NOLAND HEALTH SERVICES, INC.

Community Health Needs Assessment

MAY 2025

Implementation Strategy

Noland Hospital Anniston

Implementation Strategy

Noland Health Services (Noland) will engage key community partners in implementing evidence-based strategies across the service areas. Acknowledging the many organizations and resources in place to address the health needs of our communities, Noland Health Services has strategically reviewed both internal and external resources. This portion of the CHNA, the Implementation Strategy, will explain how Noland Health Services will address health needs identified in the CHNA by continuing existing programs and services, and by implementing new strategies. It will reflect on the previous CHNA and evaluate impact and progress of previous set strategies. In addition, the implementation plan will explain why the hospitals cannot address all the needs identified in the CHNA and, if applicable, how Noland Health Services will support other organizations in doing so.

Health Priorities

As previously mentioned in the CHNA report, the needs Noland Health Services has chosen to address are outlined in each hospital's section of the CHNA and in the following implementation plan. It will also outline why we chose to address this need, how we will address the need, who the responsible party will be, and the time frame for achieving those strategies.

Prioritization was developed and presented to Noland Hospital Administrators and other hospital division leadership. Criteria used included importance to the service area (adult residents with long-term acute needs), relevance of the health issues to the population served, and the ability of Noland to effectively impact and improve the health issue.

The following four categories were identified as priorities of issues to be addressed. Issues in these categories were brought up numerous times and serve as a framework for each facility's implementation strategies.

#1. Chronic Disease / Cardiovascular Disease and Heart Failure: Chronic disease is a prioritized health need because its prevalence is prominent in the Anniston market. The poor physical health practices of individuals have accelerated the development of certain illnesses. Chronic conditions impacting this population include obesity, high blood pressure, diabetes, depression, heart disease, and cancer. Limited access to healthy food, poor lifestyle choices, mental health, and lack of exercise all contribute to the ongoing community health issues seen. Noland Health Services seeks to align initiatives around Chronic Disease with the community health prioritize identified by the state of Alabama to maximize impact and align resources.

#2. Financial Barriers / Insurance & Cost Barriers: Financial barriers and insurance play a significant role in the Anniston market resident's ability to access healthcare. Although medical services may be available throughout the county, high unemployment, lower incomes, and a lack of insurance may prohibit people from accessing or using these resources. People who have a low or fixed income are more vulnerable to competing financial priorities. These barriers must be addressed as county and hospital resources are expended to meet the community need.

#3. Access to Healthcare / Transportation: Providing better access points to healthcare in this community is vital to enhancing the quality of life for the Anniston service area citizens. The resources that the community and Noland Health Services provide can have a significant impact on population health outcomes. If more resources are available in the community, the social and physical environments within the community will help to promote good health for all. For the Anniston market, the promotion of health education, increased provider access, and insurance literacy will help to improve the overall health of the community.

#4. Preventable Hospital Stays: Preventable hospital stays are a prioritized health need because they often reflect gaps in access to timely, quality outpatient care and chronic disease management. In the Anniston market, high rates of preventable hospitalizations show challenges related to primary care access, patient education, and follow-up care. Contributing factors may include limited transportation, health literacy, and financial barriers, which prevent individuals from seeking early intervention or routine care. Noland Health Services aims to reduce preventable hospital stays by promoting care coordination, increasing access to primary and preventive services, and supporting community-based health initiatives that keep individuals well-managed outside of the hospital settings.

Each of the community health needs identified above are interconnected. For instance, lack of knowledge of resources could lead to an access issue which in turn leads to a lack of prevention or screening and ultimately one of the major issues impacting the elderly.

As required by proposed IRS regulations, each of the following individual facilities of Noland Health created their own implementation strategies:

- Noland Hospital Anniston
- Noland Hospital Birmingham
- Noland Hospital Dothan
- Noland Hospital Tuscaloosa

The implementation strategies were developed for these priority areas by hospital. Each hospital did not address every area, but rather selected those areas of priority that it deemed it could have the greatest impact.

Each facility filled out the following table for each priority area they would address.

2025 Community Health Needs Implementation Plan

Health Need:	
Objective:	

	Description of Strategy & Tactic	Owner (Role)	Collaborating Organizations (Optional)	Committed Resources	Estimated Timeline
Strategy:					
Tactic:					
Tactic:					
Tactic:					
Strategy:					
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Tactic:					

Those areas not addressed were included in a section “Needs Not Addressed”. Most common reasons for not addressing a need were lack of resources, other local organizations already addressing the need, and needs falling outside the general scope of an LTACH facility.

Noland Hospital Anniston - Implementation Strategies

In the previous Community Health Needs Assessment conducted in 2022, Noland Hospital Anniston chose 5 areas to address in their implementation strategies. Many of these strategies are ongoing in alignment with the 2025 strategies.

#1 HEALTH COMMUNICATION – Implementation Strategy

Noland Facility:	**Anniston 2022**		
Specific Needs Identified in the CHNA:	**Health Communication**		
Goals:	Increase education in community in areas of services/resources available, and wellness		
Strategy: Educate and increase awareness of available community resources.			
Action Step	**Accountability**	**Timeline**	**Desired Outcome**
Partner with local agencies - local health department, United Way and/or a local income based medical clinic to maintain current information on patient resources.	Hospital	FY2023	Improve patient awareness of resources.
Partner with post acute providers in the community to provide continuing education related to available community resources such as medication and	Hospital	FY2023	Improve patient awareness of resources.
Strategy: Educate and increase awareness of Chronic Disease Management			
Action Step	**Accountability**	**Timeline**	**Desired Outcome**
Participate in Health Fairs and other community education opportunities to educate on importance of health screening and disease management.	Hospital	FY2023	Improved community health.
Increase focus on disease mangement education during hospitalization and at discharge	Hospital	FY2023	Improved community health.
Strategy: Educate and increase awareness of Care Navigation Resources			
Action Step	**Accountability**	**Timeline**	**Desired Outcome**
Participate with other local hospital Transition of Care team on a weekly basis to discuss patient discharge plans	Hospital	FY2023	Improved awareness of Care Navigation Resources
Educate case managers and discharge planners at other facilities on Care Navigation Resources	Hospital	FY2023	Improved awareness of Care Navigation Resources

Ongoing

Ongoing

Ongoing

#2 HEALTH CARE ACCESS – Implementation Strategy

Noland Facility:	**Anniston 2022**		
Specific Needs Identified in the CHNA:	**Health Care Access**		
Goals/Strategy	Increase access to community resources for elderly population and LTACH patients and families		
Strategy: Educate and share resources for Financial Assistance.			
Action Step	**Accountability**	**Timeline**	**Desired Outcome**
Partner with post acute care providers that have financial assistance programs available	Hospital	FY2023	Improved patient access to resources
Educate patients and family members on local financial assistance programs	Hospital	FY2023	Improved patient access to resources
Strategy: Communicate and share resources for transportation assistance			
Action Step	**Accountability**	**Timeline**	**Desired Outcome**
Provide education to patient and caregiver related to applicable community resources such as transportation	Hospital	FY2023	Improved disease management
Strategy: Communicate and share resources for uninsured / underinsured assistance			
Action Step	**Accountability**	**Timeline**	**Desired Outcome**
Partner with local resources, such as St. Michael's Medical Clinic, to provide education to our patient population on available assistance	Hospital	FY2023	Improved access to services

Ongoing

Ongoing

Ongoing

#3 PREVENTATIVE CARE – Implementation Strategy

Noland Facility:	**Anniston 2022**		
Specific Needs Identified in the CHNA:	**Preventative Care**		
Goals:	Increase knowledge of patients and family related to wellness and disease prevention.		
Strategy: Increase education to patients and families on available resources.			
Action Step	**Accountability**	**Timeline**	**Desired Outcome**
Provide current information to patients and families prior to or at discharge r/t community resources and programs.	Hospital	FY2023	Increase awareness of available resources.
Partner with host hospital and local transition of care coalition to continue patient education on importance of utilization of available resources	Hospital	FY2023	Increase utilization of available resources.
Strategy: Increase education to patients and families impact of Non-compliance			
Action Step	**Accountability**	**Timeline**	**Desired Outcome**
Partner with host hospital to continue patient education on importance of follow up care	Hospital	FY2023	Improved patient compliance
Pharmacy provides medication education prior to discharge on any patient discharged to a community	Hospital	FY2023	Improved patient compliance

Ongoing

Ongoing

#4 HEALTH ISSUES OF OLDER ADULTS – Implementation Strategy

Noland Facility:	**Anniston 2022**		
Specific Needs Identified in the CHNA:	**Health Issues of Older Adults**		
Goals:	Increase awareness of the benefits of a healthy lifestyle and management of chronic diseases.		
Strategy: Increase community education on importance of managing Diabetes.			
Action Step	**Accountability**	**Timeline**	**Desired Outcome**
Provide disease specific education to patients and caregivers during patient stay and at discharge	Hospital	FY2023	Improve management of Diabetes.
Partner with post acute care providers in the community to continue disease specific education after discharge	Hospital	FY2023	Improve management of Diabetes.
Strategy: Increase community education on importance of managing CHF.			
Action Step	**Accountability**	**Timeline**	**Desired Outcome**
Provide disease specific education to patients and caregivers during patient stay and at discharge	Hospital	FY2023	Improve management of CHF.

Ongoing

Ongoing

#5 MENTAL HEALTH AND MENTAL DISORDERS OF OLDER ADULTS – Implementation Strategy

Noland Facility:	**Anniston 2022**		
Specific Needs Identified in the CHNA:	**Mental Health and Mental Disorders of Older Adults**		
Goals:	Increase awareness of importance of disease management and family support.		
Strategy: Increase patient and family knowledge related to management of mental illnesses and disorders.			
Action Step	**Accountability**	**Timeline**	**Desired Outcome**
Provide disease specific education to patients and caregivers during patient stay and at discharge	Hospital	FY2023	Improve management of mental health
Partner with Post-Acute Care providers in the community to continue disease specific education after discharge	Hospital	FY2023	Improve management of mental health
Strategy: Increase access for family / caregiver support for patients			
Action Step	**Accountability**	**Timeline**	**Desired Outcome**
Provide disease specific education to patients and caregivers during patient stay and at discharge	Hospital	FY2023	Improve management of mental health

Ongoing

Ongoing

Noland Hospital Anniston - 2025 Implementation Strategies

Noland Hospital Anniston chose 4 areas to address in their implementation strategies. Below is a description of needs and strategies and action steps associated with each.

#1 Chronic Disease / Cardiovascular Disease and Heart Failure

Health Need:	Chronic Disease - Cardiovascular Disease and Heart Failure
Objective:	Improve the community's knowledge of health services and disease management

	Description of Strategy & Tactic	Owner (Role)	Collaborating Organizations (Optional)	Committed Resources	Estimated Timeline
Strategy:	Increase knowledge of patients and families on wellness and disease management				
Tactic:	Educate during the discharge planning conferences with family and patient about available health resources	Case Manager		Personnel, education pamphlets and materials	FY28
Tactic:	Increase focus on disease management education during hospitalization and discharge planning	Case Manager, Nurses, Physicians		Personnel, education pamphlets and materials	FY28
Tactic:	Provide pharmacist education related to medication compliance and disease management	Pharmacist		Personnel, education pamphlets and materials	FY28

Strategy:	Increase knowledge of community on wellness and disease management				
Tactic:	Participate in local health fairs	Leadership Team		Personnel and education material	FY 28
Tactic:	Seek community venues to educate people about how to apply for health benefits	Leadership Team		Personnel and education material	FY 28

#2 Financial Barriers / Insurance & Cost Barriers

Health Need:	Financial (Insurance & Cost Barriers)
Objective:	Improve community's access to current health resources

	Description of Strategy & Tactic	Owner (Role)	Collaborating Organizations (Optional)	Committed Resources	Estimated Timeline
Strategy:	Educate and share resources for healthcare financial assistance				
Tactic:	Participate with the Area Agency on Aging of East Alabama	Administrator and Case Manager		Personnel	FY28
Tactic:	National Healthcareer Association Pharmacist to seek opportunities to provide information at the point of discharge related to local resources that may reduce drug cost	Director of Pharmacy		Personnel	FY28
Tactic:	Provide discharge information to patients on their local durable medical equipment companies and contact information	Case Manager		Personnel and education material, pamphlets, etc.	FY28

Strategy:	Educate patients where LTAC fits into the continuum of care				
Tactic:	Provide education to families, patients and providers regarding the appropriateness of admission to LTAC, the benefits of LTAC, and the various other options available to provide optimum outcomes	Clinical Liaison, Case Manager		Personnel and education material, pamphlets, etc.	FY28

Strategy:	Collaborate and share resources to educate community on opportunities for financial assistance				
Tactic:	Share the Financial Assistance Policy as appropriate	Case Manager, Administrator			FY28
Tactic:	Partner with post-acute care providers that have financial assistance programs.	Case Manager, Administrator			FY28

#3 Access to Healthcare / Transportation

Health Need:	Access to Care - Transportation
Objective:	Educate Patients and Families regard services that are provided in the community

	Description of Strategy & Tactic	Owner (Role)	Collaborating Organizations (Optional)	Committed Resources	Estimated Timeline
Strategy:	Educate families on community transportation resources				
Tactic:	Educate families and discharge planners at other hospitals regarding the appropriate level of care	Clinical Liaison and Case Manager		Educational material, pamphlets, etc.	FY28
Tactic:	Partner with the local health department and United Way to maintain current information on patient resources	Administrator		Personnel and educational material, pamphlets, etc.	FY28
Tactic:	Increase family participation in interdisciplinary team rounds	Case Manager, Physician			FY28

Strategy:	Increase resources and support for disabled and elderly in the community				
Tactic:	Educate patients and families regarding community resources for disabled and elderly	Staff and Physicians		Personnel and educational material, pamphlets, etc.	FY28
Tactic:	Work with the Alabama Department of Veteran Affairs to provide education and access to services	Liaisons and Case Manager		Personnel and educational material, pamphlets, etc.	FY28

#4 Preventable Hospital Stays

Health Need:	Preventable Hospital Stays
Objective:	Educate and increase awareness of disease management and available resources

	Description of Strategy & Tactic	Owner (Role)	Collaborating Organizations (Optional)	Committed Resources	Estimated Timeline
Strategy:	Create community awareness on the importance of preventative healthcare				
Tactic:	Educate patients and families regarding the availability of post-discharge services during the interdisciplinary team meeting	Case Manager		Educational material, pamphlets, etc.	FY28
Tactic:	Seek community venues to educate people about how to apply for health benefits	Case Manager, Clinical Liaison, Administrator		Personnel	FY28
Tactic:	Educate families on the care and treatment of patient at home post discharge	Case Manager, Nurses, Respiratory Therapist, Physical Therapies, Occupational Therapist		Personnel and educational material, pamphlets, etc.	FY28
Tactic:	Develop a list of support groups and agencies as a resource to patients and families to distribute during the discharge process	Case Manger		Educational material, pamphlets, etc.	FY28

Strategy:	Educate community and care providers on the use of LTAC to prevent hospital readmissions				
Tactic:	Provide in services for case managers to educate on LTAC services	Clinical Liaisons, Administrator		Personnel and Education material, pamphlets, etc.	FY28
Tactic:	Educate physicians and other healthcare providers on LTAC services and prevention of hospital readmissions	Case Manager, Administrator		Personnel and Education material, pamphlets, etc.	FY28

Noland Health- Board Approval

Treasury Regulation Section 1-501(r)-3(c)(5)(i):

For purposes of paragraph (a)(2) of this section, an authorized body of the hospital facility must adopt the implementation strategy on or before the 15th day of the fifth month after the end of the taxable year in which the hospital facility completes the final step for the CHNA described in paragraph (b)(1) of this section, regardless of whether the hospital facility began working on the CHNA in a prior taxable year.

Noland Health's Board of Directors approves the Implementation Strategy for addressing priorities identified in the most recent Community Health Needs Assessment completed FYE June 30, 2025. This report was approved by the Noland Health Board of Directors at its meeting held on May 14, 2025.