Community Benefit Plan 2013

Community Health Needs Assessment 2013 – 2015 Implementation Strategy

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The Community Health Network's, Community Benefit Plan is driven by the practices of our founding organization, the neighborhoods and businesses surrounding Community Hospital East. These principles and practices are echoed in the teachings of the Nobel Prize winner in Economics, Elinor Ostrum PhD and the "Triple Aim" of Don Berwick, MD and the Institute for Healthcare Improvement. These community development and data driven approaches are applied and amplified in the CHNw Community Benefit Plan.

Introduction

Today, as the country remains confused at the potential changes in the health care delivery system, the Community Health Network organization only needs to look back at a hope instilled in our institution from its inception. In the1950's it was the desire to improve the health of the community that led citizens on Indianapolis' east side to raise funds and build a hospital to serve the community. Today, the original hospital has grown into the Community Health Network, the second largest not-for-profit health system in Indiana. What hasn't changed is our purpose, our compassion, and the passion of our commitment to community. It is a commitment that extends into neighborhoods, schools, businesses and churches of the communities we serve. Just as our founding community members, we are committed to illuminating and supporting those core strengths necessary to a thriving Population of healthy, well individuals within strong sustainable communities. In short we believe that any lasting cultural change in community health status will be driven by local communities initiating the change they want and need.

The 2013 Community Health Needs Assessment (CHNA) and this Implementation Strategy (IS) were undertaken by the health network to understand and address community health needs, and in accordance with proposed Internal Revenue Service (IRS) regulations pursuant to the Patient Protection and Affordable Care Act of 2010.

This implementation strategy addresses the significant community health needs described in the CHNA that the hospital plans to address in whole or in part. The hospital reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and merit enhancements to the described strategic initiatives. Alternately, other organizations in the community may decide to address certain community health needs, and the hospital may amend its strategies and refocus on other identified significant health needs. Beyond the initiatives and programs described herein, the hospital is addressing some of these needs simply by providing health care to the community, regardless of ability to pay.

About Community Health Network

Community Benefit Plan / Implementation Strategy

The board of our network plays an integral role in the community benefit plan and is involved in setting strategy, communicating the plan within the organization and the community at large. Our leadership team members, the network board, and physician leaders have developed a strategic plan and vision for our network. This plan will serve as our roadmap from 2013 through 2020. We established a mission statement, which starts with a commitment to the community:

Mission

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

Values

Our values can be encapsulated as follows:

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

Vision

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

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

History

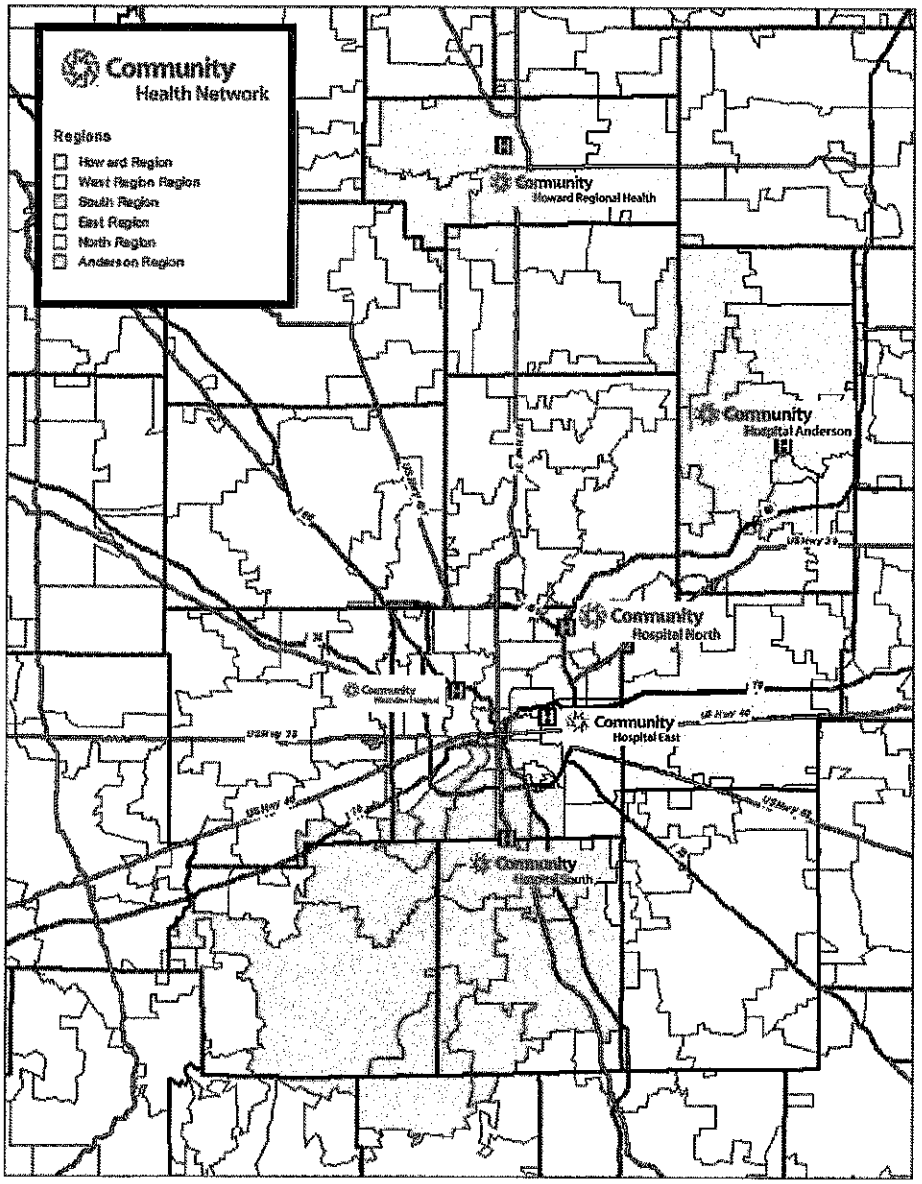
In 1954 the citizens on Indianapolis' east side decided to raise funds and build a hospital to serve the community. They did not have a name for the collective trust, action, cooperation and stewardship necessary in dealing with such a complex health and social dilemma. Nor did they understand that their transformation in 1954 would inform the leadership of the organization that they developed in the transformation of health care on the eastside into a better and more sustainable form in 2013. It wasn't until 2009, that the term for this collective care for the community resources was coined "care for the commons" by Indiana University Professor Elinor Ostrum. Her research led to the validation for what we have known and experienced since 1954, that a community can manage their own community resources successfully. Her theory was considered so significant she won the Nobel Prize in Economics.

Today Community Health Network is ranked among the nation's most integrated healthcare systems, Community Health Network is Central Indiana's leader in

providing convenient access to exceptional healthcare services, where and when patients need them—in hospitals, health pavilions and doctor's offices, as well as workplaces, schools and homes. As a non-profit health system with over 200 sites of care and affiliates throughout Central Indiana, Community's full continuum of care integrates hundreds of physicians, specialty and acute care hospitals, surgery centers, home care services, MedChecks, behavioral health and employer health services.

Overview of Communities Served by Community Health Network

Figure I: Map of Service Regions:



The above map illustrates our service areas reach into 11 Indiana Counties.

Demographics of the community:

Each hospital facility has a defined services area as illustrated in the map above. What follows is an example of the demographics for an individual service area in this case the North Market. Each market has there own set of data that is reviewed. Included is a comprehensive analysis of the top demographic issues targeted at the North service area of the network.

North

Demographics Expert 2.7
2011 Demographic Snapshot
Area: North Market
Level of Geography: ZIP Code

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA
2000 Total Population	402,103	281,421,906
2011 Total Population	535,609	310,650,750
2016 Total Population	587,014	323,031,618
% Change 2011 - 2016	9.6%	4.0%
Average Household Income	$87,021	$67,529

	2011	2016	% Change
Total Male Population	263,608	289,124	9.7%
Total Female Population	272,001	297,890	9.5%
Females, Child Bearing Age (15-44)	110,924	114,225	3.0%

POPULATION DISTRIBUTION

Age Distribution

Age Group	2011	% of Total	2016	% of Total	USA 2011 % of Total
0-14	123,037	23.0%	133,031	22.7%	20.2%
15-17	24,098	4.5%	27,248	4.6%	4.2%
18-24	42,372	7.9%	50,208	8.6%	9.7%
25-34	72,991	13.6%	70,763	12.1%	13.3%
35-54	162,617	30.4%	166,584	28.4%	27.6%
55-64	57,801	10.8%	71,894	12.2%	11.7%
65+	52,693	9.8%	67,286	11.5%	13.3%
Total	535,609	100.0%	587,014	100.0%	100.0%

HOUSEHOLD INCOME DISTRIBUTION

Income Distribution

2011 Household Income	HH Count	% of Total	USA % of Total
<$15K	14,039	6.8%	12.9%
$15-25K	15,728	7.6%	10.8%
$25-50K	46,555	22.6%	26.6%
$50-75K	41,357	20.0%	19.6%
$75-100K	31,149	15.1%	11.6%
Over $100K	57,498	27.9%	18.3%
Total	206,326	100.0%	100.0%

EDUCATION LEVEL

Education Level Distribution

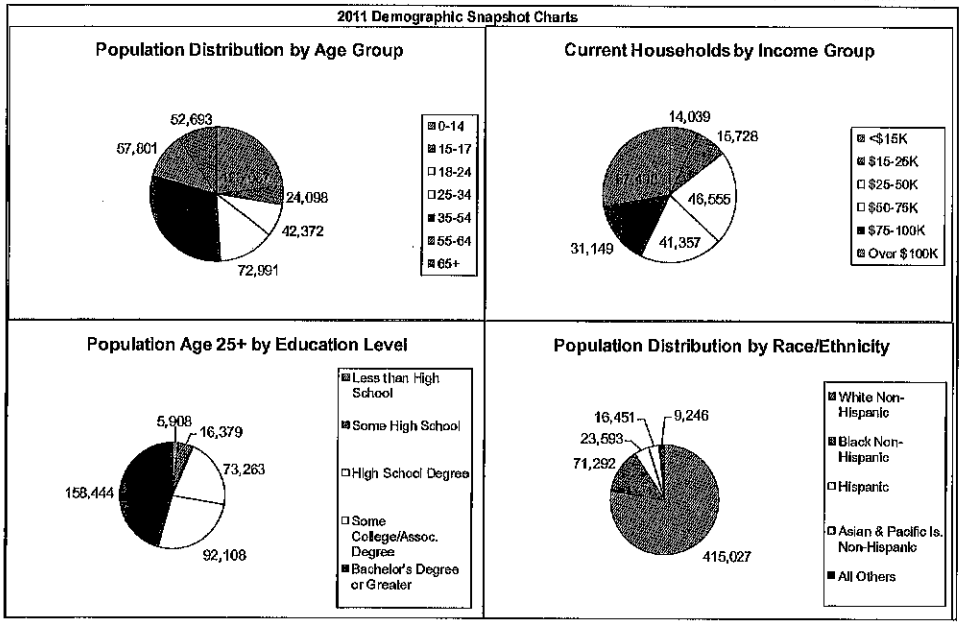
2011 Adult Education Level	Pop Age 25+	% of Total	USA % of Total
Less than High School	5,908	1.7%	6.3%
Some High School	16,379	4.7%	8.8%
High School Degree	73,263	21.2%	28.9%
Some College/Assoc. Degree	92,108	26.6%	28.3%
Bachelor's Degree or Greater	158,444	45.8%	27.7%
Total	346,102	100.0%	100.0%

RACE/ETHNICITY

Race/Ethnicity Distribution

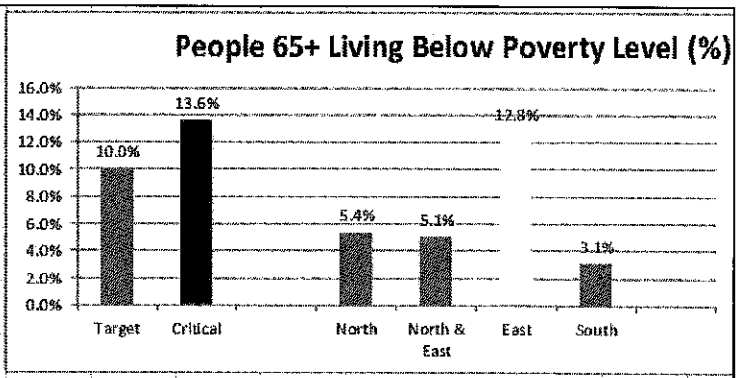
Race/Ethnicity	2011 Pop	% of Total	USA % of Total
White Non-Hispanic	415,027	77.5%	64.2%
Black Non-Hispanic	71,292	13.3%	12.1%
Hispanic	23,593	4.4%	16.1%
Asian & Pacific Is. Non-Hispanic	16,451	3.1%	4.6%
All Others	9,246	1.7%	3.0%
Total	535,609	100.0%	100.0%

2011 Demographic Snapshot Charts

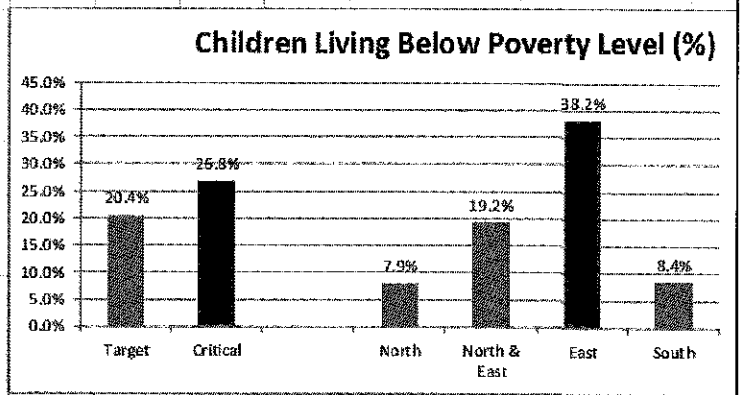


The demographics are also broken down by zip codes in service areas so that disctinctions can be made that will drive communications and marketing. To assist in building out the picture of what are community looks like and how to "target" messages for an interventions. For this reason this data is invaluable however the data is much too general to develop our implemention strategy for the market.Below is another example of the demographic data and the overview of our markets. In this case we are comparing three of the markets, North, East and South.

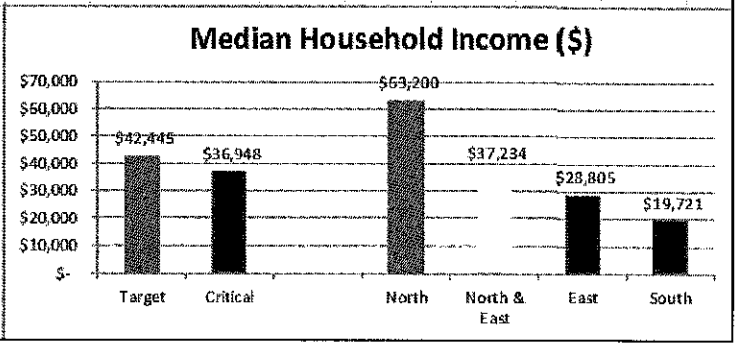
	People 65+ Living Below Poverty Level (%)
Target	10.0%
Critical	13.6%
North	5.4%
North & East	5.1%
East	12.8%
South	3.1%



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



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



Community Health Needs Assessment

The IRS requires a Community Health Needs Assessment (CHNA) and defines that a CHNA exists for each hospital service area and must "define the community it serves and assess the health needs of that community. In assessing the community's health needs, the hospital facility must take into account input from persons who represent the broad interests of its community, including those with special knowledge of or expertise in public health". Community Health Network began the process of creating a CHNA in 2011, seeking national models and best practices while attempting to use local resources to collect the necessary data. The Community Benefit department brought together a group of informed practitioners from hospital and community organizations that would also benefit from the data collected. A joint CHNA was not able to become a reality, consequently the Community Benefit strategy chosen was to forge ahead independently and chose the "Healthy Communities Institute" as the sole source of data that represents the best indicators for the social determinants of health and incorporates our hospital data into the secondary data. Our organization will continue to seek collaboration possibilities.

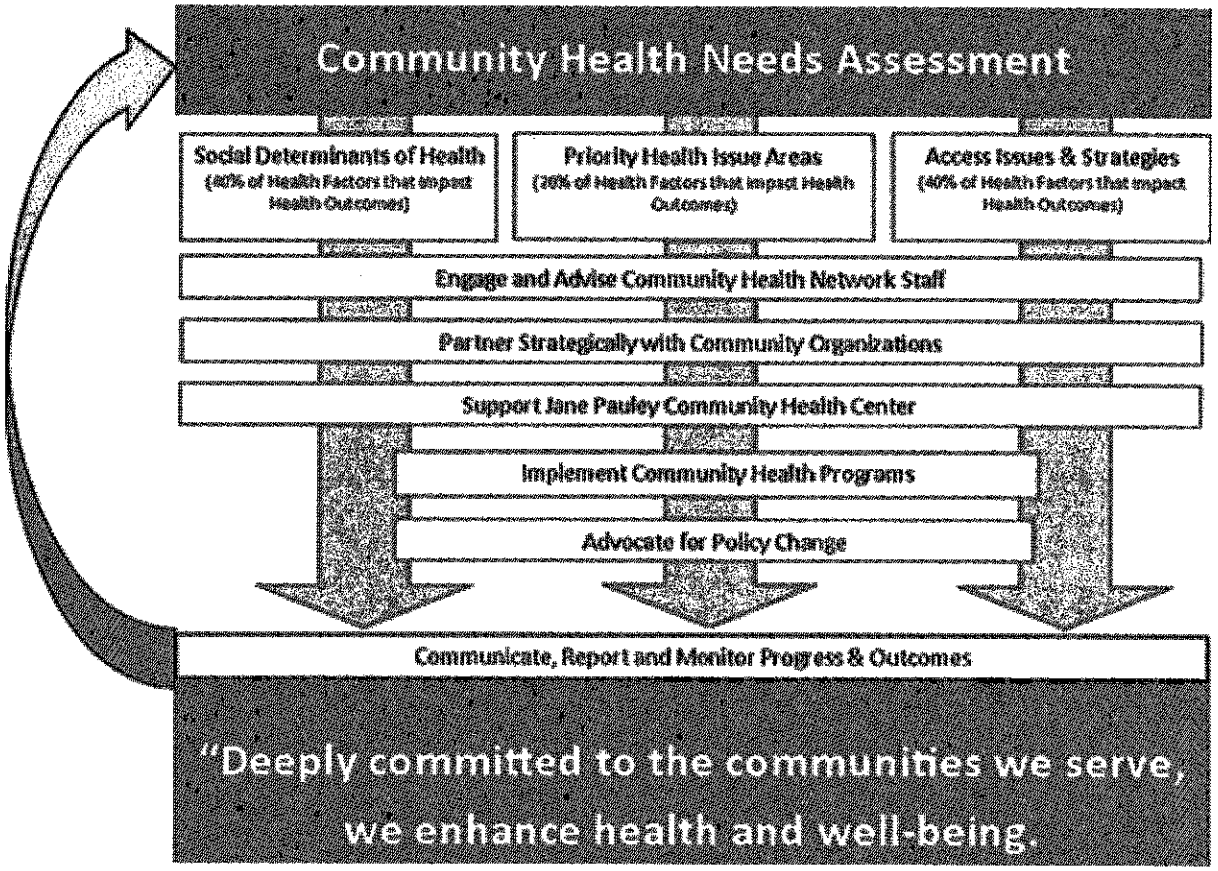
Our website, http://www.ecommunity.com/aboutus/care.aspx# displays over 125 health and quality of life indicators updated in real time, offers hundreds of community level resources for common community interventions in the "Promising Practices". Just by accessing our website, anyone in the network and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

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

Process for Developing Implementation Strategy

The Community Health Needs Assessment was broken down into three categories based on the approach of "America Health Rankings" which are based on a model of Population health that was supported by the Robert Wood Johnson Foundation and

emphasizes the many factors that, if improved, can help make communities healthier places to live, learn, work and play. The first area needing to be addressed is Access Issues and strategies. Evidence suggests that access to effective and timely primary care has the potential to improve the overall quality of care and help reduce costs. Some Populations experience additional barriers in access to preventive health services due to lack of transportation to providers' offices, lack of knowledge about preventive care, long waits to get an appointment, low health literacy, and inability to pay the high-deductible of many insurance plans and/or co-pays for receiving treatment. Our first priority therefore is access to quality health services and expanding the capacity needed to address the health issues in the areas we serve. As Don Berwick describes in the "triple aim" of healthcare improvement, the goal is to improve the health of the Population we serve, enhance our patient experience through access, quality, reliability which ultimately will reduce the cost of care.



The second area to be addressed is in priority health issues. There were several factors that helped us select asthma and diabetes as the two priority health issues to be addressed. Although access can help address many critical health issues both asthma and diabetes rank high in the preventable hospital stays for ambulatory-care

sensitive conditions and can usually be addressed in an outpatient setting, and do not normally require hospitalization if the condition is well-managed. The most striking difference between these two diseases is that diagnosis of asthma has immediate consequences as far and hospitalizations short and long term while diabetic hospitalizations are the result of longer term complications. The metrics used to determine these two areas are illustrated below.

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

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

Our third focus area or priority area is the social determinants of health. Don Berwick speaks plainly about Elinor Ostrum, the founder of term "micro-commons".

"Elinor Ostrom showed that it was possible to safeguard commonly owned resources like water and forests, writes former Medicare administrator and author of the term "Triple Aim", Donald M. Berwick,

'Her work should inspire us to looks for ways to prevent health care costs from overwhelming another shared resource: the public coffers".

In our community benefit plan, the "public coffer" Berwick refers to is referenced by our strategy to adhere to the IRS guidelines to "relieve or reduce the burden of government or other community efforts".

So as it happened in 1954, so it goes in 2013. The Community Health Network in consort with the communities we serve have set our sights to develop and implement community strategies to improve the overall health of the communities we serve. Ostrums' design principles echoed by Berwick capture a way of seeing the whole system of health care. Rather than seeing the system as a conglomerate of organizations, using Ostums' vernacular- the health systems are made up of "micro commons" and are the strength that need to be reinforced and enhanced by local strategic leadership. Only those with local knowledge of existing programs and remaining challenges can knit a stronger tapestry of health care delivery. The communities look to us to solve health issues. Their definition of a healthy communities goes beyond the diseases we treat in our hospitals and clinics. It is this implementation strategy that will rectify the disparity between their perceptions and our abilities.

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

Data Driven

Although most health care providers consider Florence Nightingale the founder of modern nursing, Nightingale was as much a celebrated British social reformer and statistician who came to prominence while serving as a nurse during the Crimean War. Like Ostrum, Nightingale believed that the problems of a community were best solved when the citizens were educated to govern themselves. She supported bills for increased self-government and improved local education. As important as her approach to cleanliness and social order Nightingale became a pioneer of the data driven approach in health care. In fact, she was a master in the visual presentation of

statistics. She used methods such as the pie chart, and developed a pie chart called "the polar area diagram" which was her way to display diseases and Population impact of care. Today Nightingale would be gratified to see we are adopting her data driven approach through our Community Health Needs Assessment and would agree that the zip code you live is a better determinant of your health expectancy than your genetic code.

Engaging and Advising Community Health Network Staff

Charity Care Strategy

As an example of how we engage and advise staff the current charity care policy was crafted in response to community need and available resources.The health network does not have the resources to meet all of the needs identifies in our community health needs assessments. We do not have the resources to offer charity care to anyone who comes to us for care. Consequently using a data driven approach we developed a Charity Care policy that reflects a strategy to target areas of highest need and restrict our charity care resources to these "Health Districts". The process in defining our Health Districts is a similar process as used with the previous prioritizations. It was developed to identify or more precisely illuminate the needs in the communities we serve and target our resources for optimization. Clearly we do not have the funds to offer charity care throughout all counties or even our own service areas, What resources we do have we need to use in a way that will make the biggest difference and to do so we need to focus in a smaller geographic area. A few points to clarify how we identified "Health Districts".

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

The Identifications of Health Districts

We used all 80 service area zip codes and selected all those zip codes identified as having median household incomes that were below the target set by the US Census

Bureau (below $43,417 in our geographic area). We came up with a total of 20 zip codes.

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

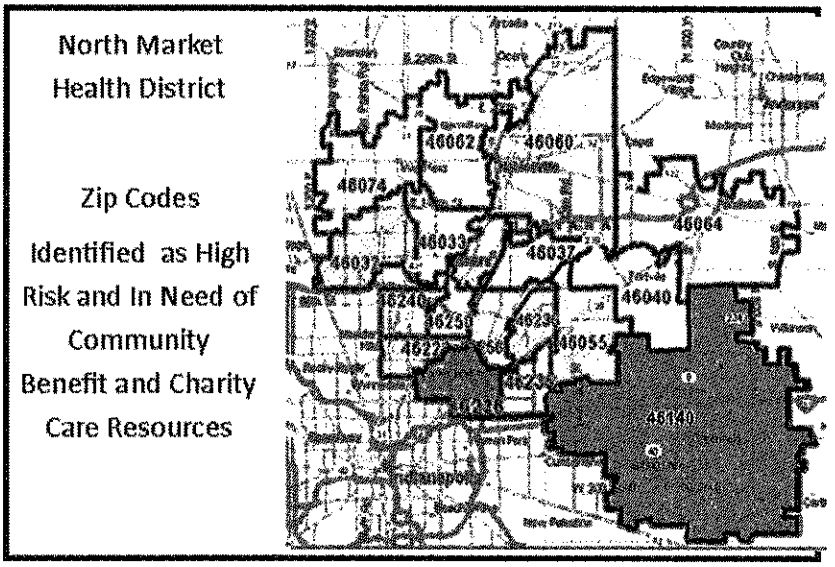
We ran a report to list all those zip codes that identified more than 15% of the zip code Population living in poverty in that specific zip code. We captured an additional 3 zip codes.

We ran a report to identify families in a specific zip code that pay more than 30% of the annual income on rent (these families would have little discretionary funds available). Any zip code that had more than 47% of the total zip code Population spending 30% (The critical level as identified by the US Census Bureau) 2 zip codes were added.

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

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

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



Partner Strategically with Community Organizations

Since our founding in 1954, we have established a culture of collaborating to optimize community resources. All of our community work is performed with the buy in from the communities we plan to work with and with the added values of the organizations they respect and trust. For several years the network has taken on the issue of access and that will remain our number one focus in our prioritized issues. The priority health issues that have been identified by the community health needs assessment are the two chronic diseases diabetes and asthma. Access, asthma and diabetes will be the top priorities however other areas of concern may be adopted as the community drives the plan and we will ultimately report our progress to those we serve. The fourth priority therefore is community driven initiatives.

We continue to take a collective approach that involves our systematic collection of the knowledge and views of informants on healthcare services and needs. These include online surveys, focus groups and one on one discussion. Valuable information is often available from the data we collect from providers, clinicians, and general practitioners, as well as from users of our services. Although such an approach blurs the distinction between need and demand and between science and vested interest, the intimate, detailed knowledge of interested parties might otherwise be overlooked. Furthermore, this collective approach is essential if policies are to be sensitive to local circumstances. Eliciting local views is not the same as being bound by them. Socioeconomic factors, particularly high poverty rates, are associated with some aspects of health system performance, but not all. There are significant variations within areas with low levels of poverty as well as within areas with high poverty levels.

This approach allows sensitivity to local circumstances as local concerns may justifiably attach priorities to particular services. Local experience and involvement will make any needs assessment easier to publicize and defend. Each facility in our network will have prioritized activities and programs determined by the input of the communities they serve which may be different from the overall corporate strategy. As discussed earlier is access to care. This access priority is illustrated by our school health strategies in the community benefit budget. Our priority health issues are asthma and diabetes, both are dramatically impacted in lifestyles and socioeconomic situations defined in the social determinants of health. Both are best addressed where children are located – in schools. But to address these health issues the partner (schools) need to see the impact in their terms of success - such as better grades and better attendance. Keeping both goals and outcomes out in front may slow the timeline down but in the end builds a support system that support a culture of health.

Support Jane Pauley Community Health Center

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

Implement Community Health Programs

In Johnson County, one of the most successful community health needs assessment and community benefit plans was initiated over 12 years ago by the collaboration of many organizations in our south market and service area. The Partnership for a Healthier Johnson County has had success while most other initiatives like it have failed. It illustrates the success of our long-term strategy adopted from the beginning and illustrated in the introduction of the Partnership website "Our health partners include hospitals, the health department and hundreds of individuals from businesses, schools, social service agencies and civic and faith-based organizations. The mission of Partnership is to plan and implement collaborative, measurable strategies to improve the health of the residents of Johnson County. This strategy developed 12

years ago continues to be our "Best Practice" and sets the stage for who we participate with and how we measure the success of our participation. Each service area and often combined service areas have unique neighborhood and community initiatives that we support.

Advocate for Policy Change

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

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

Communicate, Report and Monitor Progress and Outcomes

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

Our community beneift plan re-examines the social contract that began in 1954 with the community and citizens of the eastside. Now we ask ourselves whether twentieth century assumptions, programs and services are adequate and appropriate for twenty

first century problems and issues. The winning strategy that has been adopted by our health system and is a key driver in most innovation around the affordable care act and the adoption of its tenants is the "Triple Aim". Developed by Berwick and executed by many health orgranizations it sums up what our community beneift plan hopes to do, Improve the health of the Population we serve, enhance our patient experience through access, quality, reliability and ultimately reduce the cost of care.

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

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

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

END OF IMPLEMENTATION DOCUMENT

7. Did the hopital facility address all of the needs identified in its most recently coduvted CHNA? If "no,"explain in section C which needs it has not addesses and the reasons why it hans not addressed such needs.

"No"

Just as Nobel Prize winner Elinor Ostrom's academic habits emphasized collaboration and cooperation, so did the content of her study and so does our community benefit plan. To address all of the needs identified in the community health needs assessment would be to achieve what no community has been able to do which is maintain optimal health. However we do believe that our plan and execution will weave together a resilient web that can address many needs identified by the communities we serve.

As we move into a new century with a host of ecological health pressures the answer to "What is healthcare for?" becomes important. We need a paradigm shift to transfer the institution led paradigm to a community led one that accounts for the future of society and the environment and is informed by decision making with patients and their communities. A place based community driven approach. Healthcare begins in the community not in the institution. We need to extend the health outside the hospital walls for the benefit of all. We need to see health as owned by the community and as a "commons", a "Health Commons" – encompassing all of the physical, financial, human, and social capital resources relevant to the delivery of health care and/or the promotion of Population health in a geographic region.

Traditionally, economics taught that common ownership of resources results in excessive exploitation, as when fishermen overfish a common pond. This is the so-called tragedy of the commons, and it suggests that common resources must be managed either through privatization or government regulation, in the form of taxes, say, or limits on use. Professor Ostrom studied cases around the world in which communities successfully regulated resource use through cooperation. Her work has important applications for climate change policy today. Professor Ostrom inspired the Data Governance Council with her work demonstrating that people could effectively self-organize to govern common resources, such as fields, fish, lakes, rivers, and data. Her inspiration came not from text-books and formulas, but from field work with real people working together to govern the use of these common resources without government intervention or regulation. Self-

Organization and Self-Governance are not just nice theories. They are solutions to common human problems that have existed for milenia. These ideas are the foundation for our community benefit plan and implementation strategies.

8. ***a. Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?***
   No

Part VI / 7 State filing of a community benefit report

The organization files a community benefit report in the state of Indiana