be impacted?
    - How does the identified need impact health and quality of life?
    - Has the need changed over time?

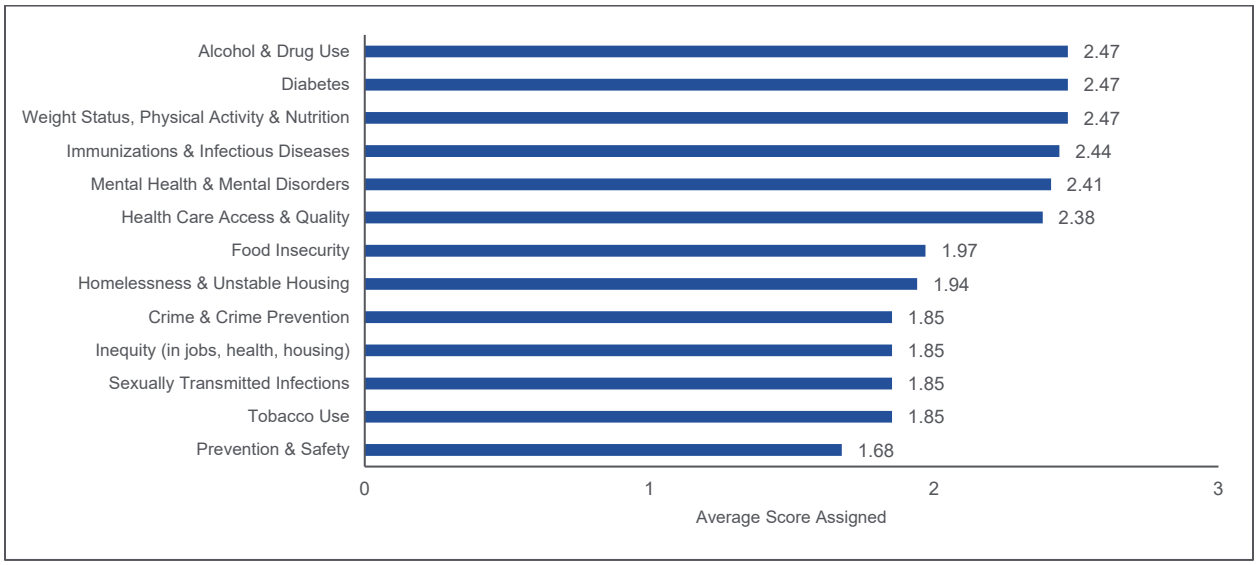
2. Ability to Impact
    - Can actionable and measurable goals be defined to address the health need? Are those goals achievable in a reasonable time frame?
    - Does the hospital or health system have the expertise or resources to address the identified health need?
    - Can the need be addressed in collaboration with community partners? Are organizations already addressing the health issue?

Participants assigned a score of 1-3 to each health topic and criterion, with a higher score indicating a greater likelihood for that topic to be prioritized. For example, participants assigned a score of 1-3 to each topic based on whether the magnitude was (1) least concerning, (2) somewhat concerning or (3)

most concerning. Along a similar line, participants assigned a score of 1-3 to each topic based on (1) least ability to impact (2) some ability to impact or (3) most ability to impact. In addition to considering the data presented by HCI in the presentation and on the prioritization cheat sheet, participants were encouraged to use their own judgment and knowledge of the community in considering how well a health topic met the criteria.

Completion of the online exercise resulted in a numerical score for each health topic and criterion. Numerical scores for the two criteria were equally weighted and averaged to produce an aggregate score and overall ranking for each health topic. The aggregate ranking can be seen in Figure 34 below. For those topics with identical scores, the health needs are listed in alphabetical order.

FIGURE 34. AGGREGATE RESULTS OF ONLINE PRIORITIZATION ACTIVITY



Prioritized Significant Health Needs

The ranked order of significant health needs that resulted from the prioritization process were presented to leadership at CHI Saint Joseph Health and Continuing Care Hospital, including the hospital's Healthy Communities / Community Benefit Committee. The committee reviewed the scoring results of the online prioritization activity for Continuing Care Hospital, in conjunction with the trending health needs that were identified as significant across all seven facilities in the CHI Saint Joseph Health system (Figure 33). While Tobacco Use did not score as high as Alcohol & Drug Use, Weight Status, Physical Activity & Nutrition and Mental Health & Mental Disorders in the online prioritization activity for Continuing Care Hospital (Figure 34), the committee ultimately decided to prioritize the four health needs that were identified as significant across all seven hospital facilities: Alcohol & Drug Use, Mental Health & Mental Disorders, Tobacco Use, and Weight Status, Physical Activity & Nutrition (Figure 33).

TABLE 12. PRIORITIZED HEALTH NEEDS

Alcohol, Tobacco & Drug Use
Mental Health & Mental Disorders
Weight Status, Physical Activity & Nutrition

A decision was made to combine the prioritized health areas of Alcohol & Drug Use and Tobacco Use, resulting in a final selection of three priority health areas that will be considered for subsequent implementation planning (Table 12). The three health needs shown in Table 12 were identified as a priority not only for Continuing Care Hospital, but across all seven facilities comprising CHI Saint Joseph

Health: Saint Joseph Hospital, Saint Joseph East, Continuing Care Hospital, Saint Joseph Berea, Saint Joseph London, Saint Joseph Mount Sterling, and Flaget Memorial Hospital.

Many of these health topics are consistent with the priority areas that emerged from the previous CHNA process, not only for Continuing Care Hospital, but for other facilities as well. The committee strategically selected the topics shown in Table 12 as the final prioritized health needs for all seven facilities to allow for consistency across the system, resulting in a larger footprint and more substantial impact. By selecting these overlapping health needs, CHI Saint Joseph Health has positioned itself to achieve greater collective impact through means of a common agenda, shared goals/objectives, and mutually reinforcing activities, all of which will be outlined in each hospital's upcoming implementation plan. Continuing Care Hospital plans to build upon efforts that emerged from its previous CHNA process, collaborating with other facilities and community partners, to address the three priority health needs outlined in Table 12.

A deeper dive into the primary and secondary data for each of these priority health topics is provided in the next section of the report. This information highlights how each topic became a high priority health need for Continuing Care Hospital.

Prioritized Significant Health Needs

The following section provides a detailed description of each prioritized health need. An overview is provided for each health topic, followed by a table highlighting the poorest performing indicators and a description of key themes that emerged from primary data. The three prioritized health needs are presented in alphabetical order.

Geographic Level of Analysis

As discussed previously in the Methodology section, the data scoring technique is only available at the county level. The data scoring results for Continuing Care Hospital are therefore presented in the context of Fayette County.

Prioritized Health Topic #1: Alcohol, Tobacco and Drug Use

Alcohol & Drug Use

Secondary Data Score: **1.80**

Key Themes from Community Input

- Ranked by survey respondents as the second most pressing health problem (48.0%)
- Lack of education, financial concerns and family dynamics cited as major factors for substance use

Warning Indicators

- Death Rate due to Drug Poisoning
- Alcohol-Impaired Driving Deaths
- Adults who Binge Drink

Tobacco Use

Secondary Data Score: **N/A**

Key Themes from Community Input

- 8.7% of survey respondents rated tobacco use as a top health issue (ranked 11th out of 26 issues)
- High rates of vaping, especially among youth
- Education and cultural issues cited as contributing factors for tobacco use and vaping

Overview

Alcohol & Drug Use were identified as a significant health need through all three data sources: secondary data, the community survey, and qualitative data, while Tobacco Use was identified as a

significant health need through just one data source, qualitative data (see Data Synthesis, Table 11 and Figure 32).

Secondary Data

From the secondary data scoring results, Alcohol & Drug Use had the third highest data score of all topic areas, with a score of 1.80. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 13 below. See Appendix A for the full list of indicators categorized within this topic, including the source from which each indicator was derived.

TABLE 13. DATA SCORING RESULTS FOR ALCOHOL & DRUG USE

SCORE	ALCOHOL & DRUG USE	Fayette County	Kentucky	U.S.	Kentucky Counties	U.S. Counties	Trend
2.47	Death Rate due to Drug Poisoning (2017-2019) *deaths/100,000 population*	36.7	31.8	21			
2.33	Liquor Store Density (2019) *stores/100,000 population*	12.7	12.6	10.5			
2.25	Alcohol-Impaired Driving Deaths (2015-2019) *percent of driving deaths with alcohol involvement*	32.2	25.5	27 **HP2030*** 28.3			
2.14	Adults who Binge Drink (2017-2019) *percent*	21	15	—		—	

*HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

From the secondary data results, there are several indicators within this topic that raise concern for Fayette County. The worst performing indicator is the Death Rate due to Drug Poisoning. In Fayette County, there were 36.7 deaths due to drug poisoning per 100,000 people in 2017-2019, which is higher than both the state and national values, and in the worst 25% of counties in the U.S. Other indicators of concern are related to alcohol use, and include both behavioral and outcome measures, as well as measures that describe the environment. Compared to Kentucky and the U.S., the number of liquor stores per 100,000 people (Liquor Store Density) in Fayette County is higher and increasing significantly. The percentage of adults in the county who binge drink (21%) is higher than the Kentucky value (15%), within the worst 25% of counties in Kentucky and is also increasing, although not significantly. Finally,

the percentage of motor vehicle crash deaths that involve alcohol is higher in Fayette County than in Kentucky and the U.S. Although trends have been steady in recent years, Fayette County has not met the Healthy People 2030 target of 28.3% for Alcohol-Impaired Driving Deaths.

Primary Data

Alcohol & Drug Use

Alcohol & Drug Use ranked as the second most pressing health problem among survey respondents, with 48.0% of respondents identifying Alcohol & Drug Use as a top priority in Fayette County (Figure 27). The high rate of deaths due to drug poisoning reported in the secondary data for Fayette County is supported with findings from the qualitative data. Nearly every key informant and focus group participant emphasized concern with the growing drug problem. Key informants pointed to heroin, increased fentanyl use and self-medication with other illegal substances as devastating a large portion of the population. Alcohol and drug use were cited as affecting all walks of life, from the affluent to the less affluent. One focus group participant elucidated that drug and alcohol use has increased among teens and is often used as a coping mechanism within the teenage population. Another key informant added that the use of drugs has led to increased crime. Stigma was identified as a major barrier to care. Further, people experiencing addiction often have severe health issues. One key informant pointed out the connection between injection drug use, HIV, and hepatitis C comorbidities, while another key informant noted that it is critical to identify and coordinate the right type of care for individuals experiencing addiction. Lack of education, financial concerns, family dynamics and childhood trauma were cited as some of the major factors for substance use. Several key informants suggested the need for more education and prevention programs, more behavioral health counseling services and more harm reduction to help curb the growing drug epidemic.

> Alcohol and drug abuse is an epidemic that plagues the region - Kentucky is in the middle of the war on drugs, and this is certainly true in Fayette County!
> – Key Informant

Tobacco Use

Tobacco Use was ranked as the 11th most pressing health issue among survey respondents, with 8.7% of respondents identifying Tobacco Use as a top priority in the community. Key informants and focus group participants discussed the high rates of vaping, particularly among youth. One key informant noted that vaping is seen as a stress reducer and added that many people do not realize its negative impacts due to the lack of smoke and odor. Another key informant commented that the tobacco industry has captured the youth market and made it cool to vape, adding that tobacco companies have developed vaping products disguised as makeup kits, magic markers, and other everyday items to make it easier to hide. Education, cultural issues, and lifestyle choices were cited as major factors for tobacco use. Key informants also emphasized the significance of tobacco farming in the region, referring to tobacco cessation as a "big deal" and tobacco farming as "the livelihood for a lot of Kentuckians."

> There's been a huge drop in smoking rates, and teenagers especially are not smoking, but they picked up vaping and e-cigarettes. There are huge numbers [of kids vaping], and this sometimes goes all the way down to elementary school.
> – Key Informant

Prioritized Health Topic #2: Mental Health and Mental Disorders

Mental Health & Mental Disorders

Secondary Data Score: **1.24**

Key Themes from Community Input

- Ranked by survey respondents as the most pressing health problem (53.3%)
- Stress, anxiety, family dynamics, domestic violence cited as factors for mental health issues
- Key informants cited a need for more mental health services and providers

Warning Indicators

- Alzheimer's Disease or Dementia: Medicare Population
- Depression: Medicare Population
- Poor Mental Health: 14+ Days

Overview

Mental Health & Mental Disorders was identified as a significant health need through two data sources, the community survey and qualitative data (see Data Synthesis, Table 11 and Figure 32).

Secondary Data

From the secondary data scoring results, Mental Health & Mental Disorders had the 15th highest data score of all topic areas, with a score of 1.24. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 14 below. See Appendix A for the full list of indicators categorized within this topic, including the source from which each indicator was derived.

TABLE 14. DATA SCORING RESULTS FOR MENTAL HEALTH & MENTAL DISORDERS

SCORE	MENTAL HEALTH & MENTAL DISORDERS	Fayette County	Kentucky	U.S.	Kentucky Counties	U.S. Counties	Trend
2.47	Alzheimer's Disease or Dementia: Medicare Population (2018) *percent*	11.5	10.3	10.8			
1.97	Depression: Medicare Population (2018) *percent*	21.1	21.5	18.4			

1.58	Poor Mental Health: 14+ Days (2018) *percent*	14.8	—	12.7			—

Poor self-reported mental health and prevalence of depression and Alzheimer's Disease are all areas of concern related to Mental Health & Mental Disorders. The percentage of Medicare beneficiaries treated for Alzheimer's disease or dementia is 11.5% in Fayette County, which is in the worst 25% of counties in both the state and nation. The indicator Depression: Medicare Population shows the percentage of Medicare beneficiaries who were treated for depression. The value for Fayette County, 21.1%, is in the worst 25% of counties in the U.S. Further, rates of depression and Alzheimer's disease in the Medicare population have been increasing in recent years, although not significantly. The indicator Poor Mental Health: 14+ Days shows the percentage of adults who stated that their mental health was not good 14 or more days in the past month. The value for Fayette County, 14.8%, is higher than the national value and in the worst 50% of counties in the nation.

Primary Data

Mental Health & Mental Disorders was ranked as the most pressing health problem among survey respondents, with 53.3% of respondents identifying Mental Health & Mental Disorders as a top priority in Fayette County (Figure 27). Approximately 33% of survey respondents reported that children in their home have experienced behavioral or mental health challenges. While mental health has always been a concern, key informants pointed out that the COVID-19 pandemic has instilled even more fear, stress, and anxiety within community members due to economic duress and social isolation.

Access to mental health services was a common theme among key informants and survey respondents, with 11.5% of survey respondents reporting that they did not receive necessary mental health services in the past year. The top reasons cited for not receiving mental health services/treatment included cost, not knowing where to go, lack of providers that the patient identifies with, inadequate insurance, and operating hours that did not fit the patient's schedule.

Stigma was identified as a major barrier to care, with one key informant stating, "we are still not normalizing concerns related to mental health – we publicly discuss BMI and blood pressure at the grocery check-out line, but we are stigmatized to say we are depressed!" Fear was cited as another barrier to seeking mental health services, especially among Black/African Americans, refugees, and undocumented residents. Efforts to bring counseling and therapists to these communities must consider a format where services are delivered/facilitated by people who look like those living in the community.

Several key informants emphasized the relationship between drugs/addiction and mental health, with stress, anxiety, domestic violence, and childhood trauma cited as some of the major contributing factors to mental health issues. One key informant observed an increase in youth suicide in recent years, stating that mental health issues among youth can often be attributed to home dynamics, including family issues, domestic violence and how people learn in the home. Mental health issues among the young LGBTQ+ community were also noted as a concern.

The lack of mental health services and providers was cited as a major challenge to ensuring people get the resources and care that they need, with one key informant stating that this has been exacerbated by the COVID-19 pandemic. While some virtual options exist, people need to be made aware of what's available and we need to reduce the stigma and educate people on the benefits of mental health

treatment. Another key informant emphasized the need for free counseling services, adding that it's not uncommon to wait 7-8 months to receive a psychiatric appointment.

> "I've seen mental heath issues in many low-income neighborhoods; often, people don't have the resources they need and can spiral quickly if they don't have family/friend support or access to medications. It is easier for them to be in a bad place mentally. We need support for mental health issues – countries with socialized medicine have much lower suicide rates and serious mental health issues because they have access to medical treatment and doctors to avoid getting into a bad place like that."
>
> – Key Informant

Prioritized Health Topic #3: Weight Status, Physical Activity & Nutrition

Weight Status, Physical Activity & Nutrition

Secondary Data Score: **1.33**

Key Themes from Community Input

- Weight status (overweight/obesity) was ranked by survey respondents as the fourth most pressing health problem (30.7%)
- 15.3% of survey respondents rated "healthy eating options at restaurants, stores and markets" as a top quality of life issue
- Lack of exercise, busy lifestyles, lack of nutritional foods and learned behaviors through multiple generations cited as key contributors to obesity

Warning Indicators

- Fast Food Restaurant Density
- SNAP Certified Stores
- Farmers Market Density
- Low-Income and Low Access to a
- Grocery Store
- Adult Fruit and Vegetable Consumption

Overview

Weight Status, Physical Activity & Nutrition was identified as a significant health need through two data sources: the community survey and qualitative data (see Data Synthesis, Table 11 and Figure 32).

Secondary Data

From the secondary data scoring results, Weight Status, Physical Activity & Nutrition had the tenth highest data score of all topic areas, with a score of 1.33. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 15 below. See Appendix A for the full list of indicators categorized within this topic, including the source from which each indicator was derived.

TABLE 15. DATA SCORING RESULTS FOR WEIGHT STATUS, PHYSICAL ACTIVITY & NUTRITION

SCORE	WEIGHT STATUS, PHYSICAL ACTIVITY & NUTRITION	Fayette County	Kentucky	U.S.	Kentucky Counties	U.S. Counties	Trend
2.14	Fast Food Restaurant Density (2016) *Restaurants/1,000 population*	0.95	—	—			

2.14	SNAP Certified Stores (2017) *Stores/1,000 population*	0.7	—	—			
1.67	Farmers Market Density (2018) *Markets/1,000 population*	0.02	—	—	—	—	
1.67	Low-Income and Low Access to a Grocery Store (2015) *percent*	6.8	—	—			—
1.64	Adult Fruit and Vegetable Consumption (2017-2019) *percent*	11	12	—		—	
1.50	Children with Low Access to a Grocery Store (2015) *percent*	3.5	—	—			—
1.50	People with Low Access to a Grocery Store (2015) *percent*	15.9	—	—			—

Some of the worst performing indicators within this topic are related to the built environment and food access. The number of fast-food restaurants per 1,000 people in Fayette County is in the worst 25% of counties in Kentucky and the U.S., and trending in a negative direction. The indicator SNAP Certified Stores shows the number of stores per 1,000 population certified to accept Supplemental Nutrition Assistance Program benefits, including supermarkets, convenience stores, warehouse club stores and specialized food stores. While the value for Fayette County is increasing in a desirable direction, the county still performs in the worst 25% of counties in the state. Other poorly performing indicators that are measures of food access include Low-Income and Low Access to a Grocery Store, Children with Low Access to a Grocery Store and People with Low Access to a Grocery Store. HCI's Food Insecurity Index, discussed earlier in this report, can be used to help identify geographic areas of low food accessibility within the community served by Continuing Care Hospital.

The indicator Adult Fruit and Vegetable Consumption shows the percentage of adults who eat five or more servings of fruit and vegetables per day. The value for Fayette County, 11%, is lower than the Kentucky value and decreasing in an undesirable direction. Studies have shown that sedentary lifestyles

and a lack of fruits and vegetables can increase the risk of many chronic diseases, including obesity, heart disease and type 2 diabetes.[15]

Primary Data

Nearly one-third (30.7%) of survey respondents rated Weight Status as a pressing health issue, and it ranked as the fourth most pressing health problem overall (Figure 27). Nutrition & Healthy Eating ranked as the fifth most pressing health issue (18.7%, Figure 27), while Physical Activity ranked as the tenth most pressing health issue (8.7%, Figure 27).

Among survey respondents with children living in the home, 10.4% reported having one or more children that are overweight. Obesity and its contribution to chronic disease was a topic of concern among key informants. Insights from qualitative data point to a lack of exercise, busy lifestyles, increased technology use, lack of nutritional foods and learned behaviors through multiple generations as being key contributors to obesity. One focus group participant emphasized that obesity disproportionately impacts those with lower incomes and less education. Another focus group participant pointed out the need for more education – people need to be taught the benefits of eating healthy and how food affects the body in positive and negative ways.

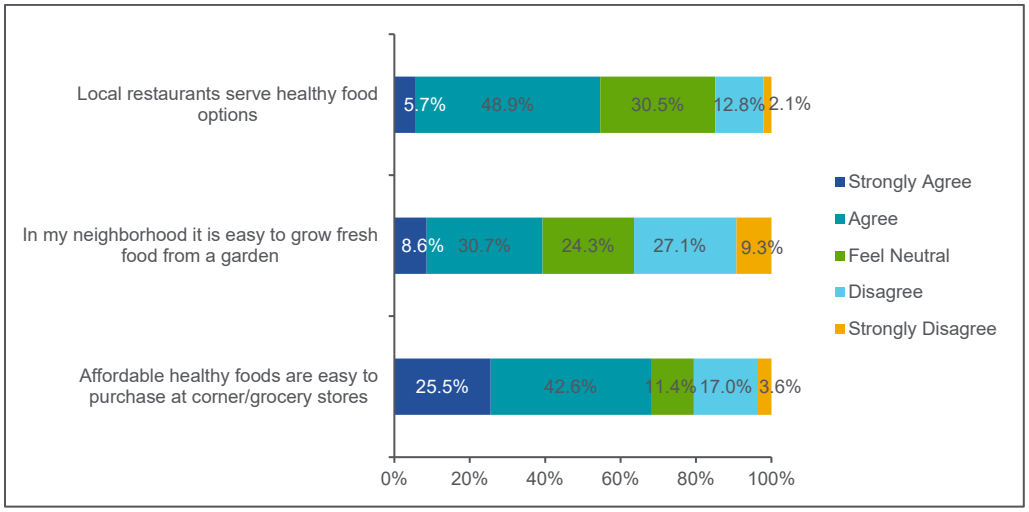
Ability to access safe parks and walking paths was rated by 6.0% of survey respondents as a priority issue, while another 6.7% of survey respondents would like to see more and/or improved bike lanes in the community. Using a Likert scale, a five-point scale used to allow the individual to express how much they agree or disagree with a particular statement, 14.9% of survey respondents disagreed or strongly disagreed that the community has good sidewalks/trails for walking safely, and another 6.4% of survey respondents disagreed or strongly disagreed that the community has good parks and recreational facilities. Another 13.6% of survey respondents reported that the COVID-19 pandemic has made it difficult to exercise. One key informant emphasized the need for more "complete streets," adding that this would promote a more active lifestyle, allowing residents to buy groceries and run errands by walking or biking rather than getting into a car.

The secondary data indicators that point to an unhealthy food environment are corroborated with results from the community survey. Healthy eating options at restaurants, stores, and markets was ranked by survey respondents as the sixth most pressing quality of life issue (15.3% of respondents, Figure 28). Survey respondents were also asked to answer a few questions about access to food in their community. Based on a five-point Likert scale, 14.9% of survey respondents disagreed or strongly disagreed that local restaurants serve healthy food options, 36.4% of respondents disagreed or strongly disagreed that it is easy to grow/harvest and eat fresh food from a home garden in their neighborhood, and 20.6% of survey respondents disagreed or strongly disagreed that affordable, healthy food options are easy to purchase at nearby corner stores, grocery stores or farmers markets (Figure 35).

> "Kentucky and the south in general has a high level of obesity. This stems from cultural factors – like the food we eat, a lack of awareness of what to put in our bodies, and lack of physical activity."
> – Key Informant

[15] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/nutrition-and-healthy-eating

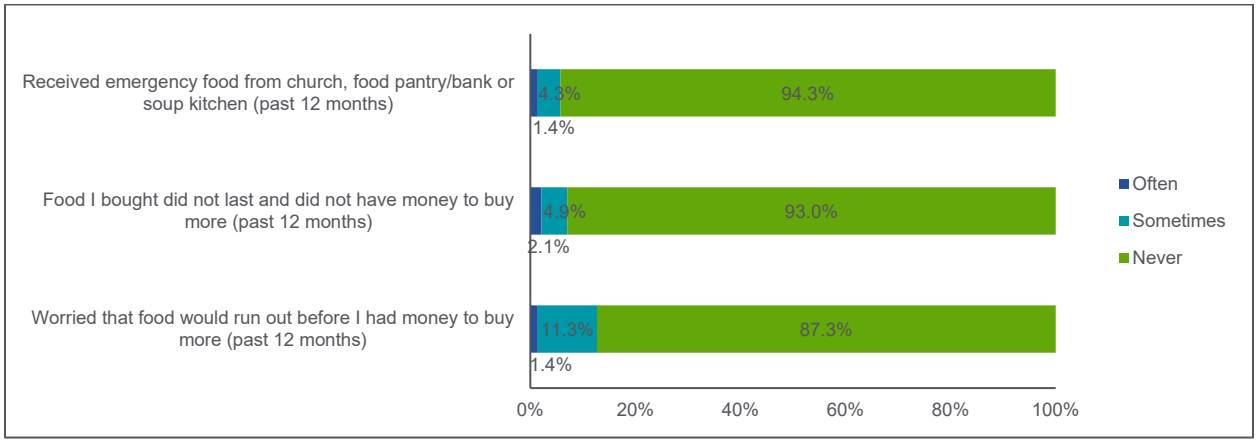
FIGURE 35. SURVEY RESPONDENTS' PERCEPTION OF ACCESS TO FOOD IN THE COMMUNITY



Key informants also pointed to the need for a healthier food environment, with one informant describing the foods served at school breakfast and lunch as "sugar and carbs," indicating that schools need to serve healthier foods. Other key informants described food deserts in various communities, including Cardinal Valley and Winburn.

Approximately 25% of survey respondents rated food insecurity or hunger as a top quality of life issue they would like to see addressed in the community, and it ranked as the fourth most pressing quality of life issue overall (Figure 28). Key informants and focus group participants spoke of food insecurity as an issue that needs to be addressed, and one informant pointed to a dramatic increase in the need for food at the height of the COVID-19 pandemic. Others added that food insecurity is often a challenge for older adults who must survive on a limited income, with one key informant stating that "seniors often must choose between food and medication." Among survey respondents, 12.7% reported they "sometimes" or "often" worried that their food would run out before they had money to buy more (Figure 36). Another 7.0% of survey respondents reported there was a time in the past 12 months when the food they bought just did not last, and they did not have money to buy more (Figure 36). Finally, 5.7% of survey respondents reported receiving emergency food from a church or food pantry in the past 12 months (Figure 36).

FIGURE 36. FOOD INSECURITY AMONG SURVEY RESPONDENTS



Non-Prioritized Significant Health Needs

The following significant health needs, presented in alphabetical order, emerged from a review of the primary and secondary data. However, Continuing Care Hospital will not focus on these topics in their Implementation Strategy.

Key themes from community input are included where relevant for each non-prioritized health need along with the secondary data score and warning indicators.

Non-Prioritized Health Need #1: Crime & Crime Prevention

Crime & Crime Prevention

Secondary Data Score: **N/A**

Key Themes from Community Input

- Ranked by survey respondents as the second most pressing quality of life issue (36.0%)
- 21.1% of survey respondents disagreed that crime is not a major issue in their neighborhood

> "Deaths and crime related to addiction is rampant!"
> – Key Informant

Non-Prioritized Health Need #2: Diabetes

Diabetes

Secondary Data Score: **0.80**

Key Themes from Community Input

- 14.7% of survey respondents rated diabetes as a top health issue (ranked 6th out of 26 issues)
- Lifestyle choices, including poor nutrition, lack of exercise and increased technology use cited as contributing factors
- Lower-income, less educated, African American and Hispanic populations disproportionately impacted

> "High blood pressure, cholesterol and diabetes are showing up in younger and younger kids. This is due to too much sugar, sugary drinks, lack of exercise and not eating properly."
> – Key Informant

Non-Prioritized Health Need #3: Food Insecurity

Food Insecurity

Secondary Data Score: N/A

Key Themes from Community Input

- 25.3% of survey respondents rated food insecurity as a top quality of life issue
- 12.7% of survey respondents worried their food would run out before they had money to buy more
- 5.7% of survey respondents received emergency food from a church, food pantry or food bank in the past 12 months

> Due to socioeconomic status, there are disparities in access to viable, healthy food options. While the affluent have access to Whole Foods, farmer's markets and other healthy options, the low-income have access to the Dollar Store and mini-marts. Due to the economy and financial struggles, people cannot afford to eat well. It's easier to eat unhealthy foods.
>
> – Key Informant

See Weight Status, Physical Activity & Nutrition and HCI's Food Insecurity Index for additional supporting evidence related to Food Insecurity.

Non-Prioritized Health Need #4: Health Care Access & Quality

Health Care Access & Quality

Secondary Data Score: **1.00**

Key Themes from Community Input

- Ranked by survey respondents as the third most pressing health problem (34.7%)
- 22.8% of survey respondents disagreed that there are affordable health care services in the community
- 7.4% of survey respondents disagreed they are connected to a primary care doctor they are happy with

Warning Indicators

- Adults who have had a Routine Checkup
- Adults with Health Insurance

> Daily, I am in contact with persons who are without insurance and as a result, access to health care. These include blacks, whites, Hispanics, and immigrants. The common denominator is that most or all are near the bottom in earning potential. What often looks like race is rooted in economics.
>
> – Key Informant

Non-Prioritized Health Need #5: Homelessness & Unstable Housing

Homelessness & Unstable Housing

Secondary Data Score: **N/A**

Key Themes from Community Input

- Ranked by survey respondents as the most pressing quality of life issue (39.3%)
- 43.7% of survey respondents disagreed that there are affordable places to live
- 5.8% of survey respondents reported their current housing situation does not meet their needs

> There has never been a time like this. It's been a challenge to get the unhoused the access they need, especially in the winter. We had to limit to only those on the bed list. The most difficult thing has been saying no and trying to find alternatives.
>
> – Focus Group Participant

Non-Prioritized Health Need #6: Immunizations & Infectious Diseases

Immunizations & Infectious Diseases

Secondary Data Score: **1.74**

Key Themes from Community Input

- Concerns with vaccine hesitancy (misleading information, minority populations)

Warning Indicators

- Syphilis Incidence Rate
- Chlamydia Incidence Rate
- Gonorrhea Incidence Rate

> The biggest challenge right now is to get people vaccinated [COVID-19]; some minority populations are not comfortable with vaccinations, and it can be a challenge reaching out to them.
> – Key Informant

Non-Prioritized Health Need #7: Inequity (in jobs, health, housing)

Inequity (in jobs, health, housing)

Secondary Data Score: **N/A**

Key Themes from Community Input

- Ranked by survey respondents as the third most pressing quality of life issue (26.7%)
- 23.5% of respondents disagreed that people can access healthcare regardless of race, gender, sexual orientation, immigration status

> The people we serve are on the fringes of healthcare and it is hard for them to trust the system. Decisions of how the system should operate are not geared towards or decided by low-income people, and that presents challenges. Those systems do not end up functioning well.
> – Key Informant

Non-Prioritized Health Need #8: Prevention & Safety

Prevention & Safety

Secondary Data Score: **2.04**

Key Themes from Community Input

- 10.7% of survey respondents rated prevention & safety as a top health issue (ranked 8th out of 26 issues)

Warning Indicators

- Death Rate due to Drug Poisoning
- Age-Adjusted Death Rate due to Unintentional Injuries
- Severe Housing Problems

Non-Prioritized Health Need #9: Sexually Transmitted Infections

Sexually Transmitted Infections

Secondary Data Score: **2.73**

Warning Indicators

- Syphilis Incidence Rate
- Chlamydia Incidence Rate
- Gonorrhea Incidence Rate

Barriers to Care

A critical component in assessing the needs of a community includes identifying barriers to health care and social services, which can inform and focus strategies for addressing the prioritized health needs. Survey respondents, key informants and focus group participants were asked to identify any barriers to health care observed or experienced in the community. The following section explores those barriers that were identified through the primary data collection.

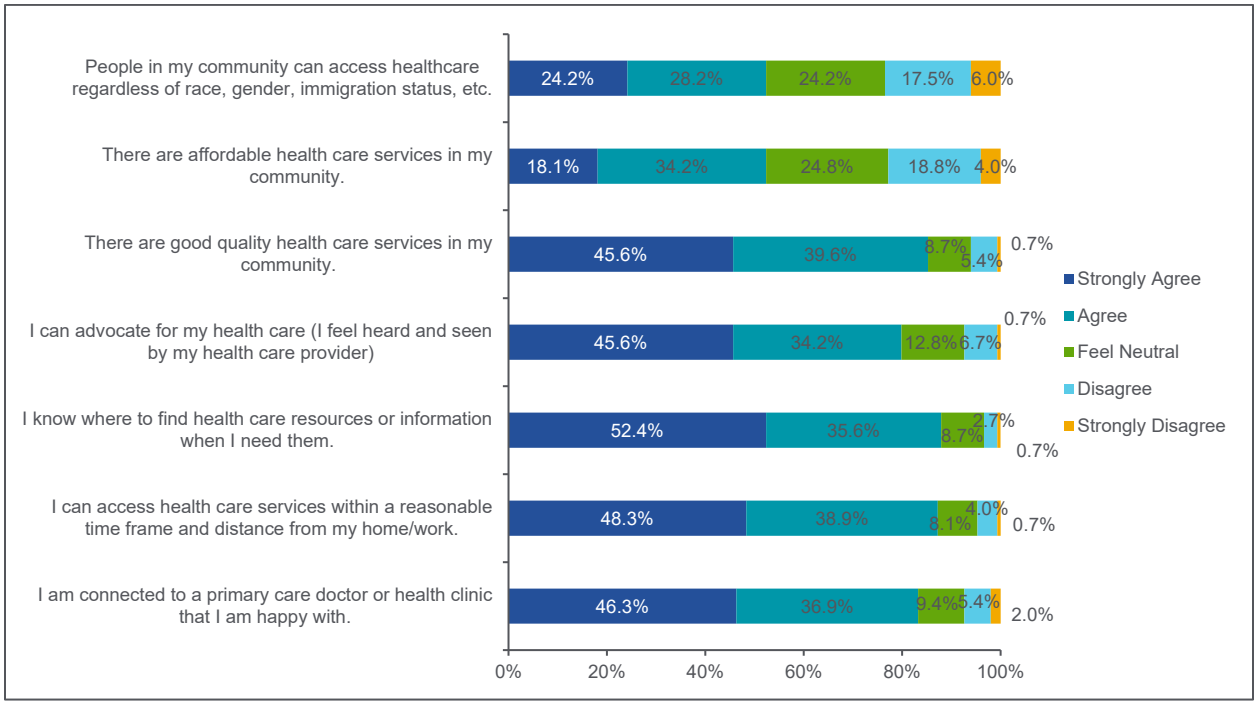
Transportation

The geography of the Continuing Care Hospital Primary Service Area lends itself to transportation issues. As described earlier in this report (see Defining the Community), the hospital's primary service area is defined by 33 zip codes. While the largest portion of the hospital's patients reside in Fayette County, the hospital's service area includes 21 counties, stretching from Anderson County in the west to Rowan County in the east and Harrison County in the north to Knox County in the south. Beyond the core population center of Lexington and Fayette County, much of the service area includes rural towns and areas. The spread of the population throughout these rural towns creates difficulties for many of those in need of care. Key informants and focus group participants frequently mentioned transportation when discussing barriers to care, with an emphasis on rural communities and elderly populations. Although Lexington has a public transportation system, several key informants emphasized that transportation for those living within city limits continues to be a barrier. One key informant suggested that there's a need to improve the number of routes and add more connections to areas that offer healthy food options. Although ride sharing services such as Uber and Lyft are readily available, another key informant explained that the service is too expensive for many families. Using a five-point Likert scale, 24.6% of survey respondents in Fayette County disagreed or strongly disagreed that public transportation is easy to access. One indicator of concern from the secondary data analysis includes Households without a Vehicle. Additional details for this indicator can be found in Appendix A.

Cost, Lack of Insurance, Underinsurance

Access to affordable health care was identified as a significant need through the community survey and qualitative data (see Data Synthesis, Table 11 and Figure 32). Among survey respondents, it ranked as the third most pressing health issue overall (34.7% of respondents, Figure 27). Based on a five-point Likert scale, 22.8% of survey respondents disagreed or strongly disagreed that there are affordable health care services in the community (Figure 37).

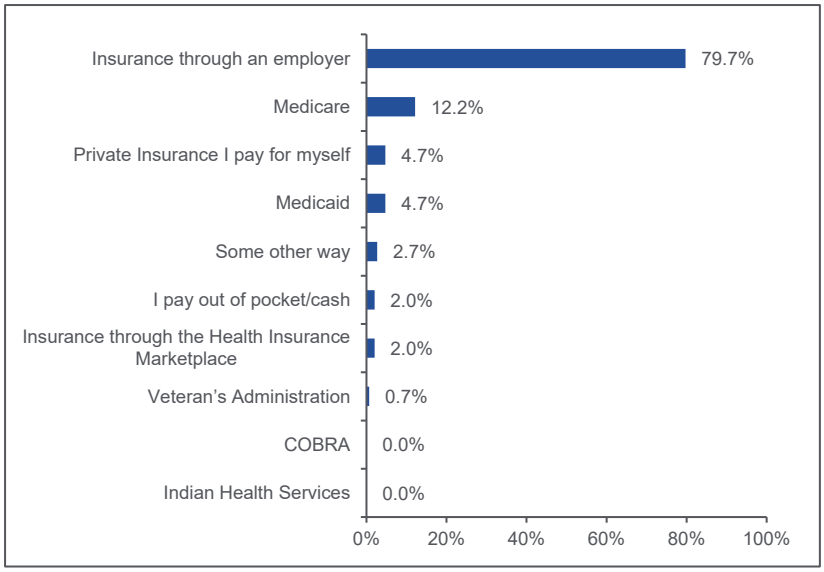
FIGURE 37. SURVEY RESPONDENTS' PERCEPTION OF HEALTH CARE SERVICES IN THEIR COMMUNITY



Among key informants and focus group participants, the most common barriers cited to accessing health care were related to overall cost, lack of insurance or underinsurance. One key informant emphasized that even with health coverage, many people still lack the disposable income necessary for co-pays, so they do without. In addition, those with health insurance may still lack dental or vision coverage.

Nearly all survey respondents (99.3%) reported having health coverage, with respondents reporting the following types of health plan(s) used to pay for health care services: health coverage through an employer (79.7%), Medicare (12.2%), private insurance (4.7%), and Medicaid (4.7%) (Figure 38).

FIGURE 38. SURVEY RESPONDENTS: WHAT TYPE OF HEALTH PLAN(S) DO YOU USE TO PAY FOR YOUR HEALTH CARE SERVICES? (SELECT ALL THAT APPLY)



The economic secondary data further support the primary data findings around cost and access. The median household income of the hospital's primary service area is $56,634, which is about $6,000 lower than the Fayette County value of $62,657. In addition, there is a disparity of approximately $18,000 in median household income for Black/African American residents, when compared to the overall median value for the hospital's service area (see Social & Economic Determinants of Health, Figures 15 and 16, for more details).

Awareness, Access to Information and Navigating the System

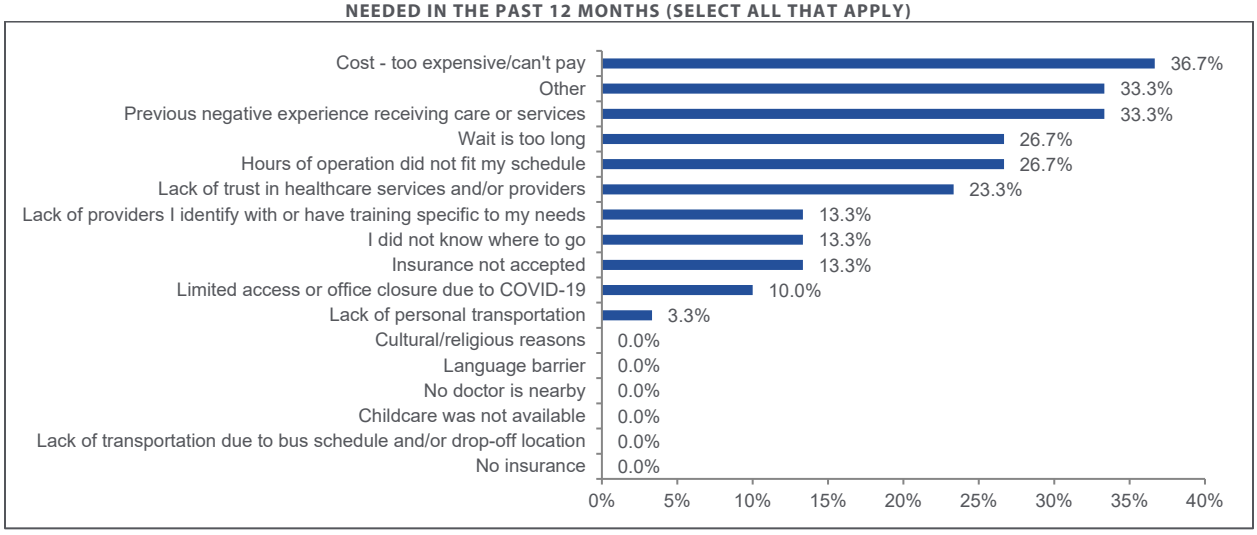
Knowledge of available resources and the ability to access information is another barrier to care, especially for those who don't have broadband or internet access. While findings from the secondary data indicate that 86.9% of households in Fayette County had an internet subscription in 2015-2019 (Figure 23), this value is likely lower in the rural areas of the hospital's primary service area. One key informant emphasized that even within Fayette County, many people do not have access to the internet which limits their ability to access care. Another key informant described how technology hurdles, including lack of access to a computer or internet and the inability to maneuver the internet, became a huge barrier in getting people registered for the COVID-19 vaccine. This was especially true among the older adult population.

Key informants also noted health system knowledge/navigation as a barrier for accessing care and pointed to a need for more outreach and consistent messaging about services and resources available to the community. While Lexington is rich in resources, one key informant characterized it as a "tangled system" and described it as "frustrating" to identify what's available. Another key informant noted that even though unemployed persons have access to Medicaid, they may not be aware and/or understand how to enroll and receive those services. Referring to the older adult population, this key informant added that many are not able to complete online surveys and/or forms and require a lot of assistance. To address these issues, one key informant envisioned "a full-blown educational effort within the communities themselves" where "presentations, including question and answer sessions, are in order." He added that these sessions should "include persons who look like the community you are seeking to reach" and should also "offer basic health care checks – blood pressure checks, mammograms, prostate exams, breast exams, and vaccinations." Another key informant emphasized the importance of integrating community educators within the school systems.

Fear, Discrimination, Language & Culture

Approximately 21% of survey respondents reported they were unable to get necessary health care services at least once in the past 12 months. For community survey respondents that did not receive the care they needed, 33.3% reported a previous negative experience receiving care or services, 23.3% reported lack of trust in health care services and/or providers, and 13.3% reported a lack of providers that "I identify with or have training specific to my needs." (Figure 39).

FIGURE 39. SURVEY RESPONDENTS: SELECT THE TOP REASONS YOU DID NOT RECEIVE THE HEALTH CARE SERVICES THAT YOU NEEDED IN THE PAST 12 MONTHS (SELECT ALL THAT APPLY)



As shown earlier in Figure 37, 7.4% of survey respondents disagreed or strongly disagreed with the statement: "I feel like I can advocate for my health care (I feel heard and seen by my health care provider)," while another 23.5% of survey respondents disagreed or strongly disagreed that people in the community can access health care services regardless of race, gender, sexual orientation, or immigration status.

Lack of trust continues to be a big issue. One key informant mentioned that fear has been exacerbated by COVID-19, but even before the pandemic began, mistrust among patients and the systems that have been provided to them has been an ongoing concern. This informant described the need for "better infrastructure and support for our patients," adding that "the patient-provider relationship is foundational." Another key informant emphasized that mistrust of health care within the Black/African American community continues to be a concern. Other informants pointed out that some people choose not to reveal their vulnerabilities because they fear the potential consequences – for example, those who are undocumented may avoid connecting with health care facilities because they fear deportation. Another key informant added that the Hispanic/Latino community is naturally disadvantaged due to concerns about documentation status.

Several focus group participants pointed to language barriers as a common issue, especially within Hispanic/Latino and refugee populations, and emphasized that the non-English speaking population often doesn't reach out for help. One key informant mentioned that language barriers are difficult to overcome in the short time allotted for medical appointments, while another informant described the difficulty in navigating the names of medications and diseases, adding that health professionals often don't speak in terms that are easily understood. Cultural barriers and religious beliefs were also cited as major barriers to care, and the stigma of seeking mental health treatment continues to be a concern.

Conclusion

This Community Health Needs Assessment (CHNA), conducted for Continuing Care Hospital, helps the hospital meet the federal requirement for charitable hospital organizations to conduct a community health needs assessment every three years [IRS Section 501(r) (3)]. CHI Saint Joseph Health and Continuing Care Hospital partnered with Conduent Healthy Communities Institute to develop this 2023-2025 CHNA.

This assessment used a comprehensive set of secondary and primary data to determine the 13 significant health needs in the community served by Continuing Care Hospital. The prioritization process identified three priorities to be considered for subsequent implementation planning: Alcohol, Tobacco & Drug Use, Mental Health & Mental Disorders and Weight Status, Physical Activity & Nutrition.

The findings in this report will be used to guide the development of the Continuing Care Hospital Implementation Strategy, which will outline strategies to address identified priorities and improve the health of the community.

Please use this online form to send any comments or feedback about this CHNA: https://www.chisaintjosephhealth.org/healthy-community-chna-feedback. Feedback received will be incorporated into the next CHNA process.

Appendices Summary

The following support documents are shared in a separate appendix available on the CHI Saint Joseph Health website: https://www.chisaintjosephhealth.org/healthycommunities.

A. Secondary Data Methodology and Data Scoring Tables

A description of the Conduent HCI data scoring methodology, including a list of secondary data sources used in the analysis and county-level topic and indicator scoring results.

B. Index of Disparity

A description of the methods used to identify disparities within the secondary data by race, ethnicity, and gender.

C. Demographic Profile of Survey Respondents

A series of charts illustrating the demographics of community survey respondents.

D. COVID-19 Impact Snapshot

A summary of the impact of the COVID-19 pandemic, including findings from the community survey, key informants and focus group participants.

E. Community Input Assessment Tools

Data collection tools that were vital in capturing community feedback, including the community survey, key informant questions and focus group guide.

F. Prioritization Toolkit

A one-page cheat sheet provided to participants to help guide the virtual prioritization activity.

G. Impact Report

A detailed progress report on the hospital's prioritized health needs from its prior CHNA and Implementation Strategy (2020-2022). Goals, objectives, strategies, target population and status are outlined in a detailed framework.

H. Healthy Communities / Community Benefit Committee

A list of members serving on the Healthy Communities / Community Benefit Committee at CHI Saint Joseph Health.

I. Resources Potentially Available to Address Needs

A list of community resources available to organizations and individuals that live in the community.

Adoption/Approval

CHI Saint Joseph Health's Board of Directors includes representation across the state and supports the work that each facility completes to improve the health of their community. The Board of Directors approves Continuing Care Hospital's community health needs assessment and the methods used to identify priority areas of need in the community served by Continuing Care Hospital.

Debra Hampton 6/7/2022

Debra Howard Date

Chair, Continuing Care Hospital Board of Directors

Bob Desotelle 6/7/2022

Bob Desotelle, MHA Date

President/CEO, Continuing Care Hospital