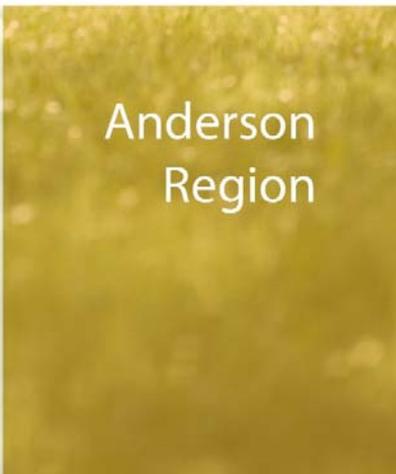
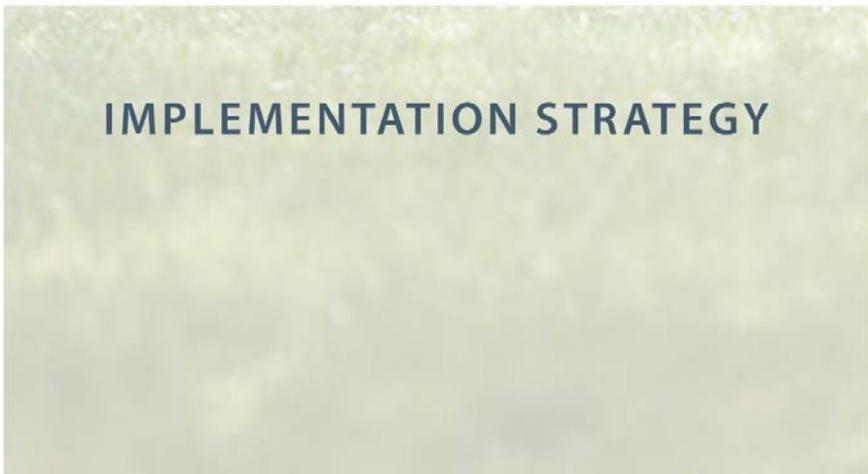




Community Health Needs Assessment



About This Document

This document describes how Community Hospital Anderson (the hospital or CHA) plans to address needs found in the Community Health Needs Assessment (CHNA) published by the hospital on December 31, 2018. See the CHNA report at:

eCommunity.com/community-benefit/archived-reports

The implementation strategy describes how the hospital plans to address significant community health needs in calendar years 2019 through 2021.

The Implementation Strategy for CHNw 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 Community Health Needs Assessment (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 permit. Certain community health needs may warrant increased focused 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.

The document contains the following information:

1. About Community Hospital Anderson
2. Definition of the Community Served, and Determining Its Needs
3. Implementation Strategy to Address Significant Health Needs
4. Needs Community Hospital Anderson Will Not Address
5. Next Steps for Implementation Strategy Adoption

Adopted by the Community Health Network, Inc. Board on February 26, 2019

About Community Hospital Anderson

Community Hospital Anderson (CHA) became part of Community Health Network (CHNw) in 1996, but its roots in the community go back much further—Madison County residents joined together to bring health care closer to home and opened the hospital in 1962.

CHA provides high quality health care for all ages. As a full service hospital, CHA offers comprehensive cardiac and surgical services with the only dedicated pediatric unit in Madison County. CHA is the market leader for inpatients in the county. CHA delivers over 65% of the births in the county and has a "Baby Friendly" designation from the World Health Organization. CHA's affiliation with MD Anderson Cancer Center provides state-of-the-art physician-coordinated medical and radiation oncology. CHA provides a transportation service, MedExpress, for patients needing medical services on our campus. As a state designated Trauma Center, all physicians in our state-of-the-art Emergency Department are Board Certified in Emergency Medicine. CHA operates a Clinical Research Center in Madison County which conducts clinical trials on both pharmaceuticals and medical devices.

Community Physician Network (CPN), the Community Health Network's integrated, multi-specialty physician group, has placed a full complement of physicians, advanced professional providers, and staff throughout Madison County. This includes MedCheck urgent care and mental health services.

Key Statistics

Admissions: 6,907

Emergency room visits: 34,618

Babies born: 862

Surgeries (at hospitals, inpatient and outpatient): 8,527

Physician & clinic visits: 199,400

The Community Served and Its Needs

Key Demographic Data

- The current population is 128,928. A five-year trend (2018-2023) shows the population at 128,601.
- Whites comprise 84.7% of the population, with African-Americans at 8.5%, Hispanic/Latino at 4.0% and 2.9% other race or ethnicity.
- The fastest growing age group is 65+ at 11%.
- The Anderson Region will experience a 0.7 percent decline in growth between 2018-2023.
- The Anderson Region has one of the lowest median household income at \$42,819.

Creating the Community Health Needs Assessment

The identification of health needs for CHNw CHA Region was carried out using two types of data: 1) secondary data from the Healthy Communities Institute (HCI) dashboard and other local and national agencies; and 2) primary data obtained through an online survey of CHNw healthcare providers and a survey of community residents in each CHNw region. To supplement these data and identify population-specific health needs, CHNw directed two focus groups with community stakeholders. Key informant interviews were also conducted with the State of Indiana's top health leaders: Director of the Marion County Public Health Department, the Commissioner for the Indiana State Department of Health (ISDH), and the Family and Social Services Administration (FSSA).

Implementation Strategy

To Address Significant Health Needs

This implementation strategy describes how CHA plans to address the significant community health needs identified in the 2019 CHNA. The hospital reviewed the CHNA findings and applied the following criteria to determine the most appropriate needs for the CHA Region to address:

- 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 2019-2021 time period.

Significant Health Needs Identified in the 2018 CHNA	Intend to Address
1. Social Determinants of Health	Y
2. Mental Health	Y
3. Services for Seniors	N
4. Substance Abuse (Alcohol)	Y
5. Substance Abuse (Opioids and Other Drugs)	Y
6. Obesity	Y
7. Access to Health Services	Y
8. Chronic Disease Management	Y
9. Tobacco Use	Y
10. Diabetes	Y

SIGNIFICANT HEALTH NEED *Social Determinants of Health*

Indicator Rankings

The Social Determinants of Health indicators ranked of highest concern at a system level are listed below. The system-level rankings can be found for each indicator in the *Highest Ranking CHNw Health Indicators* table.

- Accessibility to healthy food
- Transportation
- Miscellaneous assistance

Goal 1: Increase Access to Healthy Food

Interventions/Recommendations:

- Expand CHA's Community Farm, which was started in 2016 to distribute to fresh produce to patients and the community.
- Distribute fresh produce into areas of need in the community:
 - Partner with the Carrie Mae Hyatt Food Pantry in the heart of Anderson's west side food desert to distribute fresh, nutritious food accompanied by simple recipes
 - Partner with The Christian Center, a community soup kitchen and homeless shelter that teaches residents to prep fresh foods to feed the community
 - Continue to partner with other area non-profits as appropriate
- Partner with the Primary Care Navigation Team to get quality food and food education to patients with demonstrated need as a means to improve health outcomes.
- Engage youth ~especially at-risk youth ~ in food and farm education to promote healthy choices:
 - Implement an interactive garden learning lab and 2019 grant-funded pollinator education (bees).
- Educate the community on how to eat healthy, including how fresh produce is grown and how to prepare it. This will be accomplished by hosting workshops and offering cooking demonstrations.
- Produce flowers for inpatients and long-term care facilities to promote emotional well-being during patient stays.
- Support the newly formed Madison County Local Food Network to create a more vibrant community that provides equitable access to healthy, affordable nutritious food to all Madison County residents.
- Continue the Senior Meal Program. This program aims to expand the availability of healthy options for seniors, while also providing opportunities for social engagement through a free membership program.
- Support Second Harvest Food Bank School Pantry Program. This program places food pantries in schools throughout Madison County. It is intended to provide more readily accessible source of food assistance to low-income students.



Collaborations

- Health Care Providers
- Second Harvest Food Banks
- Schools in Madison County
- Community-based organizations

Anticipated Impacts

- Increase quality of life by:
 - Increase healthy food consumption
 - Increase food security
 - Improved nutrition
- Alleviate hunger to individuals in need

Evaluation Metrics

- Assess impact during 2021CHNA
- Increase the yield in the Community Farm to over 15,000 pounds that will be distributed throughout the community
- Number of school food pantries
- Number of Senior Meal vouchers distributed

Goal 2: Transportation

Interventions/Recommendations

- Continue to maintain the Community Bikes program, this bicycle sharing program is aimed at helping those facing economic issues including homelessness. CHA has purchased and placed 30 commercial-grade bicycles at transitional housing facilities—residents use the two-wheeled transportation to connect with jobs and healthcare.
- Continue CHA’s MedExpress transportation service. This service provides the community with transportation to and from their health care appointments offering over 10,000 rides in 2018.
- Continue CHA’s Delivering Baby Safely program. This program provides each infant born at CHA with a free car seat and the family receives car seat safety education.
- Continue to administer the Safe Kids Grant for Madison County which serves those in need of a car or booster seat. Through this initiative car seat safety checks are also offered.

Collaborations

- Health care providers
- Community Based Organizations



Anticipated Impacts

- Increase at risk individual's opportunity to gain employment
- Greater access to healthcare which will improve health status, increase the use of preventative services and lower hospitalization rates
- Ensure the patient and families are equipped with the knowledge to keep infants and children safe while traveling

Evaluation Metrics

- Assess impact during 2021 CHNA
- Number of MedExpress transports
- Number of car seats provided

Goal 3: Miscellaneous Assistance

Interventions/Recommendations:

- Continue the annual CHA Keith Trent's Community Coats of Caring. This annual event provides warm winter garments for those in need.
- Continue to offer a Warming Center to the public for residents and homeless to stay during extreme cold temperatures.

Collaborations

- Community Based Organizations

Anticipated Impacts

- Increase quality of life
- Offer a shelter in times of extreme cold

Evaluation Metrics

- Assess impact during 2021 CHNA
- Number of time the Warming Center is opened
- Number of coats provided

SIGNIFICANT HEALTH NEED *Mental Health*

Indicator Rankings

The Mental Health indicators ranked of highest concern at a system level are listed below. The system-level rankings can be found for each indicator in the *Highest Ranking CHNw Health Indicators* table.

- Adolescent Suicide and Intentional Self-inflicted Injury
- Mental Health
- Suicide and Intentional Self-Inflicted Injury

Goal 1: Treatment

Interventions/Recommendations:

- Add additional staff over the next 1-1.5 years to include two more therapists and a Life Skills Clinician to expand the following services to the community: individual therapy, group therapy, family therapy, community and office based skills training, and medication management services. In addition, services will be broadened to ensure a complete spectrum of outpatient co-occurring treatment options, including Medication Assisted Treatment (MAT) services
- Therapists who specialize in youth services will identify the needs and gaps in youth and family programming in an effort address the higher acuity of mental health issues for youth and adolescents.
- Continued support of the integration of Zero Suicide Initiatives which is already a part of the continuum of care model in Behavioral Health
- Continue to be a treatment partner in the Madison County Drug Court. Drug court participants receive intensive outpatient therapy, individual therapy, medication services, and step down group therapy as they progress in their treatment. Continue to have CHNw therapists attend weekly staff meetings with the judge, case managers, and other treatment providers. For participants receiving treatment with CHNw, the therapist also provides case management services largely related to communicating appropriate information to and from the court team. The clinical team provides the participants with services to address co-occurring disorders, including psychiatric medication not limited to MAT.

Collaborations

- Health Care Providers
- Madison County Courts
- Community-based organizations



Anticipated Impacts

- Early identification of mental health issues and increase the access to mental health services
- Increase knowledge of existing resources

Evaluation Metrics

- Assess impact during 2021CHNA
- Number of clients treated

Goal 2: Increase Education and Awareness

Interventions/Recommendations

- Continue to partner with local schools to provide education and training to educators, providers, parents and children.
- Evaluate use of Screening, Brief Intervention and Referral to Treatment (SBIRT) program in primary care settings.

Collaborations

- Health care providers
- Schools

Anticipated Impacts

- Increase quality of education surrounding mental health
- Increase knowledge of warning signs
- Reduce stigma associated with mental health
- Increase knowledge of existing resources

Evaluation Metrics

- Assess impact during 2021 CHNA
- Number of participants in education programs that understand the concepts of mental health and availability of resources through education and training
- Number of community partners (e.g., Faith Based Organizations)

SIGNIFICANT HEALTH NEED *Substance Abuse* **(Alcohol, Opioids, and Other Drugs)**

Indicator Rankings

The Substance Abuse (Alcohol, Opioids, and other drugs) indicators ranked of highest concern at a system level are listed below. The system-level rankings can be found for each indicator in the *Highest Ranking CHNw Health Indicators* table.

- Drug Poisoning
- Perinatal Substance Use Disorder
- Adults who Drink Excessively
- Substance Abuse
- Alcohol Abuse

Goal 1: Drug Poisoning Prevention

Interventions/Recommendations:

- Continue the program that places Naloxone (Narcan) throughout Madison County that allows first responders to treat an unconscious victim suffering from a drug overdose. Including maintaining:
 - Law Enforcement:
 - 14 law enforcement agencies are represented (Madison County Sheriff's Department, Alexandria, Anderson University, Chesterfield, Community Hospital, Edgewood, Elwood, Frankton, Ingalls, Lapel, Markleville, Orestes, Pendleton, and Summitville)
 - 166 Officers trained
 - 112 kits issued
 - Others:
 - Madison County Correctional Complex
 - Madison County Problem Solving Court
 - Madison County Sheriff's Department Reserve Officers
 - Madison County Adult Probation
 - Anderson Community Schools
 - Harrah's Hoosier Park Racing and Casino
 - Madison County Government Center
 - 264 agency representatives trained
 - 45 Naloxone Kits issued
- Continue to collaborate with the Madison County Health Department through an ISDH grant award by distributing Naloxone kits to additional community organizations. CHA will support the training and assist with the tracking and distribution process for the following:

- Aspire, House of Hope, and Grace House
 - 28 Agency Representatives trained
 - 51 Naloxone Kits issued
- Three Madison County law enforcement agencies have five canine officers. These drug dogs follow their noses to sniff out narcotics. This places the canine officers in harm's way of being directly exposed to an opioid. CHA's outreach program will provide training to the canine officer's handlers on how to properly administer Naloxone should the dog encounter an opioid and display symptoms.
- CHA will collaborate with the Madison County Health Department to provide Naloxone to patients upon discharge who are at high risk for overdose, as well as providing these patients with a Peer Recovery Coach upon discharge from the hospital.

Collaborations

- Madison County Health Department
- Health care providers
- Community-based organizations
- Law Enforcement and First Responders

Anticipated Impacts

- Decrease in drug poisoning events
- Decrease in deaths related to overdose

Evaluation Metrics

- Assess impact during 2021 CHNA
- Number of overdose related deaths
- Increase number of community organizations/members trained and doses of Narcan distributed
- For Narcan distributed to high risk patient upon discharge from CHA:
 - Protocols developed
 - Appropriate staff will be trained
 - Number of Naloxone distributed will be tracked and reported to the Madison County Health Department

Goal 2: Perinatal Substance Use Disorder

Interventions/Recommendations

- Establish a comprehensive Pregnant and Postpartum Women's Program which will include: Evaluate use of Screening, Brief Intervention and Referral to Treatment (SBIRT) program in primary care settings. Included in this plan will be the following ongoing activities, under these overarching categories:
 - Prenatal Care
 - Universal urine drug screens and social needs assessment at initial prenatal patient visits.
 - MOMentum Mental Health Services

- Expedited access to evaluation and treatment services based on screening results and referral by the obstetrician.
- Comprehensive evaluation and medication management by psychiatry.
- MAT for opiate use.
- Care coordination with obstetrics including engagement with treatment and psychiatric prescribing.
- Coordination with other agencies and providers who are involved in service provision to the family including other medical personnel, DCS etc.
- Intensive outpatient addictions treatment, individual and group therapies as determined to be clinically necessary which includes information that is tailored to their unique needs as a pregnant woman.
- Embed a Behavioral Health Consultant (BHC) in the Obstetrics/Gynecologist (OB/GYN) physician office whose role is to detect and address a broad spectrum of behavioral health/substance use needs of the patients with the aim of early identification, quick resolution, long-term prevention and wellness. The BHC will be a Licensed Clinical Social Worker (LCSW) who will provide a comprehensive behavioral health assessment. Based on this assessment, the LCSW determines level of care and service needs and when substance use disorder is a primary concern, refers the case within the addictions programming at CHA.

Collaborations

- Health Care Providers
- Indiana Department of Health
- Mental Health Providers
- Department of Child Service
- Community Based Organizations

Anticipated Impacts

- Prevention of Neonatal Abstinence Syndrome
- Reduce long-term impact of perinatal substance abuse

Evaluation Metrics

- Assess impact during 2021 CHNA
- A BHC is identified and hired for the OB/GYN practice
- Track baseline data to include:
 - Number of patients who participate in the program, number of patients with positive results
 - Number of patients referred for treatment services and other social and support services

Goal 3: Substance Abuse (Alcohol, Opioids, and Other Drugs)

Interventions/Recommendations

- Participate with the community in the establishment of a Trauma-Informed, Recovery Oriented Systems of Care (TI-ROSC) program.
 - Participate with the community in TI-ROSC training held by the FSSA ~ Indiana Division of Mental Health and Addiction who has partnered with the National Council of Behavioral Health to provide a comprehensive toolkit for Indiana communities to build TI-ROSC for the treatment of opioid use disorder
- Provide on-site therapist at the Madison County Drug Court to facilitate consults for the CHNw Substance Abuse Intensive Relapse Prevention program.
- Offer the “Not About Drugs” educational program to 6-9th grade students in Madison County.
- Collaborate/partner with *Bridges of Hope* to expand the number of inpatient detox beds and intensive aftercare therapy in Madison County dedicated to the underserved population.
- Place a “Medication Take Back” safe at the CHA Police Department office. This allow the public to dispose of unused medication in a safe and secure location.

Collaborations

- FSSA -Division of Mental Health and Addition
- Mental Health Providers
- Law Enforcement
- Bridges of Hope
- Drug Court
- Madison County Health Department
- St. Vincent Anderson
- Aspire
- Madison County School Corporations
- Community Based Organizations

Anticipated Impacts

- Prevention of drug and alcohol abuse
- Reduce long-term impact of drug and alcohol abuse on the community

Evaluation Metrics

- Assess impact during 2021 CHNA
- Participate in the development of TI-ROSC should the community determine to implement the program
- Number of additional detox beds added to the community

SIGNIFICANT HEALTH NEED *Obesity and Diabetes*

Indicator Rankings

The Obesity and Diabetes indicators ranked of highest concern at a system level are listed below. The system-level rankings can be found for each indicator in the *Highest Ranking CHNw Health Indicators* table.

- Long and short term complications of diabetes
- Uncontrolled diabetes

Goal: Increase Education, Awareness, and Treatment

Interventions/Recommendations:

- Maintain CHA's Diabetes Care Center. The Center is an American Diabetes Association accredited education center which offers diabetes education classes for patients with all types of diabetes.
- Continue to offer a monthly diabetes support group.
- Continue to provide medication assistance to patients from the Diabetes Care Center.
- Continue to offer diabetes health screenings in the community as well as cooking demonstrations to teach how to prepare healthy foods.
- Expand services to include medical weight management.
- Continue to provide CHA's Diabetes Care/Weight Management Center patients fresh produce from the Community Farm.
- Partner/collaborate with local farmer's markets in the community to promote CHA's health related programs, provide health screenings, and nutritional advice.

Collaborations

- Health Care Providers
- Community-based organizations

Anticipated Impacts

- Identify individuals who are unaware they have diabetes
- Increase quality of education surrounding diabetes
- Increase knowledge of warning signs of uncontrolled diabetes
- Increase the availability of medical weight loss options in the community
- Increase knowledge of existing resources

Evaluation Metrics

- Assess impact during 2021 CHNA
- Reduction of the average hemoglobin A1C of the individuals completing diabetes educational classes.
- Reduction of the average BMI of individuals participating in the weight management program.

SIGNIFICANT HEALTH NEED Access to Health Services

Indicator Rankings

The Access to Health Services indicators ranked of highest concern at a system level are listed below. The system-level rankings can be found for each indicator in the *Highest Ranking CHNw Health Indicators* table.

- Access to health insurance coverage
- Access to health care providers
- Transportation
- Access to prescriptions

Goal 1: Increase Access to Affordable Health Care Coverage

Interventions/Recommendations:

- Continue to offer financial counselors for the assessment of the individuals' financial situation to determine if the person qualifies for health insurance coverage, Medicaid, or Medicare. Offer assistance with completing the needed requirements/paperwork for coverage. Assist individuals in completing applications for Food Stamps and Temporary Assistance for Needy Families (TANF).
- Continue to partner/collaborate with community-based organizations to provide education, training and access to healthcare services such as the United Way of Madison County.

Collaborations

- Health Care Providers
- Community-based organizations

Anticipated Impacts

- Increase individuals access to healthcare, Food Stamps, and TANF
- Increase knowledge of existing resources

Evaluation Metrics

- Assess impact during 2021 CHNA
- Number of participants assisted by CHA's Financial Counselors

Goal 2: Access to Health Care Providers

Intervention

- Continue to partner with Jane Pauley Community Health Center to offer vouchers for free first time appointments for Emergency Department (ED) patients with no healthcare provider.
- Provide community education regarding the CHNw Connect to Care service that offers a convenient "one call" way to find a healthcare provider and schedule an appointment.



Collaborations

- Health Care Providers
- Jane Pauley Community Health Center

Anticipated Impacts

- Early intervention in care
- Reduce long-term impact of untreated conditions

Evaluation Metrics

- Assess impact during 2021 CHNA
- Number of Jane Pauley vouchers given in the Emergency Department
- Number of contacts through Connect to Care service

Goal 3: Transportation

See Social Determinants of Health Section – Goal #3

Goal 4: Access to Medications

Interventions/Recommendations

- Implement a program to fill prescriptions and provide initial medication to patients prior to discharge from the hospital to ensure adherence to medication recommendations.

Collaborations

- Health Care Providers

Anticipated Impacts

- Early intervention in care
- Improved compliance with medication discharge instructions and adherence to medication recommendations
- Improved clinical outcomes for conditions that are dependent on timely access to medications
- Decrease in readmissions

Evaluation Metrics

- Assess impact during 2021 CHNA
- Number of patients receiving medications prior to discharge
- Decrease in readmission rates

SIGNIFICANT HEALTH NEED *Chronic Disease Management*

Indicator Rankings

The Chronic Disease Management indicators ranked of highest concern at a system level are listed below. The system-level rankings can be found for each indicator in the *Highest Ranking CHNw Health Indicators* table.

- Heart Failure
- Long and short term Complications of Diabetes
- Coronary Heart Disease

Goal: Chronic Disease Management

Interventions/Recommendations:

- Continue to offer Healthy Hearts Heart Failure Clinic, Respiratory Clinic, Diabetes and Anticoagulation Clinic. These clinics utilize a collaborative practice model that entails a multidisciplinary team of providers including nurse practitioners, physicians, nurses, pharmacists, dietitians, and respiratory therapists to educate and help individuals manage their conditions.
- Continue to offer the following support groups: Alzheimer's, Diabetes, and Parkinson's Disease/Stroke.
- Continue to offer Primary Care Navigation in the outpatient/office settings.

Collaborations

- Health Care Providers

Anticipated Impacts

- Building knowledge regarding chronic disease self-management.
- Increase quality of life of those individuals living with chronic diseases.
- Reduce health care expenditures.
- Improve safety and quality of care
- Improve access to care
- Improve patient self-management

Evaluation Metrics

- Assess impact during 2021 CHNA
- Number of readmissions within 30 days
- Number of participants in support groups
- Patient's own assessment of the impact of the program on overall well-being

SIGNIFICANT HEALTH NEED *Tobacco Use*

Indicator Rankings

The Tobacco Use indicator ranked of highest concern at a system level are listed below. The system-level rankings can be found for each indicator in the *Highest Ranking CHNw Health Indicators* table.

- Adults who smoke
- Mothers who smoke during pregnancy
- Babies with low birth weight

Goal 1: Prevention and Cessation

Interventions/Recommendations:

- Continue to partner/collaborate with Intersect, Inc., which is a coalition of community members representing schools, health care, and other community organizations and businesses to address tobacco issues within Madison County. The coalition operates in part from the Indiana Tobacco Prevention and Cessation Agency grant.

Collaborations

- Health Care Providers
- Community-based organizations

Anticipated Impacts

- Increase quality of education surrounding tobacco use
- Decrease in tobacco use
- Increase knowledge of existing resources

Evaluation Metrics

- Assess impact during 2021 CHNA
- Number of participants in education programs that understand the concepts of mental health and availability of resources through education and training
- Number of community partners (e.g., Faith Based Organizations)

Goal 2: Prenatal Smoking

Interventions/Recommendations

- Continue to administer the Baby & Me Tobacco Free Program (BM/TFP) for Madison and Delaware Counties. Patients are referred by the OB/GYN physicians, Jane Pauley Community Health Center, WIC, and Anthem. BM/TFP enroll pregnant smoking women in their first trimester of pregnancy, when possible, and a quit partner when applicable.
- Those in the program are provided at least four prenatal cessation interventions including CO monitor testing and assist them in staying tobacco free postpartum, utilizing an incentive-

based program dictated by the ISDH and the National BM/TFP. The women and their eligible partners who are enrolled are tested with a carbon monoxide (CO) monitor at each prenatal and postpartum visit up to 12 months postpartum. The participants receive interventions and education at each session with the opportunity to receive \$25 diaper vouchers per month postpartum for up to 12 months.

- The CHA BM/TFP facilitators will continue to provide education for the CPN OB/GYN office, the Jane Pauley Community Health Center, Healthy Families, First Choice for Women and WIC. This training will include help with increased access to the prenatal clients, to update agencies and providers about program changes and/or successes, and to increase partnership with gatekeeper collaboration.
- The BM/TFP Director will continue to work directly with the ISDH and the national BM/TFP to determine barriers to success and to insure program validity.

Collaborations

- Health care providers
- Jane Pauley Community Health Center
- WIC
- Community-based organizations

Anticipated Impacts

- Reduction in infant mortality
- Decrease in low birth-weight infants
- Reduce long-term impact of untreated conditions

Evaluation Metrics

- Assess impact during 2021 CHNA
- Quit rates of 40% at the time of newborn delivery
- At baby's delivery, 90% of the participants will know the dangers of smoking and second hand smoke and know four ways to redirect the urge to smoke with concrete actions.
- Annually screen 500-800 unduplicated prenatal patients and their support person for possible participation in the program with the goal of approximately 33% being eligible for the program to achieve the following:
 - By June 2020, at least 200 unduplicated pregnant smoking women will be enrolled in the CHA BM/TFP program and agree to quit smoking and stay quit postpartum.
 - By June 2020, women enrolled in the CHA BM/TFP who have delivered babies, 90% will deliver a healthy weight baby (>5.5lbs), born no sooner than 37 weeks gestation.
 - By June 2020, at least 60% of the 200 enrolled CHA BM/TFP participants who have delivered babies, will have quit smoking and stay smoke free 3-months postpartum.

- By March 2021, project to see a decrease in the Infant Mortality Rate in our catchment area; the Eastern Region of Indiana. (The ISDH will provide this report)
- By June 2021, at least 60% of the 200 enrolled in BM/TFP participants who have delivered babies, will have quit smoking and stayed smoke free for a minimum of 6-months postpartum.

Goal 3: Support Tobacco-Related Community/State Policies

Interventions/Recommendations

- Support State Level Policies such as increase:
 - Increase in tobacco taxes
 - Increasing legal age to purchase tobacco
 - Smoke Free indoor air policies

Collaborations

- Community-based organizations
- Health care providers
- Local elected officials

Anticipated Impacts

- Reduce long-term impact of tobacco use

Evaluation Metrics

- Assess impact during 2021 CHNA



Health Needs Not Addressed

Health needs not identified as a priority fall into one of three categories:

1. Beyond the scope of CHNw services
2. Needs further intervention, but no plans to expand community benefit services at this time
3. Rely on community partners to lead efforts with expertise in these areas with CHNw in a supporting role

The needs identified below are not specifically included in the hospital's Implementation Strategy for 2019-2021:

1. Services for Seniors. Alignment with Significant Health Needs outlined in the Implementation Strategy.
2. Maternal and Child Health. Alignment with Mental Health, Substance Use Disorder, Food Insecurity and Tobacco Use.



Next Steps for Implementation Strategy Adoption

1. Build consensus around an evaluation plan
2. Decide what goals are most important to evaluate
3. Determine evaluation methods
4. Evaluate current partnerships and create new health-need focused alignment
5. Identify indicators and how to collect data (process and evaluation measures)
6. Identify benchmarks for success
7. Establish data collection and analysis systems
8. Collect credible data
9. Monitor progress toward achieving benchmarks
10. Review evaluation results and adjust programs
11. Share results with CHNw community, and as needed, with the community