Community Hospital East Implementation Strategy

This document describes how Community Hospital East (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 - East 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 East 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.

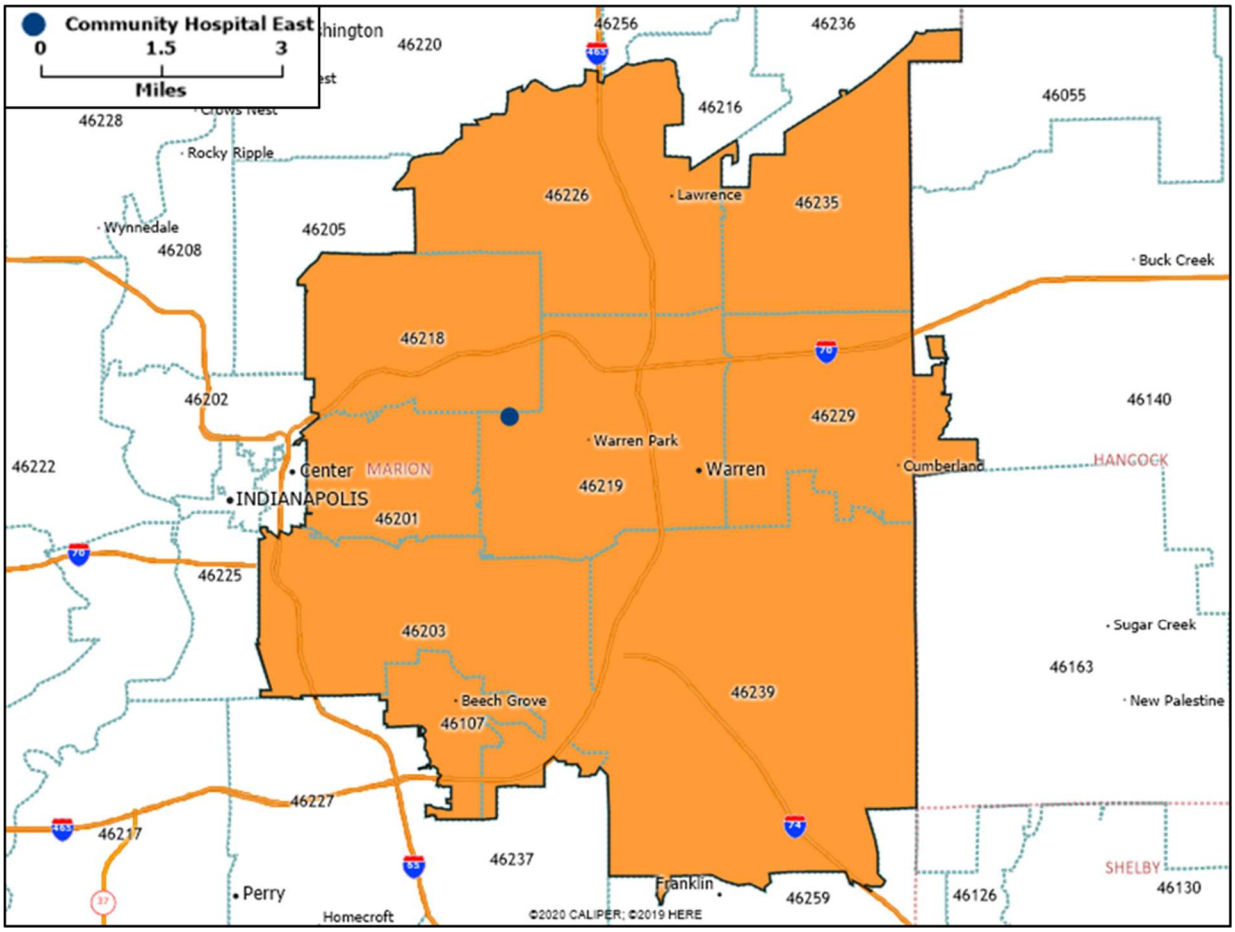
Community Hospital East reserves the right to amend this implementation strategy as circumstances warrant. Certain community health needs may warrant increased focus and resources during the next three years. Moreover, other organizations may decide to increase resources devoted to addressing one or 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 East and the Community it Serves

Community Hospital East has served primarily the Eastside of Indianapolis (East Region) for more than 60 years. In December 2020, a five-year, $175 million project was completed, and a new CHE hospital was built including a new emergency department, medical imaging, and surgery, delivery, and inpatient rooms. CHE currently provides Eastside residents with access to a wide array of health care services, including inpatient and outpatient services, behavioral health services, primary care and specialty-care physician services, school-based services, oncology services, urgent-care services, physical and rehabilitation services, ambulatory and endoscopy services, and employer health services. To expand behavioral health care access, a new inpatient adult psychiatric unit and an expanded behavioral health unit were added to leased space at the NeuroDiagnostic Institute and Advanced Treatment Center.

CHE is part of Community Health Network, an integrated health delivery system. Based in Indianapolis, Community Health Network is Central Indiana's leader in providing convenient access to exceptional healthcare services, where and when patients need them—in hospitals, health pavilions, and doctor's offices, as well as workplaces, schools, and homes. 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, nine specialty and acute care hospitals, surgery centers, home care services, Community MedCheck locations, behavioral health, and employer health services.

For purposes of this CHNA, CHE's community was defined as defined as nine ZIP codes, all of which are located in Marion County, Indiana. The community was defined by considering the geographic origins of the hospital's inpatient discharges and emergency room visits in calendar year 2020. These ZIP codes accounted for 75 percent of the hospital's inpatient discharges and over 80 percent of its emergency department visits.



Summary information regarding Community Hospital East's community:

- The nine (9) zip codes identified accounted for 75% of hospital's 2020 inpatient volumes and 80% of its emergency room visits.
- Total population of the CHE community in 2019 was approximately 287,000 persons.
    - Total population in the CHE community is projected to increase by 1.9% between 2019-2025
    - Zip codes to the eastern areas of CHE are expected to see the most growth while zip codes closer to downtown are projected to decrease in population
    - The population 65 and older is expected to increase by 10.1%
- Low-income census tracts can be found throughout the CHE community with over 17% of residents living in poverty. Poverty rates:
    - 29% of Hispanic or Latino residents are living in poverty
    - 25% of Black residents are living in poverty
    - 14% of White residents are living in poverty

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 East region.

- 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

Members of the Leadership Team at CHE 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.

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

Mental Health & Access to Mental Health Services	School-based Behavioral Health Services	Provide on-site behavioral staff to local schools to provide education and training to educators, parents and children. Track and monitor the Session Satisfaction Score (SES) on clients served with a target of 85% satisfaction.	Improved access to behavioral health services.
Access to Mental Health Services/SUD Treatment	Peer Support and Homeless Outreach	Increasing the number of Certified Peers and outreach caregivers providing recovery support services and outreach to patients in our hospitals and local community with a mental health, substance use disorder, and those experiencing homelessness.	Improved support and services for those with a mental health and or substance use disorder, 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	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
Vaccination	Covid-19 Vaccine Awareness	Continue to promote vaccination for Covid-19 to patients and the community. In partnership with the Network DEI Outreach team, provide outreach to specific populations in an effort to reduce racial disparities in vaccination rates. Track and monitor county vaccination rates quarterly.	Improved community vaccination rates.

Significant Health Need: Maternal, Infant and Child Health

Focus Area	Program/Service	Metric	Anticipated Impact
Maternal and Infant Health Outcomes	Nurse Family Partnership	Screen 100% of patients enrolled in the Perinatal Nurse Navigation program for eligibility to a home visiting program and refer 50% of eligible patients to NFP	Healthier maternal and infant outcomes for at-risk first time mothers seeking prenatal care prior to 28 weeks gestation
Maternal Mortality	Remote BP Monitoring	Track and monitor remote BP monitoring participation for at-risk OB population enrolled in GHP Care Companion.	Early intervention for progression of disease severity to improve maternal and infant outcomes
Breastfeeding	Breastfeeding	Continue to encourage and educate patients about breastfeeding and track exclusive breastfeeding rates	Increase in number of mom's exclusively breastfeeding at time of discharge
Infant Mortality	Perinatal Nurse Navigation	Complete SDoH screening on 85% of patients entering prenatal care and enroll 50% of eligible patients	Healthier maternal and infant outcomes for highest at-risk women seeking prenatal care
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 Nicotine Use	OB Nicotine Dependence Program	Complete screening on 85% of patients entering prenatal care for nicotine use and offer cessation education to those who screen positive	Engage pregnant women who are smoking in nicotine cessation counseling in order to foster a healthy pregnancy and home environment

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
Child Health	Asthma	School nurses will distribute spacers for students with diagnosed asthma. Track the number of spacers distributed annually.	Improved medication distribution and outcomes for children with asthma

Significant Health Need: Social Determinants of Health (SDoH)

Focus Area	Program/Service	Metric	Anticipated Impact
Food Insecurity/ Poverty	Community Cupboard of Lawrence	Increase the number of clients served at the Cupboard by 10%	Improved access to healthy foods for the community of the Northeast side of Indianapolis.
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	Mabel's Ride	Maintain Mabel's Ride transportation service and seek opportunities for expansion into additional areas of need. Track and monitor patients served and number of rides provided annually.	Improved access to care for patients
Housing/Poverty	MLP	In partnership with Indiana Legal Services, Inc., continue providing patients access to free legal aid maintaining a minimum of 380 referrals per year to the program.	Improve health outcomes for patients through the provision of legal services that address issues that ultimately impact social determinants of health
Food Insecurity/Social Connection	Touchpoint Senior Meal Program	Provide meal vouchers and or meal delivery service to seniors in the CHE service	Address food insecurity in the senior citizen population

		area. Track and monitor the number served and meals provided.	
Access to Care	School-based Nursing Services	Provide school-based on-site nursing services within local schools. Track and monitor the number of school nurse visits and the return to class rate.	Improved access to care for children

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	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.