Community Health Network

2024 Community Health Needs Assessment

Anderson

A Message from Community's Leadership

Why are we called "Community"? For Community Health Network, our name is like a family name. It was our own communities, the people we serve, who brought our organization to life. And like family, we have to this day maintained a strong commitment to those communities.

The reason the people and businesses of our communities created our non-profit organization in the 1950s was to bring much-needed healthcare services closer to the community. Indeed, our mission is to "enhance health and well-being." We do that through our network of hospitals, physician practice offices and other healthcare sites.

But we also know that it takes more than medical services to achieve better health, improve well-being and create a greater quality of life. That's why we also pay close attention to the broader needs of our neighbors and the neighborhoods we serve. Beyond delivering traditional care, we're involved in wide-ranging services fulfilling needs that enhance well-being.

We determine just what those needs are through our Community Health Needs Assessment. This is an in-depth study involving surveys, interviews, community meetings and data gathering—we do this every three years so we can be sure we are attuned to our communities' needs and understand how to address them.

The report you are reading outlines the results of that assessment. We identified many kinds of ongoing needs, including improving access to healthcare services, addressing substance use and mental health, reaching out to vulnerable populations, and tackling social determinants of health—those social and economic factors that aren't directly related to health care but have a powerful impact on health and well-being. We also identified opportunities to collaborate with others in our communities to help solve issues that impact health and well-being.

This Community Health Needs Assessment ensures that we know the challenges facing the communities we serve. We're committed to finding solutions to those challenges, and are developing strategies to focus our efforts on the mission-directed issues where we can make a difference.

Thank you for your support of Community Health Network. Together, we can serve the needs of our communities, and truly enhance health and well-being!

Bryan Mills
President & CEO
Community Health Network

A Message from Community Anderson's Hospital Leadership

In 1962, Community Hospital of Anderson and Madison County opened for patient care, thanks to the efforts of local residents who recognized the need for more healthcare options, closer to home. Like the Indiana health system that the hospital joined in 1996, the Anderson hospital's name significantly included the word "Community."

Calling the hospital "Community" was no accident, because our organization was created by the community to serve the community, and we have maintained that community commitment ever since. We are, of course, committed to delivering quality healthcare services, but also to the broader mission of enhancing well-being.

The report you are reading is the latest Community Health Needs Assessment for what is now known as Community Hospital Anderson. Every three years, we conduct this detailed study by surveying our community, leading community meetings, collecting input from public health experts and gathering other pertinent data. It's important that we know everything we can about the community needs we must address as we work to improve health and quality of life in Madison County.

We learned that there are significant needs involving access to health care, and that our neighbors need a strong focus on mental health, substance abuse and obesity. We found that our seniors have well-being concerns that are not fully met, and that we need to focus extra attention on the health of our children and our mothers-to-be. And we gained more insights into local food insecurity, which is a significant roadblock to better health and well-being.

Thanks to all who shared their insights and ideas with us. With fresh information about the needs facing our Madison County community, we are exploring and planning the most effective ways that we can help meet those needs. We're engaging with like-minded partners in our community and recommitting ourselves to our mission of enhancing health and well-being.

Marsha S. Meckel, MA, BSN, RN, NEA-BC
Vice President, Anderson Region Hospital Administrator and Chief Nurse Executive

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Executive Summary

Introduction

Community Hospital Anderson (CHA) conducted this Community Health Needs Assessment (CHNA) to gain an understanding of the health needs of the community it serves and prioritize the identified significant health needs. The findings of this report will help guide CHA's efforts and initiatives in improving the health and wellbeing for its community, as well as enhance collaboration with peer organizations and stakeholders that work to improve wellbeing. This CHNA also meets federal requirements set by the Patient Protection and Affordable Care Act to conduct a community health needs assessment at least once every three years.

Community Hospital Anderson

Community Hospital Anderson is an acute care hospital known for providing exceptional care for the residents of Madison and surrounding counties. Community Hospital Anderson provides a full range of medical services including award winning maternity services, comprehensive cardiac care, cancer services affiliated with MD Anderson Cancer Network®, neuro surgical care, and a level three trauma center. Additional information about CHA is available at: https://www.ecommunity.com/locations/community-hospital-anderson.

Community Hospital Anderson is part of Community Health Network, an integrated health delivery system based in Indianapolis. As a non-profit health system with more than 200 sites of care and affiliates throughout Central Indiana, Community Health Network's full continuum of care integrates hundreds of physicians, eight specialty and acute care hospitals, surgery centers, home care services, MedChecks, behavioral health, and employer health services. Additional information is available at: https://www.ecommunity.com/about.

Community Served by Community Hospital Anderson

For purposes of this assessment, the community served by CHA was defined as Madison County, Indiana. This community definition is consistent with the most recently conducted CHNA in 2021.

Collaborating Partners

Community Hospital Anderson worked with each Community Health Network hospital – Community Hospital East, Community Hospital North, Community Hospital South, and Community Howard Regional Health – as well as system-wide leadership to collect data and construct this report.

Community Health Network collaborated with Indiana University Health and Ascension St. Vincent Indiana health systems in its primary data collection activities, working together in communities served by both health systems to strengthen partnerships and maximize resources.

This CHNA was conducted by Dobson DaVanzo & Associates, LLC, a health economics and policy consulting firm. The work of our principals has influenced many public policy decisions and appears in

numerous instances in legislation and regulation. Applying decades of experience and innovative research techniques, the firm's rigorous and objective analyses make use of a variety of public and private-sector data sources.

Prioritized Significant Health Needs

The following health needs were identified as prioritized significant health needs by analyzing both primary and secondary data collected during 2024.

Infant and Child Health and Wellbeing

Infant and child health and wellbeing are significant concerns in Madison County. Children were identified as a particularly vulnerable group, and unfavorable rates of child poverty, single-parent households, teen births, and childcare expenses highlight this vulnerability. Infant health also is a concern with high infant mortality rates and percentage of low birthweight births. Disparities are also present as Black and Hispanic or Latino infants have poorer outcomes. Furthermore, stakeholders highlighted gaps in mental health support and healthcare services for children, particularly in addressing the social and emotional needs of students within schools and those without adequate home supports.

Access to Care

Access to healthcare services is a significant issue across the CHA community. Issues with the cost of care, lack of providers, transportation, health insurance, and health literacy were identified as contributing factors. Madison County also has fewer primary care, dental, and mental health providers than statewide averages and is designated as a primary care health professional shortage area for low-income residents. Indicators such as high rates of preventable hospitalizations indicate difficulties accessing preventive care, and the county has below average rates for mammograms and flu vaccinations.

Mental Health Status and Access to Mental Health Care

Mental health is a growing concern in Madison County, especially among youth. There is widespread anxiety, depression, and suicidal ideation. Despite the rising need, access to mental health services remains limited due to a shortage of mental health providers and financial obstacles. The county is designated as a mental health provider shortage area. Suicide rates in Madison County are notably higher than the state average, highlighting the critical need for expanded mental health services and more local treatment options.

Food Access and Nutrition

Food insecurity is a widespread issue in Madison County, where many residents live in food deserts with limited access to grocery stores that offer fresh and nutritious foods. Rural communities are especially affected, as transportation barriers prevent residents from accessing healthy food options. The food environment in the county ranks poorly compared to state averages, contributing to high rates of diet-related chronic condition mortality. Inflation and rising food costs have only exacerbated these issues, making it even harder for low-income families to maintain a nutritious diet.

Poverty and Housing

Poverty is an issue prevalent for many in the CHA community, impacting health and many social drivers of health. The poverty rate is above the state average and is particularly high for children living in poverty and racial and ethnic minority populations. Cost of care was commonly cited as a large barrier to receiving health services. While impacting most facets of life, poverty's relation to housing issues is increasingly a concern. The county has high rates of severe housing problems and cost burden for housing. The elderly are particularly vulnerable to housing issues.

Substance Misuse

The misuse of drugs is a pervasive issue in the Madison County, intricately tied to mental health. Stakeholders noted the opioid epidemic as a driving force along with issues with methamphetamines and other substances. Treatment options are limited and costly, with many needing to leave the community to find options. The drug overdose mortality rate is much higher than the Indiana-wide rate. More driving deaths involve alcohol than statewide, and mortality for liver disease is also elevated, perhaps indicating alcoholism concerns.

Obesity, Healthy Lifestyles, and Associated Conditions

Obesity is a major health concern in Madison County, which ranks last among counties for obesity rates. The county also has lower rates of physical activity and less access to exercise opportunities compared to state averages. Many residents face challenges in maintaining a healthy lifestyle due to a lack of safe recreational spaces, affordable gyms, and access to healthy food options. The impact of obesity is evident in the county's high rates of heart disease and diabetes, which are directly linked to poor nutrition and inactivity. Stakeholders consistently noted that promoting healthier lifestyles and improving access to nutritious foods should be a priority for the county.

CHNA Methods and Compliance

This CHNA was conducted using commonly accepted methods for assessing community health needs. Primary data was collected utilizing a multi-faceted approach of community meetings, key stakeholder interviews, and a survey of residents and caregivers. Input from those with public health expertise and representing vulnerable communities (low-income, medically underserved, etc.) was obtained and incorporated into findings. This data was collected from May through August 2024. Secondary data was collected from a number of sources and applying the most recently available data.

Significant health needs were prioritized by combining primary and secondary data findings, considering both the frequency the issue and related issues appear in the data in conjunction with the severity of the issue. Severity was determined in primary data by stakeholder prioritization and in secondary data by deviation from benchmarks, such as statewide averages.

An authorized body of the hospital facility has approved and adopted this report. CHA received no comments on the facility's most recently conducted CHNA and implementation strategy. A discussion of the actions taken to address health needs prioritized in its previous CHNA can be found in Appendix II.

Defining the Community

Defining the community is a crucial part of the Community Health Needs Assessment (CHNA) process as it shapes the geographic scope and focus of the assessment. For the 2024 CHNA, Community Hospital Anderson defined its community using a detailed analysis of 2023 patient origin data. This analysis identified the primary geographic areas where patients who utilize inpatient and emergency services reside. Assessing and defining the CHA community ensures that the hospital's strategies focus on its core patient population, surrounding community, and regions with the highest healthcare needs.

Process for Identifying the Community

To define the community, CHA examined patient origin data for inpatient discharges and emergency room (ER) visits. The data was analyzed at the county and the ZIP code level. Based on these analyses, the CHA community was defined as Madison County.

Community Hospital Anderson Community Definition

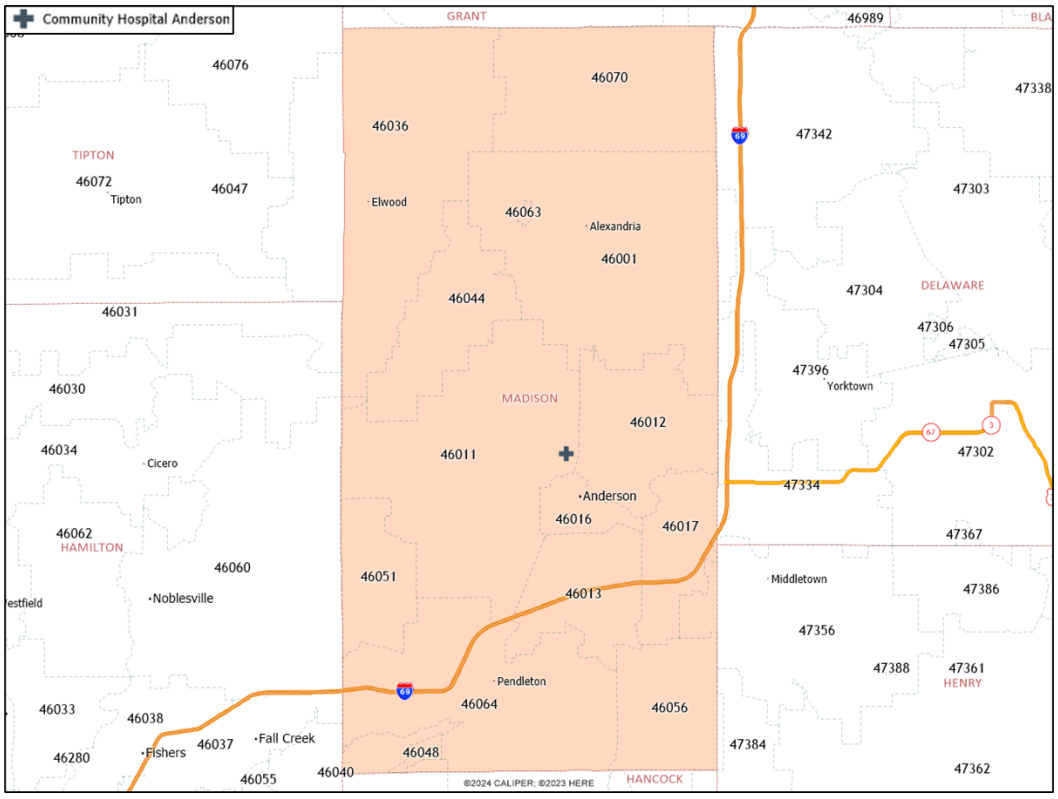
When examined at a ZIP code level, 14 ZIP codes were identified that compose almost the entirety of Madison County. These 14 ZIP codes and their accompanying patient origin statistics are presented in Figure 1. In total, the 14 ZIP codes accounted for 81.5 percent of the hospital's total inpatient discharges and 83.4 percent of its ER visits.

FIGURE 1. COMMUNITY PATIENT ORIGIN DATA

ZIP Code	County	State	Inpatient Discharges	ER Visits
46012	Madison	Indiana	925	7,052
46016	Madison	Indiana	796	7,476
46011	Madison	Indiana	776	5,406
46013	Madison	Indiana	655	4,993
46001	Madison	Indiana	500	3,389
46017	Madison	Indiana	229	1,668
46036	Madison	Indiana	163	695
46064	Madison	Indiana	163	904
46044	Madison	Indiana	134	705
46070	Madison	Indiana	95	471
46051	Madison	Indiana	51	280
46056	Madison	Indiana	38	245
46048	Madison	Indiana	16	90
46063	Madison	Indiana	8	59
Community Total			4,549	33,433
Community Percent			81.5%	83.4%
Hospital Total			5,582	40,090

Community Hospital Anderson is located at 1515 N. Madison Ave in Anderson, Indiana, ZIP code 46011. Figure 2 depicts CHA's community of Madison County and the ZIP code boundaries within the county.

FIGURE 2. MAP OF COMMUNITY AND HOSPITAL LOCATION



Geographic Levels of Data

To provide a comprehensive understanding of community health needs, this CHNA incorporates data at various geographic levels:

- Madison County: The community that CHA serves, which includes both urban and rural areas. Data at this level offers insight into county-wide health challenges and disparities.
- Madison County ZIP codes: Composed of the 14 ZIP codes listed in Figure 1 where the majority of CHA's patient base resides, as outlined in the figure above.
- Indiana: Statewide health concerns and perspectives on health issues are included to provide additional context of Madison County's needs in relation to their fellow Hoosiers.

By utilizing multiple geographic levels of data, CHA ensures that its data collection strategy, significant health need identification, and ensuing interventions are based on a breadth of perspectives and accurately targeting the specific needs of different populations, including densely populated urban zones and rural communities with limited access to healthcare.

Demographic Profile of Community Hospital Anderson Community

Understanding the demographics of CHA's community, defined as Madison County, Indiana, is crucial for tailoring healthcare services to meet the needs of the community. Based on American Community Survey (ACS) five-year estimates, this report provides detailed insights into the population characteristics within Madison County and the 14 ZIP codes within the county identified for analysis. Comparisons to Indiana and national figures are provided as available.

Geography & Data Sources

The demographic data used in this report section is sourced from the 2018-2022 ACS five-year estimates, which offer comprehensive and reliable insights into social, economic, and housing characteristics over time. The data is analyzed at the county level and additionally at the ZIP code level to provide additional granularity in analysis.

Population Overview

Utilizing the ACS five-year estimates, Madison County has a population of 130,545. The 14 ZIP codes included in the community analysis have a population of 130,247. As ZIP code borders do not conform exactly to county borders, this slight difference in population is expected. The population breakdown by ZIP code in the CHA community is found in Figure 3.

FIGURE 3. COMMUNITY POPULATION, BY COUNTY AND ZIP CODE, 2022

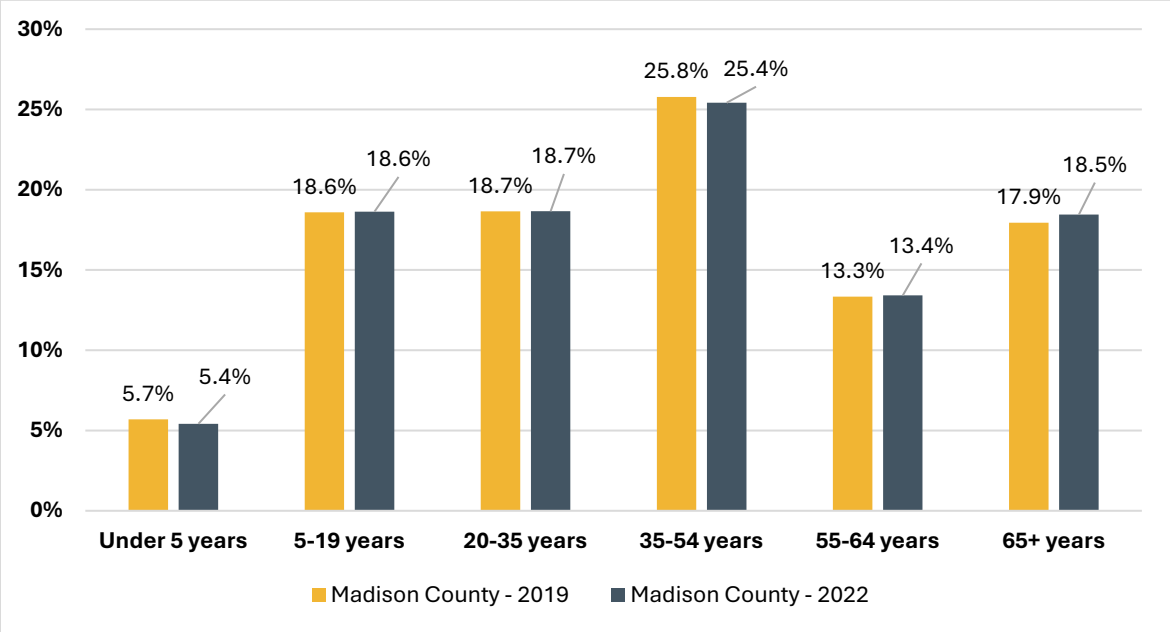
County		Population
Madison County		130,545
ZIP Code	City	Population
46012	Anderson	19,744
46016	Anderson	18,924
46011	Anderson	17,638
46064	Pendleton	17,205
46013	Anderson	16,906
46036	Elwood	11,392
46001	Alexandria	10,011
46017	Daleville	5,910
46051	Lapel	2,810
46044	Frankton	2,686
46070	Summitville	2,335
46056	Middletown	2,165
46048	Ingalls	2,159
46063	Orestes	362
Zip Code Total		130,247

The City of Anderson, where the hospital is located, has the majority of the population in the community.

Age Distribution

The age distribution in Madison County highlights variations in the population by age, with notable trends toward an aging population. The median age in Madison County is 40.7 years, above the state (38.0 years) and national (38.5 years) medians. ZIP codes such as 46017, 46044, and 46056 have particularly high median ages, exceeding 45 years, highlighting an older population outside of Anderson. Additionally, data suggests that in Madison County, the proportion of population aged less than five years is lower than in 2019, while the population aged 65 years and above is higher. These statistics suggest a growing need for healthcare services tailored to older adults and potential aging in place measures.

FIGURE 4. POPULATION BY AGE, MADISON COUNTY, 2019 AND 2022

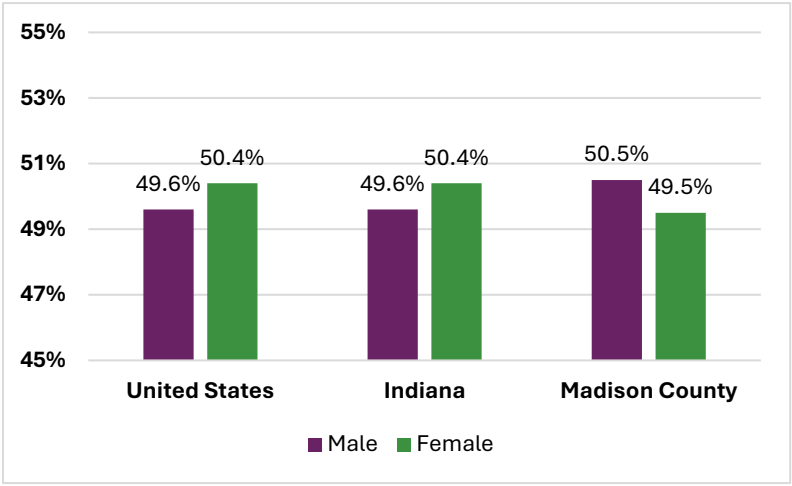


Despite the growing aging population, the working-age group (aged 20 to 64) comprises the majority of Madison County's population at 57.5 percent. This suggests an increasing need for healthcare services that cater to both an aging population and the preventive care needs of younger, working-age groups.

Population by Sex

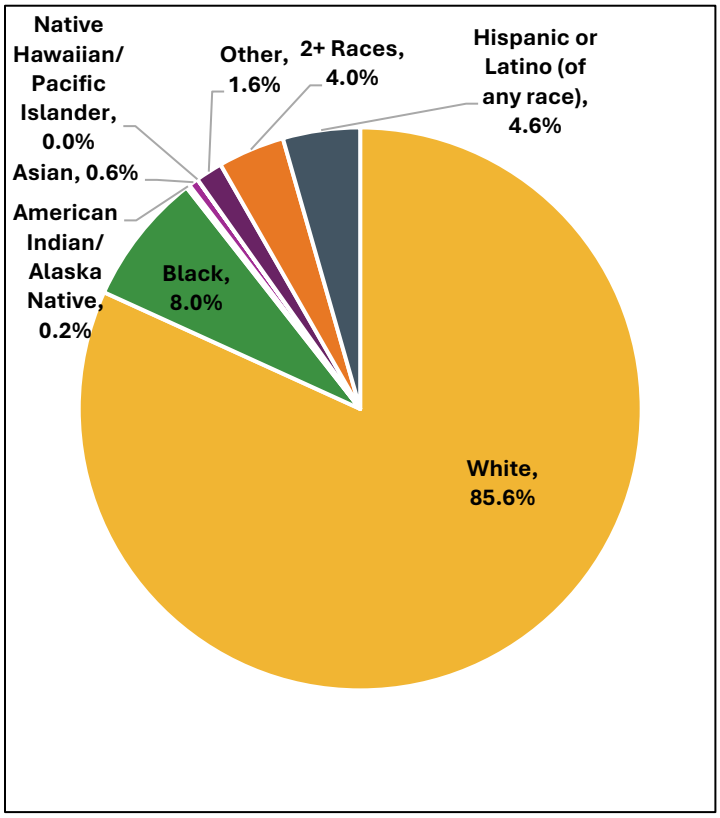
An analysis of Madison County's population by sex, found in Figure 5, finds that the proportions of male and female populations differ from state and national averages, with Madison County having a slightly higher proportion of male residents than female.

FIGURE 5. POPULATION BY SEX, 2022



Racial & Ethnic Composition

FIGURE 6. POPULATION BY RACE AND ETHNICITY, 2022



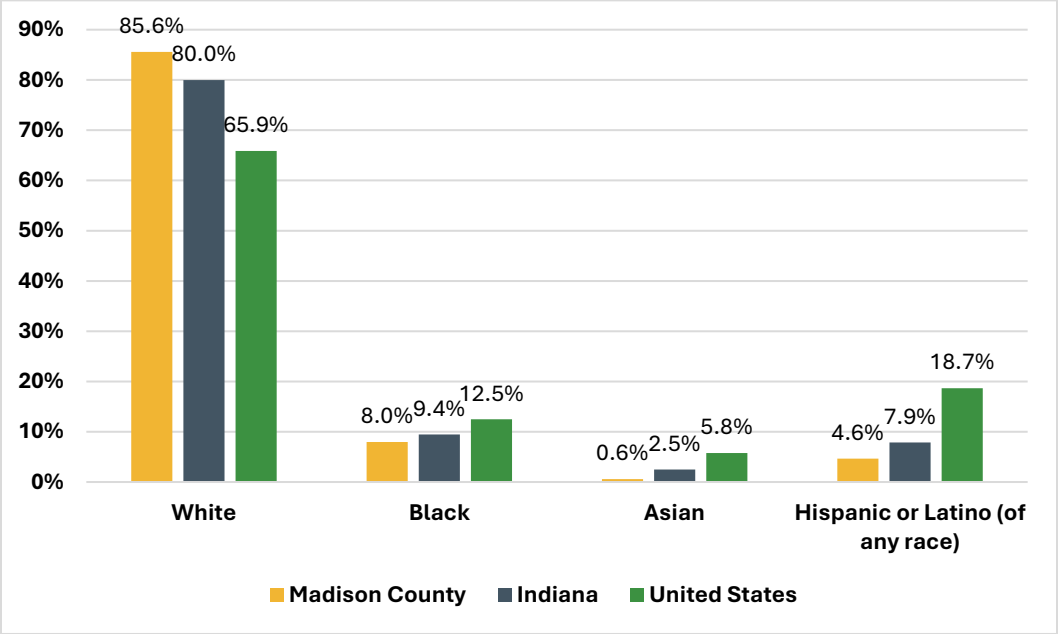
The racial and ethnic composition of a population is vital in planning for community needs, particularly for health care services and community/social programs. Analyzing health and social drivers of health by race and ethnicity can reveal disparities in housing, employment, income, and health outcomes.

In Madison County, the racial makeup reflects a majority White population, with 85.6 percent identifying as White. Black or African American residents comprise 8.0 percent of the population, making them the second-largest racial group. Other racial groups, including those identifying as two or more races (4.0 percent), Asian (0.6 percent), and Native American/Alaska Native (0.2 percent), represent smaller portions of the population. This distribution emphasizes the importance of targeted community outreach and health services that are sensitive to the needs of these diverse groups, ensuring that racial and ethnic disparities in healthcare access and outcomes are addressed effectively.

In terms of ethnicity, the Hispanic/Latino population represents 4.6 percent of the population.

When compared to state and national levels, the racial and ethnic distribution in Madison County is less diverse, particularly compared to national numbers (Figure 7). A higher proportion of the population is White (85.6 percent), and a lower proportion is Black, Asian, or Latino/Hispanic. Additionally, a lower proportion of the population is two or more races (4.0 percent) in Madison County compared to state (5.1 percent) and national (8.8 percent) figures.

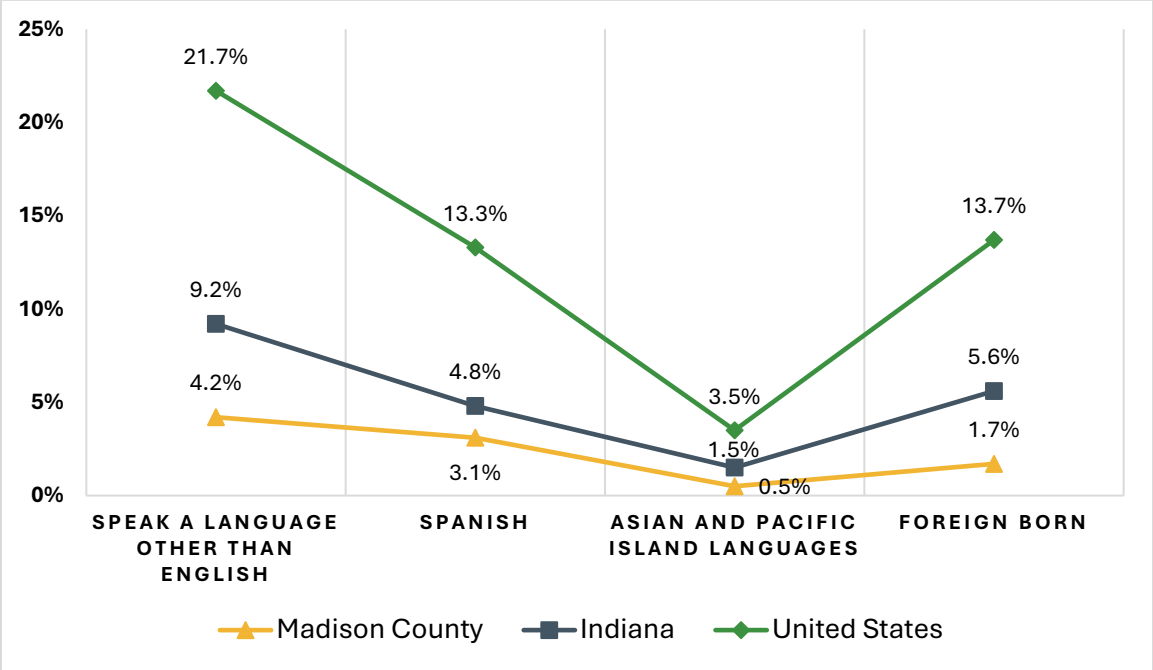
FIGURE 7. POPULATION BY RACE AND ETHNICITY COMPARISON, 2022



Language & Immigration

In Madison County, 95.8 percent of residents speak only English at home, a figure higher than both Indiana (90.8 percent) and United States (78.3 percent) averages. A small portion of the population – 4.2 percent – speaks a language other than English, with 3.1 percent speaking Spanish. While these figures may reflect a relatively low demand for multilingual services, healthcare providers and social services will encounter patients who require language support, particularly for Spanish speakers, and these populations may be overlooked due to their low visibility.

FIGURE 8. POPULATION BY LANGUAGE SPOKEN AT HOME AND FOREIGN-BORN STATUS, 2022



When examining immigration, foreign-born population statistics are similar in nature to language statistics, with a smaller proportion of residents Madison County reflecting non-native status compared to Indiana and the United States.

Primary Data Collection & Analysis

In conducting the Community Health Needs Assessment (CHNA) for Madison County, Indiana, a multi-faceted approach was employed to gather primary data from a diverse group of stakeholders. This ensured that the perspectives of residents, healthcare professionals, community leaders, public health experts, and vulnerable populations were captured and thoroughly analyzed. The primary data collection process included key informant interviews, community meetings, and a community survey. This section details the methodologies, participants, and key findings from these efforts, which supplement the secondary data analysis and provide a comprehensive understanding of the health needs and priorities in Madison County.

Key Informant Interviews & Community Meetings

To gather real-time data on health issues and gain a deeper understanding from the lived experiences within the region, key informant interviews and community meetings were conducted with individuals and organizations that have a deep understanding of the health challenges in Madison County. These sessions provided qualitative insights that were critical for understanding the context behind the quantitative data and for identifying nuanced issues that may not have been fully captured in the survey responses.

Key Informant Interviews

Key informant interviews were conducted with stakeholders from Madison County and individuals with statewide perspectives applicable to the county between May and July 2024. Participants were selected based on their expertise in public health, healthcare delivery, social services, community advocacy, and related fields. The interviews were conducted using a structured guide that covered a range of topics, including perceived health needs, barriers to care, the impact of social drivers of health, community resources available, and additional resources needed to effect change.

Participating Organizations

The following organizations participated in key informant interviews, with the number of stakeholders from each organization who provided input denoted.

- Madison County Health Department (1 participant)
- Minority Health Coalition of Madison County (1 participant)
- Indiana Minority Health Coalition (2 participants)
- Indiana Department of Health (1 participant)

Community Meetings

In addition to key informant interviews, community meetings were conducted as part of the CHNA. These meetings engaged stakeholders directly in discussions about their health concerns and priorities in a group setting, allowing participants to provide perspectives alongside others with lived experiences in the same community. Each meeting included a mix of community members and local leaders representing local government, healthcare, social service organizations, religious organizations, and health equity groups.

A community meeting was held in Madison County in May 2024 and attended by 13 stakeholders. Organizations that participated in the community meeting can be found listed in Appendix I.

Key Health Drivers & Needs Identified Through Key Informant Interviews & Community Meetings

Access to Healthcare Services

Provider Shortages: A significant theme was the shortage of healthcare providers, particularly in mental health, primary care, and specialist services. Residents face long wait times and struggle to secure timely appointments, especially in rural areas near Elwood and Alexandria, where transportation is also a barrier.

Barriers to Care: Common barriers include financial constraints, underinsurance, lack of insurance, and the complexity of navigating health insurance systems. Additionally, rural residents experience difficulties due to limited public transportation options, leading to missed appointments and delayed care.

> ***"There are not enough providers in our community, particularly for mental health and specialty care."***
>
> ***"Youth mental (and behavioral) health has gotten worse since the pandemic, especially with vaping."***
>
> ***"Lack of transportation isolates rural communities and makes accessing services difficult."***

Substance Use and Mental Health

Substance Use Disorders: Methamphetamine and fentanyl use remain significant issues. Although some residents know what to do in acute crises, follow-up care and long-term support are lacking. The police force often handles mental health-related calls, emphasizing the need for specialized services.

> ***"Meth and fentanyl are prevalent, but we lack long-term services to address addiction."***
>
> ***"Vaping among teens is an epidemic, and there are not enough prevention programs."***
>
> ***"People don't have access to health and telehealth because they don't have internet or transportation."***

Youth Mental Health Crisis: The mental health of children, particularly those in schools, has deteriorated. Behavioral issues and emotional distress are prevalent, compounded by a lack of mental health resources and an increase in suicidal ideation.

Social Drivers of Health (SDOH)

Poverty and Housing Instability: Economic challenges, including poverty and housing instability, emerged as critical social drivers affecting health. Many residents face eviction due to rising rents, and the elderly population struggles to afford housing repairs, leaving them in substandard conditions. The lack of affordable housing has worsened since the COVID-19 pandemic.

Food Insecurity: Access to nutritious food remains an issue, with many residents relying on convenience stores for groceries. Inflation has further exacerbated food insecurity, especially in food deserts and rural areas.

Transportation Barriers: Lack of transportation options was repeatedly mentioned as a barrier to accessing healthcare and social services, particularly in rural areas. Many residents lack reliable means of transport, preventing them from attending medical appointments or accessing healthy food.

Income Instability: Poverty is widespread, and job opportunities are limited. Some stakeholders expressed that a minimum basic income could address basic needs, allowing residents to focus on other health and wellness aspects.

Vulnerable Populations

Elderly Population: The elderly, particularly those in rural areas, face significant challenges in accessing healthcare services. The lack of home care services and supportive housing options leaves many elderly residents without adequate care.

"Affordable housing is scarce, and many elderly residents live in poor conditions."

"Infant mortality rates are highest among African American families due to lack of trust in providers."

"There is a cultural mistrust of healthcare, particularly among minority communities."

Racial and Ethnic Minorities: Stakeholders emphasized the challenges faced by Black, Latino, and immigrant populations in accessing care. Cultural and language barriers, mistrust of the healthcare system due to historic discrimination, and systemic inequities contribute to poorer health outcomes for these groups.

Maternal, Infant, and Child Health

Infant Mortality: High infant mortality rates continue to be a critical concern in Madison County, especially within Black communities. A lack of access to prenatal care and cultural factors, including mistrust of the healthcare system, were identified as contributing factors.

Youth Health: In addition to mental health concerns, stakeholders reported an increase in pregnant students and highlighted gaps in the data needed to track youth health outcomes.

COVID-19 Impact and Recovery

Long-Term Effects on Mental Health: The pandemic's lingering effects on mental health, particularly for children and young adults, remain a concern. The community continues to experience high rates of anxiety and depression, and stakeholders believe these effects will persist for years.

Economic Fallout: Many families continue to deal with the financial fallout of the pandemic, with issues such as eviction and income instability exacerbating other social drivers of health.

Community Collaboration and Solutions

Increased Collaboration: The interviews and meetings highlighted the importance of increased collaboration among community organizations, healthcare providers, and local government. Many

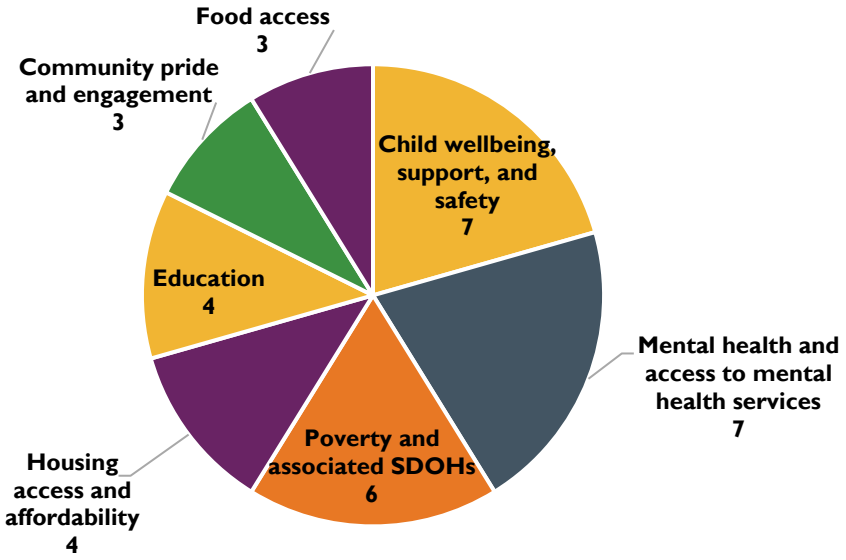
stakeholders emphasized the need for a coordinated approach to addressing health issues. Stakeholders stressed that while social services are a strength in Anderson, coordination between organizations needs improvement to better meet community needs.

Innovative Solutions: Stakeholders suggested creating more accessible services, such as mobile clinics and telehealth options, to reach underserved populations. Providing affordable housing and increasing access to healthy food were also proposed as key areas for intervention.

Community Meeting Prioritization Activity

As a concluding activity of the Madison County community meeting, participants were asked to select approximately three health needs as the most significant in impacting the ability of residents to remain well within the community. Participants were not bound to a set of options but allowed to freely identify their most significant health needs. The following needs were identified most frequently by participants, with the corresponding number of responses provided for each.

FIGURE 9. MADISON COUNTY COMMUNITY MEETING PRIORITIZATION RESPONSES



Analysis & Integration of Findings

The qualitative data from key informant interviews and community meetings were analyzed using thematic coding, organized by major themes and sub-themes. The analysis was conducted using qualitative analysis software to ensure rigorous and systematic coding of the data. The key themes identified through this process will be integrated with the findings from the community survey and secondary data analysis to provide a comprehensive understanding of the health needs in Madison County.

Visualizations were created to effectively communicate the distribution and prevalence of key health themes and sub-themes identified through primary data collection. These visuals are integral in helping stakeholders and decision-makers understand the scope and depth of the county's health challenges.

FIGURE 10. KEY THEMES FROM QUALITATIVE DATA

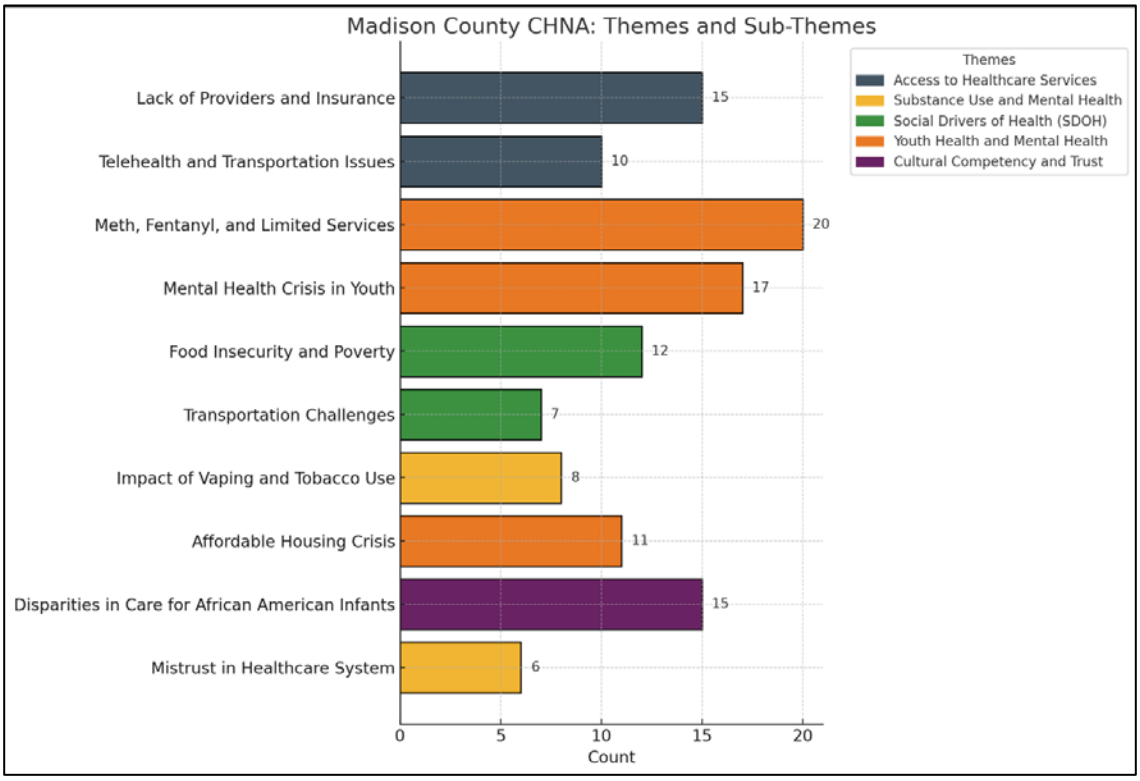
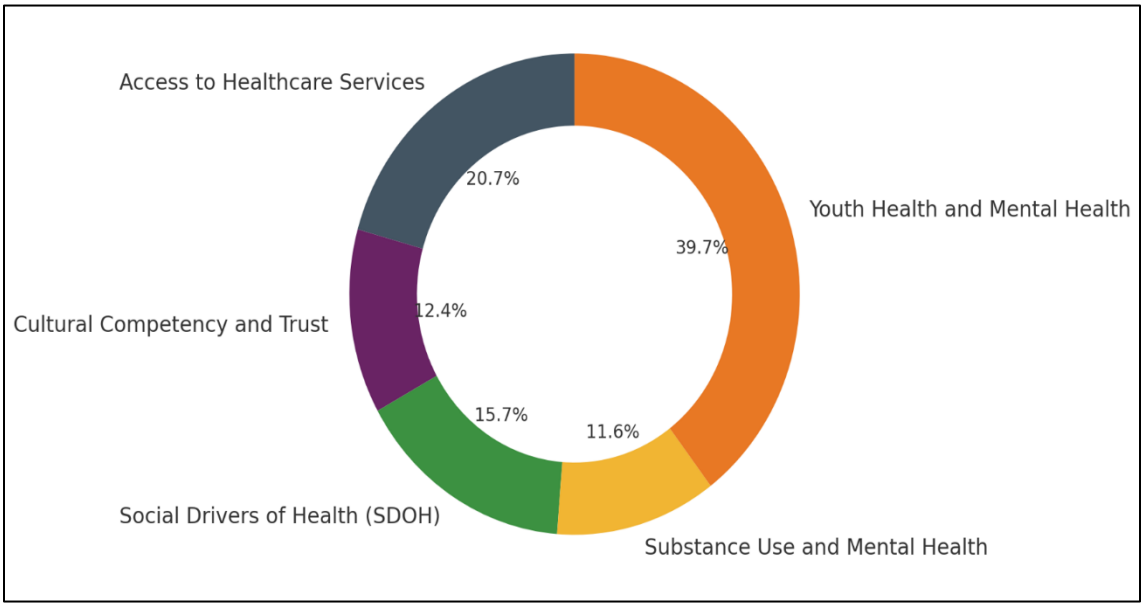


FIGURE 11. DISTRIBUTION OF KEY THEMES FROM QUALITATIVE DATA



KEY FINDINGS

- Youth Health and Mental Health emerges as the most often discussed theme, accounting for 39.7% of the health challenges identified, particularly highlighting the Mental Health Crisis in Youth
- The distribution across themes like Substance Use and Mental Health (Meth, Fentanyl, and Limited Services), Access to Healthcare Services (Lack of Providers and Insurance), and Social Drivers of Health (SDOH) (Food Insecurity and Poverty) highlights the complex and diverse nature of health concerns in the county
- The strong representation of Cultural Competency and Lack of Trust in the Healthcare System suggests that these areas are crucial issues needing targeted intervention, alongside the broader health themes

Community & Caregiver Surveys

Community Hospital Anderson, in coordination with other Community Health Network hospital facilities, also collected data regarding community health needs from residents through an online survey. This survey was designed to capture the health concerns, needs, and perceptions of a diverse cross-section of the population. The survey was disseminated widely across Madison County, leveraging various channels to ensure broad participation, including email campaigns, social media outreach, and partnerships with local organizations and businesses. The survey was made available in English, Spanish, Haitian Creole, and Hakha Chin to accommodate the linguistic diversity of the region, and a paper version was also made available to ensure accessibility for those without internet access.

In addition to a survey of community members, Community Health Network also distributed a survey that aligned with the community survey through its internal communication channels to receive feedback from caregivers regarding their perspectives on community needs.

Survey Methodology

Survey Content: The survey included six questions that cover a range of health needs topics, including significant health issues, access and barriers to healthcare services, social drivers of health, and health equity and vulnerable populations.

Distribution and Outreach: Survey distribution began in July 2024 and continued through August 2024. The survey was promoted through the Community Health Network's website, social media, direct outreach by partner organizations, and internal health network communication channels.

Response Rate: As of August 2024, a total of 19 community member responses and 41 caregiver responses were collected from Madison County and Community Hospital Anderson. As the survey was not weighted or randomized, the sample should be treated as a convenience sample only.

> ***"I believe the costs of [services] makes things very difficult. A lot of patients don't attend regular checkups and other visits due to the costs and frequency of medical bills."***

Community Survey Analysis Results

Respondents were asked to choose from a list of community health issues, while also given the option to write in their own response, to identify their top three most important or impactful in the community. Both community member respondents and caregiver respondents identified similar issues as the most pressing. The following issues were selected as the most significant:

Substance Abuse (Including Drugs & Alcohol)

Mental Health & Suicide

Obesity, Unhealthy Lifestyles, & Associated Diseases

Cancers

Smoking, Vaping, & Tobacco Use

The survey also asked which healthcare services were most difficult to access in the community, as well as the primary barriers to accessing services. Both community members and healthcare providers indicated that mental health services, child mental health services, and substance abuse treatment were among the most difficult to access. Additionally, specialty care (including cardiovascular, cancer, and other chronic condition care) was identified as limited. The primary barriers identified included the cost of care, lack of providers, and issues with or lack of health insurance.

> ***"Health and wellbeing go hand-in-hand with physical and mental health care."***

Stakeholders were also asked which social drivers of health were most impactful or of the greatest concern in the community. Both groups frequently selected poverty, housing affordability and quality, and food access and affordability as significant issues. Health literacy and understanding and employment opportunities were also commonly identified as important community factors.

To better understand vulnerable populations in the community, the survey also asked which groups were underserved or at risk for poor social and health outcomes. Both cohorts frequently identified the aging and elderly population as the most vulnerable. Many additional groups were identified as vulnerable, including populations with disabilities, children and adolescents, Black (or African American) individuals, immigrants, military veterans, and Hispanic (or Latino) individuals.

Secondary Data Collection & Analysis

This section explores the economic, environmental, and social drivers of health impacting the community served by CHA, as well as health outcomes and resources available in the community. This secondary data analysis aims to analyze the conditions that play a crucial role in determining health outcomes and inequities across populations and the resulting health concerns throughout Madison County. Throughout this section, data is provided in table and graph forms. For all tables, values are shaded that compare unfavorably to Indiana-wide measures.

Socioeconomic Factors

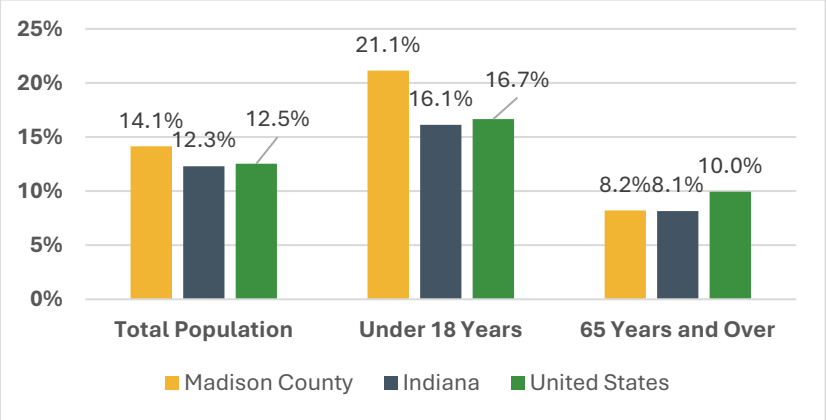
The following section outlines socioeconomic factors and social drivers of health (SDOHs). SDOHs are the conditions in which people are born, grow, work, live, and age, shaped by various forces such as economic policies and systems, social norms, and political climates. These conditions play a crucial role in determining health outcomes and inequities across populations.

Poverty Status

KEY FINDINGS

- Overall poverty and percent of children in poverty is higher in Madison County than in Indiana and U.S.

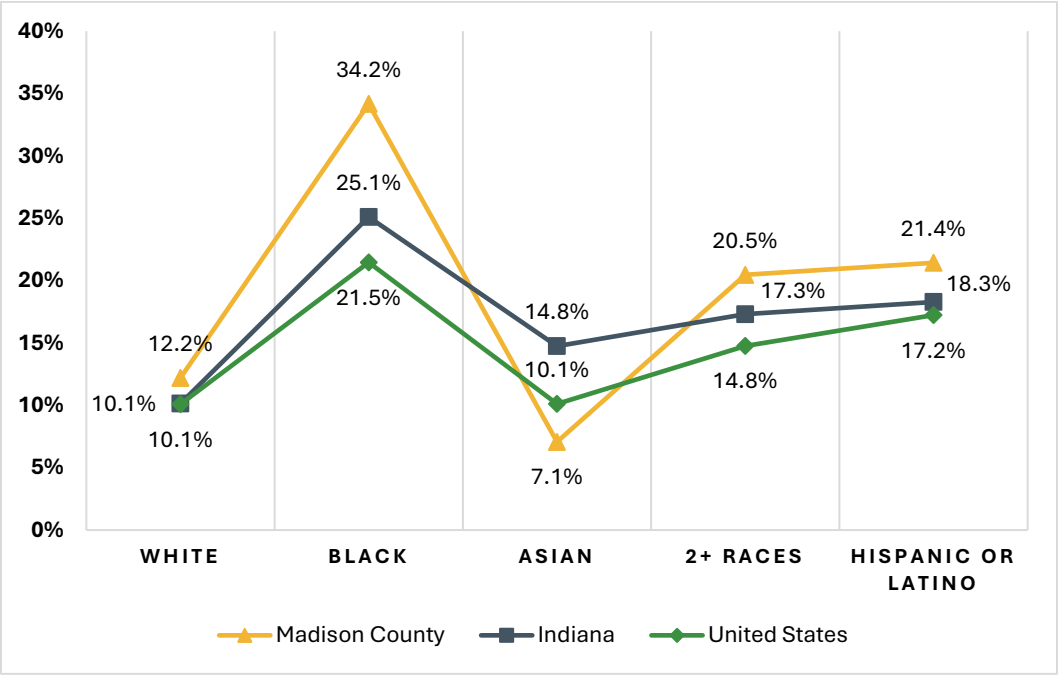
FIGURE 12. POVERTY BY AGE CATEGORY, 2022



Source: American Community Survey 5-Year Estimates, 2018-2022.

In Madison County, 14.1 percent of residents live in poverty, a figure above Indiana (12.3 percent) and United States (12.5 percent) proportions.

FIGURE 13. POVERTY BY RACE/ETHNICITY, 2022



Source: American Community Survey 5-Year Estimates, 2018-2022.

HEALTH EQUITY FOCUS

- Poverty rates for Black populations in Madison County more than double the poverty rate of White populations
- Rates for Madison County White, Black, two or more races, and Hispanic/Latino residents are above Indiana and United States rates for the same cohorts

Other Socioeconomic Factors

In addition to poverty, other social drivers of health were analyzed. Utilizing county health rankings, Figure 14 presents measure data compared to statewide figures, with indicators shaded that compare unfavorably to state average. Additionally, the county is ranked among all 92 Indiana counties for each measure, with a lower ranking being more favorable.

FIGURE 14. SOCIOECONOMIC FACTORS, MEASURE AND COUNTY RANK, 2024

Measure	Madison County	Indiana
High School Completion Percentage	89.9%	90.0%
	48	-
Percent Some College	54.8%	63.1%
	61	-
Unemployment Percentage	3.3%	3.0%
	72	-
Income Ratio	4.3	4.3
	72	-
Percent of Children in Single-Parent Households	29.9%	24.1%
	86	-
Social Association Rate	12.8	11.8
	38	-
Injury Death Rate	114.1	90.2
	79	-

Source: County Health Rankings, 2024.

KEY FINDINGS

- Bottom quartile in single-parent households, injury death rate, unemployment, and income ratio

As highlighted in Figure 15, Madison County compares unfavorably to Indiana averages for several environmental factors.

FIGURE 15. PHYSICAL ENVIRONMENT FACTORS, MEASURE AND COUNTY RANK, 2024

KEY FINDINGS

- Housing measures are a concern as Madison County is bottom quartile for severe housing problems and cost burden

Measure	Madison County	Indiana
Air Pollution - Average Daily PM2.5	8.4	8.8
	14	-
Severe Housing Problems Percentage	13.3%	12.2%
	79	-
Severe Housing Cost Burden Percentage	12.2%	10.2%
	86	-
Percent Drive Alone to Work	76.9%	78.7%
	16	-
Percent with a Long Commute Driving Alone	40.8%	32.2%
	61	-

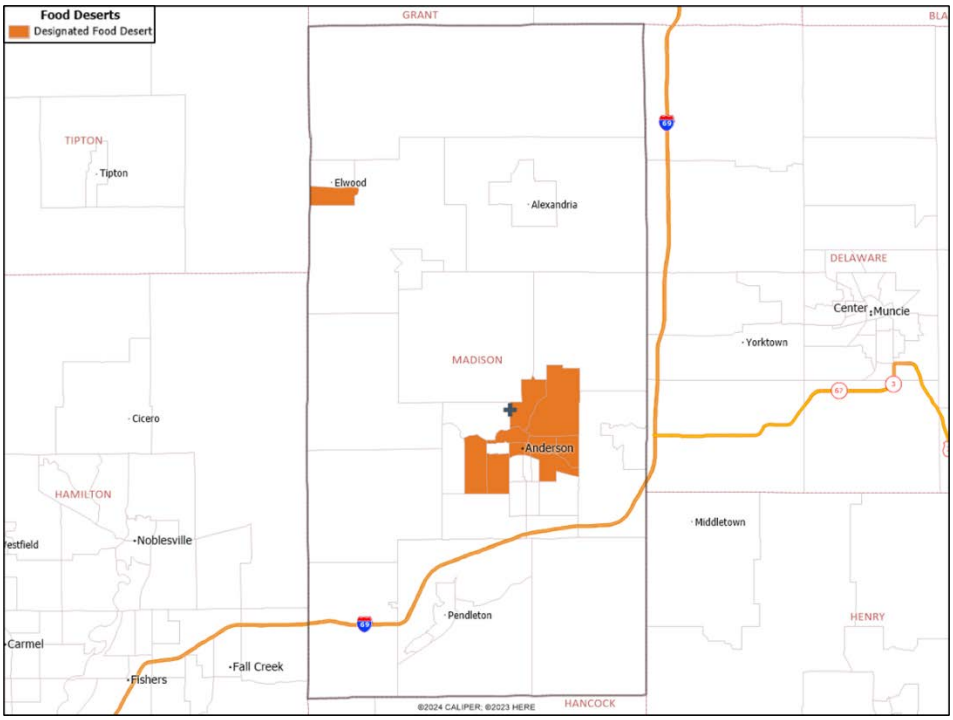
Source: County Health Rankings, 2024.

Food access is also a key driver of health and wellbeing in the community. Utilizing the U.S. Department of Agriculture food desert definition of a census tract that is both low-income and at least 500 people or 33 percent of the population living one mile (urban) and ten miles (rural) from the nearest supermarket, supercenter, or large grocery store, Madison County food deserts are mapped in Figure 16.

KEY FINDINGS

- Food deserts are in central Madison County in Anderson, as well as in Elwood

FIGURE 16. MAP OF FOOD DESERTS, 2021



Source: U.S. Department of Agriculture, April 2021, and Caliper Maptitude software.

Several other SDOH factors are highlighted in Figure 17. A higher proportion of Madison County residents are food insecure compared to statewide averages, and a higher percent of household income is required for childcare expenses.

FIGURE 17. ADDITIONAL SOCIAL DRIVER OF HEALTH MEASURES, 2024

Measure	Madison County	Indiana
Food Insecurity Percentage	12.9%	10.7%
Percent Income Required for Child Care Expenses	29.7%	25.1%
Homicide Rate	5.5	7.4

Source: County Health Rankings, 2024.

Health Status

This section highlights the various behaviors and resulting health outcomes of the CHA community. Noting the impact of social drivers, health behaviors are a significant contributor to health outcomes. An analysis of both contributing behaviors and outcomes aids in developing strategies for intervention and prevention.

Health Behaviors

Defined by County Health Rankings as "health-related practices… that can improve or damage the health of individuals or community members," the behaviors of a population are crucial in their overall health and wellbeing. However, health behaviors are impacted by the choices available in the places where people live, learn, work, and play. Noting that not all community members may have the available opportunities due to resources available, this section outlines contributing behaviors to wellbeing.

FIGURE 18. HEALTH BEHAVIORS, 2024

Measure	Madison County	Indiana
Percent Adults Reporting Currently Smoking	21.4%	18.0%
	65	-
Percent Adults Obese	43.4%	36.7%
	92	-
Food Environment Index	6.6	6.8
	85	-
Percent Physically Inactive	30.8%	25.1%
	85	-
Percent with Access to Exercise Opportunities	69.5%	76.5%
	32	-
Excessive Drinking Percent	15.9%	18.2%
	14	-
Percent of Driving Deaths with Alcohol Involvement	18.4%	18.3%
	62	-
Chlamydia Rate	526.8	510.7
	81	-
Teen Birth Rate	27.6	20.2
	72	-

Source: County Health Rankings, 2024.

KEY FINDINGS

- Last in obesity among Indiana counties
- Bottom quartile in:
  - Food environment index
  - Physical inactivity
  - Chlamydia rate
  - Teen births

HEALTH EQUITY FOCUS

- Teen birth rates among Black and Hispanic or Latino teens are significantly above average

Population	Teen Birth Rate
Black	46.1
Hispanic (or Latino)	30.7
White	25.6
Madison County Total	27.6

Health Status & Outcomes

This section highlights the health outcomes resulting from a variety of factors, including social drivers of health and health behaviors of populations.

KEY FINDINGS

- Bottom quartile among counties for:
  - Years of potential life lost (premature death)
  - Low birthweight births

FIGURE 19. HEALTH OUTCOMES, 2024

Measure	Madison County	Indiana
Years of Potential Life Lost Rate	11,034	9,317
	78	-
Percent Fair or Poor Health	18.2%	16.1%
	67	-
Average Number of Physically Unhealthy Days	4.1	3.5
	63	-
Average Number of Mentally Unhealthy Days	5.3	5.2
	48	-
Percent Low Birthweight Births	9.4%	8.3%
	87	-

Source: County Health Rankings, 2024.

Compared to Indiana averages, Madison County compares unfavorably for all measures in Figure 19.

Population	Years of Potential Life Lost Rate	Low Birthweight Births
Black	16,260	15.7%
Hispanic (or Latino)	6,738	5.9%
White	10,741	8.8%
Madison County Total	11,034	9.4%

HEALTH EQUITY FOCUS

- Black populations compare unfavorably for years of potential life lost and low birthweight births

Mortality causes were also analyzed for Madison County compared to Indiana averages, found in Figure 20.

FIGURE 20. MORTALITY RATE BY CAUSE, AGE-ADJUSTED PER 100,000, 2018-2022

Measure	Madison County	Indiana
All causes of death	1,024.2	911.3
Heart Disease	181.0	184.2
Cancer	170.6	165.0
Accidents and Adverse Effects	80.7	65.2
Chronic Lower Respiratory Disease	69.9	54.6
Cerebrovascular Disease	46.4	41.5
Alzheimer's Disease	44.9	31.5
Diabetes	38.1	28.4
Kidney Disease	22.3	17.8
Suicide	20.3	15.5
Chronic Liver Disease	16.4	13.9
Septicemia	15.5	12.8
Pneumonia	15.4	9.8
Homicide and Legal Intervention	8.4	8.7

Source: National Institutes of Health, U.S. Department of Health and Human Services, 2024.

KEY FINDINGS

- Higher rates of mortality than statewide for all causes
- Particularly higher rates of:
  - Pneumonia
  - Alzheimer's disease
  - Diabetes
  - Suicide
  - Chronic lower respiratory disease
  - Kidney disease

Figure 21 provides additional mortality and morbidity rates for Madison County compared to Indiana averages.

KEY FINDINGS

- Behavioral health concerns as drug overdose deaths and suicide rates are significantly higher
- Higher rates of infant mortality, diabetes, and motor vehicle deaths

FIGURE 21. ADDITIONAL MORBIDITY AND MORTALITY MEASURES, 2024

Measure	Madison County	Indiana
Child Mortality Rate	59.8	61.9
Infant Mortality Rate	7.1	7.0
% Adults with Diabetes	11.0%	10.8%
HIV Prevalence Rate	199.1	217.0
Drug Overdose Mortality Rate	40.8	33.7
Suicide Rate	21.4	15.6
Firearm Fatalities Rate	15.6	15.9
Motor Vehicle Mortality Rate	15.1	13.0

Source: County Health Rankings, 2024.

Population	Injury Death Rate	Life Expectancy	Child Mortality Rate	Homicide Rate	Firearm Fatalities Rate
Black	107.0	69.5	122.4	18.5	25.8
Hispanic (or Latino)	35.2	85.8	-	-	-
White	119.5	74.0	58.1	4.0	14.9
Madison County Total	114.1	73.8	59.8	5.5	15.6

HEALTH EQUITY FOCUS

- Morality rates for Black children are more than double rates for White children
- Black populations experience lower life expectancy compared to White populations by nearly five years and have higher rates of homicide deaths and firearm fatalities
- White populations have higher injury death rates than other cohorts

Access to Care

In addition to health behaviors and outcomes, the ability to access care in a community is vital to maintaining wellbeing in a community. This section highlights the various measures and factors that influence access to health care services.

FIGURE 21. CLINICAL CARE MEASURES, 2024

Measure	Madison County	Indiana
Percent Uninsured	9.0%	8.9%
	60	-
Primary Care Physicians Rate	48.2	65.6
	35	-
Dentist Rate	56.2	59.5
	24	-
Mental Health Provider Rate	151.1	199.8
	24	-
Preventable Hospitalization Rate	3,064.0	3,135
	52	-
Percent with Annual Mammogram	41.0%	45.0%
	61	-
Flu Vaccination Percentage	49.0%	50.0%
	36	-

Source: County Health Rankings, 2024.

As displayed in Figure 21, Madison County compares unfavorably to state averages for almost all measures. Preventive health issues exist as the county ranks in the bottom half of Indiana counties for uninsured adults, preventable hospitalization rates, and mammograms. The rates of health professionals are also below state averages. Additionally, Black populations experience higher preventable hospitalization rates and lower flu vaccination rates, and vaccinations are low among Hispanic residents.

Population	Preventable Hospitalization Rate	Annual Mammogram	Flu Vaccination
Black	5,188	43.0%	33.0%
Hispanic (or Latino)	-	-	42.0%
White	2,988	41.0%	49.0%
Madison County Total	3,064	41.0%	49.0%

Health Professional Shortage Areas & Medically Underserved Areas

Parts of Madison County are designated as Health Professional Shortage Areas (HPSA) by the Health Resources and Services Administration (HRSA). The low-income population of Madison County is designated as a primary care shortage area and all of Madison County is designated as a mental health provider shortage area. The county, however, is not designated as a Medically Underserved Area by HRSA.

These underserved designations make it essential to continue addressing gaps in healthcare access, particularly among low-income populations where these shortages are most acute.

Community Resources to Address Needs

This section identifies other health and wellbeing resources available to aid in addressing the prioritized health needs of community residents.

Hospitals

Three hospitals operate within Madison County and are available to serve populations.

- Community Hospital Anderson, the subject of this report, is located at 1515 N. Madison Avenue in Anderson, IN 46011.
- Ascension St. Vincent Anderson is located at 2015 Jackson Street in Anderson, IN 46016.
- Ascension St. Vincent Mercy is located at 1331 South A Street in Elwood, IN 46036.

Health Centers

Several health centers operate within Madison County, providing affordable health care, access to primary care, and a variety of health services to the community.

- Jane Pauley Community Health Center operates multiple locations within the county:
    - Jane Pauley CHC at 1629 Anderson, located at 1629 Medical Arts Boulevard, Anderson, IN 46011
    - Jane Pauley CHC at 1210B Anderson, located at 1210 Medical Arts Boulevard Suite 300, Anderson, IN 46011
    - Jane Pauley CHC at the Wigwam, located at 1229 Lincoln Street, Anderson, IN 46016
    - Jane Pauley CHC at Alexandria-Monroe Intermediate School, located at 308 W 11th Street Room G-1, Alexandria, IN 46001
    - Jane Pauley CHC at Alexandria-Monroe Junior-Senior High School, located at 1 Burden Court Room 16, Alexandria, IN 46001
    - Jane Pauley CHC at Alexandria, located at 121 W Washington Street, Alexandria, IN 46001
- Aspire Indiana Health operates multiple locations within the county:
    - Aspire Indiana Health Mobile Clinic, located at 215 W 19th Street, Anderson, IN 46016
    - Aspire Indiana Health – Dehaven, located at 2020 Brown Street, Anderson, IN 46016
    - Aspire Indiana Health – Hoak, located at 2009 Brown Street, Anderson, IN 46016

    - Aspire Indiana Health – May House, located at 6775 W State Road 32, Anderson, IN 46011
    - Aspire Indiana Health – Mockingbird Hill, located at 4038 Ridgeview Court Suite 1, Anderson, IN 46013
    - Aspire Indiana Health – Elwood, located at 10731 State Road 13, Elwood, IN 46036
- Meridian Health Services operates multiple locations within the county:
    - 2010 Brentwood Drive, Suite 1, Anderson, IN 46011
    - 1547 Ohio Ave, Anderson, IN 46016
    - 101 W 29th St, Anderson, IN 46016
    - 101 N Harrison Street, Alexandria, IN 46001
    - 1518 Main St, Elwood, IN 46036
- Open Door Health Services operates a location at 2101 Jackson Street, Suite 8, Anderson, IN 46016

Other Health and Social Services Needs

Community Connections is a Community Health Network initiative designed to help community residents locate resources, often free or reduced-cost, to aid in health and wellbeing. The search tool is available to all residents and, by entering one's ZIP code, can connect a community member with social services offered by verified social care organizations and non-profits. Services are available to aid with a variety of needs, including food, housing, daily goods, transportation, income, health and family care, education, employment, legal aid, and others. To utilize the tool, please click here or navigate to the following URL: https://communityconnect.findhelp.com/ .

Appendix I: Community Meeting Participating Organizations

Appendix I lists the organization affiliations of those who participated in the Community Input Meetings, with detailed results found in the Primary Data Collection & Analysis section of this report. More than one person from a given organization may have participated in the meeting. The organizations listed below represent attendance only as other stakeholders were invited to participate but were unable to attend.

- Anderson Housing Authority
- Anderson Preparatory Academy
- Anderson University
- Elwood Community Schools
- Essential Senior Health and Living
- Heart of Indiana United Way
- Intersect, Inc.
- Ivy Tech Community College
- Jane Pauley Community Health Center
- Madison County Chamber of Commerce
- Madison County Community Foundation
- Madison County Economic Development

Appendix II: Impact Evaluation

Appendix II describes the actions and initiatives undertaken by Community Hospital Anderson to address the priority health needs the 2021 Community Health Needs Assessment identified.

CHNA Priority: Social Determinants of Health (SDoH)		
Program Name	**Description**	**2023 Outcomes**
Community Cupboard of Lawrence	The Community Cupboard of Lawrence is a food pantry that helps relieve the strain of food insecurity and is open Wednesdays from 10 a.m. to 4 p.m. and Fridays from 10 a.m. to 4 p.m. The Cupboard assists residents of Lawrence Township of Indianapolis, specifically in the area codes of 46216, 46220, 46226, 46235, 46236, 46249, 46250, and 46256. The Cupboard works in partnership with many organizations and corporate partners, including; Gleaners Food Bank of Indiana, Midwest Food Bank, CVS Pharmacy, St. Albans Episcopal Church, Castleton United Methodist Church and Meijer. Organizations and businesses volunteer at the Cupboard, and Purdue Extension assists with keeping CHNw aware of recent USDA updates along with providing innovative food options and ideas for the clients. As part of the curriculum for community-based nursing, University of Indianapolis nursing students spend time at the Cupboard learning about the operations and the unique needs of the clients served.	174,839 individuals served 16,910 households served 17,951 lbs locally grown produce distributed 195,413 lbs of product donated by CVS distributed
Mabel's Ride	With a goal to improve patient health outcomes by eliminating transportation-related barriers to care, Mabel's Ride: a four-vehicle fleet picks up patients right at their door, and takes them directly to their CHNw healthcare provider or pharmacy of choice.	1,508 patients served 21,862 rides provided
Medical Legal Partnership	The purpose of a Medical Legal Partnership (MLP) is to improve health outcomes for patients through the provision of legal services that impact social determinants of health. Hospitals often see patients who are suffering from acute and chronic medical conditions caused or aggravated by conditions in patients' homes, issues in the patients' relationships, or patients' lack of income and other resources. Embedding an MLP attorney in the hospital allows the hospital and the MLP to work together as a team to address habitability issues in a patient's home and provide patients with the medical care and legal services they need to become healthy and stay healthy. By way of this partnership, patients have the opportunity to obtain a clean slate for future employment opportunities.	645 patients received free legal aid
Medication Assistance Program	CHNw has a free medication assistance program that helps patients obtain medications for less cost with the goal of preventing medication non-adherence, often referred to as "America's other drug problem." The Medication Assistance Program uses various approaches to reduce or eliminate	$148.5 million worth of prescription medications was provided to patients through CHNw's

	medication costs including obtaining medications for free from pharmaceutical companies, locating and applying grant funding to purchase medications, utilizing low-cost medication programs, providing drug coupons/vouchers, and, when appropriate, working with providers to switch therapy to a less expensive medication or to a medication that has a patient assistance program for which the patient qualifies.	Medication Assistance Program
WellFund	The WellFund exists to help patients navigate healthcare coverage options, including initial enrollment and ongoing maintenance of coverage. Patients have direct access to WellFund Patient Advocates during pre-service, admission and post-discharge for questions and determining which plan best meets their needs. The WellFund Patient Advocates are available to meet with patients in person or over the phone to help with enrollment.	CHNw patient advocates connected with over 87,518 unique individuals to ensure appropriate coverage across various affordable health plans.
Community Connections	Community Connections is a program to help community members find free and reduced-cost social services. It's a free search tool to connect seekers with social services offered by verified social care organizations and non-profits. The search tool uses zip codes to best be able to find resources in close proximity of the user's home. The tool has up-to-date information about location and eligibility for local food pantries, transportation services, health care, housing and other social service programs.	11,024 users 60,694 searches
SDoH Screening	Utilizing the Epic SDoH Screening tool, patients admitted to CHNw hospitals, OB patients and primary care patients are provided a comprehensive SDoH screening to identify any needs that could impact the overall health and well-being of the patient. Caregivers are trained on how to provide referral resources to assist the patient in addressing their identified need. Patients needing additional follow-up are referred for additional assistance by a case manager or health advocate.	309,054 patients were screened for SDoH needs
Community Farm of Anderson	The Community Farm of Anderson is located on more than 120 acres of land at the edge of Anderson's city limits. One of Community Farm's goals is to distribute fresh produce to patients and the community. This involves working with dietitians, primary care providers, and other integral staff to implement the process of farm-to-table, while also providing education to help patients learn how to eat healthy. Today, the produce goes to the community through various outlets including local food pantries, programs at Community, and the CHA foodservice. The farm team works closely with volunteers to coordinate free, fresh flower delivery to patients to help brighten their hospital stay, including sunflowers grown on the farm.	39,851 lbs of produce harvested
REACH Grant	Community Health Network continued the partnership with the Marion County Public Health Department serving as a sub-recipient of the Racial and Ethnic Approaches to	Implemented strategies in cafeteria at CHE and CHVH to

	Community Health (REACH) Grant from the Centers for Disease Control (CDC). REACH is a national program administered by the CDC under the Division of Nutrition, Physical Activity, and Obesity (DNPAO) designed to reduce racial and ethnic health disparities. The focus of the five-year grant in Marion County is around reducing chronic disease by addressing these five areas: Food Systems, Food Service Guidelines, Community Clinical Linkages, Physical Activity, and Breastfeeding in African American/Black Communities. Under the REACH Grant, CHNw provided Food Pantries with guidance and technical assistance on implementing aligned policy, systems and environmental changes around healthy nutrition standards/guidelines, nutrition nudges, and food procurement. This included collaboration with local food banks and hunger relief partners to foster consistency in messaging and healthy nutrition standards across the charitable food system.	encourage healthy selection by caregivers and guests. Established and expanded food pantry for patients at CHE. Assisted local food pantries with implementation of the Healthy Nudges SWAP program.
Serve360	Serve360° was created as a program to open opportunities for Community caregivers to live out the Network's mission through volunteerism. While Serve360° opportunities are available to all Community caregivers, Community's leaders are held accountable as servant leaders and are required to complete a minimum of four hours of volunteer service each year. Serve360° works to provide local nonprofits with the necessary volunteer hours to help keep expenses low, so they can focus their resources on programs that can improve the outcomes for our patients and the communities we are all working to serve. Partner organizations are selected for support based on alignment with the Network strategic CHNA priority areas.	26,937 hours of volunteer service provided to 85 local not for profit organizations
Coats of Caring	Annually, Community Hospital Anderson's Coats of Caring event offers new or gently worn coats and new hats and gloves to Madison County residents, thanks to the caring hearts at Community Hospital Anderson and supporters in the community.	Distributed over 2,000 coats and winter gear
Project SEARCH	Project SEARCH Indiana is a high school-to-work transition program targeted for students whose main goal is competitive employment. Supported by 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, Warren, Washington, and IPS school systems.	28 students graduated
Partnership with Jane Pauley Community Health Center	The Jane Pauley Community Health Center was founded in 2009 with support from Community Health Network, the Community Health Network Foundation and Warren Township Schools. In 2011, the Jane Pauley Community Health Center was awarded Federally Qualified Health Center	Over 100,000 patient visits annually. 10 sites of care.

	status by HRSA. Community Health Network continues to partner with Jane Pauley Community Health Center and provides annual financial support through a community benefit grant.	
Black Men in White Coats Youth Summit	The Black Men in White Coats Youth Summit brings students, parents, educators, clinicians, and community leaders together to uplift and engage youth and families from across Indiana. The goal of the summit is to inspire our youth to consider careers in healthcare while laying the foundation for success via mentorship and networking. Community Health Network in conjunction with the Metropolitan School District of Lawrence Township has been the host of the annual Black Men in White Coats since 2022.	1,237 youth and families registered to attend the events held in 2022 and 2023. Over 550 individuals attended.

CHNA Priority: Mental Health and Substance Use		
Program Name	**Description**	**2023 Outcomes**
School-Based Behavioral Care Services	CHNw's school-based care services provides coordinated, multi-service 'on the spot' care directly in schools to students in need by way of an embedded coordinated team of school nurses, school behavioral health professionals, school sports medicine & athletic training professionals, and virtual care providers. The program also aims to help keep school teachers, staff, employees, and administrators healthy and available to support kids in schools by way of onsite Health & Wellness clinics and EAP services for school employees and their dependents. CHNw provides over 150 behavioral staff employees to 143 schools throughout Central Indiana. These on-site behavioral health specialists provide services such as counseling, life-skills training, crisis response, trauma and depression screenings, staff education and training, testing, family services and more.	632,879 in-school behavioral health visits were provided
Have Hope	With an aspirational goal of achieving a zero percent suicide incident rate among Community Behavioral Health patients by 2025, Community Health Network's Zero Suicide initiative aims to save Community patient lives specifically through early intervention and prevention, the construction of a robust crisis network, and the utilization of innovative mental health diagnostics and treatment protocols. The strategy brings crisis, telemedicine and intensive care coordination services to the patients throughout Central Indiana, representing both Community facilities and partner organizations where Community provides behavioral health services. As part of the effort to combat suicide among youth, CHNw provides mental health and substance abuse services to students in more than 140 schools including Indianapolis Public	Total of 4,379 clients were placed on the Have Hope Pathway, a care pathway for clients at high risk for suicide.

	Schools and the Metropolitan School Districts of Lawrence and Warren townships in Marion County.	
Behavioral Health Academy	The Behavioral Health Academy™ is an ongoing partnership between Community Health Network and the Indiana University School of Social Work to prepare students for practice with mental health, substance use, and co-occurring disorders and to become dually-licensed as both a Licensed Clinical Social Worker (LCSW) and Licensed Clinical Addiction Counselor (LCAC) in Indiana. Beginning with the first Academy™ cohort in the Fall of 2019 and expanding every year since, the program is currently available at multiple locations. Currently, the IUSSW and Community Health Network collaborate with the Sandra Eskenazi Mental Health Center in Central Indiana, Oaklawn in South Bend, and Parkview Health/Park Center in Fort Wayne and receive funding from the Indiana Division of Mental Health and Addiction. 62 students across the state are enrolled in the 2023/24 Behavioral Health Academy. The Behavioral Health Academy creates significant benefits for Community Behavioral Health, students, and IUSSW and UIndy as education partners. As an employer, Community Health Network has a steady supply of high-caliber talent trained in Community Behavioral Health specific behavioral health practices, resulting in decreased orientation costs and time to productivity for new hires. The students participating in the Behavioral Health Academy receive specialized training in evidence-based practices, an opportunity to interview for employment upon graduation, a financial incentive to defray the cost of their education, and the opportunity to become dually licensed as a licensed clinical social worker (LCSW) and a licensed clinical addiction counselor (LCAC). IUSSW and UIndy can leverage the Behavioral Health Academy as a unique opportunity to attract top-tier students. The schools also benefit from close collaboration with industry experts to align curriculum with industry best practices. By filling the workforce gap, additional opportunities will be available to address the critical need for substance use disorder treatment services.	To date, 221 master's level therapists have graduated from the Behavioral Health Academy. Community Fairbanks has retained 107 of these graduates. Collectively, graduates from the BHA have served over 36,000 clients.
Community Drug Take Back Events	Unwanted and expired medicine may be a risk to human health and the environment if disposed of improperly. Wastewater treatment plants and septic systems are not designed to deal with pharmaceutical waste. Many medicines pass through the systems and are released into streams, lakes, and groundwater. The best way to reduce the impact of pharmaceutical waste on the environment is to dispose of medicine properly. State and local law enforcement agencies have established drug disposal	Hosted 2 collections days at all 5 hospital locations each year Collected 6,193 lbs of unwanted prescription drugs

	programs (often called "take-back" programs) to facilitate the collection and destruction of unused, unwanted, or expired medications. These programs help get outdated or unused medications off household shelves and out of the reach of children and teenagers.	
Community Health Network Opioid Stewardship Program	Since 2014, CHNw has dedicated resources to the prevention of opioid use disorder and overdose deaths. The Opioid Stewardship program includes safe opioid prescribing training for primary care and specialty care practitioners. By partnering with Boston University School of Medicine, a long-standing leader in educational excellence, we brought award winning curriculum to Community Health Network to educate our practitioners how to safely and effectively manage patients acute and/or chronic pain including safe opioid prescribing measures when opioids are medically necessary. CHNw is dedicated to the prevention of overdose deaths through our Narcan program. Narcan is the drug that can reverse the effects of opioids such as heroin, methadone and oxycodone. Our program provides a Narcan kit to patients and their families who are at risk for an opioid overdose when the have been discharged from an Emergency Department or the Behavioral Health Pavilion. In addition to our patient program, CHNw also provides opioid overdose awareness training and free Narcan kits to the communities we serve.	Maintained 6 Naloxboxes throughout the community. These boxes provided 377 kits to individuals. Community-based overdose prevention education provided to 1,106 people 1,710 Narcan kits distributed at community events and to at-risk patients at time of discharge
Feedback-Informed Treatment	Feedback-Informed Treatment (FIT) is a method of engagement used during targeted clinical contacts which enables caregivers to deliver Feedback Informed Treatment. The approach is used for evaluating and improving the quality and effectiveness of behavioral health services and works with existing approaches to therapy. Two measures within the FIT are the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS). The ORS, which a client completes at the start of a session, asks about their wellbeing. The SRS, which is filled out at the end, asks about the therapist's performance. For instance, one item asks if the client felt heard, understood and respected during the session. Another asks if they worked on or talked about what they wanted to. FIT is a care approach that is about empowering the client and increasing the client's voice. FIT involves routinely and most importantly formally soliciting feedback from clients about the process of therapy, working relationship with the therapist and overall wellbeing. Research has demonstrated numerous benefits to receiving ongoing formal feedback from clients. FIT has been shown to:	Session Experience/Rating Score (SRS): Received a score of 95.63% for "I felt cared for, heard, and respected"; a 93.54% for "we worked on the right things"; and a 91.66% on "we worked on what I want to change in my life"

	1. Double the rate of reliable and clinically significant client change 2. Enhance client wellbeing and overall outcomes 3. Increase engagement and decrease dropout rates by as much as 50% 4. Reduce the course of treatment	

CHNA Priority: Maternal, Infant and Child Health		
Program Name	**Description**	**2023 Outcomes**
Milk for Healthy Babies – The Milk Bank	Three Community hospitals are home to an Indiana Mothers' Milk Bank milk depot. Breastmilk donors can drop off their milk at these locations. When a mother's own milk is not available, pasteurized donor human milk is dispersed by prescription or hospital order primarily to premature infants in hospital neonatal intensive care units. Community Hospital North, Community Hospital Howard and Community Hospital Anderson participate in the Milk Bank program. Breastmilk donors can drop off their milk at these four locations.	Total breastmilk donated through CHNw Milk Depots: 74,494 Over 200,000 ounces of breastmilk has been collected since the on-site depots opened.
School-Based Asthma Care	Community has implemented an asthma initiative in school-based clinic setting to address pediatric asthma. Interventions include training teachers in signs of asthma, so students are sent to the clinic earlier aiding in a successful return to classroom compared to an emergency room visit. The education and distribution include a visual aid that reinforces early warning signs and daily practices to maintain health. Additionally, students are referred to free asthma education classes. The class trains individuals in asthma and managing their disease including the use of an asthma spacer and provides spacers to students who cannot afford one.	Free spacers provided to students in need.
School-Based Nursing Program	CHNw's school-based programs cover a wide range of needs for youth in 147 schools across Central Indiana and play a critical role in keeping children healthy in the classroom so they can learn. Onsite nurses address students' needs in the school and after-school setting, helping to ensure consistency in care and less time away from the classroom. These nursing services are primarily offered free of charge to schools thanks to CHNw's ongoing commitment to enhancing health for future generations. Nurses assess health conditions, derive nursing diagnoses, execute a nursing regimen, advocate for health, execute a medical regimen delegated by a physician, teach, administer and evaluate care for students every day. In addition, for students facing chronic health conditions and ongoing health needs, medications prescribed by physicians are administered by CHNw's school-based nursing staff. Services also include physicals, immunizations, health coaching including blood pressure and cholesterol screening and a variety of additional services helping teachers and faculty addressing everything from allergies to anxiety and bullying.	3,279,663 school nurse clinic visits provided 95.7% return to classroom rate for students

Center of Hope	Since 1998, the Center of Hope at Community Health Network has been dedicated to caring for victims of violence, abuse or neglect, especially sexual assault and interpersonal violence. The Center of Hope welcomes all victims of violence regardless of gender, sexual orientation, race, religion, origin or disability. Services are available 24/7 including weekends/holidays. Victims can be seen by a forensic nurse examiner (FNE) and receive any of the following depending on the victim's unique situation: o Medical care o Forensic nursing exam o Prophylactic medications for sexually transmitted diseases and pregnancy (as appropriate) o Injury identification and documentation o Assistance with emergency shelter placement o Forensic specimen collection (as appropriate) o Follow-up medical care post initial exam/visit o Safety planning o Referrals for crisis intervention and community-based resources such as counseling and support groups	Over 3,600 patients served
Baby & Me Tobacco Free	The Baby and Me, Tobacco Free Program is evidence-based, and has measurable positive outcomes by providing tobacco cessation education/services to pregnant and postpartum women. The proven program protocols utilize the American Congress of Obstetricians and Gynecologists (ACOG) "5 As" counseling approach, as established in the Clinical Practice Guidelines for Treating Tobacco Use and Dependence, Public Health Service Guidelines (updated 2008). The Baby and Me Tobacco Free program was discontinued in February of 2023 and cessation services were transitioned to Indiana Quitline.	100% of patients screened for nicotine use. Those that screened positive were referred to Indiana Quitline
Nurse Family Partnership	Goodwill of Central & Southern Indiana implemented the Nurse-Family Partnership (NFP), a nurse home-visiting program serving low-income mothers and babies. The goals listed in the agreement between CHNw and Goodwill of Central & Southern Indiana are: 1. Serve 25 low-income vulnerable mothers and new babies in the East Region 2. Assist in accessing prenatal care and wraparound services to improve health outcomes of the mother and child, and set them on a road to self-sufficiency 3. Lower infant deaths 4. Decrease pre-term births 5. Reduce rates of child maltreatment 6. Document metrics/milestones of baby via behavioral health methods 7. Nutrition training during well-baby check-up	267 clients served 98% breastfeeding initiation rate

	8. Increase breastfeeding rates 9. Reduce smoking during pregnancy	
B.A.B.E. Store	In partnership with the Marion County Public Health Department, Beds and Britches, Etc. (B.A.B.E.) of Indianapolis, Community Health Network opened our first store in 2015 on the east side of Indianapolis to promote responsible parenting by offering incentives to expectant parents. By encouraging accountability and improving self-esteem, the program provides goods and services that new parents need to nurture healthy babies and toddlers, and foster skills to help the family through life. Parents earn coupons with a Marion County Public Health Department estimated value of $5 each, which are redeemable at the B.A.B.E Store. Coupons are now distributed at all East Region OB and Pediatric offices, also at the Jane Pauley Community Health Center at 21st & Shadeland, Family Medicine Center on 10th street and at the Community Hospital North Women's Center.	1,317 women served 6,834 coupons redeemed
Safe Sleep for Babies	Provide comprehensive education on safe sleep for babies for all new parents delivering at CHNw hospitals. Provide pack n plays for new moms who indicate that they do not have a safe sleep space prepared upon discharge home.	Over 5,000 sleep sacks were distributed 75 pack n plays were distributed
Car Seat Safety	Provide safe car seat education to all OB and Pediatric Patients. If parent indicates that they do not have appropriate car seat at time of discharge or during a pediatric well-child visit, a new car seat is provided free of charge through the Community Benefit Car Seat Program.	95 car seats were distributed to families in need
Remote BP Monitoring	Screen at-risk prenatal women and provide remote BP monitoring.	364 women participated in remote BP monitoring

CHNA Priority: Physical Inactivity, Chronic Disease and Obesity		
Program Name	**Description**	**2023 Outcomes**
Faith Health Initiative	CHNw understands the essential role the faith communities play in promoting and sustaining wellbeing. Faith-based organizations improve the quality of life of their members, neighbors and communities by providing spiritual care, a supportive web of resources and impactful wellness ministries. Community Health Network developed the Faith Health Initiative (FHI), this initiative paves the way for a faith-health partnership. Built on respect, this partnership recognizes that both faith communities and high-quality medical treatment play a vital role in restoring health and promoting well-being, and that by working together, we are better able to meet the needs of our communities. FHI provides training for nurses to become Faith Community Nurses (FCN) and provides on-	30 active FCN participating in the FHI program Providing screening to 593 community members

	going support and resources to ensure they can create sustainable engaged health ministries and activities in their respective faith communities.	
Produce RX Program	The Produce Prescription nutrition incentive program is designed for high-risk patients from Community Health Network's REACH Clinic (Resources to Evaluate and Advance Community Health located at 2920 N. Arlington Ave, Suite B, Indianapolis, IN 46218). Patients are enrolled into free chronic disease focused nutrition education classes provided by the Ambulatory Dietitian team. Each participant receives financial incentives provided by CHNw Community Benefit that are redeemable for fruits and vegetables at local retail locations for attending.	104 program participants $19,588 redeemed for fresh produce
Diabetes Education Program	CHNw provides free virtual Diabetes Education and Support Courses for patients and community members. Each course consists of two classes. Courses are held at various times throughout the month to ensure access for all who are interested.	Each year 42 multi-class session were provided and open to the public
Indiana Black and Minority Health Fair	Each year Community Health Network sponsors the Indiana Black & Minority Health Fair, in conjunction with the Indiana Black Expo. CHNw staff and volunteers provide various screenings such as; blood pressure cholesterol, glucose, A1C and creatinine screenings. In addition to screenings CHNw provides on-site education resources to health fair participants on topics such as; diabetes, stroke, weight loss, wellness and nutrition, behavioral health and how to gain access to Community sites of care. Health Fair participants can ask physician related questions at Ask the Doc and medication questions at Ask the Pharmacist. Clinical Breast Exams are also provided on-site. CHNw Sports Medicine provides sport physicals and education to school aged children.	2,026 screenings provided 251 breast exams provided

Community Collaboration for Health Equity Grant Program	
In 2022, Community Health Network launched the Community Collaboration for Health Equity grant program. This program was designed to allow Community Health Network to partner with local not for profit organizations who are addressing one or more of the community health needs identified in the 2021 CHNA report. Over the past 3 years, Community Health Network has provided a total of $1,824,852 of funding to 27 local organizations. Below is a list of the organizations supported through this grant program:	
Funded Organization	**CHNA Priority Alignment**
Minority Health Coalition of Madison County	Obesity/Chronic Disease
Lutheran Child & Family Services	Mental Health and SDoH
Immigrant Welcome Center	SDoH
PACE, Inc	Mental Health, Substance Use and SDoH
Southeast Community Services	SDoH
Centers of Wellness for Urban Women	Obesity/Chronic Disease
Turning Point	Mental Health and Substance Use
Alternatives, Inc	Mental Health
Gleaners Food Bank	SDoH
Cancer Support Community of IN	Health Disparities
YMCA	Obesity/Chronic Disease
Operation Love	SDoH
The Ross Foundation	Mental Health/Substance Use/SDoH
Samaritan Caregivers Howard County	SDoH
Little Red Door Cancer Support	SDoH
Gilead House	Substance Use
Lifesmart	Mental Health
Warren Arts and Education Foundation	SDoH
Westminster Neighborhood Services	SDoH and Mental Health
John Boner Neighborhood Services	SDoH
National Kidney Foundation of IN	Chronic Disease
Still Waters Adult Day Center	Mental Health and SDoH
Shepard Community Center	Maternal/Infant Health
Horizon House	Mental Health and Substance Use
Sekham Institute for Holistic Healing	Mental Health
Kokomo Rescue Mission	Substance Use
Bona Vista	Mental Health and Obesity