



Community Health Needs

Action Plan

2025-2027



Goshen Health

Community Health Needs Action Plan for 2025-2027

Background

Goshen Health, as a 501(c)3 not for profit entity, is required to complete an extensive Community Health Needs Assessment (CHNA) once every three years. That report is presented to the community, and the list of prioritized community health needs established by a community committee is then to be adopted by the board of directors. The institution is then charged to recommend an action plan to the board for approval with the intent to measurably impact these community health needs as one of several ways that this not-for-profit entity directly benefits the community we serve.

2024 Community Health Needs Assessment for the 2025-2027 Action Plan Cycle

The 2024 Community Health Needs Assessment was completed in September and the results were presented to the Goshen Health Board of Directors for adoption on October 23rd, 2024. Prioritization was established by the Community Advisory Council (CAC) using the Community Health Rankings Model published by the University of Wisconsin and is as follows:

- 1. Poor Mental Health**
- 2. Substance Abuse/Addiction Disorders**
- 3. Obesity, Weight Management and Nutritional Issues**
- 4. Lack of Insurance Coverage**
- 5. Financial Hardship**
- 6. Limited Health Services**
- 7. Treatment of Chronic Disease**
- 8. Lack of Health Education**
- 9. Lack of Family and Social Support(s)**

The board directed the executive team to establish an action plan to impact a credible portion of this list, in partnership with other community entities as appropriate, and present it for approval in early 2025. Some of these health needs have been present in the community over several cycles of CHNA – in cases where Goshen Health is making headway with existing action plans, it was recommended to continue our work in those efforts.

This plan seeks to impact four of the nine priorities identified by the Community Advisory Council. Those priorities are substance abuse/addiction disorders; obesity, weight management and nutritional issues; lack of insurance paired with financial hardship; and treatment of chronic conditions.

While evaluating the priorities for action plan development, our teams also noted a sudden acute increase in community stress related to lack of transportation. Transportation has been mentioned by name in our CHNA surveys for many years and has also been noted in other regional not-for-profit organizations' community priorities. While it did not surface as "transportation needs" in this survey series, we identified that this gap in our community is acting as a contributing factor to several other listed priorities. Those priorities include financial hardship, limited health service access, and lack of family or social supports. Because we are experiencing community members with transportation needs daily in our health system, this was added as an action plan for board approval. The recommended action plans and measures of success for 2025-2027 are outlined below.



Substance Abuse and Addiction Disorders (SAAD)

The SAAD Action Plan is formed of 3 strategies:

1. Create a comprehensive, public facing, online resource guide in both English and Spanish for those struggling with SAAD (and their caregivers) to help increase access to existing resources. This strategy is intended to engage community members in resources at their point of need with low barriers to access. It is also intended to reduce stigma throughout the community and enable native Spanish speakers to engage in support services.
2. Expand Goshen Health's involvement in community-based initiatives surrounding substance abuse and addiction.
3. Goshen Health will explore an SMS Based Platform to Connect Community Resources. A low-barrier, application-based access system for our community members to use to connect with resources at the point of need would be transformative. There are existing examples of customizable, AI-powered platforms for intelligent routing of community members to websites, care concierges, doctors on call and more. If the potential is realized, this tool could also be used to support other action plans.

The short-term metrics we will track to determine impact are engagement and utilization with the tools as provided. Long term metrics include reduce number of overdose deaths per 100,000; reduce the number of impaired driving deaths; and increase awareness and utilization of community resources.

Transportation

The Transportation Action Plan includes 3 strategies:

1. Coordinate services with local partners throughout Elkhart County. This strategy hinges on establishing consistent, supported services with local partners for discharged patients. It also seeks grant funding to address transportation costs for patients without funds or family support.
2. Reduce barriers for patients to use their own benefits for ride planning. Many patients we serve in the community have benefits plans which entitle them to free healthcare-related transportation. Notable inclusions are all Medicare Advantage plans and all Indiana Medicaid offerings. Despite stating these benefits are to be provided to patients, most patients cite lack of local access, inability to contact any service, or drivers failing to arrive as barriers. Lack of transportation is a common reason for missed appointments for patients.
3. Engage provider of wheelchair van services to benefit community members. The regional wheelchair van service was recently sold, deeply reducing access to needy patients and families across Northcentral Indiana. The health system needs to engage actively with new providers of this service or contemplate how to provide the service at a palatable cost. We are currently transporting wheelchair van patients in ambulances due to this lack of service availability, which is a waste of scarce resources. It is also a direct expense that is charged back to the hospital – at a much higher rate than the patient required.

The metrics this action plan is intended to impact is to reduce our current spend for gap transportation coverage; standardize the cost to the organization to care for this patient need; and establish access for patients that is low barrier to reduce missed appointments and overall cost of care. Long term measures of success would include reduced delays to discharge and reduction in missed appointments for chronic condition patients.



Community Obesity/Nutrition

The Obesity/Nutrition Action Plan is a continuation and expansion of our successful 2019-2021 and 2022-2024 CHNA Action Plans:

1. Continue support of existing efforts and coalitions throughout our service areas that target obesity/nutrition, directly supporting efforts that impact high risk populations, cultural minorities, and children by leveraging community assets and advancing impactful programming choices.
2. Participate in new community initiatives that are targeting this area; including the pursuit of grants for partnership expansion and deeper community reach. We have successfully partnered with many groups to secure funding, including parks departments, school systems, and Cultivate Food Rescue.
3. Enhance weight management support services and resources for adult patients desiring weight loss. Following the closure of our Center for Weight Reduction in 2024, a gap has formed for care management resources of patients desiring weight loss.
4. Strengthen and align organizational external practices that are supportive of obesity as a health priority.

Short term metrics for this action plan include participation rates, improvements in health outcomes/knowledge/behaviors, partner effectiveness and community feedback. In existing programs, we have historically seen greater than 25% growth year over year and our reach continues to expand with partnerships. Long term metrics aim to reduce or maintain the % of adult population (20+) that reports BMI ≥ 30 , reduce the % of adults reporting no leisure-time physical activity within our community, and improve or maintain Food Environment Index Score.

Chronic Condition Management

The Chronic Condition Management Action Plan includes 4 tactics:

1. Strengthen coordination of care for chronic condition patients. Built upon our existing evidence-based care coordination program, we want to expand these services to support uninsured and underserved populations with multiple chronic conditions. Specific targets to improve are transportation, cost, and language barriers.
2. Expand access to chronic disease management programs via community partnerships.
3. Leverage technology to enhance chronic care management. This tactic focuses on implementing or expanding existing telehealth services and patient portals to reduce transportation or mobility barriers. This would also target increased engagement with chronic care management services.
4. Increase awareness of chronic care resources through direct marketing. This tactic encompasses a low-cost marketing campaign to raise community awareness of resources specifically for chronic condition patients.

Short term metrics for this action plan focus on utilization of access points or persons served. Long term metrics are more tightly aligned to outcomes, including collected "good save" or avoided hospitalizations for impacted population; reduction in hospitalization rates for non-ACO population; and improvement of overall Medicare star ratings for high acuity patients.



Financial Hardship and Insurance Instability

The Financial Hardship and Insurance Instability Action Plan includes 3 tactics:

1. Expand enrollment assistance for hospital patients through addition of, or increased coordination with, insurance navigators.
2. Increase awareness of healthcare resources and support for community members, potentially making this available via SMS platforms.
3. Improve affordability and accessibility of healthcare services via direct contracting.

The measures of success for this action plan include reducing the rate of uninsured adults across our community; improve access to care by increasing primary care patient panels; and increase preventative or Evaluation and Management (E&M) visits from our baseline.

