Community Health Needs Assessment

Community Health Network

2018

IMPLEMENTATION STRATEGY

East Region

About This Document

This document describes how Community Hospital East (the hospital) 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 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.

The document contains the following information:

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

Adopted by the Community Health Network, Inc. Board on: March 11, 2019

About Community Hospital East

In the 1950s, a grassroots effort to raise funds to improve health care in Indianapolis began with the end goal being to build a local, community hospital. More than 80 percent of neighborhood families donated. The original Community Hospital East (CHE) was built with those funds. In 2013, Community Health Network committed to building a new East hospital on its existing campus. The reinvestment project for the campus totaled more than $175 million.

In February 2019, the oldest hospital in the Network became the newest with the opening of a new patient tower. The new hospital was designed with input from patients, staff, and volunteers. The new Community Hospital East has all new private inpatient rooms, and all new Emergency, Medical Imaging, Surgery, Delivery units.

Key Statistics (2018)
Admissions: 8,908
Emergency room visits: 82,069
Babies born: 949
Surgeries (at hospitals, inpatient and outpatient): 2,514
Physician & Clinic Visits: 2,181,626

The Community Served and Its Needs

Key Demographic Data

- The current population is 260,207. A five-year trend (2018-2023) shows population at 266,808.
- Whites comprise 67.1% of the population, with African-Americans at 22.6%, Hispanic/Latino at 7.1% and 3.3%, other race or ethnicity.
- The fastest growing age group is 65+ at 19.1%.
- The East Region will experience a 2.5% growth between 2018-2023.
- The East Region has one of the lowest household income at $46,582 with 16% of the households having an annual income of $100,000 or more.

Creating the Community Health Needs Assessment

The identification of health needs for Community Health Network (CHNw) CHE 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.

Implementation Strategy
To Address Significant Health Needs

This implementation strategy describes how 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 East 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 period.

Significant Health Needs Identified in the 2018 CHNA	**Intend to Address (Y/N)**
1. Social Determinant(s) of Health*	Y
2. Mental Health	Y
3. Substance Abuse (Alcohol)	N
4. Substance Abuse (Opioids and Other Drugs)	Y
5. Obesity	N
6. Access to Health Services	Y
7. Chronic Disease Management	N
8. Maternal and Child Health	N
9. Food Insecurity	Y
10. Tobacco	Y

*Social Determinant(s) of Health are addressed in Access to Health Services, Food Insecurity and Tobacco.

SIGNIFICANT HEALTH NEED ***Food Insecurity***

Indicator Rankings
Food Insecurity 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

Goal: Increase Access to Healthy Food

Interventions/Recommendations

- Continue to screen expectant and new mothers for food insecurity in Women's Clinic/Maternity and providing the following to those who screen positive:
    - Emergency Grab and Go food bags
    - Food script to the Cupboard of Lawrence Township (up to 180 days)
    - Referral to social worker for screening and additional services where applicable
- Continue Rolling Harvest Food Program from May to October. The Rolling Harvest distributes fresh produce at free or low cost to areas of need in the community on the east side of Indianapolis
    - Partner with community farmers to distribute food on the east side of Indianapolis
    - Continue to partner with other area of non-profit programs as appropriate
- 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.
- 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.
- Continue partnership with the Cupboard of Lawrence Township in expanding equitable access to healthy, affordable nutritious food to Marion County residents.
- Partner with the Primary Care Navigation Team and Community Health Advocates to get quality food and food education to patients with demonstrated need as a means to improve health outcomes.
- Continue Grab and Go partnership with Jane Pauley Community Health Center (JPCHC). This program provides Grab and Go bags to patients who screen positive for food insecurity issues.
    - The patient is provided the following:
        - Emergency Grab and Go food bag,
        - Food script to the Cupboard of Lawrence Township (up to 180 days)
        - Referral to social worker for screening and additional services where applicable
    - Participating sites are:
        - JPCHC Arlington Avenue Pediatric Center
        - JPCHC 16th Street Health Center

- Continue Emergency Department outreach to the homeless population. This outreach program provide sack lunches to homeless population.
- Continue Holiday Meals Program. This program provides free meals to the community and neighbors during the following holidays:
    - Thanksgiving
    - Christmas
    - Neighborhood Cookout
    - Healthcare Team Week

Collaborations

- Food Bank
    - Gleaners
    - Midwest
- St. Albans Episcopal Church
- Lawrence Community Gardens
- Meijer
- Cupboard of Lawrence Township
- CICOA Aging and In-Home Solutions
- JPCHC

Anticipated Impact

- Increase number of people who have access to healthy food
- Increase quality of life by increasing healthy food consumption
- Improve nutrition
- Increase food security

Outcomes

- Number of Senior Meal vouchers distributed
- Food pantry
    - Number of households
    - Number of individuals
- Number of food scripts distributed at the Women's Clinic and JPCHC
- Track number of positive screens for food insecurity

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

- Continue to provide the following continuum of care to patients
    - Crisis intervention 24/7
    - Inpatient consultation
    - Outpatient therapy
    - Provide full continuum of care
    - Expansion of acute care services at the Neuro Diagnostic Institute
- Continued support of the integration of Zero Suicide Initiatives which is already a part of the continuum of care model in Behavioral Health

Collaborations

- Providers
- Gallahue Community Mental Health Center
- JPCHC
- Schools
- Faith Based Community Organizations
- Law Enforcement and First Responders and Other Governmental Agencies

Anticipated Impacts

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

Evaluation/Metrics

- Track number of patients served

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 (Opioids and Other Drugs)***

Indicator Rankings
The Substance Abuse (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
- Substance Abuse

Goal 1: Perinatal Substance Use Disorder

Interventions/Recommendations

- Embed a Behavioral Health Consultant (BHC) in the obstetrics/gynecology (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 Community Hospital East (CHE).
- 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.
    - Medication Assisted Treatment (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, Department of Child Services (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.

Collaborations

- Volunteers of America
- Nurse Family Partnership (NFP)
- Gallahue – MOMentum Program
- FSSA
- Health Care Providers
- Indiana Department of Health

- Mental Health Providers
- DCS
- Community Based Organizations

Anticipated Impacts
- Improve health outcomes for Mothers and Infants associated with Neonatal Abstinence Syndrome (NAS)
- Reduce Neonatal Intensive Care Unit (NICU) length of stay (LOS) related to NAS
- Prevention of NAS

Evaluation Metrics
- Reduction in NICU LOS related to NAS
- 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 2: Expand MAT Services to Provide Increased Access to Patients Identified with Substance Use Disorders

Interventions/Recommendations
- Develop information, education and training for providers about MAT Services
- Develop a protocol for MAT inductions in the Emergency Department
- Establish a collaborative referral and rapid access into outpatient services
- Evaluate the use of Recovery Coaches in the Emergency Department
- Expand the number of MAT prescribers in the East Indianapolis Region

Collaborations
- Emergency Room Physicians and Staff
- Family Medical Practice Providers
- Community-based Organizations
- Recovery Housing Organizations
- Faith Based Community Organizations
- Law Enforcement and First Responders
- Other Community Mental Health Centers and Treatment Providers

Anticipated Impacts
- Reduce recidivism of Emergency Room utilization related to Opioid Use Disorder and IV Drug Use related conditions
- Improve an Individuals Recovery Capital (i.e. social determinant) to maintain sobriety and reduce relapse
- Increase MAT provider capacity

Evaluation Metrics

- Assess impact during 2021 CHNA
- Growth in the number of MAT providers
- Successful outcomes related to Feedback Informed Treatment measure
- Improvement in Recovery Capital for individuals as measured by the Recovery Capital Scale

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
— 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 Marion 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 Marion County. Patients are referred by the OB/GYN physicians. 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 carbon monoxide (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 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 CHE BM/TFP facilitators will continue to provide education for the Community Physician Network (CPN) OB/GYN office, the JPCHC, Healthy Families, First Choice for Women, and Women, Infants, and Children (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
- JPCHC
- 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 CHE BM/TFP program and agree to quit smoking and stay quit postpartum.
    - By June 2020, women enrolled in the CHE 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 CHE 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 the CHE catchment area
    - 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

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 TANF.
- Continue to partner/collaborate with community-based organizations to provide education, training and access to healthcare services.

Collaborations

- Health Care Providers
- Community-based organizations

Anticipated Impacts

- Increase individuals access to healthcare, Food Stamps, and Temporary Assistance for Needy Families (TANF)
- Increase knowledge of existing resources

Evaluation Metrics

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

Goal 2: Access to Health Care Providers

Interventions

- Continue to partner with JPCHC to offer vouchers for free first time appointments for Emergency Department 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
- JPCHC

Anticipated Impacts

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

Evaluation Metrics

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

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. Substance Abuse (Alcohol). CHNw will continue its current course of action in addressing substance abuse (alcohol).
2. Obesity. CHNw will continue its current course of action addressing obesity.
3. Chronic Disease Management. CHNw will continue its current course of action addressing chronic disease management.
4. Maternal and Child Health. Maternal and Child Health is addressed in Mental Health, Access to Care, Food Insecurity, and Tobacco.

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