Community Benefit Plan 2016

Community Health Needs Assessment
2016 – 2019 Implementation Strategy

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The Community Health Network's Community Benefit Plan has developed from the strategic objectives and practices of our founding organization, as well as those of the neighborhoods and businesses surrounding Community Hospital East. Our principles and practices are echoed in the teachings of Dr. Elinor Ostrum, a Nobel Prize winner in Economics, the "Triple Aim" of Dr. Don Berwick, and the Institute for Healthcare Improvement. These innovative and efficacious community development and data driven approaches have been thoroughly consulted and applied in the CHNW Community Benefit Plan.

Introduction

In December 2014, the Internal Revenue Service and the Treasury Department published final rules implementing the Affordable Care Act's requirements for tax-exempt hospitals. The rules state that these tax-exempt hospitals must aim to "…prevent illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community."

The Community Health Network has subscribed to these objectives since its inception. In the1950's, the desire to improve upon community health led Indianapolis' Eastside citizens to raise funds to build a hospital. Today, this Eastside hospital has grown and expanded into the Community Health Network, the second largest not-for-profit health system in Indiana. The Community Health Network's purpose and goals remain based on commitment and compassion in serving the community. Such commitment extends to neighborhoods, schools, businesses and churches. Like our founding community members, The Community Health Network views community organizations as pillars and core strengths. We believe that any lasting cultural change in community health status will be driven by local communities themselves—that they are the key towards identifying and addressing needs. As such, we remain committed to working with them to ensure a thriving population of healthy individuals through myriad ambitious, sustainable initiatives.

The 2015 Community Health Needs Assessment (CHNA) and this 2016 Implementation Strategy (IS) were undertaken by the health network to understand and address community health needs, and in accordance with proposed Internal Revenue Service (IRS) regulations pursuant to the Patient Protection and Affordable Care Act of 2010.

Our implementation strategy identifies the significant community health needs described in the CHNA that the hospital plans to address in whole or in part. The hospital reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and merit enhancements to the described strategic initiatives. Alternately, other organizations in the community may decide to address certain community health needs, and the hospital may amend its strategies and refocus on other significant health needs. Beyond the initiatives and programs described herein, the hospital is addressing some

of these needs simply by providing health care to the community, regardless of ability to pay.

About Community Health Network

Community Benefit Plan / Implementation Strategy

The board of our network plays an integral role in our community benefit plan and is involved in setting strategy—communicating within the organization and the community at large. Our leadership team members, the network board, and numerous physician leaders have developed this strategic plan and vision for our network. Our plan will serve as our roadmap from 2016 through 2020.

Mission

"Deeply committed to the communities we serve, we enhance health and well-being."

Values

Our values can be encapsulated as follows:

Patients First, Relationships, Integrity, Innovation, Dedication, Excellence

Vision

To be an integrated health care delivery system – centered on patients and inspired by physicians and other clinicians, recognized and accountable for:

- Advancing the health status of our communities through outreach, wellness and prevention.

History

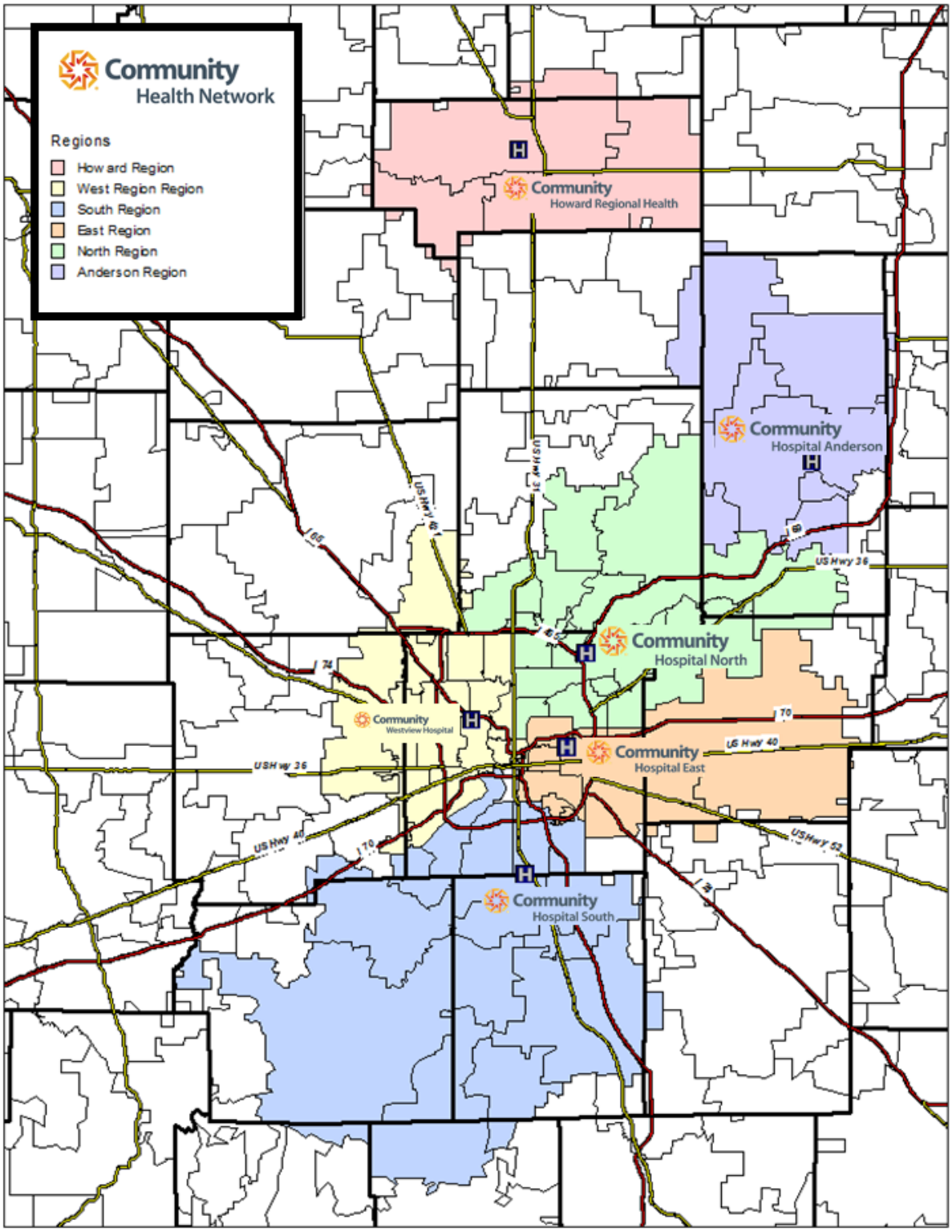
In 1954 the citizens on Indianapolis' east side decided to raise funds and build a hospital to serve the community. They did not have a name for the collective trust, action, cooperation or stewardship necessary in dealing with such a complex health and social dilemma. Nor did they understand that their transformation in 1954 would inform the leadership of the organization they initiated more than half a century later, to continuously progress health care on the Indianapolis Eastside into a better and more sustainable system in 2013. It wasn't until 2009 that the term for this collective care for the community and its resources was coined "care for the commons" by Indiana University Professor Elinor Ostrum. Her research has validated what we have known and experienced since 1954—that a community can manage its own resources

successfully. Her theory was considered so significant she won the Nobel Prize in Economics.

Today Community Health Network is ranked among the nation's most integrated healthcare systems. Community Health Network is Central Indiana's leader in providing convenient access to exceptional healthcare services, where and when patients need them. This includes providing services and support in hospitals, health pavilions and doctor's offices, or within workplaces, schools, and homes. As a non-profit health system with over 200 affiliated care sites throughout Central Indiana, Community Health Network'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.

Overview of Communities Served by Community Health Network

Figure I: Map of Service Regions:



The above map illustrates our service area, which reaches into 11 Indiana Counties.

Demographics of the community:

Each hospital facility has a defined services area as illustrated in the map above. What follows is an example of the demographics for an individual zip code in the East service area. Each service area has its own set of data that is reviewed for the implementation strategy. Below is a comprehensive analysis of the demographics compiled by searching our online database. Anyone with a computer can access this data. Our hope is that such access allows the community health needs assessment to be in "real time," so that data updated and collected at the beginning of a project can be compared to real-time data throughout a project's lifespan, encouraging continual feedback and improvement. For example, the same chart can be constructed by anyone, and the results can be found online at:

http://chn.thehcn.net/demographics

Demographics

Location Type: Zip Code Location: 46219

2015 Base Counts			
2015 Population	34,672	940,939	6,613,067
2015 Households	15,021	379,925	2,556,127
2015 Housing Units	17,379	432,898	2,868,109
2015 Families	8,482	226,236	1,710,950
Percent Pop Growth 2010 to 2015	1.58%	4.16%	1.99%
Percent Household Growth 2010 to 2015	2.93%	3.75%	2.16%
Percent Housing Unit Growth 2010 to 2015	2.72%	3.60%	2.60%
Percent Family Growth 2010 to 2015	2.89%	3.62%	2.20%
2015 Population by Sex and Ethnicity			
2015 Population by Sex	34,672	940,939	6,613,067
2015 Population by Ethnicity	34,672	940,939	6,613,067
2015 Population by Single Race and Sex			
White	24,794 (71.51%)	575,031 (61.11%)	5,503,824 (83.23%)
Black/Af Amer	6,564 (18.93%)	255,376 (27.14%)	617,304 (9.33%)
Am Ind/AK Native	95 (0.27%)	2,842 (0.30%)	19,883 (0.30%)
Asian	345 (1.00%)	22,374 (2.38%)	124,521 (1.88%)
Native HI/PI	6 (0.02%)	464 (0.05%)	2,736 (0.04%)
Some Other Race	1,842 (5.31%)	55,135 (5.86%)	196,379 (2.97%)

2+ Races	1,026 (2.96%)	29,717 (3.16%)	148,420 (2.24%)
2015 Pop by Ethnicity and Single Race			
Hisp/Lat	3,051 (8.80%)	96,606 (10.27%)	445,227 (6.73%)
Not Hisp/Lat	31,621 (91.20%)	844,333 (89.73%)	6,167,840 (93.27%)
2015 Population by Age			
2015 Population by Age	34,672	940,939	6,613,067
2015 Pop, Age <18	7,962 (22.96%)	238,412 (25.34%)	1,584,011 (23.95%)
2015 Pop, Age 18+	26,710 (77.04%)	702,527 (74.66%)	5,029,056 (76.05%)
2015 Pop, Age 25+	24,102 (69.51%)	613,522 (65.20%)	4,342,468 (65.66%)
2015 Pop, Age 65+	5,654 (16.31%)	110,031 (11.69%)	960,459 (14.52%)
2015 Median Age	40.30	34.70	37.60
2015 Population by Sex and Age			
2015 Male Population by Age	16,783	454,758	3,257,585
2015 Pop, Male: Age <18	4,148 (24.72%)	121,713 (26.76%)	809,954 (24.86%)
2015 Pop, Male: Age 18+	12,635 (75.28%)	333,045 (73.24%)	2,447,631 (75.14%)
2015 Pop, Male: Age 65+	2,252 (13.42%)	45,605 (10.03%)	417,754 (12.82%)
2015 Median Age Male	38.20	33.60	36.30
2015 Female Population by Age	17,889	486,181	3,355,482
2015 Pop, Female: Age <18	3,814 (21.32%)	116,699 (24.00%)	774,057 (23.07%)
2015 Pop, Female: Age 18+	14,075 (78.68%)	369,482 (76.00%)	2,581,425 (76.93%)
2015 Pop, Female: Age 65+	3,402 (19.02%)	64,426 (13.25%)	542,705 (16.17%)
2015 Median Age Female	42.30	35.80	38.80
2015 Pop 5+ by Language Spoken at Home			
Speak Only English at Home	29,500 (91.31%)	760,574 (87.40%)	5,669,554 (91.64%)
Speak Spanish at Home	2,214 (6.85%)	74,089 (8.51%)	284,605 (4.60%)
Speak Asian/PI Lang at Home	137 (0.42%)	10,510 (1.21%)	69,024 (1.12%)
Speak Indo-European Lang at Home	373 (1.15%)	17,196 (1.98%)	139,977 (2.26%)
Speak Other Lang at Home	82 (0.25%)	7,834 (0.90%)	23,431 (0.38%)

2015 Pop 15+ by Sex, Marital Status			
Never Married	9,181 (32.90%)	284,514 (38.49%)	1,592,040 (30.02%)
Married, Spouse present	10,990 (39.39%)	277,084 (37.48%)	2,551,794 (48.11%)
Married, Spouse absent	1,282 (4.59%)	35,059 (4.74%)	174,383 (3.29%)
Divorced	4,496 (16.11%)	103,477 (14.00%)	667,939 (12.59%)
Widowed	1,955 (7.01%)	39,128 (5.29%)	317,877 (5.99%)
2015 Owner-Occ Housing Units by Value			
2015 Own Occ HUs Median Value	$104,664	$127,980	$132,846
2015 Own Occ HUs Avg Value	$114,613	$157,272	$164,793
2015 Households by Number of People in Household			
2015 Households	15,021	379,925	2,556,127
2015 Average Household Size	2.26	2.43	2.51
2015 Households by Presence of People Under 18			
2015 Households, People < 18	4,153 (27.65%)	122,787 (32.32%)	853,189 (33.38%)
2015 Occupied Housing Units by Year Householder Moved In			
2015 Median Length of Residence	10.20	9.30	10.60
2015 Renter Occ Housing Units: Median Length of Residence	6.10	5.80	6.10
2015 Owner Occ Housing Units: Median Length of Residence	13.50	12.40	13.00
2015 Occupied Housing Units by Vehicles Available			
2015 Avg Number Vehicles Available	1.60	1.60	1.80
No Vehicle	1,518 (10.11%)	35,904 (9.45%)	177,024 (6.93%)
1 Vehicle	5,766 (38.39%)	155,710 (40.98%)	839,487 (32.84%)
2 Vehicles	5,699 (37.94%)	134,310 (35.35%)	998,470 (39.06%)
3 Vehicles	1,569 (10.45%)	40,300 (10.61%)	379,801 (14.86%)
4 Vehicles	314 (2.09%)	9,910 (2.61%)	115,921 (4.54%)
5+ Vehicles	155 (1.03%)	3,791 (1.00%)	45,424 (1.78%)
2015 Households by Household Income			
2015 Households by Income	15,021	379,925	2,556,127
2015 Median Household Income	$39,962	$42,577	$49,030
2015 Average Household Income	$52,412	$57,776	$64,249
2015 Households by Race and Household Income			

2015 Median HH Inc, White	$43,561	$49,455	$51,913
2015 Avg HH Inc, White	$55,341	$63,736	$64,991
2015 Median HH Inc, Black/Af Amer	$26,992	$30,246	$30,790
2015 Avg HH Inc, Black/Af Amer	$36,188	$41,377	$42,661
2015 Median HH Inc, Am Ind/AK Native	$34,500	$37,780	$41,337
2015 Avg HH Inc, Am Ind/AK Native	$56,646	$50,491	$56,050
2015 Median HH Inc, Asian	$32,955	$49,992	$56,428
2015 Avg HH Inc, Asian	$53,761	$62,647	$75,253
2015 Median HH Inc, Native HI/PI	$25,000	$21,022	$34,437
2015 Avg HH Inc, Native HI/PI	$25,000	$26,317	$56,046
2015 Median HH Inc, Some Other Race	$39,756	$30,640	$37,053
2015 Avg HH Inc, Some Other Race	$45,851	$34,961	$45,242
2015 Median HH Inc, 2+ Races	$54,049	$34,624	$39,746
2015 Avg HH Inc, 2+ Races	$60,885	$47,919	$52,258
2015 Households by Ethnicity and Household Income			
2015 Median HH Inc, Hisp/Lat	$33,793	$30,144	$38,911
2015 Avg HH Inc, Hisp/Lat	$45,407	$41,493	$52,934
2015 Median HH Inc, Not Hisp/Lat	$40,579	$43,849	$49,574
2015 Avg HH Inc, Not Hisp/Lat	$52,814	$58,965	$64,789
2015 Families by Poverty Status			
2015 Families Below Poverty	1,248 (14.71%)	37,796 (16.71%)	192,651 (11.26%)
2015 Families Below Poverty with Children	1,016 (11.98%)	31,141 (13.76%)	153,783 (8.99%)
2015 Population by Sex and Educational Attainment			
2015 Population 25+ with Less Than High School Graduation	3,987 (16.54%)	93,095 (15.17%)	545,925 (12.57%)
2015 Population 25+, Male, with Less Than High School Graduation	1,952 (17.24%)	45,315 (15.68%)	275,045 (13.12%)
2015 Population 25+, Female, with Less Than High School Graduation	2,035 (15.92%)	47,780 (14.73%)	270,880 (12.06%)
Population 25+ by Educational Attainment	24,102	613,522	4,342,468
Male Population 25+ by Educational Attainment	11,323	289,060	2,095,591
Female Population 25+ by Educational Attainment	12,779	324,462	2,246,877
2015 Population Age 16+ by Employment Status			
2015 Percent Civ Labor Force Unemployed	11.79%	11.39%	9.30%
2015 Percent Civ Labor Force Unemployed Male	11.41%	11.46%	9.62%
2015 Percent Civ Labor Force Unemployed Fem	12.19%	11.31%	8.94%
2015 Workers by Means of Transportation to Work			
Means of Transportation to Work	15,268	433,974	3,021,721
2015 Workers by Travel Time to Work			
Travel Time to Work	15,019	421,397	2,922,428

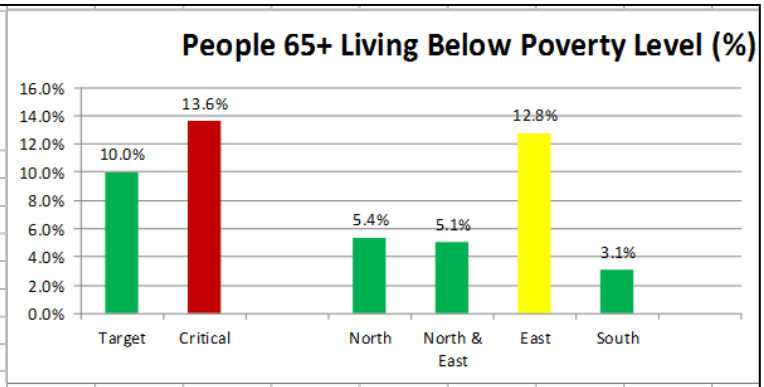
2015 Avg Commute (minutes) Workers Worked Away	25	25	26
2015 Employed Civilian 16+ Population by Industry			
Accommdtn/Food Svcs	1,120 (7.35%)	39,545 (9.06%)	225,260 (7.42%)
Admin/Spprt/Waste Mgmt	1,006 (6.60%)	24,654 (5.65%)	107,781 (3.55%)
Agriculture/Forest/Fish/Hunt	45 (0.30%)	1,233 (0.28%)	42,911 (1.41%)
Entertainment/Rec Svcs	225 (1.48%)	7,516 (1.72%)	51,804 (1.71%)
Construction	1,215 (7.98%)	22,920 (5.25%)	177,409 (5.85%)
Educational Svcs	870 (5.71%)	32,361 (7.41%)	284,185 (9.36%)
Fin/Insur/RE/Rent/Lse	998 (6.55%)	28,665 (6.57%)	160,480 (5.29%)
Health Care/Soc Asst	2,287 (15.01%)	64,797 (14.84%)	422,495 (13.92%)
Information	297 (1.95%)	6,705 (1.54%)	43,981 (1.45%)
Mgmt of Companies	27 (0.18%)	340 (0.08%)	1,848 (0.06%)
Total Manufacturing	1,789 (11.74%)	49,384 (11.31%)	577,993 (19.05%)
Oth Svcs, Not Pub Admin	784 (5.15%)	20,197 (4.63%)	147,449 (4.86%)
Prof/Sci/Tech/Admin	645 (4.23%)	26,284 (6.02%)	131,860 (4.35%)
Public Administration	887 (5.82%)	19,384 (4.44%)	106,211 (3.50%)
Retail Trade	2,086 (13.69%)	57,368 (13.14%)	358,266 (11.81%)
Transport/Warehse/Utils	781 (5.13%)	27,908 (6.39%)	160,027 (5.27%)
Wholesale Trade	490 (3.22%)	14,668 (3.36%)	78,491 (2.59%)
2015 Employed Civilian 16+ Population by Occupation			
Architect/Engineer	226 (1.48%)	5,811 (1.33%)	53,637 (1.77%)
Arts/Entertain/Sports	188 (1.23%)	6,878 (1.58%)	39,291 (1.29%)
Building Grounds Maint	694 (4.56%)	21,433 (4.91%)	116,688 (3.85%)
Business/Financial Ops	713 (4.68%)	21,832 (5.00%)	117,399 (3.87%)
Community/Soc Svcs	339 (2.23%)	8,744 (2.00%)	47,622 (1.57%)
Computer/Mathematical	350 (2.30%)	10,617 (2.43%)	50,471 (1.66%)
Construction/Extraction	1,015 (6.66%)	18,473 (4.23%)	146,853 (4.84%)
Edu/Training/Library	617 (4.05%)	22,365	175,701

		(5.12%)	(5.79%)
Farm/Fish/Forestry	14 (0.09%)	516 (0.12%)	13,138 (0.43%)
Food Prep/Serving	922 (6.05%)	28,341 (6.49%)	189,064 (6.23%)
Health Practitioner/Tec	686 (4.50%)	24,861 (5.69%)	180,259 (5.94%)
Healthcare Support	417 (2.74%)	11,683 (2.68%)	75,249 (2.48%)
Maintenance Repair	561 (3.68%)	12,320 (2.82%)	115,379 (3.80%)
Legal	149 (0.98%)	5,171 (1.18%)	25,440 (0.84%)
Life/Phys/Soc Science	51 (0.33%)	3,137 (0.72%)	19,957 (0.66%)
Management	1,061 (6.96%)	35,136 (8.05%)	261,158 (8.61%)
Office/Admin Support	2,597 (17.05%)	67,723 (15.51%)	414,783 (13.67%)
Production	1,078 (7.08%)	29,674 (6.80%)	327,434 (10.79%)
Protective Svcs	363 (2.38%)	9,247 (2.12%)	53,839 (1.77%)
Sales/Related	1,885 (12.37%)	51,920 (11.89%)	323,318 (10.65%)
Personal Care/Svc	448 (2.94%)	12,573 (2.88%)	94,115 (3.10%)
Transportation/Moving	1,178 (7.73%)	35,474 (8.13%)	237,656 (7.83%)
White Collar	8,862 (58.17%)	264,195 (60.51%)	1,709,036 (56.32%)
Blue Collar	3,832 (25.15%)	95,941 (21.97%)	827,322 (27.26%)
Service and Farm	2,858 (18.76%)	83,793 (19.19%)	542,093 (17.86%)

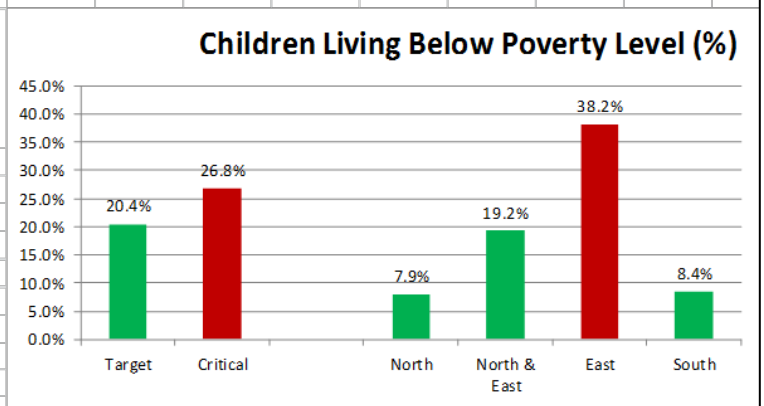
The demographics are broken down by county and zip codes, and when the data is available in census tract it is included. The more “granular” the data (i.e. specific to a geography) in a service area the easier it is to make disctinctions that can be used to drive improvement strategies, as well as communications and marketing to assist in illustrating what a community looks like and how to “target” messages for interventions. For this reason granular data is invaluable. Less data (county, state) runs the risk of being insufficient or too general to develop strategies for a particular service area.

Below is another example of the demographic data and the overview of our markets. In this case we are comparing three of the markets, North, East and South.

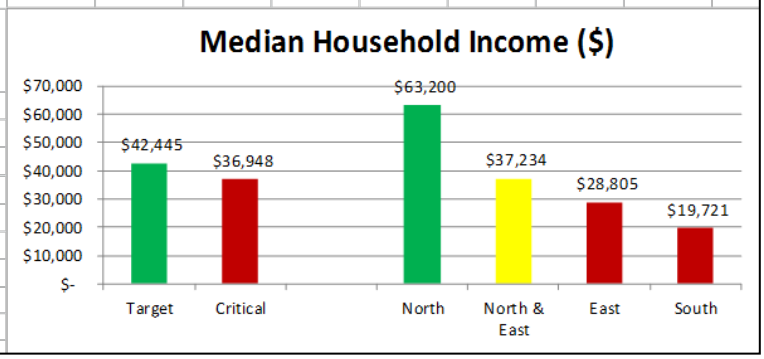
	People 65+ Living Below Poverty Level (%)
Target	10.0%
Critical	13.6%
North	5.4%
North & East	5.1%
East	12.8%
South	3.1%



	Children Living Below Poverty Level (%)
Target	20.4%
Critical	26.8%
North	7.9%
North & East	19.2%
East	38.2%
South	8.4%



	Median Household Income ($)
Target	$ 42,445
Critical	$ 36,948
North	$ 63,200
North & East	$ 37,234
East	$ 28,805
South	$ 19,721



Community Health Needs Assessment

The IRS requires a Community Health Needs Assessment (CHNA) and defines that a CHNA must exist for each hospital service area and "define the community it serves and assess the health needs of that community. In assessing the community's health needs, the hospital facility must take into account input from persons who represent the broad interests of its community, including those with special knowledge of or expertise in public health." Community Health Network began the process of creating a CHNA in 2011, seeking national models and proven practices while attempting to

use local resources to collect the necessary data. The Community Benefit department brought together a group of informed practitioners from hospital and community organizations that would also benefit from the data collected. Although a joint CHNA was not originally able to become a reality, this current CHNA does include efforts of all local health care institutions and some cooperation and planning with the local county public health departments.

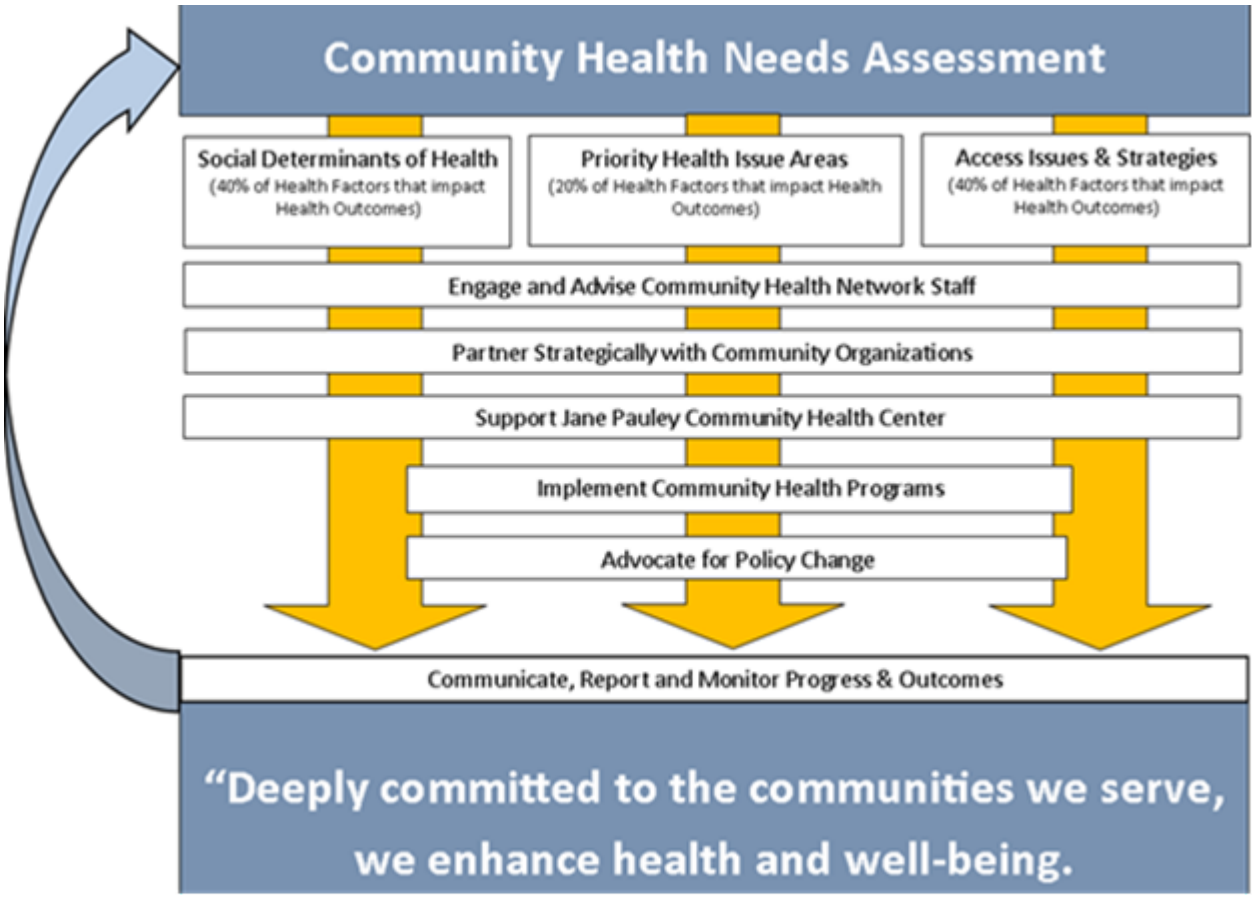
Our website, http://www.ecommunity.com/aboutus/care.aspx# displays over 125 health and quality of life indicators updated in real time. It offers hundreds of community-level resources for common community interventions in the "Promising Practices." Just by accessing our website, anyone in the network and the community can know the health needs of any locality. When they reach the CHNA section as a first-time user they are asked to take a survey of what they believe to be the health issues in their community, which is then used as primary data in our own CHNA. The website displays national, state, and county data, including our own institutional medical and data by county, zip code and census tract. Internally we can analyze financial data and incorporate sensitive data like crime statistics, which may not be used in a public display but would be valuable in setting strategies for the network.

Using all of the tools available to us, we went through a process of evaluation and started our community assessments with a list of the top community health issues for each of our IRS compliant service areas. The diagram below illustrates the process we used in interpreting our Community Health needs assessment data and transforming the data into a viable and measurable implementation strategy.

Process for Developing Implementation Strategy

The Community Health Needs Assessment was broken down into three categories based on the approach of "America Health Rankings." These rankings are based on a model of population health that was supported by the Robert Wood Johnson Foundation. It emphasizes many factors that, if improved upon, can make communities healthier places to live, learn, work, and play. The first area needing to be addressed is Access Issues and strategies. Evidence suggests that access to effective and timely primary care has the potential to improve the overall quality of care and reduce costs. Some populations experience additional barriers in access to preventive health services due to lack of transportation to providers' offices, lack of knowledge about preventive care, long waits to get an appointment, low health literacy, and inability to pay the high-deductible of many insurance plans and/or co-pays. Our first priority therefore is access to quality health services and expand the capacity needed to address health issues in the areas we serve. As Don Berwick describes in the "triple aim" of healthcare improvement, the goal is to improve the

health of the population we serve, enhance our patient experience through access, quality, and reliability, which ultimately will reduce the cost of care.



The second area to be addressed is priority health issues. Multiple factors led us to specifically identify asthma and diabetes as two priority health issues in the first CHNA. During the 2016 Implementation strategy we will continue to focus on asthma, but our focus on diabetes will change to a focus on obesity – the root cause for type 2 diabetes. Although access can help address many critical health issues, both asthma and diabetes rank high in the preventable hospital stays for ambulatory-care sensitive conditions and can usually be addressed in an outpatient setting, not normally requiring hospitalization (if the condition is well-managed). The most striking difference between these two diseases is that diagnosis of asthma has immediate consequences regarding hospitalizations short and long-term, while diabetic hospitalizations are typically the result of longer-term complications. The metrics used to determine these two areas are illustrated below. The transition to a focus on obesity is supported by the survey data collected on over 6,000 individuals. When community members were asked to select "the top five health needs in your community," obesity was always on top of others, especially when considering that it made it to at least one of the top three concerns in every survey.

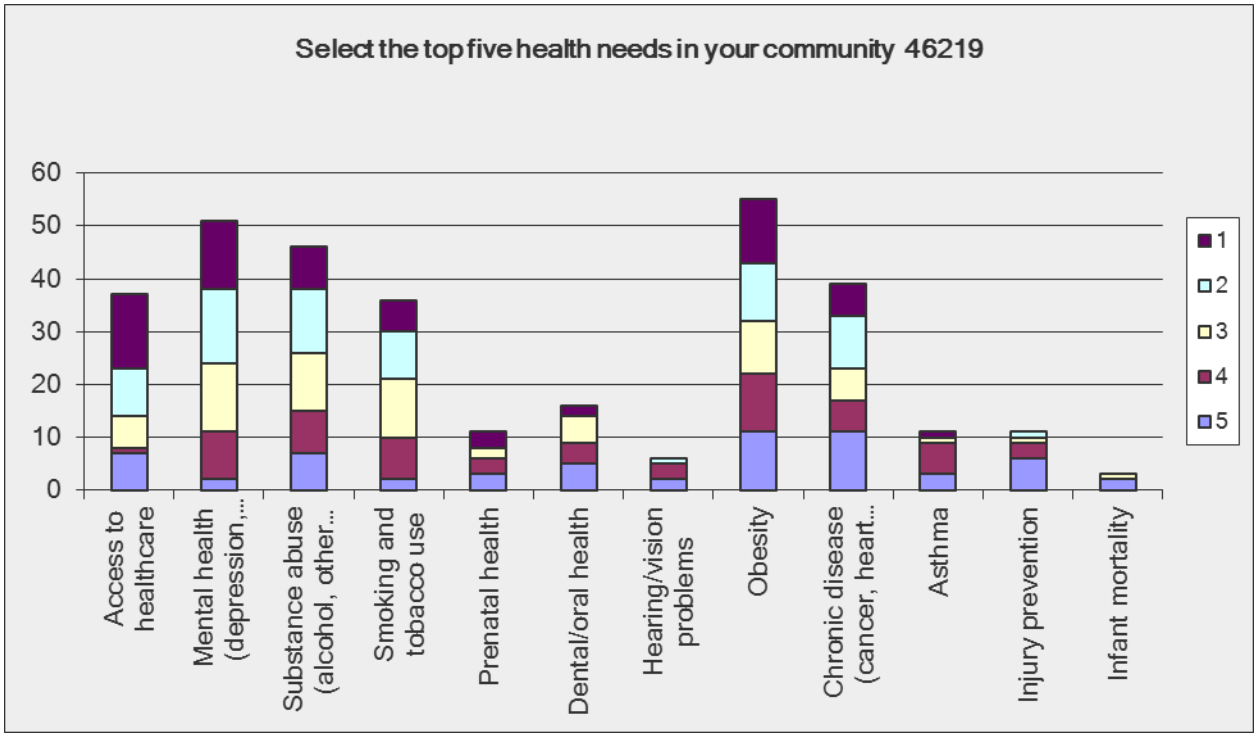
Implementation Strategy 2012 – 2015 Data

	North	South	East	Westview	Anderson	Howard	TOTAL
Age-Adjusted Hospitalization Rate due to Pediatric Asthma	7 out of 16 zip codes	4 out of 9 zip codes	9 out of 11 zip codes	12 out of 12 zip codes	4 out of 9 zip codes	2 out of 2 zip codes	38 out of 59 zip codes
	44%	44%	82%	100%	44%	100%	64%
Age-Adjusted Hospitalization Rate due to Asthma	3 out of 18 zip codes	4 out of 12 zip codes	10 out of 15 zip codes	11 out of 12 zip codes	9 out of 12 zip codes	2 out of 4 zip codes	39 out of 73 zip codes
	17%	33%	67%	92%	75%	50%	53%
Age-Adjusted Hospitalization Rate due to Long-Term Complications of Diabetes	11 out of 17 zip codes	10 out of 12 zip codes	12 out of 13 zip codes	12 out of 12 zip codes	10 out of 11 zip codes	3 out of 3 zip codes	58 out of 68 zip codes
	65%	83%	92%	100%	91%	100%	85%
Gap in Critical Incidence Percentage Impact in Zip Code of Service Areas for Hospitalization Data							
Age-Adjusted Hospitalization Rate due to Congestive Heart Failure	3 out of 19 zip codes	4 out of 17 zip codes	9 out of 16 zip codes	10 out of 12 zip codes	6 out of 13 zip codes	0 out of 4 zip codes	32 out of 81 zip codes
	16%	24%	56%	83%	46%	0%	40%
Age-Adjusted Hospitalization Rate due to Alcohol Abuse	2 out of 17 zip codes	3 out of 11 zip codes	7 out of 14 zip codes	5 out of 12 zip codes	7 out of 11 zip codes	3 out of 4 zip codes	27 out of 69 zip codes
	12%	27%	50%	42%	64%	75%	39%
Age-Adjusted Hospitalization Rate due to COPD	1 out of 19 zip codes	2 out of 16 zip codes	7 out of 16 zip codes	4 out of 12 zip codes	4 out of 13 zip codes	0 out of 4 zip codes	18 out of 80 zip codes
	5%	13%	44%	33%	31%	0%	23%
Age-Adjusted Hospitalization Rate due to Bacterial Pneumonia	0 out of 18 zip codes	4 out of 17 zip codes	1 out of 16 zip codes	2 out of 12 zip codes	7 out of 13 zip codes	0 out of 4 zip codes	14 out of 80 zip codes
	0%	24%	6%	17%	54%	0%	18%
Age-Adjusted Hospitalization Rate due to Dehydration	0 out of 17 zip codes	2 out of 12 zip codes	1 out of 14 zip codes	1 out of 12 zip codes	6 out of 11 zip codes	0 out of 3 zip codes	10 out of 69 zip codes
	0%	17%	7%	8%	55%	0%	10%

The chart above illustrates the 13% gap in the hospitalization data and belies the critical rate of 100% incidence in our smaller markets.

Implementation Strategy 2012 – 2015 Data

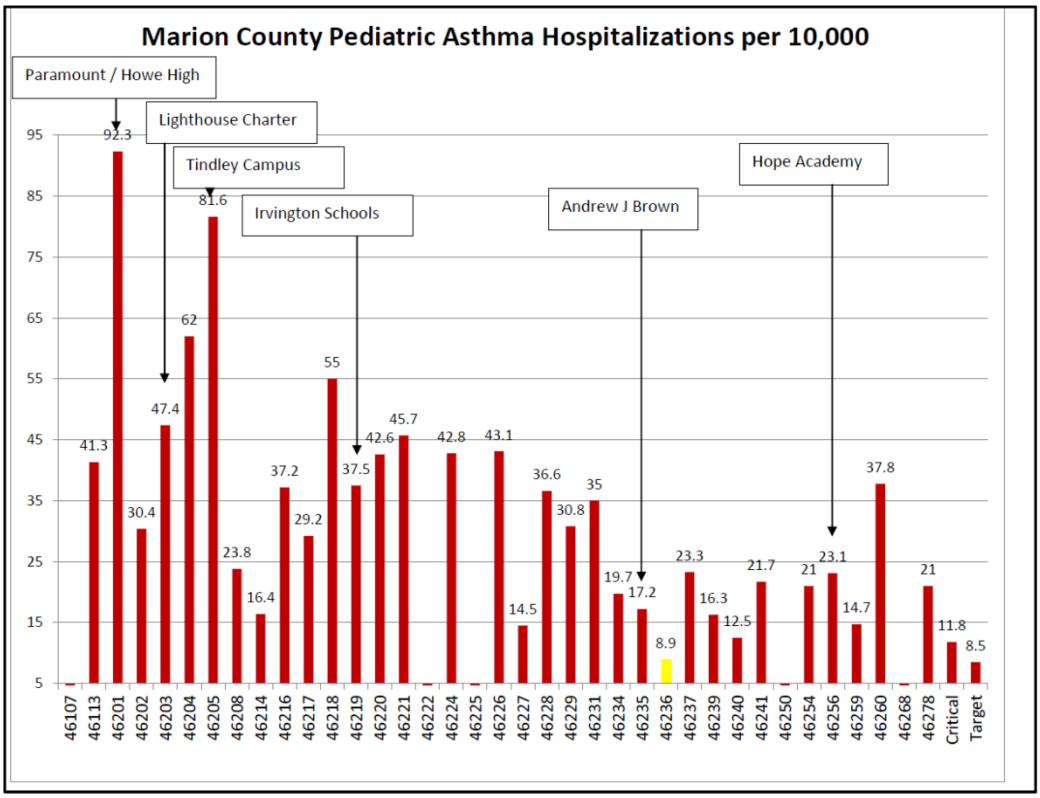
As illustrated above, the surveys justify the transition from a focus on diabetes to obesity. And given that the root cause for diabetes is grounded in living standards related to poverty, food access, and the lack of environmental support for health, the transition is supported by our focus on external community improvements.



While asthma is not often listed in the top five health care needs in the survey, our data from the schools in which we operate has pointed out why our focus on asthma has not changed. In our school based health data respiratory issues make up 9% of all visits to the school health personnel and 11% of the presenting problems. Asthma causes ~10% of all school health-related issues and yet it is an issue that has readily available interventions. By anticipating students' health needs we can send them back to class with minimal impact on behavior and academic performance.

Rank		Highest % of Actual Visits	Rank		Highest % of Presenting Problems
1	Gastrointestinal (7)	19%	1	Gastrointestinal (7)	35%
2	Musculo/ Skeletal (11)	16%	2	Dermatological (4)	31%
3	Eye/ Ears/ Nose/ Throat (5)	15%	3	Eye/ Ears/ Nose/ Throat (5)	31%
4	Dermatological (4)	14%	4	Musculo/ Skeletal (11)	27%
5	Neurological (13)	13%	5	Neurological (13)	27%
6	Respiratory (17)	9%	6	Other/ Miscellaneous (18)	16%
7	Other/ Miscellaneous (18)	7%	7	Respiratory (17)	11%
8	Psychosocial (16)	3%	8	Dental (3)	7%
9	Dental (3)	3%	9	Gynecological/ Obstetrical (9)	4%
10	Gynecological/ Obstetrical (9)	2%	10	Nutrition/ Metabolic (12)	3%
11	Endocrine (6)	2%	11	Psychosocial (16)	2%
12	Nutrition/ Metabolic (12)	1%	12	Genitourinary (8)	2%
13	Genitourinary (8)	1%	13	Parasites/ Infections (14)	1%
14	Parasites/ Infections (14)	0.36%	14	Cardiovascular (2)	1%
15	Cardiovascular (2)	0.28%	15	Immune System (allergies) (10)	1%
16	Immune System (allergies) (10)	0.21%	16	Endocrine (6)	0.37%
17	Disorder from Physical Agents (15)	0.05%	17	Disorder from Physical Agents (15)	0.16%

The illustration below focuses on specific zip codes, and shows asthma hospitalization rates relative to incidences of asthma being treated in the schools we serve. The top three zip codes where the incidences of pediatric asthma hospitalization are highest also represent communities in which we already have the capability to treat asthma through the school health program. The other zip codes with high rates could be served through our school health services.



Our third priority area is related to the social determinants of health. Don Berwick speaks plainly about Elinor Ostrum, the founder of term “micro-commons:”

> “Elinor Ostrom showed that it was possible to safeguard commonly owned resources like water and forests…Her work should inspire us to looks for ways to prevent health care costs from overwhelming another shared resource: the public coffers.”

In our community benefit plan, the “public coffers” Berwick refers to are a shared concern and are addressed by our adherence to the IRS guidelines to “relieve or reduce the burden of government or other community efforts.”

As was the case in 1954, the Community Health Network in 2013 worked to develop and implement community strategies—in consort with these communities—to improve

their overall health. Ostrums' design principles, echoed by Berwick, provide a functional paradigm through which we view our entire system of health care. Rather than seeing the health system as a conglomerate of organizations, using Ostums' vernacular, we see them as made up of "micro commons" that need to be reinforced and enhanced by local strategic leadership. Only those with local knowledge of existing programs and remaining challenges can knit a strong tapestry of health care delivery. The communities look to us to solve health issues. Their definition of an healthy communities goes beyond the diseases we treat in our hospitals and clinics. It is this implementation strategy that will rectify the disparity between perceptions and our abilities.

The Community Benefit Plan was developed from the perspective that health care does not happen exclusively in the institutions—it happens in the community. It is a place-based, community-driven approach, extending health initiatives and wellness outside the hospital walls for the benefit of all. Just as Elinor Ostroms' Nobel Prize-winning research emphasizes collaboration and cooperation, so to does our Community Benefit Plan.

Data Driven

Although most health care providers consider Florence Nightingale the founder of modern nursing, Nightingale was also celebrated British social reformer and statistician who came to prominence while nursing during the Crimean War. Like Ostrum, Nightingale believed that the problems of a community were most effectively solved when the citizens were educated in order to govern themselves. She supported bills for increased self-government and improved local education. Alongside her stances on social order, Nightingale became a pioneer of data-driven approaches to health care. In fact, she was a master of the visual presentation of statistics. She used methods such as the pie chart, and developed one called "the polar area diagram" that enabled her to illustrate the prevalence of particular diseases and the impacts of their treatments. Today, Nightingale would likely be gratified to see that we are adopting her data-driven approach in our Community Health Needs Assessment. In all likelihood, she would agree that the zip code you live is a better determinant of your health expectancy than your genetic code.

Engaging and Advising Community Health Network Staff

Charity Care Strategy

Our current charity care policy was crafted in response to community need and in relation to available resources. The health network does not always have the resources available to meet every community need identified in every health assessment. We do not always have the resources to offer charity care to anyone who comes to us for care. Consequently, using a data-driven approach we have developed a strategic Charity Care policy that targets the highest need areas and restricts our charity care resources to those "Health Districts." The process of defining our Health Districts was developed to identify or more precisely illuminate the needs in communities we serve and to target our resources for optimization. Clearly we do not have the funds to offer charity care throughout all counties or even our own service areas. What resources we do have we need to use in a way that will make the biggest difference. And to do so, we need to focus on specific geographic areas. A few points to clarify how we identified "Health Districts:"

- We started with all the zip codes in our service areas (80) and ONLY those zip codes.
- All criteria are judged "worst" by credible organizations—not our own. For example, the Census Bureau has determined through census data and other measures of poverty that a particular zip code is at critical level, or a criteria has been set by Healthy People 2020.
- We did NOT use the highest level of charity care expenditure as an initial screen. However, as would be expected the highest level of charity care expenditure was contained in these zip codes except in the South market.

The Identifications of Health Districts

We used all 80 service area zip codes and selected all those zip codes identified as having median household incomes that were below the target set by the US Census Bureau (below $43,417 in our geographic area). We came up with a total of 20 zip codes.

To make sure that this one indicator would not stand alone and we would capture or identify other zip codes "in need" or "at risk," we ran several other reports and came up with additional zip codes included in our "Health Districts."

We ran a report to list all those zip codes that identified more than 15% of the zip code population living in poverty in that specific zip code. We captured an additional 3 zip codes.

We ran a report to identify families in a specific zip code that pay more than 30% of the annual income on rent (these families would have limited discretionary funds

available). Any zip code that had more than 47% of the total zip code population spending 30% of their annual income on rent (The critical level as identified by the US Census Bureau), 2 zip codes were added.

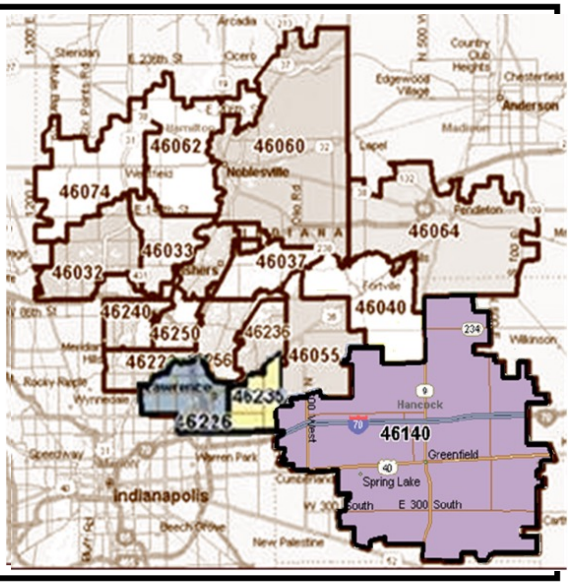
We screened the service area zip codes for “Children Living in Poverty.” Any zip code that had more than 21% of their children living in poverty, we added 3 zip codes.

The final screen we ran was People 65+ living in poverty. If there were any additional zip codes that had more than 10% of their total population 65+ living in poverty we added those zip codes. No additional zip codes were added because the zip codes at highest risk or “in need” were already identified in previous screens.

Finally three other zip codes (46217, 46142 and 46143) were added to the list in the South Market. The reason for the addition of these zip codes was because of the known immigration population and the fast changes in these zip codes’ population. They are the highest at-risk or in-need zip codes for the south market and they had the highest charity care expenditures in that market

North Market Health District

Zip Codes Identified as High Risk and In Need of Community Benefit and Charity Care Resources



Partner Strategically with Community Organizations

Since our founding in 1954, we have established a culture of collaborating in order to optimize community resources. All of our community work is performed in consort with the communities we plan to work with and with the added values of the organizations they respect and trust. For several years the network has taken on the issue of access

and that will remain our number one focus in our prioritized issues. The priority health issues that have been identified by the community health needs assessment are the two chronic diseases, diabetes and asthma. Access, asthma, and diabetes will remain top priorities, however other areas of concern may be adopted given that the communities drive the plan. The fourth priority therefore is community-driven initiatives.

We continue to take a collective approach that involves our systematic collection of the knowledge and views of informants on healthcare services and needs. These include online surveys, focus groups and one-on-one discussions. Valuable information is often available from the data we collect from providers, clinicians, and general practitioners, as well as from users of our services. Although such an approach blurs the distinction between need and demand and between science and vested interest, the intimate, detailed knowledge of interested parties might otherwise be overlooked. Furthermore, this collective approach is essential if policies are to be sensitive to local circumstances. Eliciting local views is not the same as being bound by them. Socioeconomic factors, particularly high poverty rates, are associated with some aspects of health system performance, but not all. There are significant variations within areas with low levels of poverty as well as within areas with high poverty levels. This approach allows sensitivity to local circumstances as local concerns may justifiably attach priorities to particular services. Local experience and involvement will make any needs assessment easier to publicize and defend. Each facility in our network will have prioritized activities and programs determined by the input of the communities they serve which may be different from the overall corporate strategy. As discussed earlier, access to care is a top priority. This access priority is illustrated by our school health strategies in the community benefit budget. Our priority health issues are asthma and diabetes, and both require health care access, which is of course impeded upon by socioeconomic situations defined in the social determinants of health. Both asthma and diabetes are best addressed where children are located—in schools. But to address these health issues the partner schools need to see the impact of success—such as better grades and higher attendance. Keeping both goals and outcomes out in front may slow the timeline down, but in the end it builds a support system that supports a culture of health.

Support Jane Pauley Community Health Center

The Jane Pauley Community Health Center serves the local community regardless of insurance or income, with an emphasis on integrating medical and behavioral health

along with access to various other social services. The center offers primary health care services, including preventive and annual exams, well-child care, acute care and certain procedures. The center also focuses on the management of chronic diseases, such as diabetes, cardiac disease, and depression. The Jane Pauley Community Health Center was established in 2009 with generous support from Community Health Network and the Community Health Network Foundation. It is named after Jane Pauley, a 1968 Warren Central High School graduate who grew up in the area and is well known as the former anchor of NBC-TV's "Today" and "Dateline" programs.

Implement Community Health Programs

In Johnson County, one of the most successful community health needs assessments and community benefit plans was initiated over 12 years ago by the collaboration of many organizations in our South market and service area. The Partnership for a Healthier Johnson County has had success while most other initiatives like it have failed. It illustrates the success of our long-term strategy adopted from the beginning and outlined in the introduction of the Partnership website. Our health partners include hospitals, the health department and hundreds of individuals from businesses, schools, social service agencies and civic and faith-based organizations. The mission of Partnership is to plan and implement collaborative, measurable strategies to improve the health of the residents of Johnson County. This strategy developed 12 years ago continues to be our "Best Practice" and sets the stage for who we participate with and how we measure the success of our participation. Each service area (or in many cases, combined service areas) have unique neighborhood and community initiatives that we support.

Advocate for Policy Change

Everyone knows that tobacco use is the number one cause of preventable death, as well as preventable disease in the United States. With all the awareness and educational resources being spent, one of the final efforts was in changing policy. This has been successful. Smoking kills more people in Indiana than alcohol, AIDS, car crashes, illegal drugs, murders, and suicides combined. Cigarette smoking is the number one preventable cause of premature death in Indiana. The United States Surgeon General, in his 1986 report on involuntary smoking concluded that involuntary smoking is a significant cause of diseases, including lung cancer, in otherwise healthy nonsmokers. The Center for Disease Control and Prevention is officially warning people at risk for heart disease to avoid all buildings and gathering places that allow smoking. The agency claims that as little as 30 minutes exposure of secondhand smoke can have serious and lethal effect. And still the state of Indiana has one of the highest incidence rates of smoking and one of the lowest rates of policy changes to help manage preventative strategies.

Community Health Network, as a leader among all of the health care organizations in Indiana, possess the expertise, the tradition of clinical innovation, and the institutional commitment to promote healthy activities and behaviors. In 2005, only a handful of health care organizations in the state of Indiana had a tobacco-free environment and Community Health Network, through the implementation of their policy in 2006, was among the leaders—the first hospital system in Marion County to go smoke free. It was changing policy that made the big difference. We often use policy change as a last intervention, but sometimes it is the only intervention that will shift our culture to a community that values health.

Communicate, Report and Monitor Progress and Outcomes

Each service area of each network entity will be reviewed and evaluated for the CHNA. The results will be displayed in all upcoming Community Benefit Reports with outcomes of any interventions. This data will give us a baseline and an opportunity to measure our interventions in a way that has never, to this point, been possible.

Our community beneift plan re-examines the social contract that began in 1954 with the community and citizens of the Eastside. Now we ask ourselves whether twentieth century assumptions, programs, and services are adequate and appropriate for twenty-first century problems and issues. The winning strategy that has been adopted by our health system—one that is a key driver in innovation around the Affordable Care Act and the adoption of its tenants—is the “Triple Aim.” Developed by Berwick and executed by many health orgranizations, it sums up what our community beneift plan hopes to do: to improve the health of the population we serve, enhance our patient experience through access, quality, reliability, and ultimately reduce the cost of care.

Priority Issue / Significant Health Need	Intervention	Tracking / Outcomes
Access	Outreach and interventions that improve the access to health care for the underserved and vulnerable populations	Increase to 100% the number of Primary Care Physicians in the Community Health Network accepting Medicaid patients Increase volume of patients referred to and treated at the Jane Pauley Community Health Center for uninsured and Medicaid services. Focus Charity Care in Health Districts that have the highest need.
Asthma	Provide outreach, education and intervention in the community that ultimately decreases the number of hospital admissions in our service area and Health Districts for pediatric asthma and overall increases the health of children.	Tracked through comparative county and state of Indiana hospitalization data and nationally through Healthy Community Institute.
Obesity/Diabetes	Provide outreach, education and intervention in the community that ultimately decreases the number of hospital admissions in our service area and Health Districts for long term and short term complications of diabetes in the adult population	Tracked through comparative county and state of Indiana hospitalization data and nationally through Healthy Community Institute.

Community Driven Initiatives		
Priority Issue / Significant Health Need	**Intervention**	**Tracking / Outcomes**
CHE	Eastside Economic Development Committee (Wellness Opportunity Zone) Serve 360^{O}	Complete Emerson Ave. Corridor Project. Support community driven projects and encourage data driven measurement approach to drive success and resource allocation. At least one data driven project in the master plans for the community driven activities. 100% of all CHE Leadership participate in community projects.
CHN	Healthy Hamilton County Binford Redevelopment and Growth Serve 360^{O}	Support community driven projects and encourage data driven measurement approach to drive success and resource allocation. At least one data driven project in the master plans for the community driven activities. 100% of all CHN Leadership participate in community projects.
CHS	Partnership for A Healthier Johnson County Serve 360^{O}	Support community driven projects and encourage data driven measurement approach to drive success and resource allocation. At least one data driven project in the master plans for the community driven activities. 100% of all CHS Leadership participate in community projects.

CHA	Madison County Coalition – United Way Serve 360^{O}	Support community driven projects and encourage data driven measurement approach to drive success and resource allocation. At least one data driven project in the master plans for the community driven activities. 100% of all CHA Leadership participate in community projects.
Westview	Westview Wellness Initiatives Serve 360^{O}	Support community driven projects and encourage data driven measurement approach to drive success and resource allocation. At least one data driven project in the master plans for the community driven activities. 100% of all Westview Leadership participate in community projects.
Howard	United Way Healthy Communities Serve 360^{O}	Support community driven projects and encourage data driven measurement approach to drive success and resource allocation. At least one data driven project in the master plans for the community driven activities. 100% of all Howard Leadership participate in community projects.