Community Health Needs Assessment

2025 - 2028

Powers HEALTH℠

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SECTION 1: INTRODUCTION

Powers Health is pleased to present its 2025-2028 Community Health Needs Assessment (CHNA).

Hospitals operated by Powers Health include:

- Community Hospital in Munster, IN
- St. Catherine Hospital in East Chicago, IN
- St. Mary Medical Center in Hobart, IN
- Powers Health 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 their 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.

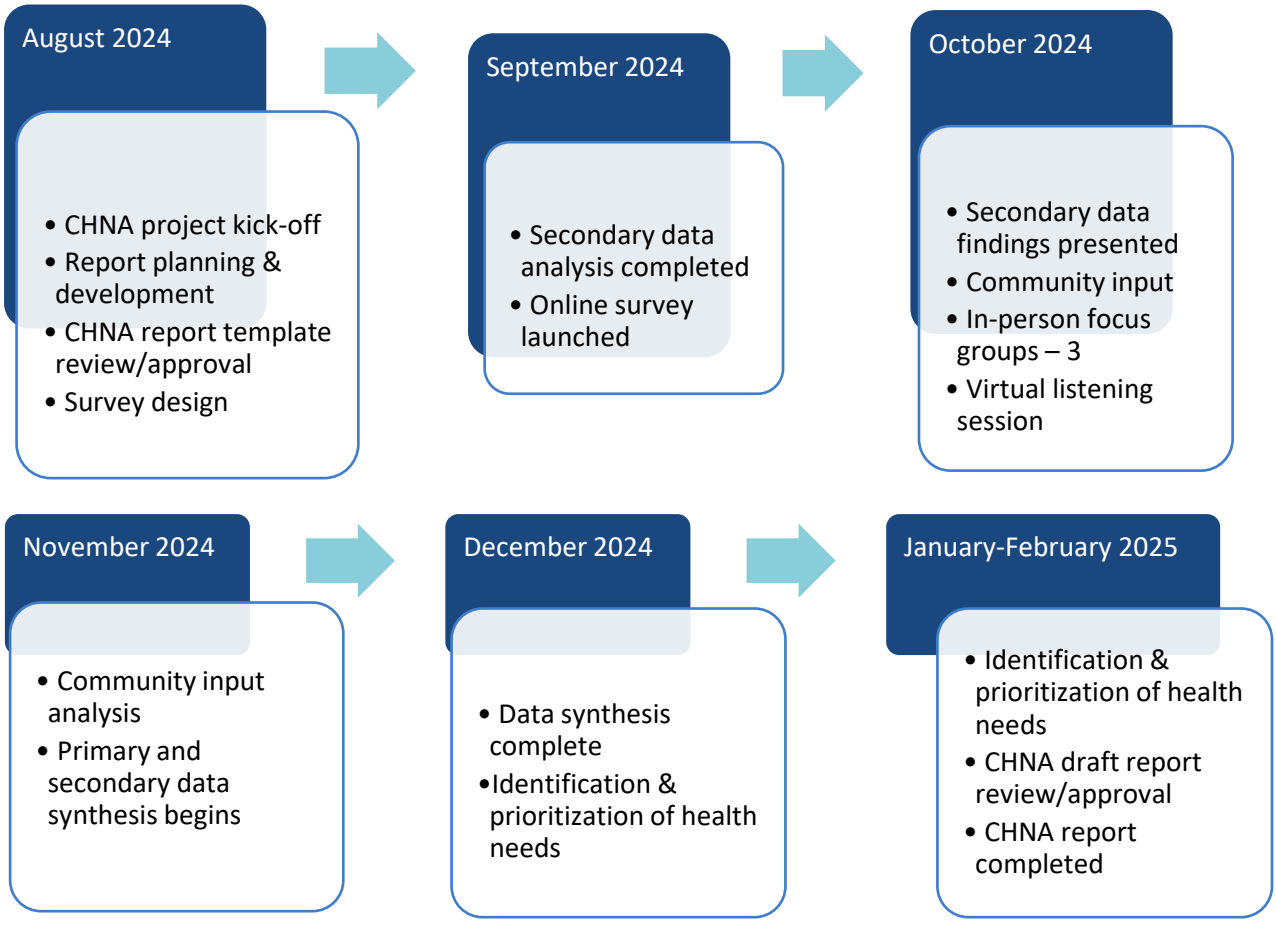
The assessment is extremely useful to Powers Health because it offers a deeper understanding of the health status, needs, disparities and wants of the communities the hospital system serves. Findings from this assessment will guide Powers Health (PH) in its quest to identify, develop and implement actionable strategies to improve residents' quality of life and health in Lake and Porter counties of Indiana.

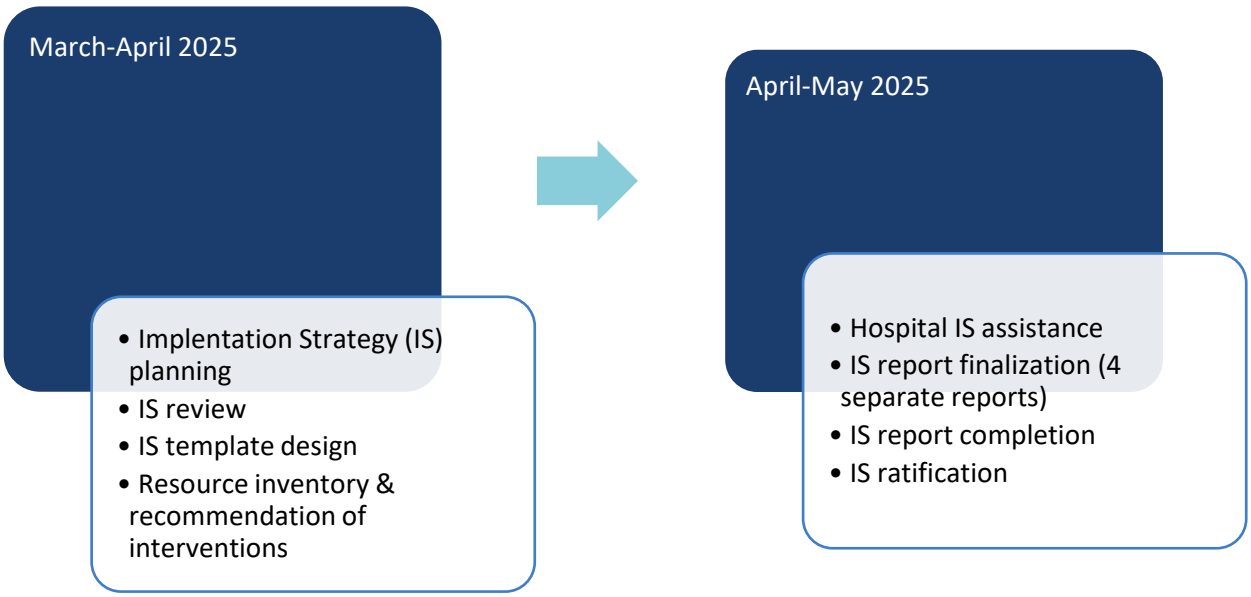
FIGURE 1: COMMUNITY HEALTH NEEDS ASSESSMENT CYCLE

This report includes a description of the:

- Community demographics and population served
- Process and method used to obtain, analyze and synthesize primary and secondary data
- Significant health needs in the community, considering the needs of uninsured, low-income and marginalized groups
- Process and criteria used in identifying specific health needs as significant and prioritizing those significant community needs

Community Health Needs Assessment Planning Timeline




March-April 2025
• Implentation Strategy (IS) planning
• IS review
• IS template design
• Resource inventory & recommendation of interventions
April-May 2025
• Hospital IS assistance
• IS report finalization (4 separate reports)
• IS report completion
• IS ratification

About Powers Health

Powers Health is comprised of four not-for-profit hospitals: Community Hospital in Munster; St. Catherine Hospital in East Chicago; St. Mary Medical Center in Hobart; specialty hospital Powers Health Rehabilitation Center in Crown Point; and Hartsfield Village, a continuing care retirement community in Munster. Owned and operated by Community Foundation of Northwest Indiana, Inc., the healthcare system's vast network of care locations includes outpatient, surgical and rehabilitation centers, physician practices, behavioral health, occupational health, home health care, a medically based fitness center, a cancer research foundation and a cancer support center.

Powers Health is an evolution of the Community Healthcare System, not a merger or acquisition. The leadership and approach to patient care remain the same. Powers Health continues its commitment to providing more expertise, locations and advanced technology. Powers Health hospitals are leaders in cancer treatment, cardiac care, neuroscience and orthopedics.

The healthcare system's parent company is the Community Foundation of Northwest Indiana, Inc. (CFNI). It is a not-for-profit 501(C) (3) organization that provides leadership and resources for enhancing health and the quality of life in Northwest Indiana. As a non-profit organization, the healthcare system offers numerous free programs, special events, preventative screenings and support groups that aim to improve the quality of life and health of residents in our community.

Powers Health Medical Group, 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 and a network of highly qualified physicians, nurses and allied health professionals, Powers Health offers exceptional care to patients across every stage of life.

MISSION:
Powers Health is committed to delivering high quality patient-centered care through advanced technology and expertise while serving the needs of all people with dignity and respect.

VISION:
Powers Health's vision is to be an integrated network of nationally recognized healthcare services with a personal approach.

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:
Community Hospital | Powers Health

CEO: Randy Neiswonger

Community Hospital blends high-tech services typically associated with major university medical centers with the personal touch uniquely provided by a community-based hospital. The hospital supports the area's largest cancer research program as a Carle Cancer Research, offering access to numerous international trials and studies. Complex heart, valve and vascular surgery, neuroendovascular surgery, neonatal intensive care and a 5,000-member medically based fitness center are other examples of the hospital's broad range of specialties.

With 458 beds and more than 3,000 employees, Community Hospital has more admissions than any single hospital in Lake County, Indiana. Community Hospital has been awarded numerous national accreditations and recognitions for its quality of care, including the Joint Commission's highest honor, Accreditation with Commendation. Community Hospital also is a Joint Commission accredited Comprehensive Stroke Center.

List of Services (Service Lines):

Audiology, Bariatric Medicine & Weight Management, Cancer Care, Cardiac Rehabilitation, Chest Pain, Diabetes (ADA certified) & Endocrinology, Diagnostics, Digestive Health (Gastroenterology), Ear, Nose and Throat (Otolaryngology), Emergency Department – 24-hours a day: Level II trauma and Obstetric, Family Birthing Services, Heart and Vascular (Cardiology), Home Health, Imaging and Radiology, Infusion Therapy, Intensive and Intermediate Specialty Care Units, Interventional Radiology, Laboratory, Lung Care (Pulmonology), Lymphedema, Maternal & Neonatal Care-NICU, Neuroscience, Nutritional Counseling, Occupational Therapy, Orthopedic & Spine Care, Outpatient Retail Pharmacy, Radiation Oncology, Sleep Medicine, Therapy Services, Stroke Care-Comprehensive Stroke Center, Urology, Women's Care Services and Wound & Ostomy Services.

Community Hospital Outpatient Facilities:
Powers Health Cancer Research Foundation and Cancer Resource Center, Munster
Community Hospital Surgery Center, Munster
Community Hospital Outpatient Centers: Munster, Schererville and St. John
Powers Health Immediate Care, Munster

St. Catherine Hospital

Address: 4321 Fir St.
East Chicago, IN 46312
Website: St. Catherine Hospital | Powers Health

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. With 216 beds, over 1,000 employees and 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. Those distinctions include Joint Commission advanced certification in Diabetes Care and accreditation as a Primary Stroke Center, American Heart Association Get with The Guidelines Silver Plus and Target: Stroke Elite Honor Roll Awards and as an Anthem Blue Cross Blue Shield Association Blue Distinction Center in Cardiac Care.

St. Catherine Hospital continues to invest in the patient care experience, combining advanced technologies and innovations to remain at the forefront of research, diagnostics and therapeutic care. Specialties include a wide range of outstanding healthcare service areas from acute, cardiac and cardiovascular care and behavioral health to diagnostic imaging, interventional radiology and radiation therapy.

List of Services (Service Lines):

Acute Inpatient Rehabilitation, Audiology, Behavioral Health Services including Intensive Outpatient Program (IOP), Cardiac Rehabilitation, Chest Pain, Diabetes (ADA certified) & Endocrinology, Diagnostics, Digestive Health (Gastroenterology), Ear, Nose and Throat (Otolaryngology), Emergency Department – 24-hours a day, Cancer and Infusion Center, Family Birthing Services, Heart and Vascular (Cardiology), Imaging and Radiology, Infusion Therapy, Intensive and Intermediate Care Units, Interventional Radiology, Laboratory, Lung Care (Pulmonology), Lymphedema, Maternal & Neonatal Care, Neuroscience, Nuclear Medicine, Nutritional Counseling, Occupational Health, Occupational Therapy, Orthopedic & Spine Care, Outpatient Retail Pharmacy, Pain Management, Radiation Oncology, Sleep Medicine, Therapy Services, Stroke Care-Primary Stroke Center, Urology, Women's Care Services and Wound & Ostomy Services.

St. Mary Medical Center

Address: 1500 S. Lake Park Ave.
Hobart, IN 46342
Website: St. Mary Medical Center | Powers Health

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 215-bed hospital utilizes multidisciplinary teams of health professionals and shared governance among the nursing staff for increased collaboration and accountability in patient care. The efforts of the hospital's 1,500 employees 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 Center of Excellence in Minimally Invasive Gynecology and Robotic Surgery.

List of Services (Service Lines):

Acute Inpatient Rehabilitation, Audiology, Bariatric Medicine & Weight Management, Cardiac Rehabilitation, Chest Pain, Diabetes & Endocrinology, Diagnostics, Digestive Health (Gastroenterology), Ear, Nose and Throat (Otolaryngology), Emergency Department – 24-hours a day, Cancer and Infusion Center, Family Birthing Services, Heart and Vascular (Cardiology), Home Health, Imaging and Radiology, Infusion Therapy, Intensive and Intermediate Care Units, Interventional Radiology, Laboratory, Lung Care (Pulmonology), Lymphedema, Maternal & Neonatal Care- Level II NICU, Neuroscience, Nuclear Medicine, Nutritional Counseling, Occupational Therapy, Orthopedic & Spine Care, Therapy Services including Pediatric, Stroke Care-Primary Stroke Center, Urology, Women's Care Services.

St. Mary Medical Center Outpatient Facilities:

St. Mary Medical Center Outpatient Centers: Hobart, Portage, Valparaiso, Winfield
St. Mary Medical Center Cardiac Rehabilitation, Hobart
St. Mary Medical Center Emergency Department, Valparaiso
St. Mary Medical Center Surgery Center at Lake Park, Hobart
Powers Health Immediate Care, Valparaiso

Powers Health Rehabilitation Center

Address: 10215 Broadway
Crown Point, IN 46307
Website: Powers Health Rehabilitation Center | Powers Health

Administrator: Craig Bolda

Powers Health Rehabilitation Center in Crown Point is a four-story, 129,000-square-foot multispecialty hospital with a 40-bed inpatient rehabilitation unit.

Powers Health Rehabilitation Center was ranked No. 2 in Indiana among America's Best Physical Rehabilitation Centers for 2023 and 2024 by Newsweek. Interdisciplinary teams are led by licensed medical, physical and rehabilitation specialists who provide personalized treatment plans and coordinate care with case managers, neuropsychologists, physical, occupational, speech and recreation therapists and rehabilitation nurses.

List of Services (Service Lines):

- Diagnostic imaging: MRI, CT, X-ray, ultrasound, 3D mammography, bone density, pulmonary function testing, EEG, EMG, echocardiography, EKG and nuclear cardiology
- Laboratory services
- Physical, occupational and speech outpatient therapies
- Physician specialties in cardiology, family medicine, gastroenterology, internal medicine, neurology, obstetrics/gynecology, orthopedics, pediatric medicine and urology
- Powers Health Immediate Care
- Valori Kolarczyk Healing Garden
- Women's Care Services

Acknowledgments

For the 2025-2028 Community Health Needs Assessment and Implementation Strategy (IS) cycle, Powers Health worked with Conduent/Healthy Communities Institute (HCI) for professional assistance with strategic planning development and metrics tracking.

Community Benefit Leadership and Team

Vice President Marketing and Corporate Communications, Marie Forszt
Director Marketing and Corporate Communications, Mary Fetsch
Director of Community Relations and Outreach, Emily Packard
Community Outreach Specialist, Khisha Anderson

Consultants

Powers Health collaborated with the Conduent Healthy Communities Institute (HCI) to support report preparation for its 2025 CHNA. HCI works with clients nationwide 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 Conduent HCI, please visit www.conduent.com/community-population-health.

Community Input

The development of the 2025-2028 Community Health Needs Assessment was a collective effort by Powers Health employees, residents, church and civic leaders, educators, healthcare professionals and community-serving organizations with a deep understanding of our residents' issues and needs.

Powers Health gratefully acknowledges this dedicated group for generously contributing their time and expertise to help guide this CHNA process.

Review of 2022-2025 Community Health Needs Assessment

An important part of the 2025-2028 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 on the next CHNA cycle. The 2022 CHNA was completed in collaboration with the HCI. Implementation strategies were finalized for Community Healthcare System, Community Hospital, St. Catherine Hospital, St. Mary Medical Center and Community Stroke and Rehabilitation Center. All entities are now Powers Health.

Priority Health Needs from Preceding CHNA

Community Healthcare System (Powers Health) based its 2022-2025 implementation strategies on these priority health areas listed in alphabetical order:

- Cancer
- Diabetes
- Heart Disease
- Maternal, Infant and Child Health
- Mental Health
- Stroke

Powers Health is working to make a measurable impact on the communities served. Participants of hospital and community-based outreach events, classes, screenings and programs are supplied 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 on an annual basis.

Below lists some of the 2022-2025 programs that were offered in-person or virtually:

Cancer

- Cancer Survivorship program
- National Cancer Survivors Day
- Physician presentations
- Support/Resource groups
- Wellness classes

Diabetes, Heart Disease and Stroke

- Cardiovascular Symposium
- Diabetes and stroke awareness health fairs
- Expanded diabetes community education presentations
- Created prediabetes education program
- L.I.V.E. (Limb Ischemic Vascular Excellence) screening program
- Expanded stroke support group
- Expanded community education opportunities
- Northwest Indiana Health Summit
- Expanded heart health awareness presentations

Maternal, Infant and Child Health

- Breastfeeding awareness campaigns
- Expanded classes for breastfeeding, labor and delivery, grandparents' education
- Empowering Women Retreat (rebranded from Extraordinary Women Conference)
- Mother and child resource fairs and showers
- Increased car seat technician certifications

Mental Health

- Suicide awareness education campaign and resource guide development
- Holiday Blues presentations
- Presentations on de-escalation practices
- Presentations on stress reduction

The 2022 Community Health Needs Assessment Reports and Implementation Strategies are available to the public via the website https://www.powershealth.org/about-us/community-partnerships
No comments were received on the preceding CHNA at the time this report was written.
To collect comments or feedback for this cycle, Powers Health has a link to a Contact Us form with a dropdown for Community Health Needs Assessment. https://www.powershealth.org/contact-us

SECTION 2: SERVICE AREA DEMOGRAPHICS

The following section explores the demographic profile of the Powers Health service areas in Lake and Porter counties. It is essential 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 unique needs and requires varied approaches to health improvement efforts. All demographic estimates are sourced from Claritas Pop-Facts® (2024 population estimates) and American Community Survey five-year (2018-2022) estimates unless otherwise indicated.

Lake County

Lake County is Indiana's second-most populous county, boasting a population of 500,325 residents in 2024. It is in the state's northwest corner 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.[1]

Porter County

Porter County is on the northern edge of Indiana, east of Lake County. The population in 2024 was 175,925, making it the tenth 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 and eight cities/towns are bordered north by Lake Michigan and south by the westward Kankakee River.[2]

Primary Service Area

The Powers Health geographical boundaries are in Lake and Porter counties. The primary service areas (PSA) are shown in the map below (**Figure 2**). They are defined by 31 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).**

[1] Lake County, Indiana-StasIndiana Indiana's Public Data Utility (2024)
https://www.stats.indiana.edu/profiles/profiles.asp?scope_choice=a&county_changer=18089

[2] Porter County, Indiana-StasIndiana Indiana's Public Data Utility (2024) U.S. Bureau of Labor Statistics.
https://www.stats.indiana.edu/profiles/profiles.asp?scope_choice=a&county_changer=18127

FIGURE 2: POWERS HEALTH SERVICE AREA

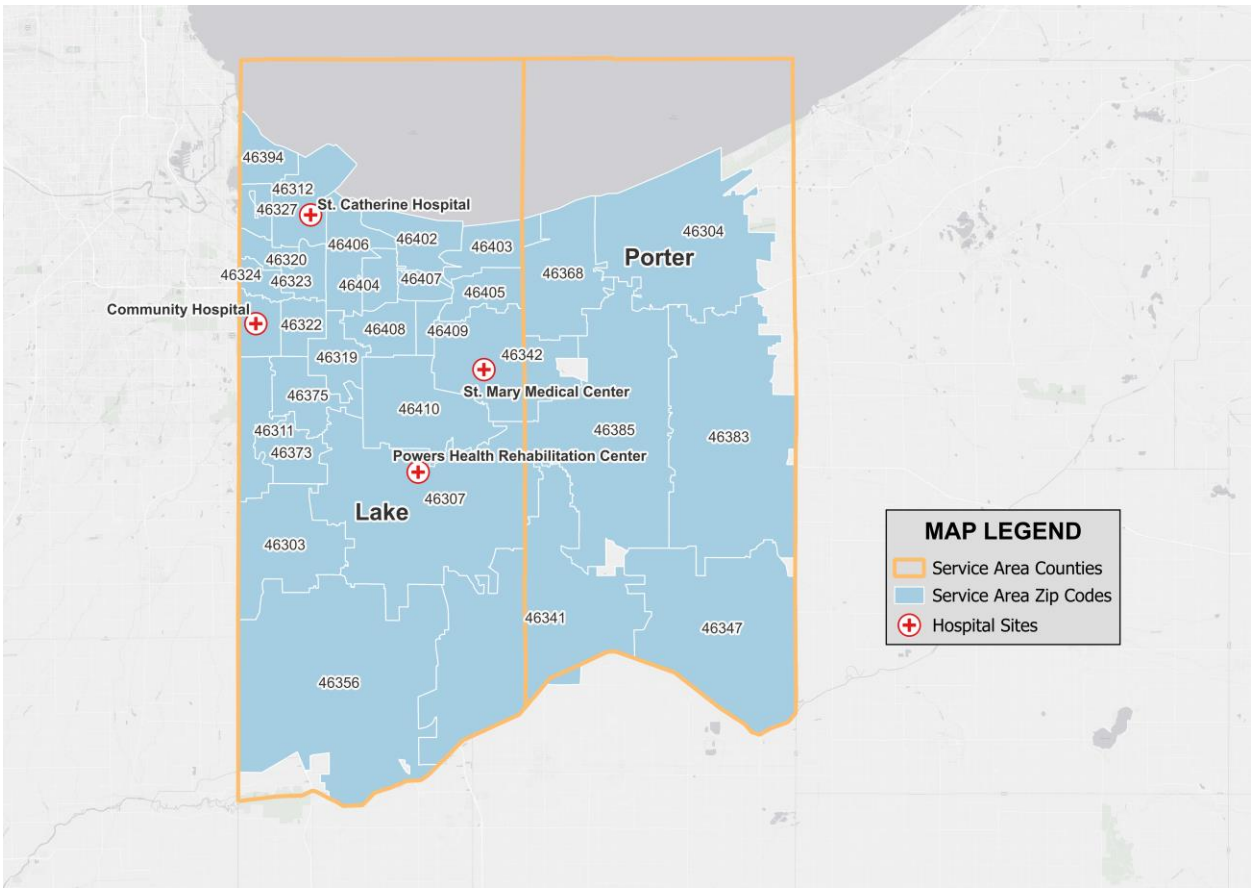


TABLE 1: PATIENT POPULATION SIZE BY SERVICE AREA

Powers Health			
Zip Code	**Population**	**Zip Code**	**Population**
46307	58,020	**46324**	25,886
46311	29,356	**46342**	58,240
46312	43,304	**46368**	38,944
46319	24,295	**46375**	39,063
46320	15,304	**46385**	39,781
46321	39,865	**46394**	15,119
46322	38,121	**46405**	15,244
46323	27,401	**46410**	29,414
Total		**558,341**	

Demographics

The following section explores the demographic profile of Lake and Porter counties. A community's demographics 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® (2024 population estimates) and American Community Survey or five-year (2018-2022) estimates unless otherwise indicated.

Population

Lake County has an estimated population of 500,325 and Porter County has an estimated population of 175,925. The most populous zip code is 46307 (Crown Point) in Lake County and the least populous is 46347 (Kouts) in Porter County.

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

FIGURE 3: POPULATION SIZE BY ZIP CODE

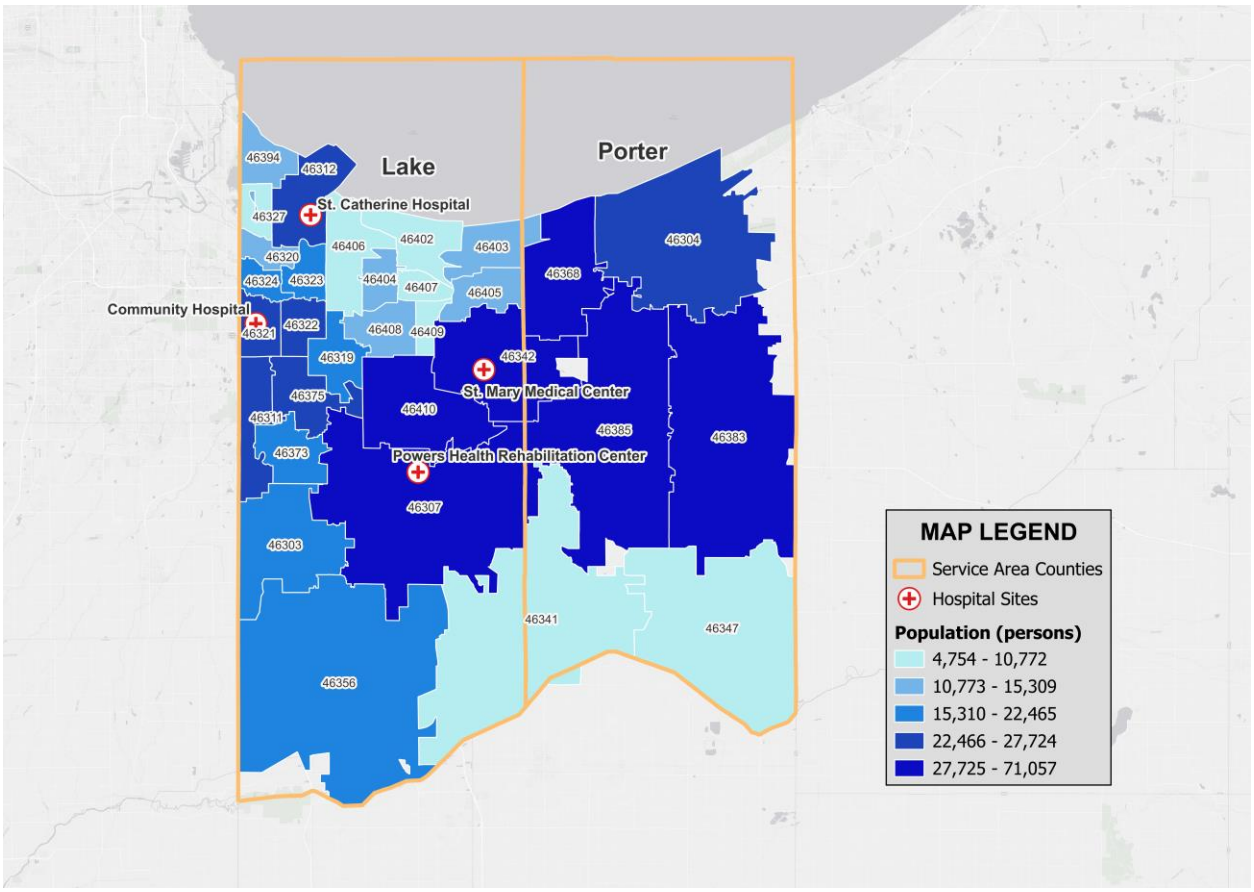
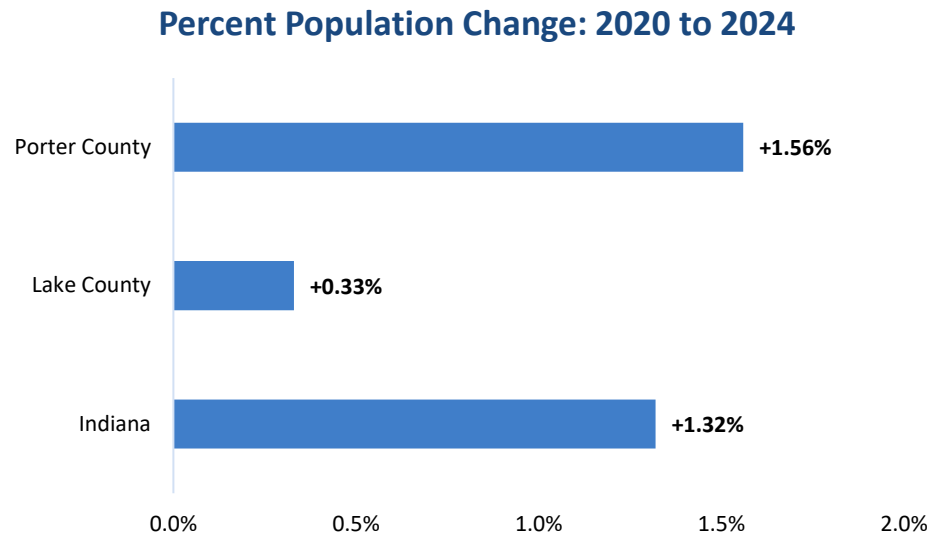


Figure 4 shows the change in population in Lake and Porter counties compared to Indiana. From 2020 to 2024, Porter County's population increased by 1.56%, which is comparable to the overall state population's increase of 1.32%. The population of Lake County experienced a smaller increase, at 0.33%.

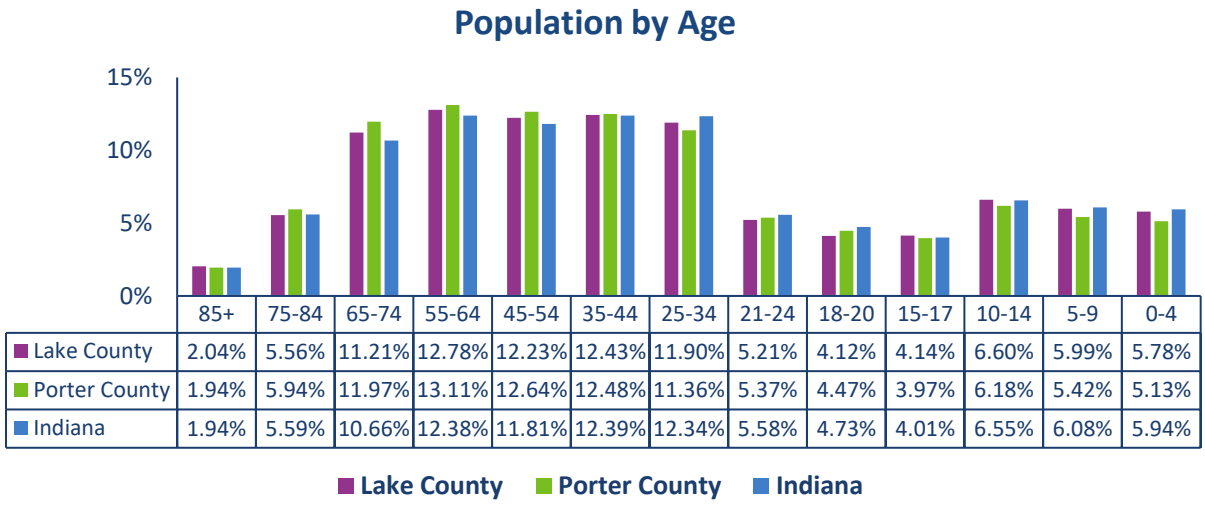
FIGURE 4: PERCENT OF POPULATION



Age

Figure 5 shows the population by age group in Indiana, Lake and Porter counties. The age distributions in both Lake and Porter counties are similar to the overall age distribution across Indiana. About half of the population for each locale is between the ages of 25 and 64.

FIGURE 5: POPULATION BY AGE

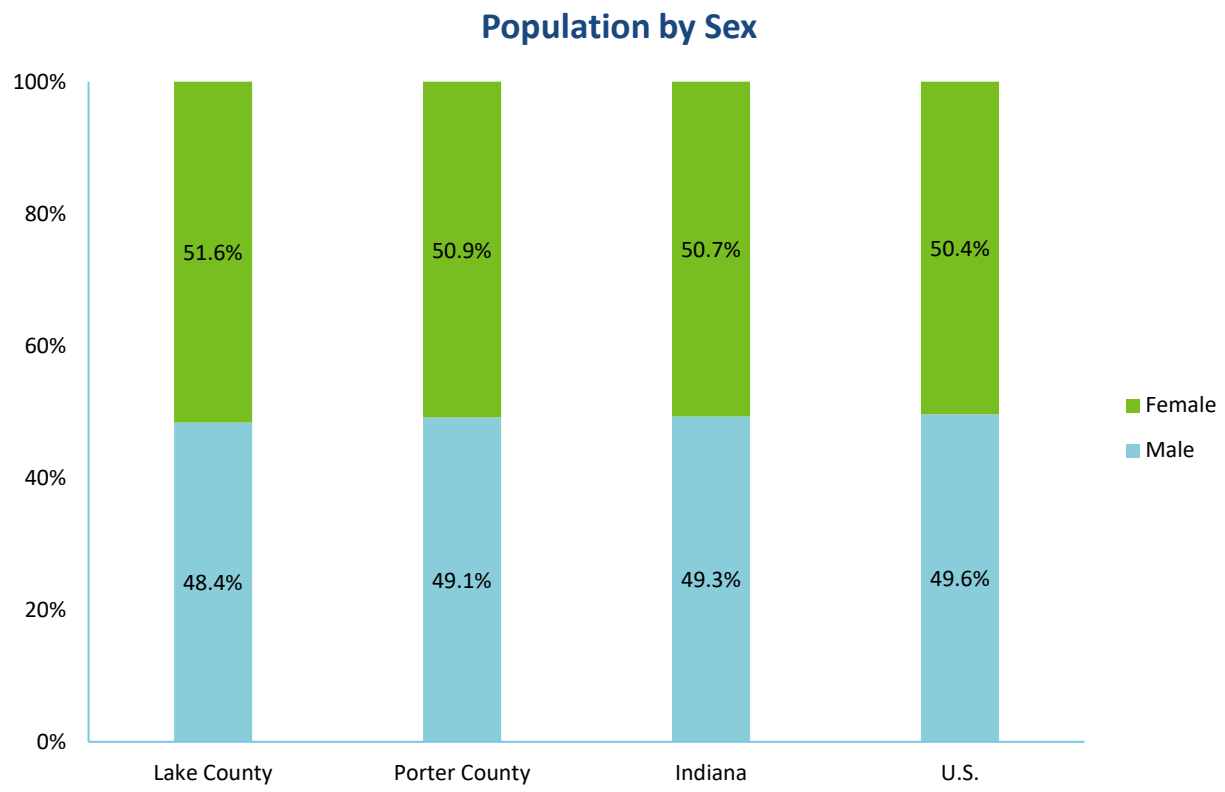


	85+	75-84	65-74	55-64	45-54	35-44	25-34	21-24	18-20	15-17	10-14	5-9	0-4
Lake County	2.04%	5.56%	11.21%	12.78%	12.23%	12.43%	11.90%	5.21%	4.12%	4.14%	6.60%	5.99%	5.78%
Porter County	1.94%	5.94%	11.97%	13.11%	12.64%	12.48%	11.36%	5.37%	4.47%	3.97%	6.18%	5.42%	5.13%
Indiana	1.94%	5.59%	10.66%	12.38%	11.81%	12.39%	12.34%	5.58%	4.73%	4.01%	6.55%	6.08%	5.94%

Sex

Figure 6 shows Lake and Porter counties population by sex. For Lake and Porter counties, as well as the overall state and nation, the female population is slightly higher than the male population. Among these locales, Lake County has the largest female population at 51.6%. Claritas Pop-Facts® and the American Community Survey only provide population estimates by sex and do not provide estimates regarding transgender or nonbinary populations.

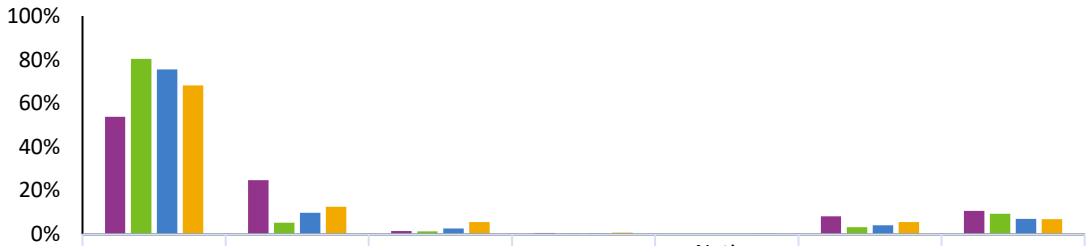
FIGURE 6: POPULATION BY SEX



Race and Ethnicity

Race and ethnicity contribute to community members' access to healthy resources, supports and opportunities. **Figure 7** shows the population by race in Lake and Porter counties. Notably, Lake County has a substantially larger Black/African American population than Porter County, Indiana and the nation. Overall, the Lake County 2024 population is 53.8% White, 24.8% Black/African American and 1.6% Asian/Asian American. The Porter County 2024 population is 80.3% White, 9.9% Black/African American and 1.3% Asian/Asian American.

FIGURE 7: POPULATION BY RACE & ETHNICITY

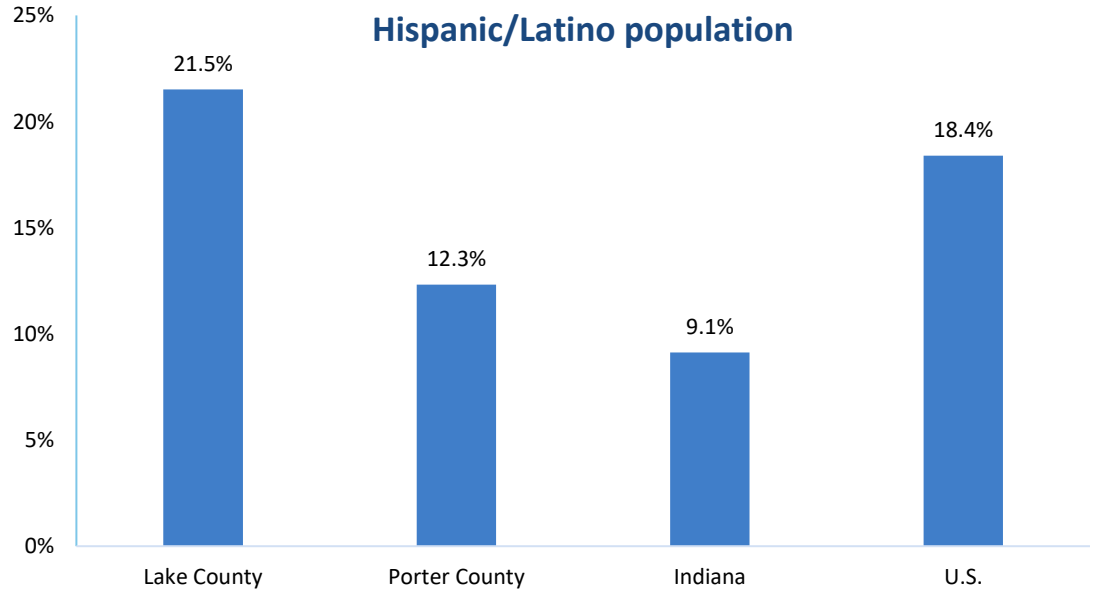


	White or Caucasian	Black or African American	Asian or Asian American	American Indian or Alaska Native	Native Hawaiian or other Pacific Islander	Another race	More than one race
Lake County	53.8%	24.8%	1.6%	0.6%	0.03%	8.3%	10.8%
Porter County	80.3%	5.3%	1.3%	0.3%	0.04%	3.3%	9.5%
Indiana	75.6%	9.9%	2.7%	0.4%	0.1%	4.2%	7.2%
U.S.	68.2%	12.6%	5.7%	0.8%	0.2%	5.6%	7.0%

Figure 8 shows the population estimates by ethnicity for Lake and Porter counties. Lake County has a particularly large Hispanic/Latino population (21.5%) compared to Porter County (12.3%). Both counties have a larger Hispanic/Latino population than Indiana overall (9.1%).

American Community Survey also offers limited data on other ethnicities, including Middle Eastern and North African (MENA) populations, although the MENA populations of Lake and Porter counties are both less than 1% of the overall populations.

FIGURE 8: HISPANIC/LATINO POPULATION



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 (SDOH) can be grouped into domains. **Figure 9** shows the Healthy People 2030 Social Determinants of Health domains.[3] 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

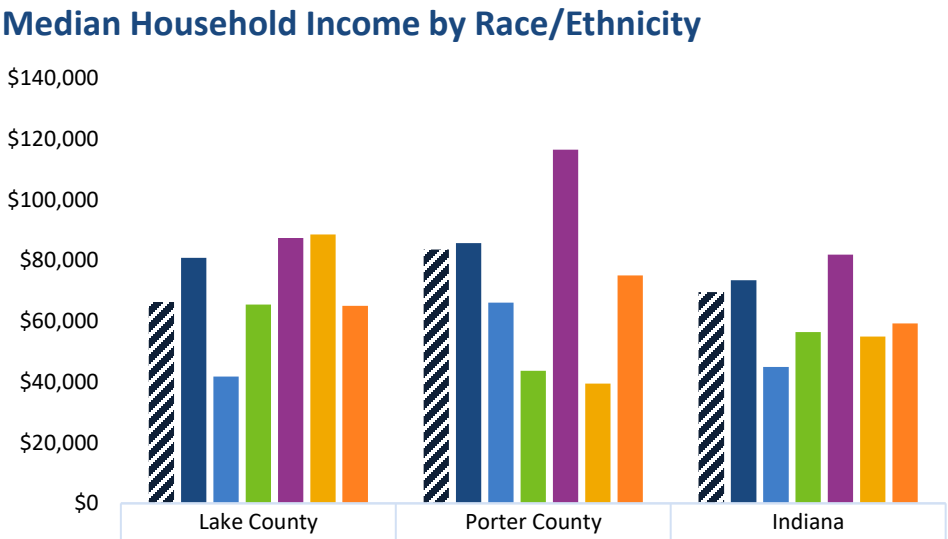
Income

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.

[3] Social Determinants of Health; https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health

As shown in **Figure 10**, the median household income for Lake County is $66,321, which is similar to that of Indiana ($69,674). The median household income in Porter County is higher, at $83,668. There are significant disparities by race/ethnicity. For both Lake and Porter counties, as well as Indiana overall, the median income for Black/African American communities are lower than the overall median income by $15,000 or more. 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
Overall	$66,321	$83,668	$69,674
White	$80,902	$85,815	$73,507
Black/African American	$41,821	$66,193	$44,964
American Indian/Alaskan Native	$65,563	$43,700	$56,409
Asian	$87,439	$116,604	$81,980
Native Hawaiian/Pacific Islander	$88,636	$39,500	$55,018
Hispanic/Latino	$65,092	$75,115	$59,318

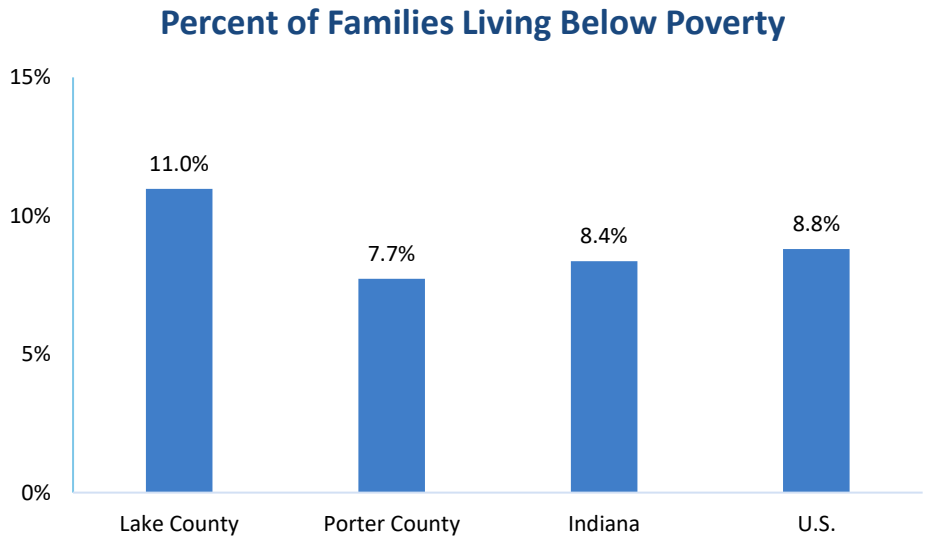
Source: Claritas, 2024

Poverty

Federal poverty thresholds are set every year by the Census Bureau and vary by the size of the family and the ages of family members. People living in poverty are less likely to have access to health care, 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 is relatively higher in Lake County (11.0%) and lower in Porter County (7.7%), compared to both Indiana (8.4%) and the United States (8.8%).

FIGURE 11: FAMILIES LIVING BELOW POVERTY



Source: Claritas, 2024; ACS, 2018-2022

Figure 12 shows the percentage of the 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 12 are the most likely population to live in poverty, followed by youth aged 12-17. All three of these age groups (Under 6, 6 to 11 and 12 to 17) are about twice as likely to experience poverty in Lake County, compared to Porter County. Young adults aged 18-24 are the most likely to experience poverty in Porter County, as well as Indiana and the nation.

FIGURE 12: PEOPLE LIVING BELOW POVERTY BY AGE

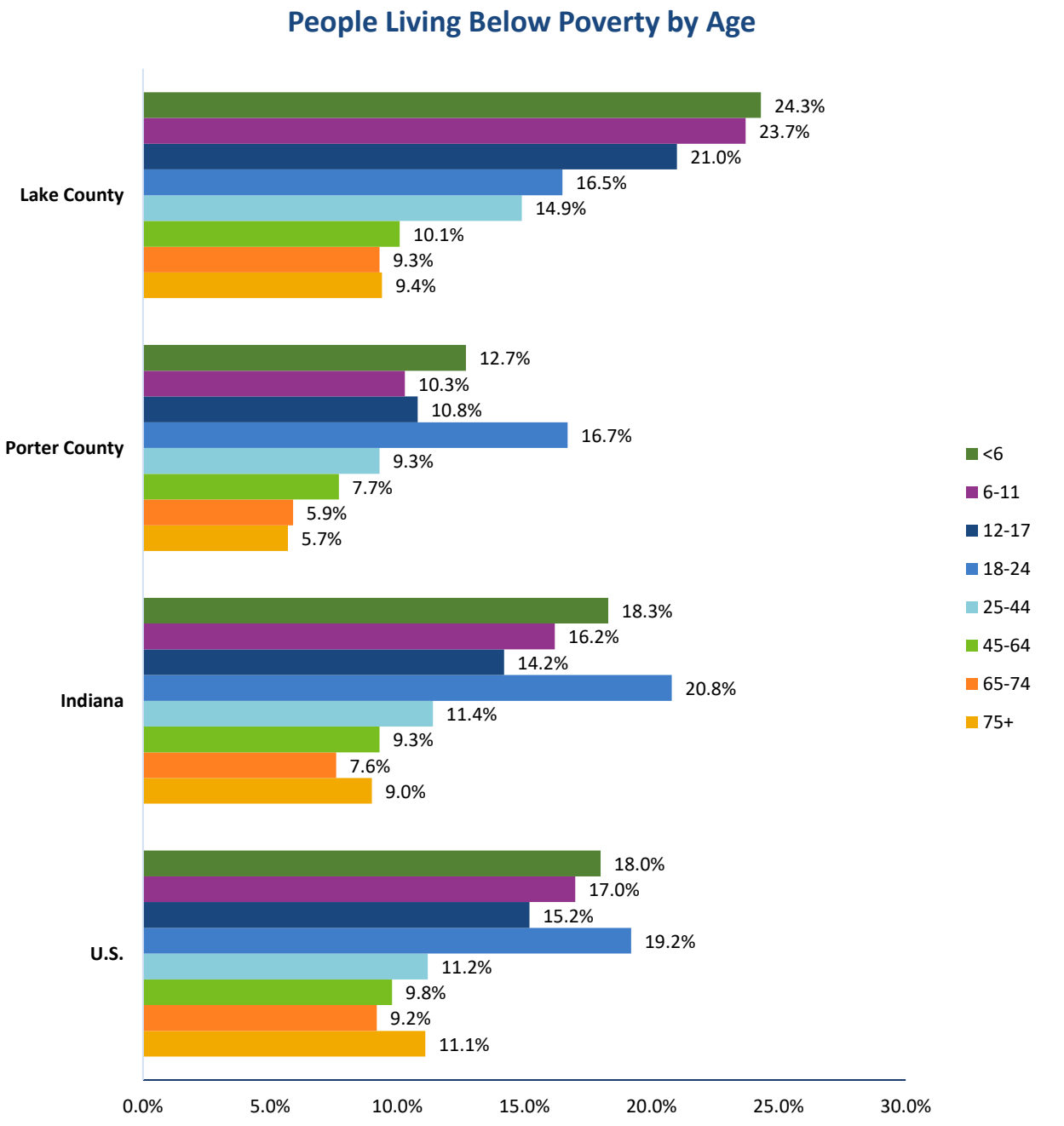


Figure 13 shows the percentage of the population in Lake County and Porter County by race and ethnicity who are living below the poverty level. Black/African American residents are most likely to experience in poverty in Lake County (28.0%), whereas American Indian/Alaska Native residents are most likely to experience poverty in Porter County (21.1%). Although Lake County has a higher overall rate of poverty than Porter County, American Indian/Alaska Native residents are are more likely to experience poverty in Porter County than Lake (21.1% vs. 16.6%).

FIGURE 13: PEOPLE LIVING BELOW POVERTY BY RACE & ETHNICITY

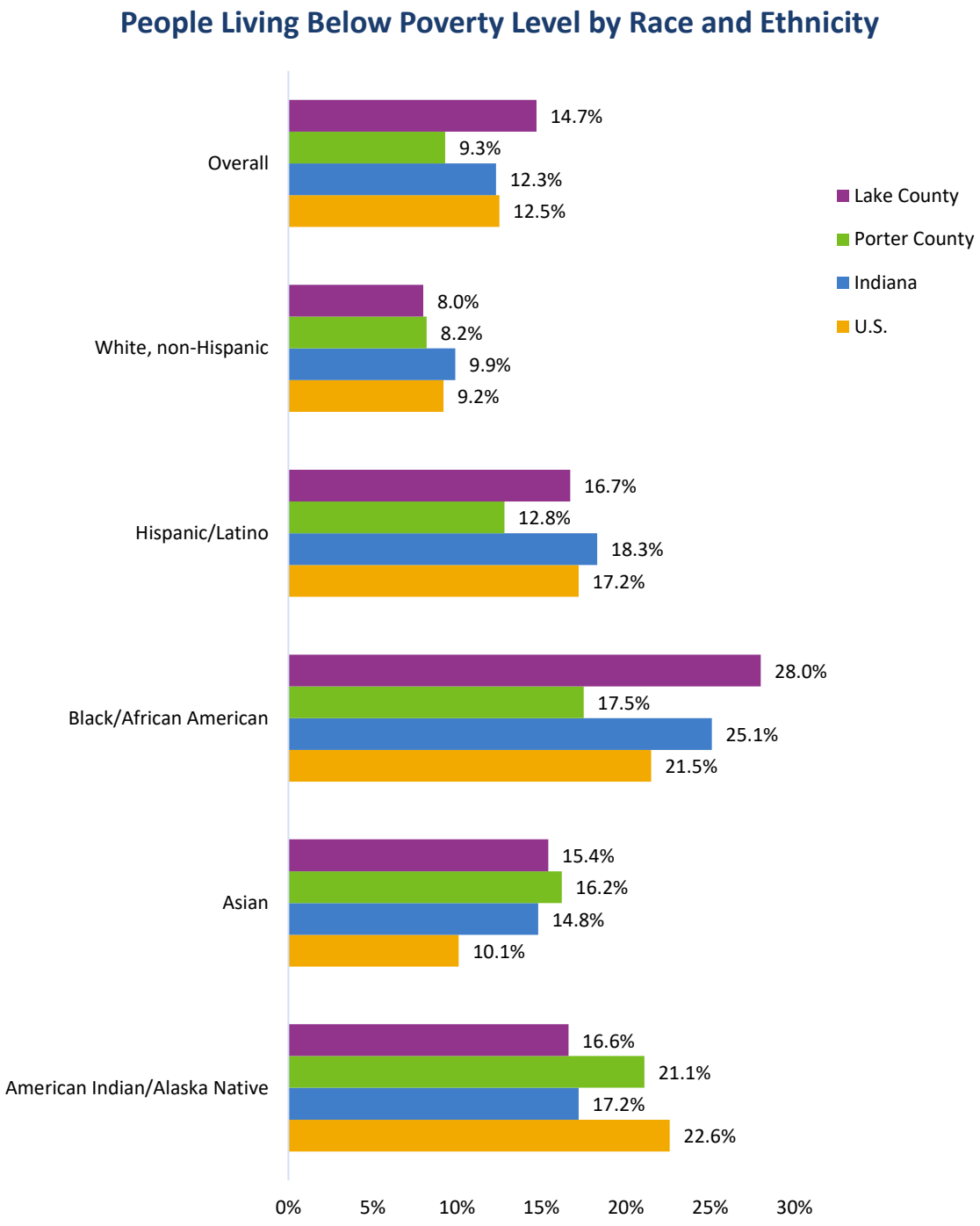
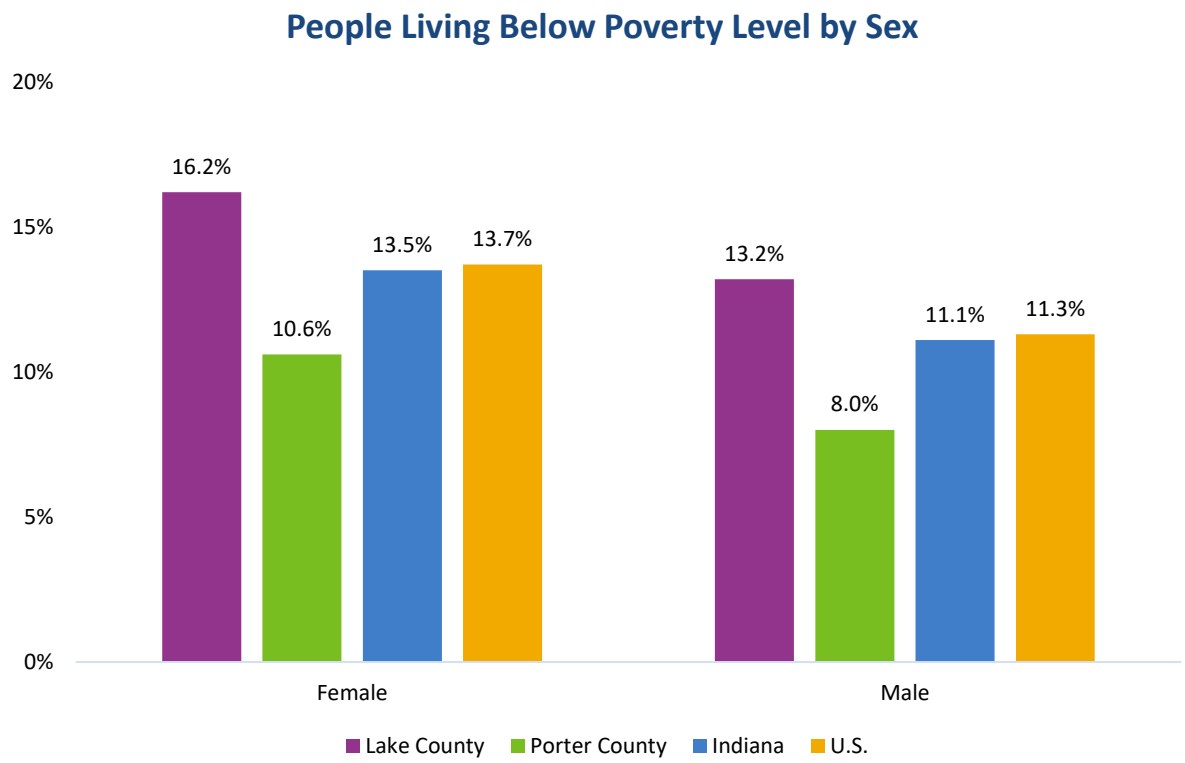


Figure 14 shows the percentage of the population in Lake and Porter counties compared to the state of Indiana and the United States by sex who are living below the poverty level. For all locales, the female population is more likely to experience poverty than the male population.

FIGURE 14: PEOPLE LIVING POVERTY LEVEL BY SEX



Employment

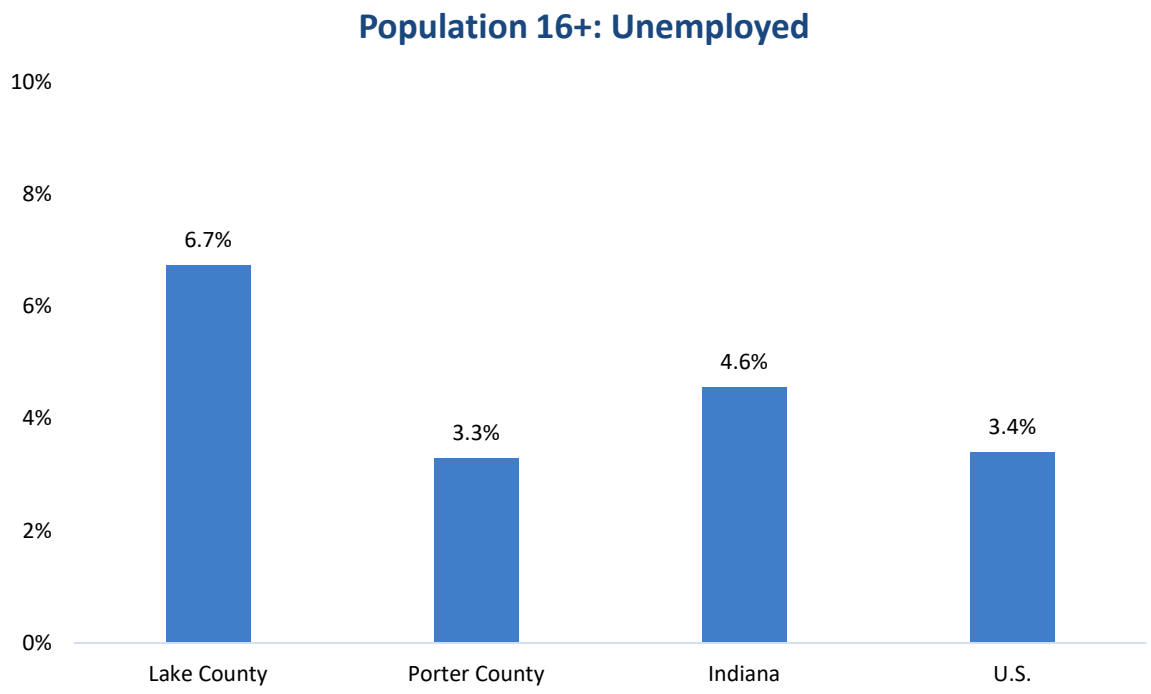
The employment rate in a community is a key indicator of the local economy. An individual's type and level of employment impact access to health care, the work environment and health behaviors and outcomes. Stable employment can help provide benefits and conditions for maintaining good health. In contrast, 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. The unemployment rate in Lake County is twice that of Porter County (6.7% vs. 3.3%) and is also higher than the statewide and nationwide unemployment rates.

FIGURE 15: POPULATION 16+ UNEMPLOYED

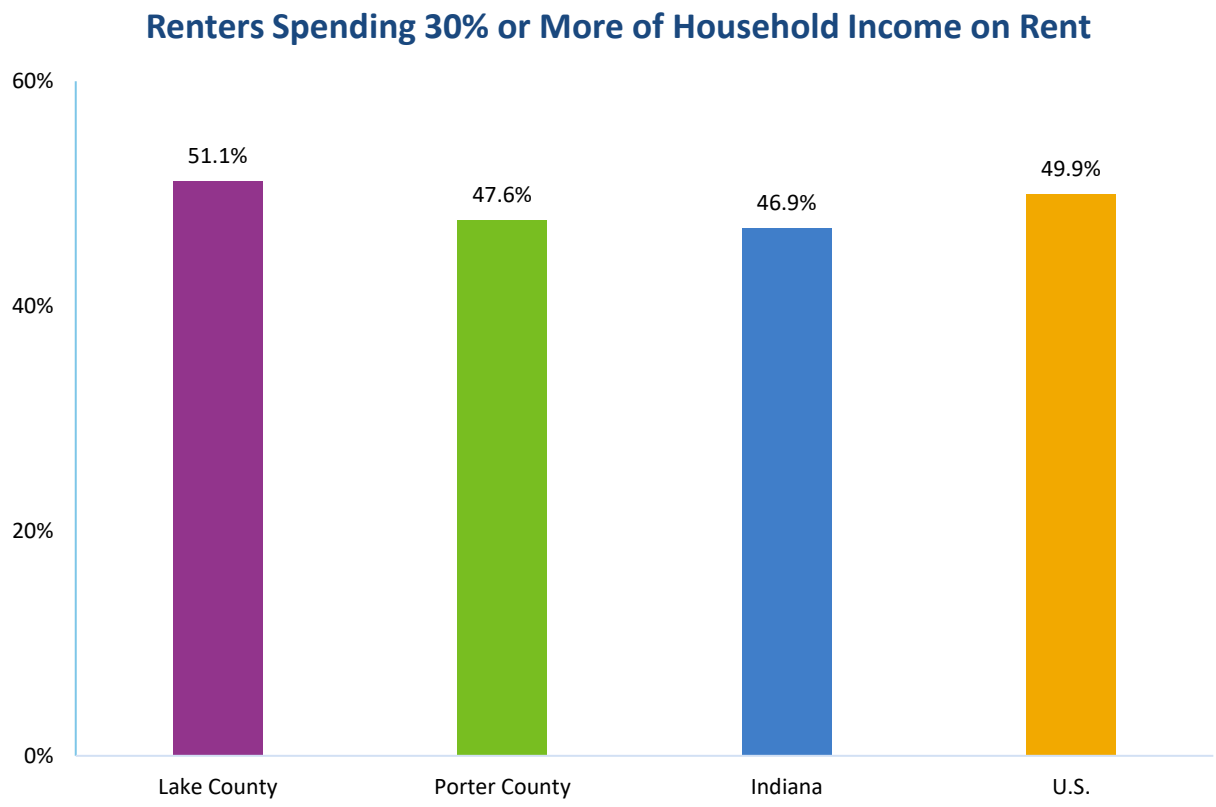


Housing

Safe, stable, affordable housing provides a critical foundation for health and well-being. 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 health care. 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, 51.1% of renters spend 30% of their income or more on rent, compared to 47.6% in Porter County.

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

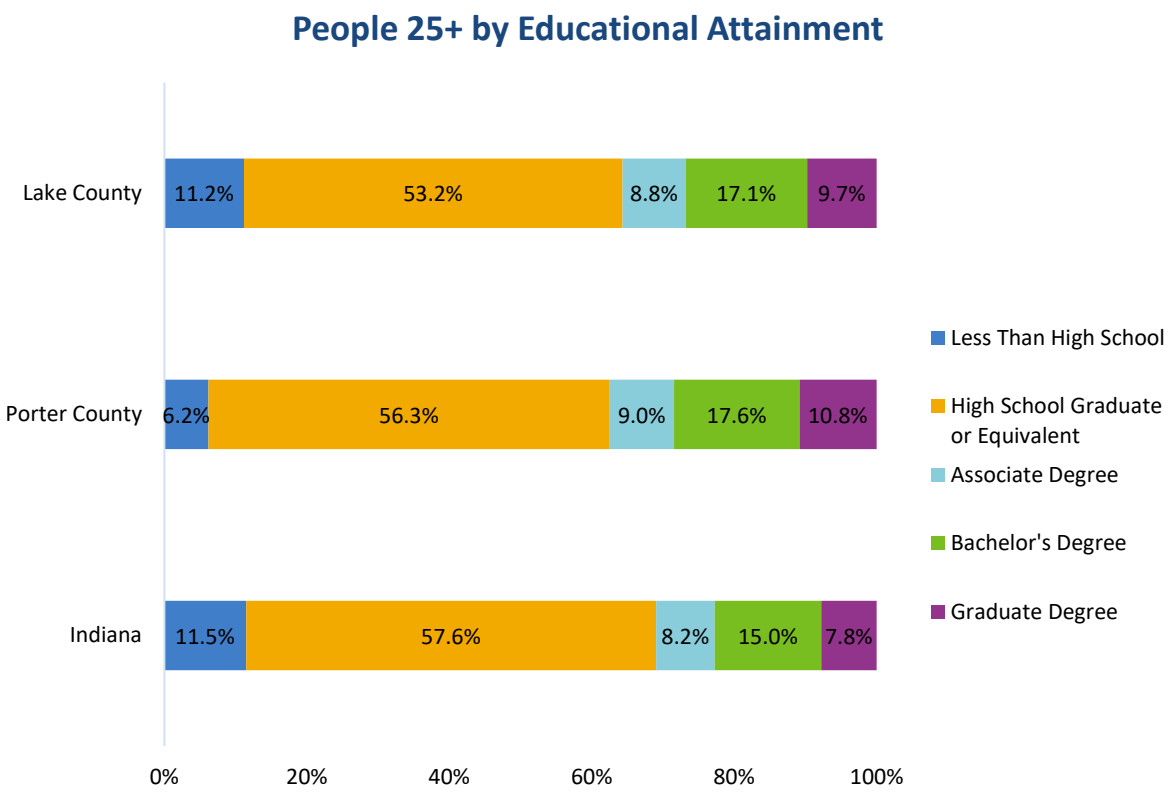


Education

Education is an important indicator of health and well-being 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 longer lives.

Figure 17 shows the percentage of the population age 25+ by educational attainment. Porter County residents are more likely than those of Lake County and Indiana overall to graduate high school. Both Lake County and Porter County residents are more likely than the statewide population to have completed an Associate's, Bachelor's, or Graduate degree.

FIGURE 17: EDUCATIONAL ATTAINMENT OF PEOPLE 25+



SECTION 3: DATA COLLECTION AND ANALYSIS

Overview

The 2025-2028 Community Health Needs Assessment combined primary and secondary data to identify current health-related issues in Lake and Porter counties.

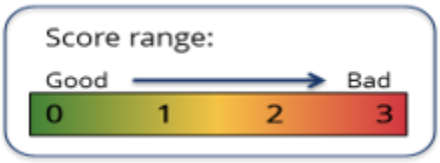
Primary data was acquired directly from the community through in-person and virtual outreach. When applicable, the data collection was conducted in English and Spanish and consisted of a community-wide survey campaign, three focus groups and a listening session. Secondary health indicator data was collected from public sources such as federal, state and local health departments.

Secondary Data Sources

Secondary data for this assessment were collected and analyzed with the Healthy Communities Institute (HCI) Community Dashboard — a web-based community health platform developed by Conduent Healthy Communities Institute. The Community Dashboard brings a wealth of information to one accessible, user-friendly location. It includes over 260 community and behavioral health indicators covering over 25 topics in health, determinants of health and quality of life. The data is primarily derived from secondary 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 outcome and 3 the worst.



The 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 at a system level. For further details on the quantitative data scoring methodology, please see Appendix A.

TABLE 2. SECONDARY DATA TOPIC SCORING RESULTS SYSTEM LEVEL

Health and Quality of Life Topics	Score
Infectious Diseases	1.97
Maternal, Fetal & Infant Health	1.78
Older Adults	1.76
Children's Health	1.73
Other Conditions	1.70
Heart Disease & Stroke	1.69
Prevention & Safety	1.67
Economy	1.65
Community	1.65
Cancer	1.63
Wellness & Lifestyle	1.62
Alcohol & Drug Use	1.59
Education	1.59
Diabetes	1.58
Women's Health	1.58
Physical Activity	1.57
Oral Health	1.53
Respiratory Diseases	1.53
Immunizations & Infectious Diseases	1.52
Environmental Health	1.48
Health Care Access & Quality	1.39
Mental Health & Mental Disorders	1.21

Race, Ethnicity and Sex Disparities: Secondary Data

Community health disparities were assessed in the secondary data using the Index of Disparity[4] analysis, which identifies disparities based on how far each subgroup (by race, ethnicity, or sex) is from the overall county value. For more detailed methodology related to the Index of Disparity, see Appendix B.
The Index of Disparity identified indicators-related inequities across several health and quality of life domains. For a complete description of each of these disparities, see the full data scoring table in Appendix A. Table 3 includes a selection of these secondary data indicators, particularly those with a significant racial or ethnic disparity from the identified topic areas of concern for Powers Health.

TABLE 3: INDICATORS WITH SIGNIFICANT RACIAL OR ETHNIC DISPARITIES: LAKE COUNTY

Health Indicator	Units	Overall Rate	Black	White	Hispanic/ Latino	AAPI	AIAN
Age-Adjusted Death Rate due to Diabetes	deaths / 100,000 population	29.3	53.7	22.9	25.7	-	-
Age-Adjusted Death Rate due to Prostate Cancer	deaths / 100,000 males	21.0	36.9	18.5	12.6	-	-
Infant Mortality Rate	deaths / 1,000 live births	7.4	12.2	-	10.2	-	-

As indicated in Table 3, the Black population of Lake County experiences greater burden of cancer, diabetes and birthing-related risks. The Black population of Lake County experiences a greater risk of death due to diabetes than the broader county population (53.7 vs. 29.3 deaths / 100,000). Black males in particular experience a greater risk of death due to prostate cancer than the overall male population of Lake County (36.9 vs. 21.0 deaths / 100,000 males). Finally, the Black population also experiences a greater risk of infant mortality than the overall county population (12.2 vs. 7.4 deaths / 1,000 live births)
We did not observe any significant racial/ethnic disparities in Porter County related to the Powers Health prioritized topic areas.Tables 4 and 5 include a selection of secondary data indicators with a significant disparity based on sex, from the identified topic areas of concern for Powers Health.

TABLE 4: INDICATORS WITH SIGNIFICANT DISPARITIES BY SEX: LAKE COUNTY

Health Indicator	Units	Overall Rate	Male	Female
Age-Adjusted Death Rate due to Suicide	deaths / 100,000 population	10.5	17.2	4.4
Oral Cavity and Pharynx Cancer Incidence Rate	cases / 100,000 population	11.5	17.1	6.9

As indicated in Table 4, the male population of Lake County experiences some greater risks related to suicide and cancer. Males are more likely than the overall county population to die by suicide (17.2 vs.

[4] Pearcy, J. & Keppel, K. (2002). A Summary Measure of Health Disparity. Public Health Reports, 117, 273-280.

10.5 deaths / 100,000 population). Males are also more likely than the general county population to develop oral cavity or pharynx cancer (17.1 vs. 11.5 cases / 100,000 population).

TABLE 5: INDICATORS WITH SIGNIFICANT DISPARITIES BY SEX: PORTER COUNTY

Health Indicator	Units	Overall Rate	Male	Female
Age-Adjusted Death Rate due to Alzheimer's Disease	deaths / 100,000 population	34.0	23.1	41.3
Age-Adjusted Death Rate due to Coronary Heart Disease	deaths / 100,000 population	75.2	103.8	52.1
Depression: Medicare Population	percent	16	11	19
Ischemic Heart Disease: Medicare Population	percent	23	32	16
Oral Cavity and Pharynx Cancer Incidence Rate	cases / 100,000 population	14.1	20.0	8.8

As indicated in Table 5, the Porter County population also experiences some disparities by sex. Males are more likely to experience some heart disease and cancer risks. For example, males have a greater risk than the general county population of dying due to coronary heart disease (103.8 vs. 75.2 deaths / 100,000 population) and males among the Medicare population have a greater risk of developing ischemic heart disease (32% vs. 23%). The female population of Porter County also experiences some disparities. Females in Porter County experience a greater risk of death due to Alzheimer's disease than the general county population (41.3 vs. 34.0 deaths / 100,000 population) and females among the Medicare population are more likely to experience depression (19% vs. 16%).

Geographic Disparities

This assessment identified specific zip codes with differences in outcomes related to health and social determinants of health. Geographic disparities were identified using the SocioNeeds Index® Suite[5] developed by Conduent Healthy Communities Institute. This suite includes the Health Equity Index, Food Insecurity Index and Mental Health Index. Each of these indices summarizes multiple socioeconomic indicators into a composite score correlated with preventable hospitalization and premature death, food insecurity, or poorer mental health outcomes, for each of these three indices, counties, zip codes and census tracts with a population over 300 persons are assigned an index value ranging from 0 to 100, with higher values indicating greater need. Understanding where there are communities with higher needs is critical to targeting prevention and outreach activities.

[5] For further detailed methodology: https://help.healthycities.org/hc/en-us/articles/4635438561943-SocioNeeds-Index-Suite

Health Equity

Health equity focuses on the fair distribution of health-related determinants, outcomes and resources across communities.[6] National trends have shown that systemic racism, poverty and gender discrimination have led to poorer health outcomes for groups such as Black/African American persons, Hispanic/Latino persons, Indigenous communities, people with incomes below the federal poverty level and LGBTQ+ communities.

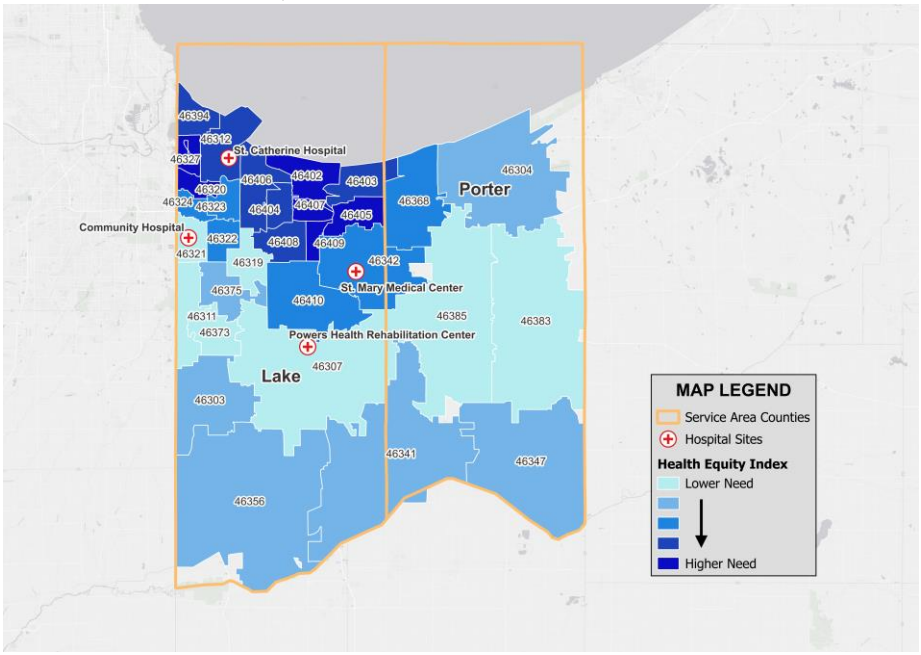
Health Equity Index

Conduent's Health Equity Index (HEI)[7] is a composite score of socioeconomic indicators related to income, poverty, employment, education, language, Medicaid enrollment and race. Each of these indicators has a strong correlation with poor health outcomes, including preventable hospitalization and premature death. Zip codes are ranked based on their index value to identify relative levels of need. Table 6 provides the index values for the highest-scoring zip codes in the Powers Health service area. The index values for all zip codes are mapped in Figure 18, with darker shades of blue indicating higher needs.

TABLE 6: HEALTH EQUITY INDEX VALUES BY ZIP CODE

Zip Code	Index Value
46402	98.2
46405	98.0
46327	95.6
46409	95.1
46320	93.8
46407	92.6
46408	91.3
46312	88.0
46406	83.3
46394	82.6

FIGURE 18: HEALTH EQUITY INDEX



[6] Klein R, Huang D. Defining and measuring disparities, inequities and inequalities in the Healthy People initiative. National Center for Health Statistics. Center for Disease Control and Prevention. https://www.cdc.gov/nchs/ppt/nchs2010/41_klein.pdf

[7] For further detailed methodology: https://help.healthycities.org/hc/en-us/articles/12946032705431-What-is-the-Health-Equity-Index-ranking-and-how-is-it-determined

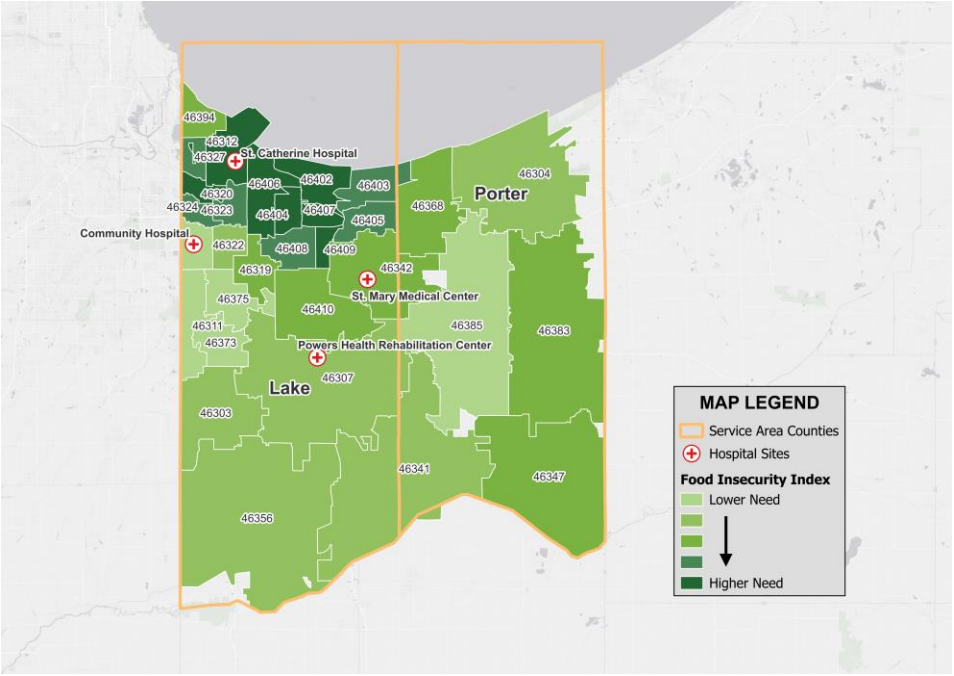
Food Insecurity Index

Conduent's Food Insecurity Index (FII)[8] is a composite score of socioeconomic indicators related to education, poverty, household environment and transportation. Each of these indicators has a strong correlation with food insecurity. Zip codes are ranked based on their index value to identify relative levels of need. Table 7 provides the index values for the highest scoring zip codes in the Powers Health service area. The index values for all zip codes are mapped in Figure 19, with higher needs indicated by darker shades of green.

TABLE 7: FOOD INSECURITY INDEX VALUES BY ZIP CODE

Zip Code	Index Value
46402	99.6
46407	99.3
46320	98.6
46312	98.5
46409	98.0
46406	97.1
46404	96.6
46408	95.8
46403	95.1
46327	91.5

FIGURE 19: FOOD INSECURITY INDEX



[8] For further detailed methodology: https://help.healthycities.org/hc/en-us/articles/5675958006039-Where-can-I-find-more-details-on-the-methodology-used-to-create-the-Food-Insecurity-Index

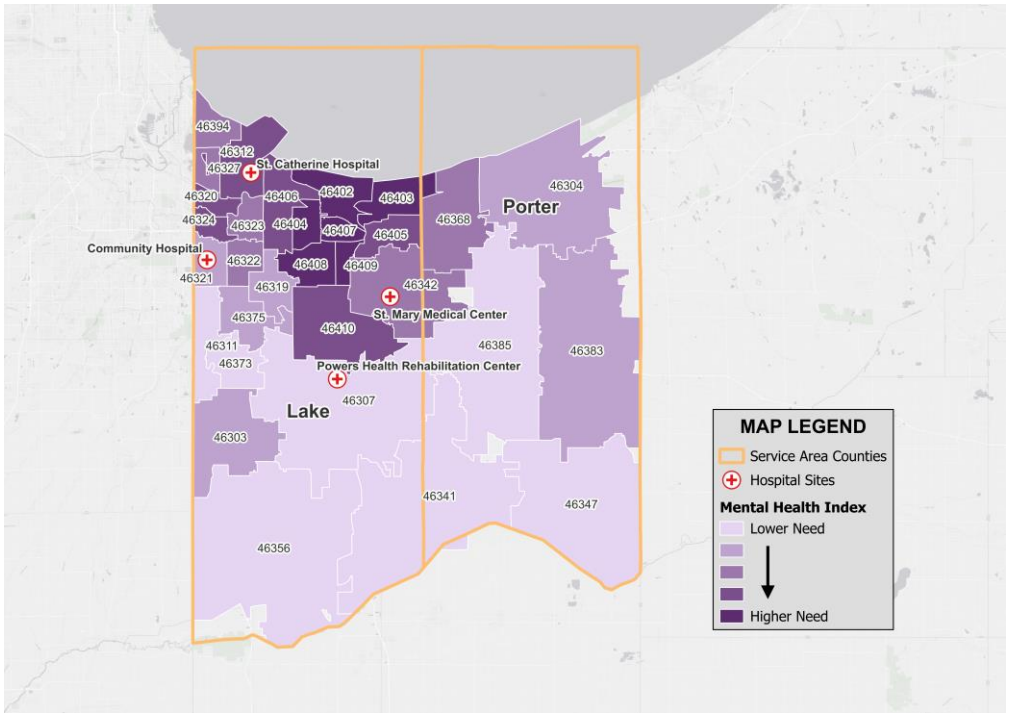
Mental Health Index

Conduent's Mental Health Index (MHI)[9] is a composite score of socioeconomic indicators related to disability, employment, health care access, household environment and transportation. Each of these indicators has a strong correlation with self-reported poor mental health. Zip codes are ranked based on their index value to identify relative levels of poor mental health outcomes. Table 8 provides the index values for the highest scoring zip codes in the Powers Health service area. The index values for all zip codes are mapped in Figure 20, with higher needs indicated by darker shades of purple.

TABLE 8: MENTAL HEALTH INDEX VALUES BY ZIP CODE

Zip Code	Index Value
46402	99.6
46407	99.5
46409	98.4
46404	98.4
46403	97.8
46408	97.0
46406	96.6
46320	95.6
46312	94.1
46410	94.1

FIGURE 20: MENTAL HEALTH INDEX



[9] For further detailed methodology: https://help.healthycities.org/hc/en-us/articles/14130448961303-Where-can-I-find-information-about-the-methodology-used-to-create-the-Mental-Health-Index

Community Input Collection & Analysis

The Community Health Needs Assessment aims to determine what the community believes are the most critical 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. Combined with the secondary data analysis, these findings provided the Powers Health with the key health needs for the 2025-2028 Community Health Needs Assessment.

In-person and virtual meetings were scheduled with help from community organizations to assist in the survey process and the promotion, recruitment and logistical needs for local community members' participation 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 the list does not reflect every resource available in the community, it can help Powers Health 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 in English and Spanish from October 15, 2024 through November 29, 2024. 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 and social and economic determinants of health. Announcements promoting the community surveys in Lake and Porter counties included a press release, social media, email blasts to various organizations and sharing the QR code at in-person events, Powers Health staff and internal and external teams. A total of 1,790 responses were collected, 1,482 from Lake County and 308 from Porter County. Response rates for Lake County met the target rate of collecting more than 384 and Porter County just under 308 surveys.

Surveys were completed in English and Spanish. Approximately seventy-six percent of survey respondents described themselves as White or Caucasian and 12.04% as Hispanic/Latino (**Figure 21).** The largest age group ranged from 55 to 64, followed by 45 to 54 **(Figure 22**). Most respondents identified as female (**Figure 23**) and 25.46% had a bachelor's degree, followed by 22.82% with a Technical/Vocational School Certificate or associate degree (**Figure 24).**

FIGURE 21: RACE/ETHNICITY OF COMMUNITY SURVEY RESPONDENTS

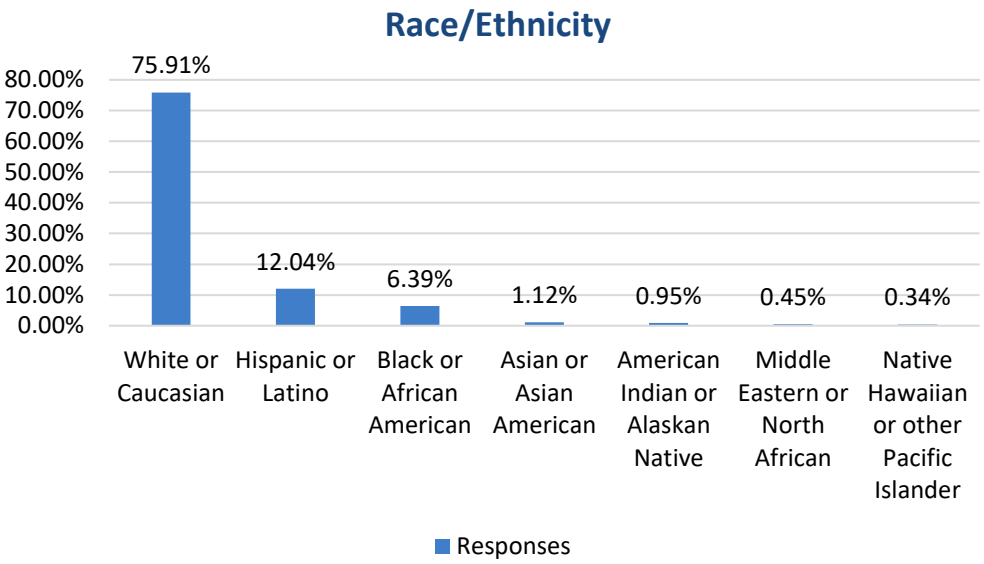


FIGURE 22: AGE OF SURVEY RESPONDENTS

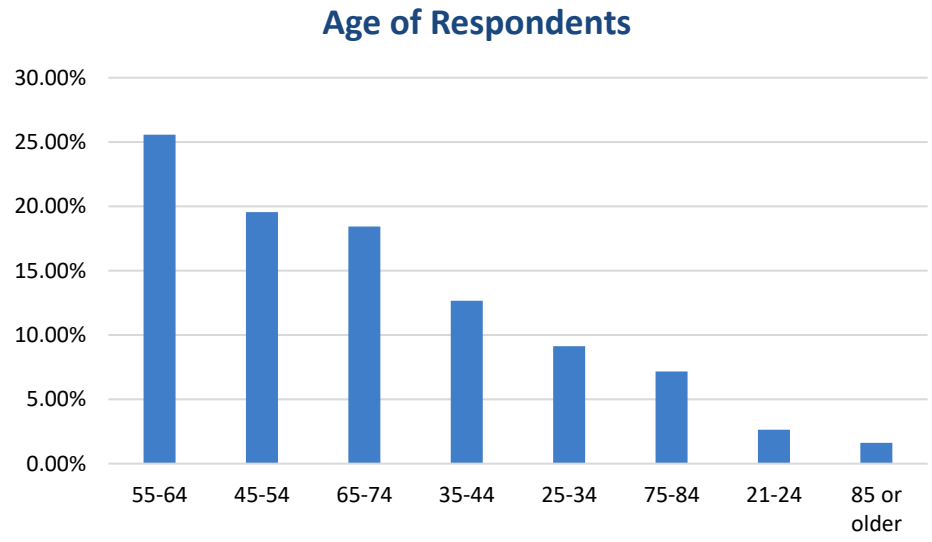


FIGURE 23: GENDER OF SURVEY RESPONDENTS

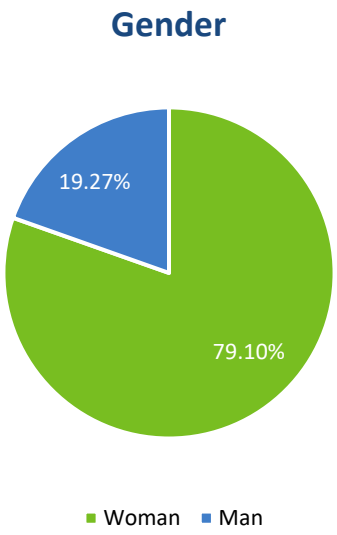
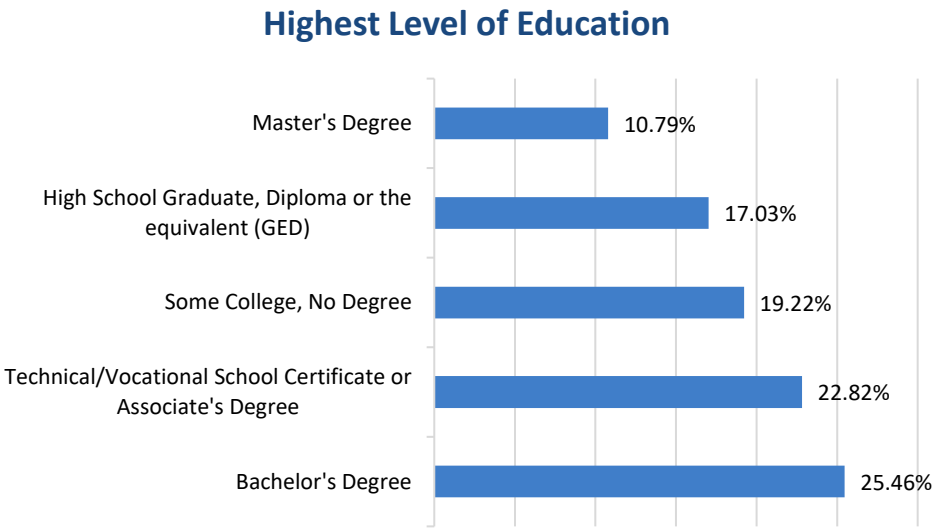


FIGURE 24: EDUCATION OF COMMUNITY SURVEY RESPONDENTS



Community Survey Analysis Results

The survey asked participants 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 Access to Affordable Healthcare Services (doctors available nearby, wait times, services available nearby, takes insurance –39.08%); Mental Health and Mental Disorders (anxiety, depression, suicide – 34.54 %); Weight Status (24.28%); Alcohol and Drug Use (22.47%); and Cancer (21.07%).

FIGURE 25: MOST IMPORTANT COMMUNITY HEALTH ISSUES

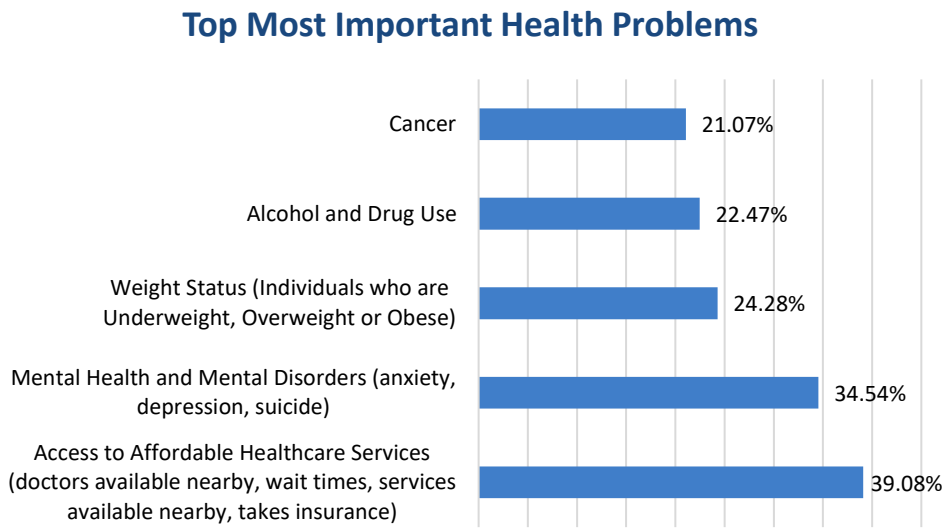
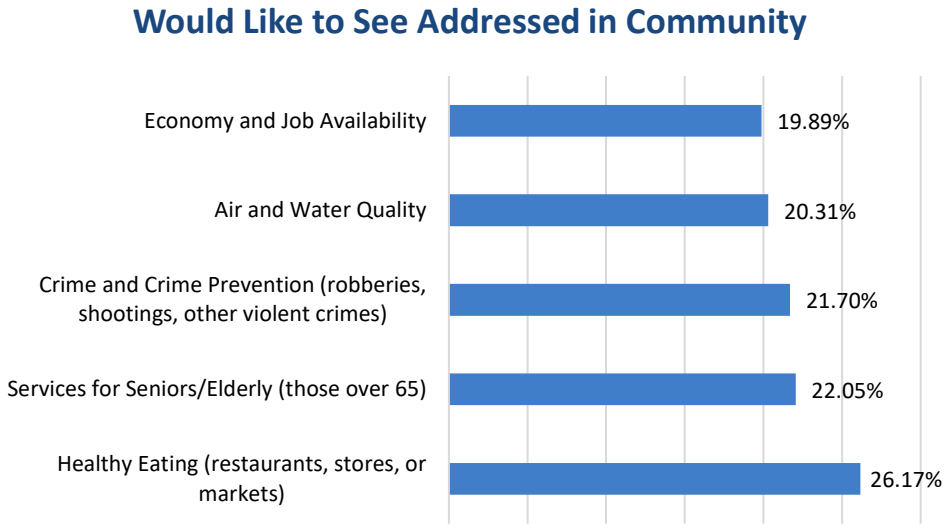


Figure 26 shows that the top issues survey respondents would like to see addressed in the community were Healthy Eating (restaurants, stores, or markets – 26.17%), services for Seniors/Elderly (those over 65 – 22.05%), Crime and Crime Prevention (robberies, shootings and other violent crime –21.70%), air and Water Quality (20.31%) and Economy and Job Availability (18.89%).

FIGURE 26: MOST LIKED TO SEE ADDRESSED



Focus Groups

Focus groups were conducted to gain deeper insight into community members' perceptions, attitudes, experiences, or beliefs about their health. It is important to note that the information collected in an individual focus group is exclusive to that group and does not represent other groups. A total of three in-person focus groups were scheduled for November 4-7, 2024: two English groups and one bilingual (English and Spanish) group. Focus groups, led by Conduent HCI facilitators, included participants from Lake and Porter counties. **Table 9** shows the three focus groups completed, which included a total of twenty participants. Individuals recruited for focus groups included those living in and/or working in Lake and Porter counties. The in-person focus group sessions lasted 60 to 90 minutes.

Residents and employees from Lake and Porter counties provided insights when facilitators asked seven questions to prompt discussion on top community health issues, barriers/challenges to health and greatest community strengths. Facilitators recorded the sessions, took notes from the focus groups and uploaded them to the web-based qualitative data analysis tool and Qualtrics. 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 needs was determined, in part, by the frequency of the topic or issue discussed across all three focus groups.

TABLE 9: LAKE AND PORTER COUNTY FOCUS GROUPS COMPLETED

Location	Facilitation Language	Total Community Participants
Porter County First United Methodist Church of Valparaiso	English	11
Lake County Public Library Merrillville, IN Multicultural Wellness Network	English	6
St. Catherine Hospital East Chicago, IN	Spanish/English	3

Themes Across All Focus Groups

Table 10 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. These results are detailed in Section 4: Key Health Needs. **Appendix B** details the main themes trending across focus group conversations.

TABLE 10: LAKE AND PORTER COUNTIES FOCUS GROUP THEMES

Maine Theme	Sub-topics: Concerns, issues and barriers
Access to Healthcare	Need for preventative services, insurance barriers-frustration over insurance limitations (inability to access dieticians or preventative medications, need for education (health literacy) on diabetes, stroke, heart disease and need for comprehensive care.
Chronic Diseases	Education, awareness of healthy food options and physical activity opportunities are needed.
Mental Health	Access to affordable services and need for support to help find services available in the community, COVID-19 exacerbated issues for youth and seniors experiencing isolation and limited facilities and resources for immediate or ongoing care. Stigma related to access care.
Transportation	Difficulties traveling to areas outside main corridors or for specialized care, limited public transportation options.

Listening Session

Powers Health and Conduent HCI conducted an online survey with key community stakeholders to capture quantitative data concerning health influences in Lake and Porter counties. HCI hosted a follow-up virtual discussion with the stakeholders to capture qualitative insights and feedback. Powers Health CHNA team identified the community partners and extended the invitations for this discussion. Various community partners were invited to participate in the listening session. The main goal of the listening session was to determine health needs, issues and opportunities to strengthen collaborations within the communities served by Powers Health.

A total of 38 listening session participants completed the online survey and attended the following 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 survey results, top community health issues, barriers/challenges to health, key strengths and resources in their community, place of work, or organization.

Table 11 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 Qualtrics.

Listening session transcripts were coded using a pre-designed codebook, organized by themes and analyzed for significant observations. The frequency with 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 Powers Health service area. Section 4: Key Health Needs provides a detailed explanation of these results. Appendix B provides the detailed results of the Listening session.

TABLE 11: LISTENING SESSION TOP HEALTH NEEDS

Main Theme	Sub-topics: Concerns, issues, and barriers
Access to Healthcare	Residents have difficulty accessing healthcare services due to various barriers, such as transportation, financial constraints and a lack of providers. The high costs associated with healthcare services make it difficult for residents to afford necessary care.
Chronic Diseases (Diabetes, Heart Disease, Hypertension)	The prevalence of asthma among residents is potentially linked to environmental factors like air pollution. Cancer is a significant health concern, with a need for better screening and treatment options. High rates of diabetes necessitate improved management and prevention strategies. Heart disease and obesity are significant health issues that require better prevention and treatment efforts.
Food Insecurity	Lack of access to nutritious food leads to food insecurity and poor nutritional literacy.
Lack of Transportation	Difficulties accessing care due to long distances to hospitals/clinics.
Mental Health	Mental health issues, including depression and anxiety, are exacerbated by factors like COVID-19, lack of providers and stigma.
Populations	Undocumented immigrants, teens, seniors/aging.

Data Considerations

Conduent 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, each topic may have varying scope and depth of secondary data indicators and findings. 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 robust indicators, while others may have limited indicators available for Powers Health service areas. 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 unavailable for the same time span or at the same level of localization due to variations in geographic boundaries, population sizes and data collection techniques. For some indicators presented here, no subpopulation data or data were only available for a limited set of racial/ethnic groups.

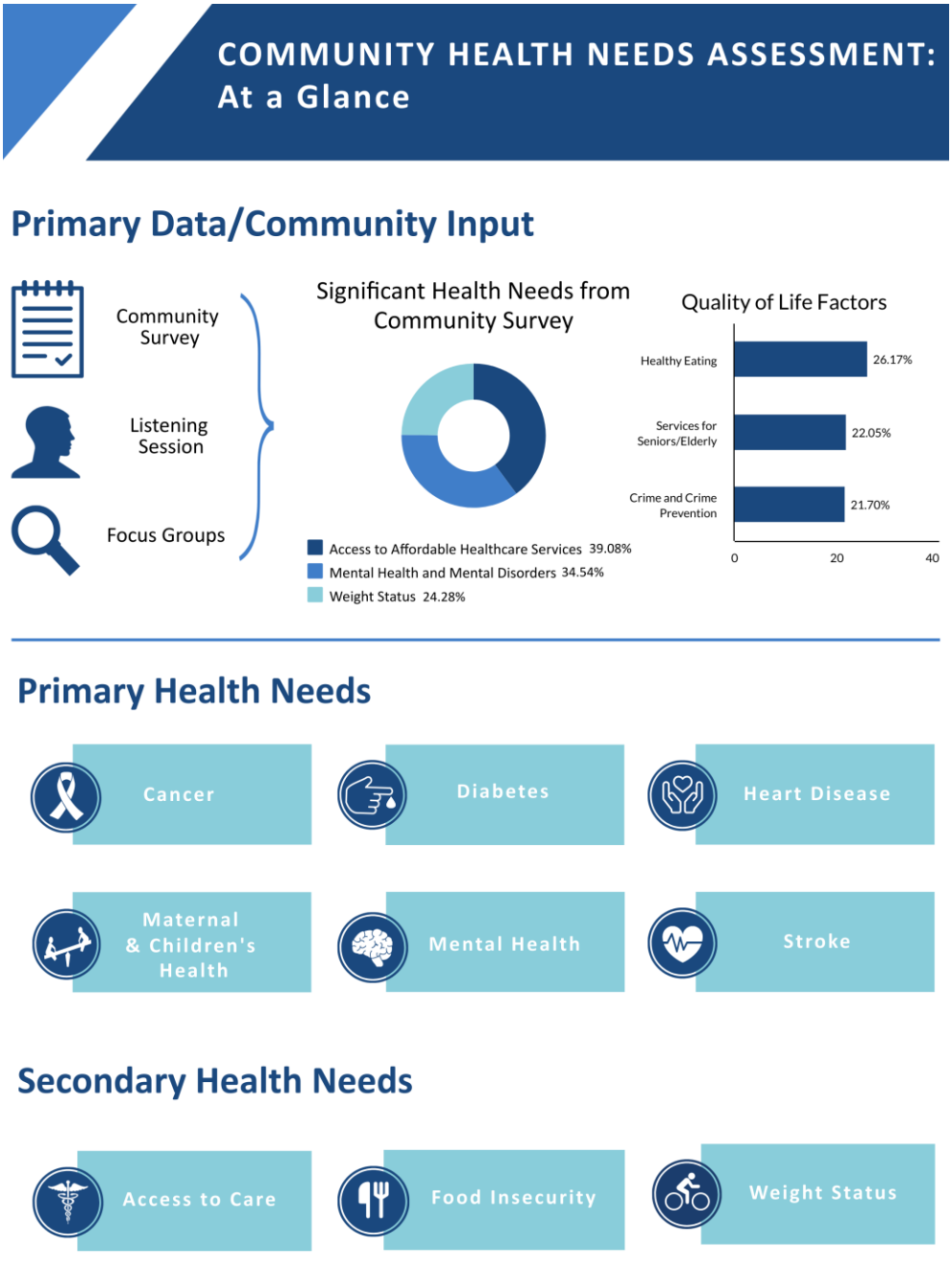
Primary Data

The community survey was a convenience sample for the primary data, which means results may be vulnerable to selection bias and make the findings less generalizable. However, the 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 of Lake and Porter counties, the findings from both the primary and secondary data across all service areas were compared and considered together. The secondary data, community survey, listening session and focus groups were treated as four separate data sources. To help summarize the data findings from the assessment, **Figure 27** highlights areas of importance.

FIGURE 27: 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 and secondary data findings identified 10 areas of need. Figure 27 shows the areas of need across areas served by Powers Health and **Table 12** shows the areas of need for Lake County and Porter County.

TABLE 12: DATA SYNTHESIS RESULTS- SYSTEM WIDE

Health/Quality of Life Category	Data Source(s)
Access to Healthcare	Secondary, Listening Session, Survey, Focus Groups
Alcohol & Drug Use	Secondary, Survey, Focus groups
Cancer	Secondary, Listening Session, Focus Groups
Children's Health/Maternal, Fetal, & Infant Health	Secondary, Listening Session
Chronic Diseases (Diabetes, Heart Disease and Stroke)	Secondary, Listening Session, Survey, Focus Groups
Food Insecurity	Secondary, Listening Session, Survey, Focus Groups
Mental Health	Listening Session, Survey, Focus Groups
Infectious Diseases	Secondary
Transportation	Listening Session, Focus Groups
Weight Status (Individuals who are underweight, overweight, obese)	Secondary, Listening Session, Focus Groups

The top health needs were presented to the Powers Health team. Ten significant health needs listed below were selected and approved to be included in the prioritization session.

- Access to Healthcare
- Alcohol & Drug Use
- Cancer
- Children's Health (Maternal & Children's Health)
- Chronic Diseases (Diabetes, Heart Disease, Stroke)
- Food Insecurity
- Mental Health
- Infectious Diseases
- Transportation
- Weight Status (Individuals who are underweight, overweight, or obese)

Prioritization

To prioritize significant health needs and to better target activities to address the most pressing health needs in the community, Powers Health convened a group of community leaders on January 21, 2025, to participate in a virtual 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 Powers Health planning team reviewed the results and determined prioritized health needs based on the same criteria used in the scoring exercise.

Process

In early January 2025, the Powers Health CHNA team invited community leaders from Lake and Porter counties to assist in determining the prioritized or key health needs for the 2025-2028 CHNA. A total of 120 individuals representing local hospital systems, health departments, educational institutions community-based and non-profit organizations were invited to the event. Fifty-seven pre-registered and attended the virtual presentation. Thirty-seven submitted feedback to the online prioritization ranking activity.

On January 21, 2025, community members, partners and leaders from Lake and Porter counties virtually convened with members from Powers Health. During this meeting, the group reviewed and discussed the results of HCI's primary and secondary data analyses, which led to the preliminary significant health needs. These health needs are discussed in detail in this report's key health needs portion. Following the session, participants were given three days to access an online link to score each significant health need by how well they met the criteria set forth by HCI and Powers Health.

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 1 to 3, with 1 meaning it did not meet the given criterion, 2 meaning it met the criterion and 3 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 judgment and knowledge of the community in considering how well a health topic met the criteria.

Completing 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 13** shows the results of the scoring activity in rank order.

TABLE 13: RESULTS OF THE SCORING ACTIVITY

Health Need
Chronic Diseases (Diabetes, Heart Disease, Stroke)
Access to Healthcare
Cancer
Mental Health
Children's Health/Maternal, Fetal, & Infant Health
Weight Status (underweight, overweight, obese)
Food Insecurity
Alcohol and Drug Use
Infectious Diseases
Transportation

The results were shared with the Powers Health team and approval was received for six health needs. Three secondary topics will be addressed within the prioritized health needs during implementation. **Table 14** shows the approved health needs with the focus areas.

TABLE 14: APPROVED HEALTH NEEDS

Primary Health Needs	Secondary Health Needs
Cancer	Access to Care Food Insecurity Weight Status
Diabetes	
Heart Disease	
Maternal and Children's Health	
Mental Health	
Stroke	

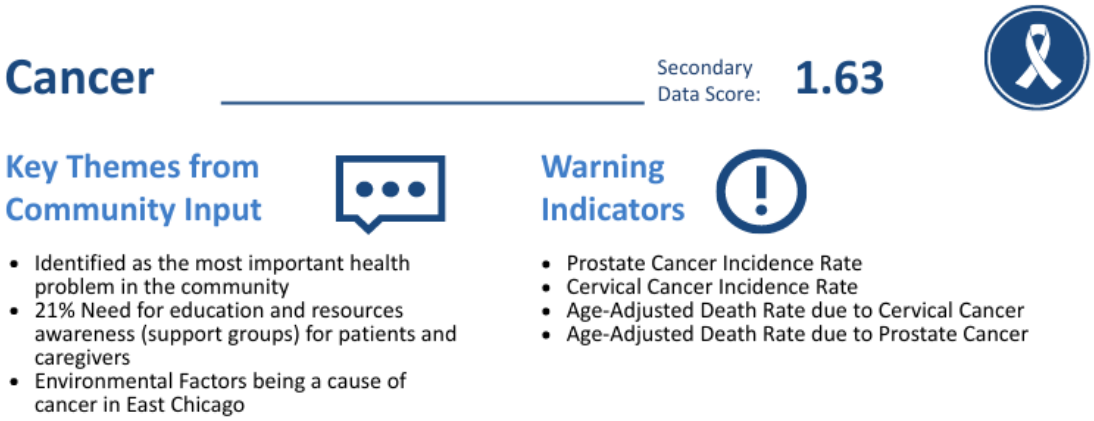
Later in the report, the primary and secondary data indicators for each priority health topic area are provided. This information highlights how each issue became a high-priority health need for Powers Health. Most of these health topic areas are consistent with the priority areas that emerged from the previous CHNA process. Powers Health plans to build upon these efforts and continue to address these health needs in its upcoming Implementation Strategy.

SECTION 4: KEY HEALTH NEEDS

Primary Health Needs

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

Key Health Need #1: Cancer



Secondary Data

Using HCI's Secondary Data scoring technique, cancer was identified as a top health need, with a system-wide score of 1.63. At the county level, cancer ranked as the number one health need in Porter County, with a score of 1.58 and twelfth in Lake County, with a score of 1.65. Further analysis was done to identify specific indicators of concern (scoring at or above the threshold of 1.75) for each county. These indicators are described in Tables 15 and 16 below.

Each indicator has an indicator score, county value, state value and national value (where available). State and national county distributions are also included for comparison, as well as indicator trend information. The legend on the right shows how to interpret the distribution gauges and trend icons used. Please see Appendix A for more information and examples of the icons used.

	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.

As shown in Table 15, prostate cancer and cervical cancer are among the areas of highest concern for Lake County. The incidence rate of prostate cancer specifically is among the worst across all counties in Indiana and both prostate and cervical cancer incidence have been significantly increasing over time. Further, the death rates due to cervical cancer, prostate cancer, breast cancer and colorectal cancer are all higher in Lake County than the overall rates across Indiana and the nation.

TABLE 15: DATA SCORING RESULTS-LAKE COUNTY

Score	CANCER	Units	Lake County	HP2030	Indiana	U.S.	IN Counties	U.S. Counties	Trend
2.75	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	123.6	-	99.9	109.9			
2.50	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	10.0	-	8.4	7.7	-		
2.14	Age-Adjusted Death Rate due to Cervical Cancer	*deaths/ 100,000 females*	4.0	-	2.7	2.2	-	-	
2.08	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	21.0	16.9	19.5	18.8	-		
1.94	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	22.2	15.3	20.4	19.6			
1.94	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	15.7	8.9	14.6	13.1			
1.81	Cancer: Medicare Population	*percent*	12.0	-	11.0	12.0			
1.78	Age-Adjusted Death Rate due to Cancer	*deaths/ 100,000 population*	167.5	122.7	166.9	149.4			
1.75	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	47.0	-	41.1	37.7			

As shown in Table 16, the incidence of breast cancer as well as oral cavity/pharynx cancer are some of the greatest areas of concern in Porter County. The incidence of breast cancer and of oral cavity and pharynx cancer are worse than in Indiana or the nation overall and the breast cancer incidence rate in Porter County is among the worst of all counties in Indiana. Further, the death rates due to colorectal and breast cancer are both higher in Porter County than the overall rates across Indiana and the nation.

TABLE 16: DATA SCORING RESULTS-PORTER COUNTY

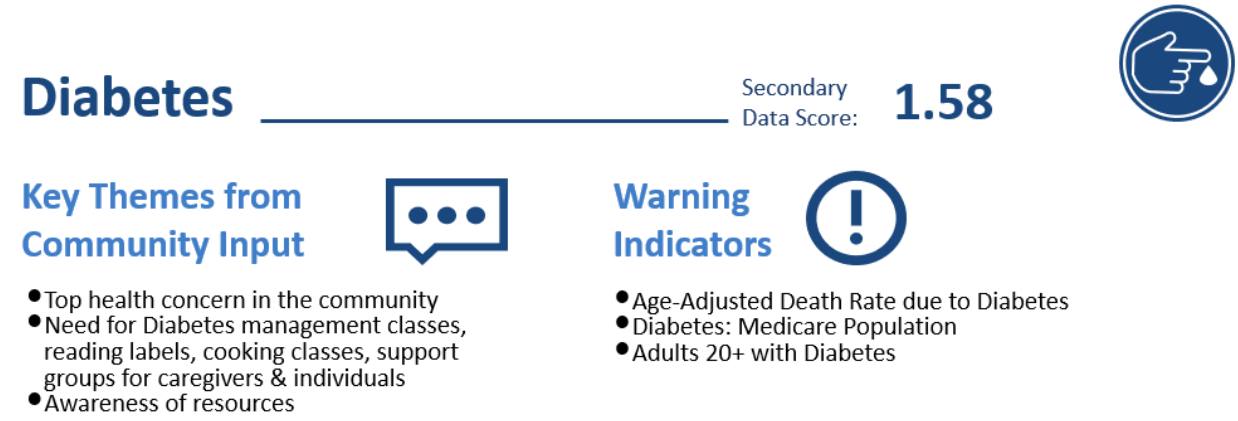
Score	CANCER	Units	Porter County	HP2030	Indiana	U.S.	IN Counties	U.S. Counties	Trend
2.42	Breast Cancer Incidence Rate	cases/ 100,000 females	133.4	-	124.3	128.1			
2.31	Oral Cavity and Pharynx Cancer Incidence Rate	cases/ 100,000 population	14.1	-	12.7	12.0			
2.25	Age-Adjusted Death Rate due to Colorectal Cancer	deaths/ 100,000 population	16.4	8.9	14.6	13.1			
2.11	Age-Adjusted Death Rate due to Breast Cancer	deaths/ 100,000 females	22.6	15.3	20.4	19.6			
1.97	All Cancer Incidence Rate	cases/ 100,000 population	467.7	-	456.8	449.4			
1.97	Prostate Cancer Incidence Rate	cases/ 100,000 males	109.3	-	99.9	109.9			
1.81	Cancer: Medicare Population	percent	12.0	-	11.0	12.0			
1.81	Lung and Bronchus Cancer Incidence Rate	cases/ 100,000 population	69.1	-	69.2	56.3			

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, 21.07% of survey respondents indicated cancer. Focus group participants discussed the need for support groups, education and resource awareness for patients and caregivers. Participants also indicated that environmental factors caused cancer, particularly in East Chicago.

> When it comes to cancer, there are programs out there, but people don't always know how to connect with them or where to find support.
>
> -Focus Group participant

Key Health Need #2: Diabetes



Secondary Data

Using HCI's Secondary Data scoring technique, diabetes was identified as a significant health need, with a system-wide score of 1.58. At the county level, diabetes was identified as a significant health need in Lake County, with a score of 1.77. However, diabetes was a less significant topic in Porter County, with a score of 1.05. Further analysis was done to identify specific indicators of concern (scoring at or above the threshold of 1.75) for each county. These indicators are described in Tables 17 and 18 below.

As shown in Table 17, only two diabetes-related indicators available in Lake County scored at or above the threshold of 1.75. However, the top three scoring indicators are presented for illustrative purposes. Lake County has a relatively high death rate due to diabetes and also has a high rate of diabetes among older adults in the Medicare population. Both of these rates are higher in Lake County than the overall state-wide and nationwide rates. Although these county-level rates appear to be improving, these trends are not significant.

TABLE 17: DATA SCORING RESULTS-LAKE COUNTY

Score	DIABETES	Units	Lake County	HP2030	Indiana	U.S.	IN Counties	U.S. Counties	Trend
1.86	Age-Adjusted Death Rate due to Diabetes	deaths/ 100,000 population	29.3	-	26.9	22.6			
1.86	Diabetes: Medicare Population	percent	27.0	-	26.0	24.0			
1.58	Adults 20+ with Diabetes	percent	11.0	-	-	-			

As shown in Table 18, none of the diabetes-related indicators available in Porter County scored at or above the threshold of 1.75. However, the top three scoring indicators are presented for illustrative purposes. The indicator of greatest concern is the rate of adults with diabetes, which is among the worst-scoring counties across the state and nation. Although this county-level prevalence of diabetes appears to be improving, this trend is not significant.

TABLE 18: DATA SCORING RESULTS-PORTER COUNTY

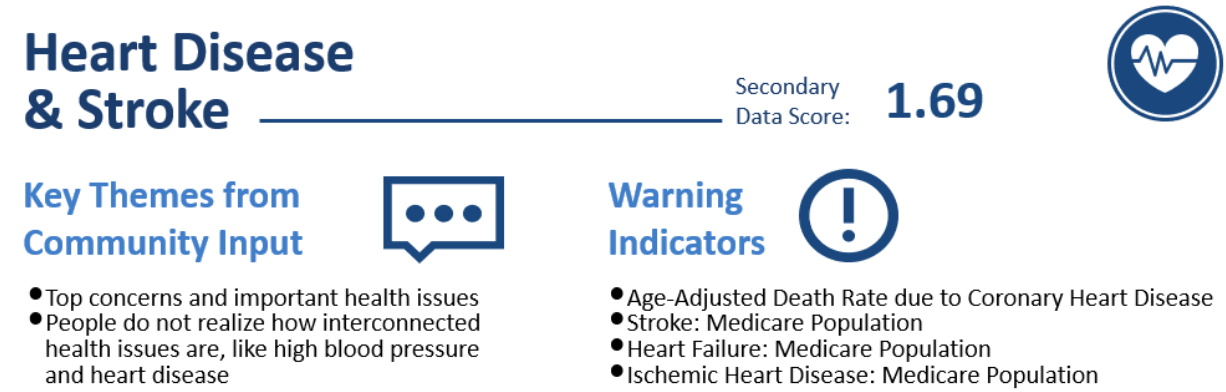
Score	DIABETES	Units	Porter County	HP2030	Indiana	U.S.	IN Counties	U.S. Counties	Trend
1.53	Adults 20+ with Diabetes	percent	9.2	-	-	-			
0.86	Diabetes: Medicare Population	percent	24.0	-	26.0	24.0			
0.75	Age-Adjusted Death Rate due to Diabetes	deaths/ 100,000 population	24.2	-	26.9	22.6			

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, 18.84% of survey respondents listed diabetes. Focus group participants identified diabetes as one of the top health issues. They specified that it is often unmanaged due to a lack of information and resources in the community. Participants also indicated the need for more comprehensive health education about nutrition, meal prep and diabetes management.

> Diabetes is one of those conditions where lifestyle changes, like exercise and better diet, can make a huge difference, but people need guidance and resources to make those changes.
>
> -Focus Group participant

Key Health Need #3 & #4: Heart Disease and Stroke



Secondary Data

Using HCI's Secondary Data scoring technique, heart disease and stroke were identified as a significant health need, with a system-wide score of 1.69. At the county level, heart disease and stroke were identified as a significant health need in Lake County, with a score of 1.80. However, heart disease and stroke were a less significant topic in Porter County, with a score of 1.39. Further analysis was done to identify specific indicators of concern (scoring at or above the threshold of 1.75) for each county. These indicators are described in Tables 19 and 20 below.

As shown in Table 19, the two areas of highest concern for Lake County are death rate due to coronary heart disease and stroke among the Medicare population. In Lake County, the death rate due to coronary heart disease is relatively high and has been significantly increasing. The percentage of those in the Medicare population experiencing a stroke is among the worst scoring counties across the state and nation. This is also true for the percent of those in the Medicare population experiencing heart failure.

TABLE 19: DATA SCORING RESULTS-LAKE COUNTY

Score	HEART DISEASE AND STROKE	Units	Lake County	HP2030	Indiana	U.S.	IN Counties	U.S. Counties	Trend
2.67	Age-Adjusted Death Rate due to coronary heart disease	deaths/ 100,000 population	106.9	71.1	95.8	90.2			
2.64	Stroke: Medicare Population	percent	7.0	-	5.0	6.0			
2.36	Heart Failure: Medicare Population	percent	14.0	-	12.0	11.0			
2.19	Ischemic Heart Disease: Medicare Population	percent	25.0	-	22.0	21.0			
1.97	Atrial Fibrillation: Medicare Population	percent	15.0	-	14.0	14.0			
1.97	Hyperlipidemia: Medicare Population	percent	67.0	-	66.0	65.0			
1.97	Hypertension: Medicare Population	percent	71.0	-	69.0	65.0			
1.89	High Blood Pressure Prevalence	percent	37.8	41.9	-	32.7			-

As shown in Table 20, nearly all indicators of concern in Porter County are health issues among the Medicare population, most of whom are older adults. These health issues include hyperlipidemia, stroke, atrial fibrillation and hypertension. Additionally, for each of these four indicators, Porter County scores among the worst 25% of all counties across the nation and these rates are trending upward, although not significantly.

TABLE 20: DATA SCORING RESULTS-PORTER COUNTY

Score	HEART DISEASE AND STROKE	Units	Porter County	HP2030	Indiana	U.S.	IN Counties	U.S. Counties	Trend
2.31	Hyperlipidemia: Medicare Population	percent	69.0	-	66.0	65.0			
2.14	Stroke: Medicare Population	percent	6.0	-	5.0	6.0			
1.97	Atrial Fibrillation: Medicare Population	percent	15.0	-	14.0	14.0			
1.81	Hypertension: Medicare Population	percent	70.0	-	69.0	65.0			
1.75	Adults who Have Taken Medications for High Blood Pressure	percent	79.1	-	-	78.2			-

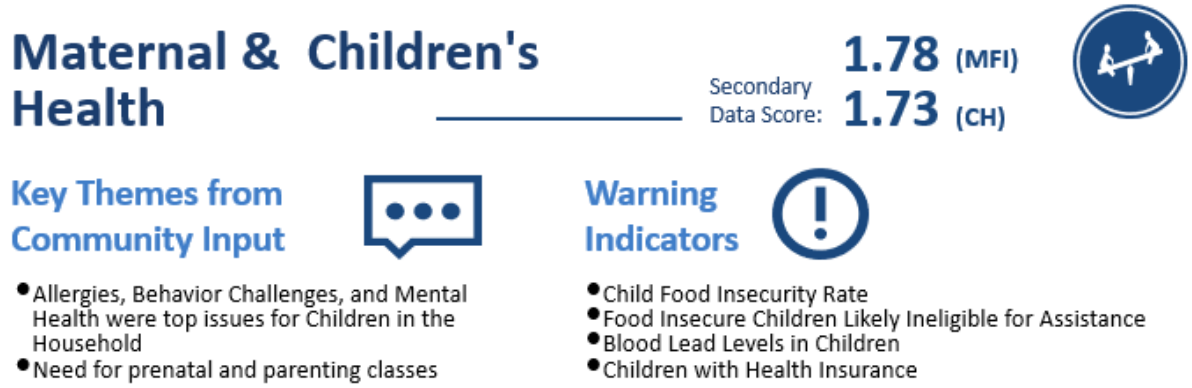
Community Input

Heart disease and stroke were identified as among the top health issues in the focus group and listening sessions. Listening session participants indicated that the causes of heart disease and stroke were that

individuals wait or do not prioritize preventative screenings or health care and health issues become more serious or critical. Below displays what a listening session participant mentioned about heart disease, stroke and putting off regular or preventative screenings.

> People putting off regular or preventive screenings or health care have exacerbated health issues to the extent that they become more serious or critical. Stroke, heart disease, COVID-19 and respiratory issues have grown in both volume and severity.
>
> -Listen Session

Key Health Need #5: Maternal & Children's Health



Secondary Data

HCI's Secondary Data scoring technique categorized maternal and children's health under two topic areas, each of which emerged as a topic of concern. At the system level, these two topic areas were categorized as children's health and maternal, fetal and infant health and had scores of 1.73 and 1.78, respectively. In Lake County specifically, these two topics ranked as the third and fourth greatest areas of concern, with scores of 1.95 (maternal, fetal and infant health) and 1.88 (children's health). In Porter County, these topics had less concerning scores of 1.31 (maternal, fetal and infant health) and 1.29 (children's health). Further analysis was done to identify specific indicators of concern (scoring at or above the threshold of 1.75) for each county. These indicators are described in Tables 21 and 22 below.

As shown in Table 21, nearly a quarter of children in Lake County (23.3%) are food insecure, which is among the worst child food insecurity rates among all counties across the state and nation. Further, over a third of food insecure children in the county (34.0%) are likely ineligible for public assistance. Birthing complications are also issues of concern in Lake County, with infant mortality, low birthweight and preterm births all worse in Lake County than in the overall state and nation and all of which are trending upward.

TABLE 21: DATA SCORING RESULTS-LAKE COUNTY

Score	MATERNAL AND CHILDREN'S HEALTH	Units	Lake County	HP2030	Indiana	U.S.	IN Counties	U.S. Counties	Trend
2.50	Child Food Insecurity Rate	percent	23.3	-	18.2	18.5			
2.47	Infant Mortality Rate	deaths/ 1,000 live births	7.4	5.0	6.7	5.4	-	-	
2.39	Babies with Very Low Birthweight	percent	1.6	-	1.3	1.4	-	-	
2.17	Babies with Low Birthweight	percent	9.3	-	8.7	8.6		-	
1.97	Preterm Births	percent	11.4	9.4	10.9	10.4		-	
1.92	Food Insecure Children Likely Ineligible for Assistance	percent	34.0	-	30.0	-			
1.83	Blood Lead Levels in Children (>=3.5 micrograms per deciliter)	Percent	2.7	-	1.7	-		-	-

As shown in Table 22, the indicator of greatest concern in Porter County is the percentage of food insecure children likely ineligible for assistance, which is among the worst rates among all counties across the state and nation. Porter County also has a relatively low prevalence of childcare centers, with only 3.1 centers per 1,000 children under age five. Finally, as with Lake County, the percentage of babies with very low birth weight is also an indicator of concern in Porter County.

TABLE 22: DATA SCORING RESULTS-PORTER COUNTY

Score	MATERNAL AND CHILDREN'S HEALTH	Units	Porter County	HP2030	Indiana	U.S.	IN Counties	U.S. Counties	Trend
2.25	Food Insecure Children Likely Ineligible for Assistance	percent	44.0	-	30.0	-			
2.08	Child Care Centers	per 1,000 population under age 5	3.1	-	3.6	7.0		-	-
1.89	Babies with Very Low Birthweight	percent	1.4	-	1.3	1.4	-	-	-

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, 12.46% had one child, 8.93% had two children and 4.32% had 3 or more. When asked about what health issues children in their home had experienced, 40.79% indicated they had not faced any health issues, 31.16% indicated allergies and 22.95% indicated behavioral challenges/mental health. When survey respondents were asked if there was a time when their children needed medical care or other health-related services and did not get the services they needed, 12.64% indicated yes. Of those respondents, 54.35% did not get mental health services. Focus group participants mentioned that the causes of children's health issues were a lack of parental guidance or lack of parenting skills, anxiety and the influence of social media.

> There are a lot of parents, young parents, we need to educate, not just kids. If the home isn't fixed, the kids don't stand a chance.
>
> -Focus Group participant

Key Health Need #6: Mental Health and Mental Disorders

Mental Health & Mental Disorders

Secondary Data Score: **1.21**

Key Themes from Community Input

- Identified as one of the most important health problems in the community
- Lack of mental health providers
- Stigma existing when seeking mental health care

Warning Indicators

- Alzheimer's Disease or Dementia: Medicare Population
- Poor Mental Health: Average Number of Days
- Poor Mental Health: 14+Days
- Depression: Medicare Population

Secondary Data

Using HCI's Secondary Data scoring technique, mental health and mental disorders were identified as a health need with a system-wide score of 1.21. At the county level, mental health and mental disorders had a score of 1.16 in Lake County and a score of 1.33 in Porter County. Further analysis was done to identify specific indicators of concern (scoring at or above the threshold of 1.75) for each county. These indicators are described in Tables 23 and 24 below.

As shown in Table 23, only two indicators available in Lake County scored at or above the threshold of 1.75. However, the top three scoring indicators are presented for illustrative purposes. In Lake County, the prevalence of Alzheimer's disease and dementia in the Medicare community is among the worst of all counties across the state and nation. Residents of Lake County report, on average, having poor mental health in 5.4 of the previous 30 days, which is higher than both the state-wide and nationwide average and is also trending upward, although not significantly.

TABLE 23: DATA SCORING RESULTS-LAKE COUNTY

Score	MENTAL HEALTH & MENTAL DISORDERS	Units	Lake County	HP2030	Indiana	U.S.	IN Counties	U.S. Counties	Trend
2.36	Alzheimer's Disease or Dementia: Medicare Population	percent	7.0		5.0	6.0			
2.14	Poor Mental Health: Average Number of Days	days	5.4		5.2	4.8			
1.25	Poor Mental Health: 14+ Days	percent	16.5			15.8			-

As shown in Table 24, none of the indicators available in Porter County scored at or above the threshold of 1.75. However, the top three scoring indicators are presented for illustrative purposes. Like in Lake County, the indicator of greatest concern in Porter County is the rate of those in the Medicare population with Alzheimer's disease or dementia, which is among the worst-scoring counties across the state. Porter County also has a relatively high rate of death due to Alzheimer's disease and a death rate due to suicide that is higher than both the U.S. rate and the Healthy People 2030 benchmark.

TABLE 24: DATA SCORING RESULTS-PORTER COUNTY

Score	MENTAL HEALTH & MENTAL DISORDERS	Units	Porter County	HP2030	Indiana	U.S.	IN Counties	U.S. Counties	Trend
1.69	Alzheimer's Disease or Dementia: Medicare Population	percent	6.0		5.0	6.0			
1.53	Age-Adjusted Death Rate due to Alzheimer's Disease	deaths/ 100,000 population	34.0		33.1	31.0			
1.36	Age-Adjusted Death Rate due to Suicide	deaths/ 100,000 population	15.0	12.8	15.1	13.9	-		

Community Input

Mental health and mental disorders were identified as top health issues in the survey, focus groups and listening sessions. When asked to list the most important "health problems" in the community, 34.54% of survey respondents identified mental health and mental disorders, including anxiety, depression and suicide, as a top health problem. When survey respondents were asked if there was a time they needed or considered seeking mental health services or alcohol/substance abuse treatment but did not get services, 11.57% indicated yes. The cost was too high, or they could not pay it. Twenty-three percent of survey respondents also indicated that their children experienced behavior challenges or mental health issues and 54.35% were not able to get the services they needed; they did not get services because the wait was too long and/or no doctors were nearby. Focus group and listening session participants indicated there continues to be stigma, a lack of local resources and a lack of facilities for immediate or ongoing care. Populations experiencing mental health issues more than others were teens, young adults and seniors and the impact of COVID-19 exacerbated mental health issues for these groups.

> Mental health just gets put on the back burner... there's not enough access to medication or therapy.
>
> -Focus Group participant

Secondary Health Needs

The following health needs emerged from a review of the primary and secondary data and were shown to be significant. These secondary needs will be addressed through the upstream efforts of the six key health needs outlined in the 2025-2028 Implementation Strategy Plan.

Secondary Key Health Need #1: Access to Healthcare

Access to Care — Secondary Data Score: **1.39**

Key Themes from Community Input

- Identified as the most important health problem in the community
- 32% Disagreed or Strongly Disagreed that there are affordable healthcare services in their community
- Most survey respondents indicated they get their health information from a doctor or health provider

Warning Indicators

- Preventable Hospital Stays: Medicare Population
- Adults who visited a Dentist
- Primary Care Provider Rate
- Children with Health Insurance

Secondary and Primary Findings

Secondary Data

Using HCI's Secondary Data scoring technique, healthcare access and quality was identified as a health need with a system-wide score of 1.39. At the county level, healthcare access and quality had a score of 1.43 in Lake County and a score of 1.28 in Porter County. This health topic includes health insurance coverage, provider rates and healthcare utilization data. Further analysis was done to identify the indicators of greatest concern for each county. These indicators are described in Tables 25 and 26 below.

TABLE 25: DATA SCORING RESULTS-LAKE COUNTY

Score	HEALTH CARE ACCESS & QUALITY	Units	Lake County	HP2030	Indiana	U.S.	IN Counties	U.S. Counties	Trend
2.08	Preventable Hospital Stays: Medicare Population	discharges/ 100,000 Medicare enrollees	4119.0		3099.0	2677.0			
1.92	Adults who Visited a Dentist	percent	57.6			63.9			-
1.83	Primary Care Provider Rate	providers/ 100,000 population	50.7		65.6	74.9			

TABLE 26: DATA SCORING RESULTS-PORTER COUNTY

Score	HEALTH CARE ACCESS & QUALITY	Units	Porter County	HP2030	Indiana	U.S.	IN Counties	U.S. Counties	Trend
2.50	Preventable Hospital Stays: Medicare Population	discharges/ 100,000 Medicare enrollees	3787.0		3099.0	2677.0			
2.25	Primary Care Provider Rate	providers/ 100,000 population	56.2		65.6	74.9			
1.42	Adults who have had a Routine Checkup	percent	77.6			76.1			-

Primary Data

Access to Care was a top health need identified in the community survey, focus group and listening session. Barriers included transportation, financial costs (healthcare services are too expensive, making it difficult for residents to afford necessary care), lack of primary care providers and long wait times for appointments, specifically for new residents.

Eighty-eight percent of survey respondents indicated they get their health information from a doctor or healthcare provider. Twenty-one percent needed healthcare services and did not get the services they needed. The top reasons that they did not receive the healthcare services needed within the past 12 months: 44.97% indicated cost, 26.85% 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 28 is a quote from a focus group participant expressing their experiences receiving basic care.

> It's too long to wait for basic care... you need to be able to see a doctor before something happens.
>
> -Focus Group participant

Secondary Key Health Need #2: Food Insecurity

Food Insecurity

Secondary Data Score: **1.65**

Key Themes from Community Input

- Healthy foods are expensive, food deserts in low-income communities
- Fast food is cheaper and more available for families, there is a need for more affordable, healthy choices
- Limited awareness of where to find healthy foods

Warning Indicators

- Unemployed Workers in the Civilian Labor Force
- Renters Spending 30% or More of Household Income on rent
- Child Food Insecurity Rate
- Median Monthly Owner Costs for Households without a mortgage

Secondary and Primary Findings

Secondary Data

At the county level, indicators related to food insecurity are concerning in both Lake County and Porter County. These indicators are described in Tables 27 and 28, including Food Insecurity Rate, Child Food Insecurity Rate and Food Insecure Children Likely Ineligible for Assistance.

TABLE 27: DATA SCORING RESULTS-LAKE COUNTY

Score	FOOD INSECURITY	Units	Lake County	HP2030	Indiana	U.S.	IN Counties	U.S. Counties	Trend
2.50	Child Food Insecurity Rate	percent	23.3		18.2	18.5			
1.92	Food Insecure Children Likely Ineligible for Assistance	percent	34.0		30.0				
1.64	Food Insecurity Rate	percent	14.0		13.9	13.5			

TABLE 28: DATA SCORING RESULTS-PORTER COUNTY

Score	FOOD INSECURITY	Units	Porter County	HP2030	Indiana	U.S.	IN Counties	U.S. Counties	Trend
2.25	Food Insecure Children Likely Ineligible for Assistance	percent	44.0		30.0				
0.97	Food Insecurity Rate	percent	12.3		13.9	13.5			
0.64	Child Food Insecurity Rate	percent	13.6		18.2	18.5			

As described previously in this report, HCI's Food Insecurity Index is a measure of food accessibility that is correlated with social and economic hardship. This index score, calculated at the zip code level, can help determine which geographic regions of the service area are most strongly impacted by socioeconomic indicators that are related to food hardship, including education, poverty, household environment and

transportation. In the Powers Health service area, this index value is highest for the zip codes 46402, 46407 and 46320. More information can be found in the Geographic Disparities section of this report.

Primary Data

Nineteen percent of survey respondents indicated that nutrition and healthy eating were important health problems in their community. This could suggest several factors: the community's need for better access to fresh, nutritious options, resources, education and support, or healthier options in school. When listening sessions and focus groups were conducted, participants indicated a lack of nutritious food and the need for improved nutritional literacy. Individuals also mentioned the cost of healthy food, making it hard for families to be healthy and dual-income households struggle with time for meal preparation and caregiving.

> I think access to food banks still may be a challenge for some individuals.
>
> -Listening Session

Secondary Key Health Need #3: Weight Status (Underweight, Overweight, Obese)

Weight Status (underweight, overweight, obese)

Secondary Data Score: **1.57**

Key Themes from Community Input

- Limited awareness of portion control
- forty-nine percent of survey respondents rated their own personal health as somewhat healthy, unhealthy or very unhealthy
- In the top three most important health problems in the county

Warning Indicators

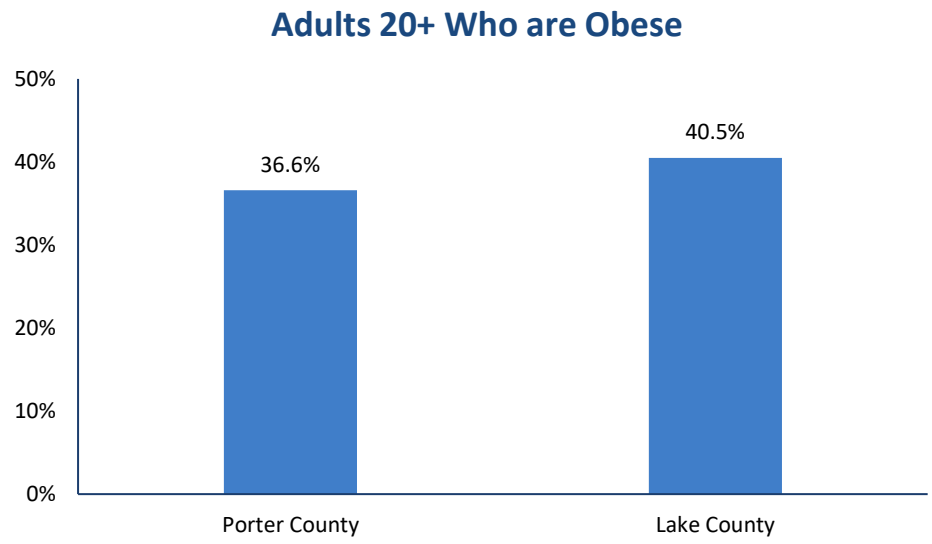
- Adults 20+ who are obese
- Workers who walk to work
- Adults 20+ who are sedentary
- Access to exercise opportunities

Secondary and Primary Findings

Secondary Data

The topic area of Weight Status was unable to be scored using HCI's Scoring Tool® due to secondary data limitations: thus, the score and warning indicators listed above are based on the physical activity topic area. As shown in Figure 29, adults are somewhat more likely to experience obesity in Lake County, compared to Porter County (40.5% vs. 36.6%).

FIGURE 29: ADULTS 20+ WHO ARE OBESE IN PORTER AND LAKE COUNTIES



Primary Data

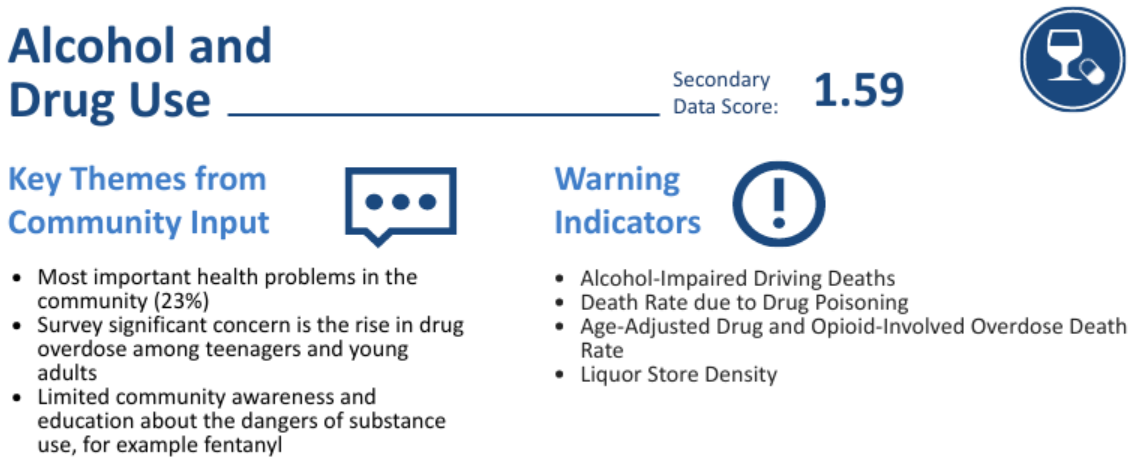
Twenty-four percent of survey respondents indicated that weight status is one of the most important problems in the community and one of the top three health issues. In focus groups and listening sessions, obesity was also listed as a top health issue. Healthy eating (restaurants, stores, or markets) was selected as the number one issue to be addressed in the community. This could suggest several community concerns like improved nutrition and access to healthy foods, limited access to healthy food options and the need for nutritional education. During the listening session and focus groups, participants were asked about the causes of obesity or being overweight; they indicated poor dietary habits, large portions, lack of access to nutritious foods and poor nutritional literacy.

> There's a lot of patients with obesity. It would help to have more classes to promote physical activity.
>
> -Focus Group participant

SECTION 5: NON-PRIORITIZED HEALTH NEEDS

The following additional significant health needs emerged from a review of the primary and secondary data. With the necessity to focus on the key health needs described above, these topics are not explicitly prioritized for efforts to be outlined in the 2025-2028 Implementation Strategy. However, many of these areas fall tangentially within the key health needs due to the interrelationship of social determinants and health. They may be addressed through upstream efforts to meet the key health needs. Additionally, many of them are addressed within ongoing programs and services in Powers Health. Examples of these efforts are provided below by topic area.

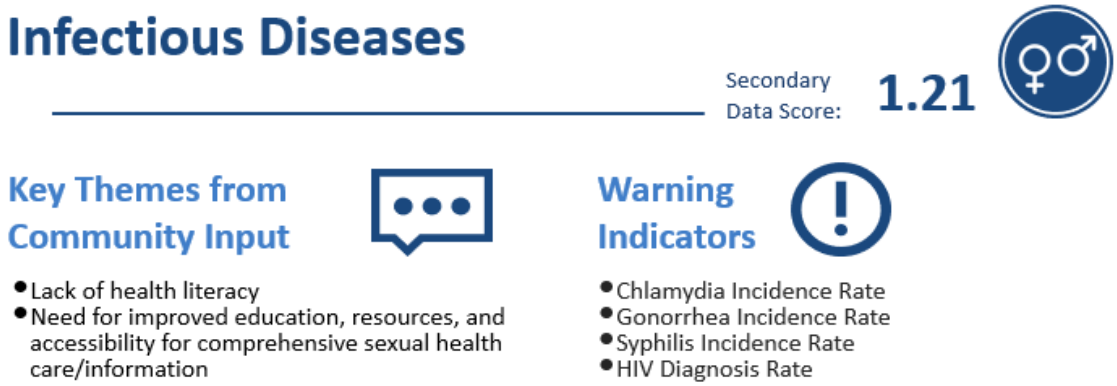
Alcohol and Drug Use



Ongoing Health System Efforts
Below are Powers Health's ongoing programs and services for addressing alcohol and drug use in Lake and Porter counties.

Although Powers Health does not have a formal drug and alcohol treatment program, this health need is addressed in the treatment of other conditions such as mental health, chronic disease maintenance, etc. Patients who require focused treatment for their addiction are referred to specialized agencies.

Infectious Diseases



Ongoing Health System Efforts
Below are Powers Health's ongoing programs and services for infectious diseases in Lake and Porter counties.

Our hospitals provide comprehensive treatment for infectious diseases, ensuring patients receive the highest level of care available.

Transportation

Ongoing Health System Efforts
Powers Health's ongoing programs and services that address transportation in Lake and Porter counties are listed below.

Powers Health offers transportation services for patients traveling to and from the hospital for appointments. A resource guide is also available for patients that list other transportation agencies offering medical and non-medical transport options.

Section 6: ACTION PLAN

Powers Health
2025 Implementation Strategy

Introduction & Purpose

Powers Health presents the completed Implementation Strategy Action Plan, which follows the development of its 2025 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 Powers Health in May 2025.

This report summarizes the plans for Powers Health - in tandem with its four hospitals - to develop and collaborate on community benefit programs which address the prioritized health needs identified in its 2025 Community Health Needs Assessment.

The prioritized health needs are:

Powers Health CHNA Priorities
• Priority 1: Cancer • Priority 2: Diabetes • Priority 3: Heart Disease • Priority 4: Maternal and Children's Health • Priority 5: Mental Health • Priority 6: Stroke

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

The following additional health needs emerged from a review of the primary and secondary data: access to care, food insecurity and weight status. With the necessity to focus on the prioritized health needs noted in the table above, the secondary topics are not directly addressed in the 2025-2028 Implementation Strategy. Because of the interrelationships that exist, the secondary health needs will be championed through upstream efforts by healthcare and community outreach staff.

Powers Health provides added support for community benefit activities that lie outside the scope of work 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 is to offer a comprehensive understanding of the health needs in the areas served by Powers Health and 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 Powers Health. Visit: www.PowersHealth.org/about-us/community-partnerships

Implementation Strategies Summary

Strategy Design Process

This Implementation Strategy & Action Plan is guided by the Community Health Needs Assessment and outlines specific activities that will be undertaken to address priority areas. This is a living document intended to adapt to an active community, market forces and will evolve. Powers Health's education efforts and community partnerships are aligned with this strategy and plan to result in improved outcomes and better health and wellness for our community.

The full Powers Health 2025-28 Community Health Needs Assessment, Implementation Strategy and Action Plan can be viewed at www.PowersHealth.org/about-us/community-partnerships

Powers Health: Priorities and Solutions

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

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

Priorities and Strategies

Priority 1: Cancer
Goal: Reduce new cases of cancer and cancer-related illness, disability and death.
Strategies:

- Provide screening opportunities to the community
- Expand cancer support programs and navigation services
- Provide educational opportunities to the community

Priority 2: Diabetes
Goal: Reduce the burden of diabetes and improve quality of life for all people who have, or are at risk for, diabetes.
Strategies:

- Provide education opportunities to the community/public
- Provide education opportunities to health professionals
- Provide community events/health fairs/screenings to the community/public

Priority 3: Heart Disease
Goal: Improve cardiovascular health and reduce deaths from heart disease and stroke.
Strategies:

- Increase knowledge and awareness of heart disease and stroke risk factors
- Increase educational opportunities for heart disease and stroke risk factors

Priority 4: Maternal and Children's Health
Goal: Improve the health and well-being of women, children and families.
Strategies:

- Increase education and awareness of maternal and children's care and services

Priority 5: Mental Health
Goal: Improve mental health
Strategies:

- Increase mental health awareness and education
- Increase mental health skills, knowledge and support by conducting staff and community trainings

Priority 6: Stroke
Goal: Improve cardiovascular health and reduce deaths from heart disease and stroke.
Strategies:

- Increase awareness and educate the community about the risk factors for stroke

Action Plans

The Action Plan lists the 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.

Planning meetings were held in March and April 2025 by hospital leaders and staff in their specialty to define strategies and activities, set goals and identify resources to achieve positive health outcomes. Measurable metrics are in place to set a definitive baseline and monitor progress toward the goals in addressing the prioritized health needs listed in alphabetical order:

- Priority 1: Cancer
- Priority 2: Diabetes
- Priority 3: Heart Disease
- Priority 4: Maternal Child Health
- Priority 5: Mental Health
- Priority 6: Stroke

To address the primary health needs of residents in Lake and Porter counties, our system will collaborate with physicians and staff groups, education departments, community partners, and healthcare professionals at Powers Health. This collaboration aims to integrate and enhance secondary health concerns, including access to care, food insecurities, and weight status, within our six prioritized health needs.

Powers Health Implementation Strategy Action Plan

Community Hospital | St. Catherine Hospital | St. Mary Medical Center
Powers Health Rehabilitation Center

Overview

The 2025-28 Implementation Strategy Action Plan builds on the progress and ever-changing healthcare needs of the communities served by Powers Health. In the 2022-25 Community Health Needs Assessment (CHNA) for Community Healthcare System, now Powers Health, the prioritized health needs were:

- Cancer
- Diabetes
- Heart Disease and Stroke
- Maternal, Infant and Child Health
- Mental Health
- Access to Care

Healthier lifestyles were promoted across all priority areas through free or discounted health screenings, classes, support/resource groups, health fairs, physician lectures, special events and symposiums. Topics included cancer, cardiology, diabetes, heart disease, nutrition, 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.

Impact measures from the 2022-25 Community Health Needs Assessment were collected using the Healthy Community Institute's Implementation Strategy template. Each prioritized health need is documented on a dedicated form listing goals, strategies, activities and objectives, if applicable.

Participants of classes, events, programs and screenings were invited to complete evaluations on the effectiveness of their outreach activity. Feedback from health data repositories, program evaluations and CHNA documentation was used to develop or expand programs to address the prioritized health needs.

A synopsis of past programming is noted in the 2025-2028 CHNA (Pages 14-15).

Below is a summary of system initiatives and programs by Community Hospital,
St. Catherine Hospital, St. Mary Medical Center and Powers Health Rehabilitation Center (PHRC). The 2022 CHNA was the first for the rehabilitation center as it opened in September 2019.

Addressing Community Needs

Powers Health 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 (CH) and St. Mary Medical Center (SMMC) are Commission on Cancer (CoC) accredited and designated by the American College of Radiology as Breast Imaging Centers of Excellence. These hospitals, and Powers Heath 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. Community Hospital and St. Mary Medical Center are accredited by the National Accreditation Program for Breast Centers (NAPBC). Together, the hospitals offer an array of services, wellness and outreach programs for cancer patients and those at risk for cancer, such as: low or no-cost screenings; early nodule detection, genetic counseling; and infusion centers. Understanding the need for cancer care in Northwest Indiana, Powers Health is constructing a cancer care center in Crown Point slated to open in Fall 2025.

In an effort to reach more of our cancer patient population, the cancer navigation program has expanded to include additional diagnoses. Navigation helps to ensure patients receive access to needed resources that help break down barriers to care, such as financial counseling, transportation, and psychosocial services. The navigation team helps coordinate care from the point of diagnosis through survivorship.

Powers Health Cancer Research Foundation offers access to more than 100 cancer clinical research trials to patients living in Northwest Indiana and nearby locales in Illinois. The Cancer Resource Center (CRC), a support program of the Foundation which offers an array of mind-body-spirit classes, informative programs and special events. The CRC has expanded class offerings to locations in East Chicago, Crown Point and Valparaiso.

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 diabetes services 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. Powers Health recognizes

that prevention is a key component to good health. A pre-diabetes education program was developed focused on reducing the onset of diabetes by encouraging lifestyle changes.

Heart Disease
The hospitals of Powers Health 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 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. Neurodiagnostic services is developing a robust stroke education component focusing on lifestyle adjustments to prevent strokes, recognizing stroke symptoms using B.E. F.A.S.T., and post-stroke support through monthly group meetings.

All three hospitals hold the Gold Plus rating from the American Heart/Stroke Association. Acute Rehabilitation units at all hospitals, including Powers Health 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.

Maternal, Infant & Child Health

Family Birthing Services 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 results in better overall outcomes for maternity patients. The three locations earned accolades from the Indiana Hospital Association (IHA), in partnership with State Health Commissioner Lindsay Weaver, MD, FACEP for being an INSpire Hospital of Distinction. St. Mary Medical Center is a designated Baby-Friendly Hospital by Baby Friendly USA, because of their dedication to promoting breastfeeding and optimal infant feeding practices. St. Catherine Hospital was recognized by U.S. News & World Report High Performing Hospital in maternity care.

In an effort to reduce the incidence of fetal and maternal mortality rates, perinatal navigation services are offered to all women who may experience a high-risk pregnancy receiving services through Powers Health. Educating families throughout the continuum of childbearing is a top priority for Powers Health. birthing, lactation, child safety, hands-only CPR and grandparent classes are offered across the hospital system. 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.

Adult Mental Health

Behavioral Health Services (BHS) operates a 64-bed adult inpatient unit at St. Catherine Hospital. Intensive Outpatient Program provides a transitional level of care for those who need it; lastly outpatient care is provided through a network of community-based providers.

The Intensive Outpatient Program is a structured treatment option designed for adults who are experiencing behavioral or emotional difficulties and do not require inpatient psychiatric care or are transitioning from hospitalized care. Individually designed group therapy sessions focus on improving daily coping skills, establishing safety, processing feelings, understanding symptoms and enhancing self-respect. The program runs six to eight weeks, meeting up to four days per week for three hours.

Behavioral health staff engage the community by offering education and presentations on various mental health topics including stress reduction/relief, Holiday Blues, meditation, and deep breathing exercises. Training for first responders covering de-escalation techniques, signs of a person in crisis and self-care.

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 screening opportunities to the community

Programs/Activities	Responsible (staff)	Evaluation Measures	Data Source	Baseline	Process Measure Y1	Process Measure Y2	Process Measure Y3	Notes
Activity 1: Offer lung cancer screenings to qualifying adults	Director of Cancer Care Services	Increase # of lung cancer screenings	# low-dose CTs	0	Baseline TBD	Increase 2%	Increase 5%	
Activity 2: Promote cervical, prostate and colon cancer screenings through Powers Health Medical Group.	Executive Director of Cancer Care Services	# of activities focused on promoting screenings	Community Benefits Reports (CBRs)	0	Planning Year	Increase activities by 2 from baseline	Increase activities by 2.	

Target Population: Patients and community (Lake and Porter counties)

Collaboration Partners: Cancer Service Line; American Cancer Society; Powers Health Medical Group (PHMG)

Anticipated Outcomes:
Increase cancer screening opportunities for patients and community members.
Increase the number of patients getting screened according to national guidelines.

Resources: (needs) American Cancer Society (educational materials)

National priorities	State priorities	Notes:

Reduce new cases of cancer and cancer-related illness, disability, and death	**Indiana Cancer Control Plan 2023-2027 (health equity, primary prevention, early detection, treatment, survivorship**	

Community Hospital Strategy 2: Expand cancer support programs and navigation services								
Programs/Activities	**Responsible (staff)**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**	**Notes**
Activity 1: Increase support groups/wellness class (CRC) participation	Administrative Assistant Cancer Care Services	# of patients	Sign-in sheets	1700 patients per year (2023)	Increase 2%	Increase 5%	Increase 5%	
Activity 2: Increase the number of distress screenings completed (navigation tool)	Oncology Outpatient Nurse Manager	# of screenings	EPIC	FY 2024 390	Increase 1%	Increase 2%	Increase 3%	
Activity 3: Expand the number of support groups/wellness classes	Administrative Assistant Cancer Care Services	# of classes	Monthly Spreadsheet/ Marketing materials	0	Add 1 class per year (different areas)	Add 2 classes per year (different areas)	Add 3 classes per year (different areas)	

Activity 4: Increase the number of newly diagnosed patients receiving navigation services for breast, lung, and gastrointestinal (GI) cancers	Director of Cancer Care Services	Navigation #s for breast, lung, GI cancers	Navigator metrics	0 Navigation #s for the newly diagnosed	Increase 1% (overall #s)	Increase 2% (overall #s)	Increase 3% (overall #s)	
Target Population: Cancer patients and the community, for individuals in active treatment, survivorship, and who are caregivers								
Collaboration Partners: PH clinical facilities; cancer medical groups; PHMG								
Anticipated Outcomes: Patients receiving cancer diagnosis are supported throughout their journey.								
Resources: (needs)								

Community Hospital Strategy 3: Provide educational opportunities to the community								
Programs/Activities	**Responsible (staff)**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**	**Notes**
Activity 1: Plan, implement, and offer presentations and workshops (CRC patients)	Administrative Assistant Cancer Care Services	# of events	Monthly spreadsheet	0	Increase by 1 event	Increase by 1 event	Increase by 1 event	
Activity 2: Plan, implement, and offer presentations and workshops (service line-community members)	Administrative Assistant Cancer Care Services	# of events/4 per year (w/partners)	Monthly spreadsheet	0	Increase by 1 event	Increase by 1 event	Increase by 1 event	
Target Population: CRC patients, Service Line/Community (Lake and Porter counties)								

Collaboration Partners: American Cancer Society; cancer physicians
Anticipated Outcomes: Increase the number of educational presentations and workshops for patients and community members.
Resources: (needs)

Priority: Heart Disease

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

Community Hospital Strategy 1: Increase knowledge and awareness of heart disease and stroke risk factors

Programs/Activities	Responsible (staff)	Evaluation Measures	Data Source	Baseline	Process Measure Y1	Process Measure Y2	Process Measure Y3	Notes
Activity 1: 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.	Cardiac Care Nurses	# of attendees	Community Benefits Reports (CBRs)	9 patients per screening	Increase by 1%	Increase by 2%	Increase by 3%	

Activity 2: Develop heart disease prevention program focusing on teens (Physicians will travel to location, if needed)	Cardiology Directors Cardiologist(s) presenters	# of presentations Pre-post survey Knowledge-based (increase knowledge)	Community Benefits Reports (CBRs)	0	Increase 1-an event per year I school per year	Increase 2 an event per year 2 schools per year	Increase 3 events per year 3 schools per year	
Target Population: Men over 55 and women over 65, post-menopausal women, people with a family history of vascular diseases, tobacco users, diabetics, and those diagnosed with either high blood pressure or high cholesterol **Target Population: Activity 1B-** High school students/ faculty								
Collaboration Partners: Collaboration Partners Activity 1A- Possibility of future screening offerings extending into local YMCAs, churches, mosques, etc. **Collaboration Partners Activity 1B-** High school administrator(s)								
Anticipated Outcomes: Activity 1A- Early detection of peripheral artery disease (PAD), timely identification and treatment offerings that prevent or delay progression of PAD; thus, improving quality of life and reducing risk for severe complications **Anticipated Outcomes: Activity 1B-** Positively influence CV health knowledge, attitudes, and self-reporting behaviors among high school students by increasing awareness of the risk factors of cardiovascular disease and promoting healthy lifestyle choices								
Resources: (needs) Marketing advertisement materials, vascular ultrasound equipment, patient screening room, TC70 (EKG cart), team resources (vascular sonographer, primary screener…Laura, billing resource…Rhonda **Resources: (needs) Activity 1B-** Space accommodation(s), cardiology presenters x 2, standardized audiovisual materials (PPT), public address system								
National priorities	**State priorities**							

Improve cardiovascular health and reduce deaths from heart disease and stroke. (Healthy People 2030)	**Reduce the burden of heart disease and stroke in the state. (Indiana Department of Health (IDOH)**			

Community Hospital Strategy 2: Increase educational opportunities for heart disease and stroke risk factors								
Programs/Activities	**Responsible (staff)**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**	**Notes**
Activity 1: Provide Healthy Eating education to the community (patient and family members/caregivers) focusing on heart health	Cardiovascular Outpatient (CVOP) nurses	CVOP monthly patient encounters	EPIC	0	Increase by 10%	Increase by 10%	Increase by 10%	
Activity 2: Provide educational events of various scales to the public with a heart disease focus.	Cardiology Directors Hospitality and Nutrition Cardiologist(s) presenters	# of events per year	Community Benefits Reports (CBRs)	40-50 participants per session	Increase # of events	Increase # of events by 2	Increase # of events by 4	Topics: Diet, Exercise, Obesity, Smoking Cessation, Blood Pressure Control, Cholesterol Control, Blood Glucose Control, Atrial Fibrillation, Trans carotid Artery Revascularization
Target Population Activity 1B- Public/Community/ Family Members of CVOP Patients **Target Population Activity 1C-** All adults ages 45 and older, people with a family history of heart disease/ stroke, minority populations								
Collaboration Partners: Collaboration Partners Activity 1B- CVOP Nursing Team(s), Marketing **Collaboration Partners Activity 1C-** Cardiologist(s)/ Electrophysiologist presenters, Marketing/ advertisement awareness and registration, venue identification and allocation, Hospitality and Nutrition (food & drink service)								

Anticipated Outcomes Activity 1B- Reduce risk of heart disease, stroke, and other cardiovascular complications, as well as potentially improved cholesterol levels, blood pressure, and overall health through dietary changes **Anticipated Outcomes Activity 1C-** Heightened understanding of heart disease/ stroke risk factors, symptoms, and the significance of timely intervention; ultimately to enhance cardiovascular health while decreasing cardiovascular mortality and disability
Resources: (needs) Marketing

Priority Area: Diabetes

Goal Statement: Goals: 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 opportunities to the community/public								
Programs/Activities	**Responsible (staff)**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**	**Notes**
Activity 1: Develop opportunities for students to observe diabetes education	Diabetes Educators Nursing Education	# of incidents	Community Benefits Reports (CBRs)	0	Increase by 1%	Increase by 2%	Increase by 3%	
Activity 2: Offer gestational diabetes education sessions (in-person)	Diabetes Educators	Total # of participations	Community Benefits Reports (CBRs)	SCH-11 CH-50 SM-21 (July-Dec 24)	Increase by 1%	Increase by 2%	Increase by 3%	
Activity 3: Offer online diabetes education videos through the Wellness Network	Diabetes Educators	Analytics/# of times video viewed	Wellness Network (Health Clips)	0	Planning year	Increase usage by 1%	Increase usage by 2%	Using Health Clips. Review clips, update if needed.
Activity 4: Develop a Health Resource program for members of the community.	Diabetes Educators	Number of people completing the program	Attendance / completion	0	Planning year	Determine baseline	Increase program completion by 2%	
Target Population: nursing students, community, Lake and Porter counties								
Collaboration Partners: American Diabetes Association, nursing students, cardiac rehab, stroke, pulmonary, Fitness Pointe, New Healthy Me, Bariatric Services, providers, support groups, cancer resource center								

Anticipated Outcomes: Increase educational opportunities for the community.		
Resources: (needs) Staffing department: difficult to cover inpatient/outpatient diabetes consultations and provide hours to community events		
State priorities	**National priorities**	**Notes**
Goal 2: Educate the public and connect individuals the tools and resources available to support them in pursuing a healthy lifestyle to prevent diabetes (Indiana Diabetes Strategic Plan 2020-2026)	Reduce the burden of diabetes and improve quality of life for all people who have, or are at risk for, diabetes. (HP 2030)	-

Community Hospital Strategy 2: Provide education opportunities to health professionals								
Programs/Activities	**Responsible (staff)**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**	**Notes**
Activity 1: Offer online diabetes education training at orientation	Education staff	Completion rates	Health Stream analytics	0	Increase by 1%	Increase by 2%	Increase by 3%	Work on an in-person next cycle
Activity 2: Conduct diabetes education training for the nurse residents (CME)	Education Director	# of nurse attendees/participants	Education Department -attendance	0	Planning year (restarting)	Increase by 2%	Increase by 3%	
Target Population: Hospital staff, patients								
Collaboration Partners: churches, fitness center, civic center								

Anticipated Outcomes: Increase educational and training opportunities for hospital staff; increase the number of "community" educators on diabetes/A1C
Resources: (needs)

Community Hospital Strategy 3: Provide community events/health fairs/screenings to the community/public								
Programs/Activities	**Responsible (staff)**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**	**Notes**
Activity 1: Host community health fairs including A1C screenings	Diabetes Educators, nurses	Lab paperwork/lab count Number of people taking A1C screening	Community Benefits Reports (CBRs)	2	Increase # of people taking A1C screenings per year	Increase # people offering A1C screenings per year	Increase # people offering A1C screenings per year	
Activity 2: Participate in community-based events by providing screenings	Diabetes Educators	# of participants	Community Benefits Reports (CBRs)	0	Planning year	Increase participation by 1%	Increase participation by 2%	
Target Population: Community members								
Collaboration Partners: American Diabetes Association								
Anticipated Outcomes: Increase community events, health fairs, and screenings; Increase the knowledge around diabetes and A1C; Increase knowledge of healthy meal planning								
Resources: (needs)								

Priority Area: Maternal and Children's Health

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

Community Hospital Strategy 1: Increase education and awareness of maternal and children's care and services

Programs/Activities	Responsible (staff)	Evaluation Measures	Data Source	Baseline	Process Measure Y1	Process Measure Y2	Process Measure Y3	Notes
Activity 1: Participate (invited) in annual community health fairs/community events per year	Family Birthing Services staff, Outreach nurses	# of events attended	Community Benefits Reports (CBRs)	One per year	1 event	2 events	3 events	
Activity 2: Host maternal/child health events per year	Family Birthing Services	# of events	Community Benefits Reports (CBRs)	0	1 Powers Health location	One location per year	One location per year	
Activity 3: Develop a curriculum for an in-person & hybrid breastfeeding	Lactation Consultants	Utilization #/# of completions	MyChart	0	Planning year	In-person program curriculum/outline	Hybrid program curriculum/outline	
Activity 4: Develop MCH educational opportunities online	Education	Course completions	Patient channel	0	Planning year	TBD	TBD	

Target Population: pre-postnatal mothers, infants, children, community members (Lake and Porter counties)

Collaboration Partners: FQHCs (Healthy Families, Mental Health America, NFP, Gemunis Prenatal Program, Health Visions Midwest, Anew Ministries

Anticipated Outcomes: Increased knowledge and awareness of maternal and children's services and resources, resulting in healthier pregnancies and birth outcomes

Resources: (needs) Resource guide				
National priorities	**State priorities**			
Improve the health and well-being of women, children and families. (HP 2030)	Ensuring all Indiana residents have access to comprehensive care, promoting healthy pregnancies and births, and improving outcomes for mothers and infants, with a particular emphasis on addressing health disparities and the social determinants of health. Source: Indiana Department of Health			

Priority Area: Mental Health

Goal Statement: Improve mental health (Healthy People 2030)								
Community Hospital Strategy 1: Increase mental health awareness and education								
Programs/Activities	**Responsible (staff)**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**	**Notes**
Activity 1: Plan and implement a suicide awareness program (vigil, in-house awareness table, Darkness Walk)	Behavioral Health Service staff	# of events	Community Benefits Reports (CBRs)	1 per year	1 event per year	1 event per year	1 event per year	
Activity 2: Develop mental health awareness programs in schools	Behavioral Health Service staff	# of schools	Community Benefits Reports (CBRs)	0	Planning Year	Outreach to 1 school/class/district	Expand to 2-3 schools/classes	
Activity 3: Develop an in-person support program for families of inpatients	Behavioral Health Service staff	# of participants	Community Benefits Reports (CBRs)	0	Planning year	50 participants	Increase participation 2%	
Activity 4: Partner with community organizations (NAMI) to provide mental health support programs for inpatient family members	Behavioral Health Service staff	# of partnerships/community organizations	TBD	0	Planning Year	TBD		

Activity 5: Develop mental health videos promoting mental wellness (Topics: seasonal depression, anxiety, stigma reduction, etc.)	Behavioral Health Service staff	# of videos/analytics	Spreadsheet/TBD	0	Planning year	1 video	2 videos	
Target Population: families, teens, community, inpatient family members, inpatients								
Collaboration Partners: NAMI, Lake and Porter County school systems, Porter Starke, Mental Health America, Federally Qualified Health Centers (FQHC),								
Anticipated Outcomes: Increase understanding, knowledge and support among Lake and Porter County residents								
Resources: (needs) production company (videos), program/event space, program materials, build partnerships with teen organizations								

National priorities	**State priorities**			
Improve mental health (HP 2030)	Improve access to quality services, promote recovery, and address disparities, with a particular emphasis on youth and families, and integrate mental health care into primary care settings. IN.gov			

Community Hospital Strategy 2: Increase mental health skills, knowledge and support by conducting staff and community trainings								
Programs/Activities	**Responsible (staff)**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**	**Notes**
Activity 1: Plan, implement, and offer education sessions/training for hospital staff on mental health education, removing stigma, and crisis intervention training (staff)	Behavioral Health Service staff	# of participants	Sign-in sheets	0	Determine baseline	Increase 2%	Increase 3%	
Activity 2: Offering standardized education and resource programs on mental health issues	Behavioral Health Service staff	# of participants	Sign-in sheet/Community Benefits Reports (CBRs)	0	Determine baseline	Increase 2%	Increase 3%	Topic: de-escalation trainings, signs of depression
Target Population: Powers Health staff and community members, Lake and Porter County								
Collaboration Partners: Employer groups, community organizations								
Anticipated Outcomes: Increase skills, knowledge, and support among staff and community members								
Resources: (needs) program materials, staff/volunteers/educators, networking opportunities for staff to attend and promote community events to build community relationships								

Priority Area: Stroke

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

Community Hospital Strategy 1: Raise awareness and educate the community about the risk factors for stroke

Programs/Activities	Responsible (staff)	Evaluation Measures	Data Source	Baseline	Process Measure Y1	Process Measure Y2	Process Measure Y3	Notes
Activity 1: Expand stroke support groups by offering in-person/virtual sessions	Stroke Coordinators	# of participants	Community Benefits Reports (CBRs)	15 participants per month	Increase by 1% per year	Increase by 2% per year	Increase by 3% per year	
Activity 2: Conduct risk assessment on stroke and stroke prevention at health fairs/community events	Stroke Coordinators	# of assessments completed	Spreadsheet /TBD	0	Determine baseline	Increase by 1% per year	Increase by 2% per year	
Activity 3: Develop stroke workshops/presentation focusing on women	Stroke Coordinators	# of events	Community Benefits Reports (CBRs)	0	Planning year	Increase by 1 event per year	Increase by 2-3 events per year	
Activity 4: Plan social media stroke prevention awareness campaign/content (all hospitals)	Stroke Coordinators	# of projects	Spreadsheet	0	Planning year	Increase 1 project per year	# of engagement/analytics (baseline)	

Target Population: Lake and Porter County community members, women, social media consumers

Collaboration Partners: Rehabilitation, churches/faith-based organizations, social groups, senior centers, schools, Powers Health therapy department, local health departments, universities, medical schools, local businesses, American Heart and Stroke Association, Stroke Consortium				
Anticipated Outcomes 1: Reducing the incidence of stroke by increasing education about signs and symptoms, prevention and risk factors **Anticipated Outcomes 2: Increasing reaction time when stroke symptoms are recognized**				
Resources: (needs) I.T., technology (tablets, laptops), stroke champions, new program space, program materials (flyers, pamphlets, BE FAST magnets)				
National priorities	**State priorities**			
Improve cardiovascular health and reduce deaths from heart disease and stroke. (Healthy People 2030)	Decrease the burden of cardiovascular disease and stroke. (IN.gov)			

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 screening opportunities to the community

Programs/Activities	Responsible (staff)	Evaluation Measures	Data Source	Baseline	Process Measure Y1	Process Measure Y2	Process Measure Y3	Notes
Activity 1: Offer lung cancer screenings to qualifying adults	Director of Cancer Care Services	Increase # of lung cancer screenings	# low-dose CTs	0	Baseline TBD	Increase 2%	Increase 5%	
Activity 2: Promote cervical, prostate and colon cancer screenings through Powers Health Medical Group.	Executive Director of Cancer Care Services	# of activities focused on promoting screenings	Community Benefits Reports (CBRs)	0	Planning Year	Increase activities by 2 from baseline	Increase activities by 2.	

Target Population: Patients and community (Lake and Porter counties)

Collaboration Partners: Cancer Service Line; American Cancer Society; Powers Health Medical Group (PHMG)

Anticipated Outcomes:
Increase cancer screening opportunities for patients and community members.
Increase the number of patients getting screened according to national guidelines.

Resources: (needs) American Cancer Society (educational materials)

National priorities	State priorities	Notes:

Reduce new cases of cancer and cancer-related illness, disability, and death	**Indiana Cancer Control Plan 2023-2027 (health equity, primary prevention, early detection, treatment, survivorship**	

St. Catherine Hospital Strategy 2: Expand cancer support programs and navigation services								
Programs/Activities	**Responsible (staff)**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**	**Notes**
Activity 1: Increase support groups/wellness class (CRC) participation	Administrative Assistant Cancer Care Services	# of patients	Sign-in sheets	1700 patients per year (2023)	Increase 2%	Increase 5%	Increase 5%	
Activity 2: Increase the number of distress screenings completed (navigation tool)	Oncology Outpatient Nurse Manager	# of screenings	EPIC	FY 2024 390	Increase 1%	Increase 2%	Increase 3%	
Activity 3: Expand the number of support groups/wellness classes	Administrative Assistant Cancer Care Services	# of classes	Monthly Spreadsheet/ Marketing materials	0	Add 1 class per year (different areas)	Add 2 classes per year (different areas)	Add 3 classes per year (different areas)	

Activity 4: Increase the number of newly diagnosed patients receiving navigation services for breast, lung, and gastrointestinal (GI) cancers	Director of Cancer Care Services	Navigation #s for breast, lung, GI cancers	Navigator metrics	0 Navigation #s for the newly diagnosed	Increase 1% (overall #s)	Increase 2% (overall #s)	Increase 3% (overall #s)	
Target Population: Cancer patients and the community, for individuals in active treatment, survivorship, and who are caregivers								
Collaboration Partners: PH clinical facilities; cancer medical groups; PHMG								
Anticipated Outcomes: Patients receiving cancer diagnosis are supported throughout their journey.								
Resources: (needs)								

St. Catherine Hospital Strategy 3: Provide educational opportunities to the community								
Programs/Activities	**Responsible (staff)**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**	**Notes**
Activity 1: Plan, implement, and offer presentations and workshops (CRC patients)	Administrative Assistant Cancer Care Services	# of events	Monthly spreadsheet	0	Increase by 1 event	Increase by 1 event	Increase by 1 event	
Activity 2: Plan, implement, and offer presentations and workshops (service line-community members)	Administrative Assistant Cancer Care Services	# of events/4 per year (w/partners)	Monthly spreadsheet	0	Increase by 1 event	Increase by 1 event	Increase by 1 event	
Target Population: CRC patients, Service Line/Community (Lake and Porter counties)								

Collaboration Partners: American Cancer Society; cancer physicians
Anticipated Outcomes: Increase the number of educational presentations and workshops for patients and community members.
Resources: (needs)

Priority: Heart Disease

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

St. Catherine Hospital Strategy 1: Increase knowledge and awareness of heart disease and stroke risk factors

Programs/Activities	Responsible (staff)	Evaluation Measures	Data Source	Baseline	Process Measure Y1	Process Measure Y2	Process Measure Y3	Notes
Activity 1: 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.	Cardiac Care Nurses	# of attendees	Community Benefits Reports (CBRs)	9 patients per screening	Increase by 1%	Increase by 2%	Increase by 3%	
Activity 2: Develop heart disease prevention program focusing on teens	Cardiology Directors Cardiologist(s) presenters	# of presentations	Community Benefits Reports (CBRs)	0	Increase 1-an event per year	Increase 2 an event per year	Increase 3 events per year	

(Physicians will travel to location, if needed)		Pre-post survey Knowledge-based (increase knowledge)			I school per year	2 schools per year	3 schools per year	
Target Population: Men over 55 and women over 65, post-menopausal women, people with a family history of vascular diseases, tobacco users, diabetics, and those diagnosed with either high blood pressure or high cholesterol **Target Population: Activity 1B-** High school students/ faculty								
Collaboration Partners: Collaboration Partners Activity 1A- Possibility of future screening offerings extending into local YMCAs, churches, mosques, etc. **Collaboration Partners Activity 1B-** High school administrator(s)								
Anticipated Outcomes: Activity 1A- Early detection of peripheral artery disease (PAD), timely identification and treatment offerings that prevent or delay progression of PAD; thus, improving quality of life and reducing risk for severe complications **Anticipated Outcomes: Activity 1B-** Positively influence CV health knowledge, attitudes, and self-reporting behaviors among high school students by increasing awareness of the risk factors of cardiovascular disease and promoting healthy lifestyle choices								
Resources: (needs) Marketing advertisement materials, vascular ultrasound equipment, patient screening room, TC70 (EKG cart), team resources (vascular sonographer, primary screener…Laura, billing resource…Rhonda **Resources: (needs) Activity 1B-** Space accommodation(s), cardiology presenters x 2, standardized audiovisual materials (PPT), public address system								
National priorities	**State priorities**							

Improve cardiovascular health and reduce deaths from heart disease and stroke. (Healthy People 2030)	**Reduce the burden of heart disease and stroke in the state. (Indiana Department of Health (IDOH)**			

St. Catherine Hospital Strategy 2: Increase educational opportunities for heart disease and stroke risk factors								
Programs/Activities	**Responsible (staff)**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**	**Notes**
Activity 1: Provide Healthy Eating education to the community (patient and family members/caregivers) focusing on heart health	Cardiovascular Outpatient (CVOP) nurses	CVOP monthly patient encounters	EPIC	0	Increase by 10%	Increase by 10%	Increase by 10%	
Activity 2: Provide educational events of various scales to the public with a heart disease focus.	Cardiology Directors Hospitality and Nutrition Cardiologist(s) presenters	# of events per year	Community Benefits Reports (CBRs)	40-50 participants per session	Increase # of events	Increase # of events by 2	Increase # of events by 4	Topics: Diet, Exercise, Obesity, Smoking Cessation, Blood Pressure Control, Cholesterol Control, Blood Glucose Control, Atrial Fibrillation, Trans carotid Artery Revascularization
Target Population Activity 1B- Public/Community/ Family Members of CVOP Patients **Target Population Activity 1C-** All adults ages 45 and older, people with a family history of heart disease/ stroke, minority populations								
Collaboration Partners: Collaboration Partners Activity 1B- CVOP Nursing Team(s), Marketing **Collaboration Partners Activity 1C-** Cardiologist(s)/ Electrophysiologist presenters, Marketing/ advertisement awareness and registration, venue identification and allocation, Hospitality and Nutrition (food & drink service)								
Anticipated Outcomes Activity 1B- Reduce risk of heart disease, stroke, and other cardiovascular complications, as well as potentially improved cholesterol levels, blood pressure, and overall health through dietary changes								

Anticipated Outcomes Activity 1C- Heightened understanding of heart disease/ stroke risk factors, symptoms, and the significance of timely intervention; ultimately to enhance cardiovascular health while decreasing cardiovascular mortality and disability
Resources: (needs) Marketing

Priority Area: Diabetes

Goal Statement: Goals: 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 opportunities to the community/public								
Programs/Activities	**Responsible (staff)**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**	**Notes**
Activity 1: Develop opportunities for students to observe diabetes education	Diabetes Educators Nursing Education	# of incidents	Community Benefits Reports (CBRs)	0	Increase by 1%	Increase by 2%	Increase by 3%	
Activity 2: Offer gestational diabetes education sessions (in-person)	Diabetes Educators	Total # of participations	Community Benefits Reports (CBRs)	SCH-11 CH-50 SM-21 (July-Dec 24)	Increase by 1%	Increase by 2%	Increase by 3%	
Activity 3: Offer online diabetes education videos through the Wellness Network	Diabetes Educators	Analytics/# of times video viewed	Wellness Network (Health Clips)	0	Planning year	Increase usage by 1%	Increase usage by 2%	Using Health Clips. Review clips, update if needed.
Activity 4: Develop a Health Resource program for members of the community.	Diabetes Educators	Number of people completing the program	Attendance/ completion	0	Planning year	Determine baseline	Increase program completion by 2%	
Target Population: nursing students, community, Lake and Porter counties								
Collaboration Partners: American Diabetes Association, nursing students, cardiac rehab, stroke, pulmonary, Fitness Pointe, New Healthy Me, Bariatric Services, providers, support groups, cancer resource center								

Anticipated Outcomes: Increase educational opportunities for the community.		
Resources: (needs) Staffing department: difficult to cover inpatient/outpatient diabetes consultations and provide hours to community events		
State priorities	**National priorities**	**Notes**
Goal 2: Educate the public and connect individuals the tools and resources available to support them in pursuing a healthy lifestyle to prevent diabetes (Indiana Diabetes Strategic Plan 2020-2026)	Reduce the burden of diabetes and improve quality of life for all people who have, or are at risk for, diabetes. (HP 2030)	-

St. Catherine Hospital Strategy 2: Provide education opportunities to health professionals								
Programs/Activities	**Responsible (staff)**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**	**Notes**
Activity 1: Offer online diabetes education training at orientation	Education staff	Completion rates	Health Stream analytics	0	Increase by 1%	Increase by 2%	Increase by 3%	Work on an in-person next cycle
Activity 2: Conduct diabetes education training for the nurse residents (CME)	Education Director	# of nurse attendees/participants	Education Department-attendance	0	Planning year (restarting)	Increase by 2%	Increase by 3%	
Target Population: Hospital staff, patients								
Collaboration Partners: churches, fitness center, civic center								
Anticipated Outcomes: Increase educational and training opportunities for hospital staff; increase the number of “community” educators on diabetes/A1C								

Resources: (needs)

St. Catherine Hospital Strategy 3: Provide community events/health fairs/screenings to the community/public								
Programs/Activities	**Responsible (staff)**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**	**Notes**
Activity 1: Host community health fairs including A1C screenings	Diabetes Educators, nurses	Lab paperwork/lab count Number of people taking A1C screening	Community Benefits Reports (CBRs)	2	Increase # of people taking A1C screenings per year	Increase # people offering A1C screenings per year	Increase # people offering A1C screenings per year	
Activity 2: Participate in community-based events by providing screenings	Diabetes Educators	# of participants	Community Benefits Reports (CBRs)	0	Planning year	Increase participation by 1%	Increase participation by 2%	
Target Population: Community members								
Collaboration Partners: American Diabetes Association								
Anticipated Outcomes: Increase community events, health fairs, and screenings; Increase the knowledge around diabetes and A1C; Increase knowledge of healthy meal planning								
Resources: (needs)								

Priority Area: Maternal and 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 education and awareness of maternal and children's care and services

Programs/Activities	Responsible (staff)	Evaluation Measures	Data Source	Baseline	Process Measure Y1	Process Measure Y2	Process Measure Y3	Notes
Activity 1: Participate (invited) in annual community health fairs/community events per year	Family Birthing Services staff, Outreach nurses	# of events attended	Community Benefits Reports (CBRs)	One per year	1 event	2 events	3 events	
Activity 2: Host maternal/child health events per year	Family Birthing Services	# of events	Community Benefits Reports (CBRs)	0	1 Powers Health location	One location per year	One location per year	
Activity 3: Develop a curriculum for an in-person & hybrid breastfeeding	Lactation Consultants	Utilization #/# of completions	MyChart	0	Planning year	In-person program curriculum/outline	Hybrid program curriculum/outline	
Activity 4: Develop MCH educational opportunities online	Education	Course completions	Patient channel	0	Planning year	TBD	TBD	

Target Population: pre-postnatal mothers, infants, children, community members (Lake and Porter counties)

Collaboration Partners: FQHCs (Healthy Families, Mental Health America, NFP, Gemunis Prenatal Program, Health Visions Midwest, Anew Ministries

Anticipated Outcomes: Increased knowledge and awareness of maternal and children's services and resources, resulting in healthier pregnancies and birth outcomes

Resources: (needs) Resource guide				
National priorities	**State priorities**			
Improve the health and well-being of women, children and families. (HP 2030)	Ensuring all Indiana residents have access to comprehensive care, promoting healthy pregnancies and births, and improving outcomes for mothers and infants, with a particular emphasis on addressing health disparities and the social determinants of health. Source: Indiana Department of Health			

Priority Area: Mental Health

Goal Statement: Improve mental health (Healthy People 2030)								
St. Catherine Hospital Strategy 1: Increase mental health awareness and education								
Programs/Activities	**Responsible (staff)**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**	**Notes**
Activity 1: Plan and implement a suicide awareness program (vigil, in-house awareness table, Darkness Walk)	Behavioral Health Service staff	# of events	Community Benefits Reports (CBRs)	1 per year	1 event per year	1 event per year	1 event per year	
Activity 2: Develop mental health awareness programs in schools	Behavioral Health Service staff	# of schools	Community Benefits Reports (CBRs)	0	Planning Year	Outreach to 1 school/class/district	Expand to 2-3 schools/classes	
Activity 3: Develop an in-person support program for families of inpatients	Behavioral Health Service staff	# of participants	Community Benefits Reports (CBRs)	0	Planning year	50 participants	Increase participation 2%	
Activity 4: Partner with community organizations (NAMI) to provide mental health support programs for inpatient family members	Behavioral Health Service staff	# of partnerships/community organizations	TBD	0	Planning Year	TBD		

Activity 5: Develop mental health videos promoting mental wellness (Topics: seasonal depression, anxiety, stigma reduction, etc.)	Behavioral Health Service staff	# of videos/analytics	Spreadsheet/TBD	0	Planning year	1 video	2 videos	
Target Population: families, teens, community, inpatient family members, inpatients								
Collaboration Partners: NAMI, Lake and Porter County school systems, Porter Starke, Mental Health America, Federally Qualified Health Centers (FQHC),								
Anticipated Outcomes: Increase understanding, knowledge and support among Lake and Porter County residents								
Resources: (needs) production company (videos), program/event space, program materials, build partnerships with teen organizations								

National priorities	**State priorities**			
Improve mental health (HP 2030)	Improve access to quality services, promote recovery, and address disparities, with a particular emphasis on youth and families, and integrate mental health care into primary care settings. IN.gov			

St. Catherine Hospital Strategy 2: Increase mental health skills, knowledge and support by conducting staff and community trainings								
Programs/Activities	**Responsible (staff)**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**	**Notes**
Activity 1: Plan, implement, and offer education sessions/training for hospital staff on mental health education, removing stigma, and crisis intervention training (staff)	Behavioral Health Service staff	# of participants	Sign-in sheets	0	Determine baseline	Increase 2%	Increase 3%	
Activity 2: Offering standardized education and resource programs on mental health issues	Behavioral Health Service staff	# of participants	Sign-in sheet/Community Benefits Reports (CBRs)	0	Determine baseline	Increase 2%	Increase 3%	Topic: de-escalation trainings, signs of depression
Target Population: Powers Health staff and community members, Lake and Porter County								
Collaboration Partners: Employer groups, community organizations								
Anticipated Outcomes: Increase skills, knowledge, and support among staff and community members								
Resources: (needs) program materials, staff/volunteers/educators, networking opportunities for staff to attend and promote community events to build community relationships								

Priority Area: Stroke

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

St. Catherine Hospital Strategy 1: Raise awareness and educate the community about the risk factors for stroke

Programs/Activities	Responsible (staff)	Evaluation Measures	Data Source	Baseline	Process Measure Y1	Process Measure Y2	Process Measure Y3	Notes
Activity 1: Expand stroke support groups by offering in-person/virtual sessions	Stroke Coordinators	# of participants	Community Benefits Reports (CBRs)	15 participants per month	Increase by 1% per year	Increase by 2% per year	Increase by 3% per year	
Activity 2: Conduct risk assessment on stroke and stroke prevention at health fairs/community events	Stroke Coordinators	# of assessments completed	Spreadsheet /TBD	0	Determine baseline	Increase by 1% per year	Increase by 2% per year	
Activity 3: Develop stroke workshops/presentation focusing on women	Stroke Coordinators	# of events	Community Benefits Reports (CBRs)	0	Planning year	Increase by 1 event per year	Increase by 2-3 events per year	
Activity 4: Plan social media stroke prevention awareness campaign/content (all hospitals)	Stroke Coordinators	# of projects	Spreadsheet	0	Planning year	Increase 1 project per year	# of engagement/analytics (baseline)	
Target Population: Lake and Porter County community members, women, social media consumers								

Collaboration Partners: Rehabilitation, churches/faith-based organizations, social groups, senior centers, schools, Powers Health therapy department, local health departments, universities, medical schools, local businesses, American Heart and Stroke Association, Stroke Consortium				
Anticipated Outcomes 1: Reducing the incidence of stroke by increasing education about signs and symptoms, prevention and risk factors **Anticipated Outcomes 2: Increasing reaction time when stroke symptoms are recognized**				
Resources: (needs) I.T., technology (tablets, laptops), stroke champions, new program space, program materials (flyers, pamphlets, BE FAST magnets)				
National priorities	**State priorities**			
Improve cardiovascular health and reduce deaths from heart disease and stroke. (Healthy People 2030)	Decrease the burden of cardiovascular disease and stroke. (IN.gov)			

St. Mary Medical Center

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 screening opportunities to the community

Programs/Activities	Responsible (staff)	Evaluation Measures	Data Source	Baseline	Process Measure Y1	Process Measure Y2	Process Measure Y3	Notes
Activity 1: Offer lung cancer screenings to qualifying adults	Director of Cancer Care Services	Increase # of lung cancer screenings	# low-dose CTs	0	Baseline TBD	Increase 2%	Increase 5%	
Activity 2: Promote cervical, prostate and colon cancer screenings through Powers Health Medical Group.	Executive Director of Cancer Care Services	# of activities focused on promoting screenings	Community Benefits Reports (CBRs)	0	Planning Year	Increase activities by 2 from baseline	Increase activities by 2.	

Target Population: Patients and community (Lake and Porter counties)

Collaboration Partners: Cancer Service Line; American Cancer Society; Powers Health Medical Group (PHMG)

Anticipated Outcomes:
Increase cancer screening opportunities for patients and community members.
Increase the number of patients getting screened according to national guidelines.

Resources: (needs) American Cancer Society (educational materials)

National priorities	State priorities	Notes:

Reduce new cases of cancer and cancer-related illness, disability, and death	**Indiana Cancer Control Plan 2023-2027 (health equity, primary prevention, early detection, treatment, survivorship**	

St. Mary Medical Center Strategy 2: Expand cancer support programs and navigation services								
Programs/Activities	**Responsible (staff)**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**	**Notes**
Activity 1: Increase support groups/wellness class (CRC) participation	Administrative Assistant Cancer Care Services	# of patients	Sign-in sheets	1700 patients per year (2023)	Increase 2%	Increase 5%	Increase 5%	
Activity 2: Increase the number of distress screenings completed (navigation tool)	Oncology Outpatient Nurse Manager	# of screenings	EPIC	FY 2024 390	Increase 1%	Increase 2%	Increase 3%	
Activity 3: Expand the number of support groups/wellness classes	Administrative Assistant Cancer Care Services	# of classes	Monthly Spreadsheet/ Marketing materials	0	Add 1 class per year (different areas)	Add 2 classes per year (different areas)	Add 3 classes per year (different areas)	

Activity 4: Increase the number of newly diagnosed patients receiving navigation services for breast, lung, and gastrointestinal (GI) cancers	Director of Cancer Care Services	Navigation #s for breast, lung, GI cancers	Navigator metrics	0 Navigation #s for the newly diagnosed	Increase 1% (overall #s)	Increase 2% (overall #s)	Increase 3% (overall #s)	
Target Population: Cancer patients and the community, for individuals in active treatment, survivorship, and who are caregivers								
Collaboration Partners: PH clinical facilities; cancer medical groups; PHMG								
Anticipated Outcomes: Patients receiving cancer diagnosis are supported throughout their journey.								
Resources: (needs)								

St. Mary Medical Center Strategy 3: Provide educational opportunities to the community								
Programs/Activities	**Responsible (staff)**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**	**Notes**
Activity 1: Plan, implement, and offer presentations and workshops (CRC patients)	Administrative Assistant Cancer Care Services	# of events	Monthly spreadsheet	0	Increase by 1 event	Increase by 1 event	Increase by 1 event	
Activity 2: Plan, implement, and offer presentations and workshops (service line-community members)	Administrative Assistant Cancer Care Services	# of events/4 per year (w/partners)	Monthly spreadsheet	0	Increase by 1 event	Increase by 1 event	Increase by 1 event	
Target Population: CRC patients, Service Line/Community (Lake and Porter counties)								
Collaboration Partners: American Cancer Society; cancer physicians								

Anticipated Outcomes: Increase the number of educational presentations and workshops for patients and community members.
Resources: (needs)

Priority: Heart Disease

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

St. Mary Medical Center Strategy 1: Increase knowledge and awareness of heart disease and stroke risk factors

Programs/Activities	Responsible (staff)	Evaluation Measures	Data Source	Baseline	Process Measure Y1	Process Measure Y2	Process Measure Y3	Notes
Activity 1: 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.	Cardiac Care Nurses	# of attendees	Community Benefits Reports (CBRs)	9 patients per screening	Increase by 1%	Increase by 2%	Increase by 3%	
Activity 2: Develop heart disease prevention program focusing on teens (Physicians will travel to location, if needed)	Cardiology Directors Cardiologist(s) presenters	# of presentations Pre-post survey Knowledge-based (increase knowledge)	Community Benefits Reports (CBRs)	0	Increase 1-an event per year	Increase 2 an event per year	Increase 3 events per year 3 schools per year	

					I school per year	2 schools per year		
Target Population: Men over 55 and women over 65, post-menopausal women, people with a family history of vascular diseases, tobacco users, diabetics, and those diagnosed with either high blood pressure or high cholesterol **Target Population: Activity 1B-** High school students/ faculty								
Collaboration Partners: Collaboration Partners Activity 1A- Possibility of future screening offerings extending into local YMCAs, churches, mosques, etc. **Collaboration Partners Activity 1B-** High school administrator(s)								
Anticipated Outcomes: Activity 1A- Early detection of peripheral artery disease (PAD), timely identification and treatment offerings that prevent or delay progression of PAD; thus, improving quality of life and reducing risk for severe complications **Anticipated Outcomes: Activity 1B-** Positively influence CV health knowledge, attitudes, and self-reporting behaviors among high school students by increasing awareness of the risk factors of cardiovascular disease and promoting healthy lifestyle choices								
Resources: (needs) Marketing advertisement materials, vascular ultrasound equipment, patient screening room, TC70 (EKG cart), team resources (vascular sonographer, primary screener…Laura, billing resource…Rhonda **Resources: (needs) Activity 1B-** Space accommodation(s), cardiology presenters x 2, standardized audiovisual materials (PPT), public address system								
National priorities	**State priorities**							
Improve cardiovascular health and reduce deaths from heart disease and stroke. (Healthy People 2030)	**Reduce the burden of heart disease and stroke in the state. (Indiana Department of Health (IDOH)**							

St. Mary Medical Center Strategy 2: Increase educational opportunities for heart disease and stroke risk factors								
Programs/Activities	**Responsible (staff)**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**	**Notes**
Activity 1: Provide Healthy Eating education to the community (patient and family members/caregivers) focusing on heart health	Cardiovascular Outpatient (CVOP) nurses	CVOP monthly patient encounters	EPIC	0	Increase by 10%	Increase by 10%	Increase by 10%	
Activity 2: Provide educational events of various scales to the public with a heart disease focus.	Cardiology Directors Hospitality and Nutrition Cardiologist(s) presenters	# of events per year	Community Benefits Reports (CBRs)	40-50 participants per session	Increase # of events	Increase # of events by 2	Increase # of events by 4	Topics: Diet, Exercise, Obesity, Smoking Cessation, Blood Pressure Control, Cholesterol Control, Blood Glucose Control, Atrial Fibrillation, Trans carotid Artery Revascularization
Target Population Activity 1B- Public/Community/ Family Members of CVOP Patients **Target Population Activity 1C-** All adults ages 45 and older, people with a family history of heart disease/ stroke, minority populations								
Collaboration Partners: Collaboration Partners Activity 1B- CVOP Nursing Team(s), Marketing **Collaboration Partners Activity 1C-** Cardiologist(s)/ Electrophysiologist presenters, Marketing/ advertisement awareness and registration, venue identification and allocation, Hospitality and Nutrition (food & drink service)								
Anticipated Outcomes Activity 1B- Reduce risk of heart disease, stroke, and other cardiovascular complications, as well as potentially improved cholesterol levels, blood pressure, and overall health through dietary changes								

Anticipated Outcomes Activity 1C- Heightened understanding of heart disease/ stroke risk factors, symptoms, and the significance of timely intervention; ultimately to enhance cardiovascular health while decreasing cardiovascular mortality and disability
Resources: (needs) Marketing

Priority Area: Diabetes

Goal Statement: Goals: 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 opportunities to the community/public								
Programs/Activities	**Responsible (staff)**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**	**Notes**
Activity 1: Develop opportunities for students to observe diabetes education	Diabetes Educators Nursing Education	# of incidents	Community Benefits Reports (CBRs)	0	Increase by 1%	Increase by 2%	Increase by 3%	
Activity 2: Offer gestational diabetes education sessions (in-person)	Diabetes Educators	Total # of participations	Community Benefits Reports (CBRs)	SCH-11 CH-50 SM-21 (July-Dec 24)	Increase by 1%	Increase by 2%	Increase by 3%	
Activity 3: Offer online diabetes education videos through the Wellness Network	Diabetes Educators	Analytics/# of times video viewed	Wellness Network (Health Clips)	0	Planning year	Increase usage by 1%	Increase usage by 2%	Using Health Clips. Review clips, update if needed.
Activity 4: Develop a Health Resource program for members of the community.	Diabetes Educators	Number of people completing the program	Attendance/ completion	0	Planning year	Determine baseline	Increase program completion by 2%	
Target Population: nursing students, community, Lake and Porter counties								
Collaboration Partners: American Diabetes Association, nursing students, cardiac rehab, stroke, pulmonary, Fitness Pointe, New Healthy Me, Bariatric Services, providers, support groups, cancer resource center								

Anticipated Outcomes: Increase educational opportunities for the community.		
Resources: (needs) Staffing department: difficult to cover inpatient/outpatient diabetes consults and provide hours to community events		
State priorities	**National priorities**	**Notes**
Goal 2: Educate the public and connect individuals the tools and resources available to support them in pursuing a healthy lifestyle to prevent diabetes (Indiana Diabetes Strategic Plan 2020-2026)	Reduce the burden of diabetes and improve quality of life for all people who have, or are at risk for, diabetes. (HP 2030)	-

St. Mary Medical Center Strategy 2: Provide education opportunities to health professionals								
Programs/Activities	**Responsible (staff)**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**	**Notes**
Activity 1: Offer online diabetes education training at orientation	Education staff	Completion rates	Health Stream analytics	0	Increase by 1%	Increase by 2%	Increase by 3%	Work on an in-person next cycle
Activity 2: Conduct diabetes education training for the nurse residents (CME)	Education Director	# of nurse attendees/participants	Education Department-attendance	0	Planning year (restarting)	Increase by 2%	Increase by 3%	
Target Population: Hospital staff, patients								
Collaboration Partners: churches, fitness center, civic center								
Anticipated Outcomes: Increase educational and training opportunities for hospital staff; increase the number of “community” educators on diabetes/A1C								

Resources: (needs)

St. Mary Medical Center Strategy 3: Provide community events/health fairs/screenings to the community/public								
Programs/Activities	**Responsible (staff)**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**	**Notes**
Activity 1: Host community health fairs including A1C screenings	Diabetes Educators, nurses	Lab paperwork/lab count Number of people taking A1C screening	Community Benefits Reports (CBRs)	2	Increase # of people taking A1C screenings per year	Increase # people offering A1C screenings per year	Increase # people offering A1C screenings per year	
Activity 2: Participate in community-based events by providing screenings	Diabetes Educators	# of participants	Community Benefits Reports (CBRs)	0	Planning year	Increase participation by 1%	Increase participation by 2%	
Target Population: Community members								
Collaboration Partners: American Diabetes Association								
Anticipated Outcomes: Increase community events, health fairs, and screenings; Increase the knowledge around diabetes and A1C; Increase knowledge of healthy meal planning								
Resources: (needs)								

Priority Area: Maternal and 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 education and awareness of maternal and children's care and services

Programs/Activities	Responsible (staff)	Evaluation Measures	Data Source	Baseline	Process Measure Y1	Process Measure Y2	Process Measure Y3	Notes
Activity 1: Participate (invited) in annual community health fairs/community events per year	Family Birthing Services staff, outreach nurses	# of events attended	Community Benefits Reports (CBRs)	One per year	1 event	2 events	3 events	
Activity 2: Host maternal/child health events per year	Family Birthing Services	# of events	Community Benefits Reports (CBRs)	0	1 Powers Health location	One location per year	One location per year	
Activity 3: Develop a curriculum for an in-person & hybrid breastfeeding	Lactation Consultants	Utilization #/# of completions	MyChart	0	Planning year	In-person program curriculum/outline	Hybrid program curriculum/outline	
Activity 4: Develop MCH educational opportunities online	Education	Course completions	Patient channel	0	Planning year	TBD	TBD	

Target Population: pre-postnatal mothers, infants, children, community members (Lake and Porter counties)

Collaboration Partners: FQHCs (Healthy Families, Mental Health America, NFP, Gemunis Prenatal Program, Health Visions Midwest, Anew Ministries

Anticipated Outcomes: Increased knowledge and awareness of maternal and children's services and resources, resulting in healthier pregnancies and birth outcomes

Resources: (needs) Resource guide				
National priorities	**State priorities**			
Improve the health and well-being of women, children and families. (HP 2030)	Ensuring all Indiana residents have access to comprehensive care, promoting healthy pregnancies and births, and improving outcomes for mothers and infants, with a particular emphasis on addressing health disparities and the social determinants of health. Source: Indiana Department of Health			

Priority Area: Mental Health

Goal Statement: Improve mental health (Healthy People 2030)								
St. Mary Medical Center Strategy 1: Increase mental health awareness and education								
Programs/Activities	**Responsible (staff)**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**	**Notes**
Activity 1: Plan and implement a suicide awareness program (vigil, in-house awareness table, Darkness Walk)	Behavioral Health Service staff	# of events	Community Benefits Reports (CBRs)	1 per year	1 event per year	1 event per year	1 event per year	
Activity 2: Develop mental health awareness programs in schools	Behavioral Health Service staff	# of schools	Community Benefits Reports (CBRs)	0	Planning Year	Outreach to 1 school/class/district	Expand to 2-3 schools/classes	
Activity 3: Develop an in-person support program for families of inpatients	Behavioral Health Service staff	# of participants	Community Benefits Reports (CBRs)	0	Planning year	50 participants	Increase participation 2%	
Activity 4: Partner with community organizations (NAMI) to provide mental health support programs for inpatient family members	Behavioral Health Service staff	# of partnerships/community organizations	TBD	0	Planning Year	TBD		

Activity 5: Develop mental health videos promoting mental wellness (Topics: seasonal depression, anxiety, stigma reduction, etc.)	Behavioral Health Service staff	# of videos/analytics	Spreadsheet/TBD	0	Planning year	1 video	2 videos	
Target Population: families, teens, community, inpatient family members, inpatients								
Collaboration Partners: NAMI, Lake and Porter County school systems, Porter Starke, Mental Health America, Federally Qualified Health Centers (FQHC),								
Anticipated Outcomes: Increase understanding, knowledge and support among Lake and Porter County residents								
Resources: (needs) production company (videos), program/event space, program materials, build partnerships with teen organizations								

National priorities	**State priorities**			
Improve mental health (HP 2030)	Improve access to quality services, promote recovery, and address disparities, with a particular emphasis on youth and families, and integrate mental health care into primary care settings. IN.gov			

St. Mary Medical Center Strategy 2: Increase mental health skills, knowledge and support by conducting staff and community trainings								
Programs/Activities	**Responsible (staff)**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**	**Notes**
Activity 1: Plan, implement, and offer education sessions/training for hospital staff on mental health education, removing stigma, and crisis intervention training (staff)	Behavioral Health Service staff	# of participants	Sign-in sheets	0	Determine baseline	Increase 2%	Increase 3%	
Activity 2: Offering standardized education and resource programs on mental health issues	Behavioral Health Service staff	# of participants	Sign-in sheet/Community Benefits Reports (CBRs)	0	Determine baseline	Increase 2%	Increase 3%	Topic: de-escalation trainings, signs of depression
Target Population: Powers Health staff and community members, Lake and Porter County								
Collaboration Partners: Employer groups, community organizations								
Anticipated Outcomes: Increase skills, knowledge, and support among staff and community members								
Resources: (needs) program materials, staff/volunteers/educators, networking opportunities for staff to attend and promote community events to build community relationships								

Priority Area: Stroke

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

St. Mary Medical Center Strategy 1: Raise awareness and educate the community about the risk factors for stroke

Programs/Activities	Responsible (staff)	Evaluation Measures	Data Source	Baseline	Process Measure Y1	Process Measure Y2	Process Measure Y3	Notes
Activity 1: Expand stroke support groups by offering in-person/virtual sessions	Stroke Coordinators	# of participants	Community Benefits Reports (CBRs)	15 participants per month	Increase by 1% per year	Increase by 2% per year	Increase by 3% per year	
Activity 2: Conduct risk assessment on stroke and stroke prevention at health fairs/community events	Stroke Coordinators	# of assessments completed	Spreadsheet /TBD	0	Determine baseline	Increase by 1% per year	Increase by 2% per year	
Activity 3: Develop stroke workshops/presentation focusing on women	Stroke Coordinators	# of events	Community Benefits Reports (CBRs)	0	Planning year	Increase by 1 event per year	Increase by 2-3 events per year	
Activity 4: Plan social media stroke prevention awareness campaign/content (all hospitals)	Stroke Coordinators	# of projects	Spreadsheet	0	Planning year	Increase 1 project per year	# of engagement/analytics (baseline)	
Target Population: Lake and Porter County community members, women, social media consumers								

Collaboration Partners: Rehabilitation, churches/faith-based organizations, social groups, senior centers, schools, Powers Health therapy department, local health departments, universities, medical schools, local businesses, American Heart and Stroke Association, Stroke Consortium				
Anticipated Outcomes 1: Reducing the incidence of stroke by increasing education about signs and symptoms, prevention and risk factors **Anticipated Outcomes 2: Increasing reaction time when stroke symptoms are recognized**				
Resources: (needs) I.T., technology (tablets, laptops), stroke champions, new program space, program materials (flyers, pamphlets, BE FAST magnets)				
National priorities	**State priorities**			
Improve cardiovascular health and reduce deaths from heart disease and stroke. (Healthy People 2030)	Decrease the burden of cardiovascular disease and stroke. (IN.gov)			

Powers Health Rehabilitation Center
Priority Area: Cancer

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

Powers Health Rehabilitation Center Strategy 1: Provide screening opportunities to the community

Programs/Activities	Responsible (staff)	Evaluation Measures	Data Source	Baseline	Process Measure Y1	Process Measure Y2	Process Measure Y3	Notes
Activity 1: Offer lung cancer screenings to qualifying adults	Director of Cancer Care Services	Increase # of lung cancer screenings	# low-dose CTs	0	Baseline TBD	Increase 2%	Increase 5%	
Activity 2: Promote cervical, prostate and colon cancer screenings through Powers Health Medical Group.	Executive Director of Cancer Care Services	# of activities focused on promoting screenings	Community Benefits Reports (CBRs)	0	Planning Year	Increase activities by 2 from baseline	Increase activities by 2.	

Target Population: Patients and community (Lake and Porter counties)

Collaboration Partners: Cancer Service Line; American Cancer Society; Powers Health Medical Group (PHMG)

Anticipated Outcomes:
Increase cancer screening opportunities for patients and community members.
Increase the number of patients getting screened according to national guidelines.

Resources: (needs) American Cancer Society (educational materials)

National priorities	State priorities	Notes:

Reduce new cases of cancer and cancer-related illness, disability, and death	**Indiana Cancer Control Plan 2023-2027 (health equity, primary prevention, early detection, treatment, survivorship**	

Powers Health Rehabilitation Center Strategy 2: Expand cancer support programs and navigation services								
Programs/Activities	**Responsible (staff)**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**	**Notes**
Activity 1: Increase support groups/wellness class (CRC) participation	Administrative Assistant Cancer Care Services	# of patients	Sign-in sheets	1700 patients per year (2023)	Increase 2%	Increase 5%	Increase 5%	
Activity 2: Increase the number of distress screenings completed (navigation tool)	Oncology Outpatient Nurse Manager	# of screenings	EPIC	FY 2024 390	Increase 1%	Increase 2%	Increase 3%	
Activity 3: Expand the number of support groups/wellness classes	Administrative Assistant Cancer Care Services	# of classes	Monthly Spreadsheet/ Marketing materials	0	Add 1 class per year (different areas)	Add 2 classes per year (different areas)	Add 3 classes per year (different areas)	

Activity 4: Increase the number of newly diagnosed patients receiving navigation services for breast, lung, and gastrointestinal (GI) cancers	Director of Cancer Care Services	Navigation #s for breast, lung, GI cancers	Navigator metrics	0 Navigation #s for the newly diagnosed	Increase 1% (overall #s)	Increase 2% (overall #s)	Increase 3% (overall #s)	
Target Population: Cancer patients and the community, for individuals in active treatment, survivorship, and who are caregivers								
Collaboration Partners: PH clinical facilities; cancer medical groups; PHMG								
Anticipated Outcomes: Patients receiving cancer diagnosis are supported throughout their journey.								
Resources: (needs)								

Powers Health Rehabilitation Center Strategy 3: Provide educational opportunities to the community								
Programs/Activities	**Responsible (staff)**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**	**Notes**
Activity 1: Plan, implement, and offer presentations and workshops (CRC patients)	Administrative Assistant Cancer Care Services	# of events	Monthly spreadsheet	0	Increase by 1 event	Increase by 1 event	Increase by 1 event	
Activity 2: Plan, implement, and offer presentations and workshops (service line-community members)	Administrative Assistant Cancer Care Services/	# of events/4 per year (w/partners)	Monthly spreadsheet	0	Increase by 1 event	Increase by 1 event	Increase by 1 event	
Target Population: CRC patients, Service Line/Community (Lake and Porter counties)								

Collaboration Partners: American Cancer Society; cancer physicians
Anticipated Outcomes: Increase the number of educational presentations and workshops for patients and community members.
Resources: (needs)

Priority: Heart Disease

Goal Statement: Improve cardiovascular health and reduce deaths from heart disease and stroke. (Healthy People 2030)								
Powers Health Rehabilitation Center Strategy 1: Increase knowledge and awareness of heart disease and stroke risk factors								
Programs/Activities	**Responsible (staff)**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**	**Notes**
Activity 1: 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.	Cardiac Care Nurses	# of attendees	Community Benefits Reports (CBRs)	9 patients per screening	Increase by 1%	Increase by 2%	Increase by 3%	
Activity 2: Develop heart disease prevention program focusing on teens (Physicians will travel to location, if needed)	Cardiology Directors Cardiologist(s) presenters	# of presentations Pre-post survey Knowledge-based (increase knowledge)	Community Benefits Reports (CBRs)	0	Increase 1-an event per year I school per year	Increase 2 an event per year 2 schools per year	Increase 3 events per year 3 schools per year	
Target Population: Men over 55 and women over 65, post-menopausal women, people with a family history of vascular diseases, tobacco users, diabetics, and those diagnosed with either high blood pressure or high cholesterol **Target Population: Activity 1B-** High school students/ faculty								

Collaboration Partners: Collaboration Partners Activity 1A- Possibility of future screening offerings extending into local YMCAs, churches, mosques, etc. **Collaboration Partners Activity 1B-** High school administrator(s)
Anticipated Outcomes: Activity 1A- Early detection of peripheral artery disease (PAD), timely identification and treatment offerings that prevent or delay progression of PAD; thus, improving quality of life and reducing risk for severe complications **Anticipated Outcomes: Activity 1B-** Positively influence CV health knowledge, attitudes, and self-reporting behaviors among high school students by increasing awareness of the risk factors of cardiovascular disease and promoting healthy lifestyle choices
Resources: (needs) Marketing advertisement materials, vascular ultrasound equipment, patient screening room, TC70 (EKG cart), team resources (vascular sonographer, primary screener…Laura, billing resource…Rhonda **Resources: (needs) Activity 1B-** Space accommodation(s), cardiology presenters x 2, standardized audiovisual materials (PPT), public address system

National priorities	**State priorities**			
Improve cardiovascular health and reduce deaths from heart disease and stroke. (Healthy People 2030)	**Reduce the burden of heart disease and stroke in the state. (Indiana Department of Health (IDOH)**			

Powers Health Rehabilitation Center Strategy 2: Increase educational opportunities for heart disease and stroke risk factors								
Programs/Activities	**Responsible (staff)**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**	**Notes**
Activity 1: Provide Healthy Eating education to the community (patient and	Cardiovascular Outpatient (CVOP) nurses	CVOP monthly	EPIC	0	Increase by 10%	Increase by 10%	Increase by 10%	

family members/caregivers) focusing on heart health		patient encounters						
Activity 2: Provide educational events of various scales to the public with a heart disease focus.	Cardiology Directors Hospitality and Nutrition Cardiologist(s) presenters	# of events per year	Community Benefits Reports (CBRs)	40-50 participants per session	Increase # of events	Increase # of events by 2	Increase # of events by 4	Topics: Diet, Exercise, Obesity, Smoking Cessation, Blood Pressure Control, Cholesterol Control, Blood Glucose Control, Atrial Fibrillation, Trans carotid Artery Revascularization
Target Population Activity 1B- Public/Community/ Family Members of CVOP Patients **Target Population Activity 1C-** All adults ages 45 and older, people with a family history of heart disease/ stroke, minority populations								
Collaboration Partners: Collaboration Partners Activity 1B- CVOP Nursing Team(s), Marketing **Collaboration Partners Activity 1C-** Cardiologist(s)/ Electrophysiologist presenters, Marketing/ advertisement awareness and registration, venue identification and allocation, Hospitality and Nutrition (food & drink service)								
Anticipated Outcomes Activity 1B- Reduce risk of heart disease, stroke, and other cardiovascular complications, as well as potentially improved cholesterol levels, blood pressure, and overall health through dietary changes **Anticipated Outcomes Activity 1C-** Heightened understanding of heart disease/ stroke risk factors, symptoms, and the significance of timely intervention; ultimately to enhance cardiovascular health while decreasing cardiovascular mortality and disability								
Resources: (needs) Marketing								

Priority Area: Diabetes

Goal Statement: Goals: Reduce the burden of diabetes and improve quality of life for all people who have, or are at risk for, diabetes. (Healthy People 2030)								
Powers Health Rehabilitation Center Strategy 1: Provide education opportunities to the community/public								
Programs/Activities	**Responsible (staff)**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**	**Notes**
Activity 1: Develop opportunities for students to observe diabetes education	Diabetes Educators Nursing Education	# of incidents	Community Benefits Reports (CBRs)	0	Increase by 1%	Increase by 2%	Increase by 3%	
Activity 2: Offer gestational diabetes education sessions (in-person)	Diabetes Educators	Total # of participations	Community Benefits Reports (CBRs)	SCH-11 CH-50 SM-21 (July-Dec 24)	Increase by 1%	Increase by 2%	Increase by 3%	
Activity 3: Offer online diabetes education videos through the Wellness Network	Diabetes Educators	Analytics/# of times video viewed	Wellness Network (Health Clips)	0	Planning year	Increase usage by 1%	Increase usage by 2%	Using Health Clips. Review clips, update if needed.
Activity 4: Develop a Health Resource program for members of the community.	Diabetes Educators	Number of people completing the program	Attendance/ completion	0	Planning year	Determine baseline	Increase program completion by 2%	
Target Population: nursing students, community, Lake and Porter counties								
Collaboration Partners: American Diabetes Association, nursing students, cardiac rehab, stroke, pulmonary, Fitness Pointe, New Healthy Me, Bariatric Services, providers, support groups, cancer resource center								

Anticipated Outcomes: Increase educational opportunities for the community.		
Resources: (needs) Staffing department: difficult to cover inpatient/outpatient diabetes consults and provide hours to community events		
State priorities	**National priorities**	**Notes**
Goal 2: Educate the public and connect individuals the tools and resources available to support them in pursuing a healthy lifestyle to prevent diabetes (Indiana Diabetes Strategic Plan 2020-2026)	Reduce the burden of diabetes and improve quality of life for all people who have, or are at risk for, diabetes. (HP 2030)	-

Powers Health Rehabilitation Center Strategy 2: Provide education opportunities to health professionals								
Programs/Activities	**Responsible (staff)**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**	**Notes**
Activity 1: Offer online diabetes education training at orientation	Education staff	Completion rates	Health Stream analytics	0	Increase by 1%	Increase by 2%	Increase by 3%	Work on an in-person next cycle
Activity 2: Conduct diabetes education training for the nurse residents (CME)	Education Director	# of nurse attendees/participants	Education Department-attendance	0	Planning year (restarting)	Increase by 2%	Increase by 3%	
Target Population: Hospital staff, patients								
Collaboration Partners: churches, fitness center, civic center								
Anticipated Outcomes: Increase educational and training opportunities for hospital staff; increase the number of “community” educators on diabetes/A1C								

Resources: (needs)

Powers Health Rehabilitation Center Strategy 3: Provide community events/health fairs/screenings to the community/public								
Programs/Activities	**Responsible (staff)**	**Evaluation Measures**	**Data Source**	**Baseline**	**Process Measure Y1**	**Process Measure Y2**	**Process Measure Y3**	**Notes**
Activity 1: Host community health fairs including A1C screenings	Diabetes Educators, nurses	Lab paperwork/lab count Number of people taking A1C screening	Community Benefits Reports (CBRs)	2	Increase # of people taking A1C screenings per year	Increase # people offering A1C screenings per year	Increase # people offering A1C screenings per year	
Activity 2: Participate in community-based events by providing screenings	Diabetes Educators	# of participants	Community Benefits Reports (CBRs)	0	Planning year	Increase participation by 1%	Increase participation by 2%	
Target Population: Community members								
Collaboration Partners: American Diabetes Association								
Anticipated Outcomes: Increase community events, health fairs, and screenings; Increase the knowledge around diabetes and A1C; Increase knowledge of healthy meal planning								
Resources: (needs)								

Priority Area: Stroke

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

Powers Health Rehabilitation Center Strategy 1: Raise awareness and educate the community about the risk factors for stroke

Programs/Activities	Responsible (staff)	Evaluation Measures	Data Source	Baseline	Process Measure Y1	Process Measure Y2	Process Measure Y3	Notes
Activity 1: Expand stroke support groups by offering in-person/virtual sessions	Stroke Coordinators	# of participants	Community Benefits Reports (CBRs)	15 participants per month	Increase by 1% per year	Increase by 2% per year	Increase by 3% per year	
Activity 2: Conduct risk assessment on stroke and stroke prevention at health fairs/community events	Stroke Coordinators	# of assessments completed	Spreadsheet /TBD	0	Determine baseline	Increase by 1% per year	Increase by 2% per year	
Activity 3: Develop stroke workshops/presentation focusing on women	Stroke Coordinators	# of events	Community Benefits Reports (CBRs)	0	Planning year	Increase by 1 event per year	Increase by 2-3 events per year	
Activity 4: Plan social media stroke prevention awareness campaign/content (all hospitals)	Stroke Coordinators	# of projects	Spreadsheet	0	Planning year	Increase 1 project per year	# of engagement/analytics (baseline)	

Target Population: Lake and Porter County community members, women, social media consumers

Collaboration Partners: Rehabilitation, churches/faith-based organizations, social groups, senior centers, schools, Powers Health therapy department, local health departments, universities, medical schools, local businesses, American Heart and Stroke Association, Stroke Consortium

Anticipated Outcomes 1: Reducing the incidence of stroke by increasing education about signs and symptoms, prevention and risk factors

Anticipated Outcomes 2: Increasing reaction time when stroke symptoms are recognized				
Resources: (needs) I.T., technology (tablets, laptops), stroke champions, new program space, program materials (flyers, pamphlets, BE FAST magnets)				
National priorities	**State priorities**			
Improve cardiovascular health and reduce deaths from heart disease and stroke. (Healthy People 2030)	Decrease the burden of cardiovascular disease and stroke. (IN.gov)			

SECTION 7: CONCLUSION

This Community Health Needs Assessment (CHNA), conducted for Powers Health used a comprehensive set of secondary and primary data to determine the health priorities listed below.

- Priority 1: Cancer
- Priority 2: Diabetes
- Priority 3: Heart Disease
- Priority 4: Maternal and Children's Health
- Priority 5: Mental Health
- Priority 6: Stroke

The findings in this report will guide the development of the Powers Health Implementation Strategy Plan, which will outline strategies to address identified priorities and improve the community's health.

- The action plan presented outlines the individual strategies and activities that Powers Health will implement to address the health needs identified through the CHNA process. The components are outlined in detail in this report. The plans include: 1) actions the healthcare system and its hospitals intend to take to address health needs identified in the CHNA process, 2) anticipated impact of these actions, noted in process and outcomes measures for each activity, 3) resources the hospital system plans to commit to each strategy, 4) any planned collaboration to support the work.

Please complete the form in the Contact Us section of the Powers Health website- https://www.powershealth.org/contact-us to send feedback and/or comments about this CHNA report. The feedback will be incorporated into the next CHNA process.

SECTION 8: REFERENCES

Food Insecurity methodology: https://help.healthycities.org/hc/en-us/articles/5675958006039-Where-can-I-find-more-details-on-the-methodology-used-to-create-the-Food-Insecurity-Index

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SECTION 9: APPENDICES SUMMARY

The following support documents are shared on the Powers Health website:

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 tools that were 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 that are 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.