

Rensselaer Community

# community
## HEALTH NEEDS ASSESSMENT

2025-2027

Franciscan HEALTH
Rensselaer





# community HEALTH NEEDS ASSESSMENT

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Franciscan HEALTH

# HOW TO USE THIS REPORT

**INTRODUCTION & FACILITY INFORMATION**

*Learn about Franciscan Health's mission & our facility*

**SECTION 1**

*Examine the geographic and demographic traits of the communities we serve*

**2**

*Explore the social and economic factors that impact health*

**3**

*Review health outcomes and prevention strategies for chronic disease*

**4**

*Listen to the voice of community members and explore community assets*

**5**

*Uncover Franciscan Health's strategic plan to help meet the needs of the community*



# community HEALTH NEEDS ASSESSMENT

## INTRODUCTION

Franciscan HEALTH

# DEAR READER,

This report provides findings from the Community Health Needs Assessment (CHNA), a comprehensive review of health data and community input on health issues relevant to the communities served by Franciscan Health. The assessment covers a large range of topics, but is not a complete analysis of any one issue. Rather, these data help to identify priorities which lead to productive community discussions and the creation of goals and objectives.

We invite you to use the information in this report to move toward solutions for healthier communities.

This report meets the current Internal Revenue Service's requirement for tax-exempt hospitals, which is based on the Patient Protection and Affordable Care Act of 2010. More importantly, this document assists Franciscan Health in providing essential services to those most in need. Based on the findings in this report, Franciscan Health has developed a three-year strategic plan on meeting community health needs as capacity and resources allow.

The CHNA includes input from persons representing the broad interests of the overall community, including those with specialized knowledge of, or expertise in, public health and residents of the communities the hospital serves. Data from a variety of federal, state, and local entities were also reviewed.

You'll find this document organized in such a way as to guide you through the community. Most importantly, please see the Call to Action. In this section, we share our commitment to improving community health in 2025-2027. We hope you will join us, as we know improving health is a total community effort.

If you have comments, suggestions, or questions about this report, please do not hesitate to contact The Community Health Improvement Department at *COMHEALTHIMPVTEAM@FranciscanAlliance.org*.

Yours in health,

**The Community Health Improvement Team**

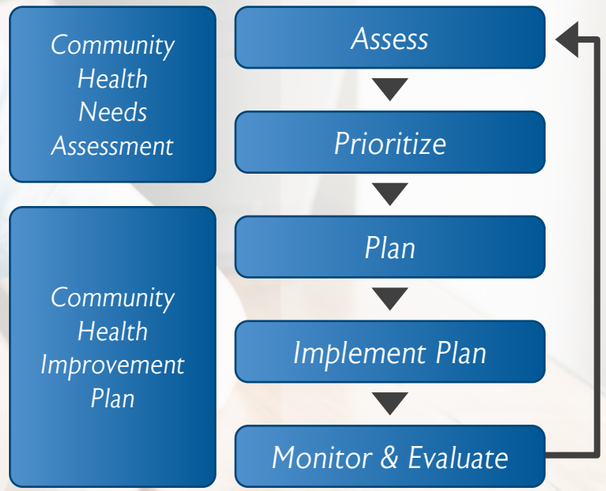




*The ultimate goal of a community health assessment is to develop strategies to address the community's health needs and identified issues. A variety of tools and processes may be used to conduct a community health assessment; the essential ingredients are community engagement and collaborative participation.*
**- Centers for Disease Control and Prevention**

# OUR PURPOSE AND METHODS

Every three years, Franciscan Health takes time to assess the health needs of the communities it serves. This assessment allows us to prioritize our resources to implement interventions that address these needs with evidence-based practices. Throughout each three year cycle, staff evaluate and monitor the effectiveness of our programs. You'll find the strategic plan, also called the Community Health Improvement Plan (CHIP) in the Call to Action Section of this document.



# TIMELINE

**2023**
The 2-year process begins for the Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP).

**April-July 2023**
Planning and consulting with public health experts on CHNA and CHIP improvements for 2025-2027 edition.

**May-September 2023**
Review of public health data for newest updates related to health status in our communities.

**October-December 2023**
Pilot survey launched and analyzed, identifying key themes in stakeholder groups.

**2024**
Start of year 2.

**February-May 2024**
Community Health Survey deployed to multiple audiences.

**January-August 2024**
Secondary data collected and refined. Primary data from Community Health Surveys are analyzed.

**August 2024**
Community health needs prioritized.

**September 2024**
Community Health Improvement Plan created.

**October-December 2024**
Franciscan Health leadership approvals.

**2025**
Launch the 2025-2027 plan.






*community* HEALTH NEEDS ASSESSMENT

FACILITY INFORMATION

Franciscan HEALTH

# ABOUT FRANCISCAN HEALTH

***Throughout our hospitals and medical practices, we offer nationally recognized Centers of Health Care Excellence.***

Since 1876, Franciscan Health has stayed true to our founding mission to care for everyone who comes through our doors. We treat our patients with the best possible care by following the guiding values embodied by our founding congregation, the Sisters of St. Francis of Perpetual Adoration. The Sisters sponsor Franciscan Health, a healthcare system which upholds the moral values and teachings of the Catholic Church. We minister with joy, care and compassion according to the ideals of Saint Francis of Assisi and our foundress Blessed Maria Theresia Bonzel.

Our healthcare system carries forth Christ's healing ministry and strengthens the Catholic health care mission by:

- Providing a broad, coordinated continuum of health care services with an emphasis on improving the health of persons and communities.
- Treating the mind, body and spirit with holistic and comprehensive medical options.
- Developing creative structures for health care delivery.
- Being advocates for those in need.
- Identifying talent and developing our coworkers to develop as mission leaders in our Franciscan system.

# FACILITY INFORMATION




**Hospital Contact Information**

CEO: Terry Wilson
COO: Carlos Vasquez
Address: 1104 East Grace St.
Rensselaer, IN 47978

Phone: (219) 866-5141
Website: www.franciscanhealth.org

Annual Inpatient Admissions (2023): 378
Annual Outpatient Admissions (2023): 55,698
Annual ED Admissions (Arrivals 2023): 8,835 Annual Births (2023): 0
Number of Employees (2023): 173
Number of Doctors (FPN, SPI, & Affiliates 2023): 223
Length of Stay (Inpatient 2023 number of days): 2.7






# OUR HISTORY



Blessed Maria Theresia Bonzel was born on Sept. 17, 1830 in Olpe, Germany. She sought to combine the contemplative and active religious life through an unfailing commitment to Perpetual Adoration of the Blessed Sacrament and the works of mercy in the spirit of Saint Francis of Assisi. She wanted to follow Christ and to serve the poor, and was asked by Bishop Konrad Martin to form a religious Congregation. And thus the Sisters of Saint Francis of Perpetual Adoration was founded on July 20, 1863. On November 25, 1875 Blessed Maria Theresia Bonzel sent six Sisters from Olpe, Germany to Lafayette, Indiana to begin a ministry of healthcare and education for the poor and neglected. After a lifetime of dedicated service and virtuous leadership, Blessed Maria Theresia Bonzel was beatified on November 10, 2013 bestowing on her the title of "Blessed" and moving her one step closer to Sainthood. Today, over 150 years later, the Sisters of Saint Francis of Perpetual Adoration are ministering in the United States, Germany, and the Philippines.

# RENSSELAER SERVICES

We offer a comprehensive list of services and service lines at Franciscan Health Rensselaer.

List of Services (Service Lines): Cancer Care, Children's Health, Diabetes and Endocrinology, Diet and Nutrition, Emergency Medicine, Heart Care, Home Health, Hospice and Palliative Care, Imaging and Radiology, Infectious Disease, Kidney, Liver, and Urinary Tract Care, Laboratory Services, Obstetrics and Gynecology, Orthopedics, Pain Management, Pharmacy, Physical Therapy and Rehabilitation, Pulmonary and Respiratory Medicine, Sleep Medicine, Surgical Services, Wound Care.

> *Start by doing what is necessary; then do what is possible; and suddenly you are doing the impossible.*
> **- Francis of Assisi**

# MISSION

*Continuing Christ's Ministry in our Franciscan Tradition.*

# OUR VALUES

## RESPECT FOR LIFE

The gift of life is so valued that each person is cared for with such joy, respect, dignity, fairness and compassion that he or she is consciously aware of being loved.

## FIDELITY TO OUR MISSION

Loyalty to and pride in the health care facility are exemplified by members of the health care family through their joy and respect in emphatically ministering to patients, visitors and co-workers.

## COMPASSIONATE CONCERN

In openness and concern for the welfare of the patients, especially the aged, the poor and the disabled, the staff works with select associations and organizations to provide a continuum of care commensurate with the individual's needs.

## JOYFUL SERVICE

The witness of Franciscan presence throughout the institution encompasses, but is not limited to, joyful availability, compassionate, respectful care and dynamic stewardship in the service of the Church.

## CHRISTIAN STEWARDSHIP

Christian stewardship is evidenced by just and fair allocation of human, spiritual, physical and financial resources in a manner respectful of the individual, responsive to the needs of society, and consistent with Church teachings.



community HEALTH NEEDS ASSESSMENT

COMMUNITY PROFILE

SECTION 1

Franciscan HEALTH

# COMMUNITY PROFILE

SECTION 1

*This section details the community that we serve. The community profile contains information such as geographic boundaries, population demographics and community diversity. Reviewing this information gives readers a sense of community strengths and how to compassionately meet the needs of the individuals within our community.*

## The Rensselaer Community

A rich agricultural heritage frames life in Rensselaer, and in Jasper and Newton Counties. Rolling hills, tidy rows of crops, and a close community make Rensselaer a quintessential Hoosier town. Country roads, small businesses, civic organizations and a good parks system contribute to the feel of small-town life.

While situated close to Interstate 65 and several rail lines, leading to cities like Lafayette and Indianapolis, Rensselaer's independent attitude means the necessities can be met close by. Agribusiness, manufacturing and retail provide a bulk of jobs, contributing to the city's economic stability. Restaurants and local shops dot the landscape.

Rensselaer, and Jasper and Newton Counties, offer a peaceful lifestyle with opportunities for outdoor recreation, a strong sense of community and access to essential amenities. It's an ideal place for those seeking a slower pace of life, complete with nature and community.

### ABOUT OUR SERVICE AREA

Franciscan Health Rensselaer community benefit programs focuses on all of the municipalities and rural lands within Newton County and Jasper County. The service area contains many of those who participate in Franciscan's community benefit activities and encompasses most of Franciscan-affiliated services and providers.

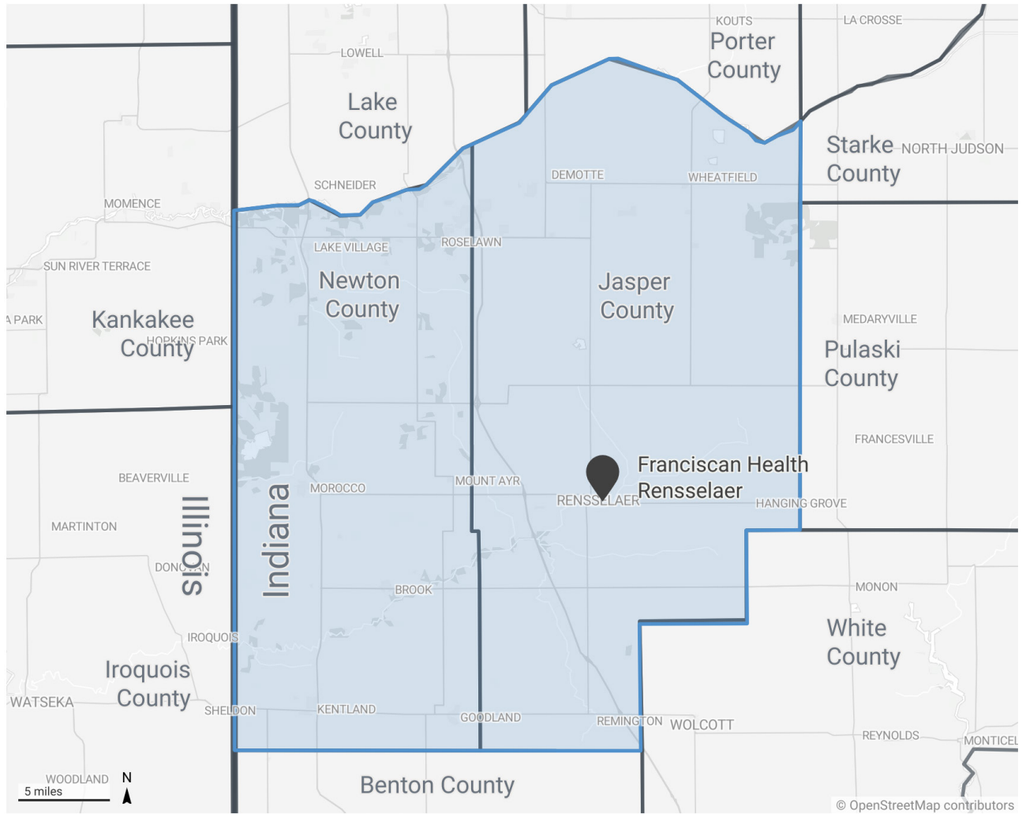


## Newton and Jasper Counties

*The Rensselaer community service area is a 2-county region primarily located in Newton and Jasper Counties in Indiana. Franciscan Health, as a health system, serves the Midwest states of Illinois and Indiana.*



## Franciscan Health Rensselaer Service Area

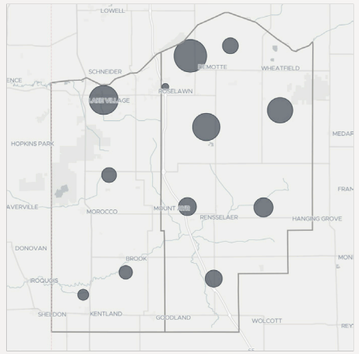



*The Franciscan Health Rensselaer community service area 2-county region that includes: Newton County, IN and Jasper County, IN.*

# THE POPULATION WE SERVE

### CITIES AND MUNICIPALITIES

The cities, villages, and municipalities within our community include Rensselaer (population: 5330 people), DeMotte (4182), Roselawn (3007), Kentland (1810), Remington (1486), Morocco (1107), Goodland (991), Brook (960), Wheatfield (853), Lake Village (579), Mount Ayr (85) and Collegeville (84).




### POPULATION AND GROWTH

In 2022, the total population of our community was estimated to be 46,874. This is a 2% decrease in 10 years. Population growth in this region has been lower compared to state and national benchmarks. For comparison, in that same time period, the average population increase in the U.S. was 7% and 5% in Indiana.

**46,874**

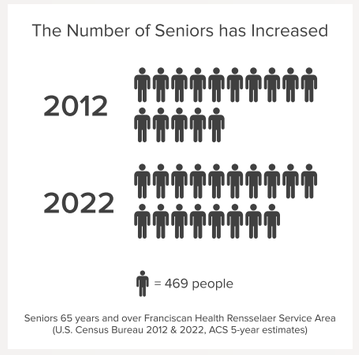
**people live in our community**

A 2% population decrease in the past 10 years

Total population and change for Franciscan Health Rensselaer Service Area (U.S. Census Bureau 2012 & 2022, ACS 5-year estimates)

### A CHANGING POPULATION

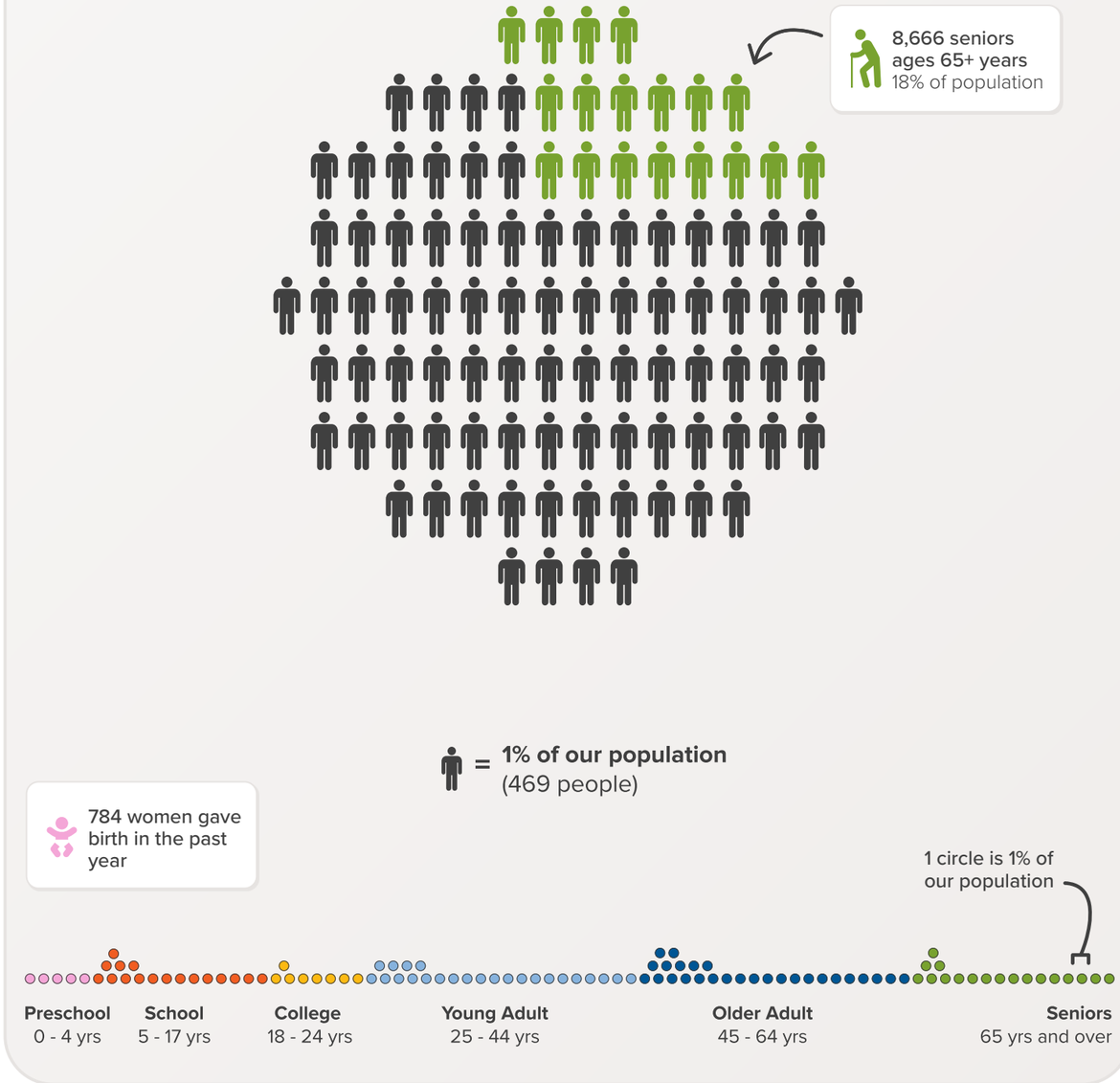
Populations grow and change. The estimated number of women who gave birth in the past year was 784 (1.7%), which is higher than the U.S. benchmark of 1.2%. The senior population ages 65 and over is approximately 8,666 people (18% of the population) and has seen a 23% percent increase from 2012 to 2022.




Seniors 65 years and over Franciscan Health Rensselaer Service Area (U.S. Census Bureau 2012 & 2022, ACS 5-year estimates)

*Population data for Franciscan Health Rensselaer 2-county service area are from U.S. Census Bureau 2012 & 2022 American Community Survey 5-year estimates. Map (above) shows circles scaled by population size within census tracts, 2016 American Community Survey 5-year estimates.*

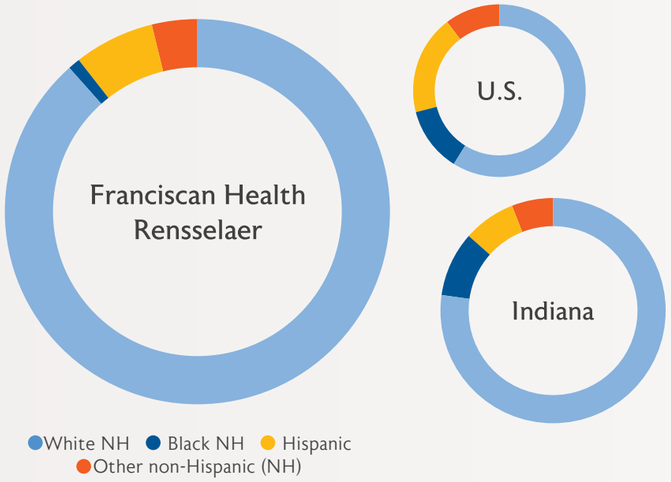
# OUR POPULATION BY AGE



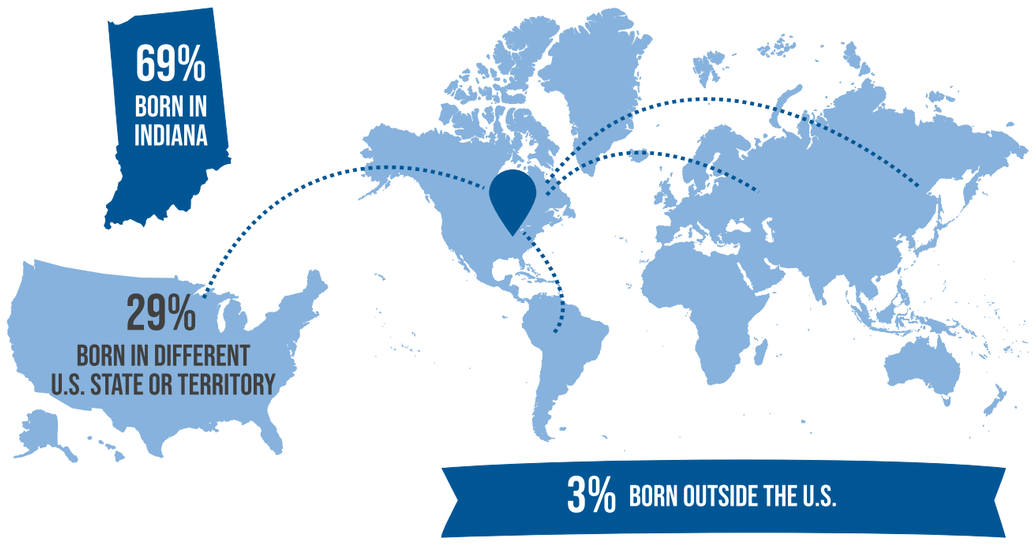

*In 2022, 5% of the population was preschool aged children (0-4 years), 17% were school-aged children (5-17 years), 8% were college-aged students (18-24 years), 24% were young adults (25-44 years), 27% were older adults (45-64 years) and 18% were seniors (65 years and older).*

# STRONGER WITH DIVERSITY

**RACE, ETHNICITY, AND BIRTHPLACE**
The most common race and ethnicity in our community is non-Hispanic White (88%). 1% of the population is non-Hispanic Black or African American and 7% are Hispanic. Most residents were born in-state, and a smaller percent were born in the U.S. and internationally.




## Birthplace of Our Community Members

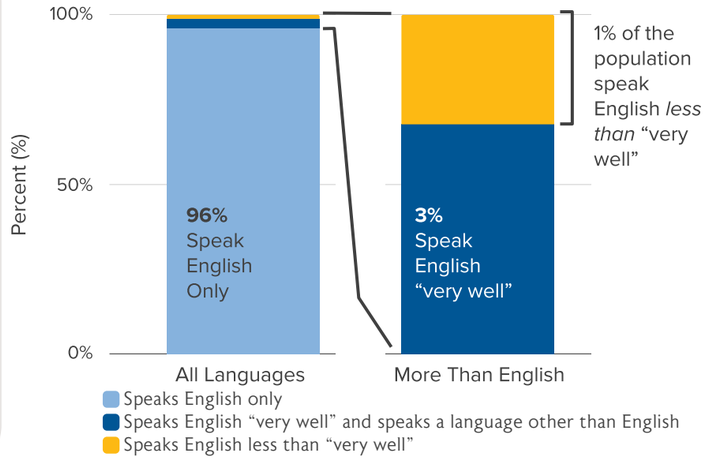



*Data on race, ethnicity, and birthplace of population in The Franciscan Health Rensselaer 2-county service area from U.S. Census Bureau, 2022 American Community Survey, 5-year estimates.*

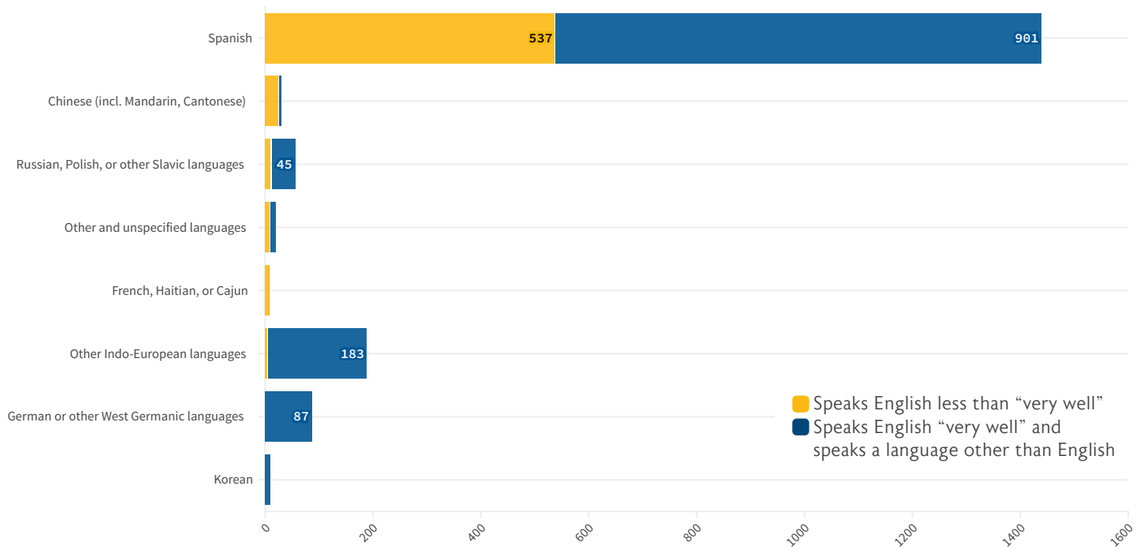


# COMMUNICATION & CARE

**LANGUAGES SPOKEN**
English is the main language spoken in the home and a majority (96%) of residents speak only English. When considering communication in healthcare, about 1% of the population speak English less than "very well" (right) with English proficiency varying by language (below).




## Non-English Languages Spoken in the Home




*Self-reported languages spoken for ages 5 and over within The Franciscan Health Rensselaer 2-county service area. Data from U.S. Census Bureau, 2022 American Community Survey, 5-year estimates.*

# UNIQUE POPULATIONS



### CARETAKERS FOR CHILDREN & TEENS

Most children under 18 in the community live with at least one parent (90.1%). This is higher than the U.S. average (87.9%). Grandparents are the main householder for 5.5% of children. This is low compared to the U.S. average (8.0%). A smaller percentage of children and teens have other family living arrangements or live with foster parents.



### SERVING OUR VETERANS

There are approximately 3,205 U.S. veterans living in the Franciscan Health Rensselaer service area according to the U.S. Census Bureau's American Community Survey. This number includes any person who has served in the military for any length of time, during different wartime and peacetime periods, in active duty, the Military Reserves and the National Guard.



### POPULATION WITH DISABILITIES

The Census Bureau defines disability as a long-lasting condition or set of conditions that make it difficult for a person to do functional or participatory activities of daily living.

According to the American Community Survey, the estimated population with a disability was 7,547 or 16% of the noninstitutionalized population. This is higher than the U.S. benchmark of 13% and 14% in Indiana.

*"Each person is cared for with respect, dignity, fairness and compassion."*



# SERVING OUR COMMUNITY



Franciscan Health is proud to serve our community with joyful, compassionate and respectful care. To better serve residents living within our community, we will explore the factors that contribute to health and specific health conditions impacting those we serve.

SECTION 2

## SECTION 1. DATA ATTRIBUTION

Demographic data for Section 1 are from American Community Survey (ACS) 5-year estimates from the U.S. Census Bureau. All data in Section 1 were for the 2-county region.

Data were queried in 2024. City-specific population data were queried from Census Reporter, another source of ACS 5-year estimates. The population map was downloaded from broadstreet.io and shows 2016 American Community Survey data. Data on childhood living conditions were queried from 2019 American Community Survey data. All other demographic data for the region were queried from data.census.gov. Trend data were from the 2012 American Community Survey 5-year estimates and were compared to the most recently available data from the 2022 American Community Survey 5-year estimates.

## DATA LIMITATIONS AND CAVEATS

Data are estimates from publicly available data. There is commonly a time delay between data collection, estimation, and reporting for publicly available data. Wherever possible, the most recently available data were utilized.

Franciscan HEALTH

# FOUNDATIONS FOR HEALTH

*The foundations of good health begin early. Health is best achieved after basic human needs are met. These needs include social and economic factors such as income, housing and the availability and affordability of food and health care. To provide care that is respectful and responsive to the needs of society, we explore the foundations of good health.*

SECTION 2

## How Do We Build Good Health?

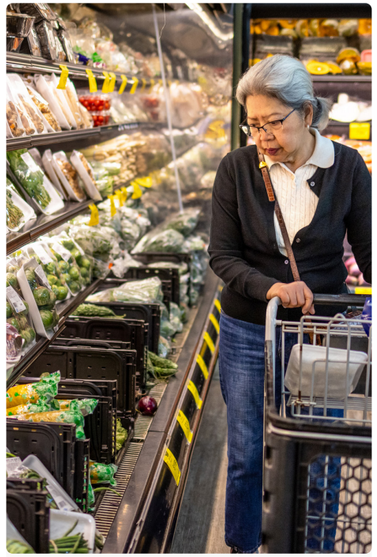
The conditions in which people are born, grow, live, work and age have a significant impact on health and well-being. These non-medical conditions are referred to as **social determinants of health**. Examples of social determinants of health include economic stability, education, social support, transportation, neighborhood environment, food access, and access to healthcare (CDC, 2024). Circumstances are shaped by policy and societal factors such the distribution of money and resources at local, national and global levels (World Health Organization, 2024).

Why are some populations healthier than others? Disparities in health can sometimes be explained by underlying social determinants of health. Vulnerable populations experience greater challenges in achieving positive health outcomes (CDC, 2024; Healthy People 2030, 2024). For example, poverty affects whether someone can afford a car. Without a motor vehicle or other mode of transportation, it is harder to shop for groceries or to get to medical appointments.

Health disparities can be addressed through action (Healthy People 2030, 2024). In this section, we will examine the factors that may be influencing health and well-being in our community. Understanding these non-medical factors will help us to identify areas where additional resources and interventions will have a meaningful impact to improve the quality of life for all.









### SOCIAL & ECONOMIC FACTORS

- INCOME & POVERTY
- EDUCATION
- EMPLOYMENT
- HOUSEHOLD CONDITIONS
- HOUSING STOCK

### FOOD ACCESS

- FOOD LOCATION & AFFORDABILITY

### ACCESS TO HEALTH CARE

- INSURANCE STATUS
- HEALTH CARE PROVIDERS IN THE REGION

*“Christian stewardship through just and fair allocation of resources in a manner respectful of the individual and responsive to the needs of society.”*

# FOUNDATIONS FOR GOOD HEALTH

## SOCIAL & ECONOMIC FACTORS

- INCOME & POVERTY
- EDUCATION
- EMPLOYMENT
- HOUSEHOLD CONDITIONS
- HOUSING STOCK

Better health is possible when compassionate care is provided at a level that matches the needs of the community. Social and economic factors highlight areas of opportunity. Factors are closely linked. For instance, education is related to income and employment. One measure that combines multiple metrics into one "score" is **The Area Deprivation Index**. The Area Deprivation Index has been well-studied in peer-reviewed literature and used for 20 years by the Health Resources and Services Administration (HRSA). High Area Deprivation scores have been linked to health outcomes such as heart disease deaths, cancer, life expectancy, and all-cause mortality (Singh *et al.*, 2003, 2004, 2006, 2011, 2012). The Area Deprivation Index is also associated with health care costs and quality measures such as 30-day hospital readmission rates (Kind *et al.*, 2014; Morenz *et al.*, 2024).

The Area Deprivation Index score is calculated by combining 17 indicators of socioeconomic status including income, disparities, poverty, education, employment, household conditions (e.g., single-parent households, having a vehicle), and housing stock (Knighton, 2016).

## ACCESS TO HEALTHCARE

Social and economic factors impact access to health care. People with lower incomes are less likely to have insurance. Fear of medical debt and out-of-pocket medical care costs may lead to a delay of health care services (Healthy People 2030, 2024). Access to healthcare includes both having insurance, as well as having clinicians nearby.

## FOOD ACCESS

Food access is closely linked to social and economic factors. Access includes being able to afford food and having a supermarket in the region. Uncertain or limited access to adequate food is known as food insecurity. Studies have linked food insecurity with a number of health outcomes such as obesity, mental health, and chronic diseases (Healthy People 2030, 2024).

## HEALTH OUTCOMES

*Better outcomes achieved with better foundations for good health.*

- HEART DISEASE
- PREVENTABLE CANCERS
- DIABETES
- INFANT MORTALITY
- MENTAL & BEHAVIORAL HEALTH

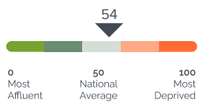
*Gary, Indiana*

The Area Deprivation Percentile score combines 17 socioeconomic factors

### Area Deprivation Percentile
Rensselaer Community

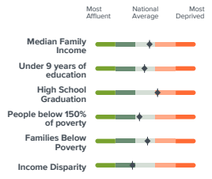
**54**

PERCENTILE FOR AREA DEPRIVATION OUR COMMUNITY vs. THE U.S.




Area Deprivation Index for the Census Block Groups in our 2-county area (BroadStreet 2021).

### Socioeconomic Status
Rensselaer Community



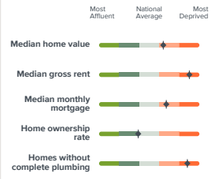

Indicators comprising The Area Deprivation Index for Census Block Groups (BroadStreet 2021).

### Household Conditions
Rensselaer Community




Indicators comprising The Area Deprivation Index for Census Block Groups (BroadStreet 2021).

### Housing Stock
Rensselaer Community




Indicators comprising The Area Deprivation Index for Census Block Groups (BroadStreet 2021).

### Median Family Income
Rensselaer Community



**$71,570**

U.S. Dollars per year

Median family income in our 2-county area (ACS 2015-2019) vs. U.S. benchmark (BroadStreet 2021).

### Under 9 Years of Education
Rensselaer Community



**3%**

of people 25 yrs and over

Education in our 2-county area (ACS 2015-2019) vs. U.S. benchmark (BroadStreet 2021).

### High School Graduation
Rensselaer Community



**88%**

of people 25 yrs and over

Education in our 2-county area (ACS 2015-2019) vs. U.S. benchmark (BroadStreet 2021).

### People below 150% of Poverty
Rensselaer Community



**16%**

of the population

Poverty in our 2-county area (ACS 2015-2019) vs. U.S. benchmark (BroadStreet 2021).

### Families Living Below Poverty
Rensselaer Community



**7%**

of families are living in poverty

Poverty in our 2-county area (ACS 2015-2019) vs. U.S. benchmark (BroadStreet 2021).

### Unemployment Rate
Rensselaer Community



**5%**

of the workforce ages 16 years and older

Employment in our 2-county area (ACS 2015-2019) vs. U.S. benchmark (BroadStreet 2021).

### White-Collar Employment
Rensselaer Community



**43%**

of employed persons ages 16 years and older

Employment in our 2-county area (ACS 2015-2019) vs. U.S. benchmark (BroadStreet 2021).

### Single Parents with Children
Rensselaer Community



**22%**

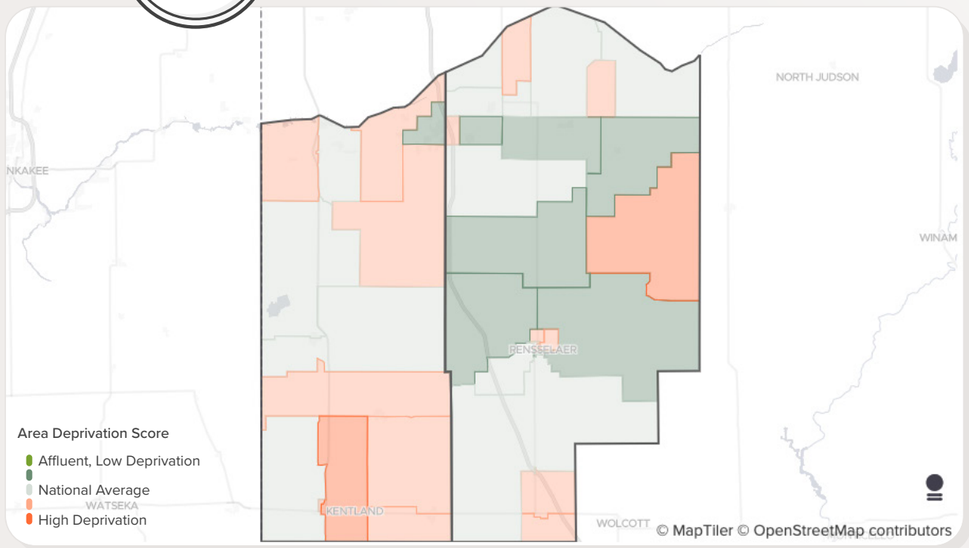
of single-parent households have children under 18 yrs

Household conditions in our 2-county area (ACS 2015-2019) vs. U.S. benchmark (BroadStreet 2021).

Opportunities to improve health can be highlighted by the Area Deprivation Index score. According to Area Deprivation percentiles within the Franciscan Health community, the area most impacted by such challenges is the city core of Kentland. Overall, the entire region has a slightly higher Area Deprivation percentile (54th percentile) compared to the United States (50th percentile). This region has similar socioeconomic status levels, with better metrics for income disparity than other regions. In the Franciscan Health community, 7% of families are living in poverty, 5% of the population is unemployed and 43% of the population has white-collar employment. Regarding housing, a low percent of occupied houses lack complete plumbing compared to national benchmarks.



# SOCIAL & ECONOMIC FACTORS




### Homes without a Motor Vehicle
Rensselaer Community



**4%**

of occupied housing units

Household conditions in our 2-county area (ACS 2015-2019) vs. U.S. benchmark (BroadStreet 2021).

### Homes without a Telephone
Rensselaer Community



**2%**

of occupied housing units

Household conditions in our 2-county area (ACS 2015-2019) vs. U.S. benchmark (BroadStreet 2021).

### Homes with Crowding
Rensselaer Community



**2%**

of housing units have over 1 person per room

Household conditions in our 2-county area (ACS 2015-2019) vs. U.S. benchmark (BroadStreet 2021).

### Median Home Value
Rensselaer Community



**$147,519**

U.S. Dollars

Housing stock in our 2-county area (ACS 2015-2019) vs. U.S. benchmark (BroadStreet 2021).

### Median Gross Rent
Rensselaer Community



**$770**

per month

Housing stock in our 2-county area (ACS 2015-2019) vs. U.S. benchmark (BroadStreet 2021).

### Median Monthly Mortgage
Rensselaer Community



**$861**

per month

Housing stock in our 2-county area (ACS 2015-2019) vs. U.S. benchmark (BroadStreet 2021).

### Home Ownership Rate
Rensselaer Community



**77%**

of housing units are occupied by the owner

Housing stock in our 2-county area (ACS 2015-2019) vs. U.S. benchmark (BroadStreet 2021).

### Homes without Complete Plumbing
Rensselaer Community



**0.1%**

of occupied housing units

Housing stock in our 2-county area (ACS 2015-2019) vs. U.S. benchmark (BroadStreet 2021).

*Area Deprivation Index calculations, graphics and maps by BroadStreet using data from the U.S. Census Bureau's American Commuity Survey 5-year estimates and methods by Knighton and colleagues (2016).*

# FOOD ACCESS

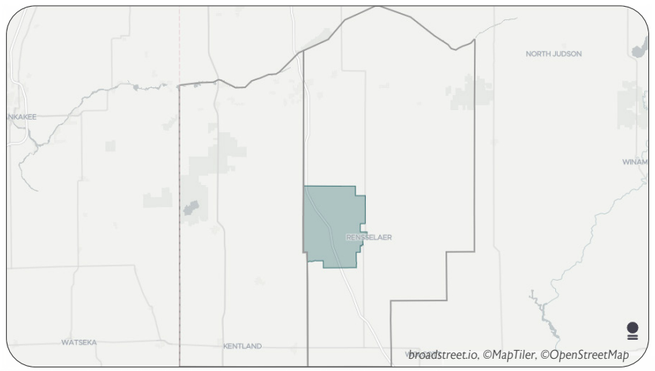


8 out of 10

a score of 10 is best

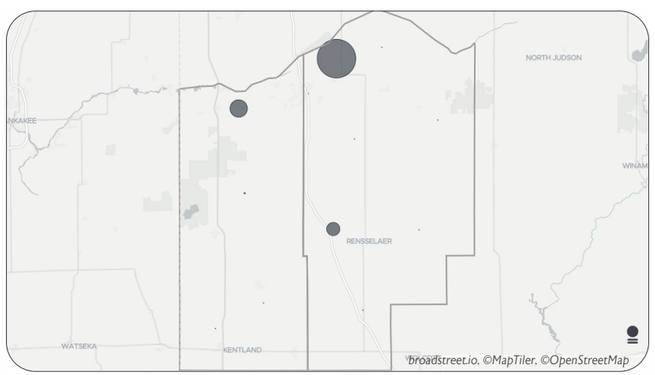
**Food Environment Index in Newton and Jasper Counties**

*The Food Environment Index is 8 out of 10, which is slightly higher compared to the average value across the country (7.7). The index is on a scale of 0 (worst) to 10 (best). The Food Environment Index combines measures of food affordability, food access, and food insecurity. The Food Environment Index was calculated by Feeding America (Gundersen et. al, 2013) and shared by County Health Rankings (CHR, 2018).*




**Low income and low access census tracts (shaded regions)**

*The community has geographical regions with low food access and affordability located in the city of Rensselaer and town of Mount Ayr.*




**Population (number of people) with low income and low access to a grocery store**

*The population with low income and low access to food is mostly located in DeMotte, as well as in Lake Village and Mount Ayr.*









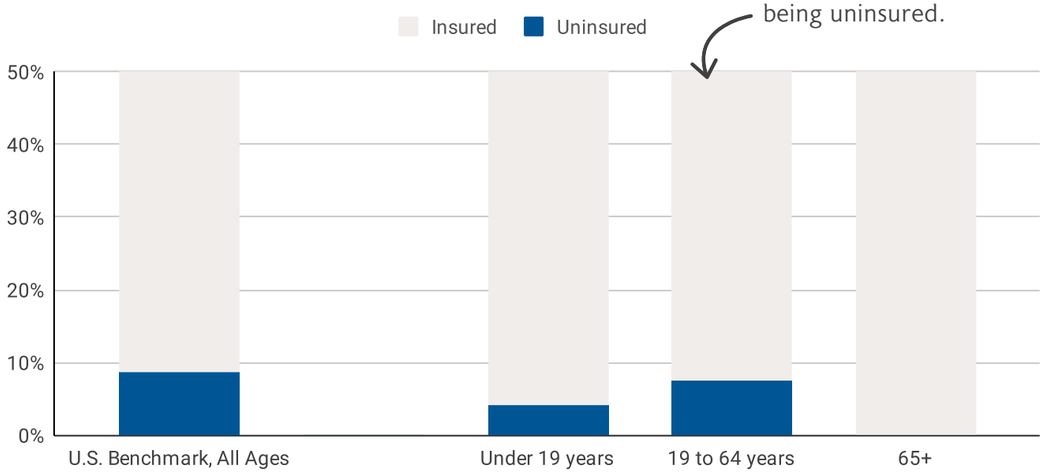



*Autumn in Indiana (top left) and volunteers at the Franciscan Health Crown Point Mobile Market and Fresh Start Market*

***About Food Access Data:*** *Food access maps (top map) are for the 2-county community and show census tracts with low income and low access. Low access is defined as census tracts where a significant proportion of residents live more than 1/2 mile (urban) or 10 miles (rural) from the nearest supermarket (shaded light blue); 1 mile (urban) or 20 miles (rural) from the nearest supermarket (shaded dark blue). Bubble map of population (bottom map) shows the number of people that are low income and have low access to a grocery store by census tract. A larger bubble indicates a larger number of people. Data are from The Food Access Research Atlas by the U.S. Department of Agriculture (FARA USDA, 2017). Maps made on broadstreet.io.*

# ACCESS TO HEALTH CARE

## Percent Uninsured Population by Age




### INSURANCE STATUS

Health insurance is one of the most important factors for good health. Preventive care is less likely to occur when adults do not have insurance. This impacts conditions such as heart disease, diabetes and cancer (Healthy People 2030, 2024). Insurance access and coverage vary by age group. Within the Franciscan Health community, adults ages 19 to 64 years have the highest rates of being uninsured (7%). 4% of the population under the age of 19 is uninsured. Less than 1% of the population ages 65 and over is uninsured, which may be a result of Medicare eligibility. For comparison, 9% of the United States population is uninsured, across all ages. Data for the 2-county region from the U.S. Census Bureau (2022).



### HEALTH CARE PROVIDERS IN THE REGION

The region around the hospital facility is not considered to be a medically underserved area. However, the region is a Primary Care and Mental Health Professional Shortage Area according to the U.S. Health Resources & Services Administration (HRSA, 2024).



# BUILDING FOUNDATIONS FOR GOOD HEALTH




*Indianapolis, Indiana*

## SECTION 2. DATA ATTRIBUTION

*BroadStreet (2020). Area Deprivation Index. Data queried on broadstreet.io.*
*County Health Rankings (2018). Food Environment Index. Data queried on countyhealthrankings.org.*
*U.S. Census Bureau (2022). American Community Survey 5-year estimates for Insurance Status (Table S2701). Queried from data.census.gov.*
*U.S. Department of Agriculture (2017). Food Access Research Atlas. Data queried on https://www.ers.usda.gov/data-products/food-access-research-atlas.*
*U.S. Health Resources & Services Administration (2022). Health Professional Shortage Areas and Medically Underserved Populations - Find Shortage Areas by Address. Data retrieved from https://data.hrsa.gov/.*

## DATA LIMITATIONS AND CAVEATS

Data are estimates from publicly available data. Calculations were also conducted on publicly available data by organizations for Health Professional Shortage Areas, the Area Deprivation Index, and the Food Environment Index. Please see original data sources for more detail on calculation methods. There is commonly a time delay between data collection, estimation, and reporting for publicly available data. Wherever possible, the most recently available data were utilized.

# *community* HEALTH NEEDS ASSESSMENT

## HEALTH PROFILE

SECTION 3

## SECTION 2. REFERENCES


### SOCIAL DETERMINANTS OF HEALTH

*Centers for Disease Control and Prevention (2024). Social Determinants of Health - Public Health Gateway. Retrieved September 2024, from https://www.cdc.gov/public-health-gateway/php/about/social-determinants-of-health.html*
*Healthy People 2030 (2024). Social Determinants of Health. Retrieved September 2024, from https://health.gov/healthypeople/priority-areas/social-determinants-health*
*World Health Organization (2024). Social Determinants of Health. Retrieved September 2024, from https://www.who.int/health-topics/social-determinants-of-health*

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*Institute of Medicine (U.S.) Committee on Health Insurance Status and Its Consequences (2009). America's uninsured crisis: Consequences for health and health care. National Academies Press.*

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*Healthy People 2030 (2024). Food Insecurity - Social determinants of Health Literature Summaries. Retrieved September 2024, from https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/food-insecurity*

### AREA DEPRIVATION INDEX

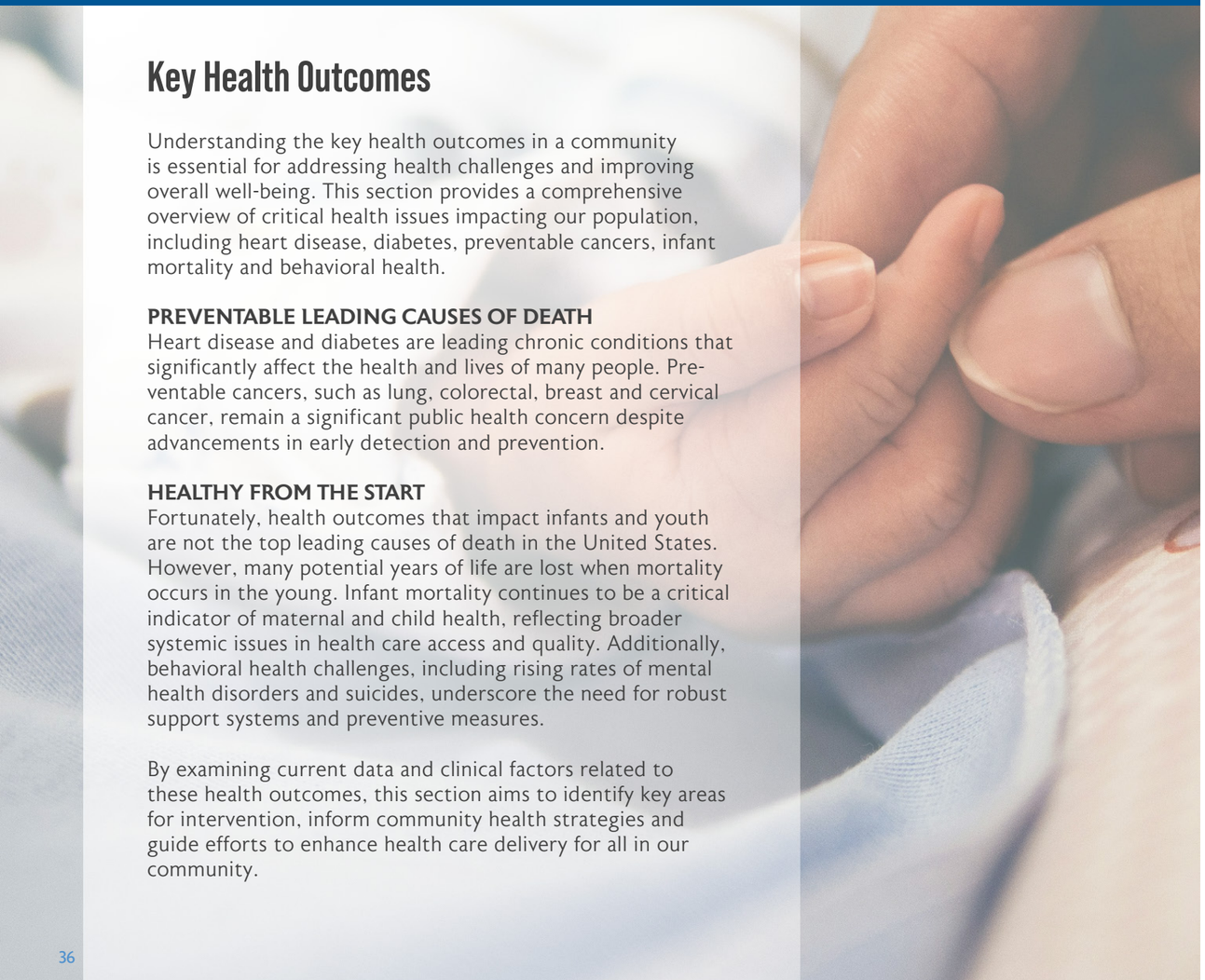
*Knighton, A.J., Savitz, L., Belnap, T., Stephenson, B., VanDerslice, J. (2016). Introduction of an Area Deprivation Index Measuring Patient Socioeconomic Status in an Integrated Health System: Implications for Population Health. EGEMS (Wash DC). 2016;4(3):1238.*
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*Morenz, AM, Liao JM, Au DH, Hayes SA (2024). Area-Level Socioeconomic Disadvantage and Health Care Spending: A Systematic Review. JAMA Netw Open. Feb 5;7(2):e2356121.*
*Singh, G.K. (2003). Area Deprivation and Widening Inequalities in US Mortality, 1969-1998. American Journal of Public Health. 93(7), 1137-1143.*
*Singh, G.K., Miller, B.A., Hankey, B.F., & Edwards, B.K. (2004). Persistent area socioeconomic disparities in U.S. incidence of cervical cancer, mortality, stage, and survival, 1975-2000. Cancer. 101(5), 1051-1057.*
*Singh, GK, & Siahpush, M. (2006). Widening socioeconomic inequalities in US life expectancy, 1980-2000. International Journal of Epidemiology. 35(4), 969-979.*
*Singh, G.K., Williams, S.D., Siahpush, M., Mulhollen, A. (2011). Socioeconomic, Rural-Urban, and Racial Inequalities in US Cancer Mortality: Part I-All Cancers and Lung Cancer and Part II-Colorectal, Prostate, Breast, and Cervical Cancers. J Cancer Epidemiol. 107497.*
*Singh, G.K., Azuine, R.E., Siahpush, M., Kogan, M.D. (2012). All-cause and cause-specific mortality among US youth: socioeconomic and rural-urban disparities and international patterns. J Urban Health. 90(3):388-405.*


Franciscan HEALTH

# HEALTH PROFILE

*A health profile is a snapshot of health within a community. The profile answers key questions: How many people in our community are living with chronic disease? Are there preventable risk factors? How widespread is clinical screening and management? By understanding this, we can better understand and meet the unique health needs of those we serve.*

SECTION 3



## Key Health Outcomes

Understanding the key health outcomes in a community is essential for addressing health challenges and improving overall well-being. This section provides a comprehensive overview of critical health issues impacting our population, including heart disease, diabetes, preventable cancers, infant mortality and behavioral health.

**PREVENTABLE LEADING CAUSES OF DEATH**
Heart disease and diabetes are leading chronic conditions that significantly affect the health and lives of many people. Preventable cancers, such as lung, colorectal, breast and cervical cancer, remain a significant public health concern despite advancements in early detection and prevention.

**HEALTHY FROM THE START**
Fortunately, health outcomes that impact infants and youth are not the top leading causes of death in the United States. However, many potential years of life are lost when mortality occurs in the young. Infant mortality continues to be a critical indicator of maternal and child health, reflecting broader systemic issues in health care access and quality. Additionally, behavioral health challenges, including rising rates of mental health disorders and suicides, underscore the need for robust support systems and preventive measures.

By examining current data and clinical factors related to these health outcomes, this section aims to identify key areas for intervention, inform community health strategies and guide efforts to enhance health care delivery for all in our community.



## 5 KEY HEALTH OUTCOMES

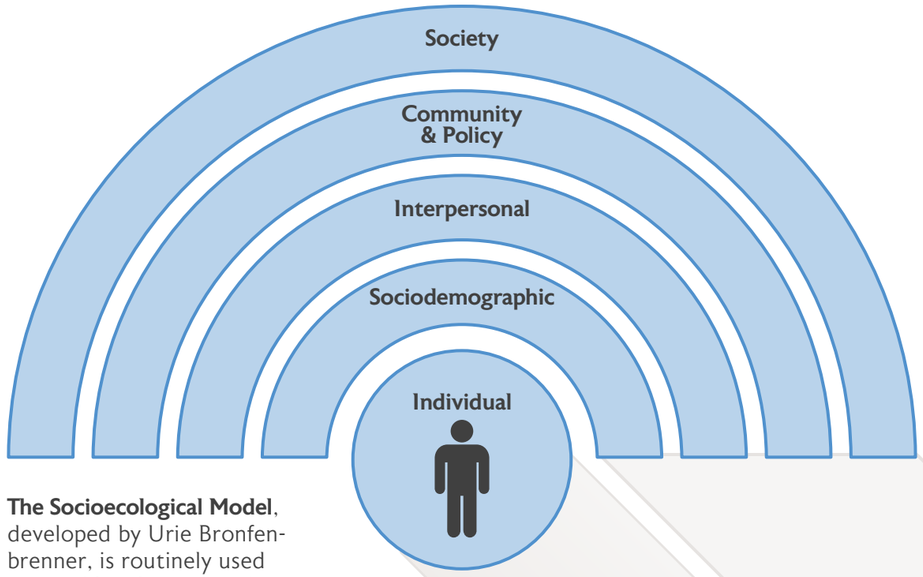
### Preventable Leading Causes of Death

- HEART DISEASE
- PREVENTABLE CANCERS
- DIABETES

### Healthy from the Start

- INFANT MORTALITY
- MENTAL & BEHAVIORAL HEALTH

# HEALTH AT ALL LEVELS




**The Socioecological Model**, developed by Urie Bronfenbrenner, is routinely used to consider the appropriate community-based strategies.

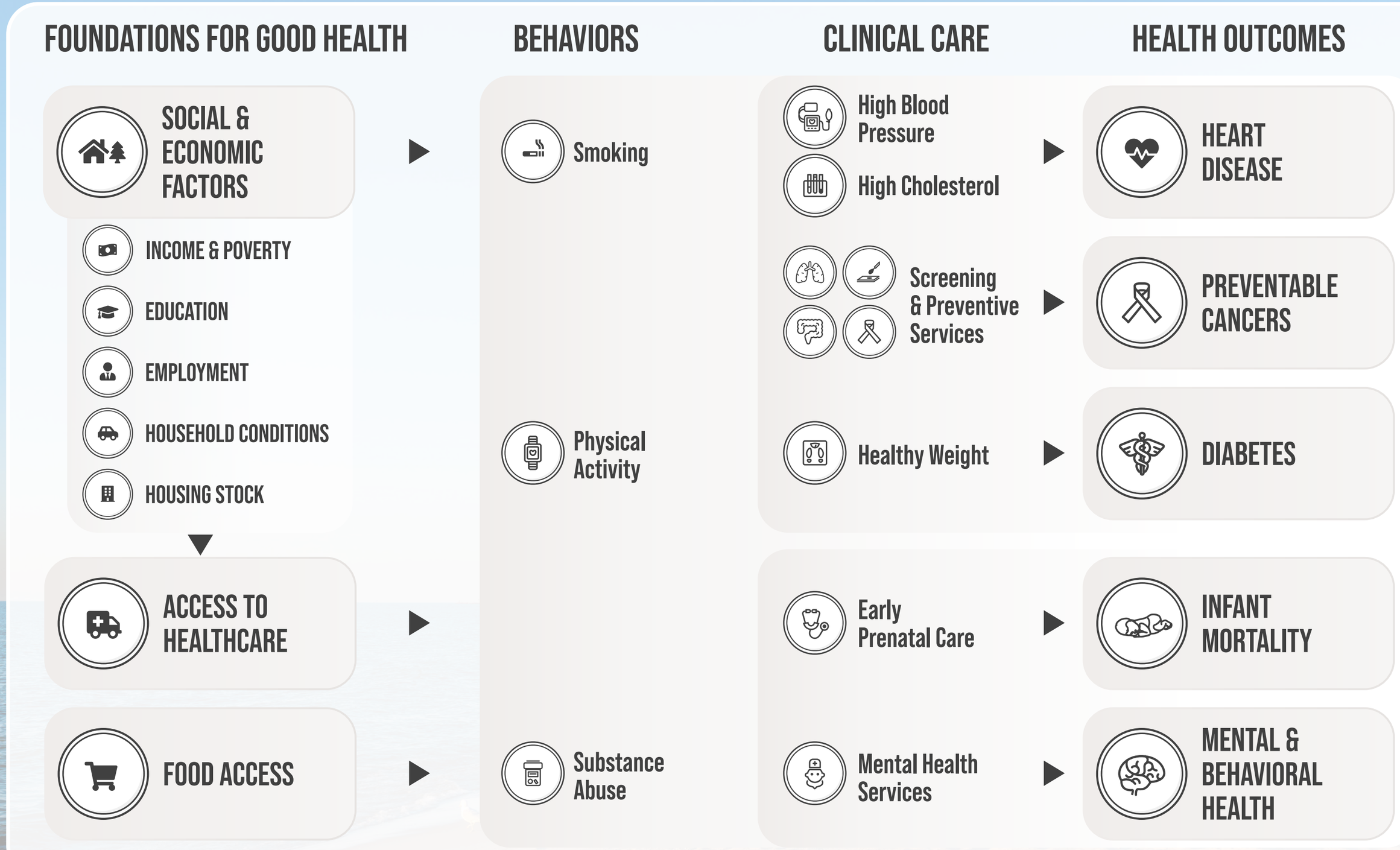
Figure adapted from Hale and colleagues (2020).

*Improving health outcomes is possible. Finding the most effective community-based strategies may include considering the circumstances surrounding an individual. Foundations for good health include interpersonal relationships, society and policies as factors that impact behaviors, clinical care and, ultimately, health.*



## FOUNDATIONS FOR GOOD HEALTH

## BEHAVIORS ▶ CLINICAL CARE ▶ HEALTH OUTCOMES




**Schematic diagram** of key health outcomes with risk factors and protective factors including behaviors and clinical care.

Note: Factors can relate to multiple outcomes. Smoking, for example, is related to heart disease, lung cancer and infant mortality.

*Indiana Dunes National Park*

# 5 KEY HEALTH OUTCOMES

## Preventable Leading Causes of Death

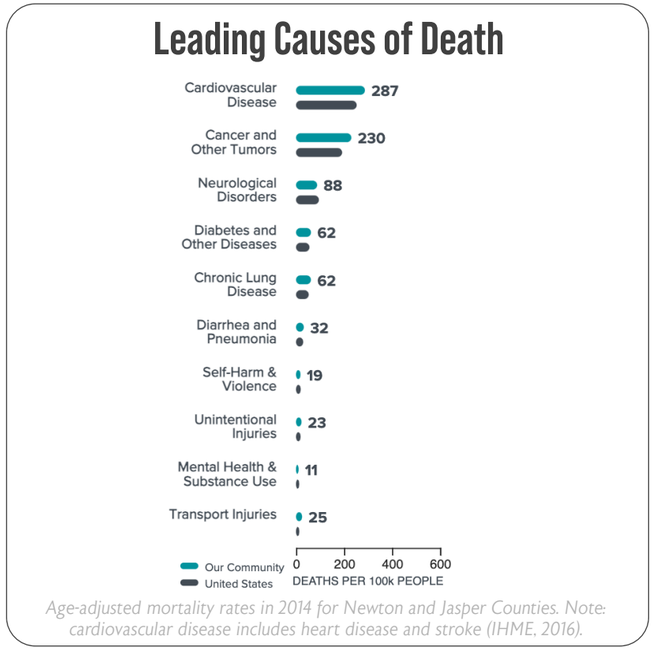
- HEART DISEASE
- PREVENTABLE CANCERS
- DIABETES

## Healthy from the Start

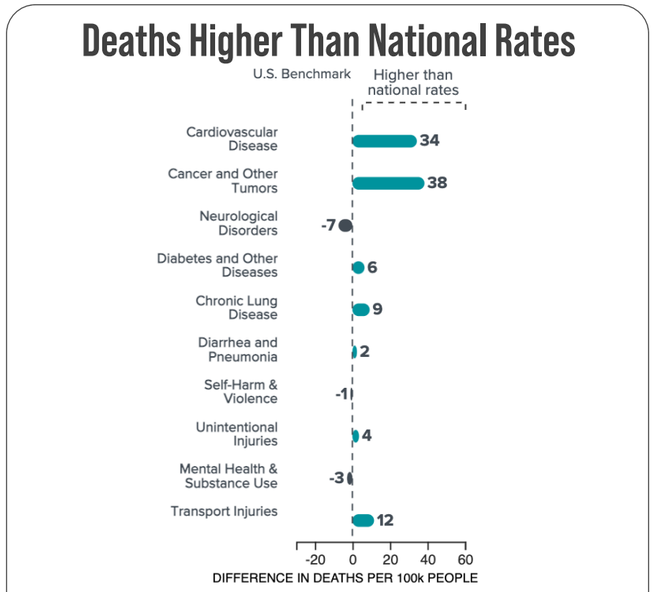
- INFANT MORTALITY
- MENTAL & BEHAVIORAL HEALTH



# OUR COMMUNITY VS. U.S. BENCHMARK




*Age-adjusted mortality rates in 2014 for Newton and Jasper Counties. Note: cardiovascular disease includes heart disease and stroke (IHME, 2016).*




*Age-adjusted mortality rates in 2014 for Newton and Jasper Counties versus U.S. mortality rate. Negative numbers indicate lower rates (IHME, 2016).*

## PREVENTABLE CAUSES OF DEATH

- HEART DISEASE
- PREVENTABLE CANCERS
- DIABETES

Community surveys identified heart disease, preventable cancers, diabetes and mental health and substance abuse as leading causes of death that were important to members of the community. Cardiovascular disease is a leading cause of death nationwide and includes heart disease and stroke. Both heart disease and stroke share similar risk factors and prevention strategies. Cancer is a broad topic and some forms of cancer are preventable with early detection and public health interventions. Diabetes is a leading cause of preventable death and is also a risk factor for cardiovascular disease. Conditions such as mental health & substance abuse account for fewer deaths overall, yet have the potential to impact younger age groups in our community.

# PREVENTABLE LEADING CAUSES OF DEATH

*Building a healthy community begins with addressing key health outcomes such as leading causes of death that are preventable. Prevention is possible with conditions that support healthy lifestyles and through clinical screening and early management.*



*Ford Heights Health and Wellness Fair*

**HEALTH DATA BY COUNTY**

In the following pages, we explore and analyze root causes for key health outcomes. Root causes can include community-factors, such as behaviors, and clinical factors, such as screening and management. When identified early, addressing root causes may prevent later outcomes such as hospitalizations and mortality. It is important to note that data are often reported at the county-level. Medicare data, in particular, provides valuable insights into the health of seniors ages 65 and over, who are often most affected by chronic diseases.



# THE TOP 3

## HEART DISEASE

Heart disease remains the leading cause of death in the United States, responsible for approximately 1 in every 4 deaths annually, according to data from the Centers for Disease Control and Prevention (CDC, 2024). Major risk factors for heart disease include high blood pressure, high LDL (bad) cholesterol, smoking, poor nutrition, physical inactivity, type 2 diabetes and obesity. Many risk factors are preventable and manageable through proper screening, early detection, medication use and lifestyle changes.

## PREVENTABLE CANCERS

Preventable cancers, including some types of lung, colorectal, breast and cervical cancers, continue to account for a substantial share of cancer diagnoses and deaths in the United States. According to the Centers for Disease Control and Prevention (CDC, 2024), more than half of cancer deaths could likely be prevented through early detection, lifestyle changes and public health interventions. Lung cancer remains the leading cause of cancer deaths, largely driven by smoking. Cervical cancer is preventable with vaccinations. Colorectal and breast cancers, where early detection is possible through screening, still pose significant risks due to disparities in healthcare access.

## DIABETES

Diabetes has become one of the most pressing public health challenges in the United States, affecting over 38 million Americans, according to the Centers for Disease Control and Prevention (CDC, 2024). Diabetes is the eighth leading cause of death, with type 2 diabetes accounting for 90-95% of all diagnosed cases. This chronic disease is closely linked to rising obesity rates, poor dietary habits and physical inactivity, particularly in under-served communities where access to health care and preventive measures is limited (American Diabetes Association, 2024).

# RISK FACTORS FOR HEART DISEASE

## HIGH BLOOD PRESSURE

**Risk Factors**

**High Blood Pressure**
38.2% of adults 18+ report having high blood pressure.
**HIGH**

**Screening & Management**

**No Blood Pressure Meds**
19.0% of seniors are not on prescribed BP medication.
**LOW**

## HIGH CHOLESTEROL

**Risk Factors**

**High Cholesterol**
38.8% of adults 18+ report having high cholesterol.
**HIGH**

**Screening & Management**

**No Cholesterol Screen**
16.4% of adults 18+ have no recent cholesterol screening.
**HIGH**

## SMOKING

**Risk Factors**

**Smoking**
20.1% of adults 18+ report being current smokers.
**HIGH**

**Screening & Management**

**No Cholesterol Meds**
14.9% of seniors are not taking cholesterol medication.
**HIGH**

*Data are from the Interactive Atlas for Heart Disease and Stroke (CDC, 2021). Atlas data originate from various publicly available data sources. Risk factor data for adults 18+ are from the PLACES dataset, a collaboration of the CDC, the Robert Wood Johnson Foundation, and the CDC Foundation. Senior data refers to Medicare beneficiaries ages 65 and over. "Meds" refers to medication usage and data are from prescription drug claims among Medicare Advantage or Medicare fee-for-service beneficiaries ages 65 years and over with Medicare Part D coverage. Hospital data are from Centers for Medicare and Medicaid Services Medicare Provider Analysis and Review (MEDPAR) file, Part A. Data on deaths are from National Vital Statistics System.*



# HEART DISEASE

## Outcomes

**Heart Disease Hospitalizations**
12.4 hospital stays for heart disease per 1,000 seniors.
**HIGH**

**Heart Disease Hospital Deaths**
4.5% of seniors died while hospitalized for heart disease.
**EQUAL**

**Heart Disease Deaths**
213.2 deaths for every 100,000 adults ages 35+
**HIGH**

## Disparities

**Deaths in the Hospital for Heart Disease in County by Gender**

| | |
|---|---|
| Men | 4.7 |
| Women | 4.4 |
| United States | 4.5 |

*Percent of hospitalized seniors 65+ Medicare beneficiaries hospitalized for heart disease who died before discharge (Interactive Atlas of Heart Disease and Stroke, 2019-2021).*

**Disparities in Heart Disease Deaths by Gender and Race/Ethnicity**

| | |
|---|---|
| Men | 290.5 |
| Women | 149.8 |
| Black, NH | 264.4 |
| White, NH | 216.6 |
| County | 213.2 |
| Indiana | 184.7 |
| United States | 177.5 |

*Coronary Heart Disease Death Rate per 100,000 people, age-standardized rate from National Vital Statistics System (Interactive Atlas of Heart Disease and Stroke, 2019-2021).*

**Summary** Newton County has high rates of high blood pressure, cholesterol and smoking when compared to national benchmarks. Medication non-adherence and non-screening for cholesterol is high when compared to national benchmarks, while medication non-adherence for blood pressure is lower. Hospitalizations and deaths due to heart disease are higher within the county when compared to the United States, with disparities present across demographics.

# RISK FACTORS FOR HEART DISEASE

## HIGH BLOOD PRESSURE

**Risk Factors**

**High Blood Pressure**
34.7% of adults 18+ report having high blood pressure.
**HIGH**

**Screening & Management**

**No Blood Pressure Meds**
18.9% of seniors are not on prescribed BP medication.
**LOW**

## HIGH CHOLESTEROL

**Risk Factors**

**High Cholesterol**
37.2% of adults 18+ report having high cholesterol.
**HIGH**

**Screening & Management**

**No Cholesterol Screen**
17.2% of adults 18+ have no recent cholesterol screening.
**HIGH**

## SMOKING

**Risk Factors**

**Smoking**
18.5% of adults 18+ report being current smokers.
**HIGH**

**Screening & Management**

**No Cholesterol Meds**
13.3% of seniors are not taking cholesterol medication.
**LOW**

# HEART DISEASE

## Outcomes

**Heart Disease Hospitalizations**
13.5 hospital stays for heart disease per 1,000 seniors.
**HIGH**

**Heart Disease Hospital Deaths**
4.4% of seniors died while hospitalized for heart disease.
**LOW**

**Heart Disease Deaths**
221.7 deaths for every 100,000 adults ages 35+
**HIGH**

## Disparities

**Deaths in the Hospital for Heart Disease in County by Gender**

| | |
|---|---|
| Men | 4.1 |
| Women | 5.1 |
| United States | 4.5 |

*Percent of hospitalized seniors 65+ Medicare beneficiaries hospitalized for heart disease who died before discharge (Interactive Atlas of Heart Disease and Stroke, 2019-2021).*

**Disparities in Heart Disease Deaths by Gender and Race/Ethnicity**

| | |
|---|---|
| Men | 294.0 |
| Women | 150.4 |
| Black, NH | 285.5 |
| White, NH | 227.6 |
| County | 221.7 |
| Indiana | 184.7 |
| United States | 177.5 |

*Coronary Heart Disease Death Rate per 100,000 people, age-standardized rate from National Vital Statistics System (Interactive Atlas of Heart Disease and Stroke, 2019-2021).*

*Data are from the Interactive Atlas for Heart Disease and Stroke (CDC, 2021). Atlas data originate from various publicly available data sources. Risk factor data for adults 18+ are from the PLACES dataset, a collaboration of the CDC, the Robert Wood Johnson Foundation, and the CDC Foundation. Senior data refers to Medicare beneficiaries ages 65 and over. "Meds" refers to medication usage and data are from prescription drug claims among Medicare Advantage or Medicare fee-for-service beneficiaries ages 65 years and over with Medicare Part D coverage. Hospital data are from Centers for Medicare and Medicaid Services Medicare Provider Analysis and Review (MEDPAR) file, Part A. Data on deaths are from National Vital Statistics System.*

**Summary** Jasper County has high rates of high blood pressure, cholesterol and smoking when compared to national benchmarks. Medication use is notably high for blood pressure and cholesterol management. Opportunities exist to improve cholesterol screening rates. Hospitalizations and deaths due to heart disease are higher within the county when compared to the United States, with disparities present across demographics.

# RISK FACTORS FOR PREVENTABLE CANCER OUTCOMES

## Screening & Management

### LUNG CANCER

**Smoking**

20.1% of adults 18+ report being current smokers.

**HIGH**

### BREAST CANCER

**No Mammogram**

64% females 65-74 years had no breast cancer screening.

**HIGH**

**No Mammogram to Screen for Breast Cancer by Race and Ethnicity**

| | | |
|---|---|---|
| White | *No Data* | - |
| Black | *No Data* | - |
| Hispanic | *No Data* | - |
| Asian | *No Data* | - |
| County | | 64% |
| Indiana | | 55% |
| U.S. | | 57% |

*Percentage of female Medicare enrollees ages 65-74 years who had no annual mammography screening in 2021 (County Health Rankings, 2024)*

### COLORECTAL CANCER

**No Colorectal Cancer Screen**

30.3% of adults report no colorectal cancer screening.

**LOW**

### CERVICAL CANCER

**No HPV Vaccination**

89.7% of 9 to 12-year-olds without 1st dose of vaccine.

**HIGH**

+

**No Cervical Cancer Screen**

19.4% of adults 18+ report no cervical cancer screening.

**HIGH**



# CANCER OUTCOMES

| New Cases | Deaths |
|---|---|
| **New Lung Cancers**<br>68.3 new lung cancer cases for every 100,000 people.<br>**HIGH** | **Lung Cancer Deaths**<br>92.0 lung cancer deaths for every 100,000 people.<br>**HIGH** |
| **New Breast Cancers**<br>135.8 new breast cancer cases per 100,000 people.<br>**HIGH** | *No Data*<br>**Breast Cancer Deaths**<br>No data for breast cancer deaths for Newton County. |
| **New Colorectal Cancers**<br>46 new colorectal cancer cases per 100,000 people.<br>**HIGH** | **Colorectal Cancer Deaths**<br>23.0 colorectal cancer deaths for every 100,000 people.<br>**HIGH** |

**Summary** The data reveal that lung cancer remains the most common preventable cancer death in Newton County, perhaps driven by high smoking rates. Despite reportedly high rates for colorectal cancer screening, new cases and deaths are higher in Newton County when compared to national benchmarks. Breast and cervical cancers may present a significant risk due to lack of preventative services, such as screening and vaccination. Data for adults are from PLACES dataset with colorectal screening rates based on self-report for 45- to 75-year-olds (CDC, 2021). Other data include mammography (CHR, 2024), vaccination data (Indiana Department of Health, 2024), cancer cases (NCI, 2015), and deaths (CDC, 2022).

# RISK FACTORS FOR PREVENTABLE CANCER OUTCOMES

## Screening & Management

### LUNG CANCER

**Smoking**

18.5% of adults 18+ report being current smokers.

**HIGH**

### BREAST CANCER

**No Mammogram**

59% females 65-74 years had no breast cancer screening.

**HIGH**

**No Mammogram to Screen for Breast Cancer by Race and Ethnicity**

| | | |
|---|---|---|
| White | | 59% |
| Black | *No Data* | - |
| Hispanic | | 75% |
| Asian | *No Data* | - |
| County | | 59% |
| Indiana | | 55% |
| U.S. | | 57% |

*Percentage of female Medicare enrollees ages 65-74 years who had no annual mammography screening in 2021 (County Health Rankings, 2024)*

### COLORECTAL CANCER

**No Colorectal Cancer Screen**

30.2% of adults report no colorectal cancer screening.

**LOW**

### CERVICAL CANCER

**No HPV Vaccination**

90.3% of 9 to 12-year-olds without 1st dose of vaccine.

**HIGH**

+

**No Cervical Cancer Screen**

19.0% of adults 18+ report no cervical cancer screening.

**HIGH**



# CANCER OUTCOMES

## New Cases

## Deaths

### LUNG CANCER

**New Lung Cancers**

78.7 new lung cancer cases for every 100,000 people.

**HIGH**

**Lung Cancer Deaths**

65.4 lung cancer deaths for every 100,000 people.

**HIGH**

### BREAST CANCER

**New Breast Cancers**

117.9 new breast cancer cases for every 100,000 people.

**LOW**

**Breast Cancer Deaths**

14.4 breast cancer deaths for every 100,000 people.

**HIGH**

### COLORECTAL CANCER

**New Colorectal Cancers**

48.8 new colorectal cancer cases per 100,000 people.

**HIGH**

**Colorectal Cancer Deaths**

20.4 colorectal cancer deaths for every 100,000 people.

**HIGH**

**Summary**

Lung cancer is the most common preventable cancer death in Jasper County, possibly due to high smoking rates. Despite reportedly high rates for colorectal cancer screening, deaths due to colorectal cancer are higher in Jasper County when compared to national benchmarks. Breast cancer deaths are high and screening rates are low. Opportunities to improve preventive services may exist for cervical cancer, because low screening and vaccination rates have been observed. Data for adults are from PLACES dataset with colorectal screening rates based on self-report for 45- to 75-year-olds (CDC, 2021). Other data include mammography (CHR, 2024), vaccination data (Indiana Department of Health, 2024), cancer cases (NCI, 2015), and deaths (CDC, 2022).

# RISK FACTORS FOR DIABETES OUTCOMES

## Risk Factors

### PHYSICAL INACTIVITY

**Physical Inactivity**
30.2% of adults 18+ report low physical activity.
**HIGH**

### OBESITY

**Obesity**
36.9% of adults 18+ estimated to be obese.
**HIGH**

### DIABETES

**Diabetes**
13.2% of adults 18+ report having a diabetes diagnosis.
**HIGH**

## Screening & Management

**No Diabetes Screen**
97% of seniors did not receive diabetes screening.
**HIGH**

*Data for adults 18+ are from the PLACES dataset (CDC, 2021). Diabetes screening rates for seniors are reported as the percent of Medicare Fee For Service beneficiaries screened for diabetes (CMS, 2022). Hospital stays for short- and long-term complications of diabetes are reported for Medicare Fee For Service beneficiaries and calculated by Centers for Medicare and Medicaid Services (CMS, 2022). Please note that data may be limited in counties with a low Medicare Fee For Service population. Obesity defined as body mass index of 30 or greater.*



# DIABETES OUTCOMES

## Outcomes

**Short-term Complications**
0 diabetes hospital stays for every 100,000 people.
**LOW**

**Long-term Complications**
278 diabetes hospital stays for every 100,000 people.
**HIGH**

**Diabetes Deaths**
40.9 deaths from diabetes for every 100,000 people.
**HIGH**

## Disparities

**Hospital Stays for Diabetes Short-term Complications by Race**

| | |
|---|---|
| White | 0 |
| Black | 0 |
| United States | 74 |

*Number of hospital admissions for diabetes short-term complications in Medicare Fee For Service population per 100,000 people CMS, 2022)..*

**Hospital Stays for Diabetes Long-term Complications by Race**

| | |
|---|---|
| White | 282 |
| Black | 0 |
| United States | 221 |

*Number of hospital admissions for diabetes long-term complications in Medicare Fee For Service population per 100,000 people (CMS, 2022).*

**Summary** Newton County has high rates of self-reported physical inactivity, obesit, and diabetes within the county when compared to national benchmarks. Screening rates in seniors are relatively low. Hospitalizations for long-term diabetes complications and deaths from diabetes are high. Data may be too sparse to draw conclusions on hospitalization rates for short-term complications of diabetes.

# RISK FACTORS FOR DIABETES OUTCOMES

## PHYSICAL INACTIVITY

**Risk Factors**

**Physical Inactivity**

26.4% of adults 18+ report low physical activity.

**HIGH**

## OBESITY

**Obesity**

34.5% of adults 18+ estimated to be obese.

**HIGH**

## DIABETES

**Diabetes**

11.8% of adults 18+ report having a diabetes diagnosis.

**HIGH**

**Screening & Management**

**No Diabetes Screen**

97% of seniors did not receive diabetes screening.

**HIGH**

*Data for adults 18+ are from the PLACES dataset (CDC, 2021). Diabetes screening rates for seniors are reported as the percent of Medicare Fee For Service beneficiaries screened for diabetes (CMS, 2022). Hospital stays for short- and long-term complications of diabetes are reported for Medicare Fee For Service beneficiaries and calculated by Centers for Medicare and Medicaid Services (CMS, 2022). Please note that data may be limited in counties with a low Medicare Fee For Service population. Obesity defined as body mass index of 30 or greater.*



# DIABETES OUTCOMES

**Outcomes**

**Short-term Complications**

54 diabetes hospital stays for every 100,000 people.

**LOW**

**Long-term Complications**

126 diabetes hospital stays for every 100,000 people.

**LOW**

**Diabetes Deaths**

19.0 deaths from diabetes for every 100,000 people.

**LOW**

**Disparities**

**Hospital Stays for Diabetes Short-term Complications by Race**

| | |
|---|---|
| White | 55 |
| Black | 0 |
| United States | 74 |

*Number of hospital admissions for diabetes short-term complications in Medicare Fee For Service population per 100,000 people CMS, 2022)..*

**Hospital Stays for Diabetes Long-term Complications by Race**

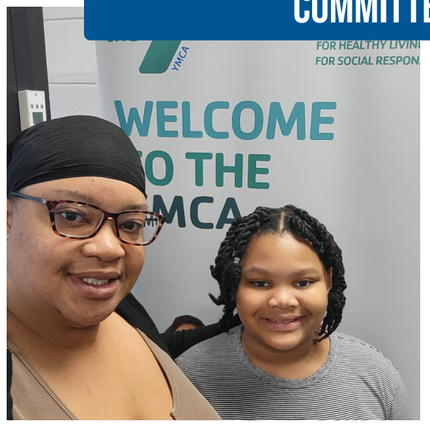
| | |
|---|---|
| White | 128 |
| Black | 0 |
| United States | 221 |

*Number of hospital admissions for diabetes long-term complications in Medicare Fee For Service population per 100,000 people (CMS, 2022).*

**Summary**

Jasper County has high rates of self-reported physical inactivity and obesity within the county when compared to national benchmarks. Diabetes is also reportedly high within the county. Despite the relatively low rates of screening for diabetes, hospitalizations for short- and long-term complications from diabetes are lower compared to benchmarks. Death rates are also low compared to national rates. Hospitalization data may be too sparse to draw conclusions regarding disparities.

# COMMITTED TO BETTER HEALTH FOR ALL















Screening for high blood pressure

# HEALTHY FROM THE START



*Franciscan Health has a continued commitment to families and improving health from the earliest possible moments. Supporting healthy pregnancies, infants, and mothers has been a major focus in many communities. Based on conversations with community members, there is evidence of a growing need for addressing mental wellness, stress and resiliency starting from an early age.*

**OVERVIEW**

Early health outcomes impacting the youngest members of our community are, thankfully, relatively rare. Though rare, it is important to consider how many valuable potential years of life are lost when mortality occurs in the young. In the following sections, we will review the risk and protective factors as they relate to infant mortality and mental and behavioral health with special attention to outcomes in the young.



## INFANT MORTALITY

An infant is a child who is less than 1 year old, and the Infant Mortality Rate (IMR) is the number of infants who die during their first year of life for every 1,000 live births. This rate is an important marker of the overall health of a society. In 2021, the IMR in the United States was 5.4 deaths per 1,000 live births
(CDC, 2024). Factors like demographics, socioeconomic status, access to care, and disparities in prenatal and postnatal care can increase the risk of infant mortality within a community.

## MENTAL & BEHAVIORAL HEALTH

Suicide is a critical public health issue in the United States, claiming over 45,000 lives annually, according to the Centers for Disease Control and Prevention (CDC, 2024). It is the second leading cause of death among individuals aged 10-34 and represents a growing crisis, particularly in under-served and rural communities where access to mental health care is limited. The National Institute of Mental Health (NIMH, 2024) underscores the importance of early intervention, mental health awareness and comprehensive suicide prevention strategies to curb this rising trend.






# INFANT RISK FACTORS



Every year, an estimated **784** women give birth in the Rensselaer community.

*Women ages 15-50 in the 2-county region (U.S. Census Bureau, ACS 5-yr estimates, 2022).*

Several risk factors contribute to infant mortality. Age of the mother is an important factor, with babies born to teenage mothers being at higher risk of infant mortality. Additional risk factors include: poverty, maternal smoking, marital status, not having early prenatal care and low birth weight. Having insurance, through Medicaid or another insurance provider, is a protective factor that is associated with improved health outcomes (CDC, 2024; Kamal, *et al.*, 2019; Morriss, 2013).

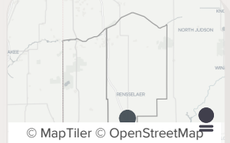


**35%** of births were paid for by Medicaid

**Teen Birth Rate**
**Rensselaer Community**



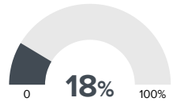

Number of births to mothers (ages 15-19 years) per 1,000 females in 2-county area (ACS 2015-2019).




**Where are teens (15 to 19 yr) who have given birth in the past year.**
**Rensselaer Community**

Births to mothers (ages 15-19 years) per 1,000 females in 2-county area (ACS 2015-2019).

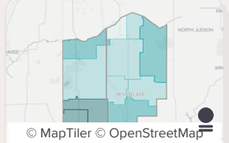
**Mothers of Infants Who Are Living in Poverty**
**Rensselaer Community**




**of mothers with infants are living in poverty**

OUR COMMUNITY U.S. BENCHMARK

Women 15-50 who gave birth last year at or below the 100% FPL in our 2-county area (ACS 2015-2019).




**Children Under 18 Years in Poverty and Single Parent Households**
**Rensselaer Community**

Selected from American Community Survey 5-year estimates (ACS 2015-2019).

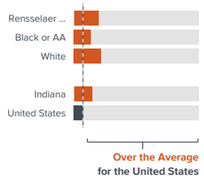
**Mothers Smoked During Pregnancy**
**Rensselaer Community**



**19%** of women giving birth in Rensselaer Community reported tobacco use during their pregnancy.

Natality Records 2012-2018 in 2-county area on CDC WONDER Online Database.

**Mothers Who Smoked During Pregnancy by Race**
**Rensselaer Community**




Natality Records 2012-2018 in 2-county area on CDC WONDER Online Database.

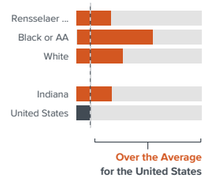
**Mothers Who Did Not Receive Early Prenatal Care**
**Rensselaer Community**



**27%** of women giving birth in our community had no prenatal care in the first trimester.

Natality Records 2012-2018 in 2-county area on CDC WONDER Online Database.

**Mothers Who Did Not Receive Early Prenatal Care by Race**
**Rensselaer Community**




Natality Records 2012-2018 in 2-county area on CDC WONDER Online Database.



# INFANT OUTCOMES



**Infant Deaths vs. Benchmark**
**Rensselaer Community**

**The infant death rate is 7 deaths for every 1,000 births.**

**The U.S. Average is 6 deaths for every 1,000 births.**

Linked Birth / Infant Death Records 2012-2018 in 2-county area on CDC WONDER Online Database.

**When do babies die**
**Rensselaer Community**

Babies born are most likely to die as **newborns** in the first 28 days of life.

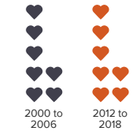
**newborn**
0 to 28 days

**older infant**
28 to 365 days

Our Community U.S.

Linked Birth / Infant Death Records 2012-2018 in 2-county area on CDC WONDER Online Database.

**Infant Death Trends**
**Rensselaer Community**




In the past few years, infant death rates have **stayed the same.**

Linked Birth / Infant Death Records in 2-county area on CDC WONDER Online Database.

**Infant Death Disparities**
**Rensselaer Community**

For every **1 baby who dies** to a white mother

**2 babies die to a Black or African American Mother.**

* based on state rates

Estimated* proportion of infant deaths by race for our 2-county area (CDC WONDER Linked Birth / Infant Death Records 2012-2018).

**Babies Born Low Birth Weight**
**Rensselaer Community**



**7%** of babies born in Rensselaer Community were low birth weight (under 2500 grams)

Babies born low birth weight (under 2500 grams) (CHR 2020).

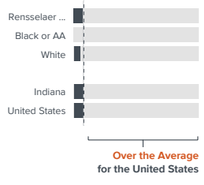
**Babies Born Very Low Birth Weight**
**Rensselaer Community**



**1%** of babies born in Rensselaer Community were very low birth weight (under 1500 grams)

Natality Records 2012-2018 in 2-county area on CDC WONDER Online Database.

**Babies Born Low Birth Weight by Race**
**Rensselaer Community**




Babies born low birth weight (under 2500 grams) (CHR 2020).

## BIRTH WEIGHT

Babies born with a low birth weight, weighing under 2500 grams at birth, have about 7 times the risk of dying in the first year compared to babies with a normal birth weight. Babies born with a *very* low birth weight (under 1500g) have an even higher risk (Kamal, *et al.*, 2019).

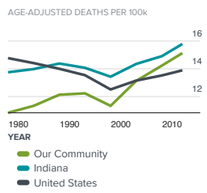
# BEHAVIORAL HEALTH RISK FACTORS & OUTCOMES

### Deaths from Suicide Rensselaer Community




Mortality rates over 7 years in 2-county area (CDC WONDER 2014-2020).

### Trends in Deaths from Suicide Rensselaer Community




Age-adjusted mortality from 1980 to 2014 for the 1-county area (IHME 2016).

### Deaths from Suicide in Youths Under 20-years-old Rensselaer Community



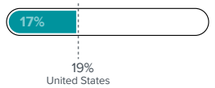

Mortality rates for ages 0-19 years over 7 years in 2-county area (CDC WONDER 2014-2020).

### Deaths from Suicide by Age Rensselaer Community




Mortality rates by age over 7 years in 2-county area (CDC WONDER 2014-2020).

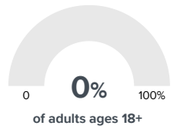
### Excessive Drinking in Adults Rensselaer Community




**17%** of adults living in **Our Community** drink in excess.

Percentage of adults reporting binge or heavy drinking in 2-county area (CHR 2020).

### Substance Use Disorders Rensselaer Community

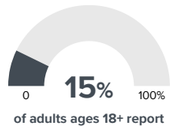



**of adults ages 18+**

OUR COMMUNITY — U.S. BENCHMARK

For our 2-county area estimated from sub-state region (SAMHSA 2016-2018).

### Frequent Mental Distress Rensselaer Community

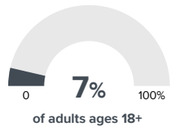



**of adults ages 18+ report 14 or more poor mental health days in the past month**

OUR COMMUNITY — U.S. BENCHMARK

Estimate for 2-county area based on self-reported poor mental health days (CDC PLACES 2020).

### At Least One Major Depressive Episode in the Past Year Rensselaer Community

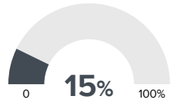



**of adults ages 18+**

OUR COMMUNITY — U.S. BENCHMARK

For our 2-county area estimated from sub-state region (SAMHSA 2016-2018).

### Received Mental Health Services in the Past Year Rensselaer Community




**of adults ages 18+**

OUR COMMUNITY — U.S. BENCHMARK

For our 2-county area estimated from sub-state region (SAMHSA 2016-2018).

### Ratio of Population to Mental Health Providers Rensselaer Community

**14,403**

**people for 1 provider**

There are enough mental health providers to meet high needs

Health Professional Shortage Area Guidelines in 2-county area (HRSA AHRF 2020-2021).

The behavioral health landscape presents a valuable opportunity to improve the well-being of our community. Suicide, one of the most preventable causes of death, can be addressed through targeted efforts that have the potential to significantly reduce its impact. By focusing on mental health conditions such as depression, anxiety and substance use disorders, we can proactively tackle challenges that contribute to suicide risk. Improving potential root causes like economic stress, social isolation, and limited access to mental health services, particularly in marginalized and underserved communities, will empower individuals, reduce adverse outcomes and foster a healthier, more resilient population.

**Emotional Impact Warning.** Please note that this report includes mention of severe mental health crises that may be difficult to read about. **Support is available:** Call or text 988 to reach the Suicide & Crisis Lifeline. Chat with the Lifeline at http://988lifeline.org/chat, or text HOME to 741-741 to speak with a trained Crisis Counselor at the Crisis Text Line.

988 SUICIDE & CRISIS LIFELINE





## SECTION 3. DATA ATTRIBUTION

HEART DISEASE, CANCER, DIABETES

*Centers for Disease Control and Prevention (2021). Interactive Atlas for Heart Disease and Stroke. Data queried from https://nccd.cdc.gov/DHDSPAtlas/Default.aspx?state=IN*
*Centers for Disease Control and Prevention (2021). PLACES. Data queried from https://experience.arcgis.com/experience/22c7182a162d45788dd52a2362f8ed65*
*Centers for Disease Control and Prevention (2022). Mortality 2018-2022 on CDC WONDER Online Database. Data queried from https://wonder.cdc.gov*
*Centers for Medicare and Medicaid Services (2022). Mapping Medicare Disparities by Population. Data queried from https://data.cms.gov/tools/mapping-medicare-disparities-by-population*
*County Health Rankings (2024). Mammography Screening amongst female Medicare enrollees ages 65-74 years in 2021. Data queried on countyhealthrankings.org*
*Indiana Department of Health (2024). Human Papillomavirus Dashboard for 9-12 Years Old. Data queried from https://www.in.gov/health/immunization/immunization-data/hpv-data/*
*Institute For Health Metrics and Evaluation (2016). U.S. Mortality by County. Data queried on broadstreet.io*
*National Cancer Institute (2015). Cancer Data - The Surveillance, Epidemiology, and End Results (SEER) 2011-2015. Data queried on broadstreet.io*

INFANT MORTALITY, MENTAL & BEHAVIORAL HEALTH

*BroadStreet (2020). Infant Mortality. Data queried on broadstreet.io*
*BroadStreet (2020). Suicide Prevention. Queried from broadstreet.io*
*U.S. Census Bureau (2022). American Community Survey 5-year estimates for Women Who Gave Birth in the Past 12 Months (Table DP02). Queried from data.census.gov*

# community HEALTH NEEDS ASSESSMENT

## COMMUNITY VOICES

SECTION 4

## SECTION 3. REFERENCES


SOCIOECOLOGICAL MODEL

*Hale, L., Troxel, W., Buysse, D.J. (2020). Sleep Health: An Opportunity for Public Health to Address Health Equity. Annu Rev Public Health. Apr 2:41:81-99.*

HEART DISEASE

*Centers for Disease Control and Prevention National Center for Chronic Disease Prevention and Health Promotion (2024). About the Division for Heart Disease and Stroke Prevention. Retrieved from https://www.cdc.gov/nccdphp/divisions-offices/about-the-division-for-heart-disease-and-stroke-prevention.html*

PREVENTABLE CANCER

*Centers for Disease Control and Prevention National Center for Chronic Disease Prevention and Health Promotion (2024). About the Division of Cancer Prevention and Control. Retrieved from https://www.cdc.gov/nccdphp/divisions-offices/about-the-division-of-cancer-prevention-and-control.html*

DIABETES

*Centers for Disease Control and Prevention National Center for Chronic Disease Prevention and Health Promotion (2024). About the Division of Diabetes Translation. Retrieved from https://www.cdc.gov/nccdphp/divisions-offices/about-the-division-of-diabetes-translation.html*
*Centers for Disease Control and Prevention (2024). National Diabetes Statistics Report - Diabetes. Retrieved from https://www.cdc.gov/diabetes/php/data-research/?CDC_AAref_Val=https://www.cdc.gov/diabetes/data/statistics-report/index.html*
*American Diabetes Association (2024). About Diabetes. Retrieved from https://diabetes.org/about-diabetes.*

INFANT MORTALITY

*Centers for Disease Control and Prevention (2024). Infant Mortality - Maternal Infant Health. Retrieved from: https://www.cdc.gov/maternal-infant-health/infant-mortality/index.html.*
*Kamal, R., Hudman, J., McDermott, D. (2019). What do we know about infant mortality in the U.S. and comparable countries. Retrieved from https://www.healthsystemtracker.org/chart-collection/infant-mortality-u-s-compare-countries/#item-start.*
*Morriss, F.H. (2013). Increased risk of death among uninsured neonates. Health services research, 48(4), 1232–1255. https://doi.org/10.1111/1475-6773.12042*

MENTAL AND BEHAVIORAL HEALTH

*Centers for Disease Control and Prevention (2024). Suicide. Retrieved from https://www.cdc.gov/suicide/about/index.html.*
*National Institute of Mental Health (2024). Suicide Prevention. Retrieved from https://www.nimh.nih.gov/health/topics/suicide-prevention.*


## DATA LIMITATIONS AND CAVEATS

Data are estimates from publicly available data. Note that calculation methodologies may differ for indicators such as mortality rates (i.e. age-adjusted, vs. crude rates). Public health data can be rather dated, as funding and infrastructure only allow for data collection every few years. County level data often does not reflect a specific community within the county. Some data may only be applicable to those with certain insurance types.

Franciscan HEALTH

# COMMUNITY VOICES

SECTION 4

*Every community has challenges. Importantly, every community has a tremendous number of assets upon which to rely. A health system cannot improve community health by acting alone—it takes everyone working together. This section is an overview of how we sought input from members and organizations in the community who are equally committed to improving health.*


*Indianapolis, Indiana*

## Over 100 Years of Collaboration

Working together, we can improve health. Franciscan Health has a service-based mission and over 100 year history of working with community-based organizations and government entities locally and regionally. As an organization, Franciscan Health has invested millions of dollars into communities and has collaborated with community organizations to address foun-dations for good health including social issues such as poverty. Franciscan is proud to have cultivated a meaningful network of community-based organizations in every region where a Franciscan facility is located. The network continues to grow.

## Conversations with the Community

How do we improve health in communities? Where should efforts be focused? Where are our strengths and assets? The data in Sections 1 through 3 provided a glimpse at the statistics. But, just as important, is the voice of the community. Hospitals need to know what the community wants from them, and review their own resources for the ability to meet some of those desires. For this edition of the CHNA 2025-2027 reports, and as a bridge to the Community Health Improvement Plan (CHIP), this section describes some of the methodology and results of our community conversations. Community conversations include meetings, group discussions, listening sessions, as well as several rounds of surveys sent to community organizations and to residents representing medically under-resourced areas. In order to ensure good representation, a list of community organizations and assets was assembled (see Appendix: Community Assets).





## The Community Health Surveys

As part of the Community Health Needs Assessment Process, community members and organizations were surveyed to better understand health needs as well as the capacity of community organizations to address health needs.

**SURVEY METHODS**
In November 2023, a 9-question pilot survey was deployed by the Franciscan Health Community Health Improvement Department. The survey was sent to 3 groups: (a) Franciscan Health employees, (b) professionals in community organizations and (c) community residents identified as under-resourced. After the pilot, another round of Community Health Surveys were sent to the 3 groups between February to May 2024.

**Survey Sample.** All surveys were a convenience sample and an oversample of our under-resourced community members. Additionally, answers from community organizations that completed surveys were reflective of only the constituents that they serve. **Data limitations.** Data limitations such as convenience sampling may limit the generalizability of results. Despite limitations, the data have been used to represent major themes within communities.

**Survey Questions.** Questions and answer choices were informed by the initial secondary data findings collected between May and September 2023. Secondary data sources included a subset of Indiana Indicators, current mortality and morbidity trends in our communities, and indicators from our data partners BroadStreet. Questions were the same on each survey, with a slight variation the resident survey and the community organizations and employees.

**Summary of Results.** Results were summarized as a health system and then by 10 facilities. Results served as the baseline for community conversations and the subsequent health improvement plan (Section 5).

## 3 Survey Goals

1. To identify conditions and needs that have agreement amongst audiences and communities
2. To validate initial community data findings
3. To identify potential health priorities (see example question below)

## Health Priorities

**Q: What health conditions do you or your family struggle to manage the most?** Options were:

- Cardiovascular disease
- Respiratory conditions, Asthma and COPD
- Diabetes
- Cancer
- Kidney Disease
- Accidents/Injury
- Stroke
- Chronic Liver Failure
- Mental Health (incl. Substance Abuse)



# SURVEY
## QUESTIONS & RESULTS

*The results from the pilot survey that were reviewed on December 5, 2023 by Community benefit professionals from Franciscan Health. All three audiences and all communities were reviewed.*

**Q1**

**Where do residents live? What regions do community organizations serve?**

The first question asked about location. This allowed responses to be grouped by facility and community: Franciscan Health Franciscan Health Crawfordsville, Crown Point, Dyer and Munster, Indianapolis, Lafayette East, Michigan City, Mooresville, Olympia Fields, Orthopedic Hospital Carmel and Rensselaer.

**Q2**

**What health conditions do patients, constituents or your family struggle to manage the most?**

**Summary of Results:** Diabetes was most prevalent amongst all audiences in all communities, followed by mental health conditions. Cardiovascular Disease, cancer and respiratory conditions (asthma, COPD) tied and appear to be community-specific. In all communities, chronic liver failure, stroke, kidney disease and accidents/injuries ranked much lower than the remaining items.

**Q3**

**What disease risk factors do your patients, constituents or your family find hard to manage?**

**Summary of Results:** Weight and anxiety or depression received high marks across all audiences and communities. High blood pressure, glucose/A1C and substance abuse rounded out the top five responses, also somewhat dependent by community.

**Q4**

**What prevents your patients, constituents, or you from improving your health? (Note: Answer choices are Adverse Community Experiences)**

**Summary of Results:** Poverty, in general, was most common. Food insecurity (low access and affordability) was the top more specific response. Housing and lack of education tied as the third most prominent response. Transportation, employment and violence were also top choices, community dependent.



**Q5**

**What other issues make improving health difficult? (Note: Answer choices are Adverse Childhood Experiences related)**

**Summary of Results:** Lack of resilience (the ability to recover quickly from difficulties) was the top response. A cluster of similar responses followed, which include lack of family and friends, lack of engagement in any community-based service/gathering space and isolation. This points to the Surgeon General's report on the epidemic of loneliness and isolation.

**Q6**

**What problems do your patients, constituents or you have when you need health care?**

**Summary of Results:** Cost of services and medical supplies were the top responses across all audiences in all communities, followed by navigating health insurance policies and benefits. In communities with high levels of minority populations, lack of culturally competent health care providers and lack of trust in providers was a prominent response (though less so amongst employees). Limited appointment times, long waits for an appointment and difficulties finding a primary care provider were also common.

**Q7**

**Resident only: What sources do you trust for health and lifestyle information?**

**Summary of Results:** The most common response was information from a doctor or nurse, followed by information from family and friends. Printed materials from providers and information shared at church tied for a third place. Websites, health fairs, information from therapists, were clustered in low to mid-level of response counts.

**Q8**

**Residents only: What would make it easier for you to manage your health between visits with your doctor?**

**Summary of Results:** Information on how to get and cook healthy food was the most prevalent response. Immunization clinics, free physical activities and blood pressure screenings were also top ranking. Online classes/virtual offerings also ranked highly.

**Q9**

**Organizations & Employees: What should Franciscan Health do to better engage residents?**

**Summary of Results:** Focusing on health inequities was the top response, but this varied by community. Community professionals' top response was to improve the partnership amongst social service agencies and the health system. Among employees, the top response was to increase the number of in-person events and activities. Both audiences noted a response that more community feedback was needed. Collaborations with faith communities and provision of opportunities for youth engagement ranked mid-level.




*Safe Kids Day*





*Indianapolis, Indiana*

*community* HEALTH NEEDS ASSESSMENT

# CALL TO ACTION

SECTION 5

Franciscan HEALTH

# CALL TO ACTION

SECTION 5

*Taking action requires careful prioritization and planning. This section outlines the prioritization process, including how we incorporated community feedback. The 2025-2027 Community Health Improvement Plan is proposed with a vision of healthy bodies, healthy connections, healthy minds, and healthy communities.*

## Selecting Health Priorities

Care was taken when selecting health priorities. In total, it was a 2-year process. Refining the final list of priorities required multiple rounds of feedback from community members, analyzing available data, and then convening as a team to narrow down the topics. During team review, topics were honed based on findings, organizational alignment, and the feasibility and availability of evidence-based solutions.

Starting in April 2023, the Franciscan Health Community Health Improvement Department consulted with public health experts from the community. Following this, secondary data sources were reviewed including leading causes of death (Section 3). The community voice matters. From October to December 2023, a pilot survey was designed and deployed to collect community input on health topics (Section 4).

Community benefit professionals from Franciscan Health met in December 2023 to review each community's data and survey results. Using the Hanlon method and multi-vote ranking, a shortened list of health topics were selected. In 2024, this process was repeated using a refined Community Health Survey and a deep dive into additional data. In September 2024, the team met to select the health priorities.






# THE TIMELINE

**2023**
The 2-year process begins for the Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP).

**April-July 2023**
Planning and consulting with public health experts on CHNA and CHIP improvements for 2025-2027 edition.

**May-September 2023**
Review of public health data for newest updates related to health status in our communities.

**October-December 2023**
Pilot survey launched and analyzed, identifying key themes in stakeholder groups.

**2024**
Start of year 2.

**February-May 2024**
Community Health Survey deployed to multiple audiences.

**January-August 2024**
Secondary data collected and refined. Primary data from Community Health Surveys are analyzed.

**August 2024**
Community health needs prioritized.

**September 2024**
Community Health Improvement Plan created.

**October-December 2024**
Franciscan Health leadership approvals.

**2025**
Launch the 2025-2027 plan.

# The Prioritization Process

The team review and prioritization process weighed 3 criteria:

**(1) Community Data.** What are the leading causes of preventable death in our community? How many people are impacted? What are the root causes? Do evidence-based solutions exist for prevention?

**(2) Community Voice.** What does the community want? What health topics do community members and organizations think are important? What community assets exist?

**(3) Organizational Alignment.** What are the hospital assets and resources? What topics are the health system facilities equipped to address and/or prevent? What topics are priorities of the health system?

## ABOUT THE 3 CRITERIA

### Community Voice

Residents and partners selected top health issues in the Community Health Survey (Feb. to May 2024): Diabetes, heart conditions, cancer and mental health were indicated as top health issues in all communities. Thus, a more specific secondary data review was conducted and results are reflected in this report (see Section 3).

### Organizational Alignment

Critical to the prioritization process was considering organizational alignment. Importantly, infant and maternal mortality have been included in this report and as priority health topic because of Franciscan Health's continued and unwaivering commitment to families. This has been a major focus in many communities, and the community data suggests it needs to be a continued priority. Conversely, mental and behavioral health services are a limited service line within the Franciscan Health System. So, while this was identified as an important topic in the pilot and Community Health Survey, it was recognized as low feasibility.

### Community Data

The data strategy was to begin with health outcomes such as leading causes of death. After a shortened list of health topics were selected, we took a deep dive into key health outcomes. Using the **Socioecological model**, root causes were identified and included social and economic factors, health behaviors, clinical screening and management as well as early outcomes such as hospitalizations. When the needs are viewed in this way, it makes it clearer to see where interventions are needed. Even when we focus on a single health outcome, it is important to note that mental health, physical health and social well-being are intertwined. With the right interventions, multiple domains can be addressed.

## THE TOP HEALTH PRIORITIES

- Heart Disease
- Diabetes
- Preventable Cancer
- Infant and Maternal Health
- Mental and Behavioral Health



# Community Feedback on Topics

| | Pilot Survey (All Franciscan Health Communities) | Community Health Survey - Residents (All Communities) | Community Health Survey - Community Organizations (All) |
|---|---|---|---|
| Cancer | ★★ | ★★★★★★★ | ★★★ |
| Mental Health Disorders | ★★★★★ | ★★★★★★★ | ★★★★★★★ |
| Diabetes | ★★★★★★★ | ★★★★★ | ★★★★★ |
| Heart Conditions | ★★ | ★★★★★ | ★★★★ |
| Substance Abuse | ★★★★★ | ★★★ | ★★★★★★ |
| Asthma | ★★ | ★★ | ★ |
| COPD/Emphysema | ★★ | ★ | ★★ |
| | | | |
| **Pilot Survey Only** | | | |
| Kidney Disease | ★ | - | - |
| Accidents/Injury | ★ | - | - |
| Stroke | ★ | - | - |
| Chronic Liver Failure | ★ | - | - |
| | | | |

This table is a schematic of health topic rank based on the percent of respondants who indicated that they were concerned or very concerned about number of people in the community with the health issue. Seven stars is a relatively high percent of people who indicated concern. Note: The question on the pilot differed from The Community Health Survey. The final question for community residents was: How concerned are you about the number of people you know that have these health issues? The Community Organization question was: How concerned are you about the ability of those you serve with these conditions to manage their condition with clinical care AND appropriate lifestyle modifications?

## The Hanlon Method

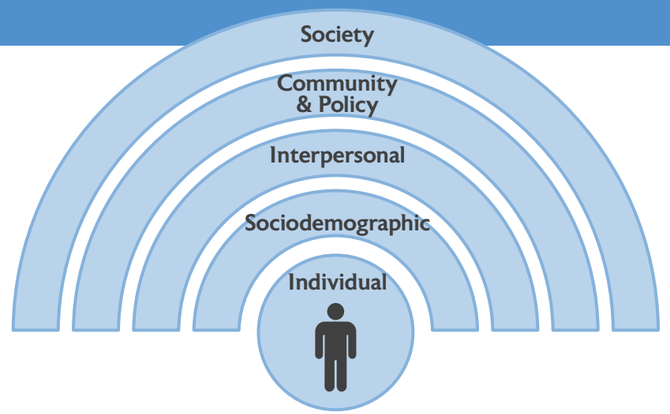
### A PRIORITIZATION STRATEGY

Health topics were ranked by community benefit professionals from Franciscan Health. The team used the Hanlon method alongside of multivote ranking, for assigning objective scores by topic or issue. Using a refined list of the top ten issues, each staff member ranked health issues based on the following criteria:

- **Size:** How many people are affected by this issue?
- **Seriousness:** How serious of an issue is this? Is it potentially deadly? How much of a threat is it to the population that is affected?
- **Equity:** How much does this affect the most vulnerable residents? Because of this, does it put those who are affected at a serious disadvantage?
- **Intervention:** How likely is it that a non-clinical intervention will change this need?
- **Time:** How urgent or pressing is this? Is there imminent danger or life-threating consequences within months?

# community
## HEALTH IMPROVEMENT PLAN

The purpose of the Community Health Improvement Plan (CHIP) is to link the data found in the CHNA to action. The federal regulation recommends that hospitals pay special attention to those in the community with significant health equity barriers and consult those same groups for acceptable interventions. Partnerships, sustainable change, and working directly with neighborhoods are priorities. Guidance from a variety of sources also recommend addressing root cause of issues, including structural injustices and social determinants of health. In this way, we can build foundations for good health

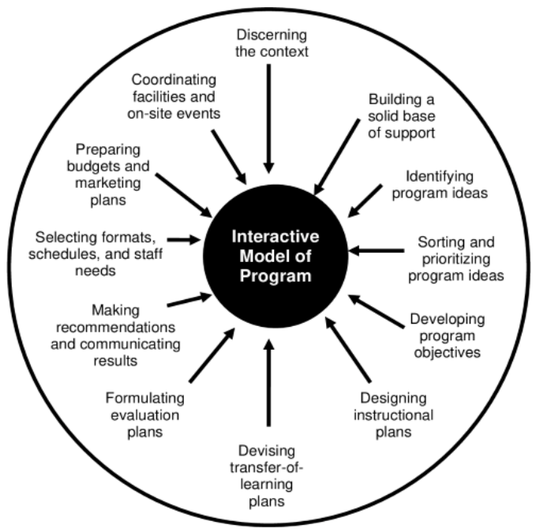



### METHODOLOGY

The Community Health Improvement Department has rooted its intervention philosophies and frameworks in public health, using evidence-based practices to ensure best possible outcomes

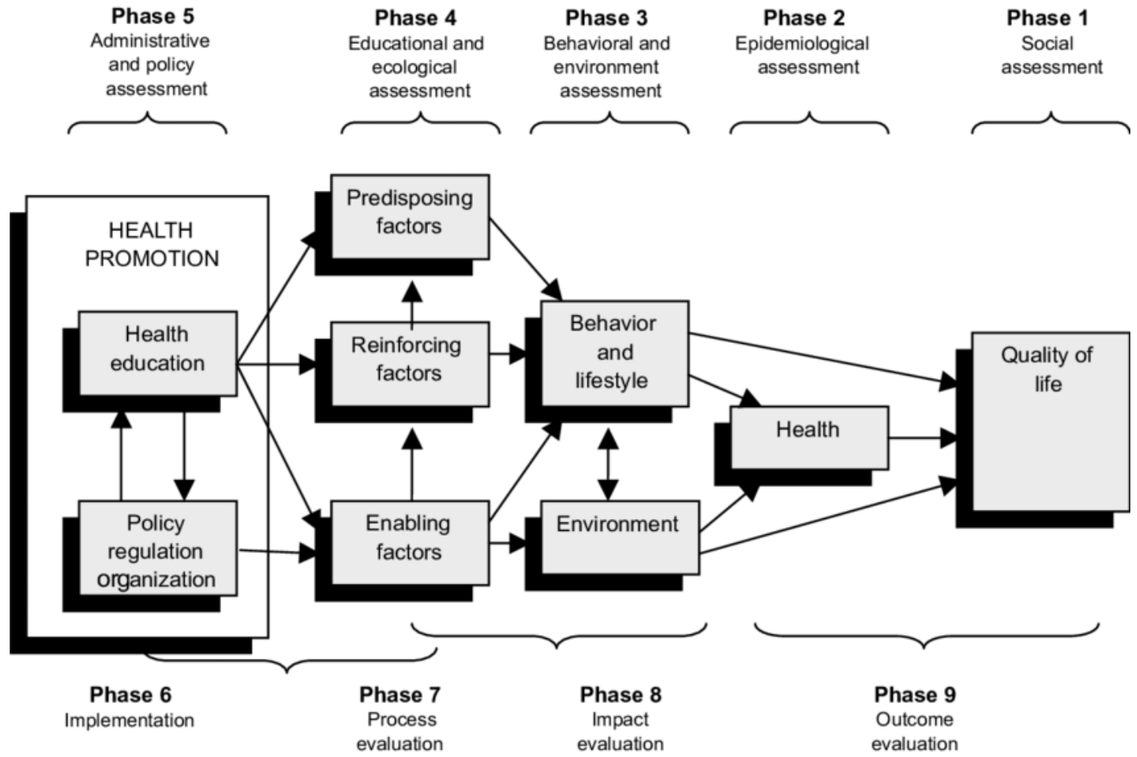
**The Socioecological Model** (above) developed by Urie Bronfenbrenner, is routinely used to consider the appropriate community-based strategies.

In terms of content, logistics, and practical matters, the Department uses Rosemary Cafarella's **Interactive Model of Program Planning for Adult Learners.**



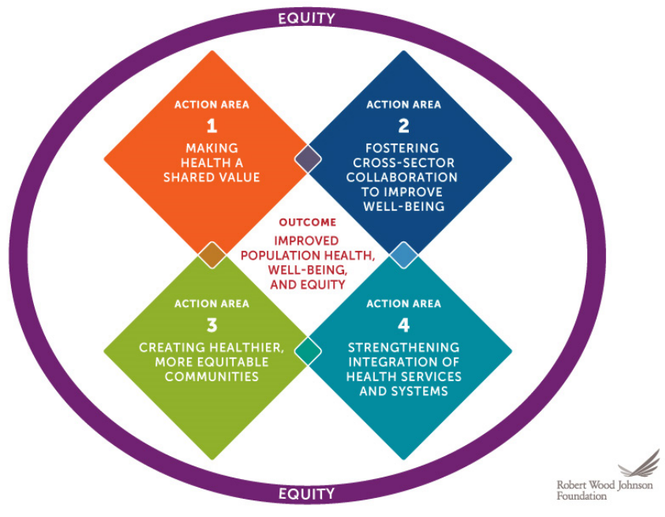



## The Precede-Proceed Model




**The Precede-Proceed Model** is used with health education and health promotion activities. This model indicates how and when to evaluate interventions and in determining potential cost and benefit.

Finally, to ensure a focus on health equity, the Department uses the Robert Wood Johnson Foundation's **Health Equity Framework** (see figure to the right).



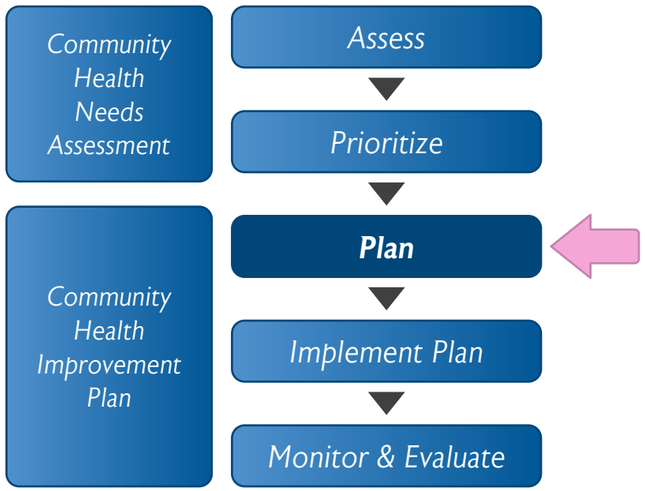
## Selecting Specific Interventions

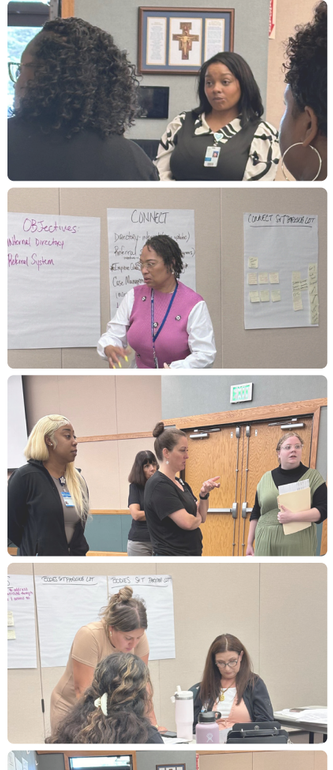
To assist with planning programs and interventions, the following criteria were used:

- **Adverse Childhood Experiences:** How strong is the relationship between this need, adverse childhood experiences, and community resiliency?
- **Internal Capacity:** To what degree does the specific Franciscan Health hospital have the resources to meet this need?
- **Community Acceptability:** How acceptable is action or an intervention to the community? Are there community organizations that also want to engage in this?
- **Sustainability:** How sustainable are efforts after three years? Are there community partners or internal departments that can continue this work for six years?
- **Long-Term Impact:** How likely is it that an intervention can create long-term or permanent change in individuals, conditions, or communities?

## The Plan

After the assessment and prioritization process, the team began creating The Community Health Improvement Plan for addressing health needs and priorities within each community.

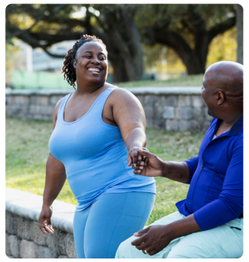




## *Healthy* **Bodies** • *Healthy* **Connections** • *Healthy* **Minds**

Physical health, mental wellness, and social well-being domains are a focus of this CHIP. This theme allows Franciscan Health to maximize resources as a system, while tailoring approaches to the unique needs of each community served. Every effort is made to serve those with the highest disparities or to build community capacity to eliminate such disparities.



### *Healthy* **Bodies**

Incorporating improvement in access to healthy food, education on physical activity and nutrition, and opportunities for community members to participate in physical activity assist in reducing obesity and chronic diseases. In addition, research shows physical activity and nutrition can build resilience and reduce the impact of childhood trauma. Franciscan Health will be partnering with community partners to expand reach, resources and the creation of sustainable infrastructures.



### *Healthy* **Connections**

Building strong community safety nets, encouraging social cohesion and developing infrastructure to better support families are vital to mental wellness and social well-being. The interventions in this area have the potential to reduce poor mental health, encourage positive community engagement, and serve as a foundation for healthier choices. Connections to meet social needs and improve social determinants of health are featured.



### *Healthy* **Minds**

Mental well-being continues to be a top concern in the communities served by Franciscan Health. Prevention and resilience intervention, like trauma informed care practices and mindfulness, are featured in the plan. Unfortunately, suicide and other harmful behaviors have increased in many communities. To address this, the plan also includes training and actions to prevent such measures.



### *Healthy* **Communities**

Healthy communities are important, too! Each community has its own unique initiative in which Franciscan Health is proud to participate. In some communities, additional resources or opportunities may exist. In this section, you'll find reference to some of these actions.

# *Healthy* **Bodies**

***39%***
*of respondents*
*would like to eat 5 servings of fruit and veggies a day.*

***46%***
*of respondents*
*would like to learn to maintain a healthy weight.*



*Good nutrition, managing weight and learning how to treat physical health as one ages are interconnected as a foundation to prevent chronic disease.*



Physical health is critical to all of the priority health needs in our community. Combining strategies for prevention, lowering risk factors, and management of chronic disease makes health improvement possible. In this plan, you'll see emphasis on physical activity, nutrition, screening, and education.

## GOALS, OBJECTIVES, STRATEGIES, & TACTICS

| | |
|---|---|
| GOAL: | Achieve a 20% increase in community members accessing interventions related to healthy lifestyle choices, preventative health, and chronic condition management by December 31, 2027. |
| | |
| OBJ 1: | Provide opportunities for senior residents to engage in physical activity and nutrition education. |
| *STRAT 1:* | *Implement a one mile walk program that includes health information 2 times a year.* |
| TACT 1: | Recruit 20 participants per session from Jasper County. |
| TACT 2: | Include 4 walking opportunities per program. |
| *STRAT 2:* | *Offer four cooking courses that respond to difficulties experienced by older individuals, such as reduced mobility and smaller budgets.* |
| TACT 1: | Recruit 15 participants for each program targeted those who are low-resourced. |
| TACT 2: | Include social networking as a part of each course. |
| | |
| OBJ 2: | Provide 2 fall prevention programs. |
| *STRAT 1:* | *Offer a minimum of 4 classes per program with content related to the role of physical activity in preventing diabetes and heart disease.* |
| TACT 1: | Recruit a minimum of 10 participants per program. |
| TACT 2: | Provide gait assessment and health screenings with each program. |
| | |
| OBJ 3: | Dissiminate education related to diabetes, heart disease, and stroke. |
| *STRAT 1:* | *Provide chronic disease management mini-series for residents living with chronic disease and their caregivers annually.* |
| TACT 1: | Recruit 40 participants from Jasper and Newton Counties, primarily over the age of 60. |
| TACT 2: | Arrange for clinical care professionals to discuss various disease issues and tips for management. |
| TACT 3: | Provide a resource guide for each participant and make available for the general public for pick up at select Franciscan Health locations. |

# *Healthy* **Connections**

**62%**
*of respondents indicated that they belong to at least two social groups that provide support.*

**40%**
*of respondents indicated that they are stressed by relationships and family issues.*

**61%**
*of young parents report struggling to maintain social activities and friendships.*

*Social connections are an integral part of mental and physical health. Our connections support us when we need extra help, provide encouragement, encourage healthy behaviors and contribute to our overall well-being and longevity.*



The Surgeon General's report on loneliness and isolation declares that these are critical public health issues that impact all of our dimensions of health. Following the advisement, the plan below brings more education and opportunity for strong ties to families, friends, neighbors and the community.

## GOALS, OBJECTIVES, STRATEGIES, & TACTICS

| | |
|---|---|
| GOAL: | Implement a series of community based interventions aimed at supporting family relationships, promoting social cohesion, and fostering a sense of community wellbeing in Jasper and Newton Counties with a positive evaluation score of 80% or better by December 31, 2027. |
| | |
| OBJ 1: | Increase awareness of childbirth, safe sleep, and appropriate diapering tactics. |
| *STRAT 1:* | *Improve number of Prenatal Assistance Program families that always follow the ABCs per evaluation to 80%.* |
| TACT 1: | Provide CDC-approved education to 95% of PAP families. |
| TACT 2: | Launch community awareness campaign targeting safe sleep, partnering with 5 community organizations. |
| *STRAT 2:* | *Increase usage of Diaper Pantry services by 15% over 2024 usage.* |
| TACT 1: | Provide additional needed services, such as vaccines, during 2 diaper pantry days. |
| TACT 2: | Register a miminum of 20 participants during community outreach events. |
| *STRAT 3:* | *Increase the number of prenatal mothers connected to childbirth education by 15% over 2024 usuage.* |
| TACT 1: | Provide 2 education programs for clinicians on the value of childbirth education. |
| TACT 2: | Increase the number of YoMingo users by 20 over annual average. |
| OBJ 2: | Increase usage of Project Swaddle in Jasper and Newton Counties. |
| *STRAT 1:* | *Recruit 15 new families into the program.* |
| TACT 1: | Develop targeted campaign for Franciscan Health patients. |
| TACT 2: | Recruit 3 community partners for direct referrals. |

# Healthy **Minds**

***61%***
*of respondents report being concerned about the impact of general stress on mental health.*

***50%***
*of community organizations feel that substance abuse disorder is the most common mental health issue they see in the community.*

***45%***
*of respondents would participate in a coping strategy involving spending time in nature.*

*Stress can exacerbate physical health issues, impair immune function and lead to worse health outcomes. By learning effective ways to handle stress and other mental health issues, social and physical health improve.*



Building on previous work with Adverse Childhood Experiences, suicide prevention and professional training on mental health issues, this plan takes interventions a step forward into mental wellbeing. This initiative brings education on building resiliency to communities in multiple modalities.

## GOALS, OBJECTIVES, STRATEGIES, & TACTICS

| | |
|---|---|
| GOAL: | Increase access to mental wellbeing resources by 15% in our community by December 31, 2027 as measured by individuals served. |
| OBJ 1: | Provide education and resources to the community that assists in the development of resiliency skills. |
| *STRAT 1:* | *Administer a community based workshop that includes resiliency and stress reduction.* |
| TACT 1: | Provide 2 workshops annually in Jasper and Newton Counties, serving 40 individuals. |
| *STRAT 2:* | *Train community partner organizations on basic workshop content for their use.* |
| TACT 1: | Recruit 5 partner agencies. |
| TACT 2: | Provide train the trainer, tools, and tracking for service to 100 individuals. |
| OBJ 3: | Increase the number of mothers participating in virtual and in person perinatal emotional support groups by 20%. |
| *STRAT 1:* | *Provide 12 monthly support groups.* |
| TACT1: | Collaborate with clinicans to include registration materials upon discharge. |
| TACT2: | Target 10 high risk Prenatal Assistance Program mothers for targeted outreach. |

# *Healthy* **Communities**

***47%***
*of respondents have been told by their doctor to make a diet change.*

***84%***
*of respondents report wanting to participate in some form of self-care.*

***75%***
*of respondents would want to attend an in-person program or event.*

*Each community has its own culture, norms and needs. Building community capacity and safety nets are vital to the health of ALL residents.*



The plan below is unique to this community and a match between Franciscan Health resources and meeting those special challenges and opportunities. This plan also highlights continued emphasis on community collaboration and bringing partners together to meet mutual goals.

## GOALS, OBJECTIVES, STRATEGIES, & TACTICS

| | |
|---|---|
| GOAL: | Build community infrastructure that supports the growth of health-related services and opportunities in Jasper and Newton Counties. |
| OBJ 1: | Further support the Jasper/Newton County Resilience Coalition through membership growth and mutually beneficial activities. |
| *STRAT 1:* | *Recruit 2 additional organizational representatives.* |
| TACT 1: | Review membership with current Coalition members. |
| TACT 2: | Review meeting candence and content with Coaltion members. |
| *STRAT 2:* | *Determine hallmark program or project benefiting residents.* |
| TACT 1: | Work with members to determine gaps in community services. |
| TACTI 2: | Develop program to assist residents in overcoming identified gap. |
| OBJ 2: | Develop and implement a signature health events focused on seniors and heart disease, diabetes, and cancer. |
| *STRAT 1:* | *Implement an annual Senior Expo serving 75 seniors.* |
| TACT 1: | Organize health resources such as screenings, warm introductions to clinicians that can assist in accessing appropriate health care, and support organizations. |
| TACT 2: | Provide a minimum of 3 education sessions that include each of the listed chronic diseases and prevention, risk factors, and management strategies. |









*Installing car seats (above), Back-to-School Event (below).*



# Reflections On The 2022-2024 Community Health Improvement Plan

Franciscan Health is proud of the progress made in the 2022-2024 Community Health Improvement Plan (CHIP). Through intentional work to strengthen access to low-cost physical activity opportunities, opening of multiple food pantries, expansion of healthy living education, and suicide prevention training, the Community Health Department saw participant knowledge, behaviors, and attitudes improve as evidenced by program evaluations. No formal individual responses were received during this period, but feedback was sought frequently by staff. Over the three-year period, coalitions reviewed plans annually to ensure the community's voice continued to guide our efforts. Strategies and tactics evolved over time and led to more robust partnerships and collaborations.

The new 2025-2027 CHIP builds upon the foundation of the last three years and refines specific programming to more fully address health at the physical, mental, social, and neighborhood level. Many successful programs will continue, such as our walking programs and nutrition education. However, more resources will be added to provide a continuum of options, from building awareness to deep, individual change. The true value of these programs long term are hard to measure, and more robust clinical and programmatic evaluations will be a feature of the next three years.

The conversation between Franciscan Health and the community doesn't end here. This report is just the beginning of the continued dialogue on working together to improve our collective health. Not only will program evaluations become part of the continuous improvement cycle, partners and collaborators will be sought to avoid duplication of effort and to strengthen our collective capacity. The plans presented here may change as these relationships develop and as our communities also continuously improve.

We invite you to join us as we work to improve prevention, risk mitigation, disease management, and survivorship. In each community, a Franciscan Health led coalition brings people together to problem solve and find new opportunity on the priority health needs listed here and the many related concerns. For current contact and meeting information, email: *COMHEALTHIMPVTEAM@FranciscanAlliance.org*.




*Prenatal Assistance Program (above), Baby Shower Montgomery (left).*

# *community* HEALTH NEEDS ASSESSMENT

## APPENDIX: COMMUNITY ASSETS

Franciscan HEALTH

# COMMUNITY ASSETS



*Gary, Indiana*



*Deer's Mill Covered Bridge crossing the Sugar Creek in Montgomery County, Indiana*

## Franciscan Health Crawfordsville Community

**Family and Youth**
Integrative Wellness (InWell)
Valley Professionals Community Health Center
Firefly Community Partner Program
Youth Service Bureau
Hope for Families
Hear Indiana
Families United

**Social Cohesion**
Senior Nutrition Site at Parks and Recreation Center
Area IV Agency on Aging and CAP
Disabled American Vets of Montgomery County
Wabash Center Adult Guardianship Program
Athena Center Senior Apartments

**Physical Activity/Built Environment**
Bachner Nature Preserve
Crawfordsville Park and Recreation
Darlington Covered Bridge
Deer's Mill Covered Bridge
Lake Waveland
Milligan Skate Park
Pine Hills Nature Preserve
Elston Grove Walking Tour
Lane Place Trees Walking Tour
Trees of GLWSM Walking Tour
Shades State Park
Sugar Creek Nature Park
Frances Wooden Northside Park
General Lew Wallace Study and Museum
Kathleen J Steele Park
Lincoln Park
Milligan Park
Nibble Park

**Food Related**
Salvation Army
Meals on Wheels
FISH Food Pantry
Crossroads Community Church
Ladoga Christian Church Food Pantry
MANNA from Heaven Food Bank
Church Alive
Friendship Baptist Church
Grace and Mercy Ministries Food Bank
New Market Christian Church
Food Finders Food Bank
First United Methodist Church
Waveland Christians In Action Food Pantry
Rosies Cupboard
Helping Hands Food Pantry
United Methodist Church of Darlington
St John Barefoot Food Pantry
A Light On the Hill
Purdue Extension Family Nutrition Program
Senior Nutrition Site at Parks and Recreation Center

**Job Skills/Employment Programs**
CAP Indiana Workforce Development
Pro Resources Staffing Services
Manpower Temporary Services
Vocational Rehabilitation Services

**Housing/Utilities**
Salvation Army
Pam's Promise Transitional Housing Corp
Habitat for Humanity of Montgomery Count
Crawfordsville Housing Authority

**Health Care**
Dr Mary Ludwig Free Clinic
Montgomery County Health Department

**Mental Health Services**
Integrative Wellness (InWell)
Valley Professionals Community Health Center
Valley Oaks Health
Rainbow Recovery Resources
Dusk to Dawn
Montgomery County Center for Women's Ministries
Salvation Army
Valley Professionals Community Health Center

**Services**
Teen Court Program - Youth Service Bureau
Indiana Legal Service Inc of Lafayette
Sunshine Vans
Library Program for Homebound Patrons

**Infant/New Parent Supplies or Services**
Women's Resource Center
La Leche League Breastfeeding Support
WIC Clinic
Healthy Families Program
Nurse Family Partnership

**Licensed Child Care**
CAP Kids Child Care Center (Head Start)
Giggles N Grins
The Story Book House
Happytown Day Care
Precious Lambs Daycare

**Community Coalitions**
Drug Free Montgomery County Coalition
Recovery Coalition
Alzheimer's Care Coalition



*The Lake County Courthouse in Crown Point, Indiana*

# South & North Lake County: Franciscan Health Crown Point, Dyer & Munster Communities

**Family and Youth**
Boys & Girls Club of Cedar Lake
Boys & Girls Club of East Chicago
Boys & Girls Club of Gary
Boys & Girls Club of Hammond
Family & Youth Services Bureau
YMCA - Crown Point (SouthLake)
YMCA - Whiting
YMCA - Hobart
YMCA - Hammond
YMCA - Schererville
YMCA- Griffith

**Social Cohesion**
Area Agency on Aging - CoAction
Dean and Barbara White Community Center
Griffith Senior Center
Hammond Sportplex - Seniors Social Activites
Little Brothers Friends of the Elderly
Maria Reiner Center
Northwest Indiana Community Action
South Lake Resource Center (Lake County Community Services)
South Side Christian Church
St. John Township - Community Center (Senior Activities)
YWCA of Northwest Indiana

**Physical Activity/Built Environment**
Boys and Girls Club - Cedar Lake
Boys and Girls Club - East Chicago
Boys and Girls Club - Gary
Boys and Girls Club - Hammond
Boys and Girls Club - Lake Station
Crown Point Parks and Recreation
Dyer Parks and Recreation
East Chicago Parks and Recreation
Griffith Parks and Recreation
Hammond Parks and Recreations
Hammond Sportsplex
Highland Parks and Recreation
Hobart Parks Department
Indiana Dunes National Park - Paul H Douglas Center for Environmental Education
Lake County Parks and Recreation
Lake Station Parks
Lowell Parks and Recreation
Merrillville Parks and Recreation
Munster Parks and Recreation
Schererville Parks and Recreation
St. John Parks Department
Whiting Parks and Recreation
YMCA - Griffith
YMCA - Hammond
YMCA - Hobart
YMCA - Schererville
YMCA - Southlake (Dean and Barbara White)
YMCA - Whiting

**Faith Based Communities**
Advancing Christ's Kingdom
Anew Life Ministry
Anthem Church
Antioch Baptist
Apostolic Church of God's Love
Bethel Temple
Caring Hands (InnerMission)
Catholic Charities
Christ Baptist
Christian Revival
Community Fellowship
Cornerstone Community Church
Embassies of Christ
Faith Temple of Christ
First Baptist
First United Methodist Church
Fish and Loaves
Gary Muslim Center
Gethsemane MB
God's Annointed Place (G.A.P)
Gospel Truth
Greater Destiny Church
Greater First Baptist
Greater Hammond Community Services
Greater Works Deliverance Ministries
Hammond Christian Reformed Church
Hammond New Harvest
Holy Spirit Church
Hope Christian Church
House of Glory
Light of Life Worship Center
Meek Baptist
Mount Zion MB
New Ebenezer
New Friendship
New Hope Missionary Baptist Church
Operation Care
Salvation Army - Munster
Salvation Army -EC
St. Ann's Conf. Soc of St. Vin Dep
St. Edward Conference
Society of St. Vincent Depaul of Gary
St. James Church Conference
Society of St. Vincent Depaul of Gary
St. John Bosco Cathlic Church
St. Joseph's Conference
Society of St. Vincent DePaul of Gary
St. Luke
St. Mark AME Zion
St. Mary of the Lakes Catholic Church
St. Mary's Crown Point
St. Thomas More Catholic Church
St. Timothy Church
The Mission of Jesus Christ
Trinity Lutheran Church
Trinity United
Van Buren Baptist

**Food Related**
Calumet Township Trustee
Cedar Creek Township Trustee - Lowell
Cedar Lake Farmers Market
Community Help Network
Dyer Community Market
Fresh Start Market at Franciscan (Hammond)
Fresh Start Market at Franciscan (Crown Point)
Griffith Central Market
Hanover Township Trustee
Hobart Summer Market on the Lake
InnerMission
Jewish Federation of NWI
Lowell Outdoor Market
Meals on Wheels
NWI Community Action
Ross Township Trustee
Salvation Army - Gary/Merrillville
South Lake County Community Services
St. Casimir Conference - Society of St. Vincent de Paul
St. John Farmers Market
St. Joseph Church Soup Kitchen
St. Matthias Roman Catholic Church
St. Stanislaus R. C. Church
St. Thomas More - SVDP
The Church of God in Christ Pantry
Whiting Farmers Market
WIC - Crown Point
WIC - East Chicago
WIC - Hammond
WIC - Lake Station
WIC - Merrillville
Winfield Farmers Market
YWCA of NWI
Purdue Extension

**Job Skills/Employment Programs**
Gary Career Center-Education
Gary Career Center-Job Skills
Gary Career Center-2nd Chance
Gary Career Center-Workforce Innovation & Opportunity
Goodwill Gary Career Center
Goodwill Gary Excel Center
Goodwill Hammond Excel Center
Gary Area Career Center
Workone Gary
Workone Hammond
Workone Portage
WorkOne Re-Entry Program

**Housing/Utilities**
Housing Opportunities
Hammond Housing Authority
East Chicago Housing Authority
Gary Housing Authority
Northwest Indiana Community Action
Habitat for Humanity of Northwest Indiana
Porter Starke Services - Shelter + Care

**Health Care**
Community Hospital
Methodist Hospitals
St. Catherine Hospital

**Mental Health Services**
Addiction and Family Counseling Inc
All Pieces Fit Inc Autism Center
Anxiety & OCD - Behavioral Health Center
Arisings, Incorporated
Behavioral Health - Community Healthcare System
Behavioral Specialists of Indiana
Bright Path Support Services
Clarity Clinic NWI
Confidential Care Dr. Vijay Jayachandran
Crown Counseling Services
Edgewater Behavioral Health Services
Epiphany & Company Counseling Services
Franciscan Behavioral Health Dyer
Franciscan Behavioral Health Outpatient
Fresh Start Counseling
Gary Community Mental Health
Heartland Wellness Center
Hopebridge Autism Therapy Center
Infinity Counseling & Wellness Center
Innovations In Learning
Kingsway Counseling LLC
Lakeside Behavioral Solutions
Life Strategies
Mental Health America - Lake County
Metro Treatment of Gary Semoran Treatment Center
Mid-America Psychological & Counseling
NeuroBehavioral Hospital of NW Indiana
New Beginnings Clubhouse
New Harvest Therapy Services
New Leaf Resources
New Vista Behavioral Health
NorthStar Services LLC
MedMark Treatment Centers - Merrillville
Pillars of Wellness Inc.
Purdue Northwest Community Counseling
Regional Health Systems
Southlake Community Mental Health
Southlake Community Mental Health Center
Transition Counseling Center
Tri-City Mental Health RBA

**Services**
Catholic Charities
Catholic Charities
International Institute of Northwest Indiana
Continental Languages
The Welcome Network
North Township Trustee
CareSource
East Chicago Transit
Gary Public Transportation Corp.

**Infant/New Parent Supplies or Services**
CAR SEAT INSPECTION - Crown Point Volunteer Fire Department
CAR SEAT INSPECTION - Franciscan Health Crown Point
Prenatal Assistance Program - Franciscan Crown Point
CAR SEAT INSPECTION - Gary Police Department
CAR SEAT INSPECTION - Griffith Police Department
CAR SEAT INSPECTIONS - Hammond Police Department
CAR SEAT INSPECTION - Northshore Hammond Clinic
Mental Health America
Prenatal Assistance Program - Franciscan Hammond
Women's Care Center
CAR SEAT INSPECTION - Northshore Lake Station Clinic
CAR SEAT INSPECTION - Northshore Health Center Merrillville
Nurse Family Partnership
CAR SEAT INSPECTION - St. John Volunteer Fire Department

**Licensed Child Care**
Cedar Lake Early Learning Academy LLC
Grand Tots, Inc.
Child Enrichment Center of Lake County, Inc
Children First Learning Center Foundation
Children First Learning Center, Inc.
Holy Family Childcare
Kiddie Academy of Crown Point
Kidzone Early Learning Center
My School Child Care Center
Bright Beginner's Academy
Empowered Minds Childcare Center
World of Rainbows
Geminus Head Start Learning Academy
Merchants of Hope Enrichment Academy
Robertson Child Development Center, Inc.
Destiny Dreamer's Academy, LLC
Elka Child Educational Center, Inc
Faith Child Care
Geminus Head Start - St Mark
Geminus Head Start St Mary's
Infant Tree Educational Rockstart LLC
Keystone Childcare Center
Lola's Education and Recreation Center
Mothers Little Tots LLC
My Safari Preparatory Academy
My Safari Preparatory Academy Georgia Street Campus
Smiling Angels Academy Inc
Super Scholars Learning Academy
Tiny Buns Childcare Center
Train Up a Child Leaning Center, LLC
We Are The Village, LLC
Young Children's Accelerated Academy
Safe Haven Academy, II
Baby's Gymboree
Kidzville Daycare Centers, LLC
Lisa's Safe Haven LLC
Little Einstein Academy
Little Graduates Childcare Academy
Little Toes Academy
Peaceful Palace Child Care Center
Woodland Child Development Center
Happy Days Highland On Main
Kids First Academy
Kinder Care Learning Center #1339
Spring Ahead Children's Academy
ABC Academy
Cerebral Palsy of NW IN. INC. DBA Center For Possibilities
Geminus Head Start - George Earle
Geminus Head Start Ridgewood
Precious Moments Kids Academy
Geminus Head Start - Hamilton
Geminus Head Start - Virgil Bailey
All About Children Inc.
Bright Beginnings Academy, MV
Good Shepherd Day Care
Happy Days Childcare - North
HAPPY DAYS OF MERRILLVILLE SOUTH
Merrillville Community School Corp Head Start - Fieler Elem School
Merrillville Community School Corp Head Start - Iddings Elem School
Merrillville Community School Corp Head Start - Miller Elem School
Tradewinds Services Inc./ Little Treasures Childcare
Village Park Child Care Center, Inc.
Kiddie Academy Of Munster
Wonder Years Learning Center
Cherie's Garden In The Gates, Inc
Li'lRascals
Childzone, 41, Inc.
Premier Child Care & Learning Center
Geminus Head Start-Whiting

**Community Coalitions**
SAFE
Northwest Indiana Community Action
CANI: Community Advocates of Northern Indiana
Lake Area United Way
Lake County Community Tobacco Prevention & Cessation Coalition



*Indianapolis, Indiana*

# Franciscan Health Indianapolis Community

**Family and Youth**
Purdue Extension
Adult and Child
Baxter YMCA
BACI
Chin Community of Indiana
Lifeline Youth & Family Services
Behavioral Health Counseling for Youth and Family
Hope Academy
YMCA
Hope for Tomorrow
Marion County Commission on Youth
Girl Scouts of Greater Indiana
Boy Scouts, Crossroads of America Council
4-H
Reach for Youth
Brighter Futures Indiana
Indiana Afterschool Network
Lifeline Youth and Family Services
Center for Leadership Development
Girls Inc
100 Black Men of Indianapolis
Big Brothers Big Sisters
FFA
Junior Achievement of Central Indiana
Boys and Girls Clubs of Indianapolis
Boys and Girls Clubs of Johnson County
Young Families of Indiana Network
Indianapolis Youth Leadership Academy
LifeBridge

**Social Cohesion**
Greenwood Public Library
Greenwood Community Center
Hornet Park Community Center
Impact Old Southside Christian Church
Shepard Community Center
Brightwood Community Center
Martin Luther King Community Center
Flanner House
Indianapolis Public Library
Hawthorne Community Center
Chin Community of Indiana
Indianapolis Marion County Public Library
Indiana Black Expo
Club Greenwood
Hornet Park Community Center

**Physical Activity/Built Environment**
Baxter YMCA
Perry Park
Sarah T. Bolton Park
Gray Park
Thompson Park
Brasswood Park
Don Challis Park
Hartman Park
Hornet Park
Greenwood Community Center
Hornet Park Community Center
Freedom Springs Aquatics Park
Northeast Park
Grassy Creek Park
Northwest Park
Craig Park
Summer Field Park
University Park
Surina Square Park
Woodmen Park
Southeast Community Services
Servants Heart of Indy
Southport Park
St. Francis Soccer Club
Greenwood Youth Sports
Johnson County Parks and Recreation
Indianapolis Soccer Club
Johnson County Youth League
Indianapolis Sports Park
Circle City Futbol Club
Franklin Township Softball League

**Food Related**
Purdue Extension
Servants Heart of Indy
Cub Pantry: Franklin Community School Food Pantry
Gleaners Mobile Pantry
IMPACT Center (Mt. Pleasant Christian Church)
Interchurch Food Pantry
Saints Francis & Clare Harvest Food Pantry
St. Vincent de Paul Food Pantry at our Lady of Greenwood
The Refuge
The Salvation Army-JC
The Social of Greenwood
Michelle's Little Free Food Pantry
Johnson County Senior Services
Great Harvest Food Pantry
The Care Center
Vinyard Community Church Food Bank
Purdue Extension-Johnson County
City of Indianapolis
Franciscan Health Fresh Start Market
Indy Hunger Network

**Job Skills/Employment Programs**
Man Power Job Placement
Autism Society of Indiana
New Beginnings by Goodwill of Central and Southern Indiana
Jobs For America's Graduates (JAG)
People Ready-Indiana
Homeless Initiative Program
Chin Community of Indiana
PACE Indy
YES Indy
EmployIndy
YouthBuild Indy

**Legal/Civic/Immigration**
Catholic Charities Indianapolis
Indiana Legal Services
Franciscan Working Well
BACI
Exodus Refugee Services

**Health Care**
Community Health Network South
Johnson Memorial Hospital
Eskanazi Health
Indiana University Health
Marion County Public Health Department
Johnson County Health Department
Ascension St. Vincent Health

**Mental Health Services**
Meridian Health Services
Adult and Child Behavioral Health Services
Beacon of Hope Crisis Center for Women
Life Recovery Center
Reach for Youth
Families First
Valley Vista
Johnson County Mental Health Center
Cummins Behavioral Health Systems

**Services**
IndyGo
Way2Go
Access Johnson County
Johnson County Senior Services

**Housing**
Indianapolis Energy Assistance Program
Townships of Marion County
Community Action of Greater Indianapolis
IndyRent
Recovery Café Indy
ASSIST Indiana

**Infant/New Parent Supplies or Service**
BABE Store
Indiana Diaper Bank
The Villages
USO Indiana
Project Home Indy
La Plaza
Family Promise of Greater Indianapolis
Early Learning Indiana
Firefly
Wheeler Mission Ministries

**Community Coalitions**
Indiana Coalition Against Domestic Violence (ICADV)
CICOA Agining & In-Home Solutions
Chin Community of Indiana
Burmese American Community Institute
Top 10 Coalition
Resilience Coalition
Healthy Johnson County Partnership
Suicide Prevention Johnson County

# Franciscan Health Lafayette East Community

**Family and Youth**
The Foster Closet at Innovation
The Villages of Indiana
The Child Care Resource Network
Gifts of Grace Adoption Support Center
Hanna Community Center
Lyn Treece Boys & Girls Club
Beck Lane Boys & Girls Club
YWCA
Job Works
Arts Federation
Heartford House
Purdue Extension 4-H
Girl Scouts
Big Brothers Big Sisters
Boy Scouts Sagamore Council
Bauer Family Support Center
YMCA
Indiana Youth Institute
Tippecanoe County CASA

**Social Cohesion**
Wabash Center
Vocational Rehabilitation
Grant's House
United Way of Greater Lafayette
Area IV Council on Aging and Community Action Programs, Inc.
Tippecanoe County Senior Center
Hanna Community Center
YMCA
Lyn Treece Boys & Girls Club
Beck Lane Boys & Girls Club
Morton Community Center
Faith Community Center
Faith West Community Center
Tippecanoe County Fairgrounds
Art Museum of Greater Lafayette
Fort Ouiatenon
Haan Museum of Indiana Art
Moses Fowler House
Purdue University Galleries
Samara House
Tippecanoe Battlefield Museum
Tippecanoe County Public Library
West Lafayette Public Library

**Physical Activity/Built Environment**
City of Lafayette: Parks & Trails
West Lafayette Wellness Center
McCallister Center
Lafayette Family YMCA
Downtown YMCA
Prophetstown State Park
Columbian Park Zoo

**Food Related**
ACE/Baptist Student Foundation at Purdue, Inc
Bethlehem Holy Temple Church
Battleground United Methodist Church
Brady Lane Church of Christ
Clarks Hill Christian Church
Connection Point Church
Elmwood Church of Christ
Evergreen Wesleyan Church
Food Finders Food Bank Fresh Market
LUM Protein Pantry
River City Community Center Food Pantry
Salvation Army of Tippecanoe County
St. James Lutheran Church
Tippecanoe County United Food Pantry
Wea Ridge Baptist Church
Whole Truth Apostolic Faith Assembly
Food Finders Food Bank
Lafayette Farmers Market
West Lafayette Farmers Market
Purdue University Extension Tippecanoe County
Mid-Land Meals - Fairington Apartments
Mid-Land Meals - Friendship House
Tippecanoe Senior Center
Area IV Agency on Aging and Community Action Programs, Inc
Mid-Land Meals
Meals on Wheels of Greater Lafayette – Tippecanoe Community Center

**Job Skills/Employment Programs**
Indiana Department of Workforce Development – Tippecanoe County
LARA - Lafayette Reading Academy
Goodwill Education Initiatives – Lafayette Excel Center
Vocational Rehabilitation Services Region 6
Wabash Center

**Housing/Utilities**
Lafayette Housing Authority
LTHC Homeless Services
Salvation Army Pathway to Hope Program
Lafayette Urban Ministry
Victory Christian Church
Trustee's Office
Safe Families
YWCA Domestic Violence Shelter
Family Promise
Homestead CS
Faith Presbyterian Church
Salvation Army Emergency Financial Assistance
Area IV Agency on Aging and Community Action Programs, Inc
Military Family Assistance Center - Lafayette
Family Promise of Greater Lafayette
The Salvation Army Family Emergency Shelter

**Health Care**
Indiana University Health-Arnett
Riverbend/North Central Health Services
Tippecanoe County Health Department
Richard L. Roudebush Veterans Affairs Medical Center

**Mental Health Services**
Valley Oaks
Meridian Health Inpatient
Meridian Health outpatient
River Bend Hospital
Empath Unit/Franciscan
Willowstone Family Services
Sycamore Springs
Mental Health of America
Celebrate Recovery at River City Community Center
Clean Slate
Groups of Indiana
Oxford House
NAMI
US Dept of Veteran Affiars
Limestone Health
Light House Recovery
Recovery Café
Tippecanoe County Health Department
Riggs Community Health Center
Alpine Health Services
Trinity Life Mission
Home with Hope
Restoration
Vision of Hope
Phoenix Recovery Solutions QRT
Brighter Way Counseling
Child and Family Partners/ Counseling Partners
Locker Psychological Services, LLC
Matrix LifeCare Center
Suncrest Psychological Services
Cary Home for Children
T.C. Harris School







*The Tippecanoe County Courthouse in Lafayette (above) Prophetstown State Park in Tippecanoe County, Indiana (opposite).*

**Services**
LARA-Lafayette Reading Academy
Legal Aid Corporation of Tippecanoe
Indiana Legal Services – Lafayette
The Immigrants' and Language Rights Center of Indiana Legal Services, Inc.
Lafayette Urban Ministry Immigration Clinic
LAVA Project, Indiana Legal Services Inc
Citybus Public Transport
ACCESS (City Bus of Lafayette)
Area IV Council on Aging
Caregiver Companion
Angels Senior Home Solutions
Brightstar Care
Comfort Keepers
Home Instead
Hoosiers at Home
Integrity Care
Cheney's Magic Cab Ride
Lafayette Senior Transport and Concierge
Tippecanoe County Senior Center
Med-a-Port
Necessities Transportation, LLC

**Infant/New Parent Supplies or Services**
Matrix LifeCare Center
Goodwill of Central and Southern NFP
Bauer Family Resources Pregnant Women's Programs
Indiana University Health
Franciscan Health
Gifts of Grace Adoption Support Center
Willowstone Family Services
Firefly
Connection Point Church

**Licensed Child Care**
Bauer Family Resources
Scooby Doo Daycare
Grace Day Care
Bright Beginning Academy
Rights Steps - Central Presbyterian
St. James Lutheran Childcare
Hanna Community Center
Rights Steps - Dennis Burton
St. Francis Early Learning Academy
Lafayette Urban Ministry
Jenn's Friends Daycare
Right Steps Child Development Centers Downtown
Little Bronchos
Bethany Child Care and Preschool
Chosen Childcare Ministry
Jennifer Pruitt
Kinder Care
Second Baptist Childcare Ministry
Right Steps - Creasy
Adventure Station Child Care
Ben and Maxin Miller Child Development Laboratory School
STEAM Academy Preschool
Rachel's Childcare and Preschool
"Safe Harbor Schools - West Lafayette Intermediate School"
Lafayette Family YMCA
Kinder Care at Work
Brookshire Learning Center
Christ United Methodist Church Child Care Ministry
Little Steps Early Learning Center
Safe Harbor Schools - West Lafayette Elementary
Kiddie Kolleg
Future Scholars
Amazing Gems Childcare
Heartland Child Care Ministry
Faith Community Infant Care
Just Us Kids
Lil' Face Childcare
Subaru Child Development Center



*Michigan City East Pierhead Lighthouse, Washington Park Beach, Michigan City, Indiana*

# Franciscan Health Michigan City Community

**Family and Youth**
Boys & Girls Club
Youth Services Bureau
YMCA La Porte
YMCA Michigan City

**Social Cohesion**
Senior Center

**Physical Activity/Built Environment**
Michigan City Skatepark
Adams Park
Canada Park
Cleveland Park
Gardena Park
Hansen Park
Joe Hawkins Memorial Park
Karwick Nature Park
Krueger Memorial Park
Oak Hills Park
Pullman Park
Ruby Woods
Striebel Pond
Tall Timbers Park
Walker Street Park
Water Tower Park
Charles R. Westcott Park
Winding Creek Cove
Oasis Splash Park

**Food Related**
Salvation Army
Pleasant Hill MB Church
Trinity Church
PAX Center
Faith City
Macedonia MB Church
Sacred Heart Church
New Disciple Love Fellowship
The Good Shepard Food Pantry
First United Methodist Church
Springfield Township
First Presbyterian Church Food/Soup Kitchen
Calvary Lighthouse
Sacred Heart Food Pantry, St. Mary's Catholic Church
Center Township Trustee
Arise & Shine Food and Outreach Center

**Job Skills/Employment Programs**
AK Smith Career Center
Grace Learning Center & Keys to Hope

**Housing/Utilities**
Citizens Concerned for the Homeless
Grace Learning Center
Stepping Stones
The Bridge
North Central Community Action Agency
Salvation Army
Anthony Adams House
Catholic Charities
Michigan Township Trustee
Center Township Trustee
Michigan City Housing Authority

**Health Care**
Open Door Adolescent Health Center (MCHS)

**Mental Health Services**
Swanson Center
Mindful Minds
Lake Effect Healing
Samaritan Counseling
Keys Counseling
Brighter Beginnings Counseling
Bowen Center

**Services**
Dial a Ride
Around the Clock

**Infant/New Parent Supplies or Services**
LaPorte County Health Department
Women's Care Center
Prenatal Assistance Program FH MC
Salvation Army
Dunebrook

**Licensed Child Care**
Granny's House
Wee Care
Imagination Station
Children of Destiny Child Care
Little Sprouts Learning Center
Kidz Paradise
Hearts & Hands Childcare
Village Kids
Giggly Wiggly
Constructive Pathways Montessori School
Kids Are Kids
Cribs to Crayons
Little Saints
Transformation Learning Center
Peek A Boo
Express Yourself Daycare

**Community Coalitions**
Healthy Community of La Porte County (Dunebrook)
Tobacco Coalition



# Franciscan Health Mooresville Community

**Family and Youth**
About Special Kids
Adult and Child Health
ARC of Indiana
Bureau of Developmental Disabilities Services (BDDS)
Boys & Girls Club of Morgan County
Girl Scouts of Central Indiana
Boy Scouts - Crossroads of America Council
4H Morgan Co Extension Office Martinsville
Clarity Pregnancy Services
Chances & Services for Youth (CASY) - Child Care Resource & Referral
Department of Child Services
Child Support County Clerk Martinsville
Child Support Prosecutor Martinsville
Division of Family Resources
First Steps Early Childhood Intervention
Head Start Center
Healthy Families
Parents of Addicted Loved Ones
Project Life Saver
Sycamore Services
The Haven Youth Center
WIC Office
YMCA (Barbara B. Jordan)
Youth First

**Social Cohesion**
Morgan County Public Library
Mooresville Public Library
Martinsville Area Senior Center
Mooresville Senior Citizens Center
A Senior Retreat - Senior Daycare Services
NBA Kennedy Living Center
Morgan County Senior Advocates
Department of Veteran's Affairs

**Physical Activity/Built Environment**
Morgan County Parks and Recreation
Bradford Woods
Mooresville Parks & Recreation
Morgan-Monroe State Forest
Pioneer Park
Jimmy Nash City Park
Patton Park Inc.
Griffin Woods
Rooker Run Park
Ravinia State Forest
Fred & Dorothy Meyer Nature Preserve
Burkhart Creek
Landersdale Trail
Bicentennial Park
North Park
Old Town Park

**Food Related**
South Central CAP Energy Assistance Program
Churches in Mission
Eminence Christian Church
First Church of the Nazarene
Gasburg Baptist Church
Gateway Tabernacle Church Martinsville
Magdalene House
Manna Mission
Monrovia Christian Church
Monrovia High School Bulldog Blessings Pantry
Morgantown Community Food Pantry
Mt. Olive United Methodist Church Martinsville
Paragon Food Pantry
Paul Hadley Middle School Food Pantry
Red Barn
Senior Citizens Center Mooresville
Wooden/Bell Family Food Pantry (John Wooden Middle School)

**Job Skills/Employment Programs**
WorkOne
Sycamore Services
Bri Staffing
Elwood Staffing

**Housing/Utilities**
Brooklyn Meadows
South Central CAP Energy Assistance Program
Churches in Mission-Martinsville
Churches in Mission-Mooresville
Coordinating Aging Services
Country View Apartments
Habitat for Humanity
Heather Heights
Ken Mar
The Retreat at Mineral Springs
Morgan House
Morgan House II
Pines Apartments
Spring Hill I
Towne View
Village of Morgantown

**Health Care**
Indiana University Health
Morgan County Health Department

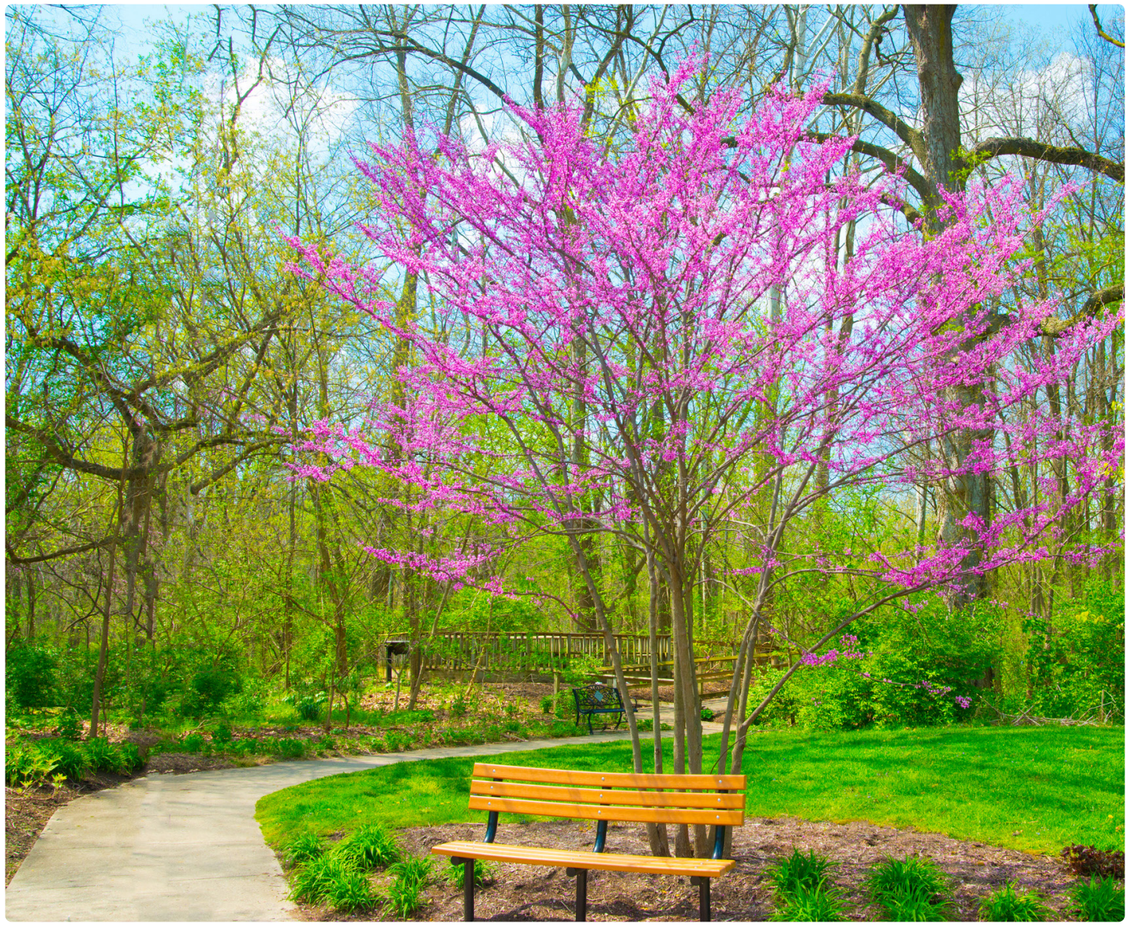
**Mental Health Services**
Centerstone Martinsville
Firefly (Child/Youth Services)
Meridian Health Services
Peace Restored
Center for Women's Ministries
Desert Rose
Morgan County Substance Abuse Council
Recovery Works
Pinnacle Treatment Center

**Services**
Indiana Legal Services, Inc.
Pro Bono Project District 10
Indianapolis Legal Aid
Society
Disability Legal Services
Morgan County Victim Assistance
Morgan County Adult Protective Services
Indianapolis Bar Legal Services
La Casa
Mariposa Legal
American Red Cross
Community Cab
CONNECT Morgan County
MHS Transportation
Medicaid - Southeastrans Trip Reservation Line
Hoosier Care Connect - MD Wise

**Licensed Child Care**
Puzzle Pieces Childcare Center LLC
Artesians Childcare LLC
Bauer Resource Center (Martinsville Head Start)
Bauer Family Resource Center (Mooresville Head Start)
Childtime Learning Center
Learning Land Childcare and Preschool
Lynns Day Care
Heathers Home Daycare
Starbabies Daycare Inc
Love Muffins Childcare

*Porter Cave in Indiana*





*Flowing Wells in Hamilton County, Indiana*

## Franciscan Health Olympia Fields Community

**Family and Youth**
Rich Township
Bloom Township

**Social Cohesion**
Village of South Chicago Heights
Prairie Green at Dixie Crossing Assisted Living

**Physical Activity/Built Environment**
Village of Park Forest
City of Chicago Heights

**Food Related**
Rich Township
Respond Now

**Job Skills/Employment Programs**
City of Chicago Heights

**Housing/Utilities**
South Suburban Pads
Respond Now

**Health Care**
Advocate South Suburban Hospital
Ingalls Memorial Hospital

**Mental Health Services**
Aunt Martha's

**Services**
Village of South Chicago Heights
Bloom Township Center

**Infant/New Parent Supplies or Services**
Jones Community Center
Respond Now

**Licensed Child Care**
Jones Community Center

**Community Coalitions**
South Suburban Cook County Resilience Coalition





*Hamilton County, Indiana*

## Franciscan Health Orthopedic Hospital Carmel Community

**Family and Youth**
Bureau of Developmental Disabilities Services (BDDS)
Boys & Girls Club of Noblesville
Girl Scouts of Central Indiana
Boy Scouts -Crossroads of America Council
Purdue Extension Hamilton County
Department of Child Services Hamilton County
Child Support County Clerk Hamilton County
Child Support Prosecutor Hamilton County
Division of Family Resources
First Steps Early Childhood Intervention
Family Development Services
YMCA

**Social Cohesion**
Hamilton County East Public Library
Hamilton County East Public Library
Carmel Clay Public Library
Carmel Clay Public Library, Joyce Winner West Branch
Physical Activity/Built Environment

**Food Related**
Meals on Wheels, Hamilton County

**Health Care**
Trinity Free Clinic
Hamilton County Health Department

**Services**
WIC Office
Hamilton County Veteran Services
SNAP Hamilton County Division of Family Resources



# Franciscan Health Rensselaer Community

**Family and Youth**
Geminus Community Partners
Family Focus, Inc.
Healthy Families of Family Focus, Inc.
North Central Indiana Rural Crisis Center
Dunebrook: Families in Crisis
Jasper County Purdue Extension
Newton County Purdue Extension
Cooperative School Services
CoAction (formerly known as Northwest Indiana Community Action Agency)

**Social Cohesion**
Gracepoint Resource Center, LLC
Alcoholics Anonymous - DeMotte Library
Alcoholics Anonymous - First Presbyterian Church
AL-ANON
Jasper County Community Services-Rensselaer
Rensselaer Care Center, Part of Life Care Centers of America
Robert A. Fase Center
Prairie Arts Council & Lilian Fendig Gallery
Jasper County Public Library - Rensselaer, DeMotte, Wheatfield
Newton County Community Services
Senior and Adult Guardianship Advocates (SAGA)
Brook Public Library
Morocco Community Library
Roselawn Library
Kentland Library
Goodland Library
Goodland Town Hall
Newton County Historical Society
Lake Village Public Library
Newton County Fairground
R. Steven Ryan Memorial Community Center

**Physical Activity/Built Environment**
DeMotte Parks & Pool
Rensselaer Parks & Pool
Blue Devil Lagoon Pool
Kankakee Sands- Nature Conservancy
Cast Park
Iroquois Park
Brookside Park
Oak Lake RV Resort
Potawatomi Park
Milroy Park
Kessler Park
Morocco Park
Flat Iron Park
Pioneer Family Campground, Inc.
Rensselaer Dog Park
Bicentennial Park
Columbia Park
Spencer Park & Pool
Field of Dreams
Lake Holiday
Conrad Savanna Nature Preserve
Holley Savanna



Fountain Park Chautauqua
Caboose Lake Campground
Rodger G. Wolcott Memorial Park
Laird's Landing
Little Creek Campground
Gish Wildlife Area
Acorn Oaks Campground
Centennial Park
Stoutsburg Savanna Nature Preserve
Prairie Border Nature Preserve
Sandhill Crane Observation Area
Jasper- Pulaski Fish & Wildlife Area

**Food Related**
Good Neighbor Food Pantry
Good Samaritan Food Pantry
Sorrowful Mother Church Food Pantry
Remington Food Pantry at First Christian Church
Covenant Federated Church Food Pantry
Cornerstone - Faith Harvest Food Pantry
Community Church - Food Pantry
Newton County Community Services - Home Delivered Meals
Newton County Community Services - Food Pantry
Freedom Community Church Food Pantry
Fowler Baptist Church Food Pantry
Community Food & Service Co-Op
Christian Church Food Pantry
The Bridge Food Pantry
The River Church - Faith Harvest Food Pantry
Meals on Wheels Northwest Indiana
Purdue Cooperative Extension Service - Jasper County

**Job Skills/Employment Programs**
IMPACT Job Training - Jasper County Office of Division of Family Resources
WorkOne Northwest Indiana
Opportunity Enterprises, Inc
Jasper County Economic Development Organization
Express Employment Professionals
Express Employment Professionals - NWI
Comprehensive Development Centers
Center of Workforce Innovations
Newton County Adult Learning Center

**Housing/Utilities**
Consumer Credit Counseling of NWI
Newton County Community Services - Emergency Assistance Program
Salvation Army - Trinity United Methodist Church
Jasper County Community Services - Emergency Energy Assistance Program
Helping Hands - Burr Oak Church
Public Housing Authority
Low Income Housing Tax Credit Properties: MADISON COTTAGES OF RENSSELAER II and MADISON COT-TAGES OF RENSSELAER I
Multifamily Housing: (Low Income, Elderly, and Special Needs Housing): SERENITY TERRACE
USDA Rural Housing: FA - Family
Multifamily Housing: (Low Income, Elderly, and Special Needs Housing): ACCESS HOUSING OF JASPER
USDA Rural Housing: EL - Elderly
USDA Rural Housing: FA - Family
Low Income Housing Tax Credit Properties: ASHLAND PLACE SENIOR HOMES

**Health Care**
Indiana University Health White County
Jasper County Health Department
Newton County Health Department

**Mental Health Services**
Jasper County Recovery House
Counselor, Chad Pulver
New Leaf Resources



*Summer in Indiana*

Ryan & Ryan Consulting and Educational Development
Wabash Valley Alliance
North Central Health Services, Inc.
Jasper County Hospital Outpatient Clinic - Franciscan Health Network
Valley Oaks Health
Sycamore Springs
Heartland Clinic - Behavioral Health
Franciscan Behavioral Health
Franciscan Hospice Care
North Central Health Services, Inc. / Riverbend Hospital
IFC - Morocco Clinic, Dr. Oranu Ibekie
Christian Clinic, Dr. James Wakefield
Heartland Recovery Center

**Services**
Jasper County Community Services - DeMotte & Wheatfield
Jasper County Community Services - Rensselaer
Newton County Community Services - Public Transportation
Pulaski County Human Services
White County Public Transit

**Infant/New Parent Supplies or Service**
Firefly
Birthright of Rensselaer
Endless Treasures
Jasper Junction
Sell-It-Again Resale Shop
Franciscan Health, Prenatal Assistance Program

**Licensed Child Care**
Goodland Head Start
Right Steps Goodland
North Jasper Head Start
Rensselaer Head Start
Roselawn Head Start
The Growing Patch Learning Center
Families of JCYC, Inc.
AppleTree

**Community Coalitions**
DeMotte Chamber of Commerce
Jasper Newton Community Foundation
Rotary - DeMotte
Chamber of Commerce
Drug Free Coalition - Newton County



*Indiana Dunes National Park*



Franciscan HEALTH
Rensselaer

The Community Health Needs Assessment explores population demographics, social and economic well-being, and health within the community. A 3-year Community Health Improvement Plan is proposed for the region served by Franciscan Health Rensselaer.

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