Community Health Network

2024 Community Health Needs Assessment

South

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 South'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. From that beginning grew a not-for-profit health system that serves communities across central and north-central Indiana. In 1989, what is now known as Community Hospital South joined the organization, and it quickly expanded to meet the growing needs of our neighbors in the southern part of the Indianapolis metropolitan area.

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 South. 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 we need to focus extra attention on the health of our children and our mothers-to-be, as well as issues related to poverty and housing, which can create significant roadblocks to better health and well-being. 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.

Anita Capps, MS, BSN, RN, NEA-BC
Vice President, Hospital Administrator and Chief Nurse Executive, Community Hospital South

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Executive Summary

Introduction

Community Hospital South (CHS) 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 CHS'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 South

Community Hospital South was originally developed as University Heights Hospital. In 1989, the hospital joined Community Health Network, which then expanded the facility and added services. Community Hospital South offers patient-centered healthcare to residents in the southern portion of the Indianapolis metropolitan area. The Community South campus continues to grow and includes access to Community Heart and Vascular, Community Cancer Center, behavioral health services, primary care and specialty-care physician practices, school-based clinics, MedCheck, a Community Surgery Center, a Community Endoscopy Center, Community Physical Therapy and Rehabilitation services, and employer health clinics. Additional information about CHS is available at: https://www.ecommunity.com/locations/community-hospital-south.

Community Hospital South 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 South

For purposes of this assessment, the community served by CHS was defined as 12 ZIP codes located within Johnson 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 South worked with each Community Health Network hospital – Community Hospital Anderson, Community Hospital East, Community Hospital North, and Community Howard Regional Health – as well as system-wide leadership to collect data and construct this report.

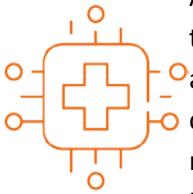
Community Health Network collaborated with Indiana University Health and Ascension St. Vincent Indiana health systems in its primary data collection activities, working together in communities served by both health systems to strengthen partnerships and maximize resources.

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.

Access to Care



Access to healthcare services is a significant issue across the CHS community. Issues with the cost of care, transportation, health insurance, and a lack of providers were identified as contributing factors. The uninsured rate is high in Marion County. Portions of the county are designated as primary care health professional shortage areas for low-income residents, and census tracts throughout are designated medically underserved areas. Both counties are also mental health professional shortage areas. Indicators such as high rates of preventable hospitalizations indicate difficulties accessing preventive care.

Mental Health Status and Access to Mental Health Care

Mental health is a significant concern in the CHS community. Anxiety, depression, and suicidal ideation are common, particularly among youth. Suicide rates in Johnson County are above the state average. Mental health issues are exacerbated by social drivers of health such as trauma, violence, and poverty. Social association rates are lower than state averages in both counties, increasing isolation and related mental health concerns. Despite the rising need, access to mental health services remains limited due to a shortage of mental health providers and financial obstacles. Marion and Johnson counties are designated as mental health provider shortage areas for low-income residents, and the mental health provider rate in Johnson County is below the statewide average.

Substance Misuse

The misuse of drugs is a pervasive issue in the CHS community and intricately tied to poor mental and physical health. The drug overdose mortality rate in Marion County is nearly double the Indiana rate and the Johnson County rate comparable to the state average. Stakeholders noted the fentanyl and opioid epidemics as driving forces along with other substance addiction issues. Treatment options are limited and costly, particularly for those with Medicaid or uninsured. Alcohol is also an issue as more driving deaths involve alcohol in Marion County than statewide.

Poverty and Housing

Poverty is an issue prevalent for many CHS community residents, impacting health and many social drivers of health. The Marion County poverty rate is above state and national averages. Poverty disparities are evident, with particularly high rates for children and racial and ethnic minority populations. Cost of care was commonly cited as a large barrier to receiving health services. While impacting most facets of life, poverty's relation to housing issues is increasingly a concern. Housing was cited as a significant concern by stakeholders with many facing rising rental costs and substandard housing conditions. Additionally, Marion County has high rates of severe housing problems and cost burden for housing.

Infant and Child Health and Wellbeing

Infant and child health are significant concerns in the CHS community. Marion County experiences unfavorable rates of single-parent households and teen births. Childcare expenses as a percentage of household income are high in both counties. 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 present as Black and Hispanic or Latino infants have poorer outcomes. Furthermore, stakeholders highlighted gaps in mental health support and healthcare services for children as significant concerns.

Healthy Lifestyles, Nutrition, and Associated Conditions

Unhealthy eating, lack of exercise, obesity, and related conditions are problems throughout the CHS community. Marion and Johnson counties both have higher obesity rates than statewide averages, and Marion County compares unfavorably for physical inactivity. There are food deserts throughout the community, Marion County has a high proportion of residents living in food insecurity, and stakeholders noted that relying on convenience stores for food is common. Many residents face challenges in maintaining a healthy lifestyle due to a lack of safe recreational spaces and access to healthy food options. Diabetes prevalence and mortality is also high in Marion County.

Community Safety and Violence

Safety is a concern for many community members, including community-based violence and domestic violence. Community survey participants cited community violence issues as a significant concern, creating mental and physical health challenges, particularly among youth residents. The homicide rate in Marion County is nearly triple the Indiana-wide average and firearm fatalities are nearly double the average. High rates of years of potential life lost may reflect premature deaths due to violence.

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. CHS 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 South 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 CHS 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, CHS 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 CHS community was defined as 12 ZIP codes in Marion County and Johnson County, Indiana.

Community Hospital South Community Definition

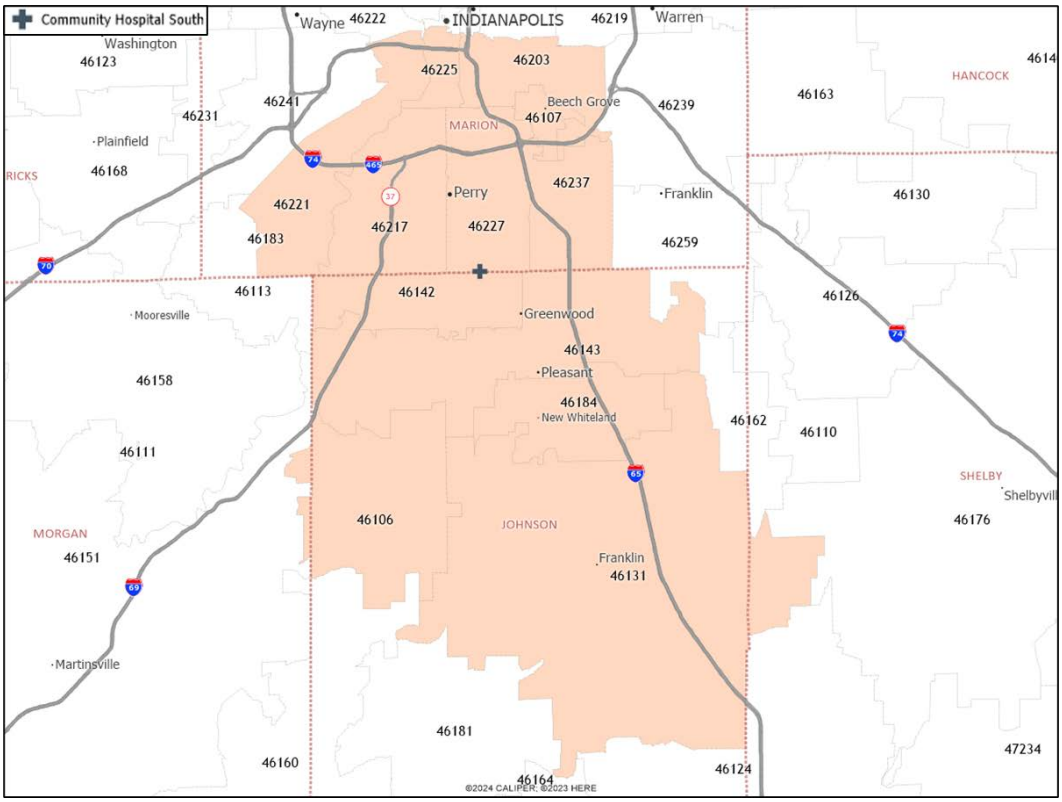
When examined at a ZIP code level, 12 ZIP codes were identified that comprise southern Marion County and almost the entirety of Johnson County. These 12 ZIP codes and their accompanying patient origin statistics are presented in Figure 1. In total, the 12 ZIP codes accounted for 72.3 percent of the hospital's total inpatient discharges and 79.9 percent of its ER visits.

FIGURE 1. COMMUNITY PATIENT ORIGIN DATA

ZIP Code	County	State	Inpatient Discharges	ER Visits
46227	Marion	Indiana	1,394	11,302
46143	Johnson	Indiana	1,377	9,371
46142	Johnson	Indiana	945	6,364
46217	Marion	Indiana	639	5,847
46131	Johnson	Indiana	527	1,903
46237	Marion	Indiana	483	2,690
46184	Johnson	Indiana	306	1,908
46203	Marion	Indiana	252	2,149
46221	Marion	Indiana	172	1,292
46106	Johnson	Indiana	151	871
46107	Marion	Indiana	113	792
46225	Marion	Indiana	76	634
Community Total			6,435	45,123
Community Percent			72.3%	79.9%
Hospital Total			8,902	56,470

Community Hospital South is located at 1402 E County Line Road in Indianapolis, Indiana, ZIP code 46227. Figure 2 depicts CHS'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 12 ZIP codes listed in Figure 1 where the majority of CHS's patient base resides, as outlined in the figure above.
- Marion and Johnson 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, CHS 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 South Community

Understanding the demographics of CHS'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 12 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 12 community ZIP codes have a population of 370,076. The population breakdown by ZIP code in the CHS community is found in Figure 3.

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

ZIP Code	City	County	Population
46227	Indianapolis	Marion	56,794
46143	Greenwood	Johnson	58,153
46142	Greenwood	Johnson	34,676
46217	Indianapolis	Marion	39,082
46131	Franklin	Johnson	34,801
46237	Indianapolis	Marion	42,223
46184	Whiteland	Johnson	12,771
46203	Indianapolis	Marion	36,544
46221	Indianapolis	Marion	27,038
46106	Bargersville	Johnson	9,616
46107	Beech Grove	Marion	12,962
46225	Indianapolis	Marion	5,416
Community Total			370,076

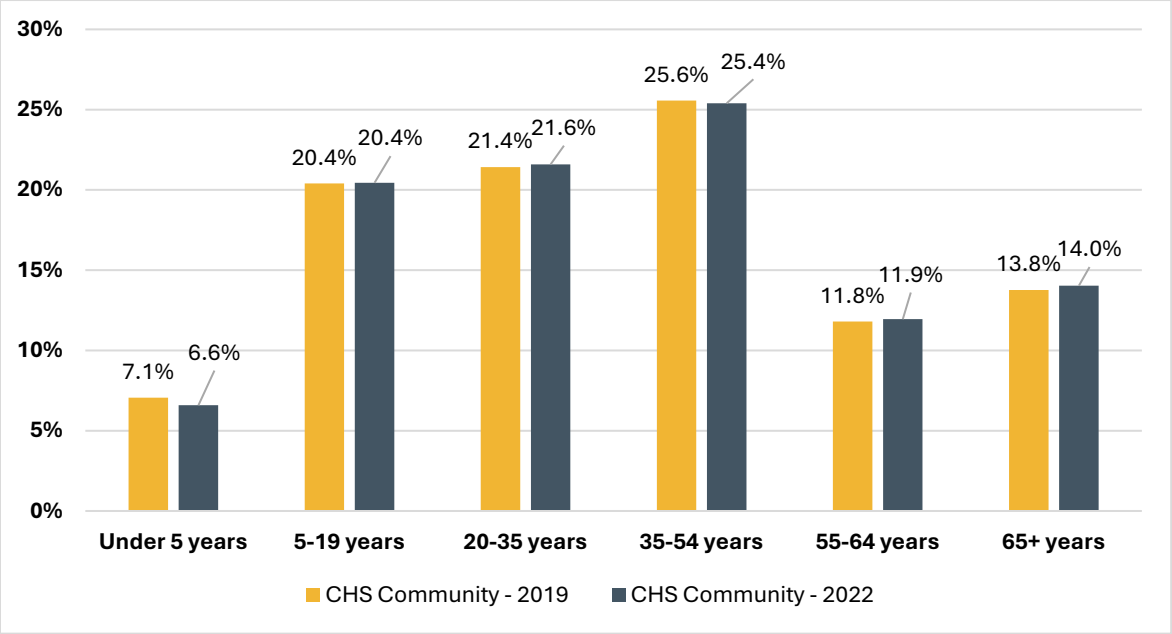
The hospital's origin ZIP code, 46227, has the second largest population within community ZIP codes.

Age Distribution

The age distribution in the CHS community highlights variations in the population by age. The median ages in Marion County and Johnson County respectively are 34.4 years and 37.9 years, below both the state (38.0 years) and national (38.5 years) medians. Additionally, data suggests that in CHS ZIP codes,

the proportions of the population aged 55-65 years and 65 years and above increased 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, CHS COMMUNITY, 2019 AND 2022

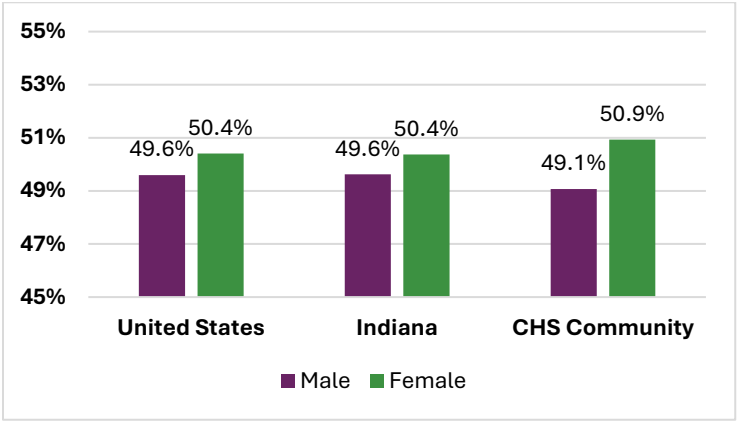


Despite the growing aging population, the working-age group (aged 20 to 64) comprises the majority of the community's population at 58.9 percent. This suggests an increasing need for healthcare services that cater to both an aging population and the preventive care needs of younger, working-age groups.

Population by Sex

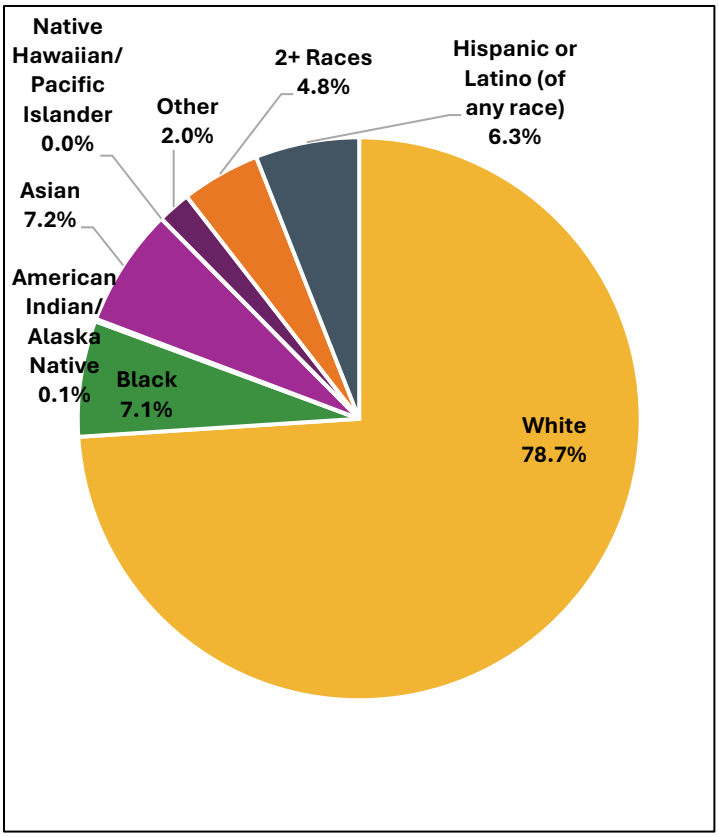
An analysis of CHS's community population by sex, found in Figure 5, finds that the proportions of male and female populations are similar to state and national averages, with CHS ZIP codes having a slightly lower proportion of male residents than female.

FIGURE 5. POPULATION BY SEX, 2022



Racial & Ethnic Composition

FIGURE 6. POPULATION BY RACE AND ETHNICITY, 2022



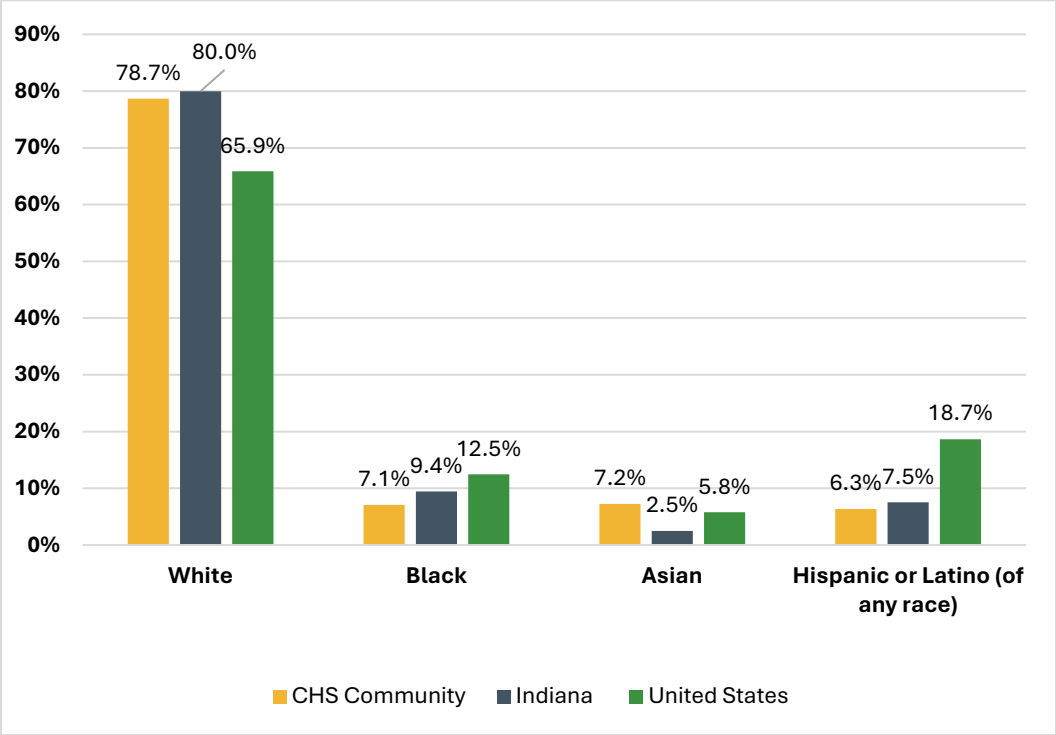
The racial and ethnic composition of a population is vital in planning for community needs, particularly for health care services and community/social programs. Analyzing health and social drivers of health by race and ethnicity can reveal disparities in housing, employment, income, and health outcomes.

In CHS community ZIP codes, the racial makeup reflects a majority White population, with 78.7 percent identifying as White. Black or African American residents comprise 7.1 percent of the population, making them the second-largest racial group. Other racial groups, including those identifying as two or more races (4.8 percent), Asian (7.2 percent), and Other (2.0 percent), represent smaller portions of the population. This distribution emphasizes the importance of targeted community outreach and health services that are sensitive to the needs of these diverse groups, ensuring that racial and ethnic disparities in healthcare access and outcomes are addressed effectively.

In terms of ethnicity, the Hispanic/Latino population represents 6.3 percent of the population.

When compared to state and national levels, the racial and ethnic distribution in CHS ZIP codes is less diverse, particularly compared to national numbers (Figure 7). A higher proportion of the population is White, and a lower proportion is Black or Hispanic/Latino. However, a high proportion of the community is Asian compared to Indiana and national statistics. Additionally, a lower proportion of the population is two or more races (4.8 percent) compared to state (5.1 percent) and national (8.8 percent) figures.

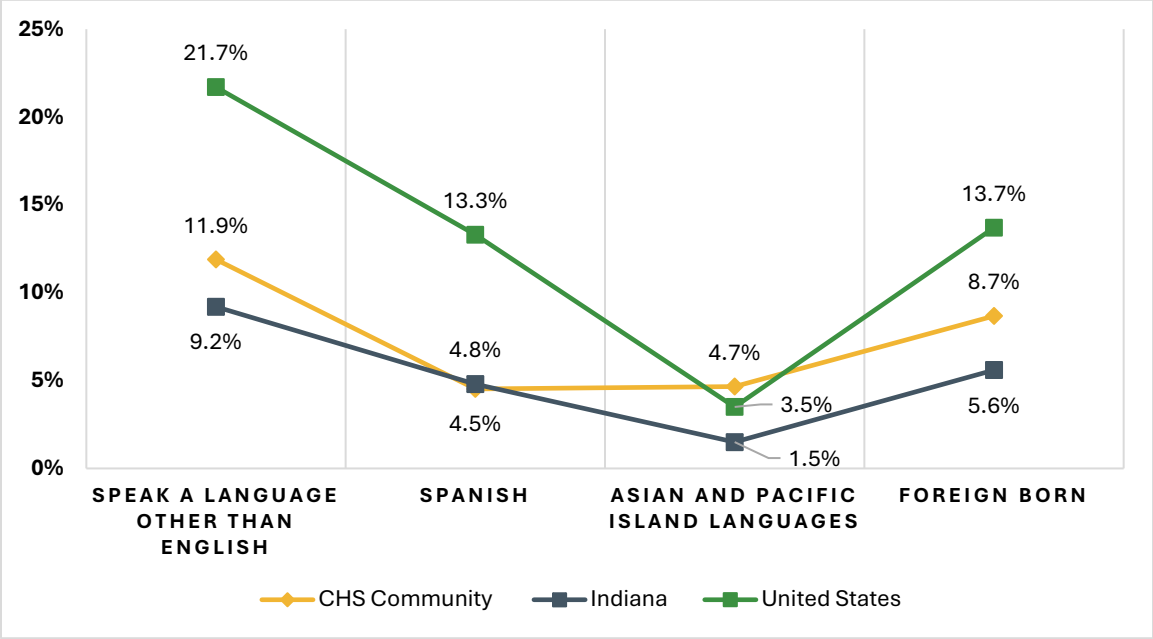
FIGURE 7. POPULATION BY RACE AND ETHNICITY COMPARISON, 2022



Language & Immigration

In the CHS community, 88.1 percent of residents speak only English at home, a figure lower than the Indiana rate (90.8 percent) but above the United States (78.3 percent). Additionally, 4.5 percent speak Spanish, below both statewide and national figures. A higher proportion of the community speaks Asian and Pacific Island languages compared to Indiana and the United States. While these percentages may indicate a relatively modest demand for multilingual services, healthcare providers and social services will encounter patients who require language support, particularly for Asian and Pacific Island language speakers.

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



When examining immigration, a higher proportion of CHS 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 South, 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 CHS 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 CHS 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 CHS 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)
- Gleaners Food Bank of Indiana (1 participant)
- Indiana Department of Health (1 participant)
- Indiana Minority Health Coalition (2 participants)
- Jane Pauley Community Health Center (3 participants)
- Johnson County Health Department (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 in May 2024 and attended by 41 stakeholders. One of these meetings 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

"The new inpatient center will only have 28 beds and already has a wait list – there is still a huge demand."

" Transportation – people cannot get to doctor's appointments, and when they do get referred elsewhere."

"Access to care for everyone, as well as housing – those are two huge barriers (to wellness) … affordability is the big thing."

Access to Healthcare Services

Provider Shortages: A recurring theme was the shortage of healthcare providers, especially in mental health, primary care, and specialized services such as obstetrics. The interviewees highlighted that long wait times, particularly for mental health services, are common and appointments must often be booked months in advance. This shortage forces many residents to seek care outside their community. High turnover among healthcare providers, driven by competition within competing health systems in the region, exacerbates this issue.

Barriers to Care: Several barriers to accessing healthcare were identified, notably transportation issues. The absence of Medicaid cabs, public transit, and affordable transportation options was particularly problematic in rural areas. This lack of transportation leads to missed appointments and delays in accessing care, disproportionately affecting the elderly and those with chronic conditions. Financial constraints, such as underinsurance, further limit access, making it difficult for residents to afford needed care even when services are available.

Substance Misuse and Mental Health

Opioid Epidemic and Substance Use Disorders: Fentanyl remains a significant challenge, with high rates of detection in syringe testing, particularly in Marion County. The community has expanded options like Medication-Assisted Treatment (MAT) programs, but access remains limited, especially for those relying on Medicaid. There is a noted lack of residential treatment facilities that accept Medicaid, creating a critical care gap for low-income individuals. Tobacco, vaping, and marijuana usage are also common, particularly among younger populations.

"We are trying to target nonfatal overdoses and reach out to families of those that committed suicide/overdose for support as they are more likely to commit similar acts."

"We need to capture this population [the youth] in the schools to educate, but it has been a difficult road."

Youth Mental Health Crisis: The mental health needs of youth in the community have grown substantially, worsened by the impacts of the COVID-19 pandemic. Increased rates of teen suicide highlight the urgency for expanded mental health services in schools and

community-based support. Despite some progress in destigmatizing mental health discussions, the availability of timely care for young people remains inadequate.

Social Drivers of Health (SDOH)

Economic Instability and Housing: Economic challenges, particularly housing issues such as high rental costs and a lack of affordable housing, emerged as key social drivers of health. Many residents face eviction due to rising rents, while others live in substandard conditions because they cannot afford home repairs. ALICE (Asset Limited, Income Constrained, Employed) populations were identified as often falling through social service gaps and requiring additional support.

Food Insecurity: Access to healthy food continues to be a significant issue, with many residents relying on convenience stores due to the absence of grocery stores in their area. This issue is especially acute in food deserts, where fresh produce is scarce, contributing to poor diet quality and increased rates of diet-related conditions like diabetes.

Transportation Barriers: Reliable transportation remains a significant challenge for residents, particularly in rural areas where options like Medicaid cabs, buses, or ride-sharing services are unavailable. This barrier not only limits access to healthcare but also restricts opportunities for employment and social engagement, contributing to social isolation.

Violence: Community violence was identified by many stakeholders as a concern, particularly impacting school-aged youth and those in Marion County. Interviewees noted that trauma resulting from community and domestic violence was impactful on mental health and has long-lasting effects. Many in the community feel unsafe walking through neighborhoods, impacting access to resources and physical activity.

Vulnerable Populations

Elderly Population: Older adults in the community face unique challenges, including limited access to healthcare services for chronic conditions and the need for fall prevention programs. The shortage of transportation options compounds these issues, making it difficult for elderly residents to reach necessary care and services.

Racial and Ethnic Minorities The interviews highlighted health disparities affecting racial and ethnic minorities, including Black, Latino, and immigrant populations. Barriers such as language differences, cultural misunderstandings, and historic mistrust of the healthcare system contribute to poorer health outcomes.

COVID-19 Impact and Recovery

Long-Term Effects on Mental Health: The lingering effects of the COVID-19 pandemic on mental health, especially

> ***"COVID shined the light on health departments working towards access to foods, exercise, education, etc. –but it's hard. It's not accessible, affordable, or convenient."***
>
> ***"When they [prisoners] are released, they need homes, food, jobs, etc. – they are looking to get within a program that helps with navigating these sources."***

for children and young adults, were emphasized. Stakeholders expressed concerns that the community continues to experience high rates of anxiety and depression, which are expected to persist for years.

Economic Hardship: The economic fallout from the pandemic has led to challenges such as eviction, job loss, and income instability. These issues have further exacerbated other social determinants like food insecurity and housing instability.

Community Collaboration and Solutions

Increased Collaboration: The interviews and meetings underscored the critical need for enhanced collaboration among community organizations, healthcare providers, and local government in Marion County. Participants noted that organizations and programs providing social support change often. Stakeholders consistently highlighted the importance of a coordinated approach to tackling health issues.

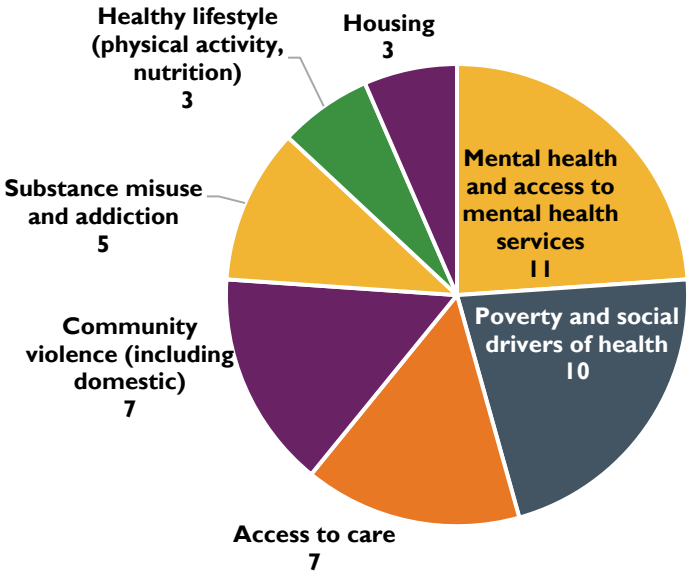
> ***"About a year ago, there was not much collaboration, but it has been a huge project and effort – they have been working more with hospitals, nonprofits, etc."***
>
> ***"Schools have been slower with making change, and public officials have been the biggest challenge – there have been more conversations lately, though."***

Innovative Solutions: Many advocated for the formation of a multi-sectoral health coalition that could bring together diverse groups to address the county's pressing health challenges. Such a coalition would play a key role in fostering better communication, facilitating resource sharing, and coordinating efforts to ensure that services reach those in need efficiently. Stakeholders emphasized that while social services are a strength in certain areas of the county, more structured coordination is required to optimize these resources and address gaps in care.

Community Meeting Prioritization Activity

As a concluding activity of the Marion County community meetings, 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. CHS COMMUNITY COUNTIES COMMUNITY 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 the community.

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

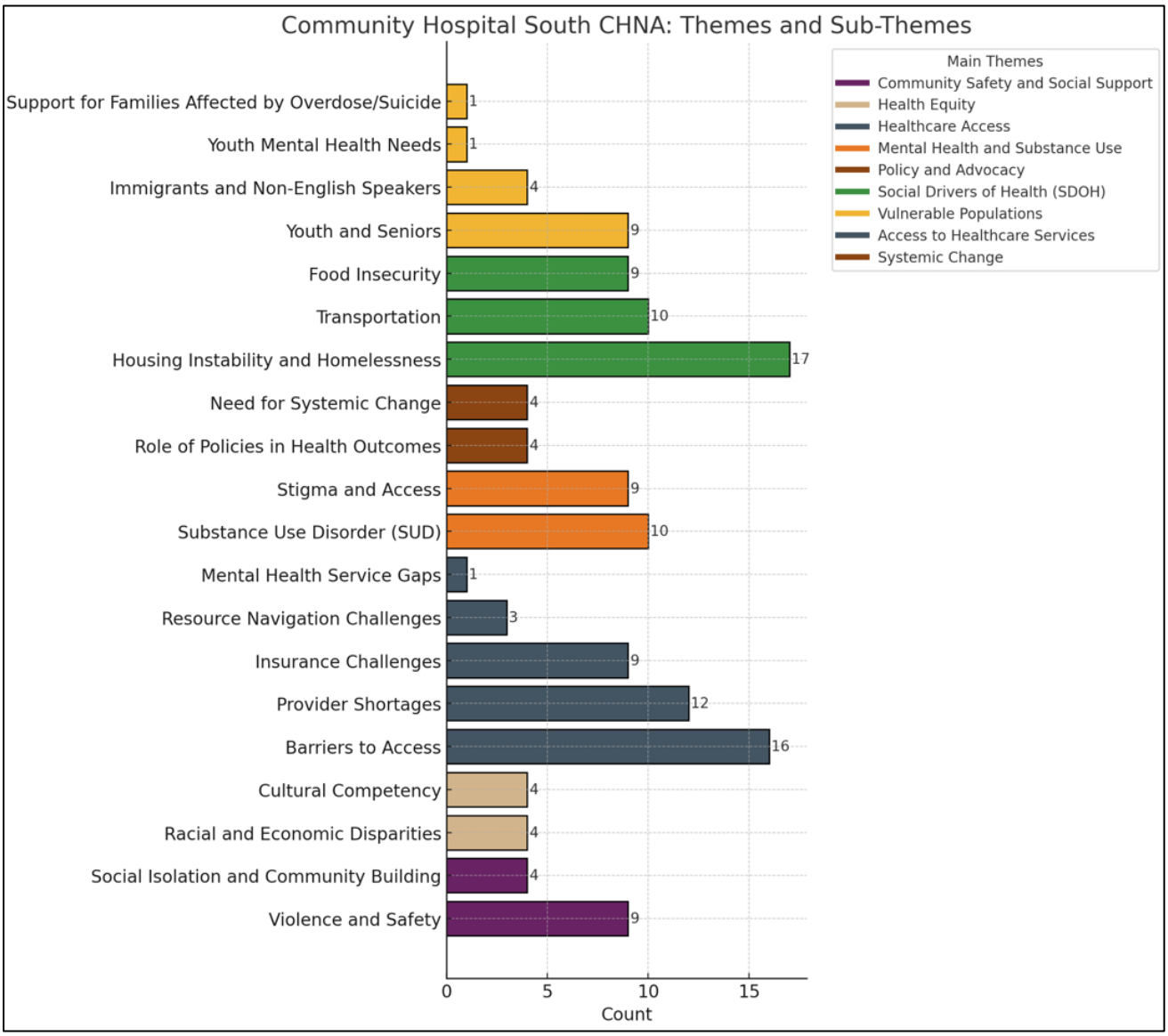
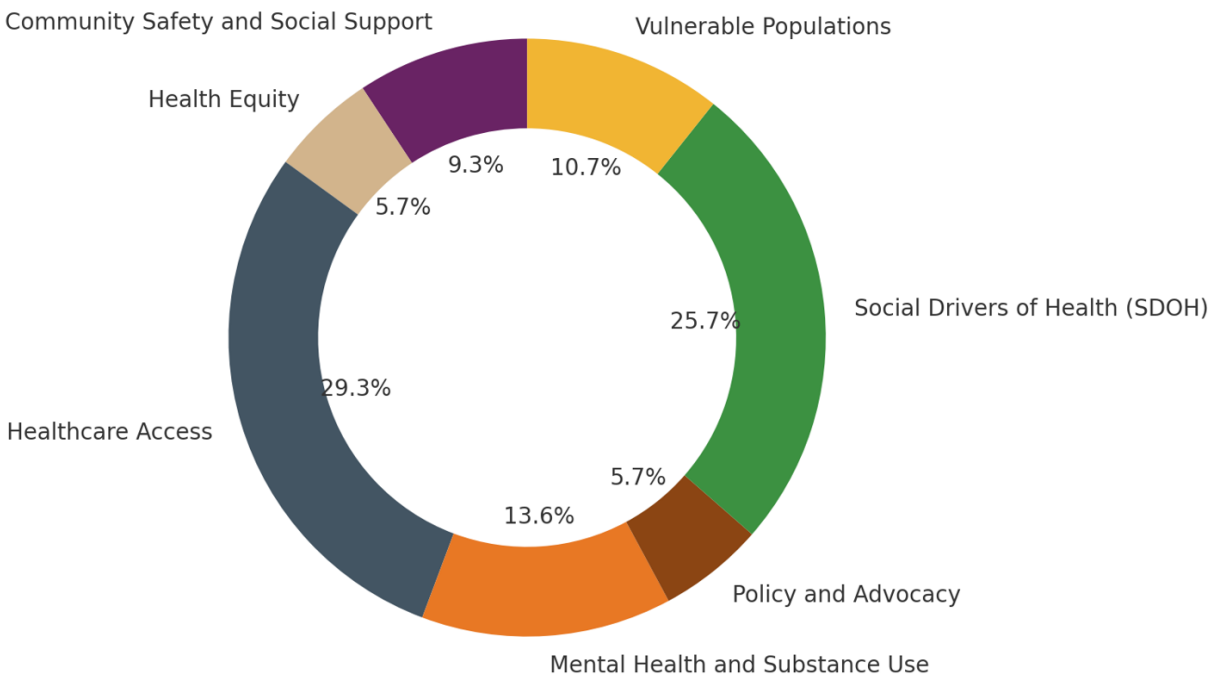


FIGURE 11. DISTRIBUTION OF KEY THEMES FROM QUALITATIVE DATA



KEY FINDINGS

- Healthcare Access and SDOH are top concerns, representing 29.3 percent and 25.7 percent of the overall focus respectively
- Mental Health and Substance Use is a significant issue, comprising 13.6 percent of the overall themes
- Support for Vulnerable Populations and Community Safety remains critical, representing 10.7 percent and 9.3 percent of themes respectively

Community & Caregiver Surveys

Community Hospital South, 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 65 community member responses and 36 caregiver responses were collected from CHS community counties and Community Hospital South. 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:

> ***"They need to put patients first over money. No money, no care. Even those with insurance still have issues as they have to prove they can pay or pay first before receiving care."***

Access to Healthcare Services

Substance Misuse (Including Drugs & Alcohol)

Mental Health & Suicide

Obesity, Unhealthy Lifestyles, & Associated Diseases

The survey also asked 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, in-home health services, and primary care were highlighted as difficult to access. The primary barriers identified included the cost of care and financial barriers, lack of access to health insurance or other issues, a lack of health providers, 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; and transportation access and affordability;. These factors highlight the underlying social determinants that significantly impact community health and wellbeing.

> ***"The south region has a large population of Burmese patients, but we have very little printed educational material available."***

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, immigrants, populations with disabilities, military veterans, and Hispanic/Latino residents.

Secondary Data Collection & Analysis

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

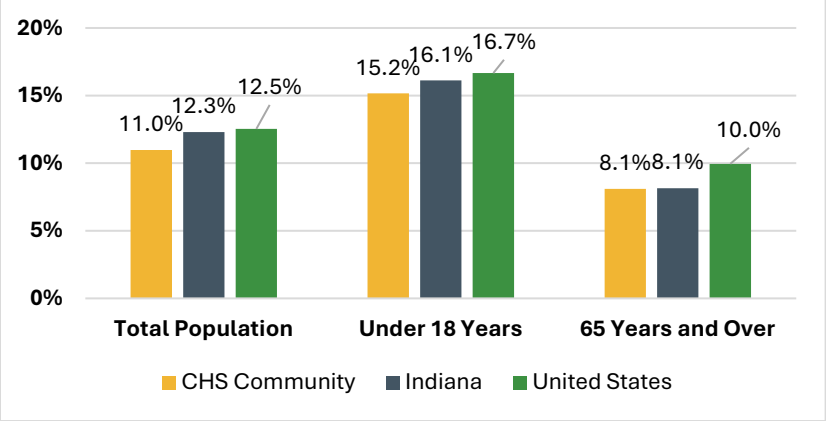
The following section outlines socioeconomic factors and social drivers of health (SDOHs). SDOHs are the conditions in which people are born, grow, work, live, and age, shaped by various forces such as economic policies and systems, social norms, and political climates. These conditions play a crucial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

Poverty Status

KEY FINDINGS

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

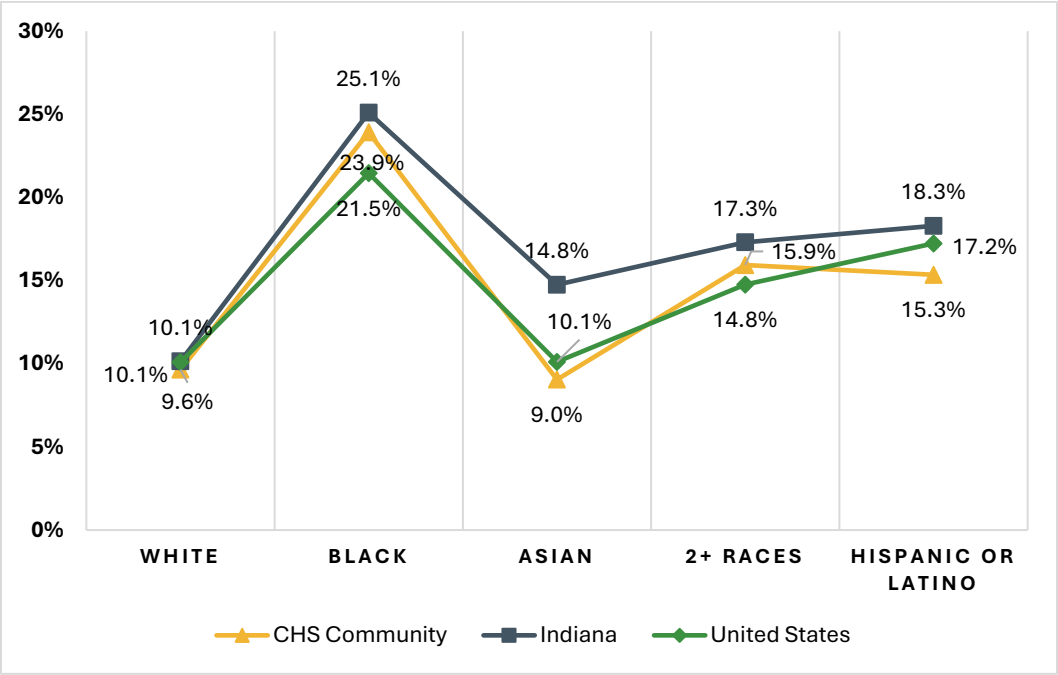
FIGURE 12. POVERTY BY AGE CATEGORY, 2022



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

In CHS community ZIP codes, 11.0 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 Johnson County (7.5 percent).

FIGURE 13. POVERTY BY RACE/ETHNICITY, 2022



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

HEALTH EQUITY FOCUS

- Poverty rates for Black residents in the CHS community more than double the poverty rate of White populations, and rates for residents that are two or more races and Hispanic/Latino are significantly above those for White populations
- Poverty rates for CHS 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, both 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	Johnson County	Indiana
High School Completion Percentage	87.3%	92.6%	90.0%
	73	16	-
Percent Some College	63.2%	68.7%	63.1%
	24	10	-
Unemployment Percentage	3.2%	2.4%	3.0%
	64	13	-
Income Ratio	4.6	3.8	4.3
	83	30	-
Percent of Children in Single-Parent Households	34.0%	15.5%	24.1%
	91	22	-
Social Association Rate	11.4	8.6	11.8
	50	78	-
Injury Death Rate	121.6	70.5	90.2
	86	21	-

Source: County Health Rankings, 2024.

KEY FINDINGS

- Marion County ranked bottom quartile in high school graduation, income ratio, single-parent households, and injury death rate
- Both counties lower rates of social associations

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

KEY FINDINGS

- Both counties ranked bottom quartile for air pollution
- Marion County is 91st of 92 in severe housing problems and housing cost burden
- Johnson County transportation measures unfavorable

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

Measure	Marion County	Johnson County	Indiana
Air Pollution - Average Daily PM2.5	12.6	9.8	8.8
	92	85	-
Severe Housing Problems Percentage	16.5%	9.7%	12.2%
	91	37	-
Severe Housing Cost Burden Percentage	14.6%	8.6%	10.2%
	91	62	-
Percent Drive Alone to Work	75.9%	79.7%	78.7%
	12	35	-
Percent with a Long Commute Driving Alone	30.9%	42.4%	32.2%
	34	67	-

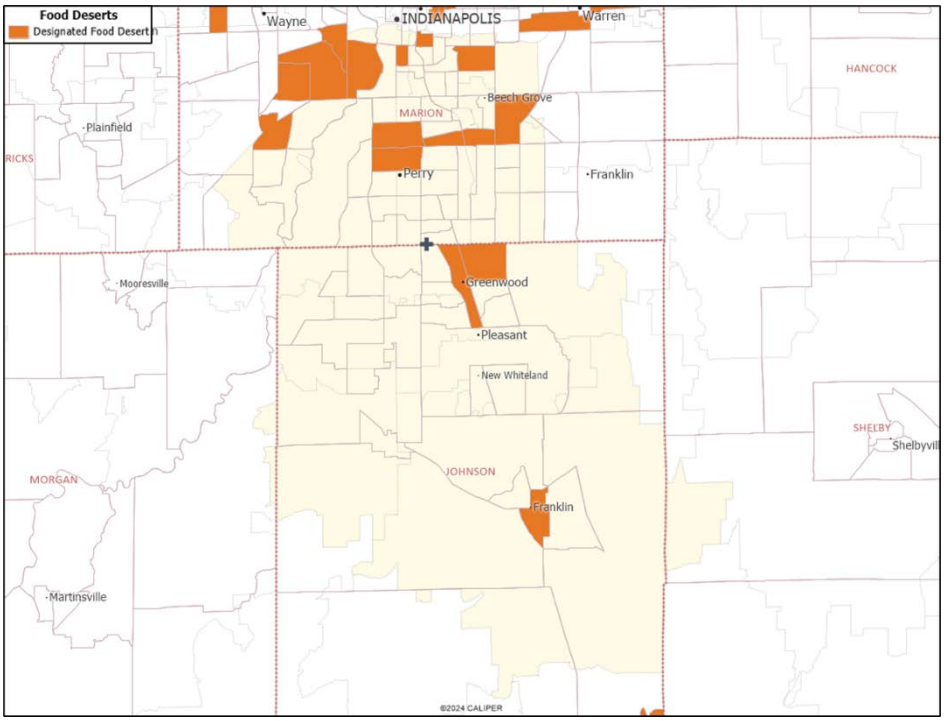
Source: County Health Rankings, 2024.

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, Marion County food deserts are mapped in Figure 16.

KEY FINDINGS

- Food deserts are located throughout, with concentrations in Marion County, Greenwood, and Franklin

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 percentage of household income is required for childcare expenses in both counties. 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	Johnson County	Indiana
Food Insecurity Percentage	11.3%	8.2%	10.7%
Percent Income Required for Child Care Expenses	32.7%	27.4%	25.1%
Homicide Rate	19.6	2.3	7.4

Source: County Health Rankings, 2024.

Health Status

This section highlights the various behaviors and resulting health outcomes of the CHS 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	Johnson County	Indiana
Percent Adults Reporting Currently Smoking	19.6%	16.5%	18.0%
	37	9	-
Percent Adults Obese	37.2%	39.3%	36.7%
	28	63	-
Food Environment Index	7.2	8.5	6.8
	77	18	-
Percent Physically Inactive	27.5%	23.7%	25.1%
	56	9	-
Percent with Access to Exercise Opportunities	91.3%	82.7%	76.5%
	3	12	-
Excessive Drinking Percent	17.1%	17.2%	18.2%
	67	70	-
Percent of Driving Deaths with Alcohol Involvement	23.2%	6.1%	18.3%
	78	11	-
Chlamydia Rate	1,102.7	326.2	510.7
	92	62	-
Teen Birth Rate	27.8	14.5	20.2
	74	15	-

Source: County Health Rankings, 2024.

KEY FINDINGS

- Marion County ranked last in chlamydia rate and bottom quartile in teen births
- Both counties compared unfavorably for adult obesity prevalence

HEALTH EQUITY FOCUS

- Teen birth rates among Black teens are significantly above average in both Marion and Johnson counties, and high for Hispanic/Latino teens in Johnson County

Population	Teen Birth Rate	
	Marion County	Johnson County
Black	34.6	22.5
Hispanic (or Latino)	44.3	12.7
White	17.7	14.2
Total	27.8	14.5

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	Johnson County	Indiana
Years of Potential Life Lost	11,769	7,221	9,317
Rate	82	14	-
Percent Fair or Poor Health	19.2%	14.0%	16.1%
	80	6	-
Average Number of Physically Unhealthy Days	3.9	3.4	3.5
	42	6	-
Average Number of Mentally Unhealthy Days	5.4	4.9	5.2
	57	9	-
Percent Low Birthweight Births	9.8%	7.3%	8.3%
	91	34	-

Source: County Health Rankings, 2024.

Compared to Indiana averages, Marion County compares unfavorably, and Johnson County compared favorably for all measures in Figure 19.

Population	Years of Potential Life Lost Rate		Low Birthweight Births	
	Marion County	Johnson County	Marion County	Johnson County
Black	15,986	11,825	14.0%	12.9%
Hispanic (or Latino)	7,620	4,913	7.4%	7.1%
White	11,072	7,525	7.9%	7.2%
Total	11,769	7,221	9.8%	7.3%

HEALTH EQUITY FOCUS

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

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	Johnson County	Indiana
All causes of death	976.6	871.7	911.3
Heart Disease	184.1	180.2	184.2
Cancer	171.3	159.9	165.0
Accidents and Adverse Effects	91.2	44.4	65.2
Chronic Lower Respiratory Disease	55.3	51.9	54.6
Cerebrovascular Disease	41.0	38.1	41.5
Alzheimer's Disease	28.4	41.3	31.5
Diabetes	30.6	19.4	28.4
Kidney Disease	20.3	11.3	17.8
Suicide	14.9	15.1	15.5
Chronic Liver Disease	15.0	10.1	13.9
Septicemia	12.8	12.4	12.8
Pneumonia	8.3	7.9	9.8
Homicide and Legal Intervention	22.1	3.4	8.7
Influenza	1.8	-	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
- Johnson County has elevated rate of Alzheimer's disease mortality

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

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
- Higher rates of suicide in Johnson County

FIGURE 21. ADDITIONAL MORBIDITY AND MORTALITY MEASURES, 2024

Measure	Marion County	Johnson County	Indiana
Child Mortality Rate	81.6	49.5	61.9
Infant Mortality Rate	7.8	5.8	7.0
% Adults with Diabetes	12.0%	9.5%	10.8%
HIV Prevalence Rate	625.1	121.9	217.0
Drug Overdose Mortality Rate	58.8	31.3	33.7
Suicide Rate	14.7	21.4	15.6
Firearm Fatalities Rate	27.2	15.6	15.9
Motor Vehicle Mortality Rate	13.8	15.1	13.0

Source: County Health Rankings, 2024.

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	Johnson County	Indiana
Percent Uninsured	10.0%	7.6%	8.9%
	73	19	-
Primary Care Physicians Rate	78.0	80.3	65.6
	10	8	-
Dentist Rate	94.1	67.6	59.5
	1	11	-
Mental Health Provider Rate	364.7	127.3	199.8
	2	29	-
Preventable Hospitalization Rate	3,372	2,863	3,135
	63	41	-
Percent with Annual Mammogram	44.0%	46.0%	45.0%
	41	25	-
Flu Vaccination Percentage	51.0%	54.0%	50.0%
	21	12	-

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. Johnson County compares unfavorably for

mental health providers per capita. Additionally, Black populations experience higher preventable hospitalization rates in Marion County, while Black and Hispanic/Latino populations experience lower mammogram percentages in both Marion and Johnson counties.

Population	Preventable Hospitalization Rate		Annual Mammogram Percent	
	Marion County	Johnson County	Marion County	Johnson County
Black	4,754	-	39.0%	37.0%
Hispanic (or Latino)	2,388	-	28.0%	27.0%
White	3,017	2,881	46.0%	46.0%
Total	3,372	2,863	44.0%	46.0%

Health Professional Shortage Areas & Medically Underserved Areas

Parts of CHS community counties are designated as Health Professional Shortage Areas (HPSA) by the Health Resources and Services Administration (HRSA). Marion and Johnson counties are both designated as mental health provider shortage areas. The low-income population of Indianapolis Center Township is designated as a primary care shortage area. Census tracts throughout both counties and county subdivisions in Johnson County have also been designated as Medically Underserved Areas by HRSA.

Community Resources to Address Needs

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

Hospitals

Three hospitals operate within CHS community ZIP codes and are available to serve populations.

- Community Hospital South, the subject of this report, is located at 1402 E County Line Road S in Indianapolis, IN 46227.
- Franciscan Health Indianapolis is located at 8111 S Emerson Avenue in Indianapolis, IN 46237.
- Hickory Treatment Center at Meridian is located at 2102 S Meridian Street in Indianapolis, IN 46225.

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.

- Adult and Child Mental Health Center Inc. operates multiple locations within the community:
    - Adult and Child Health - Northwood Plaza at 1860 Northwood Plz, Franklin, IN 46131
    - Adult and Child at Creekside Elementary at 700 E State Road 44, Franklin, IN 46131
    - Adult and Child at Ray Crowe Elementary at 1300 Ray Crowe Way, Greenwood, IN 46143
    - Adult and Child Health - Garfield Park at 234 E Southern Ave, Indianapolis, IN 46225

    - Adult and Child at Burkhart Elementary at 5701 Brill Rd, Indianapolis, IN 46227
    - Adult and Child at Southport Elementary at 261 Anniston Dr, Indianapolis, IN 46227
    - Adult and Child Health - Greenwood at 8320 Madison Ave, Indianapolis, IN 46227
    - Adult and Child - Siear Terrace at 8404 Siear Ter, Ste 100, Indianapolis, IN 46227
    - Adult and Child at Winchester Village Elementary at 1900 E Stop 12 Rd, Indianapolis, IN 46227
    - Adult and Child at MacArthur Elementary at 454 E Stop 11 Rd, Indianapolis, IN 46227
    - Adult and Child Suite 15 at Jeremiah Gray Elementary at 5225 Gray Rd, Indianapolis, IN 46237
- Windrose Health Network operates multiple locations within the community:
    - Windrose Health Network - Franklin at 55 N. Milford Drive, Franklin, IN 46131
    - Windrose Health Network - Epler Parke at 5550 S East St, Indianapolis, IN 46227
    - Windrose Health Network - Countyline at 8921 Southpointe Dr Ste A1, Indianapolis, IN 46227
- Jane Pauley Community Health Center (CHC) operates multiple locations within the community:
    - Jane Pauley CHC at County Line Road Greenwood at 333 E County Line Rd, Greenwood, IN 46143
- Health Net, Inc. operates multiple locations within the community:
    - Barrington Health Center at 3401 E Raymond St, Indianapolis, IN 46203
    - Southeast Health Center at 901 Shelby St, Indianapolis, IN 46203
    - HealthNet Homeless Initiative Program at 901 Shelby St Ste 301, Indianapolis, IN 46203
    - Southwest Health Center at 1522 W Morris St, Indianapolis, IN 46221
- Shalom Health Care Center operates multiple locations within the community:
    - IPS School 34 - Eleanor Skillen at 1404 Wade St Rm 129, Indianapolis, IN 46203
    - William McKinley School 39 at 1733 Spann Ave Rm 404, Indianapolis, IN 46203
    - IPS School 46 - Daniel Webster at 1450 S Reisner St Ste 100, Indianapolis, IN 46221
    - IPS 31 School Base Clinic - James A. Garfield at 307 Lincoln St Ste 100, Indianapolis, IN 46225
- Meridian Health Services at 5230 E Stop 11 Road STE 300, Indianapolis, IN 46237

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
- CHIP (Coalition for Homelessness Intervention and Prevention)
- CICOA
- City of Indianapolis – Department of Metropolitan Development
- 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
- Genesys Solutions
- Health by Design
- Hoosier Environmental Council
- Horizon House
- Immigrant Welcome Center
- 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
- 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

- Near North Development Corporation
- Pathway to Recovery, Inc.
- Purdue Extension
- Raphael Health Center, Inc.
- Rehabilitation Hospital of Indiana
- YMCA of Greater Indianapolis

Appendix II: Impact Evaluation

Appendix II describes the actions and initiatives undertaken by Community Hospital South 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