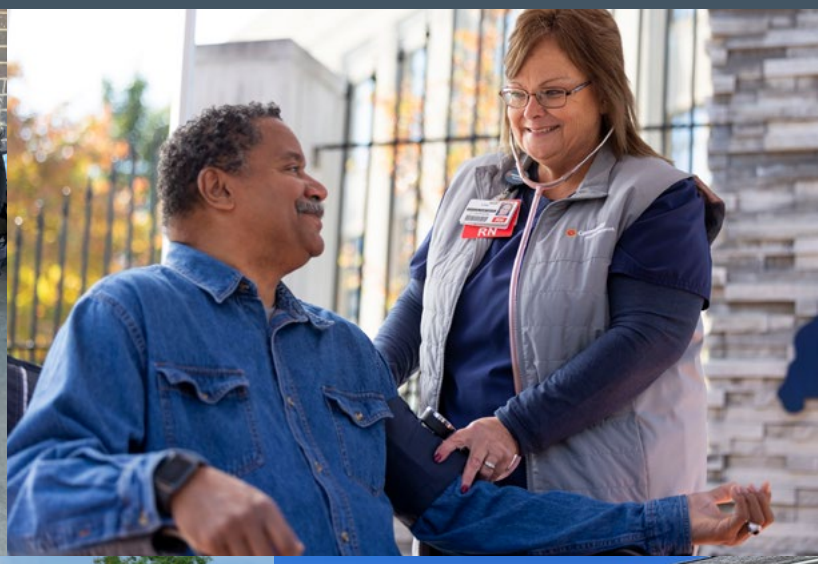
Community Health Network



2024 Community Health Needs Assessment

Howard Region

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 Howard's Hospital Leadership

In the mid-1950s, the citizens of Howard County recognized the need for more healthcare options, closer to home. They started making plans for a new hospital in Kokomo, and in 1961, they celebrated completion of what was first called Howard Community Hospital.

Like the Indiana health system that the hospital joined about five decades later, the Kokomo hospital's name significantly included the word "Community." That was no accident, because our organization was created by the community to serve the community, and we have maintained that community commitment ever since. We are, of course, committed to delivering quality healthcare services, but also to the broader mission of enhancing well-being.

The report you are reading is the latest Community Health Needs Assessment for what is now known as Community Howard Regional Health. 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 Howard County.

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

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

Derek McMichael
Vice President, Hospital Administrator
Community Howard Regional Health

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Executive Summary

Introduction

Community Howard Regional Health 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 CHRH'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 Howard Regional Health

Community Howard Regional Health (CHRH) is a full-service hospital in Kokomo, Indiana. The hospital campus offers primary and specialty inpatient and outpatient services, which include a heart program, behavioral health, oncology, orthopedics, pediatrics, emergency care, surgery, wound care, obstetrics, and gynecology. Additional information about CHRH is available at: https://www.ecommunity.com/locations/community-howard-regional-health.

Community Howard Regional Health 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 Howard Regional Health

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

Collaborating Partners

Community Howard Regional Health worked with each Community Health Network hospital – Community Hospital Anderson, Community Hospital East, Community Hospital North, and Community Hospital South – 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.

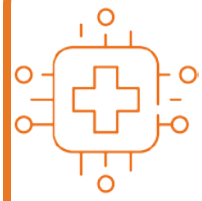
This CHNA was conducted by Dobson DaVanzo & Associates, LLC, a health economics and policy consulting firm. The work of our principals has influenced many public policy decisions and appears in numerous instances in legislation and regulation. Applying decades of experience and innovative

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.

Access to Care



Access to healthcare services is a significant issue across the CHRH community. Issues with the cost of care, lack of providers, transportation, health insurance, and wait times were identified as contributing factors. Howard County also has fewer providers than statewide averages and is designated as a medically underserved area. Indicators such as high rates of preventable hospitalizations indicate difficulties accessing preventive care.

Mental Health Status and Access to Mental Health Care

The mental health status of community members is a significant concern, and access to treatment options is limited for many residents due to limited providers and financial barriers. Anxiety and depression are widespread, and children are particularly at risk. Suicide rates in the county exceed state averages. Howard County is designated as a mental health professional shortage area, indicating lack of providers, and many residents state that travel outside the community for treatment is common.

Obesity, Healthy Lifestyles, and Associated Conditions

Obesity and its contributing factors are an issue in the community. The county has one of the highest obesity rates in the state, and residents are less physically active and have lower access to physical activity opportunities than Indiana averages. Proper nutrition was discussed as an issue by many stakeholders. Heart disease mortality rates are also excessively high.

Aging Population and Elderly Needs

The population is aging and the needs of elderly people – including chronic disease management and access to services to age in place – are an increasing need. The median age in Howard County is higher than the Indiana average, and a high proportion of residents are aged 65+. Community and caregiver survey respondents identified elderly populations as the most vulnerable in the community. Transportation options for the elderly are limited. Mortality rates for conditions common among older populations (such as Alzheimer's Disease) are also elevated.

Maternal and Child Health and Wellbeing

The health, access to care, and socioeconomic status for mothers, infants, and children is a concern in the county. Howard County ranks above state averages and in the bottom quartile among Indiana counties for low birthweight births and teen births. Rates of children in single-parent households are among the highest in the state. The proportion of income spent to afford childcare is also higher than average. Youth health status, particularly mental health concerns and access to child mental health services, were also identified by stakeholders as significant issues.

Substance Misuse

The misuse of drugs is a pervasive issue in the community, intricately tied to mental health and self-medication. Stakeholders noted the opioid and fentanyl epidemic as driving forces. Treatment options are limited and costly, with many needing to leave the community to find options. The drug overdose mortality rate is much higher than the Indiana-wide rate. Alcohol is also a concern. A third of driving deaths in Howard County involve alcohol, almost doubling Indiana rates. Mortality for liver disease is also excessively high, perhaps indicating alcoholism concerns.

Food Access and Nutrition

Access to affordable, healthy foods is critical for maintaining wellbeing. Food deserts exist throughout Howard County. The percentage of residents that are food insecure is also above the statewide rate, and the food environment index (a measure of factors that contribute to a healthy food environment such as income and food access) is in the bottom quartile of all Indiana counties. Mortality rates for several chronic conditions related to healthy eating (heart disease, diabetes) are higher than statewide averages. Rural communities face barriers due to limited stores and transportation barriers.

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. CHRH 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 Howard Regional Health (CHRH) defined its community using a detailed analysis of 2023 patient origin data. This analysis identified the primary geographic areas where patients who utilize inpatient and emergency services reside. Assessing and defining the CHRH 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, CHRH 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 CHRH community was defined as Howard County.

Community Howard Regional Health Community Definition

When examined at a ZIP code level, six ZIP codes were identified that compose almost the entirety of the county. These six ZIP codes and their accompanying patient origin statistics are presented in Figure 1. In total, the six ZIP codes accounted for 72.6 percent of the hospital's total inpatient discharges and 80.2 percent of its ER visits.

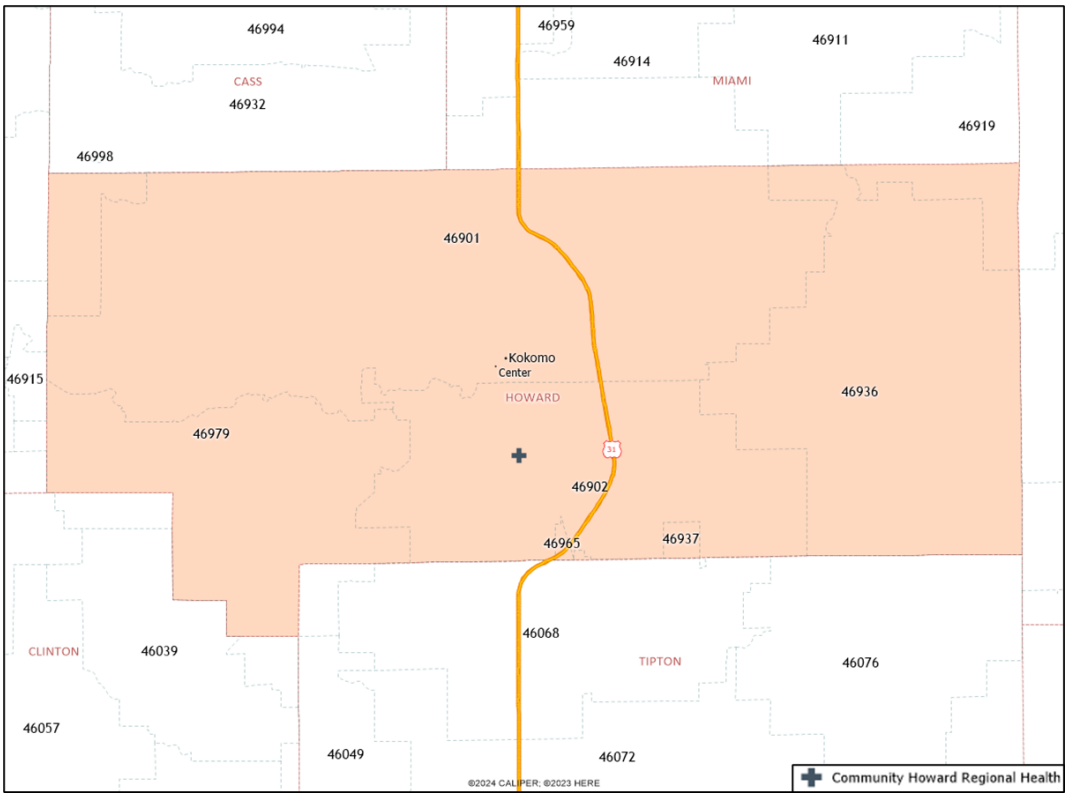
FIGURE 1. COMMUNITY PATIENT ORIGIN DATA

ZIP Code	County	State	Inpatient Discharges	ER Visits
46902	Howard	Indiana	1,578	13,616
46901	Howard	Indiana	1,251	10,310
46936	Howard	Indiana	200	1,319
46979	Howard	Indiana	100	847
46937	Howard	Indiana	12	68
46965	Howard	Indiana	2	41
Community Total			3,143	26,201
Community Percent			72.6%	80.2%
Hospital Total			4,329	32,653

ZIP codes 46902 and 46901 represent the largest patient populations for both inpatient and ER services, comprising over 60.0 percent of CHRH's service volume. These areas are key to CHRH's healthcare delivery strategy, as they serve both urban and rural communities within Howard County.

Community Howard Regional Health is located at 3500 S Lafountain Street in Kokomo, Indiana, ZIP code 46902. Figure 2 depicts CHRH's community of Howard County and the ZIP code boundaries within the county.

FIGURE 2. MAP OF COMMUNITY AND HOSPITAL LOCATION



Geographic Levels of Data

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

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

By utilizing multiple geographic levels of data, CHRH 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 Howard Regional Health Community

Understanding the demographics of CHRH's community, defined as Howard County, Indiana, is crucial for tailoring healthcare services to meet the needs of the community. Based on American Community Survey (ACS) five-year estimates, this report provides detailed insights into the population characteristics within Howard County and the six ZIP codes identified for analysis: 46902, 46901, 46936, 46979, 46937, and 46965. Comparisons to Indiana and national figures are provided as available.

Geography & Data Sources

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

Population Overview

Utilizing the ACS five-year estimates, Howard County has a population of 83,574. The six ZIP codes included in the community analysis have a population of 86,523. As ZIP code borders do not conform exactly to county borders, this slight difference in population is expected. The population breakdown by ZIP code in the CHRH community is found in Figure 3.

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

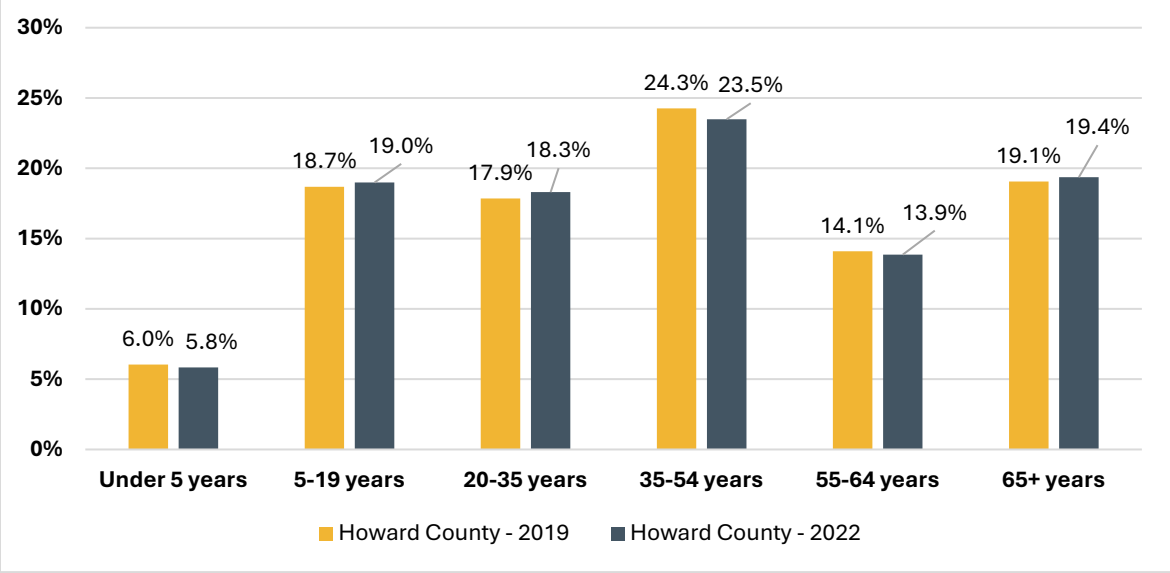
County		Population
Howard County		83,574
ZIP Code	City	Population
46902	Kokomo	36,807
46901	Kokomo	38,719
46936	Greentown	5,820
46979	Russiaville	5,159
46937	Galveston	18
46965	Windfall	-
Zip Code Total		86,523

The City of Kokomo, comprised of ZIP codes 46902 and 46901, has the vast majority of the population in the community at 87.3 percent. This concentration makes Kokomo the central healthcare hub for CHRH's services.

Age Distribution

The age distribution in Howard County highlights variations in the population by age, with notable trends toward an aging population. The median age in Howard County is 41.2 years, above the state (38.0 years) and national (38.5 years) medians. ZIP codes such as 46936 and 46979 have particularly high median ages, exceeding 43 years, highlighting an older population outside of Kokomo. Additionally, data suggests that in Howard County, the proportion of the population aged less than five years is lower than in 2019, while the population aged 65 years and above is higher. These statistics suggest a growing need for healthcare services tailored to older adults and potential aging in place measures.

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

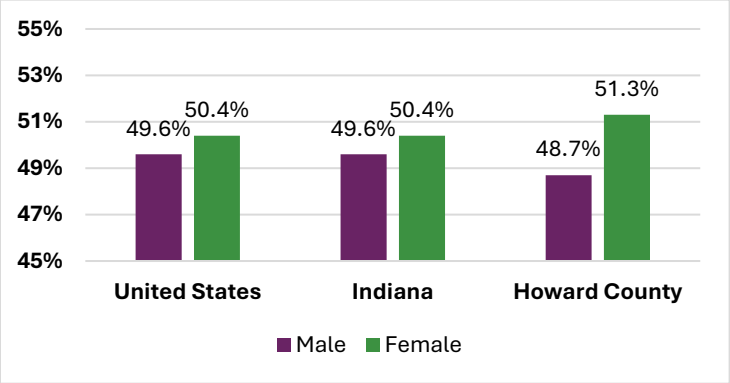


Despite the growing aging population, the working-age group (aged 20 to 64) comprises the majority of Howard County's population at 55.7 percent. This suggests an increasing need for healthcare services that cater to both an aging population and the preventive care needs of younger, working-age groups.

Population by Sex

An analysis of Howard County's population by sex, found in Figure 5, finds that the proportions of male and female populations are in line with state and national trends.

FIGURE 5. POPULATION BY SEX, 2022

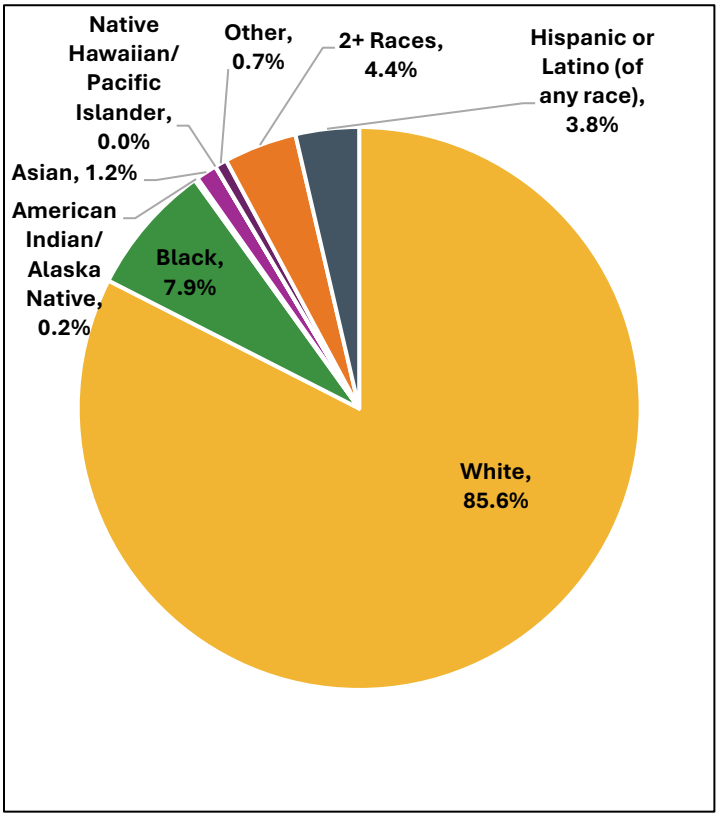


Racial & Ethnic Composition

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.

In Howard County, the racial makeup reflects a majority White population, with 85.6 percent identifying as White. Black or African American residents represent 7.9 percent of the population, the second largest racial group. Other races, such as Asian (1.2 percent), make up smaller proportions of the population (see Figure 6). This racial distribution highlights the need for targeted community outreach and health services that consider the specific needs of these populations.

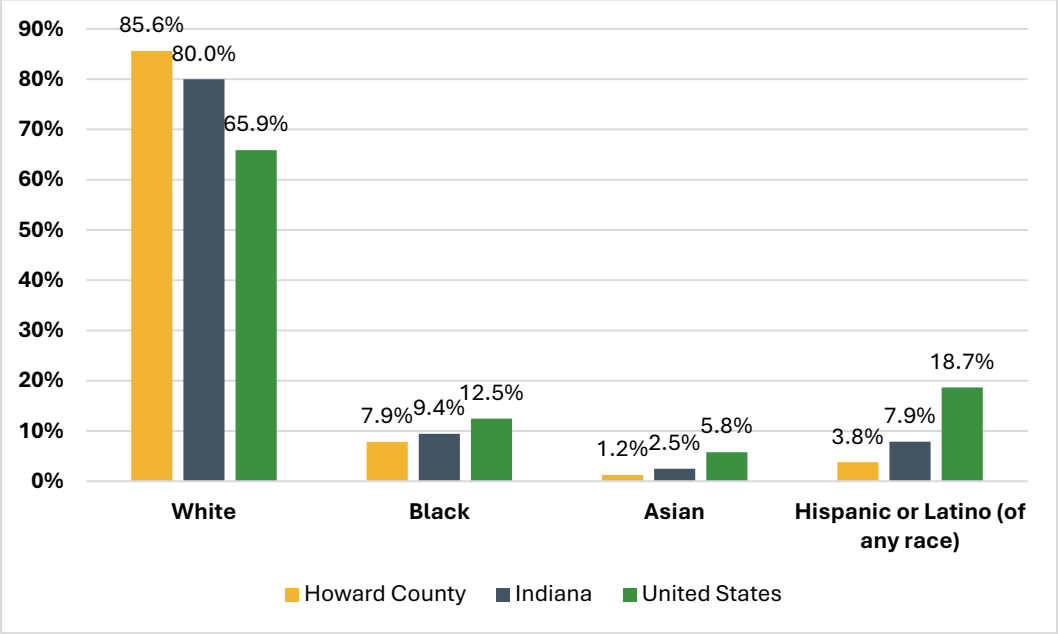
FIGURE 6. POPULATION BY RACE AND ETHNICITY, 2022



In terms of ethnicity, the Hispanic/Latino population represents 3.8 percent of the population.

When compared to state and national levels, the racial and ethnic distribution in Howard County is less diverse, particularly compared to national numbers (Figure 7). A higher proportion of the population is White, and a lower proportion is Black, Asian, or Latino/Hispanic. Additionally, a lower proportion of the population is two or more races (4.4 percent) in Howard County compared to state (5.1 percent) and national (8.8 percent) figures.

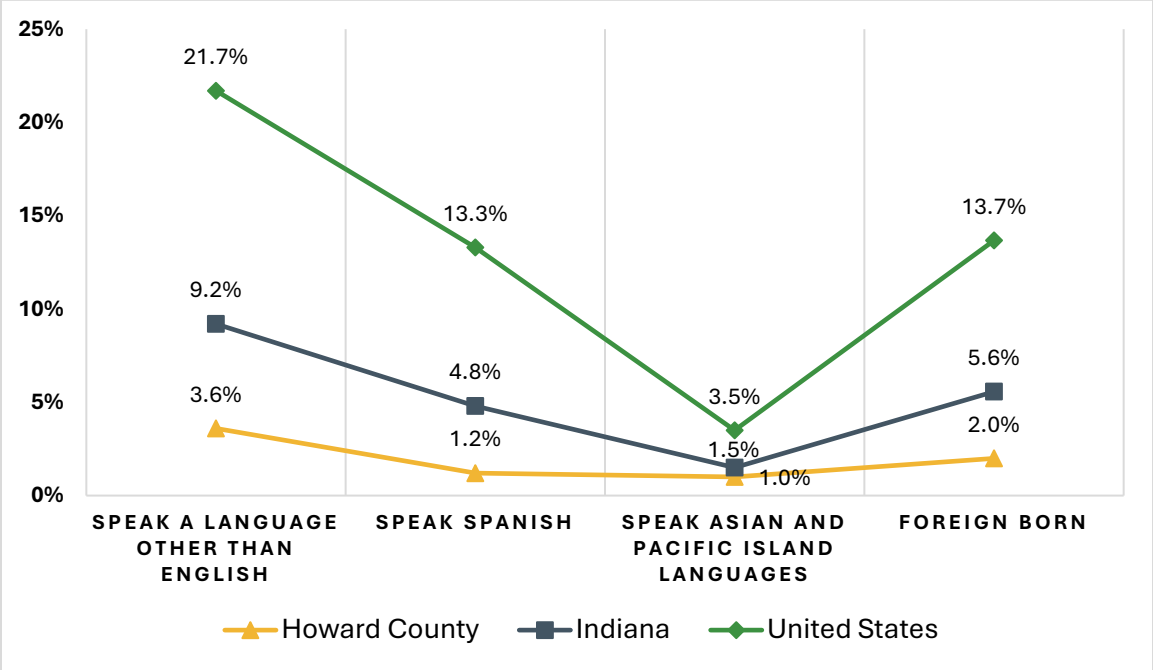
FIGURE 7. POPULATION BY RACE AND ETHNICITY COMPARISON, 2022



Language & Immigration

In Howard County, 96.4 percent of residents speak only English at home, a figure higher than both Indiana (90.8 percent) and United States (78.3 percent) averages. A small portion of the population – 3.6 percent – speaks a language other than English, with 1.2 percent speaking Spanish. While these figures may reflect a relatively low demand for multilingual services, healthcare providers and social services will encounter patients who require language support, particularly for Spanish speakers, and these populations may be overlooked due to their low visibility.

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



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

Primary Data Collection & Analysis

In conducting the Community Health Needs Assessment (CHNA) for Howard County, Indiana, a multi-faceted approach was employed to gather primary data from a wide 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 Howard County.

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 Howard County. 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 Howard County and those with statewide perspective 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, 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.

- Howard County Health Department (2 participants)
- Kokomo Rescue Mission (3 participants)
- Indiana Minority Health Coalition (2 participants)
- Indiana Department of Health (1 participant)

Community Meetings

In addition to key informant interviews, community meetings were conducted as part of the CHNA. These meetings were designed with the goal of engaging stakeholders directly in discussions about their health concerns and priorities in a group setting, allowing participants to provide perspectives among those with lived experiences in the same community. Each meeting was attended by a mix of community members and local leaders representing a variety of organizations, including (but not limited to) local government, healthcare and social service organizations, religious organizations, immigrant population services, unhoused population services, and health equity organizations.

A community meeting was held in Howard County in May 2024 and attended by 11 stakeholders. Organizations that participated in the community meeting can be found listed in Appendix I.

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

Access to Healthcare Services

Provider Shortages: A significant and consistent theme was the shortage of healthcare providers, particularly in primary care, mental health, and specialist services. Interviewees noted that residents often face long wait times, with some unable to secure timely appointments, forcing them to seek care outside the county. The high turnover of healthcare providers, driven by competition from larger metropolitan areas like Indianapolis, exacerbates this issue.

Barriers to Care: Multiple barriers to accessing healthcare were identified, including financial constraints, lack of insurance or underinsurance, and inadequate transportation. Rural residents, in particular, struggle with transportation, as public transit options are limited, and many lack access to private

vehicles. This results in missed appointments and delayed care, particularly for vulnerable populations such as the elderly and those with chronic conditions.

Substance Use and Mental Health

Opioid Epidemic and Substance Use Disorders: The opioid epidemic remains a critical concern, with Howard County experiencing one of the highest rates of overdose deaths in the state. Despite recent efforts to expand treatment options, including the introduction of Medication-Assisted Treatment (MAT) programs, access remains limited. There are no residential treatment facilities that accept Medicaid, leaving a significant gap in care for low-income individuals.

Mental Health Crisis: The mental health of residents, particularly youth, has deteriorated significantly, a trend that has been exacerbated by the COVID-19 pandemic. High rates of anxiety, depression, and suicide were reported among school-aged children, with educators noting an increase in behavioral issues and emotional distress. The shortage of mental health providers and long wait times for services are critical barriers to addressing these issues. Despite recent improvements, the stigma surrounding mental health, particularly among minority populations, further complicates efforts to provide adequate care.

"Overdose is (a) leading cause of death in Howard County. Rates have declined from 2022 to 2024, but they are still higher than we would like."

"Youth mental health is an epidemic. The pandemic is still having an effect, especially for the youngest children who missed out on kindergarten-age socialization. Kids have anxiety about the school setting."

Social Drivers of Health (SDOH)

Economic Instability: Economic challenges, including high unemployment rates, low wages, and poverty were highlighted as key social drivers affecting health outcomes in Howard County. Certain areas, particularly the northern part of Kokomo and other rural regions, were identified as having high concentrations of poverty, with residents struggling to meet basic needs such as housing, food, and healthcare.

Food Insecurity and Housing: Food insecurity remains a pervasive issue, particularly in rural areas where grocery stores are scarce, and residents rely on convenience stores with limited healthy options. The development of food resource coalitions and community gardens has provided some relief, but the problem persists. Additionally, the lack of affordable housing was identified as a significant issue, with many residents unable to find safe, affordable places to live. The housing crisis is further compounded by the influx of new residents due to local industrial growth, which has driven up housing costs and reduced availability.

Vulnerable Populations

Elderly Population: The elderly in Howard County face significant health challenges, including limited access to healthcare services, particularly for chronic disease management and fall prevention measures.

Transportation barriers are a major concern, as many elderly residents are unable to drive and lack access to reliable public transportation. The need for expanded home-based care and supportive services for aging in place was emphasized by multiple stakeholders.

"Many children are living in poverty, especially in single-parent households. Racial minorities have a higher rate of poverty."

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

Children and Youth: The mental and behavioral health of children and youth is a major concern, particularly in light of the disruptions caused by the COVID-19 pandemic. Issues such as social isolation, increased anxiety, and developmental delays were reported by educators and healthcare providers. There is a critical need for expanded mental health services in schools, as well as programs that address the social and emotional needs of students.

Minority and Immigrant Populations: Racial and ethnic minorities, particularly Black, Hispanic, and immigrant populations face significant health disparities in Howard County. Barriers to care include language barriers, cultural differences, and lack of trust in the healthcare system. The anticipated influx of Korean immigrants due to local industrial expansion highlights the need for culturally competent care and language services to address the unique needs of this population.

COVID-19 Impact and Recovery

Long-Term Effects on Mental Health: The COVID-19 pandemic has had a profound impact on mental health in Howard County, with long-term effects expected to persist for years. The disruption of social and educational structures has particularly affected children and young adults, leading to increased rates of anxiety, depression, and suicidal behavior. Recovery efforts need to prioritize mental health support and the rebuilding of social networks and community programs.

Health System Strain and Provider Burnout: The pandemic has placed significant strain on the local health system, leading to burnout among healthcare providers and staff. Many providers reported feeling overwhelmed by the increased demand for services, particularly in emergency and mental health care. There is a need for systemic changes to support healthcare workers and prevent burnout, including better resource allocation and support for mental health services.

Community Collaboration and Solutions

Increased Collaboration: The interviews and meetings highlighted the importance of increased collaboration among community organizations, healthcare providers, and local government. Many stakeholders emphasized the need for a coordinated approach to addressing health issues, including the establishment of a multi-sectoral health coalition. Such a coalition would facilitate better communication, resource sharing, and coordinated efforts to tackle the most pressing health challenges in Howard County.

Innovative Solutions: Several innovative solutions were proposed to address the identified health needs, including the creation of a one-stop-shop community center where residents could access a range of services, from healthcare to social services, in one location. The development of a community-wide electronic referral system was also suggested to improve care coordination and ensure that residents are connected to the appropriate services.

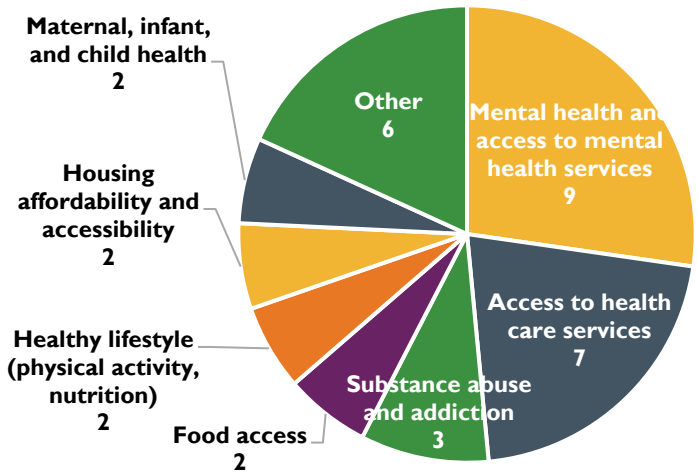
"There is a need for a coordinated approach to addressing health issues – a multi-sectoral health coalition could facilitate better communication and resource sharing."

"Our county is rich in resources but coordinating them and making them accessible needs to be a primary focus. We could offer a lot more if we were more organized."

Community Meeting Prioritization Activity

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

FIGURE 9. HOWARD COUNTY COMMUNITY MEETING PRIORITIZATION RESPONSES



Analysis & Integration of Findings

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

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

FIGURE 10. KEY THEMES FROM QUALITATIVE DATA

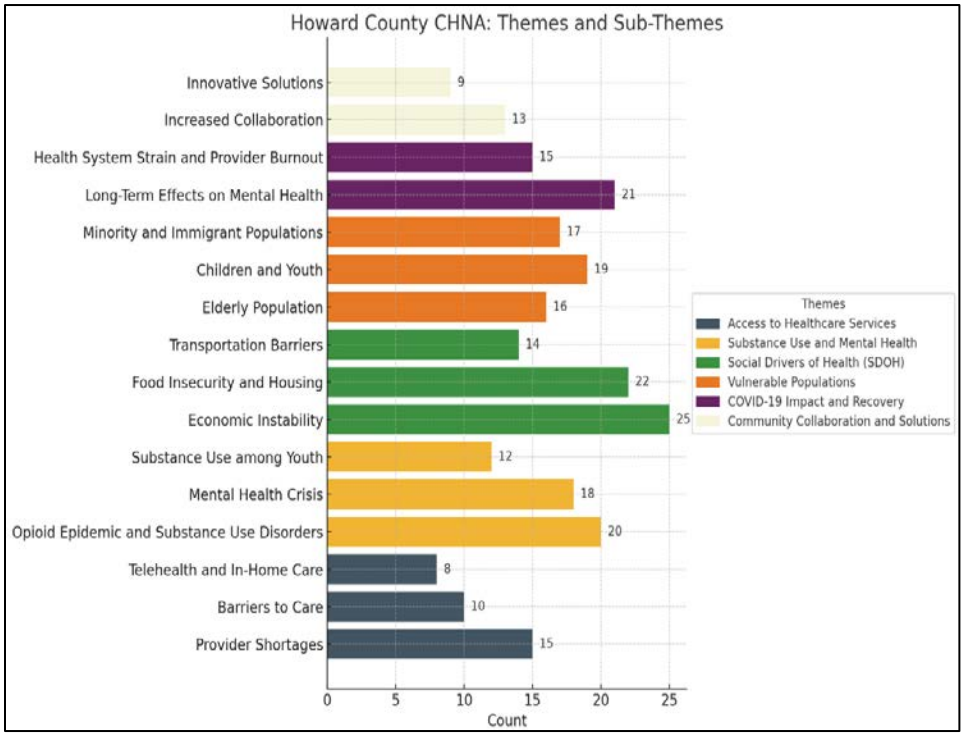
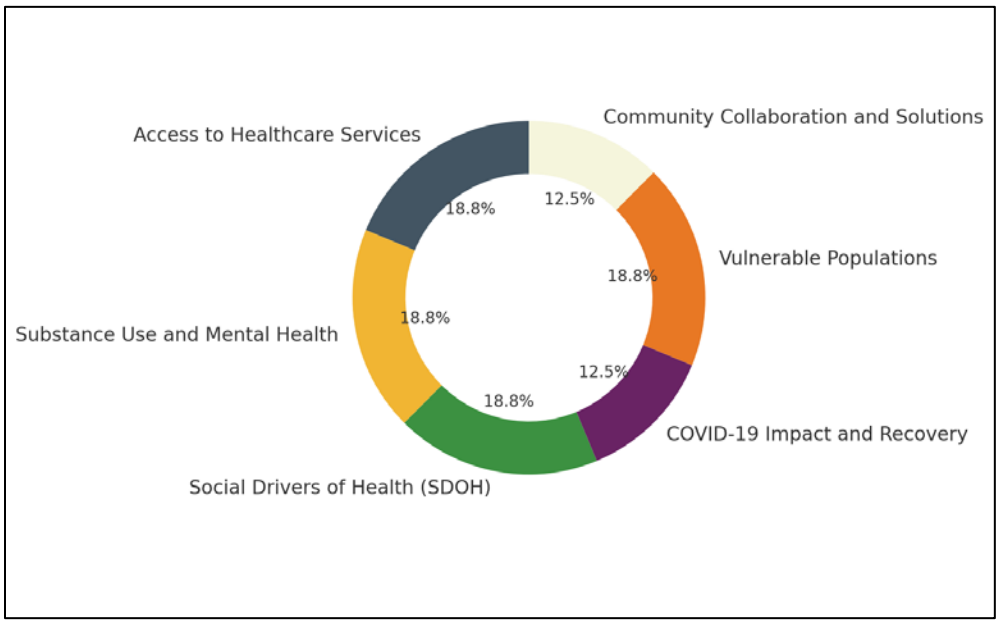


FIGURE 11. DISTRIBUTION OF KEY THEMES FROM QUALITATIVE DATA



KEY FINDINGS

- A relatively equal distribution among most themes underscores multifaceted nature of the health challenges facing Howard County
- Emphasizes the need for a comprehensive and multi-pronged approach to health interventions

Community & Caregiver Surveys

Community Howard Regional Health, 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 Howard County, leveraging various channels to ensure broad participation, including email campaigns, social media outreach, and partnerships with local organizations and businesses. The survey was made available in English, Spanish, Haitian Creole, and Hakha Chin to accommodate the linguistic diversity of the region, and a paper version was also made available to ensure accessibility for those without internet access.

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

Survey Methodology

Survey Content: The survey included six questions that 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 47 community member responses and 27 caregiver responses were collected from Howard County and Community Howard Regional Health. 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 by at least 25 percent of both cohorts of respondents:

> ***"There still seems to be a significant amount of stigma around mental health, as it is not talked about as openly as physical health."***

Access to Healthcare Services

Mental Health & Suicide

Obesity

Substance Misuse (Including Drugs & Alcohol)

The survey also asked which healthcare services were most difficult to access in the community as well as the primary barriers to accessing services. Both sets of respondents indicated that mental health services (both child and adult) and substance misuse treatment were the most difficult to access. The cost of care, lack of providers, issues with or lack of health insurance, and difficulties in navigating a robust healthcare continuum were identified as the primary barriers to accessing these services.

"The entire state needs more access to fresh fruits and vegetables, gym memberships, and preventative care."

Stakeholders were also asked which social drivers of health were most impactful on health and/or of the biggest concern in the community. Both groups selected housing affordability and quality most frequently. Food access and affordability, poverty, health literacy and understanding, and transportation access were among other choices most often selected.

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 more often than any other population as vulnerable. Other groups identified included Black (or African American), immigrants, populations with disabilities, and LGBTQIA+ populations.

Secondary Data Collection & Analysis

This section explores the economic, environmental, and social drivers of health impacting the community served by CHRH, 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 Howard County. Throughout this section, data is provided in table and graph forms. For all tables, values that compare unfavorably to Indiana-wide measures are shaded.

Socioeconomic Factors

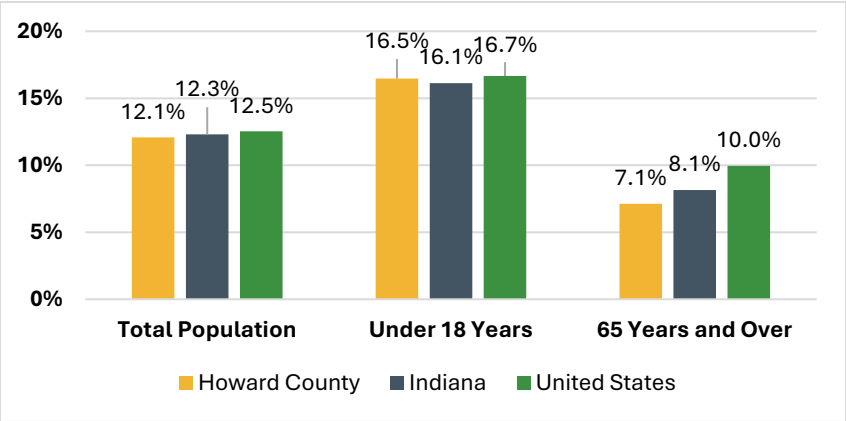
The following section outlines socioeconomic factors and social drivers of health (SDOHs). SDOHs are the conditions in which people are born, grow, work, live, and age, shaped by various forces such as economic policies and systems, social norms, and political climates. These conditions play a crucial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

Poverty Status

KEY FINDINGS

- Percent of children in poverty is higher in Howard County than in Indiana, but still below national levels
- Slightly less percentage of total population and 65+ population live in poverty compared to IN and U.S.

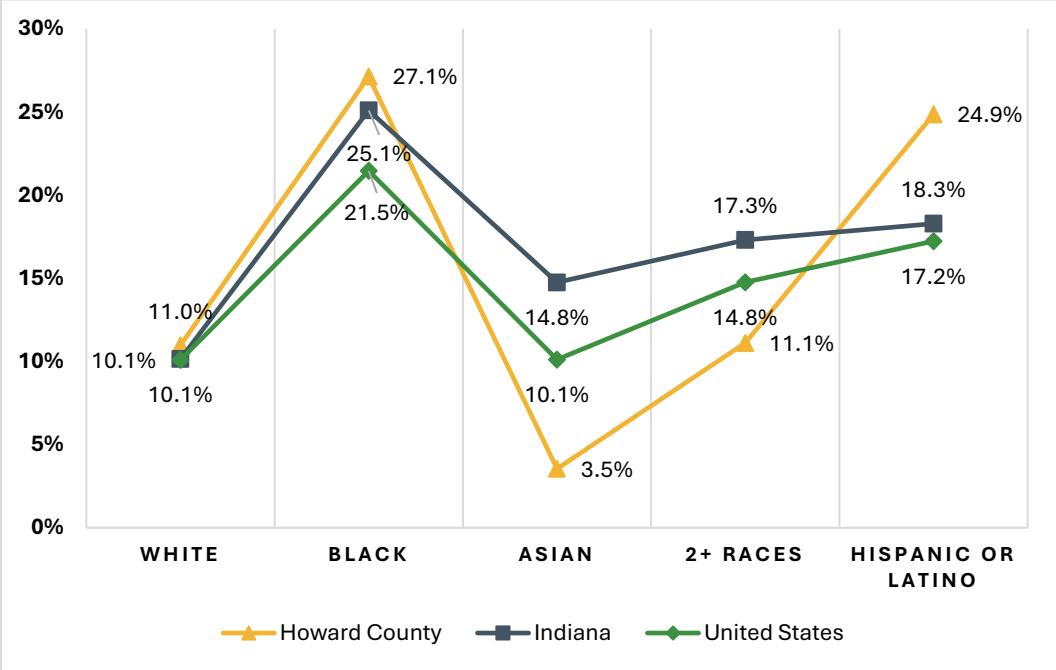
FIGURE 12. POVERTY BY AGE CATEGORY, 2022



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

In Howard County, 12.1 percent of residents live in poverty, a figure slightly below Indiana (12.3 percent) and United States (12.5 percent) proportions.

FIGURE 13. POVERTY BY RACE/ETHNICITY, 2022



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

HEALTH EQUITY FOCUS

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

Other Socioeconomic Factors

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

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

Measure	Howard County	Indiana
High School Completion Percentage	91.3%	90.0%
	26	-
Percent Some College	60.1%	63.1%
	32	-
Unemployment Percentage	5.0%	3.0%
	92	-
Income Ratio	4.0	4.3
	43	-
Percent of Children in Single-Parent Households	29.3%	24.1%
	85	-
Social Association Rate	14.6	11.8
	21	-
Injury Death Rate	118.0	90.2
	81	-

Source: County Health Rankings, 2024.

KEY FINDINGS

- Last among all counties in unemployment
- Bottom quartile in single-parent households and injury death rate

When examining environmental factors, depicted in Figure 15, Howard County compares favorably to Indiana averages for almost all measures. The county ranks in the bottom half of all Indiana counties for severe housing problems and housing cost burden.

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

Measure	Howard County	Indiana
Air Pollution - Average Daily PM2.5	7.3	8.8
	2	-
Severe Housing Problems Percentage	10.2%	12.2%
	52	-
Severe Housing Cost Burden Percentage	8.9%	10.2%
	64	-
Percent Drive Alone to Work	81.5%	78.7%
	46	-
Percent with a Long Commute Driving Alone	22.0%	32.2%
	12	-

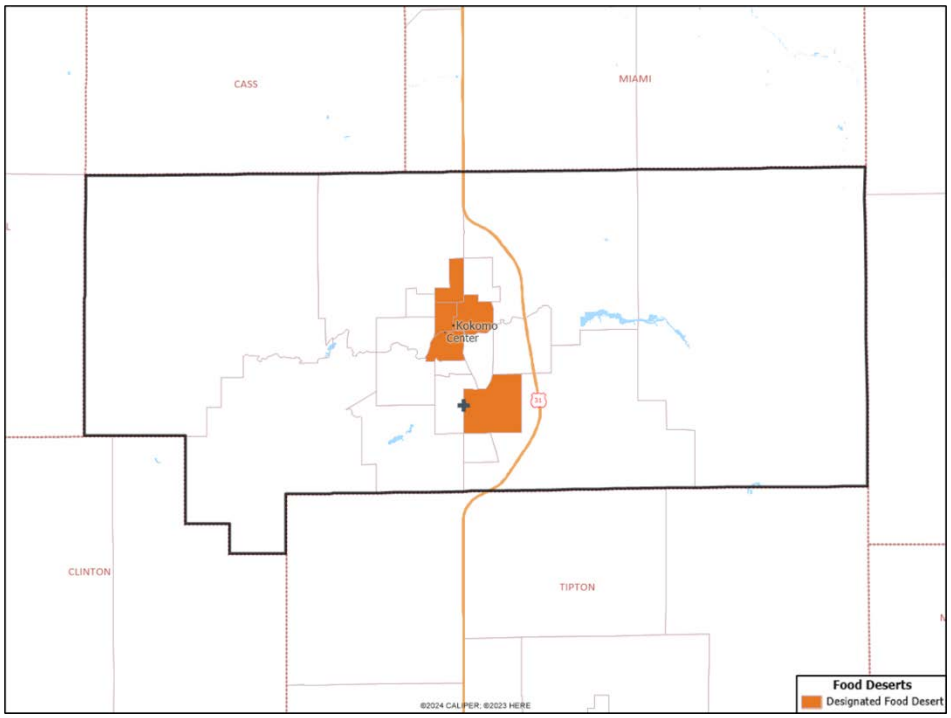
Source: County Health Rankings, 2024.

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, Howard County food deserts are mapped in Figure 16.

KEY FINDINGS

- Food deserts are in central Howard County in Kokomo, proximate to CHRH

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 Howard County residents are food insecure compared to statewide averages, and a higher percentage of household income is required for childcare expenses.

FIGURE 17. ADDITIONAL SOCIAL DRIVER OF HEALTH MEASURES, 2024

Measure	Howard County	Indiana
Food Insecurity Percentage	12.2%	10.7%
Percent Income Required for Child Care Expenses	29.6%	25.1%
Homicide Rate	6.6	7.4

Source: County Health Rankings, 2024.

Health Status

This section highlights the various behaviors and resulting health outcomes of the CHRH 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	Howard County	Indiana
Percent Adults Reporting Currently Smoking	19.7%	18.0%
	40	-
Percent Adults Obese	41.9%	36.7%
	87	-
Food Environment Index	7.2	6.8
	77	-
Percent Physically Inactive	27.1%	25.1%
	49	-
Percent with Access to Exercise Opportunities	73.3%	76.5%
	29	-
Excessive Drinking Percent	16.3%	18.2%
	32	-
Percent of Driving Deaths with Alcohol Involvement	33.3%	18.3%
	87	-
Chlamydia Rate	608.2	510.7
	89	-
Teen Birth Rate	27.9	20.2
	76	-

Source: County Health Rankings, 2024.

KEY FINDINGS

- Bottom quartile among Indiana counties in:
  - Obesity
  - Food environment index
  - Driving deaths with alcohol involvement
  - Chlamydia rate
  - Teen births

HEALTH EQUITY FOCUS

- Teen birth rates among Black teens are significantly above other cohorts

Population	Teen Birth Rate
Black	39.1
Hispanic (or Latino)	16.6
White	25.7
Howard County Total	27.9

Health Status & Outcomes

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

KEY FINDINGS

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

FIGURE 19. HEALTH OUTCOMES, 2024

Measure	Howard County	Indiana
Years of Potential Life Lost Rate	12,297	9,317
	84	-
Percent Fair or Poor Health	16.5%	16.1%
	41	-
Average Number of Physically Unhealthy Days	3.9	3.5
	44	-
Average Number of Mentally Unhealthy Days	5.0	5.2
	10	-
Percent Low Birthweight Births	8.9%	8.3%
	78	-

Source: County Health Rankings, 2024.

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

Population	Years of Potential Life Lost Rate	Low Birthweight Births
Black	15,573	13.0%
Hispanic (or Latino)	-	11.6%
White	12,552	8.0%
Howard County Total	12,297	8.9%

HEALTH EQUITY FOCUS

- Black populations compare unfavorably for years of potential life lost and low birthweight births
- Low birthweight births are higher among Hispanic populations than White

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

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

Measure	Howard County	Indiana
All causes of death	1,052.6	911.3
Heart Disease	226.6	184.2
Cancer	177.6	165.0
Accidents and Adverse Effects	85.6	65.2
Chronic Lower Respiratory Disease	67.3	54.6
Cerebrovascular Disease	44.8	41.5
Alzheimer's Disease	31.7	31.5
Diabetes	28.8	28.4
Kidney Disease	23.6	17.8
Suicide	20.2	15.5
Chronic Liver Disease	20.8	13.9
Septicemia	15.2	12.8
Pneumonia	10.0	9.8
Homicide and Legal Intervention	9.1	8.7

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

KEY FINDINGS

- Higher rates of mortality than statewide for all causes
- Particularly higher rates of:
  - Heart disease
  - Accidents
  - Chronic lower respiratory disease
  - Kidney disease
  - Suicide
  - Chronic liver disease

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

KEY FINDINGS

- Behavioral health concerns as drug overdose deaths are significantly higher and suicide rates are elevated
- Higher rates of child mortality and motor vehicle deaths

FIGURE 21. ADDITIONAL MORBIDITY AND MORTALITY MEASURES, 2024

Measure	Howard County	Indiana
Child Mortality Rate	64.4	61.9
Infant Mortality Rate	6.6	7.0
% Adults with Diabetes	10.8%	10.8%
HIV Prevalence Rate	175.7	217.0
Drug Overdose Mortality Rate	46.6	33.7
Suicide Rate	18.1	15.6
Firearm Fatalities Rate	14.5	15.9
Motor Vehicle Mortality Rate	19.5	13.0

Source: County Health Rankings, 2024.

Population	Injury Death Rate	Life Expectancy	Child Mortality Rate	Homicide Rate	Firearm Fatalities Rate
Black	116.5	69.6	148.8	27.6	31.5
Hispanic (or Latino)	74.1	83.1	-	-	-
White	124.1	72.8	56.9	4.9	13.4
Howard County Total	118.0	73.0	64.4	6.6	14.5

HEALTH EQUITY FOCUS

- Child health is a concern due to elevated child mortality rates in Howard County, and Black children mortality rates are more than double rates for White children
- Black populations experience lower life expectancy compared to White populations by nearly three years and have higher rates of homicide deaths and firearm fatalities
- White populations have higher injury death rates than other cohorts

Access to Care

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

FIGURE 21. CLINICAL CARE MEASURES, 2024

Measure	Howard County	Indiana
Percent Uninsured	7.2%	8.9%
	11	-
Primary Care Physicians Rate	55.0	65.6
	27	-
Dentist Rate	89.7	59.5
	2	-
Mental Health Provider Rate	226.1	199.8
	12	-
Preventable Hospitalization Rate	3,214	3,135
	57	-
Percent with Annual Mammogram	45.0%	45.0%
	34	-
Flu Vaccination Percentage	45.0%	50.0%
	58	-

Source: County Health Rankings, 2024.

As displayed in Figure 21, preventive health issues exist, as Howard County ranks in the bottom half of Indiana counties for preventable hospitalization rates and flu vaccination percentage. The rate of primary care physicians is also below state averages. Additionally, Black and Hispanic or Latino populations have unfavorable clinical care measures compared to White populations. Black populations experience higher preventable hospitalization rates and lower flu vaccination rates, while mammograms and vaccinations are low among Hispanic and Latino populations.

Population	Preventable Hospitalization Rate	Annual Mammogram	Flu Vaccination
Black	4,704	50.0%	31.0%
Hispanic (or Latino)	-	27.0%	25.0%
White	3,197	45.0%	46.0%
Howard County Total	3,214	45.0%	45.0%

Health Professional Shortage Areas & Medically Underserved Areas

Parts of Howard County are designated as Health Professional Shortage Areas (HPSA) and Medically Underserved Areas (MUA) by the Health Resources and Services Administration (HRSA). The low-income population of Howard County is designated as a dental health provider shortage area and all of Howard County is designated as a mental health provider shortage area. Additionally, the county is designated as a Medically Underserved Area for primary care.

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

Two hospitals operate within Howard County and are available to serve the population.

- Community Howard Regional Health, the subject of this report, is located at 3500 S Lafountain Street in Kokomo, IN 46902.
- Ascension St. Vincent Kokomo is located at 1907 W Sycamore Street in Kokomo, IN 46904.

Health Centers

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

- Indiana Health Centers (IHC) operates two locations within the county:
    - IHC at Kokomo, located at 3118 S Lafountain Street, Kokomo, IN 46902
    - IHC at Howard WIC, located at 1805 E Vaile Street, Kokomo, IN 46901
- Jane Pauley Community Health Center operates two locations within the county:
    - Jane Pauley CHC at LaFountain Street, located at 3510 S Lafountain Street, Kokomo, IN 46902
    - Jane Pauley CHC at Reed Street, located at 3611 S Reed Rd, Kokomo, IN 46902
- Meridian Health Services operates a location at 424 E Southway Boulevard, Suite 1, Kokomo, IN 46902

Other Health and Social Services Needs

Community Connections is a Community Health Network initiative designed to help community residents locate resources, often free or reduced-cost, to aid in health and wellbeing. The search tool is available to all residents and, by entering one's ZIP code, can connect a community member with social services offered by verified social care organizations and non-profits. Services are available to aid with a variety of needs, including food, housing, daily goods, transportation, income, health and family care,

education, employment, legal aid, and others. To utilize the tool, please click here or navigate to the following URL: https://communityconnect.findhelp.com/.

Appendix I: Community Meeting Participating Organizations

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

- City of Kokomo Government
- Greater Kokomo Economic Development Alliance
- Howard County Health Department
- Indiana Health Centers – Kokomo
- Ivy Tech Community College – Kokomo
- Kokomo Housing Authority
- Kokomo YMCA
- Purdue Extension – Howard County
- United Way of Howard County

Appendix II: Impact Evaluation

Appendix II describes the actions and initiatives undertaken by Community Howard Regional Health 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**
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
Community Care Mobile	In 2023, Community Howard continued to expand efforts to bring care to communities across Howard County through partnerships with agencies serving vulnerable populations and through outreach at events across Howard County reaching thousands of people with health education, free screenings and immunizations. Community Howard continued to utilize its mobile health bus, the Community CareMobile, as a primary care and urgent care walk-in clinic through the first of the year. Staffed with a Nurse Practitioner, the clinic provided convenient access to care for those in the downtown area with limited access to transportation. As summer events kicked off, the CareMobile transitioned to focus on outreach at events across Howard County—everything from screenings and free flu shots to a cool and comfortable place for breastfeeding moms to care for their infants during a hot summer fair. In addition, Community Howard began to offer blood pressure screenings at the Kokomo Family YMCA twice a week, helping to educate	Community Howard staff performed more 2.100 blood pressure or blood glucose screenings and more than 400 free flu shots at outreach events. Thousands more were reached with health education through the outreach events as well as monthly health seminars. Community's athletic trainers also continued to provide free sports physicals at area schools as well as

	hundreds of individuals on the risks associated with high blood pressure. The hospital also began to offer monthly screenings to underserved residents at the Kokomo Rescue Mission as well as regular screenings at the Kokomo Senior Center.	education, injury checks and free consultations at the YMCA – serving more than 1,102 students with physicals and nearly 300 individuals at the YMCA. In partnership with the United Way of Howard and Tipton Counties to provide funding for food assistance for children in food insecure families.
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 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.	$148.5 million worth of prescription medications was provided to patients through CHNw's Medication Assistance Program
WellFund	The WellFund exists to help patients navigate healthcare coverage options, including initial enrollment and ongoing maintenance of coverage. Patients have direct access to WellFund Patient Advocates during pre-service, admission and post-discharge for questions and determining which plan best meets their needs. The WellFund Patient Advocates are available to meet with patients in person or over the phone to help with enrollment.	CHNw patient advocates connected with over 87,518 unique individuals to ensure appropriate coverage across various affordable health plans.
Community Connections	Community Connections is a program to help community members find free and reduced-cost social services. It's a free search tool to connect seekers with social services offered by verified social care organizations and non-profits. The search tool uses zip codes to best be able to find resources in close proximity of the user's home. The tool has up-to-date information about location and eligibility for local food	11,024 users 60,694 searches

	pantries, transportation services, health care, housing and other social service programs.	
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
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
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 conjunction with the Metropolitan School District of Lawrence Township has been the host of the annual Black Men in White Coats since 2022.	1,237 youth and families registered to attend the events held in 2022 and 2023. Over 550 individuals attended.

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

	Parkview Health/Park Center in Fort Wayne and receive funding from the Indiana Division of Mental Health and Addiction. 62 students across the state are enrolled in the 2023/24 Behavioral Health Academy. The Behavioral Health Academy creates significant benefits for Community Behavioral Health, students, and IUSSW and UIndy as education partners. As an employer, Community Health Network has a steady supply of high-caliber talent trained in Community Behavioral Health specific behavioral health practices, resulting in decreased orientation costs and time to productivity for new hires. The students participating in the Behavioral Health Academy receive specialized training in evidence-based practices, an opportunity to interview for employment upon graduation, a financial incentive to defray the cost of their education, and the opportunity to become dually licensed as a licensed clinical social worker (LCSW) and a licensed clinical addiction counselor (LCAC). IUSSW and UIndy can leverage the Behavioral Health Academy as a unique opportunity to attract top-tier students. The schools also benefit from close collaboration with industry experts to align curriculum with industry best practices. By filling the workforce gap, additional opportunities will be available to address the critical need for substance use disorder treatment services.	served over 36,000 clients.
Community Drug Take Back Events	Unwanted and expired medicine may be a risk to human health and the environment if disposed of improperly. Wastewater treatment plants and septic systems are not designed to deal with pharmaceutical waste. Many medicines pass through the systems and are released into streams, lakes, and groundwater. The best way to reduce the impact of pharmaceutical waste on the environment is to dispose of medicine properly. State and local law enforcement agencies have established drug disposal 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	Maintained 6 Naloxboxs throughout the community. These boxes provided 377 kits to individuals. Community-based overdose prevention

	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 a 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 they 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.	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 service 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 critical role in keeping children healthy in the classroom so they can learn. Onsite nurses address students' needs in the school and after-school setting, helping to ensure consistency in care and less time away from the classroom. These nursing services are primarily offered free of charge to schools thanks to CHNw's ongoing commitment to enhancing health for future generations. Nurses assess health conditions, derive nursing diagnoses, execute a nursing regimen, advocate for health, execute a medical regimen delegated by a physician, teach, administer and evaluate care for students every day. In addition, for students facing chronic health conditions and ongoing health needs, medications prescribed by physicians are administered by CHNw's school-based nursing staff. Services also include physicals, immunizations, health coaching including blood pressure and cholesterol screening and a variety of additional services helping teachers and faculty addressing everything from allergies to anxiety and bullying.	3,279,663 school nurse clinic visits provided 95.7% return to classroom rate for students
Center of Hope	Since 1998, the Center of Hope at Community Health Network has been dedicated to caring for victims of violence,	Over 3,600 patients served

	misuse 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	
Baby & Me Tobacco Free	The Baby and Me, Tobacco Free Program is evidence-based, and has measurable positive outcomes by providing tobacco cessation education/services to pregnant and postpartum women. The proven program protocols utilize the American Congress of Obstetricians and Gynecologists (ACOG) "5 As" counseling approach, as established in the Clinical Practice Guidelines for Treating Tobacco Use and Dependence, Public Health Service Guidelines (updated 2008). The Baby and Me Tobacco Free program was discontinued in February of 2023 and cessation services were transitioned to Indiana Quitline.	100% of patients screened for nicotine use. Those that screened positive were referred to Indiana Quitline
Nurse Family Partnership	Goodwill of Central & Southern Indiana implemented the Nurse-Family Partnership (NFP), a nurse home-visiting program serving low-income mothers and babies. The goals listed in the agreement between CHNw and Goodwill of Central & Southern Indiana are: 1. Serve 25 low-income vulnerable mothers and new babies in the East Region 2. Assist in accessing prenatal care and wraparound services to improve health outcomes of the mother and child, and set them on a road to self-sufficiency 3. Lower infant deaths 4. Decrease pre-term births 5. Reduce rates of child maltreatment 6. Document metrics/milestones of baby via behavioral	267 clients served 98% breastfeeding initiation rate

	health methods 7. Nutrition training during well-baby check-up 8. Increase breastfeeding rates 9. Reduce smoking during pregnancy	
Safe Sleep for Babies	Provide comprehensive education on safe sleep for babies for all new parents delivering at CHNw hospitals. Provide pack n plays for new moms who indicate that they do not have a safe sleep space prepared upon discharge home.	Over 5,000 sleep sacks were distributed 75 pack n plays were distributed
Car Seat Safety	Provide safe car seat education to all OB and Pediatric Patients. If parent indicates that they do not have appropriate car seat at time of discharge or during a pediatric well-child visit, a new car seat is provided free of charge through the Community Benefit Car Seat Program.	95 car seats were distributed to families in need
Remote BP Monitoring	Screen at-risk prenatal women and provide remote BP monitoring.	364 women participated in remote BP monitoring

CHNA Priority: Physical Inactivity, Chronic Disease and Obesity		
Program Name	**Description**	**2023 Outcomes**
Faith Health Initiative	CHNw understands the essential role the faith communities play in promoting and sustaining wellbeing. Faith-based organizations improve the quality of life of their members, neighbors and communities by providing spiritual care, a supportive web of resources and impactful wellness ministries. Community Health Network developed the Faith Health Initiative (FHI), this initiative paves the way for a faith-health partnership. Built on respect, this partnership recognizes that both faith communities and high-quality medical treatment play a vital role in restoring health and promoting well-being, and that by working together, we are better able to meet the needs of our communities. FHI provides training for nurses to become Faith Community Nurses (FCN) and provides on-going support and resources to ensure they can create sustainable engaged health ministries and activities in their respective faith communities.	30 active FCN participating in the FHI program Providing screening to 593 community members
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	2,026 screenings provided

	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.	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