Community Health Needs Assessment: Community Healthcare System

Lake and Porter County

Prepared by Conduent
Healthy Communities Institute

COMMUNITY HEALTHCARE SYSTEM®

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Section 1: INTRODUCTION

Community Healthcare System is pleased to present its 2022-2025 Community Health Needs Assessment.

Hospitals operated by Community Healthcare System include:

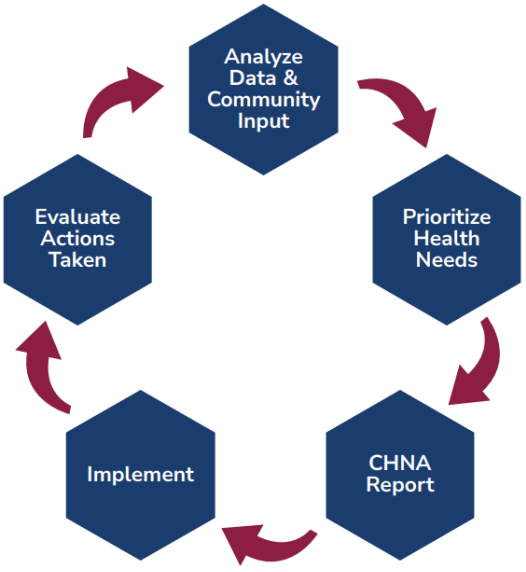
- Community Hospital in Munster, IN
- St. Catherine Hospital in East Chicago, IN
- St. Mary Medical Center in Hobart, IN
- Community Stroke & Rehabilitation Center in Crown Point, IN

About Community Health Needs Assessment

A Community Health Needs Assessment (CHNA) is an all-inclusive data collection and analysis tool used to determine key health needs in a community. The 2010 Patient Protection and Affordable Care Act (ACA) mandated not-for-profit hospital organizations to conduct a community health needs assessment every three years to maintain status as a not-for-profit provider with the U.S. Internal Revenue Service (IRS). **Figure 1** depicts the (CHNA) process and how the cycle continues after the report is completed.

The assessment is extremely useful to Community Healthcare System because it offers a deeper understanding of the health status, needs, disparities and wants of the communities the hospital system serves. Findings from this assessment will guide Community Healthcare System in its quest to identify, develop and put actionable strategies in place to improve the quality of life and health of residents in Lake County and Porter counties of Indiana.

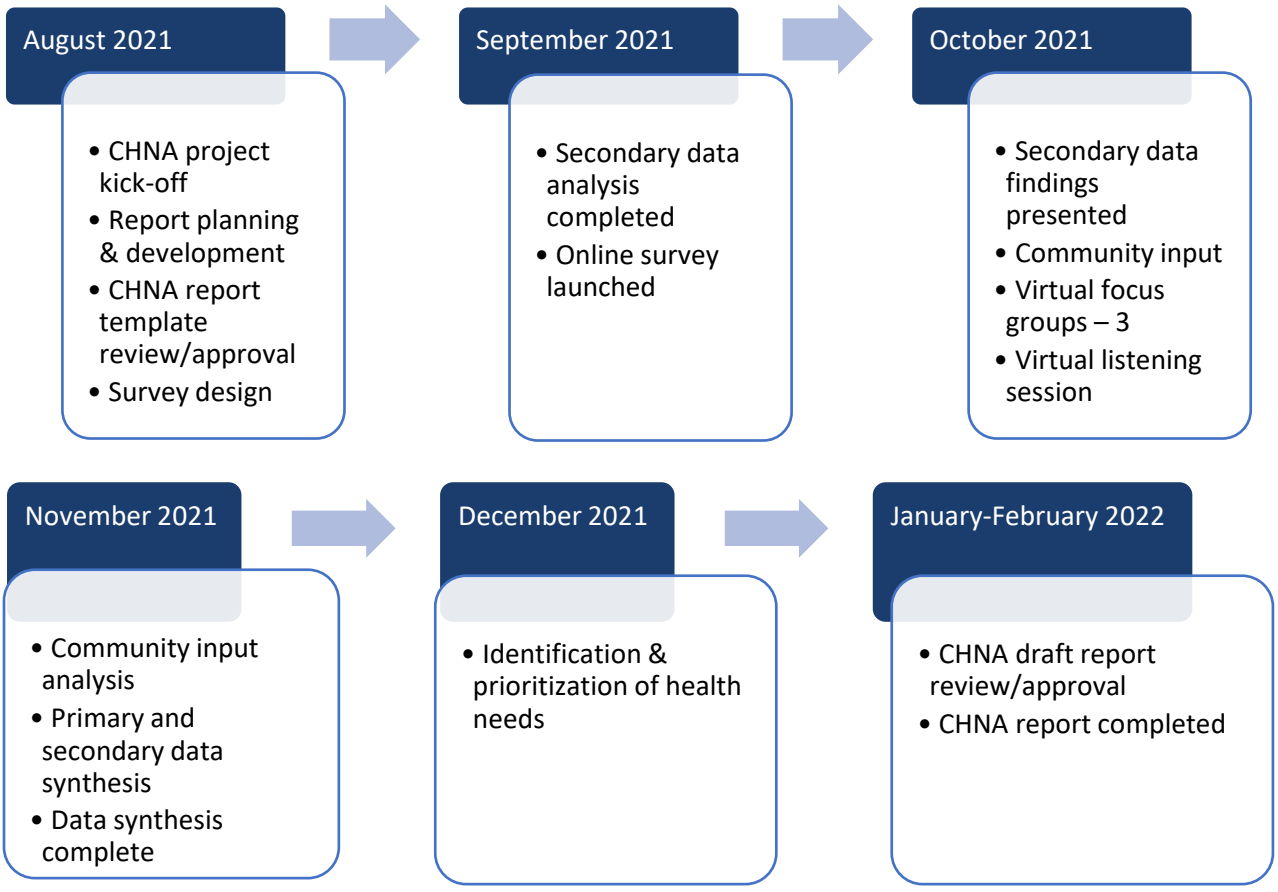
Figure 1: Community Health Needs Assessment Cycle

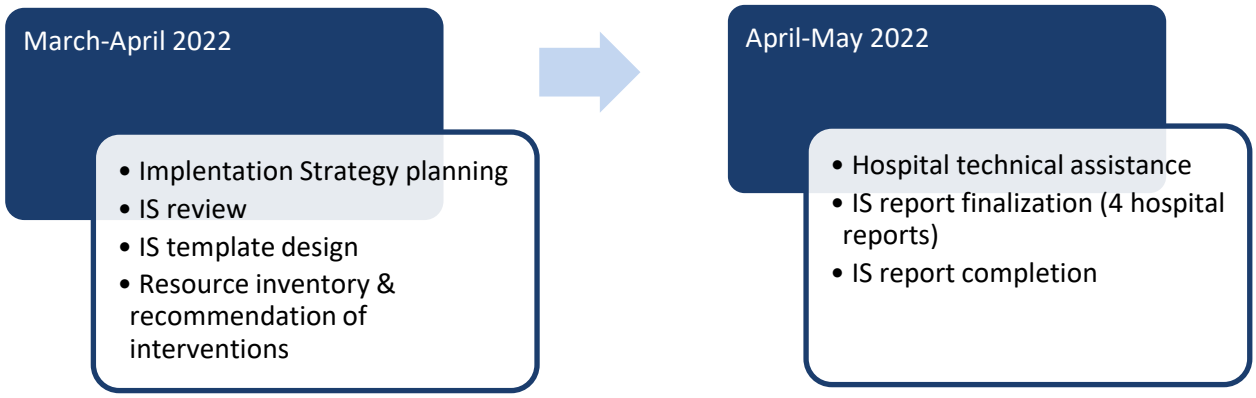


The report includes a description of the:

- Community demographics and population served
- Process and methods used to obtain, analyze and synthesize primary and secondary data
- Significant health needs in the community, taking into account the needs of the uninsured, low-income and marginalized groups
- Process and criteria used in identifying certain health needs as significant and prioritizing those significant community needs.

Community Health Needs Assessment Timeline




March-April 2022
• Implentation Strategy planning
• IS review
• IS template design
• Resource inventory & recommendation of interventions
April-May 2022
• Hospital technical assistance
• IS report finalization (4 hospital reports)
• IS report completion

About Community Healthcare System®

Community Healthcare System® is comprised of four not-for-profit hospitals: Community Hospital in Munster; St. Catherine Hospital in East Chicago; St. Mary Medical Center in Hobart; Community Stroke & Rehabilitation Center in Crown Point; as well as Hartsfield Village, a continuing care retirement community in Munster.

Community Healthcare System hospitals are regional leaders in cardiovascular and cancer care, neuroscience and orthopedics.

Its Community Care Network of physicians, with offices located throughout Northwest Indiana, provides patients with a broad spectrum of care – from family practice to internal medicine, OB/GYN and a variety of specialty medical fields. Combining advanced technology with the latest diagnostic and therapeutic procedures, forefront research and a network of highly qualified physicians, nurses and allied health professionals, Community Healthcare System offers exceptional care to patients across every stage of life.

The Northwest Indiana healthcare system's vast network of care locations includes outpatient care, surgical and rehabilitation centers, physician practices, behavioral health, occupational health, home care, a medically-based fitness center, Cancer Resource Centre, neuroscience and sports medicine center and community-based health centers.

As a non-profit organization, the healthcare system offers numerous free programs, special events, preventative screenings and support groups that aim to help to improve the quality of life and health of residents in Northwest Indiana.

The healthcare system's parent company is Community Foundation of Northwest Indiana, Inc., a 501(c)3 non-profit organization that provides leadership and resources for the enhancement of health and the quality of life in Northwest Indiana. Projects that the Foundation has fostered have served to strengthen art, culture and quality of life in local communities, including the development of The Center for Visual and Performing Arts; donation of the land and funding to create the Community Veterans Memorial and Community Estates, a residential neighborhood development in south Munster.

MISSION:

Community Healthcare System is committed to provide the highest quality care in the most cost-efficient manner, respecting the dignity of the individual, providing for the wellbeing of the community, and serving the needs of all people, including the poor and disadvantaged.

VISION:

Community Healthcare System is one medical provider organized across four hospital campuses. It links four Indiana hospitals-Community Hospital in Munster, St. Catherine Hospital in East Chicago, St. Mary Medical Center in Hobart and Community Stroke & Rehabilitation Center in Crown Point-and many outpatient clinics and physician offices. The system is dedicated to maintaining the Catholic tradition of St. Catherine Hospital and St. Mary Medical Center as well as the non-sectarian foundation of Community Hospital and Community Stroke & Rehabilitation Center. As a prominent, integrated healthcare system in Northwest Indiana, Community Healthcare System will capitalize on opportunities to increase overall growth, improve operating efficiency and realize capital to better serve our patients, physicians and employees.

VALUES:

Dignity

We value the dignity of human life, which is sacred and deserving of respect and fairness throughout its stages of existence.

Compassionate Care

We value compassionate care, treating those we serve and one another with professionalism, concern and kindness, exceeding expectations.

Community

We value meeting the vital responsibilities in the community we serve and take a leadership role in enhancing the quality of life and health, striving to reduce the incidence of illness through clinical services, education and prevention.

Quality

We value quality and strive for excellence in all we do, working together collaboratively as the power of our combined efforts exceeds what each of us can accomplish alone.

Stewardship

We value trustworthy stewardship and adherence to the highest ethical standards that justify public trust and protect what is of value to the system-its human resources, material and financial assets.

Facility Information

Community Hospital

Address: 901 MacArthur Blvd.
Munster, IN 46321
Website: COMHS.org/about-us/community-hospital

CEO: Luis F. Molina

Community Hospital in Munster, Indiana, is a non-sectarian, acute care facility recognized for meeting this nation's highest healthcare standards. The Joint Commission on Accreditation of Health Care Organizations has awarded Community Hospital its highest accreditation commendation for exemplary performance.

Community Hospital also has been awarded numerous national accreditations and recognitions for the quality of care to the community. This unmatched record of quality healthcare is backed by some of the area's most respected medical professionals and some of the most advanced medical technology available.

List of Services (Service Lines):

Advanced Cardiovascular Services, Audiology, Bariatrics, Diabetes Center - ADA Certified, Diagnostics, Dietary Counseling, Emergency Department – 24-hours a day: Level II trauma, Family Birthing Center, GI Lab, Home Health, Inpatient Surgery, Intensive Care Units – including specialty Neuroscience and Cardiac ICU, Intermediate Care Units, Medically Based Fitness Center, Neurointerventional & Certified Comprehensive Stroke Center, Obstetrics Emergency Department; Occupational Health, Oncology Services, Orthopedics Unit, Outpatient Surgery Center, Outpatient Retail Pharmacy, Perinatal Center and Level III Neonatal Intensive Care Unit, Respiratory Care Services, Sleep Diagnostics, Sports Medicine, Therapy Services, Women's Diagnostic Center, Wound & Ostomy Clinic.

Community Hospital Outpatient Facilities:

Community Diagnostic Center, Munster
Community Hospital Outpatient Center, Schererville
Community Hospital Outpatient Center, St. John
Community Immediate Care, Munster
Community Neuroscience & Sports Medicine, Schererville
Community Cancer Research Foundation and Cancer Resource Centre, Munster

St. Catherine Hospital

Address: 4321 Fir St.
East Chicago, IN 46312
Website: COMHS.org/about-us/st-catherine-hospital

CEO: Leo Correa

St. Catherine Hospital has provided compassionate, high-quality care to the city of East Chicago and neighboring communities for nearly a century. Serving more than three generations as a hospital with strong family values and commitment to medical/technological advancement, St. Catherine Hospital has achieved many notable distinctions. They include the highest possible five-star ratings for overall quality of patient care from the Centers for Medicare and Medicaid Services – an achievement shared with only 2.2 percent of more than 4,000 hospitals in the nation.

St. Catherine Hospital, a Safety-Net Hospital, relies on public subsidies to help finance its important mission to care for the uninsured, underinsured, Medicaid and other vulnerable patients. The hospital's multidisciplinary network of physicians, nurses and allied health professionals work to combine advanced technology and renovations to its units with the latest in diagnostic and therapeutic procedures to provide exceptional care for the mind, body and spirit of its patients.

List of Services (Service Lines):

Acute Inpatient Rehabilitation, Audiology, Behavioral Health Services – Adult and Older Adult Inpatient Care, Intensive Outpatient Program, Cardiology Services, Cancer and Infusion Center, Center for Diabetes - ADA Certified, CyberKnife®, Diagnostics, Ear, Nose, & Throat/Otolaryngology, Emergency Department – 24-hours a day: Level III trauma, Family Birthing Center, Gastroenterology, Home Health, Intensive Care and Intermediate Care Units, Neurodiagnostics, Nutritional Counseling, Occupational Health, Oncology, Outpatient Retail Pharmacy, Pain Management, Pastoral Care – 24-hour chaplains, Primary Stroke Center, Radiology, Respiratory Care/Pulmonary Rehabilitation, Rheumatology, Sleep Clinic, Surgery Services – Inpatient & Same Day, Therapy Services, Women's Diagnostic Center, Wound/Ostomy.

St. Mary Medical Center

Address: 1500 S. Lake Park Ave.
Hobart, IN 46342
Website: COMHS.org/about-us/st-mary-medical-center

CEO: Janice Ryba

St. Mary Medical Center is a leading provider of expert medical care to Northwest Indiana residents by investing in new technologies and innovative treatments. The hospital utilizes multidisciplinary teams of health professionals and shared governance among the nursing staff for increased collaboration and accountability in patient care. These efforts have led to the achievement of numerous quality awards and accreditations. St. Mary Medical has earned gold seals of approval as a Primary Stroke Center, Advanced Total Knee and Hip Replacement and as a Center of Excellence in Minimally Invasive Gynecology and Robotic Surgery. St. Mary Medical Center consistently achieves excellence in health outcomes and patient experience.

List of Services (Service Lines):

Acute Inpatient Rehabilitation, Advanced Imaging Center, Bariatrics, Cardiology Services, Certified Primary Stroke Center, Diabetes Education, Diagnostics, Emergency Department -24 hours a day: Level III trauma, Family Birthing Center, Gastroenterology Services, Home Health, Inpatient & Same-Day Surgery, Intensive Care and Intermediate Care Units, Level II NICU, Neurology Services, Occupational Health, Oncology Services, Pain Center, Pastoral Care: 24-hour chaplains, Primary Stroke Center, Robotic Surgery, Sleep Diagnostics Services, The Joint Academy, Therapy Services, Wound/Ostomy Continence Center.

St. Mary Medical Center Outpatient Facilities:

Cancer Care Center, Hobart
Cardiac Rehabilitation, St. Mary Medical Center, Hobart
Outpatient Rehabilitation of St. Mary Medical Center, Hobart
Outpatient Surgery at Lake Park, Hobart
Portage Health Center I & II, Portage
South Valpo Immediate Care, Family Practice & Physical Therapy, Valparaiso
Valparaiso Health Center of St. Mary Medical Center, Valparaiso
Willowcreek Health Center, Portage
Winfield Family Health Center, Winfield

Community Stroke & Rehabilitation Center

Address: 10215 Broadway
Crown Point, IN 46307
Website: **COMHS.org/about-us/community-stroke-and-rehabilitation-center/contact-us**

Administrator: Craig Bolda

Community Stroke & Rehabilitation Center is a multispecialty hospital located in Crown Point, Indiana. The Community Stroke & Rehabilitation Center provides a comprehensive inpatient rehabilitation experience allowing patients who have been disabled by injury or illness to improve their functional abilities and transition to a better quality of life at home.

Interdisciplinary teams are led by licensed medical, physical and rehabilitation specialists who provide personalized treatment plans, coordinating care with case management, neuropsychologists, physical, occupational and speech therapists, recreation therapists and rehabilitation nurses.

Therapy regimens in acute rehabilitation consist of at least three hours of physical, occupational or speech sessions or any combination of these, five days a week. The rehabilitation team puts the patient at the center of care acknowledging the unique physical, emotional and spiritual needs. The team provides support and resources to help each patient achieve and maintain their personal goals.

List of Services (Service Lines):

Clinical Laboratory
Diagnostic Imaging
Diagnostic Cardiology
Immediate Care Center
Outpatient Therapy Services
Physician Specialties
Valori Kolarczyk Healing Garden
Women's Diagnostic Center

Acknowledgments

For the 2022-2025 Community Health Needs Assessment (CHNA) and Implementation Strategy (IS) cycle, Community Healthcare System worked with Conduent/Healthy Communities Institute (HCI) for professional assistance with strategic planning development and metrics tracking.

Community Benefit Leadership and Team

- Marie Forszt, Vice President Marketing and Corporate Communications
- Mary Fetsch, Director, Marketing and Corporate Communications
- Debra Gruszecki, Director, Community Relations and Outreach
- Khisha Anderson, Community Outreach Specialist
- Christopher Manojlovich, Corporate Controller, Finance
- Wendy Czajkowski, Program Manager, Process Improvement

Consultants

Community Healthcare System collaborated with HCI to support report preparation for its 2022 CHNA. HCI works with clients across the nation to drive community health outcomes by assessing needs, developing focused strategies, identifying appropriate intervention programs, establishing monitoring systems and implementing performance evaluation processes. To learn more about HCI, please visit www.conduent.com/community-population-health.

The following HCI team members were involved in the development of this report:

- Eileen Aguilar, MS – Public Health Consultant
- Era Chaudhry, MPH MBA – Public Health Senior Analyst
- Olivia Dunn – Research Assistant
- Dari Goldman, MPH – Senior Project Specialist

Community Input

Development of the 2022-2025 CHNA was a collective effort by Community Healthcare System employees, residents, church and civic leaders, educators, healthcare professionals and community-serving organizations with a deep understanding of the issues and needs of our residents.

Community Healthcare System gratefully acknowledges this dedicated group for giving generously of their time and expertise to help guide this CHNA process.

Review of 2019-2021 Community Health Needs Assessment (CHNA)

An important part of the 2022-2025 CHNA is revisiting the progress made on priority topics from previous CHNAs. This takes place because the CHNA process is viewed as a three-year cycle. By reviewing the actions taken to address priority areas and evaluating the impact of these actions in the community, an organization can best focus its efforts over the next CHNA cycle. The 2019-2021 CHNA was completed in collaboration with the other area healthcare systems. Implementation strategies were finalized for Community Hospital, St. Catherine Hospital and St. Mary Medical Center.
Community Stroke & Rehabilitation Center was not included in the previous CHNA because the facility did not open until September 2019; after the report was formally approved.

Priority Health Needs from Preceding CHNA

Community Healthcare System based their 2019-2021 implementation strategies on these priority health areas:

- Cancer
- Diabetes
- Heart Disease and Stroke
- Nutrition and Weight status
- Maternal, Infant, and Child Health
- Adult Mental Health

Community Healthcare System did not have a formal process in place to track, evaluate or give feedback on the impact of the 2019-2021 CHNA. However, Community Healthcare System supplied participants of hospital and community-based outreach events, classes, screenings and programs with evaluations on the effectiveness of that outreach. Based on feedback from these evaluations, data from The Indiana Department of Health (IDOH) and the Centers for Disease Control and Prevention (CDC), program evaluation and development continued an annual basis.

Below lists some of the 2019-2021 programs that were offered in-person or virtually:

Cancer

- Cancer Survivorship program
- Expanded National Cancer Survivors Day
- Virtual support groups

Diabetes, Heart Disease, Neurology and Stroke

- Cardiovascular symposium
- Diabetes and Stroke Awareness health fairs
- Established Cardiovascular Disease Prevention program
- Expanded Diabetes community education presentations
- Established L.I.V.E. (Limb Ischemic Vascular Excellence) screening program
- Expanded stroke support group
- Northwest Indiana Health Summit
- Neurology symposium

- Know your Numbers health fair
- Smoking cessation classes
- Heart health awareness presentations

Maternal, Infant, and Child Health

- Breastfeeding campaigns
- Established new classes for breastfeeding, labor and delivery
- Extraordinary Women Conference (canceled due to COVID-19)
- Mom and Baby showers with Nurse-Family Partnership
- Safe Sleep campaigns and Baby Fairs

Nutrition, Exercise, and Obesity

- Created Healthy Eating Series
- Established Health Zone for annual Kawann Short football camps
- Established bi-monthly group walks and low-impact exercise classes for public
- Expanded Well Walkers club across the healthcare system
- Launched Walk and Talk with a health provider at a university-owned arboretum

Mental Health

- Alzheimer's awareness classes
- Healthy Mind; Healthy Body symposium
- Suicide Prevention Awareness vigils and education campaigns

The 2019 Community Health Needs Assessment Reports and Implementation Strategies are available to the public via the website https://www.comhs.org/about-us/community-health-needs-assessment

No comments had been received on the preceding CHNA at the time this report was written.

To collect comments or feedback for this cycle, Community Healthcare System is working to add a feedback link that will be located under the Contact Us section of the website, COMHS.org

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Section 2: SERVICE AREA DEMOGRAPHICS

The following section explores the demographic profile of Community Healthcare System's service areas in Lake and Porter counties. It is important to understand the demographics of a community because it can significantly impact its health profile. Communities are becoming more diverse with different races and ethnicities, gender identities, ages and socioeconomic groups. Each component has its own unique needs and requires varied approaches to health improvement efforts.
All demographic estimates are sourced from Claritas Pop-Facts® (2021 population estimates) and American Community Survey one-year (2019) or five-year (2015-2019) estimates, unless otherwise indicated.

Lake County

Lake County is the second-most populous county in the state of Indiana, boasting a population of 484,442 residents in 2021. Lake County is in the northwest corner of the state and is part of the Chicago metropolitan area. The county contains a mix of urban, suburban and rural areas spanning 11 townships, 19 cities/towns and 626 square miles. The county is named after its northern border of Lake Michigan (StatsIndiana, 2022 and IN.gov).

Porter County

Porter County is in the northern edge of Indiana, east of Lake County. The population in 2021 was 171,436 making it the 10th most populous county in Indiana. The largest city is Portage by area (square miles), and the county seat is Valparaiso. Porter County is 51 miles from Chicago, Illinois, and is considered part of the Chicago metropolitan area. Porter County's urban, suburban and rural areas total 522 square miles. The county's 12 townships, eight cities/towns are bordered on the north by Lake Michigan and on the south by the westward Kankakee River (StatsIndiana, 2022 and IN.gov).

Primary Service Area

The geographical boundaries of Community Healthcare System are in Lake and Porter counties. The primary service areas (PSA) are shown in the map below **(Figure 2)**. It is defined by 16 zip codes, spanning Lake County and Porter County. The zip codes and percentage of the patient population that resides in each zip code within PSA are shown below **(Table 1).**

FIGURE 2: COMMUNITY HEALTHCARE SYSTEM PRIMARY SERVICE AREA

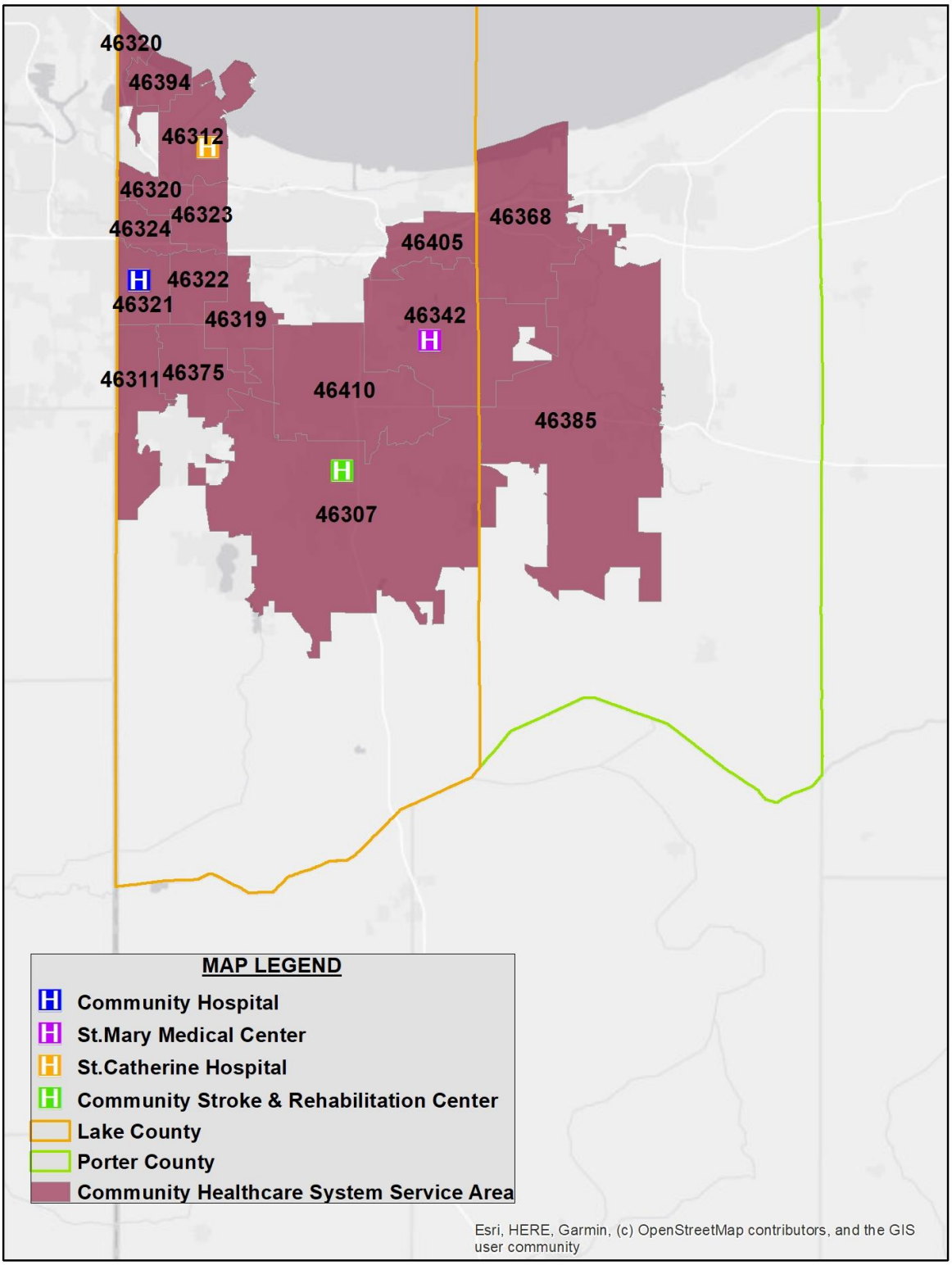


TABLE 1: PATIENT POPULATION SIZE BY SERVICE AREA

Community Healthcare System			
Zip Code	Population	**Zip Code**	Population
46307	66,057	**46324**	21,329
46311	22,135	**46342**	30,706
46312	26,768	**46368**	39,590
46319	17,875	**46405**	10,999
46320	14,082	**46410**	39,757
46321	23,136	**46375**	24,035
46322	22,482	**46394**	10,880
46323	21,315	**46385**	41,840
Total		432,986	

Demographics

The following section explores the demographic profile of Lake and Porter counties. The demographics of a community significantly impact its health profile. Different race/ethnic, age and socioeconomic groups may have unique needs and require varied approaches to health improvement efforts.

All demographic estimates are sourced from Claritas Pop-Facts® (2021 population estimates) and American Community Survey one-year (2019) or five-year (2015-2019) estimates unless otherwise indicated.

Population

Lake County has an estimated population size of 484,442. The city of Hammond is the most populated in the county. The city of Gary is the largest based on square miles. The largest zip code by population in the county is 46307 (Crown Point) and the smallest zip code is 46376 (Schneider).

Porter County population has an estimated population size of 171,436. The largest zip code by population in Porter County is 46385 (Valparaiso) and the smallest is 46347 (Kouts).

Figure 3 shows the population distribution by zip code within Lake and Porter counties. The darkest pink represents zip codes with the largest population.

FIGURE 3: POPULATION SIZE BY ZIP CODE

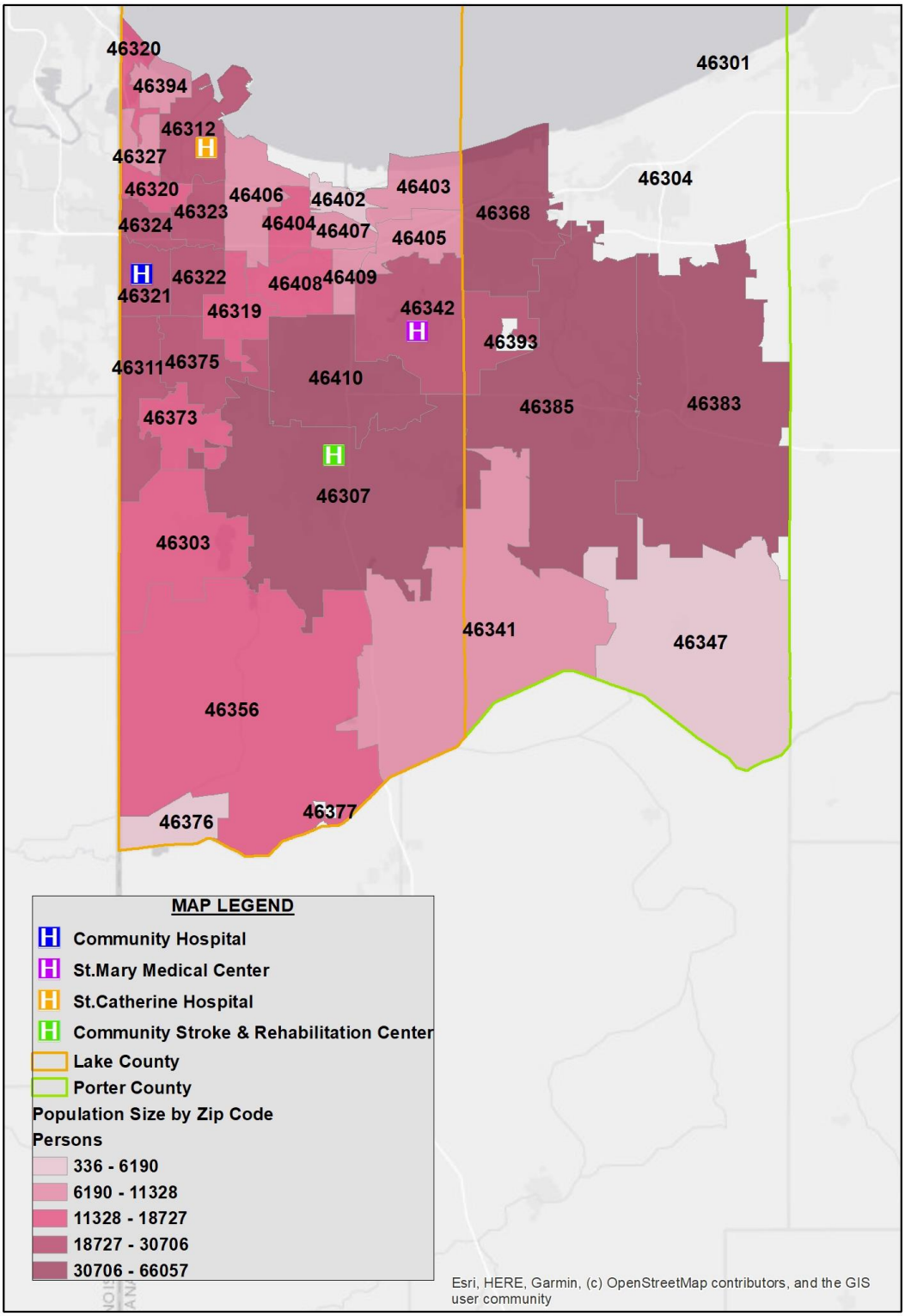
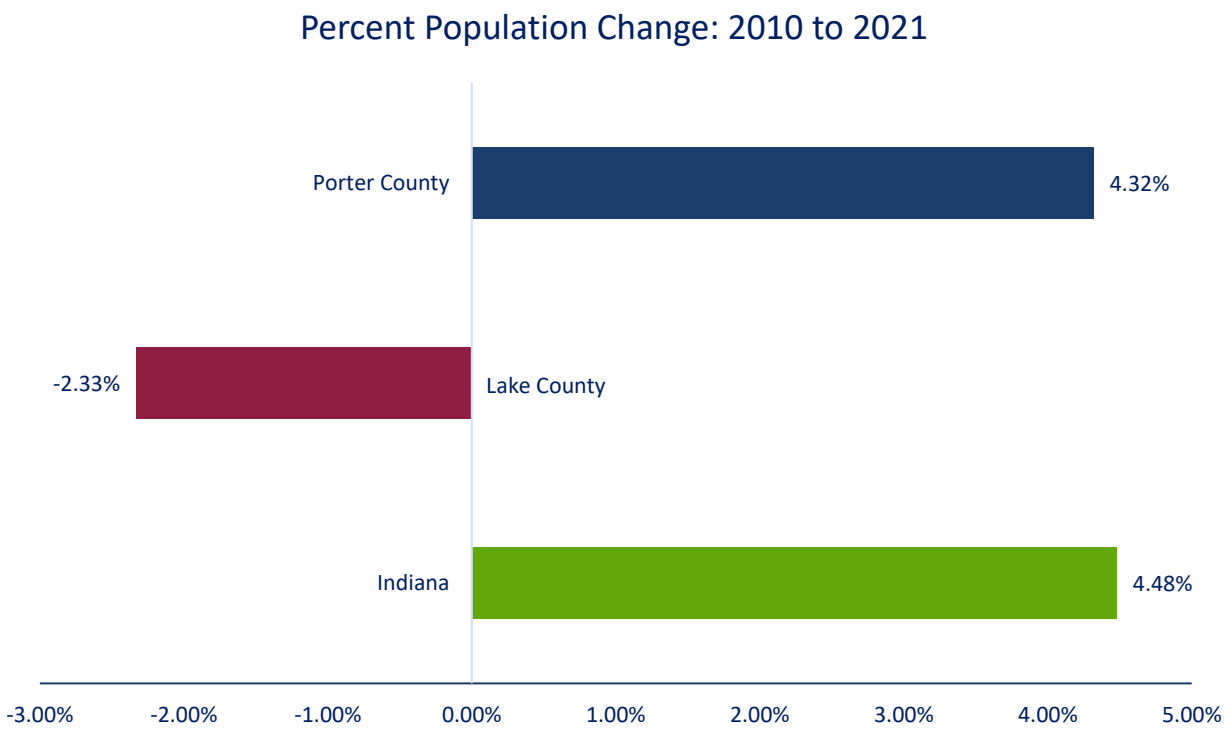


Figure 4 shows the change in population in Lake and Porter counties compared to Indiana. From 2010 to 2021, Porter County's population increased by 4.32%, whereas Lake County population decreased by 2.33%. The state of Indiana's population increased 4.48% between 2010 and 2021.

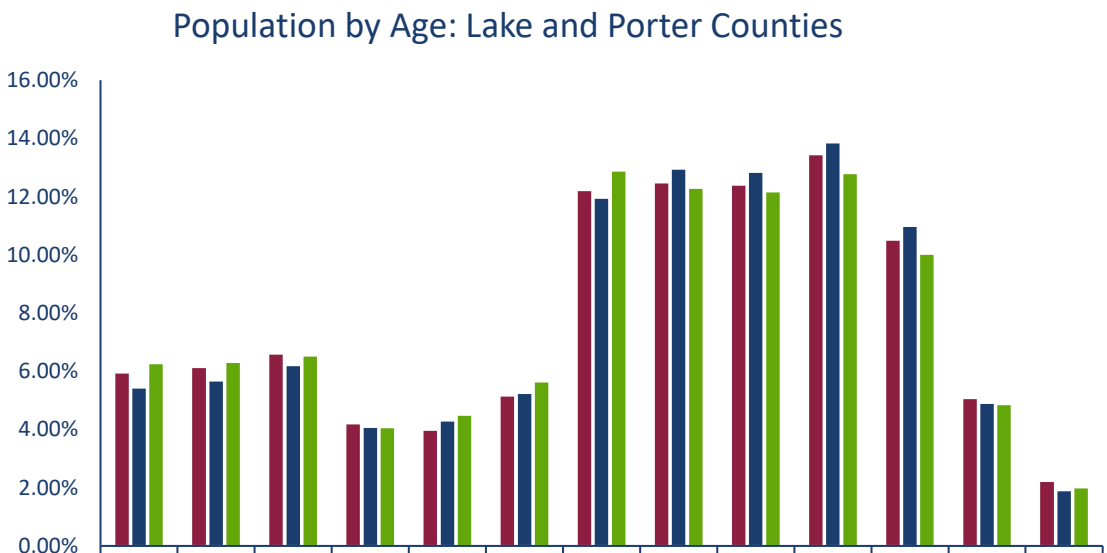
FIGURE 4: PERCENT OF POPULATION



Age

Figure 5 shows the population by age group in Indiana, Lake and Porter counties. Interesting to note, Lake County's population trends toward the younger age groups; slightly larger than Porter County's population, but nearly equal to the state. Porter County had a slightly larger population of adults ages 35-74 than Lake County and the state.

FIGURE 5: POPULATION BY AGE

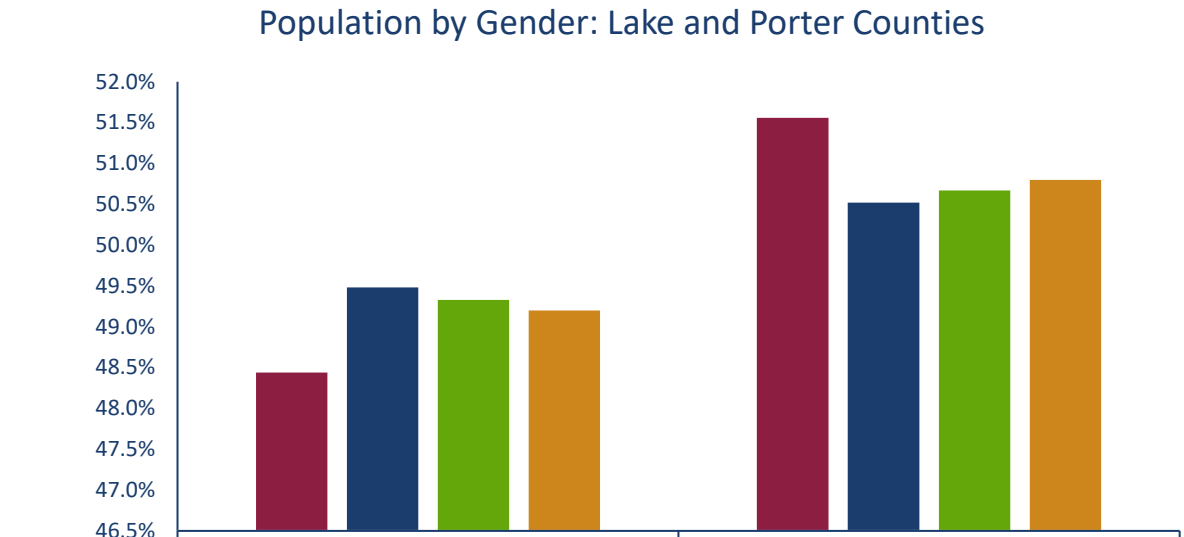


	0-4	5-9	10-14	15-17	18-20	21-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
Lake County	5.92%	6.11%	6.57%	4.17%	3.95%	5.13%	12.19%	12.45%	12.37%	13.42%	10.48%	5.04%	2.20%
Porter County	5.41%	5.65%	6.18%	4.05%	4.27%	5.22%	11.93%	12.93%	12.81%	13.83%	10.96%	4.88%	1.88%
Indiana	6.24%	6.28%	6.51%	4.04%	4.47%	5.61%	12.86%	12.27%	12.15%	12.77%	10.00%	4.83%	1.97%

Gender

Figure 6 shows population by gender in Lake and Porter counties. In Lake County, males comprise 48.4% of the population, whereas females comprise 51.6% of the population. In Porter County, males comprise 49.5% and females, 50.5% of the population. There are slightly more women in the United States than men. In the era of gender fluidity, the percentage of persons who identified as someone other than transgender or cisgender, a person whose gender identity is the same as their sex assigned at birth, was less than 1% of the population surveyed for this project.

FIGURE 6: POPULATION BY GENDER



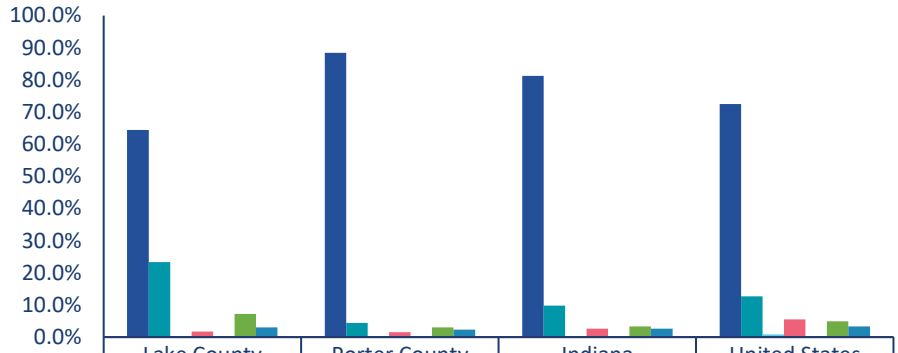
	Male	Female
Lake County	48.4%	51.6%
Porter County	49.5%	50.5%
Indiana	49.3%	50.7%
United States	49.2%	50.8%

Race and Ethnicity

Race and ethnicity contribute to the opportunity individuals and members of a community must have to be healthy. **Figure 7** shows the population by race in Lake and Porter counties.

The Lake County 2021 population is 64.5% White, 23.3% Black/African American and 1.7% Asian/Asian American. The Porter County 2021 population is 88.4% White, 4.4% Black/African American and 1.5% Asian/Asian American. Those who identified as other, or more than one race, was higher in Lake County than in any of the entries in that category.

FIGURE 7: POPULATION BY RACE

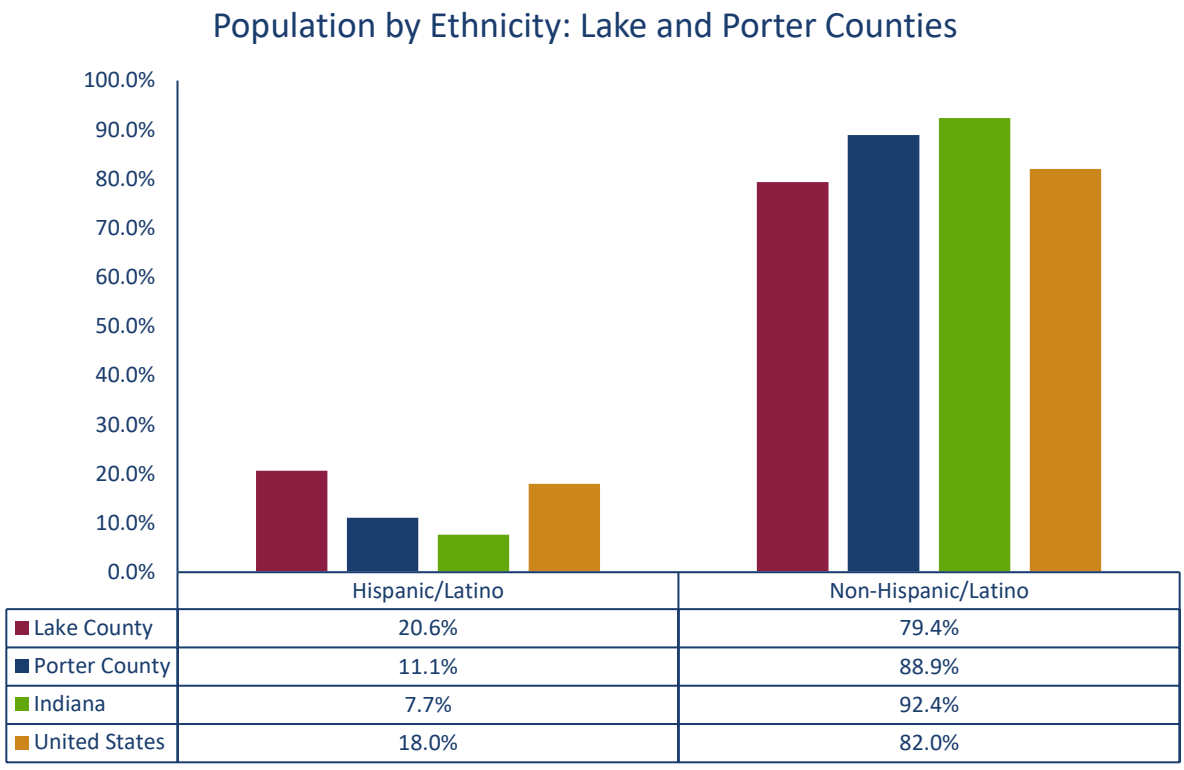


	Lake County	Porter County	Indiana	United States
White or Caucasian	64.5%	88.4%	81.3%	72.5%
Black or African American	23.3%	4.4%	9.8%	12.7%
American Indian or Alaska Native	0.3%	0.3%	0.3%	0.9%
Asian or Asian American	1.7%	1.5%	2.7%	5.5%
Native Hawaiian or other Pacific Islander	0.03%	0.03%	0.1%	0.2%
Another race	7.2%	3.0%	3.3%	4.9%
More than one race	3.0%	2.4%	2.6%	3.3%

Figure 8 shows the population by ethnicity for Lake and Porter counties. Approximately 20.6% of the population in Lake County identifies as Hispanic/Latino and 11.1% in Porter County. Both counties' percentages are higher than the state of Indiana.

For purposes of the survey, the number of ethnicities used for data collection was limited. However, it is recognized that Northwest Indiana's population includes a variety of people with ethnicities and nationalities from Europe, the Middle East and other sectors around the world.

FIGURE 8: POPULATION BY ETHNICITY



	Hispanic/Latino	Non-Hispanic/Latino
Lake County	20.6%	79.4%
Porter County	11.1%	88.9%
Indiana	7.7%	92.4%
United States	18.0%	82.0%

Social & Economic Determinants of Health

This section explores the economic, environmental and social determinants of health for Lake and Porter counties**.** Social determinants are the conditions in which people are born, live, learn, work, play, worship and age. These wider sets of forces and systems shape the conditions of daily life.

The Social Determinants of Health can be grouped into domains.

Figure 9 shows the Healthy People 2030 Social Determinants of Health domains (Healthy People 2030, 2022). It should be noted that county-level data can sometimes mask what could be going on at the zip code level in many communities. While indicators may be strong at the county level, zip code level analysis can reveal disparities.

FIGURE 9: HEALTHY PEOPLE 2030 SOCIAL DETERMINANTS OF HEALTH DOMAINS

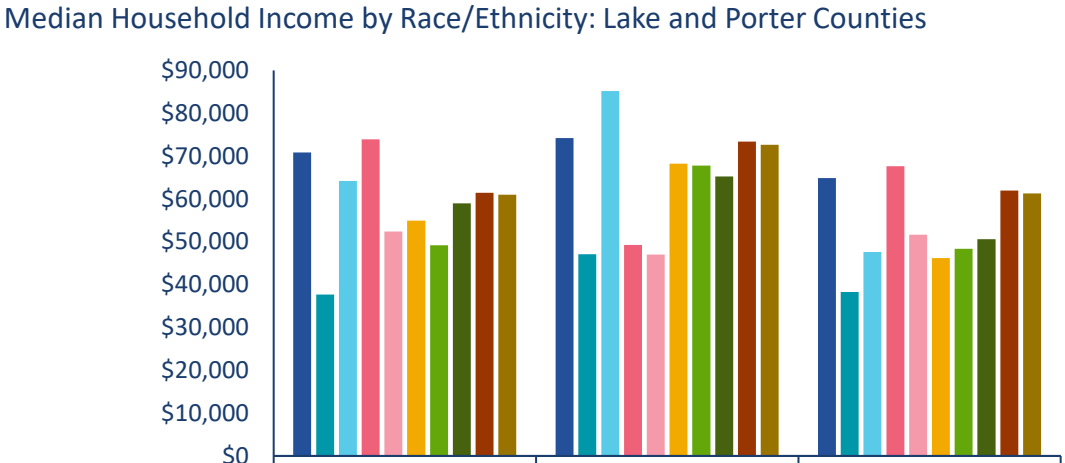
Income

Income has been shown to be strongly associated with morbidity and mortality, influencing health through various clinical, behavioral, social and environmental factors.
Those with greater wealth are more likely to have a higher life expectancy and reduced risk of a range of health conditions, including heart disease, diabetes, obesity and stroke. Poor health can also contribute to reduced income by limiting one's ability to work.

Figure 10 shows the median household income for Lake County is $60,982. In Porter County, the median household income is $72,677, higher than the state of Indiana at $61,300.

There are significant disparities by race/ethnicity. Black/African American communities are disproportionately affected by income gaps of $30,000 or more in both Lake and Porter counties. Income disparities also exist in the Hispanic/Latino and Native Hawaiian/Pacific Islander populations; not as substantial.

FIGURE 10: MEDIAN HOUSEHOLD INCOME



	Lake County	Porter County	Indiana
White	$70,815	$74,226	$64,859
Black/African American	$37,690	$47,097	$38,259
American Indian/Alaskan Native	$64,224	$85,174	$47,650
Asian	$73,930	$49,229	$67,667
Native Hawaiian/Pacific Islander	$52,381	$47,000	$51,655
Some Other Race	$54,941	$68,247	$46,222
2+ Races	$49,182	$67,800	$48,364
Hispanic/Latino	$58,947	$65,261	$50,602
Non-Hispanic/Latino	$61,418	$73,364	$61,934
Overall	$60,982	$72,677	$61,300

Source: Claritas, 2021

Poverty

Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. People living in poverty are less likely to have access to healthcare, healthy food, stable housing and opportunities for physical activity.
These disparities mean people living in poverty are more likely to experience poorer health outcomes and premature death from preventable chronic illness or disease.

Figure 11 shows the percentage of families living below the poverty level. The poverty rate in Lake County is 12.15%, a rate higher than Porter County at 7.57%, Indiana at 9.3% and the United States at 9.5%.

FIGURE 11: FAMILIES LIVING BELOW POVERTY

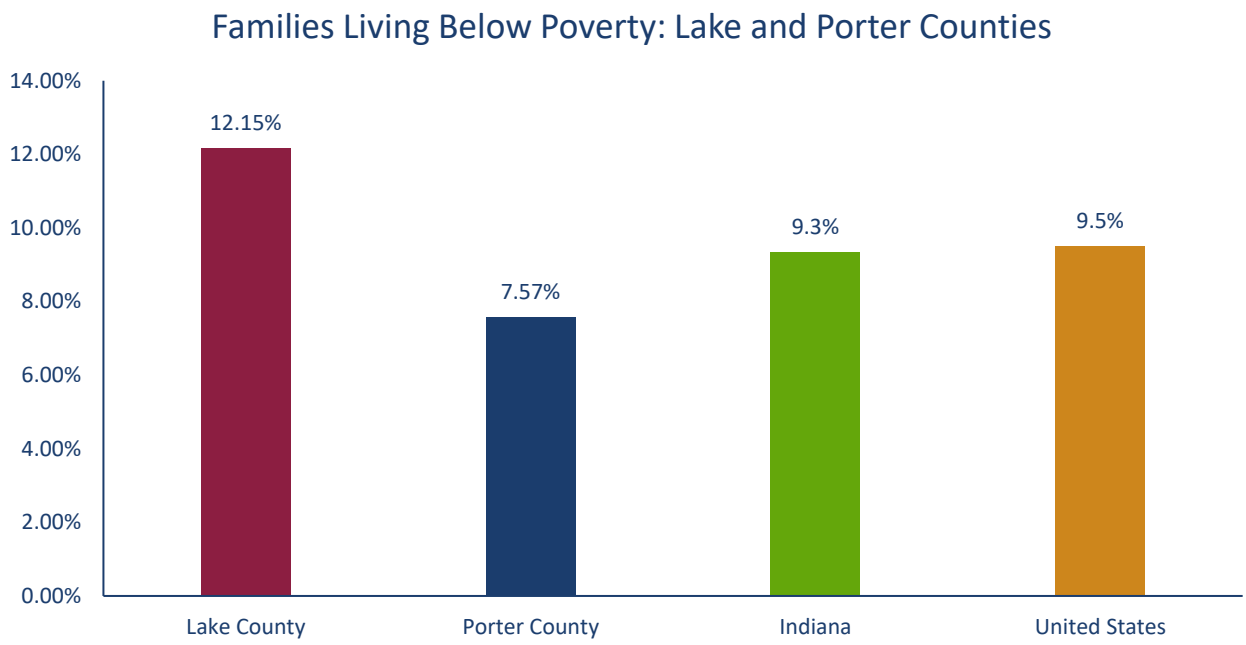
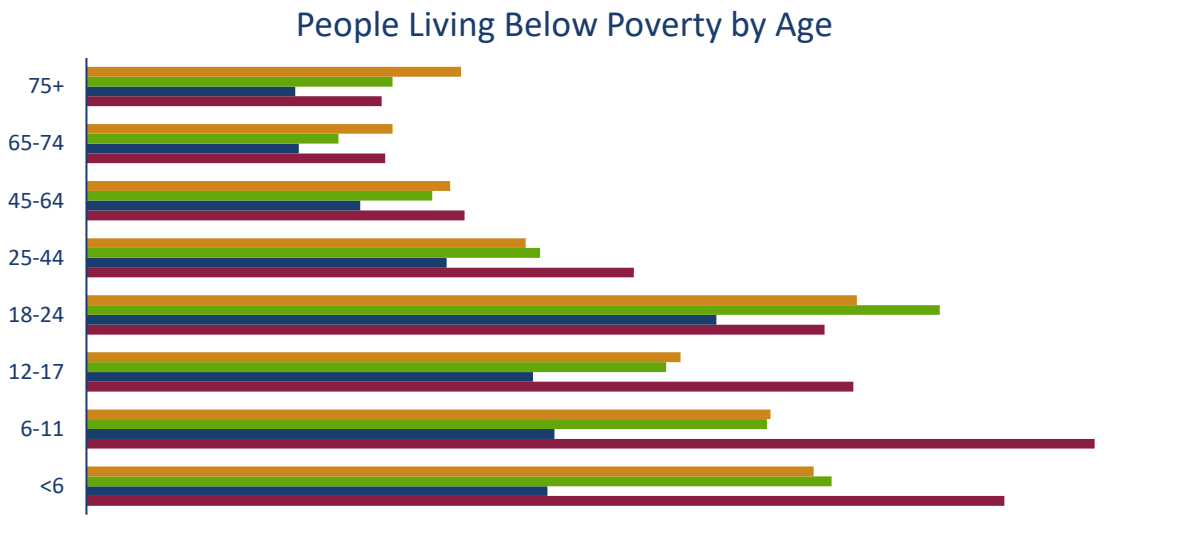


Figure 12 shows the percentage of population by age in Lake County, Porter County, Indiana, and the United States who are living below the poverty level.

In Lake County, children under the age of 11 comprise the largest age group who are living in poverty. In Porter County, those aged 18-24 comprise the largest segment of the population who live in poverty, followed by children 6-11 years old.

FIGURE 12: PEOPLE LIVING BELOW POVERTY BY AGE

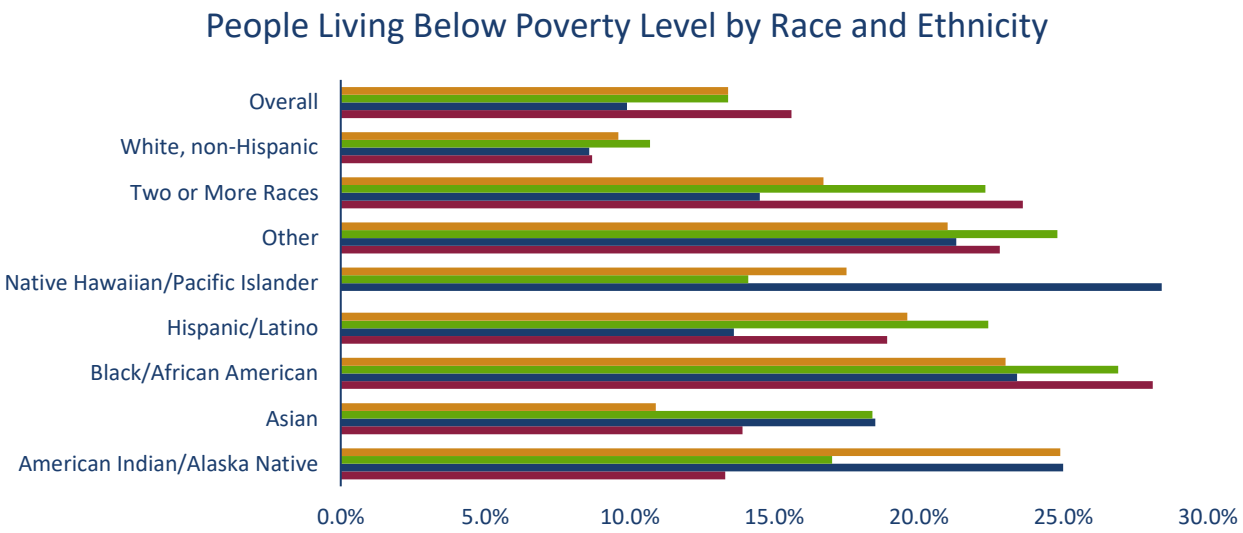


	<6	6-11	12-17	18-24	25-44	45-64	65-74	75+
United States	20.2%	19.0%	16.5%	21.4%	12.2%	10.1%	8.5%	10.4%
Indiana	20.7%	18.9%	16.1%	23.7%	12.6%	9.6%	7.0%	8.5%
Porter County	12.8%	13.0%	12.4%	17.5%	10.0%	7.6%	5.9%	5.8%
Lake County	25.5%	28.0%	21.3%	20.5%	15.2%	10.5%	8.3%	8.2%

Figure 13 shows the percentage of the population in Lake County and Porter County by race/ethnicity who are living below the poverty level.

The largest racial/ethnic group in Lake County who are living below the poverty level are those identifying as Black/African American at 28.1%, followed by those identifying as "two or more races" at 23.6%. In Porter County, Native Hawaiian/Pacific Islanders are the largest group with 28.4%, followed by American Indian/Alaska Native at 25.0%.

FIGURE 13: PEOPLE LIVING BELOW POVERTY BY RACE & ETHNICITY

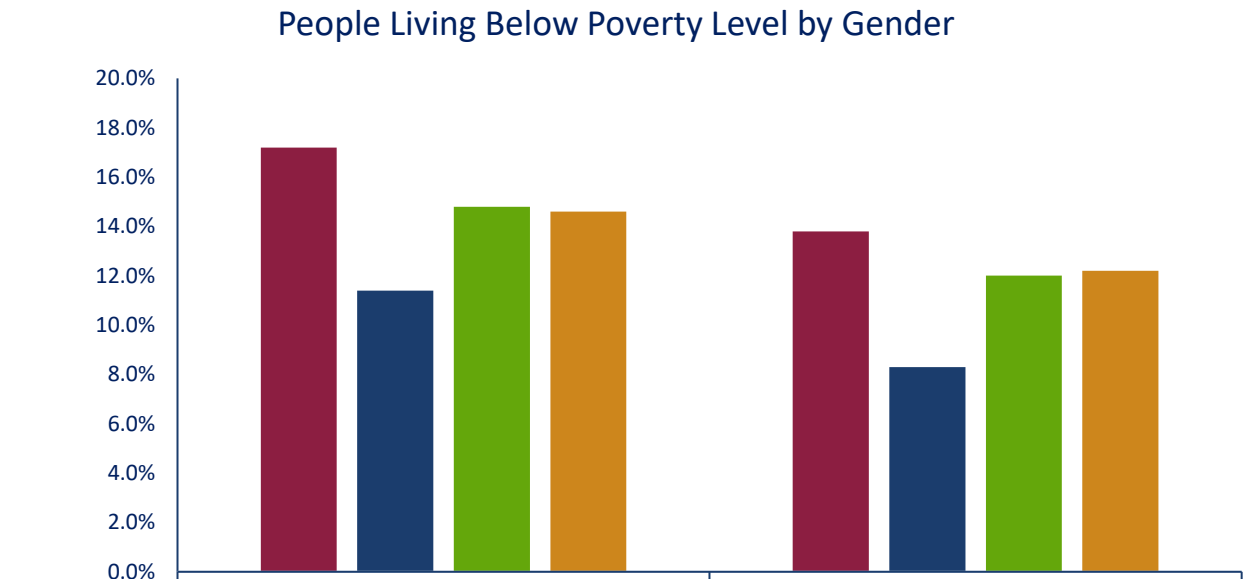


	American Indian/Alaska Native	Asian	Black/African American	Hispanic/Latino	Native Hawaiian/Pacific Islander	Other	Two or More Races	White, non-Hispanic	Overall
United States	24.9%	10.9%	23.0%	19.6%	17.5%	21.0%	16.7%	9.6%	13.4%
Indiana	17.0%	18.4%	26.9%	22.4%	14.1%	24.8%	22.3%	10.7%	13.4%
Porter County	25.0%	18.5%	23.4%	13.6%	28.4%	21.3%	14.5%	8.6%	9.9%
Lake County	13.3%	13.9%	28.1%	18.9%	0.0%	22.8%	23.6%	8.7%	15.6%

Figure 14 shows the percentage of the population in Lake and Porter counties compared to the state of Indiana and the United States by gender who are living below the poverty level.

Females make up a larger percentage of the population who are living in poverty in both Lake (17.2%) and Porter (11.4%) counties, Lake County's percentages are higher than the state of Indiana and the United States.

FIGURE 14: PEOPLE LIVING POVERTY LEVEL BY GENDER



	Female	Male
Lake County	17.2%	13.8%
Porter County	11.4%	8.3%
Indiana	14.8%	12.0%
United States	14.6%	12.2%

Employment

The employment rate in a community is a key indicator of the local economy. An individual's type and level of employment impact access to healthcare, the work environment and health behaviors and outcomes. Stable employment can help provide benefits and conditions for maintaining good health. In contrast, poor or unstable work and working conditions are linked to poor physical and mental health outcomes.

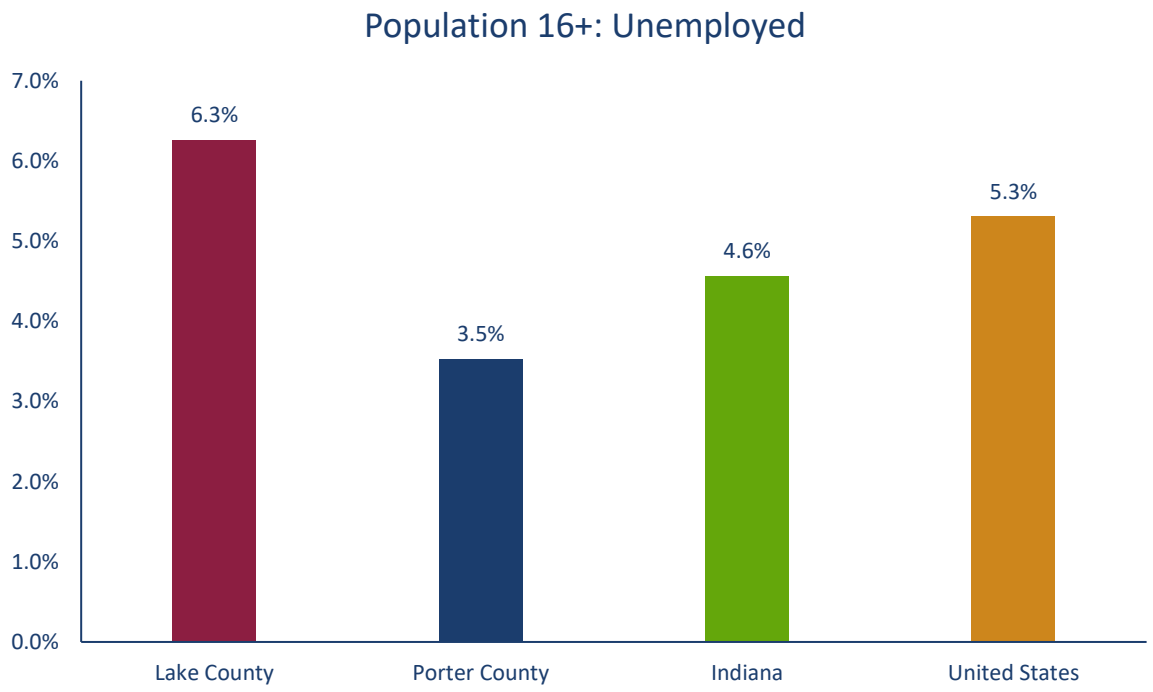
Unemployment and underemployment can limit access to health insurance coverage and preventive care services. Underemployment is described as involuntary part-time, poverty-wage and insecure employment, a term classifying individuals as being among the "working poor."

In 2021, a national push to increase the minimum wage to $15-per-hour gained momentum as a remedy for underemployed individuals.

Type of employment and working conditions can also have significant impacts on health. Work-related stress, injury and exposure to harmful chemicals are examples of ways employment can lead to poorer health.

Figure 15 shows the percentage of the population 16+ who are unemployed in Lake and Porter Counties, compared to the state and United States values. Lake County has a larger percentage of the population who are unemployed (6.3%).

FIGURE 15: POPULATION 16+ UNEMPLOYED



Housing

Safe, stable, and affordable housing provides a critical foundation for health and wellbeing.

When families must spend a large part of their income on housing, they may not have enough money to pay for things like healthy food or healthcare. This is linked to increased stress, mental health problems and an increased risk of disease.

Figure 16 shows renters who spend 30% or more of their household income on rent. In Lake County, 48.4% of renters spend 30% of their income or more compared to Porter County where just 46.6% of renters do. Both counties are below the United States value of 49.6%.

FIGURE 16: RENTERS SPENDING 30% MORE OF HOUSEHOLD INCOME ON RENT

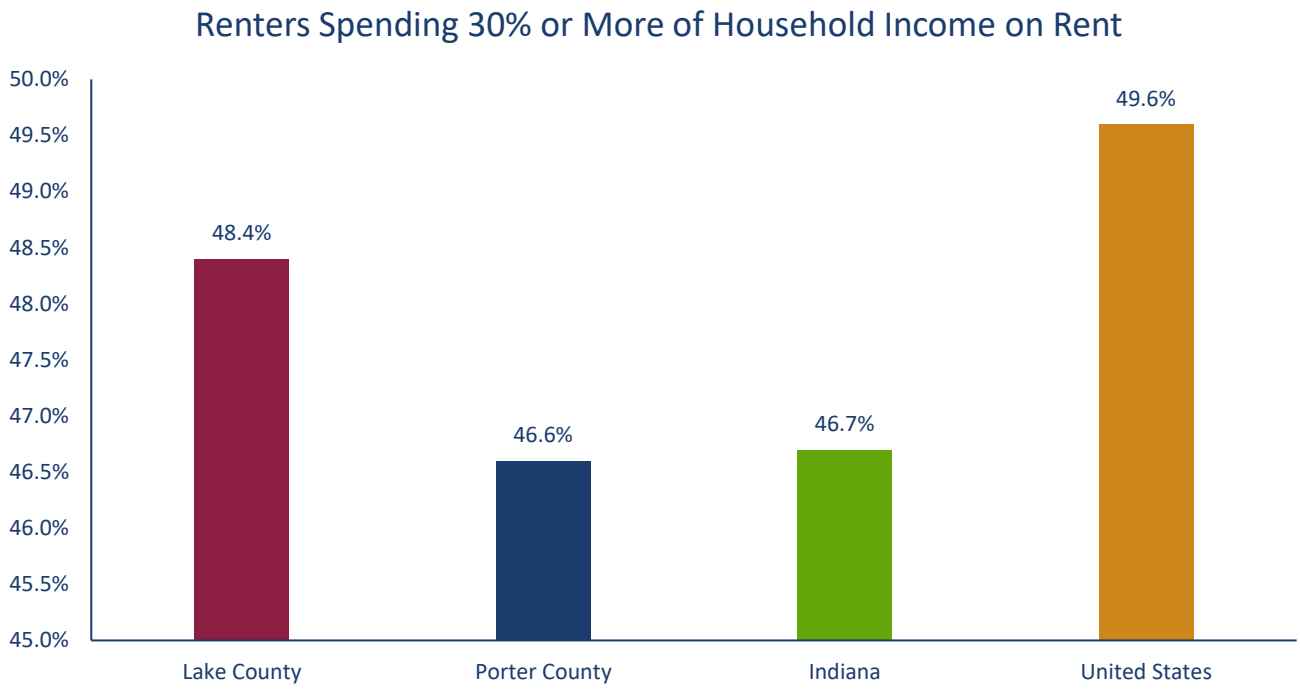


Figure 17 shows mortgaged owners who spend 30% or more of their household income on housing. In Lake County, 20.1% of mortgaged owners spend 30% of their income or more compared to Porter County where just 19.2% of mortgaged owners do. Both counties are below the United States value of 26.5%.

FIGURE 17

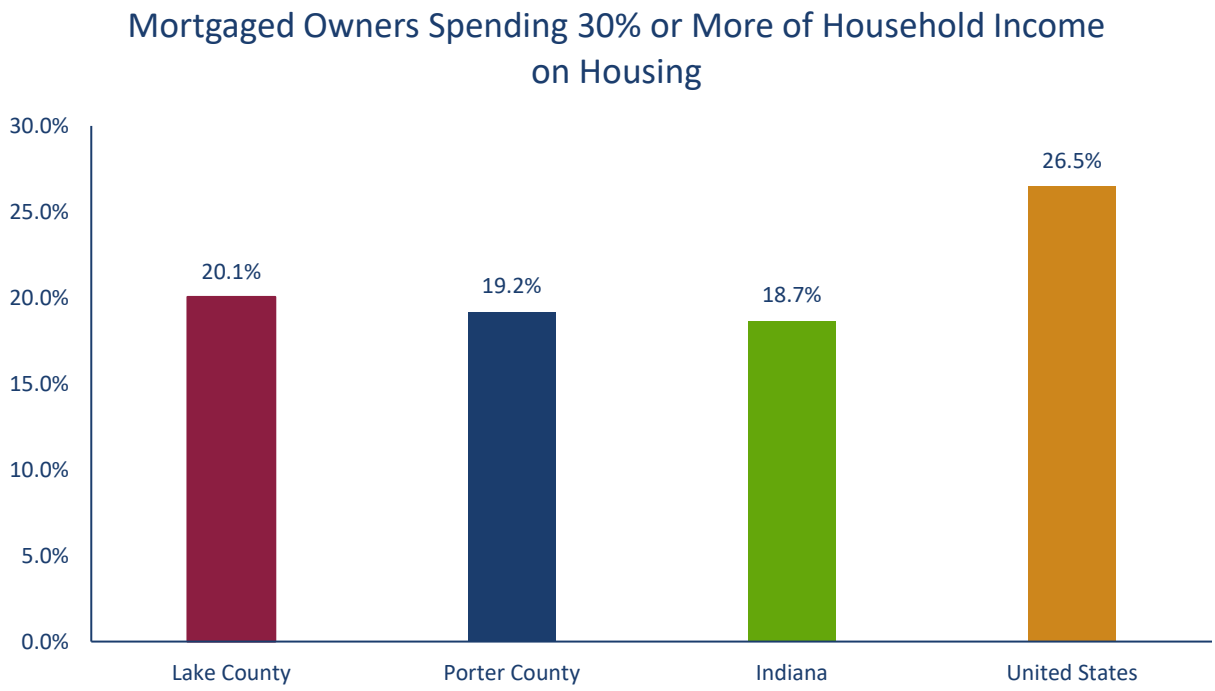
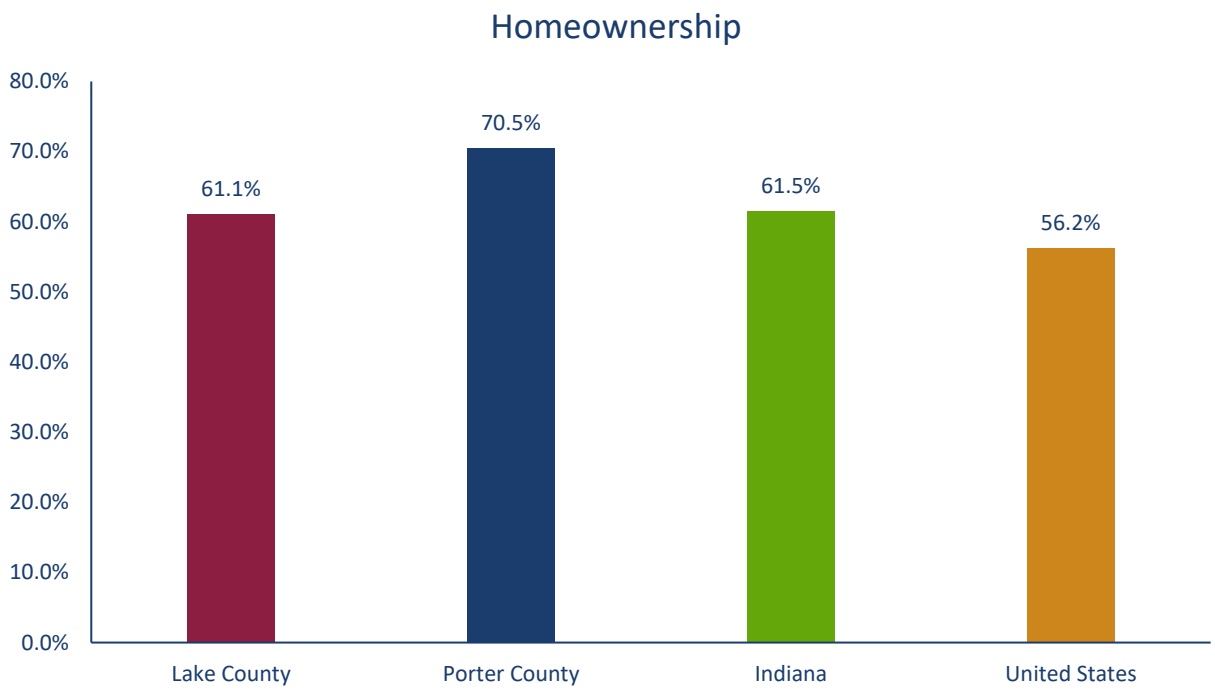


Figure 18 shows the percentage of homeownership in Lake and Porter counties.

Porter County has the highest percentage of housing units occupied by homeowners at 70.5%. In Lake County, 61.1% of housing units are occupied by homeowners, similar to the state of Indiana at 61.5%.

FIGURE 18: HOMEOWNERSHIP



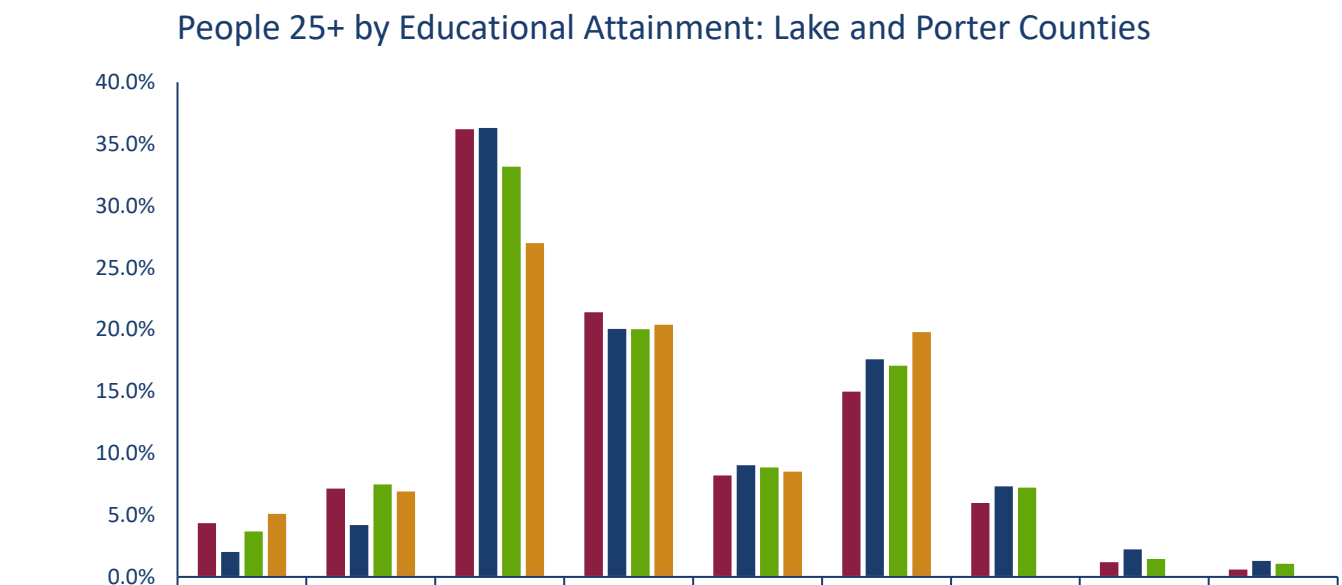
Education

Education is an important indicator of health and wellbeing across an individual's lifespan.

Education can lead to improved mental, social and physical health by providing better job opportunities with higher income. People with higher levels of education are likely to practice health-promoting behaviors, respond appropriately to a diagnosis, experience better health outcomes and live a longer life.

Figure 19 shows the percentage of the population aged 25+ years by educational attainment. In Lake (36.2%) and Porter (36.3%) counties, most individuals age 25+ are high school graduates, followed by some college, no degree (Lake County at 21.4%, Porter County at 20.1%).

FIGURE 19: EDUCATIONAL ATTAINMENT OF PEOPLE 25+



	Less than 9th Grade	Some High School, No Diploma	High School Graduate	Some College, No Degree	Associate Degree	Bachelor's Degree	Master's Degree	Professional Degree	Doctorate Degree
Lake County	4.4%	7.1%	36.2%	21.4%	8.2%	15.0%	6.0%	1.2%	0.6%
Porter County	2.0%	4.2%	36.3%	20.1%	9.0%	17.6%	7.3%	2.2%	1.3%
Indiana	3.7%	7.5%	33.2%	20.0%	8.8%	17.1%	7.2%	1.5%	1.1%
United States	5.1%	6.9%	27.0%	20.4%	8.5%	19.8%			

Section 3: DATA COLLECTION AND ANALYSIS

Overview

The 2022-2025 CHNA combined primary and secondary data to identify current health-related issues in Lake and Porter counties.

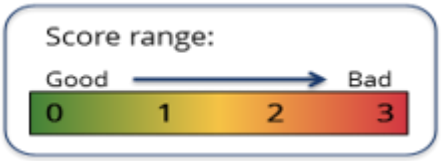
Primary data was acquired directly from the community-at-large through virtual meetings. At the time of primary data collection, Lake and Porter counties were experiencing a rise in COVID-19 cases due to the Delta variant of SARS-CoV-2. The data collection was conducted in English and Spanish, when applicable, and consisted of a community-wide survey campaign, three focus groups and a listening session. Secondary health indicator data was collected from public sources such as federal, state and local health departments.

Secondary Data Sources

Secondary data used for this assessment were collected and analyzed with the HCI Community Dashboard — a web-based community health platform developed by HCI. The Community Dashboard brings a wealth of information to one accessible, user-friendly location. It includes more than 260 community and behavioral health indicators covering some 25 topics in the areas of health, determinants of health and quality of life. The data is primarily derived from secondary data sources such as state and national sites. The value for each of these indicators is compared to other communities, nationally or locally set targets and to previous time periods.

Secondary Data Scoring

HCI's Data Scoring Tool® was used to systematically summarize multiple comparisons across the Community Dashboard to rank indicators based on the highest need. For each indicator, the Lake and Porter counties' value was compared to a distribution of Indiana and US counties, state and national values, Healthy People 2030 and significant trends. Each indicator was then given a score based on the available comparisons. These scores range from 0 to 3, where 0 indicates the best outcomes and 3 the worst.



Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected from other communities, and changes in methodology over time. These indicators were grouped into topic areas for a higher-level ranking of community health needs.

Table 2 shows the secondary data topics scoring results for Lake and Porter counties. Please see **Appendix A** for further details on the quantitative data scoring methodology.

TABLE 2. SECONDARY DATA TOPIC SCORING RESULTS

Lake County		Porter County	
Health and Quality of Life Topics	**Score**	**Health and Quality of Life Topics**	**Score**
Wellness & Lifestyle	**2.15**	**Cancer**	**1.74**
Other Conditions	**2.14**	**Older Adults**	**1.68**
Older Adults	**2.05**	**Other Conditions**	**1.65**
Prevention & Safety	**1.97**	**Physical Activity**	**1.63**
Diabetes	**1.95**	**Women's Health**	**1.61**
Children's Health	**1.92**	**Heart Disease & Stroke**	**1.57**
Heart Disease & Stroke	**1.85**	**Prevention & Safety**	**1.46**
Physical Activity	**1.75**	**Environmental Health**	**1.44**
Community	**1.70**	**Alcohol & Drug Use**	**1.38**
Education	**1.69**	**Children's Health**	**1.34**
Economy	**1.68**	**Diabetes**	**1.33**
Cancer	**1.67**	**Oral Health**	**1.33**
County Health Rankings	**1.67**	**Maternal, Fetal & Infant Health**	**1.33**
Environmental Health	**1.66**	**County Health Rankings**	**1.31**
Maternal, Fetal & Infant Health	**1.64**	**Mental Health & Mental Disorders**	**1.26**
Alcohol & Drug Use	**1.59**	**Respiratory Diseases**	**1.23**
Women's Health	**1.58**	**Community**	**1.17**

Community Input Collection & Analysis

The purpose of the CHNA is to determine what the community believes are the most important health issues facing them and their families. To ensure the perspectives of community members were included, several opportunities were offered to collect input from the residents of Lake and Porter counties. The primary data used in this assessment consisted of an online survey and focus groups available in English and Spanish. These findings combined with the secondary data analysis provided Community Healthcare System with the key health needs for the 2022-2025 CHNA.

As previously mentioned, the assessment was conducted during a high point of the COVID-19 pandemic. Primary data collection methods were conducted in the safest way possible. To maintain the health and wellbeing of the participants, in-person data collection was substituted with online communication.

Virtual meetings were scheduled with help from community organizations to assist in the survey process as well as the promotion, recruitment and logistical needs for local participation by community members in focus groups.

Participants were asked to list and describe resources or assets available in their local community that can help address key health issues. Although not reflective of every resource available in the community, the list can help Community Healthcare System expand and support existing programs and resources. The compiled list of community assets is available in **Appendix D**.

Community Survey

Community input was collected through an online community survey available in English and Spanish from Sept. 22, 2021, through Nov. 17, 2021. The survey consisted of 55 questions related to top health needs in the community and everyone's perception of their overall health, access to healthcare services, as well as social and economic determinants of health. Announcements promoting the community surveys in Lake and Porter counties included a press release, radio broadcast, social media and emails blasts to various organizations, Community Healthcare System staff, internal and external teams. A total of 1,741 responses were collected, 1,385 from Lake County and 356 from Porter County. Response rates for both counties met the target rate of collecting more than 768 surveys.

Surveys were completed in English and Spanish. Seventy-eight percent of survey respondents described themselves as White or Caucasian (**Figure 20)** and 14% as Hispanic/Latino/Latinx (**Figure 21).** The largest age group ranged from 55-64, followed by 45-56 **(Figure 22**). Most respondents identified as female (**Figure 23**) and 26.69% had a bachelor's degree, followed by 17.55% with an associate degree (**Figure 24).**

FIGURE 20: RACE OF COMMUNITY SURVEY RESPONDENTS

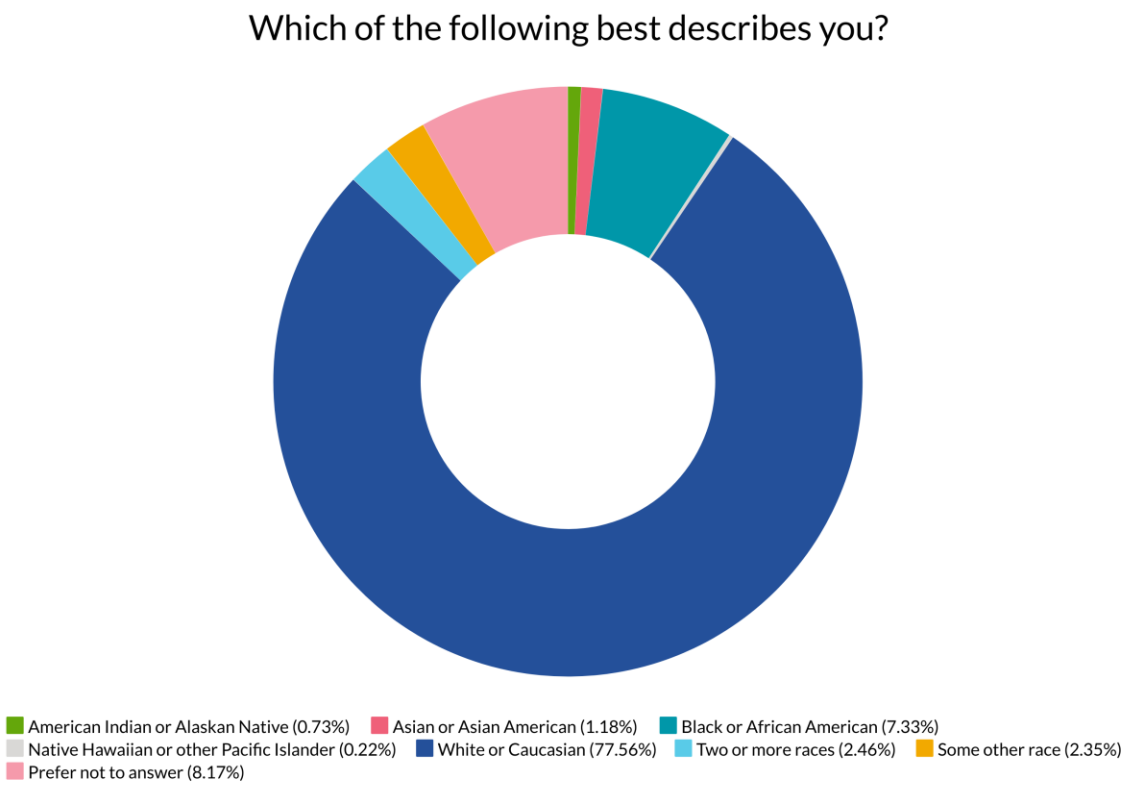


FIGURE 21: ETHNICITY OF COMMUNITY SURVEY RESPONDENTS

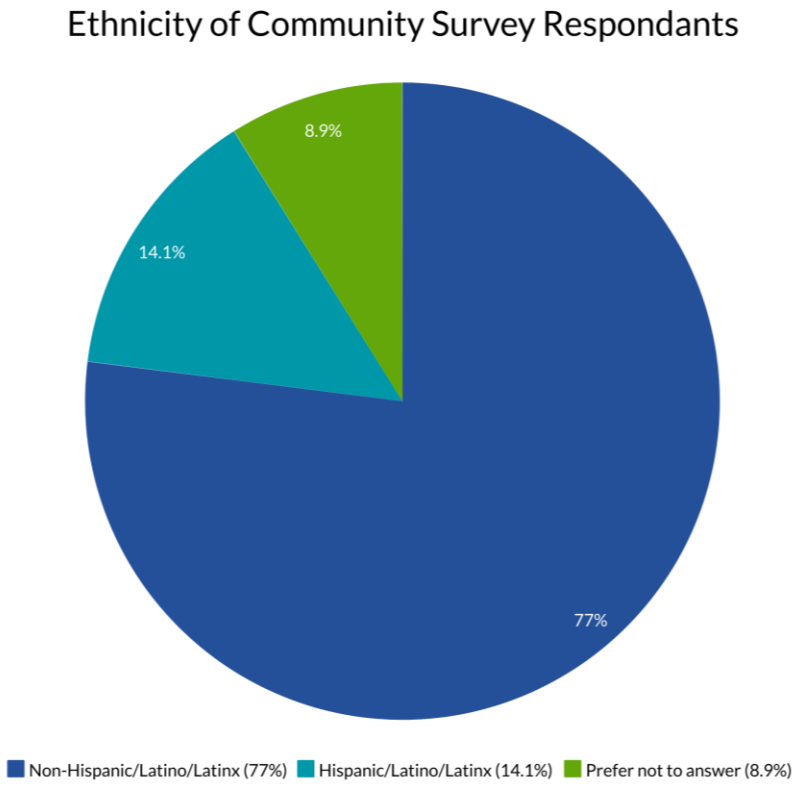


FIGURE 22: AGE OF SURVEY RESPONDENTS

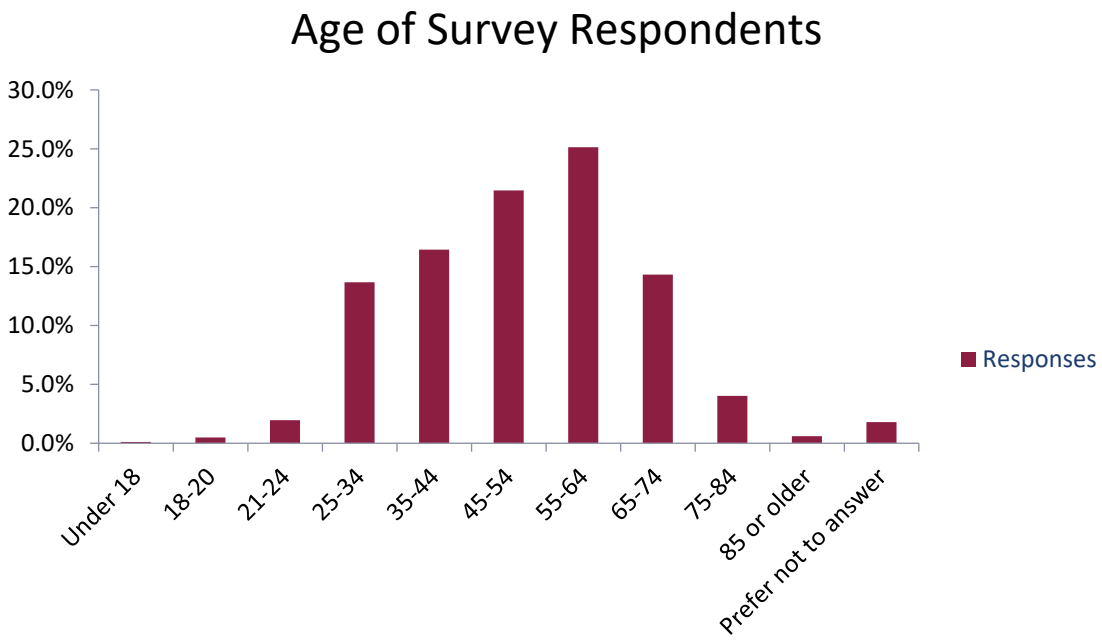


FIGURE 23: GENDER OF SURVEY RESPONDENTS

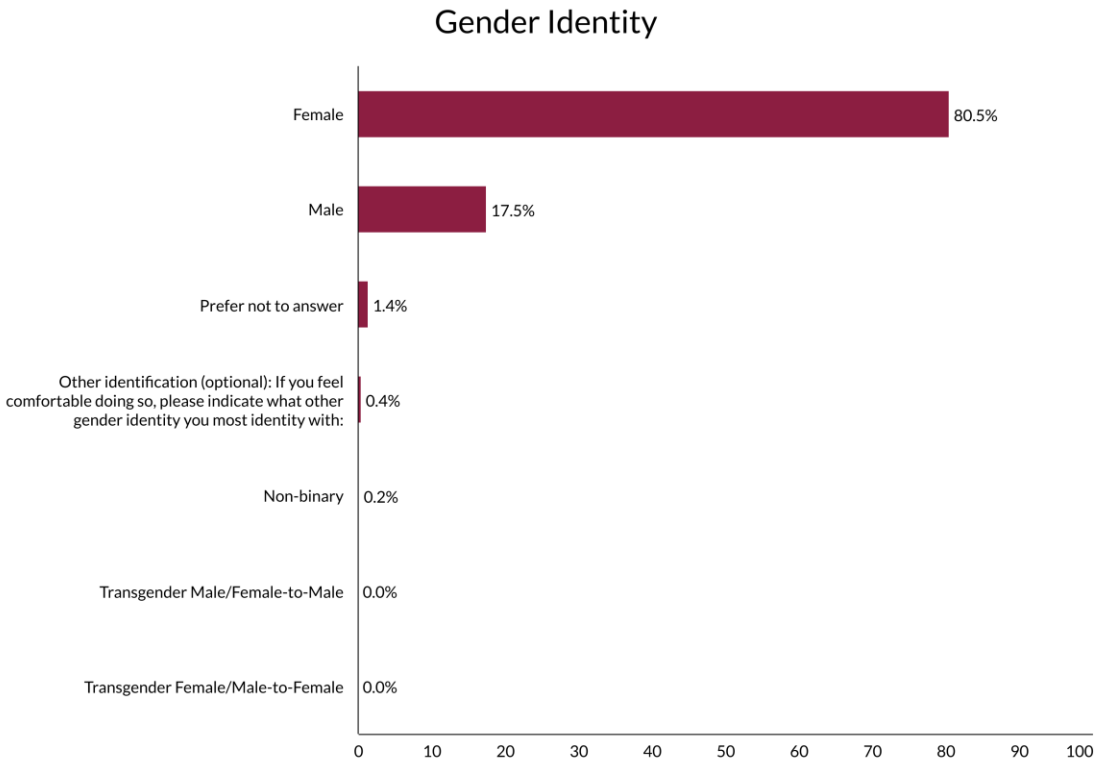
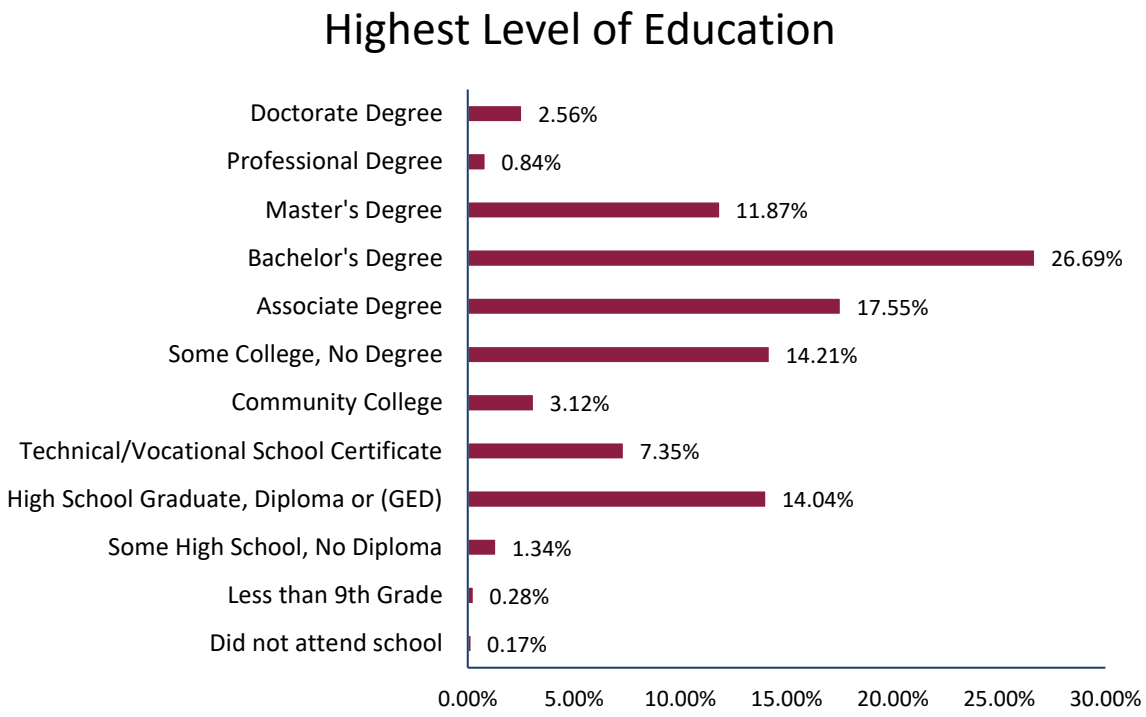


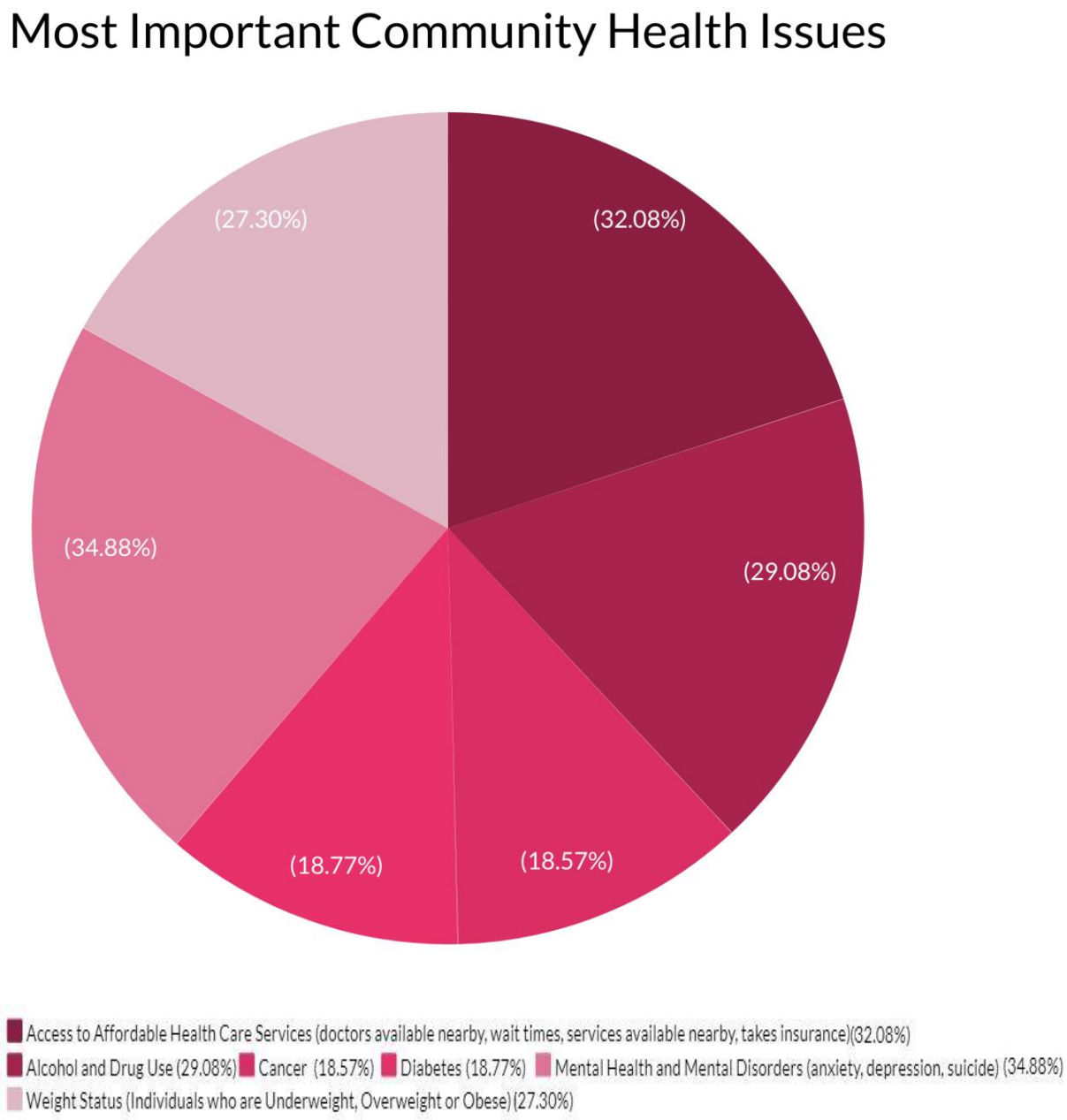
FIGURE 24: EDUCATION OF COMMUNITY SURVEY RESPONDENTS



Community Survey Analysis Results

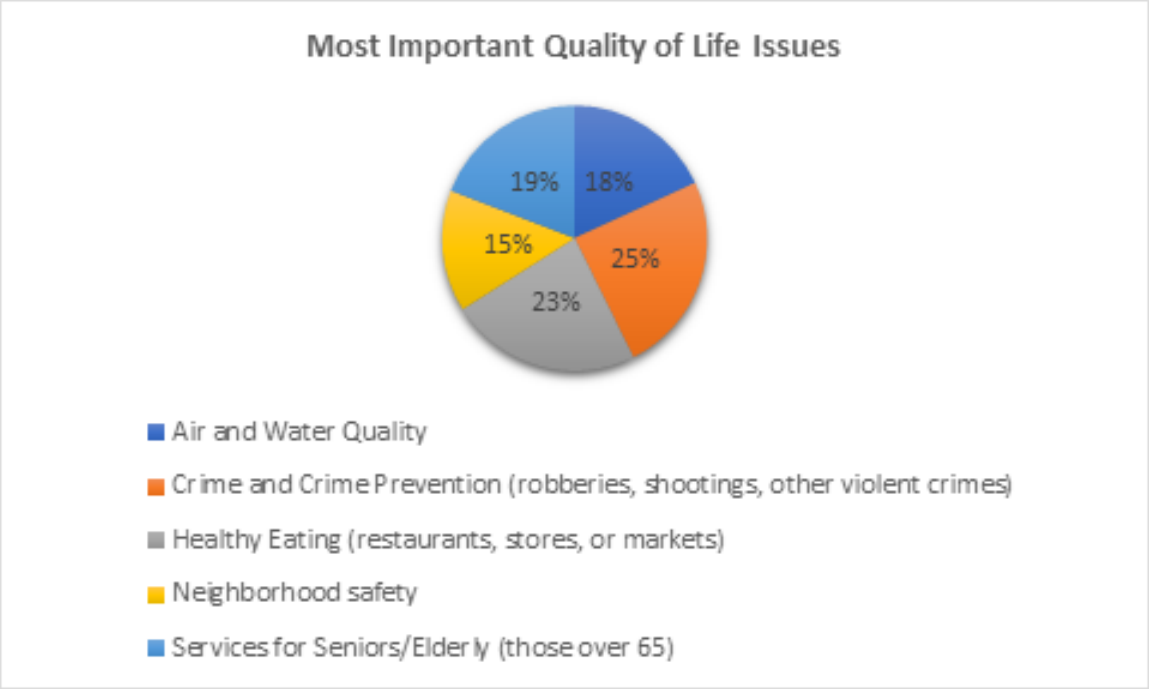
In the survey, participants were asked about important health and quality of life issues in their communities. The five "Most Important Community Health Issues" (**Figure 25**) indicated by the survey were Mental Health and Mental Disorders (anxiety, depression, suicide – 34.88 %); Access to Affordable Healthcare Services (doctors available nearby, wait times, services available nearby, takes insurance – 32.08%); Alcohol and Drug Use (29.08%); Weight Status (27.30%) and Diabetes (18.77%).

FIGURE 25: MOST IMPORTANT COMMUNITY HEALTH ISSUES



In **Figure 26,** the top five "Quality of Life Issues" were Crime and Crime Prevention (robberies, shootings, other violent crime --26.42%); Healthy Eating (restaurants, stores or markets -- 25.05%); Services for Seniors/Elderly (those over 65 – 20.61%); Air and Water Quality (19.52%) and Neighborhood Safety (15.97%). The survey included questions on the impact COVID-19 has had on the respondents and their community. Feedback on the impact of COVID-19 on the community is included in Section 6 of this report.

FIGURE 26: QUALITY OF LIFE ISSUES



Focus Groups

Community Healthcare System and HCI conducted focus groups to gain deeper insight into perceptions, attitudes, experiences or beliefs held by community members about their health. It is important to note that the information collected in an individual focus group is exclusive to that group and is not representative of other groups. A total of four virtual focus groups were scheduled for November 2021: three English groups and one Spanish group. The Spanish group was canceled after numerous attempts and varied approaches to recruiting a sufficient number of Spanish-speaking participants. Focus groups, led via Microsoft Teams, included participants from Lake and Porter counties. **Table 3** shows the three focus groups completed, which included a total of 33 participants. Individuals recruited for focus groups included those who were living in and/or working in Lake and Porter counties. The virtual focus group sessions lasted 60 minutes.

An array of residents and employees from Lake and Porter counties provided insights when facilitators asked a series of seven questions to prompt discussion on top community health issues,

barriers/challenges to health and the impact of COVID-19. Facilitators recorded the sessions and notes from the focus groups and uploaded them to the web-based qualitative data analysis tool, Dedoose[1]. Focus group transcripts were coded using a pre-designed codebook, organized by themes and analyzed for significant observations. The relative importance of health and/or social need was determined, in part, by the frequency of the topic or issue discussed across all three focus groups.

Table 3: Lake County and Porter County Focus Group Completed

Number of Sessions	Facilitation Language	Total Community Participants
3	English	33

Themes Across All Focus Groups

Table 4, below, summarizes the main themes and topics that trended across the focus group conversations. There were 110 codes extracted from the focus group interviews. The findings from the qualitative analysis were combined with the findings from other data sources and incorporated into the data synthesis and collection, key health needs, and COVID-19 sections of this report.
A detailed explanation of these results is available in Section 4: Key Health Needs, and Section 6: COVID-19 impact**. Appendix B** provides more detail of the main themes trending across focus group conversations.

Table 4: Lake County and Porter County Focus Group Theme Summary

Main Theme	Sub-topics: Concerns, issues, and barriers
Quality of Life	Lack of services, stress, safety, not feeling safe in the neighborhood, inactivity, traffic congestion, not enough healthy options, food insecurity
Mental Health	Lack of services, resources, seniors struggling with loneliness, isolation
Populations	Seniors/Elderly, Latino, Black/African American Families, low-income, minorities, children, homeless
Chronic Disease- heart disease and Stroke, Diabetes, Cancer, Overweight/Obesity	Food deserts, lack of exercise, cost of food, transportation, not enough resources, sedentary lifestyle
COVID-19	Fear of virus, misinformation, isolation, childcare, not being able to attend church/school/restaurants/neighbors, access to food, lack of technology, children less connected to school and social activities

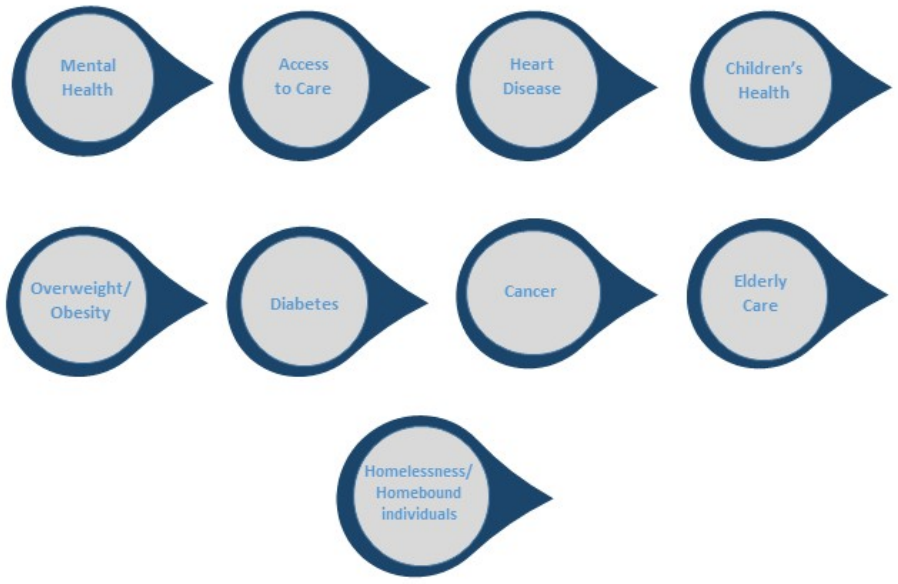
Listening Session

Community Healthcare System and HCI conducted an online survey with key community stakeholders to capture quantitative data in relation to influences on health in Lake and Porter counties. HCI hosted a follow-up virtual discussion with the stakeholders to capture qualitative insights and feedback. Community Healthcare System identified the community partners and extended the invitations for this discussion.

Because health and wellness can be influenced by environmental matters existing outside of healthcare, a wide variety of community partners were invited to participate in the listening session. The main goal of the listening session was to determine opportunities to strengthen collaborations within the communities served by Community Healthcare System.

A total of 21 listening session participants completed the online survey and 21 attended the follow-up session. Invited community leaders were from the following sectors: education, non-profit, philanthropy, state/local government, for-profit, healthcare and justice/law enforcement. At the recorded session, participants provided facilitators with additional feedback when asked questions about the results of the survey, top community health issues, barriers/challenges to health and the impact of COVID-19 on their community, place of work or organization.
Listening session transcripts were coded using a pre-designed codebook, organized by themes and analyzed for significant observations.
The frequency in which a health topic was mentioned was used to assess the relative importance of that health and/or social need. The findings from the qualitative analysis were combined with the findings from other data sources to develop the prioritized health needs for the Community Healthcare System service area. A detailed explanation of these results is available in Section 4: Key Health Needs and Section 6: COVID-19 Impact. **Appendix B** provides the detailed results of the Listening session.

Figure 27 shows the key health needs identified at the listening session. Notes from the listening session were uploaded to the web-based qualitative data analysis tool, Dedoose[1].



Data Considerations

Conduent/Healthy Communities Institute (HCI) made substantial efforts to comprehensively collect and analyze data for this assessment. Although there is a wide range of health and health-related areas, there may be varying scope and depth of secondary data indicators and findings within each topic. Data sources do not all function, analyze and categorize information the same way which may lead to variations in results.

Secondary Data

When analyzing secondary data, some health topic areas have a robust set of indicators, while others may have a limited number of indicators available. Population health and demographic data are often delayed in their release, so data is presented for the most recent years available for any given data source. There is also variability in the geographic level at which data sets are available from census tracts or zip codes to statewide or national geographies. Whenever possible, the most relevant localized data is reported. Some datasets are not available for the same time span or at the same level of localization due to variations in geographic boundaries, population sizes and data collection techniques. The Index of Disparity[2], used to analyze the secondary data, is also limited by the availability of subpopulation data from the data source. In some instances, there was no subpopulation data for indicators, while a select number of race/ethnic groups had minimal values.

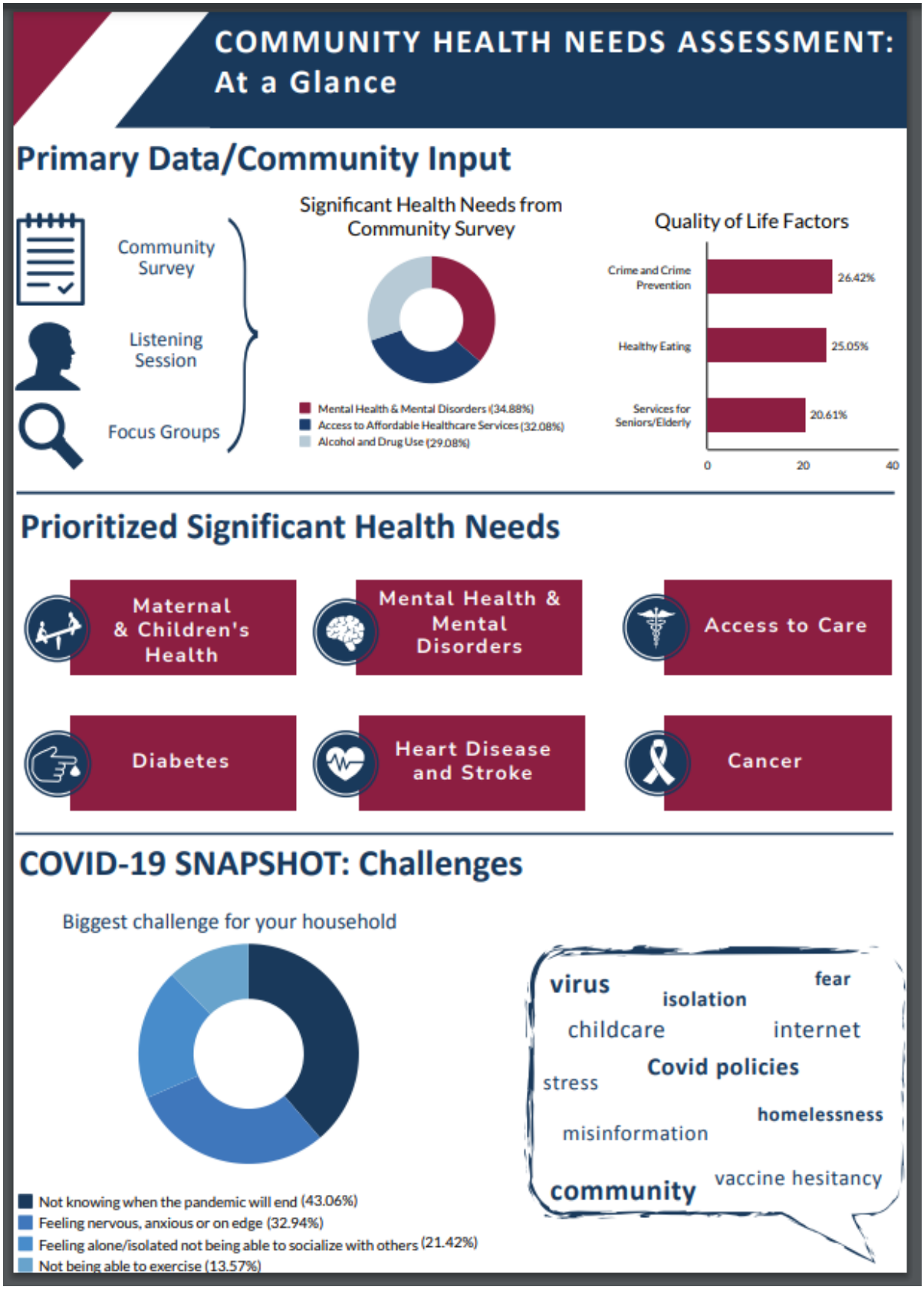
Primary Data

For the primary data, the community survey was a convenience sample, which means results may be vulnerable to selection bias and makes the findings less generalizable. However, findings did show that the community survey participant sample was representative of the overall demographics of Lake and Porter counties. For all data, efforts were made to include a wide range of secondary data indicators and community member expertise areas.

Data Synthesis and Prioritization

To gain a comprehensive understanding of the significant health needs for Community Healthcare System, the findings from both the primary and secondary data across all service areas were compared and considered together. The secondary data, community survey and focus groups were treated as three separate sources of data. To help summarize the data finding from the assessment, **Figure 28** highlights areas of importance.

FIGURE 28: AT A GLANCE



Data Synthesis Results

The top health needs identified from data sources were analyzed for areas of overlap. Primary data from focus groups, community surveys, listening session data, as well as secondary data findings identified 10 areas of need. **Figure 29** shows the areas of need across areas served by Community Healthcare System and **Figure 30** shows the areas of need for Lake County and Porter County.

FIGURE 29: DATA SYNTHESIS RESULTS- SYSTEM WIDE

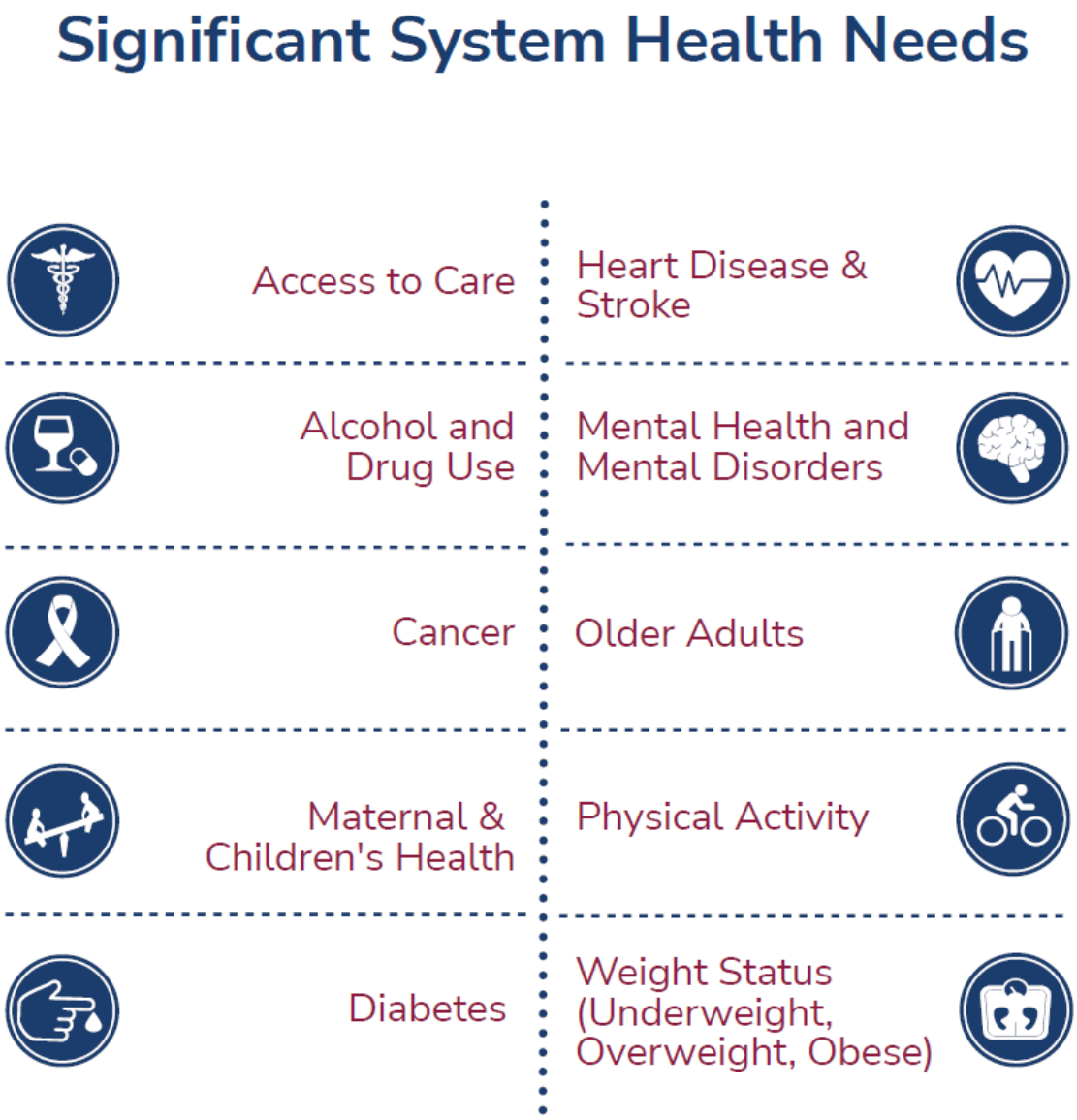
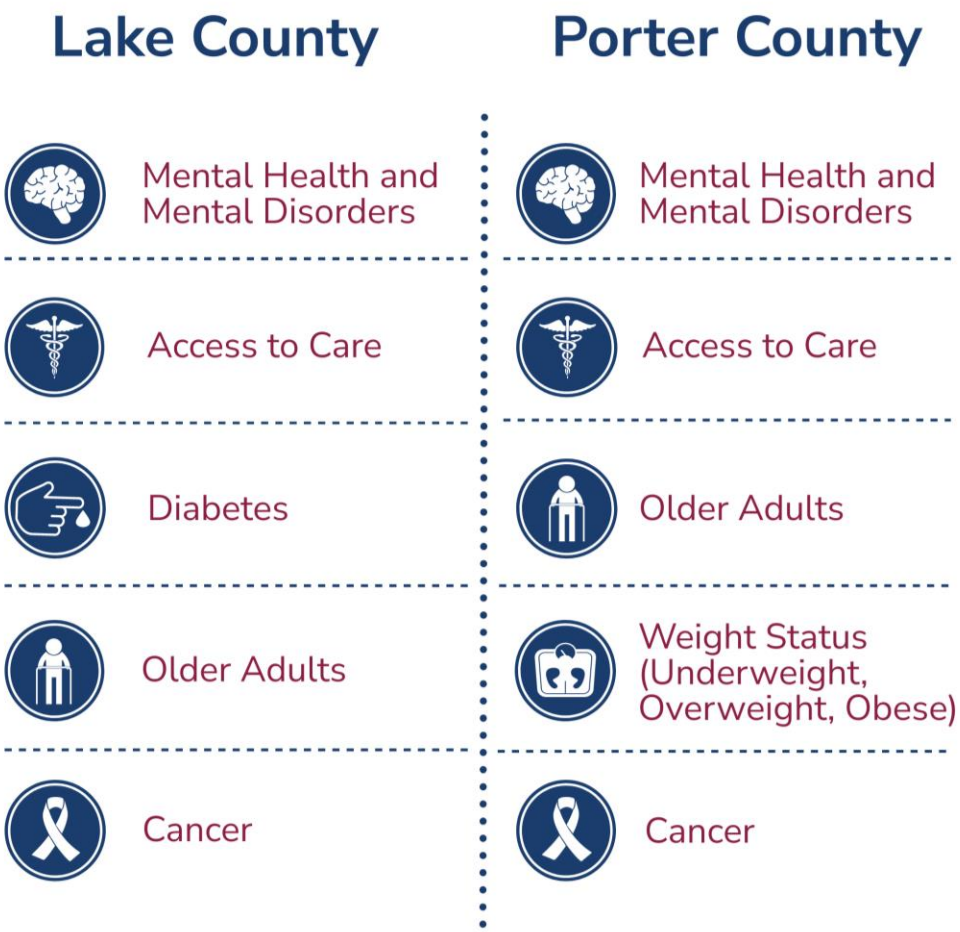


FIGURE 30: DATA SYNTHESIS RESULTS FOR LAKE COUNTY AND PORTER COUNTY



The top health needs were presented to the Community Healthcare System team. From the list of 10 health needs, six significant health needs listed below were selected and approved to be included in the prioritization session. Topics not selected are directly slated to be secondary health needs:

- Access to Healthcare
- Cancer
- Children's Health (Maternal & Children's Health)
- Diabetes
- Heart Disease & Stroke
- Mental Health and Mental Disorders

Prioritization

To prioritize significant health needs and better target activities to address the most pressing health needs in the community, Community Healthcare System convened a group of community leaders on December 15, 2021, to participate in a presentation of data on significant health needs facilitated by HCI. Following the presentation and question session, participants were given access to an online link to complete a scoring exercise. Significant health needs based on a set of criteria were then ranked.

The session was conducted virtually to maintain social distancing and safety guidelines related to the COVID-19 pandemic.

The Community Healthcare System planning team reviewed the results and determined prioritized health needs based on the same set of criteria used in the scoring exercise.

Process

In early December 2021, Community Healthcare System invited community leaders from Lake and Porter counties to assist in determining the prioritized or key health needs for the 2022-2025 CHNA. A total of 78 individuals representing local hospital systems, health departments, educational institutions as well as community-based and non-profit organizations were invited to the event. Thirty-seven of those registered attended the virtual presentation and of these, 21 submitted feedback to the online prioritization ranking activity.

On Dec. 15, 2021, more than 20 community members from Lake and Porter counties, including members from Community Healthcare System, community partners and other community leaders, were virtually convened. During this meeting, the group reviewed and discussed the results of HCI's primary and secondary data analyses leading to the preliminary significant health needs. These health needs are discussed in detail in the key health needs portion of this report. Following the session, participants were given three days to access an online link to score each of the significant health needs by how well they met the criteria set forth by HCI and Community Healthcare System. The criteria for prioritization included:

- Ability to Impact: the perceived likelihood of positive impact on each health issue
- Scope & Severity: their gauge on the magnitude of each health issue

The group also agreed that root causes, disparities and social determinants of health would be considered for all prioritized health topics resulting from prioritization.

Participants scored each health area against each criterion on a scale from one to three, with one meaning it did not meet the given criterion, two meaning it met the criterion and three meaning it strongly met the criterion. In addition to considering the data presented by HCI in the presentation and on the health topic note sheet, participants were encouraged to use their own judgment and knowledge of the community in considering how well a health topic met the criteria.

Completion of the online exercise resulted in a numerical score for each health need that correlated with how well that need met the criteria for prioritization. HCI downloaded the online results, calculated

the scores, and then ranked the significant health needs according to their topic scores. The highest scoring health needs received the highest priority ranking.

Table 5 shows the results from the scoring activity. Results were shared with the Community Healthcare System team and approval was received for the ranked health needs.

TABLE 5: RESULTS OF PRIORITIZATION ACTIVITY & APPROVED HEALTH NEEDS

Top Ranked Health Needs
1. Maternal & Children's Health
2. Mental Health & Mental Disorders
3. Access to Healthcare
4. Diabetes
5. Heart Disease and Stroke
6. Cancer

A deeper dive into the primary data and secondary data indicators for each of these six priority health topic areas is provided later in the report. This information highlights how each issue became a high priority health need for Community Healthcare System.

Most of these health topic areas are consistent with the priority areas that emerged from the previous CHNA process.

Community Healthcare System plans to build upon these efforts and continue to address these health needs in their upcoming Implementation Strategy.

Section 4: KEY HEALTH NEEDS

PRIMARY HEALTH NEEDS

The following section provides a deeper look into each of the community health needs to understand how findings from secondary and primary data led to the health topic becoming a significant need. The six health needs are presented in ranked order below.

Primary Health Need #1: Maternal & Children's Health

Maternal & Children's Health

Secondary Data Score: 1.34 (Porter) 1.92 (Lake)

Key Themes from Community Input

- Top health concerns were identifed as
  - Maternal child health was identified as a top health concern
- Leading factors contributing to health issues:
  - Resources for sick children
  - Transportation
- Populations struggling the most: Children, parents needing childcare

Warning Indicators

- Food insecure children likely ineligible for assistance
- Children with low access to a grocery store
- Child food insecurity rate
- Projected child food insecurity rate
- Mothers who received early prenatal care
- Preterm births

Secondary Data

Based on the secondary data scoring results, Children's Health along with Maternal and Infant Health were identified as top health needs in Lake and Porter counties. To incorporate all the findings under one key need, the data is listed as Maternal and Children's Health. Using HCI's Secondary Data scoring technique, analysis was done to identify specific indicators of concern across the counties. Individual indicators with high data scores within a topic area were categorized as indicators of concern and are listed in **Tables 6 and 7** below.

For each indicator, there is an indicator score, county value, state value, and national value (where available). Additionally, there are state and national county distributions for comparison along with indicator trend information. The legend on the right shows how to interpret the distribution gauges and trend icons used. For more information and examples on the icons used, please see **Appendix A.**

	Indicates the county fell in the bottom 10% of all counties in the distribution. The county fares worse than 90% of all counties in the distribution.
	Indicates the county is in the top 30% of all counties in the distribution. The county fares better than 70% of all counties in the distribution.
	The indicator is trending up, significantly, and this is not the ideal direction.
	The indicator is trending up and this is not the ideal direction.
	The indicator is trending down, signifcantly, and this is the ideal direction.
	The indicator is trending down and this is the ideal direction.
	The indicator is trending up, significantly, and this is the ideal direction.
	The indicator is trending up and this is the ideal direction.

For Lake County, the tables show that Maternal & Children's health has two areas of concern, low access to grocery stores and other themes dealing with food insecurity. A lack of access to healthy foods is often a significant barrier to healthy eating habits. Low-income and underserved areas often have a limited number of stores that sell healthy foods. All measures of food insecurity were well above the Indiana and U.S. scores. This table also shows food insecurity is not only a problem in Lake County, but in other areas of Indiana.

The other topic of concern, "Mothers who Received Early Prenatal Care" ranks highly on the table. Pregnant women are getting prenatal care in the early weeks of their gestation at a lower rate than those in the state of Indiana and the overall United States. However, the number of mothers receiving early prenatal care is trending upward. Early prenatal care can help to reduce preterm labor, low-birth weight and infant mortality.

TABLE 6: DATA SCORING RESULTS-LAKE COUNTY

SCORE	Maternal & Children's Health	Lake County	Indiana	US	IN Counties	US Counties	Trend
2.50	Food Insecure Children Likely Ineligible for Assistance	35	28	23			—
2.50	Mothers who Received Early Prenatal Care	64.6	68.9	75.8		—	
2.33	Child Food Insecurity Rate	19.2	15.3	14.6			—
2.08	Projected Child Food Insecurity Rate	22.2	16.6	—			—
2.00	Children with Low Access to a Grocery Store	7.7	—	—			—
1.78	Preterm Births	10.2	10.1	10 *HP2030** *9.4*		—	
1.75	Blood Lead Levels in Children (>=5 micrograms per deciliter)	2.8	2.4	—	—	—	—
1.67	Babies with Very Low Birth Weight	1.5	1.3	1.4		—	
1.61	Infant Mortality Rate	6	6.5	— *HP2030**		—	

				5			
1.58	Babies with Low Birth Weight	8.3	8.2	8.3		—	
1.58	Child Abuse Rate	15.3	17.1	—		—	
1.44	Teen Birth Rate: 15-19	20.7	20.7	16.7		—	
1.22	Children with Health Insurance	94.2	93	—			
0.75	Mothers Who Smoked During Pregnancy	6.3	11.8	5.9 *HP2030* 4.3*		—	

**HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.*

In **Table 7** the secondary data scoring indicates Children's Health shows two areas of concern for Lake County. First, Food Insecure Children Likely Ineligible for Assistance, Child Food Insecurity Rate, Projected Child Food Insecurity Rate, and Children with Low Access to a Grocery Store all rank highly as top needs in the county. A lack of access to healthy foods is often a significant barrier to healthy eating habits. Low-income and underserved areas often have limited numbers of stores that sell healthy foods. Lastly, Mothers who Received Early Prenatal Care rank highly. Lake County has a lower number of mothers receiving early prenatal care than Indiana and the United States.

TABLE 7: DATA SCORING RESULTS-PORTER COUNTY

SCORE	(Maternal & Children's Health)	Porter County	Indiana	US	IN Counties	US Counties	Trend
2.50	Food Insecure Children Likely Ineligible for Assistance	38	28	23			—
2.00	Children with Low Access to a Grocery Store	8.1	—	—			—
1.92	Preterm Births	10.3	10.1	10 *HP2030* 9.4*		—	
1.44	Mothers who Received Early Prenatal Care	72.9	68.9	75.8		—	
1.42	Babies with Very Low Birth Weight	1.5	1.5	1.4		—	—

1.33	Infant Mortality Rate	5.3	7.3	5.9 *HP2030* 5*		—	
1.25	Blood Lead Levels in Children (>=5 micrograms per deciliter)	1.2	2.4	—	—	—	—
1.22	Children with Health Insurance	95	93	—			
1.19	Mothers Who Smoked During Pregnancy	9	11.8	5.9 *HP2030* 4.3*		—	
1.14	Child Abuse Rate	12.3	20.8	—		—	
0.78	Babies with Low Birth Weight	7.1	8.2	8.3		—	
0.75	Projected Child Food Insecurity Rate	14.2	16.6	—			—
0.61	Teen Birth Rate: 15-19	10.9	20.7	16.7		—	
0.50	Child Food Insecurity Rate	12.3	15.3	14.6			—

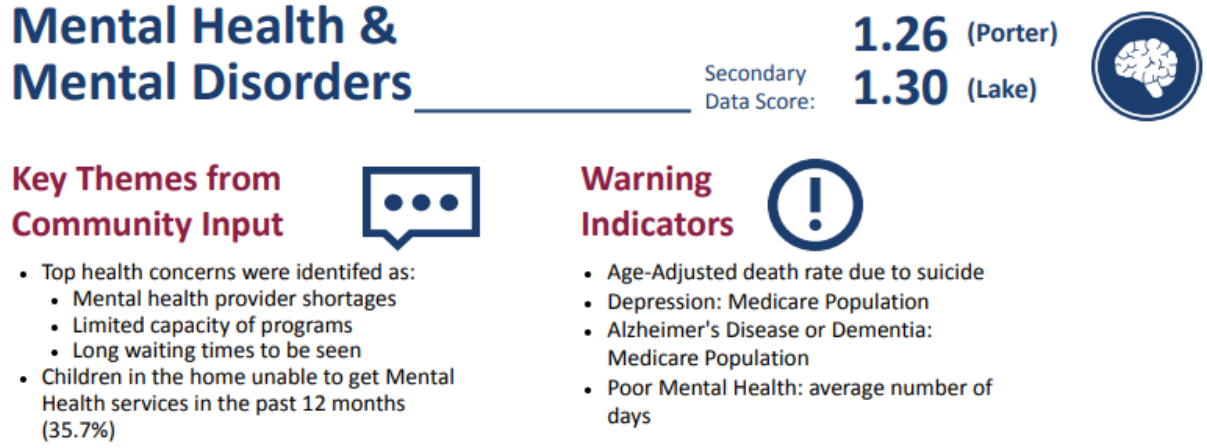
**HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.*

In Porter County, Food Insecure Children Likely Ineligible for Assistance and Children with Low Access to a Grocery Store rank as top indicators in this category. In addition, Preterm Birth is another area of concern with higher rates in Porter County than in Indiana and the United States. Preterm Births in Porter County also exceed the Healthy People 2030 target of 9.4.

Community Input

Maternal and children's health was identified as a top health concern. When survey respondents were asked how many children (under age 18) live in the home, 16.6% had one child, 10.1% had two children, and 5.3% had 3 or more. When asked about what health issues children in their home had experienced, 40.5% indicated their children had not faced any health issues, 28.2% indicated allergies and 17.5% indicated behavioral challenges/mental health. Focus group participants mentioned transportation as a concern in getting children to programs and/or services.

Primary Health Need #2: Mental Health and Mental Disorders



Secondary Data

Based on the secondary data scoring results, Mental Health & Mental Disorders was identified as a top health need in Lake and Porter counties. This health topic includes data on mental health prevalence, provider rates and self-reported days of poor mental health. Using HCI's Secondary Data scoring technique, analysis was done to identify specific indicators of concern across the counties. Individual indicators with high data scores within a topic area were categorized as indicators of concern and are listed in **Tables 8 and 9** below.

TABLE 8: DATA SCORING RESULTS-LAKE COUNTY

SCORE	Mental Health & Mental Disorders	Lake County	Indiana	US	IN Counties	US Counties	Trend
2.31	Alzheimer's Disease or Dementia: Medicare Population	11.5	11	10.8			
2.00	Poor Mental Health: Average Number of Days	5	4.7	4.1			—
1.83	Frequent Mental Distress	15.5	14.7	13			—
1.75	Poor Mental Health: 14+ Days	14.9	—	12.7			—
1.08	Depression: Medicare Population	16.4	21.1	18.4			

0.58	Age-Adjusted Death Rate due to Suicide	11.9	15.5	14.1 *HP2030* 12.8*	—		
0.50	Mental Health Provider Rate	186.4	168.3	—			
0.36	Age-Adjusted Death Rate due to Alzheimer's Disease	21.7	33.4	30.5			

**HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.*

The secondary data scoring analysis revealed Lake County has a significantly increasing number of Alzheimer's disease or dementia within the Medicare population. The county also is in the worst quartile when compared to Indiana and United States counties. In addition, Lake County has a high number of reported poor mental health and frequent mental distress.

Table 9: Data Scoring Results-Porter County

SCORE	Mental Health & Mental Disorders	Porter County	Indiana	US	IN Counties	US Counties	Trend
1.97	Age-Adjusted Death Rate due to Suicide	16.9	15.5	14.1 *HP2030* 12.8*	—		
1.75	Depression: Medicare Population	18.8	21.1	18.4			
1.25	Poor Mental Health: 14+ Days	13.5	—	12.7			—
1.19	Alzheimer's Disease or Dementia: Medicare Population	10.1	11	10.8			
1.17	Frequent Mental Distress	13.9	14.7	13			—
1.17	Poor Mental Health: Average Number of Days	4.5	4.7	4.1			—
0.92	Age-Adjusted Death Rate due to Alzheimer's Disease	33.4	33.4	30.5			
0.67	Mental Health Provider Rate	174.3	168.3	—			

**HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.*

Age-Adjusted Death Rate due to Suicide is an area of concern for Porter County. The trend data suggests it is significantly increasing. Porter County has a higher rate of death due to suicide than the state and the country. Additionally, Depression: Medicare Population shows concern with a score of 1.75 and a significantly increasing trend.

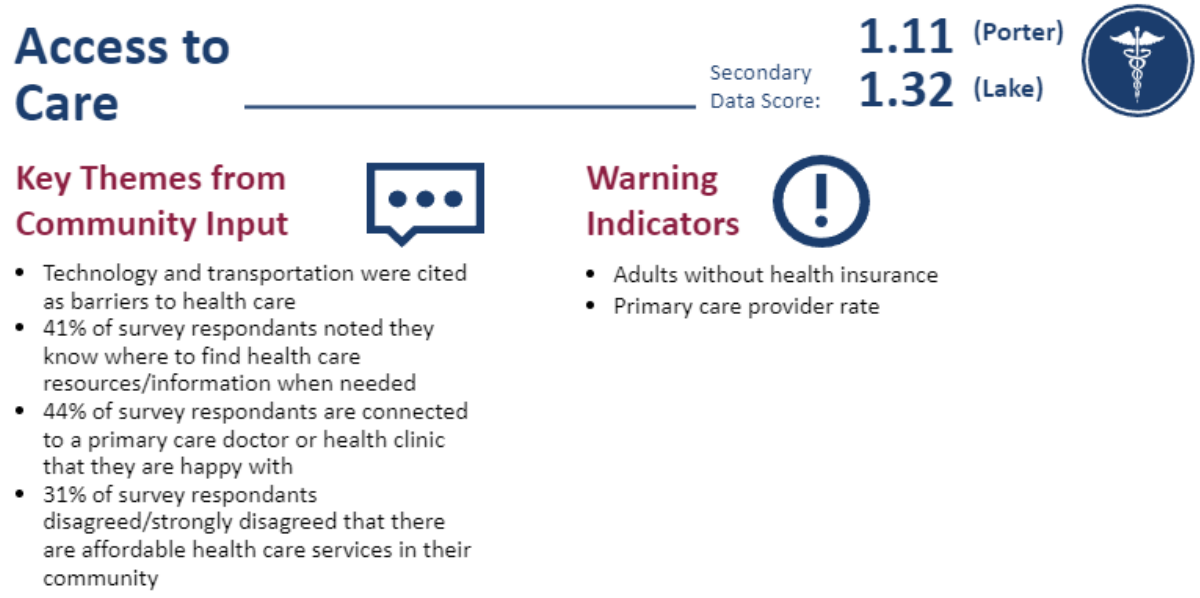
Community Input

Mental Health and Mental Disorders were identified as top health issues in the survey, focus groups and the listening session. When asked to list the most important "health programs" in the community, 34.88% of survey respondents identified mental health and mental disorders, including anxiety, depression and suicide as a top health problem.

When survey respondents were asked about what services they were not able to get in the past 12 months for their children, 37.71% indicated mental health services. When asked about causes, focus group participants responded that there was a limited capacity for mental health programs and it took a long time, from weeks to months, to get appointments.

Other causes included not having enough resources and/or programs and of those services available, they were limited. Focus group and listening session participants indicated that older adults, elderly/seniors were struggling more with mental health issues, loneliness, isolation, lack of knowledge when it comes to resources and substance use.

Primary Health Need #3: Access to Healthcare



Secondary Data

Based on the secondary data scoring results, Access to Healthcare was identified as a top health need in Lake and Porter counties. This health topic includes data on health insurance coverage, provider rates and healthcare utilization. Using HCI's Secondary Data scoring technique, analysis was done to identify specific indicators of concern across the counties. Individual indicators with high data scores within a topic area were categorized as indicators of concern and are listed in **Tables 10 and 11** below.

TABLE 10: DATA SCORING RESULTS-LAKE COUNTY

SCORE	Access to Healthcare	Lake County	Indiana	US	IN Counties	US Counties	Trend
2.08	Adults without Health Insurance	16.9	—	12.2			—
2.00	Primary Care Provider Rate	52	66.8	—			
1.92	Adults who Visited a Dentist	59.4	—	66.5			—
1.75	Clinical Care Ranking	79	—	—		—	—
1.56	Adults with Health Insurance: 18-64	88.4	88.3	—			
1.42	Persons with Health Insurance	90.1	89.7	— *HP2030* 92.1*			
1.22	Children with Health Insurance	94.2	93	—			
0.92	Adults who have had a Routine Checkup	78.9	—	76.7			—
0.83	Non-Physician Primary Care Provider Rate	92.3	100.6	—			
0.50	Mental Health Provider Rate	186.4	168.3	—			
0.33	Dentist Rate	65.1	57.1	—			

**HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.*

From the secondary data results, there were several indicators in this topic area that raise concern for Lake County. Compared to other counties in Indiana, Lake County has higher rates of adults without health insurance and has a worse clinical care ranking. The clinical care ranking is a ranking of the county in clinical care according to the County Health Rankings. The ranking is based on a summary composite score calculated from the following measures: uninsured, primary care physicians, mental health providers, dentists, preventable hospital stays, diabetic monitoring and mammography screening.

In addition, the primary care provider rate has been decreasing in recent years in the county.

TABLE 11: DATA SCORING RESULTS-PORTER COUNTY

SCORE	Access to Healthcare	Porter County	Indiana	US	IN Counties	US Counties	Trend
1.42	Adults who have had a Routine Checkup	76.8	—	76.7			—
1.42	Clinical Care Ranking	39	—	—		—	—
1.33	Non-Physician Primary Care Provider Rate	64.6	100.6	—			
1.25	Adults without Health Insurance	12.4	—	12.2			—
1.22	Children with Health Insurance	95	93	—			
1.11	Primary Care Provider Rate	63.1	66.8	—			
1.06	Adults with Health Insurance: 18-64	91.6	88.3	—			
1.03	Persons with Health Insurance	92.6	89.7	— *HP2030* 92.1*			
0.92	Adults who Visited a Dentist	66.7	—	66.5			—
0.83	Dentist Rate	56.9	57.1	—			
0.67	Mental Health Provider Rate	174.3	168.3	—			

**HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.*

Looking at the secondary data results, Porter County fares better than Lake County in access to care, but there are still concerning areas. Adults who have had a routine check-up and clinical care ranking scored the highest in the analysis, but not enough to be critical. Porter County is trending positively in all areas of Access to Care.

Community Input

Access to Care was a top health need identified in the community survey and listening session. Barriers included technology, fear, transportation, cost (healthcare services being too expensive or could not pay), insurance not accepted, hours of operation did not fit the schedule and wait time to see a doctor or health provider.

Figure 31 shows the top reasons survey respondents did not receive healthcare services that they needed within the past 12 months: 44.22% indicated cost, it was too expensive, could not pay, 23.90% stated the wait was too long and 20.72% of respondents indicated hours of operation did not fit their schedule or their insurance was not accepted. **Figure 32** is a quote from a focus group participant who shared that people were afraid to access healthcare services.

FIGURE 31: TOP REASONS DID NOT RECEIVE HEALTHCARE SERVICES

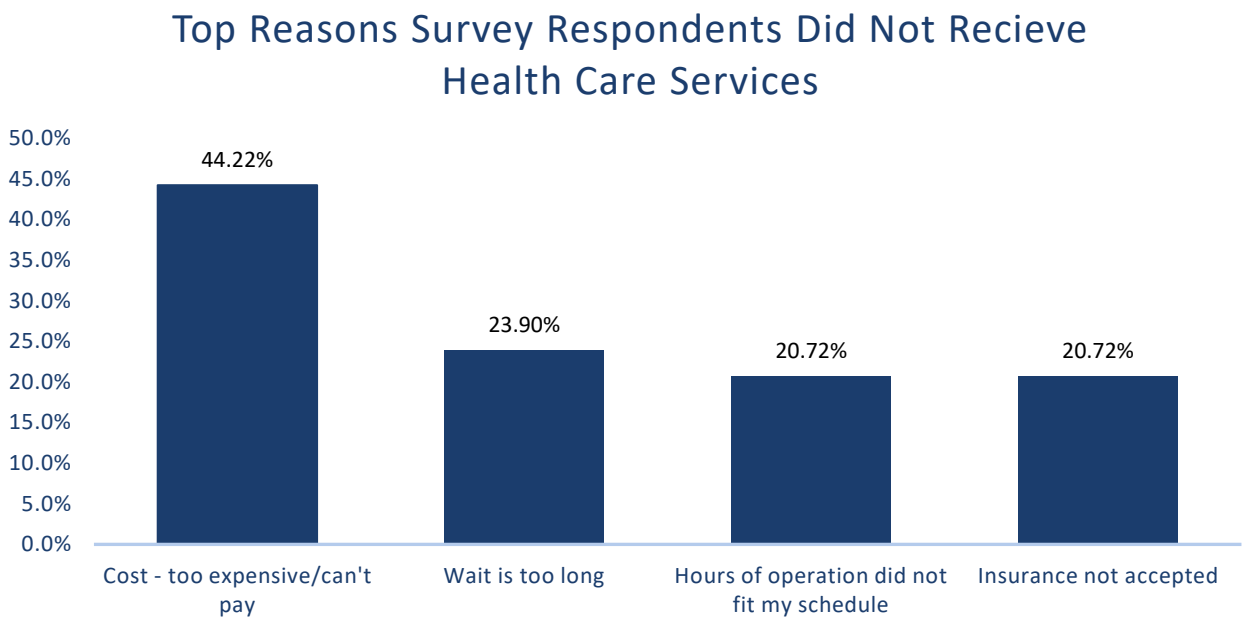
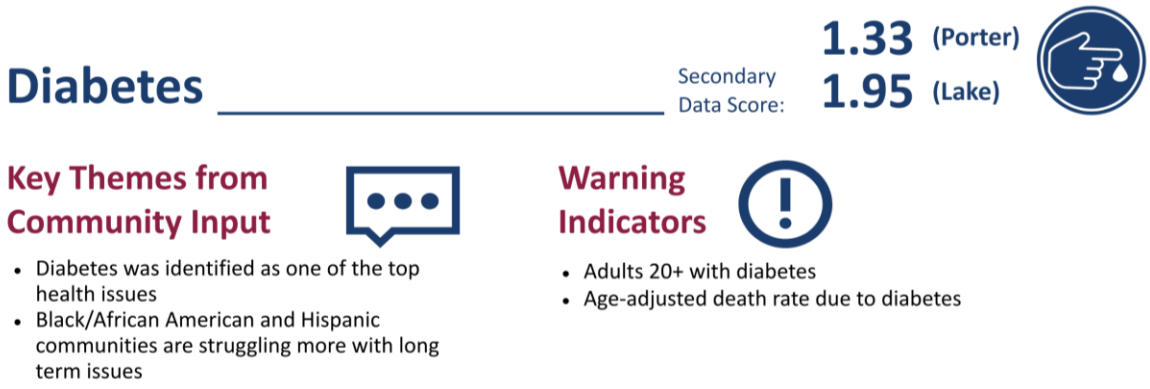


FIGURE 32: QUOTE FROM FOCUS GROUPS PARTICIPANTS

> *"Residents are afraid to access healthcare services, screenings, and regular Doctor's visits. "I've seen a lot of people who are afraid to access healthcare services, afraid to get their regular screenings and regular doctors' visits." -Focus Group*

Primary Health Need #4: Diabetes



Secondary Data

Diabetes was identified as a significant health need. It had the fifth-highest data score of all topic areas in Lake County, with a score of 1.95, and had the 11th highest data score in Porter County at 1.33. Further analysis was done to identify specific indicators of concern across the county.

Individual indicators with high data scores within the topic area were categorized as indicators of concern and are listed in **Table 12** for Lake County and **Table 13** for Porter County.

Secondary data results revealed that Lake County has a high number of adults with diabetes as well as high rates of death due to diabetes. Although these numbers have been decreasing over periods of time as seen by the trend data, Lake County has worse rates than Indiana and the United States.

TABLE 12: DATA SCORING RESULTS-LAKE COUNTY

SCORE	Diabetes	Lake County	Indiana	U.S.	IN Counties	U.S. Counties	Trend
2.08	Adults 20+ with Diabetes	11.9	—	—			
2.03	Age-Adjusted Death Rate due to Diabetes	28.9	25.9	21.5			
1.75	Diabetes: Medicare Population	29.7	27.8	27			

**HP2030 – Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.*

Secondary data results revealed Porter County also has a high rate of death due to diabetes. The trend for death due to diabetes is moving downward. However, Porter County's adult population is seeing a significant rise in the cases of diabetes. Additionally, Adults 20+ with diabetes is significantly increasing.

The chart shows that numbers are in the yellow phase, trending toward critical.

TABLE 13: DATA SCORING RESULTS-PORTER COUNTY

SCORE	Diabetes	Porter County	Indiana	U.S.	IN Counties	U.S. Counties	Trend
1.67	Age-Adjusted Death Rate due to Diabetes	25.8	25.9	21.5			
1.47	Adults 20+ with Diabetes	9.8	—	—			
0.86	Diabetes: Medicare Population	26.2	27.8	27			

**HP2030 – Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.*

Community Input

Diabetes is a serious, costly, and growing health problem in Lake and Porter counties. When survey respondents were asked to list the most important "health problems" in the community, 18.77% of survey respondents listed diabetes.

The listening session and focus group participants identified diabetes as one of the top health issues and specified that Black/African American and Hispanic communities struggled with diabetes more than other races/ethnicities in their communities. Participants also indicated that the cost of healthy foods, lack of places to exercise, culture and stress contributed to increased rates of diabetes.

Primary Health Need #5: Heart Disease and Stroke

Heart Disease & Stroke

Secondary Data Score: **1.57** (Porter) **1.85** (Lake)

Key Themes from Community Input

- Heart disease & stroke identified as one of the top health issues

Warning Indicators

- Atrial fibrillation: Medicare population
- Hyperlipidemia: Medicare population
- Heart failure: Medicare population
- Hypertension: Medicare population
- Age-adjusted death rate due to coronary heart disease
- Stroke: Medicare population
- Ischemic heart disease: Medicare population
- High blood pressure prevalence

Secondary Data

From the secondary data scoring results, heart disease and stroke were identified as a significant health need in both Lake and Porter counties. This health need had the seventh data score of all topic areas in Lake County, with a score of 1.85. It had the sixth-highest data score in Porter County at 1.57.

Further analysis was done to identify specific indicators of concern across the county. Individual indicators with high data scores within the topic area were categorized as indicators of concern and are listed in Table 14 below.

As shown in **Table 14**, atrial fibrillation in the Medicare population is an overwhelming area of concern for Lake County with a score of 2.92 out of 3. The trend data shows this issue is significantly increasing and Lake County has higher rates than the state and country.

Additionally, the age-adjusted death rate due to coronary heart disease, hypertension in the Medicare population and heart failure in the Medicare population are other important areas of concern. Cardiovascular disease is the number one cause of death for all Americans and is a high priority need.

TABLE 14: DATA SCORING RESULTS-LAKE COUNTY

SCORE	Heart Disease & Stroke	Lake County	Indiana	US	IN Counties	US Counties	Trend
2.92	Atrial Fibrillation: Medicare Population	9.6	8.5	8.4			
2.50	Age-Adjusted Death Rate due to coronary heart disease	102	97.8	90.5 *HP2030* 71.1*			
2.47	Hypertension: Medicare Population	63.8	59.6	57.2			
2.36	Heart Failure: Medicare Population	18.5	15.1	14			
2.36	Stroke: Medicare Population	5.4	3.7	3.8			
2.08	Ischemic Heart Disease: Medicare Population	31.2	28.3	26.8			
2.00	High Blood Pressure Prevalence	38.3	—	32.4 *HP2030* 27.7*			—
2.00	Hyperlipidemia: Medicare Population	50.7	47.9	47.7			
1.75	Adults who Experienced a Stroke	4.1	—	3.4			—
1.58	Adults who Experienced Coronary Heart Disease	7.7	—	6.8			—
1.42	Adults who Have Taken Medications for High Blood Pressure	78.4	—	75.8			—
1.28	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	38.9	40.3	37.2 *HP2030* 33.4*			

1.25	High Cholesterol Prevalence: Adults 18+	35.9	—	34.1			—
0.92	Cholesterol Test History	81.7	—	81.5			—
0.86	Age-Adjusted Death Rate due to Heart Attack	43.6	67.8	—		—	

**HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.*

Table 15 shows similarly to Lake County, where atrial fibrillation in the Medicare population is an overwhelming area of concern for Porter County with a score of 2.47 out of 3.

The trend data shows this issue is significantly increasing while Porter County also has higher rates than the state and country. Hyperlipidemia in the Medicare population is another area of overwhelming concern with a score of 2.47.

The trend data shows this issue is also significantly increasing. Heart failure, hypertension, ischemic heart disease and stroke within the Medicare population are all other areas of high concern for Porter County.

TABLE 15: DATA SCORING RESULTS-PORTER COUNTY

SCORE	Heart Disease & Stroke	Porter County	Indiana	US	IN Counties	US Counties	Trend
2.47	Atrial Fibrillation: Medicare Population	9.3	8.5	8.4			
2.47	Hyperlipidemia: Medicare Population	52.5	47.9	47.7			
2.31	Heart Failure: Medicare Population	16.3	15.1	14			
2.25	Hypertension: Medicare Population	61.5	59.6	57.2			
1.97	Ischemic Heart Disease: Medicare Population	28.3	28.3	26.8			
1.86	Stroke: Medicare Population	3.9	3.7	3.8			

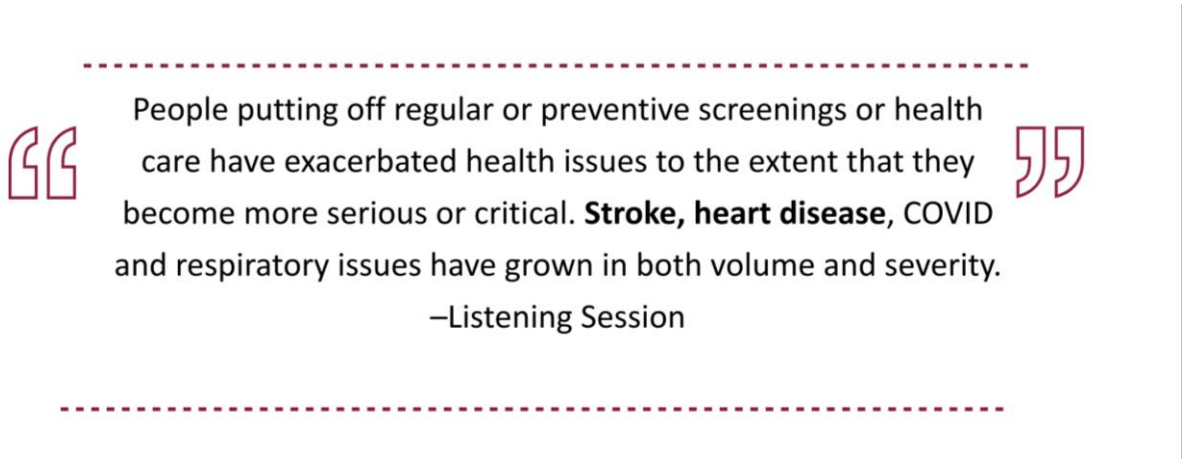
1.75	Adults who Have Taken Medications for High Blood Pressure	76.3	—	75.8			—
1.33	High Blood Pressure Prevalence	35	—	32.4 *HP2030** *27.7*			—
1.28	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	34.6	40.3	37.2 *HP2030** *33.4*			
1.25	Cholesterol Test History	81	—	81.5			—
1.25	High Cholesterol Prevalence: Adults 18+	35.4	—	34.1			—
1.08	Adults who Experienced Coronary Heart Disease	7	—	6.8			—
1.03	Age-Adjusted Death Rate due to Heart Attack	57.8	67.8	—		—	
0.92	Adults who Experienced a Stroke	3.2	—	3.4			—
0.39	Age-Adjusted Death Rate due to coronary heart disease	73.2	97.8	90.5 *HP2030** *71.1*			

**HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.*

Community Input

Heart disease and stroke was identified as one of the top health issues in the focus group and listening sessions. **Figure 33** below displays what a listening session participant mentioned about heart disease, stroke and putting off regular or preventative screenings.

FIGURE 33: QUOTE FROM A LISTENING SESSION PARTICIPANT



Primary Health Need #6: Cancer

Cancer

Secondary Data Score: **1.74** (Porter) **1.67** (Lake)

Key Themes from Community Input

- Cancer was identified as a top priority (Survey, Focus Groups, Listening Session

Warning Indicators

- Cancer: Medicare population
- Colon cancer screening
- Colorectal cancer incidence rate
- Prostate cancer incidence rate
- Age-adjusted death rate due to breast cancer
- Age-adjusted death rate due to prostate cancer
- Oral cavity and pharynx cancer incidence rate

Secondary Data

Based on the secondary data scoring results, cancer was identified as a top health need in Lake and Porter counties. Cancer ranked as the number one health need in Porter County and the 12th in Lake County. Using HCI's Secondary Data scoring technique, analysis was done to identify specific indicators of concern across the counties.

Individual indicators with high data scores within a topic area were categorized as indicators of concern and are listed in **Tables 16 and 17** below.

Cancer within the Medicare population and colon cancer screenings are areas of concern for Lake County.

The trend of cancer in the Lake County Medicare population is significantly increasing and Lake County ranks in the worst quartile of all Indiana counties in this area.

In addition, preventative measures such as colon cancer screenings are important because according to the Centers for Disease Control and Prevention (CDC), colorectal cancer— cancer of the colon or rectum – is one of the most diagnosed cancers in the United States. In Lake County, the trend indicates that colon cancer rates are decreasing.

TABLE 16: DATA SCORING RESULTS-LAKE COUNTY

SCORE	Cancer	Lake County	Indiana	US	IN Counties	US Counties	Trend
2.47	Cancer: Medicare Population	8.9	8	8.4			
2.33	Colon Cancer Screening	58.8	—	66.4 *HP2030* 74.4*			—
2.08	Colorectal Cancer Incidence Rate	48.2	42.6	38.4			
2.03	Prostate Cancer Incidence Rate	112.1	94.2	104.5			
2.00	Age-Adjusted Death Rate due to Breast Cancer	24	20.8	20.1 *HP2030* 15.3*			
1.78	Age-Adjusted Death Rate due to Prostate Cancer	20.4	19.5	19 *HP2030* 16.9*			
1.67	Age-Adjusted Death Rate due to Colorectal Cancer	16.6	15.1	13.7 *HP2030* 8.9*			
1.61	Mammogram in Past 2 Years: 50-74	70.9	—	74.8 *HP2030* 77.1*			—
1.44	Cervical Cancer Screening: 21-65	84	—	84.7 *HP2030* 84.3*			—
1.25	Adults with Cancer	7.3	—	6.9			—
1.25	Breast Cancer Incidence Rate	123.6	122.9	125.9			
1.25	Lung and Bronchus Cancer Incidence Rate	68.8	72.2	58.3			
1.25	Oral Cavity and Pharynx Cancer Incidence Rate	11.3	12.7	11.8			
1.00	Age-Adjusted Death Rate due to Lung Cancer	44.9	48.7	38.5			

**HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.*

Cancer within the Medicare population is an overwhelming concern for Porter County with a score of 2.75 out of 3. Porter County ranks in the worst quartile among both Indiana counties and counties within the United States.

The trend within the Medicare population is getting worse. Additionally, the age-adjusted death rates due to prostate and breast cancers are another major area of concern for Porter County. Although the trend of deaths due to these cancers is decreasing.

TABLE 17: DATA SCORING RESULTS-PORTER COUNTY

SCORE	Cancer	Porter County	Indiana	US	IN Counties	US Counties	Trend
2.75	Cancer: Medicare Population	9.1	8	8.4			
2.67	Age-Adjusted Death Rate due to Prostate Cancer	21.7	19.5	19 *HP2030* 16.9*			
2.39	Age-Adjusted Death Rate due to Breast Cancer	23.1	20.8	20.1 *HP2030* 15.3*			
2.31	Oral Cavity and Pharynx Cancer Incidence Rate	14.1	12.7	11.8			
1.94	Age-Adjusted Death Rate due to Colorectal Cancer	15.8	15.1	13.7 *HP2030* 8.9*			
1.69	Colorectal Cancer Incidence Rate	43.7	42.6	38.4			
1.61	Mammogram in Past 2 Years: 50-74	70.6	—	74.8 *HP2030* 77.1*			—
1.58	Prostate Cancer Incidence Rate	103.9	94.2	104.5			
1.53	Breast Cancer Incidence Rate	124.4	122.9	125.9			
1.53	Lung and Bronchus Cancer Incidence Rate	68	72.2	58.3			

1.33	Colon Cancer Screening	64.6	—	66.4 *HP2030* 74.4*			—
1.25	Adults with Cancer	7.3	—	6.9			—
0.89	Cervical Cancer Screening: 21-65	85.1	—	84.7 *HP2030* 84.3*			—
0.83	Age-Adjusted Death Rate due to Lung Cancer	43.3	48.7	38.5			

**HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.*

Community Input

Cancer was identified as a top health issue in the survey and listening session. When asked what the most important health problems in the community were, 18.57% of survey respondents indicated cancer.

SECONDARY HEALTH NEEDS

The following health needs emerged from a review of the primary and secondary data and were shown to be significant. With the necessity to focus on the key health needs described above, these topics are not specifically prioritized for efforts to be outlined in the 2022-2025 Implementation Strategy Plan. These secondary needs will be addressed through the upstream efforts of the six key health needs.

Secondary Health Need #1: Alcohol and Drug Use

Alcohol and Drug Use

Secondary Data Score: **1.38** (Porter) **1.59** (Lake)

Key Themes from Community Input

- One of the top reasons individuals did not receive alcohol/substance abuse treatment or mental health services was not knowing where to go (32.2%)
- Access to substance abuse treatment resources in a timely manner noted as a challenge

Warning Indicators

- Adults who drink excessively
- Liquor store density
- Death rate due to drug poisoning
- Age-adjusted drug and opioid-involved overdose death rate
- Substance abuse treatment rate: alcohol
- Alcohol-impaired driving deaths

Secondary and Primary Data Findings

Primary Data

Substance abuse has a major impact on individuals, families, and communities. Substance abuse refers to a set of related conditions associated with mind and behavior-altering substances that have negative mental and health outcomes (Healthy People, 2030). When survey respondents in Lake and Porter counties were asked what were the most important health problems in their community, alcohol and drug use (29.08%) ranked third. Focus groups participants indicated that seniors struggle with substance abuse issues: and listening session participants identified substance abuse as a top health issue in the community.

Secondary Data

Secondary data analysis was done for Alcohol and Drug Use to identify specific indicators of concern across the counties. Individual indicators with high data scores within the topic area were categorized as indicators of concern, the top five are listed in **Tables 18 and 19** below.

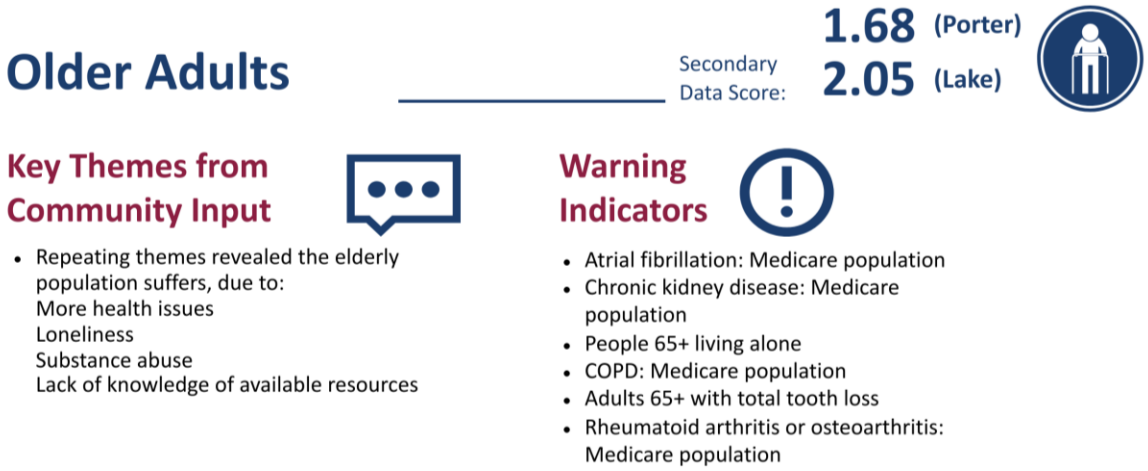
TABLE 18: DATA SCORING RESULTS-LAKE COUNTY

SCORE	ALCOHOL & DRUG USE	UNITS	LAKE COUNTY	Indiana	U S	Measurement Year
2.75	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	30.9	25.8	21	*2017-2019*
2.19	Liquor Store Density	*stores/ 100,000 population*	16.7	12.2	10.5	*2019*
2.08	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*deaths/ 100,000 population*	35.1	29.4	22.8	*2017-2019*
1.69	Substance Abuse Treatment Rate: Alcohol	*rate/ 100,000 population*	240	197.1		*2015*
1.61	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	24.9	18.8	27	*2015-2019*

TABLE 19: DATA SCORING RESULTS-PORTER COUNTY

SCORE	ALCOHOL & DRUG USE	UNITS	PORTER COUNTY	Indiana	US	MEASUREMENT PERIOD
2.33	Adults who Drink Excessively	*percent*	21.3	18.7	19	*2018*
1.92	Adults who Binge Drink	*percent*	17.8		16.4	*2018*
1.69	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	24.2	25.8	21	*2017-2019*
1.58	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*deaths/ 100,000 population*	27.4	29.4	22.8	*2017-2019*

Secondary Health Need #2: Older Adults



Secondary and Primary Data Findings

Focus group and listening session participants identified the needs of the Elderly/Senior population as a top health issue in the community. When survey respondents were asked, 'what they would most like to see addressed in the community," 20.6% cited services for adults (those over age 65).

From the secondary data scoring results, older adults were identified as a significant health need. It had the third data score of all topic areas in Lake County and the second score in Porter County, with scores of 2.05 for Lake County and 1.68 for Porter County, respectively. Further analysis was done to identify specific indicators of concern across the counties. Individual indicators with high data scores within the topic area were categorized as indicators of concern, the top five are listed in Tables 20 and 21 below.

TABLE 20: DATA SCORING RESULTS-LAKE COUNTY

SCORE	OLDER ADULTS	LAKE COUNTY	Indiana	US	MEASUREMENT PERIOD	Source
2.92	Atrial Fibrillation: Medicare population	9.6	8.5	8.4	*2018*	6
2.47	Cancer: Medicare population	8.9	8	8.4	*2018*	6
2.47	Chronic Kidney Disease: Medicare population	27.1	25.5	24.5	*2018*	6
2.47	Hypertension: Medicare population	63.8	59.6	57.2	*2018*	6

TABLE 21: DATA SCORING RESULTS-PORTER COUNTY

Score	OLDER ADULTS	PORTER COUNTY	Indiana	U.S.	MEASUREMENT PERIOD	Source
2.75	Cancer: Medicare population	9.1	8	8.4	*2018*	6
2.47	Atrial Fibrillation: Medicare population	9.3	8.5	8.4	*2018*	6
2.47	Hyperlipidemia: Medicare population	52.5	47.9	47.7	*2018*	6
2.47	Rheumatoid Arthritis or Osteoarthritis: Medicare population	37.5	35	33.5	*2018*	6
2.31	Heart Failure: Medicare population	16.3	15.1	14	*2018*	6
2.47	Rheumatoid Arthritis or Osteoarthritis: Medicare population	37.6	35	33.5	*2018*	6

Health System Efforts

Community Healthcare System's ongoing programs and services that address the older adult population in Lake and Porter counties are listed below.

Cancer

- Cancer Navigation program
- Cancer Survivorship programming
- Expanded reach and cancer support group offerings

Diabetes, Heart Disease, Neurology, and Stroke

- Cardiovascular symposium
- Diabetes and Stroke health fair
- Diabetes education classes
- Expanded stroke support group
- Know your Numbers health fair
- Heart health presentations

Mental Health

- Alzheimer's awareness classes
- Healthy Mind, Healthy Body symposium
- Suicide Prevention Awareness vigils

Secondary Health Need #3: Physical Activity

Physical Activity

Secondary Data Score: 1.63 (Porter) 1.75 (Lake)

Key Themes from Community Input

- Concern over safety was noted as a barrier to physical activity, specifically in African-American and Hispanic communities
- Inactivity and sedentary lifestyle were noted as causes of residents to be unhealthy in their community

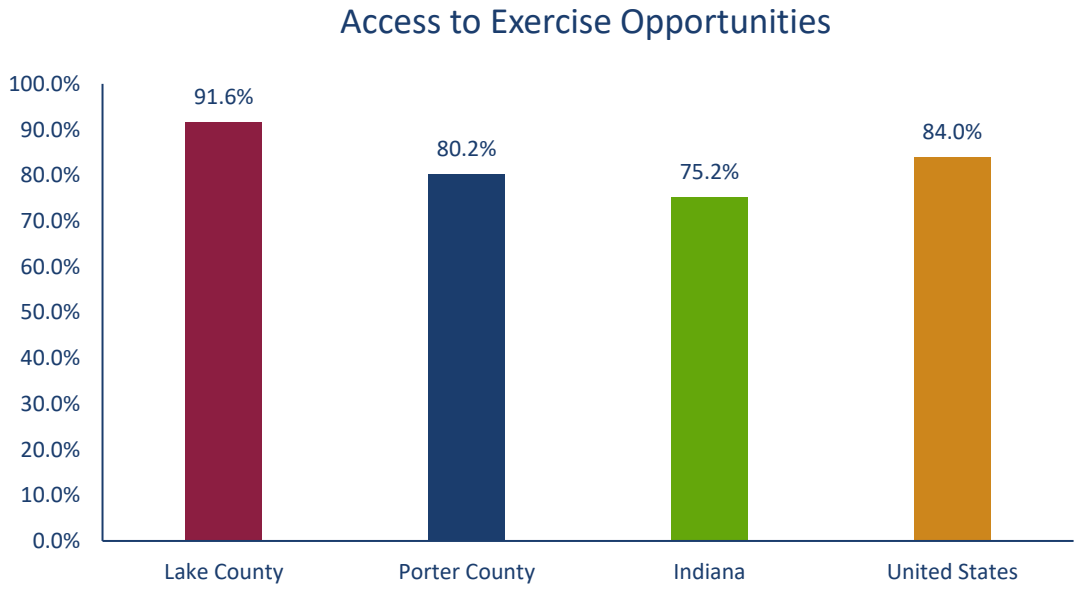
Warning Indicators

- Workers who walk to work
- Children with low access to a grocery store
- WIC-certified stores
- SNAP-certified Stores
- Fast food restaurant density

Secondary and Primary Data Findings

Figure 34 shows Lake County has the highest percentage of exercise opportunities at 91.6% compared to Porter County. This indicator measures the percentage of individuals who live reasonably close to a park or recreational facility.

FIGURE 34: ACCESS TO EXERCISE OPPORTUNITIES



Source: County Health Rankings, 2020

Health System Efforts

Community Healthcare System's ongoing programs and services that address physical activity in Lake and Porter counties are listed below.

Nutrition, Exercise, and Obesity

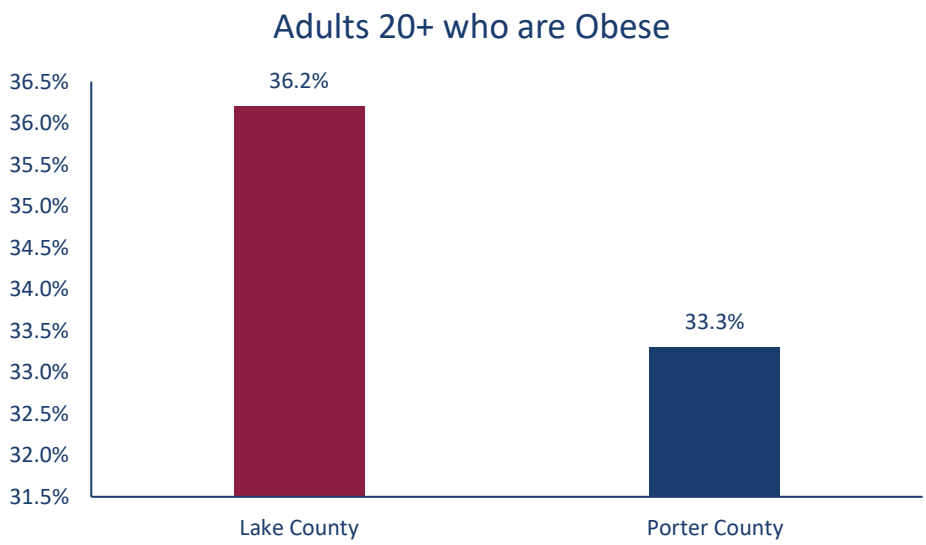
- Created Healthy Eating Series
- Established Health Zone at Kawann Short football & STEM camp (children & parents)
- Established Walk and Talk program with healthcare providers
- Held low-impact exercise classes
- Launched bi-monthly group walks for the public across service areas

Secondary Health Need #4: Weight Status (underweight, overweight, obese)

Secondary and Primary Data Findings

The topic area of Weight Status was unable to be scored using HCI's Scoring Tool® due to secondary data limitations. In focus group and listening sessions, obesity was listed as a top health issue. **Figure 35** shows Adults 20+ who are Obese. In Lake County, 36.20% of adults 20+ are obese and in Porter County, 33.3% are obese. When survey respondents were asked to select what one of the most important health problems in their community were, 27.3% responded with weight Status (Individuals who are underweight, overweight, or obese).

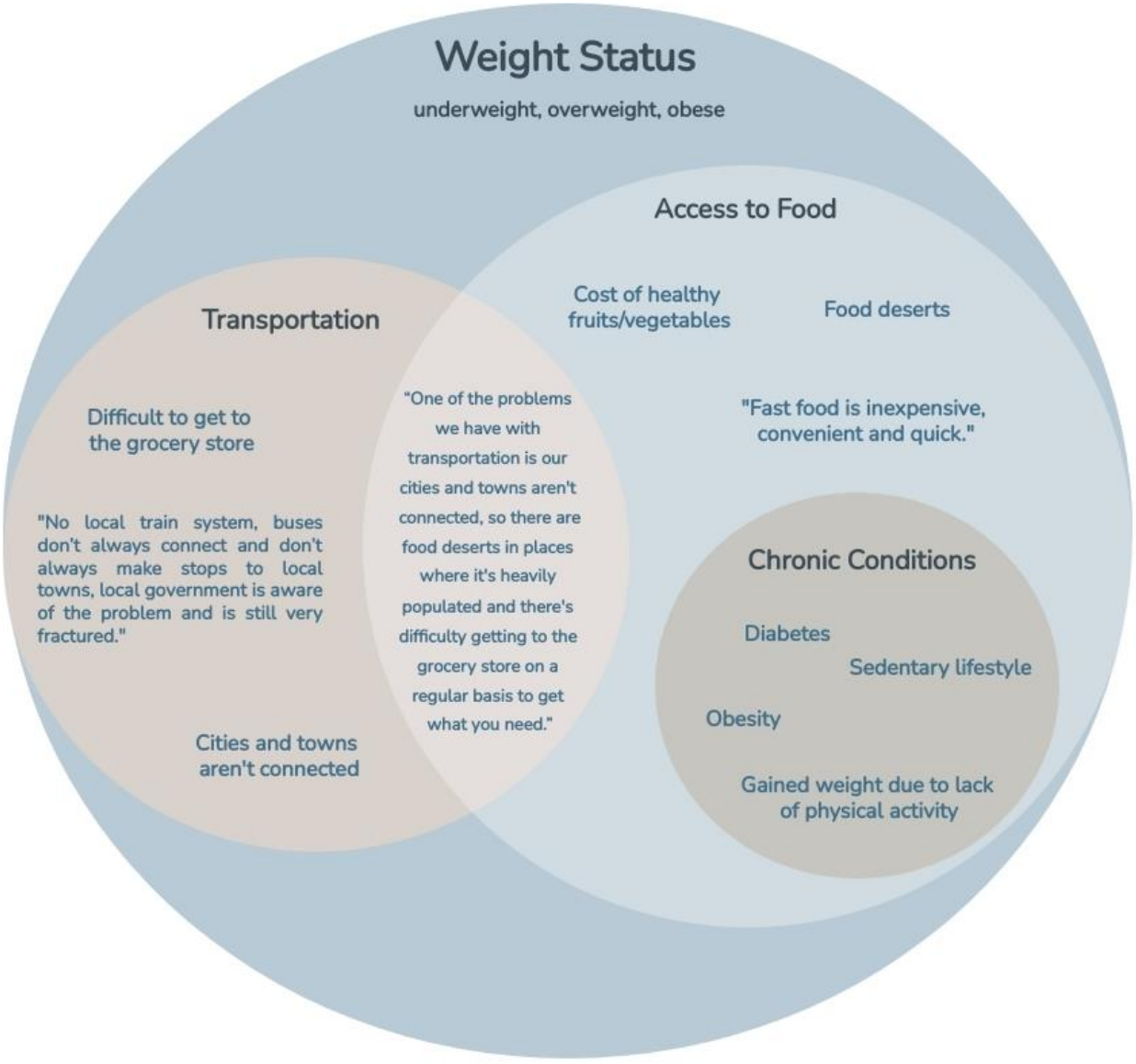
FIGURE 35: ADULTS 20+ OBESE



Source: Centers for Disease Control and Prevention, 2019

Figure 36 illustrates the interconnectedness between transportation, access to food, chronic conditions and weight status from primary data collected in Lake and Porter counties.
Access to reliable transportation is critical in ensuring equitable access to healthy fruits and vegetables. Transportation hurdles can put individuals at risk of developing chronic conditions.
Thus, it is evident that the relationship between transportation, access to food and chronic conditions contribute to weight status and the overall health of communities.

FIGURE 36: INTERCONNECTEDNESS FROM PRIMARY DATA



Source: Focus Group/Listening Session Commentary

Health System Efforts

Community Healthcare System's ongoing programs and services that address Weight Status in Lake and Porter counties are listed below.

Nutrition, Exercise, and Obesity

- Created Healthy Eating Series
- Developed a seasonal Walk and Talk program at a local arboretum featuring health topics
- Established Health Zone at Kawann Short football & STEM camp
- Expanded the Well Walkers Club to new areas/launched bi-monthly group walks for the public
- Held low-impact exercise classes

Section 5: OTHER FINDINGS

Critical components in assessing the needs of a community are identifying barriers to and disparities in healthcare. Additionally, the identification of barriers and disparities will help inform and focus strategies for addressing the prioritized health needs. The following section identifies barriers and disparities as they pertain to Lake and Porter counties.

Barriers to Care

Community health barriers for Lake and Porter counties were identified as part of the primary and secondary data collection. Secondary data was analyzed. In the community survey, focus group and listening session participants were asked to identify barriers to the healthcare they observed or experienced in the community.

Cost, Wait Times, Literacy

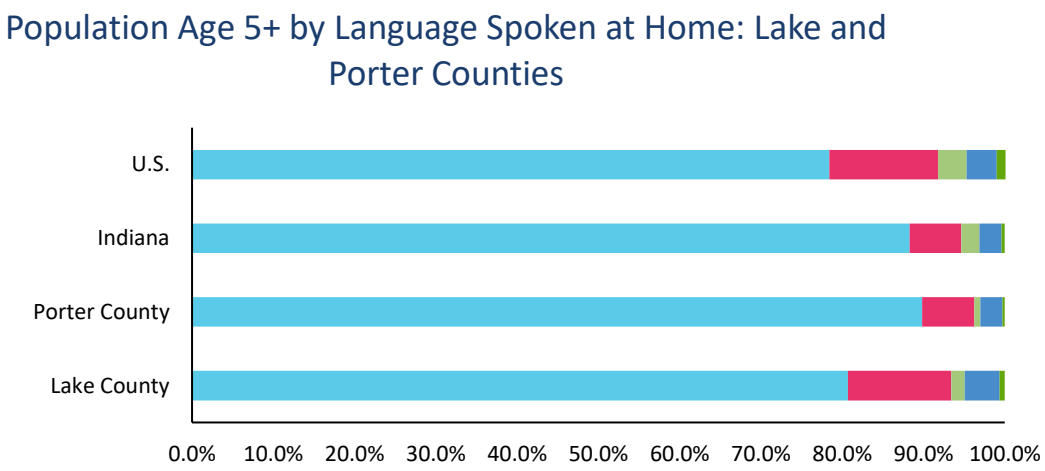
Access to affordable healthcare was a common barrier that was discussed whether due to out-of-pocket costs for those who were insured, had no insurance or were underinsured. Among community survey respondents who said they did not receive the care they needed, 44.2% selected cost/too expensive/can't pay as a barrier, 23.9 % noted that the wait to be seen was too long and 20.7% said the indicated hours of operation either did not fit their schedule or the provider did not accept their insurance. Focus group participants added that barriers to care included not having the infrastructure for access to the internet and computers/laptops. Even when the technology is available, knowledge on how to navigate the system may be lacking.

Language

Health literacy issues and language barriers make seeking care more difficult, especially for older adults, Black/African American and Hispanic/Latino populations.

Figure 37 shows a larger proportion of residents in Porter County speak only English, 89.9%, while approximately 80% of the population in Lake County speak only English. The second most spoken language in the two counties is Spanish, with 12.7% of residents speaking Spanish in Lake County and 6.4% of residents speaking Spanish in Porter County.

FIGURE 37: LANGUAGE SPOKEN AT HOME AGE 5+



	Lake County	Porter County	Indiana	U.S.
Only English	80.7%	89.8%	88.3%	78.4%
Spanish	12.7%	6.4%	6.3%	13.4%
Asian/Pacific Islander Language	1.6%	0.7%	2.2%	3.5%
Indo-European Language	4.3%	2.7%	2.7%	3.7%
Other Language	0.6%	0.3%	0.4%	1.1%

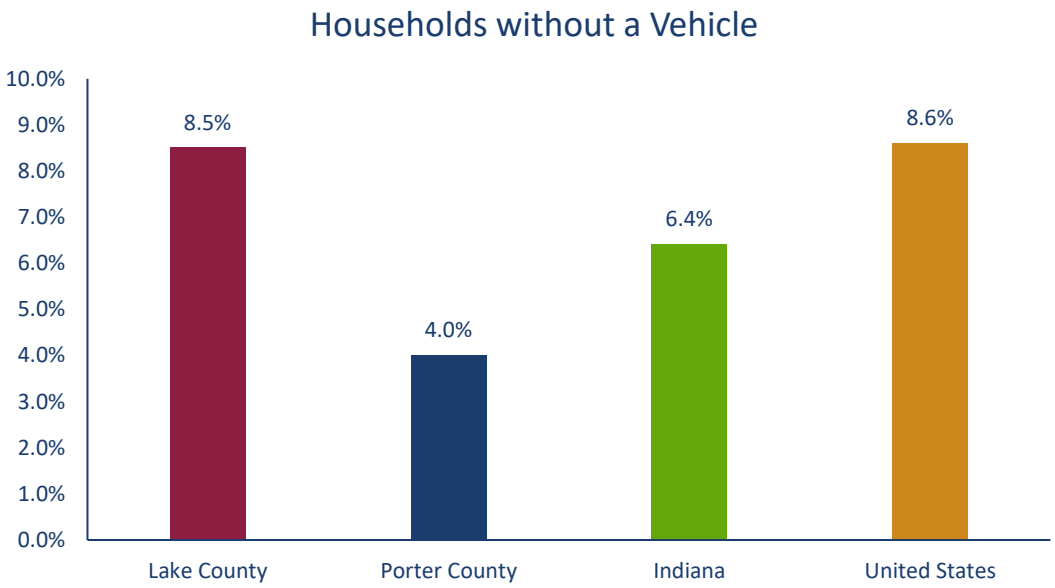
Source: Claritas, 2021

Transportation

Vehicle ownership is directly related to the ability to travel. People living in a household without a car make fewer trips compared to those with a car. Not having a vehicle can limit access to essential services such as grocery stores, doctor's offices and hospitals.

Figure 38 shows 8.5% of households in Lake County do not have a vehicle, slightly less than the United States percentage of households. In Porter County, 4% of households are without a vehicle, far more than households in Indiana and the United States.

FIGURE 38: HOUSEHOLDS WITHOUT A VEHICLE



Source: American Community Survey, 2015-2019

Race/Ethnic & Age Disparities

Community health disparities were assessed in both the primary and secondary data collection processes.
Table 22 below identifies secondary data health indicators with a statistically significant race or ethnic disparity for Lake County.

TABLE 22: INDICATORS WITH SIGNIFICANT RACE/ETHNIC DISPARITIES: LAKE COUNTY

Health Indicator	Group Negatively Impacted (highest rates)
Prostate Cancer Incidence Rate	Black / African American
Age-Adjusted Death Rate due to Prostate Cancer	Black / African American
Workers who Walk to Work	White, non-Hispanic
People Living Below Poverty Level	Black / African American/Hispanic / Latino/ Multiple Races/Other Races
Children Living Below Poverty Level	Black / African American/Hispanic / Latino/Other Races
Young Children Living Below Poverty Level	Black / African American/Other Races
Workers Commuting by Public Transportation	Multiple Races/Other Races
Age-Adjusted Death Rate due to Diabetes	Black / African American
Families Living Below Poverty	Black / African American/Hispanic / Latino/ Multiple Races/Other Races/American Indian / Alaska Native
People 65+ Living Below Poverty Level	Black / African American/Multiple Races

Table 23 below identifies secondary data health indicators with a statistically significant race or ethnic disparity for Porter County.

TABLE 23. INDICATORS WITH SIGNIFICANT RACE/ETHNIC DISPARITIES: PORTER COUNTY

Health Indicator	Group Negatively Impacted (highest rates)
People Living Below Poverty Level	Black / African American
Children Living Below Poverty Level	Black / African American/Hispanic / Latino
Young Children Living Below Poverty Level	Asian/American Indian / Alaska Native
Families Living Below Poverty	Black / African American/Asian/Multiple Races/Other Races/Hispanic / Latino
People 65+ Living Below Poverty Level	Asian/Multiple Races/Other Races
Babies with Very Low Birthweight	Hispanic, Any Race

Geographic Disparities

HCI developed the SocioNeeds Index® (SNI) and the Food Insecurity Index (FII) to easily identify areas of higher socioeconomic need. County-level data can sometimes mask what might be going on at the zip code level in many communities. While county-level indicators may be strong, using these indices in combination with county-level data can reveal disparities and ensure that efforts are directed to the communities with the highest need.

SocioNeeds Index

The SNI index incorporates estimates for six different social and economic determinants of health that are associated with poor health outcomes. The data, which cover income, poverty, unemployment, occupation, educational attainment, and linguistic barriers, are then standardized and averaged to create one composite index value for every zip code in the United States. The areas must have a population of at least 200. Zip codes have index values ranging from zero to 100, where higher values are estimated to have the highest socioeconomic need and are correlated with poor health outcomes including preventable hospitalizations and premature death.

Within the Community Healthcare System service area, zip codes are ranked based on their index value to identify the relative levels of need, as illustrated by the map in **Figure 39**.
The following zip codes had the highest level of socioeconomic need (as indicated by the darkest shades): 46402 (Lake County) and 46312 (Lake County). **Table 24** provides the index values for each zip code. Understanding where there are communities with high socioeconomic needs and associated poor health outcomes is critical to targeting prevention and outreach activities.

FIGURE 39: SOCIONEEDS INDEX MAP

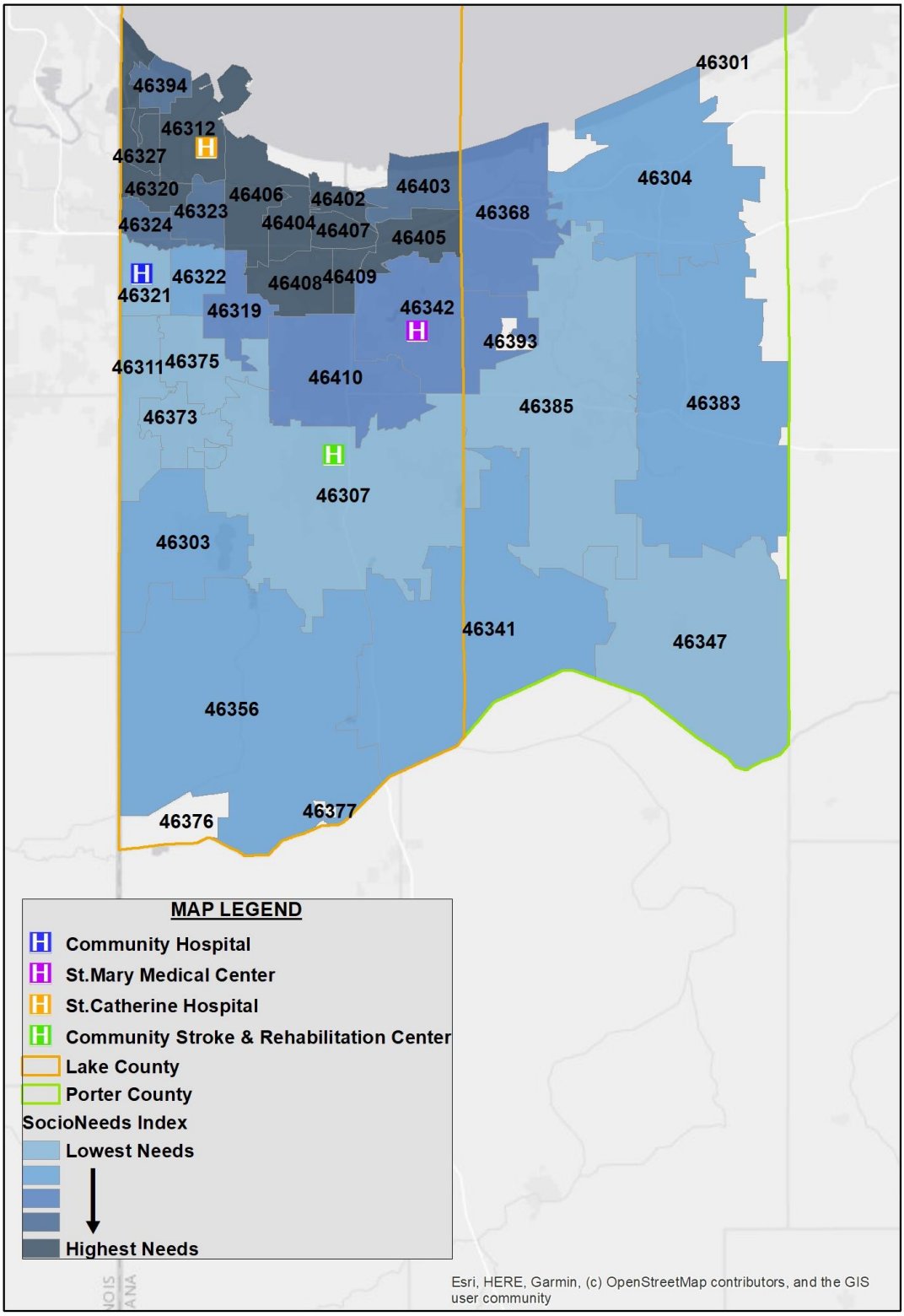


TABLE 24: SOCIONEEDS INDEX ZIP CODES

Lake County					
Zip Code	**City**	**Index Value**	**Zip Code**	**City**	**Index Value**
46402	Gary	98.6	**46394**	Whiting	76.1
46312	East Chicago	98.2	**46342**	Hobart	67.1
46407	Gary	97.9	**46410**	Merrillville	58.8
46320	Hammond	97.5	**46319**	Griffith	50.7
46409	Gary	96.4	**46303**	Cedar Lake	38
46327	Hammond	96	**46356**	Lowell	33.5
46404	Gary	94.9	**46322**	Highland	30.8
46406	Gary	94.4	**46307**	Crown Point	20
46405	Lake Station	93.4	**46375**	Schererville	19.6
46408	Gary	92.7	**46311**	Dyer	16.5
46324	Hammond	84.2	**46373**	Saint John	12.4
46323	Hessville	82.4	**46321**	Munster	11.2
46403	Gary	80			

Porter County		
Zip Code	**City**	**Index Value**
46368	Portage	60
46383	Valparaiso	27.9
46304	Chesterton	27.1
46341	Hebron	24.9
46347	Kouts	22.6
46385	Valparaiso	17.3

Food Insecurity Index

The Food Insecurity Index (FII) is a measure of food accessibility that is correlated with social and economic hardship. This index combines multiple socioeconomic and health indicators into a single composite value. All zip codes, census tracts and counties in the United States are given an index value from 0 (low need) to 100 (high need). To help find the areas of highest need in the service area, locales were ranked from 1 to 5 based on their index value, color-coded and displayed in **Figure 40**.

Table 25 provides the index values for each zip code. Understanding where there are communities with food insecurity are many times associated with poor health outcomes and is critical to targeting prevention and outreach activities.

FIGURE 40: FOOD INSECURITY INDEX MAP

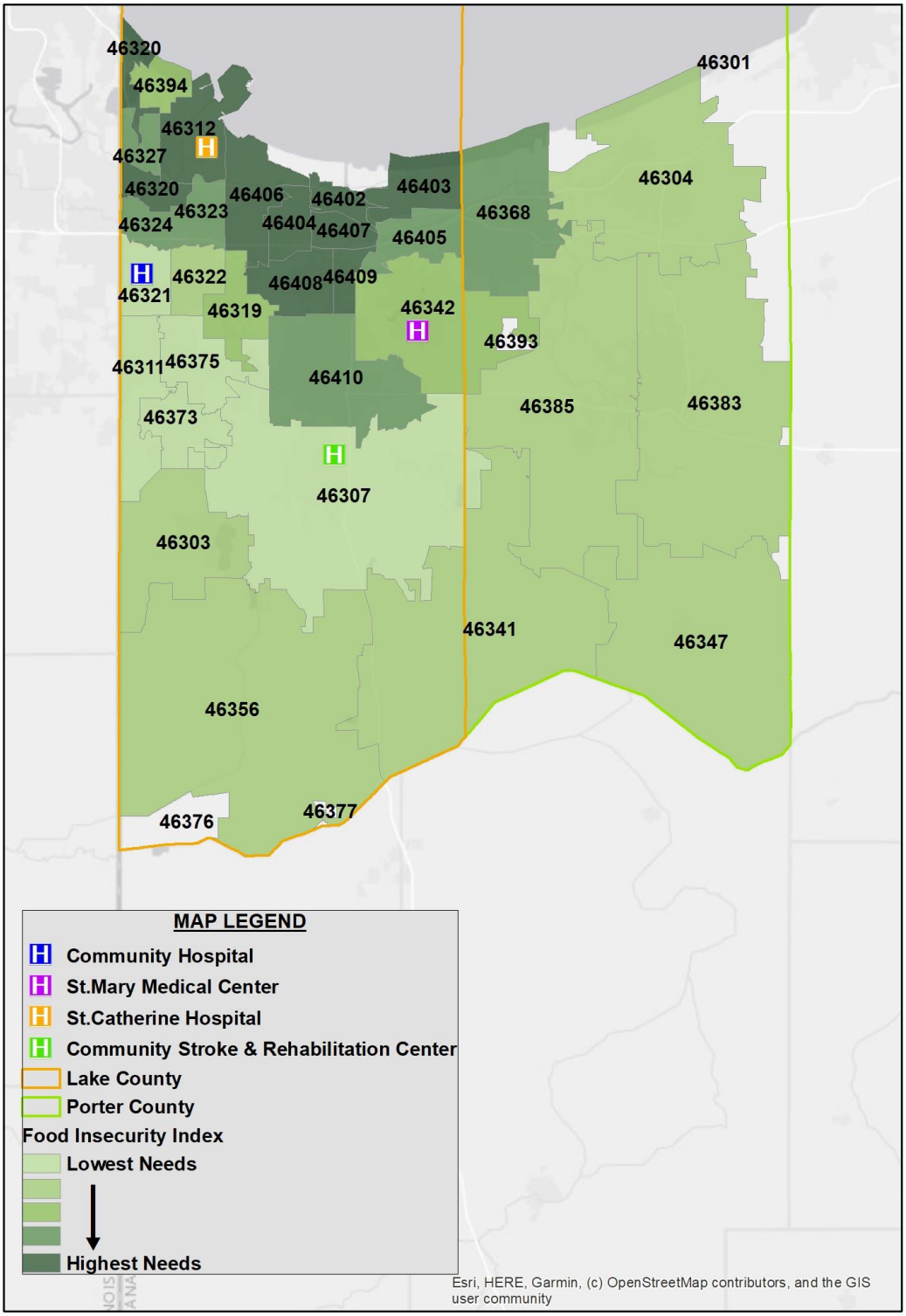


TABLE 25: FOOD INSECURITY INDEX ZIP CODES

Lake County					
Zip Code	**City**	**Index Value**	**Zip Code**	**City**	**Index Value**
46402	Gary	99.8	**46410**	Merrillville	61.6
46407	Gary	99.4	**46319**	Griffith	52.4
46312	East Chicago	99.2	**46394**	Whiting	42.7
46320	Hammond	97.6	**46342**	Hobart	40.8
46404	Gary	97.4	**46322**	Highland	24.8
46409	Gary	96.5	**46356**	Lowell	24.6
46406	Gary	96.4	**46303**	Cedar Lake	23.4
46403	Gary	95.6	**46375**	Schererville	14.8
46408	Gary	91.9	**46307**	Crown Point	13.9
46324	Hammond	76.8	**46321**	Munster	10.6
46327	Hammond	74.6	**46311**	Dyer	9.6
46405	Lake Station	71.2	**46373**	Saint John	4.9
46323	Hessville	65			

Porter County		
Zip Code	**City**	**Index Value**
46368	Portage	58.2
46383	Valparaiso	33.6
46304	Chesterton	31
46347	Kouts	26.6
46341	Hebron	26.2
46385	Valparaiso	20.1

Future Considerations

While identifying barriers and disparities are critical components in assessing the needs of a community, it is equally important to understand the social determinants of health and other upstream factors that influence a community's health as well. The challenges and barriers faced by a community must be balanced by identifying practical, community-driven solutions. Together, these factors come to inform and focus strategies to positively impact a community's health.

Section 6: COVID-19 IMPACT

Introduction

At the time that Community Healthcare System began its collaborative CHA/CHNA process, Lake and Porter counties and the state of Indiana were dealing with the novel coronavirus (COVID-19) pandemic. The process for conducting the assessment remained fundamentally the same. However, there were some adjustments made during the primary data collection to ensure the health and safety of those participating.

Pandemic Overview[1]

On March 13, 2020, a U.S. national emergency was declared over the novel coronavirus outbreak first reported in the Wuhan Provence of China in December 2019. Officially named COVID-19 by the World Health Organization (WHO) in February, WHO declared COVID-19 a pandemic on March 11, 2020. Upon completion of this report in February 2022, the pandemic was still a health concern across the United States and other countries.

Community Insights

The CHNA project team researched additional sources of secondary data and gathered primary data to provide a snapshot of the impact of COVID-19 on Lake and Porter Counties between September 2021 and January 2022. Findings are reported below.

COVID-19 Cases and Deaths in Indiana, Lake County and Porter County

For current cases and deaths due to COVID-19 visit the Indiana Department of Health https://www.coronavirus.in.gov/indiana-covid-19-dashboard-and-map/ the Lake County Health Department https://lakecountyin.org/departments/health/covid-19-dashboard-c/ and the Porter County Health Department https://www.porterco.org/297/Health.

Vulnerability Index[2]

Beyond looking at what we know about COVID-19 cases and deaths, the Conduent Vulnerability Index is a measure of potential severe illness burden due to COVID-19 by county. Counties are given an index value from 1 (low vulnerability) to 10 (high vulnerability). A county with a high vulnerability score can be described as a location where a higher percentage of COVID-19 cases would result in severe outcomes such as hospitalization or death as compared to a county with a low vulnerability score.

What does this score mean?

Figure 41 shows Lake County's Vulnerability Index Score is 1 out of 10 as of February 1, 2022. This means that county residents generally have low death rates due to chronic conditions, low socio-economic needs and adequate access to healthcare and services to protect themselves from severe COVID-19 cases and death.

FIGURE 41: LAKE COUNTY VULNERABILITY INDEX SCORE

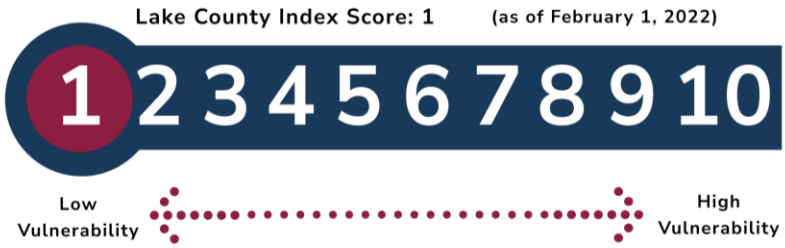
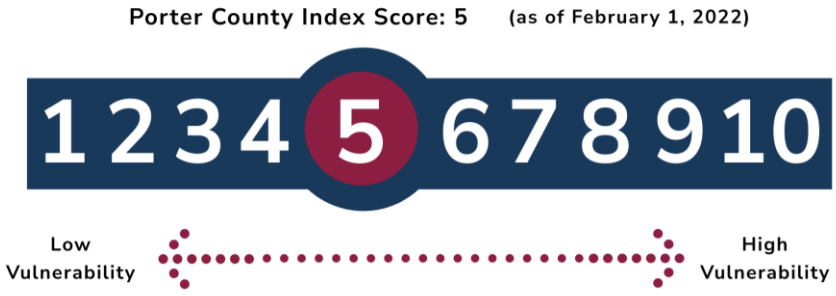


Figure 42 shows Porter County's Vulnerability Index Score is 5 out of 10 as of February 1, 2022. This means that county residents generally have moderate death rates. Porter County's score of 5 indicates their residents have a lower vulnerability than a county with higher rates of chronic disease, risky behavior, and/or low access to health services. The median Vulnerability Index value in Indiana is 5 out of 10. Eighty-five counties meet the inclusion criteria for the model and have calculated Vulnerability Index values.

FIGURE 42: PORTER COUNTY VULNERABILITY INDEX SCORE



Please note, this is a predictive model based on various chronic conditions, SocioNeeds Index®, and recent case counts and deaths. For more information, please see the "Learn More" section in the Conduent Vulnerability Index.

Unemployment Rates[3]

Figure 43 and **Table 26** show the monthly unemployment rate from January 2020 to September 2021 in Lake County, Porter County, Indiana, and the United States. We see a major increase in unemployment around March 2020 right at the start of the pandemic. As of September 2021, unemployment rates had dropped from 20.3% to 4.7% in Lake County, a rate still higher than Indiana and United States – and 17.9% to 2.9% in Porter County.

FIGURE 43: UNEMPLOYMENT

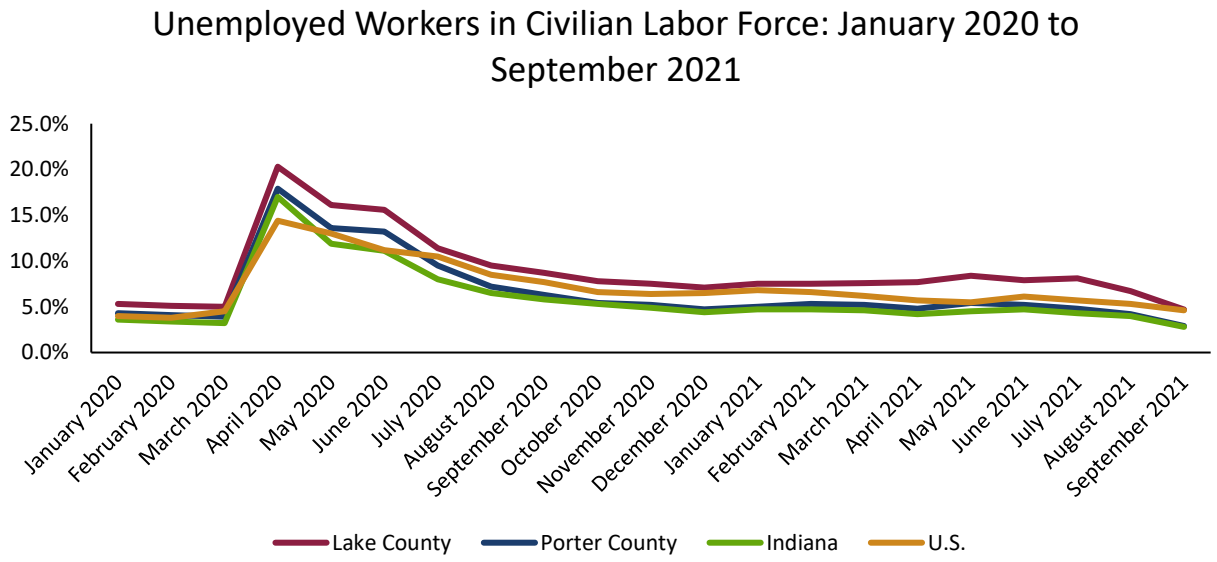


TABLE 26: MONTHLY UNEMPLOYMENT RATE FROM JANUARY 2020-SEPTEMBER 2021

	Lake County	Porter County	Indiana	United States
January 2020	5.3%	4.3%	3.6%	4.0%
February 2020	5.1%	4.1%	3.4%	3.8%
March 2020	5.0%	3.9%	3.2%	4.5%
April 2020	20.3%	17.9%	17.0%	14.4%
May 2020	16.1%	13.6%	11.9%	13.0%
June 2020	15.6%	13.2%	11.1%	11.2%
July 2020	11.4%	9.5%	8.0%	10.5%
August 2020	9.5%	7.2%	6.5%	8.5%
September 2020	8.7%	6.3%	5.8%	7.7%
October 2020	7.8%	5.4%	5.3%	6.6%
November 2020	7.5%	5.2%	4.9%	6.4%
December 2020	7.1%	4.7%	4.4%	6.5%
January 2021	7.5%	5.0%	4.7%	6.8%
February 2021	7.5%	5.3%	4.7%	6.6%
March 2021	7.6%	5.2%	4.6%	6.2%

April 2021	7.7%	4.8%	4.2%	5.7%
May 2021	8.4%	5.4%	4.5%	5.5%
June 2021	7.90%	5.20%	4.70%	6.1%
July 2021	8.10%	4.80%	4.30%	5.7%
August 2021	6.70%	4.20%	4%	5.3%
September 2021	4.70%	2.90%	2.80%	4.6%

Community Feedback

The community health survey, focus groups, and listening session results were used to capture insights and perspectives on the health needs of Lake County and Porter County. Included in these primary data collection tools were questions specific to COVID-19. Survey respondents were specifically asked about the biggest challenges their households were currently facing due to COVID-19. Of the 1,741 respondents who answered this question:

- 43% reported not knowing when the pandemic will end
- 33% reported feeling nervous or anxious
- 21% reported feeling alone or isolated, not being able to socialize with other people
- 14% reported not being able to exercise

Table 27 provide more insight into the challenges Lake County and Porter County residents faced during the pandemic.

TABLE 27. COVID-19 PRIMARY DATA INSIGHTS

Focus Group Insights	Listening Session Insights
COVID-19 Challenges	
Need for additional mental health programs/services	Supply chain shortages (price increases and delays)
Misinformation/confusion about the vaccine/pandemic	Inconsistent messaging about the importance of infection control, mitigation, vaccination
Isolation/lack of socialization	Mental Health
Fear to go outside of the home to exercise, fear of vaccines, fear of getting others sick	Staffing issues & shortages, difficulty with COVID-19 guidelines/policies, and relaying information to staff
Decreased attendance at community events/health fairs/screenings	Vaccine hesitancy
Fear and anger of the unknown	Technology-elderly/seniors lack of knowledge

Additionally, **Figure 44** summarizes insights from community members who engaged in the various primary data collection methods from September to November 2021 regarding the impact of COVID-19 on their community.

FIGURE 44: COVID-19 PRIMARY DATA SUMMARY

Recommended Data Sources

As local, state, and national data are updated and become available, these data can continue to help inform approaches to meeting existing and developing needs related to the pandemic. Recommended data sources for Lake and Porter counties are included here:

National Data Sources

- Centers for Disease Control and Prevention: https://www.cdc.gov/coronavirus/2019-ncov/php/open-america/surveillance-data-analytics.html
- Centers for Disease Control and Prevention: COVID Data Tracker: https://covid.cdc.gov/covid-data-tracker/?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fcases-updates%2Fcases-in-us.html#cases_casesinlast7days
- Johns Hopkins Coronavirus Resource Center: https://coronavirus.jhu.edu/us-map
- Conduent COVID At Risk – Vulnerability Index: https://www.covid19atrisk.org/
- Conduent COVID-19 Vulnerability Index: https://www.covid19atrisk.org/vulnerability.html
- National Association of County and City Health Officials (NACCHO) Coronavirus Resources for Health: https://covid19-naccho.hub.arcgis.com/
- Feeding America (The Impact of the Coronavirus on Local Food Insecurity): https://www.feedingamerica.org/sites/default/files/2020-05/Brief_Local%20Impact_5.19.2020.pdf
- Unemployment Rates: https://fred.stlouisfed.org/series/ILDEKA5URN and https://fred.stlouisfed.org/series/ILKEND3URN

State Data Sources

Data and recommendations from the following websites are updated regularly and may provide additional information on the impact of COVID-19 in the state of Indiana and the Community Healthcare System regional service area.

- State of Indiana: https://www.coronavirus.in.gov/
- Indiana COVID-19 Data Report: https://www.coronavirus.in.gov/indiana-covid-19-dashboard-and-map/
- Indiana 211: https://indianacommunityconnect.in.gov/betaresources/s/?language=en_US
- Indiana Department of Health: https://www.coronavirus.in.gov/covid-19-actions-regulatory-waivers/
- Lake County Indiana: https://www.lakecountyin.org/departments/health/covid-19-dashboard-c/
- Porter County Indiana Health Department: https://www.porterco.org/1598/Coronavirus-COVID-19-Updates

Section 7: CALL TO ACTION

Community Healthcare System
2022 Implementation Strategy

Introduction & Purpose

Community Healthcare System is pleased to share its Implementation Strategy Action Plan, which follows the development of its 2022 Community Health Needs Assessment (CHNA). In accordance with requirements in the Affordable Care Act and IRS 990 Schedule H requirements, this plan was approved by the Community Foundation of Northwest Indiana, Inc., Board of Directors for Community Healthcare System on June 15, 2022.

This report summarizes the plans for Community Healthcare System - in tandem with its four hospitals - to develop and collaborate on community benefit programs which address the prioritized health needs identified in its 2022 Community Health Needs Assessment.

The prioritized health needs are:

Community Healthcare System CHNA Priorities
• Priority 1: Maternal Health & Children's Health • Priority 2: Mental Health & Mental Disorders • Priority 3: Access to Healthcare • Priority 4: Diabetes • Priority 5: Heart Disease and Stroke • Priority 6: Cancer

These health needs affect our residents, whether directly or indirectly. Our progress toward improvement will be a collaborative effort by Community Healthcare System as a whole, and its individual hospitals, to key in on health disparities that are germane to each of the service population areas.

The following additional health needs emerged from a review of the primary and secondary data: Alcohol and Drug Use, Older Adults, Physical Activity and Barriers to Care. Barriers to Care includes: age, ethnic, geographic and race disparities, cost, language, literacy, social/economic needs and wait times.

With the need to focus on prioritized health needs noted in the table above, the secondary topics are not specifically prioritized efforts in the 2022-2025 Implementation Strategy. Many of these areas fall within Community Healthcare System's prioritized health needs due to interrelationships of social determinant needs. Therefore, many of the secondary health needs will be addressed through upstream efforts by healthcare and community outreach staff.

Community Healthcare System provides added support for community benefit activities that lay outside the scope of programs and activities noted in this Implementation Strategy. To keep a focus on the main initiatives, those activities will not be explored in detail in this report.

The purpose of the CHNA was to offer a comprehensive understanding of the health needs in Community Healthcare System service areas to guide the planning efforts that address those needs. Special attention was given to the needs of vulnerable or underserved populations, gaps in services and unmet health needs through a vetting process with healthcare professionals, not-for-profit organizations, civic leaders and community residents.
For further information on the process to identify and prioritize significant health needs, please refer to the CHNA report for Community Healthcare System. Visit: www.COMhs.org/about-us/community-health-needs-assessment

Implementation Strategies Summary

Strategy Design Process

This Implementation Strategy & Action Plan outlines specific activities (described in the three-year plan) that will be undertaken to address priority areas.
This is a living document intended to adapt to a dynamic community and market forces, and will evolve over time. Community Healthcare System education efforts and community partnerships are aligned to this Strategy & Plan to result in improved outcomes and better health and wellness for our community.
The Implementation Strategy & Plan is guided by the Community Health Needs Assessment. This reflects a three-year commitment to make meaningful progress in addressing issues prioritized in the 2019-2021 CHNA and its corresponding Community Healthcare System Implementation Strategy & Plan. To learn more, visit: www.COMhs.org/about-us/community-health-needs-assessment

Community Healthcare System: PRIORITIES AND STRATEGIES

Implementation strategies outlined below summarize the goals and activities that will be taken on by Community Healthcare System to directly address the health needs of greatest concern, as identified in the Community Health Needs Assessment process.

The action plan also will include strategies that may be unique to a hospital and service area within Community Healthcare System to help ensure serving the diverse needs of all of our residents. Hospital specific strategies will appear in blue.

Our mission is to have the greatest possible impact on community health status and meet Healthy People 2030 goals.

Priorities and Strategies

Priority 1: Maternal Health & Children's Health
Goal: Improve the health and wellbeing of women, children and families.
Strategies:

- Increase awareness of maternal and children's care and services.
- Provide navigation and support services to expectant, postpartum and breastfeeding mothers.

Priority 2: Mental Health & Mental Disorders
Goal: Improve mental health.
Strategies:

- Increase the importance of mental health awareness.
- Conduct internal and community training.
- Increase access to mental healthcare by expanding services within the hospital system.

Priority 3: Access to Care

Goal: Access to healthcare will be addressed in each of the other health priority implementation plans.
Strategies: Each hospital will draw upon its resources and community partners to develop programs and services to improve access to care for Lake and Porter county residents.

Priority 4: Diabetes

Goal: Reduce the burden of diabetes and improve quality of life for all people who have or are at risk for, diabetes.
Strategies:

- Offer education/training opportunities to public and staff members.
- Provide community events/health fairs/screenings.

Priority 5: Heart Disease and Stroke

Heart Disease
Goal: Improve cardiovascular health and reduce deaths from heart disease and stroke.
Objective: By June 2025, increase the number of individuals participating in screenings and heart disease programs by 25 percent.
Strategies:

- Increase awareness of heart disease and stroke risk factors.
- Provide multiple educational opportunities to the public.

Stroke
Goal: Improve cardiovascular health and reduce deaths from heart disease and stroke.
Objective: By June 2025, increase the number of individuals participating in stroke prevention programs by 25 percent.
Strategies:

- Increase awareness of heart disease and stroke risk factors.

Objective: By June 2025, increase access for individuals who have experienced a stroke to therapies/medications by 10 percent.
Strategies:

- Increase access to medications for stroke patients.

Priority 6: Cancer

Goal: Reduce new cases of cancer and cancer-related illness, disability and death.
Strategies:

- Provide multiple screening opportunities to the public.
- Develop a navigation and support program.
- Provide multiple educational opportunities to the public.

Action Plan Summary

The Action Plan lists the individual strategies and activities put in place to address priority health needs through the Community Health Needs Assessment (CHNA) process.
The following components, outlined in detail in tables within this report, will address:

- Actions the healthcare system and its hospitals intend to take to address health needs identified in the CHNA process.
- Anticipated impact of these actions, noted in process and outcomes measures for each activity.
- Resources the hospital system plans to commit to each strategy.
- Any planned collaboration to support the work.

Action Plans 2022-2025

Planning meetings were held in April and May by hospital staff and leaders in their specialty to define strategies and activities, set goals and identify resources to achieve positive health outcomes.
For the current CHNA, measurable metrics are in place to set a definitive baseline and monitor progress toward the goals in addressing the prioritized health needs:

- Priority 1: Maternal Health & Children's Health
- Priority 2: Mental Health & Mental Disorders
- Priority 3: Access to Healthcare
- Priority 4: Diabetes
- Priority 5: Heart Disease and Stroke
- Priority 6: Cancer Strategy

Access to Care will be addressed through other health priority implementation plans. In developing programs and services to improve access to care for residents in Lake and Porter counties, each hospital will draw upon its employed physician/staff groups, education departments, community partners and the expertise of healthcare professionals within Community Healthcare System to improve access to care. Access to Care activities include:

- Free and low cost health services/screenings through special promotions/events/health fairs/mobile units
- Access to affordable medications
- Access to healthcare information
- Access to clinical services, screenings and programs
- Free transportation for patient care in underserved populations or critical care areas

Community Healthcare System Implementation Strategy Action Plan

Community Hospital | St. Catherine Hospital | St. Mary Medical Center Community Stroke & Rehabilitation Center

Overview

The 2022 Implementation Strategy Action Plan builds on the progress and ever-changing healthcare needs of the communities served by Community Healthcare System. The needs were identified in the 2019-2021 Community Health Needs Assessment (CHNA) for Community Hospital, St. Catherine Hospital and St. Mary Medical Center on these priority health areas:

- Cancer
- Diabetes
- Heart Disease and Stroke
- Maternal, Infant and Child Health
- Adult Mental Health
- Nutrition and Weight Management

Healthier lifestyles were promoted across all priority areas through free or discounted health screenings, health fairs, physician lectures, special events and symposiums. Topics included cancer, cardiology, diabetes, heart disease, nutrition, weight management, adult mental health, stroke and maternal child health. Screenings have included low or no-cost mammograms, balance and bone density tests, PVD screenings and heart attack/stroke risk assessments.

Community Healthcare System hospitals did not have a formal process in place to track/evaluate or give feedback on the impact of the 2019-2021 Community Health Needs Assessment.
However, participants of classes, events, programs and screenings were invited to complete evaluations on the effectiveness of their outreach activity. From this feedback, and health data repositories, program evaluation and development continued on an annual basis. In an effort to reach residents isolating in response to COVID-19, the healthcare system mobilized to develop in-person and online outreach programming.

A synopsis of past programming is noted in the 2022-2025 CHNA (Pages 13-14).

Below is a summary of system initiatives and unique programs by Community Hospital, St. Catherine Hospital and St. Mary Medical Center. For Community Stroke & Rehabilitation Center (CSRC), opened in September 2019, this will be the specialty hospital's first Implementation Strategy Action Plan. See Page 175 of this Action Plan.

Addressing Community Needs

Community Healthcare System offers a diverse range of programs and services to make improvements in the health of residents in our communities.

An important entity is the medically based fitness center, Fitness Pointe®, and the workplace wellness program, New Healthy Me which serves employees in the hospital system and work settings in our communities. Our Occupational Health program offers work-related screenings, wellness services and educational programs to businesses, corporations, municipalities and school districts in Lake and Porter counties to optimize health in the workplace. Additionally, our outpatient care centers for general medicine or specialty services are strategically positioned in population growth areas.

Cancer

Community Hospital, along with St. Catherine Hospital and St. Mary Medical Center, are designated by American College of Radiology as Breast Imaging Centers of Excellence. These hospitals, and Community Stroke and Rehabilitation Center, are also designated as Care Continuum Centers of Excellence for Lung Cancer by the GO2 Foundation for delivering best practice and patient-centered multidisciplinary care. Together, the hospitals offer an array of services, wellness and outreach programs for cancer patients and those who are at risk for cancer, such as: Low or no-cost screenings; early nodule, genetic and geonomics testing; and infusion centers. The Cancer Resource Centre offers an array of mind-body-spirit classes, informative programs, special events, and access to more than 100 clinical cancer research trials to patients living in Northwest Indiana and nearby locales in Illinois.

In 2021, a breast and lung cancer nurse navigator program began taking shape to coordinate care for patients across disciplines and beyond hospital walls, ensuring access to needed psycho-social services and medical care from the point of diagnosis and treatment to survivorship. Recognizing that transportation can be a barrier to care, new cancer care/provider support locations were added at two hospitals (St. Catherine/CSRC) and the Valparaiso Health Center of St. Mary Medical Center. American Cancer Society funding was sought for develop transportation services for appointments.

Diabetes, Heart Disease and Stroke

Community Healthcare System adopted a multidisciplinary approach to provide the highest-possible standard of care, rehabilitation and outreach to patients with diabetes, heart disease and stroke.

Diabetes

The Centers for Diabetes at our hospitals follow set procedures, blood-glucose monitoring protocols and treatment plans to help detect diabetes in its early stages, and help patients already struggling with the disease regain their balance as quickly as they can for a healthier life. St. Catherine Hospital, serving an area with some of the highest diabetes rates in the state, has consistently earned the Gold Seal of Approval from The Joint Commission for Advanced Inpatient Diabetes Care.

Heart Disease

The hospitals of Community Healthcare System operate one of the largest, most advanced cardiovascular programs in Northwest Indiana through our Advanced Heart & Vascular Institute, Cardiac ICU and Chest Pain Centers. Our teams provide a high level of expertise in performing diagnostic testing,

cardiac and peripheral interventions, open heart and minimally invasive surgeries, including transcatheter aortic valve replacement (TAVR) and aortic aneurysm repair (TEVAR), heart valve care through electrophysiology and cardiac catheterization, cardiac rehabilitation, heart failure management and disease prevention. The cardiovascular services program is distinguished for its outstanding treatment of heart attack patients, and meeting goals to treat complex coronary artery disease with high compliance to core standard levels of care.

Stroke

Community Hospital, an accredited Neurointerventional & Certified Comprehensive Stroke Center, works closely with the Primary Stroke Centers at St. Catherine Hospital and St. Mary Medical Center on best practices regarding stroke prevention, treatment and rehabilitation. All three hospitals hold the Gold Plus rating from the American Heart/Stroke Association. Acute Rehabilitation units at all hospitals, including Community Stroke & Rehabilitation Center, provide a full spectrum of care to achieve the best recovery possible in the shortest amount of time. The Acute Rehabilitation units have some of the best return-to-home performance evaluation measures in the country.

Outreach

Founded on a belief that diabetes, heart disease and stroke is preventable, Community Healthcare System strives offers free or discounted screenings, presentations on innovative technology such as the Watchman™, CardioMEMS™, and Transcatheter aortic valve replacement (TAVR), and Stroke & Diabetes Prevention Awareness Symposiums. Additionally, diabetes and stroke support groups and classes are offered in our facilities and communities. Our healthcare teams work with individuals and families to promote lifestyle choices that lower the risk of development diabetes, heart, neurological and vascular disease.

Maternal, Infant & Child Health

Family Birthing Centers at all three hospitals are Blue Distinction Centers +™ for Maternity Care by Anthem Blue Cross and Blue Shield of Indiana, meaning the facilities consistently deliver quality care that result in better overall outcomes for maternity patients.

St. Mary Medical Center, a Baby-Friendly Hospital by Baby Friendly USA, recently was recognized recently by U.S. News & World Report as high-performing in maternity care and childbirth services.

Together, significant advancements have been made as part by the Family Birthing Centers, as part of their 2019-2021 Action Plan to provide a higher level of care for mothers and babies across Northwest Indiana.

Expectant mothers facing high-risk or complicated pregnancies are able to access specialize care at Community Hospital's Certified Perinatal Center. In 2020-21, Community Hospital's Neonatal Intensive Care Unit (NICU) was expanded to include an OB Emergency Department, providing critical care and transport services to mothers and babies at risk across our service areas.

Educating the community about risk factors for Sudden Unidentified Infant Deaths (SUIDS) and well-baby care also has remained a priority of our Birthing Centers.

New families receive free SleepSacks and a free car seat to take home. Certified lactation consultants encourage moms during and after their hospital stay to breast feed their babies. Peer-counselors interact with mothers of newborns in the NICU unit who are often pump dependent. Birthing, lactation and grandparent classes are offered across the hospital system.

In 2021-22, the Indiana Department of Health presented Community Healthcare System with the INspire award for efforts to reduce infant mortality and provide interventional support to mothers. In 2019, St. Catherine Hospital was recognized for infant-life advocacy through its installation of a Safe Haven Baby Box outside the Family Birthing Center.

Adult Mental Health

Behavioral Health Services (BHS), operates two adult inpatient units at St. Catherine Hospital and provides outpatient care through a network of community-based providers. Construction of a third inpatient unit, begun in 2020, will conclude in 2022. BHS also conducts mental health assessments for the general hospital population.

An Intensive Outpatient Program, paused due to the pandemic, is expected to resume in 2022. Recognizing the impact COVID-19 has had on mental health, a community resource guidebook for psycho-social needs was developed for the patients, social workers and medical providers. An activity book with mental health tips was also designed to hand to patients at all hospitals, if the nursing team noticed signs anxiety or depression.

Behavioral Health professionals conducted a Healthy Mind/Healthy Body symposium before the pandemic and hosted a pre-recorded Suicide Prevention Vigil during the pandemic. In an effort to connect with patients during COVID-19, BHS staff launched Telehealth services and offered training sessions with first-responders on mental health de-escalation techniques.

Nutrition and Weight Management

Nutrition and weight management did not surface as a priority issue for the 2022-2025 CHNA. However, Community Healthcare System recognizes that nutrition and weight management are contributing factors in wellness, mental health and chronic disease. For those reasons, nutrition and weight management will be addressed as we focus on our priority health issues in the 2022-2025 Action Plan.

Community Hospital

PRIORITY: Maternal & Children's Health

Goal Statement: Improve the health and well-being of women, children, and families. (Healthy People 2030)

Community Hospital Strategy 1: Increase awareness of maternal and children's care and services							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Participate in annual health fairs/ community events for public.	Family Birthing Center staff; CFNI Marketing/CHS Community Outreach	Number of materials distributed	Community Benefits Reports	Set up in Y1 Baseline 0	Develop/ redesign needed materials	Increase materials distributed by 2%	Increase materials distributed by 2% over Y2
Activity 1B: Develop an online educational series for pre- and post-natal mothers with trusted informational resources.	Patient Education; IT; CFNI Marketing/CHS Community Outreach	Number of engagements/ views	Analytical tools	Set up in Y1 Baseline 0	Set-up access links/ trial run	Increase engagement by 2%	Increase engagement by 5%
Activity 1C: Provide car seat safety clinic at all hospitals.	Family Birthing Center; CHS Community Outreach	Number of participants	Registration records	Set up in Y1 Baseline 0	Develop parameters for program; establish partnerships needed for event	Increase participants by 3%	Increase participants by 5%
Anticipated Outcomes: • **Short-Term:** Increased awareness of services offered. • **Medium-Term:** Increase in utilization of services. • **Long-Term:** Women use services at appropriate time (e.g., prenatal care starts before 14 weeks).							
Target Population(s): • Teen mothers • Breast feeding mothers • Expectant mothers • Families							
Resources: • Safe Haven Baby Box- provides materials, funding • Car seats • Staff time							

Collaboration Partners:

- First Things First
- Nurse Family Partnership
- EMS director
- Moms Taking Charge
- Baby-Friendly USA
- Certified car seat safety specialists (local Fire Departments, Lake County)

Community Hospital

Community Hospital Strategy 2: Provide navigation and support services to expectant/postpartum/breastfeeding mothers							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Conduct Social Determinates of Health Assessment for expectant and new mothers.	Family Birthing Centers; Nurse navigators; social workers; social services	Number of assessments	Hospital records	Set up in Y1 Baseline 0	Set-up resources and processes to administer assessment	Increase screenings/ referrals by 2%	Increase screenings/ referrals by 3%
Activity 1B: Offer educational classes (childbirth, teen parents, baby care, breastfeeding, grandparents)	Family Birthing Centers; Nursing Education	Class participants	Sign in sheets/ records	Set up in Y1 Baseline 0	Determine # of class participants	Increase class participants by 2%	Increase class participants by 3%
Activity 1C: Offer nutrition services/gestational diabetes OP counseling	Family Birthing Center; Nursing Education; Dietitians;	Number of patients receiving services	Hospital records	Set up in Y1 Baseline 0	Determine # of individuals referred for counseling	Increase # of referrals by 2%	Increase # of referrals by 3%
Activity 1D: Expand the neonatal care program	**Neonatal Intensive Care Unit; Family Birthing Centers; Nursing Education**	**Patients receiving access or transport to OB/GYN**	**Hospital records; EPIC**	**Set up in Y1 Baseline 0**	**Set baselines and protocols for referrals to/use of neonatal services by all CHS hospitals**	**Increase # of referrals by 2%**	**Increase # of referrals by 3%**

Anticipated Outcomes:

- **Short-Term**: Increase knowledge on services.
- **Medium-Term:** Increase use of services if needed.
- **Long Term:** Reduce low weight births.

Target Population(s):

- Infants needing neonatal care
- Adults 18+
- Expectant mothers / postpartum mothers
- Teen parents
- Grandparents
- Individuals experiencing high risk pregnancies
- Breast feeding mothers

Resources:

- Staff time
- Specialized nurses, advanced providers, respiratory therapists
- Cribs for Kids-funding/grant
- SUIDS Education/Safe Sleep programs
- American Academy of Pediatrics
- U.S. Consumer Product Safety Commission

Collaboration Partners:

- Mental Health America of Northwest Indiana
- Look-alike Federally Qualified Health Centers
- WIC
- Healthy Families
- First Things First
- Nurse-Family Partnership

Community Hospital

PRIORITY: Mental Health & Mental Disorders

Goal Statement: Improve Mental Health (Healthy People 2030)

Community Hospital Strategy 1: Increase the importance of mental health awareness							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Develop mental health website/web page to be more interactive.	Behavioral Health Services; Marketing and Communications, IT	Number of engagements/ views	Analytical tools	Set up in Y1 Baseline 0	Set-up access links/page design/trial run	Increase engagement by 2%	Increase engagement by 5%
Activity 1B: Plan and implement suicide awareness programs (vigil, in-house awareness table, digital campaign).	Behavioral Health Services; CFNI Marketing/CHS Community Outreach	Number of hosted awareness activities	Activity logs/Community Benefits Reports	Set up in Y1 Baseline 0	Develop suicide awareness program plans for community and staff	Host one in-house and community event (2 total)	Increase # of events by 2
Activity 1C: Develop family support and resource groups. Groups will cover topics including skill development, resources and support for participants.	Behavioral Health Services	Attendees at support groups	Registration logs/Community Benefits Reports	Set up in Y1 Baseline 0	Develop support group strategies/ trial run	Increase # of participants by 2%	Increase # of participants by 3%
Activity 1D: Increase local media representation on mental health through Podcast	Behavioral Health Services; CFNI Marketing and Communications	Number of engagements for podcast	Analytics logs	Set up in Y1 Baseline 0	Develop podcast content/trial run	Increase # of engagements By 2%	Increase # of engagements by 5%

Anticipated Outcomes:

- **Short-Term:** Increase mental health awareness through education and support.
- **Short-Term:** People know the types of mental health services that are available to them.
- **Medium-Term**: People recognize the need to access mental health services.
- **Long-Term:** Lower the incidence of suicide in Lake and Porter Counties.

Target Population(s):

- Everyone
- Adults 18+
- Students
- People with mental health concerns
- People with mental health history

Resources:

- Mental Health America of Northwest Indiana
- American Psychological Association
- National Alliance on Mental Illness
- National Suicide Prevention Lifeline

Collaboration Partners:

- Purdue University Counseling Department

Community Hospital

Community Hospital Strategy 2: Conduct Internal Training and Community Training							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Plan, implement, and offer education sessions/trainings for hospital personnel on mental health education, removing stigma, crisis intervention training.	Behavioral Health Services; Education	Number of trainings	Community Benefits Reports/ employee logs	Set up in Y1 Baseline 0	Develop training program/trail-run	Conduct 2 training sessions per year	Conduct 4 training sessions per year
Activity 1B: Support community trainings on mental health crisis response training (first responders - police, firefighters, EMS; workplace, colleges/universities).	Behavioral Health Services; Education; CHS Occupational Health	Number of trainings	Community Benefits Reports/attendee logs	Set up in Y1 Baseline 0	Develop training program/trail-run	Conduct 2 training sessions per year	Conduct 4 training sessions per year
Activity 1C: Plan and host expert panel to present on mental health issues in the workplace, de-escalation trainings to promote safe workplace environment (Part of community workplace outreach, e.g., steelworkers, large/small employers, schools).	Behavioral Health Services; Occupational Health	Number of events hosted with that include a panel discussions	Community Benefits Reports	Set up in Y1 Baseline 0	Develop a group of presenters to conduct training	Host 1 event that features a mental health panel	Host 2 events that of feature a mental health panel
Anticipated Outcomes: • **Short-Term:** Increase mental health awareness through education and support. • **Short-Term:** First responders, counselors, employers, human resources directors, etc., know that de-escalation training is available. • **Medium-Term**: People use the techniques they are taught. • **Long-Term:** De-escalating any situations becomes the norm during emergency situations in Lake and Porter Counties.							
Target Population(s): • Everyone • Adults 18+ • Students • People with mental health concerns • Counselors/Educators • First Responders							

Resources: • Mental Health of America • American Psychological Association • National Alliance on Mental Illness
Collaboration Partners: • Local EMS • Local Police Departments • Local School Districts

Community Hospital

Community Hospital Strategy 3: Increase access to mental health care by expanding services to sister hospitals							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Expand look-alike Federally Qualified Health Center outpatient services.	Behavioral Health Services; Human Resources; 219 Health Network	Additional staff and/or services	Hospital Records	Set up in Y1 Baseline 0	Create a plan to expand services or higher additional staff	Service development and staff recruitment	Institute new service(s)
Activity 1B: Grow Integrated Primary Care model: integrate nurse practitioners in primary care settings, look-alike Federally Qualified Health Centers (FQHC) to close the gap between medical health and mental health "Pathway Program" patients referred to FQHC providers.	Behavioral Health Services; Nursing	Patients switching to Integrated Primary Care	Hospital records/EPIC	Set up in Y1 Baseline 0	Lay the groundwork for Care Model use within CHS	Care Model tested at St. Catherine Hospital, with plan to expand to sister hospitals in Y2	Expansion completed
Anticipated Outcomes: • **Short-Term:** Increase access to mental health services. • **Medium-Term**: Streamline delivery of services. • **Long-Term:** Provide the best possible mental health care to the citizens in Lake and Porter Counties.							
Target Population(s): • Everyone • Adults 18+ • People with mental health concerns							
Resources: • Integrated Primary Care https://www.integratedprimarycare.com/							
Collaboration Partners: • Look-a-Like Federally Qualified Health Centers (FQHC)							

Community Hospital

PRIORITY: Diabetes

Goal Statement: Reduce the burden of diabetes and improve quality of life for all people who have, or are at risk for, diabetes. (Healthy People 2030)

Community Hospital Strategy 1: Provide education/training opportunities to public and staff members.							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Offer diabetes education training to staff.	Nursing Education Department	Staff attendance	Learning Management System	Set up in Y1 Baseline 0	Determine baseline # of trainings	Increase trainings by 2%	Increase trainings by 3%
Activity 1B: Develop opportunities for nursing students to observe diabetes education classes for class credit/points.	Nursing Education; Diabetes Centers	Number of students enrolled in program	Student attendance log sheets/ or copy of signature forms	Set up in Y1 Baseline 0	Develop parameters of the program/ trial run	Determine baseline # of student participating in program	Increase # of students enrolled in program by 3%
Activity 1C: Offer in-person/ virtual gestational diabetes sessions.	Family Birthing Centers; Diabetes Educators; Dieticians	Registration sheets/lists	Community Benefits Report, EPIC	Set up in Y1 Baseline 0	Determine baseline # of sessions per year	Increase # of sessions by 2%	Increase # of sessions by 3%
Activity 1D: Develop diabetes prevention program.	Diabetes Educators; CFNI Marketing/CHS Community Outreach	Pre/post-tests; participant evaluations; scheduled programs	Community Benefits	Set up Y1 Baseline 0	Develop program content/ conduct trial run	Determine baseline # of participants	Increase participation by 3%

Anticipated Outcomes:

- **Short-Term:** Increased knowledge of diabetes among participants.
- **Short-Term:** Participants complete diabetes educational/prevention opportunities.
- **Medium-Term:** Participants make lifestyle changes to prevent or delay onset of diabetes.
- **Long-Term**: Reduce amount of new diabetes cases in Lake and Porter counties.
- **Long-Term:** Increase the amount of people with controlled diabetes.

Target Population(s):

- Adults 18+
- Patients
- Secondary education/college students

• Community members • Pregnant Women
Resources: • Staff time • Foundations of East Chicago (grant funding) • The Joint Commission
Collaboration Partners: • American Diabetes Association®

Community Hospital

Community Hospital Strategy 2: Provide community events/health fairs/screenings							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Offer community health fairs including A1C and Diabetes mellitus (DM) risk assessments.	Nursing Education Department; CFNI Marketing/CHS Community Outreach	Sign-in sheets	Community Benefit Report	Set up Y1 Baseline 0	Determine # health fairs per year	Increase # of health fairs per year by 1	Increase # of health fairs per year by 1
Activity 1B: Participate in community based events providing screenings/education.	Nursing; Community outreach	Registration/lab paperwork	Community Benefit Report; hospital records	Set up Y1 Baseline 0	Determine # of fairs requesting participation	Increase participation by 2%	Increase participation by 4%
Anticipated Outcomes: • **Short-Term:** Patients have increased knowledge and awareness of diabetes. • **Short-Term:** Increase participation in screening opportunities. • **Medium-Term:** Provide access to care and follow-up for those determined to be diabetic through screenings • **Long-Term:** Reduced new cases of diabetes/related illness in our communities (e.g., reduced readmission rates due to diabetes, reduced burden of diabetes and improved quality of life).							
Target Population(s): • Adults 18+ • People unaware of diabetes status							
Resources: • Foundation grants							
Collaboration Partners: • American Diabetes Association®							

Community Hospital

PRIORITY: Heart Disease and Stroke

Goal Statement: Improve cardiovascular health and reduce deaths from heart disease and stroke. (Healthy People 2030)

Community Hospital Strategy 1: Increase awareness of heart disease and stroke risk factors							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Offer free or discounted vascular screenings, blood pressure readings, Peripheral Arterial Disease (PAD) and Limb Ischemia and Vascular Excellence (L.I.V.E.), screenings through Health Fairs.	Cardiology; CFNI Marketing/CHS Community Outreach	Number of patient labs	Hospital records/EPIC	Set up in Y1 Baseline 0	Develop baseline # of participants using screenings	Increase screening participants by 2%	Increase screening participants by 5%
Activity 1B: Offer echocardiogram (ECHO) screening 1-2 per times year at a reduced cost.	Cardiology	Number of patient labs	Hospital records/EPIC	Set up in Y1 Baseline 0	Develop baseline # of participants using screenings	Increase screening participants by 5%	Increase screening participants by 5%
Activity 1C: Develop heart disease prevention focusing on teen athletes. The program to provide screenings & follow-ups during youth physical exams (EKG, risk assessment, etc.).	Cardiology; Sports Medicine	Number of students evaluated	Hospital records	Set up in Y1 Baseline 0	Planning phase/ partnership development	Report screenings completed	Increase screening participants by 2%
Activity 1D: Redesign and start the Cardiovascular Disease Prevention Program.	Cardiology	Number of participants	Hospital records/EPIC	Set up in Y1 Baseline 0	Planning phase/ redevelopment of program	Report screenings completed	Increase screening participants by 2%
Activity 1E: Offer free or discounted screenings through Stroke Prevention Awareness events at a minimum of 3 sites (rotating) to reach each hospital demographic.	Stroke Centers; CFNI Marketing/CHS Community Outreach	Number of patient labs	Hospital reports; Epic; Community Benefit Reports (CBR)	Set up in Y1 Baseline 0	Determine baseline # of participants using screenings	Increase participant screenings by 5%	Increase participant screenings by 5%

Programs/Activities	Responsible	Evaluation Measures	Data Source	Baseline	Process Measure Y1	Process Measure Y2	Process Measure Y3
Activity 1F: Offer stroke patient support groups and workshops.	Stroke Centers	Number of offerings per year	Registration files	Set up in Y1 Baseline 0	Determine baseline	Have one new offering each year	Have one new offering each year
Activity 1G: Develop and distribute educational materials to patients to increase awareness (3 x per year).	Stroke Centers; CFNI Marketing/CHS Community Outreach	Number of educational materials	CBR	Set up in Y1 Baseline 0	Develop and determine baseline # for growth	Increase material distribution by 1 each year	Increase material distribution by 1 each year
Activity 1H: Conduct Stroke Risk Assessments to determine and elevate the knowledge level of the community (inpatient & health fairs) on stroke and stroke prevention.	Stroke Centers	Number of assessments	System-level spreadsheet w/total number assessments	Set up in Y1 Baseline 0	Determine baseline for growth	Increase assessments by 5%	Increase assessments by 5%
Activity 1I: Plan a Brain/Heart Symposium and/or other large scale community events (1 per year).	Stroke Centers; CFNI Marketing/CHS Community Outreach	Number of participants attending per year	Registration files	Set up in Y1 Baseline 0	Plan event(s); determine baseline for participation growth	Increase participants by 2%	Increase participants by 5%
Activity 1J: Disseminate monthly MyChart alerts on stroke programs, support groups, recipes, and other patient information.	Stroke Centers	Number of emails/number of alerts	EPIC; hospital reports	Set up in Y1 Baseline 0	Determine baseline # of participants and # of alerts	Increase 5%	Increase 5%
Activity 1K: Plan social media awareness campaign, e.g., heart & stroke.	Stoke Centers; CFNI Marketing/CHS Community Outreach	Number of social media counts, messages, etc.	Analytics/CRM	Set up in Y1 Baseline 0	Plan campaign; set baseline for alerts and participant engagement	Increase engagement by 5%	Increase engagements by 5%

Anticipated Outcomes:

- **Short-Term**: Increase knowledge and screening opportunities, Patients have increased knowledge and awareness of how to identify stroke risks.
- **Short-Term:** Determine risks for patients and help get appropriate treatments/referrals, Lower patient readmission rates due to stroke.
- **Medium-Term**: Reduce hospital readmission rates related to cardiovascular disease, Increase access to care related to stroke symptoms., Ensure patient has resources for healthy lifestyle modifications.
- **Long-Term:** Reduce deaths from heart disease and improve quality of life, Reduce deaths and disability from stroke

Target Population(s):

- Adults 18+
- Inpatients
- Outpatients
- Athletes 13-17

Resources:

- American Heart Association & American Stroke Association

Collaboration Partners:

- Patients
- School districts
- YMCAs
- Universities
- Device representatives
- Cardinal Tech
- Hospital Ancillary (Lab, Pharmacy)
- Indiana Stroke Consortium
- District One Stroke Alliance (DOSA)
- YMCAs
- Kindred Rehabilitation

Community Hospital

Community Hospital Strategy 2: Provide multiple educational opportunities to the public Objective: By June 2025, increase the number of individuals participating in Heart Disease Prevention programs by 25%							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Provide heart related education sessions to youth.	Cardiology; CFNI Marketing/CHS Community Outreach	Number of participants	Registration files	Set up in Y1 Baseline 0	Set participant baseline	Increase participants by 2%	Increase participants by 5%
Activity 1D: Provide Healthy Eating education to community focusing on heart health.	Cardiology; CFNI Marketing/CHS Community Outreach; Clinical Dietitians	Number of participants	Registration files	Set up in Y1 Baseline 0	Set participant baseline	Increase participants by 2%	Increase participants by 5%
Activity 1D: Provide educational events of various scale to the public with a heart disease focus. Topics: Atrial Fibrillation (AFib); Peripheral Vascular Disease (PVD); Heart & Brain; Watchman™; virtual classes/webinars.	Cardiology; CFNI Marketing/CHS Community Outreach,	Number of participants	Event schedule/ registration files	Set up in Y1 Baseline 0	Set participant baseline	Increase participants by 2%	Increase participants by 5%
Anticipated Outcomes: **Short-Term:** Patients have increased knowledge and awareness on identifying heart disease symptoms. **Medium-Term:** Patients will access health care when faced with heart disease symptoms. **Long-Term:** Reduce deaths and disability from heart disease.							
Target Population(s): Adults 18+ Patients Middle school and high school students Community members							
Resources: • American Heart Association & American Stroke Association • American College of Cardiology • The Joint Commission							
Collaboration Partners: School districts Dietitians							

Community Hospital

Community Hospital Strategy 3 : Increase access to medications for stroke patients Objective: By June 2025, increase access for individuals who have experienced a stroke to therapies/medications by 10%							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Work with physician offices & industry to determine cost-effective drug/provide sample medications (discount cards).	Stroke Centers; Pharmacy	Follow-up calls; lists of patients on new medications related to stroke	EPIC; hospital records	Set up in Y1 Baseline 0	Set up and determine baseline of confirmed medications filled by prescription	Increase filled prescription medications by 2%	Increase filled prescription medications by 5%
Activity 1B: Improve plan to connect patient pharmacy and case management program to provide stroke patients with resources.	Stroke Centers, Social workers; Pharmacy	Medication status	EPIC; hospital records	Set up in Y1 Baseline 0	Set up and set baseline on number of patients needing medications and/or resources	Increase patients served by 2%	Increase patients served by 5%
Activity 1C: Provide medications to inpatients prior to discharge through outpatient pharmacy services.	Stroke Centers, Social workers; Pharmacy	Meds-to-Beds	EPIC; hospital records	Set up in Y1 Baseline 0	Set baseline of patient needing medications	Increase patients receiving medication assistance by 2%	Increase patient receiving medication assistance by 5%
Activity 1D: Provide follow-up call to patients who are discharged from the stroke program.	Stroke Center(s) Navigators	Call logs (# of patient calls)	EPIC; hospital records; and/or patient call logs	Set up in Y1 Baseline 0	Establish baseline of patients reached through follow up calls	Increase patients reached through follow-up calls by 2%	Increase patients reached through follow-up calls by 5%
Anticipated Outcomes: • **Short-Term:** Patients receive appropriate medications treatment. • **Medium-Term:** Increase patient treatment/response to medications. • **Medium-Term:** Lower readmission rates. • **Medium-Term:** Reduce hospital readmission. • **Medium-Term:** Ensure patient has resources healthy lifestyle modification. • **Long-Term**: Reduce deaths from stroke and improve quality of life.							
Target Population(s): • Adults 18+ • Inpatients • Outpatients							

Resources: • Samples, discount cards from pharmaceutical representatives • American Heart & Stroke Association (AHA)
Collaboration Partners: • Access to Medications – pharmaceutical representatives • Kindred Rehabilitation

Community Hospital

PRIORITY: Cancer

Goal Statement: Reduce new cases of cancer and cancer-related illness, disability, and death. (Healthy People 2030)

Community Hospital Strategy 1: Provide multiple screening opportunities to the public							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Offer free or discounted screenings through special promotions and events.	Cancer Care Services	Number of screenings	Hospital records; Community Benefit Reports (CBR)	Set up in Y1	# of screenings	Increase screenings by 2%	Increase screenings by 5%
Activity 1B: Provide referrals for cancer genetics screening.	Cancer Care Services; cancer genetics counselor	Number of referrals	Hospital records	Set up in Y1	# of screenings	Increase screenings by 2%	Increase screenings by 5%
Anticipated Outcomes: • **Short-Term:** Patients have increased knowledge and awareness of how to schedule a screening. • **Medium-Term:** Patients have access to free or discounted screening opportunities. • **Long-Term:** Outreach reduces new cases of cancer or cancer-related illness in our communities (e.g., reduced readmission rates due to cancer; reduced death rates due to cancer).							
Target Population(s): • Adults 18+ • Cancer patients in Northwest Indiana							
Resources: • Anderson grants • Various fundraisers							
Collaboration Partners: • Private physician practices • Local YMCAs • American Cancer Society • American College of Surgeons (Commission on Cancer/National Accreditation Program for Breast Cancers)							

Community Hospital

Community Hospital Strategy 2: Developing a navigation and support program							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Increase enrollment and opportunities for patients to participate in clinical trials.	Manager, Community Cancer Research Foundation (CCRF)	Enrollment	CCRF Cancer research data base	Set up in Y1	Determine baseline #	Increase participants by 25	Increase participants by 25
Activity 1B: Expand support groups/wellness class participation for patients in active treatment, survivorship and caregivers.	Cancer Resource Centre (CRC); Manager, CRC Cancer Outreach	Participants	Cancer Resource Centre records; CBRs	Set up in Y1	Determine baseline #	Increase participants by 2%	Increase participants by 5%
Activity 1C: Increase the number of patients receiving navigation services for breast, lung and gastrointestinal cancers.	Cancer Care Services	People served by navigation program	Navigation Data Metrics	Set up in Y1	Determine baseline # for patients served	Increase # of patients served by 5%	Increase # of patients served by 7%
Activity 1D: Increase the number of distress screenings completed on cancer patients.	Cancer Care Services; Cancer Care Navigators	Distress screenings	Hospital records	Set up in Y1	Determine Baseline #	Increase # of distress screenings by 5%	Increase # of distress screenings by 5%
Activity 1E: Utilize EON software to recognize nodules and identify risk in patients coming in for routine exam.	Cancer Care Services; Cancer Care Navigators	Patients receiving Low-Dose CT lung scan (LDCT)	Hospital records	Set up in Y1	Determine Baseline #	Increase patients receiving LDCT by 2%	Increase patients receiving LDCT by 3%
Anticipated Outcomes: • **Short-Term:** Patients have the support they need to deal with their diagnosis and treatment. • **Medium-Term:** Patients have a better care outcome and experience. • **Long-Term:** Patients have an improved quality of life and increased survival rates.							
Target Population(s): • Adults 18+ • Caregivers, patients, family members							
Resources: • American Cancer Society Transportation Grant							
Collaboration Partners: • Carle Clinic • EON							

- American College of Surgeons (Commission on Cancer/National Accreditation Program for Breast Cancers)
- American Cancer Society

Community Hospital

Community Hospital Strategy 3: Provide multiple educational opportunities to the public							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Plan, implement, and offer physician symposiums, workshops, etc. for the community.	Cancer Care Services; Manager, CRC Community Outreach	Registration sheets/lists, pre/post-tests and participant evaluations	Community Benefit Reports	1 event a year	1 event	2 events	3 events
Activity 1B: Develop and distribute educational materials to community to increase awareness.	Cancer Resource Centre; CFNI Marketing/CHS Community Outreach	Number of materials distributed	Educational distribution list	Set up in Y1	Develop educational materials	Increase # of materials distributed by 2%	Increase # of materials distributed by 5%
Activity 1C: Increase the number of participants attending events for the community.	Cancer Care Services; Manager, CRC Community Outreach	% of participants	Cancer Resource Centre records; Community Benefit Reports	Set up in Y1	Determine baseline	Increase participants by 2%	Increase participants by 5%
Anticipated Outcomes: • **Short-Term**: Patients have increased knowledge and awareness of cancer in general. • **Medium-Term:** Increased participation in free or discounted screening opportunities. • **Long-Term:** Reduced new cases of cancer or cancer-related illness in our communities (e.g., reduced readmission rates due to cancer; reduced death rates due to cancer).							
Target Population(s): • Adults 18+ • Patients • Caregivers • Family members							
Resources: • American Cancer Society • American College of Surgeons (Commission on Cancer/National Accreditation Program for Breast Cancers) • Carle Clinic • EON Health							

Collaboration Partners:

- Private physician practices
- Local YMCAs
- American Cancer Society
- Urshel Laboratories, Inc.

St. Catherine Hospital

PRIORITY: Maternal & Children's Health

Goal Statement: Improve the health and well-being of women, children, and families. (Healthy People 2030)

St. Catherine Hospital Strategy 1: Increase awareness of maternal and children's care and services							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Participate in annual health fairs/ community events for public.	Family Birthing Center staff; CFNI Marketing/CHS Community Outreach	Number of materials distributed	Community Benefits Reports	Set up in Y1 Baseline 0	Develop/ redesign needed materials	Increase materials distributed by 2%	Increase materials distributed by 2% over Y2
Activity 1B: Develop an online educational series for pre- and post-natal mothers with trusted informational resources.	Patient Education; IT; CFNI Marketing/CHS Community Outreach	Number of engagements/ views	Analytical tools	Set up in Y1 Baseline 0	Set-up access links/ trial run	Increase engagement by 2%	Increase engagement by 5%
Activity 1C: Provide car seat safety clinic at all hospitals.	Family Birthing Center; CHS Community Outreach	Number of participants	Registration records	Set up in Y1 Baseline 0	Develop parameters for program; establish partnerships needed for event	Increase participants by 3%	Increase participants by 5%
Activity 1D: Develop materials to drive awareness of Safe Haven Baby Box in year 1 for social workers, fire departments, school Counselors	**Family Birthing Center; Social Services; EMS director (to assist with disbursement); Community Outreach**	**Number of materials distributed**	**Educational distribution list**	**Set up in Y1 Baseline 0**	**Educational materials developed; baseline set**	**Increase # of materials distributed by 2% from baseline**	**Increase # of materials distributed by 2% from Y2**
Anticipated Outcomes: • **Short-Term:** Increased awareness of services offered. • **Medium-Term:** Increase in utilization of services. • **Long-Term:** Women use services at appropriate time (e.g., prenatal care starts before 14 weeks).							
Target Population(s): • Teen mothers • Breast feeding mothers							

- Expectant mothers
- Families

Resources:

- Safe Haven Baby Box- provides materials, funding
- Car seats
- Staff time

Collaboration Partners:

- First Things First
- Nurse Family Partnership
- EMS director
- Moms Taking Charge
- Baby-Friendly USA
- Certified car seat safety specialists (local Fire Departments, Lake County)

St. Catherine Hospital

St. Catherine Hospital Strategy 2: Provide navigation and support services to expectant/postpartum/breastfeeding mothers							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Conduct Social Determinates of Health Assessment for expectant and new mothers.	Family Birthing Centers; Nurse navigators; social workers; social services	Number of assessments	Hospital records	Set up in Y1 Baseline 0	Set-up resources and processes to administer assessment	Increase screenings/ referrals by 2%	Increase screenings/ referrals by 3%
Activity 1B: Offer educational classes (childbirth, teen parents, baby care, breastfeeding, grandparents)	Family Birthing Centers; Nursing Education	Class participants	Sign in sheets/ records	Set up in Y1 Baseline 0	Determine # of class participants	Increase class participants by 2%	Increase class participants by 3%
Activity 1C: Offer nutrition services/gestational diabetes OP counseling	Family Birthing Center; Nursing Education; Dietitians;	Number of patients receiving services	Hospital records	Set up in Y1 Baseline 0	Determine # of individuals referred for counseling	Increase # of referrals by 2%	Increase # of referrals by 3%

Anticipated Outcomes:

- **Short-Term**: Increase knowledge on services.
- **Medium-Term:** Increase use of services if needed.
- **Long-Term:** Reduce low weight births.

Target Population(s):

- Infants needing neonatal care
- Adults 18+
- Expectant mothers / postpartum mothers
- Teen parents
- Grandparents
- Individuals experiencing high risk pregnancies
- Breast feeding mothers

Resources:

- Staff time
- Specialized nurses, advanced providers, respiratory therapists
- Cribs for Kids-funding/grant
- SUIDS Education/Safe Sleep programs
- American Academy of Pediatrics

- U.S. Consumer Product Safety Commission

Collaboration Partners:

- Mental Health America of Northwest Indiana
- Look-alike Federally Qualified Health Centers
- WIC
- Healthy Families
- First Things First
- Nurse-Family Partnership

St. Catherine Hospital

PRIORITY: Mental Health & Mental Disorders

Goal Statement: Improve Mental Health (Healthy People 2030)

St. Catherine Hospital Strategy 1: Increase the importance of mental health awareness							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Develop mental health website/web page to be more interactive.	Behavioral Health Services; Marketing and Communications, IT	Number of engagements/ views	Analytical tools	Set up in Y1 Baseline 0	Set-up access links/page design/trial run	Increase engagement by 2%	Increase engagement by 5%
Activity 1B: Increase awareness of 219 Health Network (Look-A-Like FQHC) & other FQHCs offering mental health services.	Behavioral Health Services; FQHC; CFNI Marketing/CHS Community Outreach	Number of materials distributed	Community Benefits Reports/activity logs	Set up in Y1 Baseline 0	Develop materials that showcase services/trial run	Increase # materials distributed by 2%	Increase # materials distributed by 2% from Y2
Activity 1C: Plan and implement suicide awareness programs (vigil, in-house awareness table, digital campaign).	Behavioral Health Services; CFNI Marketing/CHS Community Outreach	Number of hosted awareness activities	Activity logs/Community Benefits Reports	Set up in Y1 Baseline 0	Develop suicide awareness program plans for community and staff	Host one in-house and community event (2 total)	Increase # of events by 2
Activity 1D: Develop family support and resource groups. Groups will cover topics including skill development, resources and support for participants.	Behavioral Health Services	Attendees at support groups	Registration logs/Community Benefits Reports	Set up in Y1 Baseline 0	Develop support group strategies/ trial run	Increase # of participants by 2%	Increase # of participants by 3%
Activity 1E: Increase local media representation on mental health through podcast	Behavioral Health Services; CFNI Marketing and Communications	Number of engagements for podcast	Analytics logs	Set up in Y1 Baseline 0	Develop podcast content/trial run	Increase # of engagements By 2%	Increase # of engagements by 5%

Anticipated Outcomes:

- **Short-Term:** Increase mental health awareness through education and support.
- **Short-Term:** People know the types of mental health services that are available to them.
- **Medium-Term**: People recognize the need to access mental health services.
- **Long-Term:** Lower the incidence of suicide in Lake and Porter Counties.

Target Population(s):

- Everyone
- Adults +18
- Students
- People with mental health concerns
- People with mental health history

Resources:

- Mental Health America of Northwest Indiana
- American Psychological Association
- National Alliance on Mental Illness
- National Suicide Prevention Lifeline

Collaboration Partners:

- Purdue University Counseling Department

St. Catherine Hospital

St. Catherine Hospital Strategy 2: Conduct Internal Training and Community Training							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Plan, implement, and offer education sessions/trainings for hospital personnel on mental health education, removing stigma, crisis intervention training.	Behavioral Health Services; Education	Number of trainings	Community Benefits Reports/ employee logs	Set up in Y1 Baseline 0	Develop training program/trail-run	Conduct 2 training sessions per year	Conduct 4 training sessions per year
Activity 1B: Support community trainings on mental health crisis response training (first responders - police, firefighters, EMS; workplace, colleges/universities).	Behavioral Health Services; Education; CHS Occupational Health	Number of trainings	Community Benefits Reports/attendee logs	Set up in Y1 Baseline 0	Develop training program/trail-run	Conduct 2 training sessions per year	Conduct 4 training sessions per year
Activity 1C: Plan and host expert panel to present on mental health issues in the workplace, de-escalation trainings to promote safe workplace environment (Part of community workplace outreach, e.g., steelworkers, large/small employers, schools).	Behavioral Health Services; Occupational Health	Number of events hosted with that include a panel discussions	Community Benefits Reports	Set up in Y1 Baseline 0	Develop a group of presenters to conduct training	Host 1 event that features a mental health panel	Host 2 events that of feature a mental health panel

Anticipated Outcomes:

- **Short-Term:** Increase mental health awareness through education and support.
- **Short-Term:** First responders, counselors, employers, human resources directors, etc., know that de-escalation training is available.
- **Medium-Term**: People use the techniques they are taught.
- **Long-Term:** De-escalating any situations becomes the norm during emergency situations in Lake and Porter Counties.

Target Population(s):

- Everyone
- Adults +18
- Students
- People with mental health concerns
- Counselors/Educators
- First Responders

Resources:

- Mental Health of America
- American Psychological Association
- National Alliance on Mental Illness

Collaboration Partners:

- Local EMS
- Local Police Departments
- Local School Districts

St. Catherine Hospital

St. Catherine Hospital Strategy 3: Increase access to mental health care by expanding services to sister hospitals							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Expand look-alike Federally Qualified Health Center outpatient services.	Behavioral Health Services; Human Resources; 219 Health Network	Additional staff and/or services	Hospital Records	Set up in Y1 Baseline 0	Create a plan to expand services or higher additional staff	Service development and staff recruitment	Institute new service(s)
Activity 1B: Grow Integrated Primary Care model: integrate nurse practitioners in primary care settings, look-alike Federally Qualified Health Centers (FQHC) to close the gap between medical health and mental health "Pathway Program" patients referred to FQHC providers.	Behavioral Health Services; Nursing	Patients switching to Integrated Primary Care	Hospital records/EPIC	Set up in Y1 Baseline 0	Lay the groundwork for Care Model use within CHS	Care Model tested at St. Catherine Hospital, with plan to expand to sister hospitals in Y2	Expansion completed
Anticipated Outcomes: • **Short-Term:** Increase access to mental health services. • **Medium-Term**: Streamline delivery of services. • **Long-Term:** Provide the best possible mental health care to the citizens in Lake and Porter Counties.							
Target Population(s): • Everyone • Adults +18 • People with mental health concerns							
Resources: • Integrated Primary Care https://www.integratedprimarycare.com/							
Collaboration Partners: • Look-a-Like Federally Qualified Health Centers (FQHC)							

St. Catherine Hospital

PRIORITY: Diabetes

Goal Statement: Reduce the burden of diabetes and improve quality of life for all people who have, or are at risk for, diabetes. (Healthy People 2030)

St. Catherine Hospital Strategy 1: Provide education/training opportunities to public and staff members.							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Offer diabetes education training to staff.	Nursing Education Department	Staff attendance	Learning Management System	Set up in Y1 Baseline 0	Determine baseline # of trainings	Increase trainings by 2%	Increase trainings by 3%
Activity 1B: Develop opportunities for nursing students to observe diabetes education classes for class credit/points.	Nursing Education; Diabetes Centers	Number of students enrolled in program	Student attendance log sheets/ or copy of signature forms	Set up in Y1 Baseline 0	Develop parameters of the program/ trial run	Determine baseline # of student participating in program	Increase # of students enrolled in program by 3%
Activity 1C: Offer in-person/ virtual gestational diabetes sessions.	Family Birthing Centers; Diabetes Educators; Dieticians	Registration sheets/lists	Community Benefits Report, EPIC	Set up in Y1 Baseline 0	Determine baseline # of sessions per year	Increase # of sessions by 2%	Increase # of sessions by 3%
Activity 1D: Develop diabetes prevention program.	Diabetes Educators; CFNI Marketing/CHS Community Outreach	Pre/post-tests; participant evaluations; scheduled programs	Community Benefits	Set up Y1 Baseline 0	Develop program content/ conduct trial run	Determine baseline # of participants	Increase participation by 3%

Anticipated Outcomes:

- **Short-Term:** Increased knowledge of diabetes among participants.
- **Short-Term:** Participants complete diabetes educational/prevention opportunities.
- **Medium-Term:** Participants make lifestyle changes to prevent or delay onset of diabetes.
- **Long-Term:** Reduce amount of new diabetes cases in Lake and Porter counties.
- **Long-Term:** Increase the amount of people with controlled diabetes.

Target Population(s):

- Adults 18+
- Patients
- Secondary education/college students
- Community members
- Pregnant Women

Resources: • Staff time • Foundations of East Chicago (grant funding) • The Joint Commission
Collaboration Partners: • American Diabetes Association®

St. Catherine Hospital

St. Catherine Hospital Strategy 2: Provide community events/health fairs/screenings							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Offer community health fairs including A1C and Diabetes mellitus (DM) risk assessments.	Nursing Education Department; CFNI Marketing/CHS Community Outreach	Sign-in sheets	Community Benefit Report	Set up Y1 Baseline 0	Determine # health fairs per year	Increase # of health fairs per year by 1	Increase # of health fairs per year by 1
Activity 1B: Participate in community based events providing screenings/education.	Nursing; Community outreach	Registration/lab paperwork	Community Benefit Report; hospital records	Set up Y1 Baseline 0	Determine # of fairs requesting participation	Increase participation by 2%	Increase participation by 4%

Anticipated Outcomes:

- **Short-Term:** Patients have increased knowledge and awareness of diabetes.
- **Short-Term:** Increase participation in screening opportunities.
- **Medium-Term:** Provide access to care and follow-up for those determined to be diabetic through screenings
- **Long-Term:** Reduced new cases of diabetes/related illness in our communities (e.g., reduced readmission rates due to diabetes, reduced burden of diabetes and improved quality of life).

Target Population(s):

- Adults 18+
- People unaware of diabetes status

Resources:

- Foundation grants

Collaboration Partners:

- American Diabetes Association®

St. Catherine Hospital

PRIORITY: Heart Disease and Stroke

Goal Statement: Improve cardiovascular health and reduce deaths from heart disease and stroke. (Healthy People 2030)

St. Catherine Hospital Strategy 1: Increase awareness of heart disease and stroke risk factors							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Offer free or discounted vascular screenings, blood pressure readings, Peripheral Arterial Disease (PAD) and Limb Ischemia and Vascular Excellence (L.I.V.E.), screenings through Health Fairs.	Cardiology; CFNI Marketing/CHS Community Outreach	Number of patient labs	Hospital records/EPIC	Set up in Y1 Baseline 0	Develop baseline # of participants using screenings	Increase screening participants by 2%	Increase screening participants by 5%
Activity 1B: Offer echocardiogram (ECHO) screening 1-2 per times year at a reduced cost.	Cardiology	Number of patient labs	Hospital records/EPIC	Set up in Y1 Baseline 0	Develop baseline # of participants using screenings	Increase screening participants by 5%	Increase screening participants by 5%
Activity 1C: Develop heart disease prevention focusing on teen athletes. The program to provide screenings & follow-ups during youth physical exams (EKG, risk assessment, etc.).	Cardiology; Sports Medicine	Number of students evaluated	Hospital records	Set up in Y1 Baseline 0	Planning phase/ partnership development	Report screenings completed	Increase screening participants by 2%
Activity 1D: Redesign and start the Cardiovascular Disease Prevention Program.	Cardiology	Number of participants	Hospital records/EPIC	Set up in Y1 Baseline 0	Planning phase/ redevelopment of program	Report screenings completed	Increase screening participants by 2%
Activity 1E: Offer free or discounted screenings through Stroke Prevention Awareness events at a minimum of 3 sites (rotating) to reach each hospital demographic.	Stroke Centers; CFNI Marketing/CHS Community Outreach	Number of patient labs	Hospital reports; Epic; Community Benefit Reports (CBR)	Set up in Y1 Baseline 0	Determine baseline # of participants using screenings	Increase participant screenings by 5%	Increase participant screenings by 5%

Programs/Activities	Responsible	Evaluation Measures	Data Source	Baseline	Process Measure Y1	Process Measure Y2	Process Measure Y3
Activity 1F: Offer stroke patient support groups and workshops.	Stroke Centers	Number of offerings per Year	Registration files	Set up in Y1 Baseline 0	Determine baseline	Have one new offering each year	Have one new offering each year
Activity 1G: Develop and distribute educational materials to patients to increase awareness (3 x per year).	Stroke Centers; CFNI Marketing/CHS Community Outreach	Number of educational materials	CBR	Set up in Y1 Baseline 0	Develop and determine baseline # for growth	Increase material distribution by 1 each year	Increase material distribution by 1 each year
Activity 1H: Conduct Stroke Risk Assessments to determine and elevate the knowledge level of the community (inpatient & health fairs) on stroke and stroke prevention.	Stroke Centers	Number of assessments	System-level spreadsheet w/total number assessments	Set up in Y1 Baseline 0	Determine baseline for growth	Increase assessments by 5%	Increase assessments by 5%
Activity 1I: Plan a Brain/Heart Symposium and/or other large scale community events (1 per year).	Stroke Centers; CFNI Marketing/CHS Community Outreach	Number of participants attending per year	Registration files	Set up in Y1 Baseline 0	Plan event(s); determine baseline for participation growth	Increase participants by 2%	Increase participants by 5%
Activity 1J: Disseminate monthly MyChart alerts on stroke programs, support groups, recipes, and other patient information.	Stroke Centers	Number of emails/number of alerts	EPIC; hospital reports	Set up in Y1 Baseline 0	Determine baseline # of participants and # of alerts	Increase 5%	Increase 5%
Activity 1K: Plan social media awareness campaign, e.g., heart & stroke.	Stoke Centers; CFNI Marketing/CHS Community Outreach	Number of social media counts, messages, etc.	Analytics/CRM	Set up in Y1 Baseline 0	Plan campaign; set baseline for alerts and participant engagement	Increase engagement by 5%	Increase engagements by 5%

Anticipated Outcomes:

- **Short-Term**: Increase knowledge and screening opportunities, Patients have increased knowledge and awareness of how to identify stroke risks.
- **Short-Term:** Determine risks for patients and help get appropriate treatments/referrals, Lower patient readmission rates due to stroke.
- **Medium-Term**: Reduce hospital readmission rates related to cardiovascular disease, Increase access to care related to stroke symptoms. Ensure patient has resources for healthy lifestyle modifications.
- **Long-Term:** Reduce deaths from heart disease and improve quality of life, Reduce deaths and disability from stroke.

Target Population(s):

- Adults 18+
- Inpatients
- Outpatients
- Athletes 13-17

Resources:

- American Heart Association & American Stroke Association

Collaboration Partners:

- Patients
- School districts
- YMCAs
- Universities
- Device representatives
- Cardinal Tech
- Hospital Ancillary (Lab, Pharmacy)
- Indiana Stroke Consortium
- District One Stroke Alliance (DOSA)
- YMCAs
- Kindred Rehabilitation

St. Catherine Hospital

St. Catherine Hospital Strategy 2: Provide multiple educational opportunities to the public
Objective: By June 2025, increase the number of individuals participating in Heart Disease Prevention programs by 25%

Programs/Activities	Responsible	Evaluation Measures	Data Source	Baseline	Process Measure Y1	Process Measure Y2	Process Measure Y3
Activity 1A: Provide heart related education sessions to youth.	Cardiology; CFNI Marketing/CHS Community Outreach	Number of participants	Registration files	Set up in Y1 Baseline 0	Set participant baseline	Increase participants by 2%	Increase participants by 5%
Activity 1D: Provide Healthy Eating education to community focusing on heart health.	Cardiology; CFNI Marketing/CHS Community Outreach; Clinical Dietitians	Number of participants	Registration files	Set up in Y1 Baseline 0	Set participant baseline	Increase participants by 2%	Increase participants by 5%
Activity 1D: Provide educational events of various scale to the public with a heart disease focus. Topics: Atrial Fibrillation (AFib); Peripheral Vascular Disease (PVD); Heart & Brain; Watchman™; virtual classes/webinars.	Cardiology; CFNI Marketing/CHS Community Outreach,	Number of participants	Event schedule/ registration files	Set up in Y1 Baseline 0	Set participant baseline	Increase participants by 2%	Increase participants by 5%

Anticipated Outcomes:
Short-Term: Patients have increased knowledge and awareness on identifying heart disease symptoms.
Medium-Term: Patients will access health care when faced with heart disease symptoms.
Long-Term: Reduce deaths and disability from heart disease.

Target Population(s):
Adults 18+
Patients
Middle school and high school students
Community members

Resources:
- American Heart Association & American Stroke Association
- American College of Cardiology
- The Joint Commission

Collaboration Partners:
School districts
Dietitians

St. Catherine Hospital

St. Catherine Hospital Strategy 3 : Increase access to medications for stroke patients Objective: By June 2025, increase access for individuals who have experienced a stroke to therapies/medications by 10%							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Work with physician offices & industry to determine cost-effective drug/provide sample medications (discount cards).	Stroke Centers; Pharmacy	Follow-up calls; lists of patients on new medications related to Stroke	EPIC; hospital records	Set up in Y1 Baseline 0	Set up and determine baseline of confirmed medications filled by prescription	Increase filled prescription medications by 2%	Increase filled prescription medications by 5%
Activity 1B: Improve plan to connect patient pharmacy and case management program to provide stroke patients with resources.	Stroke Centers, Social workers; Pharmacy	Medication status	EPIC; hospital records	Set up in Y1 Baseline 0	Set up and set baseline on number of patients needing medications and/or resources	Increase patients served by 2%	Increase patients served by 5%
Activity 1C: Provide medications to inpatients prior to discharge through outpatient pharmacy services.	Stroke Centers, Social workers; Pharmacy	Meds-to-Beds	EPIC; hospital records	Set up in Y1 Baseline 0	Set baseline of patient needing medications	Increase patients receiving medication assistance by 2%	Increase patient receiving medication assistance by 5%
Activity 1D: Provide follow-up call to patients who are discharged from the stroke program.	Stroke Center(s) Navigators	Call logs (# of patient calls)	EPIC; hospital records; and/or patient call logs	Set up in Y1 Baseline 0	Establish baseline of patients reached through follow up calls	Increase patients reached through follow-up calls by 2%	Increase patients reached through follow-up calls by 5%
Anticipated Outcomes: • **Short-Term:** Patients receive appropriate medications treatment. • **Medium-Term:** Increase patient treatment/response to medications. • **Medium-Term:** Lower readmission rates.							

• **Medium-Term:** Reduce hospital readmission. • **Medium-Term:** Ensure patient has resources healthy lifestyle modification. • **Long-Term**: Reduce deaths from stroke and improve quality of life.
Target Population(s): • Adults 18+ • Inpatients • Outpatients
Resources: • Samples, discount cards from pharmaceutical representatives • American Heart & Stroke Association (AHA)
Collaboration Partners: • Access to Medications – pharmaceutical representatives • Kindred Rehabilitation

St. Catherine Hospital

PRIORITY: Cancer

Goal Statement: Reduce new cases of cancer and cancer-related illness, disability, and death. (Healthy People 2030)

St. Catherine Hospital Strategy 1: Provide multiple screening opportunities to the public							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Offer free or discounted screenings through special promotions and events.	Cancer Care Services	Number of screenings	Hospital records; Community Benefit Reports (CBR)	Set up in Y1	# of screenings	Increase screenings by 2%	Increase screenings by 5%
Activity 1B: Provide referrals for cancer genetics screening.	Cancer Care Services; cancer genetics counselor	Number of referrals	Hospital records	Set up in Y1	# of screenings	Increase screenings by 2%	Increase screenings by 5%
Anticipated Outcomes: • **Short-Term:** Patients have increased knowledge and awareness of how to schedule a screening. • **Medium-Term:** Patients have access to free or discounted screening opportunities. • **Long-Term:** Outreach reduces new cases of cancer or cancer-related illness in our communities (e.g., reduced readmission rates due to cancer; reduced death rates due to cancer).							
Target Population(s): • Adults 18+ • Cancer patients in Northwest Indiana							
Resources: • Anderson grants • Various fundraisers							
Collaboration Partners: • Private physician practices • Local YMCAs • American Cancer Society • American College of Surgeons (Commission on Cancer/National Accreditation Program for Breast Cancers)							

St. Catherine Hospital

St. Catherine Hospital Strategy 2: Developing a navigation and support program							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Increase enrollment and opportunities for patients to participate in clinical trials.	Manager, Community Cancer Research Foundation (CCRF)	Enrollment	CCRF Cancer research data base	Set up in Y1	Determine baseline #	Increase participants by 25	Increase participants by 25
Activity 1B: Expand support groups/wellness class participation for patients in active treatment, survivorship and caregivers.	Cancer Resource Centre (CRC); Manager, CRC Cancer Outreach	Participants	Cancer Resource Centre records; CBRs	Set up in Y1	Determine baseline #	Increase participants by 2%	Increase participants by 5%
Activity 1C: Increase the number of patients receiving navigation services for breast, lung and gastrointestinal cancers.	Cancer Care Services	People served by navigation program	Navigation Data Metrics	Set up in Y1	Determine baseline # for patients served	Increase # of patients served by 5%	Increase # of patients served by 7%
Activity 1D: Increase the number of distress screenings completed on cancer patients.	Cancer Care Services; Cancer Care Navigators	Distress screenings	Hospital records	Set up in Y1	Determine Baseline #	Increase # of distress screenings by 5%	Increase # of distress screenings by 5%
Activity 1E: Utilize EON software to recognize nodules and identify risk in patients coming in for routine exam.	Cancer Care Services; Cancer Care Navigators	Patients receiving Low-Dose CT lung scan (LDCT)	Hospital records	Set up in Y1	Determine Baseline #	Increase patients receiving LDCT by 2%	Increase patients receiving LDCT by 3%
Anticipated Outcomes: • **Short-Term:** Patients have the support they need to deal with their diagnosis and treatment. • **Medium-Term:** Patients have a better care outcome and experience. • **Long-Term:** Patients have an improved quality of life and increased survival rates.							
Target Population(s): • Adults 18+ • Caregivers, patients, family members							
Resources: • American Cancer Society Transportation Grant							
Collaboration Partners:							

- Carle Clinic
- EON
- American College of Surgeons (Commission on Cancer/National Accreditation Program for Breast Cancers)
- American Cancer Society

St. Catherine Hospital

St. Catherine Hospital Strategy 3: Provide multiple educational opportunities to the public							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Plan, implement, and offer physician symposiums, workshops, etc. for the community.	Cancer Care Services; Manager, CRC Community Outreach	Registration sheets/lists, pre/post-tests and participant Evaluations	Community Benefit Reports	1 event a year	1 event	2 events	3 events
Activity 1B: Develop and distribute educational materials to community to increase awareness.	Cancer Resource Centre; CFNI Marketing/CHS Community Outreach	Number of materials distributed	Educational distribution list	Set up in Y1	Develop educational materials	Increase # of materials distributed by 2%	Increase # of materials distributed by 5%
Activity 1C: Increase the number of participants attending events for the community.	Cancer Care Services; Manager, CRC Community Outreach	% of participants	Cancer Resource Centre records; Community Benefit Reports	Set up in Y1	Determine baseline	Increase participants by 2%	Increase participants by 5%

Anticipated Outcomes:

- **Short-Term**: Patients have increased knowledge and awareness of cancer in general.
- **Medium-Term:** Increased participation in free or discounted screening opportunities.
- **Long-Term:** Reduced new cases of cancer or cancer-related illness in our communities (e.g., reduced readmission rates due to cancer; reduced death rates due to cancer).

Target Population(s):

- Adults 18+
- Patients
- Caregivers
- Family members

Resources:

- American Cancer Society
- American College of Surgeons (Commission on Cancer/National Accreditation Program for Breast Cancers)
- Carle Clinic
- EON Health

Collaboration Partners:

- Private physician practices
- Local YMCAs
- American Cancer Society
- Urshel Laboratories, Inc.

St. Mary Medical Center

PRIORITY: Maternal & Children's Health

Goal Statement: Improve the health and well-being of women, children, and families. (Healthy People 2030)

St. Mary Medical Center Strategy 1: Increase awareness of maternal and children's care and services							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Participate in annual health fairs/ community events for public.	Family Birthing Center staff; CFNI Marketing/CHS Community Outreach	Number of materials distributed	Community Benefits Reports	Set up in Y1 Baseline 0	Develop/ redesign needed materials	Increase materials distributed by 2%	Increase materials distributed by 2% over Y2
Activity 1B: Develop an online educational series for pre- and post-natal mothers with trusted informational resources.	Patient Education; IT; CFNI Marketing/CHS Community Outreach	Number of engagements/ views	Analytical tools	Set up in Y1 Baseline 0	Set-up access links/ trial run	Increase engagement by 2%	Increase engagement by 5%
Activity 1C: Provide car seat safety clinic at all hospitals.	Family Birthing Center; CHS Community Outreach	Number of participants	Registration records	Set up in Y1 Baseline 0	Develop parameters for program; establish partnerships needed for event	Increase participants by 3%	Increase participants by 5%
Anticipated Outcomes: • **Short-Term:** Increased awareness of services offered. • **Medium-Term:** Increase in utilization of services. • **Long-Term:** Women use services at appropriate time (e.g., prenatal care starts before 14 weeks).							
Target Population(s): • Teen mothers • Breast feeding mothers • Expectant mothers • Families							
Resources: • Safe Haven Baby Box- provides materials, funding • Car seats • Staff time							

Collaboration Partners:

- First Things First
- Nurse Family Partnership
- EMS director
- Moms Taking Charge
- Baby-Friendly USA
- Certified car seat safety specialists (local Fire Departments, Lake County)

St. Mary Medical Center

St. Mary Medical Center Strategy 2: Provide navigation and support services to expectant/postpartum/breastfeeding mothers							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Conduct Social Determinates of Health Assessment for expectant and new mothers.	Family Birthing Centers; Nurse navigators; social workers; social services	Number of assessments	Hospital records	Set up in Y1 Baseline 0	Set-up resources and processes to administer assessment	Increase screenings/ referrals by 2%	Increase screenings/ referrals by 3%
Activity 1B: Offer educational classes (childbirth, teen parents, baby care, breastfeeding, grandparents)	Family Birthing Centers; Nursing Education	Class participants	Sign in sheets/ records	Set up in Y1 Baseline 0	Determine # of class participants	Increase class participants by 2%	Increase class participants by 3%
Activity 1C: Offer nutrition services/gestational diabetes OP counseling	Family Birthing Center; Nursing Education; Dietitians;	Number of patients receiving Services	Hospital records	Set up in Y1 Baseline 0	Determine # of individuals referred for counseling	Increase # of referrals by 2%	Increase # of referrals by 3%
Activity 1E: Expand awareness of Baby Friendly initiative	**FBC, SMMC; Nursing Education; Lactation staff; CFNI Marketing/CHS Community Outreach**	**Number of patients receiving services Assess Merits**	**Hospital records**	**Determine baseline of existing program**	**Assess merits of program and awareness of Baby Friendly designation**	**Plan campaign to increase awareness**	**Measure campaign results**
Anticipated Outcomes: • **Short-Term**: Increase knowledge on services. • **Medium-Term:** Increase use of services if needed. • **Long Term:** Reduce low weight births.							
Target Population(s): • Infants needing neonatal care • Adults 18+ • Expectant mothers / postpartum mothers • Teen parents • Grandparents • Individuals experiencing high risk pregnancies • Breast feeding mothers							

Resources:

- Staff time
- Specialized nurses, advanced providers, respiratory therapists
- Cribs for Kids-funding/grant
- SUIDS Education/Safe Sleep programs
- American Academy of Pediatrics
- U.S. Consumer Product Safety Commission

Collaboration Partners:

- Mental Health America of Northwest Indiana
- Look-alike Federally Qualified Health Centers
- WIC
- Healthy Families
- First Things First
- Nurse-Family Partnership

St. Mary Medical Center

PRIORITY: Mental Health & Mental Disorders

Goal Statement: Improve Mental Health (Healthy People 2030)

St. Mary Medical Center Strategy 1: Increase the importance of mental health awareness							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Develop mental health website/web page to be more interactive.	Behavioral Health Services; Marketing and Communications, IT	Number of engagements/ views	Analytical tools	Set up in Y1 Baseline 0	Set-up access links/page design/trial run	Increase engagement by 2%	Increase engagement by 5%
Activity 1B: Increase awareness of 219 Health Network (Look-A-Like FQHC) & other FQHCs offering mental health services.	Behavioral Health Services; FQHC; CFNI Marketing/CHS Community Outreach	Number of materials distributed	Community Benefits Reports/activity logs	Set up in Y1 Baseline 0	Develop materials that showcase services/trial run	Increase # materials distributed by 2%	Increase # materials distributed by 2% from Y2
Activity 1C: Plan and implement suicide awareness programs (vigil, in-house awareness table, digital campaign).	Behavioral Health Services; CFNI Marketing/CHS Community Outreach	Number of hosted awareness activities	Activity logs/Community Benefits Reports	Set up in Y1 Baseline 0	Develop suicide awareness program plans for community and staff	Host one in-house and community event (2 total)	Increase # of events by 2
Activity 1D: Develop family support and resource groups. Groups will cover topics including skill development, resources and support for participants.	Behavioral Health Services	Attendees at support groups	Registration logs/Community Benefits Reports	Set up in Y1 Baseline 0	Develop support group strategies/ trial run	Increase # of participants by 2%	Increase # of participants by 3%
Activity 1E: Increase local media representation on mental health through podcast	Behavioral Health Services; CFNI Marketing and Communications	Number of engagements for podcast	Analytics logs	Set up in Y1 Baseline 0	Develop podcast content/trial run	Increase # of engagements By 2%	Increase # of engagements by 5%

Anticipated Outcomes:

- **Short-Term:** Increase mental health awareness through education and support.
- **Short-Term:** People know the types of mental health services that are available to them.
- **Medium-Term**: People recognize the need to access mental health services.
- **Long-Term:** Lower the incidence of suicide in Lake and Porter Counties.

Target Population(s):

- Everyone
- Adults 18+
- Students
- People with mental health concerns
- People with mental health history

Resources:

- Mental Health America of Northwest Indiana
- American Psychological Association
- National Alliance on Mental Illness
- National Suicide Prevention Lifeline

Collaboration Partners:

- Purdue University Counseling Department

St. Mary Medical Center

St. Mary Medical Center Strategy 2: Conduct Internal Training and Community Training							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Plan, implement, and offer education sessions/trainings for hospital personnel on mental health education, removing stigma, crisis intervention training.	Behavioral Health Services; Education	Number of trainings	Community Benefits Reports/ employee logs	Set up in Y1 Baseline 0	Develop training program/trail-run	Conduct 2 training sessions per year	Conduct 4 training sessions per year
Activity 1B: Support community trainings on mental health crisis response training (first responders - police, firefighters, EMS; workplace, colleges/universities).	Behavioral Health Services; Education; CHS Occupational Health	Number of trainings	Community Benefits Reports/attendee logs	Set up in Y1 Baseline 0	Develop training program/trail-run	Conduct 2 training sessions per year	Conduct 4 training sessions per year
Activity 1C: Plan and host expert panel to present on mental health issues in the workplace, de-escalation trainings to promote safe workplace environment (Part of community workplace outreach, e.g., steelworkers, large/small employers, schools).	Behavioral Health Services; Occupational Health	Number of events hosted with that include a panel discussions	Community Benefits Reports	Set up in Y1 Baseline 0	Develop a group of presenters to conduct training	Host 1 event that features a mental health panel	Host 2 events that of feature a mental health panel

Anticipated Outcomes:

- **Short-Term:** Increase mental health awareness through education and support.
- **Short-Term:** First responders, counselors, employers, human resources directors, etc., know that de-escalation training is available.
- **Medium-Term**: People use the techniques they are taught.
- **Long-Term:** De-escalating any situations becomes the norm during emergency situations in Lake and Porter Counties.

Target Population(s):

- Everyone
- Adults 18+
- Students
- People with mental health concerns
- Counselors/Educators
- First Responders

Resources: • Mental Health of America • American Psychological Association • National Alliance on Mental Illness
Collaboration Partners: • Local EMS • Local Police Departments • Local School Districts

St. Mary Medical Center

St. Mary Medical Center Strategy 3: Increase access to mental health care by expanding services to sister hospitals							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Expand look-alike Federally Qualified Health Center outpatient services.	Behavioral Health Services; Human Resources; 219 Health Network	Additional staff and/or services	Hospital Records	Set up in Y1 Baseline 0	Create a plan to expand services or higher additional staff	Service development and staff recruitment	Institute new service(s)
Activity 1B: Grow Integrated Primary Care model: integrate nurse practitioners in primary care settings, look-alike Federally Qualified Health Centers (FQHC) to close the gap between medical health and mental health "Pathway Program" patients referred to FQHC providers.	Behavioral Health Services; Nursing	Patients switching to Integrated Primary Care	Hospital records/EPIC	Set up in Y1 Baseline 0	Lay the groundwork for Care Model use within CHS	Care Model tested at St. Catherine Hospital, with plan to expand to sister hospitals in Y2	Expansion completed
Anticipated Outcomes: • **Short-Term:** Increase access to mental health services. • **Medium-Term**: Streamline delivery of services. • **Long-Term:** Provide the best possible mental health care to the citizens in Lake and Porter Counties.							
Target Population(s): • Everyone • Adults 18+ • People with mental health concerns							
Resources: • Integrated Primary Care https://www.integratedprimarycare.com/							
Collaboration Partners: • Look-a-Like Federally Qualified Health Centers (FQHC)							

St. Mary Medical Center

PRIORITY: Diabetes

Goal Statement: Reduce the burden of diabetes and improve quality of life for all people who have, or are at risk for, diabetes. (Healthy People 2030)

St. Mary Medical Center Strategy 1: Provide education/training opportunities to public and staff members.							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Offer diabetes education training to staff.	Nursing Education Department	Staff attendance	Learning Management System	Set up in Y1 Baseline 0	Determine baseline # of trainings	Increase trainings by 2%	Increase trainings by 3%
Activity 1B: Develop opportunities for nursing students to observe diabetes education classes for class credit/points.	Nursing Education; Diabetes Centers	Number of students enrolled in program	Student attendance log sheets/ or copy of signature forms	Set up in Y1 Baseline 0	Develop parameters of the program/ trial run	Determine baseline # of student participating in program	Increase # of students enrolled in program by 3%
Activity 1C: Offer in-person/ virtual gestational diabetes sessions.	Family Birthing Centers; Diabetes Educators; Dieticians	Registration sheets/lists	Community Benefits Report, EPIC	Set up in Y1 Baseline 0	Determine baseline # of sessions per year	Increase # of sessions by 2%	Increase # of sessions by 3%
Activity 1D: Develop diabetes prevention program.	Diabetes Educators; CFNI Marketing/CHS Community Outreach	Pre/post-tests; participant evaluations; scheduled programs	Community Benefits	Set up Y1 Baseline 0	Develop program content/ conduct trial run	Determine baseline # of participants	Increase participation by 3%

Anticipated Outcomes:

- **Short-Term:** Increased knowledge of diabetes among participants.
- **Short-Term:** Participants complete diabetes educational/prevention opportunities.
- **Medium-Term:** Participants make lifestyle changes to prevent or delay onset of diabetes.
- **Long-Term**: Reduce amount of new diabetes cases in Lake and Porter counties.
- **Long-Term:** Increase the amount of people with controlled diabetes.

Target Population(s):

- Adults 18+
- Patients
- Secondary education/college students
- Community members
- Pregnant Women

Resources: • Staff time • Foundations of East Chicago (grant funding) • The Joint Commission
Collaboration Partners: • American Diabetes Association®

St. Mary Medical Center

St. Mary Medical Center Strategy 2: Provide community events/health fairs/screenings							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Offer community health fairs including A1C and Diabetes mellitus (DM) risk assessments.	Nursing Education Department; CFNI Marketing/CHS Community Outreach	Sign-in sheets	Community Benefit Report	Set up Y1 Baseline 0	Determine # health fairs per year	Increase # of health fairs per year by 1	Increase # of health fairs per year by 1
Activity 1B: Participate in community based events providing screenings/education.	Nursing; Community outreach	Registration/lab paperwork	Community Benefit Report; hospital records	Set up Y1 Baseline 0	Determine # of fairs requesting participation	Increase participation by 2%	Increase participation by 4%
Anticipated Outcomes: • **Short-Term:** Patients have increased knowledge and awareness of diabetes. • **Short-Term:** Increase participation in screening opportunities. • **Medium-Term:** Provide access to care and follow-up for those determined to be diabetic through screenings • **Long-Term:** Reduced new cases of diabetes/related illness in our communities (e.g., reduced readmission rates due to diabetes, reduced burden of diabetes and improved quality of life).							
Target Population(s): • Adults 18+ • People unaware of diabetes status							
Resources: • Foundation grants							
Collaboration Partners: • American Diabetes Association®							

St. Mary Medical Center

PRIORITY: Heart Disease and Stroke

Goal Statement: Improve cardiovascular health and reduce deaths from heart disease and stroke. (Healthy People 2030)

St. Mary Medical Center Strategy 1: Increase awareness of heart disease and stroke risk factors							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Offer free or discounted vascular screenings, blood pressure readings, Peripheral Arterial Disease (PAD) and Limb Ischemia and Vascular Excellence (L.I.V.E.), screenings through Health Fairs.	Cardiology; CFNI Marketing/CHS Community Outreach	Number of patient labs	Hospital records/EPIC	Set up in Y1 Baseline 0	Develop baseline # of participants using screenings	Increase screening participants by 2%	Increase screening participants by 5%
Activity 1B: Offer echocardiogram (ECHO) screening 1-2 per times year at a reduced cost.	Cardiology	Number of patient labs	Hospital records/EPIC	Set up in Y1 Baseline 0	Develop baseline # of participants using screenings	Increase screening participants by 5%	Increase screening participants by 5%
Activity 1C: Develop heart disease prevention focusing on teen athletes. The program to provide screenings & follow-ups during youth physical exams (EKG, risk assessment, etc.).	Cardiology; Sports Medicine	Number of students evaluated	Hospital records	Set up in Y1 Baseline 0	Planning phase/ partnership development	Report screenings completed	Increase screening participants by 2%
Activity 1D: Redesign and start the Cardiovascular Disease Prevention Program.	Cardiology	Number of participants	Hospital records/EPIC	Set up in Y1 Baseline 0	Planning phase/ redevelopment of program	Report screenings completed	Increase screening participants by 2%
Activity 1E: Offer free or discounted screenings through Stroke Prevention Awareness events at a minimum of 3 sites (rotating) to reach each hospital demographic.	Stroke Centers; CFNI Marketing/CHS Community Outreach	Number of patient labs	Hospital reports; Epic; Community Benefit Reports (CBR)	Set up in Y1 Baseline 0	Determine baseline # of participants using screenings	Increase participant screenings by 5%	Increase participant screenings by 5%

Programs/Activities	Responsible	Evaluation Measures	Data Source	Baseline	Process Measure Y1	Process Measure Y2	Process Measure Y3
Activity 1F: Offer stroke patient support groups and workshops.	Stroke Centers	Number of offerings per year	Registration files	Set up in Y1 Baseline 0	Determine baseline	Have one new offering each year	Have one new offering each year
Activity 1G: Develop and distribute educational materials to patients to increase awareness (3 x per year).	Stroke Centers; CFNI Marketing/CHS Community Outreach	Number of educational materials	CBR	Set up in Y1 Baseline 0	Develop and determine baseline # for growth	Increase material distribution by 1 each year	Increase material distribution by 1 each year
Activity 1H: Conduct Stroke Risk Assessments to determine and elevate the knowledge level of the community (inpatient & health fairs) on stroke and stroke prevention.	Stroke Centers	Number of assessments	System-level spreadsheet w/total number assessments	Set up in Y1 Baseline 0	Determine baseline for growth	Increase assessments by 5%	Increase assessments by 5%
Activity 1I: Plan a Brain/Heart Symposium and/or other large scale community events (1 per year).	Stroke Centers; CFNI Marketing/CHS Community Outreach	Number of participants attending per year	Registration files	Set up in Y1 Baseline 0	Plan event(s); determine baseline for participation growth	Increase participants by 2%	Increase participants by 5%
Activity 1J: Disseminate monthly MyChart alerts on stroke programs, support groups, recipes, and other patient information.	Stroke Centers	Number of emails/number of alerts	EPIC; hospital reports	Set up in Y1 Baseline 0	Determine baseline # of participants and # of alerts	Increase 5%	Increase 5%
Activity 1K: Plan social media awareness campaign, e.g., heart & stroke.	Stoke Centers; CFNI Marketing/CHS Community Outreach	Number of social media counts, messages, etc.	Analytics/CRM	Set up in Y1 Baseline 0	Plan campaign; set baseline for alerts and participant engagement	Increase engagement by 5%	Increase engagements by 5%

Anticipated Outcomes:

- **Short-Term**: Increase knowledge and screening opportunities, Patients have increased knowledge and awareness of how to identify stroke risks.
- **Short-Term:** Determine risks for patients and help get appropriate treatments/referrals, Lower patient readmission rates due to stroke.
- **Medium-Term**: Reduce hospital readmission rates related to cardiovascular disease, Increase access to care related to stroke symptoms. Ensure patient has resources for healthy lifestyle modifications.
- **Long-Term:** Reduce deaths from heart disease and improve quality of life, Reduce deaths and disability from stroke

Target Population(s):

- Adults 18+
- Inpatients
- Outpatients
- Athletes 13-17

Resources:

- American Heart Association & American Stroke Association

Collaboration Partners:

- Patients
- School districts
- YMCAs
- Universities
- Device representatives
- Cardinal Tech
- Hospital Ancillary (Lab, Pharmacy)
- Indiana Stroke Consortium
- District One Stroke Alliance (DOSA)
- YMCAs
- Kindred Rehabilitation

St. Mary Medical Center

St. Mary Medical Center Strategy 2: Provide multiple educational opportunities to the public Objective: By June 2025, increase the number of individuals participating in Heart Disease Prevention programs by 25%							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Provide heart related education sessions to youth.	Cardiology; CFNI Marketing/CHS Community Outreach	Number of participants	Registration files	Set up in Y1 Baseline 0	Set participant baseline	Increase participants by 2%	Increase participants by 5%
Activity 1D: Provide Healthy Eating education to community focusing on heart health.	Cardiology; CFNI Marketing/CHS Community Outreach; Clinical Dietitians	Number of participants	Registration files	Set up in Y1 Baseline 0	Set participant baseline	Increase participants by 2%	Increase participants by 5%
Activity 1D: Provide educational events of various scale to the public with a heart disease focus. Topics: Atrial Fibrillation (AFib); Peripheral Vascular Disease (PVD); Heart & Brain; Watchman™; virtual classes/webinars.	Cardiology; CFNI Marketing/CHS Community Outreach,	Number of participants	Event schedule/ registration files	Set up in Y1 Baseline 0	Set participant baseline	Increase participants by 2%	Increase participants by 5%
Anticipated Outcomes: **Short-Term:** Patients have increased knowledge and awareness on identifying heart disease symptoms. **Medium-Term:** Patients will access health care when faced with heart disease symptoms. **Long-Term:** Reduce deaths and disability from heart disease.							
Target Population(s): Adults 18+ Patients Middle school and high school students Community members							
Resources: • American Heart Association & American Stroke Association • American College of Cardiology • The Joint Commission							
Collaboration Partners: School districts Dietitians							

St. Mary Medical Center

St. Mary Medical Center Strategy 3 : Increase access to medications for stroke patients Objective: By June 2025, increase access for individuals who have experienced a stroke to therapies/medications by 10%							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Work with physician offices & industry to determine cost-effective drug/provide sample medications (discount cards).	Stroke Centers; Pharmacy	Follow-up calls; lists of patients on new medications related to stroke	EPIC; hospital records	Set up in Y1 Baseline 0	Set up and determine baseline of confirmed medications filled by prescription	Increase filled prescription medications by 2%	Increase filled prescription medications by 5%
Activity 1B: Improve plan to connect patient pharmacy and case management program to provide stroke patients with resources.	Stroke Centers, Social workers; Pharmacy	Medication status	EPIC; hospital records	Set up in Y1 Baseline 0	Set up and set baseline on number of patients needing medications and/or resources	Increase patients served by 2%	Increase patients served by 5%
Activity 1C: Provide medications to inpatients prior to discharge through outpatient pharmacy services.	Stroke Centers, Social workers; Pharmacy	Meds-to-Beds	EPIC; hospital records	Set up in Y1 Baseline 0	Set baseline of patient needing medications	Increase patients receiving medication assistance by 2%	Increase patient receiving medication assistance by 5%
Activity 1D: Provide follow-up call to patients who are discharged from the stroke program.	Stroke Center(s) Navigators	Call logs (# of patient calls)	EPIC; hospital records; and/or patient call logs	Set up in Y1 Baseline 0	Establish baseline of patients reached through follow up Calls	Increase patients reached through follow-up calls by 2%	Increase patients reached through follow-up calls by 5%
Anticipated Outcomes: • **Short-Term:** Patients receive appropriate medications treatment. • **Medium-Term:** Increase patient treatment/response to medications. • **Medium-Term:** Lower readmission rates.							

• **Medium-Term:** Reduce hospital readmission. • **Medium-Term:** Ensure patient has resources healthy lifestyle modification. • **Long-Term**: Reduce deaths from stroke and improve quality of life.
Target Population(s): • Adults 18+ • Inpatients • Outpatients
Resources: • Samples, discount cards from pharmaceutical representatives • American Heart & Stroke Association (AHA)
Collaboration Partners: • Access to Medications – pharmaceutical representatives • Kindred Rehabilitation

St. Catherine Hospital

PRIORITY: Cancer

Goal Statement: Reduce new cases of cancer and cancer-related illness, disability, and death. (Healthy People 2030)

St. Mary Medical Center Strategy 1: Provide multiple screening opportunities to the public							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Offer free or discounted screenings through special promotions and events.	Cancer Care Services	Number of screenings	Hospital records; Community Benefit Reports (CBR)	Set up in Y1	# of screenings	Increase screenings by 2%	Increase screenings by 5%
Activity 1B: Provide referrals for cancer genetics screening.	Cancer Care Services; cancer genetics counselor	Number of referrals	Hospital records	Set up in Y1	# of screenings	Increase screenings by 2%	Increase screenings by 5%
Anticipated Outcomes: • **Short-Term:** Patients have increased knowledge and awareness of how to schedule a screening. • **Medium-Term:** Patients have access to free or discounted screening opportunities. • **Long-Term:** Outreach reduces new cases of cancer or cancer-related illness in our communities (e.g., reduced readmission rates due to cancer; reduced death rates due to cancer).							
Target Population(s): • Adults 18+ • Cancer patients in Northwest Indiana							
Resources: • Anderson grants • Various fundraisers							
Collaboration Partners: • Private physician practices • Local YMCAs • American Cancer Society • American College of Surgeons (Commission on Cancer/National Accreditation Program for Breast Cancers)							

St. Mary Medical Center

St. Mary Medical Center Strategy 2: Developing a navigation and support program							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Increase enrollment and opportunities for patients to participate in clinical trials.	Manager, Community Cancer Research Foundation (CCRF)	Enrollment	CCRF Cancer research data base	Set up in Y1	Determine baseline #	Increase participants by 25	Increase participants by 25
Activity 1B: Expand support groups/wellness class participation for patients in active treatment, survivorship and caregivers.	Cancer Resource Centre (CRC); Manager, CRC Cancer Outreach	Participants	Cancer Resource Centre records; CBRs	Set up in Y1	Determine baseline #	Increase participants by 2%	Increase participants by 5%
Activity 1C: Increase the number of patients receiving navigation services for breast, lung and gastrointestinal cancers.	Cancer Care Services	People served by navigation program	Navigation Data Metrics	Set up in Y1	Determine baseline # for patients Served	Increase # of patients served by 5%	Increase # of patients served by 7%
Activity 1D: Increase the number of distress screenings completed on cancer patients.	Cancer Care Services; Cancer Care Navigators	Distress screenings	Hospital records	Set up in Y1	Determine Baseline #	Increase # of distress screenings by 5%	Increase # of distress screenings by 5%
Activity 1E: Utilize EON software to recognize nodules and identify risk in patients coming in for routine exam.	Cancer Care Services; Cancer Care Navigators	Patients receiving Low-Dose CT lung scan (LDCT)	Hospital records	Set up in Y1	Determine Baseline #	Increase patients receiving LDCT by 2%	Increase patients receiving LDCT by 3%
Anticipated Outcomes: • **Short-Term:** Patients have the support they need to deal with their diagnosis and treatment. • **Medium-Term:** Patients have a better care outcome and experience. • **Long-Term:** Patients have an improved quality of life and increased survival rates.							
Target Population(s): • Adults 18+ • Caregivers, patients, family members							
Resources: • American Cancer Society Transportation Grant							

Collaboration Partners:

- Carle Clinic
- EON
- American College of Surgeons (Commission on Cancer/National Accreditation Program for Breast Cancers)
- American Cancer Society

St. Mary Medical Center

St. Mary Medical Center Strategy 3: Provide multiple educational opportunities to the public							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Plan, implement, and offer physician symposiums, workshops, etc. for the community.	Cancer Care Services; Manager, CRC Community Outreach	Registration sheets/lists, pre/post-tests and participant evaluations	Community Benefit Reports	1 event a year	1 event	2 events	3 events
Activity 1B: Develop and distribute educational materials to community to increase awareness.	Cancer Resource Centre; CFNI Marketing/CHS Community Outreach	Number of materials distributed	Educational distribution list	Set up in Y1	Develop educational materials	Increase # of materials distributed by 2%	Increase # of materials distributed by 5%
Activity 1C: Increase the number of participants attending events for the community.	Cancer Care Services; Manager, CRC Community Outreach	% of participants	Cancer Resource Centre records; Community Benefit Reports	Set up in Y1	Determine baseline	Increase participants by 2%	Increase participants by 5%

Anticipated Outcomes:

- **Short-Term**: Patients have increased knowledge and awareness of cancer in general.
- **Medium-Term:** Increased participation in free or discounted screening opportunities.
- **Long-Term:** Reduced new cases of cancer or cancer-related illness in our communities (e.g., reduced readmission rates due to cancer; reduced death rates due to cancer).

Target Population(s):

- Adults 18+
- Patients
- Caregivers
- Family members

Resources:

- American Cancer Society
- American College of Surgeons (Commission on Cancer/National Accreditation Program for Breast Cancers)
- Carle Clinic
- EON Health

Collaboration Partners:

- Private physician practices

- Local YMCAs
- American Cancer Society
- Urshel Laboratories, Inc.

Community Healthcare System Implementation Strategy Action Plan

Community Stroke & Rehabilitation Center

Community Stroke & Rehabilitation Center (CSRC), opening in September 2019, is a multispecialty hospital with a 40-bed inpatient rehabilitation unit and additional services including:

- Immediate Care Center
- Outpatient Therapy – physical, occupational and speech
- Diagnostic Imaging
- Diagnostic Cardiology
- Clinical Laboratory
- Women's Diagnostic Center
- Physician specialties in cardiology, family/internal medicine, gastroenterology, neurology, neurosurgery, obstetrics/gynecology, orthopedics, pediatric medicine and urology

The CSRC has been accredited by The Joint Commission. Although this is the hospital's first Implementation Strategy Action Plan, the multispecialty hospital already has engaged in community outreach and strategies since opening to be on the leading edge of patient care and healthy quality of life outcomes.

Outreach activities, though limited due to the COVID-19 pandemic, included distribution of COVID-19 vaccines to the public, physician and staff participation in a virtual Stroke & Diabetes Awareness Fair, development of a stroke support group program and planning for preventive education in the community for the 2022-2025 Action Plan. Prostate and breast cancer support groups formed at the CSRC in 2021 to meet a goal to offer bring supportive care to patients close to their homes.

Activity plans for the 2022-2025 CHNA have taken shape to host screenings, clinical diabetes and stroke education classes, talks for the community at-large on healthy eating, occupational therapy, medication management and rehabilitative exercise. To help address healthcare staffing shortages across the nation, CSRC intends to work with area schools on an incubator program to recruit and train nursing assistants, registered nurses and nursing fellows.

Community Stroke & Rehabilitation Center

PRIORITY: Diabetes

Goal Statement: Reduce the burden of diabetes and improve quality of life for all people who have, or are at risk for, diabetes. (Healthy People 2030)

Hospital Strategy 1: **Hospital Strategy 1**: Provide education/training opportunities to public and staff members.							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Offer diabetes education training to staff.	Nursing Education Department	Staff attendance	Learning Management System	Set up in Y1 Baseline 0	Determine baseline # of trainings	Increase trainings by 2%	Increase trainings by 3%
Anticipated Outcomes: • **Short-Term:** Patients have increased knowledge and awareness of diabetes. • **Short-Term:** Increase participation in screening opportunities. • **Medium-Term:** Provide access to care and follow-up for those determined to be diabetic through screenings • **Long-Term:** Reduced new cases of diabetes/related illness in our communities (e.g., reduced readmission rates due to diabetes, reduced burden of diabetes and improved quality of life).							
Target Population(s): • Adults 18+ • People unaware of diabetes status							
Resources: • Foundation grants							
Collaboration Partners: • American Diabetes Association®							

Community Stroke & Rehabilitation Center

Hospital Strategy 2: Provide community events/health fairs/screenings

Programs/Activities	Responsible	Evaluation Measures	Data Source	Baseline	Process Measure Y1	Process Measure Y2	Process Measure Y3
Activity 1A: Offer community health fairs including A1C and Diabetes mellitus (DM) risk assessments.	Nursing Education Department; CFNI Marketing/CHS Community Outreach	Sign-in sheets	Community Benefit Report	Set up Y1 Baseline 0	Determine # health fairs per year	Increase # of health fairs per year by 1	Increase # of health fairs per year by 1
Activity 1B: Participate in community based events providing screenings/education.	Nursing; Community outreach	Registration/lab paperwork	Community Benefit Report; hospital records	Set up Y1 Baseline 0	Determine # of fairs requesting participation	Increase participation by 2%	Increase participation by 4%

Anticipated Outcomes:

- **Short-Term:** Patients have increased knowledge and awareness of diabetes.
- **Short-Term:** Increase participation in screening opportunities.
- **Medium-Term:** Provide access to care and follow-up for those determined to be diabetic through screenings
- **Long-Term:** Reduced new cases of diabetes/related illness in our communities (e.g., reduced readmission rates due to diabetes, reduced burden of diabetes and improved quality of life).

Target Population(s):

- Adults 18+
- People unaware of diabetes status

Resources:

- Foundation grants

Collaboration Partners:

- American Diabetes Association®

Community Stroke & Rehabilitation Center

PRIORITY: Heart Disease and Stroke

Goal Statement: Improve cardiovascular health and reduce deaths from heart disease and stroke. (Healthy People 2030)

Hospital Strategy 1 (System): Increase awareness of heart disease and stroke risk factors
Objective: By June 2025, increase the number of individuals participating in Stroke Prevention programs by 25%

Programs/Activities	Responsible	Evaluation Measures	Data Source	Baseline	Process Measure Y1	Process Measure Y2	Process Measure Y3
Activity 1A: Offer free or discounted screenings through Stroke Prevention Awareness events at a minimum of 3 sites (rotating) to reach each hospital demographic.	Stroke Centers; CFNI Marketing/CHS Community Outreach	Number of patient labs	Hospital reports; Epic; Community Benefit Reports	Set up in Y1 Baseline 0	Determine baseline # of participants using screenings	Increase participant screenings by 5%	Increase participant screenings by 5%
Activity 1B: Offer stroke patient support groups and workshops.	Stroke Centers	Number of offerings per year	Registration files	Set up in Y1 Baseline 0	Determine baseline	Have one new offering each year	Have one new offering each year
Activity 1C: Develop and distribute educational materials to patients to increase awareness (3 x per year).	Stroke Centers; CFNI Marketing/CHS Community Outreach	Number of educational materials	Community Benefits Reports	Set up in Y1 Baseline 0	Develop and determine baseline # for growth	Increase material distribution by 1 each year	Increase material distribution by 1 each year
Activity D: Conduct Stroke Risk Assessments to determine and elevate the knowledge level of the community (inpatient & health fairs) on stroke and stroke prevention.	Stroke Centers	Number of assessments	System-level spreadsheet w/total number assessments	Set up in Y1 Baseline 0	Determine baseline for growth	Increase assessments by 5%	Increase assessments by 5%

Anticipated Outcomes:

- **Short-Term:** Patients have increased knowledge and awareness of how to identify stroke risks.
- **Medium-Term:** Lower patient readmission rates due to stroke.
- **Medium-Term:** Increase access to care related to stroke symptoms.
- **Long-Term:** Reduce deaths and disability from stroke.

Target Population(s):

- Adults 18+
- Inpatients
- Outpatients

Resources:

- American Heart & Stroke Association (AHA)

Collaboration Partners:

- Indiana Stroke Consortium
- District One Stroke Alliance (DOSA)
- YMCAs
- Kindred Rehabilitation

Community Stroke & Rehabilitation Center

PRIORITY: Cancer

Goal Statement: Reduce new cases of cancer and cancer-related illness, disability, and death. (Healthy People 2030)

Hospital Strategy 1: Provide multiple educational opportunities to the public							
Programs/Activities	**Responsible**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**
Activity 1A: Plan, implement, and offer physician symposiums, workshops, etc. for the community.	Cancer Care Services; Manager, CRC Community Outreach	Registration sheets/lists, pre/post-tests and participant evaluations	Community Benefit Reports	1 event a year	1 event	2 events	3 events
Activity 1B: Increase the number of participants attending events for the community.	Cancer Care Services; Manager, CRC Community Outreach	% of participants	Cancer Resource Centre records; Community Benefit Reports	Set up in Y1	Determine baseline	Increase participants by 2%	Increase participants by 5%
Anticipated Outcomes: • **Short-Term**: Patients have increased knowledge and awareness of cancer in general. • **Medium-Term:** Increased participation in free or discounted screening opportunities. • **Long-Term:** Reduced new cases of cancer or cancer-related illness in our communities (e.g., reduced readmission rates due to cancer; reduced death rates due to cancer).							
Target Population(s): • Adults 18+ • Patients • Caregivers • Family members							
Resources: • American Cancer Society • American College of Surgeons (Commission on Cancer/National Accreditation Program for Breast Cancers) • Carle Clinic • EON Health							
Collaboration Partners: • Private physician practices • Local YMCAs • American Cancer Society • Urshel Laboratories, Inc.							

Section 8: CONCLUSION

This CHNA conducted for Community Healthcare System used a comprehensive set of secondary and primary data sets to determine the six health priorities listed below.

1. Maternal & Children's Health
2. Mental Health & Mental Disorders
3. Access to Healthcare
4. Diabetes
5. Heart Disease and Stroke
6. Cancer

The findings in this report will be used to guide the development of the Community Healthcare System Implementation Strategy Plan, which will outline strategies to address identified priorities and improve the health of the community.

The Action Plan presented outlines the individual strategies and activities Community Healthcare System will implement to address the health needs identified though the CHNA process. The components are outlined in detail in this report. The plans include: 1) actions the hospital intends to take to address the health needs identified in the CHNA, 2) the anticipated impact of these actions as reflected in the Process and Outcomes measures for each activity, 3) the resources the hospital plans to commit to each strategy, and 4) any planned collaboration to support the work outlined.

Please send any feedback and/or comments about this CHNA report by completing the form in the *Contact Us* section of the Community Healthcare System website- https://www.comhs.org/contact-us. Feedback received will be incorporated into the next CHNA process.

SECTION 9: REFERENCES

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Lake County, Indiana-StasIndiana Indiana's Public Data Utility (2022)

https://www.stats.indiana.edu/profiles/profiles.asp?scope_choice=a&county_changer=18089

Porter County, Indiana-StasIndiana Indiana's Public Data Utility (2022) U.S. Bureau of Labor Statistics. https://www.stats.indiana.edu/profiles/profiles.asp?scope_choice=a&county_changer=18127

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Section 10: APPENDICES SUMMARY

The following support documents are part of the 2022 Community Health Needs Assessment, posted on the Community Healthcare System website: https://www.comhs.org/about-us/community-health-needs-assessment

A. Detailed Methodology and Data Scoring Tables

A detailed overview of the Conduent HCI data scoring methodology and indicator scoring results from the secondary data analysis.

B. Community Input Collection Tools

Quantitative and qualitative community feedback data collection tool that was vital in capturing community feedback during this CHNA:

- Community survey
- Focus Group Sessions
- Community Listening Session

C. Community Resources

This document highlights existing resources that organizations are currently using and available widely in the community.

D. Potential Community Partners

The tables in this section highlight potential community partners who were identified during the qualitative data collection process for this CHNA.

Appendix A. Secondary Data Methodology

Secondary Data Sources

The main source for the secondary data or data that has been previously collected, is the community indicator database maintained by Conduent Healthy Communities Institute. The following is a list of both local and national data sources used in the Community Healthcare System Community Health Needs Assessment.

- American Community Survey
- Annie E. Casey Foundation
- Centers for Disease Control and Prevention (CDC) - PLACES
- Centers for Disease Control and Prevention
- Centers for Medicare & Medicaid Services
- County Health Rankings
- Feeding America
- Indiana Department of Health
- Indiana University Center for Health Policy
- Indiana Department of Corrections
- Indiana Secretary of State
- National Cancer Institute
- National Center for Education Statistics
- National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- National Environmental Public Health Tracking Network
- US Bureau of Labor Statistics
- US Census - County Business Patterns
- US Department of Agriculture - Food Environment Atlas
- US Environmental Protection Agency
- United For ALICE (Asset Limited, Income Constrained, Employed)

Community Healthcare System Demographics

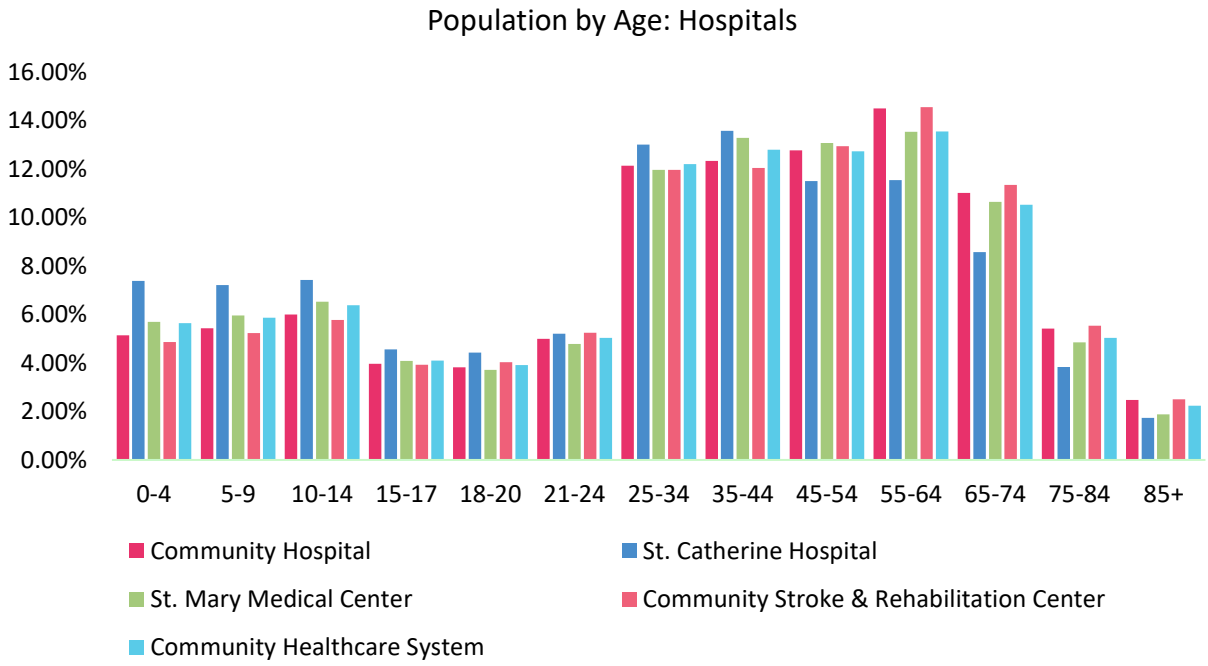
Population by Service Area

Community Healthcare System			
Zip Code	Population	Zip Code	Population
46307	66,057	46368	39,590
46312	26,768	46405	10,999
46319	17,875	46410	39,757
46321	23,136	46311	22,135
46322	22,482	46375	24,035
46323	21,315	46320	14,082
46324	21,329	46394	10,880
46342	30,706	46385	41,840
Total		432,986	

Community Hospital		Community Stroke & Rehabilitation Center	
Zip Code	Population	Zip Code	Population
46311	22,135	46322	22,482
46319	17,875	46319	17,875
46321	23,136	46307	66,057
46322	22,482	46375	24,035
46323	21,315	46323	21,315
46324	21,329	46311	22,135
46375	24,035	46321	23,136
Total	152,307	Total	197,035

St. Mary Medical Center		St. Catherine Hospital	
Zip Code	Population	Zip Code	Population
46342	30,706	46312	26,768
46368	39,590	46320	14,082
46385	41,840	46323	21,315
46405	10,999	46394	10,880
Total	123,135	**Total**	73,045

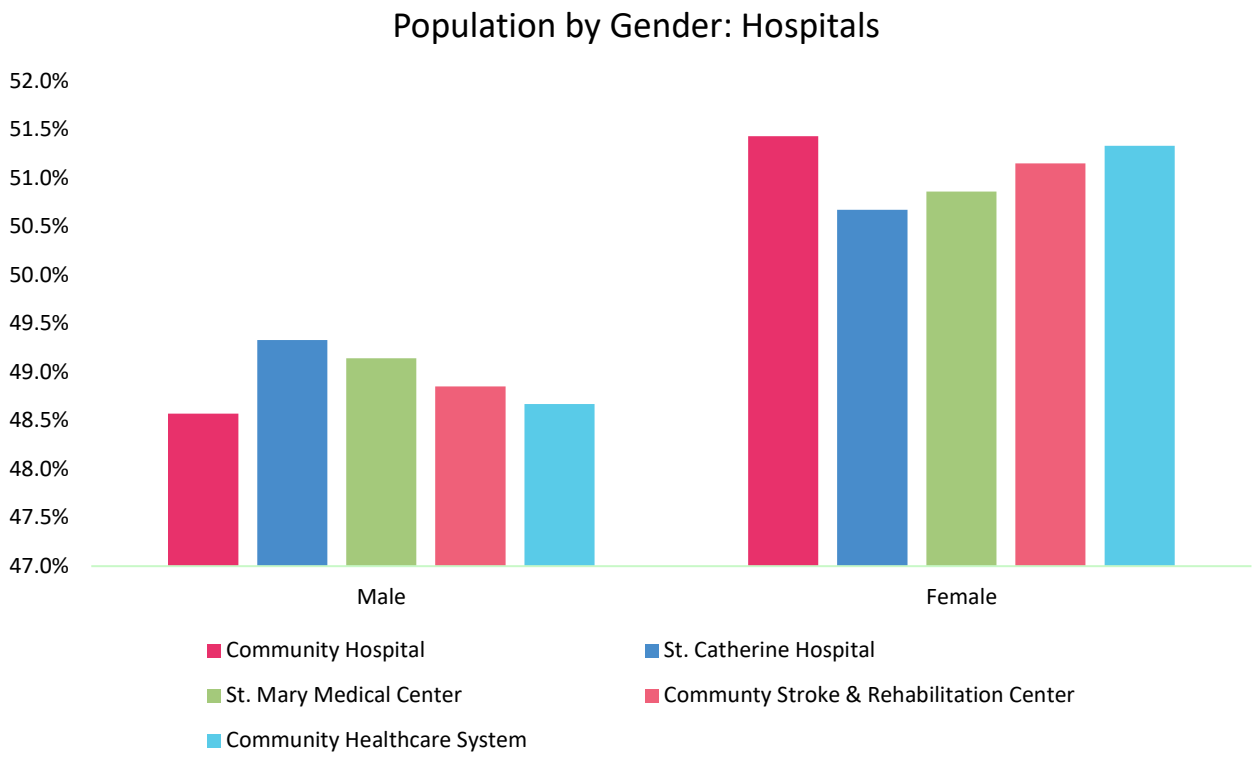
Population by Age



Population by Age: Hospitals					
Category	**Community Hospital**	**St. Catherine Hospital**	**St. Mary Medical Center**	**Community Stroke & Rehabilitation Center**	**Community Healthcare System**
0-4	5.14%	7.38%	5.69%	4.87%	5.64%
5-9	5.43%	7.21%	5.96%	5.23%	5.87%
10-14	6.00%	7.43%	6.53%	5.78%	6.38%
15-17	3.97%	4.56%	4.09%	3.93%	4.10%
18-20	3.82%	4.43%	3.72%	4.03%	3.91%
21-24	4.99%	5.21%	4.79%	5.25%	5.04%
25-34	12.14%	13.01%	11.96%	11.96%	12.20%
35-44	12.33%	13.58%	13.28%	12.05%	12.80%
45-54	12.77%	11.50%	13.07%	12.94%	12.73%
55-64	14.50%	11.55%	13.54%	14.56%	13.55%
65-74	11.01%	8.57%	10.64%	11.35%	10.53%
75-84	5.42%	3.84%	4.85%	5.54%	5.03%
85+	2.47%	1.73%	1.88%	2.50%	2.24%

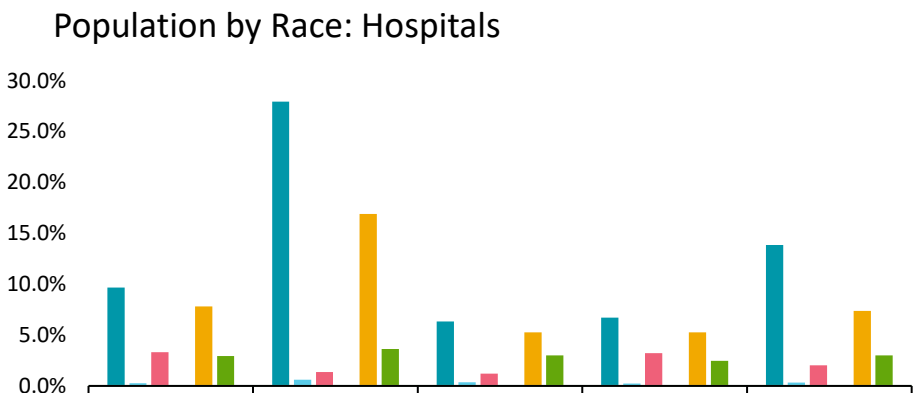
Source: Claritas, 2021

Population by Gender



Source: Claritas, 2021

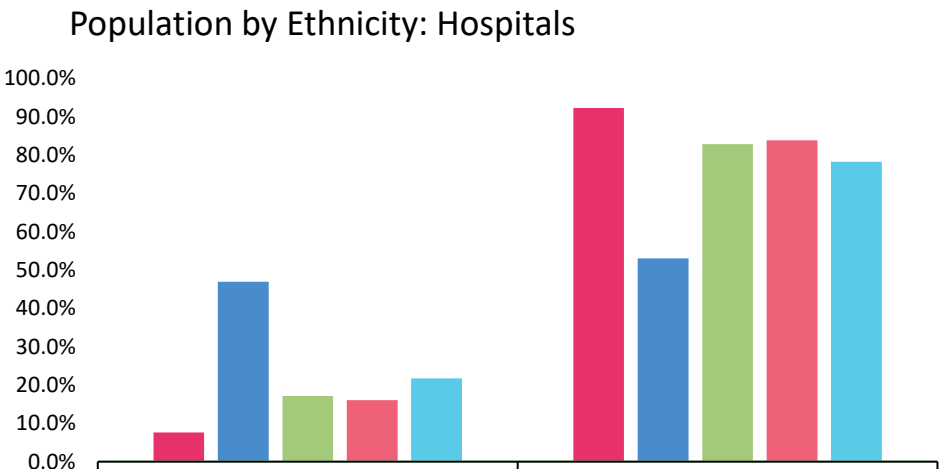
Population by Race



	Community Hospital	St. Catherine Hospital	St. Mary Medical Center	Communty Stroke & Rehabilitation Center	Community Healthcare System
Black or African American	9.7%	28.0%	6.4%	6.7%	13.8%
American Indian or Alaska Native	0.3%	0.6%	0.4%	0.2%	0.3%
Asian or Asian American	3.3%	1.4%	1.2%	3.2%	2.0%
Native Hawaiian or other Pacific Islander	0.02%	0.04%	0.03%	0.02%	0.03%
Another race	7.8%	16.9%	5.3%	5.3%	7.4%
More than one race	2.9%	3.6%	3.0%	2.5%	3.0%

Source: Claritas, 2021

Population by Ethnicity

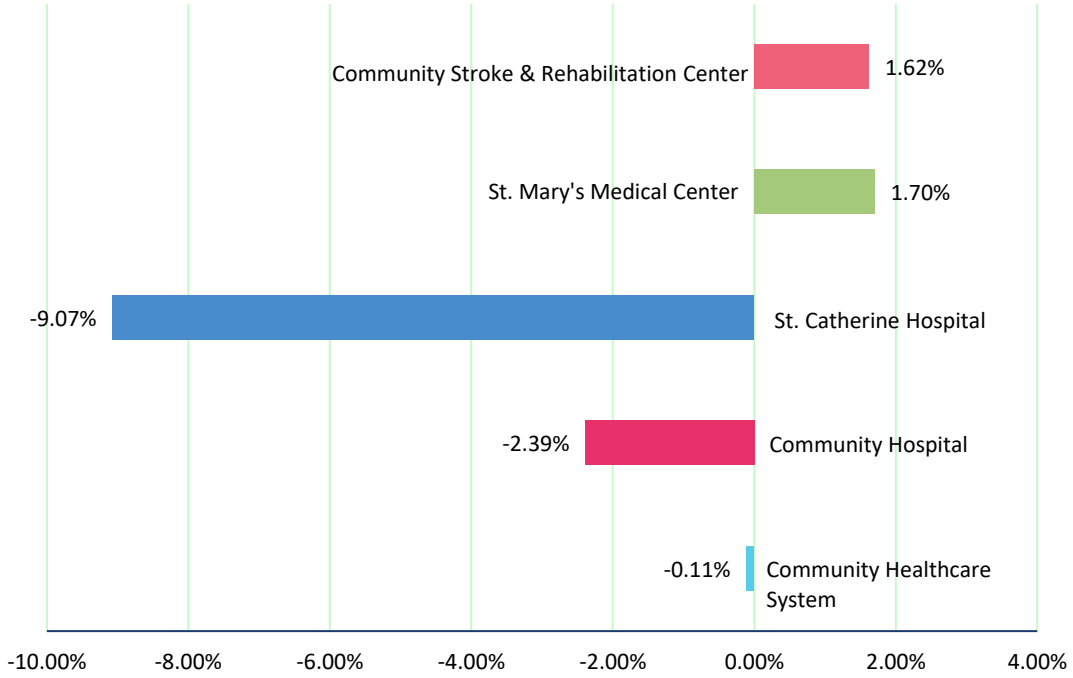


	Hispanic/Latino	Non-Hispanic/Latino
Community Hospital	7.7%	92.4%
St. Catherine Hospital	46.9%	53.1%
St. Mary Medical Center	17.1%	82.9%
Communty Stroke & Rehabilitation Center	16.1%	83.9%
Community Healthcare System	21.7%	78.3%

Source: Claritas, 2021

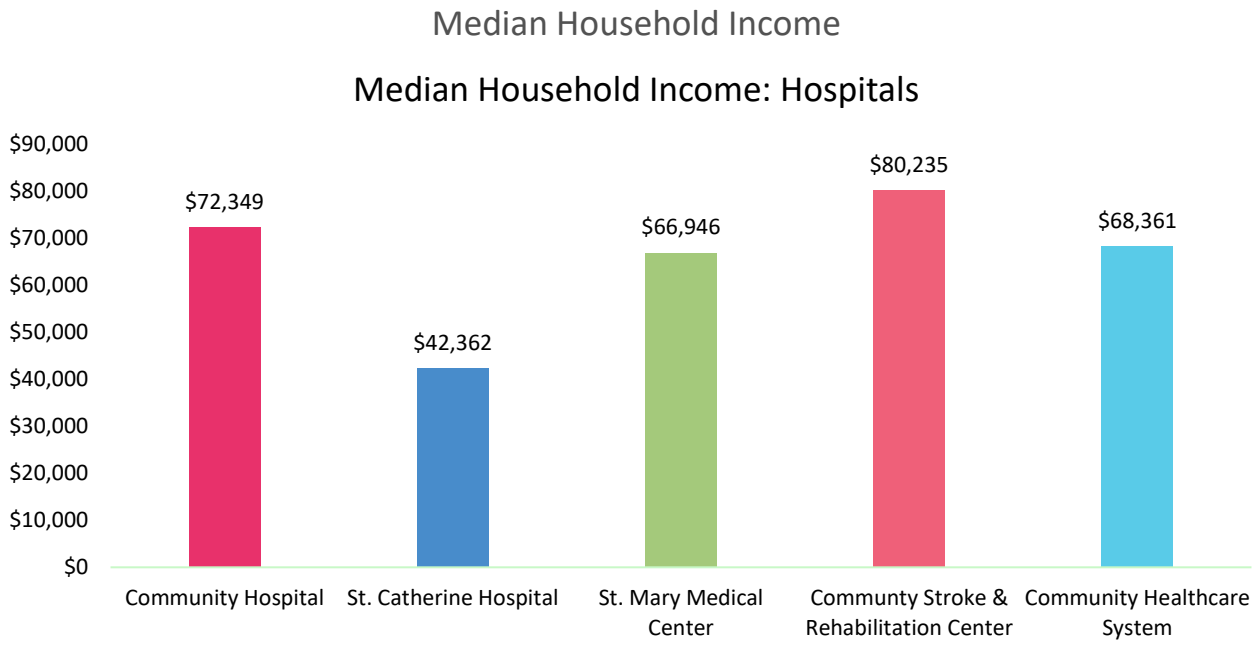
Percent Population Change

Percent Population Change: 2010 to 2021



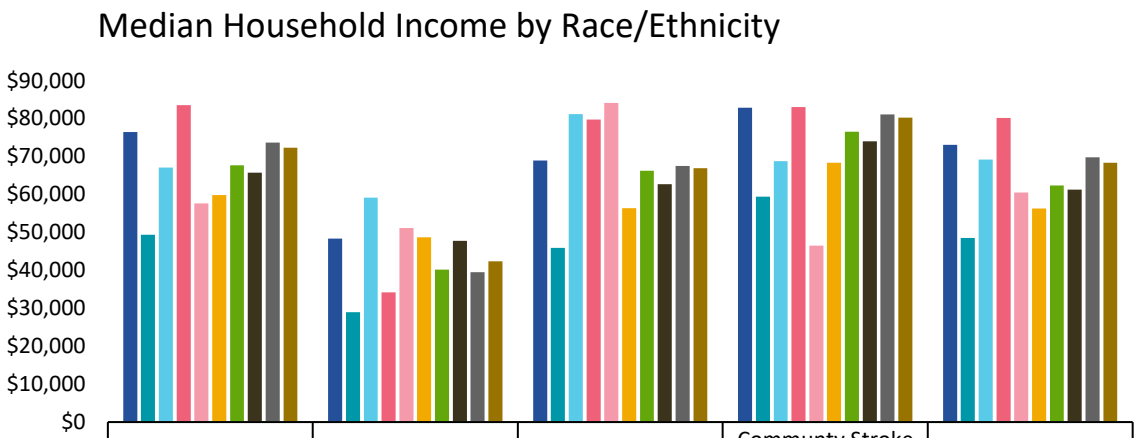
Source: Claritas, 2021

Community Healthcare System Social Determinants of Health



Source: Claritas, 2021

Median Household Income by Race/Ethnicity

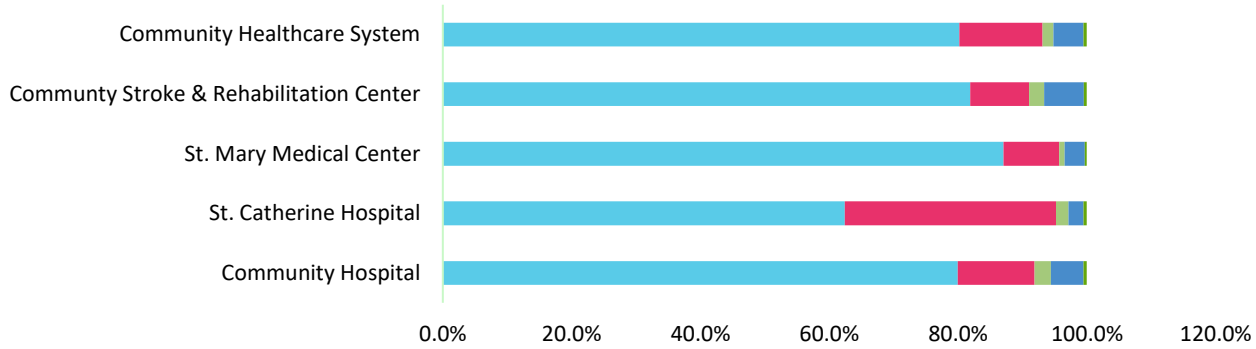


	Community Hospital	St. Catherine Hospital	St. Mary Medical Center	Community Stroke & Rehabilitation Center	Community Healthcare System
White	$76,490	$48,347	$68,993	$82,871	$73,112
Black/African American	$49,379	$28,997	$45,904	$59,395	$48,520
American Indian/Alaskan Native	$67,148	$59,179	$81,211	$68,813	$69,220
Asian	$83,525	$34,227	$79,801	$83,012	$80,162
Native Hawaiian/Pacific Islander	$57,639	$51,186	$84,135	$46,518	$60,553
Some Other Race	$59,877	$48,753	$56,384	$68,392	$56,271
2+ Races	$67,665	$40,152	$66,300	$76,555	$62,401
Hispanic/Latino	$65,740	$47,750	$62,747	$74,047	$61,278
Non-Hispanic/Latino	$73,663	$39,486	$67,510	$81,128	$69,834
Overall	$72,349	$42,362	$66,946	$80,235	$68,361

Source: Claritas, 2021

Language

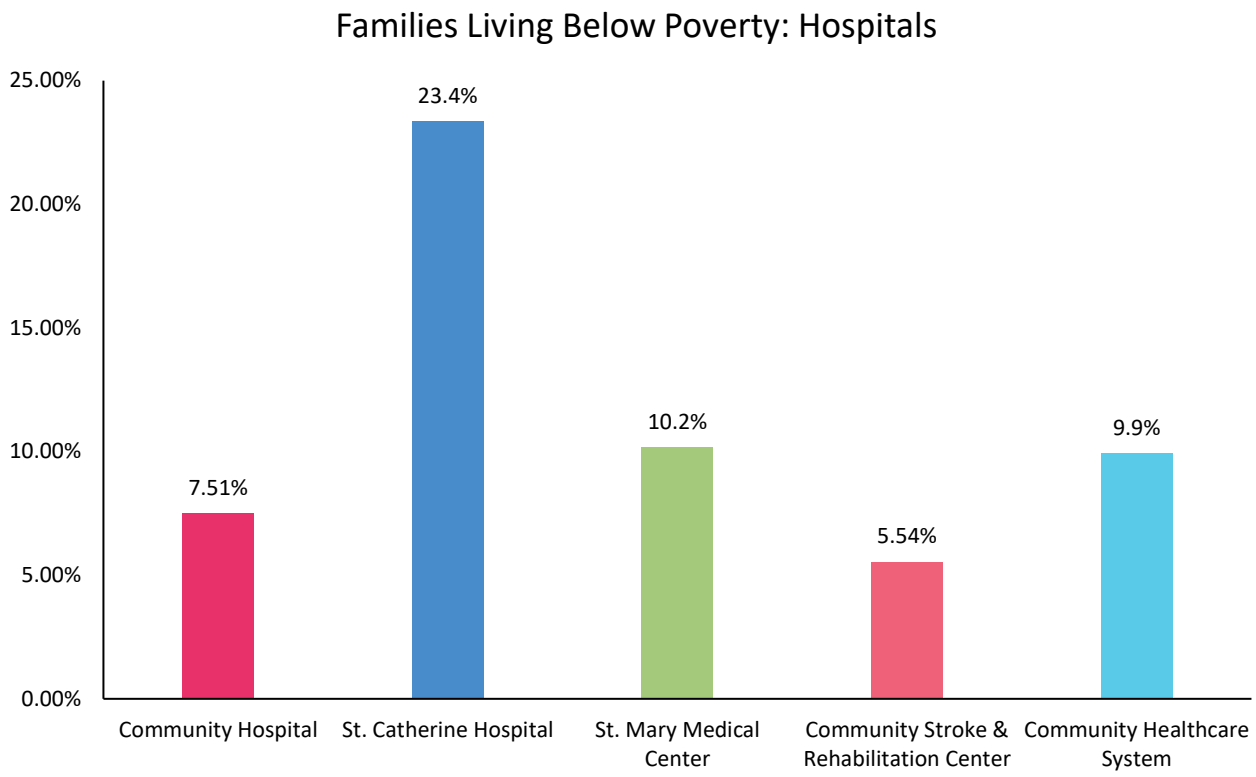
Population Age 5+ by Language Spoken at Home: Hospitals



	Community Hospital	St. Catherine Hospital	St. Mary Medical Center	Communty Stroke & Rehabilitation Center	Community Healthcare System
Only English	80.0%	62.4%	87.1%	81.9%	80.2%
Spanish	11.9%	32.8%	8.7%	9.2%	12.9%
Asian/Pacific Islander Language	2.5%	1.9%	0.8%	2.3%	1.7%
Indo-European Language	5.1%	2.4%	3.1%	6.2%	4.7%
Other Language	0.5%	0.5%	0.3%	0.5%	0.5%

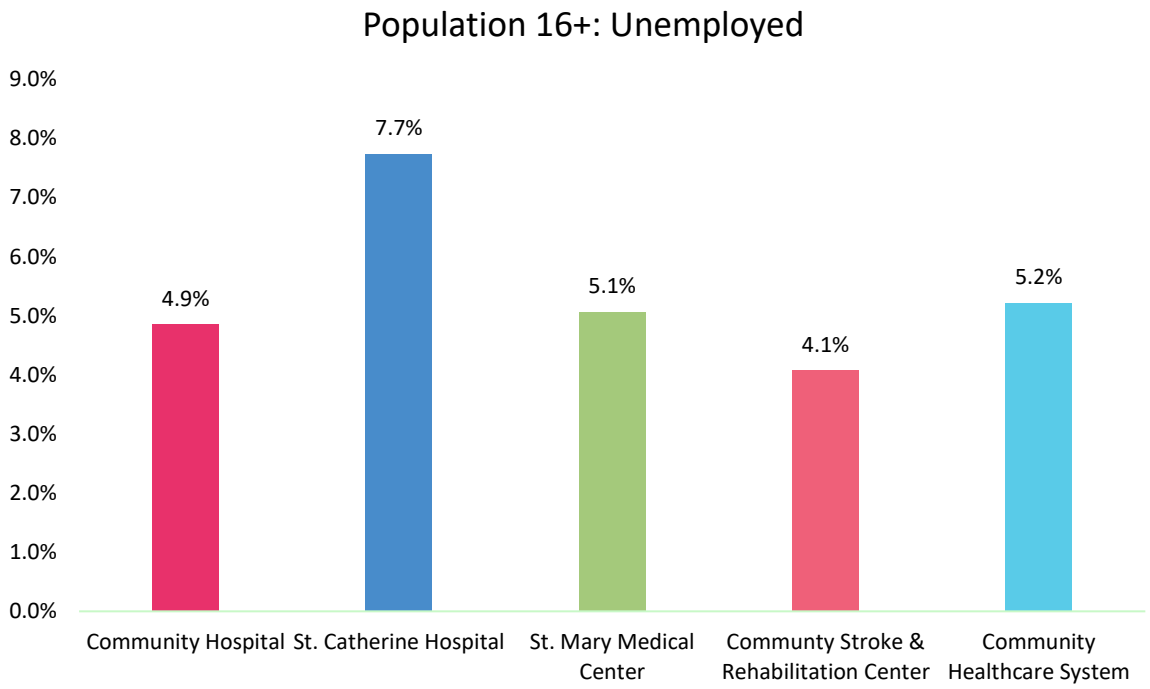
Source: Claritas, 2021

Poverty



Source: Claritas, 2021

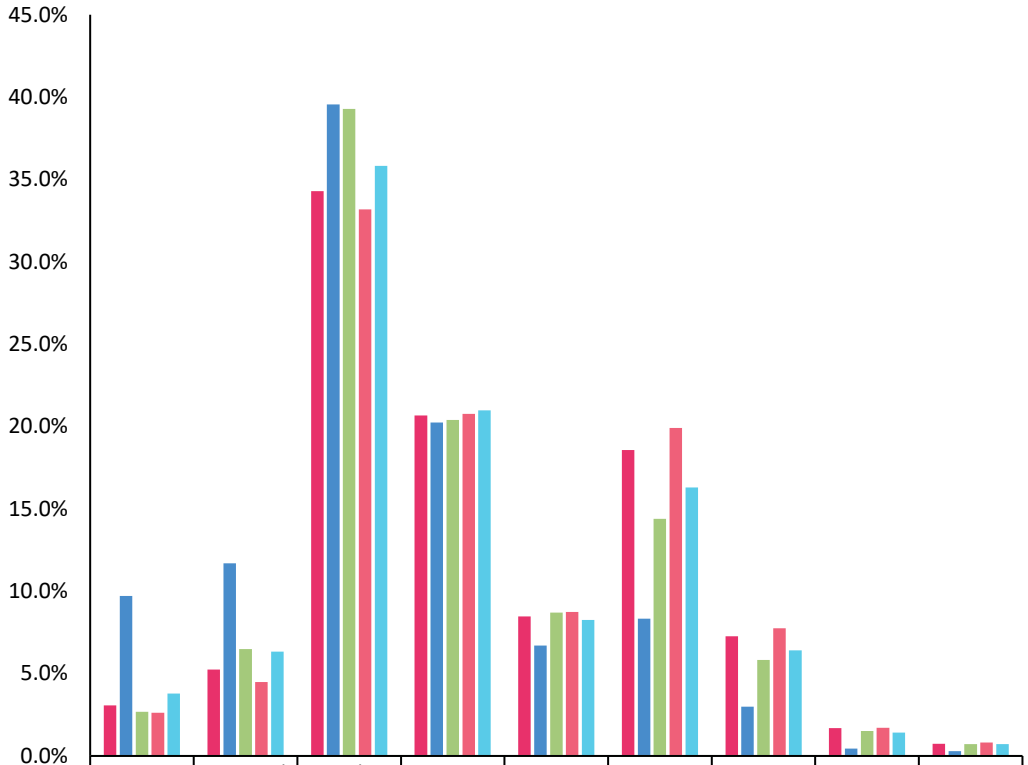
Employment



Source: Claritas, 2021

Education

People 25+ by Educational Attainment: Hospitals



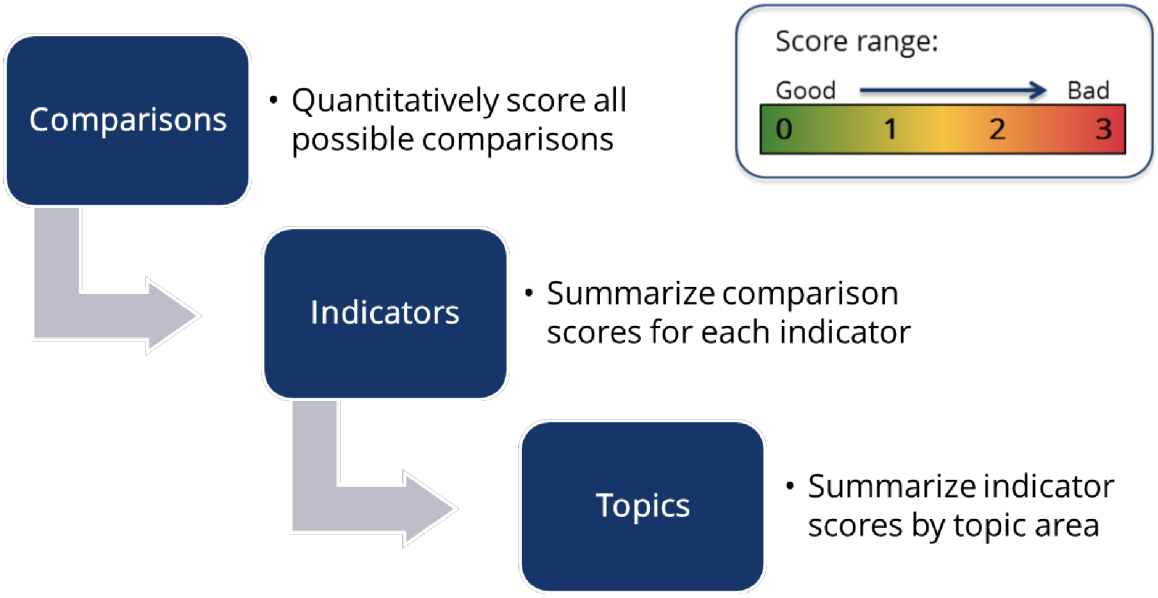
	Less than 9th Grade	Some High School, No Diploma	High School Graduate	Some College, No Degree	Associate Degree	Bachelor's Degree	Master's Degree	Professional Degree	Doctorate Degree
Community Hospital	3.1%	5.2%	34.3%	20.7%	8.5%	18.6%	7.3%	1.7%	0.7%
St. Catherine Hospital	9.7%	11.7%	39.6%	20.3%	6.7%	8.3%	3.0%	0.5%	0.3%
St. Mary Medical Center	2.7%	6.5%	39.3%	20.4%	8.7%	14.4%	5.8%	1.5%	0.7%
Community Stroke & Rehabilitation Center	2.6%	4.5%	33.2%	20.8%	8.7%	19.9%	7.8%	1.7%	0.8%
Community Healthcare System	3.8%	6.3%	35.8%	21.0%	8.3%	16.3%	6.4%	1.4%	0.7%

Source: Claritas, 2021

Secondary Data Scoring

Secondary Data Scoring Detailed Methodology

Data Scoring is done in three stages:



For every indicator available, each county in the Hospital Service Area is assigned a score based on its comparison to other communities, whether health targets have been met, and the trend of the indicator value over time. These comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities, and changes in methodology over time. Indicators are categorized into topic areas and each topic area receives a score. Indicators may be categorized in more than one topic area. Topic scores are determined by the comparisons of all indicators within the topic. Secondary data for this report are up to date as of November 1, 2021.

Comparison to a Distribution of County Values: Within State and Nation

For ease of interpretation and analysis, indicator data on the Community Dashboard is visually represented as a green-yellow-red gauge showing how the community is faring against a distribution of counties in the state or the United States. A distribution is created by taking all county values within the state or nation, ordering them from low to high, and dividing them into three groups (green, yellow, red) based on their order. Indicators with the poorest comparisons ("in the red") scored high, whereas indicators with good comparisons ("in the green") scored low.

Comparison Data to Values: State, National and Targets

The county is compared to the state value, the national value and target values. Target values include the nationwide Healthy People 2030 (HP2020) goals. Healthy People 2030 goals are national objectives for improving the health of the nation set by the Department of Health and Human Services' (DHHS) Healthy People Initiative. For all value comparisons, the scoring depends on whether the county value is better or worse than the comparison value, as well as how close the county value is to the target value.

Trend Over Time

The Mann-Kendall statistical test for trend was used to assess whether the county value is increasing over time or decreasing over time, and whether the trend is statistically significant. The trend comparison uses the four most recent comparable values for the county, and statistical significance is determined at the 90% confidence level. For each indicator with values available for four time periods, scoring was determined by direction of the trend and statistical significance.

Missing Values

Indicator scores are calculated using the comparison scores, availability of which depends on the data source. If the comparison type is possible for an adequate proportion of indicators on the community dashboard, it will be included in the indicator score. After exclusion of comparison types with inadequate availability, all missing comparisons are substituted with a neutral score for the purposes of calculating the indicator's weighted average. When information is unknown due to lack of comparable data, the neutral value assumes that the missing comparison score is neither good nor bad.

Indicator Scoring

Indicator scores are calculated as a weighted average of all included comparison scores. If none of the included comparison types are possible for an indicator, no score is calculated, and the indicator is excluded from the data scoring results.

Data Scoring

Indicator scores are averaged by topic area to calculate topic scores. Each indicator may be included in up to three topic areas if appropriate. Resulting scores range from 0-3, where a higher score indicates a greater level of need as evidenced by the data. A topic score is only calculated if it includes at least three indicators.

Secondary Data Source Key

For every indicator in a county's data scoring table, the associated source is specified in the last column. Please refer to the key below to identify sources.

Key	Source
1	American Community Survey
2	American Lung Association
3	Annie E. Casey Foundation
4	CDC - PLACES
5	Centers for Disease Control and Prevention
6	Centers for Medicare & Medicaid Services
7	County Health Rankings
8	Fatality Analysis Reporting System
9	Feeding America
10	Healthy Communities Institute
11	Indiana Department of Correction
12	Indiana Secretary of State
13	Indiana Department of Health
14	Indiana University Center for Health Policy
15	National Cancer Institute
16	National Center for Education Statistics
17	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
18	National Environmental Public Health Tracking Network
19	US Bureau of Labor Statistics
20	US Census - County Business Patterns
21	US Census Bureau - Small Area Health Insurance Estimates
22	US Department of Agriculture - Food Environment Atlas
23	US Environmental Protection Agency
24	United For ALICE (Asset Limited, Income Constrained, Employed)

Secondary Data Scoring Legend

Icons were used in the secondary data tables displayed in the Prioritized Significant Health Needs section of the report. Below is a breakdown of the type of icons used and how to interpret them.

County Distribution Gauges

Where data allows, Lake and Porter counties were compared to the distribution of Indiana and United States counties for each indicator. Below is a breakdown of the gauges used to represent where Lake County and Porter County fell within the distribution.

	Indicates the county fell in the bottom percent of all counties in the distribution. The county fares worse than 100% of all counties in the distribution.
	Indicates the county fell in the bottom 10% of all counties in the distribution. The county fares worse than 90% of all counties in the distribution.
	Indicates the county fell in the bottom 20% of all counties in the distribution. The county fares worse than 80% of all counties in the distribution.
	Indicates the county fell in the bottom 30% of all counties in the distribution. The county fares worse than 70% of all counties in the distribution.
	Indicates the county fell in the bottom 40% of all counties in the distribution. The county fares worse than 60% of all counties in the distribution.
	Indicates the county fell in the bottom 50% of all counties in the distribution. The county fares worse than 50% of all counties in the distribution.
	Indicates the county is in the top 40% of all counties in the distribution. The county fares better than 60% of all counties in the distribution.
	Indicates the county is in the top 30% of all counties in the distribution. The county fares better than 70% of all counties in the distribution.
	Indicates the county is in the top 20% of all counties in the distribution. The county fares better than 80% of all counties in the distribution.
	Indicates the county is in the top 10% of all counties in the distribution. The county fares better than 90% of all counties in the distribution.

	Indicates the county fell in the top percent of all counties in the distribution. The county fares better than 100% of all counties in the distribution.
—	Not enough data to analyze distribution.

Trend Icons

Where data allows, each indicator value for Lake and Porter counties was analyzed for trend. The Mann-Kendall statistical test for trend is used to assess whether the county value is increasing over time or decreasing over time, and whether the trend is statistically significant. Below is a list of icons used to represent the trend for each indicator in each county.

	The indicator is trending down, significantly, and this is not the ideal direction.
	The indicator is trending down and this is not the ideal direction.
	The indicator is trending up, significantly, and this is not the ideal direction.
	The indicator is trending up and this is not the ideal direction.
	The indicator is trending down, signifcantly, and this is the ideal direction.
	The indicator is trending down and this is the ideal direction.
	The indicator is trending up, significantly, and this is the ideal direction.
	The indicator is trending up and this is the ideal direction.
—	Not enough data to analyze trend.

Hospital Service Area County Data Scoring Results

Lake County Topic Scores

Health and Quality of Life Topics	Score
Wellness & Lifestyle	**2.15**
Other Conditions	**2.14**
Older Adults	**2.05**
Prevention & Safety	**1.97**
Diabetes	**1.95**
Children's Health	**1.92**
Heart Disease & Stroke	**1.85**
Physical Activity	**1.75**
Community	**1.70**
Education	**1.69**
Economy	**1.68**
Cancer	**1.67**
County Health Rankings	**1.67**
Environmental Health	**1.66**
Maternal, Fetal & Infant Health	**1.64**
Alcohol & Drug Use	**1.59**
Women's Health	**1.58**
Respiratory Diseases	**1.37**
Immunizations & Infectious Diseases	**1.36**
Healthcare Access & Quality	**1.32**
Oral Health	**1.31**
Mental Health & Mental Disorders	**1.30**

Lake County Indicator Scores

SCORE	ALCOHOL & DRUG USE	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.75	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	30.9		25.8	21	*2017-2019*		7
2.19	Liquor Store Density	*stores/ 100,000 population*	16.7		12.2	10.5	*2019*		20
2.08	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*deaths per 100,000 population*	35.1		29.4	22.8	*2017-2019*		5
1.69	Substance Abuse Treatment Rate: Alcohol	*rate per 100,000 population*	240		197.1		*2015*		13
1.61	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	24.9	*28.3*	18.8	27	*2015-2019*		7
1.42	Health Behaviors	*ranking*	35				*2021*		7

SCORE	**ALCOHOL & DRUG USE**	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.25	Adults who Binge Drink	*percent*	15.5			16.4	*2018*		4
0.83	Adults who Drink Excessively	*percent*	17		18.7	19	*2018*		7
0.75	Mothers who Smoked During Pregnancy	*percent*	6.3	*4.3*	11.8	5.9	*2019*		13

SCORE	**CANCER**	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.47	Cancer: Medicare Population	*percent*	8.9		8	8.4	*2018*		6
2.33	Colon Cancer Screening	*percent*	58.8	*74.4*		66.4	*2018*		4
2.08	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	48.2		42.6	38.4	*2013-2017*		15
2.03	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	112.1		94.2	104.5	*2013-2017*	Black (177.9) White (95.5) Hisp (79.8)	15
2.00	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	24	*15.3*	20.8	20.1	*2013-2017*		15
1.78	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	20.4	*16.9*	19.5	19	*2013-2017*	Black (36.2) White (17.4) Hisp (14.5)	15
1.67	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	16.6	*8.9*	15.1	13.7	*2013-2017*		15
1.61	Mammogram in Past 2 Years: 50-74	*percent*	70.9	*77.1*		74.8	*2018*		4
1.44	Cervical Cancer Screening: 21-65	*Percent*	84	*84.3*		84.7	*2018*		4

SCORE	**CANCER**	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.25	Adults with Cancer	*percent*	7.3			6.9	*2018*		4
1.25	Breast Cancer Incidence Rate	*cases/ 100,000 females*	123.6		122.9	125.9	*2013-2017*		15
1.25	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	68.8		72.2	58.3	*2013-2017*		15
1.25	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	11.3		12.7	11.8	*2013-2017*		15
1.00	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	44.9	*25.1*	48.7	38.5	*2013-2017*		15

SCORE	CHILDREN'S HEALTH	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.50	Food Insecure Children Likely Ineligible for Assistance	*percent*	35		28	23	*2019*		9
2.33	Child Food Insecurity Rate	*percent*	19.2		15.3	14.6	*2019*		9
2.08	Projected Child Food Insecurity Rate	*percent*	22.2		16.6		*2021*		9
2.00	Children with Low Access to a Grocery Store	*percent*	7.7				*2015*		22
1.75	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	2.8		2.4		*2014*		18
1.58	Child Abuse Rate	*cases/ 1,000 children*	15.3		17.1		*2015*		3
1.22	Children with Health Insurance	*percent*	94.2		93		*2019*		21

SCORE	**COMMUNITY**	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.75	Mean Travel Time to Work	*minutes*	29.2		23.8	26.9	*2015-2019*		1
2.47	Solo Drivers with a Long Commute	*percent*	40.9		31.7	37	*2015-2019*		7
2.47	Workers who Walk to Work	*percent*	1.2		2.2	2.7	*2015-2019*	Black (1.9) White (0.7) Asian (1.9) AIAN (1.6) NHPI (0) Mult (1.7) Other (1.9) Hisp (1.7)	1
2.42	People 65+ Living Alone	*percent*	29		28	26.1	*2015-2019*		1
2.36	Single-Parent Households	*percent*	32.7		25.1	25.5	*2015-2019*		1
2.33	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	454		409	500	*2015-2019*		1
2.17	Total Employment Change	*percent*	-0.2		0.6	1.6	*2018-2019*		20
2.14	Social Associations	*membership associations / 10,000 population*	9.8		12.3	9.3	*2018*		7
2.03	Households without a Vehicle	*percent*	8.5		6.4	8.6	*2015-2019*		1
2.00	Median Household Gross Rent	*dollars*	886		826	1,062	*2015-2019*		1

SCORE	**COMMUNITY**	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.00	Mortgaged Owners Median Monthly Household Costs	*dollars*	1,239		1,148	1,595	*2015-2019*		1
2.00	People Living Below Poverty Level	*percent*	15.6	*8*	13.4	13.4	*2015-2019*	Black (28.1) White (8.7) Asian (13.9) AIAN (13.3) NHPI (0) Mult (23.6) Other (22.8) Hisp (18.9)	1
1.97	Voter Turnout: Presidential Election	*percent*	60		65		*2020*		12
1.92	Children Living Below Poverty Level	*percent*	24.8		18.5	18.5	*2015-2019*	Black (43.6) White (11.1) Asian (7.9) AIAN (36.3) NHPI (0) Mult (26.4) Other (37.7) Hisp (28.6)	1
1.92	Violent Crime Rate	*crimes/ 100,000 population*	395.3		385.1	386.5	*2014-2016*		7
1.92	Young Children Living Below Poverty Level	*percent*	25.4		20.8	20.3	*2015-2019*	Black (45.7) White (10) Asian (8.8) AIAN (100) Mult (29.4) Other (41.8) Hisp (30.5)	1

SCORE	**COMMUNITY**	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.81	Population 16+ in Civilian Labor Force	*percent*	57.1		60.7	59.6	*2015-2019*		1
1.75	Social and Economic Factors Ranking	*ranking*	90				*2021*		7
1.61	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	24.9	*28.3*	18.8	27	*2015-2019*		7
1.58	Child Abuse Rate	*cases/ 1,000 children*	15.3		17.1		*2015*		3
1.53	Workers who Drive Alone to Work	*percent*	83.6		82.6	76.3	*2015-2019*		1
1.50	Female Population 16+ in Civilian Labor Force	*percent*	56.5		59.1	58.3	*2015-2019*		1
1.50	Households with an Internet Subscription	*percent*	80.3		80.6	83	*2015-2019*		1
1.50	Households with One or More Types of Computing Devices	*percent*	87.5		88.7	90.3	*2015-2019*		1
1.42	Persons with an Internet Subscription	*percent*	84.6		84.1	86.2	*2015-2019*		1
1.42	Persons with Health Insurance	*percent*	90.1	*92.1*	89.7		*2019*		21

SCORE	COMMUNITY	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.36	Adults Admitted into Correctional Facilities	*adults*	109				*2020*		11
1.36	Average Daily Jail Population	*offenders*	14				*2019*		11
1.36	Juveniles Admitted into Correctional Facilities	*juveniles*	12				*2020*		11
1.36	Pedestrian Deaths	*deaths*	8				*2014*		8
1.33	Households with No Car and Low Access to a Grocery Store	*percent*	2.4				*2015*		22
1.25	Homeownership	*percent*	61.1		61.5	56.2	*2015-2019*		1
1.25	Median Household Income	*dollars*	56,128		56,303	62,843	*2015-2019*		1
1.25	People 25+ with a Bachelor's Degree or Higher	*percent*	22.6		26.5	32.1	*2015-2019*		1
1.25	Per Capita Income	*dollars*	28,923		29,777	34,103	*2015-2019*		1
1.19	People 25+ with a High School Degree or Higher	*percent*	88.7		88.8	88	*2015-2019*		1
1.00	Median Housing Unit Value	*dollars*	149,500		141,700	217,500	*2015-2019*		1
0.94	Workers Commuting by Public Transportation	*percent*	2.9	*5.3*	1	5	*2015-2019*	Black (5.2) White (2.3) Asian (3.2) AIAN (1.2) NHPI (0) Mult (0.5)	1

								Other (1.7) Hisp (2.6)	
0.86	Age-Adjusted Death Rate due to Motor Vehicle Traffic Collisions	*deaths/ 100,000 population*	10	*10.1*	12.5	11.3	*2017-2019*		5

SCORE	**COUNTY HEALTH RANKINGS**	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.75	Clinical Care Ranking	*ranking*	79				*2021*		7
1.75	Morbidity Ranking	*ranking*	81				*2021*		7
1.75	Physical Environment Ranking	*ranking*	92				*2021*		7
1.75	Social and Economic Factors Ranking	*ranking*	90				*2021*		7
1.58	Mortality Ranking	*ranking*	65				*2021*		7
1.42	Health Behaviors Ranking	*ranking*	35				*2021*		7

SCORE	**DIABETES**	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.08	Adults 20+ with Diabetes	*percent*	11.9				*2017*		5
2.03	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	28.9		25.9	21.5	*2017-2019*	Black (54.6) White (22.4) Hisp (26.5)	5
1.75	Diabetes: Medicare Population	*percent*	29.7		27.8	27	*2018*		6

SCORE	**ECONOMY**	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.92	Unemployed Workers in Civilian Labor Force	*percent*	8.4		4.5	5.5	*May 2021*		19
2.50	Food Insecure Children Likely Ineligible for Assistance	*percent*	35		28	23	*2019*		9
2.33	Child Food Insecurity Rate	*percent*	19.2		15.3	14.6	*2019*		9
2.33	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	454		409	500	*2015-2019*		1
2.17	Total Employment Change	*percent*	-0.2		0.6	1.6	*2018-2019*		20
2.08	Projected Child Food Insecurity Rate	*percent*	22.2		16.6		*2021*		9
2.00	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	28.7		24		*2018*		24

SCORE	**ECONOMY**	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.00	Median Household Gross Rent	*dollars*	886		826	1,062	*2015-2019*		1
2.00	Mortgaged Owners Median Monthly Household Costs	*dollars*	1,239		1,148	1595	*2015-2019*		1
2.00	People Living Below Poverty Level	*percent*	15.6	*8*	13.4	13.4	*2015-2019*	Black (28.1) White (8.7) Asian (13.9) AIAN (13.3) NHPI (0) Mult (23.6) Other (22.8) Hisp (18.9)	1
2.00	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*		22
1.97	Renters Spending 30% or More of Household Income on Rent	*percent*	48.4		46.7	49.6	*2015-2019*		1
1.92	Children Living Below Poverty Level	*percent*	24.8		18.5	18.5	*2015-2019*	Black (43.6) White (11.1) Asian (7.9) AIAN (36.3) NHPI (0) Mult (26.4) Other (37.7) Hisp (28.6)	1

SCORE	**ECONOMY**	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.92	Families Living Below Poverty Level	*percent*	11.9		9.3	9.5	*2015-2019*	Black (23.3) White (5.9) Asian (3.8) AIAN (18.6) NHPI (0) Mult (20) Other (20.5) Hisp (17.4)	1
1.92	Young Children Living Below Poverty Level	*percent*	25.4		20.8	20.3	*2015-2019*	Black (45.7) White (10) Asian (8.8) AIAN (100) Mult (29.4) Other (41.8) Hisp (30.5)	1
1.83	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	57.5		63		*2018*		24
1.83	Low-Income and Low Access to a Grocery Store	*percent*	10.2				*2015*		22
1.83	Students Eligible for the Free Lunch Program	*percent*	47.7				*2019-2020*		16

SCORE	ECONOMY	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.81	Population 16+ in Civilian Labor Force	*percent*	57.1		60.7	59.6	*2015-2019*		1
1.81	SNAP Certified Stores	*stores/ 1,000 population*	0.8				*2017*		22
1.75	Social and Economic Factors Ranking	*ranking*	90				*2021*		7
1.69	Overcrowded Households	*percent of households*	2.1		1.6		*2015-2019*		1
1.67	Households that are Below the Federal Poverty Level	*percent*	13.8		13		*2018*		24
1.58	Projected Food Insecurity Rate	*percent*	13.9		13.3		*2021*		9
1.50	Female Population 16+ in Civilian Labor Force	*percent*	56.5		59.1	58.3	*2015-2019*		1
1.50	Food Insecurity Rate	*percent*	12.1		12.4	10.9	*2019*		9
1.47	People 65+ Living Below Poverty Level	*percent*	8.3		7.6	9.3	*2015-2019*	Black (13.3) White (6.5) Asian (4.4) AIAN (18.4) NHPI (0) Mult (21.4) Other (8.6) Hisp (10.1)	1
1.42	Severe Housing Problems	*percent*	15		12.9	18	*2013-2017*		7

SCORE	**ECONOMY**	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.25	Homeownership	*percent*	61.1		61.5	56.2	*2015-2019*		1
1.25	Median Household Income	*dollars*	56,128		56,303	62,843	*2015-2019*		1
1.25	People Living 200% Above Poverty Level	*percent*	67		68.4	69.1	*2015-2019*		1
1.25	Per Capita Income	*dollars*	28,923		29,777	34,103	*2015-2019*		1
1.11	Persons with Disability Living in Poverty	*percent*	23.6		25.6	25	*2019*		1
1.00	Median Housing Unit Value	*dollars*	149,500		141,700	217,500	*2015-2019*		1
0.86	Homeowner Vacancy Rate	*percent*	1.4		1.5	1.6	*2015-2019*		1
0.83	Mortgaged Owners Spending 30% or More of Household Income on Housing	*percent*	20		18.7	26.5	*2019*		1
0.75	Persons with Disability Living in Poverty (5-year)	*percent*	25.4		26.5	26.1	*2015-2019*		1
0.42	Households with Cash Public Assistance Income	*percent*	1.4		1.6	2.4	*2015-2019*		1

SCORE	EDUCATION	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.25	4th Grade Students Proficient in English/ Language Arts	*percent*	60.7		64.9		*2017*		3
2.14	8th Grade Students Proficient in Math	*percent*	46		54.4		*2017*		3
1.92	High School Graduation	*percent*	87.5	*90.7*	88.7	84.6	*2017*		3
1.81	4th Grade Students Proficient in Math	*percent*	58.8		61.2		*2017*		3
1.81	8th Grade Students Proficient in English/ Language Arts	*percent*	56.3		60.7		*2017*		3
1.25	People 25+ with a Bachelor's Degree or Higher	*percent*	22.6		26.5	32.1	*2015-2019*		1
1.19	People 25+ with a High School Degree or Higher	*percent*	88.7		88.8	88	*2015-2019*		1
1.14	Student-to-Teacher Ratio	*students/ teacher*	8				*2019-2020*		16

SCORE	**ENVIRONMENTAL HEALTH**	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.19	Liquor Store Density	*stores/ 100,000 population*	16.7		12.2	10.5	*2019*		20
2.17	Houses Built Prior to 1950	*percent*	26.9		22.9	17.5	*2015-2019*		1
2.14	Fast Food Restaurant Density	*restaurants / 1,000 population*	0.8				*2016*		22
2.08	Asthma: Medicare Population	*percent*	5.6		4.9	5	*2018*		6
2.00	Children with Low Access to a Grocery Store	*percent*	7.7				*2015*		22
2.00	People with Low Access to a Grocery Store	*percent*	29.8				*2015*		22
2.00	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*		22
1.83	Farmers Market Density	*markets/ 1,000 population*	0				*2018*		22
1.83	Low-Income and Low Access to a Grocery Store	*percent*	10.2				*2015*		22
1.83	People 65+ with Low Access to a Grocery Store	*percent*	3.8				*2015*		22

SCORE	**ENVIRONMENTAL HEALTH**	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.81	SNAP Certified Stores	*stores/ 1,000 population*	0.8				*2017*		22
1.75	Adults with Current Asthma	*percent*	10.2			9.2	*2018*		4
1.75	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	2.8		2.4		*2014*		18
1.75	Physical Environment Ranking	*ranking*	92				*2021*		7
1.69	Food Environment Index		7.2		7	7.8	*2021*		7
1.69	Overcrowded Households	*percent of households*	2.1		1.6		*2015-2019*		1
1.64	Number of Extreme Precipitation Days	*days*	36				*2016*		18
1.61	Annual Particle Pollution	*grade*	C				*2017-2019*		2
1.50	Grocery Store Density	*stores/ 1,000 population*	0.2				*2016*		22
1.50	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*		22
1.44	Annual Ozone Air Quality	*grade*	D				*2017-2019*		2

SCORE	ENVIRONMENTAL HEALTH	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.42	Severe Housing Problems	*percent*	15		12.9	18	*2013-2017*		7
1.36	Months of Mild Drought or Worse	*months per year*	5				*2016*		18
1.36	Number of Extreme Heat Days	*days*	21				*2016*		18
1.36	PBT Released	*pounds*	704,931.7				*2019*		23
1.36	Recognized Carcinogens Released into Air	*pounds*	49,440.4				*2019*		23
1.33	Households with No Car and Low Access to a Grocery Store	*percent*	2.4				*2015*		22
1.03	Daily Dose of UV Irradiance	*Joule per square meter*	2,298		2,427		*2015*		18
0.67	Access to Exercise Opportunities	*percent*	91.6		75.2	84	*2020*		7

SCORE	**HEALTH CARE ACCESS & QUALITY**	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.08	Adults without Health Insurance	*percent*	16.9			12.2	*2018*		4
2.00	Primary Care Provider Rate	*providers/ 100,000 population*	52		66.8		*2018*		7
1.92	Adults who Visited a Dentist	*percent*	59.4			66.5	*2018*		4
1.75	Clinical Care Ranking	*ranking*	79				*2021*		7
1.56	Adults with Health Insurance: 18-64	*percent*	88.4		88.3		*2019*		21
1.42	Persons with Health Insurance	*percent*	90.1	*92.1*	89.7		*2019*		21
1.22	Children with Health Insurance	*percent*	94.2		93		*2019*		21
0.92	Adults who have had a Routine Checkup	*percent*	78.9			76.7	*2018*		4
0.83	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	92.3		100.6		*2020*		7
0.50	Mental Health Provider Rate	*providers/ 100,000 population*	186.4		168.3		*2020*		7
0.33	Dentist Rate	*dentists/ 100,000 population*	65.1		57.1		*2019*		7

SCORE	**HEART DISEASE & STROKE**	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.92	Atrial Fibrillation: Medicare Population	*percent*	9.6		8.5	8.4	*2018*		6
2.50	Age-Adjusted Death Rate due to Coronary Heart Disease	*deaths/ 100,000 population*	102	*71.1*	97.8	90.5	*2017-2019*	Male (135.8)	5
2.47	Hypertension: Medicare Population	*percent*	63.8		59.6	57.2	*2018*		6
2.36	Heart Failure: Medicare Population	*percent*	18.5		15.1	14	*2018*		6
2.36	Stroke: Medicare Population	*percent*	5.4		3.7	3.8	*2018*		6
2.08	Ischemic Heart Disease: Medicare Population	*percent*	31.2		28.3	26.8	*2018*		6
2.00	High Blood Pressure Prevalence	*percent*	38.3	*27.7*		32.4	*2017*		4
2.00	Hyperlipidemia: Medicare Population	*percent*	50.7		47.9	47.7	*2018*		6
1.75	Adults who Experienced a Stroke	*percent*	4.1			3.4	*2018*		4

SCORE	HEART DISEASE & STROKE	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.58	Adults who Experienced Coronary Heart Disease	*percent*	7.7			6.8	*2018*		4
1.42	Adults who Have Taken Medications for High Blood Pressure	*percent*	78.4			75.8	*2017*		4
1.28	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	38.9	*33.4*	40.3	37.2	*2017-2019*		5
1.25	High Cholesterol Prevalence: Adults 18+	*percent*	35.9			34.1	*2017*		4
0.92	Cholesterol Test History	*percent*	81.7			81.5	*2017*		4
0.86	Age-Adjusted Death Rate due to Heart Attack	*deaths/ 100,000 population 35+ years*	43.6		67.8		*2018*		18

SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.31	Chlamydia Incidence Rate	*cases/ 100,000 population*	562.4		523.9	539.9	*2018*		17
2.08	Salmonella Infection Incidence Rate	*cases/ 100,000 population*	16.5	*11.1*	11.9		*2018*		13
1.97	Gonorrhea Incidence Rate	*cases/ 100,000 population*	172.6		182.9	179.1	*2018*		17
1.69	Overcrowded Households	*percent of households*	2.1		1.6		*2015-2019*		1
1.17	Hepatitis C Prevalence	*Rate per 100,000 population*	61.4		90		*2019*		13
1.03	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0.8		0.8	1.3	*Sept. 10, 2021*		10
0.83	Persons Fully Vaccinated Against COVID-19	*percent*	47.8				*Sept. 10, 2021*		5
0.81	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	31.4		68.7	56.5	*Sept. 10, 2021*		10
0.36	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	10.6		13.1	13.8	*2017-2019*		5

SCORE	**MATERNAL, FETAL & INFANT HEALTH**	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.50	Mothers who Received Early Prenatal Care	*percent*	64.6		68.9	75.8	*2019*		13
1.78	Preterm Births	*percent*	10.2	*9.4*	10.1	10	*2019*		13
1.67	Babies with Very Low Birth Weight	*percent*	1.5		1.3	1.4	*2019*		13
1.61	Infant Mortality Rate	*deaths/ 1,000 live births*	6	*5*	6.5		*2019*		13
1.58	Babies with Low Birth Weight	*percent*	8.3		8.2	8.3	*2019*		13
1.44	Teen Birth Rate: 15-19	*live births/ 1,000 females aged 15-19*	20.7		20.7	16.7	*2019*		13
0.75	Mothers who Smoked During Pregnancy	*percent*	6.3	*4.3*	11.8	5.9	*2019*		13

SCORE	**MENTAL HEALTH & MENTAL DISORDERS**	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.31	Alzheimer's Disease or Dementia: Medicare Population	*percent*	11.5		11	10.8	*2018*		6
2.00	Poor Mental Health: Average Number of Days	*days*	5		4.7	4.1	*2018*		7
1.83	Frequent Mental Distress	*percent*	15.5		14.7	13	*2018*		7
1.75	Poor Mental Health: 14+ Days	*percent*	14.9			12.7	*2018*		4
1.08	Depression: Medicare Population	*percent*	16.4		21.1	18.4	*2018*		6
0.58	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	11.9	*12.8*	15.5	14.1	*2017-2019*		5
0.50	Mental Health Provider Rate	*providers/ 100,000 population*	186.4		168.3		*2020*		7
0.36	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	21.7		33.4	30.5	*2017-2019*		5

SCORE	**OLDER ADULTS**	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.92	Atrial Fibrillation: Medicare Population	*percent*	9.6		8.5	8.4	*2018*		6
2.47	Cancer: Medicare Population	*percent*	8.9		8	8.4	*2018*		6
2.47	Chronic Kidney Disease: Medicare Population	*percent*	27.1		25.5	24.5	*2018*		6
2.47	Hypertension: Medicare Population	*percent*	63.8		59.6	57.2	*2018*		6
2.47	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	37.6		35	33.5	*2018*		6
2.42	People 65+ Living Alone	*percent*	29		28	26.1	*2015-2019*		1
2.36	Heart Failure: Medicare Population	*percent*	18.5		15.1	14	*2018*		6
2.36	Stroke: Medicare Population	*percent*	5.4		3.7	3.8	*2018*		6
2.33	Colon Cancer Screening	*percent*	58.8	*74.4*		66.4	*2018*		4
2.33	COPD: Medicare Population	*percent*	15.8		14.3	11.5	*2018*		6

SCORE	**OLDER ADULTS**	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.31	Alzheimer's Disease or Dementia: Medicare Population	*percent*	11.5		11	10.8	*2018*		6
2.25	Adults 65+ who Received Recommended Preventive Services: Females	*percent*	20.6			28.4	*2018*		4
2.25	Adults 65+ who Received Recommended Preventive Services: Males	*percent*	20.4			32.4	*2018*		4
2.08	Asthma: Medicare Population	*percent*	5.6		4.9	5	*2018*		6
2.08	Ischemic Heart Disease: Medicare Population	*percent*	31.2		28.3	26.8	*2018*		6
2.00	Hyperlipidemia: Medicare Population	*percent*	50.7		47.9	47.7	*2018*		6
1.83	People 65+ with Low Access to a Grocery Store	*percent*	3.8				*2015*		22
1.75	Adults 65+ with Total Tooth Loss	*percent*	17.4			13.5	*2018*		4
1.75	Adults with Arthritis	*percent*	30.7			25.8	*2018*		4

SCORE	**OLDER ADULTS**	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.75	Diabetes: Medicare Population	*percent*	29.7		27.8	27	*2018*		6
1.64	Osteoporosis: Medicare Population	*percent*	6.2		6.3	6.6	*2018*		6
1.47	People 65+ Living Below Poverty Level	*percent*	8.3		7.6	9.3	*2015-2019*	Black (13.3) White (6.5) Asian (4.4) AIAN (18.4) NHPI (0) Mult (21.4) Other (8.6) Hisp (10.1)	1
1.08	Depression: Medicare Population	*percent*	16.4		21.1	18.4	*2018*		6
0.36	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	21.7		33.4	30.5	*2017-2019*		5

SCORE	**ORAL HEALTH**	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.92	Adults who Visited a Dentist	*percent*	59.4			66.5	*2018*		4
1.75	Adults 65+ with Total Tooth Loss	*percent*	17.4			13.5	*2018*		4
1.25	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	11.3		12.7	11.8	*2013-2017*		15
0.33	Dentist Rate	*dentists/ 100,000 population*	65.1		57.1		*2019*		7

SCORE	**OTHER CONDITIONS**	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.92	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	24.8		17.7	12.9	*2017-2019*		5
2.47	Chronic Kidney Disease: Medicare Population	*percent*	27.1		25.5	24.5	*2018*		6
2.47	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	37.6		35	33.5	*2018*		6
1.75	Adults with Arthritis	*percent*	30.7			25.8	*2018*		4
1.64	Osteoporosis: Medicare Population	*percent*	6.2		6.3	6.6	*2018*		6
1.58	Adults with Kidney Disease	*percent of adults*	3.4			3.1	*2018*		4

SCORE	**PHYSICAL ACTIVITY**	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.47	Workers who Walk to Work	*percent*	1.2		2.2	2.7	*2015-2019*	Black (1.9) White (0.7) Asian (1.9) AIAN (1.6) NHPI (0) Mult (1.7) Other (1.9) Hisp (1.7)	1
2.44	Adults 20+ who are Obese	*percent*	38.1	*36*			*2017*		5
2.14	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.8				*2016*		22
2.00	Children with Low Access to a Grocery Store	*percent*	7.7				*2015*		22
2.00	People with Low Access to a Grocery Store	*percent*	29.8				*2015*		22
2.00	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*		22
1.83	Farmers Market Density	*markets/ 1,000 population*	0.01				*2018*		22
1.83	Low-Income and Low Access to a Grocery Store	*percent*	10.2				*2015*		22
1.83	People 65+ with Low Access to a Grocery Store	*percent*	3.8				*2015*		22
1.81	SNAP Certified Stores	*stores/ 1,000 population*	0.8				*2017*		22

SCORE	**PHYSICAL ACTIVITY**	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.69	Food Environment Index		7.2		7	7.8	*2021*		7
1.50	Grocery Store Density	*stores/ 1,000 population*	0.2				*2016*		22
1.50	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*		22
1.42	Health Behaviors Ranking	*ranking*	35				*2021*		7
1.36	Adults 20+ who are Sedentary	*percent*	25.6				*2017*		5
1.33	Households with No Car and Low Access to a Grocery Store	*percent*	2.4				*2015*		22
0.67	Access to Exercise Opportunities	*percent*	91.6		75.2	84	*2020*		7

SCORE	**PREVENTION & SAFETY**	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.75	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	30.9		25.8	21	*2017-2019*		7
2.33	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/ 100,000 population*	59.3	*43.2*	56.7	48.9	*2017-2019*	Male (82.7)	5
1.42	Severe Housing Problems	*percent*	15		12.9	18	*2013-2017*		7
1.36	Pedestrian Deaths	*deaths*	8				*2014*		8

SCORE	**RESPIRATORY DISEASES**	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.33	COPD: Medicare Population	*percent*	15.8		14.3	11.5	*2018*		6
2.08	Asthma: Medicare Population	*percent*	5.6		4.9	5	*2018*		6
1.75	Adults with Current Asthma	*percent*	10.2			9.2	*2018*		4
1.58	Adults who Smoke	*percent*	21.4	*5*	21.7	17	*2018*		7
1.58	Adults with COPD	*percent of adults*	9.4			6.9	*2018*		4
1.31	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	*deaths/ 100,000 population*	46.5		56.2	39.6	*2017-2019*		5
1.25	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	68.8		72.2	58.3	*2013-2017*		15
1.03	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0.8		0.8	1.3	*Sept. 10, 2021*		10
1.00	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	44.9	*25.1*	48.7	38.5	*2013-2017*		15

SCORE	**RESPIRATORY DISEASES**	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
0.81	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	31.4		68.7	56.5	*Sept. 10, 2021*		10
0.36	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	10.6		13.1	13.8	*2017-2019*		5

SCORE	WELLNESS & LIFESTYLE	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.42	Insufficient Sleep	*percent*	40.1	*31.4*	38	35	*2018*		7
2.33	Frequent Physical Distress	*percent*	14.2		12.3	11	*2018*		7
2.33	Poor Physical Health: Average Number of Days	*days*	4.6		4	3.7	*2018*		7
2.33	Self-Reported General Health Assessment: Poor or Fair	*percent*	22.6		18.2	17	*2018*		7
2.00	High Blood Pressure Prevalence	*percent*	38.3	*27.7*		32.4	*2017*		4
1.92	Poor Physical Health: 14+ Days	*percent*	15.2			12.5	*2018*		4
1.75	Morbidity Ranking	*ranking*	81				*2021*		7

SCORE	**WOMEN'S HEALTH**	UNITS	LAKE COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.00	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	24	*15.3*	20.8	20.1	*2013-2017*		15
1.61	Mammogram in Past 2 Years: 50-74	*percent*	70.9	*77.1*		74.8	*2018*		4
1.44	Cervical Cancer Screening: 21-65	*percent*	84	*84.3*		84.7	*2018*		4
1.25	Breast Cancer Incidence Rate	*cases/ 100,000 females*	123.6		122.9	125.9	*2013-2017*		15

Porter County Data Scoring Results

Porter County Topic Scores

Health and Quality of Life Topics	Score
Cancer	1.74
Older Adults	1.68
Other Conditions	1.65
Physical Activity	1.63
Women's Health	1.61
Heart Disease & Stroke	1.57
Prevention & Safety	1.46
Environmental Health	1.44
Alcohol & Drug Use	1.38
Children's Health	1.34
Diabetes	1.33
Oral Health	1.33
Maternal, Fetal & Infant Health	1.33
County Health Rankings	1.31
Mental Health & Mental Disorders	1.26
Respiratory Diseases	1.23
Community	1.17
Economy	1.15
Education	1.14
Healthcare Access & Quality	1.11
Wellness & Lifestyle	1.10
Immunizations & Infectious Diseases	1.03

Porter County Indicator Scores

SCORE	ALCOHOL & DRUG USE	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY *	Source
2.33	Adults who Drink Excessively	*percent*	21.3		18.7	19	*2018*		7
1.92	Adults who Binge Drink	*percent*	17.8			16.4	*2018*		4
1.69	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	24.2		25.8	21	*2017-2019*		7
1.58	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*deaths per 100,000 population*	27.4		29.4	22.8	*2017-2019*		5
1.25	Health Behaviors Ranking	*ranking*	14				*2021*		7
1.19	Mothers who Smoked During Pregnancy	*percent*	9	*4.3*	11.8	5.9	*2019*		13
1.03	Liquor Store Density	*stores/ 100,000 population*	10.6		12.2	10.5	*2019*		20
0.92	Non-Fatal Emergency Department Visits due to Opioid Overdoses	*rate per 100,000 population*	61.6		75.2		*2019*		13
0.50	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	18.1	*28.3*	18.8	27	*2015-2019*		7

SCORE	CANCER	UNITS	PORTER COUNTY	HP2030	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY *	Source
2.75	Cancer: Medicare Population	*percent*	9.1		8	8.4	*2018*		6
2.67	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	21.7	*16.9*	19.5	19	*2013-2017*		15
2.39	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	23.1	*15.3*	20.8	20.1	*2013-2017*		15
2.31	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	14.1		12.7	11.8	*2013-2017*		15
1.94	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	15.8	*8.9*	15.1	13.7	*2013-2017*		15
1.69	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	43.7		42.6	38.4	*2013-2017*		15
1.61	Mammogram in Past 2 Years: 50-74	*percent*	70.6	*77.1*		74.8	*2018*		4
1.58	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	103.9		94.2	104.5	*2013-2017*		15
1.53	Breast Cancer Incidence Rate	*cases/ 100,000 females*	124.4		122.9	125.9	*2013-2017*		15
1.53	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	68		72.2	58.3	*2013-2017*		15

SCORE	**CANCER**	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY *	Source
1.33	Colon Cancer Screening	*percent*	64.6	*74.4*		66.4	*2018*		4
1.25	Adults with Cancer	*percent*	7.3			6.9	*2018*		4
0.89	Cervical Cancer Screening: 21-65	*Percent*	85.1	*84.3*		84.7	*2018*		4
0.83	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	43.3	*25.1*	48.7	38.5	*2013-2017*		15

SCORE	**CHILDREN'S HEALTH**	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.50	Food Insecure Children Likely Ineligible for Assistance	*percent*	38		28	23	*2019*		9
2.00	Children with Low Access to a Grocery Store	*percent*	8.1				*2015*		22
1.25	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	1.2		2.4		*2014*		18
1.22	Children with Health Insurance	*percent*	95		93		*2019*		21
1.14	Child Abuse Rate	*cases/ 1,000 children*	12.3		20.8		*2017*		3
0.75	Projected Child Food Insecurity Rate	*percent*	14.2		16.6		*2021*		9
0.50	Child Food Insecurity Rate	*percent*	12.3		15.3	14.6	*2019*		9

SCORE	COMMUNITY	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.75	Mean Travel Time to Work	*minutes*	27.8		23.8	26.9	*2015-2019*		1
2.47	Solo Drivers with a Long Commute	*percent*	40.9		31.7	37	*2015-2019*		7
2.33	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	481		409	500	*2015-2019*		1
2.31	Workers who Walk to Work	*percent*	1.5		2.2	2.7	*2015-2019*		1
2.17	Median Household Gross Rent	*dollars*	933		826	1,062	*2015-2019*		1
2.17	Mortgaged Owners Median Monthly Household Costs	*dollars*	1,391		1,148	1,595	*2015-2019*		1
2.03	Workers who Drive Alone to Work	*percent*	85.9		82.6	76.3	*2015-2019*		1
2.00	Social Associations	*membership associations / 10,000 population*	9.6		12.3	9.3	*2018*		7
1.81	Population 16+ in Civilian Labor Force	*percent*	58.9		60.7	59.6	*2015-2019*		1
1.67	Female Population 16+ in Civilian Labor Force	*percent*	55.2		59.1	58.3	*2015-2019*		1
1.42	Social and Economic Factors Ranking	*ranking*	24				*2021*		7

SCORE	COMMUNITY	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.36	Adults Admitted into Correctional Facilities	*adults*	29				*2020*		11
1.36	Average Daily Jail Population	*offenders*	3				*2019*		11
1.36	Juveniles Admitted into Correctional Facilities	*juveniles*	6				*2020*		11
1.36	Pedestrian Deaths	*deaths*	2				*2014*		8
1.33	Voter Turnout: Presidential Election	*percent*	67		65		*2020*		12
1.22	Workers Commuting by Public Transportation	*percent*	1.1	*5.3*	1	5	*2015-2019*		1
1.17	Households with No Car and Low Access to a Grocery Store	*percent*	1.7				*2015*		22
1.14	Child Abuse Rate	*cases/ 1,000 children*	12.3		20.8		*2017*		3
1.08	Persons with an Internet Subscription	*percent*	88.1		84.1	86.2	*2015-2019*		1
1.03	Persons with Health Insurance	*percent*	92.6	*92.1*	89.7		*2019*		21
0.83	Households with an Internet Subscription	*percent*	84.6		80.6	83	*2015-2019*		1
0.83	Households with One or More Types of Computing Devices	*percent*	91.9		88.7	90.3	*2015-2019*		1
0.83	Median Housing Unit Value	*dollars*	185,400		141,170	217,500	*2015-2019*		1

SCORE	COMMUNITY	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
0.83	Single-Parent Households	*percent*	20.8		25.1	25.5	*2015-2019*		1
0.81	Households without a Vehicle	*percent*	4		6.4	8.6	*2015-2019*		1
0.75	People 25+ with a Bachelor's Degree or Higher	*percent*	28.4		26.5	32.1	*2015-2019*		1
0.64	Homeownership	*percent*	70.5		61.5	56.2	*2015-2019*		1
0.61	People Living Below Poverty Level	*percent*	9.9	*8*	13.4	13.4	*2015-2019*	Black (23.4) White (8.6) Asian (18.5) AIAN (25) NHPI (28.4) Mult (14.5) Other (21.3) Hisp (13.6)	1
0.58	Age-Adjusted Death Rate due to Motor Vehicle Traffic Collisions	*deaths/ 100,000 population*	9.6	*10.1*	12.5	11.3	*2017-2019*		5
0.53	People 65+ Living Alone	*percent*	23.6		28	26.1	*2015-2019*		1
0.50	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	18.1	*28.3*	18.8	27	*2015-2019*		7
0.50	Violent Crime Rate	*crimes/ 100,000 population*	96.9		385.1	386.5	*2014-2016*		7

SCORE	**COMMUNITY**	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
0.42	People 25+ with a High School Degree or Higher	*percent*	93.6		88.8	88	*2015-2019*		1
0.42	Total Employment Change	*percent*	1.8		0.6	1.6	*2018-2019*		20
0.36	Children Living Below Poverty Level	*percent*	12.7		18.5	18.5	*2015-2019*	Black (35.1) White (10) Asian (16.5) AIAN (87.5) NHPI (0) Mult (14.6) Other (34.2) Hisp (19) Female (13.5)	1
0.36	Young Children Living Below Poverty Level	*percent*	12.8		20.8	20.3	*2015-2019*	Black (21.5) White (11.6) Asian (53.6) AIAN (100) Mult (5.5) Other (0) Hisp (18.3)	1
0.25	Per Capita Income	*dollars*	34,595		29,777	34,103	*2015-2019*		1
0.08	Median Household Income	*dollars*	71,152		56,303	62,843	*2015-2019*		1

SCORE	**COUNTY HEALTH RANKINGS**	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.42	Clinical Care Ranking	*ranking*	39				*2021*		7
1.42	Social and Economic Factors Ranking	*ranking*	24				*2021*		7
1.25	Health Behaviors Ranking	*ranking*	14				*2021*		7
1.25	Morbidity Ranking	*ranking*	10				*2021*		7
1.25	Mortality Ranking	*ranking*	18				*2021*		7
1.25	Physical Environment Ranking	*ranking*	23				*2021*		7

SCORE	**DIABETES**	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.67	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	25.8		25.9	21.5	*2017-2019*		5
1.47	Adults 20+ with Diabetes	*percent*	9.8				*2017*		5
0.86	Diabetes: Medicare Population	*percent*	26.2		27.8	27	*2018*		6

SCORE	ECONOMY	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.50	Food Insecure Children Likely Ineligible for Assistance	*percent*	38		28	23	*2019*		9
2.33	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	481		409	500	*2015-2019*		1
2.17	Median Household Gross Rent	*dollars*	933		826	1,062	*2015-2019*		1
2.17	Mortgaged Owners Median Monthly Household Costs	*dollars*	1,391		1,148	1,595	*2015-2019*		1
2.00	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	26.5		24		*2018*		24
2.00	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*		22
1.97	Unemployed Workers in Civilian Labor Force	*percent*	5.2		4.7	6.1	*June 2021*		19
1.86	SNAP Certified Stores	*stores/ 1,000 population*	0.6				*2017*		22
1.83	Low-Income and Low Access to a Grocery Store	*percent*	7.9				*2015*		22
1.81	Population 16+ in Civilian Labor Force	*percent*	58.9		60.7	59.6	*2015-2019*		1

SCORE	ECONOMY	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.67	Female Population 16+ in Civilian Labor Force	*percent*	55.2		59.1	58.3	*2015-2019*		1
1.64	Renters Spending 30% or More of Household Income on Rent	*percent*	46.6		46.7	49.6	*2015-2019*		1
1.50	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	63.8		63		*2018*		24
1.42	Social and Economic Factors Ranking	*ranking*	24				*2021*		7
1.36	Severe Housing Problems	*percent*	13		12.9	18	*2013-2017*		7
1.22	Persons with Disability Living in Poverty	*percent*	23		25.6	25	*2019*		1
1.08	Size of Labor Force	*persons*	84,909				*June 2021*		19
1.03	Overcrowded Households	*percent of household s*	1.3		1.6		*2015-2019*		1
1.00	Households that are Below the Federal Poverty Level	*percent*	9.7		13		*2018*		24
1.00	Students Eligible for the Free Lunch Program	*percent*	28.7				*2019-2020*		16

SCORE	ECONOMY	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
0.94	Mortgaged Owners Spending 30% or More of Household Income on Housing	*percent*	19.2		18.7	26.5	*2019*		1
0.92	Projected Food Insecurity Rate	*percent*	11.7		13.3		*2021*		9
0.83	Median Housing Unit Value	*dollars*	185,400		141,700	217,500	*2015-2019*		1
0.83	Persons with Disability Living in Poverty (5-year)	*percent*	21.3		26.5	26.1	*2015-2019*		1
0.75	Projected Child Food Insecurity Rate	*percent*	14.2		16.6		*2021*		9
0.69	Families Living Below Poverty Level	*percent*	7.3		9.3	9.5	*2015-2019*	Black (21.8) White (6.1) Asian (11.1) AIAN (0) Mult (17.4) Other (22.7) Hisp (13.5)	1
0.67	Food Insecurity Rate	*percent*	10.4		12.4	10.9	*2019*		9
0.64	Homeowner Vacancy Rate	*percent*	1.1		1.5	1.6	*2015-2019*		1
0.64	Homeownership	*percent*	70.5		61.5	56.2	*2015-2019*		1
0.64	Households with Cash Public Assistance Income	*percent*	1.1		1.6	2.4	*2015-2019*		1

SCORE	ECONOMY	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
0.61	People Living Below Poverty Level	*percent*	9.9	*8*	13.4	13.4	*2015-2019*	Black (23.4) White (8.6) Asian (18.5) AIAN (25) NHPI (28.4) Mult (14.5) Other (21.3) Hisp (13.6)	1
0.50	Child Food Insecurity Rate	*percent*	12.3		15.3	14.6	*2019*		9
0.42	Total Employment Change	*percent*	1.8		0.6	1.6	*2018-2019*		20
0.36	Children Living Below Poverty Level	*percent*	12.7		18.5	18.5	*2015-2019*	Black (35.1) White (10) Asian (16.5) AIAN (87.5) NHPI (0) Mult (14.6) Other (34.2) Hisp (19) Female (13.5)	1
0.36	People Living 200% Above Poverty Level	*percent*	77.8		68.4	69.1	*2015-2019*		1
0.36	Young Children Living Below Poverty Level	*percent*	12.8		20.8	20.3	*2015-2019*	Black (21.5) White (11.6) Asian (53.6) AIAN (100) Mult (5.5) Other (0) Hisp (18.3)	1
0.25	Per Capita Income	*dollars*	34,595		29,777	34,103	*2015-2019*		1
0.08	Median Household Income	*dollars*	71,152		56,303	62,843	*2015-2019*		1

SCORE	**EDUCATION**	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.86	Student-to-Teacher Ratio	*students/ teacher*	17.8				*2019-2020*		16
1.53	High School Graduation	*percent*	90.8	*90.7*	88.7	84.6	*2017*		3
1.14	4th Grade Students Proficient in English/Language Arts	*percent*	75.8		64.9		*2017*		3
1.14	4th Grade Students Proficient in Math	*percent*	73.5		61.2		*2017*		3
1.14	8th Grade Students Proficient in English/Language Arts	*percent*	68.1		60.7		*2017*		3
1.14	8th Grade Students Proficient in Math	*percent*	64.4		54.4		*2017*		3
0.75	People 25+ with a Bachelor's Degree or Higher	*percent*	28.4		26.5	32.1	*2015-2019*		1
0.42	People 25+ with a High School Degree or Higher	*percent*	93.6		88.8	88	*2015-2019*		1

SCORE	ENVIRONMENTAL HEALTH	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.00	Children with Low Access to a Grocery Store	*percent*	8.1				*2015*		22
2.00	Grocery Store Density	*stores/ 1,000 population*	0.1				*2016*		22
2.00	People with Low Access to a Grocery Store	*percent*	31.9				*2015*		22
2.00	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*		22
1.86	SNAP Certified Stores	*stores/ 1,000 population*	0.6				*2017*		22
1.83	Farmers Market Density	*markets/ 1,000 population*	0.02				*2018*		22
1.83	Low-Income and Low Access to a Grocery Store	*percent*	7.9				*2015*		22
1.83	People 65+ with Low Access to a Grocery Store	*percent*	3.8				*2015*		22
1.81	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.7				*2016*		22
1.75	Annual Ozone Air Quality	*grade*	F				*2017-2019*		2

SCORE	ENVIRONMENTAL HEALTH	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.64	Months of Mild Drought or Worse	*months/ year*	5				*2016*		18
1.44	Annual Particle Pollution	*grade*	B				*2017-2019*		2
1.36	Number of Extreme Heat Days	*days*	26				*2016*		18
1.36	PBT Released	*pounds*	76,567.8				*2019*		23
1.36	Severe Housing Problems	*percent*	13		12.9	18	*2013-2017*		7
1.33	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*		22
1.25	Adults with Current Asthma	*percent*	9.4			9.2	*2018*		4
1.25	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	1.2		2.4		*2014*		18
1.25	Physical Environment Ranking	*ranking*	23				*2021*		7
1.19	Daily Dose of UV Irradiance	*Joule per square meter*	2,317		2,427		*2015*		18
1.17	Access to Exercise Opportunities	*percent*	80.2		75.2	84	*2020*		7
1.17	Households with No Car and Low Access to a Grocery Store	*percent*	1.7				*2015*		22

SCORE	**ENVIRONMENTAL HEALTH**	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.08	Asthma: Medicare Population	*percent*	4.8		4.9	5	*2018*		6
1.08	Recognized Carcinogens Released into Air	*pounds*	62,968.2				*2019*		23
1.03	Liquor Store Density	*stores/ 100,000 population*	10.6		12.2	10.5	*2019*		20
1.03	Overcrowded Households	*percent of households*	1.3		1.6		*2015-2019*		1
1.00	Food Environment Index		8		7	7.8	*2021*		7
0.53	Houses Built Prior to 1950	*percent*	11.1		22.9	17.5	*2015-2019*		1

SCORE	**HEALTH CARE ACCESS & QUALITY**	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.42	Adults who have had a Routine Checkup	*percent*	76.8			76.7	*2018*		4
1.42	Clinical Care Ranking	*ranking*	39				*2021*		7
1.33	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	64.6		100.6		*2020*		7
1.25	Adults without Health Insurance	*percent*	12.4			12.2	*2018*		4
1.22	Children with Health Insurance	*percent*	95		93		*2019*		21
1.11	Primary Care Provider Rate	*providers/ 100,000 population*	63.1		66.8		*2018*		7
1.06	Adults with Health Insurance: 18-64	*percent*	91.6		88.3		*2019*		21
1.03	Persons with Health Insurance	*percent*	92.6	*92.1*	89.7		*2019*		21
0.92	Adults who Visited a Dentist	*percent*	66.7			66.5	*2018*		4
0.83	Dentist Rate	*dentists/ 100,000 population*	56.9		57.1		*2019*		7
0.67	Mental Health Provider Rate	*providers/ 100,000 population*	174.3		168.3		*2020*		7

SCORE	**HEART DISEASE & STROKE**	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.47	Atrial Fibrillation: Medicare Population	*percent*	9.3		8.5	8.4	*2018*		6
2.47	Hyperlipidemia: Medicare Population	*percent*	52.5		47.9	47.7	*2018*		6
2.31	Heart Failure: Medicare Population	*percent*	16.3		15.1	14	*2018*		6
2.25	Hypertension: Medicare Population	*percent*	61.5		59.6	57.2	*2018*		6
1.97	Ischemic Heart Disease: Medicare Population	*percent*	28.3		28.3	26.8	*2018*		6
1.86	Stroke: Medicare Population	*percent*	3.9		3.7	3.8	*2018*		6
1.75	Adults who Have Taken Medications for High Blood Pressure	*percent*	76.3			75.8	*2017*		4
1.33	High Blood Pressure Prevalence	*percent*	35	*27.7*		32.4	*2017*		4
1.28	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	34.6	*33.4*	40.3	37.2	*2017-2019*		5
1.25	Cholesterol Test History	*percent*	81			81.5	*2017*		4
1.25	High Cholesterol Prevalence: Adults 18+	*percent*	35.4			34.1	*2017*		4
1.08	Adults who Experienced Coronary Heart Disease	*percent*	7			6.8	*2018*		4

SCORE	HEART DISEASE & STROKE	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.03	Age-Adjusted Death Rate due to Heart Attack	*deaths/ 100,000 population 35+ years*	57.8		67.8		*2018*		18
0.92	Adults who Experienced a Stroke	*percent*	3.2			3.4	*2018*		4
0.39	Age-Adjusted Death Rate due to coronary heart disease	*deaths/ 100,000 population*	73.2	*71.1*	97.8	90.5	*2017-2019*		5

SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.81	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	1.7		1.4	2	*September 24, 2021*		10
1.44	Salmonella Infection Incidence Rate	*cases/ 100,000 population*	10.6	*11.1*	11.9		*2018*		13
1.31	Hepatitis C Prevalence	*Rate per 100,000 population*	54		90		*2019*		13
1.14	Chlamydia Incidence Rate	*cases/ 100,000 population*	288.6		523.9	539.9	*2018*		17
1.03	Overcrowded Households	*percent of households*	1.3		1.6		*2015-2019*		1
0.83	Persons Fully Vaccinated Against COVID-19	*percent*	50.6				*Sept. 24, 2021*		5
0.81	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	30.1		54.6	51.4	*Sept. 24, 2021*		10
0.81	Gonorrhea Incidence Rate	*cases/ 100,000 population*	44.5		182.9	179.1	*2018*		17
0.08	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	8.9		13.1	13.8	*2017-2019*		5

SCORE	**MATERNAL, FETAL & INFANT HEALTH**	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.92	Preterm Births	*percent*	10.3	*9.4*	10.1	10	*2019*		13
1.44	Mothers who Received Early Prenatal Care	*percent*	72.9		68.9	75.8	*2019*		13
1.42	Babies with Very Low Birth Weight	*percent*	1.5		1.5	1.4	*2016*	White (1.4) Hisp (4.2)	13
1.33	Infant Mortality Rate	*deaths/ 1,000 live births*	5.3	*5*	7.3	5.9	*2013-2017*		13
1.19	Mothers who Smoked During Pregnancy	*percent*	9	*4.3*	11.8	5.9	*2019*		13
0.78	Babies with Low Birth Weight	*percent*	7.1		8.2	8.3	*2019*		13
0.61	Teen Birth Rate: 15-19	*live births/ 1,000 females aged 15-19*	10.9		20.7	16.7	*2019*		13

SCORE	**MENTAL HEALTH & MENTAL DISORDERS**	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.97	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	16.9	*12.8*	15.5	14.1	*2017-2019*		5
1.75	Depression: Medicare Population	*percent*	18.8		21.1	18.4	*2018*		6
1.25	Poor Mental Health: 14+ Days	*percent*	13.5			12.7	*2018*		4
1.19	Alzheimer's Disease or Dementia: Medicare Population	*percent*	10.1		11	10.8	*2018*		6
1.17	Frequent Mental Distress	*percent*	13.9		14.7	13	*2018*		7
1.17	Poor Mental Health: Average Number of Days	*days*	4.5		4.7	4.1	*2018*		7
0.92	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	33.4		33.4	30.5	*2017-2019*		5
0.67	Mental Health Provider Rate	*providers/ 100,000 population*	174.3		168.3		*2020*		7

SCORE	**OLDER ADULTS**	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.75	Cancer: Medicare Population	*percent*	9.1		8	8.4	*2018*		6
2.47	Atrial Fibrillation: Medicare Population	*percent*	9.3		8.5	8.4	*2018*		6
2.47	Hyperlipidemia: Medicare Population	*percent*	52.5		47.9	47.7	*2018*		6
2.47	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	37.5		35	33.5	*2018*		6
2.31	Heart Failure: Medicare Population	*percent*	16.3		15.1	14	*2018*		6
2.25	Hypertension: Medicare Population	*percent*	61.5		59.6	57.2	*2018*		6
2.08	Adults 65+ who Received Recommended Preventive Services: Males	*percent*	25			32.4	*2018*		4
1.97	Chronic Kidney Disease: Medicare Population	*percent*	26.2		25.5	24.5	*2018*		6
1.97	Ischemic Heart Disease: Medicare Population	*percent*	28.3		28.3	26.8	*2018*		6
1.86	Stroke: Medicare Population	*percent*	3.9		3.7	3.8	*2018*		6
1.83	People 65+ with Low Access to a Grocery Store	*percent*	3.8				*2015*		22

SCORE	**OLDER ADULTS**	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.75	Depression: Medicare Population	*percent*	18.8		21.1	18.4	*2018*		6
1.69	COPD: Medicare Population	*percent*	14.7		14.3	11.5	*2018*		6
1.64	Osteoporosis: Medicare Population	*percent*	6.1		6.3	6.6	*2018*		6
1.58	Adults 65+ who Received Recommended Preventive Services: Females	*percent*	27			28.4	*2018*		4
1.42	Adults with Arthritis	*percent*	28.5			25.8	*2018*		4
1.33	Colon Cancer Screening	*percent*	64.6	*74.4*		66.4	*2018*		4
1.25	Adults 65+ with Total Tooth Loss	*percent*	14			13.5	*2018*		4
1.19	Alzheimer's Disease or Dementia: Medicare Population	*percent*	10.1		11	10.8	*2018*		6
1.08	Asthma: Medicare Population	*percent*	4.8		4.9	5	*2018*		6
0.92	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	33.4		33.4	30.5	*2017-2019*		5
0.86	Diabetes: Medicare Population	*percent*	26.2		27.8	27	*2018*		6

SCORE	**OLDER ADULTS**	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
0.64	People 65+ Living Below Poverty Level	*percent*	5.8		7.6	9.3	*2015-2019*	Black (5.7) White (5.6) Asian (14.9) AIAN (0) NHPI (0) Mult (30.8) Other (21.7) Hisp (7.3)	1
0.53	People 65+ Living Alone	*percent*	23.6		28	26.1	*2015-2019*		1

SCORE	ORAL HEALTH	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.31	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	14.1		12.7	11.8	*2013-2017*		15
1.25	Adults 65+ with Total Tooth Loss	*percent*	14			13.5	*2018*		4
0.92	Adults who Visited a Dentist	*percent*	66.7			66.5	*2018*		4
0.83	Dentist Rate	*dentists/ 100,000 population*	56.9		57.1		*2019*		7

SCORE	OTHER CONDITIONS	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.47	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	37.5		35	33.5	*2018*		6
1.97	Chronic Kidney Disease: Medicare Population	*percent*	26.2		25.5	24.5	*2018*		6
1.64	Osteoporosis: Medicare Population	*percent*	6.1		6.3	6.6	*2018*		6
1.47	Age-Adjusted Death Rate due to kidney disease	*deaths/ 100,000 population*	15.6		17.7	12.9	*2017-2019*		5
1.42	Adults with Arthritis	*percent*	28.5			25.8	*2018*		4
0.92	Adults with Kidney Disease	*percent of adults*	2.8			3.1	*2018*		4

SCORE	PHYSICAL ACTIVITY	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.31	Workers who Walk to Work	*percent*	1.5		2.2	2.7	*2015-2019*		1
2.00	Children with Low Access to a Grocery Store	*percent*	8.1				*2015*		22
2.00	Grocery Store Density	*stores/ 1,000 population*	0.1				*2016*		22
2.00	People with Low Access to a Grocery Store	*percent*	31.9				*2015*		22
2.00	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*		22
1.86	SNAP Certified Stores	*stores/ 1,000 population*	0.6				*2017*		22
1.83	Farmers Market Density	*markets/ 1,000 population*	0				*2018*		22
1.83	Low-Income and Low Access to a Grocery Store	*percent*	7.9				*2015*		22
1.83	People 65+ with Low Access to a Grocery Store	*percent*	3.8				*2015*		22
1.81	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.7				*2016*		22

SCORE	PHYSICAL ACTIVITY	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.33	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*		22
1.31	Adults 20+ who are Obese	*percent*	33.2	*36*			*2017*		5
1.25	Health Behaviors Ranking	*ranking*	14				*2021*		7
1.17	Access to Exercise Opportunities	*percent*	80.2		75.2	84	*2020*		7
1.17	Households with No Car and Low Access to a Grocery Store	*percent*	1.7				*2015*		22
1.03	Adults 20+ who are Sedentary	*percent*	22.4				*2017*		5
1.00	Food Environment Index		8		7	7.8	*2021*		7

SCORE	PREVENTION & SAFETY	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.69	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	24.2		25.8	21	*2017-2019*		7
1.42	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/ 100,000 population*	51.2	*43.2*	56.7	48.9	*2017-2019*		5
1.36	Pedestrian Deaths	*deaths*	2				*2014*		8
1.36	Severe Housing Problems	*percent*	13		12.9	18	*2013-2017*		7

SCORE	**RESPIRATORY DISEASES**	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.81	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	1.7		1.4	2	*Sept. 24, 2021*		10
1.69	COPD: Medicare Population	*percent*	14.7		14.3	11.5	*2018*		6
1.58	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	*deaths/ 100,000 population*	48.4		56.2	39.6	*2017-2019*		5
1.53	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	68		72.2	58.3	*2013-2017*		15
1.42	Adults who Smoke	*percent*	21.1	*5*	21.7	17	*2018*		7
1.42	Adults with COPD	*Percent of adults*	8.1			6.9	*2018*		4
1.25	Adults with Current Asthma	*percent*	9.4			9.2	*2018*		4
1.08	Asthma: Medicare Population	*percent*	4.8		4.9	5	*2018*		6
0.83	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	43.3	*25.1*	48.7	38.5	*2013-2017*		15
0.81	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	30.1		54.6	51.4	*Sept. 24, 2021*		10
0.08	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	8.9		13.1	13.8	*2017-2019*		5

SCORE	WELLNESS & LIFESTYLE	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.33	High Blood Pressure Prevalence	*percent*	35	*27.7*		32.4	*2017*		4
1.25	Morbidity Ranking	*ranking*	10				*2021*		7
1.17	Poor Physical Health: Average Number of Days	*days*	3.9		4	3.7	*2018*		7
1.03	Insufficient Sleep	*percent*	34.5	*31.4*	38	35	*2018*		7
1.00	Frequent Physical Distress	*percent*	11.5		12.3	11	*2018*		7
1.00	Self-Reported General Health Assessment: Poor or Fair	*percent*	16.6		18.2	17	*2018*		7
0.92	Poor Physical Health: 14+ Days	*percent*	12.3			12.5	*2018*		4

SCORE	WOMEN'S HEALTH	UNITS	PORTER COUNTY	*HP2030*	Indiana	US	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.39	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	23.1	*15.3*	20.8	20.1	*2013-2017*		15
1.61	Mammogram in Past 2 Years: 50-74	*percent*	70.6	*77.1*		74.8	*2018*		4
1.53	Breast Cancer Incidence Rate	*cases/ 100,000 females*	124.4		122.9	125.9	*2013-2017*		15
0.89	Cervical Cancer Screening: 21-65	*percent*	85.1	*84.3*		84.7	*2018*		4

Appendix B. Community Input Assessment Tools

Community Survey (English)

LAKE AND PORTER COUNTY COMMUNITY HEALTH NEEDS SURVEY

This community health survey is supported by the Community Foundation of Northwest Indiana (CFNI). The information collected in this survey will allow community organizations across Lake and Porter counties to better understand the health needs in our community. The knowledge gained will be used to implement programs that will benefit everyone in the community. We can better understand community needs by gathering the voices of community members like you to tell us about the issues that you feel are the most important.

Note: You must be 18 years old or older to complete this survey. We estimate that it will take 10-15 minutes to complete. Survey results will be available and shared broadly in the community within the next year. The responses that you provide will remain anonymous and not attributed to you personally in any way. Your participation in this survey is completely voluntary. If you have any questions, please contact Eileen Aguilar by email at eileen.aguilar@conduent.com. Thank you very much for your input and your time!

I. Please answer a few questions about yourself so that we can see how different types of people feel about local health issues.

Q1. What county do you live in?

- ❍ Lake County
- ❍ Porter County

Q2. What is your 5-digit zip code?

Q3. Are you of Hispanic or Latino origin or descent? Select one.

- ❍ Hispanic/Latino/Latinx
- ❍ Non-Hispanic/Latino/Latinx
- ❍ Prefer not to answer

Q4. Which of the following best describes you? Select one.

- ❍ American Indian or Alaskan Native
- ❍ Asian or Asian American
- ❍ Black or African American
- ❍ Native Hawaiian or other Pacific Islander
- ❍ White or Caucasian
- ❍ Two or more races
- ❍ Some other race
- ❍ Prefer not to answer

Q5. What is your age? Select one.

- ❍ Under 18
- ❍ 18-20
- ❍ 21-24
- ❍ 25-34
- ❍ 35-44
- ❍ 45-54
- ❍ 55-64
- ❍ 65-74
- ❍ 75-84
- ❍ 85 or older
- ❍ Prefer not to answer

Q6. To which gender identity do you most identify? Select one.

- ❍ Female
- ❍ Male
- ❍ Transgender Female
- ❍ Transgender Male
- ❍ Gender Non-Conforming
- ❍ Prefer not to answer
- ❍ Other identification

If you feel comfortable doing so, please indicate what other gender identity you most identity with:

Q7. Please consider sharing your sexual orientation with us. Do you think of yourself as (select one):

- ❍ Straight (not lesbian or gay)
- ❍ Gay
- ❍ Lesbian
- ❍ Bisexual
- ❍ Pansexual
- ❍ Queer
- ❍ I don't know
- ❍ Prefer not to answer
- ❍ Other identification

If you feel comfortable doing so, please indicate what other sexual orientation you think of yourself as:

Q8. What is the highest level of education you have completed? Select one.

- ❍ Did not attend school
- ❍ Less than 9th Grade
- ❍ Some High School, No Diploma
- ❍ High School Graduate
- ❍ Technical/Vocational School Certificate
- ❍ Community College Degree
- ❍ Some college, No Degree
- ❍ Associate degree

- ❍ Bachelor's Degree
- ❍ Master's Degree
- ❍ Professional Degree
- ❍ Doctorate Degree

Q9. How much total combined money did all members of your household earn in the previous year? Select one.

- ❍ Less than $15,000
- ❍ $15,000 to $24,999
- ❍ $25,000 to $34,999
- ❍ $35,000 to $49,999
- ❍ $50,000 to $74,999
- ❍ $75,000 to $99,999
- ❍ $100,000 to $124,999
- ❍ $125,000 to $149,999
- ❍ $150,000 to $199,999
- ❍ $200,000 to $249,999
- ❍ $250,000 to $499,999
- ❍ $500,000 or more
- ❍ Prefer not to answer

Q10. What language do you mainly speak at home? Select one.

- ❍ Speak English
- ❍ Speak Spanish
- ❍ Some other language (please specify) _____

Q11. Do you identify with any of the following statements? Select all that apply.

- ❍ I have a disability
- ❍ I am active-duty Military
- ❍ I am retired Military
- ❍ I am a Veteran
- ❍ I am an immigrant or refugee
- ❍ Prefer not to answer
- ❍ Does not apply

Q12. Which of the following best describes your current housing situation?

- ❍ Homeowner
- ❍ Renter
- ❍ Living with others but not paying rent or mortgage
- ❍ Living with other and assisting with paying rent or mortgage
- ❍ I do not identify with any of these.

Q13. Including yourself, how many people currently live in your household?

- ❍ 1
- ❍ 2
- ❍ 3
- ❍ 4
- ❍ 5
- ❍ 6 or more (Please specify a number) _____

II. In this survey, "community" refers to the major areas where you live, shop, play, work, and get services.

Q14. How would you rate your community as a healthy place to live? Select one.

- ❍ Very Healthy
- ❍ Healthy
- ❍ Somewhat Healthy
- ❍ Unhealthy
- ❍ Very Unhealthy

Q15. In the following list, what do you think are the three most important "health problems" in your community? (Those problems that have the greatest impact on overall community health.) <u>Select up to 3.</u>

____ Access to Affordable Healthcare Services (doctors available nearby, wait times, services available nearby, takes insurance)

____ Adolescent /Teen Health

____ Alcohol and Drug Use

____ Autoimmune Diseases (Multiple Sclerosis, Crohn's Disease, etc.)

____ Cancer

____ Children's Health

____ Chronic Pain

____ Diabetes

____ Family Planning Services (birth control)

____ Heart Disease

_____Hypertension/High Blood Pressure

_____Stroke

____ Injury and Violence

____ Maternal and Infant Health

____Men's Health (ex: prostate exam, prostate health)

____ Mental Health/ Disorders (anxiety, depression, suicide)

____ Nutrition and Healthy Eating

____ Older Adult's Health (hearing/vision loss, arthritis, etc.)

____ Oral Health and Access to Dentistry Services (dentists available nearby)

____ People Living with Disabilities

____ Physical Activity

____ Respiratory/Lung Diseases (asthma, COPD, etc.)

____ Sexually Transmitted Diseases/Infections (STDs/STIs)

____ Tobacco Use (including e-cigarettes, chewing tobacco, etc.)

____ Weight Status (Individuals who are underweight, overweight, or obese)

____ Women's Health

____ Other (please specify)

____ Quality of Healthcare Services Available

Q16. In your opinion, which of the following would you most like to see addressed in your community? <u>Select up to 3.</u>

____ Access to Higher Education (2-year or 4-year degrees)

____ Air and Water Quality

____ Accessible sidewalks and other structures for those living with disabilities

____ Ability to access safe parks and walking paths

____ Bike Lanes

____ Crime and Crime Prevention (robberies, shootings, other violent crimes)

____ Discrimination or Inequity based on race/ethnicity, gender, age, sex

____ Domestic Violence and Abuse (intimate partner, family, or child abuse)

____ Economy and Job Availability

____ Education and Schools (Pre-K to 12th grade)

____ Emergency Preparedness

____ Inequity in jobs, health, housing etc. for underserved populations

____Food Insecurity or Hunger

____ Healthy Eating (restaurants, stores, or markets)

____ Homelessness and Unstable Housing

____ Injury Prevention (traffic safety, drownings, bicycling and pedestrian accidents)

____ Neighborhood Safety

____ Persons who've experienced physical and/or emotional trauma

____ Safe Air and Water Quality

____ Safe Housing

____ Services for Seniors/Elderly (those over 65)

____ Social Isolation/Feeling Lonely

____ Support for families with children (childcare, parenting support)

____ Transportation

____ Other (please specify)
_____

Q17. Below are some statements about healthcare services in your community. Please rate how much you agree or disagree with each statement. <u>Place an X for your response in each row below.</u>

	Strongly Agree	Agree	Disagree	Strongly Disagree
There are quality healthcare services in my community.				
There are affordable health care services in my community.				
I am connected to a primary care doctor or health clinic that I am happy with				
I can access the health care services that I need within a reasonable time frame and distance from my home or work				
I know where to find the healthcare resources or information when I need them				
Individuals in my community can access healthcare services regardless of race, gender, sexual orientation, immigration status, etc.				

Q18. Where do you get most of your health information? (Check all that apply).

- ❍ Non-Profit Organizations/Agencies in your community
- ❍ Doctor or healthcare provider
- ❍ Facebook, Instagram, or Twitter
- ❍ Other social media
- ❍ Family or friends
- ❍ Health Department
- ❍ Hospital
- ❍ Internet
- ❍ Library
- ❍ Newspaper/Magazine
- ❍ Radio
- ❍ Church or church group
- ❍ School or college
- ❍ TV
- ❍ Workplace
- ❍ Other (please specify) _____
- ❍ Other social media, different than listed above (please specify) _____

Q19. How would you rate your own personal health in the past 12 months? Select one.

- ❍ Very Healthy
- ❍ Healthy
- ❍ Somewhat Healthy
- ❍ Unhealthy
- ❍ Very Unhealthy

Q20. Do you currently have a health insurance plan/health coverage? Select one.

- ❍ Yes – PLEASE ANSWER Q21 NEXT
- ❍ No – SKIP TO Q22
- ❍ I don't know – SKIP TO Q22

Q21. Which type(s) of health plan(s) do you use to pay for your health care services? Select all that apply.

- ❍ Medicaid
- ❍ Medicare
- ❍ Insurance through an employer (HMO/PPO) - either my own or partner/spouse/parent
- ❍ Insurance through the Health Insurance Marketplace/Obama Care/Affordable Care Act (ACA)
- ❍ Private Insurance I pay for myself (HMO/PPO)
- ❍ Indian Health Services
- ❍ Veteran's Administration
- ❍ COBRA
- ❍ I pay out of pocket/cash
- ❍ Some other way (please specify) _____

Q22. In the past 12 months, was there a time that you needed health care services but did not get the care that you needed? Select one.

- ❍ Yes – PLEASE ANSWER Q23 NEXT
- ❍ No, I got the services that I needed – SKIP TO Q24
- ❍ Does not apply, I did not need health care services in the past year – SKIP TO Q24

Q23. Select the top reason(s) that you did not receive the health care services that you needed in the past 12 months. Select all that apply.

- ❍ Cost - too expensive/can't pay
- ❍ No insurance
- ❍ Insurance not accepted
- ❍ Lack of personal transportation
- ❍ Lack of transportation due to bus schedule and/or drop-off location
- ❍ Hours of operation did not fit my schedule
- ❍ Childcare was not available
- ❍ Wait is too long
- ❍ No doctor is nearby
- ❍ I did not know where to go
- ❍ Office/service/program has limited access or is closed due to COVID-19
- ❍ Language barrier
- ❍ Cultural/religious reasons
- ❍ Lack of trust in healthcare services and/or providers
- ❍ Previous negative experience receiving care or services
- ❍ Lack of providers that I identify with (race, ethnicity, gender)
- ❍ Lack of providers with training specific to my needs
- ❍ Other (please specify) _____

Q24. In the past 12 months, was there a time that you needed dental or oral health services but did not get the care that you needed? Select one.

- ❍ Yes – PLEASE ANSWER Q25
- ❍ No, I got the services that I needed – SKIP TO Q26
- ❍ Does not apply, I did not need dental/oral health services in the past year – SKIP TO Q26

Q25. Select the top reason(s) that you did not receive the dental or oral health services that you needed in the past 12 months. Select all that apply.

- ❍ Cost - too expensive/can't pay
- ❍ No insurance
- ❍ Insurance not accepted
- ❍ Lack of personal transportation
- ❍ Lack of transportation due to bus schedule and/or drop-off location
- ❍ Hours of operation did not fit my schedule
- ❍ Childcare was not available
- ❍ Wait is too long
- ❍ No doctor is nearby
- ❍ I did not know where to go
- ❍ Office/service/program has limited access or is closed due to COVID-19
- ❍ Language barrier

- ❍ Cultural/religious reasons
- ❍ Lack of trust in healthcare services and/or providers
- ❍ Previous negative experience receiving care or services
- ❍ Lack of providers that I identify with (race, ethnicity, gender) or have training specific to my needs
- ❍ Other (please specify) _____

Q26. In the past 12 months, was there a time that you needed or considered seeking mental health services or alcohol/substance abuse treatment but did not get services? Select one.

- ❍ Yes – PLEASE ANSWER Q27
- ❍ No, I got the services that I needed – SKIP TO Q28
- ❍ Does not apply, I did not need services in the past year – SKIP TO Q28

Q27. Select the top reason(s) that you did not receive mental health services or alcohol/substance use treatment. Select all that apply.

- ❍ Cost - too expensive/can't pay
- ❍ No insurance
- ❍ Insurance not accepted
- ❍ Lack of personal transportation
- ❍ Lack of transportation due to bus schedule and/or drop-off location
- ❍ Hours of operation did not fit my schedule
- ❍ Childcare was not available
- ❍ Wait is too long
- ❍ No doctor is nearby
- ❍ I did not know where to go
- ❍ Office/service/program has limited access or is closed due to COVID-19
- ❍ Language barrier
- ❍ I did not know how treatment would work
- ❍ I worried that others would judge me
- ❍ Cultural/religious reasons
- ❍ Lack of trust in healthcare services and/or providers
- ❍ Previous negative experience receiving care or services
- ❍ Lack of providers that I identify with (race, ethnicity, gender) or have training specific to my needs
- ❍ Other (please specify) _____

Q28. In the past 12 months, did you go to a hospital Emergency Department (ED)? Select one.

- ❍ Yes – PLEASE ANSWER Q29 AND Q30
- ❍ No, I have not gone to the hospital ED – SKIP TO Q31

Q29. Please select the number of times you have gone to the ED in the past 12 months. Select one.

- ❍ 1
- ❍ 2
- ❍ 3
- ❍ 4
- ❍ 5
- ❍ 6 or more

Q30. What were the main reasons that you went to the ED instead of a doctor's office or clinic? Select any that apply.

- ❍ After clinic hours/weekend
- ❍ I don't have a regular doctor/clinic
- ❍ I do not have health insurance
- ❍ I feel more comfortable accessing care in the ED instead of a doctor's office or clinic
- ❍ Concerns about cost or co-pays
- ❍ Emergency/Life-threatening situation
- ❍ Long wait for an appointment with my regular doctor
- ❍ Needed food, shelter, or other resources
- ❍ No Urgent or Immediate Care available near me
- ❍ My doctor (or another provider) told me to go
- ❍ Other (please specify) _____

III. If there are any children under 18 that live in your home, please answer Q31 through Q36. If there are NOT any children under 18 that live in your home, please skip to Q37.

Q31. How many children (under age 18) currently live in your home? Select one.

- ❍ 1
- ❍ 2
- ❍ 3
- ❍ 4
- ❍ 5
- ❍ 6 or more
- ❍ None

Q32. Which type(s) of health plans(s) do children in your home have to cover the costs of health care services? Select all that apply.

- ❍ Medicaid/Children's Health Insurance Program (CHIP)
- ❍ Insurance through an employer (HMO/PPO) - either my own or partner/spouse
- ❍ Insurance through the Health Insurance Marketplace/Obama Care/Affordable Care Act (ACA)
- ❍ Private Insurance I pay for myself (HMO/PPO)
- ❍ Indian Health Services
- ❍ Veteran's Administration
- ❍ COBRA
- ❍ I pay out of pocket/cash
- ❍ Other (please specify) _____

Q33. Have the children (under 18) in your home experienced any of the following health issues? Select all that apply.

____ No, the child/children have not faced any health issues

____ Childhood Disabilities/Special Needs

____ Allergies

____ Asthma

____ Autoimmune diseases

____ Behavior Challenges/Mental Health

____ Birth-Related (ex. low birth weight, premature, prenatal)

____ Cancer

____ Child abuse/Child neglect

____ Child/Children Overweight

____ Child/Children Underweight

____ Diabetes/Pre-diabetes/High blood sugar

____ Drug or alcohol use

____ Hearing and /or vision

____ Injuries or accidents that required immediate medical care (ex. sports injuries, bicycle accidents)

____ Heart Disease or other Heart Conditions

____ Nervous system disorders

____ Sexually Transmitted Disease

____ Stroke

____ Teen pregnancy

____ Using Tobacco, e-cigarettes, or vaping

____ Other (please specify) _____

Q34. In the past 12 months, was there a time when children in your home needed medical care or other health related services but did not get the services that they needed? Select one.

- ❍ Yes – PLEASE ANSWER Q35 AND Q36
- ❍ No, they got the services that they needed – SKIP TO Q37
- ❍ Does not apply, the child/children did not need services – SKIP TO Q37

Q35. Which of the following services were the children in your home not able to get in the past 12 months when they needed them? Select all that apply.

- ❍ Alcohol or other substance abuse treatment
- ❍ Dental care (routine cleaning or urgent care)
- ❍ Emergency care services
- ❍ Mental health services
- ❍ Nutrition services
- ❍ Prescription medications
- ❍ Routine care/treatment for ongoing or chronic condition – ex. allergies, respiratory conditions, diabetes
- ❍ Scheduled vaccination(s)
- ❍ Services for Special Needs
- ❍ Sick visit/urgent care visit
- ❍ Well child visit/check-up
- ❍ Other (please specify) _____

Q36. Select the top reason(s) that children in your home did not get the medical/health care services that they needed in the past 12 months. Select all that apply.

- ❍ Cost - too expensive/can't pay
- ❍ No insurance
- ❍ Insurance not accepted
- ❍ Lack of personal transportation
- ❍ Lack of transportation due to bus schedule and/or drop-off location
- ❍ Hours of operation did not fit my schedule
- ❍ Childcare was not available
- ❍ Wait is too long
- ❍ No doctor is nearby
- ❍ I did not know where to go
- ❍ Office/service/program has limited access or is closed due to COVID-19
- ❍ Language barrier
- ❍ Cultural/religious reasons
- ❍ Lack of trust in healthcare services and/or providers
- ❍ Previous negative experience receiving care or services
- ❍ Lack of providers that I identify with (race, ethnicity, gender)
- ❍ Lack of providers with training specific to my needs
- ❍ Other (please specify) _____

IV. This section of the survey asks you to reflect on employment, education, and other resources in your community.

Q37. Below are some statements about employment and education in your community. Please rate how much you agree or disagree with each statement. <u>Place an X for your response in each row below.</u>

	Strongly Agree	Agree	Disagree	Strongly Disagree
There are plenty of jobs available for those who are over 18 years old				
There are plenty of jobs available for those who are 14 to 18 years old				
There are job trainings or employment resources for those who need them				
There are resources for individuals in my community to start a business (financing, training, real estate, etc.)				
Childcare (daycare/pre- school) resources are affordable and available for those who need them				
The K-12 schools in my community are well funded and provide good quality education				
Our local University/Community College provides quality education at an affordable cost				

Q38. Which is your current employment status? Select one.

- ❍ Employed, working full-time – SKIP TO Q40
- ❍ Employed, working part-time – SKIP TO Q40
- ❍ Not working my choice – SKIP TO 40
- ❍ Out of work, looking for work – PLEASE ANSWER Q39
- ❍ Out of work, but NOT currently looking for work – SKIP TO Q40
- ❍ A student – SKIP TO 40
- ❍ Retired – SKIP TO 40
- ❍ Unable to work – PLEASE ANSWER Q39

Q39. Do any of the following reasons make it difficult for you to find or keep a job? Select any that apply.

- ❍ Attending school
- ❍ Available jobs do not pay a wage that allows me to care for myself and my family
- ❍ Cannot find childcare
- ❍ Cost of childcare is too high
- ❍ Caregiver for a family member
- ❍ Full time work is too much
- ❍ Part time work is not enough
- ❍ Furloughed or temporarily unemployed
- ❍ Shifts do not work with my schedule
- ❍ Lack of transportation
- ❍ Positive drug test/drug screen
- ❍ Criminal history
- ❍ Under 18 years old
- ❍ Have not received my high school diploma or GED
- ❍ Physically disabled
- ❍ I did not have a fair chance to get a job
- ❍ Other (please specify) _____

Q40. Below are some statements about housing, transportation, and safety in your community. Please rate how much you agree or disagree with each statement. <u>Place an X for your response in each row below.</u>

	Strongly Agree	Agree	Disagree	Strongly Disagree
There are affordable places to live in my community				
Streets in my community are typically clean and buildings are well maintained				
I feel safe in my own neighborhood				
Crime is not a major issue in my neighborhood				
There is a feeling of trust in law enforcement in my community				
Transportation is easy to get to if I need it				

Q41. What transportation do you use most often to go places? Select one.

- ❍ Drove my own car
- ❍ Hitchhike
- ❍ Walk
- ❍ Ride a bicycle
- ❍ Ride a motorcycle or scooter
- ❍ Take a bus
- ❍ Take a taxi or ride share service (Uber/Lyft)
- ❍ Use medical transportation/specialty van transport
- ❍ Use senior transportation
- ❍ Someone drives me
- ❍ Other (please specify) _____

Q42. Which of the following categories best reflects your current living situation? Select one.

- ❍ Live alone in a home (house, apartment, condo, trailer, etc.)
- ❍ Live in a home with another person such as a partner, sibling(s), or roommate(s)
- ❍ Live-in single-family home that includes a spouse or partner AND a child/children under age 25
- ❍ Live in a multi-generational home (home includes grand-parents or adult children over age 25)
- ❍ Multi-family home (more than one family lives in the home)
- ❍ Assisted living
- ❍ Adult foster care
- ❍ Long-term care/nursing home
- ❍ Temporarily staying with a relative or friend
- ❍ Staying in a shelter or are homeless (living on the street)
- ❍ Living in a tent, recreational vehicle (RV)
- ❍ Hotel/motel (long-term stay)
- ❍ Other _____

Q43. Does your current housing situation meet your needs? Select one.

- ❍ Yes – PLEASE ANSWER Q44

- ❍ No – SKIP TO Q45

Q44. What issues do you have with your current housing situation? Select all that apply.

- ❍ Eviction concerns (prior, current, or potential)
- ❍ Current housing is temporary, need permanent housing
- ❍ Mortgage is too expensive
- ❍ Need assisted living or long-term care
- ❍ Rent/facility is too expensive
- ❍ Too far from town/services
- ❍ To run down or unhealthy environment (ex. mold, lead)
- ❍ Too small/crowded, problems with other people
- ❍ Unsafe, high crime
- ❍ None of the above
- ❍ Other (please specify) _____

Q45. In the past 2 years, was there a time when you (and your family) were living on the street, in a car, or in a temporary shelter? Select one.

- ❍ Yes, 1 or 2 times in the past 2 years
- ❍ Yes, 3 or more times in the past 2 years
- ❍ No

Q46. In the past 12 months, has the utility company shut off your service for not paying your bills? Select one.

- ❍ Yes
- ❍ No
- ❍ Does not apply – I am not responsible for utility bills

Q47. Are you worried or concerned that in the next 2 months you (and your family) may not have stable housing that you own, rent, or stay in as part of a household? Select one.

- ❍ Yes
- ❍ No

Q48. Below are some statements about access to food and resources in your community. Please rate how much you agree or disagree with each statement. Place an X for your response in each row below.

	Strongly Agree	Agree	Disagree	Strongly Disagree
I am not able to make my own food				
I can get to a grocery store when I need food or other household supplies				
Affordable healthy food options are easy to purchase at nearby grocery stores or farmer's markets				
In my neighborhood it is easy to grow/harvest and eat fresh food from a home garden				
Local restaurants serve healthy food options				
We have good parks and recreational facilities				
There are good sidewalks or trails for walking safely				
It is easy for people to get around regardless of abilities				
Air and water quality are good in my community				

Q49. In the past 12 months, did you worry about whether your food would run out before you got money to buy more? Select one.

- ❍ Often
- ❍ Sometimes
- ❍ Never

Q50. In the past 12 months, was there a time when the food that you bought just did not last, and you did not have money to get more? Select one.

- ❍ Often
- ❍ Sometimes
- ❍ Never

Q51. In the past 12 months, did you or someone living in your home receive emergency food from a church, a food pantry, or a food bank, or eat in a soup kitchen? Select one.

- ❍ Often
- ❍ Sometimes
- ❍ Never

V. During this time, we understand that COVID-19 has impacted everyone's lives, directly and indirectly. We would like to know how these events have impacted you and your household to better understand how our community has been affected overall.

REMINDER: This is an anonymous survey. If you or anyone in your household has questions or concerns related to COVID-19, information is available at **Indiana State Department of Health https://www.coronavirus.in.gov/**. If you need assistance finding local resources and support services, please call 211.

Q52. We know the COVID-19 pandemic is challenging in many ways. Please select from the following list the issues that are the biggest challenge for your household right now. <u>Select all that apply.</u>

____ Access to basic medical care
____ Access to emergency medical services
____ Access to prescription medications
____ A shortage of food
____ A shortage of healthy food choices
____ A shortage of sanitation and cleaning supplies (e.g., toilet paper, disinfectants, etc.)
____ Challenges for my children attending school (in person or virtually)
____ Experience housing challenges or homelessness
____ Feeling alone/isolated, not being able to socialize with other people
____ Feeling nervous, anxious, or on edge
____ Household members not getting along
____ Household member(s) have or have had COVID-19 or COVID-like symptoms (fever, shortness of breath, dry cough)
____ Lack of technology to communicate with people outside of my household, access virtual school, or work remotely from home (e.g., internet access, computer, tablet, etc.)
____ Lack of skills to use technology to communicate, access virtual school, or work remotely from home
____ Not being able to exercise
____ Not knowing when the pandemic will end/not feeling in control
____ Options for childcare services/lack of childcare support
____ Unable to find work
____ None of the following apply
____ Other (please specify)
_____

Q53. What is your COVID-19 Vaccine status?

- ❍ I am vaccinated
- ❍ I plan to get vaccinated - PLEASE ANSWER Q54
- ❍ I do not plan to get vaccinated – SKIP to Q55

Q54. If you are planning to get vaccinated, are any of the following contributing to the delay in your vaccine? Select all that apply.

- ❍ No challenges, I have just not scheduled my appointment
- ❍ Uncertain about the safety or side effects of the vaccine
- ❍ Challenges getting a vaccine appointment
- ❍ Lack of transportation
- ❍ Not able to take off work for an appointment
- ❍ Language barrier
- ❍ Wait is too long
- ❍ No vaccine site is nearby
- ❍ Other (please specify) _____

Q55. If you do not plan to get vaccinated, help us understand why:

- ❍ I do not believe the vaccine is safe for me
- ❍ I have a pre-existing condition that makes me ineligible
- ❍ Cultural or religious reasons
- ❍ Other_____

Thank you for taking the time to participate in this community survey. Your feedback and insight are vital as we work to improve and address issues impacting our community's health.

END OF SURVEY

Community Survey (Spanish)

ENCUESTA DE SALUD COMUNITARIA DEL CONDADO DE LAKE Y PORTER

Esta encuesta de salud comunitaria cuenta con el apoyo de Community Foundation of Northwest Indiana (CFNI). La información recopilada en esta encuesta permitirá a las organizaciones comunitarias de los condados de Lake y Porter comprender mejor las necesidades sanitarias de su comunidad. La información obtenida se utilizará para poner en marcha programas que beneficien a todos los miembros de la comunidad. Podemos entender mejor las necesidades de la comunidad si recurrimos a las voces de los miembros de la misma como usted para que nos hablen de los temas que consideran más importantes.

Nota: Debe tener 18 años o más para completar esta encuesta. Calculamos que le llevará 10 o 15 minutos completarla. Los resultados de la encuesta estarán disponibles y se compartirán de forma generalizada en la comunidad durante el próximo año. Las respuestas que proporcione serán anónimas y no se le atribuirán personalmente de ninguna manera. Su participación en esta encuesta es completamente voluntaria. Si tiene alguna pregunta, comuníquese con Eileen Aguilar por correo electrónico a eileen.aguilar@conduent.com. Muchas gracias por su contribución y su tiempo.

I. Responda algunas preguntas sobre usted para que podamos ver cómo se sienten los diferentes tipos de personas sobre los asuntos de salud local.

P1. ¿En qué condado vive?

- ❍ Condado de Lake
- ❍ Condado de Porter

P2. ¿Cuál es su código postal de 5 dígitos?

P3. ¿Es usted de origen o ascendencia hispana o latina? Seleccione una opción.

- ❍ Hispano/latino/latinx
- ❍ No hispano/latino/latinx
- ❍ Prefiero no contestar

P4. ¿Cuál de las siguientes opciones le describe mejor? Seleccione una opción.

- ❍ Indígena americano o nativo de Alaska
- ❍ Asiático o asiático-americano
- ❍ Negro o afroamericano
- ❍ Nativo de Hawái o de otras islas del Pacífico
- ❍ Blanco o caucásico
- ❍ Dos o más razas
- ❍ Alguna otra raza
- ❍ Prefiero no contestar

P5. ¿Qué edad tiene? Seleccione una opción.

- ❍ Menor de 18 años
- ❍ 18-20
- ❍ 21-24
- ❍ 25-34
- ❍ 35-44
- ❍ 45-54
- ❍ 55-64
- ❍ 65-74
- ❍ 75-84
- ❍ 85 años o más
- ❍ Prefiero no contestar

P6. ¿Con qué identidad de género se identifica más? Seleccione una opción.

- ❍ Mujer
- ❍ Hombre
- ❍ Mujer transgénero
- ❍ Hombre transgénero
- ❍ No conforme con el género
- ❍ Prefiero no contestar
- ❍ Otra identificación

Si le resulta cómodo, indique con qué otra identidad de género se identifica más:

P7. Considere compartir su orientación sexual con nosotros. Se considera a sí mismo como (seleccione una opción):

- ❍ Heterosexual (ni lesbiana ni gay)
- ❍ Gay
- ❍ Lesbiana
- ❍ Bisexual
- ❍ Pansexual
- ❍ Queer
- ❍ No sé
- ❍ Prefiero no contestar
- ❍ Otra identificación

Si le resulta cómodo, indique con qué otra orientación sexual se identifica:

P8. ¿Cuál es el nivel más alto de educación que ha completado? Seleccione una opción.

- ❍ No asistió a la escuela
- ❍ Menos del 9.° grado
- ❍ Algunos estudios secundarios, sin diploma
- ❍ Graduado de la escuela secundaria
- ❍ Certificado de escuela técnica / vocacional
- ❍ Título de colegio comunitario
- ❍ Un período de universidad, sin título
- ❍ Grado universitario intermedio
- ❍ Título de grado
- ❍ Maestría
- ❍ Título profesional
- ❍ Doctorado

P9. ¿Cuánto dinero en total ganaron todos los miembros de su hogar en el año anterior? Seleccione una opción.

- ❍ Menos de $15.000
- ❍ $15.000 a $24.999
- ❍ $25.000 a $34.999
- ❍ $35.000 a $49.999
- ❍ $50.000 a $74.999
- ❍ $75.000 a $99.999
- ❍ $100.000 a $124.999
- ❍ $125.000 a $149.999
- ❍ $150.000 a $199.999
- ❍ $200.000 a $249.999
- ❍ $250.000 a $499.999
- ❍ $500.000 o más
- ❍ Prefiero no contestar

P10. ¿Qué idioma habla principalmente en su hogar? Seleccione una opción.

- ❍ Habla inglés
- ❍ Habla español
- ❍ Algún otro idioma (especifique)_____

P11. ¿Se identifica con alguna de las siguientes afirmaciones? Seleccione todas las opciones que correspondan.

- ❍ Tengo una discapacidad
- ❍ Soy militar en servicio activo
- ❍ Soy militar retirado
- ❍ Soy un veterano
- ❍ Soy inmigrante o refugiado
- ❍ Prefiero no contestar
- ❍ No aplica

P12. ¿Cuál de las siguientes opciones describe mejor su situación habitacional actual?

- ❍ Propietario
- ❍ Inquilino
- ❍ Vive con otras personas pero no paga el alquiler o la hipoteca
- ❍ Vive con otras personas y ayuda a pagar el alquiler o la hipoteca
- ❍ No me identifico con ninguno de estos.

P13. Con usted incluido, ¿cuántas personas viven actualmente en su hogar?

- ❍ 1
- ❍ 2
- ❍ 3
- ❍ 4
- ❍ 5
- ❍ 6 o más (especifique un número) _____

II. En esta encuesta, el término "comunidad" se refiere a las principales zonas donde vive, compra, juega, trabaja y obtiene servicios.

P14. ¿Cómo calificaría a su comunidad en cuanto a un lugar saludable para vivir? Seleccione una opción.

- ❍ Muy saludable
- ❍ Saludable
- ❍ Algo saludable
- ❍ Poco saludable
- ❍ Muy poco saludable

P15. En la siguiente lista, ¿cuáles cree que son los tres "problemas de salud" más importantes en su comunidad? (Aquellos problemas que tienen mayor impacto en la salud general de la comunidad). <u>Seleccione hasta 3.</u>

____ Acceso a servicios de atención médica económicos (médicos disponibles en las cercanías, tiempos de espera, servicios disponibles en las cercanías, aceptación de seguros)

____ Salud de los adolescentes

____ Consumo de alcohol y drogas

____ Enfermedades autoinmunes (esclerosis múltiple, enfermedad de Crohn, etc.)

____ Cáncer

____ Salud infantil

____ Dolor crónico

____ Diabetes

____ Servicios de planificación familiar (métodos anticonceptivos)

____ Enfermedad cardíaca

_____Hipertensión/Presión arterial alta

____ Accidente cerebrovascular

____ Lesiones y violencia

____ Salud maternoinfantil

____ Salud del hombre (por ejemplo: examen de próstata, salud de la próstata)

____ Salud/trastornos mentales (ansiedad, depresión, suicidio)

____ Nutrición y alimentación saludable

____ Salud de los adultos mayores (pérdida de audición/visión, artritis, etc.)

____ Salud oral y acceso a servicios de odontología (odontólogos disponibles en las cercanías)

____ Personas que viven con discapacidades

____ Actividad física

____ Calidad de los servicios de atención médica disponibles

____ Enfermedades respiratorias/pulmonares (asma, EPOC, etc.)

____ Enfermedades/infecciones de transmisión sexual (ETS/ITS)

____ Consumo de tabaco (incluidos los cigarrillos electrónicos, el tabaco para masticar, etc.)

____ Estado de peso (personas con bajo peso, sobrepeso u obesidad)

____ Salud de la mujer

____ Otros (especifique)

P16. En su opinión, ¿cuál de los siguientes aspectos le gustaría más que se abordara en su comunidad? <u>Seleccione hasta 3.</u>

____ Acceso a la educación superior (títulos de 2 o 4 años)

____ Calidad del aire y del agua

____ Aceras y otras estructuras accesibles para las personas que viven con discapacidades

____ Posibilidad de acceder a parques seguros y senderos para caminar

____ Carriles para bicicletas

____ Delincuencia y prevención del delito (robos, tiroteos, otros delitos violentos)

____ Discriminación o desigualdad por motivos de raza/etnia, género, edad o sexo

____ Violencia doméstica y abuso (abuso de la pareja, de la familia o de los niños)

____ Economía y disponibilidad de empleo

____ Educación y escuelas (de preescolar a 12.º grado)

____ Preparación ante emergencias

____ Inequidad en el empleo, la salud, la vivienda, etc. para las poblaciones desatendidas

____ Inseguridad alimentaria o hambre

____ Alimentación saludable (restaurantes, tiendas o mercados)

____ Personas sin hogar y viviendas inestables

____ Prevención de lesiones (seguridad vial, ahogamientos, accidentes de ciclistas y peatones)

____ Seguridad en el vecindario

____ Personas que han sufrido traumas físicos o emocionales

____ Calidad segura del aire y del agua

____ Vivienda segura

____ Servicios para la tercera edad (mayores de 65 años)

____ Aislamiento social/sentimiento de soledad

____ Apoyo a las familias con hijos (guardería, apoyo a la crianza)

____ Transporte

____ Otro (especifique) _____

P17. A continuación, encontrará algunas afirmaciones sobre los servicios de atención médica en su comunidad. Califique en qué medida está de acuerdo o en desacuerdo con cada afirmación. Coloque una X para su respuesta en cada fila a continuación.

	Totalmente de acuerdo	De acuerdo	En desacuerdo	Totalmente en desacuerdo
Hay servicios de atención médica de calidad en mi comunidad.				
Hay servicios de atención médica económicos en mi comunidad.				
Estoy en contacto con un médico de atención primaria o a una clínica de salud con la que estoy conforme				
Puedo acceder a los servicios de atención médica que necesito en un plazo y a una distancia razonables de mi casa o trabajo				
Sé dónde encontrar los recursos médicos o la información sobre atención médica cuando los necesito				
Las personas de mi comunidad pueden acceder a los servicios de atención médica independientemente de su raza, sexo, orientación sexual, condición de inmigrante, etc.				

P18. ¿De dónde obtiene la mayor parte de la información sobre salud? (Marque todas las opciones que correspondan).

- ❍ Organizaciones/organismos sin fines de lucro en su comunidad
- ❍ Médico o proveedor de atención médica
- ❍ Facebook, Instagram o Twitter
- ❍ Otras redes sociales
- ❍ Familiares o amigos
- ❍ Departamento de salud
- ❍ Hospital
- ❍ Internet
- ❍ Biblioteca
- ❍ Periódico/revista
- ❍ Radio
- ❍ Iglesia o grupo religioso
- ❍ Escuela o colegio
- ❍ Televisión
- ❍ Lugar de trabajo
- ❍ Otro (especifique) _____
- ❍ Otras redes sociales, diferentes de las enumeradas anteriormente (especifique) _____

P19. ¿Cómo calificaría su propia salud personal en los últimos 12 meses? Seleccione una opción.

- ❍ Muy saludable
- ❍ Saludable
- ❍ Algo saludable
- ❍ Poco saludable
- ❍ Muy poco saludable

P20. ¿Tiene actualmente un plan de seguro médico/cobertura médica? Seleccione una opción.

- ❍ Sí. RESPONDA LA P21 A CONTINUACIÓN
- ❍ No. PASE A LA P22
- ❍ No sé. PASE A LA P22

P21. ¿Qué tipo de plan(es) de salud utiliza para pagar sus servicios de atención médica? Seleccione todas las opciones que correspondan.

- ❍ Medicaid
- ❍ Medicare
- ❍ Seguro a través de un empleador (HMO/PPO); ya sea el mío propio o el de mi pareja/cónyuge/padre/madre
- ❍ Seguro a través del mercado de seguros de salud/Obama Care/Ley de Cuidado de Salud a Bajo Precio (ACA)
- ❍ Seguro privado que pago por mí mismo (HMO/PPO)
- ❍ Servicio de Salud Indígena
- ❍ Administración de Veteranos
- ❍ COBRA
- ❍ Pago de bolsillo/en efectivo
- ❍ De otra manera (especifique) _____

P22. En los últimos 12 meses, ¿hubo algún momento en el que necesitara servicios de atención médica pero que no recibiera la atención que necesitaba? Seleccione una opción.

- ❍ Sí. RESPONDA LA P23 A CONTINUACIÓN
- ❍ No, obtuve los servicios que necesitaba - PASE A LA P24
- ❍ No aplica; no necesité servicios de atención médica en el último año. PASE A LA P24

P23. Seleccione la(s) principal(es) razón(es) por la(s) que no recibió los servicios de atención médica que necesitaba en los últimos 12 meses. Seleccione todas las opciones que correspondan.

- ❍ Costo: demasiado costoso/no puedo pagarlo
- ❍ Sin seguro
- ❍ No se acepta seguro
- ❍ Falta de transporte personal
- ❍ Falta de transporte debido a los horarios de los autobuses o a la ubicación de destino
- ❍ El horario de atención no se ajustaba a mis horarios
- ❍ El cuidado de los niños no estaba disponible
- ❍ La espera es demasiado larga
- ❍ No hay ningún médico cerca
- ❍ No sabía dónde ir
- ❍ El consultorio, servicio o programa tiene acceso limitado o está cerrado debido al COVID-19
- ❍ Barrera idiomática
- ❍ Razones culturales/religiosas
- ❍ Falta de confianza en los servicios o los proveedores de atención médica
- ❍ Experiencia anterior negativa al recibir atención o servicios
- ❍ Falta de proveedores con los que me identifique (raza, etnia, género)
- ❍ Falta de proveedores con capacitación específica para mis necesidades
- ❍ Otro (especifique) _____

P24. En los últimos 12 meses, ¿hubo algún momento en el que necesitara servicios odontológicos o de salud oral pero que no recibiera la atención que necesitaba? Seleccione una opción.

- ❍ Sí. RESPONDA LA P25
- ❍ No, obtuve los servicios que necesitaba - PASE A LA P26
- ❍ No aplica; no necesité servicios de salud dental/oral en el último año. PASE A LA P26

P25. Seleccione la(s) principal(es) razón(es) por la(s) que no recibió los servicios odontológicos o de salud oral que necesitaba en los últimos 12 meses. Seleccione todas las opciones que correspondan.

- ❍ Costo: demasiado costoso/no puedo pagarlo
- ❍ Sin seguro
- ❍ No se acepta seguro
- ❍ Falta de transporte personal
- ❍ Falta de transporte debido a los horarios de los autobuses o a la ubicación de destino
- ❍ El horario de atención no se ajustaba a mis horarios
- ❍ El cuidado de los niños no estaba disponible
- ❍ La espera es demasiado larga
- ❍ No hay ningún médico cerca
- ❍ No sabía dónde ir
- ❍ El consultorio, servicio o programa tiene acceso limitado o está cerrado debido al COVID-19
- ❍ Barrera idiomática
- ❍ Razones culturales/religiosas
- ❍ Falta de confianza en los servicios o los proveedores de atención médica
- ❍ Experiencia anterior negativa al recibir atención o servicios
- ❍ Falta de proveedores con los que me identifique (raza, etnia, género) o que tengan formación específica para mis necesidades
- ❍ Otro (especifique) _____

P26. En los últimos 12 meses, ¿hubo algún momento en que necesitó o pensó en buscar servicios de salud mental o tratamiento contra el alcoholismo o la drogadicción, pero no pudo acceder a ellos? Seleccione una opción.

- ❍ Sí. RESPONDA LA P27
- ❍ No, obtuve los servicios que necesitaba - PASE A LA P28
- ❍ No aplica; no necesité servicios en el último año - PASE A LA P28

P27. Seleccione la(s) razón(es) principal(es) por la(s) que no recibió servicios de salud mental o tratamiento por alcoholismo o drogadicción. Seleccione todas las opciones que correspondan.

- ❍ Costo: demasiado costoso/no puedo pagarlo
- ❍ Sin seguro
- ❍ No se acepta seguro
- ❍ Falta de transporte personal
- ❍ Falta de transporte debido a los horarios de los autobuses o a la ubicación de destino
- ❍ El horario de atención no se ajustaba a mis horarios
- ❍ El cuidado de los niños no estaba disponible
- ❍ La espera es demasiado larga
- ❍ No hay ningún médico cerca
- ❍ No sabía dónde ir
- ❍ El consultorio, servicio o programa tiene acceso limitado o está cerrado debido al COVID-19
- ❍ Barrera idiomática
- ❍ No sabía cómo funcionaría el tratamiento
- ❍ Me preocupaba que los demás me juzgaran
- ❍ Razones culturales/religiosas
- ❍ Falta de confianza en los servicios o los proveedores de atención médica
- ❍ Experiencia anterior negativa al recibir atención o servicios
- ❍ Falta de proveedores con los que me identifique (raza, etnia, género) o que tengan formación específica para mis necesidades
- ❍ Otro (especifique) _____

P28. En los últimos 12 meses, ¿acudió a un servicio de urgencias (Emergency Department, ED) de un hospital? Seleccione una opción.

- ❍ Sí. RESPONDA LA P29 Y P30
- ❍ No, no he ido al ED de un hospital. PASE A LA P31

P29. Seleccione el número de veces que ha acudido al ED en los últimos 12 meses. Seleccione una opción.

- ❍ 1
- ❍ 2
- ❍ 3
- ❍ 4
- ❍ 5
- ❍ 6 o más

P30. ¿Cuáles fueron las principales razones por las que acudió al ED en lugar de ir al consultorio médico o a la clínica? Seleccione lo que corresponda.

- ❍ Fuera del horario de la clínica/fin de semana
- ❍ No tengo un médico o una clínica habitual
- ❍ No tengo seguro médico
- ❍ Me resulta más cómodo acceder a atención médica en el ED en lugar de hacerlo en una consulta médica o clínica
- ❍ Preocupaciones por el costo o los copagos
- ❍ Situación de emergencia o de peligro para la vida
- ❍ Larga espera para conseguir una cita con mi médico habitual
- ❍ Necesitaba comida, refugio u otros recursos
- ❍ No hay atención urgente o inmediata disponible cerca de mi domicilio
- ❍ Mi médico (u otro proveedor) me dijo que fuera
- ❍ Otro (especifique) _____

P31. ¿Cuántos niños (menores de 18 años) viven actualmente en su hogar? Seleccione una opción.

- ❍ 1
- ❍ 2
- ❍ 3
- ❍ 4
- ❍ 5
- ❍ 6 o más
- ❍ Ninguno

III. Si algún niño menor de 18 años vive en su hogar, responda de la P32 a la P36. Si NO hay ningún niño menor de 18 años que viva en su hogar, pase a la P37.

P32. ¿Qué tipo(s) de plan(es) de salud tienen los niños en su hogar para cubrir los costos de los servicios de atención médica? Seleccione todas las opciones que correspondan.

- ❍ Medicaid/Programa de Seguro Médico para Niños (CHIP)
- ❍ Seguro a través de un empleador (HMO/PPO), ya sea el mío propio o el de mi pareja o cónyuge
- ❍ Seguro a través del mercado de seguros de salud/Obama Care/Ley de Cuidado de Salud a Bajo Precio (ACA)
- ❍ Seguro privado que pago por mí mismo (HMO/PPO)
- ❍ Servicio de Salud Indígena
- ❍ Administración de Veteranos
- ❍ COBRA
- ❍ Pago de bolsillo/en efectivo
- ❍ Otro (especifique) _____

P33. ¿Los niños (menores de 18 años) en su hogar han tenido alguno de los siguientes problemas de salud? Seleccione todas las opciones que correspondan.

____ No, el o los niños no tuvieron ningún problema de salud

____ Discapacidades infantiles/necesidades especiales

____ Alergias

____ Asma

____ Enfermedades autoinmunes

____ Desafíos de comportamiento/salud mental

____ Problemas relacionados con el nacimiento (por ejemplo: bajo peso al nacer, nacimiento prematuro o prenatal)

____ Cáncer

____ Maltrato y descuido de menores

____ Niño/Niños con sobrepeso

____ Niño/Niños bajos de peso

____ Diabetes/prediabetes/hiperglucemia

____ Consumo de drogas o alcohol

____ Audición o visión

____ Lesiones o accidentes que requieren atención médica inmediata (por ejemplo: lesiones deportivas, accidentes en bicicleta)

____ Enfermedades del corazón u otras afecciones cardíacas

____ Trastornos del sistema nervioso

____ Enfermedades de transmisión sexual

____ Accidente cerebrovascular

____ Embarazo adolescente

____ Consumo de tabaco o cigarrillos electrónicos

____ Otros (especifique) _____

P34. En los últimos 12 meses, ¿hubo algún momento en el que los niños en su hogar necesitaron atención médica u otros servicios relacionados con la salud, pero que no recibieron los servicios que necesitaban? Seleccione una opción.

- ❍ Sí. RESPONDA LA P35 Y P36
- ❍ No, recibieron los servicios que necesitaban. PASE A P37
- ❍ No aplicable; el o los niños no necesitaron servicios. PASE A P37

P35. ¿Cuáles de los siguientes servicios los niños en su hogar no pudieron recibir en los últimos 12 meses cuando los necesitaban? Seleccione todas las opciones que correspondan.

- ❍ Tratamiento del abuso de alcohol u otras sustancias
- ❍ Atención odontológica (limpieza de rutina o atención de urgencia)
- ❍ Servicios de atención de emergencia
- ❍ Servicios de salud mental
- ❍ Servicios de nutrición
- ❍ Medicamentos recetados
- ❍ Atención o tratamiento de rutina para afecciones crónicas o en curso, p. ej., alergias, afecciones respiratorias, diabetes
- ❍ Vacunación(es) programada(s)
- ❍ Servicios para necesidades especiales
- ❍ Visita por enfermedad/visita para atención de urgencia
- ❍ Visita o control de rutina del niño
- ❍ Otro (especifique) _____

P36. Seleccione la(s) razón(es) principal(es) por la(s) que los niños en su hogar no recibieron los servicios médicos o de atención médica que necesitaban en los últimos 12 meses. Seleccione todas las opciones que correspondan.

- ❍ Costo: demasiado costoso/no puedo pagarlo
- ❍ Sin seguro
- ❍ No se acepta seguro
- ❍ Falta de transporte personal
- ❍ Falta de transporte debido a los horarios de los autobuses o a la ubicación de destino
- ❍ El horario de atención no se ajustaba a mis horarios
- ❍ El cuidado de los niños no estaba disponible
- ❍ La espera es demasiado larga
- ❍ No hay ningún médico cerca
- ❍ No sabía dónde ir
- ❍ El consultorio, servicio o programa tiene acceso limitado o está cerrado debido al COVID-19
- ❍ Barrera idiomática
- ❍ Razones culturales/religiosas
- ❍ Falta de confianza en los servicios o los proveedores de atención médica
- ❍ Experiencia anterior negativa al recibir atención o servicios
- ❍ Falta de proveedores con los que me identifique (raza, etnia, género)
- ❍ Falta de proveedores con capacitación específica para mis necesidades
- ❍ Otro (especifique) _____

IV. Esta sección de la encuesta le pide que reflexione sobre el empleo, la educación y otros recursos en su comunidad.

P37. A continuación, se presentan algunas afirmaciones sobre el empleo y la educación en su comunidad. Califique en qué medida está de acuerdo o en desacuerdo con cada afirmación. Coloque una X para su respuesta en cada fila a continuación.

	Totalmente de acuerdo	De acuerdo	En desacuerdo	Totalmente en desacuerdo
Hay muchos trabajos disponibles para los mayores de 18 años				
Hay muchos trabajos disponibles para los que tienen entre 14 y 18 años				
Hay capacitaciones laborales o recursos de empleo para quienes los necesitan				
Existen recursos para que las personas de mi comunidad puedan poner en marcha un negocio (financiación, capacitación, bienes inmuebles, etc.)				
Los recursos para el cuidado de los niños (guardería/preescolar) son económicos y están disponibles para quienes los necesitan				
Las escuelas K-12 (preescolar a escuela secundaria) de mi comunidad están bien financiadas y ofrecen una educación de buena calidad				
Nuestra universidad o escuela comunitaria local ofrece una educación de calidad a un costo económico				

P38. ¿Cuál es su situación laboral actual? Seleccione una opción.

- ❍ Con un empleo a tiempo completo. PASE A LA P40
- ❍ Con un empleo de tiempo parcial. PASE A LA P40
- ❍ No trabajo por elección. PASE A LA P40
- ❍ Sin trabajo, buscando trabajo. RESPONDA LA P39
- ❍ Sin trabajo, pero NO busca trabajo actualmente. PASE A LA P40
- ❍ Estudiante. PASE A LA P40
- ❍ Jubilado. PASE A LA P40
- ❍ No puedo trabajar. RESPONDA LA P39

P39. ¿Alguna de las siguientes razones le dificulta encontrar o conservar un empleo? Seleccione lo que corresponda.

- ❍ Asistencia a la escuela
- ❍ Los trabajos disponibles no pagan un salario que me permita mantenerme a mí y a mi familia
- ❍ No se puede encontrar cuidado de niños
- ❍ El costo del cuidado de niños es demasiado alto
- ❍ Cuidador de un miembro de la familia
- ❍ El trabajo a tiempo completo es demasiado
- ❍ El trabajo a tiempo parcial no es suficiente

- ❍ Suspendido o desempleado temporalmente
- ❍ Los turnos no se adaptan a mi horario
- ❍ Falta de transporte
- ❍ Prueba de drogas/examen de drogas positivo
- ❍ Antecedentes penales
- ❍ Menor de 18 años
- ❍ No he recibido mi diploma de secundaria o GED
- ❍ Discapacidad física
- ❍ No tuve una oportunidad justa de conseguir un empleo
- ❍ Otro (especifique) _____

P40. A continuación, se presentan algunas afirmaciones sobre la vivienda, el transporte y la seguridad en su comunidad. Califique en qué medida está de acuerdo o en desacuerdo con cada afirmación. Coloque una X para su respuesta en cada fila a continuación.

	Totalmente de acuerdo	De acuerdo	En desacuerdo	Totalmente en desacuerdo
Hay lugares económicos para vivir en mi comunidad				
Las calles de mi comunidad suelen estar limpias y los edificios están en buen estado de mantenimiento				
Me siento seguro en mi propio vecindario				
La delincuencia no es un problema importante en mi vecindario				
Hay un sentimiento de confianza en las fuerzas de seguridad en mi comunidad				
El transporte es fácil de conseguir si lo necesito				

P41. ¿Qué transporte utiliza con más frecuencia para ir a distintos lugares? Seleccione una opción.

- ❍ Conduzco mi propio coche
- ❍ Hago autostop
- ❍ Camino
- ❍ Ando en bicicleta
- ❍ Conduzco una moto o un scooter
- ❍ Tomo un autobús
- ❍ Tomo un taxi o un servicio de transporte compartido (Uber/Lyft)
- ❍ Utilizo el transporte médico/transporte en furgoneta especializada
- ❍ Utilizo el transporte de personas mayores
- ❍ Alguien me lleva
- ❍ Otro (especifique) _____

P42. ¿Cuál de las siguientes categorías refleja mejor su situación de vida actual? Seleccione una opción.

- ❍ Vive solo en una casa (casa, apartamento, condominio, remolque, etc.)
- ❍ Vive en un hogar con otra persona, como la pareja, hermanos o compañeros de piso
- ❍ Vive en un hogar unifamiliar que incluye un cónyuge o pareja Y un hijo o hijos menores de 25 años
- ❍ Vive en un hogar multigeneracional (el hogar incluye abuelos o hijos adultos mayores de 25 años)
- ❍ Hogar multifamiliar (más de una familia vive en el hogar)
- ❍ Vida asistida
- ❍ Cuidado tutelar de adultos
- ❍ Instalación de cuidados de larga duración/hogar de ancianos
- ❍ Se aloja temporalmente en casa de un familiar o amigo
- ❍ Se encuentra en un refugio o no tiene hogar (vive en la calle)
- ❍ Vive en una tienda de campaña o en un vehículo recreativo (RV)
- ❍ Hotel/motel (estancia de larga duración)
- ❍ Otros _____

P43. ¿Su actual situación de vivienda satisface sus necesidades? Seleccione una opción.

- ❍ Sí. RESPONDA LA P44
- ❍ No. PASE A LA P45

P44. ¿Qué problemas tiene con su actual situación de vivienda? Seleccione todas las opciones que correspondan.

- ❍ Preocupaciones por desalojo (anteriores, actuales o potenciales)
- ❍ La vivienda actual es temporal; necesito una vivienda permanente
- ❍ La hipoteca es demasiado costosa
- ❍ Necesita cuidados de vida asistida o de larga duración
- ❍ El alquiler o las instalaciones son demasiado costosos
- ❍ Demasiado lejos de la ciudad/servicios
- ❍ Ambiente demasiado deteriorado o insalubre (por ejemplo, moho, plomo)
- ❍ Demasiado pequeño/problemas de hacinamiento con otras personas
- ❍ Inseguro, alta criminalidad
- ❍ Ninguna de las opciones anteriores
- ❍ Otro (especifique) _____

P45. En los últimos 2 años, ¿hubo un momento en que usted (y su familia) vivían en la calle, en un automóvil o en un refugio temporal? Seleccione una opción.

- ❍ Sí, 1 o 2 veces en los últimos 2 años
- ❍ Sí, 3 o más veces en los últimos 2 años
- ❍ No

P46. En los últimos 12 meses, ¿la compañía de servicios públicos ha cortado su servicio por no pagar sus facturas? Seleccione una opción.

- ❍ Sí
- ❍ No
- ❍ No aplica – No soy responsable de las facturas de servicios públicos

P47. ¿Le preocupa o inquieta que en los próximos 2 meses usted (y su familia) no tengan una vivienda estable que posea, alquile o en la que se quede como parte de un hogar? Seleccione una opción.

- ❍ Sí
- ❍ No

P48. A continuación se presentan algunas afirmaciones sobre el acceso a los alimentos y los recursos en su comunidad. Califique en qué medida está de acuerdo o en desacuerdo con cada afirmación. <u>Coloque una X para su respuesta en cada fila a continuación.</u>

	Totalmente de acuerdo	De acuerdo	En desacuerdo	Totalmente en desacuerdo
No soy capaz de preparar mi propia comida				
Puedo ir a una tienda de comestibles cuando necesito comida u otros suministros para el hogar				
Las opciones de alimentos saludables económicas son fáciles de adquirir en las tiendas de barrio, tiendas de comestibles o mercados agrícolas cercanos				
En mi barrio es fácil cultivar/cosechar y comer alimentos frescos de un huerto familiar				
Los restaurantes locales ofrecen opciones de comida saludable				
Tenemos buenos parques e instalaciones recreativas				
Hay buenas aceras o senderos para caminar de forma segura				
Es fácil que la gente se desplace independientemente de sus capacidades				
La calidad del aire y del agua es buena en mi comunidad				

P49. En los últimos 12 meses, ¿se preocupó por si su comida se agotaría antes de obtener dinero para comprar más? Seleccione una opción.

- ❍ Frecuentemente
- ❍ A veces
- ❍ Nunca

P50. En los últimos 12 meses, ¿hubo un momento en que la comida que compró simplemente no duró, y no tenía dinero para obtener más? Seleccione una opción.

- ❍ Frecuentemente
- ❍ A veces
- ❍ Nunca

P51. En los últimos 12 meses, ¿usted o alguien que vive en su hogar recibió alimentos de emergencia de una iglesia, despensa de alimentos o banco de alimentos, o comió en un comedor público? Seleccione una opción.

- ❍ Frecuentemente
- ❍ A veces
- ❍ Nunca

V. Durante este tiempo, entendemos que el COVID-19 ha impactado en la vida de todos, directa e indirectamente. Nos gustaría saber cómo estos acontecimientos le han afectado a usted y a su hogar para comprender mejor cómo se ha visto afectada nuestra comunidad en general.

RECORDATORIO: esta es una encuesta anónima. Si usted o alguien en su hogar tiene preguntas o inquietudes relacionadas con el COVID-19, la información está disponible en el **Departamento de salud del estado de Indiana https://www.coronavirus.in.gov/**. Si necesita ayuda para encontrar recursos locales y servicios de apoyo, llame al 211.

P52. Sabemos que la pandemia de COVID-19 es un desafío en muchos sentidos. Seleccione de la siguiente lista los problemas que suponen el mayor desafío para su hogar en este momento. <u>Seleccione todas las opciones que correspondan.</u>

____ Acceso a la atención médica básica
____ Acceso a los servicios médicos de urgencia
____ Acceso a medicamentos recetados
____ Escasez de alimentos
____ Escasez de opciones de alimentos saludables
____ Escasez de suministros de higiene y limpieza (por ejemplo, papel higiénico, desinfectantes, etc.)
____ Desafíos para que mis hijos asistan a la escuela (de forma presencial o virtual)
____ Experimentar problemas de vivienda o carecer de ella
____ Sentirse solo/aislado, no poder socializar con otras personas
____ Sentir nervios, ansiedad o tensión
____ Los miembros del hogar no se llevan bien
____ Los miembros del hogar tienen o han tenido síntomas de COVID-19 o similares a los del COVID (fiebre, dificultad para respirar, tos seca)
____ Falta de tecnología para comunicarme con personas fuera de mi hogar, acceder a la escuela de forma virtual o trabajar de forma remota desde casa (por ejemplo, acceso a Internet, computadora, tableta, etc.)
____ Falta de habilidades para utilizar la tecnología para comunicarme, acceder a la escuela de forma virtual o trabajar de forma remota desde casa
____ No poder hacer ejercicio
____ No saber cuándo terminará la pandemia/no sentirse en control
____ Opciones de servicios de cuidado de niños/falta de apoyo al cuidado de niños
____ Imposibilidad de encontrar trabajo

____ No corresponde ninguna de las siguientes opciones
____ Otros (especifique)
_____

P53. ¿Cuál es su situación de vacunación contra el COVID-19?

- ❍ Estoy vacunado
- ❍ Planeo vacunarme: RESPONDA LA P54
- ❍ No planeo vacunarme - PASE A LA P55

P54. Si está planeando vacunarse, ¿alguno de los siguientes factores ha contribuido al retraso de su vacunación? Seleccione todas las opciones que correspondan.

- ❍ No hay desafíos, simplemente no he programado mi cita
- ❍ Incertidumbre sobre la seguridad o los efectos secundarios de la vacuna
- ❍ Dificultad para conseguir una cita para vacunarse
- ❍ Falta de transporte
- ❍ No puedo ausentarme del trabajo para acudir a una cita
- ❍ Barrera idiomática
- ❍ La espera es demasiado larga
- ❍ No hay ningún centro de vacunación cercano
- ❍ Otro (especifique) _____

P55. Si no tiene planes de vacunarse, ayúdenos a entender por qué:

- ❍ No creo que la vacuna sea segura para mí
- ❍ Tengo una enfermedad preexistente que hace que no cumpla con los requisitos
- ❍ Razones culturales o religiosas
- ❍ Otra razón_____

Gracias por tomarse el tiempo de participar en esta encuesta de la comunidad. Sus comentarios y opiniones son vitales para mejorar y abordar los problemas que afectan la salud de nuestra comunidad.

FIN DE LA ENCUESTA

Survey Promotional Flyer (English & Spanish)

We want to hear from you!

Lake and Porter County Community Needs Survey

Results of this survey will help organizations across Lake and Porter County better understand community health concerns to guide improvement efforts.

Your voice matters and we are grateful for your time.

CLICK HERE: SURVEY LINK

Encuesta comunitaria de Lake y Porter County

¿Puede dedicar unos minutos para realizar una encuesta sobre las necesidades de salud en nuestra comunidad?

Escriba esta dirección web en cualquier dispositivo y realice la encuesta:

https://bit.ly/LPCCNHASP

También puede escanear este código QR para realizar la encuesta:

COMMUNITY HEALTHCARE SYSTEM®

Focus Group & Listening Session Tools

Focus Group Questions

COVID-19 QUESTION

1. **We know that COVID-19 has significantly impacted everyone's lives. What have you seen as the biggest challenges in Lake and Porter County during the pandemic?**
   [Probe 1: Which groups of people are having the hardest time right now?]
   [Probe 2: How have you seen these challenges being addressed, if all?]
   [Probe 3: What are some of the positives? What has worked?]

GENERAL HEALTH QUESTIONS

2. **What is the top health related problem that residents are facing in your community that you would change or improve?**
   [*Probe 1: Why do you think this is the most important health issue?]*

3. **What do you think is the cause of this problem in your community?**
   [Probe 1: What would you do to address this problem? What is needed to address this problem?]

4. **From the health issues and challenges we've just discussed, which do you think are the hardest to overcome?**
   [Probe: Are some of these issues more urgent or important than others? If so, why?]

5. **Are there groups in your community that are facing particular health issues or challenges? Which groups are these?**
   [*Probe: Are these health challenges different if the person is a particular age, or gender, race or ethnicity? Or lives in a certain part of the county for example?]*

6. **What do you think causes residents to be healthy or unhealthy in your community?**
   [*Probe 1: What types of things influence their health, to make it better or worse?]*
   [*Probe 2: What might prevent someone from accessing care for these health challenges? Examples could include lack of transportation, lack of health insurance coverage, doctor's office hours, language or cultural barriers, etc.]*

7. **What resources are available for residents in your community?**
   [Probe 1: Are there specific community organizations or agencies that you see taking a strong leadership role for improving the health of particular groups in your community?]
   [*Probe 2: Do you see residents taking advantage of them? Why or why not?]*
   [*Probe 3: What additional programs and resources do you think are needed to best meet the needs of residents in Lake and Porter County?]*

CLOSING QUESTION

8. **Can you think of any other ways we could improve the health of residents in the community that we have not already talked about today?**
   [Probe: Is there anything else you would like to add that we haven't discussed?]

Focus Group Sessions Main Themes

Themes	Sub-Topics
COVID-19 Challenges	No one prepared Fear about the virus Misinformation/confusion about the vaccine Mental health issues Isolation Impact on Elderly Childcare Not being able to attend church, restaurants Increase hand washing practices Homelessness Access to food Lack of social connection for children Lack of broadband services
Health Issues	Elderly with health issues Overweight/obesity Heart disease Smoking Mental health Food deserts Violence Safety Injuries and recovery Access to technology Ability to use technology Diabetes Arthritis Cancer Homelessness Unemployment Children's health Transportation

Causes of Health Issues	Food deserts Cultural barriers Unemployment Generational poverty Drug abuse No access to healthy foods Poor eating habits Lack of exercise Obesity Lifestyle-stress management Single parents Cost of healthy food transportation-difficult to get to grocery stores No train system, cities do not connect
Health Issue Hardest to Overcome	Mental Health
Populations/Disparities	Elderly/Older adults/Seniors Ethnic minorities Latino and Black/African American
Health of the Community	Diet Lifestyle Education Physical activity -participating in group activities Sleep Being positive Access to parks Stay away from media Accountability-being part of something Self-worth Income
Unhealthy Community	Misinformation on healthcare Not have primary care doctor Using emergency rooms for healthcare Stress Safety, not feeling safe in your neighborhood Inactivity/sedentary life Traffic congestion Living in an industrial area and dealing with pollution (Air quality) Fast food

Focus Group Recruitment Flyer

COMMUNITY HEALTHCARE SYSTEM®

We want to hear from you!

Lake/Porter County Community Discussions

We want to hear from YOU about how to make our community healthier. Your feedback will help organizations across the county improve services and better meet the needs of residents just like you.

The discussion will take place online

on **Friday, November 12th at 10:00 AM**

The discussion will be a 60 minute online/phone meeting.

Please send questions to

Sheila George (219) 980-9504 (219) 712-5765

eileen.aguilar@conduent.com

Your voice matters and we are grateful for your time.

Listening Session Results

Key Strengths and Community Resources

Strengths

- Educational Seminars
- Back to school events
- Student Clinic/counseling
- Food Banks
- Health Screenings
- Community Outreach
- Partnerships
- Access to Specialists

Resources

- Senior Centers
- HealthVisions Midwest
- Northwest Indiana Community Action (NWICA)
- Nurse-Family Partnership (NFP) (Maternal & Infant Health)
- Mental Health of America
- Catholic Charities
- Salvation Army
- Grace Beyond Borders-Homeless shelter
- United Way of NWI
- St. Catherine Hospital
- Patient Advocacy Committees
- FQHCs
- Immediate Care Facilities
- COVID-19 Vaccination Clinics
- Community Health Networks
- Church groups
- St. Vincent De Paul
- YMCA

LEADING FACTORS CONTRIBUTING TO HEALTH ISSUES

- Access to care (lack of)
- Unemployment
- Fear
- Poverty
- Lack of/access to community services
- Lack of knowing what services are offered
- Financial/Cost
- Education
- Isolation
- Sedentary Lifestyle
- Access to food
- Cultural disparities/Language
- Transportation
- Lack of family support

COVID-19 CHALLENGES IN LAKE COUNTY AND PORTER COUNTY

- Vaccine Hesitancy
- Supply Chain Shortages (price increases and delays)
- Inconsistent messaging about the importance of infection control, mitigation, vaccination
- Mental Health
- Decline in health and mobility (elderly)
- Staffing issues and shortages
- Delay in routine preventive care-resulting in patients with greater need
- Difficulty with COVID-19 guidelines/policies and relying information to staff
- Fear and anger of the unknown
- Technology-lack of knowledge (elderly)

GROUPS/POPULATIONS STRUGGLING

- Elderly, Older Adults
- Low-income populations
- Homeless
- Homebound
- Hispanic
- Black/African American
- Undocumented Individuals
- Single parents
- Individuals w/ low educational attainment

GEOGRAPHIC PARTS OF COMMUNITY WITH GREATER HEALTH OR SOCIAL NEEDS

- East Chicago
- Community-Wide (Northern Part of Northwest Indiana)
- Age restricted neighborhoods (55 and older)
- Area of Gary, Lake Station, Northwest Hobart, South Haven
- North Lake County: East Chicago, Hammond

ACCESSING HEALTH CARE OR SOCIAL SERVICES-BARRIERS OR CHALLENGES

- Transportation
- Lack of health insurance
- Education
- Language and cultural barriers
- Requirements for undocumented individuals
- Low income
- Child care
- COVID-19 concerns, fear
- Relationships (primary care provider)
- Financial

PROGRAMS AND SERVICES-GREATEST IMPACT-LISTENING SESSION RESPONSES

- Addressing food deserts
- Access to education and job training
- Accessibility to medical care/clinics
- Affordable health insurance & transportation –Elderly
- Access to public transportation
- Boys and Girls Clubs
- Community Outreach
- Enhanced public health care options for home care and visits
- Education programs (healthy recipes on a limited budget)
- Local health departments mental health services
- Medical taxis
- Northwest IN Regional Transportation Corp.
- NWICA
- YWCA

Appendix C. Prioritization Tools

Prioritization Cheat Sheet: Community Healthcare System

For this activity, we will prioritize 10 significant health needs, considering the following two criteria: (1) Ability to Impact and (2) Scope and Severity. Please review the considerations for each of these criteria below, then assign a score of 1-3 to each health topic and criterion.

Considerations: ABILITY TO IMPACT

Can actionable and measurable goals be defined to address the health need?

Are those goals achievable in a reasonable time frame?

Does the hospital or health system have the expertise or resources to address the identified health need?

Considerations: SCOPE AND SEVERITY

How many people in the community are or will be impacted?

How does the identified need impact health and quality of life?

****The health needs listed below are listed in alphabetical order (not order of importance)***

Health Need*	ABILITY TO IMPACT	SCOPE AND SEVERITY
Access to Healthcare		
Cancer		
Diabetes		
Heart Disease & Stroke		
Maternal and Children's Health		
Mental Health and Mental Disorders		

Prioritized Health Needs for Consideration

The top ranked health needs from the Prioritization Activity on December 20, 2021, were:

1. Maternal & Children's Health
2. Mental Health & Mental Disorders
3. Access to Healthcare
4. Diabetes
5. Health Disease and Stroke
6. Cancer

Appendix D. Community Resources and Potential Community Partners

Community Resource List

219 Health Network
100 W. Chicago Ave, Suite F.East Chicago

Al-Haq Masjid
1627 Cline Ave. Griffith

American Legion Post 0485
7485 Burr St., Schererville

Anthem Blue Cross and Blue Shield
41 W 78th Place, #51, Merrillville

Bethel Church
10202 Broadway, Crown Point

Boy Scouts of America-Pathway to Adventure Council 8751 Calumet Ave., Munster

Catholic Charities - Gary
940 Broadway, Gary

Center of Workforce Innovations
2804 Boilermaker Ct., Ste E, Valparaiso

Community HealthNet Health Center
1021 W. 5th Ave., Gary

Crisis Center, Inc.
101 N. Montgomery, Gary

East Chicago Department of Health
100 W. Chicago Ave., East Chicago

East Chicago Public Library
2401 E. Columbus Dr., East Chicago

Food Bank of Northwest Indiana
6490 Broadway, Merrillville

Gary Public Transit Corporation
Adam Benjamin Jr Metro Center
100 W. 4th Ave., Gary

Griffith Police Department
115 N. Broad St., Griffith

Hartsfield Village
10000 Columbia Ave., Munster

Home Health Crusaders
3191 Willowcreek Rd., Portage

Illiana Islamic Association
9608 Spring St., Highland

Indiana University Northwest
3400 Broadway, Gary

Ivy Tech Lake County Campus
3491 Broadway, Gary

Lakeshore Chamber of Commerce Board
5246 Hohman Ave., Suite 100, Hammond

Legacy Foundation
370 E. 84th Dr., Suite 100, Merrillville

Maria Reiner Center
705 E. 4th St., Hobart

Multicultural Wellness Network
PO Box 1556, Highland

NAACP Gary
P.O. Box 64843, Gary

Northwest Community Action
5240 Fountain Dr., Crown Point,

Porter County CASA (part of Family and Youth Services Bureau) 257 W Lincolnway, Valparaiso

Porter County Health & Environment
155 Indiana Ave, Valparaiso

Porter County Parks & Recreation
155 Indiana Ave., #304, Valparaiso

Porter-Starke Services
601 Wall St., Valparaiso

Sojourner Truth House
1419 S. Lake Park Ave., Hobart

St George Hellenic Greek Church
528 W 77th Ave, Schererville

St. George Serbian Orthodox Church
905 E Joliet St., Schererville

St. Josaphat Ukrainian Catholic
8624 White Oak Ave., Munster

St. Elijah Serbian American Orthodox Church
8700 Taft St., Merrillville

Valparaiso University Alliance (LGBTQ+)
1700 Chapel Dr., Valparaiso

Valparasio Parks and Recreation
3210 N. Campbell St., Valparaiso

We Care from the Heart Social Services
200 Russell St., Floor 8, Hammond

Potential Community Partners list

Community Health Network
Fair Haven Rape Crisis Center
Gary Department of Health
Grace Beyond Borders (homeless shelter) IMPACT (job training)
Northwest Indiana Food Bank
Salvation Army
Senior Centers
TradeWinds
United Way of Northwest Indiana