Ascension St. Vincent Carmel

Implementation Strategy for the 2021 CHNA
Hamilton County, Indiana

Ascension

The purpose of this Implementation Strategy is to describe how the hospital plans to address prioritized health needs from its current Community Health Needs Assessment (CHNA). The significant health needs that the hospital does not intend to address are identified and a rationale is provided. Special attention has been given to the needs of individuals and communities who are more vulnerable, unmet health needs or gaps in services, and input gathered from the community.

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The 2021 Implementation Strategy was approved by the Ascension St. Vincent Carmel Board of Directors on October 5, 2022 (2021 tax year) and applies to the following three-year cycle: July 2022 to June 2025 (FY2023 - FY2025). This report, as well as the previous report, can be found at our public website.

We value the community's voice and welcome feedback on this report. Please visit our public website (Community Health Needs Assessments | Ascension) to submit your comments.

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Introduction

As one of the leading non-profit and Catholic health systems in the United States, Ascension is committed to delivering compassionate, personalized care to all, with special attention to persons living in poverty and those most vulnerable.

Ascension St. Vincent Carmel

As a Ministry of the Catholic Church, Ascension St. Vincent Carmel is a non-profit hospital governed by a local board of trustees represented by community members, medical staff, and sister sponsorships. For many years, the hospital has been providing medical care for residents of Hamilton County, Indiana and neighboring areas. In 1985, St. Vincent Carmel was built in Hamilton County. Since then, there have been several expansions to meet the needs of the growing county. Ascension St. Vincent Carmel hospital is a 125-bed, acute care facility and offers the following services: bariatric services, cancer, cardiovascular services, cosmetics & plastic surgery, digestive health, emergency medicine, interventional radiology, laboratory services, maternity services, medical imaging, neuroscience, nutrition support, orthopedics, pediatrics, post-acute care, primary care, rehabilitation services, respiratory care, spiritual care, surgery, wellness medicine, and women's health. Ascension St. Vincent Carmel's primary service area is Hamilton County which is in Central Indiana.

For more information about Ascension St. Vincent Carmel, visit Ascension St. Vincent Carmel

Overview of the Implementation Strategy

Purpose

This Implementation Strategy (IS) is the hospital's response to the health needs prioritized from its current Community Health Needs Assessment (CHNA). It describes the actions the hospital will take to address prioritized needs, allocate resources, and mobilize hospital programs and community partners to work together. This approach aligns with Ascension St. Vincent Carmel's commitment to offer programs designed to address the health needs of a community, with special attention to persons who are underserved and vulnerable.

IRS 501(r)(3) and Form 990, Schedule H Compliance

The CHNA and IS satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection and Affordable Care Act of 2010, more commonly known as the Affordable Care Act (ACA). As part of the ACA, all not-for-profit hospitals are required to conduct a CHNA and adopt an Implementation Strategy every three years. Requirements for 501(c)(3) Hospitals Under the Affordable Care Act are described in Code Section 501(r)(3) and include making the CHNA report (current and previous) widely available to the public. In accordance with this requirement, electronic reports of both the CHNA and the current Implementation Strategy can be found at

https://healthcare.ascension.org/CHNA and paper versions can be requested at Ascension St. Vincent Carmel's information desk located in the main lobby.

Process to Prioritize Needs

Included in Code Section 501(r)(3) is the requirement that hospitals must provide a description of the process and criteria used to determine the most significant health needs of the community identified through the CHNA, along with a description of the process and criteria used to determine the prioritized needs to be addressed by the hospital. Accordingly, Ascension St. Vincent Carmel used a phased prioritization approach to identify the needs within Hamilton County. The first step was to determine the broader set of identified needs. Through the CHNA, identified needs were then narrowed to a set of significant needs which were determined most crucial for community stakeholders to address. For more information on the methods and analysis used to determine community health needs, please visit 2021 CHNA - Ascension St. Vincent Carmel - Hamilton County

Following the completion of the CHNA, significant needs were further narrowed down to a set of prioritized needs that the hospital will address within the Implementation Strategy. To arrive at the prioritized needs, Ascension St. Vincent Carmel used the following process and criteria: hospital leaders reviewed the 2021 CHNA significant health needs and the data used to define each as significant, then voted on the top 3-5 needs they determined the hospital could address in the next three years.

The criteria used to prioritize the significant needs were:

- Alignment with the organization's mission, values, and strategic priorities.
- Alignment with existing service and area of expertise.
- Concern for low-income or vulnerable persons.
- Ability for organization to have an impact.
- Ability to leverage organizational assets.

Needs That Will Be Addressed

Following the completion of the current CHNA, Ascension St. Vincent Carmel has selected the prioritized needs outlined below for its FY2023 - FY2025 Implementation Strategy. Ascension St. Vincent Carmel has defined "prioritized needs" as the significant needs which have been prioritized by the hospital to address through the three-year CHNA cycle:

- **Access to Care** – This need was selected because access to care indicators such as adults reporting fair or poor health, low birthweight babies, per capita supply of healthcare providers, preventable hospital stays, and/or core preventive services compared unfavorably to peer counties or U.S. averages and because community meeting participants identified access to care (including preventive services) as a priority.

- **Mental Health** – This need was selected because mental health indicators such as number of mentally unhealthy days, number of mental health providers per population, depression rate and/or suicide rate compared unfavorably to peer counties or U.S. averages and because community meeting participants identified mental health and adverse childhood experiences (ACEs) as a priority.

- **Substance Use Disorders** - This need was selected because indicators such as drug poisoning deaths, overdose rates, excessive drinking, and/or alcohol-impaired driving deaths exceed Indiana and/or national averages. Community input indicated substance use disorders are prevalent and are closely associated with mental health concerns. In addition, the Indiana State Health Improvement Plan prioritized the need to reduce injury and death due to opioid usage.

Ascension St. Vincent Carmel understands the importance of all the health needs of the community and is committed to playing an active role in improving the health of the people in the communities it serves. For the purposes of this Implementation Strategy, Ascension St. Vincent Carmel has chosen to focus its efforts on the priorities listed above.

Needs That Will Not Be Addressed

Based on the prioritization criteria, the health needs identified through the CHNA that Ascension St. Vincent Carmel does not plan to address in this Implementation Strategy include:

- **COVID-19 Pandemic** - The hospital, together with Ascension Medical Group (AMG), a physician-led provider organization, continues to provide treatment for community members diagnosed with COVID-19, as it has done since the beginning of the pandemic. As federal, state, and local authorities are providing leadership for prevention and surveillance activities, the hospital will not directly address the COVID-19 pandemic in the current Implementation Strategy.
- **Senior Services** - The hospital, together with AMG, works collaboratively with the Ascension St. Vincent - Center for Healthy Aging to support older adults as they cope with complex health problems that can be associated with aging. Additionally, the hospital remains committed to partnering with community groups to address these identified health needs and will continue to seek opportunities to do so. As federal, state, and local authorities, as well as community-based organizations, are working to address needs of seniors, the hospital will not directly address this need in the current Implementation Strategy.

While these needs are not the focus of this Implementation Strategy, Ascension St. Vincent Carmel may consider investing resources in these areas as appropriate, depending on opportunities to leverage organizational assets in partnership with local communities and organizations. Also, this report does not encompass a complete inventory of everything Ascension St. Vincent Carmel does to support health within the community.

To find a list of resources for each need not being addressed, please refer to the: Ascension St. Vincent Carmel 2021 CHNA.

Acute Community Concern Acknowledgement

A CHNA and Implementation Strategy offer a construct for identifying and addressing needs within the community(s) it serves. However, unforeseen events or situations, which may be severe and sudden, may affect a community. At Ascension, this is referred to as an acute community concern. This could describe anything from a health crisis (e.g., COVID-19), water poisoning, environmental events (e.g., hurricane, flood) or other event that suddenly impacts a community. In which case, if adjustments to an IS are necessary, the hospital will develop documentation, in the form of a SBAR (Situation-Background-Assessment-Response) evaluation summary, to notify key internal and external stakeholders of those possible adjustments.

Written Comments

This Implementation Strategy is available to the public and is open for public comment. Questions or comments about this Implementation Strategy can be submitted via the website: Community Health Needs Assessments | Ascension.

Approval and Adoption by Ascension St. Vincent Carmel Board of Directors

To ensure the Ascension St. Vincent Carmel's efforts meet the needs of the community and have a lasting and meaningful impact, the 2021 Implementation Strategy was presented and adopted by the Ascension St. Vincent Carmel Board of Directors on October 5, 2022. Although an authorized body of the hospital must adopt the IS to be compliant with the provisions in the Affordable Care Act, adoption of the IS also demonstrates that the board is aware of the IS, endorses the priorities identified, and supports the action plans that have been developed to address prioritized needs.

Action Plans

The IS below is based on prioritized needs from the hospital's most recent CHNA. These strategies and action plans represent where the hospital will focus its community efforts over the next three years. While these remain a priority, the hospital will continue to offer additional programs and services to meet the needs of the community, with special attention to those who are poor and vulnerable.

GOAL: **Increase access to comprehensive, high-quality health care services.**	
Hospital Name Ascension St. Vincent Carmel	
Prioritized Health Need #1 Access to Care	
Strategy #1 Increase the proportion of people with a usual primary care provider. (AHS-07)	
Strategy Source Healthy People 2030, Healthcare Access and Quality	
Objective 1. By June 30, 2025, Ascension St. Vincent Carmel will increase the number of patients established with a medical home by 2.0% each year, amongst individuals who complete a Medical Home Pathway, from baseline established in FY2023. 2. By June 30, 2025, Ascension St. Vincent Carmel and Care Continuity, will increase the number of self-pay/charity Emergency Department patients connected with a provider by 5.0%, from baseline established in FY2023.	
Target Population ● People with lower incomes, older adults, people with undocumented status, people experiencing homelessness, people with disabilities, people at risk for chronic conditions or with pre-existing medical conditions, Black or African American persons, Hispanic or Latino persons or other racial and ethnic minority groups who experience discrimination, and the LBGTQ community. ● Medically Underserved Population: People who are uninsured or underinsured and people who are underserved by mental and medical health resources.	
Collaborators ● Health Access Department ● Consultants: Care Continuity	
Resources ● Community Health Workers (CHW) from Health Access Department ● Consultants: Care Continuity ● Existing community partners	
ACTION STEPS	**ROLE/OWNER**
Objective 1: Community Health Workers assess and address barriers to establishing a medical home, refers patients to a medical	Health Access Department

home, educates, assists with scheduling, confirms attendance at appointment, and follows up for ongoing concerns to complete the medical home pathway.	
Complete all reporting requested by the Community Development and Health Improvement (CDHI) Department, such as quarterly progress reports.	Health Access Department
Track and enter all community benefit hours and dollars into community benefit tracking software (CBISA) per fiscal year.	CDHI Department
Objective 2: ED Concierge team members receive referral from an Emergency Department provider.	Care Continuity
ED Concierge team members engage patients, assists with scheduling doctor appointments, arranges transportation, and follows with appointment reminders and confirmation.	Care Continuity
Complete all reporting requested by CDHI, such as quarterly progress reports.	Care Continuity

Output and/or Outcome Objective #1

- Baseline: The number of medical home pathways completed in FY2023.
- Target: The number of patients established with a medical home will increase by 2.0% each year, from baseline.
- Data Source; Data Owner: Optum Care Coordination Program, Medical Home Completed Templates Report; Health Access Department

Output and/or Outcome Objective #2

- Baseline: The number of self-pay/charity Emergency Department patients connected with a provider via Care Continuity in FY2023.
- Target: The number of self-pay/charity Emergency Department patients connected with a provider via Care Continuity will increase by 5.0%, from baseline.
- Data Source; Data Owner: Care Continuity Report, Care Continuity

ANTICIPATED IMPACT

The anticipated impact of these actions is an increase in the number of community members who receive comprehensive, high quality health care services by establishing a medical home and connection to a provider.

GOAL: Increase access to comprehensive, high-quality health care services.	
Hospital Name Ascension St. Vincent Carmel	
Prioritized Health Need #1 Access to Care	
Strategy #2 Increase the proportion of people with health insurance. (AHS-01)	
Strategy Source Healthy People 2030, Healthcare Access and Quality	
Objective By June 30, 2025, Ascension St. Vincent Carmel will increase the number of people enrolled in a health insurance plan by 5.0% each year, amongst individuals who complete an enrollment pathway, from baseline established in FY2023.	
Target Population ● People with lower incomes, older adults, people with undocumented status, people experiencing homelessness, people with disabilities, people at risk for chronic conditions or with pre-existing medical conditions, Black or African American persons, Hispanic or Latino persons or other racial and ethnic minority groups who experience discrimination, and the LBGTQ community. ● Medically Underserved Population: People who are uninsured or underinsured and people who are underserved by mental and medical health resources.	
Collaborators ● Collaborators: Family and Social Services Agency (FSSA) ● Health Access Department	
Resources ● Community Health Workers (CHW) from Health Access Department ● Existing community partners	
ACTION STEPS	**ROLE/OWNER**
Community Health Worker verifies appropriate application is completed, reviews referrals for social determinants of health (SDOH), assesses and addresses barriers, monitors patient progress, and provides ongoing management to complete the Enrollment Pathway.	Health Access Department
Complete all reporting requested by the Community Development and Health Improvement (CDHI) Department, such as quarterly progress reports.	Health Access Department
Track and enter all community benefit hours and dollars into community benefit tracking software (CBISA) per fiscal year.	CDHI Department
Output and/or Outcome ● Baseline: The number of completed enrollments in FY2023. ● Target: The number of patients established with a health insurance plan will increase by 5.0% each year, from baseline.	

• Data Source; Data Owner: Optum Care Coordination Program, Completed Enrollments Report; Health Access Department
ANTICIPATED IMPACT
The anticipated impact of these actions is an increase in the number of community members who receive comprehensive, high quality health care services by establishing enrollment in a health insurance plan.

GOAL: **Increase access to comprehensive, high-quality health care services.**	
Hospital Name Ascension St. Vincent Carmel	
Prioritized Health Need #1 Access to Care	
Strategy #3 Strengthen community engagement by supporting coalitions and implementing partners.	
Strategy Source Centers for Disease Control and Prevention, Principles of Community Engagement 2nd Edition	
Objective By June 30, 2025, Ascension St. Vincent Carmel will strengthen community engagement to expand the reach of evidence-based programs, advocacy, and/or services through financial support, facilitation, and/or promotion.	
Target Population • People with lower incomes, older adults, people with undocumented status, people experiencing homelessness, people with disabilities, people at risk for chronic conditions or with pre-existing medical conditions, Black or African American persons, Hispanic or Latino persons or other racial and ethnic minority groups who experience discrimination, and the LBGTQ community. • Medically Underserved Population: People who are uninsured or underinsured and people who are underserved by mental and medical health resources.	
Collaborators • Local community coalitions • Non-profit organizations • Governmental agencies	
Resources • ASVI Foundation • ASVI staff for board and coalition support • Community benefit funding	
ACTION STEPS	**ROLE/OWNER**
FY23: Identify a lead, assemble a workstream and identify or develop an assessment tool.	Regional President and Community Development and Health Improvement (CDHI) Department

FY24: Assess, identify opportunities, and make recommendations for strengthening community engagement.	Workstream group and CDHI Department
FY24: Develop strategy for community engagement.	Workstream group
FY25: Execute strategic plan for community engagement and investment at system and regional level.	Workstream Lead and CDHI Department
Ongoing: Complete all reporting requested by CDHI.	Workstream Lead
Ongoing: Track and enter all community benefit hours and dollars into CBISA per fiscal year.	Workstream Lead and CDHI Department

Output and/or Outcome

- Baseline: Current level of community partnerships supporting evidence-based programs, advocacy, and/or services through financial support, facilitation, and/or promotion at the hospital's highest level of engagement capacity.
- Target: Maintained or improved level of community partnerships supporting evidence-based programs, advocacy, and/or services through financial support, facilitation, and/or promotion at the hospital's highest level of engagement capacity.
- Data Source; Data Owner: Community Engagement Summary Report, Workstream Lead

ANTICIPATED IMPACT

The anticipated impact of these actions is an increase in the number of community members who receive comprehensive, high quality health care services by supporting and engaging with coalitions and implementing partners addressing access to health care services.

GOAL:
Improve mental health.

Hospital Name
Ascension St. Vincent Carmel

Prioritized Health Need #2
Mental Health

Strategy #1
Reduce the suicide rate. MHMD-01

Strategy Source
Healthy People 2030, Mental Health and Mental Disorders

Objective
By June 30, 2025, Ascension St. Vincent Carmel, in collaboration with the Stress Center, will provide at least one session of QPR (Question, Persuade, Refer) Training for community members.

Target Population

- Community members, first responders, educators, students, faith-based organizations
- Medically Underserved Population: People who are uninsured or underinsured and people who are underserved by mental and medical health resources.

Collaborators

- ASVI Stress Center

Resources

- ASVI Stress Center staff and QPR Trainers

• Substance Abuse and Mental Health Services Administration (SAMHSA) Grant	
ACTION STEPS	**ROLE/OWNER**
FY23: Identify a hospital lead, identify partners, and develop a resource list. Plan promotion activities.	Community Development and Health Improvement (CDHI) Department and President/Administrator
FY24 & FY25: Promote and offer the event.	CDHI Department and Hospital Lead
FY24 & FY25: Obtain applicable outputs and/or outcomes.	CDHI Department and Hospital Lead
Ongoing: Complete all reporting requested by CDHI.	Hospital Lead
Ongoing: Track and enter all community benefit hours and dollars into community benefit tracking software (CBISA) per fiscal year.	Hospital Lead
Output and/or Outcome • Baseline: QPR Training currently not offered by the hospital. • Target: Deliver at least one session of QPR Training by the hospital. • Data Source; Data Owner: QPR Summary Report, Hospital Lead	
ANTICIPATED IMPACT	
The anticipated impact of these actions is an increase in the number of community members who can identify the warning signs of suicide crisis and respond appropriately to prevent suicide.	

GOAL: **Improve mental health.**
Hospital Name Ascension St. Vincent Carmel
Prioritized Health Need #2 Mental Health
Strategy #2 Strengthen community engagement by supporting coalitions and implementing partners.
Strategy Source Centers for Disease Control and Prevention, Principles of Community Engagement 2nd Edition
Objective By June 30, 2025, Ascension St. Vincent Carmel will strengthen community engagement to expand the reach of evidence-based programs, advocacy, and/or services through financial support, facilitation, and/or promotion.
Target Population • Community members • Medically Underserved Population: People who are uninsured or underinsured and people who are underserved by mental and medical health resources.
Collaborators • Local community coalitions • Non-profit organizations • Governmental agencies
Resources

• ASVI Foundation • ASVI staff for board and coalition support • Community benefit funding	
ACTION STEPS	**ROLE/OWNER**
FY23: Identify a lead, assemble a workstream and identify or develop an assessment tool.	Regional President and Community Development and Health Improvement (CDHI) Department
FY24: Assess, identify opportunities, and make recommendations for strengthening community engagement.	Workstream group and CDHI Department
FY24: Develop strategy for community engagement.	Workstream group
FY25: Execute strategic plan for community engagement and investment at system and regional level.	Workstream Lead and CDHI Department
Ongoing: Complete all reporting requested by CDHI.	Workstream Lead
Ongoing: Track and enter all community benefit hours and dollars into community benefit tracking software (CBISA) per fiscal year.	Workstream Lead and CDHI Department
Output and/or Outcome • Baseline: Current level of community partnerships supporting evidence-based programs, advocacy, and/or services through financial support, facilitation, and/or promotion at the hospital's highest level of engagement capacity. • Target: Maintained or improved level of community partnerships supporting evidence-based programs, advocacy, and/or services through financial support, facilitation, and/or promotion at the hospital's highest level of engagement capacity. • Data Source; Data Owner: Community Engagement Summary Report, Workstream Lead	
ANTICIPATED IMPACT	
The anticipated impact of these actions is to improve mental health by supporting and engaging with coalitions and implementing partners addressing mental health concerns.	

GOAL: **Reduce misuse of drugs and alcohol.**
Hospital Name Ascension St. Vincent Carmel
Prioritized Health Need #3 Substance Use Disorder
Strategy #1 Increase the proportion of people with substance use disorder who got treatment in the past year. SU-01
Strategy Source Healthy People 2030, Drug and Alcohol Use
Objective By June 30, 2025, Ascension St. Vincent Carmel will develop a process to partner with community providers to enhance care coordination for persons with mental health and substance use disorder.

Target Population ● Emergency Department patients with mental health and substance use disorder ● Medically Underserved Population: People who are uninsured or underinsured, people who are underserved by mental and medical health resources.	
Collaborators ● Community crisis support centers ● Community halfway houses for men and women ● First Responders ● Emergency Department	
Resources ● Case Management Staff ● Emergency Department Staff ● Inpatient and Outpatient Treatment Centers	
ACTION STEPS	**ROLE/OWNER**
FY23: Identify lead and assemble planning committee including community providers.	Regional Director of Behavioral Health Services
FY24: Develop a plan to standardize a process for collaborating with community providers.	Regional Director of Behavioral Health Services
FY25: Implement standardization process.	Regional Director of Behavioral Health Services
Ongoing: Complete all reporting requested by the Community Development and Health Improvement (CDHI) Department, such as quarterly progress reports.	Regional Director of Behavioral Health Services
Ongoing: Track and enter all community benefit hours and dollars into community benefit tracking software (CBISA) per fiscal year.	Regional Director of Behavioral Health Services
Output and/or Outcome ● Baseline: Existing processes. ● Target: Documented coordinated, collaborative process. ● Data Source; Data Owner: Process Development Summary Report, Regional Director of Behavioral Health Services	
ANTICIPATED IMPACT	
The anticipated impact of these actions is to enhance care coordination for persons with mental health and substance use disorder.	

GOAL: **Reduce misuse of drugs and alcohol.**
Hospital Name Ascension St. Vincent Carmel
Prioritized Health Need #3 Substance Use Disorder

Strategy #2

Strengthen community engagement by supporting coalitions and implementing partners.

Strategy Source

Centers for Disease Control and Prevention, Principles of Community Engagement 2nd Edition

Objective

By June 30, 2025, Ascension St. Vincent Carmel will strengthen community engagement to expand the reach of evidence-based programs, advocacy, and/or services through financial support, facilitation, and/or promotion.

Target Population

- Adolescents and young adults, community members with higher risk factors and fewer protective factors
- Medically Underserved Population: People who are uninsured or underinsured, people who are underserved by mental and medical health resources.

Collaborators

- Evidence-based substance use prevention program partners
- Local community coalitions
- Non-profit organizations
- Governmental agencies

Resources

- ASVI Foundation
- ASVI staff for board and coalition support
- Community benefit funding

ACTION STEPS	ROLE/OWNER
FY23: Identify a lead, assemble a workstream and identify or develop an assessment tool.	Regional President and Community Development and Health Improvement (CDHI) Department
FY24: Assess, identify opportunities, and make recommendations for strengthening community engagement.	Workstream group and CDHI Department
FY24: Develop strategy for community engagement.	Workstream group
FY25: Execute strategic plan for community engagement and investment at system and regional level.	Workstream Lead and CDHI Department
Ongoing: Complete all reporting requested by CDHI.	Workstream Lead
Ongoing: Track and enter all community benefit hours and dollars into community benefit tracking software (CBISA) per fiscal year.	Workstream Lead and CDHI Department

Output and/or Outcome

- Baseline: Current level of community partnerships supporting evidence-based programs, advocacy, and/or services through financial support, facilitation, and/or promotion at the hospital's highest level of engagement capacity.
- Target: Maintained or improved level of community partnerships supporting evidence-based programs, advocacy, and/or services through financial support, facilitation, and/or promotion at the hospital's highest level of engagement capacity.
- Data Source; Data Owner: Community Engagement Summary Report, Workstream Lead

ANTICIPATED IMPACT
The anticipated impact of these actions is to reduce misuse of drugs and alcohol, by supporting and engaging with coalitions and implementing partners addressing substance use disorders.

Evaluation

Ascension St. Vincent Carmel will develop a comprehensive measurement and evaluation process for the Implementation Strategy. The Ministry will monitor and evaluate the action plans outlined in this plan for the purpose of reporting and documenting the impact these action plans have on the community. Ascension St. Vincent Carmel uses a tracking system to capture community benefit activities and implementation. To ensure accountability, data will be aggregated into an annual Community Benefit report that will be made available to the community.