Community Health Needs Assessment

Community Health Network

2018

RICHARD M. FAIRBANKS SCHOOL OF PUBLIC HEALTH Indianapolis

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Howard Region

CONTRIBUTORS

Community Health Network strives to improve the health and well-being of the communities it serves. To fulfill this mission and meet federal requirements to complete a community health needs assessment (CHNA) every three years, Community Health Network partnered with The Polis Center at IUPUI (Polis) and the Richard M. Fairbanks School of Public Health (FSPH) to conduct its 2018 Community Health Needs Assessment.

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WITH SUPPORT FROM SAVI

A program of The Polis Center at IUPUI, SAVI is one of the nation's first and largest community information systems. SAVI empowers nonprofits, governments, and citizens with the community information they need by bringing together numerous data sources to power SAVI tools and research. Communities use this information to plan, secure, and target resources as well as to advocate on the behalf of vulnerable populations.

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Contents

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Organization of the Report

This CHNA report contains the following sections:

1. **Community Definition**
2. **Community Demographics and Socioeconomic Characteristics**
3. **Process, Methods, and Data Sources**
4. **Data Analysis (Primary and Secondary)**

The Appendices include information on individuals and organizations that provided community input, resources available to meet identified community health needs, and an evaluation of the impact of community health programs implemented by **Community Howard Regional Health** since its last CHNA was conducted.

INTRODUCTION

Community Howard Regional Health admitted its first patients in 1961. It was originally known as Howard Community Hospital, and opened following nearly a decade of planning and community fundraising. The hospital joined Community Health Network (CHNw) in 2012. CHNw is Central Indiana's leader in providing convenient access to exceptional healthcare services, when and where patients' need them. This includes providing services and support in hospitals, health pavilions and doctors' offices, or within workplaces, schools, and homes. As a non-profit health system with more than 200 affiliated sites throughout Central Indiana, CHNw's full continuum of care integrates hundreds of physicians, specialty and acute care hospitals, surgery centers, home care services, MedChecks, behavioral health, and employer health services.

THE COMMUNITY SERVED BY COMMUNITY HOWARD REGIONAL HEALTH

For purposes of this CHNA, CHNw defined the community served by Community Howard Regional Health (the **Howard Region**) to include ZIP codes 46901, 46902, 46936, 46979. Figure 1 depicts the Howard Region in green. Historically, these ZIP codes have accounted for over 75 percent of Community Howard Regional Health's inpatient admissions.

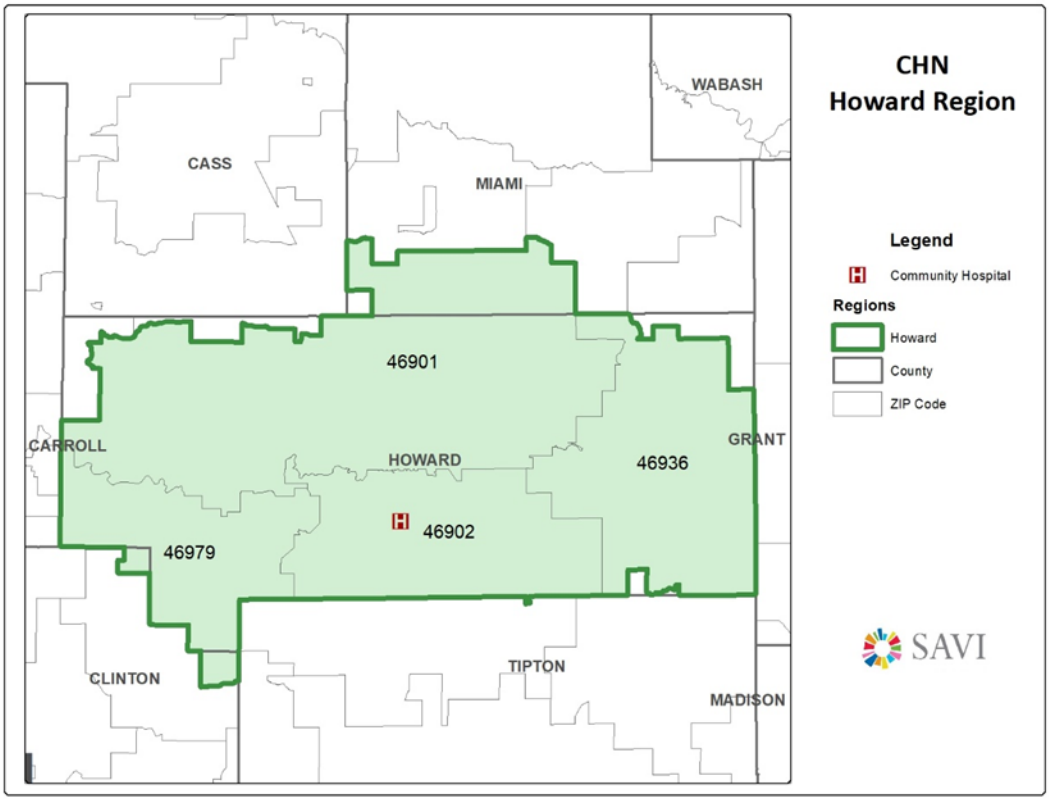
Community Health Network's primary service area encompasses 11 counties in Central Indiana, including Boone, Hamilton, Hancock, Hendricks, Howard, Johnson, Madison, Marion, Morgan, Shelby, and Tipton. This service area has a population of 3.3 million, which is forecast to grow 3% by 2023.

COMMUNITY HOWARD REGIONAL HEALTH AT-A-GLANCE

Admissions:	4,864
Emergency room visits:	26,864
Babies born:	383
Surgeries (at hospital, inpatient and outpatient):	3,291

2017 annual statistics

Figure 1: Community Served by Community Howard Regional Health



The Howard Region consists largely of Howard County, Indiana.

DEMOGRAPHICS

Population Size

The Howard Region had a population of over 86,000 based on 2012-2016 five-year US Census estimates (Table 1). Its population was the smallest in size of all the CHNw regions. Howard County, which makes up a large portion of the Howard Region (see Figure 1), experienced a slight decline in population (0.5%) between 2010 and 2017 (Table 2).

Table 1. Population

	Anderson	East	Howard	North	South	Indy MSA	IN
Population	99,659	252,099	**86,536**	519,611	371,888	1,968,768	6,589,578

Source: US Census Bureau (American Community Survey 2012-2016 Five-year Estimates)

Table 2. Population Change in CHNw Counties

	Madison	Hancock	Howard	Hamilton	Morgan	Johnson	Marion
Population, 2017	129,498	74,985	**82,363**	323,747	69,713	153,897	950,082
Population, 2010	131,636	70,002	**82,752**	274,569	68,894	139,654	903,390
% Change	-1.6%	7.1%	**-0.5%**	17.9%	1.2%	10.2%	5.2%

Source: Stats Indiana

The projected rate of change for the population in these counties from 2018 to 2023 is shown in Table 2a. The population projected rate3 of change for Howard Region by age is shown in Table 2b.

Table 2a. County Population Trend in Five Years

County	2018	2023	%Chg.
Hamilton County	315,326	337,036	6.9%
Hancock County	81,288	85,425	5.1%
Howard County	83,863	84,279	0.5%
Johnson County	161,057	169,294	5.1%
Madison County	128,928	128,601	-0.3%
Marion County	979,046	1,007,236	2.9%

Source: Claritas

Table 2b. Howard Region Population Trend in Five Years

Age	2018	2023	%Chg.
00-04	5,011	4,999	-0.2%
5-17	13,699	13,354	-2.5%
18-64	48,772	47,597	-2.4%
65+	16,381	18,329	11.9%

Source: Claritas

Age

The median age in the Howard Region was 41.5 (Table 3). This was greater than both the median age for Indianapolis and the median age across the State of Indiana. Compared to the other CHNw regions, the Howard Region had the highest median age.

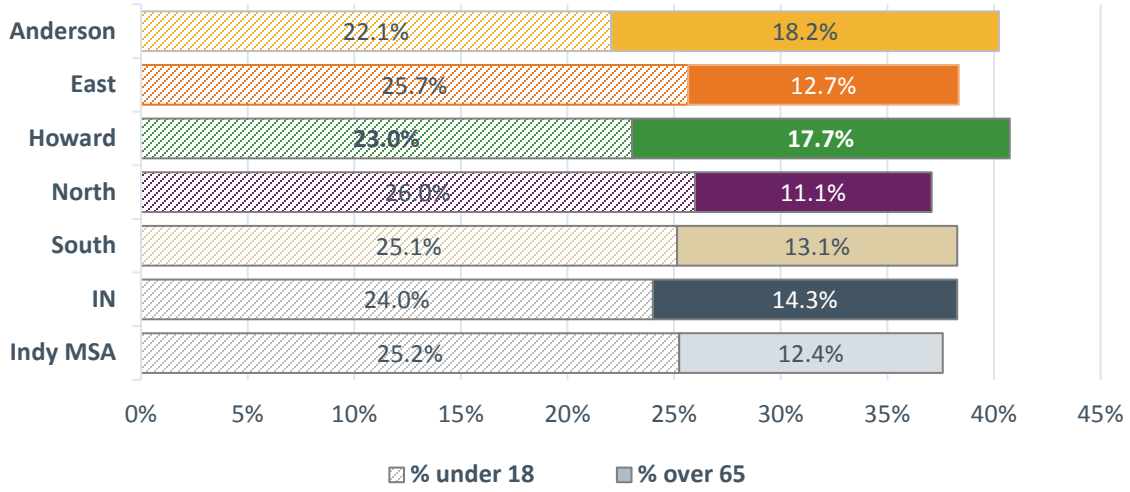
Table 3: Median Age

	Anderson	East	Howard	North	South	Indy MSA	IN
Median Age	40.6	36.7	**41.5**	36.1	36.8	36.1	37.4

Source: US Census Bureau (American Community Survey 2012-2016 Five-year Estimates)

Different age groups require different levels and types of care. Among CHNw regions, Howard Region had the second lowest percentage of population under 18 years old, following the Anderson Region. In contrast, it had the second highest percentage of population over 65 years old (Figure 2).

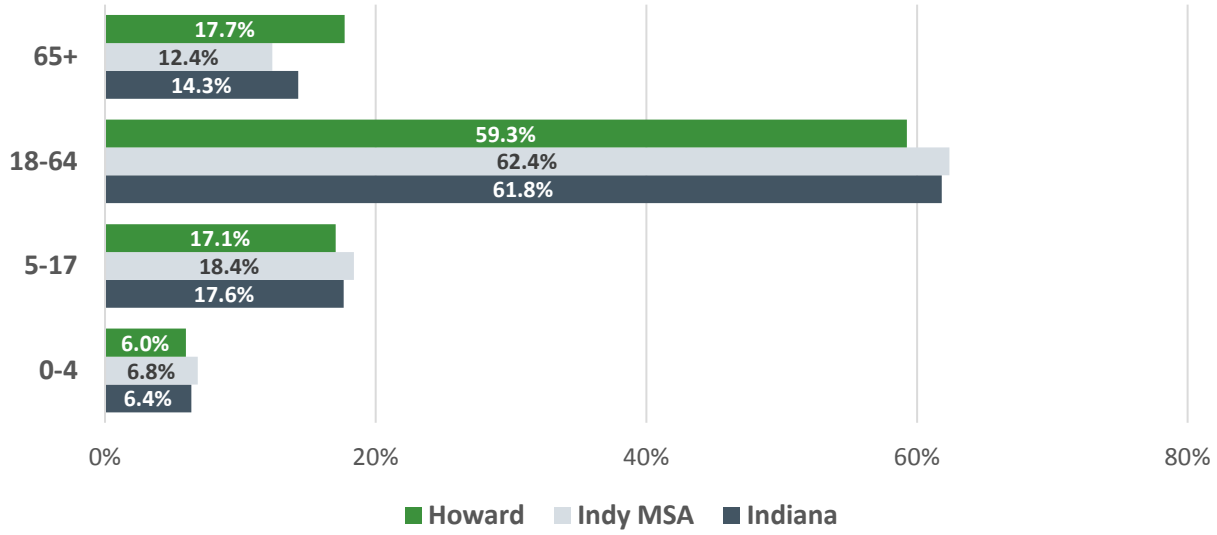
Figure 2: Children and Seniors



Source: US Census Bureau (American Community Survey 2012-2016 Five-year Estimates)

As shown in Figure 3, the Howard Region had a slightly different age distribution than the Indianapolis Metropolitan Statistical Area (MSA) and Indiana, including a higher percentage of 65+.

Figure 3: Population by Age Group

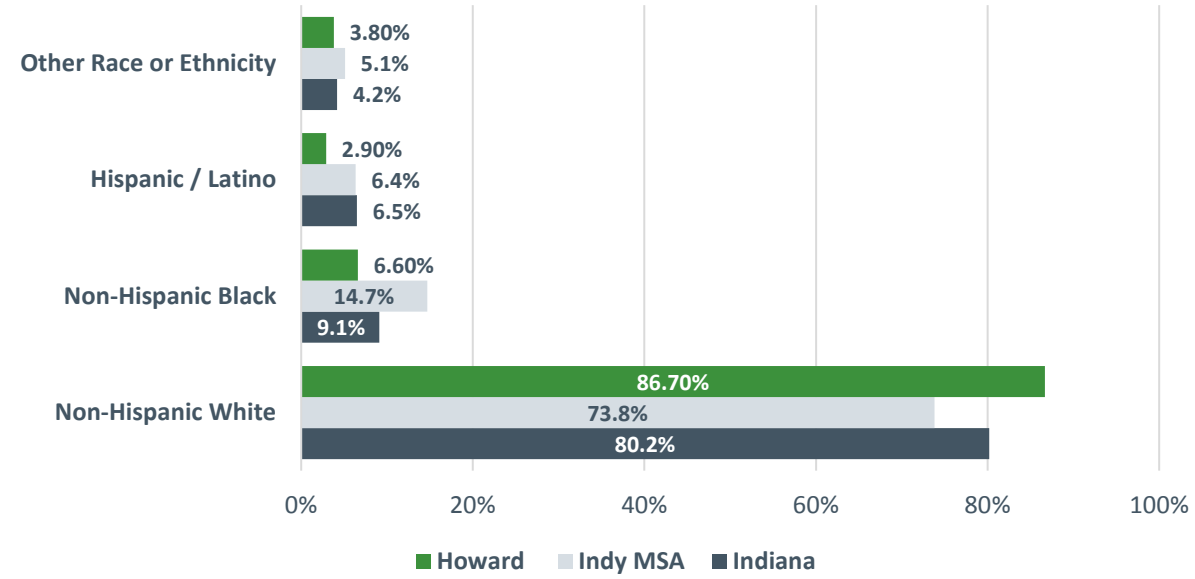


Source: US Census Bureau (American Community Survey 2012-2016 Five-year Estimates)

Race and Ethnicity

The Howard Region was 86.7% White, 6.6% Non-Hispanic Black, 2.9% Hispanic/Latino, and 3.8% Other Race or Ethnicity. In general, the Howard Region was less diverse than the population of Indianapolis or the State of Indiana (Figure 4).

Figure 4: Race and Ethnicity



Source: US Census Bureau (American Community Survey 2012-2016 Five-year Estimates)

Projections

The demographic data include projections and other information provided to CHNw by SG2 and Claritas. Statistics for the Howard Region have been compared to those for the 11-County region served by one or more CHNw hospital facilities.

The total population of the Howard Region is anticipated to grow 0.5 percent between 2018 and 2023. By far, the population cohort aged 65 years and older is expected to grow the fastest (11.9 percent).

SOCIAL DETERMINANTS OF HEALTH

Social determinants of health are conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. The five key determinants include economic stability (e.g., employment, food insecurity, housing instability, and poverty), education (e.g., literacy, high school graduation), social and community context (e.g., discrimination and incarceration), health and health care (e.g., access to primary care and health literacy); and neighborhood and built environment (e.g., access to healthy food, crime and violence). The following section provides data surrounding social determinants in the East region.

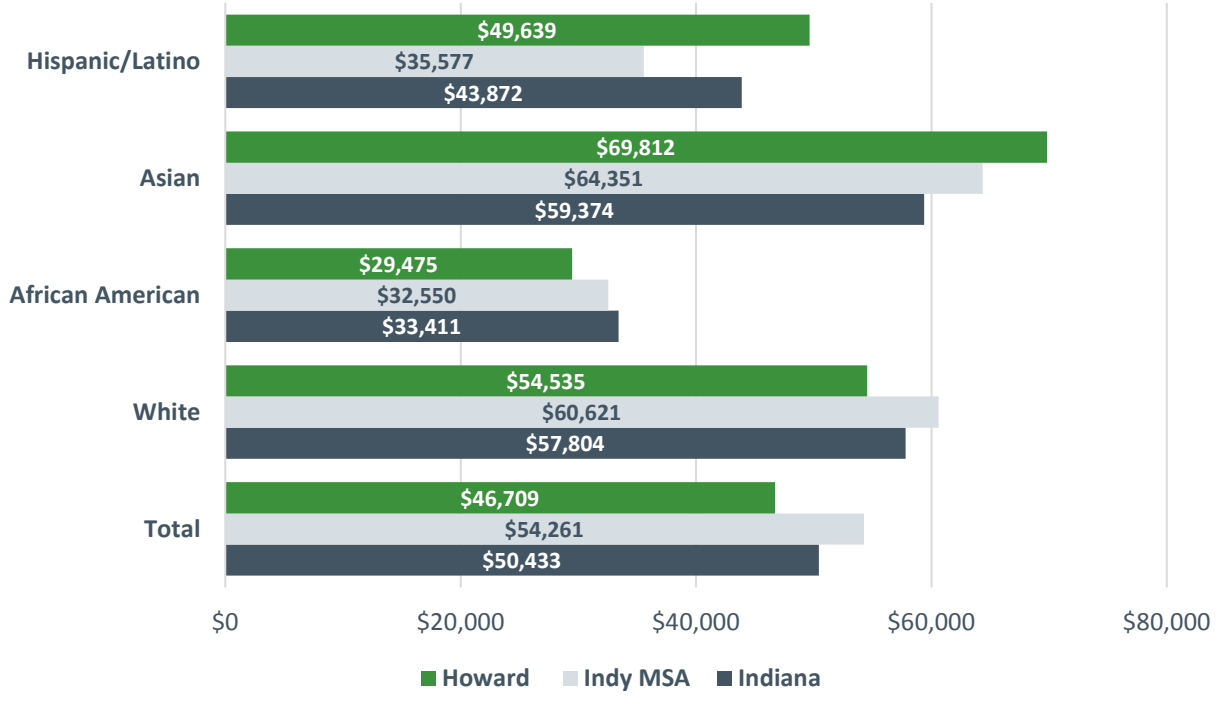
SOCIOECONOMIC STATUS

Socioeconomic status, often measured by income level, employment status, and level of education, is an important social determinant of health.

Median Household Income

The Howard Region had a lower median household income than the State and the Indianapolis MSA. Howard Region fell in the middle of the CHNw regions in terms of its median household income. Similar to the MSA and the State, economic disparities exist in the Howard Region, with African American and Hispanic/Latino populations generally making less than the White and Asian populations (Figure 5).

Figure 5: Median Household Income by Race/Ethnicity

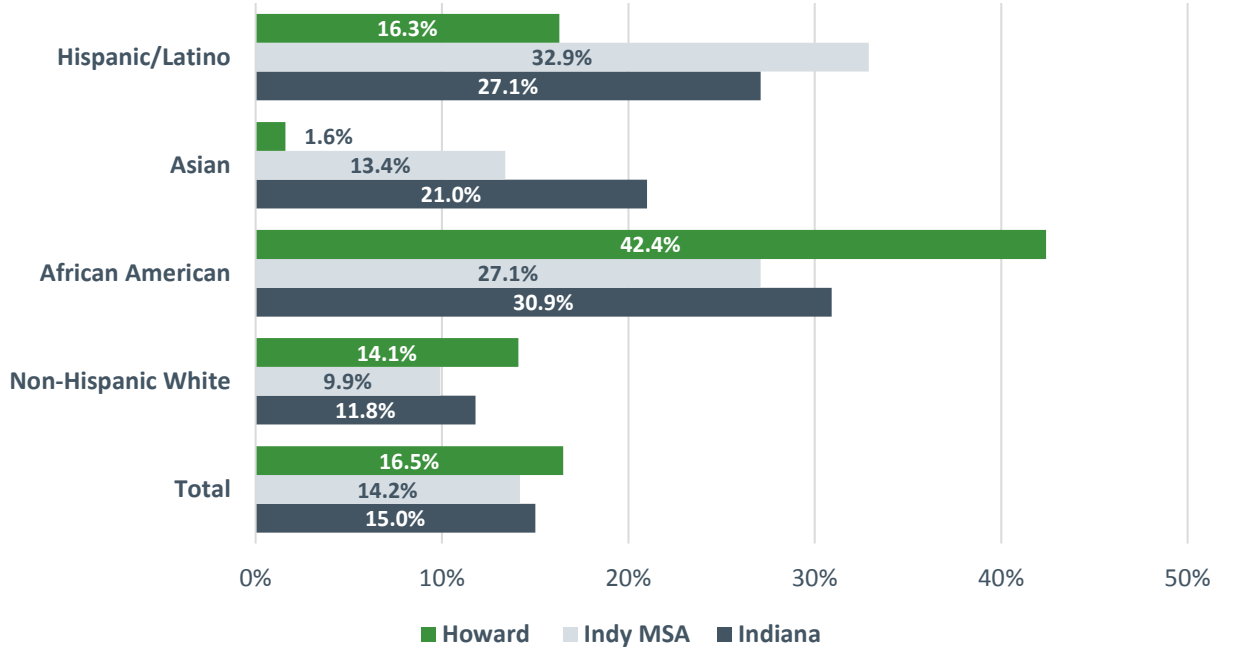


Source: US Census Bureau (American Community Survey 2012-2016 Five-year Estimates)

Poverty

The Howard Region had a slightly higher poverty rate than the Indianapolis MSA and the State (Figure 6). Howard Region fell in the middle of the CHNw regions in terms of its population in poverty. In addition, the Howard Region had the highest regional poverty rate for African Americans at almost 43%.

Figure 6: Population Below the Federal Poverty Level by Race/Ethnicity

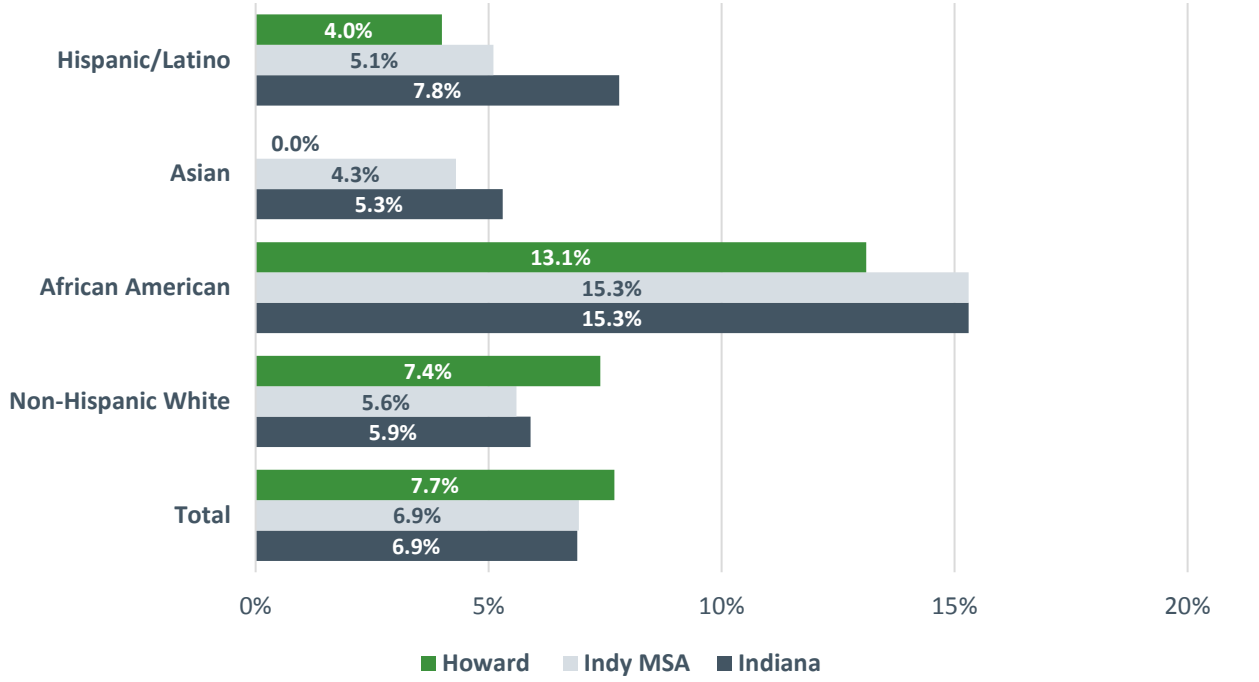


Source: US Census Bureau (American Community Survey 2012-2016 Five-year Estimates)

Unemployment

Unemployment in the Howard Region was slightly higher than in the Indianapolis MSA and the State (Figure 7). Based on five-year averages from 2012-2016, the Howard Region fell in the middle of the CHNw regions in terms of unemployment with 7.7% of the labor force out of work. These data reflect 2012-2016 five-year estimates. Data were not yet available to reflect more recent trends of lower unemployment.

Figure 7: Unemployment Rate by Race/Ethnicity

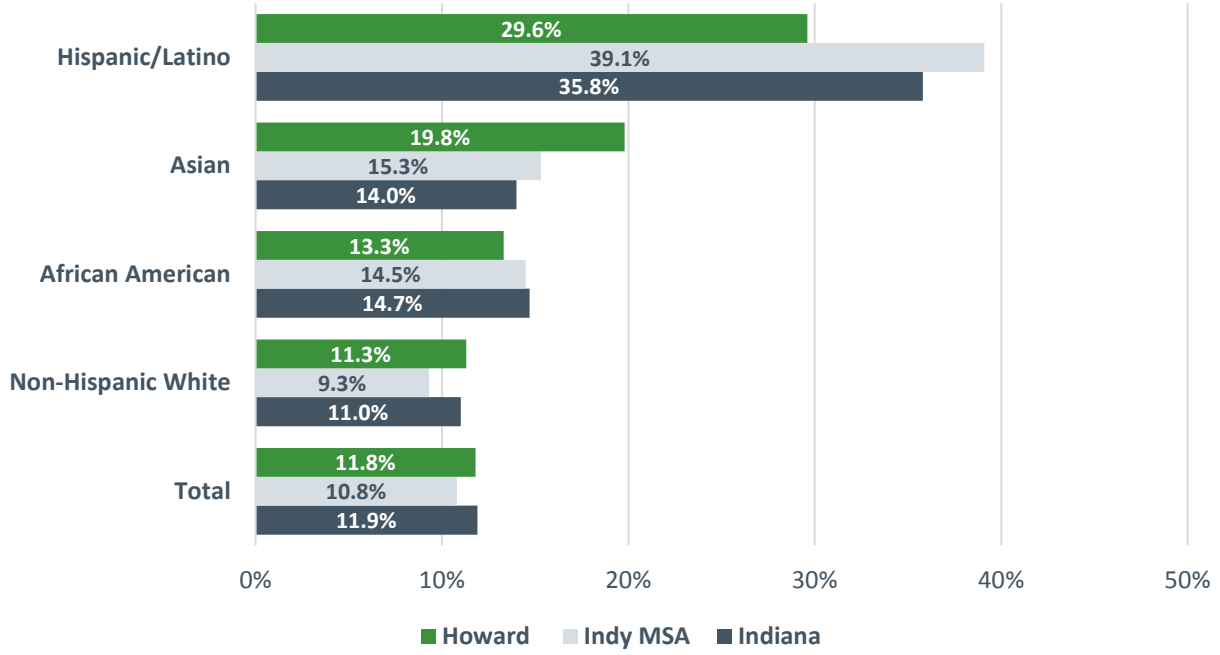


Source: US Census Bureau (American Community Survey 2012-2016 Five-year Estimates)

Education

Education is a powerful predictor of the other social determinants in this section. Education leads to higher incomes, lower poverty, and lower unemployment. The percentage of the population without a high school diploma in the Howard Region was slightly higher than the Indianapolis MSA and slightly lower than Indiana (Figure 8). Among the CHNw regions, the Howard Region fell in the middle in terms of population without a high school diploma.

Figure 8: Population without a High School Diploma by Race/Ethnicity



Source: US Census Bureau (American Community Survey 2012-2016 Five-year Estimates)

Table 4. ZIP Code Level Demographic Data

ZIP Code	Post Office Name	Total Population (2012-2016)	Percent of Population Low-Income (2012-2016)	Percent of Population Uninsured (Estimated, 2016)	Racial/Ethnic Minority % of Population (2012-2016)	Population with Less Than High School Education (2012-2016)
46901	Kokomo	39,867	43%	7.5%	14%	15%
46902	Kokomo	35,993	34%	6.2%	15%	9%
46936	Greentown	5,800	22%	5.2%	5%	8%
46979	Russiaville	4,876	18%	4.6%	3%	5%
Subtotal		86,536	36%	6.7%	13%	12%
All CHNw ZIP Codes		1,311,586	31%	7.0%	19%	10%

Source: HRSA USDA Mapper, 2018

Zip Codes 46901 and 46902 have the highest percentage of residents, number of low-income residents and is the most diverse.

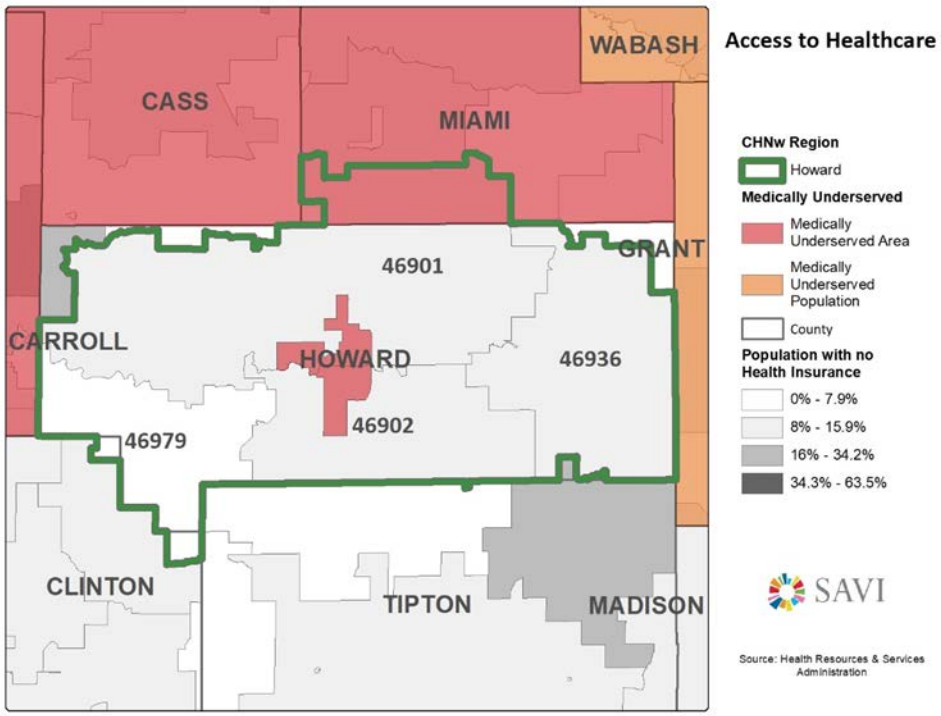
ACCESS TO HEALTHCARE

A lack of access to healthcare services also contributes to poor health status. Barriers to access can include cost, a lack of insurance coverage, transportation, language, lack of knowledge about available services, an undersupply of providers, and other factors. Measures regarding lack of access to primary care services and lack of health insurance are readily available.

Medically Underserved Areas and Populations

Medically underserved areas and medically underserved populations identify as geographic areas and populations with a lack of access to primary care services. Areas designated by the Health Resources and Services Administration as medically underserved in the Howard Region were primarily in the 46901 and 46902 ZIP codes (Figure 9, shown in red). The percentage of uninsured populations in the Howard Region ranged from 3.3% to 12.9%, with the higher rates occurring in the 46901 ZIP code (Figure 9, darker grey area).

Figure 9: Medically Underserved Areas and Populations



Sources: Medically underserved areas from Health Resources & Services Administration, 2018. Health Insurance data from the US Census Bureau (American Community Survey 2012-2016 Five-year Estimates)

HRSA encourages Federally Qualified Health Centers (FQHCs or "community health centers") to served Medically Underserved Areas and Populations. Table 5 indicates that the majority of patients who are low income and uninsured reside in the 46901 and 46902 zip code. (Table 5)

Table 5. Community Health Center (FQHC) Penetration Rates.

ZIP Code	Post Office Name	Health Center Program Patients, 2017	Health Center Penetration Rates		
			Of Low-Income Patients	Of Uninsured Patients	Of Medicaid/CHIP Recipients
46901	Kokomo	3,774	23%	15%	39%
46902	Kokomo	2,809	23%	16%	36%
46936	Greentown	129	10%	3%	13%
46979	Russiaville	141	16%	8%	17%
Subtotal		6,853	22%	15%	35%
All CHNw ZIP Codes		133,850	34%	23%	39%

Health Insurance

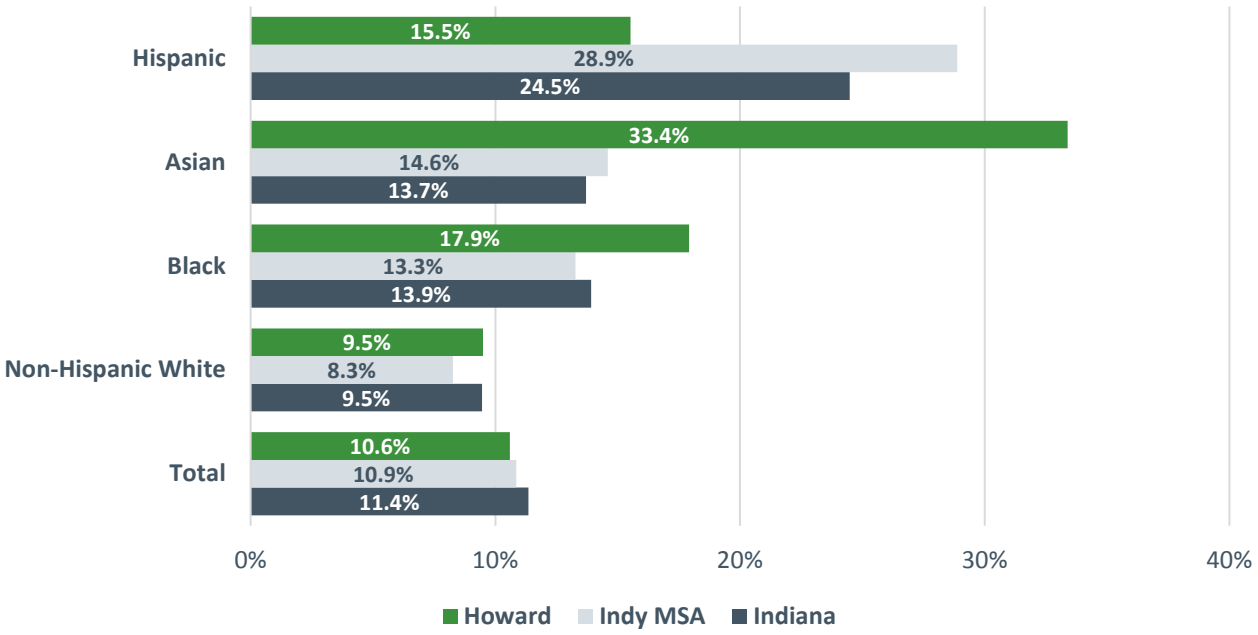
The Howard Region had a lower percentage (10.6%) of the population without health insurance than the Indianapolis MSA (10.9%) and the State of Indiana (11.4%) (Table 6). Similar to the MSA and State, the Howard Region had population disparities in health insurance rates. In the Howard Region, the Asian population had the highest rate of no health insurance (33.4%), followed by the Black population (17.9%) (Figure 10).

Table 6. Health Insurance

	Anderson	East	Howard	North	South	Indy MSA	IN
Population without health insurance (%)	12.3	13.8	**10.6**	8.5	10.3	10.9	11.4
Adults without health insurance (%)	11.0	12.3	**9.6**	7.4	8.8	9.4	9.7
Children without health insurance (%)	6.7	5.8	**4.6**	4.3	6.0	5.8	7.3

Source: US Census Bureau (American Community Survey 2012-2016 Five-year Estimates)

Figure 10: Lack of Health Insurance by Race/Ethnicity



Source: US Census Bureau (American Community Survey 2012-2016 Five-year Estimates)

The data in Table 6 show US Census Bureau data for the five-year period 2012-2016. The most recent data (provided by SG2, Claritas) indicate that– about 52 percent of Howard Region residents have some form of commercial coverage; 24 percent have Medicare and 11 percent have Medicaid; almost 5 percent are uninsured.

In January 2015, the Centers for Medicare and Medicaid Services (CMS) approved Indiana's amendment of its § 1115 demonstration, the Healthy Indiana Plan (HIP).1 The amended waiver implements the Affordable Care Act's (ACA) Medicaid expansion by building on the prior HIP demonstration. Beginning February 1, 2015, the new demonstration covered nearly all adults ages 19-64 with income from 0-138% of the federal poverty level (FPL, about $16,242 per year for an individual in 2015). A waiver amendment adding a work requirement (among other changes) was approved February 2, 2018, expiring December 31, 2020."

Discharges for Ambulatory Care Sensitive Conditions

ACSCs are health "conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease." [Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators] As such, rates of hospitalization for these conditions can "provide insight into the quality of the health care system outside of the hospital," including the accessibility and utilization of primary care, preventive care and health

education. Among these conditions are: angina without procedure, diabetes, perforated appendixes, chronic obstructive pulmonary disease (COPD), hypertension, congestive heart failure, dehydration, bacterial pneumonia, urinary tract infection, and asthma.

Disproportionately high rates of discharges for ACSC indicate potential problems with the availability or accessibility of ambulatory care and preventive services and can suggest areas for improvement in the health care system and ways to improve outcomes. (Table 7).

Table 7. Discharges for Ambulatory Care Sensitive Conditions per 100,000, 2017

ACSC (PQI)	Madison	Hancock	Howard	Hamilton	Morgan	Johnson	Marion	IN
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults	852	478	798	239	567	440	728	664
Perforated Appendix	611	467	500	629	444	629	695	633
Heart Failure	580	306	504	176	329	315	508	435
Community-Acquired Pneumonia	302	137	201	99	183	163	134	185
Urinary Tract Infection	179	106	153	88	144	159	131	148
Dehydration	221	97	208	63	78	112	111	139
Diabetes Long-Term Complications	131	52	145	39	87	43	108	110
Lower-Extremity Amputation Among Patients with Diabetes	116	118	133	26	123	63	89	82
Hypertension	114	34	90	40	43	29	102	63
Diabetes Short-Term Complications	81	65	91	21	34	45	80	59
Uncontrolled Diabetes	56	13	45	17	23	22	46	41
Asthma in Younger Adults	53	50	31	16	25	13	42	32

Source: Analysis of Data Provided by the Indiana Hospital Association; rates are not age-adjusted

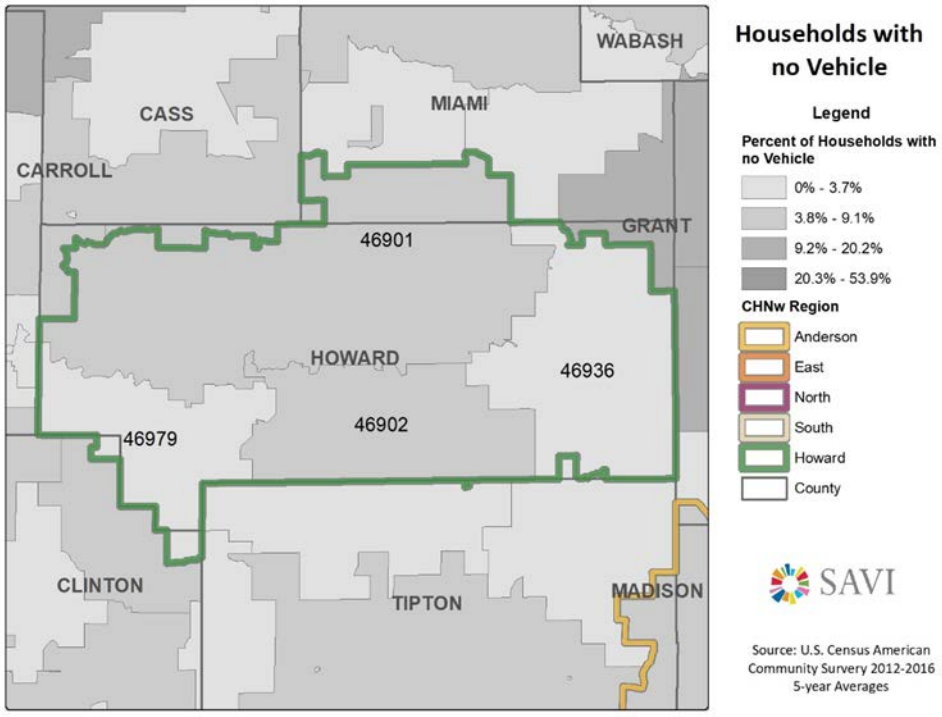
Howard County rates of admissions for ACSC exceeded Indiana averages for several conditions, including COPD/adults asthma, heart failure, community-acquired pneumonia, and hypertension. Because the statistics in Table 7 are not age-adjusted, a portion of the above average rates likely is due to the prevalence of older adults in the county.

Transportation

In the Howard Region, the percentage of households without a vehicle varies from 3.7% to 53.9%, with the higher rates occurring in the more urban ZIP codes of the region.

In the Howard Region, the percentage of households without a vehicle varied from 1.1% to 8.5%, with the higher rates occurring in the 46902 ZIP code. (Figure 11).

Figure 11: Households with No Vehicle



The identification of health needs for CHNw regions was carried out using two types of data: 1) secondary data from the Healthy Communities Institute (HCI) dashboard and other local and national agencies (e.g. County Health Rankings), and 2) primary data obtained through an online survey of CHNw healthcare providers (e.g., physicians, nurses, social workers) and a survey of community residents in each CHNw region. To supplement these data and identify population-specific health needs among community members in the Howard Region in particular, focus groups with community stakeholders were also conducted. These data sources are described in the following sections.

Secondary Data

The Community Health Network Community Dashboard developed by HCI was used as a primary source of secondary data. This dashboard includes data from the Indiana Hospital Association as well as the Indiana State Department of Health, National Cancer Institute, Centers for Disease Control and Prevention, Centers for Medicaid and Medicare Services, the National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Institute for Health Metrics and Evaluation, County Health Rankings website, US Census Bureau, US Department of Agriculture, and other sources.

Additional state and national secondary data sources were accessed by the CHNA team for more recent and geographically specific information, including the following:

- **American Lung Association:** A voluntary organization committed to research on screening, treatment, and cures for all lung diseases. Data are compiled from various government surveys to produce reports on lung disease mortality, prevalence, hospitalization, economic costs, and risk factors.
- **Annie E. Casey Foundation:** A philanthropic organization committed to improving child welfare. Data are compiled from a variety of national and state sources to produce reports on various child well-being topics.
- **Centers for Disease Control and Prevention National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (CDC-NCHHSTP) Atlas**: A federal source of data regarding sexually transmitted infections and diseases.
- **County Health Rankings:** A Robert Wood Johnson Foundation program implemented by the University of Wisconsin Population Health Institute that releases new estimates annually measuring health across all US counties. These data are compiled from a variety of providers and typically combines data across multiple years to release estimates for areas with small populations, such as rural counties.

- **Feeding America:** A nonprofit organization striving to feed America's hungry through foodbanks. Data are compiled from the Current Population Survey (CPS), the American Community Survey (ACS), and the Bureau of Labor Statistics (BLS) to produce food-insecurity reports.
- **Health Indicators Warehouse:** Developed by the National Center for Health Statistics, the Health Indicators Warehouse compiles data from a variety of governmental and non-governmental sources to provide standardized health indicators and associated interventions in a single location.
- **Indiana State Department of Health (ISDH):** The ISDH's annual natality report includes information on live births in Indiana, as well as a mortality report compiling information on the deaths of Indiana residents.
- **Indiana University Center for Health Policy:** A collaborative and multidisciplinary research center addressing health care issues regarding healthcare for vulnerable populations, healthcare reform, HIV/AIDS, mental illness, obesity, and substance abuse prevention and treatment.
- **SG2, Claritas:** Providers of historical and projected demographic and utilization data.
- **US Census Bureau:** A leading source of data on the people and economy of the United States.
- **The Youth Risk Behavior Surveillance System (YRBSS, published by the Centers for Disease Control):** Monitors six categories of health-related behaviors that contribute to the leading causes of death and disability among youth and adults, including behaviors that contribute to unintentional injuries and violence. sexual behaviors related to unintended pregnancy and sexually transmitted diseases (including HIV infection), alcohol and other drug use, tobacco use, unhealthy dietary behaviors, and inadequate physical activity.

Community Input (Primary Data)

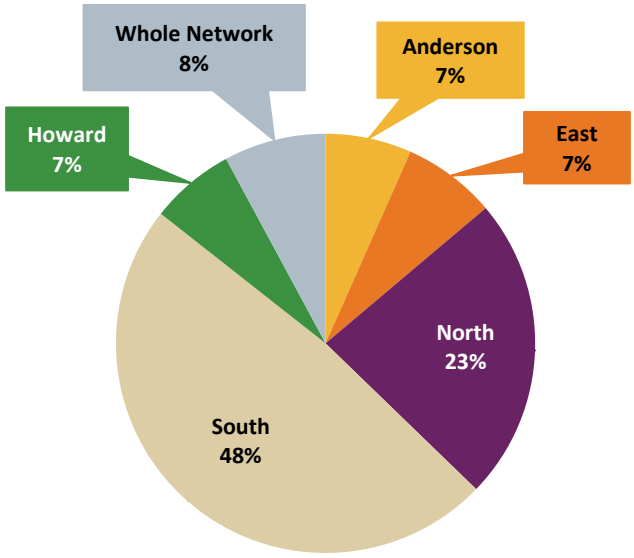
This assessment used three sources of community input: 1) an online survey of CHNw providers; 2) focus groups with community stakeholder organizations; and 3) a community survey. Importantly, focus groups conducted for this CHNA included one or more representatives from a governmental health department. The primary data gathering and analysis process is described in more detail below.

CHNw Provider Survey

An online survey of CHNw health providers was conducted in April 2018 to collect CHNw provider perceptions about what populations were at greatest social/medical disadvantage and which community circumstances impacting population health were most urgent. Any clinician that interacts with patients was invited to participate in the provider survey. The survey was designed by Polis and the Fairbanks

School of Public Health (FSPH) in partnership with CHNw and implemented using Qualtrics, an online survey service. The CHNw Community Benefits team collaborated with the executive leadership team in each region to distribute the survey to their regional CHNw provider networks. A total of 819 CHNw providers responded to the survey. Seven percent (7%, n=58) of those named the Howard Region as their region of primary practice or service. Figure 9 shows the proportion of provider respondents by CHNw region of primary practice.

Figure 12: CHNw Provider Survey Respondents



The majority of the respondents from the Howard Region were PT/OT/Speech Therapist (23%), Other (21%), and Nurse (12%) followed by Behavioral Health Provider (14%), Primary (10%) and Specialty(10%) Healthcare Provider, Administrator (5%) and Social Worker/Case Manager (5%).

Focus Groups

A focus group with community stakeholder organizations from the Howard Region was organized by CHNw and designed and conducted by FSPH on April 10, 2018. Representatives from fifteen organizations in Howard County participated in the CHNw Howard Region focus group. A variety of organization types, including school systems, social services, healthcare, state government, law enforcement, and governmental public health were represented in the focus groups. Specific details about the organizations that participated are included in Appendix A.

Focus group participants were asked to indicate the two most important unmet needs affecting the health of their community and the two most vulnerable populations. At the end of the focus groups, participants were asked to discuss possible solutions to address the unmet needs among the most vulnerable populations.

Community Survey

The five major hospital systems in Indianapolis, referred to as the Indianapolis Hospital Collaborative and including CHNw, jointly contracted the University of Evansville and the Indiana University Center for Survey Research (CSR) to design and conduct a broad community survey in 2018. This survey was designed and conducted independently of the CHNA activities conducted by Polis and FSPH. Two questions from this survey were used as measures of community concern for the CHNw CHNA--One question asked respondents to choose what they perceived as top health concerns in their community and a second question asked respondents to indicate how important listed health and community services were for their community. These survey questions are included in Appendix B.

As part of their survey effort, CSR selected random, address-based population samples from each of the five CHNw regions and administered a mail survey to those samples. The results of the survey were delivered to CHNw in July 2018. The survey results were algorithmically weighted by CSR to control for differences in the demographic makeup of survey participants compared to the total population of each region.

Identification of Significant Community Health Needs

Community health needs and issues presented in this report were considered *significant* if they were identified as problematic in two or more of the primary and secondary data sources described in this section. For example, Food Insecurity was mentioned as problematic in the provider survey, in focus groups, and in the community survey. Poverty was found to be above average in secondary data, and providers responding to the provider survey identified low-income/impoverished people to be at "greatest disadvantage" in the Howard Region.

Data Limitations

Secondary Data: One of the most notable limitations of the secondary data was that different data sources applied different models to estimate community health indicators. Some indicators were based on administrative data while others were based on sample surveys. In addition, secondary data was sourced from different data years, based on data availability. The year of the available data ranged from a 2010-2014 five-year average in some cases to 2018 in others.

Another notable limitation was that when mortality and morbidity rates were not available, hospitalization rates were used. Hospitalization rates are available from state hospital associations and are often used as surrogate measures of community health need. Hospitalization rates typically are based on patient home address versus treatment location, which is appropriate when attempting to use these rates to measure community health. However, a limitation is that hospitalization rates may underreport

the rate of a health condition because hospitalization rates only capture data from individuals who seek hospital care and do not capture data from individuals who have the health condition but do not receive associated hospital care. Another limitation is that populations with closer proximity to a hospital facility may be more likely to seek treatment for health conditions and as such areas with a hospital facility may appear to have populations with higher rates of health conditions.

Another limitation was that the geographic level of available data did not always match the hospital service area (region). CHNw regions were defined as collections of ZIP codes but not all data are available at the ZIP code level. In cases where only county-level data were available, the total population within the intersections of the CHNw region and the county(ies) were used to generate weighted values and build regional estimates.

Provider Survey: The principal limitation of the provider survey was that it was not conducted using a random sampling technique and may reflect response bias. This means that the responses were not necessarily representative of the full population of CHNw providers. Another limitation was that respondents were asked to select from pre-defined lists of disadvantaged populations and potential concerns. While the list of possible concerns was developed based on expert knowledge, it is possible that there were other concerns that were not listed.

Community Survey: A general limitation of broad community surveys is that participation tends to be greater among retirees or those otherwise unemployed compared to younger, employed persons. Statistical weighting was utilized by the Indiana University Center for Survey Research (CSR) to correct for these and other differences.

Another limitation that should be noted is that the community survey deviated enough from the provider survey and secondary data so that direct comparisons could not be drawn. Future iterations of the provider and the community survey should contain the same language and options.

SECONDARY DATA ANALYSIS

Based on a review of over 700 indicators, Table 8 lists the health outcomes and behaviors for which any county served by CHNw was in the lowest performing quartile of Indiana counties. Each of these indicators was included in the identification of significant community health needs.

Table 8. Health Indicator Rates and Trends

Indicator	Madison	Hancock	Howard	Hamilton	Johnson	Morgan	Marion
Adults who Drink Excessively				■	■		■
Adolescent Suicide and Intentional Self-inflicted Injury*					■	■	
Adult Asthma*	■						■
Adults 20+ who are Obese		■					
Adults who Smoke	■		■				■
Alcohol Abuse*	■		■				■
Alcohol-Impaired Driving Deaths			■			■	
Alzheimer's Disease **	■						
Asthma*	■						■
Babies with Low Birth Weight							■
Bacterial Pneumonia*	■						
Breast Cancer*						■	
Breast Cancer (Incidence Rate)		■		■		■	■
Chlamydia Incidence			■				■
Chronic Lower Respiratory Diseases **	■					■	
Coronary Heart Disease **			■				
Dehydration*	■		■				
Diabetes*	■		■				■
Drug Poisoning (Death rate)	■					■	■
Frequent Mental Distress	■						■
Gonorrhea Incidence	■		■		■		■
Heart Failure	■						■

*Age-adjusted hospitalization rate. **Age-adjusted death rate.
Source: CHNw Community Dashboard, Healthy Communities Institute. **May 2018**.

Table 8. Health Indicator Rates and Trends (continued)

Indicator	Madison	Hancock	Howard	Hamilton	Johnson	Morgan	Marion
Hepatitis*							
Hypertension*							
Immunization-Preventable Pneumonia and Influenza*							
Infant Mortality Rate							
Influenza and Pneumonia **							
Insufficient Sleep							
Kidney Disease **							
Long-Term Complications of Diabetes*							
Lung and Bronchus Cancer (Incidence)							
Lung Cancer **							
Mental Health*							
Mothers who Smoked During Pregnancy							
Oral Cavity and Pharynx Cancer (Incidence)							
Pediatric Asthma*							
Pediatric Mental Health*							
Preterm Births							
Prostate Cancer (Incidence Rate)							
Short-Term Complications of Diabetes*							
Substance Abuse*							
Suicide and Intentional Self-inflicted Injury*							
Teen Birth Rate: 15-19							
Uncontrolled Diabetes							
Unintentional Injuries **							
Urinary Tract Infections*							

*Age-adjusted hospitalization rate. **Age-adjusted death rate.
Source: CHNw Community Dashboard, Healthy Communities Institute. **May 2018**.

Asthma

Asthma is a chronic, incurable disease which causes many symptoms that make breathing difficult [2]. The disease burden is high due to expensive and potentially life-long costs associated with managing symptoms of asthma. There are several clinical intervention strategies recommended by healthcare professionals to reduce the frequency and severity of symptoms. (Table 9).

Table 9. Asthma

Indicator	Howard	IN	USA
Adult Asthma (AHR*) per 10,000^	6.6	7.6	N/A
Pediatric Asthma (AHR*) per 10,000^	7.1	7.9	N/A

*Age-adjusted hospitalization rate. Source: Indiana Hospital Association ^2014-2016

Cancer

Cancer (the suite of diseases resulting in abnormally and often uncontrollable growth of malignant cells) collectively forms the second leading cause of death in the United States. The CDC believes it will soon become the leading cause of death [3]. Many preventative and clinical treatments exist to prevent or manage a variety of cancers. (Table 10).

Table 10. Cancer

Indicator	Howard	IN	USA
Breast Cancer (Incidence Rate) per 100,000^	105.5	121.7	124.7
Breast Cancer (Age-Adjusted Death Rate) per 100,000^	22.6	21.8	21.2
Lung and Bronchus Cancer (Incidence Rate) per 100,000^	74.7	72.8	60.2
Lung Cancer (Age-Adjusted Death Rate) per 100,000	52.8	55.1	44.7
Oral Cavity and Pharynx Cancer (Incidence Rate) per 100,000^	11.2	12.0	11.6
Prostate Cancer (Incidence Rate) per 100,000^	78.3	92.7	109.0

Source: National Cancer Institute ^2014-2016 three-year averages

Cardiovascular Disease

Heart disease is the leading cause of death according to the CDC [4]. The most common of these is coronary artery disease, which can lead to heart attack. Heart disease affects populations of all races and genders, and usually occurs in middle age. (Table 11).

Table 11. Cardiovascular Disease

Indicator	Howard	IN	U.S.
Coronary Heart Disease (Age-Adjusted Death Rate) per 100,000^	125.9	102.6	96.8
Heart Failure (AHR*) per 10,000^	37.2	38.7	N/A
Hypertension (AHR*) per 10,000^	3.1	4.5	N/A

Sources: Centers for Disease Control and Prevention, Indiana Hospital Association ^2014-2016 three-year averages

Diabetes

Diabetes is a group of diseases which affect the way the body uses blood sugar. A diabetes diagnosis means a person has too much blood sugar, which can lead to other, more serious, health complications [5]. Diabetes has both preventive and clinical interventions recommended by healthcare providers and professionals. (Table 12).

Table 12. Diabetes

Indicator	Howard	IN	U.S.
Adult Diabetes (AHR*) per 10,000^	25.3	20.3	N/A
Short-Term Complications of Adult Diabetes (AHR*) per 10,000^	15.1	9.0	N/A
Long-Term Complications of Adult Diabetes (AHR*) per 10,000^	8.9	9.5	N/A
Uncontrolled Diabetes (AHR*) per 10,000^	0.9	1.5	N/A

*Age-adjusted hospitalization rate. Source: Indiana Hospital Association ^2014-2016

Drug and Alcohol Abuse and Addiction

Drug use and dependence can cause accidental death, unintentional injury, or other health problems. Substance abuse is preventable and may be treatable. According to the CDC, excessive alcohol use can lead to an increased risk of health problems, such as liver disease [6] and unintentional injuries. (Table 13).

Table 13. Substance Abuse

Indicator	Howard	IN	U.S.
Adults who Drink Excessively (%)^	15.8	18.6	18.0
Alcohol Abuse (AHR*) per 10,000^^	26.9	12.0	N/A
Drug Poisoning (Death Rate) per 100,000^^	25.8	19.9	16.9
Substance Abuse (AHR*) per 10,000^^	54.0	11.4	N/A

*Age-adjusted hospitalization rate. Sources: County Health Rankings, Indiana Hospital Association ^2018 ^^2014-2016

Maternal, Infant, and Child Health

Maternal, infant, and child health care is a broad category which encompasses a variety of health indicators related to pregnancy, birth, and complications at the time of and immediately following birth. Populations affected include both mothers and their children. Behavioral changes prior to birth, including smoking cessation for mothers, have important outcomes in infant health. (Table 14).

Table 14. Maternal, Infant, and Child Health

Indicator	Howard	IN	U.S.
Babies with Low Birth Weight (%)^	8.4	8.0	8.0
Infant Mortality Rate deaths per 1,000^	6.1	7.2	6.0
Mothers who Smoked During Pregnancy (%)^	22.0	14.3	8.4
Preterm Births (%)^	7.5	9.6	9.6

Source: Indiana State Department of Health ^2016

Mental Health

Depression is a serious illness that affects an individual's ability to perform daily tasks or cope with daily life. Individuals with depression are at higher risk for other mental illnesses, injury, or death. Depression is also linked to economic and social burdens which may perpetuate depressive episodes. While depression may not be preventable, it is treatable. However, many of the affected do not have the means to seek or afford treatment, making intervention strategies complex for all affected populations. (Table 15).

Table 15. Mental Health

Indicator	Howard	IN	U.S.
Adolescent Suicide and Intentional Self-inflicted Injury (AHR*) per 10,000^	49.5	73.9	N/A
Adult Mental Health (AHR*) per 10,000^	102.2	57.4	N/A
Pediatric Mental Health (AHR*) per 10,000^	34.1	44.5	N/A
Suicide and Intentional Self-inflicted Injury (AHR*) per 10,000^	29.1	32.4	N/A

*Age-adjusted hospitalization rate. Source: Indiana Hospital Association ^2014-2016

Obesity

Obesity (having a body mass index greater than 30.0) affects all age groups and disproportionately affects people of lower socioeconomic statuses and racial/ethnic groups. There are many complications that can occur as a direct or indirect result of obesity. (Table 16).

Table 16. Obesity

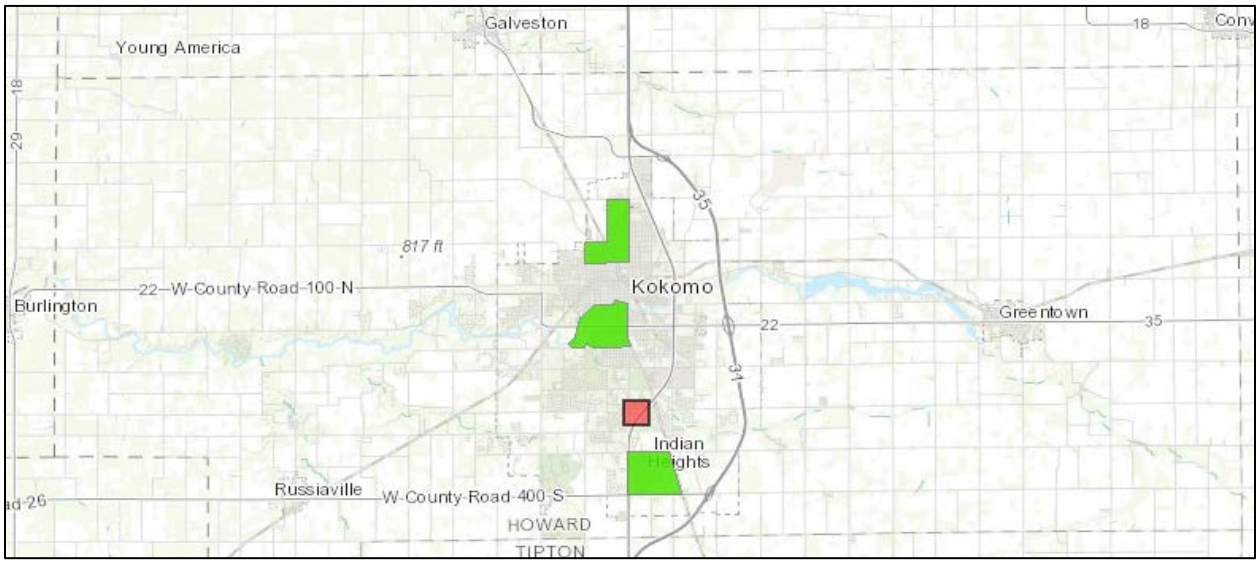
Indicator	Howard	IN	U.S.
Adults 20+ who are Obese (%)^	31.4	32.0	28.0

Source: Centers for Disease Control and Prevention ^2013

Food Insecurity

The U.S. Department of Agriculture's Economic Research Service identifies census tracts that are considered "food deserts" because they include lower-income persons without supermarkets or large grocery stores nearby. As shown in Figure 13, several census tracts within the Howard Region have been designated as food deserts.

Figure 13: Census Tracts Designated as Food Deserts



Source: US Department of Agriculture, ^2018

Sexually Transmitted Infections

Chlamydia and gonorrhea are two common sexually transmitted diseases that, in some cases, present no symptoms, but can lead to serious health problems if left untreated [7, 8]. Treatment is usually relatively simple once diagnosed. Younger populations, those with multiple partners, and those who do not use a condom during sex are at high risk to contract these and other sexually transmitted infections. Those who have or have had sexually transmitted infections in the past are at even greater risk. (Table 17).

Table 17. Sexually Transmitted Infections

Indicator	Howard	IN	U.S.
Chlamydia (Incidence Rate) per 100,000^	423.6	466.0	497.3
Gonorrhea (Incidence Rate) per 100,000^	149.4	142.8	145.8

Source: County Health Rankings ^2016

Tobacco Use/Smoking

Smoking is the leading cause of preventable death [9]. People of all ages, races, and genders are susceptible to the effects of smoking and secondhand smoke. (Table 18).

Table 18. Smoking

Indicator	Howard	IN	U.S.
Adults who Smoke (%)^	24.0	21.1	17.1

Source: County Health Rankings ^2016

ZIP Code Variation of the Howard Region

Table 19 provides certain health indicators by ZIP Code.

Table 19. Selected Health Indicators by ZIP Code

ZIP Code	Post Office Name	Low Birth Weight Rate (Estimated 2012-2014)	Adults Ever Told Have Diabetes, est. (%)	Adults Ever Told Have High Blood Pressure, est. (%)	Adults Who Are Obese, est. (%)	Adults with No Dental Visit in Past Year, est. (%)	Adults with No Usual Source of Care, est. (%)
46901	Kokomo	6.3%	12.7%	35.6%	37.8%	32.9%	14.2%
46902	Kokomo	6.3%	12.9%	35.8%	38.9%	32.7%	14.3%
46936	Greentown	6.9%	12.8%	35.4%	39.3%	33.3%	13.1%
46979	Russiaville	6.8%	13.0%	35.7%	38.7%	33.7%	13.3%
Subtotal		6.4%	12.8%	35.7%	38.4%	32.9%	14.1%
All CHNw ZIP Codes		7.3%	9.1%	28.8%	27.8%	27.6%	16.2%

Source: HRSA UDS Mapper, 2018

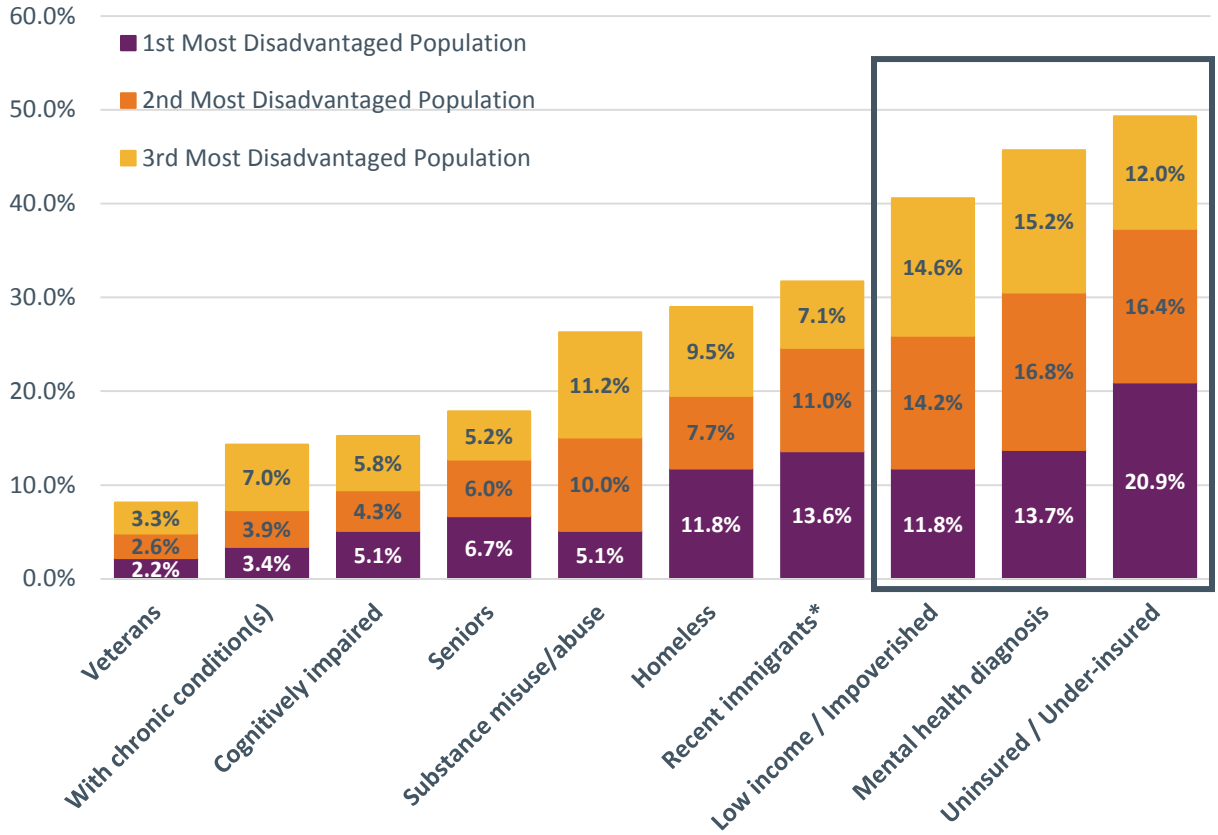
The majority of zip codes are in the within similar ranges for all six categories.

PROVIDER SURVEY RESULTS

Patient Populations at Greatest Disadvantage

Based on the responses of CHNw providers, populations of most concern in terms of their medical and or social disadvantage are the populations who are **uninsured/under-insured**, with a **mental health diagnosis,** or **low income/impoverished** (Figure 14). Table 20 shows responses of CHNw providers by region.

Figure 14: Patient Populations Perceived to be at Most Disadvantage by CHNw Providers



*and non-English speaking

Table 20. Provider Perceptions of Disadvantaged Populations, by Region

Populations	Anderson	East	Howard	North	South	CHNw
	Percent of Providers who Responded that the Population was among the Most Disadvantaged					
Uninsured/Underinsured	68.1	48.7	76.1	49	43.4	49.3
Mental health diagnosis	53.2	33.3	39.2	43.8	47.5	45.7
Low income/Impoverished	55.3	71.5	46.7	37.4	32.8	40.6
Recent immigrants*	14.9	27.9	22.4	25.3	41.4	31.7
Homeless	4.3	27.8	26.1	33.8	31.7	29
Substance misuse/Abuse	27.7	29.8	24.3	26.4	25.3	26.3
Seniors	8.5	15.7	20.5	14.8	20.6	17.9
Cognitively impaired	10.6	5.2	3.7	23.2	15.3	15.2
With chronic condition(s)	19.2	7	15	15.8	13.6	14.3
Veterans	4.3	5.3	13	5.3	9.7	8.1

*and non-English speaking

Most Urgent Community Issues

In terms of the most urgent community circumstances on which CHNw should focus its efforts on, CHNw providers indicated **cost of medication**, **lack of insurance or underinsurance,** and **chronic disease management** are the top three urgent issues (Figure 15). Table 21 shows responses of CHNw providers by Region.

Figure 15: Community Issues Perceived to be Most Urgent by CHNw Providers

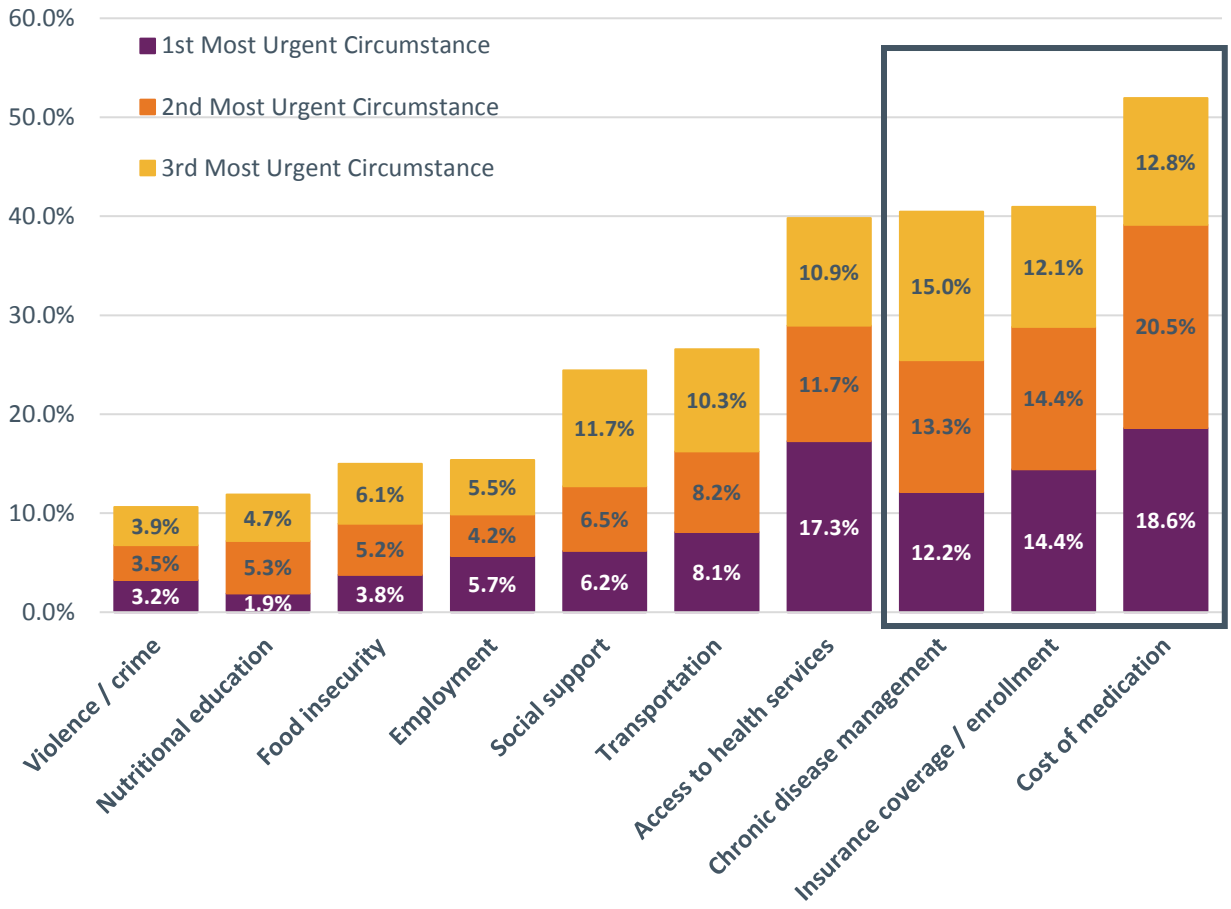


Table 21. Provider Perceptions of Community Issues, by Region

Community Issues	Anderson	East	Howard	North	South	CHNw
	Percent of Providers who Responded that the Community Issue was among the Most Urgent					
Cost of medication	47	50.2	46.0	53.4	55.8	51.9
Insurance coverage/Enrollment	51.5	37.7	53.3	40.5	38.1	40.9
Chronic disease management	36.6	21.6	28.7	44.3	43.4	40.5
Access to health services	34.1	32.2	45.8	39.8	40.2	39.8
Transportation	25.7	45	36.3	20.3	24.7	26.6
Social support	36.6	32.3	21.2	25.8	22.2	24.4
Employment	27.8	16.2	19.2	14.2	13.7	15.4
Food insecurity	12.9	23.4	15.3	14.8	13.7	15
Nutritional education	6.4	10.8	7.7	13.7	12.8	11.9
Violence/Crime	2.1	14.4	3.8	9.9	12.5	10.6

FOCUS GROUP RESULTS

Howard Region focus group participants indicated that their most vulnerable populations were children, the uninsured/underinsured/ and individuals with a history of substance abuse/misuse. Relative to their vulnerable populations, Howard Region participants identified the need for more food programs to meet the nutritional needs of children living in poverty and education programs to help break the cycle of generational poverty, as well as more affordable insurance and more timely access to services to help treat addiction.

Table 22 summarizes what CHNw focus group participants identified as unmet service needs in their region. The Howard Region focus group results are shown in green. Participants discussed the need for improved access to specialty and mental health services as there are not a lot of options for these services in town. They also identified the need for improved transportation for individuals receiving specialty care out of town, which was reiterated upon discussion of the need for improved chronic disease management.

Table 22. Top Unmet Needs

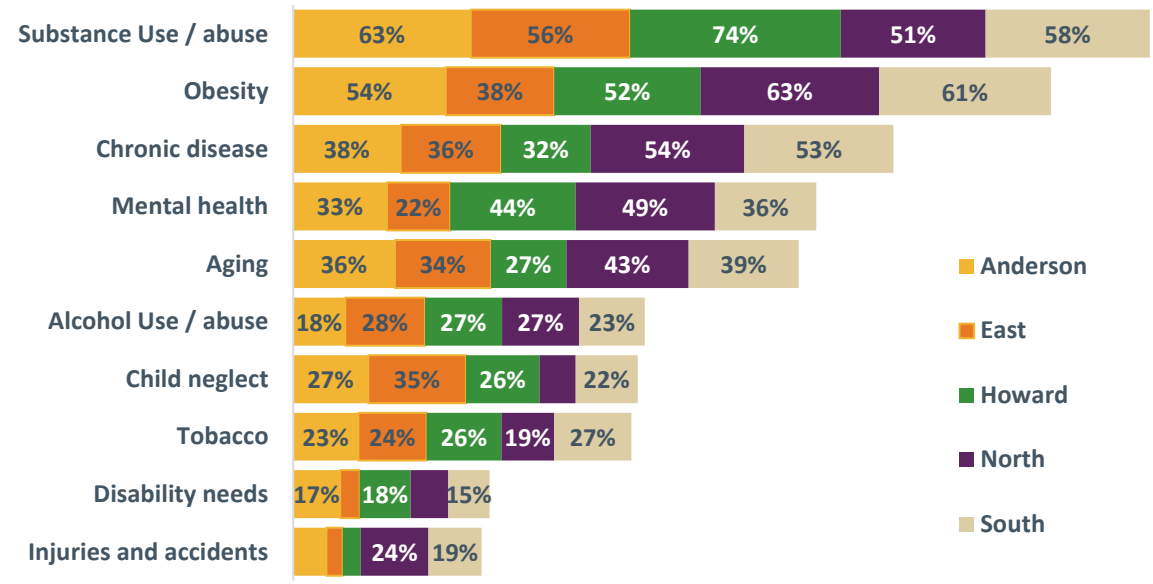
Service Needs	Anderson	East		Howard	North		South
		Marion	East		Hamilton	North	
Assistance with finding housing	X		X	X	X		X
Financial assistance/education	X	X		X			
Legal assistance							
Assistance getting health insurance	X			X	X		X
Job training/assistance finding a job			X			X	
Assistance with transportation	X		X	X	X		X
Services for Women/Infants/Children							X
Food stamps/SNAP							
Food pantries	X	X				X	X
Free or emergency child care							
Nutrition education	X	X	X				
Physical activity programs							
Substance abuse services (prevention or treatment)	X	X		X	X		X
Mental health counseling and support programs	X	X		X	X		X
Family planning services			X				X
Walking trails/bike trails/outdoor recreation spaces	X				X		X
Quick access primary care/retail care							X
Aging and older adult programs				X			X
Assistance with filling prescriptions	X						X
Parenting education/support	X		X	X		X	X
Awareness of existing social supports	X		X		X		X

COMMUNITY SURVEY RESULTS

Community Health Concerns

Similar to the network as a whole, survey respondents in the Howard Region identified **substance use/abuse** as their most important (74%) health concern (Figure 16).

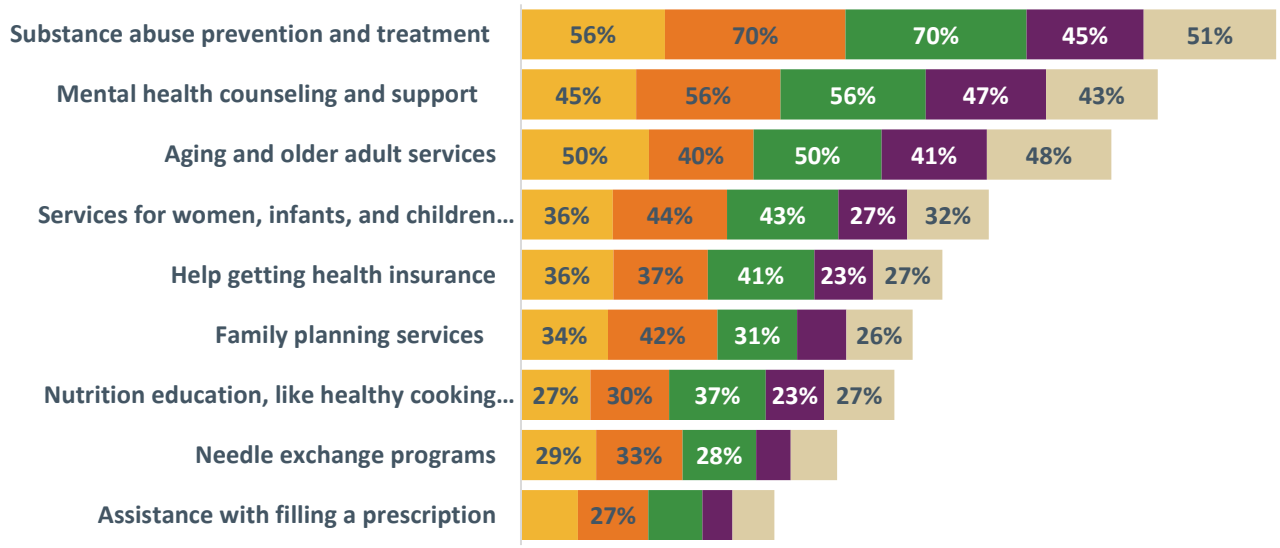
Figure 16: Top Health Concerns Identified by the Community



Health Services Important to the Community

Also similar to the network as a whole, **substance use prevention and treatment** was most frequently indicated by Howard Region respondents as a very important health service for their community (70%) (Figure 17).

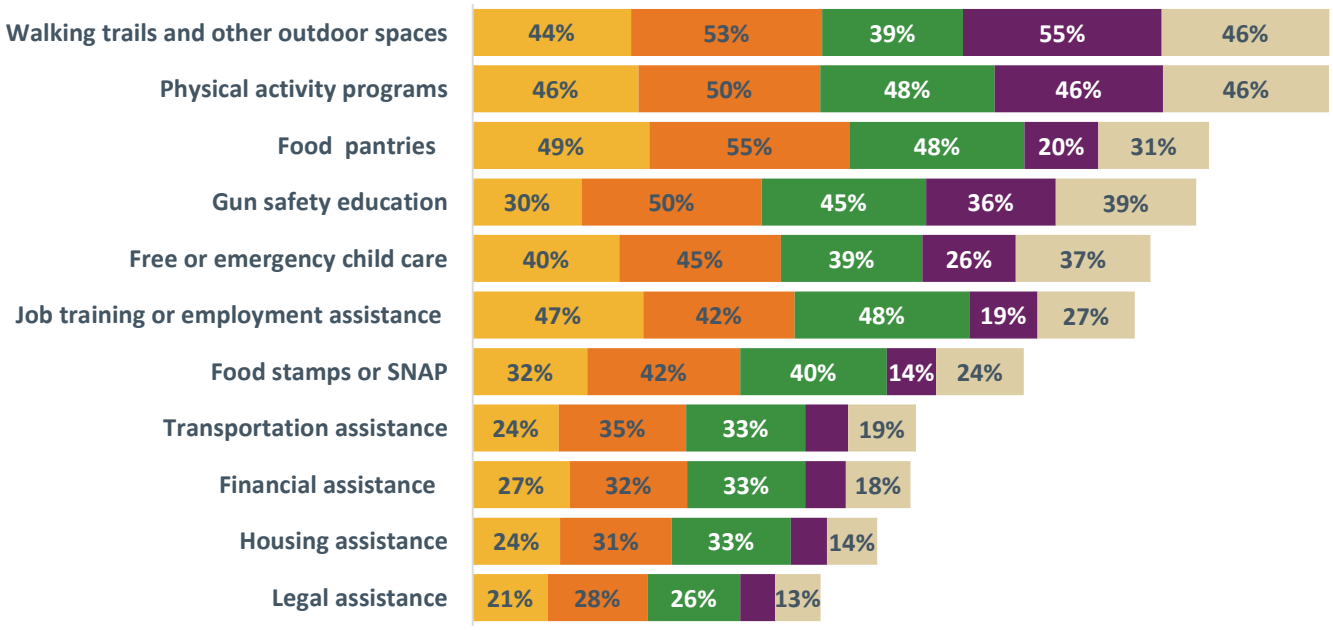
Figure 17: Health Services "Very Important" for the Community



Community Services Important to the Community

When asked to identify very important community services, those most frequently identified by Howard Region respondents were **physical activity programs** (48%), **food pantries** (48%), **job training or employment assistance** (48%) (Figure 18).

Figure 18: Community Services "Very Important" for the Community



AVAILABLE COMMUNITY RESOURCES

Appendix C includes information on reosurces available to meet identified communit health needs.

EVALUATION REPORT

Appendix D includes an evaluation of the impact of community health programs implemented by CHNw, including the Howard Region since its last CHNA was conducted.

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The following community stakeholder organizations participated in the April 10, 2018 focus group in the Howard Region.

1. YMCA
2. Kokomo Schools
3. Gilead House
4. United Way (211)
5. Samaritan Caregivers
6. Project Access
7. Howard County Health Department
8. Kokomo City Council
9. Mental Health America – Howard County
10. Indiana Minority Health Coalition
11. Indiana Health Center
12. Taylor School Corporation
13. Western School Corporation
14. Kokomo Rescue
15. Kokomo Housing Authority

The following two questions from the community survey were used to measure community health concerns.

Below are some issues present in many communities. Please pick FIVE that you think pose the greatest health concern for people who live in your community. (Select only five out of all options 1 - 21.)

A. Food access, affordability, and safety	K. Suicide
B. Environmental issues	L. Infectious diseases, like HIV, STDs, and hepatitis
C. Tobacco use	M. Poverty
D. Substance use or abuse	N. Homelessness
E. Alcohol use or abuse	O. Reproductive health and family planning
F. Assault, violent crime, and domestic violence	P. Infant mortality
G. Child neglect and abuse	Q. Injuries and accidents
H. Sexual violence, assault, rape, or human trafficking	R. Mental health
I. Obesity	S. Aging and older adult needs
J. Chronic diseases, like diabetes, cancer, and heart disease	T. Dental care
	U. Disability need

Below is a list of programs or services in many communities. Please mark how important these programs or services are for your community. (Select one answer for EACH row.) 1 - Not at all important. 2 - Not very important for my community. 3 - Moderately important for my community. 4 - Very important for my community

A. Nutrition education, like healthy cooking classes	K. Housing assistance
B. Physical activity programs	L. Financial assistance
C. Substance abuse prevention and treatment	M. Legal assistance
D. Needle exchange programs	N. Help getting health insurance
E. Mental health counseling and support	O. Job training or employment assistance
F. Gun safety education	P. Transportation assistance
G. Family planning services	Q. Services for women, infants, and children (WIC)
H. Walking trails and other outdoor spaces	R. Food stamps or SNAP
I. Aging and older adult services	S. Food pantries
J. Assistance with filling a prescription	T. Free or emergency child care

TRANSPORTATION			
Name	**City**	**ZIP Code**	**Service**
Kokomo and Howard County Governmental Coordinating Council	Kokomo	46901	Transportation For Disabled
Kokomo and Howard County Governmental Coordinating Council	Kokomo	46901	Senior Ride Program
FOOD PANTRIES			
Name	**City**	**ZiIP Code**	**Service**
Kokomo Downtown Farmers Market	Kokomo	46901	Farmers Market
United Way Of Howard County	Kokomo	46901	Food Pantry
Food Finders Food Bank - Mobile Food Pantry Sites (Tzion Temple)	Kokomo	46901	Food Pantry
Food Finders Food Bank - Mobile Food Pantry Sites (Wayman Chapel African Methodist Episcopal Church)	Kokomo	46901	Food Pantry
Hillsdale United Methodist Church	Kokomo	46901	Food Pantry
Saint Vincent De Paul Of Howard County	Kokomo	46901	Food Pantry
Kokomo Rescue Mission	Kokomo	46901	Food Pantry
Kokomo Urban Outreach - Carver Community Center	Kokomo	46901	Food Pantry
New Life Church	Kokomo	46901	Food Pantry
Tzion Church	Kokomo	46901	Food Pantry
Wayman Chapel African Methodist Episcopal Church	Kokomo	46901	Food Pantry
Woodland Church Of God - Samaritan Love Center	Kokomo	46901	Food Pantry
Food Finders Mobile Pantry - Uaw Local 685	Kokomo	46902	Food Pantry
Food Finders Whistle Stop Pantry - Woodland Church Of God	Kokomo	46902	Food Pantry
Grace Community Foursquare Church	Kokomo	46902	Food Pantry
Kokomo Urban Outreach - Kokomo Regency	Kokomo	46902	Food Pantry
New Life Church	Kokomo	46901	Food Pantry
Tzion Church	Kokomo	46901	Food Pantry
Wayman Chapel African Methodist Episcopal Church	Kokomo	46901	Food Pantry
Woodland Church Of God - Samaritan Love Center	Kokomo	46901	Food Pantry
Food Finders Mobile Pantry - Uaw Local 685	Kokomo	46902	Food Pantry
Food Finders Whistle Stop Pantry - Woodland Church Of God	Kokomo	46902	Food Pantry
Grace Community Foursquare Church	Kokomo	46902	Food Pantry
Kokomo Urban Outreach - Kokomo Regency	Kokomo	46902	Food Pantry
Kokomo Urban Outreach - Kokomo Urban Outreach Reformation Faith Ministries	Kokomo	46902	Food Pantry
Food Finders Whistle Stop Pantry - Hands Of Grace Storehouse	Kokomo	46902	Food Pantry

Food Finders Whistle Stop Pantry - New Hope Church	Kokomo	46902	Food Pantry
Crossroads Community Church	Kokomo	46902	Food Pantry
Kokomo Urban Outreach - Pine Valley Community Room	Kokomo	46902	Food Pantry
New Hope Church	Kokomo	46902	Food Pantry
Saint Luke's United Methodist Church	Kokomo	46902	Food Pantry
Salvation Army Howard County	Kokomo	46902	Food Pantry
Jerome Christian Church	Greentown	46936	Food Pantry
Greentown Wesleyan Church	Greentown	46936	Food Pantry
Russiaville Community Food Pantry	Russiaville	46979	Food Pantry
JOB TRAINING			
Name	**City**	**ZIP Code**	**Service**
*Kokomo Rescue	Kokomo	46901	Life Skills Programs
*Aiming for Success	Kokomo	46901	Resume building, interviewing skills, assistance with job applications
*Advantage Home			Life Skills
*YMCA	Kokomo	46901	Financial management
Gilead House	Kokomo	46901	Career Counseling/Development
United Way of Howard County	Kokomo	46901	Job Search/Placement
Gilead House	Kokomo	46901	Job Search/Placement
Gilead House	Kokomo	46901	Pre-Job Guidance
Bureau of Rehabilitation Services, Indiana Division of Disability and Rehabilitative Services	Kokomo	46902	Vocational Assessment
Bureau of Rehabilitation Services, Indiana Division of Disability and Rehabilitative Services	Kokomo	46902	Vocational Rehabilitation
YOUTH MENTORING			
Name	**City**	**ZIP Code**	**Service**
Carver Community Center	Kokomo	46901	Enrichment Programs
Girl Scouts of Central Indiana	Kokomo	46901	Enrichment Programs
PARENTING EDUCATION AND SUPPORT			
Name	**City**	**ZIP Code**	**Service**
*Healthy Families	Kokomo	46901	Education, prevention, and crisis intervention programs to promote healthy families

IMPACT OF ACTIONS TAKEN SINCE THE 2015 CHNA

This evaluation discusses community health improvement actions taken by Community Health Network, Inc. (CHNw) to address significant community health needs since its last CHNA report was conducted. The significant health needs identified in the 2015 CHNA are access, obesity/diabetes and asthma. The impact (both expected and achieved) of each community health program is described below:

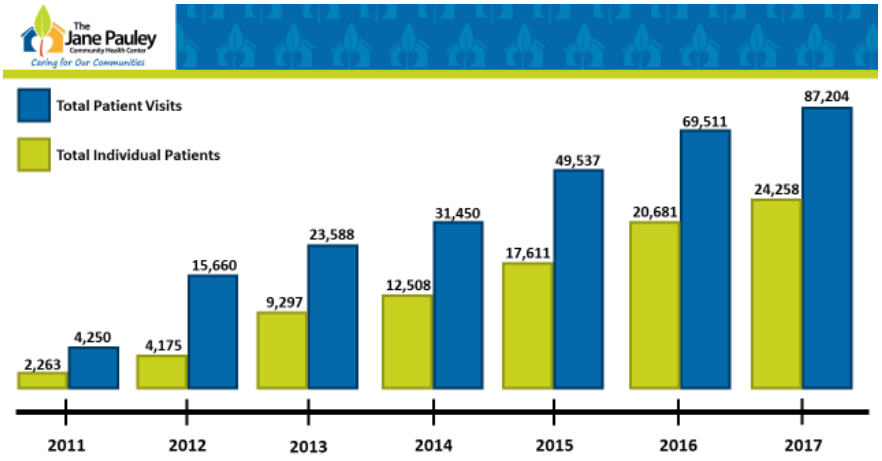
Priority Issue/Significant Health Needs are the following:

ACCESS

1. **Jane Pauley Community Health Center.** Regardless if a patient has the ability to pay for primary health services, Community Health Network strives to provide exceptional care to all of its patients. Community Health Network supports the Jane Pauley Community Health Center (JPCHC), which opened its doors in September 2009. The JPCHC is named after Jane Pauley, a former well-known news anchor that grew up in the Warren Township area;; one area in which JPCHC serves. Following JPCHC's inception, in 2011, the JPCHC was awarded Federally Qualified Health Center (FQHC) status by the Health Resources and Service Administration (HRSA). This recognition allows the JPCHC to serve more patients and expand its services.

   While there are 16 patient access sites in four counties, the JPCHC received approval in 2017 to expand their service area to 22 approved sites. Many of these expansion sites have been implemented in Madison County which resulted in a partnership with Alexandria Schools to provide Behavioral Health sites in all of their schools. Additionally, JPCHC partners with the Metropolitan School District of Warren Township, the Community Health Network Foundation, Hancock Regional Hospital, and Major Health Partners allowing it to offer the Emergency Department Voucher Program which allows patients the opportunity to come to a JPCHC site free of charge for a first visit. Services thereafter are provided on a discounted basis based on the patient's household income. The JPCHC offers a full range of services including primary healthcare, case management, prescription assistance and behavioral health services, while also focusing on the management of chronic diseases such as diabetes, cardiac disease and depression. Furthermore, JPCHC in partnership with IU School of Dentistry provides dental services at three dental centers, resulting in a total of 4,359 dental visits.
   In 2017, the JPCHC had 87,204 total visits, a nearly 25% increase from 2016, and nearly a 75% increase from 2015. The increase in patient visits over the past three years should be noted because JPCHC was the primary strategy for ACCESS. Moreover, JPCHC has a patient total of 24,258. See Figure 1.

Figure 1.



2. **School Based Clinics Program.** Community Health Network's school-based programs cover a wide range of needs for youth across Central Indiana. Onsite nurses, therapists and physicians address students' needs in the school and after-school setting, helping to ensure consistency in care and less time away from the classroom or playing field. The vast majority of these services, including any nursing or behavioral health support, are offered free of charge to schools thanks to Community's on-going commitment to enhancing health for future generations.

   From everyday scrapes and bruises on the playground to managing chronic illnesses like asthma and diabetes, Community nurses offer support for students at more than 100 schools in 11 school systems in the communities we serve. Their work ensured a 97.2 percent return to classroom rate for students who came to them for care in 2017 and 96.6 percent in 2016, respectively. See Table 2.

   Specific services offered to students include:

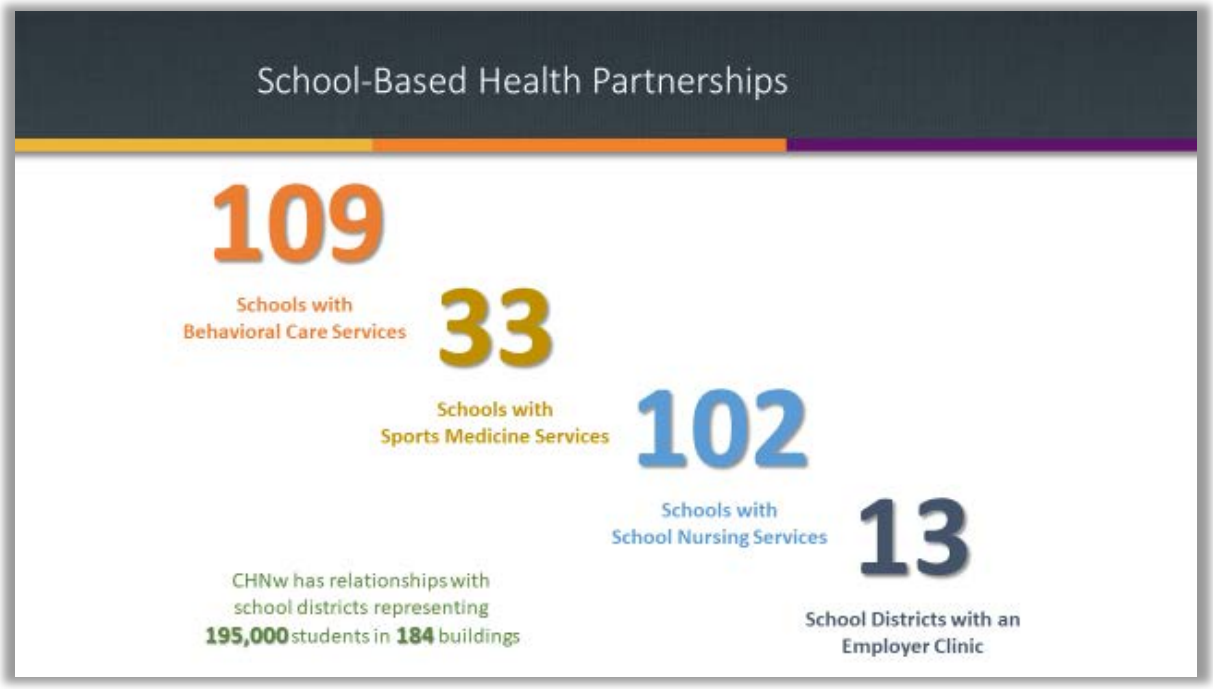
   - Management of injuries requiring first aid;
   - Management of life-threatening allergies, asthma, diabetes and seizures;
   - Management of any health concern and referral to appropriate care when needed; and
   - Emergency response to any health-related concern within the school building.

   In addition, for students facing chronic health conditions and ongoing health needs, medications prescribed by physicians are administered by Community's school-based nursing staff. Services also include physicals, immunizations, health coaching including blood pressure and cholesterol screening and a variety of additional services helping teachers and faculty battling everything from allergies to anxiety.

Table 2. School-Based Clinical Care Academic Year Comparison: Clinic Visit, Return to Class Percentage and Referrals

ACADEMIC SCHOOL YEAR	2017/2018	2016/2017	2015/2016	2014/2015	2013/2014
RUNNING TOTAL OF VISITS	825,436	770,405	650,314	507,331	443,271
RUNNING TOTAL RETURN TO CLASS %	97.28	96.6298	96.752	96.38816	96.19217
RUNNING TOTAL COMMUNITY REFERRALS	11,464	8,779	6,930	6,486	2,383

Figure 2.



3. **Rebuilding of Community Hospital East Hospital**. In order to address access to care issues on the eastside of Indianapolis, Community Health Network is investing in a new hospital slated to open in the spring of 2019. This new hospital will have new operating rooms, a larger emergency room and a 175-bed patient tower. The hospital will have 250,000 square feet of new space, less than the original hospital, but will be more efficient.

4. **Indiana Neuro Diagnostic Institute on the campus of Community Hospital East.** Community Health Network and the Indiana Family and Social Services Administration, an agency of the State of Indiana ("FSSA") collaborated for the development of the new Indiana Neuro Diagnositc Institute ("NDI"). The 159-bed facility is designed to fill a critical gap in the state's mental health landscape.

5. **Health Fair Screenings.** Aligning with the 2015 CHNA Implementation Strategy goal regarding increasing access to services, Community brought screenings and health education to the annual INShape Indiana Black and Minority Health Fair held alongside the Indiana Black Expo, Inc. Indiana Black Expo, Inc. has been a pillar of the community for nearly 40 years. Community's presence at the Minority Health Fair is made possible by the efforts of many Serve360 volunteers including more than 206 Community employees who volunteer at CHNw's booth. In 2017, CHNw completed 1186 health screenings, including its "one-stick" lab testing for a range of conditions, from diabetes to cholesterol screenings, sickle cell testing to sexually transmitted diseases. Providers from Community Physician Network participated in an "Ask the Doctor" service, and Community Touchpoint shared valuable information with attendees on Senior Night. Clinical breast exams were also available in 2017 as well. Because many attendees do not have regular access to primary care, we offer to schedule an appointment and make connections for additional care. Community Health Network also extended its reach in the community by providing over 400 health screenings at the Circle Up Indy, Latino Expo, and INPride events in 2017. More than 171 Serve360 volunteers supported these events. In 2016, CHNw provided approximately 1,300 health screenings to attendees.

6. **Medical-Legal Partnership.** The purpose of a medical legal partnership (MLP) is to improve health outcomes for patients through the provision of legal services that impact social determinants of health. Hospitals often see patients who are suffering from acute and chronic medical conditions caused or aggravated by conditions in patients' homes, issues in the patients' relationships or patients' lack of income and other resources. Embedding an MLP attorney in the hospital allows the hospital and the MLP to work together as a team to provide patients with the medical care and legal services they need to become healthy and stay healthy. From addressing habitability issues in a patient's home to helping a patient obtain a clean slate so the patient may find employment, the hospital and MLP work together to improve patient outcomes by treating the patient as a whole.

   CHNw's dedication to its patients and the community CHNw serves has allowed the MLP to address civil legal issues that prevent patients from getting well and staying well as well as impact the patient's access to care. During its first year, the MLP recovered more than $133,000 for

patients in benefits, debt forgiveness, and property recovery. The MLP provided more than 40 advance directives for patients in the first year, a cost savings of more than $250 per patient per document based on local rates. The MLP provided estate planning to approximately 10 patients in its first year, a savings of approximately $795 per estate plan based on local rates. Nearly 200 patients received advice and/or representation from the MLP in 2017.

7. **Milk for Healthy Babies**. Community Hospital Anderson established a human milk program to ensure the best range of options for newborns in our care. Affiliated with The Milk Bank, a nonprofit donor human milk bank located in Indianapolis, Community Hospital Anderson now makes pasteurized human milk available for newborns, primarily to premature infants in the hospital neonatal intensive care units. In 2017, Community Hospital Anderson was able to serve 153 babies and had 1,196 ounces of pasteurized donated milk. Community Hospital Anderson will also serve as a milk depot, a location where breastfeeding mothers can drop off donated milk.

8. **Community Paramedicine Programs**. Community Paramedicine is an integrated approach to transitional care. Emergency personnel known as Paramedics fill a critical gap in the healthcare system by primarily responding to the medical need of patients with chronic disease, especially in underserved populations. Additionally, community paramedics can work in collaboration with local public health agencies and primary care roles to identify gaps in care and address the needs of the community.

   With the understanding of the paramedicine program benefits, CHNw launched its first community paramedicine program in July 2014, known as the *WeCare: A Community Paramedicine Program* which serves the north district of Indianapolis. In 2017, the network's paramedicine program expanded to include two additional programs: The Community *Cares* Paramedicine Program that serves the east district and the Beech Grove *Cares* Community Paramedicine program that serves both the east and south districts within the service area of the Beech Grove Fire and Rescue Departments. Through these programs, the network has increased patient support during critical healthcare transitions in care and hopes to see an overall improvement of chronic disease self-management skills.

9. **Faith Health Initiative**. CHNw understands the essential role the faith communities play in promoting and sustaining wellbeing. Faith-based organizations improve the quality of life of their members, neighbors and communities by providing spiritual care, a supportive web of resources and impactful wellness ministries. We know this is true for many of our patients whose faith communities are an indispensable part of their care team.

   For this reason, CHNw developed the Faith Health Initiative (FHI). This initiative paves the way for a faith-health partnership. Built on respect, this partnership recognizes that both faith communities and high-quality, medical treatment play a vital role in restoring health and promoting wellbeing, and that by working together, we are better able to meet the needs of our communities.

10. **Have Hope.** The Indiana Division of Mental Health and Addiction and CHNw, have partnered to spearhead the State's suicide prevention movement to save young lives. With an aspirational goal of achieving a zero percent suicide incident rate among patients by 2024, Community Health Network's Zero Suicide initiative aims to save Hoosier lives specifically through early intervention and prevention, the construction of a robust Central Indiana crisis network, and the utilization of innovative mental health diagnostics and treatment protocols. The strategy brings crisis, telemedicine and intensive care coordination services to more than 600 primary care physicians, 10 emergency departments and 12 hospitals located throughout the state, representing both Community facilities and partner organizations where Community provides behavioral health services. As part of the effort to combat suicide among young Community provides mental health and substance abuse services to students in more than 80 sites for Indianapolis Public Schools and the Metropolitan School Districts of Lawrence, Warren, Washington and Wayne townships. In addition, Community Health Network and WTHR-TV Channel 13 joined forces to launch *Have Hope*, a two-year public service effort to raise awareness about suicide in Indiana and to help more Hoosiers get the help they need. The Have Hope effort complements Community's HaveHope.com, an online suicide prevention resource for teenagers, parents and educators. In 2017, there was a total of 17,366 visits to the website.

11. **Operation Overcome: Helping Officers Save Lives.** Police in two of our regions, Howard and Anderson/Madison Counties, are on the front lines of the opioid epidemic, equipped with medication from Community. Community Howard Regional Health, together with officials from Howard County and the city of Kokomo, continue a joint effort to equip additional first responders with the drugs, devices and training needed to offer potentially lifesaving treatment to opioid overdose victims. Through Operation Overcome, Community Howard donates the drug naloxone, nasal atomizers and bag valve masks to approximately 75 personnel within the Kokomo Police Department. Community Howard will donate the same assets to 65 personnel affiliated with Howard County, including the Sheriff's Department, Howard County Criminal Justice Center and Adult Probation. Community Anderson has trained and equipped all Madison County patrol officers with Narcan. Officers used Narcan twice in the first two weeks since they were trained, saving two lives.

12. **Fishers Mental Health Task Force.** Community Health Network, Hamilton Southeastern Schools and City of Fishers created a unique partnership to consider how to pool resources and coordinate efforts to ensure that mental health challenges are addressed within the community. The mission of the mental health task force was to develop a community that embraces mental health treatment before crises occur, protect the welfare and safety of Fishers residents and take a systemic approach to mental health challenges in the community.

    Community Health Network provided licensed providers for six schools and started providing an on-site therapist along with a transition coordinator to assist students and families transitioning out of inpatient treatment and back into school. They launched a suicide prevention curriculum for students in grade 8-12. All teachers completed Question, Persuade, and Respond (QPR) suicide prevention training. The task force also did outreach to the community with a Big Brains installation to encourage conversation around brain health. They hosted a booth at the Fishers Farmer's Market and Fishers Freedom Festival to spread awareness about mental health. A

Campaign to Change Direction pledged to change the culture around mental illness in the schools and the city to eliminate the stigma surrounding mental health. #StigmaFreeFishers .

13. **Crisis Intervention Training for Marion, Boone and Hamilton County**. A Crisis Intervention Team (CIT) program is a model for community policing that brings together law enforcement, mental health providers, the National Alliance on Mental Illness (NAMI), hospital emergency departments and individuals with mental illness and their families to improve responses to people in crisis. The CIT programs provide officers with 40 hours of intensive training, including a four-hour shadowing experience in a local Crisis Department, which is offered at the Crisis Department at Community Hospital North. In 2017, the Community Health Network CIT Training expanded the reach of its program in several counties throughout Indiana, totaling 393 trainees. These trainees ranged from a variety of professions that included dispatchers, medics, hospital police/security, deputy prosecutors, and behavioral health staff.

14. **Community Hospital Graduate Medical Education programs (GME).** Community Health Network sponsors multiple advanced medical education training programs, and is in itself a sponsoring institution for GME. Graduate medical education represents the post-medical school education and clinical service training of physicians. Currently, Community sponsors two family medicine programs, East and South; a psychiatry residency training program; a hospitalist fellowship program; a podiatry residency program, a proctology program, and is developing additional training programs.
    - Community Hospital East Family Medicine Residency Program. Since the program began, 221 graduates have completed training. Community trains ten residents per year in this program.
    - The South Osteopathic Family Medicine Program. This program received preliminary approval by the ACGME after moving from the AOA (as all programs must now do) in 2017.
    - Psychiatry Residency Program. Community's new psychiatry residency program received accreditation in February 2015 and accepted its first class in July 2016. We are currently recruiting for our third class to begin July 2018. The residency sponsors four trainees for each of four years. Community Hospital North Behavioral Health Pavilion serves as the site for multiple rotations, including emergency medicine, neurology, consultation liaison psychiatry, inpatient psychiatry, inpatient geriatric psychiatry, inpatient child and adolescent psychiatry, and emergency psychiatry.
    - Podiatry Residency Program. Community provides podiatry residents with a diverse education in all aspects of podiatric medicine including advanced wound care, sports medicine, surgery, inpatient care and private office management. Residents can expect an abundance of first-hand surgical experience including forefoot procedures, trauma, and reconstructive rear foot and ankle cases. Currently, residents cover five hospitals and seven surgery centers in our expanding health network, with a receptive educational community.
    - Hospitalist fellowship program. The program at South CHS started two years ago, and is a one year training program which allows graduates of internal medicine or family medicine programs to train to work in adult hospitalist and intensive care settings. The

program has graduated and retained three of four trainees, and is starting in August with two more.

- Medical Assisting (MA) Fellowship Program. MA Fellowship Program was created with the help of Community Health Network Foundation in late 2010. CHNw experienced a large number of open MA positions while experiencing difficulty to fill those positions with highly qualified staff. The MA Fellowship Program began as a pipeline strategy to recruit and retain highly skilled in MAs and continues to support the continued demand for qualified MAs. CHNw has affiliation agreements with nine colleges within the Indianapolis and Anderson region. Community Health Network is the only network within the Indianapolis region that has a full program to support MA externs within our ambulatory sites with additional clinical orientation and EMR training. Since the program began, CHNw has received 637 student applications with 391 selected to date. In 2017 we received 57 applications with 35 selected and completed the program. The overall retention rate for 2017 is 96%.
- Pharmacy Residency Program. Our pharmacy residency programs provide training for four residents in the PGY1 year with additional residents in ambulatory care, pharmacotherapy and psychiatry.

15. **Medicaid and Medicare Providers.** All employed physicians are required to treat Medicaid and Medicare patients.

OBESITY/DIABETES

Access to affordable, fresh, and healthy whole foods is a challenge for many people that live in Central Indiana. In Indiana, 14.8% of families are food insecure with the national average being 13.7%. In Marion County, 175,000 people are classified as food insecure of which 42,000 (27%) are children. Through various partnerships, Community seeks to connect low-income families and individuals to fresh, Indiana-grown food that provides real sustenance for themselves and their communities. This initiative is part of the 2015 Community Health Needs Assessment (CHNA) implementation strategy to address diabetes/obesity issues in the community.

1. **Community Gardens.** CHNw supports many urban farming and farmers market initiatives that provide fresh produce and healthy options. In the summer of 2018, CHNw planted 30 community gardens at schools and community centers. This enabled members of the community from children to senior citizens to grow fresh vegetables. Community members harvested and used over 1200 pounds of vegetables from these community gardens during the 2018 summer.

2. **Partnerships with Community Organizations.**
    a. Community supports the Market at Hague that is an initiative of Binford Redevelopment and Growth (BRAG). The Market at Hague joined with other farmer's markets in 2013 to start a token program to help farmers market vendors accept Supplemental Nutrition Assistance Program (SNAP) and to help get more farm-direct produce into the hands of our low-income neighbors. Formerly known as the Food Stamp Program, SNAP benefits are distributed through the Hoosier Works Card, which is used like a debit card. This

helps our community members leverage Indy Hunger Network's Fresh Bucks program that is an incentive program that doubles SNAP dollars on purchases of Indiana-grown specialty crops. A SNAP user can get up to an extra $20 to spend around the market. The dollar for dollar match can be used to purchase Indiana-grown: fresh and dried produce, herbs, honey, maple syrup, and even seedlings for edible plants. In 2017, more than 1,100 persons per week visited the Market from April to October. In 2018, that number doubled per week.

b. Felege Hiywot Center. Community Health Network collaborates with Felege Hiywot Center (Felege) which supports youth and environmental preservation in Indianapolis. Felege houses a youth development program wherein high school students from Indianapolis and surrounding counties work together to manage an urban farming plot.

c. CHNw also partnered with Brandywine Creek Farms to create the Rolling Harvest Food Truck Pilot Program to neighborhoods in 2017, respectively, that were experiencing food insecurity issues as a result of the closing of Marsh Supermarkets, particularly on the east side of Indianapolis. The Rolling Harvest delivered fresh produce to the following locations on a weekly basis during the summer months:

- The Cupboard of Lawrence
- Community Hospital East ("The Market at East")
- The Shepard Center
- The Community Alliance of the Far East Side

As a result of this partnership, CHNw provided fresh fruits and vegetables to over 1,000 persons free or at a very low cost in 2017 and 2018, respectively. A survey of those served indicated the following:

1. 100% said the quality of produce "good" to "excellent"
2. 56% said they were eating more fruits and vegetables now that Rolling Harvest came to their community
3. 52% said that if it were not for Rolling Harvest they would not have access to fresh fruits and vegetables.

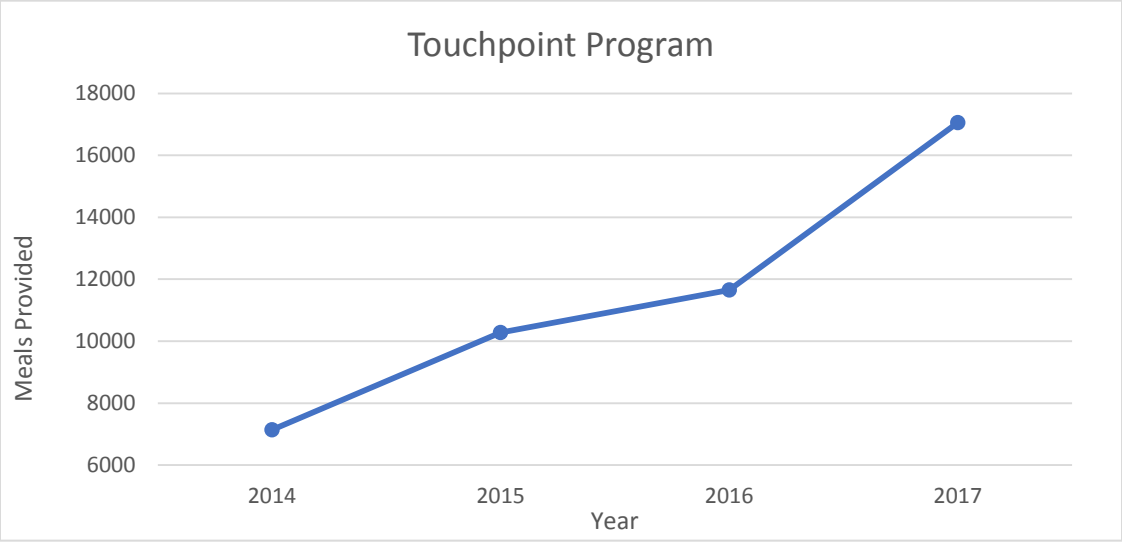
Additionally, in 2017 CHNw's leadership packed over 1,200 grab and go bags (equaling 14,000-16,000 pounds of fresh produce) for residents in food insecure areas. The Board of Directors, in 2018, packed 1200 grab and go bags for children who were food insecure for one of the township schools in which it has a school based clinics.

3. **Community Cupboard of Lawrence.** In 2016, the Lawrence Township Hunger Coalition transitioned *The Cupboard of Lawrence Township* to the Community Health Network. The Cupboard is a client-choice food pantry that helps relieve the strain caused by food insecurity, and is open Wednesdays from 10 a.m. to 4 p.m. and 6 p.m. to 8 p.m., and Fridays from 10 a.m. to 4 p.m.. The Cupboard continues to assist residents of Lawrence Township of Indianapolis, specifically in the area codes of 46216, 46220, 46226, 46235, 46236, 46249, 46250, and 46256. In 2017, it served 56,435 individuals, which represents 16,518 households. In 2016, it served 57,317 individuals, which represent 13,526 households.

With an awareness of this great need, Community Health Network partners with Gleaners Food Bank of Indiana, Midwest Food Bank, CVS Pharmacy, and Meijer to support the Cupboard by providing produce, over-the-counter medicines, and various toiletries to our clients. Community Health Network has also established partnerships with local religious institutions, Harrison Hills Elementary School and Monarch Beverage who help serve our clients and ensure that they have access to fresh produce. Furthermore, organizations and businesses volunteer at the Cupboard, and Purdue Extension assists with keeping Community Health Network aware of recent USDA updates along with providing innovative food options and ideas for our clients.

The Cupboard of Lawrence Township also offers Cooking Matters classes to its clients. In the Cooking Matters classes, clients learn how to cook meals using food that the pantry provides to the community. They are required to attend four out of six classes in order to receive credit and cooking utensils/pots and/or pans. This opportunity is in partnership with the Indy Hunger Network, the Marion County Public Health Department, and the YMCA Top 10 Coalition.

4. **Touchpoint's Senior Meals Program.** Community Health Network supports the needs of seniors through nutrition with the À la Carte Senior Meal Program, made possible through collaboration with Community Health Network Foundation and CICOA Aging and In-Home Solutions. This program aims to expand the availability of healthy meal options for seniors, while also providing opportunities for social engagement through the free membership program. Meal recipients must be 60 and older, or the spouse of an enrollee. Up to four meal vouchers are available each month. Recipients may redeem meal vouchers for breakfast, lunch or dinner at any of Community's hospital cafeterias, and designated menus are designed by a registered dietitian to ensure a nutritionally balanced meal for seniors. Participants choose a meat or protein item, one hot side item, one cold side item and a beverage. The program provided 17,051 meals to seniors in 2017. The line graph displays the increase of meals provided from the year 2014 to 2017.



5. **Jump IN**. CHNw provides support to Jump IN for Healthy Kids that is a community-wide effort to give children and families real opportunities to make healthy choices. Jump IN has created a comprehensive, multi-sector strategy that engages the entire community in implementing a set of evidence-based interventions to improve the policies and practices in those places that most directly influence the behaviors of children and families. The Jump IN initiative focuses on creating Healthy Places, Healthy Neighborhoods, and Healthy Communities where healthy choices are the easy and default choices. In 2017, Jump IN expanded the number of childcare providers trained to 158 impacting 13,705 children, we increased the number of schools utilizing the Fitness gram Assessment Tool to 178, which affects 25,801 children, and pushed its employer wellness toolkit through multiple employer channels to make it easier for small to mid- size employers to get started in worksite wellness. They also began food access work by collaborating with The Food Trust on analysis of the food access space in our county and determining the role for healthy corner stores in the mix of food access resources.

- Childcares: 15 childcares participated in the CDC funded Taking Steps to Healthy Success Childcare training affecting nearly 350 preschoolers. The centers adopted an average of 22 additional best practice policies or practices.
- Schools: Fifteen school buildings initiated healthy eating improvements and seven completed the project in the 2017-18 school year, benefitting 4,170 K-6 students. In the first year of implementation, more than 3,000 students participated in Go Noodle activities each month, racking up 2.3 million minutes of physical activity during 2017-18. This tool allows teachers to utilize videos that combine physical activity with learning. Go Noodle helped these teachers and students move from 67% to 75-80% of their target 30 minutes of physical activity per day.
- Community Gardens: Several new community gardens provided more than 12,000 pounds of fresh produce to local residents -- through farmers markets, mobile delivery to apartments, and donations to local food pantries. Food pantry directors estimated that 2,500 people received fresh produce at the pantries last year.
- Healthier Food Pantries: Purdue Extension worked with three local pantries to add “healthy nudges” such as labeling healthy food options and incorporating cooking workshops to increase consumption of healthier foods, including fresh produce.
- Public Awareness: Jump IN created a 52-week public awareness campaign based on Let’s Go! Maine’s 5-2-1-0 program (with resources in English and Spanish). Lawrence Township Schools, Benjamin Harrison YMCA and Community Health Network are sharing these messages on their email and social media platforms, resulting in tens of thousands of impressions for local families.
- Clinician Engagement: Jump IN partnered with Community Health Network (CHNw) and Energy Krazed, a not-for-profit that provides an individually designed nutrition and activity plan for children ages 11-18, on a physician-supervised healthy weight treatment pilot. Six children and their families were engaged to improve five mental and physical health goals. All participants made improvement in four out of the five goals as evaluated using nationally recognized measures.
- Employers. Collaborating with the Lawrence Chamber of Commerce and the Indy Chamber, Jump IN invited local employers to participate in an employee wellness-coaching program. One business has joined the program and we are continuing to engage additional employers.
- Physical Activity/Built Environment: Three local organizations launched new physical activity programs for youth, providing an estimated 20 hours of structured activity each week for approximately 350 young people.

ASTHMA

CHNw has commenced an Asthma Initiative in school-based clinical care to address pediatric asthma. The types of interventions include training teachers in signs of asthma, zone education, and referral to Asthma Education Class, training the student to use the asthma spacer and providing spacers to students who cannot afford the nebulizer.

Community also provides asthma education and training to patients and members of the community in all of its regions.

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