Community Health Network

2024 Community Health Needs Assessment

North

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 North's Hospital Leadership

Community Health Network was created in the 1950s by local residents who recognized the need for more healthcare options, closer to home. The not-for-profit health system initially served neighbors on the east side of Indianapolis, but three decades later that need for care closer to home was growing to the northeast, and in 1985, Community Hospital North opened its doors.

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 Community Hospital North. 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 the communities we serve.

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 the need to focus on community safety and violence.

Thanks to all who shared their insights and ideas with us. With fresh information about the needs facing our local 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.

Jennifer Hindman
Vice President and Hospital Administrator, Community Hospital North

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Executive Summary

Introduction

Community Hospital North (CHN) 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 CHN'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 North

Community Hospital North opened in 1985 and continues to serve the growing needs of the north side of Indianapolis, Hamilton County, and patients from around the state. The exceptional care on the North campus includes access to specialists at Community Heart and Vascular Hospital, Community Cancer Center North, Community Fairbanks Recovery Center, Behavioral Health services, Community Surgery Center, Community Endoscopy Center, Community Physical Therapy and Rehabilitation services, primary and specialty-care physician practices, along with school-based clinics, MedCheck, and employer health clinics. Additional information about CHN is available at: https://www.ecommunity.com/locations/community-hospital-north.

Community Hospital North 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 North

For purposes of this assessment, the community served by CHN was defined as 20 ZIP codes located within Hamilton County, Hancock County, and Marion County, Indiana. A full list of these ZIP codes can be found in Figure 1 below, as well as a map of the community in Figure 2.

Collaborating Partners

Community Hospital North worked with each Community Health Network hospital – Community Hospital Anderson, Community Hospital East, 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.

Mental Health Status and Access to Mental Health Care

Mental health is a significant concern in the CHN community, identified by stakeholders more frequently than any other issues. Anxiety, depression, and suicidal ideation are common, particularly among youth, and a stigma against mental health concerns persists. Despite the rising need, access to mental health services remains limited due to a shortage of mental health providers and financial obstacles. Marion, Hamilton, and Hancock counties are each designated as mental health provider shortage areas for low-income residents, and mental health provider rates in Hamilton and Hancock counties are below the statewide average.

Access to Care

Access to healthcare services is a significant issue across the CHN community. Issues with transportation, the cost of care, wait times, health insurance, and cultural competency in care were identified as contributing factors. The uninsured rate is high in Marion County, and a high preventable hospitalization rate indicates access concerns. Portions of Marion County are designated as primary care professional shortage areas for low-income residents and census tracts throughout are designated medically underserved areas. Indicators such as high rates of preventable hospitalizations indicate difficulties accessing preventive care.

Housing and Transportation

Housing and transportation are primary social driver of health concerns in the CHN community. Housing was cited as a significant concern by stakeholders, and lack of affordable options has pushed many low-income families into substandard living conditions or out of the community. Marion County has high rates of severe housing problems and cost burden for housing. Public transportation options are limited, particularly in suburban and rural areas. Both Hamilton and Hancock counties have a high rate of long commutes driving alone.

Infant and Child Health and Wellbeing

Infant and child health and wellbeing are significant concerns in the CHN community. Marion County experiences unfavorable rates of child poverty, single-parent households, and teen births. Infant and child mortality rates are also above Indiana rates in Marion County, and the county ranks second to last in Indiana for low birthweight births. Disparities are also evident in all community counties 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 emotional needs of school-aged youth after the COVID-19 pandemic.

Community Safety and Violence

Safety is a concern for many community members, including domestic violence concerns. Community meeting and survey participants both cited community violence issues as a significant concern, creating mental and physical health challenges, particularly among youth residents. Marion County stakeholders noted issues with community-based violence, and Hamilton County stakeholders noted concerns with domestic and child abuse. The homicide rate in Marion County is nearly triple the Indiana-wide average and firearm fatalities are nearly double the average.

Substance Misuse

The misuse of drugs and substances is a pervasive issue in the CHN community and intricately tied to poor mental and physical health. The drug overdose mortality rate in Marion County is nearly double the Indiana rate. Stakeholders noted the fentanyl and opioid epidemics as driving forces along with other substance addiction issues such as methamphetamines. Treatment options are limited, costly, and often have long wait lists, particularly for those with Medicaid or uninsured. Alcohol misuse is also a concern. Each community county ranks in the bottom quartile in Indiana for driving deaths involving alcohol.

Aging Population and Elderly Needs

The population is aging and the needs of elderly people – including access to services to age in place – are an increasing need. The median age in Hancock County is higher than the Indiana average, and an increasing proportion of residents are aged 65+. Survey respondents identified elderly populations as vulnerable more often than any other cohort. Transportation options for the elderly are limited and, lacking reliable alternatives, results in unmet needs and isolation.

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. CHN 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 North defined its community using a detailed analysis of 2023 patient origin data that identified the primary geographic areas where patients who utilize inpatient and emergency services reside. Assessing and defining the CHN 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, CHN 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 CHN community was defined as 20 ZIP codes in Marion County, Hamilton County, and Hancock County, Indiana.

Community Hospital North Community Definition

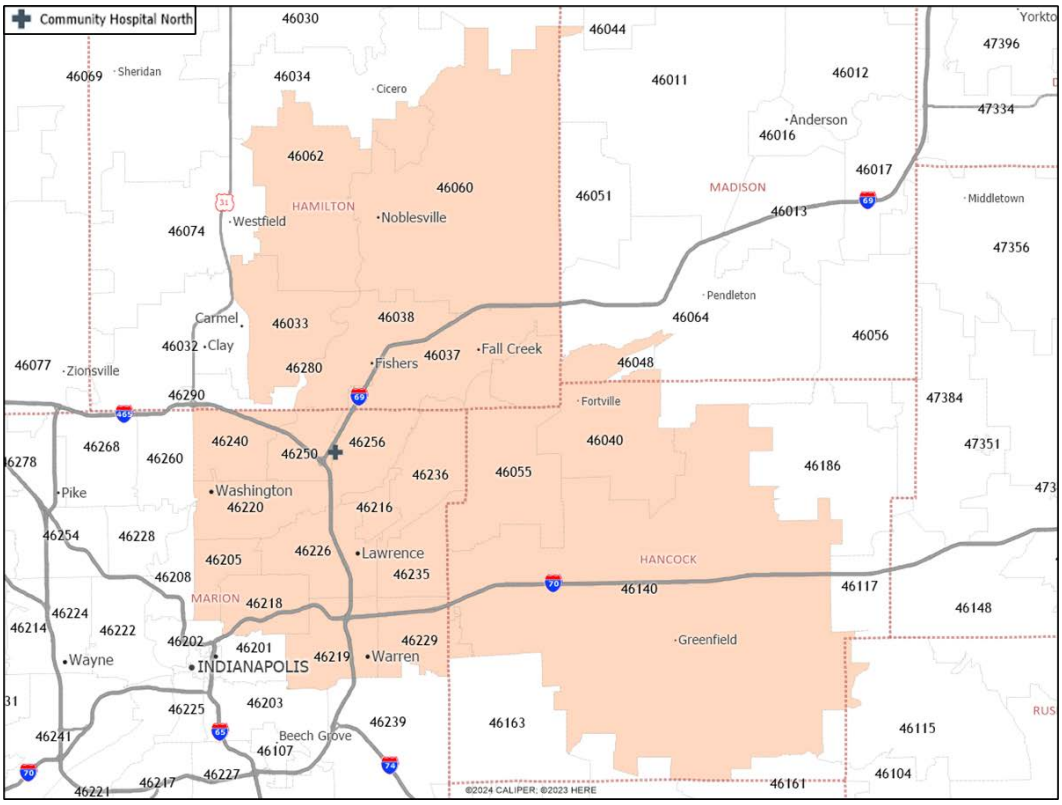
When examined at a ZIP code level, 20 ZIP codes were identified that comprise northeast Marion County, eastern Hamilton County, and most of Hancock County. These 20 ZIP codes and their accompanying patient origin statistics are presented in Figure 1. In total, the 20 ZIP codes accounted for 65.2 percent of the hospital's total inpatient discharges and 77.4 percent of its ER visits.

FIGURE 1. COMMUNITY PATIENT ORIGIN DATA

ZIP Code	County	State	Inpatient Discharges	ER Visits
46226	Marion	IN	1,180	8,712
46236	Marion	IN	825	4,163
46235	Marion	IN	779	6,108
46256	Marion	IN	769	4,109
46038	Hamilton	IN	708	2,325
46037	Hamilton	IN	646	1,862
46250	Marion	IN	637	3,054
46220	Marion	IN	616	3,137
46060	Hamilton	IN	511	1,636
46229	Marion	IN	460	2,707
46140	Hancock	IN	405	1,016
46055	Hancock	IN	395	1,498
46218	Marion	IN	367	2,225
46219	Marion	IN	352	1,814
46205	Marion	IN	304	1,701
46240	Marion	IN	278	1,210
46062	Hamilton	IN	266	620
46040	Hancock	IN	253	820
46033	Hamilton	IN	174	450
46216	Marion	IN	122	662
Community Total			10,047	49,829
Community Percent			15,412	64,416
Hospital Total			65.2%	77.4%

Community Hospital North is located at 7150 Clearvista Drive in Indianapolis, Indiana, ZIP code 46256. Figure 2 depicts CHN's community and the ZIP code boundaries within this community.

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:

- Community ZIP codes: Composed of the 20 ZIP codes listed in Figure 1 where the majority of CHN's patient base resides, as outlined in the figure above.
- Marion, Hamilton, and Hancock counties: Data at this level offers insight into county-wide health challenges and disparities.
- Indiana: Statewide health concerns and perspectives on health issues are included to provide additional context of the community's needs in relation to their fellow Hoosiers.

By utilizing multiple geographic levels of data, CHN 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 North Community

Understanding the demographics of CHN's community is crucial for tailoring healthcare services to meet the needs of the population. Based on American Community Survey (ACS) five-year estimates, this report provides detailed insights into the population characteristics within the 20 ZIP codes identified for analysis. Comparisons to county-wide, 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, the 20 community ZIP codes have a population of 617,639. The population breakdown by ZIP code in the CHN community is found in Figure 3.

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

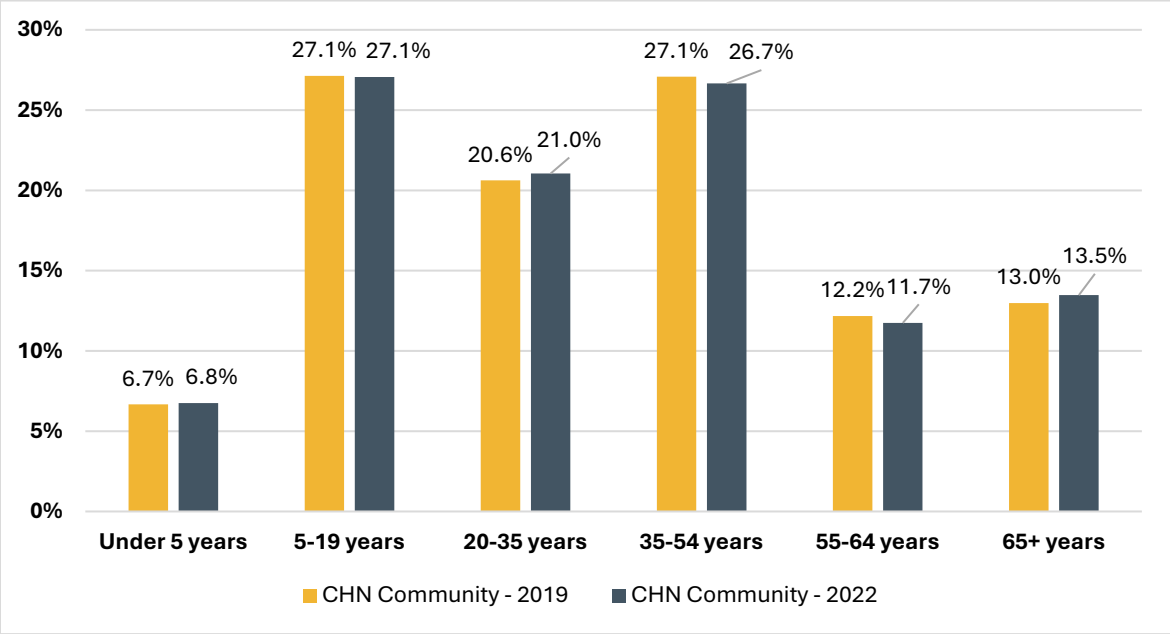
ZIP Code	City	County	Population
46226	Indianapolis	Marion	45,716
46236	Indianapolis	Marion	26,993
46235	Indianapolis	Marion	34,289
46256	Indianapolis	Marion	22,373
46038	Fishers	Hamilton	43,112
46037	Fishers	Hamilton	46,858
46250	Indianapolis	Marion	17,131
46220	Indianapolis	Marion	37,102
46060	Noblesville	Hamilton	47,340
46229	Indianapolis	Marion	28,629
46140	Greenfield	Hancock	41,879
46055	McCordsville	Hancock	14,130
46218	Indianapolis	Marion	28,951
46219	Indianapolis	Marion	38,681
46205	Indianapolis	Marion	28,327
46240	Indianapolis	Marion	20,123
46062	Noblesville	Hamilton	37,191
46040	Fortville	Hancock	16,680
46033	Carmel	Hamilton	39,859
46216	Indianapolis	Marion	2,275
Community Total			617,639

The hospital's origin ZIP code, 46256, has the seventh smallest population within community ZIP codes.

Age Distribution

The age distribution in the CHN community highlights variations in the population by age. The median ages in Marion County and Hamilton County respectively are 34.4 years and 37.8 years, below both the state (38.0 years) and national (38.5 years) medians. Hancock County (39.6 years) is above state and national medians. Additionally, data suggests that in CHN ZIP codes, the proportion of the population aged 65 years and above increased more than any other cohort from 2019 to 2022. These statistics suggest a growing need for healthcare services tailored to older adults and potential aging in place measures.

FIGURE 4. POPULATION BY AGE, CHN COMMUNITY, 2019 AND 2022

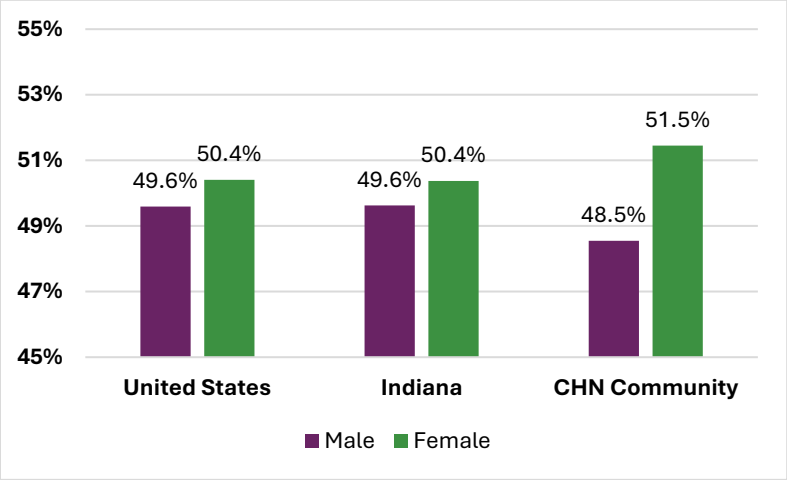


Despite the growing aging population, the working-age group (aged 20 to 64) comprises the majority of the community's population at 59.5 percent. This suggests an increasing need for healthcare services that cater to both an aging population and the preventive care needs of younger, working-age groups.

Population by Sex

An analysis of CHN's community population by sex, found in Figure 5, finds that the proportions of male and female populations are similar to state and national averages, with CHN community ZIP codes having a slightly lower proportion of male residents than female.

FIGURE 5. POPULATION BY SEX, 2022

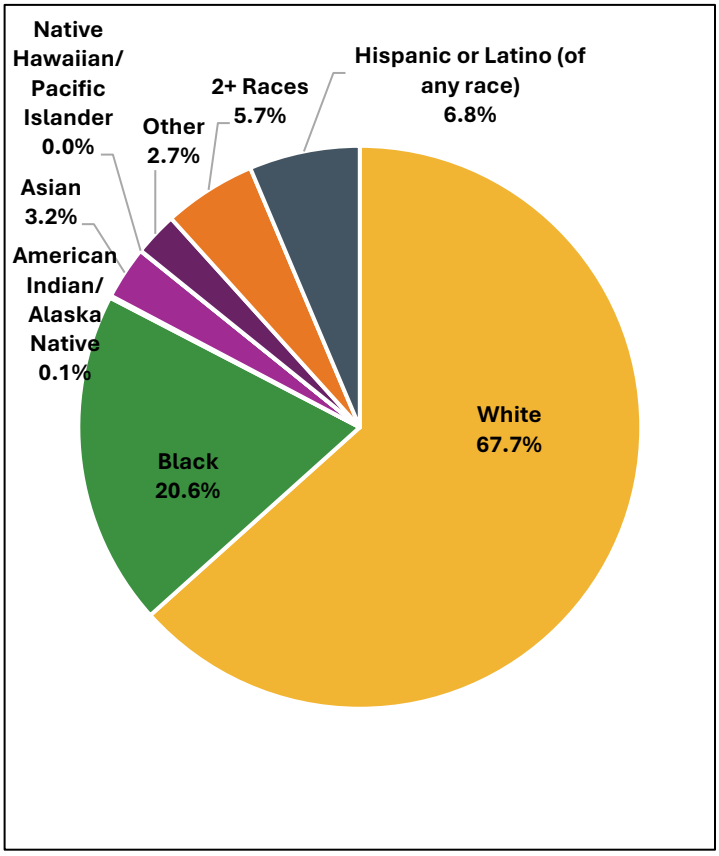


Racial & Ethnic Composition

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.

CHN community ZIP codes reflect substantial racial and ethnic diversity. White residents compose 67.7 percent of the population and Black or African American residents comprise 20.6 percent of the population. Other racial groups, including those identifying as two or more races (5.7 percent), Asian (3.2 percent), and Other (2.7 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.

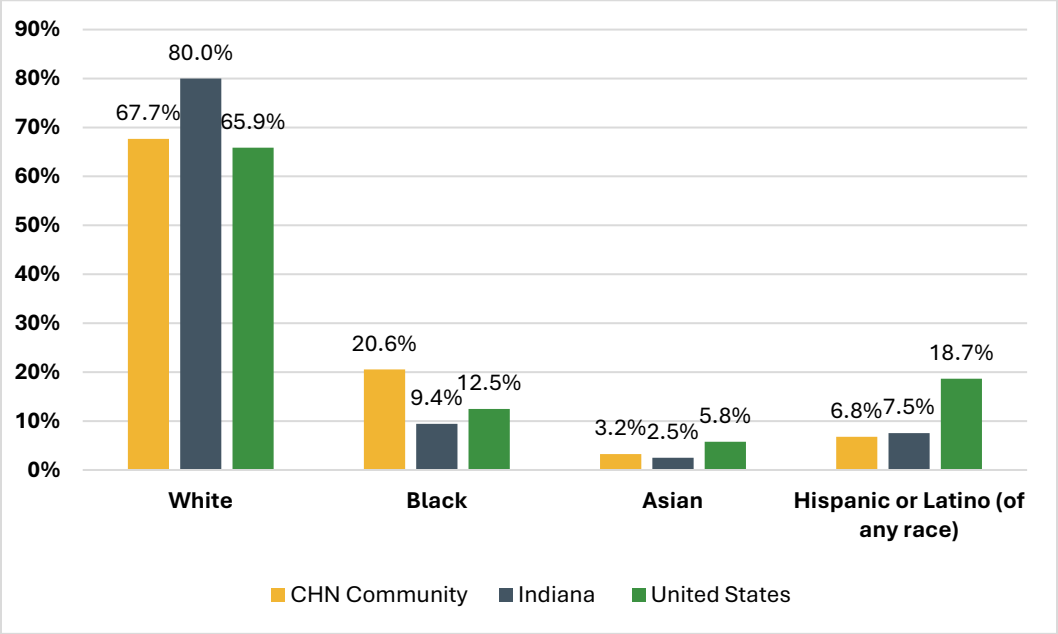
FIGURE 6. POPULATION BY RACE AND ETHNICITY, 2022



In terms of ethnicity, the Hispanic/Latino population represents 6.8 percent of the population.

When compared to state and national levels, the racial and ethnic distribution in the CHN community is more diverse (Figure 7). A lower proportion of the population is White, and a higher proportion is Black, Asian, or Hispanic/Latino across community ZIP codes compared to Indiana. Additionally, a higher proportion of the population is two or more races (5.7 percent) compared to the state average of 5.1 percent.

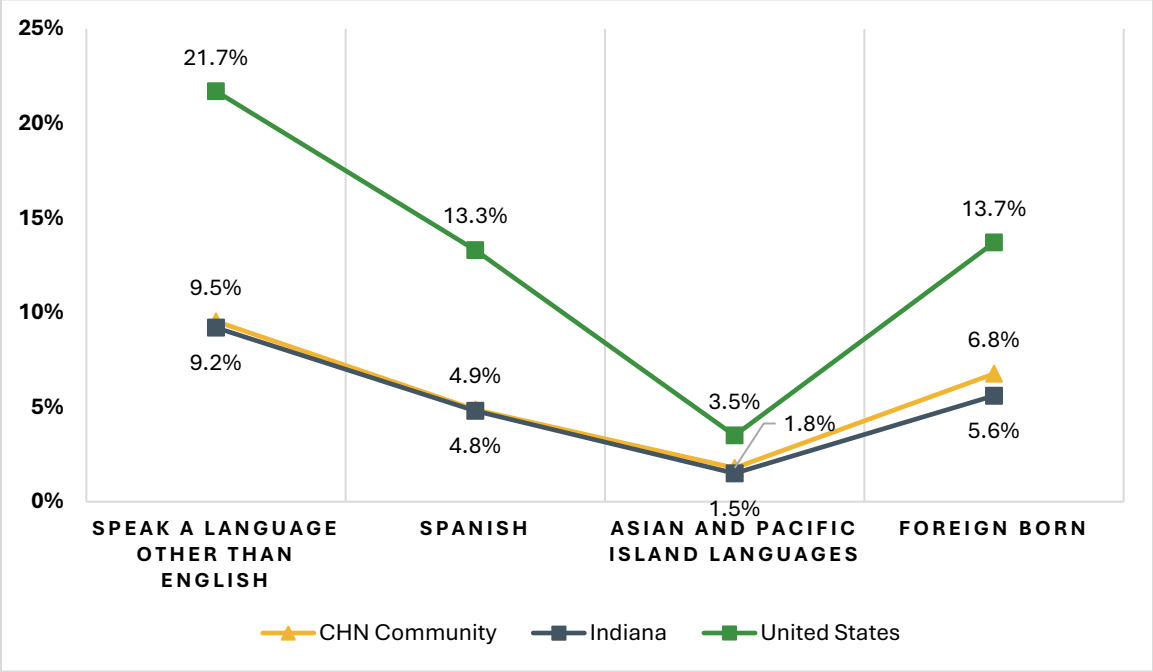
FIGURE 7. POPULATION BY RACE AND ETHNICITY COMPARISON, 2022



Language & Immigration

In the CHN community, 90.5 percent of residents speak only English at home, a figure in line with the Indiana rate (90.8 percent) but above the United States (78.3 percent). Additionally, 9.5 percent speak a language other than English, with 4.9 percent speaking Spanish, both consistent with statewide figures but below national figures. While these percentages may indicate a relatively low demand for multilingual services, healthcare providers and social services will encounter patients who require language support, particularly for Spanish speakers.

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. A slightly higher proportion of CHN community residents are foreign born compared to Indiana, but the proportion is below the United States average.

Primary Data Collection & Analysis

In conducting the CHNA for Community Hospital North, a multi-faceted approach was employed to gather primary data from a diverse range of stakeholders. This approach 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 the CHN community.

Key Informant Interviews & Community Meetings

To gather timely data on pressing health issues and gain perspective 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 CHN community counties. These sessions provided qualitative insights that are critical for understanding the context behind the quantitative data and for identifying nuanced issues that may not be fully captured in quantitative data and survey responses.

Key Informant Interviews

Various key informant interviews were conducted with stakeholders from CHN community counties and individuals with statewide perspectives applicable to the county between May and August 2024. Participants were selected based on their expertise in public health, healthcare delivery, social services, community advocacy, and other pertinent 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 (SDOH), 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.

- CICOA Aging & In-Home Solutions (1 participant)
- Eastern Star Church (1 participant)
- Fishers Health Department (2 participants)
- Gleaners Food Bank of Indiana (1 participant)
- Hamilton County Health Department (4 participants)
- Indiana Department of Health (1 participant)
- Indiana Minority Health Coalition (2 participants)
- Jane Pauley Community Health Center (3 participants)
- Marion County Health Department (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.

Two community meetings were held in Marion County and two were held in Hamilton County in May 2024 and attended by 79 stakeholders. One of these meetings in each county was conducted via an in-person session and the other was conducted virtually. A list of the organizations that participated in the community meetings can be found in Appendix I. In addition to the two community meetings, meetings were also held with social workers and community health workers employed by local hospitals, including those from Community Health Network, Ascension St. Vincent Indiana, and Indiana University Health. These meetings aimed to gain additional perspectives from providers who work closely with patient populations, particularly those vulnerable to poor health outcomes and unfavorable SDOHs.

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

Access to Healthcare Services

"Access to care still an issue especially for children in crisis – as well as navigating the system… Folks do not know how to use their insurance."

"Many people in the community do not have a primary care physician, especially as older physicians continue to retire."

Provider Shortages: A significant theme across interviews and meetings was the shortage of healthcare providers, particularly in mental health and primary care. Respondents highlighted the difficulty in securing timely appointments, with many residents facing delays of several weeks to months for health services. This shortage is especially acute in rural areas, where residents often lack access to nearby providers and may need to travel long distances to receive care. Turnover among healthcare providers is common.

Barriers to Care: Multiple barriers to accessing healthcare were identified, including transportation challenges, financial constraints, lack of insurance, and lack of cultural competency in care. Transportation remains a critical issue, particularly in suburban and rural areas where public transit options are minimal. Many residents, including those with chronic conditions and the elderly, struggle to reach healthcare facilities, leading to missed appointments and delayed care. The lack of transportation also perpetuates health inequities, as those without access to private vehicles are disproportionately affected.

Substance Misuse and Mental Health

Opioid Epidemic and Substance Use Disorders: Substance misuse remains a pervasive concern, with overdose rates continuing to impact communities significantly. Despite efforts to expand treatment options, including Medication-Assisted Treatment (MAT) programs, access to care remains constrained. Key informants noted that treatment facilities often lack capacity, and few residential treatment options accept Medicaid, leaving low-income individuals without necessary support.

Mental Health Crisis: Mental health issues, particularly among youth, have worsened, with high rates of anxiety, depression, and suicides reported. The shortage of mental health providers is a major barrier, leading to long wait times for services. Stigma around seeking

"Mental health continues to be a top concern among residents especially for younger folks – primarily anxiety and depression."

"Transportation is a major issue as there is very little public transportation which limits access to jobs, healthcare, and schools."

mental health care, especially among minority populations, remains a challenge. Efforts to address these concerns include increasing community awareness and building out support networks, but the demand still exceeds the available resources.

Social Drivers of Health (SDOH)

Transportation Barriers: Transportation challenges were frequently highlighted as a significant social determinant of health. Limited public transportation options, especially in suburban and rural areas, make it difficult for residents to access essential services, including healthcare, grocery stores, and employment opportunities. This lack of mobility exacerbates health disparities, particularly for those without access to private transportation. Isolation is an increasing concern among those with limited transportation options.

Housing Instability: Housing affordability is a critical issue, with many residents unable to find safe, affordable places to live. As housing costs have increased, driven in part by local industrial growth, the availability of affordable housing has decreased, pushing many low-income families into substandard living conditions or out of the county altogether. Efforts to build affordable housing units are ongoing, but the demand far exceeds the current supply.

Violence: Violence was identified by many stakeholders as a concern, particularly impacting school-aged youth. While community violence was noted particularly in Marion County, domestic violence was identified as a issue throughout community counties that is often overlooked. Interviewees noted that trauma resulting from community and domestic violence was impactful on mental health. Many in the community feel unsafe walking through neighborhoods, impacting access to resources and physical activity.

"The aging population has grown by 235% - we are struggling with planning for the future and need the infrastructure."

"The impact of COVID-19 on mental health, particularly in children and young adults, is profound – we expect these effects to persist for years."

Vulnerable Populations

Elderly Population: The elderly in CHN community counties face significant health challenges, including limited access to healthcare services and transportation barriers. Many elderly residents are unable to drive and lack reliable alternatives, resulting in delayed care and unmet needs. There is a growing demand for home-based care and supportive services to allow seniors to age in place safely.

Children and Youth: The COVID-19 pandemic has exacerbated mental health issues among children and youth, leading to increased anxiety, social isolation, and behavioral challenges. Schools have become a critical point of intervention, but there is a pressing need for expanded mental health services and support programs to address the social and emotional wellbeing of students.

Minority and Immigrant Populations: Minority populations, including immigrants and refugees, face unique barriers to care, such as language and cultural differences. Many of these individuals struggle with navigating the healthcare system, and access to culturally competent care remains limited. The expected influx of immigrants due to industrial growth underscores the need for tailored services to meet the needs of these communities.

COVID-19 Impact and Recovery

Long-Term Effects on Mental Health: The pandemic's impact on mental health has been profound, with long-term effects still being felt across all age groups. The disruption of social and community support structures has particularly affected children and older adults. Recovery efforts must prioritize mental health services and rebuilding community ties to address the lingering impacts.

Health System Strain and Provider Burnout: Healthcare providers have faced significant strain during the pandemic, leading to high rates of burnout and turnover. Many have reported feeling overwhelmed by the demand for care, particularly in emergency and mental health services. Addressing this issue will require systemic changes, including better support for healthcare workers and enhanced resource allocation.

Community Collaboration and Solutions

Increased Collaboration: The importance of collaboration among healthcare providers, community organizations, and local government was emphasized by stakeholders. A coordinated approach, such as the formation of multi-sectoral coalitions, is seen as key to addressing health challenges and improving communication across sectors. Navigating resources is also challenging for both residents and providers due to frequent changes in service offerings and lack of communication leading to overlap and gaps.

Innovative Solutions: Community members suggested innovative strategies, such as the development of centralized community hubs that offer integrated services, from healthcare to social support.

"It takes a whole community to make this happen."

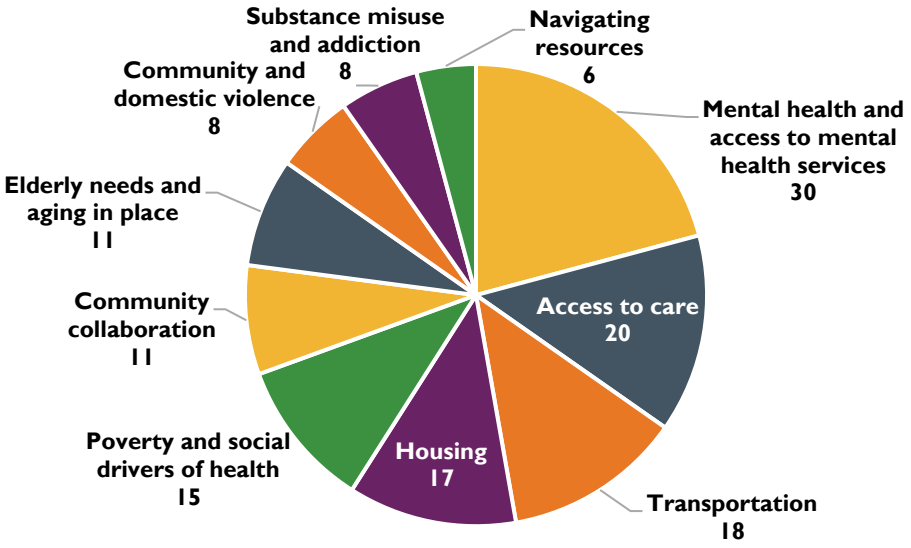
"We need more education and job training incentivizing people to stay and work here."

"The information is out there if you know how to search for it or take the time to search for it."

Community Meeting Prioritization Activity

As a concluding activity of the CHN community counties 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. CHN COMMUNITY COUNTIES MEETING PRIORITIZATION RESPONSES



Analysis & Integration of Findings

The qualitative data from key informant interviews and community meetings was 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 CHN community counties.

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

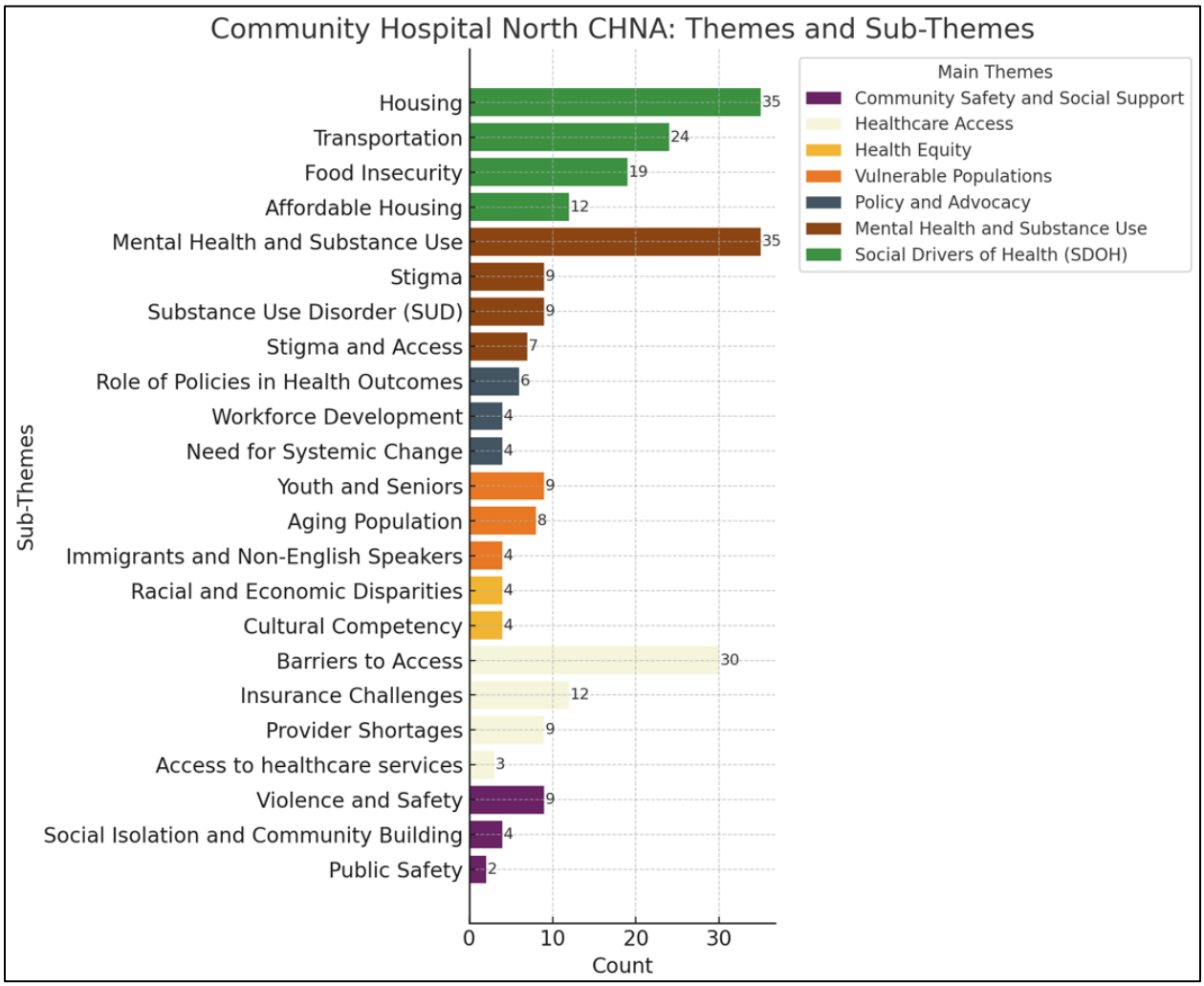
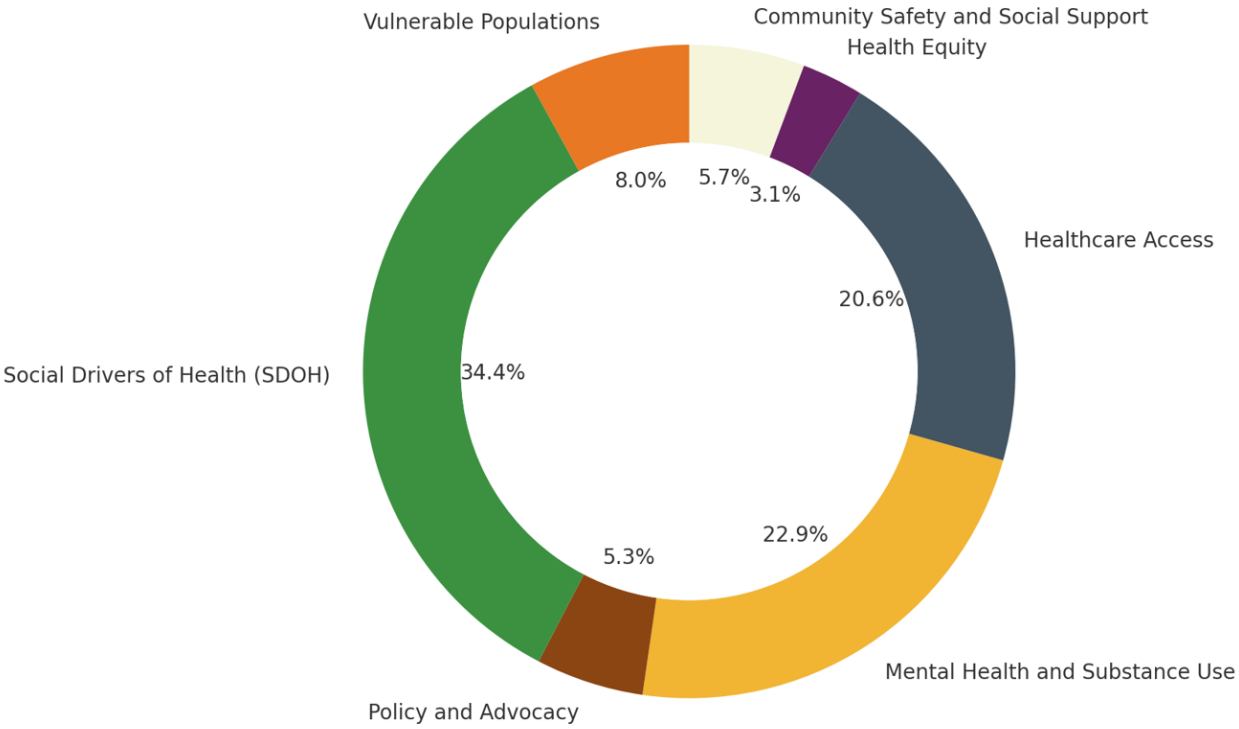


FIGURE 11. DISTRIBUTION OF KEY THEMES FROM QUALITATIVE DATA



KEY FINDINGS

- Social Drivers of Health are a top concern, representing 34.4 percent of the overall focus
- Mental health and substance use is a significant issue, comprising 22.9 percent of the overall themes
- Healthcare access issues remain critical, representing 20.6 percent of the focus

Community & Caregiver Surveys

Community Hospital North, 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 community counties, 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 covered 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 87 community member responses and 76 caregiver responses were collected from community counties and Community Hospital North. As the survey was not weighted or randomized, the sample should be treated as a convenience sample only.

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 identifying 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 most commonly by both cohorts of respondents:

Mental Health & Suicide

Access to Healthcare Services

Substance Misuse (Including Drugs & Alcohol)

Obesity & Unhealthy Lifestyles

Community Violence and Homicide

"People need access to mental health care that doesn't require an inpatient stay to obtain. They need access to mental health care that is accessible both with insurance and without insurance. They need care that specializes in geriatric needs and specialties. They need safe and sustainable housing. They need someone to walk alongside them through all their healthcare needs."

The survey examined which healthcare services were most difficult to access in the community and the primary barriers to accessing these services. Both sets of respondents indicated that mental health services (including child mental health services) and substance misuse treatment were the most challenging to access. Additionally, preventive health services and in-home health services were highlighted as difficult to access. The primary barriers identified included the cost of care and financial barriers, lack of providers, lack of access to health insurance or other issues, and difficulties navigating the healthcare continuum.

The survey also asked about the most impactful social and community factors on health in the community. Both community member respondents and caregiver respondents identified similar concerns. The most frequently selected factors included housing affordability and quality; food access, affordability, and quality; health literacy and understanding; poverty; community safety; and transportation access and affordability. These factors highlight the underlying social determinants that significantly impact community health and wellbeing.

To better understand vulnerable populations in the community, the survey also asked which populations were underserved or at risk for poor social and health outcomes. Both cohorts identified the aging and elderly population as vulnerable more often than any other group. Other groups identified included Black or African American individuals, populations with disabilities, immigrants, children and adolescents, and LGBTQIA+ populations.

"It is important to acknowledge and recognize that Indianapolis is becoming a melting pot for various cultures and people. I believe that Community Health Network should have in-person translators."

Secondary Data Collection & Analysis

This section explores the economic, environmental, and social drivers of health impacting the community served by CHN, 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 CHN community ZIP codes and counties. 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

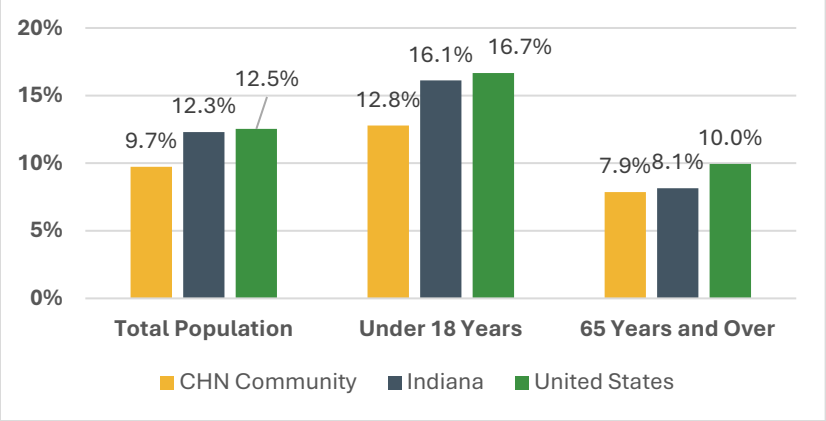
The following section outlines socioeconomic factors and social drivers of health (SDOHs). SDOHs are the conditions in which people are born, grow, work, live, and age, shaped by various forces such as economic policies and systems, social norms, and political climates. These conditions play a crucial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

Poverty Status

KEY FINDINGS

- Poverty rates in CHN community ZIP codes are below Indiana and U.S. averages for all cohorts

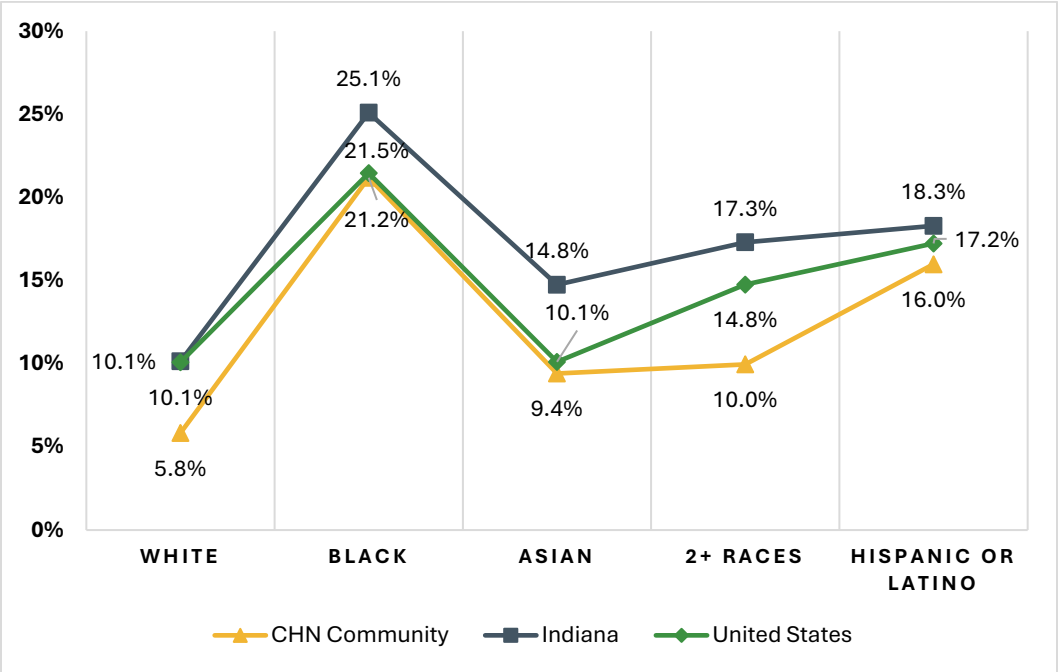
FIGURE 12. POVERTY BY AGE CATEGORY, 2022



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

In CHN community ZIP codes, 9.7 percent of residents live in poverty, a figure below Indiana (12.3 percent) and United States (12.5 percent) proportions. This figure is also below the Marion County total (15.4 percent), but above Hamilton County (4.2 percent) and Hancock County (4.9 percent).

FIGURE 13. POVERTY BY RACE/ETHNICITY, 2022



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

HEALTH EQUITY FOCUS

- Poverty rates for Black and Hispanic/Latino populations in the CHN community more than triple the poverty rate of White populations
- Poverty rates for CHN community residents are below 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, community counties are 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	Marion County	Hamilton County	Hancock County	Indiana
High School Completion Percentage	87.3%	97.2%	93.3%	90.0%
	73	1	8	-
Percent Some College	63.2%	87.2%	75.1%	63.1%
	24	1	5	-
Unemployment Percentage	3.2%	2.1%	2.6%	3.0%
	64	2	30	-
Income Ratio	4.6	3.9	3.5	4.3
	83	32	8	-
Percent of Children in Single-Parent Households	34.0%	13.0%	14.4%	24.1%
	91	9	16	-
Social Association Rate	11.4	9.8	8.2	11.8
	50	69	82	-
Injury Death Rate	121.6	45.7	70.1	90.2
	86	1	19	-

Source: County Health Rankings, 2024.

KEY FINDINGS

- Marion County ranked in bottom quartile in high school graduation, income ratio, single-parent households, and injury death rate
- All counties have a low social association rate

As highlighted in Figure 15, community counties compare unfavorably to Indiana averages for several environmental factors.

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

KEY FINDINGS

- All three counties ranked in bottom quartile for air pollution
- Marion County is 91st of 92 in severe housing problems and housing cost burden

Measure	Marion County	Hamilton County	Hancock County	Indiana
Air Pollution - Average Daily PM2.5	12.6	10.2	9.7	8.8
	92	88	84	-
Severe Housing Problems Percentage	16.5%	8.4%	7.6%	12.2%
	91	19	9	-
Severe Housing Cost Burden Percentage	14.6%	7.2%	6.6%	10.2%
	91	27	18	-
Percent Drive Alone to Work	75.9%	74.1%	78.4%	78.7%
	12	5	23	-
Percent with a Long Commute Driving Alone	30.9%	43.4%	42.6%	32.2%
	34	72	69	-

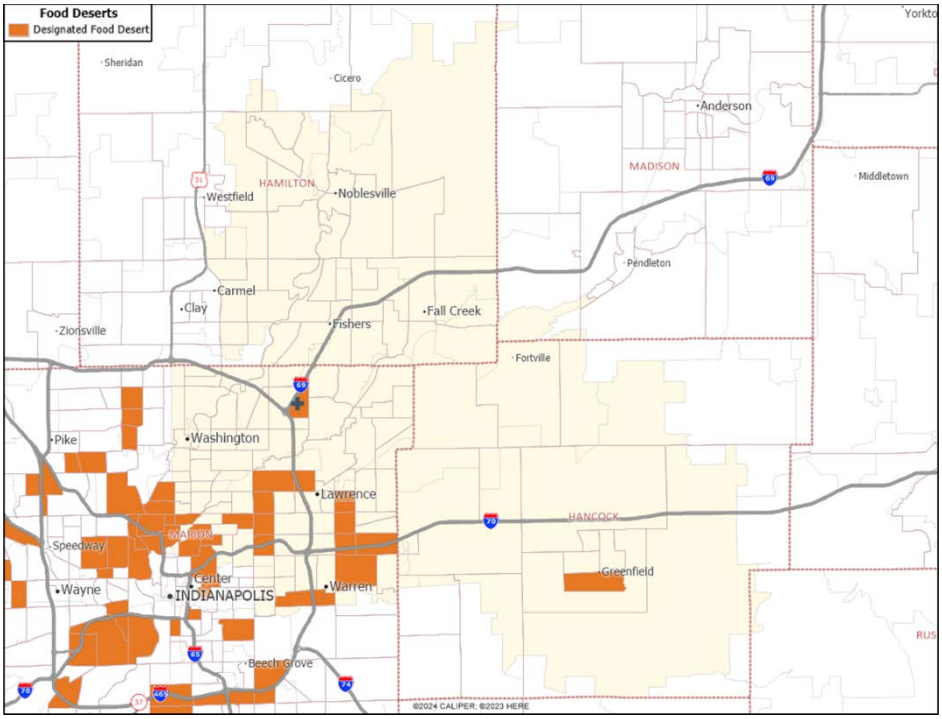
Source: County Health Rankings, 2024.

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, food deserts are mapped in Figure 16.

KEY FINDINGS

- Food deserts are located throughout, with concentrations Lawrence, Warren, Greenfield, and the area surrounding the hospital

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 Marion County residents are food insecure compared to statewide averages, and a higher percent of household income is required for childcare expenses. Additionally, the homicide rate in Marion County nearly triples the Indiana-wide figure.

FIGURE 17. ADDITIONAL SOCIAL DRIVER OF HEALTH MEASURES, 2024

Measure	Marion County	Hamilton County	Hancock County	Indiana
Food Insecurity Percentage	11.3%	6.0%	7.3%	10.7%
Percent Income Required for Child Care Expenses	32.7%	23.8%	23.7%	25.1%
Homicide Rate	19.6	1.4	2.2	7.4

Source: County Health Rankings, 2024.

Health Status

This section highlights the various behaviors and resulting health outcomes of the CHN 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	Marion County	Hamilton County	Hancock County	Indiana
Percent Adults Reporting Currently Smoking	19.6%	10.2%	15.7%	18.0%
	37	1	5	-
Percent Adults Obese	37.2%	28.5%	32.7%	36.7%
	28	1	3	-
Food Environment Index	7.2	9.0	8.4	6.8
	77	3	21	-
Percent Physically Inactive	27.5%	16.5%	21.5%	25.1%
	56	1	3	-
Percent with Access to Exercise Opportunities	91.3%	92.2%	69.3%	76.5%
	3	2	34	-
Excessive Drinking Percent	17.1%	17.4%	16.9%	18.2%
	67	72	59	-
Percent of Driving Deaths with Alcohol Involvement	23.2%	20.9%	24.5%	18.3%
	78	71	80	-
Chlamydia Rate	1,102.7	208.0	240.9	510.7
	92	21	33	-
Teen Birth Rate	27.8	4.1	9.5	20.2
	74	1	5	-

Source: County Health Rankings, 2024.

KEY FINDINGS

- All counties ranked in bottom quartile for alcohol-involved driving deaths
- Marion County ranked last in chlamydia rate and bottom quartile in teen births
- Higher proportion of Marion County residents are physically inactive, and access to exercise opportunities is lower in Hancock County

HEALTH EQUITY FOCUS

- Teen birth rates among Hispanic/Latino and Black teens are significantly above average in both Marion and Hamilton counties

Population	Teen Birth Rate	
	Marion County	Hamilton County
Black	34.6	11.8
Hispanic (or Latino)	44.3	10.2
White	17.7	3.4
Total	27.8	4.1

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

- Marion county bottom quartile for:
  - Years of potential life lost (premature death)
  - Fair or poor health
  - Low birthweight births

FIGURE 19. HEALTH OUTCOMES, 2024

Measure	Marion County	Hamilton County	Hancock County	Indiana
Years of Potential Life Lost	11,769	4,661	6,739	9,317
Rate	82	1	9	-
Percent Fair or Poor	19.2%	9.7%	13.2%	16.1%
Health	80	1	5	-
Average Number of	3.9	2.5	3.4	3.5
Physically Unhealthy Days	42	1	7	-
Average Number of	5.4	4.2	4.4	5.2
Mentally Unhealthy Days	57	1	3	-
Percent Low Birthweight	9.8%	6.6%	6.5%	8.3%
Births	91	12	8	-

Source: County Health Rankings, 2024.

Compared to Indiana averages, Marion County compares unfavorably for all measures in Figure 19, while Hamilton and Hancock counties compare favorably for all measures.

Population	Years of Potential Life Lost Rate			Low Birthweight Births		
	Marion County	Hamilton County	Hancock County	Marion County	Hamilton County	Hancock County
Black	15,986	7,254.7	-	14.0%	11.8%	12.9%
Hispanic (or Latino)	7,620	2,420.9	-	7.4%	7.2%	-
White	11,072	4,765.9	-	7.9%	5.9%	6.3%
Total	11,769	4,661.2	6,739.0	9.8%	6.6%	6.5%

HEALTH EQUITY FOCUS

- Black populations compare unfavorably for years of potential life lost and low birthweight births for each county with available data

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

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

Measure	Marion County	Hamilton County	Hancock County	Indiana
All causes of death	976.6	652.5	818.6	911.3
Heart Disease	184.1	122.4	148.4	184.2
Cancer	171.3	123.7	154.1	165.0
Accidents and Adverse Effects	91.2	32.3	56.4	65.2
Chronic Lower Respiratory Disease	55.3	32.4	57.0	54.6
Cerebrovascular Disease	41.0	33.6	40.8	41.5
Alzheimer's Disease	28.4	27.8	25.1	31.5
Diabetes	30.6	14.9	21.1	28.4
Kidney Disease	20.3	13.1	20.9	17.8
Suicide	14.9	11.4	13.8	15.5
Chronic Liver Disease	15.0	8.2	10.8	13.9
Septicemia	12.8	7.1	12.1	12.8
Pneumonia	8.3	5.1	6.9	9.8
Homicide and Legal Intervention	22.1	1.9	-	8.7
Influenza	1.8	1.4	-	1.9

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

KEY FINDINGS

- Marion County has particularly unfavorable rates of:
  - Homicide and legal intervention
  - Accidents
  - Kidney disease
  - Chronic liver disease
  - Diabetes
- Hancock County has elevated rate of kidney disease mortality

Figure 21 provides additional mortality and morbidity rates for community counties compared to Indiana averages.

FIGURE 21. ADDITIONAL MORBIDITY AND MORTALITY MEASURES, 2024

Measure	Marion County	Hamilton County	Hancock County	Indiana
Child Mortality Rate	81.6	36.4	33.6	61.9
Infant Mortality Rate	7.8	5.1	4.0	7.0
% Adults with Diabetes	12.0%	8.1%	8.7%	10.8%
HIV Prevalence Rate	625.1	95.4	93.4	217.0
Drug Overdose Mortality Rate	58.8	12.7	25.1	33.7
Suicide Rate	14.7	11.5	13.6	15.6
Firearm Fatalities Rate	27.2	8.1	12.0	15.9
Motor Vehicle Mortality Rate	13.8	5.2	12.7	13.0

Source: County Health Rankings, 2024.

KEY FINDINGS

- Marion County HIV prevalence rate is nearly triple state average
- Marion County also has higher rates of child & infant mortality, diabetes, drug overdose mortality, firearm fatalities, and motor vehicle deaths

Population	Life Expectancy	Child Mortality Rate	Infant Mortality Rate	Drug Overdose Rate	Suicide Rate	Homicide Rate
Black	70.5	131.4	11.5	57.1	8.9	51.0
Hispanic (or Latino)	80.1	62.9	6.4	17.1	5.4	11.7
White	74.4	61.3	5.7	75.0	19.9	6.9
Marion County Total	73.8	81.6	7.8	58.8	14.7	19.6

HEALTH EQUITY FOCUS – MARION COUNTY STATISTICS

- Morality rates for Black infants and children are more than double rates for White infants and children
- Black populations experience lower life expectancy compared to White populations by nearly four years and have higher rates of homicide deaths
- White populations have higher drug overdose and suicide mortality rates

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	Marion County	Hamilton County	Hancock County	Indiana
Percent Uninsured	10.0%	5.1%	6.6%	8.9%
	73	1	8	-
Primary Care Physicians Rate	78.0	138.8	83.1	65.6
	10	3	6	-
Dentist Rate	94.1	74.3	33.7	59.5
	1	6	58	-
Mental Health Provider Rate	364.7	184.7	113.2	199.8
	2	18	37	-
Preventable Hospitalization Rate	3,372	2,105	2,495	3,135
	63	13	27	-
Percent with Annual Mammogram	44.0%	53.0%	52.0%	45.0%
	41	3	4	-
Flu Vaccination Percentage	51.0%	60.0%	57.0%	50.0%
	21	1	6	-

Source: County Health Rankings, 2024.

As displayed in Figure 21, Marion County compares unfavorably to state averages for uninsured adults, preventable hospitalizations, and annual mammograms. Hancock County compares unfavorably for

dentists per capita, and both Hamilton and Hancock counties for mental health providers per capita. Additionally, Black populations experience higher preventable hospitalization rates in all three counties, while Black and Hispanic/Latino populations experience lower mammogram percentages in both Marion and Hamilton counties.

Population	Preventable Hospitalization Rate			Annual Mammogram Percent		
	Marion County	Hamilton County	Hancock County	Marion County	Hamilton County	Hancock County
Black	4,754	2,221	4,638	39.0%	43.0%	57.0%
Hispanic (or Latino)	2,388	-	-	28.0%	24.0%	-
White	3,017	2,097	2,474	46.0%	53.0%	52.0%
Total	3,372	2,105	2,495	44.0%	53.0%	52.0%

Health Professional Shortage Areas & Medically Underserved Areas

Parts of CHN community counties are designated as Health Professional Shortage Areas (HPSA) by the Health Resources and Services Administration (HRSA). Marion, Hamilton, and Hancock counties are each designated as mental health provider shortage areas for low-income populations. The low-income population of Indianapolis Center Township is designated as a primary care shortage area. Census tracts throughout Marion County have also been designated as Medically Underserved Areas 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

Seven hospitals operate within CHN community ZIP codes and are available to serve populations.

- Community Hospital North, the subject of this report, is located at 7150 Clearvista Drive in Indianapolis, IN 46256.
- Community Fairbanks Recovery Center is located at 8102 Clearvista Parkway in Indianapolis, IN 46256.
- Community Health Network Rehabilitation Hospital is located at 7343 Clearvista Drive in Indianapolis, IN 46256.
- Kindred Hospital Indianapolis North is located at 8060 Knue Road in Indianapolis, IN 46250.
- Midland House Inc. is located at 3940 E 56th Street in Indianapolis, IN 46220.
- Neurodiagnostic Institute is located at 5435 E 16th Street in Indianapolis, IN 46218.
- Options Behavioral Health System is located at 5602 Caito Drive in Indianapolis, IN 46226.

Health Centers

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

- Aspire Indiana Health operates multiple locations within the community:
    - Aspire Indiana Health - Noblesville at 17840 Cumberland Rd, Noblesville, IN 46060
    - Aspire Indiana Health - Willowbrook at 2506 Willowbrook Pkwy, Indianapolis, IN 46205
- IHC Hamilton County WIC at 942 N 10th St, Noblesville, IN 46060
- Jane Pauley Community Health Center (CHC) operates multiple locations within the community:
    - Jane Pauley CHC at Greenfield at 1107 N State St, Greenfield, IN 46140
    - Jane Pauley CHC at 16th Street at 5317 E 16TH St, Indianapolis, IN 46218
    - Jane Pauley CHC at Arlington at 1315 N Arlington Ave, Indianapolis, IN 46219
    - Jane Pauley CHC at Washington Street at 7910 E Washington St, Ste 300, Indianapolis, IN 46219
    - Jane Pauley CHC at Shadeland at 2040 N Shadeland Ave, Ste 300, Indianapolis, IN 46219
    - Jane Pauley CHC at Post at 8931 E 30th St, Indianapolis, IN 46219
    - Jane Pauley CHC at Castleton at 7481 N Shadeland Ave Ste A, Indianapolis, IN 46250
- Adult and Child Mental Health Center Inc. operates multiple locations within the community:
    - Adult and Child at Center for Inquiry School 70 at 510 E 46th St, Indianapolis, IN 46205
    - Adult and Child at KIPP Indy at 1740 E 30th St, Indianapolis, IN 46218
    - Adult and Child at Center for Inquiry School 84 at 440 E 57th St, Indianapolis, IN 46220
    - Adult and Child at Circle City Prep at 4002 N Franklin Rd, Indianapolis, IN 46226
- Health Net, Inc. operates multiple locations within the community:
    - Northeast Health Center at 3908 Meadows Dr, Indianapolis, IN 46205
    - Avondale Meadows Academy School-Based Health Center at 3980 Meadows Dr, Indianapolis, IN 46205
    - Interfaith Hospitality Network at 1850 N Arsenal Ave, Indianapolis, IN 46218
    - KIPP Indy Legacy Clinic at 2255 Ralston Ave Rm 106, Indianapolis, IN 46218
    - Martindale Brightwood Health Center at 2855 N Keystone Ave Ste 100, Indianapolis, IN 46218
    - KIPP School Based Health Center at 1740 E 30th St, Indianapolis, IN 46218
    - HealthNet Mobile Health Center at 6425 Olivia Ln Unit 409, Indianapolis, IN 46226
- Meridian Health Services Corporation at 4755 Kingsway Dr Ste 105A, Indianapolis, IN 46205
- Raphael Health Center at 401 E 34th St, Indianapolis, IN 46205
- Shalom Health Care Center operates multiple locations within the community:
    - IPS School 88 - Anna Brochhausen at 5801 E 16th St Rm 413, Indianapolis, IN 46218
    - James Russel Lowell IPS School 51 at 3426 Roosevelt Ave, Indianapolis, IN 46218
    - Sankofa at Arlington Woods #99 at 5801 E 30th St Rm 104, Indianapolis, IN 46218
    - Charles W. Fairbanks IPS School 105 at 8620 Montery Rd, Indianapolis, IN 46226
    - Indiana Math and Science Academy North at 7435 N Keystone Ave, Indianapolis, IN 46240
- Eskenazi Health Center operates multiple locations within the community:

- Eskenazi Health Center Grande at 6002 E 38th St, Indianapolis, IN 46226
- Eskenazi Health Center Grassy Creek at 9443 E 38th St, Indianapolis, IN 46235

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. The organizations listed below represent attendance only as other stakeholders were invited to participate but were unable to attend.

- Ascension St. Vincent Indiana
- Breathe Easy Hamilton County
- Boys and Girls Club of Noblesville
- CarePatrol
- Cherish Center
- Children's TherAplay Foundation
- CHIP (Coalition for Homelessness Intervention and Prevention)
- CICOA
- City of Fishers EMS
- City of Indianapolis – Department of Metropolitan Development
- City of Westfield
- Coburn Place
- Community Health Network
- Consulate of Mexico in Indianapolis
- Covering Kids & Families of Indiana
- Damien Center
- Dove Recovery House for Women
- Early Learning Indiana
- Exodus Refugee Immigration
- Family Promise of Hamilton County
- Genesys Solutions
- Hamilton County Community Foundation
- Hamilton County Council on Alcohol and Other Drugs
- Hamilton County Health Department
- Hamilton County Parks and Recreation
- Hamilton County Sheriff's Office
- Hamilton County Veterans Corporation
- Hamilton Heights High School
- HAND, Inc. (Hamilton County Area Neighborhood Development)
- Health by Design
- Healthier Hamilton County Systems of Care

- Heart and Soul Clinic
- Hoosier Environmental Council
- HOPE Family Care Center
- Horizon House
- Ignite Transform
- Immigrant Welcome Center
- Indiana Parkinson Foundation
- Indiana Public Health Association
- Indiana University Health
- Indiana University Center for Global Health Equity
- Indianapolis Public Library
- Indy Public Safety Foundation Inc.
- IndyGo Foundation
- Intend Indiana
- Jane Pauley Community Health Center
- Janus Developmental Services
- La Plaza
- Latino Health Organization
- Madam Walker Legacy Center
- Marion County Public Health Department
- Medical-Legal Partnerships of Indiana Legal Services
- Mount Zion Baptist Church of Indianapolis
- Mudsock Youth Athletics
- Near North Development Corporation
- Noblesville Chamber of Commerce
- Noblesville Fire Department
- Pathway to Recovery, Inc.
- PrimeLife Enrichment Senior Center
- Purdue Extension
- Raphael Health Center, Inc.
- Rehabilitation Hospital of Indiana
- Riverview Health
- Shepherd's Center of Hamilton County
- Student Impact of Westfield
- Suburban North Club
- The O'Connor House
- Trinity Free Clinic
- White River Christian Church
- YMCA of Greater Indianapolis
- Youth Mentoring Initiative

Appendix II: Impact Evaluation

Appendix II describes the actions and initiatives undertaken by Community Hospital North 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 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	$148.5 million worth of prescription medications was provided to patients through CHNw's Medication Assistance Program

	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.	
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
BRAG Farmers Market	CHNw provides financial support to the BRAG Farmer's Market. Some of the other programs, also supported by CHNw at the farmer's market, included: • **Supplemental Nutrition Assistance Program (SNAP)**: Helped get more farm-direct produce into the hands of our low-income neighbors. Formerly known as the Food Stamp Program, SNAP benefits are distributed through the Hoosier Works Card, which is used like a debit card. This helps our community members leverage food resources. • **Fresh Bucks**: Doubling food stamp program for fresh fruits, vegetables and herbs (including edible starter plants). • **WIC**: Women, Infants and Children healthy food program • **Donations to the Community Cupboard of Lawrence**	80 local vendors Over 800 visitors each week
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 Community Health (REACH) Grant from the Centers for Disease Control (CDC). REACH is a national program	Implemented strategies in cafeteria at CHE and CHVH to encourage healthy

	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.	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
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 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.	Over 100,000 patient visits annually. 10 sites of care.
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	1,237 youth and families registered to attend the events held in 2022 and 2023. Over 550 individuals attended.

	conjunction with the Metropolitan School District of Lawrence Township has been the host of the annual Black Men in White Coats since 2022.	

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 Schools and the Metropolitan School Districts of Lawrence and Warren townships in Marion County.	Total of 4,379 clients were placed on the Have Hope Pathway, a care pathway for clients at high risk for suicide.
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.	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.

	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.	
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 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.	Hosted 2 collections days at all 5 hospital locations each year Collected 6,193 lbs of unwanted prescription drugs
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 Naloxboxs 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: 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	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"

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 about 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	3,279,663 school nurse clinic visits provided

	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.	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 were 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	267 clients served

	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 8. Increase breastfeeding rates 9. Reduce smoking during pregnancy	98% breastfeeding initiation rate
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.	30 active FCN participating in the FHI program

	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-going support and resources to ensure they can create sustainable engaged health ministries and activities in their respective faith communities.	Providing screening to 593 community members
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
Indiana Latino Expo	The Indiana Latino Expo "ILE" is a nonprofit statewide organization that represents a platform of opportunities for the Latino community. During the annual expo event, Community provides health and wellness screenings to participants.	350 BP and cholesterol screenings provided 87 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