Community Howard Regional Health Implementation Strategy

2025-2027

This document describes how Community Howard Regional Health (CHRH 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:

CHRH_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 Howard Regional Health 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.

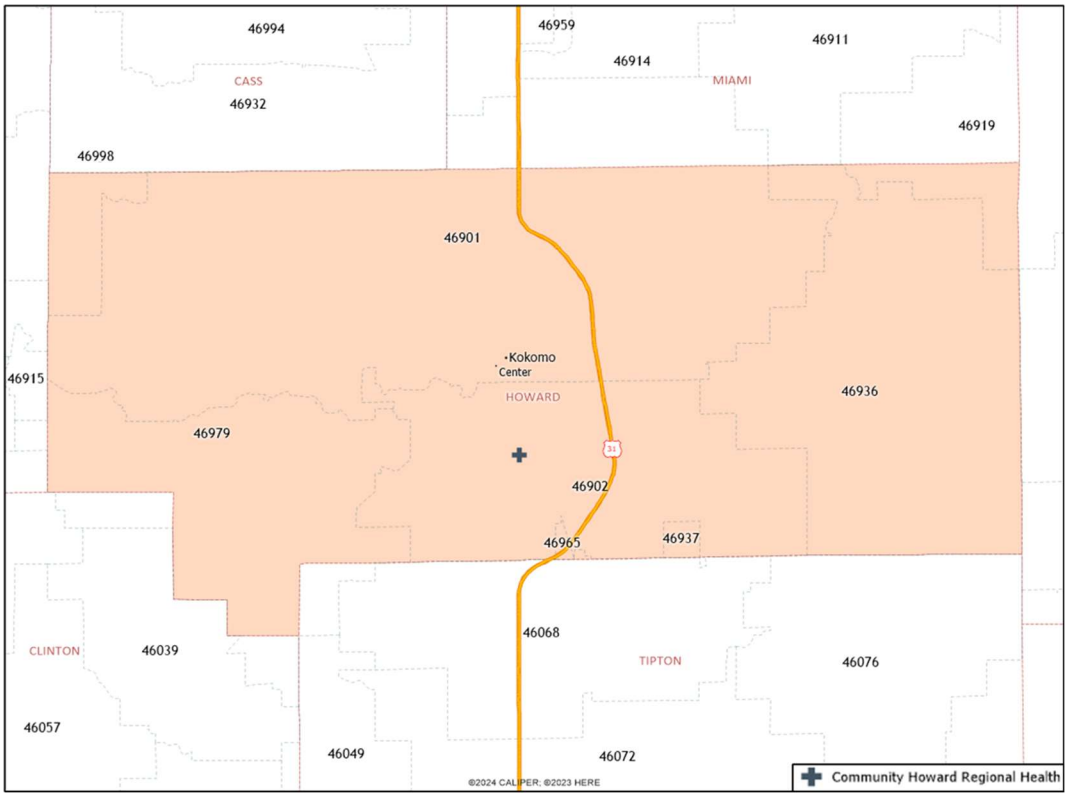
Community Howard Regional Health reserves the right to amend this implementation strategy as circumstances warrant. Certain community health needs may warrant increased focus and resources during the next three years. Moreover, other organizations may decide to increase resources devoted to addressing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

Community Howard Regional Health (CHRH) is a full-service hospital in Kokomo, Indiana. The hospital campus offers primary and specialty inpatient and outpatient services, which include a heart program, behavioral health, oncology, orthopedics, emergency care, surgery, wound care, obstetrics, and gynecology.

Community Howard Regional Health 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, CHRH's community was defined as Howard 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. Howard County accounted for 73 percent of the hospital's inpatient discharges and 80 percent of its emergency department visits.



Summary information regarding the Community Howard Regional Health community:

- Total population of Howard County was approximately 83,574 persons.
- Approximately 12% of residents in the community served by CHRH 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 Howard Regional Health 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 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
Aging Population and Elderly Needs	Y
Maternal & Child Health and Wellbeing	Y
Food Access and Nutrition	N
Obesity, Healthy Lifestyles and Assoc Conditions	Y

While Community Howard Community Health does not plan to specifically address Food Access and Nutrition in the 2025-27 implementation plan, they are actively addressing these needs through partnerships with local organizations addressing food insecurity and nutrition. These partnerships include in-kind support such as volunteers and donations as well as through grant opportunities through our Community Collaboration for Health Equity grant program. In addition, CHRH will actively engage with the Howard County Food Access Alliance.

Members of the Leadership Team at CHRH 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
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	Improved health outcomes for patients served in the program. Increase new patient growth by 5% annually.

		worsened symptoms of a chronic illness.	
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	CareMobile Mobile Clinic	Continue to expand access to care by offering health screenings, education and flu vaccinations at events across Howard County. In addition to public events, Community Howard's CareMobile outreach registered nurse will partner with agencies serving vulnerable populations to deliver health screenings and education.	Provide health education to thousands of attendees at events across Howard County. Perform approximately 1,000 screenings annually, including blood pressure, blood glucose and flu vaccinations.
Access	Jane Pauley Partnership	Continue partnership and support of Jane Pauley Community Health Center to provide pediatric care in the Howard County Community	Improved access to care for low-income and uninsured pediatric patients in Howard County.

Significant Health Need: MENTAL HEALTH

Focus Area	Program/Service	Strategy	Anticipated Impact
Mental Health	Clubhouse International	Plan for expansion of the Clubhouse International program in Howard County. Clubhouse is a supportive community for individuals living with mental illness, providing social connection, structured activities, and skill development. Clubhouses promote long-term recovery by offering a safe,	Once implemented, Clubhouse International will reduce isolation, and help members build confidence through peer support, employment opportunities, and wellness programs.

		empowering, and affordable space for personal growth and stability.	
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 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
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 –	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

		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.	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 & CHILD HEALTH and WELLBEING

Focus Area	Program/Service	Strategy	Anticipated Impact
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	Breast Feeding Drop-In Center	Continue to offer a weekly Mom's Group/Breastfeeding Drop-In Cener to provide a free opportunity for new mothers to weigh their baby and ask questions and receive support from a certified lactation consultant.	Enable more mothers to have the knowledge and confidence to successfully breastfeed their newborn.

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.
Infant/Child Health	Car Seat Safety	Provide free car seats for eligible patients in need. Provide car seat safety education.	Reduction of infant/child 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.
Maternal and Infant Health Outcomes	Perinatal Nurse Navigation	Expand Perinatal Nurse Navigation program with CHRH OB to improve maternal and infant health outcomes for at-risk mothers and newborns.	Removal of barriers to a healthy pregnancy and postpartum and increase in gestation and birthweight for at-risk OB population.

Significant Health Need: OBESITY, HEALTHY LIFESTYLES and RELATED 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.	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.
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
Education and Prevention	Partnership with the Kokomo YMCA	Provide monthly educational content and speakers regarding key health topics like chronic disease management, heart health and disease prevention	Improved understanding of disease prevention and management.

Significant Health Need: AGING POPULATION and ELDERLY NEEDS

Focus Area	Program/Service	Strategy	Anticipated Impact
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.
Geriatric Care	HELP	Plan and implement expansion of the HELP program to CHRH. This program identifies independent seniors at the beginning of their inpatient stay and engages a specialized team to ensure they maintain their independence and mental clarity throughout the duration of their hospital stay.	Reduction of patients experiencing delirium while inpatient, improving patient experience and outcomes. Maintain less than 5% of all enrolled patients will experience delirium during their admission.