Community Benefit Report

IRS 990 Schedule H Supplemental Information

Fiscal Year 2016

Part II: Community Building Activities

Line 1. "Physical improvements and housing"

After the Storm

In 2016, a series of violent storms crossed Indiana. Our team members prepared immediately to serve the community in our role as healthcare providers, preparing for casualties that thankfully never happened, serving extended shifts, gathering emergency supplies. Our thoughts later turned to our own team members. The worst damage was in Kokomo, Indiana, where Community Howard felt the impact of tornado damage. Our Community family stepped up to work on behalf of the storm-damaged community in numerous ways, including volunteering on storm cleanup crews and providing sack lunches for relief workers. Relief funds were also pledged by Community employees by the Community Howard Regional Health Foundation and the Community Health Network Foundation.

Line 2. "Economic development"

Eastside Redevelopment Project

Convened by Community Hospital East, the Indianapolis East Redevelopment (IERC) serves as a collaborative platform for addressing quality of life issues on the Eastside of Indianapolis. The organization got its start when Emerson Avenue was in need of repaving from I-70 to 21st Street, and the city looked for community involvement to get the project off the ground. Area partners— Community Hospital East, Warren Township Schools, Raytheon, Community East Hospital, Finish Line, and Caito Foods, Indy Chamber, Marriott East and Far Eastside Neighborhood Association— came together, but soon found a greater common interest beyond paving a road: revitalization on the Eastside of Indy. Today, a foundational initiative of the IERC has been the Emerson Corridor Strategy. This strategy has identified major employers in the area. The IERC has used this information to expand the reach and grow the numbers of businesses and organizations in the community that are participating. One of IERC's strategies for economic development is to provide job resources to graduating students immediately joining the workforce. Working with Warren Township Schools, the largest employer on the Eastside, IERC coordinated a Job Resource Fair in May 2016 for Warren Central High School graduating seniors. These students were able to access job training and job placement through the Walker Career Center, WorkOne, and EmployIndy. Other goals of the IERC include emphasizing public safety through community policing and job training programs, showcasing Eastside success stories, and expanding the Emerson Corridor Strategy from 10th Street to Washington Avenue.

Quality of Life Partnership

Community Hospital South is a key supporter of the South Indy Quality of Life Plan (QoL). In the Spring of 2015, Local Initiative Support Corporation of Indianapolis (LISC), University of Indianapolis (UIndy) and Fifth Third Bank announced the ninth QoL planning area in South Indy. This includes the following neighborhoods: Bean Creek, Garfield Park, University Heights, Carson Heights, Meridian Raymond, South Village, Northwest Perry, and Rosedale Hills. By the end of December 2015, the study accumulated 108 interviews, 100 online surveys and 268 university-based interviews. In February 2016, a Visioning Summit was held and afterwards volunteers formed seven action teams to create each part of the plan. Those action team topics are: community building, housing, connectivity, Madison Avenue Corridor, education and workforce, Shelby Street Corridor and health and wellness. This feedback

informed neighborhood leaders about the planning efforts in seven QoL areas: Community Building, Connectivity, Education and Workforce Development, Health and Wellness, Housing and Shelby Street and Madison Avenue Corridors. The South Indy QoL effort is just the beginning. In 2017, residents and community partners will move from planning to implementation.

Line 3. “Community support”

Medical Information Partnership

Community Health Network has partnered with Reid Health in Richmond, Indiana, to bring a new, nationally recognized patient and care management system to the region served by Reid. The partnership will bring electronic medical record and business applications from Epic Systems to Reid Health system patients. The system will include a patient-friendly patient portal and access to records at all care sites of both health systems. The collaboration will also provide Reid Health the benefit of a connection to a larger health system for sharing of clinical practice standards while maintaining independence as a regional referral center. The ultimate beneficiaries are patients of both Community and Reid, as we work together to create patient-centered care aimed not just at treating medical issues, but enhancing health and well-being. The collaboration is made possible through Epic Connect, an approach that Wisconsin-based Epic Systems employs to allow existing users to securely share their Epic implementations with other healthcare organizations throughout the country. Reid Health care sites will be integrated into Community Health Network’s Epic Systems infrastructure, also allowing Reid to benefit from the expertise that Community has developed while using the Epic applications over the course of several years. The system also provides an enhanced patient portal that will eventually replace the one currently offered through the Reid Health system. The portal provides a direct electronic connection between patients and their providers for access to patient care management and medical record information.

Serve 360

Building upon a legacy of volunteerism, Community Health Network has an unprecedented employee volunteerism initiative to demonstrate its deep commitment to the local communities it serves. Serve360º offers Community employees a way to live the network’s mission (to enhance health and well-being) and cultivate the spirit of volunteer service. Serve360 was named to reflect Community’s way of completing the circle, collectively giving back to the people and neighborhoods that gave birth to the network and continue to support it. Projects are vetted by a committee and those that are in alignment with the mission of the hospital are given priority. Many community events are staffed by Serve 360 volunteers and every year the amount of time committed by employees grows. Today, the leadership of the network are held accountable for at least one Serve 360 event a year. From staffing a food kitchen to painting a home the purpose is to decrease cost for not for profit organizations serving their community while increasing the economic viability and effectiveness of the organizations; Serve360 works with community organizations to deliver the volunteer hours necessary to keep expenses low while improving the outcomes for the organizations we serve.

Urban Farming and Farmers Markets

Access to affordable, fresh, and healthy whole foods is a challenge for many people that live in Central Indiana. 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.

Community Health Network supports many urban farming and farmers market initiatives that provide fresh produce and healthy options. For instance, Community supports the Market at Hague. Market at Hague is an initiative of Binford Redevelopment and Growth, Inc. (BRAG). By bringing together Indiana food and craft artisans, musicians, and area businesses and non-profits at Market at Hague— BRAG creates a vibrant community gathering that offers local, fresh food, support for local businesses, and cultural and ethnic educational opportunities. 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 which 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 addition, Community Health Network supports 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. This youth-led initiative provides experiential learning opportunities; implementation of real-world life and business principles; service to the community and an outlet for local agriculture. The students in this program are placed in charge of a year-long community farming program under the guidance of experienced adult leadership. Through this program, students also learn the value of dedication, teamwork, planning, and agriculture while also being compensated for their efforts.

Community employees also volunteer and support Indy Urban Acres which is an organic farm that donates 100% of the fresh fruits and vegetables harvested to local food pantries through a partnership with Gleaners Food Bank. Since 2011, Indy Urban Acres has grown into a multi-disciplinary farm that provides food equality for low-income families, educates thousands of youth through tours and farm-to-plate workshops, provides community engagement to thousands of volunteers and groups, teaches teenagers valuable job skills and helps improve Indy's food system.

Have Hope

Community Health Network, Central Indiana's largest provider of behavioral health services, is committed to becoming the first health care system in the country to fully implement the Zero Suicide model, developed by the National Action Alliance for Suicide Prevention and other partners. At the same time, the Indiana Division of Mental Health and Addiction and Community Health Network, 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 Hoosiers, Community provides mental health and substance abuse

services to students in the school environment 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. One commercial offers statistics to build awareness of teen suicide in Indiana. Another shares a message with parents, teachers, caregivers and loved ones about the role they play in supporting the children and teens in their lives. A third commercial that has already been on the air has been updated and will continue as part of the new campaign. WTHR news staff will also read public service announcements.

Community Cupboard of Lawrence

Community Health Network manages the operation of *The Cupboard*, a food pantry that serves residents of Lawrence Township of Indianapolis, and assists an estimated 300 families per week, provides healthier food options and helps relieve the strain caused by food insecurity. Specifically, in 2016, *The Cupboard* served 57,317 individuals which represent 13,526 households. The Cupboard is a client-choice food pantry, serving residents through partnerships with Gleaners Food Bank of Indiana, Midwest Food Bank, and local religious institutions and businesses. The food pantry is open Wednesdays from 10 a.m. to 4 p.m. and 6 p.m. to 8 p.m., Fridays from 10 a.m. to 4 p.m. and the third Saturday of the month from 10 a.m. to 12 p.m.

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. Meal vouchers can be redeemed for breakfast, lunch or dinner at the 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.

Reaching Out at the Health Fair

Community once again brought screenings and health education to the 2016 INShape Indiana Black and Minority Health Fair, part of Indiana Black Expo, Inc. Indiana Black Expo, Inc. has been a pillar of the community for nearly 40 years. It has encouraged, uplifted and celebrated the accomplishments and achievements of African Americans throughout Indiana. Community's presence at Black Expo was made possible by the efforts of many Serve360° volunteers along with more than $30,000 in funding from Community Health Network Foundation. More than 275 Community employees stepped up to volunteer at our booth, where we completed almost 1,300 health screenings. Volunteers represented many areas across the network, including the stroke teams from Community East, North and South; Behavioral Health; the Center for Advanced Heart Care; pharmacists; and team members from the Jane Pauley Community Health Center. 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 this year, and we showcased the features of Community

Healthplex. Because many attendees did not have regular access to primary care, we again offered to schedule an appointment and make connections to additional care.

On the Ice with the Fuel

Our partnership with the Indy Fuel professional hockey team continues to score. We teamed up with the Indy Fuel in a "Fuel your Health Challenge," inviting 100 ticketholders to compete for the most daily steps in February and March of 2016. Participants won prizes and, even more important, built a healthier lifestyle. Meanwhile, Community Heart and Vascular was in attendance at the Fuel's Community Day to offer heart health information before the game.

Milk for Healthy Babies

Community Anderson recently 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 Anderson will now make pasteurized human milk available for newborns. Community Anderson will also serve as a milk depot, a location where breastfeeding mothers can drop off donated milk.

Coats for Caring

In 2011, Community Anderson launched a Coats for Caring after another community organization unexpectedly discontinued its annual coat giveaway to Madison County residents in need of winter coats. More than 15,000 coats have been distributed in Madison County, thanks to the caring hearts at Community Hospital Anderson and supporters in the community.

Operation Overcome

Community Howard Regional Health, together with officials from Howard County and the city of Kokomo, recently announced 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 is donating 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. Naloxone, also known as Narcan and by other names, is a medication used to reverse the effects of opioids, especially in an overdose. EMS crews from Community Howard already carry and administer the drug.

Line 4. "Environmental improvements"

Line 5. "Leadership development and training for community members"

A New Class

Project Search Indiana is a high school transition program targeted for students whose main goal is competitive employment. The program is a worksite-based school-to-work program for students with developmental and/or physical disabilities. Community North is once again partnering to make Project Search Indiana a success. We've just welcomed a new cohort of students to take part in the program. Project Search Indiana is a collaborative effort with the Indiana Family and Social Services

Administration's Office of Vocational Rehabilitation, the Indiana University Indiana Institute on Disability and Community, Easter Seals Crossroads and Lawrence Township schools.

Fisher Mental Health Task Force

Community Health Network, Hamilton Southeastern Schools and City of Fishers have created a unique partnership to consider how to pool resources and coordinate efforts to ensure that mental health challenges don't go untreated within the community. The mission of the mental health task force is 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. Through the process, the mental health task force identified two objectives for moving forward: 1) Improve education and training; and, 2) Enhance local resources and access to services. The task force is hopeful that these actions will provide support for those who may encounter mental health challenges. Education and training goals focus on thorough and consistent training among professionals most likely to encounter residents that may requires care, as well as community education to eliminate the stigma surrounding mental health. They are:

- Develop an education and training program for public safety officials
- Develop systemic training for teachers and coaches
- Develop a community-wide communications campaign
- Enhance the City's partnerships with behavioral health specialists

Resources and access goals are aimed at enhancing the delivery of services across the spectrum, including those services needed when a mental health crisis occurs and those that work to prevent crises. These goals include:

- Remodel the community para-medicine program to include protocols for mental health calls
- Develop an Intensive Care Coordination program for youth

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. CIT programs enhance communication, identify mental health resources for assisting people in crisis and ensure that officers get the training and support that they need. CIT programs provide officers with 40 hours of intensive training, including a four-hour shadowing experience in a local Crisis Department (often at our Crisis Department at Community Hospital North). One of the reasons CIT is successful is that it connects officers with a team of clinicians and fellow officers who can advise, problem-solve and support them when a challenging situation occurs, such as initiating an Immediate Detention. In the training, officers learn and practice verbal de-escalation skills that accounts for both officer safety and safety for the person experiencing a crisis. The original CIT program began in Memphis, TN in 1988 when the Memphis Police Department joined the Memphis Chapter of NAMI, mental health providers, and two local universities (the University of Memphis and the University of Tennessee) in organizing, training, and implementing a specialized unit. This alliance was established for the purpose of developing a more intelligent, understandable, and safe approach to mental crises. In 1999 or 2000, a few folks from Indianapolis (including a representative from Community Health Network – Behavioral Health) travelled to Memphis to take CIT training. CIT gives officers more tools to do their

job safely and effectively. It helps keep people with mental illness out of jail, and get them into treatment, where they are more likely to get on the road to recovery.

- After the introduction of CIT in Memphis, Tenn., officer injuries sustained during responses to "mental disturbance" calls dropped 80%.
- Compared to other jail diversion programs, officers say CIT is better at minimizing the amount of time they spend on mental disturbance calls, more effective at meeting the needs of people with mental illness and better at maintaining community safety.
- CIT saves public money. Pre-booking jail diversion programs, including CIT, reduce the number of re-arrests of people with mental illness by a staggering 58%. Individuals who encounter a CIT-trained officer receive more counseling, medication and other forms of treatment than individuals who are not diverted. For example, in a study in Detroit, housing an inmate with mental illness in jail costs $31,000/year, while community-based mental health treatment costs only $10,000/year.

Helping Officers Save Lives

Police in two of our regions are on the front lines of the opioid epidemic, equipped with training and medication from Community. Though the programs have only recently begun, they've already saved lives. Community Anderson has trained and equipped all Madison County patrol officers with Narcan, a drug that can reverse the effects of drug overdoses. Officers used Narcan twice in the first two weeks since they were trained, saving two lives. Community Howard Regional Health also trained and provided supplies to the Howard County Sheriff's Department. Deputies there marked their first successful use of Narcan in late January, saving a man from an opioid overdose.

Line 6. "Coalition building"

Covering Kids and Family

In 2016, Community Health Network provided substantial support to Covering Kids and Family (CKF-IN). Advocating health coverage for all, CKF-IN of Indiana establishes local coalitions that find and keep health coverage for Indiana residents. In addition, CKF-IN informs statewide policy makers on healthcare issues and advocates on behalf of our coalitions and consumers for policies designed to improve healthcare access, retention and outcomes. CKF-IN is also the lead agency for the Indiana School Health Network (ISHN) which is a statewide organization to help convene networking opportunities for school health professionals and advocates and resource information to help promote school health initiatives across the state.

During 2016, CKF-IN made great progress toward the goal of being a state-wide entity, welcoming four new coalitions covering twelve counties. This is a 28% increase in counties covered in 2016 and a 72% increase in the last two years. In 2016, CKF-IN coalitions and partners completed over 33,000 applications for healthcare coverage. To support the work of the coalitions, CKF-IN published the Guidebook to School-Linked Outreach and provided initial and continuing education training to over 120 individuals for their certifications as Indiana navigators. CKF-IN was also successful in getting language inserted into House Enrolled Act (HEA 1347) requiring the Indiana Department of Insurance to conduct a study on current capacity, training, adequacy and barriers to navigators.

ISHN sponsored its 8th annual conference in June of 2016 with a record setting 305 registrations. The conference's theme was *Pump up the Volume* as attendees were introduced to the Whole School, Whole Community, Whole Child model. Through this partnership, Community Health Network aligns in our desire to help more Indiana resident acquire healthcare coverage and support the health of children.

Domestic Violence Network

In 2016, Community Health Network collaborated and supported the Domestic Violence Network (DVN). DVN engages the community to end domestic violence through advocacy, education, and collaboration. For twenty years, the Domestic Violence Network has been a leader in the community to address issues surrounding the prevention and response of domestic violence in Central Indiana. Through our partnership, Community Health Network is the title sponsor for DVN's Community Wide Plan: *Intersections* which will examine the risk and protective factors associated with domestic violence and a variety of social concerns. Throughout the course of the next three years, DVN will select a different risk factor every six months. Guided by challenges and opportunities specifically related to each risk factor, DVN will facilitate community conversations, consult with experts, and provide educational opportunities to understand the intersection between specific issues and domestic violence. Additionally, DVN will convene agencies that directly address each risk factor and facilitate collaboration between these agencies and domestic violence service providers. After learning from one another, specific goals and outcomes will be identified for the organizations to work toward together.

In 2016, DVN educated 2,276 youth on the dynamics of teen dating violence, healthy relationships and consent; as well as provided training to 451 youth workers on how to recognize and respond to teen dating violence. In addition, DVN provided 9 best practices trainings to 361 advocates and educated 440 business professionals on how to recognize and respond to domestic violence in the workplace. Through this dynamic partnership, we are working together and expanding our knowledge of the correlation between risk and protective factors with those who experience abuse, the community will be better equipped to prevent and respond to domestic violence today, tomorrow, and for years to come.

Jump IN

Community Health network provides support to Jump IN for Healthy Kids which is a community-wide effort to give children and families real opportunities to make healthy choices. Jump IN is implementing several evidence-based strategies to address the complex causes of childhood obesity by focusing on three core strategic areas: *Healthy Places*, *Healthy Neighborhoods*, and *Healthy Communities*.

Under the *Health Places* tenet— Jump IN has worked closely with national and local experts to develop a targeted training program for child care providers that helps them adopt healthy policies and procedures for their facilities. More than 150 providers have been trained to date. In addition, Jump IN has created *Healthy Worksites, Healthy Children* a coaching program that connects these smaller businesses with large employers that have implemented best practice employee wellness programs.

Under the *Healthy Neighborhoods* tenet— Jump IN has created Community Demonstration Projects to engage civic and government leadership in higher risk areas to address systemic issues such as lack of access to affordable, healthy foods and infrastructure or policies relating to physical activity and the built environment. The initial Community Demonstration Project is focused in Lawrence Township and the far eastside of Marion County.

Under the *Healthy Communities* tenet— Jump IN supports clinicians with continuing education workshops, evidence-based, expert-authored resource kits, and connections to community resources and programs that can be shared with patients. Through our partnership with Jump IN, Community Health Network seeks to establish healthy places, neighborhoods, and communities where families have real opportunities to make healthy choices that promote their health, vitality and well-being, including access to affordable, healthy food and meaningful opportunities to play and be active.

Meaningful Collaboration in Johnson County

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 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.

Healthy Partnership for Hamilton County

The 2016 Community Health Needs Assessment Survey conducted by Community Health Network, IU Health, St. Vincent Health, Riverview Health and Franciscan St. Francis Health, identified three significant priorities for the health of Hamilton County residents:

- Optimizing Access to Healthcare
- Integrating Healthy Behaviors
- Promoting Preventive Health Services

In response, these health systems created the Healthy Partnership for Hamilton County (PHHC). Integral to PHHC is a coalition of community partners who lend their knowledge and talents as we work toward achieving our objectives. This coalition is comprised of representatives from a cross-section of health care, human service, health and fitness organizations, churches, and youth-serving programs. The PHHC coalition meets quarterly and is driven by subcommittees that focus on:

- Access to Care
- Food/Nutrition/Physical Activity
- Mental Health/Behavioral Health/Suicide Prevention/Substance Abuse
- Tobacco Prevention and Cessation

In addition, PHHC is the lead organization for the Hamilton County Tobacco Prevention and Cessation Commission. Through this Commission, PHHC works with the Indiana State Department of Health to reduce the disease and economic burden of tobacco use by focusing on four priorities: prevent youth smoking, increase the number of Hamilton County residents not exposed to secondhand smoke,

decrease adult smoking rates and build a network of community partners. Through this partnership, Community Health Network seeks to support regional partners establish a community health based improvement plan that begins to address the needs of Hamilton county.

Line 7. *"Community health improvement advocacy"*

Health Insurance Marketplace Partnership

More people than ever have health insurance. The Census Bureau survey showed the number of Indiana residents without insurance dropped from 903,000 in 2013 to 628,000 in 2015[1]. That's a 30 percent decline, compared with a 34 percent decline nationally. But many still need help getting and paying for care. People without insurance coverage have worse access to care than people who are insured. One in five uninsured adults in 2015 (20%) went without needed medical care due to cost[2]. Studies repeatedly demonstrate that the uninsured are less likely than those with insurance to receive preventive care and services for major health conditions and chronic diseases.[3] In addition, in 2015, over half of uninsured people (53%) said that they or someone in their household had problems paying medical bills in the past 12 months.[4] These bills can quickly translate into medical debt since most of the uninsured have low or moderate incomes and have little, if any, savings.

The cost of providing quality care continues to increase and Community Health Network encourages everyone to get the healthcare they need. We realize that finding affordable coverage can be challenging. Consequently, we have partnered with WellFund on the behalf of our patients who would benefit from signing up for insurance. WellFund is an insurance program that helps make the connection. Through a phone and mail campaign, the WellFund reaches out to Community patients who don't presently have insurance, helping them explore their insurance options. In some cases, Community is able to help these patients afford their premiums, and that, in turn, provides them greater access to the care they need. Last year we helped some 850 people afford their coverage, and we expect to reach a similar number this year as they sign up for 2017 coverage.

Alliance for a Healthier Indiana

We support our communities in many ways, including by advocating on behalf of better health. That's why our president and CEO, Bryan Mills, has joined with a number of partners from healthcare and the business community—including the Indiana Hospital Association, the Indiana State Medical Association and the Indiana Chamber of Commerce—to create a new organization known as the Alliance for a Healthier Indiana. In 2016, the group announced plans to tackle its first challenge: the high rate of tobacco use in our state.

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[1] Barnett, Jessica C. and Marina S. Vornovitsky, Current Population Reports, P60-257(RV), Health Insurance Coverage in the United States: 2015, U.S. Government Printing Office, Washington, DC, 2016

[2] *Ibid.*

[3] Kaiser Family Foundation analysis of the 2015 National Health Interview Survey. http://files.kff.org/attachment/fact-sheet-key-facts-about-the-uninsured-population. Accessed June 7, 2017.

[4] Kaiser Family Foundation/New York Times Medical Bills Survey, Jan 2016, https://kaiserfamilyfoundation.files.wordpress.com/2016/01/8806-t-the-burden-of-medical-debt-results-from-the-kaiser-family-foundation-new-york-times-medical-bills-survey-topline.pdf. Accessed June 7, 2017.

Tobacco use leads to disease and disability and harms nearly every organ of the body. It is the leading cause of preventable death[5]. Research has shown that smoke from cigars, cigarettes, and pipes harms your body in many ways, but it is especially harmful to the lungs of a person with asthma.[6] Tobacco smoke —including secondhand smoke— is one of the most common asthma triggers.

The Alliance asked Indiana's state legislature to consider a variety of measures, including higher tobacco taxes, an increase in the smoking age and a repeal of the smokers' bill of rights. Community Health Network made a major investment of time and resources into a combined tobacco campaign this year, and while we did not get the tobacco tax increase we sought, we did move the ball forward on a tax and secure a partial victory on tobacco cessation funding. Indiana Legislators provided a 50% increase in state funding for tobacco cessation services, bringing the annual tobacco cessation budget to $7.5 million. The new Alliance for a Healthier Indiana is a great example of how we at Community partner with others to further our work. From food insecurity to educational challenges to suicide to smoking and other addictions, we're committed to tackling societal issues that affect health and quality of life.

Jane Pauley Community Health Center

In addition, Community Health Network supports the Jane Pauley Community Health Center (JPCHC) which opened its doors in September 2009 to provide primary health services, regardless of a person's income or insurance coverage. 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.

With 16 location/patient access sites in four counties, four of which were added in 2016 respectfully, the JPCHC serves also in partnership with the Metropolitan School District of Warren Township, the Community Health Network Foundation, IU School of Dentistry and Hancock Regional Hospital. Services 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.

In 2016, the JPCHC had 71,957 total visits, which exceeded the total number of visits in 2015, which was 49,534 and that in 2014, of 32,584. 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 total number of patients of 20,681.

JPCHC is named after Ms. Pauley began her journalism career as a "temporary, probationary employee for 90 days" at WISH-TV in her hometown of Indianapolis, but within three years became the first woman to anchor a weekday evening newscast in Chicago at NBC's WMAQ-TV. Only one year later, Ms. Pauley vaulted to the top of network news as co-host of NBC's Today Show – she was only 25.

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[5] Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention. https://www.cdc.gov/tobacco/campaign/tips/diseases/?gclid=Cj0KCQjwtJzLBRC7ARIsAGMkOAkG7c3OGrHjsZa4ZHNABhbkS3GFMy3VInFNBVQ18AD3HO4FkonRO3gaAr0LEALw_wcB. Accessed July 13, 2017.

[6] Smoking and Asthma. http://www.webmd.com/asthma/guide/smoking-and-asthma#1. Accessed July 13, 2017.

For the next thirteen years, she interviewed thousands of newsmakers from every walk of life and in location all over the world-from the Vatican to the Great Wall of China. First teamed with Tom Brokaw and later with Bryant Gumbel, Ms. Pauley was on the scene of a dozen presidential nominating conventions.

Ms. Pauley is recognized as a powerful advocate in the field of mental health. In her memoir, the New York Times bestseller, *Skywriting: A Life out of the Blue*, Ms. Pauley wrote candidly about being diagnosed with mental illness at the age of 50, after medical treatment for hives triggered a previously unrecognized vulnerability to bipolar depression. In 2008, the National Alliance on Mental Illness presented Ms. Pauley with their highest honor, The Rona and Ken Purdy Award, for her national contribution to the fight against discrimination and stigma. Ms. Pauley is a member of the Leadership Board of the McGovern Institute for Brain Research at MIT.

School-Based Clinical Care

Community Health Network's school-based programs cover a wide range of needs for youth across Central Indiana. See Figure 1, School Based Clinic Site Map. 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 the communities we serve. Their work ensured a 95.1 percent return to classroom rate for students who came to them for care in 2016. 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. In the instance of occasional medication needs, parents furnish over-the-counter medications that are then administered by nursing staff. For preventative care purposes, nursing staff administer flu vaccines at a number of local charter schools to ensure the wellness of students throughout the school year.

Healthy educators and staff mean more consistent learning for young people, so Community Health Network offers on-site clinics for employees at 11 school systems and two universities across Central Indiana. Services 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. See School-Based Clinical Care information in the following Tables and Figures below: Table 1, School-Based Clinical Care Statistics; Table 2, School-Based Clinical Care Academic Year Comparison: Clinic Visit, Return to Class Percentage and Referrals; Figure 1, Nursing Referrals for Academic School Year 2016-2017; Figure 2, Return to Classroom Percentages for Academic

School Year, 2016-2017; Figure 3, School-Based Clinics Site Map; and Table 3, School Based Clinical Care Sites, Location and Staff Support.

Table 1: School-Based Clinical Care Statistics

School District Name	% FRL *	# School Nurse Clinics	#CHNw Nursing Staff	# School District Staff	# Students	# School Nurse Clinic Visits during 2016-2017	% RT
Beech Grove	**65.4%**	**5**	**8**	**251**	**3,107**	**53,093**	**97%**
Decatur	**66.8%**	**8**	**15**	**671**	**6,452**	**73,873**	**96.7%**
Franklin	**36.7%**	**11**	**19**	**743**	**9,151**	**81,850**	**96.7%**
Greenwood	**44.9%**	**6**	**11**	**375**	**3,902**	**52,389**	**97%**
Lawrence	**63.3%**	**21**	**35**	**2,175**	**15,936**	**184,488**	**97.6%**
Warren	**73.2%**	**15**	**23**	**1,450**	**12,297**	**128,679**	**97.1%**
Clark Pleasant	**45.1%**	**7**	**12**	**1,125**	**6,671**	**64,393**	**95.2%**
Charter Schools	**73.9%**	**17**	**20**	**379**	**6,826**	**63,443**	**96.5%**
Perry Township	**62.9%**	**18**	**22**	**1,978**	**16,128**	**68,197**	**95.4%**
TOTALS	**60.6%**	**108**	**128**	**9,147**	**80,470**	**770,405**	**96.8%**

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

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

Figure 1: Nursing Referrals for Academic School Year 2016-2017

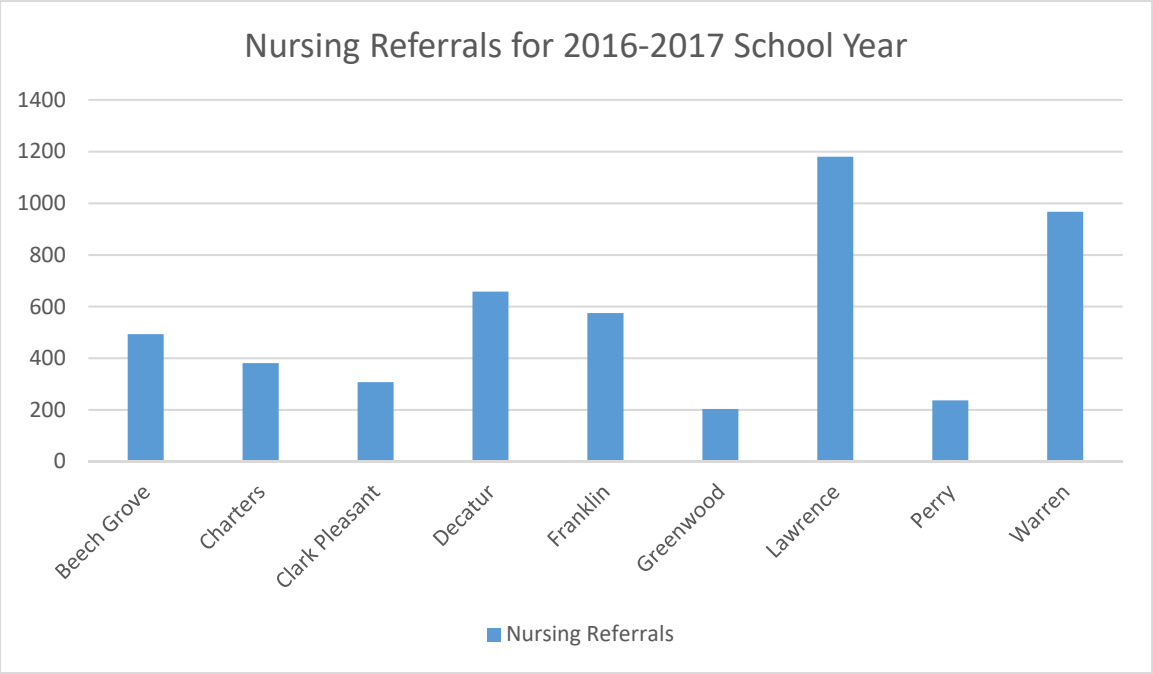

Figure 2: Return to Classroom Percentages for Academic School Year 2016-2017

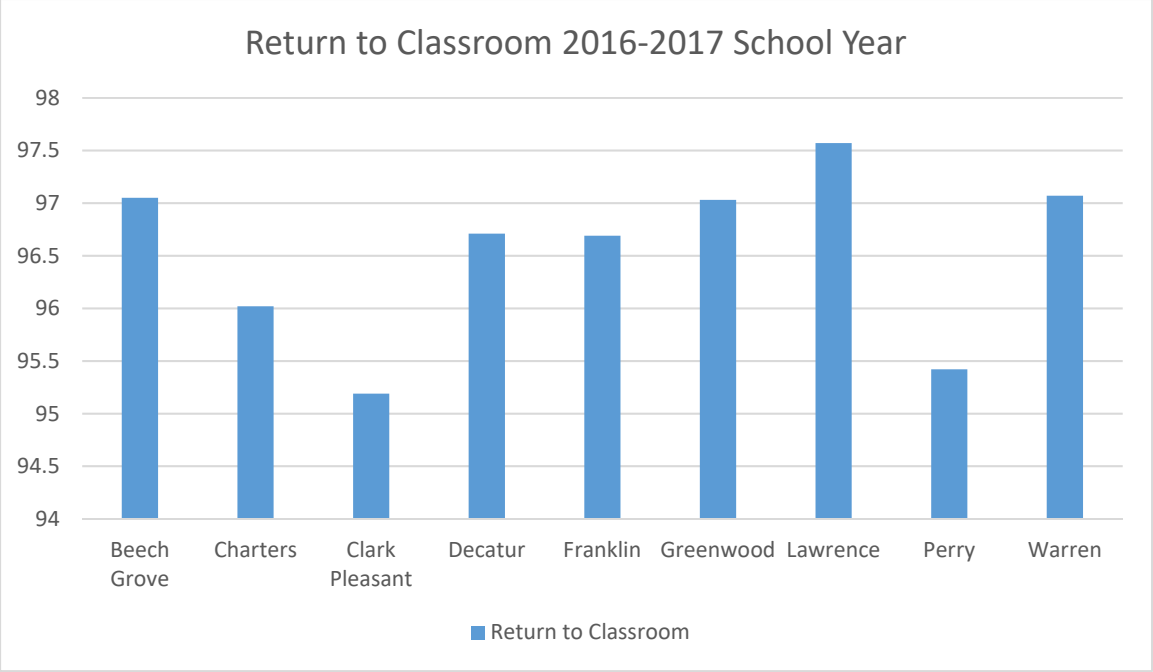

Figure 3: School-Based Clinics Site Map

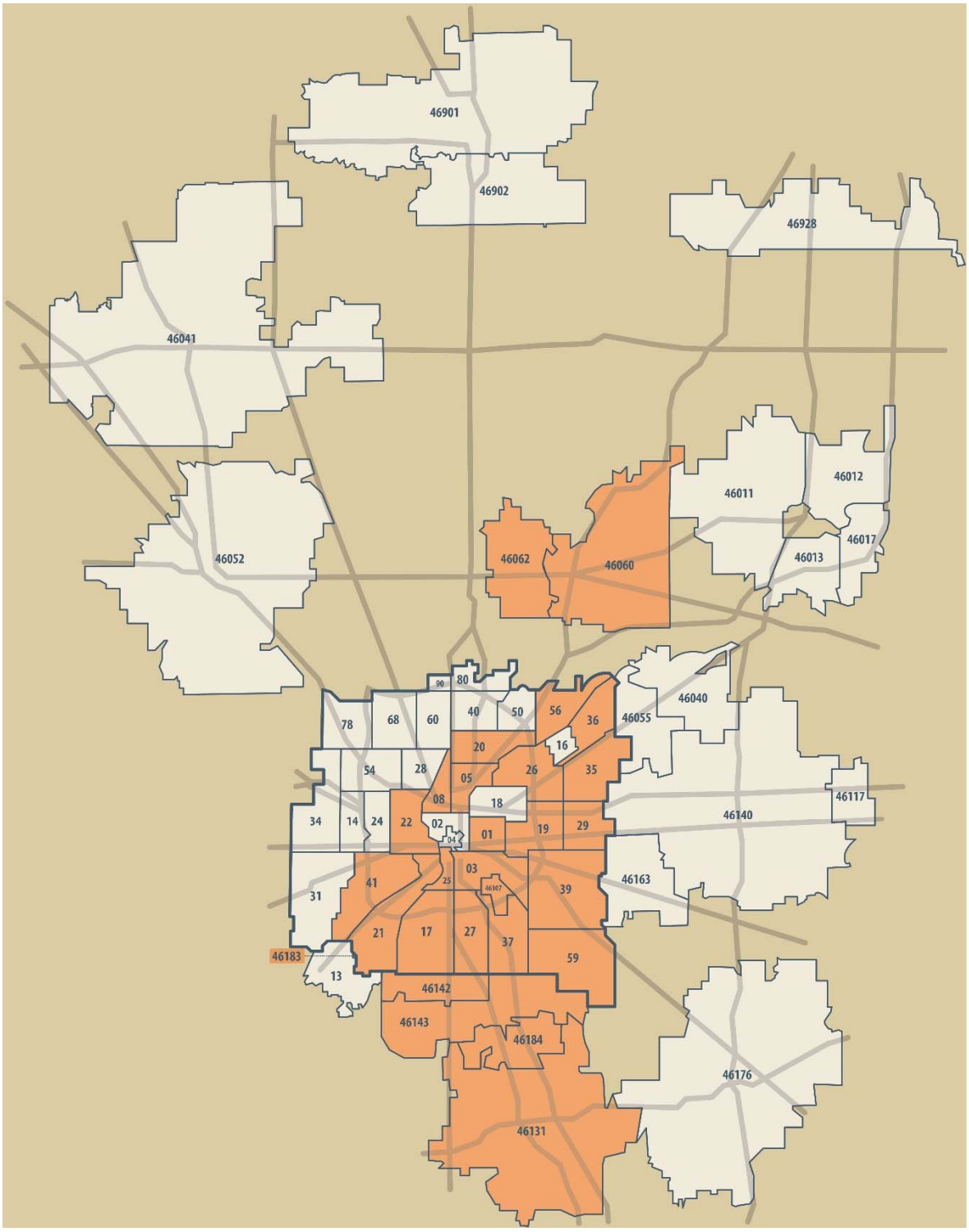

Table 3: School-Based Clinical Care Sites, Location and Staff Support

DISTRICT	SCHOOL	ADDRESS	DAILY STAFFING
BEECH GROVE	Beech Grove High School	5330 Hornet Ave. 46107	1 LPN
BEECH GROVE	Beech Grove Middle School	1248 Buffalo St. 46107	1 RN
BEECH GROVE	South Grove Intermediate School	851 South 9th Av. 46107	1 LPN
BEECH GROVE	Central Elementary	1000 Main St. 46107	1 LPN
BEECH GROVE	Hornet Park Elementary	5249 Hornet Ave. 46107	1 RN
CHARTER	Christel House Academy South	2717 South East St. 46225	1 RN
CHARTER	Christel House Academy West	55 N. Tibbs Ave. 46222	1 RN
CHARTER	Irvington Elementary	6705 E. Julian Ave. 46219	1 RN
CHARTER	Irvington Middle	6040 E. Pleasant Pkwy South 46219	1 LPN
CHARTER	Irvington Prep Academy	5751 E. University Ave. 46219	1 MA
CHARTER	Paramount School of Excellence	3020 Nowland Ave. 46201	1 RN
CLARK-PLEASANT	Break O Day Elementary School	900 Sawmill Rd. 46184	1 RN
CLARK-PLEASANT	Clark Elementary School	5764 East 700 North 46131	1 RN
CLARK-PLEASANT	Pleasant Crossing Elementary School	3030 N 125 West 46184	1 RN
CLARK-PLEASANT	Whiteland Elementary School	120 Center St. 46184	1 RN
CLARK-PLEASANT	Grassy Creek Elementary School	2111 Sheek Rd. 46143	1 RN
CLARK-PLEASANT	Clark Pleasant Middle School	1354 E. Worthsville Rd. 46143	2 RN
CLARK-PLEASANT	Whiteland Community High School	300 Main St. 46184	2 RN
DECATUR	Liberty Early Elementary	4640 Santa Fe Drive 46221	1 RN
DECATUR	Stephen Decatur Elementary	3425 South Foltz St. 46221	1 RN
DECATUR	Valley Mills Elementary	5101 South High School Rd 46221	1 RN
DECATUR	West Newton Elementary	7529 Mooresville Rd 46183	1 RN
DECATUR	Blue Academy	5650 Mann Rd 46221	1 RN
DECATUR	Gold Academy	5650 Mann Rd 46221	1 LPN
DECATUR	Decatur Middle School	5108 South High School Rd 46221	1 RN
DECATUR	Decatur Central High School	5251 Kentucky Ave 46221	1 RN and 1 LPN
DECATUR	Decatur Township School of Excellence	5106 South High School Rd. Ste. B 46221	1 LPN
FRANKLIN	Adams Elementary School	7341 E. Stop 11 Rd. 46259	1 RN
FRANKLIN	Arlington Elementary School	5814 S. Arlington Ave. 46237	1 RN
FRANKLIN	Bunker Elementary School	6620 Shelbyville Rd. 46237	1 RN
FRANKLIN	Kitley Elementary School	8735 Indian Creek Rd. 46259	2 RN (job share)
FRANKLIN	South Elementary School	9010 E. Southport Rd. 46239	1 RN

FRANKLIN	Thompson Crossing Elementary School	7525 E. Thompson Rd. 46239	1 LPN
FRANKLIN	Franklin Township Middle School- East	10440 Indian Creek Rd. 46259	1 1/2 RN
FRANKLIN	Franklin Township Middle School- West	7620 Edgewood Ave. 46239	1 RN
FRANKLIN	Franklin Central High School	6215 S. Franklin Rd. 46239	2 RN and 1/2 LPN
GREENWOOD	Greenwood Community High School	615 West Smith Valley Rd. 46143	1 RN
GREENWOOD	Greenwood Middle School	523 South Madison Ave. 46143/1584 Averitt Rd 46143	1 RN (job share)
GREENWOOD	Northeast Elementary School	99 Crestview Dr. 46143	1/2 RN and 1/2 LPN
GREENWOOD	Southwest Elementary School	619 West Smith Valley Rd. 46143	1 LPN
GREENWOOD	Westwood Elementary School	889 Honey Creek Rd. 46143	1 RN
GREENWOOD	V.O. Isom Elementary School	50 East Broadway Ave. 46143	1 RN
LAWRENCE	Lawrence Advanced Academy	6501 Sunnyside Rd. 46236	1/2 RN
LAWRENCE	Early Learning Center @ AB	11660 Fox Rd. 46236	1 LPN
LAWRENCE	Early Learning Center @ BP	5249 N. David St. 46236	1 LPN
LAWRENCE	Early Learning Center @ MC	8510 E. 82nd St. 46256	1 RN
LAWRENCE	Early Learning Center @ WR	11845 E. 46th St. 46236	1 LPN
LAWRENCE	Amy Beverland Elementary	11650 Fox Rd. 46236	1 RN
LAWRENCE	Brook Park Elementary	5259 N. David St. 46226	1 RN
LAWRENCE	Crestview Elementary School	7600 E. 71st St. 46256	1 RN and 1 LPN
LAWRENCE	Forest Glen Elementary	6333 Lee Rd. 46236	1 RN
LAWRENCE	Harrison Hill Elementary	7510 E. 53rd St. 46226	1 RN
LAWRENCE	Indian Creek Elementary	10833 E. 56th St. 46235	1 RN
LAWRENCE	Mary Castle Elementary	8502 E. 82nd St. 46256	1 RN
LAWRENCE	Oaklandon Elementary	6702 Oaklandon Rd. 46236	1 RN
LAWRENCE	Skiles Test Elementary	7001 Johnson Rd. 46220	1 RN
LAWRENCE	Sunnyside Elementary	6345 Sunnyside Rd. 46236	1 RN
LAWRENCE	Winding Ridge Elementary	11825 E. 46th St. 46236	1 RN
LAWRENCE	Belzer Middle School	7555 E. 46226	1.25 RN (job share)
LAWRENCE	Fall Creek Valley Middle School	9701 E/ 63rd St. 46226	1.25 RN (job share)
LAWRENCE	Lawrence Central High School	7300 E. 56th St. 46226	1 RN and 1 LPN
LAWRENCE	Lawrence North High School	78020 N. Hague Rd. 46256	2 RN (job share)
LAWRENCE	McKenzie Career Center	7250 E. 75th St. 46256	1 RN (job share)
PERRY	Abraham Lincoln Elementary	5241 Brehob Road 46217	1 RN and 1 MA
PERRY	Clinton Young Elementary	5740 McFarland Rd. 46227	1 RN
PERRY	Douglas MacArthur Elementary	454 E. Stop 11 Road 46217	1 RN
PERRY	Douglas MacArthur Kindergarten		1 CMA
PERRY	Glenns Valley Elementary	8239 Morgantown Rd. 46217	1 RN
PERRY	Homecroft Elementary	1551 Southview Rd. 46227	1 RN
PERRY	Homecroft Kindergarten		1 LPN
PERRY	Jeremiah Gray-Edison Elementary	5225 Gray Rd. 46237	1 LPN
PERRY	JG Kindergarten		1 LPN
PERRY	Mary Bryan Elementary	4335 E. Stop 11 Rd. 46237	1 RN

PERRY	Rosa Parks-Edison Elementary	7525 Wellingshire Blvd. 46217	1 LPN
PERRY	Rosa Parks-Edison Kindergarten		1 LPN
PERRY	Southport Elementary	61 E. Anniston Drive 46227	1 RN
PERRY	William Henry Burkhart Elementary	5701 Brill Road 46227	1 LPN
PERRY	Winchester Village Elementary	1900 E. Stop 12 Road 46217	1 LPN
PERRY	Perry Township Education Center - Pre-School	6548 Orinoco Avenue 46227	1 RN
PERRY	Perry Township 6th Grade Academy	202 W. Meridian School Road 46217	1 CMA
PERRY	Perry Meridian Middle School	202 W. Meridian School Road 46217	2 RN
PERRY	Perry Meridian High School	401 W. Meridian School Road 46217	1 RN and 1 LPN
PERRY	Southport 6th Grade Academy	5715 S. Keystone Ave 46227	1 RN
PERRY	Southport Middle School	5715 S. Keystone Ave 46227	1 LPN and 1 CMA
PERRY	Southport High School	971 E. Banta Road 46227	1 RN +A1:D104and 1 LPN
WARREN	Bookview	1550 N Cumberland Rd. 46229	1 LPN
WARREN	Creston MS/IA	10925 E. Prospect St. 46239	1 RN and 1 MA
WARREN	Early Childhood	1401 N. Mitthoeffer Rd. 46229	1 RN
WARREN	Eastridge	10930 E 10th St. 46229	1 LPN
WARREN	Grassy Creek	10330 E. Prospect St. 46239	1 RN
WARREN	Hawthorne	8301 E. Rawles Ave. 46219	1 LPN
WARREN	Lakeside	9601 E. 21st St. 46229	1 RN
WARREN	Liberty Park	8425 E. Raymond St. 46239	1 LPN
WARREN	Lowell	2150 Hunter Rd. 46239	1 LPN
WARREN	Pleasant Run	1800 N Franklin Rd. 46219	
WARREN	Raymond Park MS/IA	8575 E. Raymond St. 46239	1 RN and 1 MA
WARREN	Renaissance	8931 E. 30th St. 46219	1 LPN
WARREN	Stonybrook MS/IA	11300 Stonybrook Dr. 46229	1 RN and 1 MA
WARREN	Sunny Heights	11149 Stonybrook Dr. 46229	1 RN
WARREN	Warren Central / Walker Career Center	9500 E. 16th St, 46229	2 RN

TOTAL STAFF BY DISTRICT INCLUDES PRN STAFF

BEECH GROVE = 8

CHARTER/DONOR = 10

CLARK PLEASANT = 12

DECATUR = 15

FRANKLIN = 19

GREENWOOD = 11

LAWRENCE = 35

PERRY = 32

WARREN = 23

ADMIN = 2

Touchpoint

Community Health Network's Touchpoint helps seniors access and navigate health care services, while maximizing their quality of life through fun and fellowship with other seniors. Touchpoint is a free program that brings together a variety of services offered by Community Health Network to assist seniors and older adults during their times of need and help them transition into new phases of life. Touchpoint helps seniors access and navigate health care services and offers opportunities for fun and fellowship with other seniors. We aim to provide an exceptional experience for those who are aging, as well as their caregivers. Touchpoint includes a free membership program for older adults who wish to stay healthy and young at heart. Member benefits include: quarterly and monthly newsletters with tips for healthy living and senior programs; health-related education classes, health screenings and support groups (most are free); social activities, including fun day trips and travel opportunities; connections to volunteer opportunities and listings of local resources and programs.

Community Benefit Payeeship for Individuals with Serious Mental Illness

Community Health Network houses a Social Security's Representative Payment Program in which we provide financial management for clients who are incapable of managing their Social Security or SSI payments. As a representative payee, our responsibilities include: using benefits to pay for the current and foreseeable needs of the beneficiaries; appropriately saving any remaining benefits; and keeping good records of how the benefits were spent. When an individual lacks these necessities, consequences can include the development or exacerbation of health problems, which may require hospitalization; a decision to turn to criminal activity to obtain money, resulting in legal charges and possible incarceration; and inability to pay rent, which can lead to homelessness or institutionalization[7]. A Psychiatrist deems the individual unable to oversee their money and then the Social Security Office review's the application to move a person's benefits to a payeeship program. We work with the client to set up budgets, pay their bills directly to vendors—this ensures they have a place to live, utilities, food and personal spending money. Through our program each client has a debit card that we load money on—daily, weekly or monthly— depending on their ability to manage money. We have successfully been able to help those on the payeeship program to become more independent while reducing the number of clients being evicted. Representative payee programs have been found to have significant positive effects on a beneficiary's ability to live independently, which in turn affects the individual's health and well-being[8]. Appointment of a representative payee is associated with increased ability to meet basic needs; declines in homelessness, victimization, and arrests; and increased adherence to outpatient substance abuse treatment[9,10,11,12] . For individuals diagnosed with a mental impairment, better money

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[7] Conrad, K. J., G. Lutz, M. D. Matters, L. Donner, E. Clark, and P. Lynch. 2006. Randomized trial of psychiatric care with representative payeeship for persons with serious mental illness. Psychiatric Services (Washington, D.C.) 57(2):197-204.

[8] *Ibid.*

[9] Luchins, D., D. Roberts, and P. Hanrahan. 2003. Representative payeeship and mental illness: A review. Administration in Policy in Mental Health 30(4):341-353.

[10] Rosenheck, R., J. Lam, and F. Randolph. 1997. Impact of representative payees on substance use by homeless persons with serious mental illness. Psychiatric Services (Washington, D.C.) 48(6):800-806.

[11] Stoner, M. R. 1989. Money management services for the homeless mentally ill. Hospital and Community Psychiatry 40(7):751-763.

[12] Ries, R. K., and K. A. Comtois. 1997. Managing disability benefits as part of treatment for persons with severe mental illness and comorbid drug/alcohol disorders: A comparative study of payee and non-payee participants. *American Journal on Addictions* 6(4):330-338.

management is associated with superior quality of life, fewer hospitalizations, improved treatment compliance, and greater self-efficacy[13].

Line 8. "Workforce development"

Community Hospital East Family Medicine Residency Program

Community Health Network's Family Medicine Residency Program has a track record of more than 40 years of excellence, and is currently being expanded to grow along with the need for physicians. Community Hospital East Family Medicine Residency Program trains physicians to practice in the Patient Centered Medical Home. Since the program began, 221 graduates have completed training and we have recently expanded to a class size of 10 (up from 8).

The Family Medicine Residency program at Community Hospital East offers an allopathic program; training in a new ambulatory model - a patient-centered medical home four-module curriculum; three educational tracks (underserved populations, obstetrics and sports medicine); and uses an in-office experience as basis for training. In addition, our program is continually accredited by the ACGME and our graduates have outstanding success on their ABFP certification exams.

Our core faculty consists of full-time and part-time family physicians (allopathic and osteopathic), behavioral faculty, a program administrator, a residency coordinator and a practice administrator. Obstetrician-gynecologists, pediatricians, clinical pharmacists, social workers and nurse practitioners are also part of our educational staff. Volunteer family physicians from the community, subspecialist physicians and clinical instructors in other fields round out the faculty.

We care for many underserved patients in our offices and hospitals—which prompted us to establish an exciting partnership with the Jane Pauley Community Health Centers to create an underserved residency track. Through this track we seek to develop family physicians who specialize in the advocacy and care of underserved populations. The Jane Pauley Community Health Center-Shadeland— a Federally Qualified Health Center— is the site for the residents to provide primary care to a continuity panel of patients over a three-year period, supervised by faculty from the residency program. The Jane Pauley Community Health Center-Shadeland will serve as a patient-centered medical home to its patients, with an interdisciplinary team-based care model, involving physicians, nurse practitioners, clinical pharmacists, social workers, and nurse care managers.

Psychiatry Residency Program

As the area's leading provider of behavioral health services, we recognize that the coming caregiver shortage extends to psychiatric care, so we plan to be part of the solution in this area. 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. Our focus is to provide exceptional resident training using a robust array of mental health service experiences combined with a comprehensive didactic curriculum. We are committed to prepare residents to succeed at the forefront of the evolving role of psychiatry in the

[13] Elbogen, E. B., J. Tiegreen, C. Vaughan, and D. W. Bradford. 2011. Money management, mental health, and psychiatric disability: A recovery-oriented model for improving financial skills. Psychiatric Rehabilitation Journal 34(3):223-231.

delivery of healthcare. We strongly believe we will provide you with the educational opportunities, clinical experiences, supervision and mentorship to guide you in achieving this goal.

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. The Behavioral Health Pavilion is a full-service, 122-bed inpatient behavioral health hospital and has nine units which offer unique programming to fit the needs of our patients. The inpatient experiences focus on the thorough evaluation and stabilization of an acute episode with follow-up care arranged in the community. Residents are supervised by board-certified psychiatrists and will engage with multidisciplinary staff members in the treatment of patients. In addition, three of Gallahue Behavioral Health Service's multiple regional locations will serve as required clinical rotation sites: Gallahue Hillsdale (Partial Hospitalization Program/Intensive Outpatient Program rotation and outpatient psychiatry clinic), Community Support Services (community psychiatry rotation) and Southpointe Clinic (outpatient child and adolescent rotation). Other rotation sites include private practices (geriatric psychiatry outpatient, forensic psychiatry, neurology outpatient), Fairbanks Hospital (addictions), Community Heart and Vascular Hospital (consultation liaison), Community Hospital East (consultation liaison, inpatient medicine) and Community Hospital South (inpatient medicine).

Line 9. "Other"

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. Our residents enjoy training opportunities in settings ranging from acute care hospitals and a specialty cardiology hospital to pediatrics, and extensive array of primary care and specialty care clinics, and the largest behavioral care pavilion in the state. Each program affords the resident with an opportunity to pursue an academic experience with close faculty mentorship to lead case discussions and serve as a co-preceptor during the year.

Podiatry Residency Program

Community podiatry residents are provided 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. All residents are given the opportunity to participate in research, and there is ample opportunity for publication. Journal club, M&M conferences, a radiology course, tumor board, surgical workshops, and PRESENT lectures provide continued didactic experiences. Residents enjoy a comfortable lifestyle in a clean and safe major metropolitan area, boasting professional sports teams, plentiful outdoor activities, attractive cost of living, and family-friendly activities. The program has been approved to take three residents per year.

Clinical Pastoral Education

Community Howard Regional (CHRH) Clinical Pastoral Education (CPE) program is one of only approximately 450 accredited CPE centers in the United States. The Clinical Pastoral Education program,

with its 40 years of history, is designed to support the student chaplains' goal of pursuing board certification by credentialing bodies such as the Association for Professional Chaplaincy, the National Association of Catholic Chaplains, and the National Association of Jewish Chaplains.

CPE is a creative movement that prepares persons who engage in theological education for ministry. It has its roots in the efforts of pioneers who sought to bring the theological students into supervised encounters with persons in crisis. Students learn about the human condition, their spiritual needs and the care of souls through a holistic approach in ministry. Hence, the concept of learning from the "Living Human Documents" is central in CPE. It is an experienced-based, process-oriented, person-centered theological education. CPE at CHRH offers you the opportunity to learn and discover some of the following, which are competency criteria in chaplaincy board certification.

- Cultivate listening skills: spiritual assessment, support and crisis intervention.
- Develop sensitivity and knowledge in ethics, psychology and cultural issues in patient-care ministry.
- Advocate for the well-being of staff and organization.
- Develop cultural competence in inter-ethnic and inter-cultural relationships.
- Nurture and sustain ministry relationships with an inter-disciplinary team.
- Deepen the ability to reflect theologically and critically.
- Respect differences in religions, cultures and theological perspectives.
- Identify specific goals in ministry formation with references to personal strengths and weaknesses.
- Demonstrate ministry competence in the practice of continuous quality improvement.
- Demonstrate a working and culturally relevant knowledge of current theory and practice.
- Effective use of Family System Theory in ministry.

Part V: Facility Information, Section B Facilities Policies and Practices, Community Health Needs Assessment

Part V, Section B Line 5

In 2015, Community Health Network conducted a CHNA to understand the greatest health needs in the communities served by our hospitals. This assessment was in large part a joint process among four Indiana health systems: Community Health Network, IU Health, St. Francis Alliance, and St. Vincent. Combined, these are the largest health systems in Indiana. Through this collaborative partnership, community health data was collected in three ways:

- Secondary Data Collection: Data on health and wellness issues was collected. Sources include County Health Rankings, Census Bureau Data, various reports from the Indiana State Department of Health, and other national reports. Indiana Indicators, Community Commons,

and Healthy Communities Institute data management systems also contributed to the secondary data used. Sources of the secondary data are identified throughout this report.

- Community Health Survey: A core of 20 mandatory questions based on perception of community and personal needs were created. In addition, professionals assigned to each county worked with established community health collaborative, local hospitals, and the local health department to develop voluntary Community Health Needs Assessment to create 9 questions specific to the county. This resulted in a survey with 20 to 29 questions, dependent on the respondent's county of residents.
- Focus Groups: In addition to the survey the partnership hosted focus groups that included 15-60 community leaders from governmental public health, health care, social service agencies, related nonprofits, civic organizations, and grassroots/neighborhood organizations. In larger focus groups, sub-groups were utilized to give all participants a voice. Each focus group determined the top four to six health needs in the community; potential resources or partners; and some actions/interventions that might work best.

Community Health Network consulted the following people for the CHNA:

Table 4: Community Health Network CHNA Partner Engagement

Alice McCray – CAFÉ	Helen Machal – Marion Cty. Prosecutor's Office	Maria Tischner – Indiana Latino Institute
Allison King – John H. Boner Community Center	Jake Readon-McSoley – Fishers YMCA	Mary McBeth – Windsor Village
Amandula Anderson – United North East Community Development Corporation	James Jackson – Pastor Fervent Prayer Church	Mary McKee – Associate Director
Ann Yeakle – Community Health Network	James Taylor- John H. Boner Community Center	Mary Moriarity Adams – City-County Council Office
Anne Majewski – Lutherwood	Jan Diggins – Citizens Gas	Matt Hedrix – GIPC
Anne-Marrie Taylor – INRC	Jane Beers – St. Thomas Clinic	Melissa Drew – CAFÉ
Bea Northcott – Marriage Investors	Janette Helm – St. Vincent	Michael Halstead – Halstead Architects
Beverly Brown – Community Relations Senator Breaux	Jenny Skeehan – Irvington Development	Mike Kolenda – CEO Windrose Health Networks
Beverly Mukes – Gaither Fifth Third Bank	Jim Ginder – Hamilton Cty. Health Department	Mike Lindbloom – Fishers YMCA
Bill Oakes – Director of Business Development	Jim McGuiness – Scecina Memorial High School	Millicent Fleming-Moran – Epidemiologist/Researcher
Bill Taft – Local Initiatives Support Corporation	Joe Gibson – Director of Epidemiology	Miriam Aceveda Davis – LaPlaza
Book Thomas – HealthNet Health Centers	Joe Sagrsky – Indiana Heart Physicians, St. Francis	Nancy chance – Executive Director Good Samaritan Network
Brenda Horn – Attorney	Joe Thurber – Scecina Memorial High School	Orin Bell, President CICOA
Carla Slauter – Center Grover Schools	John Ault – Franklin Insurance	Paula Mandel – Johnson Cty. Health Department

Cathy Burton – Marion Cty. Alliance of Neighborhood Associations	John Kunzer – Wishard Primary Care Services	Phyllis Price – Eastside Resident
Chris Gilmore, RN – Grace UMC	Johnny Washington – MDwise	Rev. Angelique Walker-Smith – The Church Federation of Greater Indianapolis
Chris Weaver – CMO Wishard Health Services	Joy Davis – IU Saxony	Rebecca Rominger – Counselor
Christine Gree-Hayes – Eastside Resident	Judy Ferguson – Meridian Management Corp.	Rebecca Seifert – Executive Director
Chuck Brandenburg – United Way	Judy Jacobs – Windrose Health Network	Rev. Alice Goshorn – St. Thomas Episcopal Church
Cleven McBeth – Windsor Village	Juli Paini – Office of Disability Affairs, Mayor's Office	Rita Steinberg – ISO
David Forsell – Keep Indianapolis Beautiful	Karen Lightbourne – Mayor's Office of Neighborhood Services	Rob Riewoldt – Certified Mortgage Banker
David Minor – Hunger Alliance	Karen Luehmann – Gateway Services	Sara VanSlambrook – Local Initiatives Support Corporation
Dawn Underwood – Franklin College	Kate Hill-Johnson – St. Francis	Sarah Ketterer – IU Health
Deb Johnson – Whiteland Community High School	Kelly Peisker – St. Vincent	Schefcik Morris – Little Flower Neighborhood Association
Diane Hannel – Marion Cty. Prosecutor's Office	Kelly Wansing – NESCO (near Eastside Neighborhood Association)	Yvonne Shaheen – CHNw Board Member
Dick Hammon – American Senior Communities	Kevin Robinson – Olympic Products	Spalding Irvington Development
Donna Vaughn – Aspire	Larry Heydon – President/CEO Johnson Memorial Hospital	Sue Burrow – Indiana Public Policy Institute
Doreen St. Clair – Health Educator	Linda Ruskowski – RT Community Health Network	Suzanne Miller – Juvenile Probation
Duncan Brown - Aspire	Lori Hazlett – Indianapolis Parks Foundation	Tamara Moore – Education Services Director
Ellen Quigley – Grants Officer	Lori Meyers – Johnson Cty. Community Corrections	Tammy Hughes – East 10th St. Civic Association
Frank Hancock – Sports Graphic, Inc.	Margaret Lawrence Banning – Irvington Development Organization	Terri Nigh – Director of Health Services
Gloria Nordemyer – Rosewalk at Lutherwood	Margarita Hart – Executive Director Esperanza Ministries	Terry West – Financial Consultant Riverview Hospital
Greg Ernest – 38th & Shadeland Business Group	Maria Rusomaroff – City of Indianapolis, DMD	Virginia Caine – Director, Public Health MCPHD
Gregory Steele – Associate Professor, IUPUI		

Outside of the collaborative, Community Health Network invited key public health informants to provide their input on community health needs. The following informants were interviewed: Duane Krambeck-

Principal of Christian Park Elementary School in Indianapolis Public Schools; Mary Conway, MSN, RN Administrative Coordinator for Nursing Services in Indianapolis Public Schools; Randy Miller Executive Director of Drug Free Marion County.

These quantitative and qualitative data collection mechanisms helped identify community health needs and secondary data confirmed the needs perform below state averages. Further review of the health needs determined the extent to which health inequities may exist and which segments of the population are more negatively impacted.

Part V, Section B, Line *6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C*

Yes, we included all hospital facilities in the Community Health Network for the CHNA which were: Community Hospital South, Community Hospital North, Community Hospital East, Community Howard Regional Hospital and Community Hospital of Anderson and Madison County. Additionally, we included IU Health, Franciscan Health, St. Francis Health and St. Vincent.

Part V, Section B, Line *6b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C*

Yes, the CHNA was conducted with Healthy Communities Institute.

Part V, Section B, Line 7 indicate how the hospital facility made the CHNA widely available to the public by checking all applicable boxes. If the hospital facility made the CHNA widely available to the public by means other than those listed in lines 7a through 7c, check line 7d, "Other," and describe these means in Part V, Section C.

a. Hospital facility website: ecommunity.com

c. Made a copy available for public inspection without charge at the hospital facility upon request

Part V, Section B, Line 7a URL, where the CHNA can be accessed.

http://webapp.ecommunity.com/aboutus/

Part V, Section B, Line 10a. List in the space provided the direct website address, or URL, where the implementation strategy can be found

http://webapp.ecommunity.com/aboutus/

Part V, Section B, Line 10b. Answer "Yes" if the hospital facility's most recently adopted implementation strategy is attached.

Yes.

Part V, Section B, Line 11. Explain in Part V, Section C, how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that aren't being addressed together with the reasons why such needs aren't being addressed. For example, a hospital facility might identify limited financial or other resources as reasons why it did not take action to address a need identified in its most recently conducted CHNA

Community developed an Implementation Strategy (IS) to address the significant community health needs discovered through the CHNA process. The IS is a working 'community benefit plan' that provides direction for action and resource commitment.

Implementation Strategy

Community Benefit Implementation Strategy is based on the Health Rankings model of population health. The *Rankings* model of population health emphasizes the many factors that, if improved, can help make communities healthier places to live, learn, work and play[14]. In this model the health of a county is measured with two types of health outcomes: how long people live (length of life) and how healthy people feel while alive (quality of life)[15]. Health factors in the model represent what influences the health of a county. There are four types of health factors: health behaviors, clinical care, social and economic factors, and physical environment. In turn, each of these factors is based on several measures. A fifth set of factors that influence health (genetics and biology) is not included in the Rankings[16]. In our IS, Community is focusing primarily on three health factors Clinical Care; Health Behaviors and Social and Economic Factors as they relate to Access to Care, Pediatric Asthma and Obesity. The IS also gleans its objectives and best practices from Healthy People 2020 and the Culture of Health Framework.

In 2016, Community Health Network reinforced its support of the organization's community benefit mission and put in place operational elements that sustain community benefit programs such as qualified staff, sufficient budgets, and supportive policies and procedures. By doing this Community will continue to adopt standardized principles and practices to account for community benefit and establish effective administrative and accounting processes to accurately account for and report community benefit to various stakeholders, including the IRS and state/local agencies. *See attachment 1: Community Health Network Implementation Strategy.*

Implementation Strategy Evaluation

Community's community benefit leadership and staff will regularly monitor and report on progress towards the IS objectives and provide an annual report to the Hospital's Executive Leadership. Additional progress on the IS will be reported annually through the hospital's IRS Form 990 Schedule H filing and other reporting sources associated with strategic partners and community coalitions.

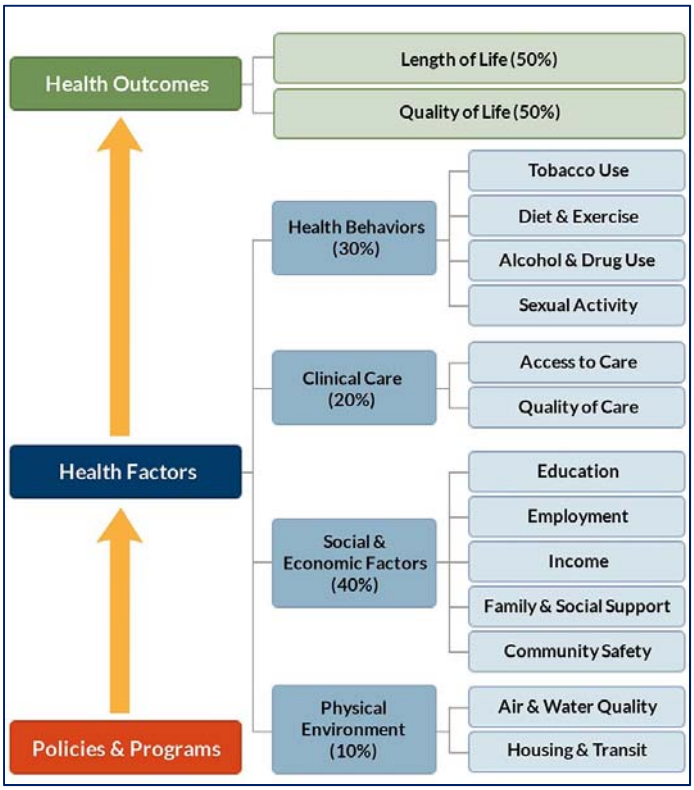
The following section highlights how Community Health Network has worked with public health experts and community partners to assess and prioritize community health needs and develop programs based on goals, measurable outcomes and evidence-based interventions.

[14] Remington, P. L., Catlin, B. B., & Gennuso K. P. (2015) The County Health Ranking: rationale and methods. Popul Health Metr, 13(11). doi: 10.1186/s12963-015-0044-2.

[15] "Framework Approach". *County Health Rankings Health Outcomes Approach*. http://www.countyhealthrankings.org/our-approach/health-outcomes. Accessed July 2017.

[16] *Ibid.*

Figure 4: County Health Rankings Health Outcomes Approach



PART V. QUESTION 3 COMMUNITY HEALTH NEEDS ASSESSMENT

3A,C Definition of Community Served/Existing Healthcare Facilities

	Cities and Towns	*Zip Codes*	*Community Facility*
County			
Hamilton	Arcadia | Atlanta | Carmel | Cicero | Fishers | Noblesville | Sheridan | Westfield	Noblesville - 46060 Noblesville - 46060 Carmel - 46032 Carmel - 46032 Fishers - 46037 Fishers - 46037	Community Health Pavilion Noblesville MedCheck Noblesville Community Health Pavilion Carmel MedCheck Carmel KidsExpress Community Health Pavilion Saxony
Hancock	Cumberland | Fortville | Greenfield | McCordsville | New Palestine | Shirley | Spring Lake | Wilkinson	Greenfield - 46140	Community Health Pavilion Greenfield
Howard	Greentown | Kokomo | Russiaville	Kokomo - 46902	Community Howard Regional Health Community Oncology Center - Kokomo Community Howard Specialty Hospital
Johnson	Bargersville | Edinburgh | Franklin | Greenwood | New Whiteland | Princes Lakes | Trafalgar | Whiteland	Greenwood - 46143 Greenwood - 46143 Greenwood - 46142	Stones Crossing Health Pavilion Community Health Pavilion County Line MedCheck Greenwood
Madison	Alexandria |Anderson | Chesterfield | Country Club Heights | Edgewood | Elwood | Frankton | Ingalls | Lapel | Markleville | Orestes | Pendleton | River Forest | Summitville | Woodlawn Height	Anderson - 46011 Anderson - 46011 Anderson - 46011 Anderson - 46013 Anderson - 46013	Community Hospital Anderson Community Cancer Center Anderson - Medical Onc. Community Cancer Center Anderson - Rad. Onc. MedCheck Anderson Community Health Pavilion Anderson
Marion	Beech Grove | Clermont | Crows Nest | Cumberland | Homecroft | Indianapolis | Lawrence | Meridian Hills | North Crows Nest | Rocky Ripple | Southport | Speedway | Spring Hill | Warren Park | Williams Creek | Wynnedale	Lawrence - 46216 Eastgate - 46219 Eastgate - 46219 Eastgate - 46219 Eastgate - 46219 Eastgate - 46219 Speedway - 46224 Castleton - 46256 Castleton - 46256 Castleton - 46256 Castleton - 46250 Castleton - 46250 Southport - 46227 Southport - 46227 Cumberland - 46229	Community Health Pavilion Fort Benjamin Harrison Community Health Pavilion Washington (w/ MedCheck East) Community Health Pavilion Shadeland Community Hospital East Community Cancer Center East - Med. Onc. Community Cancer Center East - Rad. Onc. Community Westview Health Pavilion (w/ MedCheck Speedway) MedCheck Castleton Community Rehabilitation Hospital Community Hospital North Community Heart and Vascular Hospital Community Cancer Center North Community Cancer Center South Community Hospital South Community Health Pavilion East
Morgan	Bethany | Brooklyn | Martinsville | Monrovia | Mooresville |Morgantown| Paragon		

Sites of Care Map, 2016:

H-Hospital; P-Pavillion; S-Surgery Center; C-Cancer Center; M–Medcheck; B-Behavioral Health; I-Imaging; E-Endoscopy Center; ●-Physican Network Site

3B. Demographics of the Community

		Age		*Race*						*Gender*
	Total Population	% < 18	% 65 and over	% African American	% American Indian/Alaskan Native	% Asian	% Native Hawaiian/ Pacific Islander	% Hispanic	% Non-Hispanic White	% Female
Location	6,596,855	24.0	14.3	9.2	0.4	2.0	0.1	6.6	80.3	50.7
Indiana	302,623	28.5	10.4	3.9	0.2	5.6	0.1	3.8	84.9	51.2
Hamilton	71,978	24.1	15.1	2.2	0.3	0.9	0.0	2.1	93.4	50.9
Hancock	82,982	23.0	18.0	7.1	0.4	1.1	0.0	3.1	86.0	51.7
Howard	147,538	25.4	13.8	1.7	0.3	2.5	0.1	3.4	90.8	50.7
Johnson	130,069	22.1	16.9	8.4	0.4	0.6	0.1	3.7	85.6	50.1
Madison	131,636	22.8	16.0	8.3	0.2	0.4	0	3.2	87.7	50.1
Marion	941,229	24.9	11.8	28.5	0.5	3.1	0.1	10.2	65.0	51.8
Morgan	69,698	23.0	16.2	0.5	0.3	0.5	0	1.5	97.5	50.4
United States Census Bureau County Quick Facts: *https://www.census.gov/quickfacts/fact/table/US/PST045216*										

3D. How data was obtained

In 2015, Community Health Network conducted a CHNA to understand the greatest health needs in the communities served by our hospitals. This assessment was in large part a joint process among four Indiana health systems: Community Health Network, IU Health, St. Francis Alliance, and St. Vincent. Combined, these are the largest health systems in Indiana. Through this collaborative partnership, community health data was collected in three ways:

- Secondary Data Collection: Data on health and wellness issues was collected. Sources include County Health Rankings, Census Bureau Data, various reports from the Indiana State Department of Health, and other national reports. Indiana Indicators, Community Commons, and Healthy Communities Institute data management systems also contributed to the secondary data used. Sources of the secondary data are identified throughout this report.
- Community Health Survey: A core of 20 mandatory questions based on perception of community and personal needs were created. In addition, professionals assigned to each county worked with established community health collaboratives, local hospitals, and the local health department to develop voluntary Community Health Needs Assessment to create 9 questions specific to the county. This resulted in a survey with 20 to 29 questions, dependent on the respondent's county of residents.
- Focus Groups: In addition to the survey the partnership hosted focus groups that included 15-60 community leaders from governmental public health, health care, social service agencies, related nonprofits, civic organizations, and grassroots/neighborhood organizations. In larger focus groups, sub-groups were utilized to give all participants a voice. Each focus group

determined the top four to six health needs in the community; potential resources or partners; and some actions/interventions that might work best.

Outside of the collaborative, Community Health Network invited twelve key public health informants to provide their input on community health needs. Of those, five persons responded with interest. However, due to time and further interest, only three informants were interviewed: Duane Krambeck- Principal of Christian Park Elementary School in Indianapolis Public Schools; Mary Conway, MSN, RN Administrative Coordinator for Nursing Services in Indianapolis Public Schools; Randy Miller Executive Director of Drug Free Marion County.

These quantitative and qualitative data collection mechanisms helped identify community health needs and secondary data confirmed the needs perform below state averages. Further review of the health needs determined the extent to which health inequities may exist and which segments of the population are more negatively impacted.

3E. Significant Health Needs

CHNA data was analyzed and prioritized using these key factors: feasibility for our hospitals to impact change, health system expertise in the field of the assessed need, and the hospitals ability to be the most effective with the resources available. The four significant health needs identified in all our communities are:

- Access to Healthcare
- Obesity
- Pediatric Asthma
- Community Driven Initiatives

During the assessment phase we identified many needs that fall outside the expertise of the health system and its core competencies. Examples of needs identified but falling outside of the health system core competencies include long commute times, lack of bachelor degree attainment, and reading at grade level. While some of our programs may systemically improve needs such as reading level or bachelor degree attainment, the prioritization process criteria dictate that the health system narrow its focus to clinical core competencies.

3F. Primary and chronic disease needs

According to the United Health Foundation's America's Health Rankings Annual Report, Indiana ranked 39th among all 50 states in 2016[17]. This report analyzes data on a wide range of behaviors, community and environmental conditions, policy, clinical care, and outcomes. As in previous years, Indiana ranks high in high school graduation rates, immunizations and low incidences of salmonella. The state's biggest improvement came in disparity in health status by education. That disparity decreased by 17 percent, from 27 percent to 22.4 percent, ranking Indiana seventh in the nation. It ranked 20th a year

[17] United Health Foundation America's Health Rankings 2016. http://assets.americashealthrankings.org/app/uploads/ahr16-complete-v2.pdf. Accessed July 4 2017.

ago. Indiana also showed improvement in obesity and smoking this year. The number of Indiana residents who smoke decreased by 2.3 percent, while the state's obesity rate declined by 1.4 percent. The state's 39th overall ranking suggests it still has a long way to go toward becoming healthier. Heart Disease is the leading cause of death in Indiana which is followed by cancer. In the past five years, drug deaths in Indiana have increased by 27 percent, from 13.1 to 16.7 deaths per 100,000 people. Statewide, more Hoosiers die by suicide than homicide, and Indiana has the nation's highest rate of high school students contemplating suicide. Suicide is the second leading cause of death for youth ages 15 to 24, and the third leading cause for youth ages 10 to 14. In the past year, the prevalence of diabetes increased 6.5 percent in Indiana while it decreased 13 percent nationwide. The report also showed a 2.9 percent rise in the rate of infant mortality in Indiana, dropping the state's rank from 36th in 2015 to 43rd in 2016. The top five causes of infant death are birth defects, preterm birth and low birth weight, maternal complications of pregnancy, sudden infant death syndrome, and injuries. These causes account for 57 percent of infant deaths. Indiana also ranks very low (49th out of 50) for public health funding. Combining state dollars dedicated to public health with federal dollars directed to Indiana, the Hoosier allocation is just $41 per person; the No. 1 state in that category, Alaska, has $261 per person.

County Health Rankings

Community Health Network is central in Central Indiana with its service area including the following counties: Hamilton, Hancock, Howard, Johnson, Madison, Marion and Morgan. Below is a snapshot of these counties based on data from the 2016 County Health Rankings report[18]. This report looks at 30 factors including poverty, education, transportation, housing, violent crime, jobs, and access to medical care. They also look at a variety of measures that affect the future health of communities, such as high school graduation rates, access to healthy foods, rates of smoking, obesity, and teen births.

County Health Rankings and Roadmaps, Indiana, County Comparison, Hamilton, Hancock, Howard, Madison, Marion and Morgan

	Indiana	Hamilton	Hancock	Howard	Johnson	Madison	Marion	Morgan
Health Outcomes County Rank in Indiana		1	7	66	5	78	79	41
Length of Life County Rank in Indiana		1	12	58	8	65	74	51
Premature Death	7,700	3,800	6,200	8,400	5,900	8,700	9,000	7,900
Quality of Life County Rank in Indiana		1	7	68	8	83	81	30
Poor or Fair Health	18%	10%	13%	17%	13%	17%	18%	13%
Poor Physical Health Days	4.0	2.9	3.2	4.2	3.4	4.4	3.7	3.5
Poor Mental Health Days	4.1	3.1	3.6	4.1	3.7	4.3	4.2	3.8
Low Birthweight	8%	7%	7%	7%	7%	8%	9%	8%
Health Factors County Rank in Indiana		1	6	62	8	73	92	42
Health Behaviors County Rank in Indiana		1	14	64	13	74	92	41

[18] County Health Rankings 2016. www.countyhealthrankings.org. Accessed July 2, 2017.

Adult smoking	21%	13%	15%	18%	17%	20%	21%	17%
Adult Obesity	32%	26%	35%	31%	30%	33%	32%	33%
Food Environment Index	7.2	8.6	7.8	6.6	7.8	6.9	6.1	7.8
Physical Inactivity	26%	16%	27%	28%	22%	26%	26%	29%
Access to exercise opportunities	75%	91%	64%	73%	87%	71%	90%	64%
Excessive drinking	17%	17%	18%	16%	17%	16%	18%	17%
Alcohol-impaired driving deaths	24%	30%	26%	24%	21%	10%	19%	30%
Sexually transmitted infections	434.0	190.1	233.3	329.9	270.0	310.4	1,024.7	295.2
Teen births	35	11	23	46	30	45	49	35

3G. Process for identifying and prioritizing community health needs

CHNA data was analyzed and prioritized using these key factors: feasibility for our hospitals to impact change, health system expertise in the field of the assessed need, and the hospitals ability to be the most effective with the resources available. The four significant health needs identified in all our communities are:

- Access to Healthcare
- Obesity
- Pediatric Asthma
- Community Driven Initiatives

During the assessment phase we identified many needs that fall outside the expertise of the health system and its core competencies. Examples of needs identified but falling outside of the health system core competencies include long commute times, lack of bachelor degree attainment, and reading at grade level. While some of our programs may systemically improve needs such as reading level or bachelor degree attainment, the prioritization process criteria dictate that the health system narrow its focus to clinical core competencies.

3H. Process for consulting with persons representing community interest

In addition to the survey Community Health Network along with partners within the Hospital Collaborative hosted focus groups that included 15-60 community leaders from governmental public health, health care, social service agencies, related nonprofits, civic organizations, and grassroots/neighborhood organizations. In larger focus groups, sub-groups were utilized to give all participants a voice. Each focus group determined the top four to six health needs in the community; potential resources or partners; and some actions/interventions that might work best.

Community Health Network consulted the following people for the CHNA:

Alice McCray – CAFÉ	Helen Machal – Marion Cty. Prosecutor's Office	Maria Tischner – Indiana Latino Institute
Allison King – John H. Boner Community Center	Jake Readon-McSoley – Fishers YMCA	Mary McBeth – Windsor Village
Amandula Anderson – United North East Community Development Corporation	James Jackson – Pastor Fervent Prayer Church	Mary McKee – Associate Director
Ann Yeakle – Community Health Network	James Taylor- John H. Boner Community Center	Mary Moriarity Adams – City-County Council Office
Anne Majewski – Lutherwood	Jan Diggins – Citizens Gas	Matt Hedrix – GIPC
Anne-Marrie Taylor – INRC	Jane Beers – St. Thomas Clinic	Melissa Drew – CAFÉ
Bea Northcott – Marriage Investors	Janette Helm – St. Vincent	Michael Halstead – Halstead Architects
Beverly Brown – Community Relations Senator Breaux	Jenny Skeehan – Irvington Development	Mike Kolenda – CEO Windrose Health Networks
Beverly Mukes – Gaither Fifth Third Bank	Jim Ginder – Hamilton Cty. Health Department	Mike Lindbloom – Fishers YMCA
Bill Oakes – Director of Business Development	Jim McGuiness – Scecina Memorial High School	Millicent Fleming-Moran – Epidemiologist/Researcher
Bill Taft – Local Initiatives Support Corporation	Joe Gibson – Director of Epidemiology	Miriam Aceveda Davis – LaPlaza
Book Thomas – HealthNet Health Centers	Joe Sagrsky – Indiana Heart Physicians, St. Francis	Nancy chance – Executive Director Good Samaritan Network
Brenda Horn – Attorney	Joe Thurber – Scecina Memorial High School	Orin Bell, President CICOA
Carla Slauter – Center Grover Schools	John Ault – Franklin Insurance	Paula Mandel – Johnson Cty. Health Department
Cathy Burton – Marion Cty. Alliance of Neighborhood Associations	John Kunzer – Wishard Primary Care Services	Phyllis Price – Eastside Resident
Chris Gilmore, RN – Grace UMC	Johnny Washington – MDwise	Rev. Angelique Walker-Smith – The Church Federation of Greater Indianapolis
Chris Weaver – CMO Wishard Health Services	Joy Davis – IU Saxony	Rebecca Rominger – Counselor
Christine Gree-Hayes – Eastside Resident	Judy Ferguson – Meridian Management Corp.	Rebecca Seifert – Executive Director
Chuck Brandenburg – United Way	Judy Jacobs – Windrose Health Network	Rev. Alice Goshorn – St. Thomas Episcopal Church
Cleven McBeth – Windsor Village	Juli Paini – Office of Disability Affairs, Mayor's Office	Rita Steinberg – ISO
David Forsell – Keep Indianapolis Beautiful	Karen Lightbourne – Mayor's Office of Neighborhood Services	Rob Riewoldt – Certified Mortgage Banker
David Minor – Hunger Alliance	Karen Luehmann – Gateway Services	Sara VanSlambrook – Local Initiatives Support Corporation
Dawn Underwood – Franklin College	Kate Hill-Johnson – St. Francis	Sarah Ketterer – IU Health
Deb Johnson – Whiteland Community High School	Kelly Peisker – St. Vincent	Schefcik Morris – Little Flower Neighborhood Association
Diane Hannel – Marion Cty. Prosecutor's Office	Kelly Wansing – NESCO (near Eastside Neighborhood Association)	Yvonne Shaheen – CHNw Board Member
Dick Hammon – American Senior Communities	Kevin Robinson – Olympic Products	Spalding Irvington Development
Donna Vaughn – Aspire	Larry Heydon – President/CEO Johnson Memorial Hospital	Sue Burrow – Indiana Public Policy Institute
Doreen St. Clair – Health Educator	Linda Ruskowski – RT Community Health Network	Suzanne Miller – Juvenile Probation

Duncan Brown - Aspire	Lori Hazlett – Indianapolis Parks Foundation	Tamara Moore – Education Services Director
Ellen Quigley – Grants Officer	Lori Meyers – Johnson Cty. Community Corrections	Tammy Hughes – East 10th St. Civic Association
Frank Hancock – Sports Graphic, Inc.	Margaret Lawrence Banning – Irvington Development Organization	Terri Nigh – Director of Health Services
Gloria Nordemyer – Rosewalk at Lutherwood	Margarita Hart – Executive Director Esperanza Ministries	Terry West – Financial Consultant Riverview Hospital
Greg Ernest – 38th & Shadeland Business Group	Maria Rusomaroff – City of Indianapolis, DMD	Virginia Caine – Director, Public Health MCPHD
Gregory Steele – Associate Professor, IUPUI		