Community Hospital East Implementation Strategy

2025-2027

This document describes how Community Hospital East (CHE 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:

CHE_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 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.

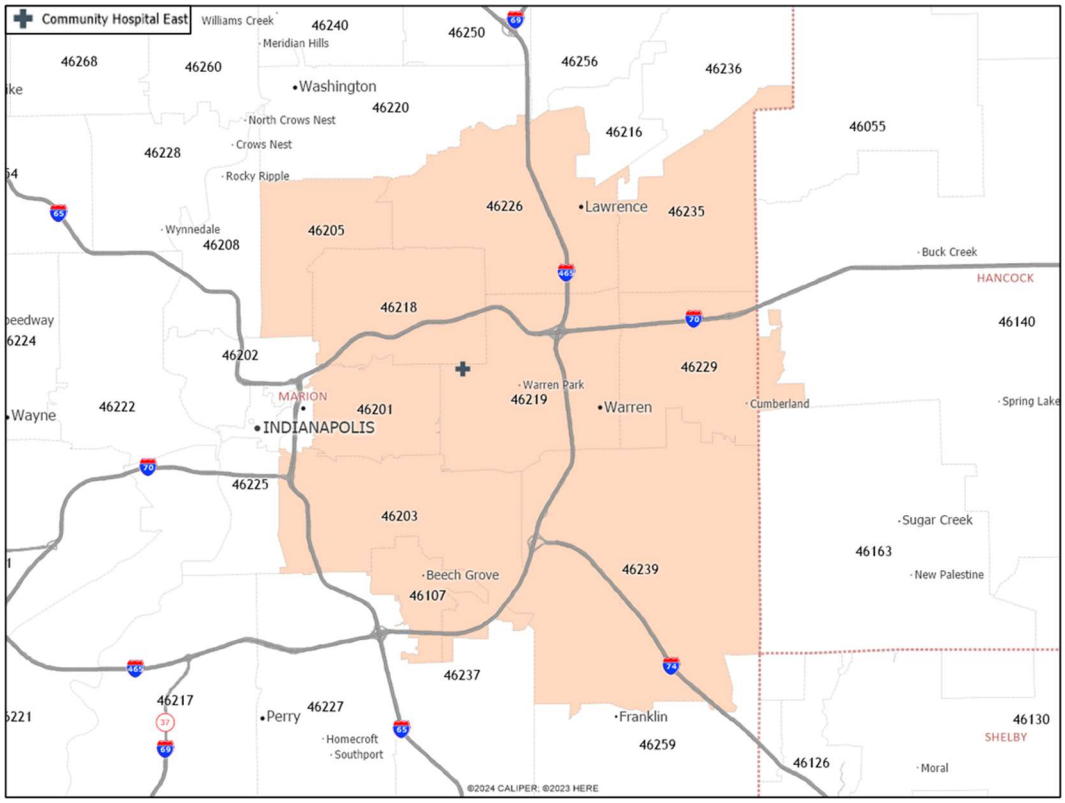
Community Hospital East reserves the right to amend this implementation strategy as circumstances warrant. Certain community health needs may warrant increased focus and resources during the next three years. Moreover, other organizations may decide to increase resources devoted to addressing one or 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 East Indianapolis for more than 60 years. In 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 behavioral health services, primary care and specialty-care physician practices, school-based clinics, MedChecks, Community Cancer Centers, a Community Surgery Center, a Community Endoscopy Center, Community Physical Therapy and Rehabilitation services, and employer health clinics. To expand behavioral health care access, a new inpatient adult psychiatric unit and an expanded behavioral health unit were completed as a part of the new facility.

Community Hospital East 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, CHE's community was defined as 10 ZIP codes 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 2023. These ZIP codes accounted for 77 percent of the hospital's inpatient discharges and 82 percent of its emergency department visits.



Summary information regarding Community Hospital East community:

- Total population of the 10 zip codes that comprise the CHE community was approximately 319,332 persons.
- Low-income census tracts can be found throughout the service area. Approximately 18.3% of residents in the zip codes served by CHE 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 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 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
Community Safety and Violence	Y
Infant & Child Health	Y
Poverty and Housing	N
Healthy Lifestyles, Nutrition and Assoc Conditions	Y

While Community Hospital East 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, CHE will support our community partners 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	Mabel's Ride/Uber Health	Mabel's Ride is a dedicated fleet of cars providing free transportation to and from oncology and cardiology for existing Network patients in need. Mabel's Ride Uber Health provides free Uber Health rides to existing patients to and from CHNw ambulatory sites of care.	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 annually who are eligible to become dually licensed as LCACs and are specially trained in SUD	60+ dually licensed eligible therapists added to the workforce each year.
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.
Primary Care	School-based Nursing	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 school-aged children.
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, OB/GYN, behavioral health and dental care in the community.	Improved access to care for low-income and uninsured individuals.

Significant Health Need: MENTAL HEALTH

Focus Area	Program/Service	Strategy	Anticipated Impact
Mental Health	Clubhouse International	Clubhouse is a supportive community for individuals living with mental illness, providing social connection, structured activities, and skill development. It fosters a sense of belonging, reduces isolation, and helps members build confidence through peer support, employment opportunities, and wellness programs. Clubhouses promote long-term recovery by offering a safe, empowering, and affordable space for personal growth and stability	Improved support and stability for individuals living with mental illness.
Mental Health	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	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 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.	Improved support and services for those with mental health and or substance use disorder presenting in the emergency department.

Mental Health	Crisis Intervention Team	Community Fairbanks Behavioral Health and Recovery Center will engage with first responders, the National Alliance on Mental Illness (NAMI), and community resource partners to provide mental health and substance use disorder education to those attending Crisis Intervention Team (CIT) trainings. Currently, Community Fairbanks Behavioral Health and Recovery Center employees sit on the committees of and/or provide educational expertise to CIT progams in Marion, Boone, Hamilton, Hancock, Hendricks, Johnson, and Bartholomew Counties.	Community Fairbanks Behavioral Health and Recovery Center employees will provide at least two lectures per year for at least two county CIT trainings.

Significant Health Need: SUBSTANCE USE

Focus Area	Program/Service	Strategy	Anticipated Impact
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 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 anyone family member or friend 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: MATERNAL, INFANT and CHILD HEALTH

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 enrolled in GHP Care Companion.	60% or more babies born in the program will be born at > 37 weeks gestation and > 5.8 lbs birthweight.
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
Maternal/Infant Health	BABE Store	Beds and Britches, Etc. (B.A.B.E.) is an incentive program that provides coupons to parents who utilize health care and social services. Coupons are redeemed at B.A.B.E. stores for new and gently used baby supplies	Serve prenatal patients from across the community with access to needed baby supplies while encouraging and incentivizing routine prenatal care.
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	Provide free car seats for eligible patients in need.	Reduction of infant/child mortality.

		Provide car seat safety education.	
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.

Significant Health Need: HEALTHY LIFESTYLES, NUTRITION and RELATED CONDITIONS

Focus Area	Program/Service	Strategy	Anticipated Impact
Chronic Disease Management	Produce RX	The Produce Prescription nutrition incentive program is designed for high-risk patients. Patients are enrolled into free chronic disease focused nutrition education classes provided by the Ambulatory Dietitian team. Each participant receives financial incentives provided by CHNw that are redeemable for fruits and vegetables at local retail locations for attending	Improved chronic disease management and sustainable behavior change among participating patients.
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 awareness screening events and hypertension prevention and management education in	Increase the incidence of early detection of hypertension and improve blood pressure control among those already diagnosed.

		their faith communities from 10% to 25%	
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
Health Equity	Central Indiana Health Equity Collaborative	Continue collaboration with the Central Indiana Alliance for Health Equity which includes Community Health Network, Eskenazi Health, Franciscan Health and Indiana University Health in partnership with the Indianapolis Recorder and Greater Indianapolis Branch of the NAACP.	Develop community wide cardiovascular/hypertension program to increase awareness of blood pressure control for adults and/or increase in # of people engaged around their blood pressure health

Significant Health Need: COMMUNITY SAFETY and VIOLENCE

Focus Area	Program/Service	Strategy	Anticipated Impact
Safety	Community Police Department	Maintain a fully staffed police force providing a wide range of services to all Community sites of care with the purpose of keeping all patients, visitors and caregivers safe.	Improved safety for all patients, visitors and caregivers at Community Health Network sites of care. Alleviate volume of calls to local police departments therefore improving their capacity to support the needs of the communities we serve.