Community Hospital Anderson Implementation Strategy

2025-2027

This document describes how Community Hospital Anderson (CHA or the hospital) plans to address the needs identified in the Community Health Needs Assessment (CHNA) published by the hospital on December 18, 2024. The CHNA report can be found at:

CHA_CHNA_Report_2024.pdf

The Implementation Strategy describes how the hospital plans to address significant needs throughout the calendar years 2025 through 2027.

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.

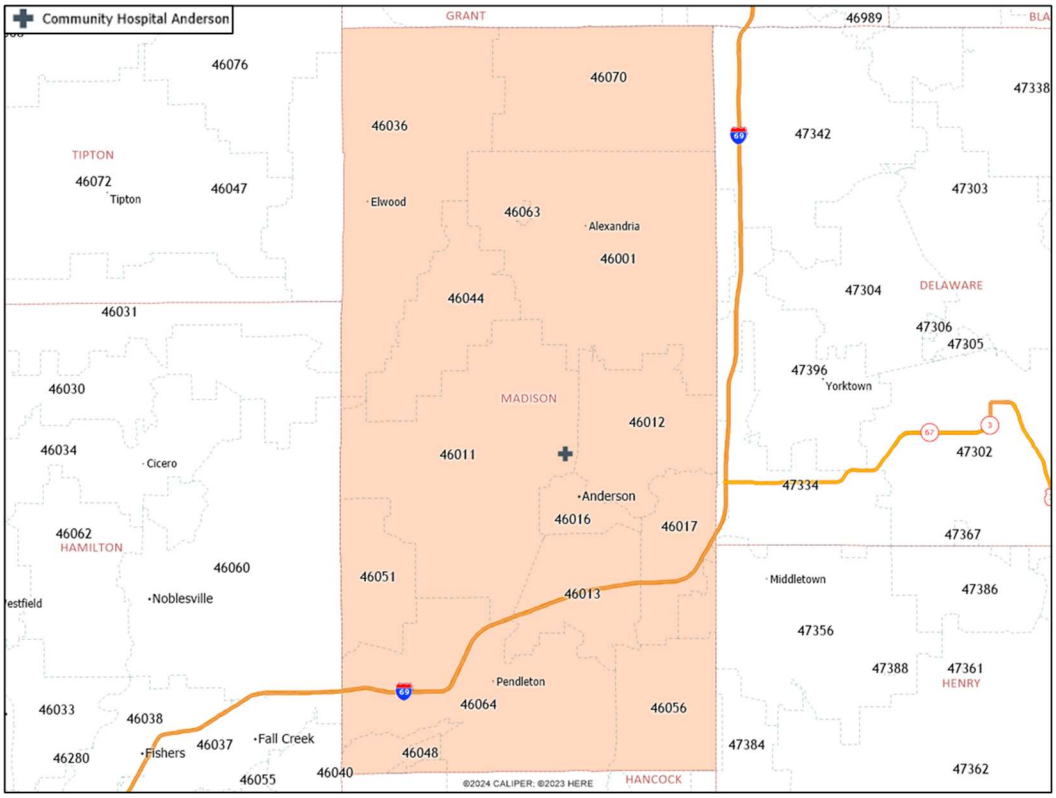
About Community Hospital Anderson and the Community it Serves

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, MedChecks, behavioral health, and employer health services.

For purposes of this CHNA, CHA's community was defined as 14 ZIP codes which are located in Madison County, Indiana. The community was defined by considering the geographic origins of the hospital's inpatient discharges and emergency room visits in calendar year 2023. These ZIP codes

accounted for 82 percent of the hospital's inpatient discharges and 83 percent of its emergency department visits.



Summary information regarding the Community Hospital Anderson community:

- Total population of the 14 zip codes that comprise the CHA community was approximately 130,247 persons.
- Low-income census tracts can be found throughout the service area. Approximately 14.1% of residents in the zip codes served by CHA live 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 Anderson 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 2025-2027 period.

Significant Health Needs Identified in the 2024 CHNA	Intend to Address (Y/N)
Access to Care	Y
Mental Health & Access to Mental Health Services	Y
Substance Use & Overdose	Y
Poverty and Housing	N
Infant & Child Health	Y
Food Access and Nutrition	Y
Obesity, Healthy Lifestyles and Assoc Conditions	Y

While Community Hospital Anderson does not plan to specifically address Poverty and Housing in the 2025-27 implementation plan, they will focus efforts on screening patients and connecting to resources. In addition, CHA will support our community partners addressing Poverty and Housing with in-kind support such as volunteers and donations as well as through grant opportunities through our Community Collaboration for Health Equity grant program.

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 2025-2027 should focus on the key areas and strategies described below. The strategies listed below are not inclusive of all hospital and Network activities that impact the needs identified.

Significant Health Need: ACCESS TO CARE

Focus Area	Program/Service	Strategy	Anticipated Impact
Transportation	MedExpress	A transportation service for patients who need medical services on the CHA campus. MedExpress has vans equipped with lifts for wheelchairs and serves all of Madison County.	Reduction in cancellations and no shows for patients experiencing a transportation barrier.
Workforce Development	Behavioral Health Academy	Continue to provide the Behavioral Health Academy academic program to yield an additional 60 clinically licensed eligible therapists	60+ dually licensed eligible therapists added to the workforce each year.

		annually who are eligible to become dually licensed as LCACs and are specially trained in SUD.	
Access	Community ProCare @ Home	Community ProCare at Home is a house-call care service for patients who are unable to leave their home for care, are recovering from a recent hospital stay, or may have worsened symptoms of a chronic illness.	Improved health outcomes for patients served in the program. Increase new patient growth by 5% annually.
Health Coverage Enrollment	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.
Access	Jane Pauley Partnership	Continue partnership and support of Jane Pauley Community Health Center to provide improved access to primary, pediatrics, behavioral health and dental care in the community.	Improved access to care for low-income and uninsured individuals.

Significant Health Need: MENTAL HEALTH and SUBSTANCE USE

Focus Area	Program/Service	Strategy	Anticipated Impact
Access to Mental Health Services/SUD Treatment	Peer Support	Peer support professionals in the emergency department offer support and connection to patients who present for care related to substance use disorders. They utilize their lived experience to help patients feel seen and	Improved support and services for those with mental health and or substance use disorder presenting in the emergency department.

		develop motivation for and connections to all varieties of recovery pathways. When the desire for treatment is identified, they facilitate patient being connected or admitted to care.	
Prevention	Promoting Mindfulness and Wellness	Weekly wellness classes designed to promote physical and mental well-being.	Improved mental wellness and increased opportunity for free wellness activities for the community.
Substance Use	Community Drug Take Back	Provide a free collection site for community members to safely dispose of unwanted prescription drugs. This collection site is open M-F.	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 Education	Educate community members through public training and distribution of kits by attending community health fairs, service organization meetings, and university campus events.	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, continue to install Naloxone distribution boxes (i.e. NaloxBox) in targeted locations based upon state overdose data. Continue to ensure a Narcan supply in all supported NaloxBox.	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.
Substance Use	Peer Support	Peer Recovery Specialists at Community Fairbanks Recovery Center provide patients with a substance use disorder valuable guidance by sharing their own recovery experiences, addressing needs the patient is facing in early recovery, and improving social connectedness and identifying new social environments.	Number of patients receiving peer services and the total number of interactions (Once patient satisfaction surveys are available for all programs, will be able to report on patient satisfaction with peer services.)

Caregiver Support	Family Connections	Family Connections is a no-cost service that helps families and friends get answers to the many questions they may have when learning about – and trying to understand – substance-abuse disorders of their loved ones. It is open to family members or friends seeking answers to their questions about substance use disorders and in need of support.	Change in client's Happiness Scale rating - comparing the rating at the beginning of the program to the rating at completion of the program. The scale rates the client's happiness with their life in ten areas.
SUD Prevention	Education	Community Fairbanks Recovery Center offers preventive substance use disorder education for individuals with high-risk behaviors associated with drugs and/or alcohol. Program participants learn about their relationship with alcohol, marijuana and other drugs, and increase their understanding about the consequences of addiction.	Intervention and prevention of substance use disorder for high-risk individuals.

Significant Health Need: INFANT & CHILD HEALTH and WELL-BEING

Focus Area	Program/Service	Strategy	Anticipated Impact
Maternal and Infant Health Outcomes	Perinatal Nurse Navigation	Screen 100% of patients for Social Drivers of Health and connect to resources at prenatal intake. Screen again at delivery.	Removal of barriers to a healthy pregnancy and postpartum for high risk mothers.
Maternal and Infant Health Outcomes	Perinatal Nurse Navigation	Track and monitor remote BP monitoring participation for at-risk OB population	60% or more babies born in the program will be born at > 37 weeks gestation and > 5.8 lbs birthweight.

		enrolled in GHP Care Companion.	
Maternal/Infant Outcomes & SUD	CHOICE Program	Provide comprehensive SUD and prenatal care for pregnant women enrolled in the program.	Improved adherence to prenatal care for enrolled moms and reduction of infants born with neonatal abstinence syndrome.
Infant/Child Health	Indiana Diaper Bank	Serve as a collection site for Indiana Diaper Bank. Promote the need for diapers and serve as a storage hub for donated diapers in partnership with IDB.	Reduce diaper need in the community by providing reliable and accessible access to essential.
Breastfeeding	The Milk Bank, Milk Depot	In partnership with The Milk Bank, serve as a community collection site for breastmilk donation.	Improved access to breastmilk for those in need.
Infant/Child Health	Car Seat Safety	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.	Reduction of infant/child injury and mortality.
Maternal/Infant Health	Spinning Babies Workshops	Sponsor on-site classes to increase the number of RNs and providers with Spinning Babies training.	Promote vaginal births using unique techniques designed to optimize fetal positioning in the womb.
Child Health	Bike Rodeo	Host bike safety events offering free helmets, education and bike safety checks.	Prevention of traumatic brain injuries.

Significant Health Need: OBESITY, HEALTHY LIFESTYLES, and ASSOCIATED CONDITIONS

Focus Area	Program/Service	Strategy	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.
Prevention	Faith Health Initiative	Among the faith community nurses supported by Faith Health Initiative, increase the percentage who offer blood pressure screening events, hypertension prevention and management education in their faith communities.	Increase the incidence of early detection of hypertension and improve blood pressure control among those already diagnosed.
Prevention	Disease Prevention and Health Outcomes Council	Implement quarterly (REaL) data reviews with the CHNw Disease Prevention and Health Outcomes Council on key network priorities including breast cancer screening, diabetes, and advance care planning.	Determine strategies for addressing screening gap and health outcomes disparities among various populations.
Chronic Disease Management	Rock Steady Boxing	Rock Steady Boxing is a gym that is dedicated to helping patients with Parkinson's disease fight their symptoms with noncontact boxing drills. Exercises are designed to help with strength and balance.	Improve access to physical activity for community members with Parkinson's disease.
Physical Activity	Community in Motion	This initiative reduces barriers and increases opportunities for physical activity in Madison County. The program includes community events, tournaments, walking clubs, exercise groups, and more,	Increase the number of people engaged in physical activity in Madison County.

		all for little to no cost to the participants.	

Significant Health Need: FOOD ACCESS & NUTRITION

Focus Area	Program/Service	Strategy	Anticipated Impact
Access	Community Farm	The Community Farm is a 3-acre farm that grows and distributes fresh produce to patients and the community. The Farm employs two farmers. Produce grown on the farm goes to the community through various outlets including local food pantries, programs at Community, and CHA foodservice.	Increase availability of local produce to community members. Reduce food insecurity for patients and community members.
Education	Food Preservation Classes	Provide free classes regarding canning and storing freshly grown produce for optimal nutrition quality.	Increased awareness of safe and healthy food preservation practices.
Education	Cooking and Gardening Classes	In partnership with Bloom Madison County, host cooking classes and a gardening club to educate and inform community members on healthy eating. Community garden plots are available at the Community Farm for community members to grow their own produce.	Improved understanding of healthy cooking and the importance of incorporating fresh, locally grown produce into meal time.