FRANCISCAN HEALTHCARE - MUNSTER

COMMUNITY HEALTH NEEDS ASSESSMENT

2012-2013

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EXECUTIVE SUMMARY

The Community Health Needs Assessment (CHNA) is designed to provide an understanding of the current health status and needs of the residents of the Franciscan Healthcare – Munster (FHM) campus primary service area (PSA). This service area includes portions of Lake County, Indiana and Cook County, Illinois. The information and findings from the CHNA were used to prioritize the identified needs and how to plan and act upon these health needs. The CHNA also recognizes community strengths, assets and resources to address these needs.

Beyond the educational and informative aspect, the CHNA is a newly required legal document for tax-exempt health care organizations around the country in order to be compliant with new Patient Protection and Affordable Care Act of 2010 (PPACA).

In order to better understand the health needs of the community and population FHM serves, there was substantial primary and secondary research. This CHNA incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research through a survey produced by the CHNA Advisory Committee and secondary research (vital statistics, Healthy Communities Institute (HCI) and other existing health-related data). These quantitative components allow for comparison to benchmark data against state and national levels. Interviews of opinion-leaders in the community also allowed for input from specific fields and interests to help shape and support primary and secondary research.

Physical health issues including affordability and access to health, substance abuse, and access to healthy food and wellness programs can be linked to a variety of social issues including unavailability of jobs, poverty, and transportation issues. The main findings from primary and secondary research show:

- The number one cause of death in our PSA is Major Cardiovascular disease.
- High rates of hospitalizations due to congestive heart failure.
- Cancer is the second cause of all mortality in our PSA.
- High Rates of ER and Hospitalizations due to poor respiratory health especially due to asthma (in both children and adults)
- High Rates of ER and Hospitalization due to diabetes.
- High rates for low birth weights and pre-term birth deaths.
- High rates and population percentage of adult obesity.
- High percentage of adults who smoke.
- High Rate of preventable Hospital Stays

The findings from the CHNA have helped to identify the priorities on which Franciscan Healthcare - Munster will focus their efforts. These priorities include:

- Colon cancer
- Diabetes

INTRODUCTION

In the spring of 2012, Franciscan Healthcare – Munster (FHM) embarked on a comprehensive Community Needs Assessment (CHNA) process to identify and address the key health issues for our community.

FHM, based in Munster, Indiana, is a not-for-profit, 62 licensed bed hospital with 274.5 full time employees serving Lake County, Indiana and portion of Cook County, IL. FHM is part of Franciscan Alliance, a 13 hospital Catholic system based in Mishawaka, IN. FHM provides service primarily to residents of the central part of Lake County, but also serves those in neighboring cities and towns. FHM is accredited by Healthcare Facilities Accreditation Program (HFAP).

The doctors and employees of Franciscan Healthcare - Munster, along with other Franciscan Alliance hospitals, work to live our hospital's mission: "Continuing Christ's Ministry in Our Franciscan Tradition". In following our mission we live and work by a set of common values that include respect for life, fidelity to our mission, compassionate concern, joyful service and Christian stewardship. FHM provides the following services:

- Breast Health
- Cancer Care
- Colon and Rectal Surgery
- Diabetes Care
- Ear, Nose and Throat
- Employee Assistance Program
- Heart & Vascular
- Hospitalists
- Imaging
- Interventional Radiology
- Laboratory Services
- Mammography
- Nuclear Medicine
- Orthopedics
- Outpatient Services
- Palliative Medicine
- Primary Care Physicians
- Pulmonary Medicine
- Respiratory Care
- Stroke Care
- Surgical Services
- Wound Care

PURPOSE

The purpose of the Community Health Needs Assessment (CHNA) is to provide an understanding of the current health status and needs of the FHM service area. This information will be used to prioritize the identified needs, and to plan and act upon these health needs. The CHNA will also recognize community strengths, assets and potential resources to address those needs.

Beyond the educational and informative aspect - the CHNA is a new legal requirement for tax-exempt health care organizations around the country. The CHNA must be conducted in order to be compliant with new Affordable Care Act (ACA) requirements. The Internal Revenue Service (IRS) has drafted guidelines of what must be included in the assessment. These guidelines state a community health needs assessment must:

- Be conducted every three years.
- Take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health.
- Be made widely available to the public.
- Adopt an implementation strategy to meet the community health needs identified through the assessment.

- Report how addressing the needs identified in the CHNA and a description of needs that are not being addressed with the reason why such needs are not being addressed.

The community survey and focus group aspects of this assessment were conducted on behalf of FHM by Professional Research Consultants, Inc. (PRC). PRC is a nationally-recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments such as this in hundreds of communities across the United States since 1994. The PRC community survey work on this CHNA was done in collaboration with Community Healthcare System and Methodist Hospital, two other area hospital systems.

GOALS AND OBJECTIVES

The objectives of this CHNA are to:

1. Develop a comprehensive profile of health status, quality of care, and care management indicators overall and by county for those residing within the FHM primary service area.
2. Identify the priority health needs (public health and healthcare) within the FHM primary service area.
3. Serve as a foundation for developing subsequent detailed recommendations on implementation strategies that can be utilized by healthcare providers, communities and policy makers in order to improve the health status of persons residing in the FHM primary service area.
4. Supply public access to the CHNA results in order to inform the community and provide assistance to those invested in the transformation to the community's healthcare network
5. Improve access to health services, enhance population health, advance general knowledge and relieve or reduce the burden of government to improve health of persons living in the FHM primary service area.

This CHNA is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in Lake County and the primary service area of FHM. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment provides the information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status. This Community Health Needs Assessment will serve as a tool toward reaching three basic goals:

- **To improve residents' health status, increase their life spans, and elevate their overall quality of life**. A healthy community is not only one where its residents suffer little from physical and mental illness, but also one where its residents enjoy a high quality of life.

- **To reduce the health disparities among residents.** By gathering demographic information along with health status and behavior data, it will be possible to identify population segments that are most at-risk for various diseases and injuries. Intervention plans aimed at targeting these individuals may then be developed to combat some of the socio-economic factors which have historically had a negative impact on residents' health.

- **To increase accessibility to preventive services for all community residents.** More accessible preventive services will prove beneficial in accomplishing the first goal (improving health status, increasing life spans, and elevating the quality of life), as well as lowering the costs associated with caring for late-stage diseases resulting from a lack of preventive care.

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METHODOLOGY

This assessment incorporates data from both quantitative and qualitative sources. Quantitative and qualitative data are found in the primary research data (the PRC Community Health Survey) and quantitative data are found in secondary research (vital statistics and other existing health-related data); these quantitative components allow for trending and comparison to benchmark data at the state and national levels. Qualitative data input includes primary research gathered through a series of Key Informant Focus Groups.

Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by FHM and PRC.

Sample Approach & Design

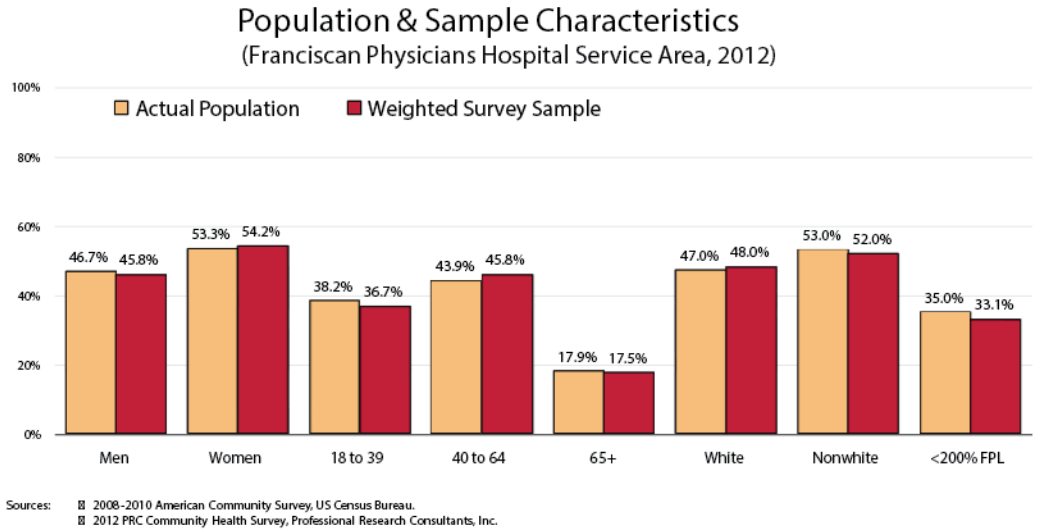
A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the *PRC Community Health Survey*. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology — one that incorporates both landline and cell phone interviews — was employed. The primary advantages of telephone interviewing are timeliness, efficiency and random-selection capabilities.

The sample design used for this effort consisted of a random sample of 825 individuals age 18 and older in the FHM service area. All administration of the surveys, data collection and data analysis was conducted by Professional Research Consultants, Inc. (PRC).

The complete PRC Community Survey and Focus Group report can be reviewed by using this link:

http://www.franciscanalliance.org/community/community-needs-assessment/Documents/2012_PRC_CHNA_Report-FPH.pdf

The following charts outline the characteristics of the FHM service area sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child's healthcare needs, and these children are not represented demographically in this chart.]



Further note that the poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household *(e.g., the 2012 guidelines place the poverty threshold for a family of four at $23,050 annual household income or lower)*.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

KEY INFORMANT FOCUS GROUPS

As part of the community health needs assessment, five focus groups were held on November 27 and 28, 2012, comprised of 44 key informants in the community, including: physicians; other health professionals; employers; social service providers, and other community leaders.

A list of recommended participants for the focus groups was provided by the sponsors. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall. Participants included several individuals who work with low-income, minority or other medically underserved populations, and those who work with persons with chronic disease conditions.

NOTE: These findings represent qualitative rather than quantitative data. The groups were designed to gather input from participants regarding their opinions and perceptions of the health of the residents in the area. Thus, these findings are based on perceptions, not facts.

FRANCISCAN HEALTHCARE – MUNSTER

COMMUNITY HEALTH NEEDS ASSESSMENT STEERING COMMITTEE MEMBERS

To guide the CHNA process and to assess survey and other data research results, a Steering Committee was formed. This Committee, with assistance from the FHM Mission Committee addressed the needs that would be addressed in this CHNA initiative.

Barb Greene
President, Franciscan Healthcare - Munster

Tracey Franovich
Vice President, Franciscan Healthcare - Munster

Dr. Alexander Stemer
President, Franciscan Medical Specialists

John Kessler
Regional VP Mission Services and NWI CHNA Coordinator

Dr. T. Gopan
Endocrinologist, Franciscan Medical Specialists

Dr. Jean Kim
Endocrinologist, Franciscan Hammond Clinic

Dr. Alan Auerbach
Gastroenterologist, Franciscan Hammond Clinic

Dr. James Cantorna
Internist, Franciscan Medical Specialists

Lucy W. Cole, MA, RD, CDE, ACE cpt, CD
Diabetes Program Administrator and Educator

Theresa Henderson
Endoscopy Manger, Franciscan Healthcare – Munster

Colleen Zubeck
Marketing Director, CHNA Team Coordinator

Natalie Reisen
Marketing Coordinator, CHNA Team Coordinator

If you would like more information or have questions regarding the Community Health Needs Assessment, please call Natalie Reisen at 219-922-5534

PUBLIC HEALTH, VITAL STATISTICS & OTHER DATA

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Centers for Disease Control & Prevention
- GeoLytics Demographic Estimates & Projections
- Indiana State Department of Health
- National Center for Health Statistics
- US Census Bureau
- US Department of Health and Human Services
- US Department of Justice, Federal Bureau of Investigation

Note that secondary data reflect county-level data (Lake County, Indiana).

Benchmark Data

Indiana Risk Factor Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data are reported in the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trend Data* published by the Centers for Disease Control and Prevention and the US Department of Health & Human Services. State-level vital statistics are also provided for comparison of secondary data indicators.

Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2011 PRC National Health Survey*; the methodological approach for the national study is identical to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

Healthy People 2020

Healthy People 2020 is a widely recognized source of information which provides science-based, 10-year national objectives for improving the health of all Americans. The Healthy People initiative is grounded in the principle that setting national objectives and monitoring progress can motivate action. For three decades, Healthy People has established benchmarks and monitored progress over time in order to:

- Encourage collaborations across sectors.
- Guide individuals toward making informed health decisions.
- Measure the impact of prevention activities.

Healthy People 2020 is the product of an extensive stakeholder feedback process that is unparalleled in government and health. It integrates input from public health and prevention experts, a wide range of federal, state and local government officials, a consortium of more than 2,000 organizations, and perhaps most importantly, the public. More than 8,000 comments were considered in drafting a comprehensive set of Healthy People 2020 objectives.

INFORMATION GAPS

While this Community Health Needs Assessment is quite comprehensive, FHM recognized that it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups—such as homeless, institutionalized persons, or those who only speak a language other than English or Spanish—are not represented in the survey data. Other population groups might not be represented in numbers sufficient for independent analyses.
In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly some medical conditions that are not specifically addressed.

VULNERABLE POPULATIONS

The CHNA analysis and report yielded a wealth of information about the health status, behaviors and needs for our population. A distinct advantage of the primary quantitative (survey) research is the ability to segment findings by geographic, demographic and health characteristics to identify the primary and chronic disease needs and other health issues of vulnerable populations, such as uninsured persons, low-income persons, and racial/ethnic minority groups.

PUBLIC DISSEMINATION

This Community Health Needs Assessment is available to the public at www.franciscanalliance.org/community

In addition, Franciscan Alliance recently purchased the Healthy Communities Institute (HCI) web-based product that measures community health, shares best practices, identifies new funding sources, compares actual performance to Healthy People 2020 Goals and, supports improved community health. HCI is a nationally recognized organization (recent winner of the Best Community Health Application) that serves the informational needs of the community health sector nationally. It aggregates national, state and county information into one convenient site for easy access and review. This can be found at the following link for each of the hospitals and their specific service areas within the Franciscan Alliance system: http://www.franciscanalliance.org/community/community-needs-assessment/Pages/default.aspx

This site:

- Informs readers that the CHNA Report is available and provides instructions for downloading it;
- Offers the CHNA Report document in a format that, when accessed, downloaded, viewed, and printed in hard copy, exactly reproduces the image of the report;
- Grants access to download, view, and print the document without special computer hardware or software required for that format (other than software that is readily available to members of the public without payment of any fee) and without payment of a fee to the hospital organization or facility or to another entity maintaining the website.

COLLABORATING ENTITIES

As previously described, the PRC Community survey and Focus Groups was the consequence of collaboration among FHM (and other Franciscan Alliance hospitals in the region) and Community Healthcare System and Methodist Hospitals – all serving in contiguous or overlapping markets.

Existing Health and Social Service Organizations

Hospitals

- Pinnacle Hospital – Merrillville
- Methodist Hospital – Merrillville
- Franciscan St. Margaret Health – Dyer
- Franciscan Healthcare - Munster – Munster
- Franciscan St. Margaret Health - Hammond
- Community Healthcare – Munster

Home Health

- Franciscan Home Health
- St. Margaret Home Care

Long Term Care

- St. Anthony Home
- Hartsfield Village
- Wittenburg Village
- Chicagoland Christian village

Mental and Behavioral Health

- Samaritan Counseling Center
- Regional Mental Health Center
- Franciscan St. Margaret Health
- Edgewater Systems for Balanced Living
- Alcoholics Anonymous

Community and Social Service

- American Red Cross
- Boys and Girls Clubs
- YMCA
- Brothers' Keepers Shelter
- Caring Place
- Catholic Charities
- United Way
- Lake County Health Department
- Lutheran Social Services of Indiana

The above organizations represent resources that now address a number of the identified concerns in this CHNA and which have the potential to address community health concerns in collaborative ways – a direction FHM supports.

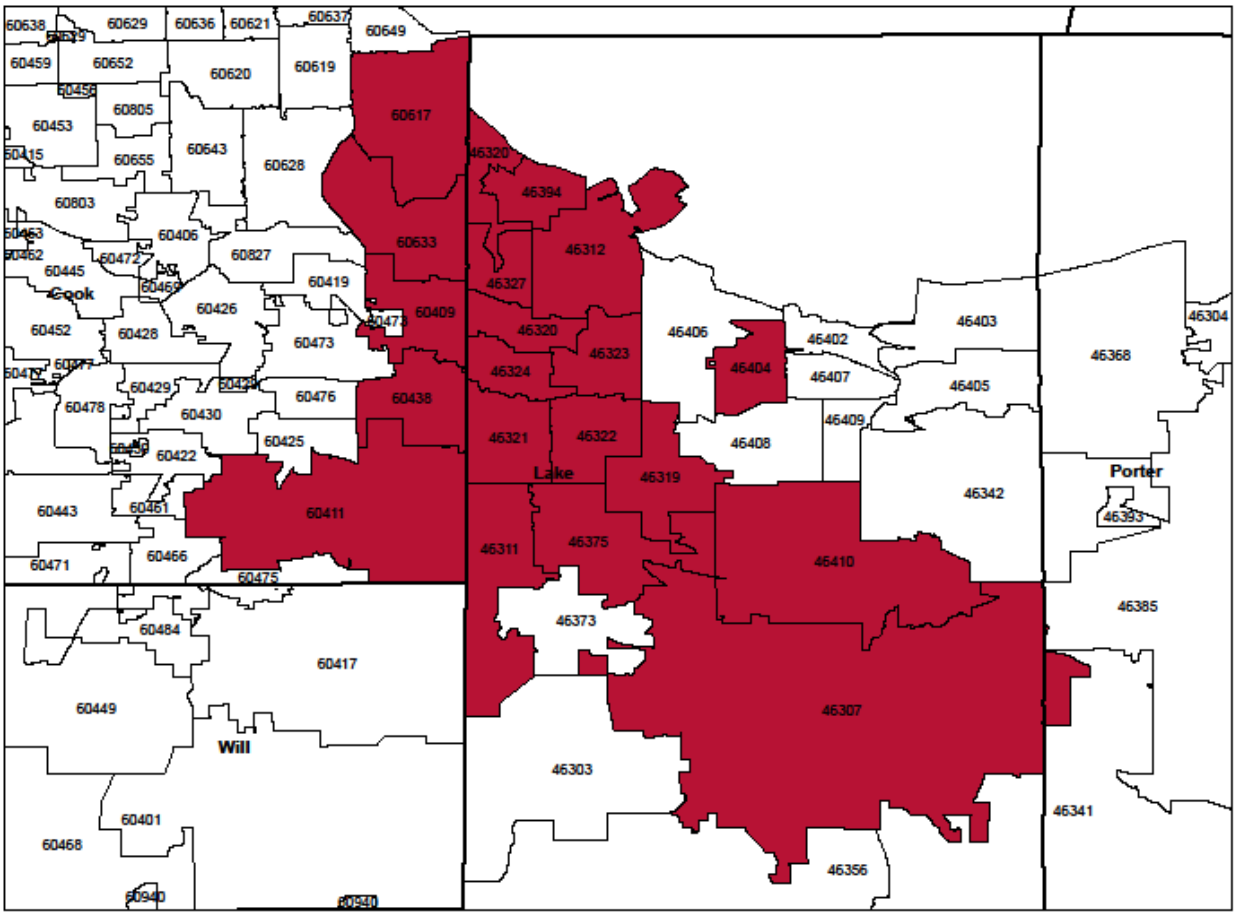
CHNA COMMUNITY DEFINITION

FHM's community, as defined for the purposes of the Community Health Needs Assessment, includes portion of Lake County, Indiana and Cook County, Illinois, specifically, the zip codes in the following table. These zip codes comprise FHM primary service area (PSA). PSA is determined by the zip codes that make up 75% of inpatient volume.

PRIMARY SERVICE AREA

ZIP Code	City	County	% of inpatient volume
46324	Hammond	Lake	8.4%
46321	Munster	Lake	6.4%
46322	Highland	Lake	5.6%
60438	Lansing	Cook	4.9%
60409	Calumet City	Cook	4.9%
46323	Hammond	Lake	4.5%
46394	Whiting	Lake	4.2%
46311	Dyer	Lake	4.0%
46312	East Chicago	Lake	3.6%
46319	Griffith	Lake	3.5%
46320	Hammond	Lake	3.5%
46408	Gary	Lake	3.5%
46375	Schererville	Lake	3.4%
46404	Gary	Lake	3.0%
46307	Crown Point	Lake	2.8%
60411	Chicago Heights	Cook	2.7%
60617	Chicago	Cook	2.4%
46410	Merrillville	Lake	2.3%
46327	Hammond	Lake	2.2%

GEOGRAPHIC VIEW OF PRIMARY SERVICE AREA



DEMOGRAPHICS OF THE COMMUNITY

The demographic information presented in the table below is for the PSA for FHM. [1]

Demographics Expert 2.7
2013 Demographic Snapshot
Area: FHM-PSA 2012
Level of Geography: ZIP Code

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA
2010 Total Population	567,712	308,745,538
2013 Total Population	566,840	314,861,807
2018 Total Population	566,618	325,322,277
% Change 2013 - 2018	0.0%	3.3%
Average Household Income	$54,648	$69,637

	2013	2018	% Change
Total Male Population	271,356	271,948	0.2%
Total Female Population	295,484	294,670	-0.3%
Females, Child Bearing Age (15-44)	113,007	110,725	-2.0%

POPULATION DISTRIBUTION

	Age Distribution				
Age Group	2013	% of Total	2018	% of Total	USA 2013 % of Total
0-14	119,482	21.1%	116,890	20.6%	19.6%
15-17	26,659	4.7%	24,977	4.4%	4.1%
18-24	54,658	9.6%	55,574	9.8%	10.0%
25-34	69,111	12.2%	67,837	12.0%	13.1%
35-54	148,494	26.2%	141,007	24.9%	26.9%
55-64	69,859	12.3%	73,177	12.9%	12.4%
65+	78,577	13.9%	87,156	15.4%	13.9%
Total	566,840	100.0%	566,618	100.0%	100.0%

HOUSEHOLD INCOME DISTRIBUTION

	Income Distribution		
2013 Household Income	HH Count	% of Total	USA % of Total
<$15K	34,128	16.3%	13.8%
$15-25K	28,311	13.5%	11.6%
$25-50K	57,353	27.4%	25.3%
$50-75K	40,283	19.2%	18.1%
$75-100K	23,587	11.2%	11.7%
Over $100K	26,023	12.4%	19.5%
Total	209,685	100.0%	100.0%

EDUCATION LEVEL

	Education Level Distribution		
2013 Adult Education Level	Pop Age 25+	% of Total	USA % of Total
Less than High School	22,229	6.1%	6.2%
Some High School	32,517	8.9%	8.4%
High School Degree	124,440	34.0%	28.4%
Some College/Assoc. Degree	114,481	31.3%	28.9%
Bachelor's Degree or Greater	72,374	19.8%	28.1%
Total	366,041	100.0%	100.0%

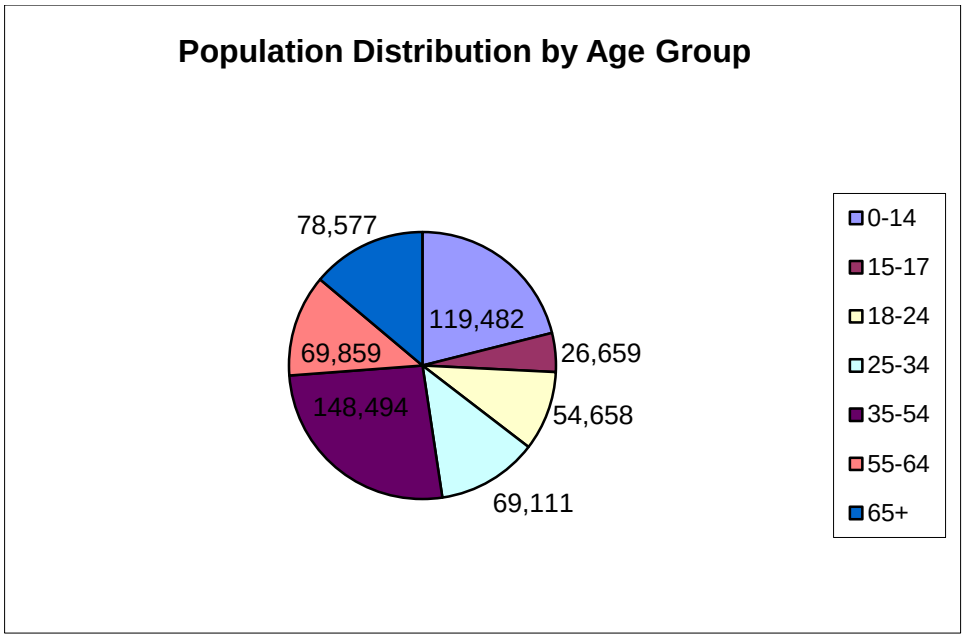
RACE/ETHNICITY

	Race/Ethnicity Distribution		
Race/Ethnicity	2013 Pop	% of Total	USA % of Total
White Non-Hispanic	226,495	40.0%	62.3%
Black Non-Hispanic	194,824	34.4%	12.3%
Hispanic	130,040	22.9%	17.3%
Asian & Pacific Is. Non-Hispanic	6,720	1.2%	5.1%
All Others	8,761	1.5%	2.9%
Total	566,840	100.0%	100.0%

The population of the hospital's PSA is estimated at 566,840 people. The race/ethnicity mix in the PSA is non-Hispanic White (40.0%), non-Hispanic Black (34.4%) and Hispanic (22.9%). The population of the PSA is concentrated in the western portion of Lake County, Indiana and eastern portion of Cook County, Illinois. Within the total PSA, 64.6 % of the population is ages 25+ and 29.8% of the population is below the poverty line. [1] The communities of Hammond and Munster, Indiana represent 21.5% of the hospital's PSA. Of that 21.5%, Hammond accounts for 15.4% of the PSA.

Hammond is a city located in Lake County, Indiana. The latest census (2010) reported a population of 80,830, a decline of 27.7% from the population peak of 111,698 reported in the 1960 US Census. [2] Hammond is a diverse community with many different races and ethnicities represented. Approximately 59% of the population identifies itself as non-Hispanic White. Thirty four and one tenth percent of the population is Hispanic and 22.5% is non-Hispanic Black. Nearly 22.1% of the population is below the poverty line and face the many challenges of widespread poverty and unemployment. [3]

The Town of Munster, while relatively close to Hammond, is a substantially different community. Munster is also located in Lake County, Indiana. The population of Munster is 23,603 according to the 2010 US Census. Almost 86% of the population is non-Hispanic White. About 5.9% of the population lives below the poverty line. [3]


Population Distribution by Age Group
78,577
119,482
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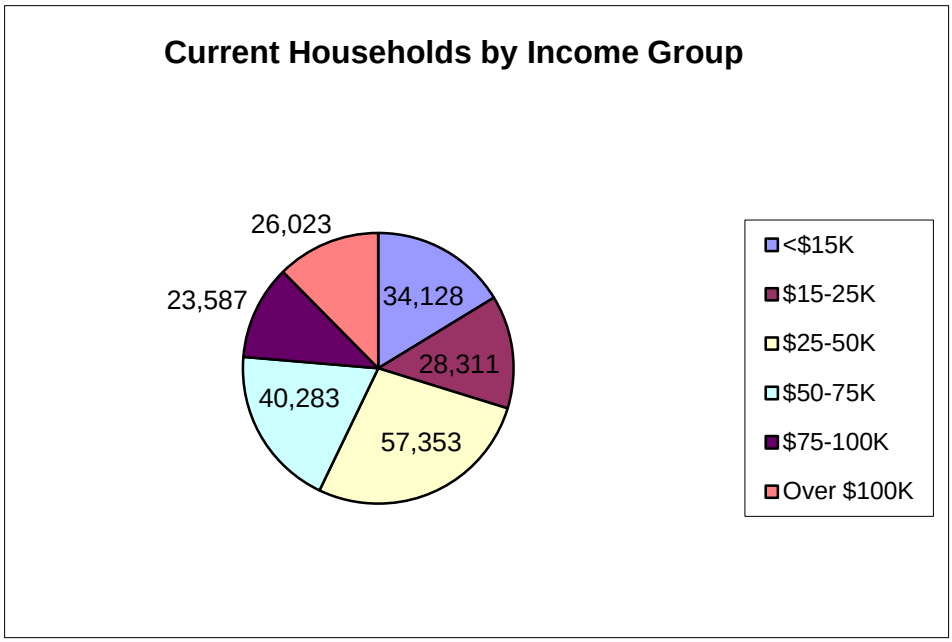
55-64
65+


Current Households by Income Group
26,023
23,587
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57,353
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$50-75K
$75-100K
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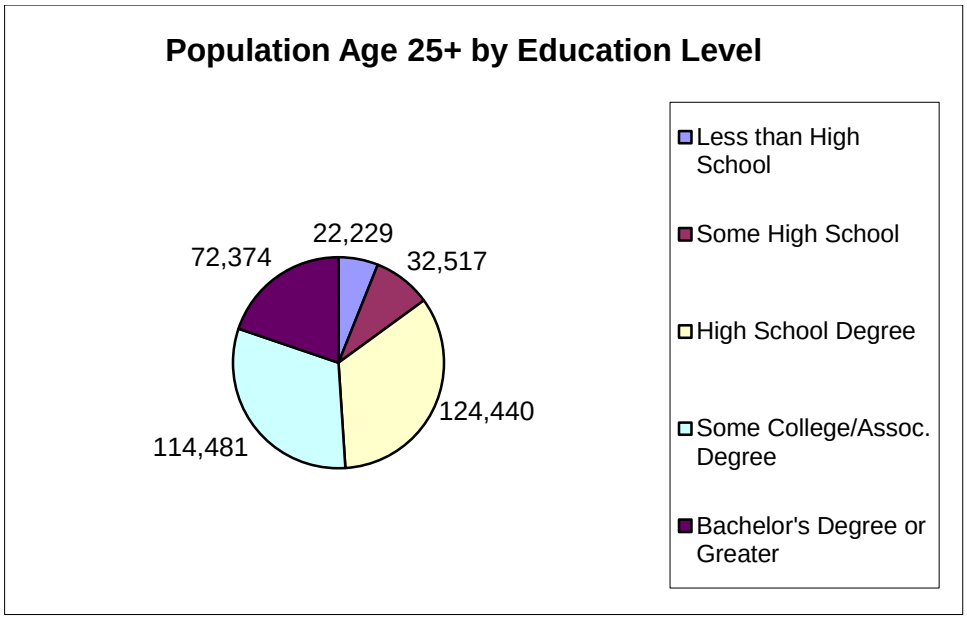
Population Age 25+ by Education Level
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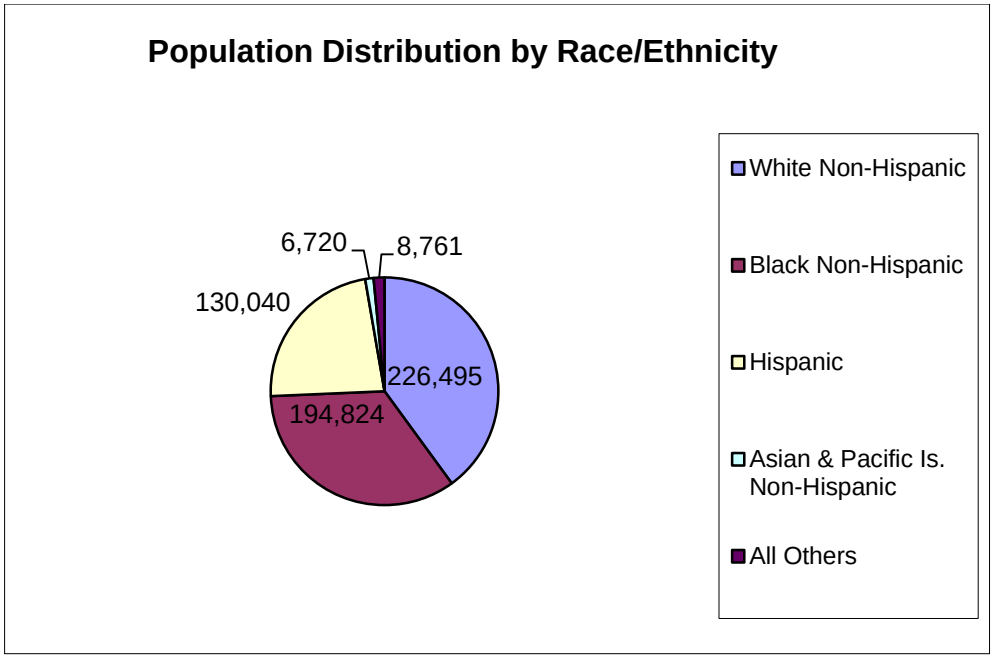
Bachelor's Degree or Greater


Population Distribution by Race/Ethnicity
6,720
8,761
130,040
226,495
194,824
White Non-Hispanic
Black Non-Hispanic
Hispanic
Asian & Pacific Is. Non-Hispanic
All Others

AREAS OF OPPORTUNITY FOR COMMUNITY HEALTH IMPROVEMENT

The following "health priorities" represent recommended areas of intervention, based on the information gathered through this Community Health Needs Assessment and the guidelines set forth in *Healthy People 2020*. From these data, opportunities for health improvement exist in the region with regard to the following health areas (see also the summary tables presented in the following section). These areas of concern are subject to the discretion of area providers, the steering committee, or other local organizations and community leaders as to feasibility vs. actionability and priority.

Areas of Opportunity Identified Through This Assessment	

Access to Health Services	• Difficulty Accessing Healthcare
	• Barriers to Healthcare
	  ○ *Inconvenient Office Hours*
	  ○ *Transportation to Doctor's Office*
	• Top Focus Group Concern
	  ○ *Barriers to Access (Health Literacy; Poverty; Insurance Issues; Cost of Care; Medicaid; Hours of Operation; Use of the ER; Transportation; Language)*
	  ○ *Need for a Local Trauma Center*

Cancer	• Cancer Death Rate
Chronic Kidney Disease	• Kidney Disease Death Rate
Diabetes	• Diabetes Mellitus Death Rate • Prevalence of Diabetes
Family Planning	• Teen Births
Heart Disease & Stroke	• Heart Disease Death Rate • Stroke Death Rate
Injury & Violence Prevention	• Firearm-Related Death Rate • Homicide Rate • Crime Victimization
Maternal, Infant & Child Health	• Low Birthweight • Infant Mortality

Mental Health & Mental Disorders	• Top Focus Group Concern
	  ○ *Inadequate Treatment Options*
	  ○ *Self-Medication (See Also "Substance Abuse")*
	  ○ *Stigma*

Nutrition, Physical Activity & Weight Status	• Fruit/Vegetable Consumption
	• Prevalence of Obesity (Adults)
	• Prevalence of Obesity (Children)
	• Top Focus Group Concern
	  ○ *Lack of Nutrition & Physical Activity*
	  ○ *Cost of Healthy Foods*
	  ○ *Food Deserts*
	  ○ *Education*

Oral Health	○ Recent Dental Visits

Substance Abuse	• Top Focus Group Concern
	  ○ *Prevalence of Drug Use*
	  ○ *Easy Access/Parental Complacency*
	  ○ *Limited Treatment Programs*
	  ○ *Inadequate Funding*

Tobacco Use	• Current Smokers

TOP COMMUNITY HEALTH CONCERNS AMONG COMMUNITY KEY INFORMANTS

At the conclusion of each key informant focus group, participants were asked to write down what they individually perceive as the top five health priorities for the community, based on the group discussion as well as on their own experiences and perceptions. Their responses were collected, categorized and tallied to produce the top-ranked priorities as identified among key informants. These should be used to complement and corroborate findings that emerge from the quantitative dataset.

1. Access to Healthcare Services, Including Transportation

Mentioned resources available to address this issue: Gary Public Transportation Corporation; Medicaid/Medicare; Ambulance Services; Cab Service; Health Clinics; NorthShore Health Centers; Catherine McAuley Clinic; Walgreens; CVS; Townships; Federally Qualified Health Centers; Northwest Indiana Regional Planning; Urgent Care Facilities; Dental Clinics; Health Visions Midwest; St. Catherine Hospital.

2. Health Education & Prevention

Mentioned resources available to address this issue: Health Department; Schools; Universities; Social Service Agencies; Employers; Faith-Based Organizations; Literacy Coalition.

3. Obesity

Mentioned resources available to address this issue: Primary Care Providers; Hospitals: Community Gardens; Public Walk/Bike Trails; Health Clinics; Schools; Fitness Clubs; YMCA; YWCA; United Way Agencies; Social Service Agencies; Faith-Based Organizations; Recreation Departments; Healthy Families; St. Mary Medical Center; Dieticians.

4. Substance Abuse

Mentioned resources available to address this issue: Reformers Unanimous Home in Hammond; Social Service Agencies; Regional Medical Center; Porter Starke Services; Edgewater Systems for Balanced Living; United Way Support Groups; Alcoholics Anonymous Groups; The Villages in Northwest Indiana; Regional Medical Center; St. Catherine Hospital

5. Mental Health

Mentioned resources available to address this issue: Hospitals; Community Mental Health Centers; Social Service Agencies; Lake County Jail; Porter Starke Services; Edgewater Systems for Balanced Living; Indiana University; Regional Medical Center; Private Practitioners.

PRIORITIZATION PROCESS

The CHNA Advisory Committee met to consider all of the CHNA information developed and to determine the health needs to be addressed for FY2014-FY2016. The committee reviewed the detailed results, existing services available through other healthcare facilities, and health needs being addressed by local hospitals through CHNA. In acknowledging the wide range of priority health issues that emerged from the CHNA process, FHM determined that it could effectively focus on those which it deemed most pressing, most under-addressed, and most within its ability to influence. The following criteria were used also in making the decision:

Criteria

- *Magnitude* - The number of persons affected, also taking into account variance from benchmark data and Healthy People targets.
- *Impact/Seriousness* - The degree to which the issue affects or exacerbates other quality of life and health-related issues.
- *Feasibility* - The ability to reasonably impact the issue, given available resources.
- *Consequences of Inaction* - The risk of not addressing the problem at the earliest opportunity.

INTEGRATION WITH OPERATIONAL PLANNING

Community Benefit Planning is a part of FHM's approach to operations and strategic planning. The CHNA Report and Strategic implementation Plan will be made an integral part of the FHM Operational and Strategic Plans to assure continuity of practices already in place.

HEALTH PRIORITIES SELECTED

In consideration of the top health priorities identified through the CHNA process – and taking into account hospital resources and overall alignment with the hospital's mission, goals and strategic priorities – it was determined that FHM would focus on developing and/or supporting strategies and initiatives to improve:

- **Diabetes**
- **Colon Cancer**

HEALTH PRIORITIES NOT SELECTED

In acknowledging the wide range of priority health issues that emerged from the CHNA process, FHM determined that it could only effectively focus on those which it deemed most pressing, most under-addressed, and most within its ability to influence. Additionally, of the many areas of need our CHNA identifies, needs associated with employment, transportation, public education, air quality, crime and other such issues are outside of our area of funding, knowledge, purpose or expertise and therefore were not considered.

- **Access to Care** – FHM provides substantial care to adults without health insurance through our charity care policies. Sister hospitals within the region operate primary care clinics for low income

populations and, the problem is largely a matter of public policy (which the Affordable Care Act is addressing to some degree) and thus, beyond our capability. An exception to this is the possibility to improve access by targeted populations with specific health needs to very specific services.

- **Preventable Hospitalizations** - are being addressed by our participation in the Franciscan Alliance Accountable Care Organization program plus efforts at targeted conditions to reduce readmissions are focusing on this need.

- **Maternal and Child Health** - FHM does not offer obstetrics services nor pediatric care and we thus, do not have many of the resources necessary for leading such efforts, therefore we will not address maternal and child health, however, many of our sister hospitals in our system and in the area address this need.

- **Adult Immunizations** – It was felt that more pressing health needs existed. Limited resources and lower priority excluded this as an area chosen for action. Physician offices, pharmacies and other groups are very active in providing immunizations.

- **Asthma** - Because of the complexity and the need for a systemic and multi-disciplinary approach this need was not selected. It is the intention of FHM, Franciscan Medical Specialists and Franciscan Hammond Clinic to explore opportunities to increase access to asthma health through the creation of an Asthma Clinic. Our desire is to partner with other constituents that are working on interventions to address these community health needs.

- **Health Education** – It was felt that more pressing health needs other than broad based patient education existed. There is some belief that education material is reasonably accessible and that the problem is how to motivate more people to act on that information. More important, we say this is not a selected priority because the diabetes education and self management and colon health and screening have emphasis on patient education within the core program areas.

- **Substance Use (including tobacco)** – There are a number of other sources of assistance for the these conditions and it was felt that the specialized expertise of FHM that other organizations do not have is better applied to conditions for which others have fewer resources.

- **Oral Health** – FHM does not have resources or expertise appropriate to this need.

- **Nutrition, Physical Activity and Weight Loss** – These concerns will be a part of the diabetes program FHM is implementing and are concerns that are addressed in the care of all patients at FHM. Other organizations address these concerns in various sectors of the community and education sectors.

- **Mental Health** – FHM does not have services or expertise in this area whereas a sister hospital does provide these services in our primary service area. Additionally, there are other organizations in the area that address this need.

- **Heart Disease and** Stroke – FHM sister hospitals are addressing these needs through their CHNA efforts and FHM addresses these needs through its ongoing clinical programs in heart and cardiovascular disease.

- **Teen Births** – FHM does not offer childbirth obstetric services and is thus, limited in its resources. FHM sister hospitals offer obstetric services as well as services targeting specifically at teen pregnancies and related issues.

- **Chronic Kidney Disease** – Many of the concerns of this condition will be addressed in the diabetes program being implemented. FHM does not have a dialysis program or other service elements important to this need.

The identified needs and the specific plans to address them are described in the Implementation Plan that follows.

Reference:

1. 2013 The Nielsen Company, Truven Health Analytics Inc.
2. http://www.stats.indiana.edu/population/PopTotals/historic_counts_cities.asp
3. http://quickfacts.census.gov

Franciscan HEALTHCARE
Munster

FY2014-FY2016 Implementation Strategy

This summary outlines Franciscan Healthcare – Munster's plan (Implementation Strategy) to address our community's health needs by 1) sustaining efforts operating within a targeted health priority area; 2) developing new programs and initiatives to address identified health needs; and 3) promoting an understanding of these health needs among other community organizations and within the public itself. Franciscan Healthcare – Munster is participating in the Accountable Care Organization (ACO) formed by Franciscan Alliance. The ACO is a model designed to improve patient care, reduce medical costs and enhance the delivery of health care and will be active during the CHNA implementation period of 2014-2016. Being part of the ACO has brought a greater focus on a number of health issues which has influenced the priority selection process for Franciscan Healthcare – Munster.

Prioritization Process

After reviewing the Community Health Needs Assessment findings, the CHNA Steering Committee met to review the health needs to be prioritized for action in FY2014-FY2016. During the detailed presentation of the CHNA findings, steering committee members and Senior Management were guided through a process of understanding key local data findings (Areas of Opportunity) and ranking identified health issues against the following established, uniform criteria:

- **Magnitude.** The number of persons affected, also taking into account variance from benchmark data and Healthy People targets.

- **Impact/Seriousness.** The degree to which the issue affects or exacerbates other quality of life and health-related issues.

- **Feasibility.** The ability to reasonably impact the issue, given available resources.

- **Consequences of Inaction.** The risk of not addressing the problem at the earliest opportunity.

- **Existing programs or organizations addressing the issue**. Whether or not there are other organizations or entities with programs that specifically address the issue in our service area and

whether or not Franciscan Healthcare – Munster serves as a partner with other organizations in addressing the issue.

Identified Priorities of Community Health Improvement

The following "health priorities" represent recommended areas of intervention, based on the information gathered through this Community Health Needs Assessment which is supported by the findings of Healthy Communities Institute and PRC and the guidelines set forth in Healthy People 2020. We have chosen to focus on at-risk populations within our service area realizing that they are the most vulnerable and we are using a "pilot" approach in which a smaller, more manageable, number of participants will be the focus and the overall goal will be to determine if such an approach can be expanded to have greater community impact.

From these data, opportunities for health improvement exist in the region with regard to the following health areas:

Areas of Opportunity Identified Through This Assessment

Medical Priorities	
Colon Cancer	Cancer deaths and increase in incidence (colon)
Adult Immunizations	High ER rate due to Immunization-Preventable Pneumonia and Influenza
Asthma	High ER and Hospitalization rates for both adults and children
Diabetes	Increasing percent of adults diagnosed with Diabetes
	High ER and hospitalization rates due to complications
Health Information Sources	

Healthy Living Education	Limited source of healthcare information from other sources than family physician.

Alignment with Community Partners

It is in FHM's best interest to align our priorities with other entities in the area in order to better address these issues. The table below presents this alignment with Community Partners in the area.

Integration With Strategic and Operational Planning [IRS Form 990, Schedule H, Part V, Section B, 6e]

Health Priorities Not Chosen for Action	*Reason*

Beginning in 2011, Franciscan Healthcare – Munster included a Community Benefit section within its Strategic Plan and operational planning documents.

Priority Health Issues That Will Not Be Addressed & Why [IRS Form 990, Schedule H, Part V, Section B, 7]

Adult Immunizations	*Advisory committee members felt that more pressing health needs existed. Limited resources and lower priority excluded this as an area chosen for action. Physician offices, pharmacies and other groups are very active in providing immunizations.*
Asthma	*Because of the complexity and the need for a systemic and multi-disciplinary approach this need was not selected. It is the intention of Franciscan Healthcare – Munster, Franciscan Medical Specialists and Franciscan Hammond Clinic to explore opportunities to increase access to asthma health through the creation of an Asthma Clinic. Our desire is to partner with other constituents that are working on interventions to address these community health needs.*
Health Education	*Advisory committee members felt that more pressing health needs other than broad based patient education existed. There is some belief that education material is reasonably accessible and that the problem is how to motivate more people to act on that information. More important, we say this is not a selected priority because the diabetes education and self management and colon health and screening have emphasis on patient education within the core program areas.*

In acknowledging the wide range of priority health issues that emerged from the CHNA process, Franciscan Healthcare – Munster determined that it could only effectively focus on those which it deemed most pressing, most under-addressed, and most within its ability to influence. Additionally, of the many areas of need our CHNA indentifies, employment and transportation issues are outside of our area of expertise therefore were not considered.

Implementation Strategies & Action Plans [IRS Form 990, Schedule H, Part V, Section B, 6f-6h]

The following outlines Franciscan Healthcare – Munster's plan to address those priority health issues chosen for action in the FY2014-FY2016 period. The CHNA Steering Committee will manage and direct executive responsibility and has appointed teams for each prioritized need. These teams will engage key community partners and implement evidence based strategies across the designated at-risk areas. The selected at-risk areas, Diabetes Education & Self Management and Colon Health & Screening, represent a current area of community need in which the hospital has acknowledged competencies and expertise and are supported by organizational resources that ensure we have the systems, staff and support to initiate and maintain the program. We understand this Implementation Plan is a "living document" and subject to change and enhancement. Based upon program effectiveness, the steering committee will consider seeking additional participants in the programs and expanding identified service areas.

Diabetes Education & Self Management	
Community Partners	Churches in Hammond Indiana YMCA in Hammond Indiana
Goal	The goal is to improve healthcare access services by providing pre-diabetes, diabetes education and disease self management tools within the high risk Hispanic Adult population. The program will meet the specific needs of the community with regard to language, culture and literacy level.
Outcome Measures	**Short term measure:** develop, write and launch the program to a target group of participants. **Intermediate term measure:** maintain 50% of participant participation. In addition, participants will write a personal health goal. **Long term measure:** increase awareness of the importance of A1C, maintenance of a healthy weight and the importance of diabetic medications. A1C is a common blood test used to gauge how well a diabetic is managing their diabetes. The A1C test result reflects a patient's average blood sugar level for the past two to three months. The

	higher your A1C level, the poorer your blood sugar control and the higher your risk of diabetes complications.
Timeframe	FY2014-FY2016
Scope	This strategy will focus on a targeted at-risk population of adults, ages 35 and greater within the FHM service areas located within the high risk Hispanic adult population within the 46324 zip code. This population was selected due to its significantly high level of diabetes related complications, including ER admissions and death.
Strategies & Objectives	**Strategy #1:** Support the members of the community partners identified above concerning diabetes self-management by incorporating proficient medical staff to provide the education. **Strategy #2:** Identify the appropriate time to provide the education, number of sessions and length of each session. **Strategy #3:** Develop an educational outline, class outlines and goals. Develop handouts or identify class materials. **Strategy #4**: Identify individual support for class education. **Strategy #5:** Continuously review the program in relation to the needs of the participants, knowing that complete re-design is not possible. However, obvious education needs identified will be added to the curriculum.
Financial Commitment	TBD

Anticipated Outcomes	**Short term outcomes, 2014**: Develop and implement program. **Intermediate term outcomes, 2015-2016:** Maintain a 50% participation rate of program participants. In addition, 100% of participants will write a personal health goal. **Long term outcomes, 2016 and beyond:** 50% of the participants will impact one or more of the following factors: increased awareness of the importance of A1C, maintenance of a healthy weight and the importance of diabetic medications.
Results	*TBD*

Colon Health & Screening

Community Partners	Churches in Hammond Indiana YMCA in Hammond Indiana
Goal	The goal is to utilize a multi-component community-based education program and colorectal cancer screening by fecal occult blood test in the high-risk African American adult community. The program will promote awareness of preventable cancer risk factors and increase knowledge of cancer prevention behaviors in a population of un- and/or under screened individuals. The program will meet the specific needs of the community with regard to language, culture and literacy level.
Outcome Measures	**Short term measure:** develop, write and launch the program within the at-risk African American community **Intermediate term measure**: maintain 50% participant participation in education program **Long term measure:** decrease incidence of undetected colon cancer by increasing the number of at-risk participants who report having fecal occult blood test after participating in the program.
Timeframe	FY2014-FY2016
Scope	This strategy will focus on a targeted at-risk population of no more than adults ages 35 and greater within the FHM service areas located within the 46324 zip code. This population was selected due to its significantly high number of patients with undiagnosed colon cancer.
Strategies & Objectives	**Strategy #1:** Support the members of the community partners identified above concerning colon cancer prevention by incorporating proficient medical staff to provide the education. **Strategy #2**: Identify the appropriate time to provide the education, number of sessions and length of each session. **Strategy #3:** Develop an educational outline, class outlines and goals. Develop handouts or identify class materials. **Strategy #4**: Identify at-risk individuals for colorectal cancer screening by fecal occult blood test. Screen, monitor results and refer positive results for further clinical evaluation. **Strategy #5:** Continuously review the program in relation to the needs of the

	community participants to encourage awareness, behavior modification, activities that reduce the risk of developing cancer.
Financial Commitment	TBD
Anticipated Outcomes	**Short term outcome, 2014:** develop, write and launch the program within the at-risk African American community. **Intermediate term outcome, 2015-2016**: maintain 50% participant participation in education program. **Long term outcome, 2016 and beyond:** decrease incidence of undetected colon cancer by increasing the number of at-risk participants who report having fecal occult blood test after participating in the program.
Results	Pending

Adoption of Implementation Strategy [IRS Form 990, Schedule H, Part V, Section B, 6a-6b]

On September XX, 2013, the Northern Indiana Region Board of Franciscan Alliance, which includes representatives from the community, met to discuss this plan for addressing the community health priorities identified through our Community Health Needs Assessment. Upon review, the Board approved this Implementation Strategy and the related budget items to undertake these measures to meet the health needs of the community and forwarded the recommendations to the Corporate Board of the Franciscan Alliance for consideration at their October __ Board Meeting.

Northern Indiana Region Board of Franciscan Alliance Board Approval & Adoption:

By Name & Title

Date