**Community Hospital Anderson Implementation Strategy**

This document describes how Community Hospital Anderson (the hospital) plans to address the needs identified in the Community Health Needs Assessment (CHNA) published by the hospital on December 31, 2021. The CHNA report can be found at:

Microsoft Word - Anderson Needs Assessment 2021-1209 (ecommunity.com)

The Implementation Strategy describes how the hospital plans to address significant needs throughout the calendar years 2022 through 2024.

The Implementation Strategy for Community Hospital Anderson has been prepared to comply with federal tax law requirements set forth in Internal Revenue Code Section 501(r) requiring hospital facilities owned and operated by an organization described in Code Section 501(c)(3) to conduct a CHNA every three years. Secondly, it will adopt an Implementation Strategy to meet the community health needs identified through the Community Health Needs Assessment reports for each hospital facility. The Implementation Strategy will satisfy each of the applicable requirements.

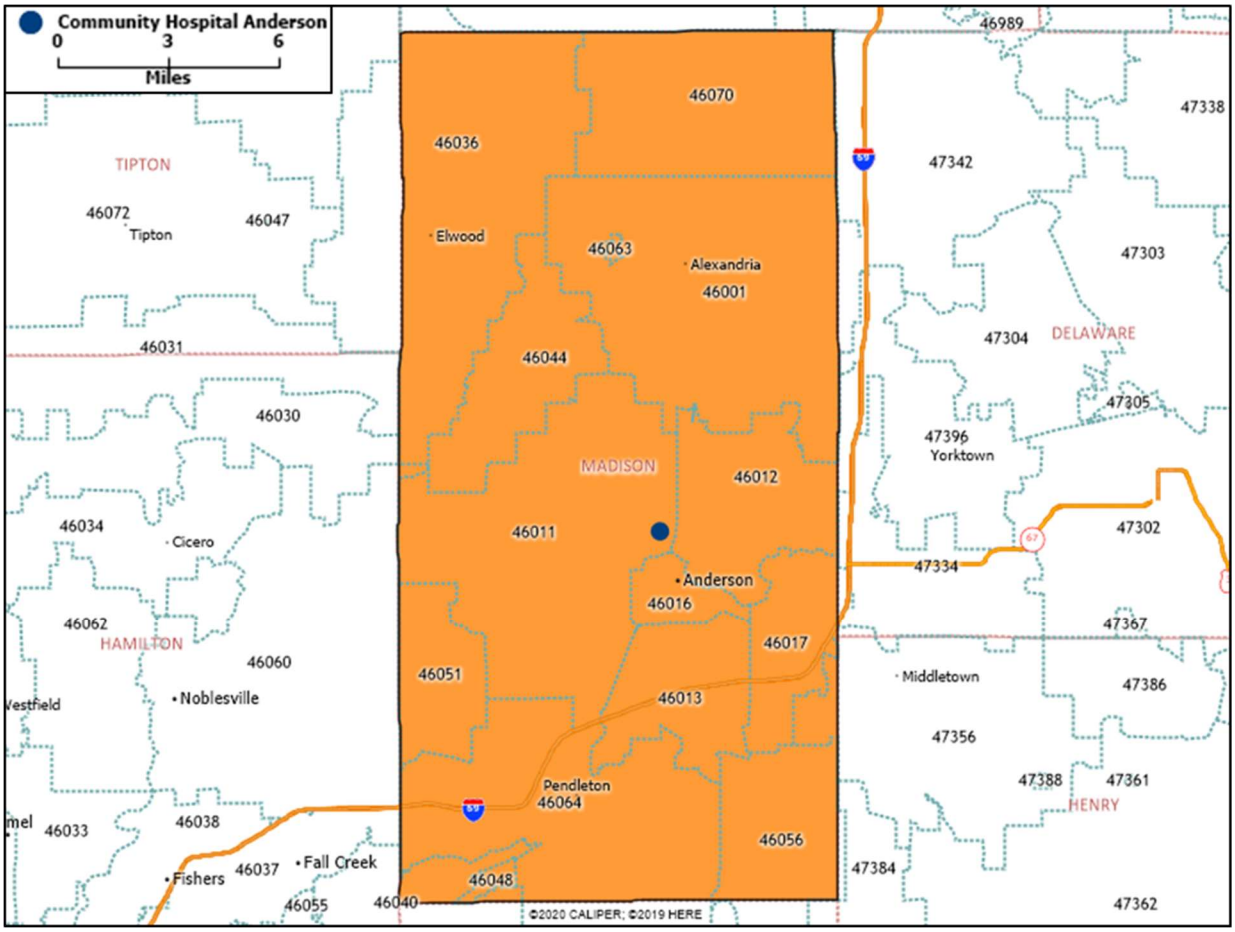
Community Hospital Anderson reserves the right to amend this implementation strategy as circumstances warrant. Certain community health needs may warrant increased focus and resources during the next three years. Moreover, other organizations may decide to increase resources devoted to addressing one or more of the significant community health needs or grant funds that support described initiatives may become unavailable, and as a result, the hospital may amend its strategies and focus on other identified needs.

**About Community Hospital Anderson and the Community it Serves**

Community Hospital Anderson is an acute care hospital known for providing exceptional care for the residents of Madison and surrounding counties. Community Hospital Anderson provides a full range of medical services including award winning maternity services, comprehensive cardiac care, cancer services affiliated with MD Anderson Cancer Network®, neuro surgical care, and a level three trauma center.

Community Hospital Anderson is part of Community Health Network, an integrated health delivery system based in Indianapolis. As a non-profit health system with more than 200 sites of care and affiliates throughout Central Indiana, Community Health Network's full continuum of care integrates hundreds of physicians, eight specialty and acute care hospitals, surgery centers, home care services, Community MedCheck locations, behavioral health, and employer health services.

For purposes of this CHNA, Community Hospital Anderson's community was defined as Madison County, Indiana. The community was defined by considering the geographic origins of the hospital's inpatient discharges and emergency room visits in quarter four of calendar year 2020. Madison County accounted for approximately 84 percent of the hospital's inpatient discharges and 86 percent of its emergency department visits.




Summary information regarding Community Hospital Anderson's (CHA) community:

- Total population of the CHA community in 2019 was approximately 129,455 persons.
  - Total population in the CHA community is projected to decrease by 0.3% between 2019-2025
  - The population 65 and older is expected to increase by 11.7%
- Low-income census tracts can be found throughout Madison County, particularly in Anderson, Elwood and Alexandria. Approximately 16.5% of residents are living in poverty. Poverty rates:
  - 28% of Hispanic or Latino residents are living in poverty
  - 33% of Black residents are living in poverty
  - 15% of White residents are living in poverty

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**Selection on Significant Health Needs to Addressed**

The hospital reviewed the CHNA findings and applied the following criteria to determine the most appropriate needs for the Community Hospital Anderson community.

- The extent to which the hospital has resources and competencies to address the need
- The impact that the hospital could have on the need (i.e., the number of lives the hospital can impact)

- The frequency with which stakeholders identified the need as a significant priority
- The extent of community support for the hospital to address the issue and potential for partnerships to address the issue

By applying these criteria, the hospital determined that it will address the significant health needs identified by Y (for Yes) in the table that follows. Issues identified by N (for No) represent issues that the hospital does not plan to address during the 2022-2024 period.

| Significant Health Needs Identified in the 2021 CHNA | Intend to Address (Y/N) |
|---|---|
| Covid-19 | Y |
| Mental Health & Access to Mental Health Services | Y |
| Substance Use & Overdose | Y |
| Obesity, Physical Inactivity & Chronic Disease | Y |
| Maternal, Infant & Child Health | Y |
| SDoH | Y |
| Tobacco Use | N |

Members of the Leadership Team at CHA along with Leadership throughout Community Health Network met to review the findings of the CHNA and concluded that the hospital's implementations strategy for 2022-2024 should focus on the key areas and strategies described below.

While tobacco use was identified as a significant health need in the CHNA report, tobacco use will not be addressed by CHA in the implementation plan. CHA staff are actively involved in tobacco prevention and cessation activities in partnership with Intersect, Inc a coalition addressing tobacco use and prevention throughout Madison County. CHA will continue to support the work of the coalition to reduce tobacco use across Madison County.

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**Significant Health Need: Behavioral Health and Access to Behavioral Health Services**

| Focus Area | Program/Service | Metric | Anticipated Impact |
|---|---|---|---|
| Mental Health | Have Hope | Improved safety planning for patients at high-risk for suicide presenting throughout the Product Line by 10% | Improved support and services for patients at high risk for suicide. |
| Access to Mental Health Services/SUD Treatment | Behavioral Health Academy | Continue to provide the Behavioral Health Academy academic program to yield an additional 125 clinically licensed eligible therapists who are eligible to become dually licensed as LCACs and are specially trained in SUD | 125 dually licensed eligible therapists added to the workforce |
| Access to Mental Health | Peer Support and Homeless Outreach | Increasing the number of Certified Peers and outreach caregivers providing recovery | Improved support and services for those with a mental health and or substance use disorder, |

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| Services/SUD Treatment | | support services and outreach to patients in our hospitals and local community with a mental health, substance use disorder, and those experiencing homelessness. | and those experiencing homelessness in the hospitals and local community |
| Substance Use | Community Drug Take Back Events | Host at least one Community Drug Take Back event during each calendar year | Eliminate unwanted pharmaceutical drugs in an effort to keep unused medications off household shelves and out of the reach of children and teenagers. |
| Overdose Prevention | Naloxone Distribution | Expand distribution of Naloxone kits throughout the Network by 33 % | Increase availability of Naloxone to our patients at discharge and the people in the community who are at risk for an opioid overdose resulting in a decrease in opioid overdose deaths. |
| Overdose Prevention | Naloxone Education | Increase total number of community members who receive education about opioid overdose and prevention of death with Naloxone by 33% | Decrease the stigma of SUD, increase the number of people in the community with a Naloxone kit resulting in a decrease in opioid overdose deaths in the communities we serve. |
| Overdose Prevention | Naloxone Box | In partnership with Overdose Lifeline by 2024 have one Naloxone box in each CHNw region (CHRH, CHE and CHA) | Increase 24/7 availability of Naloxone which will result in a decrease of opioid overdose deaths in the at-risk populations we serve in each region. |

**Significant Health Need: Covid-19**

| Focus Area | Program/Service | Metric | Anticipated Impact |
|---|---|---|---|
| Prevention | Covid-19 Vaccination Clinics | Continue to improve community vaccination rates by providing free vaccinations to the community at the Community Hospital Anderson Covid Clinic. Track the number of vaccinations provided at both the Covid Clinic and any pop-up and physician practice sites. | Improved community Covid vaccination rates. |

**Significant Health Need: Maternal, Infant and Child Health**

| Focus Area | Program/Service | Metric | Anticipated Impact |
|---|---|---|---|
| Maternal Mortality | Remote BP Monitoring | Provide remote blood pressure monitoring cuffs for OB patients with hypertensive disorder. Track and monitor remote OB BP monitoring participation. | Improved maternal and infant health outcomes |
| Breastfeeding | Breastfeeding | Continue to encourage and educate patients about breastfeeding and track exclusive breastfeeding rates | Increase in moms exclusively breastfeeding |
| Infant Mortality | Sleep Sacks | Educate patients on safe sleep for infants and provide a sleep sack to all newborns upon discharge. Track the number of sleep sacks distributed. | Increase in infant safe sleep habits |
| Prenatal Tobacco Use | OB Nicotine Dependence Program | Screen 90% of all patients entering prenatal care for tobacco use and provide cessation education for those who screen positive | Decrease prenatal smoking rates for patients cared for a CHNw facilities |
| Maternal/Infant Outcomes & SUD | CHOICE Program | Success Day Planners will be distributed to 95% of women that enroll in the CHOICE program. | Prenatal patients will utilize planner to help stay on track with both prenatal care and substance use recovery |
| Infant Health | Car Seat Distribution | Inpatient and outpatient programs get free car seats to those who need them. Social workers facilitate inpatient program and access needs. The outpatient program holds car seat safety events, providing car seats and teaching safe installation. | Decrease in traumatic automobile injuries to children |
| Child Health | Bike Rodeo | We host a bike safety event where we offer free helmets, education, and bike safety checks. | Decrease in traumatic head injuries |

**Significant Health Need: Social Determinants of Health (SDoH)**

| Focus Area | Program/Service | Metric | Anticipated Impact |
|---|---|---|---|
| Food Insecurity/ Poverty | Community Farm of Anderson | Increase connections to community groups to provide fresh produce and education about growing nutritious food to the community. | Improved access to fresh produce to food insecure community members. |
| Access to Care/ Poverty | WellFund | Continue to provide enrollment assistance for health insurance coverage to patients, families and community members. Assist over 19,000 individuals annually. | Improved access to care for over 57,000 Central Indiana Hoosiers. |
| All SDoH | Community Connections | Increase Community Connections usage by increasing the number of searches by 10%. | Improved community awareness of the availability of Community Connections |
| Transportation/ Poverty/ Access to Care | MedExpress | Continue to provide transportation to medical appointments at Community Hospital Anderson to Madison County residents without reliable transportation. Track and monitor number of patients served and rides provided. | Residents will have improved health outcomes, as they will be able to attend important medical appointments. Rides are free, donations accepted, thus removing transportation barriers. |
| Poverty | Coats for Caring | Continue to provide warm winter coats, hats, and gloves to all Madison County residents who need them. Track and monitor the number of coats provided each year. | Improve access to weather-appropriate clothing, preventing weather-related health issues and easing clothing burden for those living in poverty. |
| Transportation | Community Bike Program | Continue to provide, at no charge, 40 high quality bicycles to homeless shelters and halfway houses in Madison County. Continue the bike rental program in Pendleton. Track and monitor bike usage each year. | Improve transportation and increase access to care, and employment. The bike rental program also provides physical activity opportunities. |
| Poverty/Education | The Anderson Crossing | Continue to provide job training to Crossing | Decrease high school dropout rate, decrease poverty rate. |

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| | | students to empower them to become contributing members of the community. | |

**Significant Health Need: Physical Inactivity/Obesity & Chronic Disease**

| Focus Area | Program/Service | Metric | Anticipated Impact |
|---|---|---|---|
| Chronic Disease Management | Diabetes Education | Provide free online diabetes education program for patients and community members. Each two-part series will be provided at least three times each month. Track and monitor program participation. | Improved education, medication management, exercise, nutrition and monitoring for people with diabetes. |
| Chronic Disease Management | Faith Health Initiative | Among the faith community nurses supported by Faith Health Initiative, increase the percentage who offer blood pressure awareness screening events and hypertension prevention and management education in their faith communities from 10% to 25%. | Increase the incidence of early detection of hypertension and improve blood pressure control among those already diagnosed. |
| Physical Activity/Access to Care | Community in Motion | Implement the Community in Motion initiative that will reduce barriers and increase opportunities for physical activity in Madison County. The program will include community events, tournaments, walking clubs, exercise groups, and more, all for little to no cost to the participants. Track and monitor the number of participants annually. | Increase the number of people engaged in physical activity in Madison County. Provide health screenings and follow-up to reduce high blood pressure, cholesterol levels, A1C levels, etc. |
| Physical Activity | Rock Steady Boxing | Rock Steady Boxing is a gym that is dedicated to helping patients with Parkinson's disease fight their symptoms with non-contact boxing drills. Exercises are designed to help with strength and balance. Since 2019, 141 boxers have benefited from the program, | Improve access to physical activity for community members with Parkinson's disease. |

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| | | including 43 in 2019, 57 in 2020 and 41 in 2021. | |
| Physical Activity | Free virtual fitness classes | Continue to provide free virtual fitness classes to cancer survivors and patients. Track and monitor the number of participants annually. | Improve access to physical activity for those who are immune compromised or have transportation issues. |