2026-2028 Implementation Strategy

Reid Health

Created in response to the 2025 Community Health Needs Assessment

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Reid Health: Organization and Mission

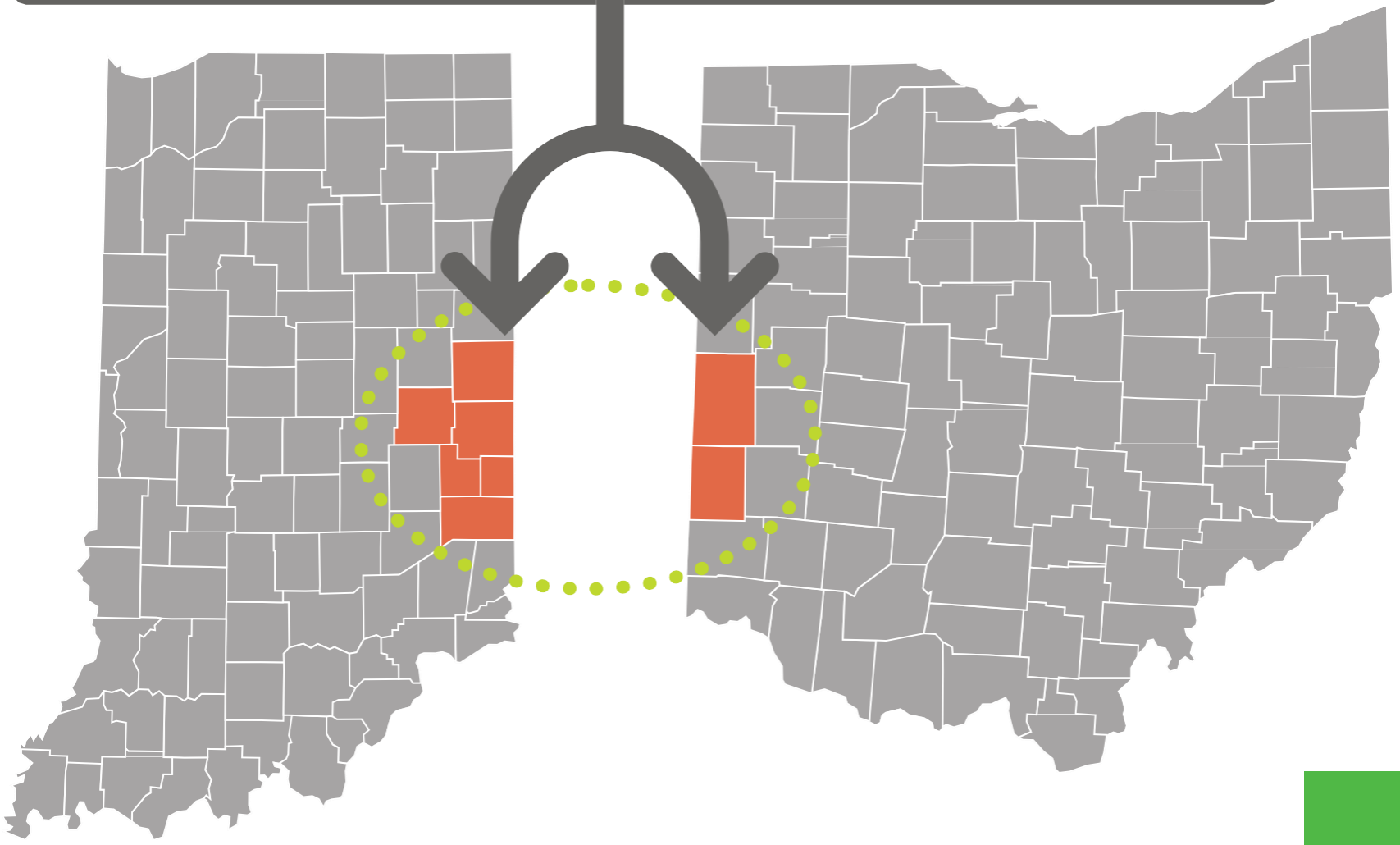
This document represents the 2026-2028 Community Benefit Implementation Strategy for Reid Health and is in direct response to the 2025 Community Health Needs Assessment (CHNA) conducted by Conduent Healthy Communities Institute (HCI) on behalf of Reid Health in conjunction with the communities within the service area. The Reid Health Governing Board approved this strategy in January of 2026.

Reid Health is a regional health system serving East-Central Indiana and West-Central Ohio, with a main hospital campus in Richmond, IN, that includes a 227-bed inpatient hospital and numerous satellite locations in seven regional counties. Reid Health's service area is home to about 285,502 people spanning eight counties across two states. Though a new hospital was opened in 2008, Reid Hospital originated in 1905 when Daniel G. Reid financed construction for the hospital in memory of his wife and son. Through the years, Reid Health has grown to employ over 3,200 people and has the support of nearly 100 volunteers. Major service lines within the organization include Heart & Vascular Services, Cancer Center, Women's Health, Orthopedics & Spine, Rehab Services, and Psychiatric Care.

Mission, Vision and Values

Target Communities

The target communities for the strategy include the counties of Fayette, Franklin, Henry, Randolph, Union, and Wayne in Indiana and Darke and Preble counties of Ohio.



Characteristics of the Population

According to the 2023 U.S. Census Bureau population estimates, the Reid Health Service Area has an estimated population of 285,502 persons. The most populated zip code area within the service area is zip code 47374 (Wayne County) with a population of 45,186 persons. Wayne County is also the largest county with 66,377 people while Union County is the smallest with a population of 7,028.

Population

92.8% of the population in the Reid Health Service Area identifies as White—significantly higher than Indiana (78.5%), Ohio (77.8%), and the U.S. overall (63.4%). Black or African American residents make up just 1.8% of the area's population, compared to 9.3% in Indiana and 12.3% in Ohio. Hispanic residents account for 2.4% of the service area, also lower than in Indiana (8.4%) and Ohio (4.6%).

Race & Ethnicity

According to the American Community Survey, 1.5% of residents in the Reid Health service area were born outside the U.S. By county, 2.9% of residents in Wayne County were born outside the U.S., while only 0.5% of residents in Preble County are foreign born. In the Reid Health service area, 0.5% of households have difficulty speaking English.

Language & Immigration

Overall, 9.9% of families in the Reid Health service area live below the poverty level, which is higher than the Indiana state value of 8.4% and lower than the Ohio state value of 9.2%. Wayne County and Darke County having the highest percentages at (23.9%) and (21.2%).

Poverty

Most of the population in Reid Health's service area falls between the ages of 25-64 years (49.8%). The area has fewer individuals within the age groups of birth to 19 years of age (24.7%) and 20 to 44 (28.7%) years of age than both the Indiana and Ohio averages. Reid's service area demonstrated a higher percentage of individuals older than 45 years (46.5%) than the state averages.

Age

Within Reid Health's service area, only Franklin County ($79,702) maintains a median household income above the national value ($78,538). Fayette ($56,659) and Wayne ($56,652) counties of Indiana demonstrated the lowest values of median household income and are well below the state median household income of ($70,051). Preble County ($71,237) is slightly higher than the Ohio average of ($69,680), while Darke County falls short at ($64.654).

Income

Three counties in Reid's service area reported an amount lower than the 89.4% national average for earning a high school degree, or higher, for those age 25 years and older. Reid Health service area has a percentage of 89.8% of residents over 25 with at least a high school degree, which is lower than both the Indiana state value (90.2%) and Ohio state value (91.6%) but slightly higher than the U.S. value (89.4%).

Education

Of the counties in Reid's service area, Fayette County has the highest unemployment rate at 6.6%, significantly higher than both the Reid Health Service Area and the state of Indiana, each at 4.2%. Most other counties hover near the state and national averages, with Union County, IN and Preble County, OH showing the lowest rates at 3.4%.

Unemployment

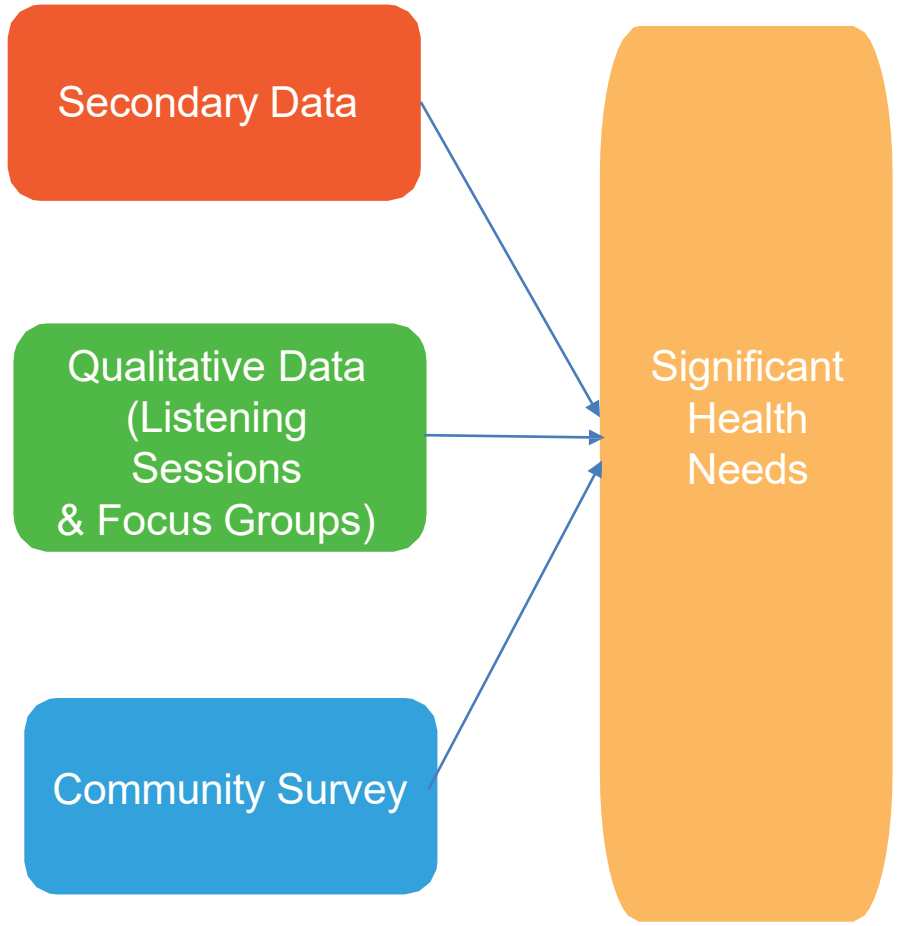
Data Collection

To prepare the Community Health Needs Assessment, Reid collected data and information from secondary sources, key stakeholders and the communities within Reid's service area.

Secondary data, or numerical health indicators, from HCI's community indicator database, were analyzed and scored based on their values.

2 Listening Sessions and **5 Focus Groups** were conducted with community members who have a fundamental understanding of public health and represent the broad interests of the community. **68** different organizations participated in the process, including the local health department, social service organizations, local businesses, and representatives from the education sector.

3,649 residents from Reid Service Area participated in the **Community Survey.** The survey was offered in English and Spanish, and a paper version was also available.



Data Synthesis

Primary and secondary data were collected, analyzed, and synthesized to identify the significant community health needs in Reid Health service area.
The significant health needs identified from data sources were analyzed based on the areas of data overlap. Primary data from the community survey, listening sessions, and focus groups as well as secondary data findings identified eight areas of significant need. The table below outlines the eight significant health needs (in alphabetical order) alongside the corresponding data sets that identified the need as significant.

HEALTH TOPIC (ALPHABETICAL ORDER)	LISTENING SESSIONS	FOCUS GROUPS	COMMUNITY SURVEY	SECONDARY DATA
CHRONIC DISEASE (DIABETES, HEART DISEASE AND STROKE)	✓	✓	✓	✓
HEALTH CARE ACCESS AND QUALITY	✓	✓	✓	
MATERNAL AND INFANT HEALTH	✓	✓		✓
MENTAL HEALTH	✓	✓	✓	✓
ORAL HEALTH	✓			✓
SUBSTANCE MISUSE	✓	✓	✓	✓
SOCIAL DETERMINANTS OF HEALTH (HOUSING, TRANSPORTATION, AND ECONOMIC STABILITY)	✓	✓	✓	
WELLNESS AND LIFESTYLE (NUTRITION AND OBESITY)	✓	✓	✓	✓

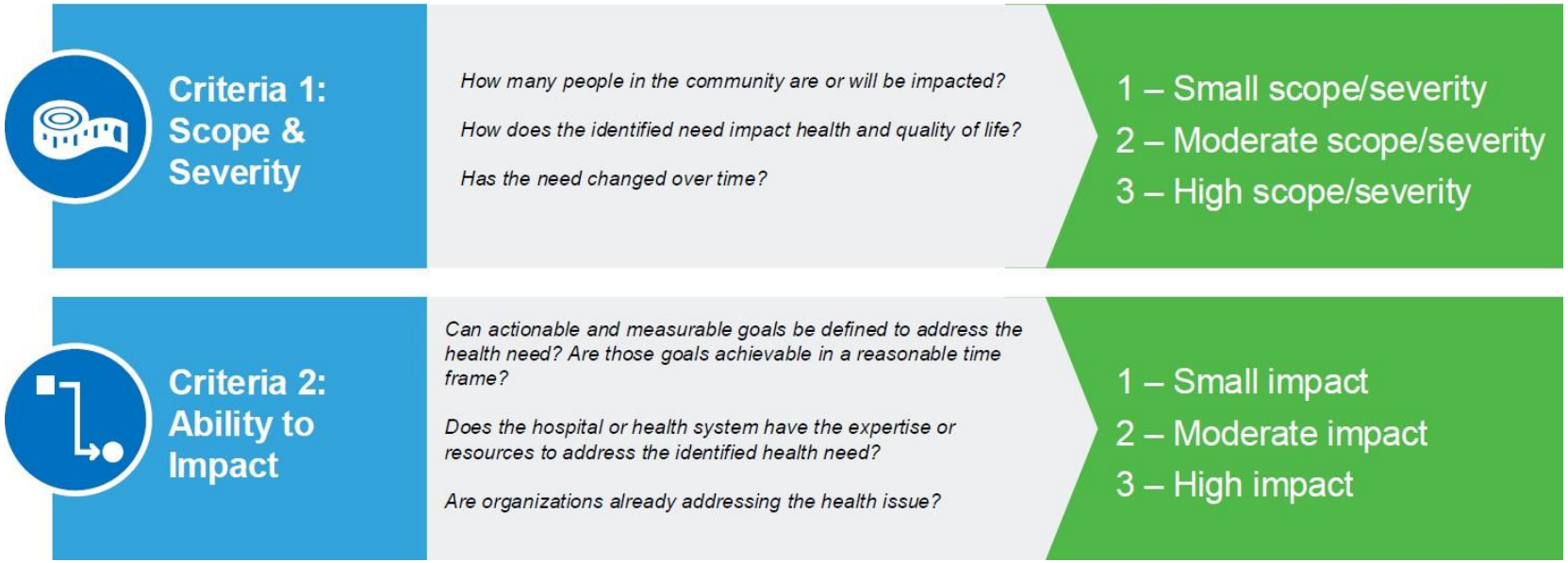
Prioritization

Invitations to participate in the Reid Health CHNA data synthesis presentation and prioritization activity were distributed in the weeks leading up to the meetings held on June 25, 2025, and June 27, 2025. A total of 56 participants attended the in-person session, while 33 attended virtually. Attendees represented a broad range of sectors, including local law enforcement, education, veteran services, health and fitness organizations, senior services, health clinics, and community mental health centers. Of these participants, 54 completed the online prioritization activity.

Prioritization

Prioritization Activity

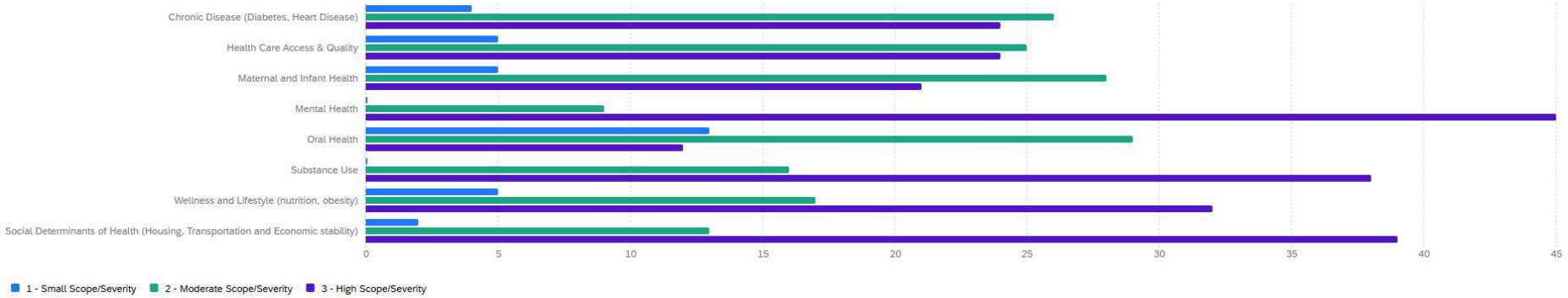
Assign a score of 1-3 to each health topic and criterion.



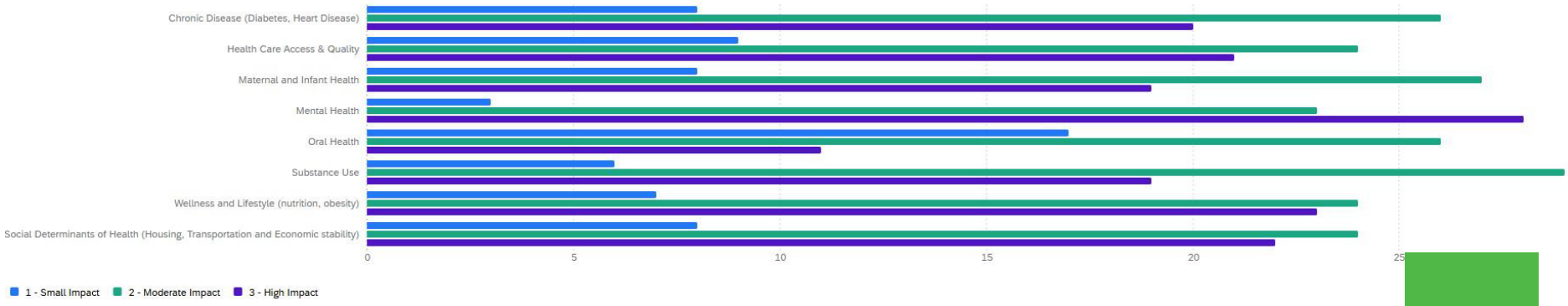
During the sessions, participants reviewed and discussed the results of HCI's primary and secondary data analyses. They were then asked to complete the online scoring exercise, assigning scores to each health need based on how well it met the hospital's established criteria. The group also agreed that root causes, disparities, and social determinants of health should be factored into all prioritized health topics identified through this process.

Prioritization

Scope & Severity:
Gauges the magnitude of each health issue

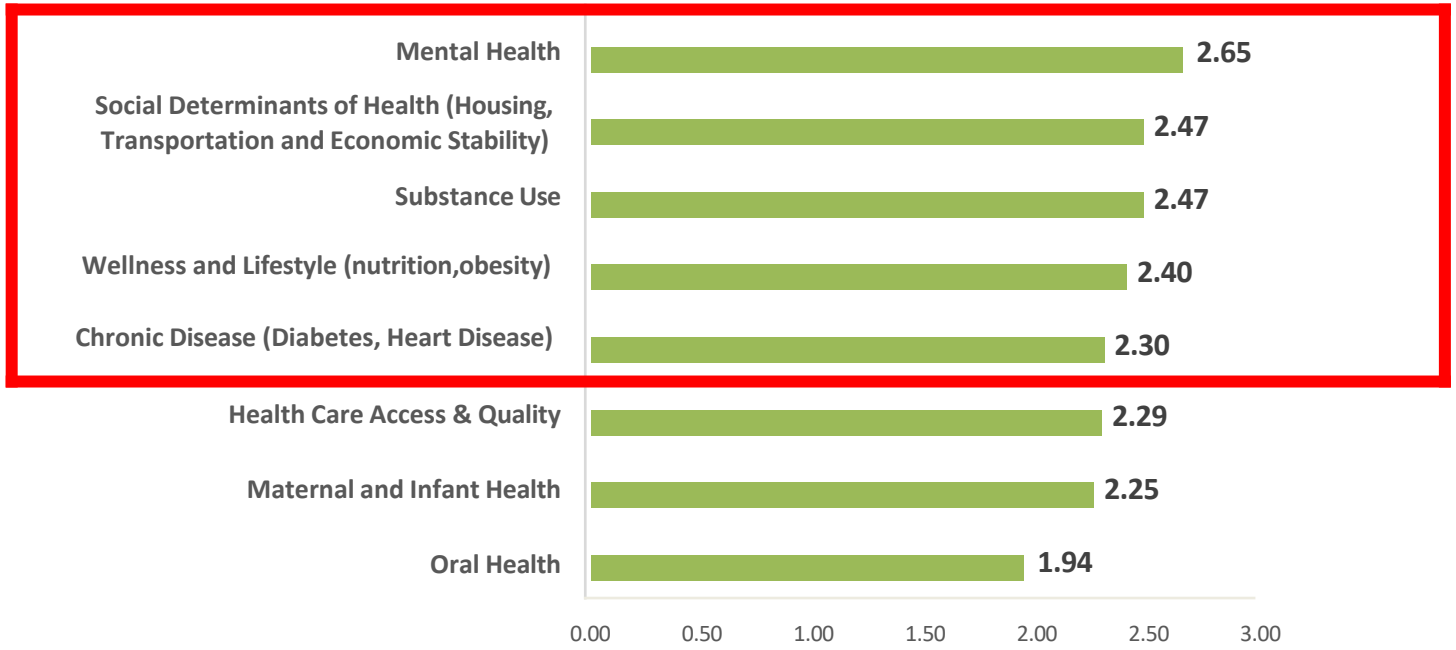


Ability to Impact:
The perceived likelihood of positive impact on each health issue



Prioritization

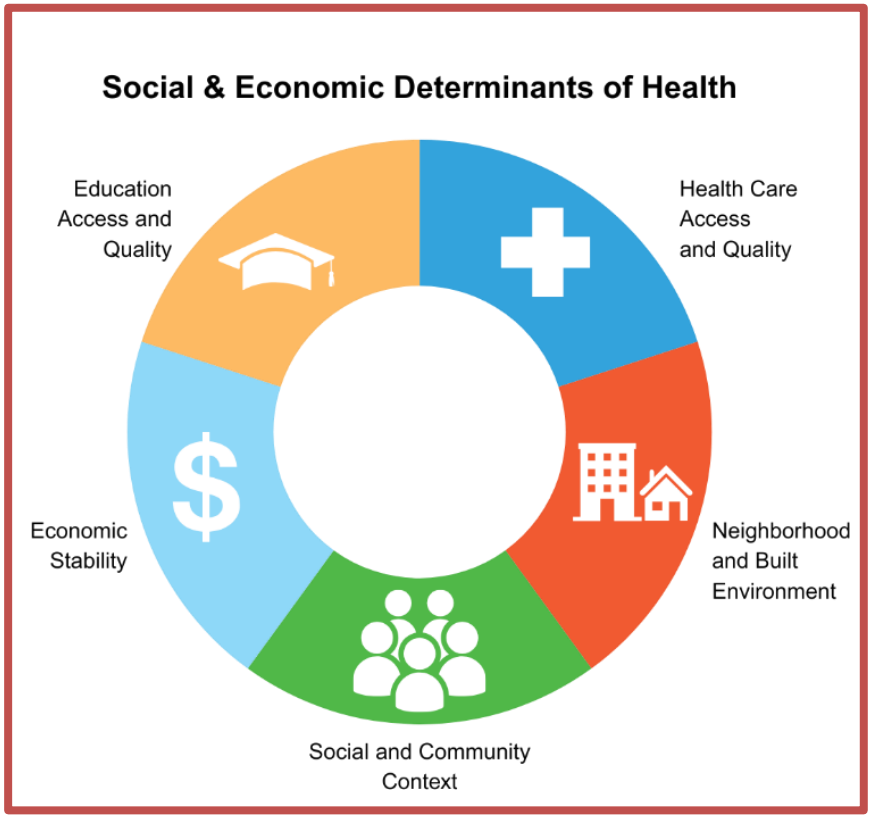
Completion of the online scoring exercise generated numerical results for each health topic and criterion. These results were equally weighted and averaged to produce an aggregate score and overall ranking for each health issue. Those results are below.



Reid Health's CHNA team reviewed the scoring results of the significant community needs and determined prioritized health needs based on the same set of criteria used in the scoring exercise. In one instance, topics overlapped and were combined. For example, substance use, and mental health often relate or co-exist. Therefore, it was determined these two groups should be combined as one health need to be addressed; as they have been in previous implementation plans.

Social Determinants of Health

Reid Health chose to emphasize Social Determinants of Health (SDOH) as a guiding framework because of its underlying impact on prioritized health outcomes which include mental health and substance use, wellness and lifestyle, and chronic disease. SDOH elements often determine whether someone can access nutritious food, afford medications, find safe housing, or receive timely mental health care. By focusing on SDOH, Reid Health is not just treating symptoms but tackling the root causes that contribute to poor health, especially in vulnerable populations who face systemic barriers to optimal health.



Social Determinants of Health

Addressing SDOH is particularly vital in Reid Health's service area, where data from the Community Health Needs Assessment revealed significant challenges related to mental health, substance use, and chronic disease. Vulnerable groups such as low-income families, rural residents, and individuals with limited access to transportation or education are disproportionately affected by these issues. By aligning funding and programming with SDOH, Reid Health ensures that its initiatives are both strategic and equitable. The overarching SDOH theme allows Reid to invest in interventions that create lasting change and uplift those who need it most.

> **Transportation is a huge challenge. People can't get to the doctor or even to the store for their basic needs to be met.**

Significant Health Needs to Be Addressed

Over the next three years, Reid Health is committed to efforts to improve the following significant health needs identified in our 2025 Community Health Needs Assessment:

Reid Health CHNA Priorities

Cross-Cutting Priority Area

Social Determinants of Health

Priority Area 1	Priority Area 2	Priority Area 3
		
Chronic Disease (Diabetes, Heart Disease and Stroke)	**Mental Health and Substance Use**	**Wellness and Lifestyle (Nutrition and Obesity)**

Implementation Strategy Process

Step 1: Establish Goals and Objectives

The CHNA team of Reid Health identified a goal and objectives for each of the prioritized needs based on the identified gaps, areas of opportunity and health indicators.

Social Determinants of Health

Chronic Disease (Diabetes, Heart Disease and Stroke)

Goal

Reduce and prevent chronic disease and improve the overall health and well-being of the community by addressing social determinants of health through coordinated, community-centered strategies.

Objectives

1. Increase access to health education and resources for chronic disease prevention and management
2. Strengthen cross-sector collaboration to address chronic disease

Indicators

- Adults who experienced Coronary Heart Disease
- Age-adjusted death rate due to heart attack
- Diabetes: Medicare population
- Heart Failure: Medicare population
- High blood pressure prevalence
- Hyperlipidemia: Medicare population

Social Determinants of Health

Mental Health and Substance Use

Goal

Promote mental, emotional, and behavioral well-being within the communities we serve by addressing social determinants of health and improving mental health outcomes, while reducing substance use through coordinated, community-driven efforts across stakeholders and non-profit partners.

Objectives

1. Enhance community mental health and reduce substance use
2. Strengthen cross-sector collaboration to improve access and outcomes

Indicators

- Adults who smoke
- Age-adjusted death rate due to suicide
- Death rate due to drug poisoning
- Depression: Medicare population
- Mothers who smoked during pregnancy
- Poor mental health: Average number of days

Social Determinants of Health

Wellness and Lifestyle (Nutrition and Obesity)

Goal

Advance community well-being by addressing social determinants of health and ensuring equitable access to healthy living resources, while fostering collaborative partnerships that support sustainable lifestyle changes.

Objectives

1. Increase opportunities for active living and access to nutritious food to reduce chronic health risks
2. Strengthen cross-sector collaboration to address wellness and lifestyle

Indicators

- Access to parks
- Adults 20+ who are sedentary
- Food insecurity rate
- High blood pressure prevalence
- Life expectancy
- Poor physical health: Average number of days

Implementation Strategy Process

Step 2: Identify Resources

Next, the CHNA team of Reid Health identified resources that were already existing through the efforts of Reid Health or through other community organizations or agencies.

Resources

Chronic Disease (Diabetes, Heart Disease and Stroke)

Supported programs and activities

AED Grant Program, Chronic disease support groups (Reid), Community Needs requests, community blood pressure checks (Reid), community glucose tests (Reid), health education tabling and workshops (Reid), Health Education Table Talks (Reid), health fairs (Reid), Let's Talk Together (Reid), Medical Monday (Reid), Monday Mashups (Reid), nonprofit collaborations and partnerships, PACE Center (Reid), Senior center Partnerships, SNAP Double Dollars Connersville, Winchester, Richmond and Centerville Farmers Markets, Thriving Thursday (Reid), Wayne County Tobacco Prevention and Cessation Coalition.

Community partners

Birth to Five, Inc., Circle U Help Center, Darke County Health Department, Earlham College, Fayette County Health Department, Firefly Family Resource Center, Franklin County Health Department, Girls Inc. of Wayne County, Gleaners Food Bank of Indiana, Healthy Fayette County, Henry County Health Department, Indiana Department of Health, Indiana University East, Ivy Tech Community College, libraries throughout the area, Meridian Health Services, Neighborhood Health Center, Preble County Health Department, Purdue Extension Programs, Randolph County Health Department, Reid Health departments, Ronald L. McDaniel Foundation, schools throughout the area, senior centers throughout the area, Siloam Clinic, Trustee offices throughout the area, Union County Health Department, Wayne County Health Department.

Resources

Mental Health and Substance Use

Supported programs and activities

Bereavement Support (Reid), Boys and Girls Club activities, Community Benefit Grant Program (Reid), Community Needs requests, Connection Café, Dispose Rx overdose prevention tool (Reid), Drug Coalition Support (Drug Free Wayne County, Reach All Randolph County, Fayette County Drug Coalition), Education and outreach events with a variety of partners, Homeless outreach events (Wayne County, Fayette County, Union County Continuum of Care), Hope Center support, Indiana Youth Institute initiatives, International Overdose Awareness Day (Wayne and Fayette counties), Jacy House support, Let's Talk Together (Reid), Medical Monday (Reid), mental health support groups facilitated by Reid staff, Narcan distribution program to first responders, Parent Cafes, Perinatal Bereavement & Perinatal Loss Support Group (Reid), Preble Arts mental health and healing initiatives, Purdue Extension outreach and education, stigma reduction events, suicide prevention and support outreach and events (American Foundation for Suicide Prevention), Systems of Care (various counties), Thriving Thursday (Reid), Various support groups (Reid), various movie screenings, Wayne County Tobacco Prevention and Cessation Coalition, Youth Mental Health education, outreach and events.

Community partners

988, 228 Club, Inc., A Better Life Brianna's Hope - Richmond chapter, A Better Way Services, Inc., Abington Township Volunteer Fire Department Auxiliary, Inc., Achieva Resources, Inc., American Foundation of Suicide Prevention , ARC Center, Birth to Five, Inc., Boys & Girls Clubs of Wayne County Indiana, Inc., Bridges for Life, Brighter Path, Inc., Centerstone , Children's & Justice Advocacy Center, Inc., Choices Cert., Circle You Help Center, Inc., City of Eaton, Communities In Schools of Wayne County, community centers throughout the area, Community Christian School, Connection Café, Cope Environmental Center, corners' offices throughout the area, Darke County YMCA, Drug Free Wayne County Partnership, Dublin Community Club, Every Child Can Read, Fayette County Probation, Fayette County Drug Coalition, Fayette County Harm Reduction Alliance , Firefly Children & Family Alliance , Forward Wayne County , Friends of the Union County Library , From The Heart Int,l., Inc., Gateway Hunger Relief Center, Girls Inc. of Wayne County, Gleaners Food Bank of Indiana, Growing Branches for Christ Ministries , Hagerstown Trustee , Hope Center, House of Ruth , Housing Authority of the City of Richmond, Imagination Library of Franklin County, Independent Living Center of Eastern Indiana, Inc., Indiana Department of Health , IU East, JACY House, Journey Home Shelter , Knightstown Community Education & Law Enforcement Foundation, Inc., Leaders in Training, Meridian Health Services, Mezzo Solutions, Monroe Central Elementary, Mount Zion Baptist Church, Natco Community Empowerment Center, Neighborhood Health Center, Northeastern Wayne Schools, Oak Park Church, Inc.- Oak Park Early Learning Academy, Open Arms Ministries , Pathways to Damascus , Preble Arts , Preble County Council on Aging, Inc., Preble County Educational Service Center - Success Academy, Preble County YMCA, Pregnancy Care Center of Randolph County , Purdue Extension Programs, Randolph County YMCA, Randolph Eastern School Corporation, Recovery & Wellness Board of Ohio , Recovery Rocks Club, Inc., Reid Health departments, Richmond Comprehensive Treatment Center , Richmond Friends School, Richmond High School, Richmond Police Department, Richmond State Hospital, Ronald L. McDaniel Foundation, Salt of the Earth, Inc., school districts throughout the area, Senior Opportunities Services, Servants at Work, Soldiers in the Army of the Lord, Start with Art Ltd, Stayin' Alive, Straughn Volunteer Fire Department, Stride Center, Systems of Care, The Dwyer Community Center , The Independent Living Center of Eastern Indiana, The Journey Home, The Nest - Meridian Health Services, The Shepherds Way Christian Ministries - Cross Road Recovery Center for Women, Town of Hagerstown Police Department, United Way of Whitewater Valley , Wayne County Probation, Wayne County Sheriff's Office, Wayne County Trustee, Whole Family Community Initiative, Inc. - House of Ruth.

Resources

Wellness and Lifestyle (Nutrition and Obesity)

Supported programs and activities

Access to low-cost sports physicals (Reid), AED Grant Program, Athletic trainer program at area high schools (Reid), Circle U milk donation and excess food donation, community meal sites, Community Benefit Grant Program (Reid), Community Health Partnership with Wayne County Health Department, Community Needs requests, Connersville Parks activities, Diabetes event (Reid), Food Council support (various counties through service area), Fresh Fruit Distribution, Girls Inc Summer Meal Program, Gleaners Mobile Food Distribution, Healthier on the Go, Healthy Cooking Classes, Higi Health Kiosks, Housing Authority of Richmond initiatives, Let's Talk Together (Reid), Medical Monday (Reid), Prenatal Breastfeeding classes, Purdue Extension Initiatives, Reid Fitness (Reid), Richmond Parks Department activities, SNAP Double Dollars Connersville, Winchester, Richmond and Centerville Farmers Markets, Senior center partnerships, Thriving Thursday (Reid), various events/outreach/education (Reid), various fitness events, various holiday meals/baskets, walking trails.

Community partners

Abilities Richmond, Inc., Achieva Resources Corporation, Inc., Alquina Blue Arrows Park, Amigos, Bentonville Volunteer Fire Department, Bethel African Methodist Episcopal Church, Birth to Five, Inc., Boys & Girls Clubs of Wayne County Indiana Inc., Bread Box Food Pantry, Bridges for Life, Cardinal Greenway, Inc., Central United Methodist Church, Circle You Help Center, Inc., City of Eaton, College Corner Union School - Special Education Department, Communities in Schools of Wayne County, community centers throughout the area, Connersville Parks & Recreation, Connersville Youth Football, Cope Environmental Center, Core Community Center, Council on Rural Service Programs, Inc - Gateway Youth Programs, Cross Road Christian Recovery Center, Dennis Middle School, Discover Connersville, Dublin Community Club, Faith United Lutheran - Helping Others During the Holidays, farmers markets throughout the area, Fayette County Community Voices, Fayette County Food Council - Fayette County Community Voices, Fayette County Senior Center, Food and Growers Association , Franklin County Community Foundation, Franklin County School Corporation, Friends of the Preble County Park District, Friends of the Union County Public Library, Gateway Hunger Relief Center, Girls Inc. of Wayne County, Gleaners Food Bank of Indiana, Golay Community Center, Good News Habitat for Humanity, Handley Our Own Inc. d.b.a Impact wRestling Club, Hayes Arboretum, Healthy Fayette County, Hope Center, Housing Authority of the City of Richmond, Indiana University East, Ivy Tech Community College, LifeStream Services, Lighthouse Assembly of God, Lighthouse Compassion Bus Program, Meridian Health Services, Monroe Central School Corporation, Mt. Zion Baptist Church, Nettle Creek School Corporation, New Deliverance Temple Ministries International, O.R. Baker Elementary, Oak Park Church, Inc. - Oak Park Early Learning Academy, Pathway to Damascus, Inc., Petra Projects, Inc. - Rock Solid Ministries, Play in the Park, Preble Arts, Preble County Council on Aging, Preble County YMCA, Purdue Extension, Randolph Central School Corporation, Randolph County YMCA, Red Life Pantry - Redemption Life Church, Refuge of Hope, Reid Health departments, Richmond Community Schools - Hibberd Program Building, Richmond Family YMCA, Richmond Friends School, Richmond Indiana Pickleball Inc, Richmond Parks & Recreation, Richmond Senior Center, Ronald L. McDaniel Foundation, Safety Village of Wayne County, Salt in the Earth - Salt of the Earth, school districts throughout the area, Second Harvest Food Bank of East Central Indiana, Servants at Work, Soldiers in the Army of the Lord Ministries, Start with Art, Sunrise, Inc., The Arcanum Public Library, The Common Good of Preble, The Haven, The Shepherds Way Christian Ministries - Cross Road Recovery Center for Women, The Working Hungry, Town of Brookville, Indiana, Union County Parks & Recreation Board of Trustees, United Way of Whitewater Valley, Wayne County Foundation, Wayne County Sheriff's Office, Whitewater Valley Community TV, YMCA of Darke County, YWCA Dayton

Implementation Strategy Process

Step 3: Review Data and Get Community Input

Lists of community representatives with a specific interest or ability to impact the prioritized needs were compiled according to which need their work supported. These individuals were then invited for a discussion pertaining to the prioritized need. Sessions were held at Reid Health to facilitate these discussions on:

- September 15, 2025: Mental Health and Substance Use
- September 18, 2025: Wellness and Lifestyle (Nutrition and Obesity)
- September 19, 2025: Chronic Disease (Diabetes, Heart Disease, and Stroke)

Implementation Planning Session Participants

Chronic Disease (Diabetes, Heart Disease and Stroke

Andrew Hoover, Reid Health; Anna Osborn-Brown, Reid Health; Ashley Shepard, Reid Health; Elizabeth Gwinn, Reid Health; Emily Bockover, Reid Health; Erika Millsaps, Reid Health; Jessica Przybysz, Reid Health; Katie Stephen, Reid Health; Nathan Hogg, Reid Health; Sharrie Harlin, Reid Health.

Mental Health and Substance Use

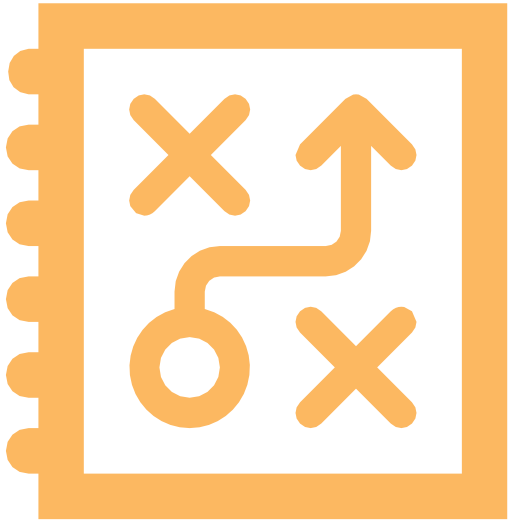
Acacia St. John, Forward Wayne County, Reid Well-Being Committee Member; Andrew Hoover, Reid Health; April Coffin, Reid Health; Dan Burk, Wayne County Health Department; Dana Sinclair, Natco Community Empowerment Center; Elizabeth Gwinn, Reid Health; Heather Wierzbinski-Cross, Ivy Tech, Reid Well-Being Committee Member; Jamie Andrews, Centerstone Stride Center; Katie Vance, Meridian Health Services-The Nest; Kyle Weatherly, Richmond Police Department; Lisa Felsman, Centerstone/ Systems of Care; Marquette Stokes, Centerstone Stride Center; Mike Gross, Meridian Health Services; Nathan Hogg, Reid Health; Nicole Stults, Reid Community Well-Being Committee; Paul Lower, Boys & Girls Club of Wayne County; Robin Henry, Reid Well-Being Committee Chair; Susan Ream, Reid Health; Tamara Brinkman, United Way of Whitewater Valley; Tanja McFarland, Reid Health; Terah Legg, Reid Health; Tim Pierson, Bridges For Life; Zoe Robinson, Purdue Extension

Wellness and Lifestyle (Nutrition and Obesity)

Acacia St. John, Forward Wayne County, Reid Well-Being Committee Member; Alicia Painter, Boys & Girls Club of Wayne County; Ashleigh Buffenbarger, Preble County YMCA; Ashley Shepard, Reid Health; Becky Marvel, Fayette County Food Council; Becky Thompson, Richmond Senior Center; Brian Schleeper, Wayne County Foundation; Dan Burk, Wayne County Health Department; Denise Retz, Richmond Parks Department, Reid Governing Board Member; John Przybysz, Earlham-Revitalize Richmond; Jon Blevins, Meridian Health Services; Kay Riker-Peyton, Union County Health Department ; Lindsay Freed, Housing Authority of the City of Richmond; Mark Harrington, Reid Governing Board Chair; Marla Steele, Connersville Parks Department; Michelle Malott, IU East, Reid Well-Being Committee Member; Misty Hollis, Richmond YMCA; Robin Henry, Reid Well-Being Committee Chair; Sally Price, Randolph County YMCA; Steve Hayes Jr., Hayes Arboretum ; Tamara Brinkman, United Way of Whitewater Valley

Implementation Strategy Process

During the session, the CHNA team of Reid Health shared the implementation strategy development process and the goals and objectives for each identified prioritized need. The team also shared current initiatives impacting each need. The group then reviewed health indicators, data, and key themes from community input for each county within Reid's service area.



Key Themes from Community Input

Chronic Disease (Diabetes, Heart Disease and Stroke)

Key Themes from Community Input

Mental Health and Substance Use

Key Themes from Community Input

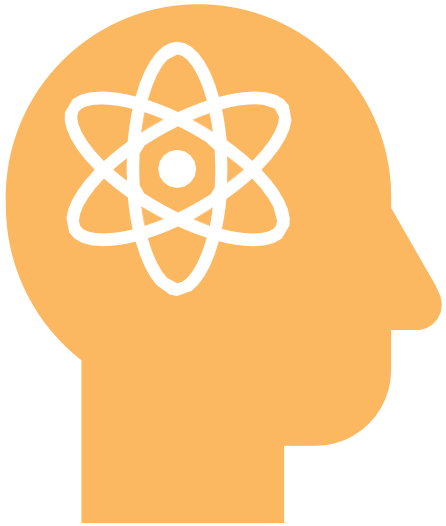
Wellness and Lifestyle (Nutrition and Obesity)

Implementation Strategy Process

Step 4 Part 2: Receive Tactical Input and Evaluate

Following that, the group engaged in a Social Determinants of Health (SDOH) activity, where they were tasked with identifying barriers to improving the health indicators and prioritized needs. Participants were encouraged to think critically and collaboratively, using the SDOH framework to guide their brainstorming and discussion.

After compiling the list of barriers from the brainstorming session, the CHNA team grouped the barriers into categories and then performed voting to identify the most significant barriers.



Barriers

Chronic Disease (Diabetes, Heart Disease and Stroke)

Economic Stability:

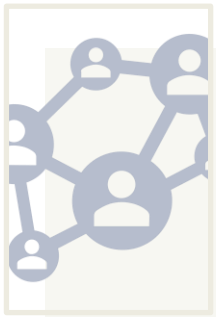
Afraid of cost, prescription cost, money, legal status/proper, paperwork, no solid public transportation to good paying, manufacturing jobs in Wayne County

Education Access and Quality:

Not educated (2) , knowledge, lack of education, education regarding health in general, lack of education about health, lack of education surrounding where to go to get checked and when, lack of education around available resources like good rx and manufacturer assist, lack of early childhood resources

Health Care Access and Quality:

Access to care (2), medical facilities not in walking distance to low income neighborhoods, many people cannot afford to take off work to see the doctor, not knowing where to go, insurance (4), insurance requires documentation and the unhoused often do not have it, lack of staff knowledge around the low income population, lack of trust of healthcare professionals, lack of public knowledge about insurance and how it works



Social and Community Context:

“You are doing too much” culture, society and being too busy, generational, not caring, afraid of not having enough resources, fear, lack of cross-sector collaboration, health isn’t trending “the healthy way isn’t fun”

Neighborhood and Built Environment:

Transportation (4), cost of healthy food, food deserts, quick easy food that is processed is cheaper than healthy food, 24 hour fast food but no 24 hour groceries, kids are picky and parents give them quick, unhealthy foods because they don’t know better, easy access to unhealthy foods, cigarettes, alcohol, etc.

Barriers

Mental Health and Substance Use

Barriers identified, separated by SDOH

Economic Stability:

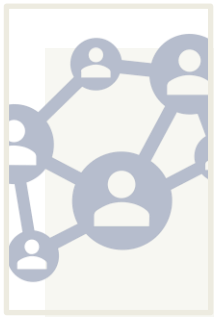
Low wages (2), earning a livable wage to cover all basic needs and essentials, financial struggle, money, poverty in ALICE population, generational poverty, poverty (3), unemployment, lack of full-time work, economic fear of losing benefits if you try to get a job, education/training to get a job to earn a livable wage, lack of money managing skills, legal records

Education Access and Quality:

Lack of early childhood education, low education, lack of education (2), unclear educational paths, first generation doesn't know where to start, youth financial education, skill jobs aren't encouraged by high school counselors and some parents, more people and resources in the schools to work 1:1 with students and parents, lack of college students serving as mentors to high school and middle school students, lack of basic understanding of wellness, health literacy, lack of understanding, ignorance, lack of technology or knowledge of technology

Health Care Access and Quality:

Lack of knowledge of Medicare and Medicaid, lack of knowledge for healthcare workers on what is happening in the community and why, health is last resort, lack of understanding mental health, lack of recovery treatment options, affordable healthcare, not qualified for affordable insurance like Medicaid, insurance barrier, insurance acceptable, cost of no insurance or little insurance, access to affordable insurance, economic stability, health/insurance coverage sometimes doesn't pay for enough of the visit to seem "worthwhile" to the patient, shortage of providers (3), not enough mental health providers, diversity of mental health providers, not plugged in with a healthcare provider so they don't have a "point person", transportation (18)



Social and Community Context:

Lack of mentor and peer support, parent/guardian interaction, lack of family support, lack of supporters for kids at home, support system, social isolation particularly in seniors, impact of social media on self-worth, fear of others finding out their issues/hiding behavior, stigma (6), fear (4), shame, trust, pride (3), afraid to reach out for services due to legal status, "that's not the way we do it" thinking, not caring about their health, perceived need. They don't think of or understand the importance of testings/screenings, no one is advocating for them/encouraging their patients to visit the doctor or get the screenings

Neighborhood and Built Environment:

Lack of affordable housing, housing for people who work but do not make enough for today's market, lack of housing, prices, slumlords, no second chance housing, shelters and who can go to them, some areas lack safe places to walk, engage, connect, need for safer neighborhoods, City government not wellness focused, politics of the world, system can hold people back, groups not working together, low or no cost social connection options for free events

Barriers

Wellness and Lifestyle (Nutrition and Obesity)

Barriers identified, separated by SDOH

Economic Stability:

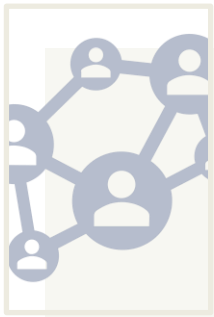
Affordable childcare, income, eating healthy is often more expensive, household income (3), lack of high paying jobs, financial, funding, financial literacy, funding cuts to establish programs, financial ability to pay for gym membership, human capital

Education Access and Quality:

Education (2), food education (2), cooking, food prep, shopping, budgeting, basic nutrition, ability to know how to cook healthy, knowledge (3), education on healthy eating habits, lack of cooking and nutrition classes in school, nutrition/fitness education, cooking classes, knowledge of all 8 points of wellness, education, why it's important, what to do, how to do it, children not exposed to healthy foods

Health Care Access and Quality:

Access to care, follow up to reinforce behavior and progress, poor mental health, lack of motivation, convincing people they can change, motivation, poor health keeps people indoors



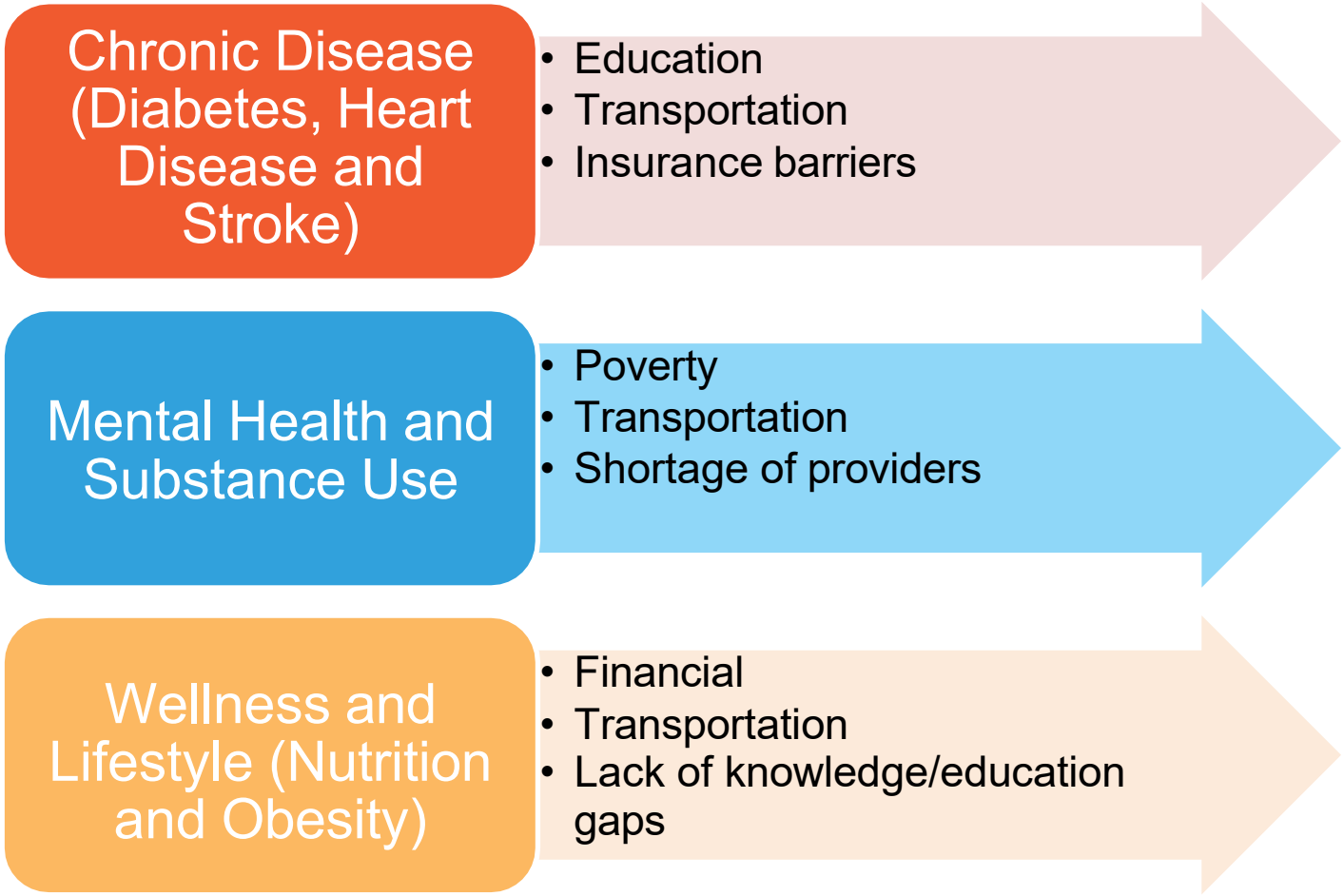
Social and Community Context:

Social connection options, low or no cost social events, neighbors not knowing neighbors, culture of making food at home, eating communally, generational values, shame, not given the questions and permission to ask, not being able to be successful with the plate example, reimagining movement measurements, getting/encouraging people to participate in programs, food pantries not communicating and working together, overwhelmed on how to start being active and exercise, screen time (3), time (4), awareness of events and resources (2)

Neighborhood and Built Environment:

Food deserts (2), shelf life of healthy fruits and vegetables vs. packaged foods, unhealthy food is sometimes cheaper, access to healthy food, transportation (13), sidewalks to safely walk on, after hours bus transportation, no appliances (4), lack of resources to make food at home (2), resources

Most Significant Barriers



Implementation Strategy Process

Step 4 Part 2: Receive Tactical Input and Evaluate

Next, participants were asked “What’s Missing?” for their healthy community and were asked to provide impactful tactics under each category connected to the prioritized health need. Participants were encouraged to brainstorm with the knowledge of resources and the barriers just identified top of mind.

After compiling the list of tactics/initiatives and things to explore from the brainstorming session, the CHNA team grouped the suggestions into affinity categories and then performed nominal voting to identify what they felt would be most impactful.

What's missing? Tactics to explore

Chronic Disease (Diabetes, Heart Disease and Stroke)

Food Insecurity and Ripple Effects

- Increased knowledge on simple and easy meals for families
- Cooking classes for healthier meal options
- How to meal prep for those with busy schedules
- Provide informational classes on how to cook healthy meals with fresh food
- Demos and follow along cooking classes
- Education on resources that are available such as food pantries and farmers markets
- Stop food waste, use every bite in a meaningful way. Easy to donate
- Stop using bad food as a reward, it's cheap but not teaching the right habits
- Mobile food trucks
- Continue to fund food insecurity including expanding hours

Education

- Expand on community programs that fit all ages and all needs
- Fall and summer festivals
- Community education on health topics
- Help them understand why they should care
- Collaborate with local partners to increase education on insurance
- Provide services in locations that are already used
- Do more in the schools for entire family education
- Start educating younger to prevent vs. fix
- Early education
- Starting prevention with kids
- Free and safe care starting in infancy and ongoing for education
- The sooner you reach folks, the sooner you can do prevention
- Education programs for youth

Access

- We need to find ways to collaborate with governments and private partners to increase access to public transportation
- Free bus service offered during event times, food pantries, education
- Expand on a program where we help patients with bus passes or taxis
- Provide resources to fee-based facilities
- Expand information on Claim-Aid resources and expand on forgiveness for no insurance
- Bring point of care testing to them in the community, then connect to resources
- Community screenings like blood pressure, cholesterol, glucose
- Screenings at low-income job sites
- Make it easier to understand, simplify forms and provide more access to helpers for the providers
- Allow folks to consent for a proxy to complete needed forms, jump through hoops for them

Other

- Provide education to medical staff on the issues happening and how to address them
- Provide education on platforms youth already access like social media, etc.
- Meeting people where they are

Lack of Physical Activity

- Gym memberships and exercise equipment are expensive – free access to exercise ideas at home
- Education on what is physical activity, easy items to do at home, help others think outside the box
- Bike ride school routes. Adult leaders make a safe way to carpool kids on bicycles to schools
- Better free access to use exercise equipment with instruction at younger ages
- Expand on already impactful programs at non-profits

What's missing? Tactics to explore

Mental Health and Substance Use

Substance use and addiction

- One on one person to get to the root cause
- More peer recovery access
- Youth substance groups
- Treatment for teens
- Working with law enforcement to allow people to get help and understand recovery
- Additional treatment programs in the county/region
- Low cost/no cost access to build community prevention efforts
- Mini grants available to help people get ahead (housing, legal)
- Hear stories at the places who use these services to better improve

Stigma

- One on one person to get to the root cause
- More peer recovery access
- Youth substance groups
- Treatment for teens
- Working with law enforcement to allow people to get help and understand recovery
- Additional treatment programs in the county/region
- Low cost/no cost access to build community prevention efforts
- Mini grants available to help people get ahead (housing, legal)
- Hear stories at the places who use these services to better improve

Trauma

- Fear of disclosing trauma
- Lived experienced welcomed to the table
- Sequential Intercept Training (SIM)
- First responder education on trauma
- First responder trauma support
- CIT training for law enforcement
- Increased knowledge in how to handle trauma
- Free online resources for mental health, trauma, resilience, etc.
- Trauma education for the community
- Follow up care with those who face traumatic losses

Support System

- Teacher support group
- Teaching the teen brain
- Youth groups
- Support groups (not community leaders) that help community leaders
- Centralized support groups
- Volunteer time and resources
- After hours support
- Peer and school support groups
- Mentors for all issues
- Parent Cafes
- Provide health advocate mentors who are available to help patients navigate their health needs
- Mental health first aid training X2
- Area health education centers
- More opportunities for social interaction
- Fun social events at Dublin Community Club and Williamsburg Community Center
- Community builders
- Consistent meetings/spaces to provide education on serving local neighborhoods, meeting people where they are
- Wayne County Walking Club, get people moving in communities.
- Work with area employers through workshops and hotlines
- Partner and fund senior centers in Richmond, Cambridge City, Hagerstown, Centerville, Fountain City and others
- Education for teachers on helping students with trauma and mental health issues
- Financial education in schools
- Financial education
- Start educating, informing and supporting kids/youth at a younger age to help prevent challenges later in life once hardships occur

Mental Health Challenges

- Mental health care that is not only M-F 8am-5pm
- Expanded hours for mental health care or use of texting for mental health support
- Share out where the services are and who has programs addressing them
- More education on 988 and resources available
- More immediate access to quality mental health clinic support (less waitlists to see someone)
- Education on how to provide services to people refusing them
- Career pipeline for more providers
- Recruit mental health providers
- Need more mental health providers
- Free counseling
- Help for family members
- Help for the helpers
- More education for those working with youth and families

Other

- Help build Hagerstown trail
- Get out of silos and work together
- Provide free services or waive fees when possible
- Drop in emergency childcare
- Transportation, free car repairs and pay payments
- More affordable housing
- Urgent housing for families
- An empath unit with connections to Stride Center and Reid

What's missing? Tactics to explore

Wellness and Lifestyle (Nutrition and Obesity)

Education and Awareness

- Healthier options for sweets and moderation
- Resources such as application opportunities for mobile phones
- Nutrition education focused on not only healthy foods, but macro and micro nutrition
- Financial literacy/budgeting education and teaching families to make fitness and nutrition a part of the monthly budget
- Partner with youth serving organizations to meet more families
- Transportation options, all kinds such as bus, bike, car, etc.
- Monday Mash Ups (Collaborative education program at the Senior Center)
- Monday Mash Ups (Collaborative education program at the Senior Center)
- Campaigns for volunteerism
- Hold cooking classes for parents and kids at their schools
- Paid community wide facilitation of communication and partnership between social service providers and more staff dedicated to coalition building
- Meet community members where they are by attending events in neighborhoods
- Collocated existing programs brought onsite in middle, elementary and high schools to Ivy Tech, public housing, neighborhoods and apartment complexes
- Teen health councils at all high schools
- More social media education clips on the importance of getting outside
- Collaboration and programming, example: schools to educate children about nutrition, exercise and wellness

Food Access and Insecurity

- Ride shares to help with transportation to work, school, grocery and doctors appointments
- More coordination between food serving organizations
- Resource hub, advise somewhere neutral
- Effective public transportation system
- Loyalty card at market
- Sharing food purchases
- Bike rentals available, like in Indianapolis
- Financial education in communities
- Food education in neighborhoods
- Farmers market that changes locations each week
- Increased bus routes
- Public transportation on the weekends
- Take and make food bags with healthy options and substitutions

Physical Activity and Fitness Resources

- Partner with arts organizations to get people moving
- Monday Mash Ups (Collaborative education program at the Senior Center)
- Access to parks, which neighborhoods are closest/furthest to a part. Map to see if you can provide transportation to the farthest park
- Recreation grab bags with fun exercises and equipment
- Bike share program
- A community owned, centrally located recreational center. Pricing on a scale, scale bond of income, regular transportation, fitness classes, education classes and a pool
- Programs with multi-generational attendees
- Do programs at parks such as yoga
- Community walking club
- Provide fitness classes in park
- Work to create an app to access all Wayne County parks and recreation
- More blood pressure/wellness machines
- Community exercise classes at the park or senior center
- Dog walking club
- Fitness on the go
- Fitness at work locations
- Fitness at different locations
- Walking groups with free training
- Funding for more fitness classes such as chair yoga and walking clubs
- Pop up fitness classes in underserved areas
- Structured afterschool programs that get kids moving and not sitting around
- Bus access to parks
- Car share to access parks and trails

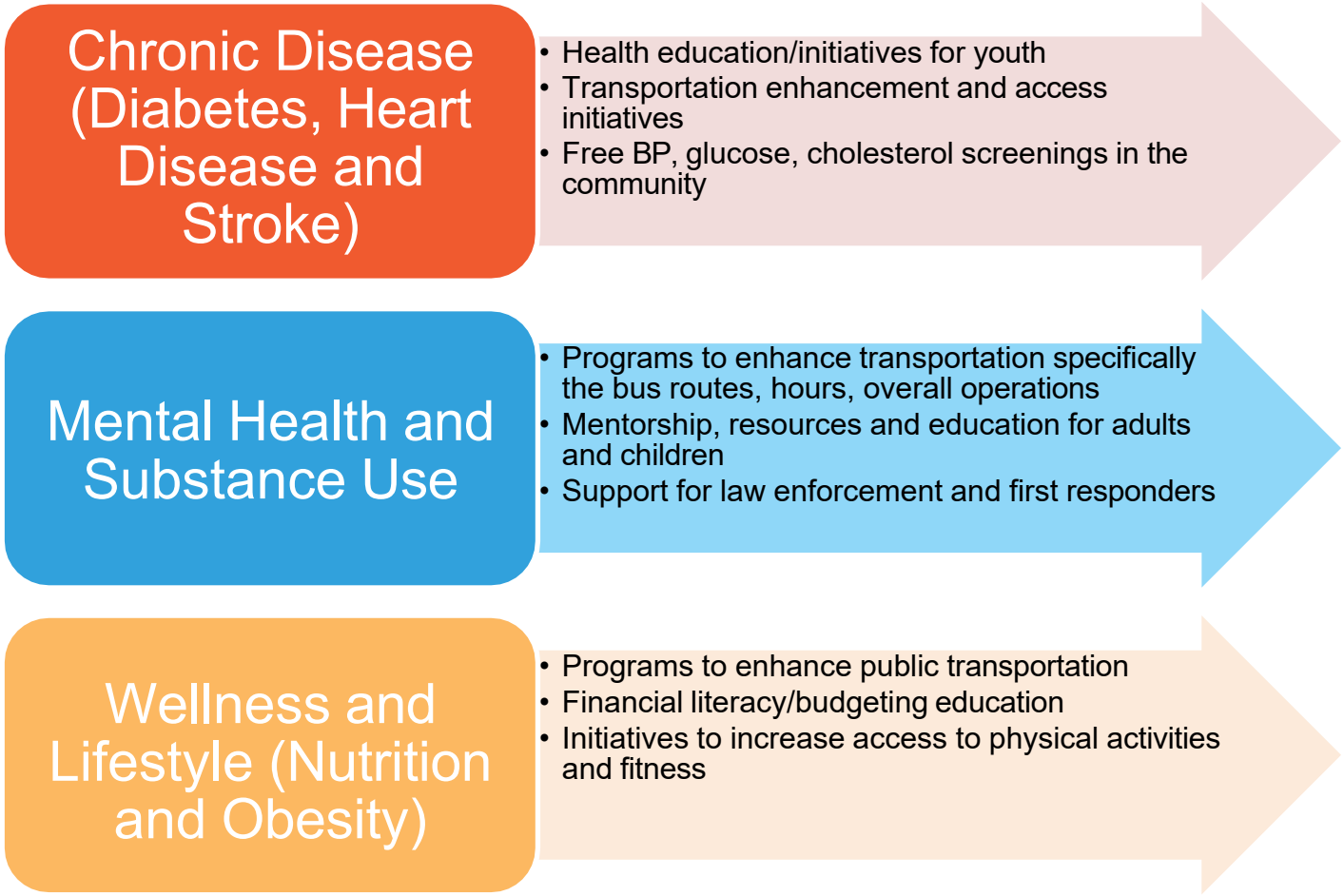
Nutrition and Health Concerns

- Fresh fruit and vegetables at gas stations/convenience stores
- Replace health snacks for kid programs
- Intentional education to patients who need help with health and wellness, examples including providing a wellness navigator or coach to help people get more healthy
- Fund recipe cards with local food pantries. Create recipes for the food they get that week.
- Education on how to store produce from farmers markets to last longer
- Mobile urgent cares/little clinics
- Replace junk food for kid programs with healthy snacks
- More fruits and less fish crackers
- Paid coordination, facilitation and staff for larger scale such as state/federal grants
- Host wellness challenges with incentives utilizing community partners
- Food is Medicine
- Education on sodium, it's already in food and we add excessive amounts more
- Cooking classes/contests
- Cooking education for one person household
- Cooking classes for and with family
- Cooking classes at farmers markets, or show a dish with a recipe
- Cooking classes in schools and at non-profits
- Healthy cooking classes at community partners to help with attendance

Other

- Mentors
- Connection hub with exercise partners, cooking partners, not online
- More partnerships together

Highest Impactful Tactics/Initiatives



Implementation Strategy Process

Step 5: Evaluate Input and Determine Implementation Strategy

The CHNA team of Reid Health then reviewed and evaluated the affinity groupings, valuations and tactics identified by the prioritization session participants. Armed with that input as well as the data synthesized data provided by the health needs assessment, the CHNA team of Reid Health then further prioritized the input by considering:

- the tactic/initiative's ability to address social determinants of health
- the number of indicators the program/activity would impact
- resources available
- ability to create sustained change
- ability to make a generational impact

After careful consideration, activities were then identified to include in the implementation strategy.

Implementation Strategy: Chronic Disease (Diabetes, Heart Disease and Stroke)

Overarching Goal: Reduce and prevent chronic disease and improve the overall health and well-being of the community by addressing social determinants of health through coordinated, community-centered strategies.

Objective 1: Increase access to health education and resources for chronic disease prevention and management

Strategy 1.1: Improve access to services and resources for chronic disease prevention and management; **Strategy 1.2:** Reduce education gaps by providing health education workshops and tablings in the community related to chronic disease

Activity	Economic Stability	Education Access and Quality	Health Care Access and Quality	Neighborhood and Built Environment	Social and Community Context	Process Measure	Internal and External Partner	Year 1	Year 2	Year 3
Collaborate with organizations leading resource guides to promote use and increase access*	X	X	X	X	X	Identified partners owning resource guide updates per County	Firefly Children and Family Alliance, Reid Health Community Engagement, Reid Health Community Health, external organizations	X	X	X
Continue community outreach initatives, such as Medical Monday, Thriving Thursday and Let's Talk Together*		X	X	X	X	Number of people served	Reid Health Community Health, Reid Health Community Engagement, Reid Health internal content experts	X	X	X
Continue to apply for grant funding that aligns with community health priorities*	X	X	X	X	X	Application volume Success rate	Director of Community Health and Engagement at Reid Health	X	X	X
Continue to provide programming that brings together health education and physical activity, targeting vulnerable populations and areas lacking resources						Number of participants % of participants with increased health knowledge at the end of programming Number of classes	Reid Health Community Health, content experts from various Reid Health departments, external organizations and non-profits	X	X	X
Create asset map of transportation offerings per county*	X	X	X	X	X	Establish baseline in year 1 and update plan accordingly for year 2 and year 3	Reid Health Community Engagement Manager, external partners involved with transportation	X		
Provide community health workshops/tablings, specific to diabetes, heart disease and stroke			X	X	X	Number of workshops Number of tablings Number of partners Number of people served	Reid Health Community Health, Reid Health Community Engagement, Tobacco Prevention and Cessation, internal content experts	X	X	X
Provide direct referrals and warm hand offs to schedule appointments for health insurance navigation	X		X			Number of individual referrals % of referrals that followed through with appointment	Reid Health Community Health, Reid Health Community Engagement, ClaimAid	X	X	X
Provide direct referrals and warm hand offs to schedule appointments for primary care providers			X		X	Number of individual referrals	Reid Health Community Health, Reid Health Community Engagement, area primary care providers	X	X	X
Provide education and resources upon request/need to area organizations and non-profits*			X		X	Number of organizations Number of resource packets/toolkits distributed Number of educational sessions provided Number of resource packets/toolkits distributed Number of education/resource requests received from organizations	Reid Health Community Health, Reid Health Community Engagement, Tobacco Prevention and Cessation	X	X	X
Provide free BP, glucose, and cholesterol screenings in the community and results for follow up			X		X	Number of screenings % of participants referred to a healthcare provider based on abnormal results % of participants who completed a follow-up appointment after referral	Reid Health Community Health	X	X	X

***represents activities that apply to more than one prioritized health need strategy**

Objective 2: Strengthen cross-sector collaboration to address chronic disease

Strategy 2.1: Build stronger partnerships to improve chronic disease

Activity	Economic Stability	Education Access and Quality	Health Care Access and Quality	Neighborhood and Built Environment	Social and Community Context	Process Measure	Internal and External Partner	Year 1	Year 2	Year 3
Continue attendance and participation in local collaboratives*	X		X	X	X	Number of partnerships Number of collaborative activities supported or co-hosted	Reid Health Community Engagement, Reid Health Community Health, other internal departments at Reid engaged in community meetings	X	X	X
Create and maintain a calendar of events and initiatives that can be shared externally and internally*			X		X	Monthly calendar updates	Reid Health Community Engagement, Reid Community Health	X	X	X
Host annual Diabetes education event			X	X	X	Number of partners in attendance Number of people served	Reid Health Diabetes Nutrition and Education, Reid Health Community Health, Reid Health Community Engagement, Reid Health Endocrinology, external area partners	X	X	X
Partner with local organizations and non-profits to provide health education on chronic disease			X		X	Number of partnerships Number of chronic disease education sessions delivered Number of educational materials distributed	Reid Community Health, Reid Health Community Engagement, Reid Behavioral Health, local organizations serving vulnerable populations	X	X	X
Provide funding for support coalitions, groups, activities, initiatives and events*	X	X	X	X	X	Percentage of funded initiatives that meet or exceed stated outcome	Reid Health Community Engagement, Reid Health Community Health, other internal departments at Reid Health, external non-profits and organizations	X	X	X
Support partner-led events by providing space, promotional assistance and staff support if needed			X		X	Number of events held at Reid Health locations by external organizations	Reid Health Community Engagement, Internal Events Committee of Reid Health	X	X	X

***represents activities that apply to more than one prioritized health need strategy**

Implementation Strategy: Mental Health and Substance Use

Overarching Goal: Promote mental, emotional, and behavioral well-being within the communities we serve by addressing social determinants of health and improving mental health outcomes, while reducing substance use through coordinated, community-driven efforts across stakeholders and non-profit partners.

Objective 1: Enhance community mental health and reduce substance use

Strategy 1.1: Improve access to services and resources for mental health and substance use**; Strategy 1.2:** Reduce stigma associated with mental health and substance use; **Strategy 1.3:** Reduce opioid-related overdoses in the community by improving access to prevention and treatment

Activity	Economic Stability	Education Access and Quality	Health Care Access and Quality	Neighborhood and Built Environment	Social and Community Context	Process Measure	Internal and External Partner	Year 1	Year 2	Year 3
Collaborate with organizations leading resource guides to promote use and increase access*	X	X	X	X	X	Identified partners owning resource guide updates per County	Firefly Children and Family Alliance, Reid Health Community Engagement, Reid Health Community Health, external organizations	X	X	X
Continue Challenge Days for 8th grade students		X			X	Number of students in attendance % of adult volunteers providing follow up	Challenge Day, Reid Health Community Engagement, Reid Health Community Health, external contract partners, area schools	X	X	X
Continue community outreach initatives, such as Medical Monday, Thriving Thursday and Let's Talk Together*		X	X	X	X	Number of people served	Reid Health Community Health, Reid Health Community Engagement, Reid Health internal content experts	X	X	X
Continue Dispose RX program			X	X		Number of kits provided	Reid Health Community Engagement, external non-profits and organizations	X	X	X
Continue providing Narcan to law enforcement and EMS agencies			X	X	X	Number of kits provided	Reid Health, law enforcement agencies, EMS agencies	X	X	X
Continue support of Overdose Awareness Day events and initatives			X	X	X	Number of people reached	External leading organizations, Reid Health Community Engagement, Reid Health Community Health	X	X	X
Continue support of Parent Cafes		X	X		X	Number of cafes Number of people reached	Birth to Five, Meridian Health Services, The Nest, Purdue Extension, Reid Health Community Engagement	X	X	X
Continue to apply for grant funding that aligns with community health priorities*	X	X	X	X	X	Application volume Success rate	Director of Community Health and Engagement at Reid Health	X	X	X
Create asset map of transportation offerings per county*	X	X	X	X	X	Establish baseline in year 1 and update plan accordingly for year 2 and year 3	Reid Health Community Engagement, external partners involved with transportation	X		
Create campaign to highlight real stories of people living in recovery			X		X	Number of stories Reach and engagement metrics	Community members, Reid Health Community Engagement, Reid Health Marketing		X	
Distribute educational resources on naloxone, including information on where and how to access it, and deliver community training sessions for vulnerable populations			X	X	X	Number of education sessions Number of people reached	Reid Health Community Engagement, Reid Health Trauma, Reid Health Community Health, Overdose Lifeline, external non-profits and organizations	X	X	X
Participate in health fairs and community outreach events to raise awareness and support tobacco education and cessation efforts			X	X	X	Number of Quit Now Enrollments Number of attended events Number of workshops hosted	Tobacco Control Coordinator of Reid Health, Reid Health Tobacco Prevention and Cessation, Reid Health Community Engagement, Reid Health Community Health, Indiana Depatment of Health, external non-profits and organizations	X	X	X
Partner with county coroners to provide education and support materials for staff and families			X		X	Number of support packets provided	The American Foundation for Suicide Prevention, Reid Health Community Engagement, local county coroner offices	X	X	X
Promote 988 services			X		X	Number of events/engagements where 988 was promoted Volume of 988 promotional materials distributed	988, American Foundation for Suicide Prevention, Reid Health Community Engagement, Reid Health Community Health, Reid Behavioral Health	X	X	X
Promote stigma reduction language			X		X	Number of community events/engagements where material is promoted Number of partners committed to using stigma-reducing language	Reid Health Community Engagement, Reid Health Marketing, Reid Behavioral Health	X	X	X
Provide funding for support coalitions, groups, activities, initiatives and events*	X	X	X	X	X	Percentage of funded initiatives that meet or exceed stated outcome	Reid Health Community Engagement, Reid Health Community Health, other internal departments at Reid Health, external non-profits and organizations	X	X	X

***represents activities that apply to more than one prioritized health need strategy**

Activity	Economic Stability	Education Access and Quality	Health Care Access and Quality	Neighborhood and Built Environment	Social and Community Context	Process Measure	Internal and External Partner	Year 1	Year 2	Year 3
Reid Health Community Grant Program	X	X	X	X	X	Number of grants provided % of grants that improve access to services % of projects achieving stated outcomes Number people who participated in physical activity Number of meals served Number of people who quit smoking Number of rides given to essential appointments/places	Reid Community Engagement, various eligible non-profits and organizations in Reid Health's service area	X	X	X
Support the coordination and leadership of local committees in partnership with the American Foundation for Suicide Prevention to deliver community education and outreach initiatives			X		X	Number of outreach events Number of collaborating partners Number of trainings provided from local committee	Reid Health Communtiy Engagement, Reid Behavioral Health, Reid Community Health, American Foundation for Suicide Prevention, several organizations that will be inventoried and listed at a later date	X	X	X
Objective 2: Strengthen cross-sector collaboration to improve access and outcomes										
Strategy 2.1: Build stronger partnerships to improve mental health and substance use										
Activity	**Economic Stability**	**Education Access and Quality**	**Health Care Access and Quality**	**Neighborhood and Built Environment**	**Social and Community Context**	**Process Measure**	**Internal and External Partner**	**Year 1**	**Year 2**	**Year 3**
Continue attendance and participation in local collaboratives*	X		X	X	X	Number of collaboratives	Reid Health Community Engagement, Reid Health Community Health, other internal departments at Reid engaged in community meetings	X	X	X
Create and maintain a calendar of events and initiatives that can be shared externally and internally*			X		X	Monthly calendar updates	Reid Health Community Engagement, Reid Community Health	X		
Lead the Wayne County Tobacco Prevention and Cessation Coalition			X		X	Number of partners engaged in the coalition	Tobacco Control Coordinator of Reid Health, Tobacco Prevention and Cessation	X	X	X
Partner with local organizations to provide health education on mental health and substance use			X		X	Number of partnerships Number of health education sessions delivered Number of educational materials distributed	Reid Community Health, Reid Health Community Engagement, Reid Behavioral Health, local organizations serving vulnerable populations	X	X	X
Support partner-led events by providing space, promotional assistance and staff support if needed*			X		X	Number of events held at Reid Health locations by external organizations	Reid Health Community Engagement, Internal Events Committee of Reid Health	X	X	X

***represents activities that apply to more than one prioritized health need strategy**

Implementation Strategy: Wellness and Lifestyle (Nutrition and Obesity)

Overarching Goal: Advance community well-being by addressing social determinants of health and ensuring equitable access to healthy living resources, while fostering collaborative partnerships that support sustainable lifestyle changes.

Objective 1: Increase opportunities for active living and access to nutritious food to reduce chronic health risks

Strategy 1.1: Improve access to food, services, and resources related to wellness and lifestyle; **Strategy 1.2:** Promote and support resources and programs that support physical activity and nutrition; **Strategy 1.3:** Reduce education gaps by providing health education workshops and tablings in the community related to nutrition and obesity

Activity	Economic Stability	Education Access and Quality	Health Care Access and Quality	Neighborhood and Built Environment	Social and Community Context	Process Measure	Internal and External Partner	Year 1	Year 2	Year 3
Collaborate with organizations leading resource guides to promote use and increase access*	X	X	X	X	X	Identified partners owning resource guide updates per County	Firefly Children and Family Alliance, Reid Health Community Engagement, Reid Health Community Health, external organizations	X	X	X
Continue community outreach initatives, such as Medical Monday, Thriving Thursday and Let's Talk Together*		X	X	X	X	Number of people served	Reid Health Community Health, Reid Health Community Engagement, Reid Health internal content experts	X	X	X
Continue partnerships with area parks departments and non-profits	X			X	X	As outlined in the specific plans according to activities funded	Reid Health Community Engagement, Reid Health Community Health, area parks departments	X	X	X
Continue the support of Farmers Markets and other match activities to increase access to nutritious food	X			X		SNAP dollars cashed out Number of SNAP vendors	Reid Health Community Engagement, Farmers Markets, Richmond Parks Department	X	X	X
Continue to apply for grant funding that aligns with community health priorities*	X	X	X	X	X	Application volume Success rate	Director of Community Health and Engagement at Reid Health	X	X	X
Create asset map of transportation offerings per county*	X	X	X	X	X	Establish baseline in year 1 and update plan accordingly for year 2 and year 3	Reid Health Community Engagement, external partners involved with transportation	X		
Provide community health workshops/tablings, specific to obesity and nutrition			X	X	X	Number of workshops Number of tablings Number of partners Number of people served	Reid Health Community Health, Reid Health Community Engagement, Tobacco Prevention and Cessation, internal content experts	X	X	X
Provide education and resources upon request/need to area organizations and non-profits*			X		X	Number of organizations	Reid Health Community Health, Reid Health Community Engagement, Tobacco Prevention and Cessation	X	X	X
Provide funding for support coalitions, groups, activities, initiatives and events*	X	X	X	X	X	Number of funded initiatives that meet or exceed stated outcome	Reid Health Community Engagement, Reid Health Community Health, other internal departments at Reid Health, external non-profits and organizations	X	X	X

Objective 2: Strengthen cross-sector collaboration to address wellness and lifestyle

Strategy 2.1: Build stronger partnerships to improve wellness and lifestyle

Activity	Economic Stability	Education Access and Quality	Health Care Access and Quality	Neighborhood and Built Environment	Social and Community Context	Process Measure	Internal and External Partner	Year 1	Year 2	Year 3
Continue attendance and participation in local collaboratives*	X		X	X	X	Number of collaboratives	Reid Health Community Engagement, Reid Health Community Health, other internal departments at Reid engaged in community meetings	X	X	X
Create and maintain a calendar of events and initiatives that can be shared externally and internally*			X		X	Monthly calendar updates	Reid Health Community Engagement, Reid Community Health	X	X	X
Partner with local organizations and non-profits to provide health education on nutrition and obesity			X	X	X	Number of partnerships Number of nutrition and obesity education sessions delivered Number of educational materials distributed	Reid Community Health, Reid Health Community Engagement, Reid Behavioral Health, local organizations serving vulnerable populations	X	X	X
Provide support to local organizations for health education on wellness and lifestyle, to include budgeting and financial literacy	X		X		X	Number of partnerships Number of health education sessions delivered	Reid Community Health, Reid Health Community Engagement, Reid Behavioral Health, local organizations serving vulnerable populations	X	X	X
Support partner-led events by providing space, promotional assistance and staff support if needed*			X		X	Number of events held at Reid Health locations by external organizations	Reid Health Community Engagement, Internal Events Committee of Reid Health	X	X	X

***represents activities that apply to more than one prioritized health need strategy**

Significant Health Needs Not Addressed

Health Care Access and Quality

While Health Care Access and Quality is not a prioritized health need for Reid Health, we will continue to address this area by the implementing the cross-cutting prioritized health need of social determinants of health. Additionally, Reid Health will continue to support ongoing initiatives related to access to care which include the following:

- Insurance enrollment services
- Charity care
- Financial assistance
- Transition Coaching program
- Support of lab processing for free clinics
- Athletic training services
- The Residency Program
- Community health screenings
- Reid Community Grant program
- Reid AED Grant program
- Community requests as needs arise

Maternal and Infant Health

While this implementation strategy will not include a focused effort on maternal and infant health in the communities served, Reid Health will continue to support the ongoing initiatives related to maternal and infant health as a community health need, which will include the following:

- Baby Care Basics
- Car Seat program
- Childbirth classes
- Community baby showers
- Hope Center
- Indiana Youth Institute initiatives and collaborative work
- Jacy House support
- Lactation outreach and breastfeeding classes
- Parent Cafes
- Perinatal services
- Prevent child abuse initiatives
- Programs targeting family resiliency
- Safe Sleep education
- Reid Community Grant program
- Community requests as needs arise

Oral Health

This implementation strategy will not include a focused effort on oral health in the communities served. Reid Health will support ongoing initiatives related to oral health which include the following:

- Collaborate with resource managers to keep dental provider lists current
- Include oral health in community outreach with provider info and supplies (toothbrushes, toothpaste, floss)
- Partner with local organizations to integrate oral health education into existing platforms
- Promote oral health education
- Support partners in promoting oral health services

Strategy Adoption

Step 6: Strategy Approval and Implementation

Upon completion of the implementation strategy, the Community Well-Being Committee of Reid Health reviewed and approved the strategy in January of 2026. The strategy was then presented to the Reid Governing Board and adopted as the strategy for the next three years in January of 2026.

The implementation strategy will serve as the guide for Reid Health to follow to improve the prioritized health needs of the population it serves. Progress toward the goals within the strategy will be shared with the Community Well-Being Committee of Reid Health on a quarterly basis and reviewed by the Reid Governing Board annually.