BEACON HEALTH SYSTEM

2021 Community Health Needs Assessment Report

Table of Contents

1. Executive Summary

Beginning in January 2021, Beacon Health System undertook completing a Community Health Needs Assessment (CHNA). This assessment focused on creating a better understanding of the health needs of the Beacon Community (Elkhart, LaPorte, Marshall, and St. Joseph counties) and the response necessary to address the need. Data was collected through secondary data collection, a key informant survey, and community focus groups on a variety of topics centered on health indicators and social determinants of health.

The goal of the CHNA is to provide Beacon Health System with a clear picture of Elkhart, LaPorte, Marshall, and St. Joseph County, which constitutes the service areas of Elkhart General Hospital, Memorial Hospital of South Bend, and Community Hospital of Bremen. The findings from the assessment will be used by Beacon Health System to prioritize health issues in the community.

The project took the following approach to better understand the community health needs:

- Key Informant Survey - A survey was provided to community leaders and those knowledgeable about the communities' health issues. The list of key informants was developed by Beacon Community Impact staff along with input from a variety of key stakeholders. Two hundred and seven completed responses were collected and analyzed.

- Secondary Data Research - information related to the current state of the communities' economic, social and health status published by established sources. Data, when possible, was collected for a three-year period in order to establish a trend. Over 1,000 data points were collected and analyzed, encompassing more than 80 best practice indicators. Data from Beacon Health System's electronic health record (EHR) were also used as a secondary data source.

- Community Focus Groups - groups of 3 - 18 individuals were engaged in conversations about the current health needs of the community. Beacon Community Impact utilized Stanford's Focus Group Guide adapted from protocol developed by Actionable Insights, LLC. Three focus groups per county (Elkhart, Marshall, and St. Joseph) were conducted. Staff conducted at least two English and one Spanish focus group per county. Each focus group was recorded for continuity. Focus group recordings were transcribed and de-identified using a professional transcription service and qualitative research software tools were utilized to analyze the transcripts for common themes. Staff then engaged in an interrater reliability check to ensure accuracy of identified themes.

The top Community Health Needs as identified by key informants, secondary data, and focus groups are:

1. Mental Health
2. Chronic Disease
3. Healthcare Access

Substance Use was also identified as a key health issue, particularly by community members in focus groups and in open-ended responses in the key informant survey. More specifically, substance use disorder rates have increased because of the COVID-19 pandemic.

Next Steps

Beacon Health System's Executive Leadership Team, comprised of executives from Beacon Health System, and the Presidents of Bremen Community Hospital, Elkhart General Hospital, and Memorial Hospital of South Bend, reviewed a summary of the CHNA Report and approved Mental Health and Healthcare Access as the top priority areas on October 6, 2021. A final version of the CHNA report will be approved by the of Beacon's hospital board as follows:

Elkhart General Hospital	November 9, 2021
Memorial Hospital of South Bend	November 30, 2021
Bremen Community Hospital	December 16, 2021

On these dates, Beacon Community Impact will present an Implementation Strategy that will be reviewed, revised, and approved by each of the hospital boards. A final, published 2022-2024 Community Health Needs Assessment and Implementation Strategy will be available at: CHNA Community Health Resources - Beacon Community Impact (beaconhealthsystem.org).

2. Introduction

Community Health Needs Assessment Overview

In accordance with the IRS requirements, "in conducting a CHNA, a hospital facility must define the community it serves and assess the health needs of that community. In assessing the community's health needs, the hospital facility must solicit and take into account input received from persons who represent the broad interests of its community. The hospital facility must also document the CHNA in a written report (CHNA report) that is adopted for the hospital facility by an authorized body of the hospital facility. Finally, the hospital facility must make the CHNA report widely available to the public. A hospital facility is considered to have conducted a CHNA on the date it has completed all of these steps, including making the CHNA report widely available to the public." [1]

In addition to the federal requirements, a community-wide needs assessment such as the CHNA enables community members, government bodies and institutions, private and philanthropic institutions, representatives of the local businesses,workforce development organizations, neighborhood and faith-based associations, among other stakeholders, to have a comprehensive understanding of the health related gaps or needs of a given population, as well as to identify existing and potential resources (infrastructure, partnerships, funding opportunities) to address such needs.

Starting in early 2021, Beacon Community Impact began developing a plan to create a data-driven, evidence-based assessment of the Beacon Health System community (Elkhart, LaPorte, Marshall, and St. Joseph County).

The data contained herein was collected via focus groups with the general public, key informant survey responses, and an extensive review of secondary data, in order to comply with the requirements contained in the Patient Protection and Affordable Care Act, and the Internal Revenue Service (IRS) to Non-for-profit hospitals in the country, to present a CHNA every three years. In addition to meeting the legal requirements, the CHNA is designed to serve two fundamental purposes: 1) to identify community health needs, and 2) to prioritize such needs and determine the strategic objectives for Beacon Health System community programming.

At the time this CHNA report was completed, Beacon Health System had not received written, formal comments about the 2018 CHNA report. The hospital system will continue to track any submissions made and will ensure that all relevant comments, if submitted, are reviewed and addressed by appropriate hospital staff. To submit a comment about the Beacon Health System CHNA, please message: BeaconCommunityImpact@beaconhealthsystem.org

3. Assessment Methodology

Methodology Overview

This CHNA Report aims to guide strategic decisions and improve community health programming. Using information from this report, Beacon Health System will be able to determine what programs and projects should be developed and/or supported, whether within Beacon Community Impact (BCI), another Beacon department, or through partner community organizations, to improve the effectiveness of their community outreach services.

When conducting the CHNA, BCI determined a mixed methods approach would be preferable. Mixed methods is defined as "a purposeful mixing of methods in data collection, data analysis and interpretation of evidence."[1] This approach allowed Beacon Community Impact to use a broad lens to understanding the breadths and depth of the health issues facing our community. The goal was to ensure that existing knowledge and best practices were considered and incorporated while ensuring that this information was paired with the voice of the community and participants who are most likely to be affected by programming offered.

Our approach utilizes both quantitative data (secondary data, key informant survey) and qualitative data (focus groups, open-ended responses). Once the results of the survey were determined, a qualitative approach was used to gather richer insight into the main issues faced by the community. Therefore, the methodology followed for this needs assessment consists of three steps: 1) Identify needs; 2) Analyze the links between the needs and the information required to make decisions; 3) Make recommendations that guide decision-making.

The 2021 CHNA process will try to answer four main questions:

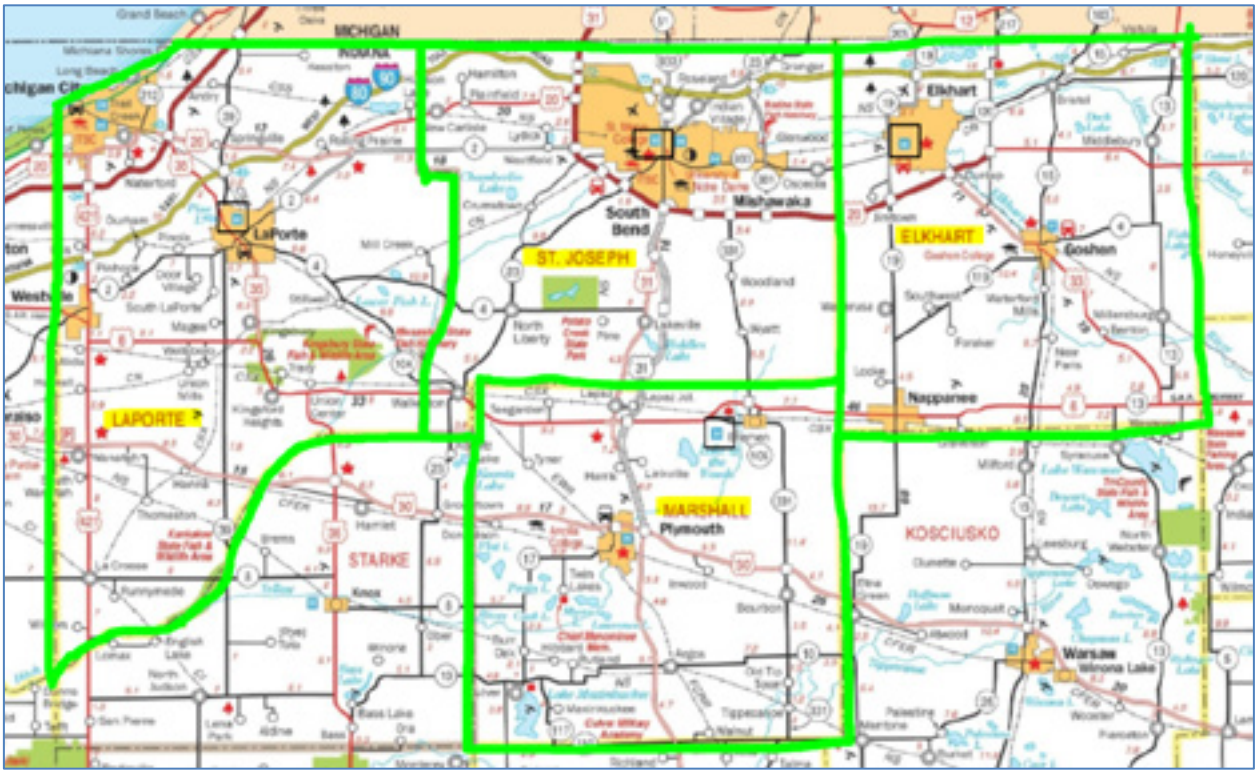
- What are the top health needs of our community?
- What policies or resources are needed to address these health needs?
- What are the most significant determinates of health that keep people from improving their health?
- What populations would most benefit from community health programming?

Defining Community

To define the "community" for Beacon's CHNA BCI staff focused on identifying the geographic areas in which the majority of the health system's clientele reside. This was taken from conversations with Beacon staff, a review of past CHNAs, and review of past Beacon's EHR data analysis. Through this analysis, four counties were identified as encompassing the Beacon healthcare community: Elkhart, LaPorte, St. Joseph, and Marshall Counties in Indiana. Beacon Health System is comprised of two

[1] https://ebn.bmj.com/content/20/3/74

primary hospitals, Memorial Hospital of South Bend and Elkhart General Hospital, as well as four ancillary hospital sites that serve a smaller patient population in outlying rural areas. One of the hospitals, Bremen Community Hospital, is a Critical Access Hospital. The community served is defined solely by geography, and not by a specific population as defined by age, gender, race, targeted disease, or other factor.



Data Collection

The IRS regulations on the CHNA have established that: "in assessing the health needs of its community, a hospital facility must take into account input received from, at a minimum, the following three sources: (1) At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of the community; (2) members of medically underserved, low-income, and minority populations in the community, or individuals or organizations serving or representing the interests of such populations; and (3) written comments received on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy." To meet this standard, information was collected from three major data streams that were analyzed, in aggregate, to inform the identification of community health needs. Beacon Community Impact relied on publically-available data, known community partners to contact as key informants and to assist with recruiting focus groups, and local qualitative researchers to assist with analyzing qualitative data.

Key Informant Survey

The Key Informant Survey engaged a variety of community and health leaders in an effort to identify the top health needs of the Beacon community and help determine what activities and programs will be most effective in addressing those needs. This survey was designed and implemented in order to meet the IRS requirement to "solicit and take into account input received from persons who represent the community, including those with special knowledge of or expertise in public health."

This survey has two primary purposes:

- Identify the top health priorities
- Inform BCI's Implementation Strategy

This digital survey was distributed via email to leaders and experts from the communities of Elkhart, LaPorte, Marshall, and St. Joseph Counties. Representatives from all relevant sectors (business, education, faith, government, healthcare, non-profit, etc.) were identified and asked to provide their special knowledge, expertise, and insights on the top health needs, populations most in need of assistance, and effective programming frameworks. They also provided written feedback about current program delivery and community funding which was based on the previous CHNA and implementation strategy.

The survey was launched in February 2021 and closed May 2021. The following organizations had one or more representatives respond:

- AIDS Ministries
- American Cancer Society
- American University Beirut
- Baugo Community Schools
- Beacon Cancer Care
- Beacon Community Impact
- Beacon Health System
- Pokagon Health Services
- IU School of Medicine - South Bend
- Beacon Medical Group
- Beacon Pediatric Specialty
- Beacon - North Central Indiana Sickle Cell Initiative
- Big Brothers Big Sisters Southern Lake Michigan Region
- Bowen Center
- Boys & Girls Club of St. Joseph County
- Bremen Public Schools
- CAPS
- Catholic Charities
- Center for Civic Innovation
- Center for Healing & Hope
- Center for the Homeless
- Child and Parent Services, Inc.
- City of South Bend
- Community Hospital of Bremen
- Crossroads United Way
- Cultivate Food Rescue
- David's Courage

- Division of Family Resources
- Elkhart Community Schools
- Elkhart County Health Department
- Elkhart Education Foundation
- Elkhart General Hospital
- enFocus, Inc.
- Goodwill Industries of Michiana, Inc.
- Goshen Family Physicians
- Greenspire Solutions
- Harper Cancer Research Institute
- Health Improvement Alliance of St. Joseph County
- Healthlinc
- HealthMarkets
- Horizon Education Alliance
- Elkhart City Council
- Imani Unidad
- Indiana University
- Indiana University South Bend
- Indiana University South Bend - Elkhart Center
- Ivy Tech Community College
- Junior Achievement
- La Casa de Amistad
- Marshall County Project HOPE
- Marshall County Board of Health
- Marshall County Community Foundation
- Memorial Hospital of South Bend
- Mental Health Awareness of Michiana
- Michiana Area Council of Governments
- Michiana Health Information Network/Indiana Health Information Exchange
- Middlebury Community Schools
- Minority Health Coalition Elkhart County
- Near Northwest Neighborhood
- Northern Indiana Hispanic Health Coalition
- Oaklawn Psychiatric Center
- OI
- Partnership for Drug-Free St. Joseph County
- Purdue Extension - St. Joseph County
- REAL Services
- Reins of Life, Inc.
- Ribbon of Hope, Inc.
- RiverBend Cancer Services
- Robinson Community Learning Center
- Saint Joseph Health System
- School City of Mishawaka
- Shaw Center for Children and Families at the University of Notre Dame
- SJC Cares
- Smoke Free St. Joe
- South Bend Adult Education
- South Bend Common Council
- South Bend Community School Corporation
- South Bend Elkhart Regional Partnership
- South Bend Heritage Foundation
- South Bend Regional Chamber
- Spiritual & Personal Adjustments - Women's Ministry Homes
- St. Joseph County Department of Health
- St. Joseph County Public Library
- St. Vincent de Paul Society
- The Community Foundation of Elkhart County
- The Jewish Community
- The LGBTQ Center
- The Michiana Athletic and

Recreation Association
- United Health Services Suicide Prevention Center
- United Way of LaPorte County
- United Way of Marshall County
- United Way of St. Joseph County
- Unity Gardens Inc.
- University of Notre Dame
- Upper Room Recovery Community
- WIC
- YMCA of Greater Michiana
- Youth Service Bureau of St. Joseph County
- YWCA North Central Indiana

Secondary Data Collection

For the secondary data collection, the Beacon Community Impact team collected relevant data from reputable sources of federal and state levels of government, as well as from academia and well-known national research centers. The main sources of secondary information for this needs assessment were:

- Centers for Disease Control and Prevention (CDC). WONDER Online Databases.
- PLACES Project, in collaboration with the CDC, the Robert Wood Johnson Foundation, and the CDC Foundation.
- Indiana University, Kelley School of Business. STATS Indiana Statistical Data Utility.
- Indiana University, Indiana Business Research Center at the Kelly School of Business. Indiana Indicators.
- University of Wisconsin. County Health Rankings and Roadmaps (CHRR).
- United States Census Bureau, American FactFinder. 2016 American Community Survey estimates.
- Substance Abuse and Mental Health Services Administration (SAMHSA).
- Beacon Health System electronic health record data

Efforts focused on collecting data and indicators that could provide descriptive information on demographic and socioeconomic characteristics, health status, and health determinants of the communities of interest of this report (behaviors, social and physical environment, access to healthcare services). To achieve a viable and trusted data set the following process was used:

- Identify data or indicators that may be contained in previous CHNA reports.
- List the characteristics or attributes to select secondary data sources. Below is a list of key characteristics to select secondary data sources:
    - Methodologically sound (valid, reliable, and collected over time)
    - Feasible (available or collectable)
    - Meaningful (relevant, actionable, and ideally, linked to evidence-based interventions)
    - Important (linked to significant disease burden or disparity in the target community)
- Develop a document (protocol) for data review. Complete the protocol for every source of secondary data reviewed.

- Identify specific instances where information from different documents may disagree, documents containing similar information, potential sources for additional information, and information that is not available either at local, State or National levels.

To the extent possible, to be able to compare trends and scales, the aim was to collect Secondary Data at County (for Elkhart, LaPorte, Marshall, and St. Joseph Counties), State and National level, from the most recent available 3 years (2016, 2017, and 2018).

Data collection began in February 2021 and was completed in May 2021.

Community Focus Groups

Community voices are an important part of any CHNA process. These voices help to identify gaps in our healthcare system, current and emerging health issues, and innovative solutions that promote health and wellbeing. As part of our own CHNA process, Beacon Health System gathered qualitative data by hosting community focus groups across Elkhart, Marshall, and St. Joseph counties. These focus group discussions covered the following topics:

1. What are the biggest health needs in our community?
2. What barriers exist that impact these top health needs?
3. What access issues exist, if any?
4. To what extent is mental health a need in the community?
5. What policies or resources are needed?

Elkhart, Marshall, and St. Joseph County participants were recruited through existing Beacon Community Impact community partners. Verbal consent was received and recorded prior to the start of each focus group. In addition, each participant filled out a short, demographic questionnaire for later analysis. As part of this questionnaire, there was an additional consent form to read and sign. A bilingual staff member led focus groups conducted in Spanish. All participants received a $30 gift card for participation in the focus groups. Individuals representing high-need populations (low income, minority, undocumented, medically underserved, etc.) were included. Additionally, special care was taken to ensure a mix of participants from different gender, age, ethnicity, and race categories. Enrollment for the focus groups began in August 2021. The focus group discussions were completed in September 2021.

4. Our Community

The Beacon Health System community has been defined as a four county region: Elkhart, LaPorte, Marshall, and St. Joseph counties. The following community profiles were created to help establish a clearer picture of the population that lives in each county to help provide a lens for viewing the data collected from the three data areas (key informant survey, secondary data, and focus groups).

Population

Population and Age Composition

Indicator	Elkhart	LaPorte	Marshall	St. Joseph	Indiana
Total Population	205,560	110,007	46,248	270,771	6,732,219
Under 18 years of age	27.50%	21.4%	25.1%	23.60%	23.40%
65 years of age and older	14.70%	17.9%	17.9%	15.80%	15.80%

Source: US Census Bureau. Estimates 2019.

Race and Ethnicity Composition

Indicator	Elkhart	LaPorte	Marshall	St. Joseph	Indiana
African American	5.6%	11.3%	0.6%	13.3%	9.50%
American Indian/Alaskan Native	0.6%	0.5%	0.4%	0.6%	0.40%
Asian	1.2%	0.7%	0.7%	2.7%	2.60%
Native Hawaiian	0.1%	0%	0.1%	0.1%	0.4%
Hispanic	16.8%	6.9%	10.7%	9.1%	7.10%
Non-Hispanic White	74.1%	78.8%	86.6%	71.8%	78.90%

Source: US Census Bureau. Estimates 2019.

Population with Limited English Proficiency

Indicator	Elkhart	LaPorte	Marshall	St. Joseph	Indiana
Population Age 5+	189,083	103,638	43,514	252,836	6,247,018
Population Age 5+ with Limited English Proficiency	14,399	1,935	2,247	8,715	202,620
Population Age 5+ with Limited English Proficiency, Percent	7.62%	1.87%	5.16%	3.45%	3.24%

Source: US Census Bureau. American Community Survey. 2015 – 2019.

Percentage of the Total County Population by Gender

Indicator	Elkhart	LaPorte	Marshall	St. Joseph	Indiana
Female	50.6%	48.5%	50.2%	51.3%	50.70%
Male	49.4%	51.5%	49.8%	48.7%	49.3%

Source: US Census Bureau. Estimates 2019.

Urban and Rural Population

Indicator	Elkhart	LaPorte	Marshall	St. Joseph	Indiana
Urban Population, percent	79.41%	64.37%	36.65%	91.00%	72.44%
Rural Population, percent	20.59%	35.63%	63.35%	9.00%	27.56%
Rural Population	40,672	39,713	29,805	24,028	

Source US Census Bureau, Decennial Census*. 2010.*

Social Determinants of Health

Educational Achievement

Indicator	Elkhart	LaPorte	Marshall	St. Joseph	Indiana
High school graduation	81%	88%	85%	89%	89%
Bachelor's Degree or Higher (age 25+)	19.75%	18.02%	19.67%	29.57%	26.46%

Source: American Community Survey, 5-year estimates. 2015-2019

Children in Single Parent Households

Indicator	Elkhart	LaPorte	Marshall	St. Joseph	Indiana
% of Children in Single Parent Households	22%	32%	16%	28%	25%
# of Children in Single Parent Households	12,158	7,616	1,845	17,654	

Source: American Community Survey, 5-year estimates. 2015-2019

Poverty Rate

Indicator	Elkhart	LaPorte	Marshall	St. Joseph	Indiana
Poverty Rate	9.6%	13.4%	10.9%	15.3%	11.9%

Source: US Census Bureau - Small Area Income and Poverty Estimates. 2019.

Median Household Income

Indicator	Elkhart	LaPorte	Marshall	St. Joseph	Indiana
Median household Income	$55,782	$56,427	$53,695	$53,881	$57,617

Source: US Census Bureau - Small Area Income and Poverty Estimates. 2019.

Annual Unemployment Rate

Indicator	Elkhart	LaPorte	Marshall	St. Joseph	Indiana
Unemployment	7.5%	9.5%	6.4%	8.4%	7.1%

Source: Indiana Department of Workforce Development. 2020.

Uninsured

Indicator	Elkhart	LaPorte	Marshall	St. Joseph	Indiana
Uninsured Adults	15%	9%	13%	10%	10%
Uninsured Children	12%	5%	10%	7%	7%

Source: US Census Bureau - Small Area Health Insurance Estimate. 2018

Severe Housing Problems

Indicator	Elkhart	LaPorte	Marshall	St. Joseph	Indiana
Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.	13%	13%	12%	12%	13%

Source: U.S. Department of Housing and Urban Development - Comprehensive Housing Affordability Strategy. 2013 - 2017.

Households Below the Poverty Line

Indicator	Elkhart	LaPorte	Marshall	St. Joseph	Indiana
Households living below the federal poverty level (5-year estimates)	8.9%	11.1%	9.2%	11.2%	7.8%

Source: American Community Survey. 2015 - 2019.

ALICE (Asset Limited, Income Constrained, Employed) Survival Threshold

Indicator	Elkhart	LaPorte	Marshall	St. Joseph	Indiana
% of Households Living Below the ALICE Survival Threshold – Under Age 65	40%	38%	36%	41%	N/A

Source: ALICE 2020 Local Update, University of Notre Dame, 3/23/2021.

Indicator	Elkhart	LaPorte	Marshall	St. Joseph	Indiana
% of Households Living Below the ALICE Survival Threshold – 65 and Older	50%	40%	45%	51%	N/A

Source: ALICE 2020 Local Update, University of Notre Dame, 3/23/2021.

Health Status

Poor or Fair Health

Indicator	Elkhart	LaPorte	Marshall	St. Joseph	Indiana
Percentage of adults reporting fair or poor health	21%	22%	20%	19%	18%

Source: The Behavioral Risk Factor Surveillance System. 2018.

Life Expectancy

Indicators	Elkhart	LaPorte	Marshall	St. Joseph	Indiana
Average number of years a person can expect to live	78.7	76.3	78.9	79.9	77.1

Source: Nation Center for Health Statistics - Mortality Files. 2017 - 2019

5. Findings

Analysis Overview

Extensive review and analysis of the three data sets (Key Informant survey, secondary data, and focus group discussions) were completed. The tools used to complete the analysis and visualization of findings included Qualtrics, Excel, and dedoose. From the Key Informant Survey, quantitative responses were tallied and top categories were identified. Free-text qualitative responses were coded for themes, and most frequently mentioned themes were identified. The top qualitative and quantitative responses were compared to determine where they were similar and where they differed. Publically-available Secondary Data were grouped according to the same health issues as found in the Key Informant Survey. Each indicator was rated on a 1-3-5 scale as improving, staying the same, or getting worse at the county level, and the subsequent "trend" score is the average of all scores at the county level for that health issue. Similarly, each metric was rated on a 1-3-5 scale as better than, the same as, or worse than the metric for the State of Indiana. The subsequent "benchmark" score is the average of all scores at the county level for that health issue. The two scores were added together to create an overall score for the health issue according to secondary data, the possible score range, thus is 2-10, with the higher numbers representing larger health issues.

To explore potential health disparities in Beacon's service area, where available, secondary data were stratified by race, ethnicity, age, and/or gender to demonstrate potential inequities in health status based on those characteristics. In some cases the data were broken down by a smaller area than the county level, such as the ZIP code or census tract, which were then analyzed for composition by race, ethnicity, age, or gender. A subset of data from the largest portion of Beacon's electronic health record

(EHR) was pulled for the data range 8/15/2020 – 3/31/2021. These records were analyzed for potential differences in the rate of diagnosis for a given population relative to the population as a whole.

Like the key informants, each focus group participant identified the top three health issues they believed our community would face over the next three years. Votes were tabulated and the priorities with the most votes were discussed in further detail.

Free response options in both the key informant survey and focus groups were used to substantiate the quantitative data, to further understand the specific concerns in each of the health issues, as well as understand potential approaches to addressing the issues.

Findings

Key Informants were asked to identify the top three health issues that they believed the community would face over the next three years out of a list of 15 potential options. Their responses are below:

Health Issue	# of Responses
Mental Health	123
Economic Stability	60
Chronic Disease Support	53
Healthcare Access	51
Educational Achievement	47
Overweight/Obesity	47
Substance Abuse	46
Racism	44
Housing	35
Maternal / Infant Health	26
Food Access	20
Injury & Violence Prevention	17
Immunizations & Infectious Disease (Non COVID-19)	14
Environmental Issues	13
Sexually Transmitted Diseases	3

Thus, the top health issues, as opposed to social determinants of health, according to key informants are Mental Health, Chronic Disease Support, Overweight / Obesity and Substance Abuse. Healthcare Access was the number one social determinant of health identified by key informants, behind economic stability.

Secondary Data: Health issues were ranked as 1 – Better, 3 – Same, 5 – Worse for both the trend over three years (generally 2016 – 2018), and relative to the State of Indiana. This score represents the average of all of the metrics recorded for that health issue.

Health Issue Trend	Score
Mental Health	4.45
Sexually Transmitted Disease	4.33
Injury / Violence Prevention	4.20
Overweight/Obesity	3.88
Substance Abuse	3.50
Chronic Disease	3.29
Immunization & Infectious Disease	3.00
Maternal / Infant Health	3.00
Housing	2.92
Educational Achievement	2.67
Healthcare Access	2.38
Environmental Issues	2.33
Racism	2.33
Economic Stability	2.10
Food Access	2.00

Health Issue Relative to Indiana	Score
Mental Health	4.27
Overweight/Obesity	4.25
Immunization & Infectious Disease	3.75
Healthcare Access	3.50
Economic Stability	3.50
Food Access	3.50
Maternal / Infant Health	3.42
Injury / Violence Prevention	3.00
Environmental Issues	3.00
Chronic Disease	2.95
Educational Achievement	2.67
Housing	2.58
Sexually Transmitted Disease	2.33
Substance Abuse	2.00
Racism	2.00

The ranked health issues according to secondary data, when the trend score and benchmark score are combined are:

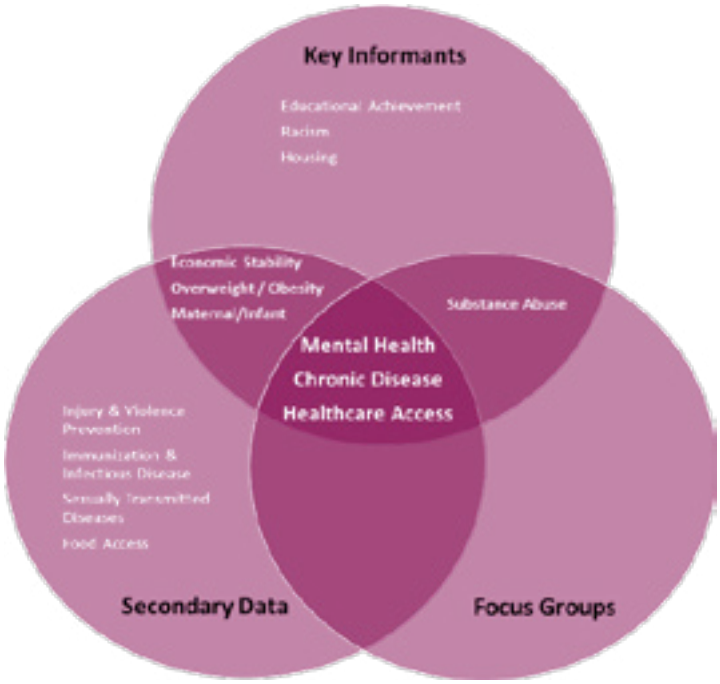
Ranked Health Issues per Secondary Data	Score
Mental Health	8.73
Overweight/Obesity	8.13
Injury / Violence Prevention	7.20
Immunization & Infectious Disease	6.75
Sexually Transmitted Disease	6.67
Maternal / Infant Health	6.42
Chronic Disease	6.23
Healthcare Access	5.88
Economic Stability	5.60
Food Access	5.50
Housing	5.50
Substance Abuse	5.50
Environmental Issues	5.33
Educational Achievement	5.33
Racism	4.33

Each **Focus Group** identified the top three health issues that they believed the community would face over the next three years out of a list of 15 potential options. The results are shown in the table below:

Focus Groups: Health Issue in Top 3	#
Mental Health	7
Healthcare Access	6
Chronic Disease	5
Substance Abuse	5
Economic Stability	4
Housing	3
Overweight/Obesity	3
Racism	3
Educational Achievement	2
Food Access	1
Injury / Violence Prevention	1
Environmental Issues	0
Immunization & Infectious Disease	0
Maternal / Infant Health	0
Sexually Transmitted Disease	0

Top Community Health Issues

By overlapping the top identified needs from the Key Informants, Secondary Data, and Focus Groups, we see that Mental Health, Chronic Disease, and Healthcare Access are the top health issues identified by all data sources combined. Other issues may have ranked higher by just one source, but not all three. Notably, sexually transmitted disease, immunization and infectious disease, and injury and violence prevention were among the top issues according to secondary data, but among the lowest rated issues according to key informants and focus groups. Overweight / obesity is also a top health issue according to secondary data; it ranked as a moderate health issue according to the other sources, just not at the top.



Qualitative Reponses – Key Informants and Focus Groups

In free response questions, key informants validated these topics. The top theme identified in response to the question, "Please share any additional information regarding these health issues, barriers, and your reasons for ranking them this way" was healthcare access.

As one Key Informant stated, "I often hear about lack of access to health resources due to a lack of transportation or a difficulty in accessing transportation. In addition, preventative health measures often become secondary to concerns associated with poverty, such as housing instability, low wages, low opportunity, etc."

These thoughts were mirrored by another Key Informant who stated, “Low-income and minority communities face many barriers. Insurance and access to health care remains most challenging for this set of demographics.”

Following along these lines, yet another participant noted the relationship between lower-income and inequalities in healthcare. “Inequities in health outcomes exist due to barriers built into systems and policies more than individual health behaviors. What needs to change are the policies and structures that create disparities, but in the meantime, people of color and people with lower incomes need more resources and support to navigate systems.”

Focus Group participants, likewise, further explained the challenges facing the community in the areas of these top health issues: mental health, substance abuse, healthcare access, and chronic diseases.

Mental Health/Suicide/Adverse Childhood Experiences emerged as one of the top health needs in more than half of all focus groups. Participants expressed concerns over the lack of mental health providers in each county particularly in Elkhart and Marshall Counties where ‘monopolies’ exist. Participants in these focus groups verbalized concerns with long wait times, filling prescriptions, and language barriers. Participants explained when scheduling appointments with mental health providers, waitlists are often months out. Individuals are then told to utilize the emergency room if their symptoms become unmanageable and/or to call back daily in case of cancellations. As one participant explained, “I just feel like we don't have any solid center for mental health care in our community and it's just the past year and a half with everybody being even more isolated. I think the need has just exploded. I think a couple of weeks to get a mental health appointment is being very generous. I think it can be months.”

Additionally, participants explained that Spanish-speaking providers were rare and those that did provide care had even longer waitlists. Participants, parents or not, requested age appropriate mental health programming, expressing interest in classes as early as kindergarten and continuing throughout their educational experience. One female participant explained, “I think we need more people in the schools and community centers that work with our kids that are picking up on the signs earlier of mental health [and programming]. I think we have too many kids in the system who get labeled as bad kids or troubled kids and really it is mental health [related].”

When discussing stigma, some focus group participants noted vast improvements around the mental health rhetoric with individuals being more accepting of others seeking treatment (i.e. medication, therapy). Other participants agreed but noted this was not true for all households, particularly those living in Black households.

Additionally, participants in focus groups and open-ended responses in the key informant survey requested a more trauma-informed approached to care. As one participant noted: “I think overall the state of mental health in America has gone down dramatically in the last three years. Yeah, we have a majority of our patient panel are very complex patients with a lot of mental health concerns on top of, of physical health concerns. And that trauma informed care model that we spoke of earlier is so crucial

in identifying how those mental health concerns affect your physical health and identifying those mental health concerns is number one priority for most of our providers." Some participants in focus groups explained they too have experience re-traumatization during healthcare visits in local facilities. Another participant explained, "I think there should be more trauma informed healthcare… I think more trauma informed healthcare would help solve a lot of the problems that we've been identifying."

Substance Abuse (Drugs, Alcohol, and Tobacco) was also marked as a need for our community. When discussing substance use disorder (SUD), participants noted the uptick in substance use with the COVID-19 pandemic. They equated it to loneliness and depression. Participants explained that substance use and mental health often go hand-in-hand. Again, participants noted the long wait times to receive Medicated Assisted Treatment (MAT) or getting in to see a psychiatrist/therapist. As one participant noted, "You've got people out here dying and you guys wonder why the opioid epidemic is so bad. [People] are sitting here begging you to give them the shot and you are like [no]. It would be easier just to go use."

Participants noted a gap in education surrounding substance use and abuse with many kids not receiving any form of education. Participants noted the importance of prevention-based curriculum as active addiction is much harder to treat.

One focus group participant summed it up, "Well, the amount of stress because of lack of health care and lack of affordable housing and literally everything we struggle with, there's no clear path to like an un-stressful lifestyle and stress is what causes a turn to substances, which then becomes substance abuse and then once it becomes a habit, it's a lot harder to break and it's a lot harder to quit when you're around so many people and it's so easily accessible."

Healthcare Access/Literacy/Insurance made up a large percentage of the discussion for a majority of the focus groups. For some, the concerns around healthcare access involved physical barriers. Elkhart and Marshall County participants were vocal about a lack of reliable and affordable public transportation. One Marshall County participant explained the only time you can have a medical emergency in the town is between normal business hours or nobody is going to pick you up. Elkhart County noted having an Uber presence now but it was not an affordable option for most people. The bus and trolley system are also too expensive and/or unreliable. In St. Joseph County, the bus system is not easy to navigate and individuals are unaware of voucher programs that exist. Additionally, medicaid funded transportation is unreliable. Individuals shared that they have had scheduled rides to and from appointments and the driver simply did not show up. Others explained they had to wait up to four hours after their appointment for a ride home.

Facilitators asked participants in the focus groups if they, and other community members, all had similar access to healthcare and medication. The answer was a resounding no. Quite a few of the participants in the focus groups explained they did not currently have health insurance and did not know where to start. Individuals requested a free-of-charge case manager or social worker that was well marketed and easily accessible that they could use to help navigate the entire healthcare system. Issues such as

healthcare enrollment, understanding bills, locating an in-network specialist, finding care with state insurance, language barriers, and racist providers all arose. Many participants felt unsupported by the current healthcare system and were afraid to seek services due to these factors. When asked if participants were familiar with healthcare navigators, the majority said no.

> "I have no access to health insurance at this time. I'm struggling with [this disease] and I'm trying to get insured and it's just wall after wall. I feel like getting health insurance should be as simple and easy as it would be to get a car insurance policy, and it is not like that at all."

Chronic Disease support (Diabetes, Cancer, etc.) falls along the same lines as with many of the other priorities listed above. Transportation to and from appointments, cost of medical treatments and medications, and healthcare navigation all negatively affected patient care. Participants told personal stories of battling chronic illnesses and the uncertainty that surrounds them on a daily basis. One participant shared their story by explaining their most recent interaction with the health care industry when getting care. She stated, "The hospital couldn't help me. They could not even really direct me which way to go. Because I do not know, you know. Just to get tests. So, pretty much I am waiting on Medicaid to be able to get a new doctor but none of the doctors are taking new patients. What am I to do?"

Health Equity and Disparities

The secondary data reviewed so far has all been aggregated at the county level, and does not reveal when there are differences in indicators based on race, ethnicity, age, neighborhood, or socio-economic status. When stratified by these categories, publically available sources and data from Beacon's electronic health record (EHR) from late 2020 – early 2021, demonstrate disparities in both health outcomes and social determinants of health.

Mental Health - The measure of Frequent Mental Health Distress (% of the population with $\geq$ 14 poor mental health days per month), certain census tracts, particularly near the downtown cities in Beacon's service area, have a notably higher rate of frequent mental health distress than the predominantly suburban or rural areas. These neighborhoods are also predominantly Black and Hispanic, and of lower socioeconomic status.

In Beacon's EHR data, it is noted that Black people are overrepresented relative to the local population for both psychotic disorder and suicide attempt. It is also notable that white people are overrepresented relative to the local population when diagnosed with anxiety disorder and mood disorder.

Chronic Disease - Chronic diseases show a similar pattern of disparity by neighborhood, particularly diabetes, high blood pressure, asthma, and COPD.

Cancer, while not always a chronic disease, can be categorized as one. There is little difference between cancer incidence rates between white and Black people, and the incidence rate for Hispanic people is lower than both. The cancer mortality rate, however, is notably worse for Black people in Elkhart and St. Joseph counties.

Healthcare Access - The percent of the population that is uninsured is as high as nearly 23% in certain urban census tracts, often the ones closest to Beacon hospitals. There are rural census tracts with very high percentage uninsured, but these likely reflect the Amish population who are uninsured by choice. Stratified by ethnicity, the uninsured population is more likely to be Hispanic than not Hispanic.

Poverty - The secondary data are striking when examining economic stability. As economic stability is a driver of social determinants of health such as food insecurity, housing instability, lack of education/day care, lack of transportation, and those lead to poor mental and physical health, it is no surprise that there are poor health outcomes among marginalized populations in Beacon's service area.

Median Household Income by Race/Ethnicity

	White	Black	Hispanic
Elkhart	$ 60,814	$ 25,236	$ 49,827
LaPorte	$ 56,089	$ 30,837	$ 58,679
Marshall	$ 54,414	$ 35,625	$ 32,146
St. Joseph	$ 57,930	$ 30,467	$ 43,739

Source: US Census Bureau, American Community Survey. 2015-19.

Population in Poverty by Race Alone, Percent By Ethnicity

	White	Black	Hispanic
Elkhart	10.65%	34.80%	21.62%
LaPorte	12.52%	31.02%	18.57%
Marshall	12.89%	47.60%	24.55%
St. Joseph	11.69%	31.14%	25.83%

Source: US Census Bureau, American Community Survey. 2015-19.

% of children who live in poverty, by Race / Ethnicity

	White	Black	Hispanic
Elkhart	10.26%	50.61%	23.94%
LaPorte	22.12%	50.80%	25.52%
Marshall	13.94%	66.67%	28.05%
St. Joseph	12.51%	43.45%	32.21%

Source: US Census Bureau, American Community Survey. 2015-19.

Impact of COVID-19

The COVID-19 pandemic has had an impact on the Community Health Needs Assessment process. A substantial part of our open-ended text questions, focus groups, and overall conversations included COVID-19 concerns and how the pandemic will widen the gap between the upper and lower class arose frequently. When asked: "How do you think COVID-19 will impact our community in the coming years?" The following feedback was provided:

Mental health was the most frequently cited concern, particularly among school-aged children. Key Informants that completed the survey expressed concern about isolation, lack of face-to-face interaction, and delayed learning as major concerns. Additionally, individuals believed reintegration into school would be just as harmful as isolation during the pandemic. Children are also experiencing death and major economic crises. Parents are not able to be as present with other mounting concerns (job security, food, etc.). Lastly, mental health providers are backlogged with rapidly increasing wait times.

Another area of concern, that mirrors the focus groups, is the delay in physical health care. Key Informants mentioned that those who needed physical exams, routine checks, or outpatient procedures are delaying these services due to fear of COVID-19 or inaccessibility of medical providers. More specifically, people cited doctor's offices refusing to see patients if they had any symptoms shared with COVID-19. Patients who also had possibly dangerous health conditions (i.e. cancer) were too afraid to seek medical care.

One positive that has arisen from COVID-19, is the desire for collaboration. Many Key Informants, and even those in the focus groups, believed this pandemic has allowed organizations to come together for a shared purpose. Organizations are working in a more collaborative network aiming to treat patients and working less often in silos. There is a desire among the community for these networks to continue expanding.

Pediatric Health Needs

Key informants identified Mental Health, Poverty, and Nurturing Family Lifestyle as the top three pediatric health issues to face the community for the next three years. . In free text comments, key informants noted that pediatric mental health is a significant issue as the community begins to re-engage following or during the COVID-19 pandemic. Multiple people commented that addressing student mental health issues cannot be left to the schools alone. Finally, key informants indicate that children/youth are the #2 population that would most benefit from programming, after people with low-incomes.

As discussed within the adult population, mental health is a growing concern. Parents, teachers, and the community at large believe programming around mental health is increasingly important. The COVID-19 pandemic is having a significant impact on children's mental health. There is growing concern about the isolation children are experience from not being able to participate in face-to-face school, extra-curricular events, and traditionally "kid" activities. Many participants in the focus groups expressed interest in social workers or therapists in each school that can help navigate mental health treatment/care. Starting mental health programming early in school would help to reduce the stigma around treatment and teach children how to handle their emotions properly. As one parent stated, "The only way you're going to change that stigma and get people treated is if we can catch it. A third grader has no idea if they are depressed; they have no idea that they're anxious because there's issues at home."

Using the same methodology applied to data for the adult population, poverty, child abuse and neglect, immunizations, and nurturing family lifestyle / ACEs mitigation are the most significant health needs in secondary data. Child abuse and neglect, special health needs and childhood poverty all trend in the "worse" direction.

As for social determinants of health, childhood poverty is particularly pronounced in minority children. The percentage of children in single parent households is also higher than the state of Indiana in both LaPorte and St. Joseph counties, this may lead to increased economic challenges for these families which could ultimately impact their health. Related to the needs of single parents is the availability of quality child care. The rate of licensed child care slots per 100 children ages 0-5 in Indiana is 21.3 (as of 2017), it is 9.7 in Elkhart, 24.5 in LaPorte, 10.8 in Marshall, and 22.5 in St. Joseph. The lack of licensed childcare in Elkhart and Marshall county may add a significant burden to working single parents to find quality daycare. This supports the indication from the key informants. The rates of children without health insurance in Elkhart and Marshall counties is also higher than the Indiana average.

Focus group participants substantiate the challenges with child care:

> "That's what I was going to say, the younger they are it's so expensive. There's almost no point in working because you're paying someone else to take care of your child, and your pay check's going to childcare."
>
> "A lot of the day cares are not open on time. If you are an early worker for factory or whatever, you can't just drop them off because the day cares are not always open. And then there's also the ones that go with the school system that they're only open when the school year is going and then they close."
>
> "I waited a year once before for my older son to get him into childcare on the voucher."

Rural Health Needs

Many of the same health needs were identified in both urban and rural settings. In Beacon's service area, Marshall County has the highest percentage of the population living in a rural setting, at just over 63%, St. Joseph County is the least rural at 9%. Key informants identified mental health as the top health priority in all counties. In Marshall County, the most rural, substance abuse and overweight / obesity were recognized as the second highest priorities. In Elkhart and St. Joseph counties, the two most urban, economic stability was the second most recognized priority. Similar social determinants of health were identified as well, with poverty as the number one issue. The more urban counties identified discrimination/racism as the second most important driver of health, whereas the second most significant drivers of health in Marshall County were identified as food insecurity and housing instability. This is not surprising given that Marshall County is 86.6% non-Hispanic white.

Lack of access to providers in small, urban towns is a concern. With a lack of public transportation between Marshall County and Elkhart or St. Joseph, participants struggled with making specialist appointments. Additionally, wait times for mental health providers was long regardless of urban or rural status. Additionally, parents in rural and urban communities noted hardship securing safe, affordable housing and childcare.

Transportation, though not identified by key informants as one of the top drivers of health, is consistently mentioned as a barrier. In rural areas, people with low incomes need transportation to drive to grocery stores that are less expensive than their local stores. Similarly, they need transportation to drive to specialty medical appointments that are not available locally for either physical or mental health. For people who cannot afford transportation or do not drive long distances, this compounds their problems accessing healthy food and health care. The ride sharing services that have developed in urban areas have not cropped up in rural areas. Lack of internet access is also highest in Marshall County, so access to tele-health is likewise less available. In Elkhart County, lack transportation is also noted as a challenge. In 2018 8.4% of the population had no vehicle available, and public transportation is absent or unreliable.

Focus group attendees also commented upon transportation:

> "There's a lot of people who cannot get a license just due to either driving without a license, or not having enough education to pass a driving test, and our public transportation is terrible. You can't really get the bus in the evenings, you can't get the bus on the weekends, Sunday there's no bus. And so, if you try to get a factory job that is going to pay you better money, you don't have access to get to it at the times that the factories are open."

> "One of the things I hear about, I'm sorry, is that people don't have transportation to get to the food banks, or they don't have transportation to get to the on-site to pick up food. So, that's one of the barriers that they can't get to the food. So, it's hard for people to get food."

6. Addressing the Top Health Needs

Populations to Serve

When considering secondary data stratified by neighborhood, race, ethnicity, or age, it becomes clear that the greatest needs are present among the low-income, Black and Hispanic communities. The urban areas of all four counties in Beacon's service area, often have a higher proportion of Black and Hispanic community members, lower-incomes, and more significant health issues, particularly in the areas of chronic diseases. These neighborhoods also tend to have a larger population under the age of 18, and a higher proportion of single parents.

Key informants identified low-income, children / youth, and minority communities as the top populations who would benefit from health programming.

Focus groups mirrored the key informants identifying those as low-income, children/youth, and minority communities as needing the most programmatic support.

Programming Options

The Beacon community is fortunate to have a strong and diverse group of nonprofit, governmental and higher education organizations committed to improving the community using a wide variety of methods, approaches.

Community Strengths

Key informants identified collaboration among non-profit service providers, agencies addressing food insecurity, and the public parks system, particularly South Bend's Venues Parks and Arts, as strengths in the community. They identified a number of organizations who do quality work to improve the health of the community. These include medical providers who serve low-income or the uninsured population, multiple organizations who provide emergency food access, some who serve specific populations such as homeless individuals, people with cancer, children, or people with substance use disorder. Again, collaborative efforts were noticed by the key informants.

Community Gaps

Key Informants provided many ideas on areas of improvement. Most commonly, is the concern about the lack of mental health providers in the area. "From my experience, our biggest challenge stems from work-force shortages in mental health. If we could hire the amount of staff we need, our capacity would be much greater. It has been very difficult to find a competent and caring staff that can maintain a career in mental health and substance use."

More specifically, the area needs more programs and/or services around pediatric mental health. As one Key Informant stated, “Mental health issues have drastically increased in our K-12 student population. We need to empower more school personnel to help students with these issues, and we need more mental health professionals in our school systems.”

Accessing mental health and more broadly, health services, is increasily hard for low-income individuals. Focus group participants and Key Informants noted how navigating the healthcare system is too complex. Health insurance navigators and additional community resources are needed to ensure everyone can get to the appointments they need to get to and are informed. “I believe we need more outreach efforts. I think Beacon has the ability to meet families where they are-- whether it's at the childcare provider or a place of employment. We need to make healthcare more accessible.” Another Key Informant went on to mirror these thoughts, “I think our wellness system is still not accessible to everyone. Self advocacy, tenacity and resilience are necessary to access health systems and to navigate social support systems. We need ways to reach people by attraction and positive experiences without screening highest need which causes further barriers.”

Programs that Create Impact

Key informants indicated specific approaches to addressing the community’s health needs. Their responses are below:

Community Health Programs that Create Impact	Mean Score
Educational programming for a target populations (students, at-risk population, etc.)	2.99
Deep engagement with a limited number of individuals focused on improving participant well-being	2.1
Programming focused on creating clinical health outcomes	1.98
Small Group Educational Program for general public that offer knowledge on key health issues.	1.28
Broad marketing efforts (social media, billboards, radio, etc.)	1.1
Large educational events (lectures, speakers, and/or expos)	0.55

Appendix 1: Report of Progress

Beacon Community Impact (BCI), on behalf of Beacon Health System, developed and received approval for an implementation strategy using the 2018 Community Health Needs Assessment. Four ‘priority areas’ were identified:

- Healthy Body (Overweight/Obesity)
- Healthy Family (Maternal/Infant Health)
- Healthy Mind (Mental Health)
- Healthy Spirit (Substance Abuse)

BCI used a multifaceted approach addressing the priorities over the past three years (2019, 2020, and 2021) in the Beacon community. Below are the number of programs supported, number of people served, and the financial support provided, broken down by each of the priority areas and by year.

2019

	Healthy Body	Healthy Family	Healthy Mind	Healthy Spirit	Total
Programs Supported (Beacon programming and community organizations)	9	17	23	6	55
Number of people served	9,505	13,324	16,674	739	40,242
Financial support provided to community organizations	$25,000	$79,750	$127,500	$25,000	$257,250

2020

	Healthy Body	Healthy Family	Healthy Mind	Healthy Spirit	Total
Programs Supported (Beacon programming and community organizations)	12	12	26	7	65
Number of people served	12,012	6,004	9,654	934	34,182
Financial support provided to community organizations	$100,640	$25,000	$175,000	$48,695	$417,000

2021

	Healthy Body	Healthy Family	Healthy Mind	Healthy Spirit	Total
Programs Supported (Beacon programming and community organizations)	8	16	28	8	60
Number of people served as of 6/30/2021	11,287	11,059	19,427	1,981	43,754
Financial support provided to community organizations	$51,000	$45,000	$301,000	$20,000	$417,000

Priority	Indicator Improvement		
	2019	2020	2021
Healthy Body	142.78% increase in number of minutes of physical activity reported by adults (17.39 to 42.23 minutes)	130% increase in the number of minutes of physical activity reported by adults.	Not available for 2021
Healthy Family	75.95% quit rate for in mothers who smoked (259 of 341 mothers)	26.2% decrease in the smoking rate during pregnancy.	90.2% of pregnant women who smoked quit during their pregnancy.
Healthy Mind	6.46% improvement in youth with an adult they can talk to about a serious problem (87.06% to 92.68%)	24.6% of participants showed improvement in # of poor mental health days. 37.7% of youth participants showed an improvement in having an adult to talk with about serious problems.	60.0% of youth participants showed an improvement in having an adult to talk with about serious problems.
Healthy Spirit	43.7% improvement in the number of smokers (26.67% to 15%)	100% of participants showed an improvement in smoking rates.	100% of participants showed an improvement in smoking rates.
Collective Impact	1.2% decrease in the number of poor physical health days	.5% decrease in the number of poor physical health days	38% improvement in poor physical health days per person.

Appendix 2: Resources to Address Needs

The Beacon community has a plethora of great resources to help contribute to addressing the most pressing health needs. The following are potential organizations and partners that could be brought together to assist in improving the health of our community.

Beacon Community Programming

- ACE (Adverse Childhood Experiences) Interface Presentations
- ATIP-EMDR
- BABE Store
- Baby and Me Tobacco Free
- Beacon Health Navigators
- Childhood Safety Program
- Dedicated Active Dads (DADS)
- Lead Screenings
- Little Noggins Nook
- Motivated Moms (MOMs)
- North Central Indiana Sickle Cell Initiative
- Perinatal Care Coordination (PNCC)
- ROSES
- Safe Sleep
- Safety Pin
- Women, Infants, and Children
- Achieve
- CATCH My Breath
- Dame Tu Mano
- Digital Citizenship
- Draw the Line/Respect the Line (DRL/RTL)
- Naloxone Training
- PATHS
- PEERS
- QPR Suicide Prevention Training
- This is (Not) About Drugs (TINAD)
- Project Hope
- Leighton Lecture

Community Partners

- Big Brothers Big Sisters
- Bike Michiana Coalition
- Center for Healing & Hope
- Center for the Homeless
- Child and Parent Services, Inc. (CAPS)
- enFocus, Inc.
- Cultivate Culinary School & Catering
- Elkhart County Health Department
- Elkhart Education Foundation
- Gentlemen and Scholars, Inc.
- Goodwill Industries of Michiana
- Health Improvement Alliance of St. Joseph County
- Horizon Education Alliance
- Housing Authority - City of Elkhart
- Imani Unidad, Inc.
- La Casa de Amistad
- Mental Health Awareness of Michiana
- Michiana Athletic and Recreation Association
- Michiana VegFest, Inc.
- Mosaic Health & Healing Arts
- Near Northwest Neighborhood, Inc.
- Northern Indiana Hispanic Health Coalition
- Oaklawn Psychiatric Center, Inc.
- Purdue Extension
- Reins of Life, Inc.
- Ribbon of Hope, Inc.
- Riverbend Cancer Services
- Robinson Community Learning Center
- South Bend Heritage Foundation
- SPA Women's Ministry Homes
- St. Joseph County Health Department
- The LGBTQ Center
- United Health Services of St. Joseph County, Inc.
- United Way of St. Joseph County
- Unity Garden
- Upper Room Recovery Community
- YWCA

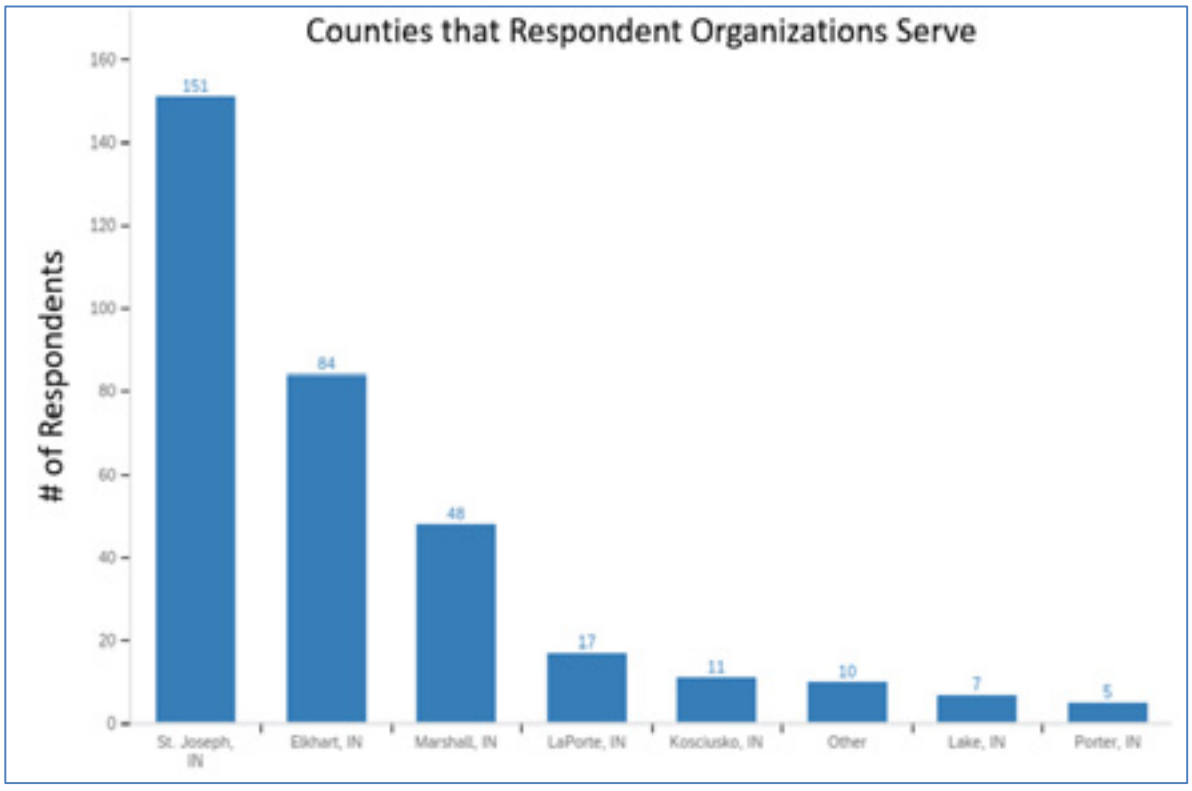
Appendix 3: Key Informant Survey

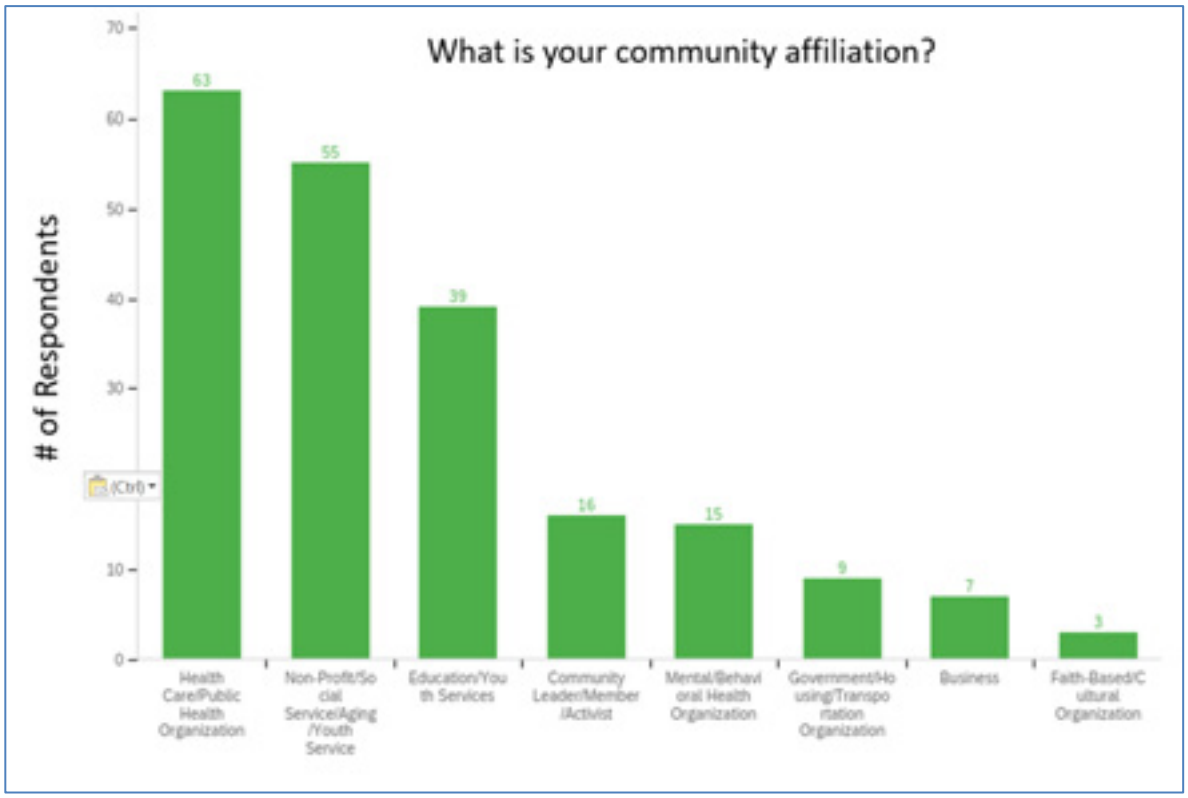
Key Informants were identified in Elkhart, LaPorte, Marshall, and St. Joseph Counties in Indiana and invited to participate in a survey. The goal of the survey was to collect both quantitative and qualitative information and feedback on the current status of community health in their place of residence. As in previous CHNAs key informants were defined as "community stakeholders with expert knowledge, including public health and health care professionals, social service providers, nonprofit leaders, school health providers, and other community leaders." Beacon Community Impact staff worked together to identify a list of key informant participants. A total of 207 key informants completed the survey between February 2021 and May 2021.

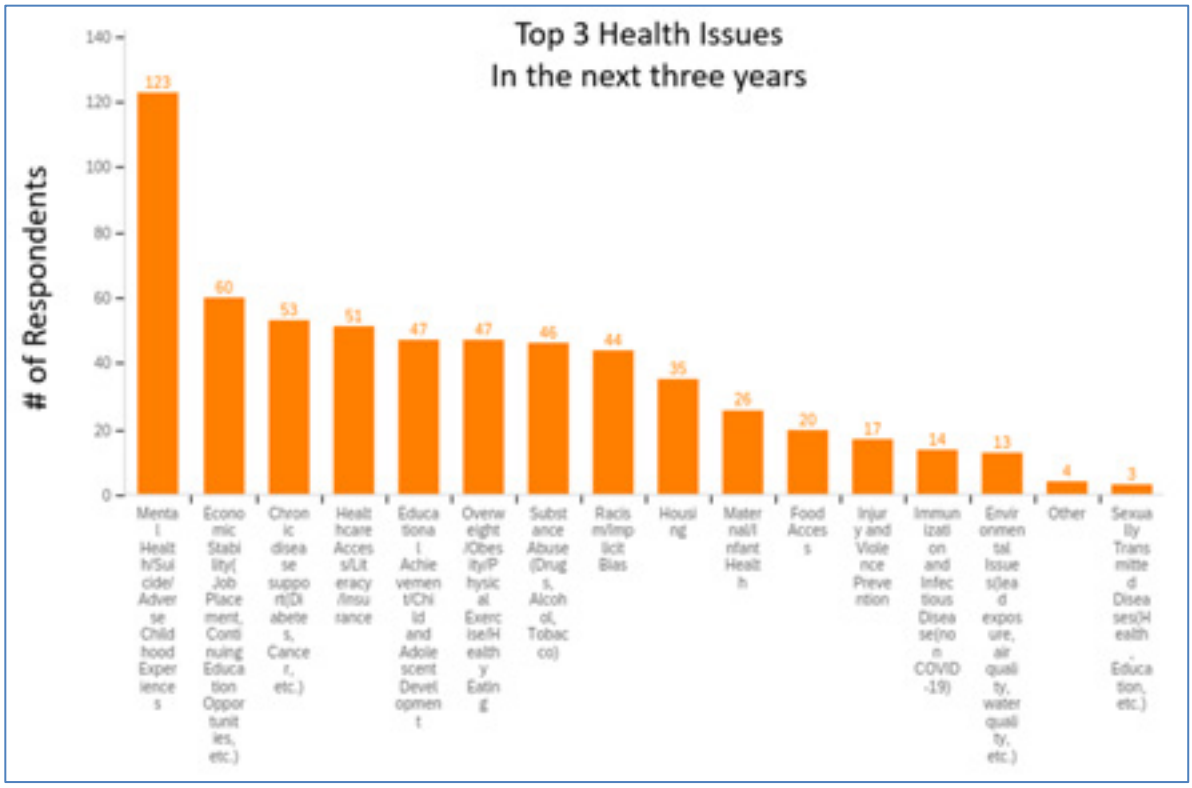
Respondents were also asked to identify:

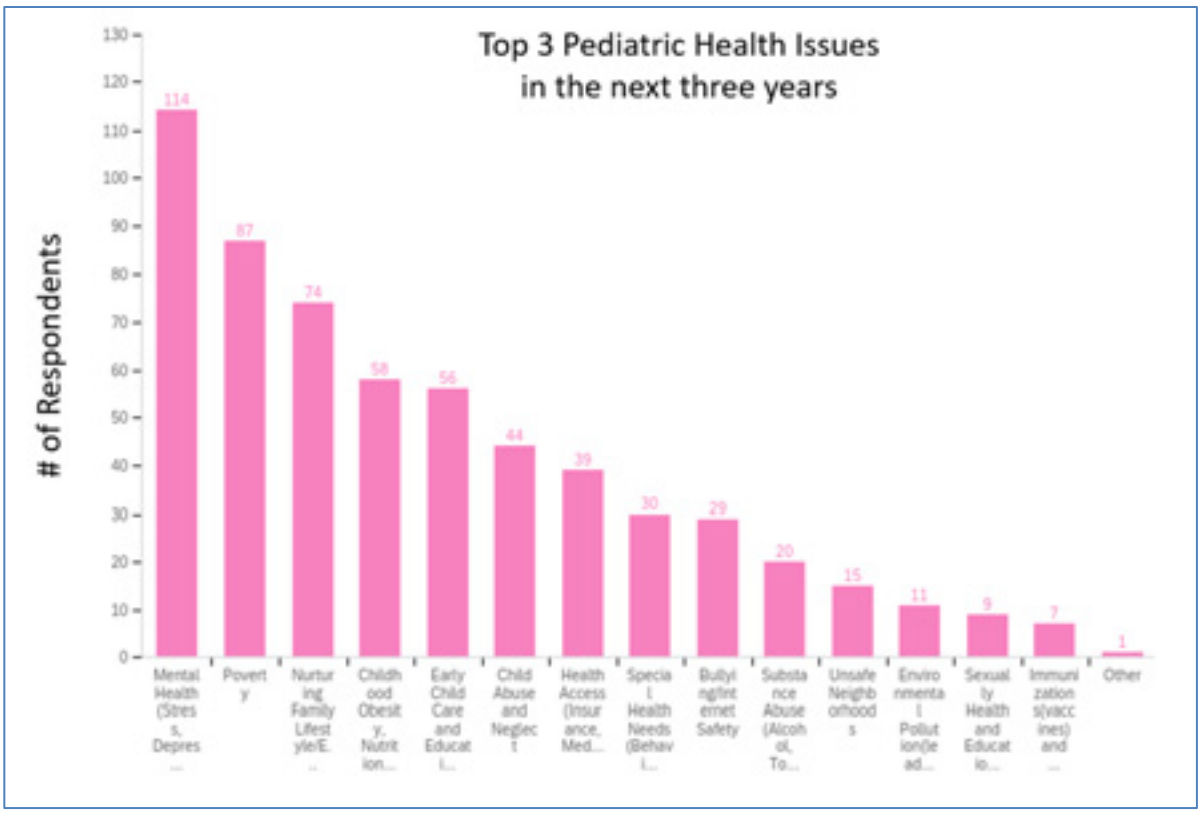
1. The **counties** where they serve. Respondents were able to choose more than one county. Therefore, the total of the counts across the counties may be greater than the actual number of key informants who completed the survey.
2. Their **community affiliation**.
3. The **top three health issues** facing the community in the next three years.
4. The **top three pediatric health issues** facing the community in the next three years.The **top three most significant social determinants of health** that keep people from improving their health.
5. The **top three populations** who would benefit most from programming.
6. Which **community health programs** create the most impact by allocating ten points across six options.

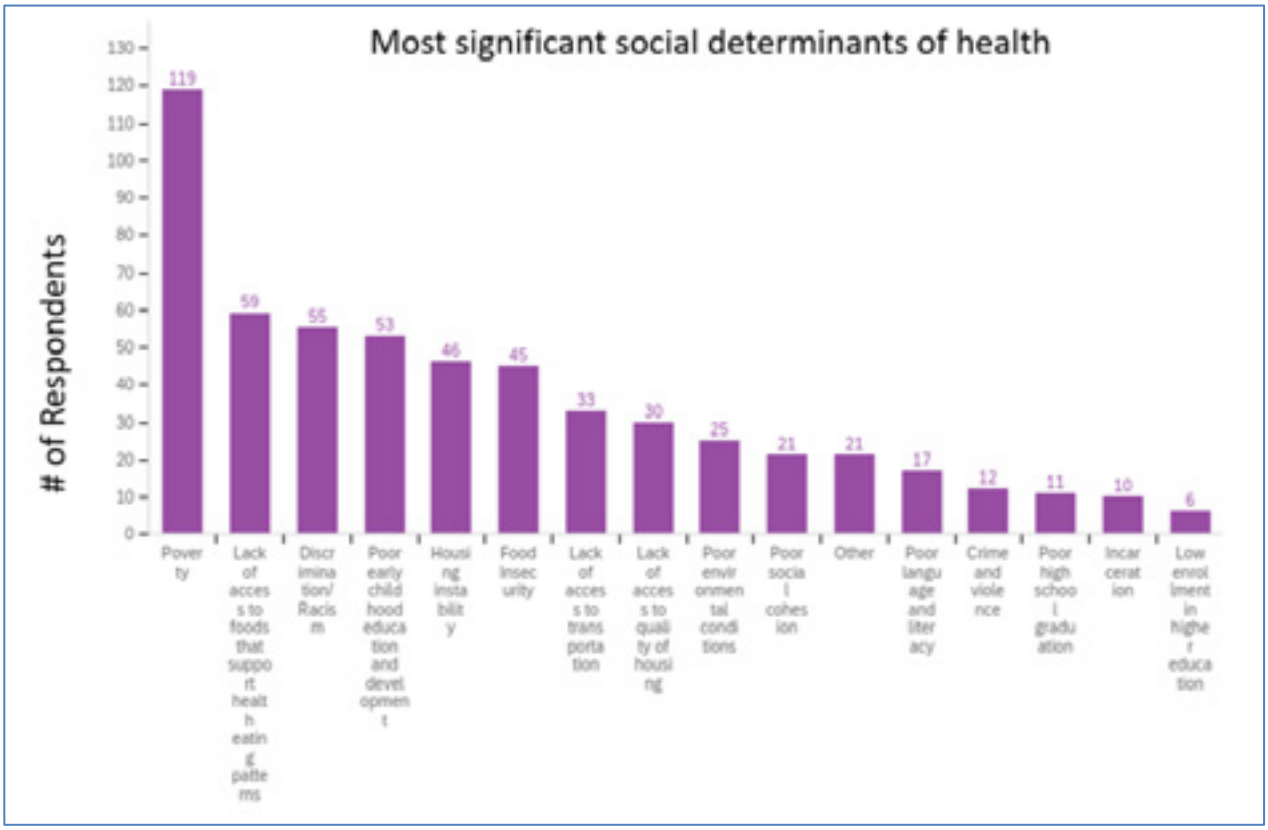
Responses from the key informant survey are shown below:

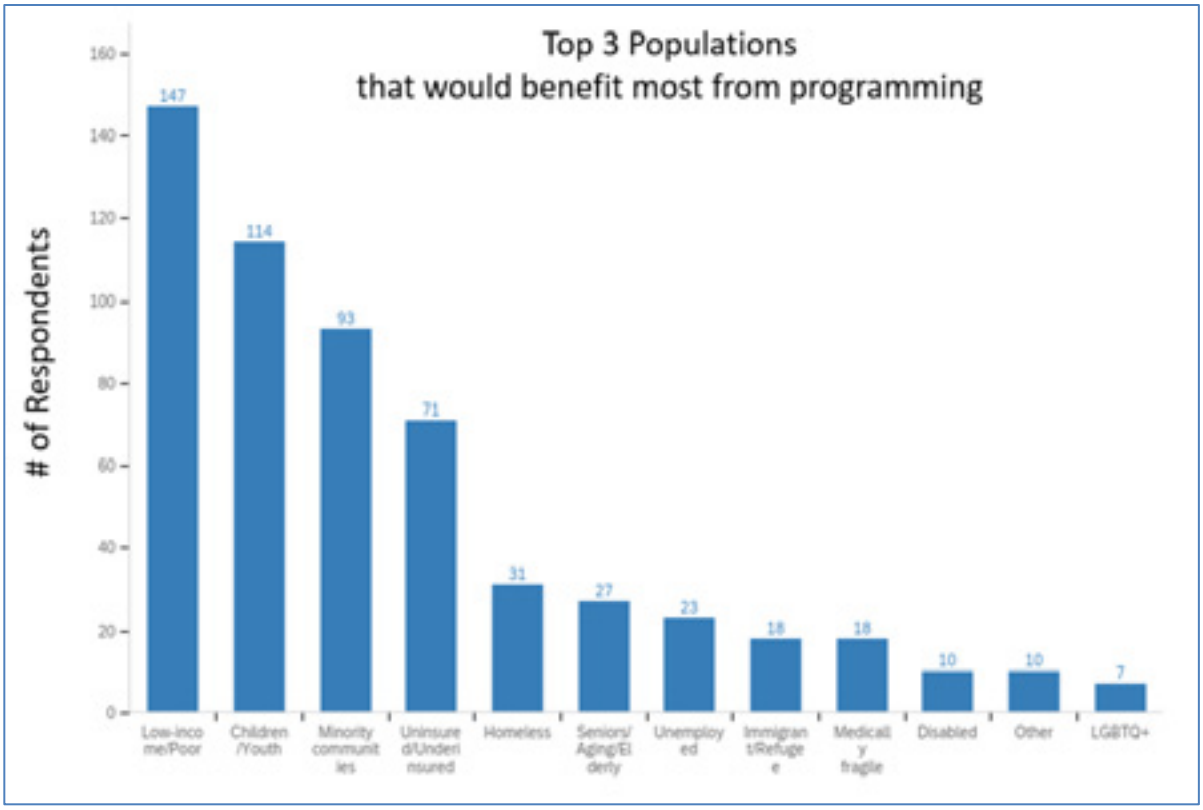



What is your community affiliation?
# of Respondents
70
60
50
40
30
10
0
63
55
39
16
15
9
7
3
Health Care/Public Health Organization
Non-Profit/Social Service/Aging/Youth Service
Education/Youth Services
Community Leader/Member/Activist
Mental/Behavioral Health Organization
Government/Housing/Transportation Organization
Business
Faith-Based/Cultural Organization


Top 3 Health Issues
In the next three years
# of Respondents
140
120
100
80
60
40
20
0
123
60
53
51
47
47
46
44
35
26
20
17
14
13
4
3
Mental Health/Suicide/Adverse Childhood Experiences
Economic Stability(Job Placement, Continuing Education Opportunities, etc.)
Chronic disease support(Diabetes, Cancer, etc.)
Healthcare Access/Literacy/Insurance
Educational Achievement/Child and Adolescent Development
Overweight/Obesity/Physical Exercise/Healthy Eating
Substance Abuse (Drugs, Alcohol, Tobacco)
Racism/Implicit Bias
Housing
Maternal/Infant Health
Food Access
Injury and Violence Prevention
Immunization and Infectious Disease(non COVID-19)
Environmental Issues&ead exposure, air quality, water quality, etc.)
Other
Sexually Transmitted Diseases(Health Education, etc.)


Top 3 Pediatric Health Issues
in the next three years
# of Respondents
130
120
110
100
90
80
70
60
50
40
30
20
10
0
114
87
74
58
56
44
39
30
29
20
15
11
9
7
1
Mental Health (Stress, Depres...
Poverty
Nurturing Family Lifestyle/E...
Childhood Obesity, Nutrition...
Early Child Care and Educati...
Child Abuse and Neglect
Health Access (Insurance, Med...
Special Health Needs (Behavi...
Bullying/Internet Safety
Substance Abuse (Alcohol, To...
Unsafe Neighborhoods
Environmental Pollution(lead...
Sexually Health and Education...
Immunizations(vaccines) and ...
Other


Most significant social determinants of health
# of Respondents
130
120
110
100
90
80
70
60
50
40
30
20
10
0
119
59
55
53
46
45
33
30
25
21
21
17
12
11
10
6
Poverty
Lack of access to foods that support healthy eating patterns
Discrimination/ Racism
Poor early childhood education and development
Housing instability
Food Insecurity
Lack of access to transportation
Lack of access to quality of housing
Poor environmental conditions
Poor social cohesion
Other
Poor language and literacy
Crime and violence
Poor high school graduation
Incarceration
Low enrollment in higher education



Appendix 4: Secondary Data Collection

Secondary data was identified to help support and inform the potential health priority areas identified by Key Informants. The focus was to understand the breadth, depth, and trend of the potential health priorities facing the community. A priority was put on identifying and compiling data that allowed for trending, was available in all four counties, and could, potentially, be addressed through community health programming.

According to the "County Health Rankings and Roadmaps," in 2021 Outcomes, Elkhart County ranked 27th, LaPorte County ranked 69th, Marshall County ranked 21st, and St. Joseph County ranked 55th among the 92 counties in Indiana. To calculate this rank County Health Rankings and Roadmaps looks at a number of indicators in the areas of Health Outcomes and Health Factors and produces a rank within each of these areas.

Secondary Data Metrics					
Category	**Metric**	**Used For**	**Most Recent Data Set**	**Source**	**URL**
Community Profile	Total Population	CHNA	2018	County Health Rankings - Census Bureau's Population	https://www.countyhealthrankings.org/app/indiana/2020/compare/snapshot?c

				Estimates Program	ounties=18_039%2B18_141%2B18_099%2B18_091
Community Profile	Under 18 years of age	CHNA		County Health Rankings - Census Bureau's Population Estimates Program	https://www.countyhealthrankings.org/app/indiana/2020/compare/snapshot?counties=18_039%2B18_141%2B18_099%2B18_091
Community Profile	65 years of age and older	CHNA		County Health Rankings - Census Bureau's Population Estimates Program	https://www.countyhealthrankings.org/app/indiana/2020/compare/snapshot?counties=18_039%2B18_141%2B18_099%2B18_091
Community Profile	Race	CHNA		County Health Rankings - Census Bureau's Population Estimates Program	https://www.countyhealthrankings.org/app/indiana/2020/compare/snapshot?counties=18_039%2B18_141%2B18_099%2B18_091
Community Profile	Gender	CHNA	2018	County Health Rankings - Census Bureau's Population Estimates Program	https://www.countyhealthrankings.org/app/indiana/2020/compare/snapshot?counties=18_039%2B18_141%2B18_099%2B18_091
Community Profile	Education Level	CHNA	2017	County Health Rankings - Census Bureau's Population Estimates Program	https://www.countyhealthrankings.org/app/indiana/2020/compare/snapshot?counties=18_039%2B18_141%2B18_099%2B18_091
Community Profile	School Enrollment	CHNA			http://www.stats.indiana.edu/profiles/profiles.asp?scope_choice=a&county_changer=18141
Community Profile	Poverty Rate	CHNA	2019	US Census Bureau - Small Area Income and Poverty Estimates	https://www.census.gov/data-tools/demo/saipe/#/?map_geoSelector=aa_c&s_measures=aa_snc&s_year=2019
Community Profile	Median Household Income	CHNA	2019	US Census Bureau - Small Area Income and Poverty Estimates	https://www.census.gov/data-tools/demo/saipe/#/?map_geoSelector=mhi_c&s_measures=mhi_snc&s_year=2019
Community Profile	Annual Unemployment Rate	CHNA	2019	Stats Indiana - Indiana Department of Workforce Development	http://www.stats.indiana.edu/profiles/profiles.asp?scope_choice=a&county_changer=18039

Community Profile	Uninsured Rate - Adults	CHNA	2017	County Health Rankings - US Census Bureau's Small Area Health Insurance Estimates	https://www.countyhealthrankings.org/app/indiana/2020/compare/snapshot?counties=18_039%2B18_141%2B18_099%2B18_091
Community Profile	Uninsured Rate - Children	CHNA	2017	County Health Rankings - US Census Bureau's Small Area Health Insurance Estimates	https://www.countyhealthrankings.org/app/indiana/2020/compare/snapshot?counties=18_039%2B18_141%2B18_099%2B18_091
Community Profile	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.	CHNA		County Health Rankings - U.S. Department of Housing and Urban Development	https://www.countyhealthrankings.org/app/indiana/2020/compare/snapshot?counties=18_039%2B18_141%2B18_099%2B18_091
Community Profile	Percentage of adults reporting fair or poor health	CHNA	2017	County Health Rankings - Behavioral Risk Factor Surveillance System	https://www.countyhealthrankings.org/app/indiana/2020/compare/snapshot?counties=18_039%2B18_141%2B18_099%2B18_091
Community Profile	Average number of physically unhealthy days reported in past 30 days	CHNA	2017	County Health Rankings - Behavioral Risk Factor Surveillance System	https://www.countyhealthrankings.org/app/indiana/2020/compare/snapshot?counties=18_039%2B18_141%2B18_099%2B18_091
Community Profile	Average number of mentally unhealthy days reported in past 30 days	CHNA		County Health Rankings - Behavioral Risk Factor Surveillance System	https://www.countyhealthrankings.org/app/indiana/2020/compare/snapshot?counties=18_039%2B18_141%2B18_099%2B18_091
Community Profile	Average number of years a person can expect to live	CHNA	2018	County Health Rankings - National Center for Health Statistics	https://www.countyhealthrankings.org/app/indiana/2020/compare/snapshot?counties=18_039%2B18_141%2B18_099%2B18_091
Community Profile	Households living below the federal poverty level(5-year esitmates)	CHNA		NCHHSTP AtlasPlus	https://gis.cdc.gov/grasp/nchhstpatlas/tables.html
Community Profile	Survival Budget Yearly Costs - Single Parent 3yo	CHNA	2020	Notre Dame ALICE study	

Community Profile	Survival Budget Yearly Costs - Family of four: 3 & 5yo	CHNA	2020	Notre Dame ALICE study	
Community Profile	Above ALICE HH PCT - Under 65	CHNA	2020	Notre Dame ALICE study	
Community Profile	ALICE HH Pct - Under 65	CHNA	2020	Notre Dame ALICE study	
Chronic Disease	Adults with Diagnosed Diabetes	CHNA	2017	CDC: Behavioral Risk Factor Surveillance System	https://gis.cdc.gov/grasp/diabetes/DiabetesAtlas.html#
Chronic Disease	Cancer incidence rate	CHNA	2017	U.S. Cancer Statistics Working Group	https://gis.cdc.gov/Cancer/USCS/DataViz.html
Chronic Disease	Percent of adults ever diagnosed with asthma who report they currently have asthma	CHNA	2016	National Environmental Public Health Tracking Network	https://ephtracking.cdc.gov/DataExplorer/?query=4E04F504-A4A2-405C-85AB-9BC6B3F7325D&fips=18141&allyears=1
Chronic Disease	Heart Disease Hospitalizations Per 10k	CHNA	2017	Indiana State Department of Health	http://indianaindicators.org/dash/overview.aspx
Chronic Disease	PERCENT OF POPULATION AGED 5 YEARS AND OVER WITH A DISABILITY	CHNA	2018	National Environmental Public Health Tracking Network	https://ephtracking.cdc.gov/DataExplorer/?query=4E04F504-A4A2-405C-85AB-9BC6B3F7325D&fips=18141&allyears=1
Economic Stability	Ratio of household income at the 80th percentile to income at the 20th percentile.	CHNA	2018	American Community Survey (ACS)	https://www.countyhealthrankings.org/app/indiana/2020/measure/factors/44/data
Economic Stability	Median household income	CHNA	2018	The Census Bureau	https://datausa.io/profile/geo/st-joseph-county-in#economy
Economic Stability	PERCENT OF HOUSEHOLDS WITH NO INTERNET ACCESS	CHNA	2018	U.S. Census Bureau, American Factfinder, American Community Survey (ACS) 5-year estimates	https://ephtracking.cdc.gov/DataExplorer/?query=4E04F504-A4A2-405C-85AB-9BC6B3F7325D&fips=18141&allyears=1
Economic Stability	PERCENT OF HOUSING UNITS WITH NO VEHICLE AVAILABLE	CHNA	2018	U.S. Census Bureau, American Factfinder, American Community Survey (ACS) 5-year estimates	https://ephtracking.cdc.gov/DataExplorer/?query=4E04F504-A4A2-405C-85AB-9BC6B3F7325D&fips=18141&allyears=1

Environmental Issues	National Ambient Air Quality	CHNA	2016	CDC's National Environmental Public Health Tracking Network	https://ephtracking.cdc.gov/DataExplorer/?query=4E04F504-A4A2-405C-85AB-9BC6B3F7325D&fips=18141&allyears=1
Environmental Issues	PERCENT OF CHILDREN TESTED WITH CONFIRMED BLOOD LEAD LEVELS OF 10 MG/DL OR GREATER	CHNA	2014	CDC Lead Poisoning Prevention Program	https://ephtracking.cdc.gov/DataExplorer/?query=4E04F504-A4A2-405C-85AB-9BC6B3F7325D&fips=18141&allyears=1
Environmental Issues	PERCENT OF POPULATION LIVING WITHIN A HALF MILE OF A PARK	CHNA	2015	National Environmental Public Health Tracking Network	
Environmental Issues	AVERAGE ONE-WAY COMMUTE TIME (MINUTES) FOR WORKERS 16 YEARS AND OLDER FOR ALL TRAVEL MODES	CHNA	2016	National Environmental Public Health Tracking Network	https://ephtracking.cdc.gov/DataExplorer/?query=4E04F504-A4A2-405C-85AB-9BC6B3F7325D&fips=18141&allyears=1
Food Access	Food Insecurity Rate	CHNA	2018		http://map.feedingamerica.org/county/2018/overall/indiana
Food Access	Population with Low Access to store	CHNA	2015	U.S. Department of Agriculture	https://www.ers.usda.gov/data-products/food-environment-atlas/go-to-the-atlas/
Healthcare Access/Insurance	Percentage of population under age 65 without health insurance	CHNA	2017	US Census Bureau's Small Area Health Insurance Estimates	https://www.countyhealthrankings.org/app/indiana/2020/measure/factors/85/data
Healthcare Access/Insurance	Primary care physicians per 100k	CHNA	2017	The Area Health Resource File	https://www.countyhealthrankings.org/app/indiana/2020/measure/factors/4/data
Healthcare Access/Insurance	Mental health providers	CHNA	2019	The NPI Registry	https://www.countyhealthrankings.org/app/indiana/2018/measure/factors/62/data
Healthcare Access/Insurance	Uninsured Children	CHNA	2017	County Health Rankings; Small Area Health Insurance Estimates	http://indianaindicators.org/dash/comparison.aspx?geo_id=18141
Heart Disease and Stroke	Heart Disease Deaths Per 100k	CHNA	2016	Indiana State Department of Health	http://indianaindicators.org/dash/overview.aspx

Heart Disease and Stroke	Stroke Deaths Per 100k	CHNA	2017	Indiana State Department of Health	http://indianaindicators.org/dash/overview.aspx
Heart Disease and Stroke	Hypertension Death Rate per 100,000	CHNA	2018	Interactive Atlas of Heart Disease and Stroke	https://nccd.cdc.gov/DHDSPAtlas/reports.aspx?geographyType=county&state=IN&themeId=17&filterIds=9,2,3,4,7&filterOptions=1,1,1,1,1&countyTab#report
Heart Disease and Stroke	Stroke Deaths Per 100k	CHNA	2016	Indiana State Department of Health	http://indianaindicators.org/dash/comparison.aspx?geo_id=18141
Housing	Owner-Occupied housing unit rate	CHNA	2018	The American Community Survey (ACS)	https://www.countyhealthrankings.org/app/indiana/2019/measure/factors/153/data
Housing	Severe housing cost burden	CHNA	2018	The American Community Survey	https://www.countyhealthrankings.org/app/indiana/2019/measure/factors/154/data
Housing	Eviction Rate	CHNA	2016	Eviction Lab	https://evictionlab.org/map/#/2016?geography=counties&bounds=-102.534,36.044,-75.095,45.993&type=er&locations=18091,-86.741,41.546%2B18099,-86.263,41.325%2B18141,-86.29,41.617
Housing	% of Renter Homes	CHNA	2016	Eviction Lab	https://evictionlab.org/map/#/2014?geography=states&bounds=-112.969,33.469,-67.157,49.825&type=er&locations=18141,-86.293,41.597%2B18,-86.273,39.911
Housing	PERCENT OF VACANT HOUSING UNITS	CHNA	2018	National Environmental Public Health Tracking Network	https://ephtracking.cdc.gov/DataExplorer/?query=4E04F504-A4A2-405C-85AB-9BC6B3F7325D&fips=18141&allyears=1
Immunization and Infectious Disease	Flu vaccinations %	CHNA	2017	The Centers for Medicare & Medicaid Services Office of Minority Health's Mapping Medicare Disparities	https://www.countyhealthrankings.org/app/indiana/2020/measure/factors/155/data
Immunization and Infectious Disease	Infants with Recommended Immunizations	CHNA	2016	Indiana State Department of Health	http://indianaindicators.org/dash/overview.aspx

Injury and Violence Prevention	Number of reported violent crime offenses per 100,000 population	CHNA	2016	The Uniform Crime Reporting (UCR)	
Injury and Violence Prevention	Number of deaths due to injury per 100,000 population	CHNA	2018	National Vital Statistics System (NVSS)	https://www.countyhealthrankings.org/app/indiana/2018/measure/factors/135/data
Maternal/Infant Health	Percentage of live births with low birthweight (< 2,500 grams)	CHNA	2018	Indiana State Department of Health	http://indianaindicators.org/dash/comparison.aspx?geo_id=18141
Maternal/Infant Health	Number of deaths among children under age 18 per 100,000 population	CHNA	2018	National Center for Health Statistics - Mortality Files	https://www.countyhealthrankings.org/app/indiana/2018/measure/outcomes/128/data
Maternal/Infant Health	Premature Births	CHNA	2016	Indiana State Department of Health	http://indianaindicators.org/dash/overview.aspx
Maternal/Infant Health	Mothers Who Breastfed Their Baby	CHNA	2016	Indiana State Department of Health	http://indianaindicators.org/dash/overview.aspx
Maternal/Infant Health	Births With Prenatal Care in First Trimester	CHNA	2016	Indiana State Department of Health	http://indianaindicators.org/dash/overview.aspx
Mental Health / Suicide	Number of deaths due to suicide per 100,000 population	CHNA	2019	CDC Wonder	https://wonder.cdc.gov/controller/datarequest/D76;jsessionid=30B04492F648FCD662A4672E9755
Mental Health / Suicide	Percentage of adults reporting 14 or more days of poor mental health per month	CHNA	2017	Behavioral Risk Factor Surveillance System (BRFSS)	https://www.countyhealthrankings.org/app/indiana/2017/measure/outcomes/145/data
Mental Health / Suicide	Number of Poor Mental Health Days Per Month	CHNA	2016	Indiana State Department of Health	http://indianaindicators.org/dash/overview.aspx
Overweight / Obesity	Adult Obesity	CHNA	2020	CDC Diabetes Interactive Atlas	http://indianaindicators.org/dash/overview.aspx
Overweight / Obesity	Percentage of adults age 20 and over reporting no leisure-time physical activity.	CHNA	2017	United States Diabetes Surveillance System	https://www.countyhealthrankings.org/app/indiana/2020/measure/factors/70/data
Overweight / Obesity	Poor physical health days	CHNA	2017	Behavioral Risk Factor Surveillance System	https://www.countyhealthrankings.org/app/indiana/2018/measure/outcomes/36/data
Racism	Residential Segregation - black/white	CHNA	2018	The American Community Survey	https://www.countyhealthrankings.org/app/indiana/2020/measure/factors/141/datasource

Racism	Percent in Poverty	CHNA	2019	U.S. Census Bureau, Small Area Income and Poverty Estimates	https://www.census.gov/data-tools/demo/saipe/#/?map_geoSelector=aa_c&s_state=18&s_year=2017&s_county=18039,18091,18099,18141&map_yearSelector=2017
Racism	Income by Race	CHNA	2019	US Census Bureau, American Community Survey	Assessment - SparkMap
Sexually Transmitted Diseases	Number of newly diagnosed chlamydia cases per 100,000 population.	CHNA	2017	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)	https://www.countyhealthrankings.org/app/indiana/2020/measure/factors/45/data
Sexually Transmitted Diseases	HIV Prevalence - Rate per 100,000	CHNA	2018	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	https://gis.cdc.gov/grasp/nchhstpatlas/tables.html
Sexually Transmitted Diseases	Gonorrhea - rate per 100,000	CHNA	2018	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	https://gis.cdc.gov/grasp/nchhstpatlas/tables.html
Substance Abuse	Number of drug poisoning deaths per 100,000 population.	CHNA	2018	CDC WONDER mortality data	https://www.countyhealthrankings.org/app/indiana/2018/measure/factors/138/data
Substance Abuse	Excessive drinking rate	CHNA	2017	The Behavioral Risk Factor Surveillance System (BRFSS	https://www.countyhealthrankings.org/app/indiana/2020/measure/factors/49/data
Substance Abuse	Smoking rate of adults	CHNA	2017	The Behavioral Risk Factor Surveillance System (BRFSS)	https://www.countyhealthrankings.org/app/indiana/2018/measure/factors/9/data
Child Abuse and Neglect	The rate of substantiated cases of child abuse and neglect per 1,000 children younger than age 18	Peds	2017	Indiana Department of Child Services	https://datacenter.kidscount.org/data/tables/1130-child-abuse-and-neglect-rate-per-1000-children-under-age-18?loc=16&loct=2#detailed/2/any/false/871,870,573/any/2467
Child Abuse and Neglect	Children in Need of Services (CHINS) as of June of the year listed	Peds	2017	Indiana Department of Child Services, Office of Data Management,	https://datacenter.kidscount.org/data/tables/4663-children-in-need-of-services-chins?loc=16&loct=2#detai

				Reports, and Analysis	led/2/any/false/871,870,573/any/10860
Early child care and education	Children not enrolled in school	Peds			
Early child care and education	Licensed child care slots per 100 children, ages 0-5	Peds	2017	Indiana Family and Social Services Administration	https://datacenter.kidscount.org/data/tables/1160-licensed-child-care-slots-per-100-children-ages-0-5?loc=16&loct=5#detailed/2/any/false/871,870,573/any/2527
Immunization and Infectious Disease	Immunization completion rate 19-35 months of age	Peds	2019	Stats Explorer, Epidemiology Resource Center, Indiana State Dept. of Health	ISDH ERC Stats Explorer (in.gov)
Nurturing Family Lifestyle/Environment(ACES mitigation)	% Children in Single-Parent Households	Peds	2018	American Community Survey, 5-year estimates	https://www.countyhealthrankings.org/app/indiana/2018/measure/factors/82/data?sort=sc-0
Nurturing Family Lifestyle/Environment(ACES mitigation)	Child food insecurity in Indiana	Peds	2016	Feeding America	https://datacenter.kidscount.org/data/tables/7809-child-food-insecurity?loc=16&loct=5#detailed/5/2311,2337,2341,2362/true/870,573,869/any/15078
Poverty	Public school students receiving free or reduced price lunches	Peds	2017	Indiana Department of Education	https://datacenter.kidscount.org/data/tables/5187-public-school-students-receiving-free-or-reduced-price-lunches?loc=16&loct=5#detailed/2/any/false/871,870,573/1279,1280,1281/13762,11655
Poverty	Children under age 18 in poverty	Peds	2017	U.S. Census Bureau, Housing and Household Economic Statistics Division, Small Area Estimates Branch	https://datacenter.kidscount.org/data/tables/1115-children-under-age-18-in-poverty?loc=16&loct=5#detailed/5/2311,2337,2341,2362/false/871,870,573/any/9429
Sexuality Health and Education(STIs, Teen Pregnancy, etc.)	Number of births per 1,000 female population ages 15-19	Peds	2018	National Center for Health Statistics	https://www.countyhealthrankings.org/app/indiana/2018/measure/factors/14/data

Special Health Needs (Behavioral and Chronic Health Issues)	Public School students Pre-K through 12+ receiving Special Education	Peds	2017	Indiana Department of Education	https://datacenter.kidscount.org/data/tables/1178-special-education-students?loc=16&loct=5#detailed/5/2311,2337,2341,2362/true/871,870,573/any/2563
Unsafe neighborhoods	Juvenile case filings by type in Indiana - Delinquency cases	Peds	2017	Indiana Supreme Court	https://datacenter.kidscount.org/data/tables/6472-juvenile-case-filings-by-type?loc=16&loct=5#detailed/5/2311,2337,2341,2362/true/871,870,573/2769,2773,2771,2770,2772/13410

Appendix 5: Focus Group Protocol

Focus Group Screening and Consent

Q1 What is your preferred language?

- ○ English (1)
- ○ Spanish (2)

Q2 Thank you for choosing to participate in the Beacon Health System 2021 Community Health Needs Assessment. This summer our team will be conducting focus groups with community members to understand how we can best support the community. The following questions will determine your eligibility to participate. Should you be eligible our team will reach out to you with more information.

Q3 Are you willing to participate in the Community Health Needs Assessment focus group?

- ○ Yes (1)
- ○ No (2)

Q4 Are you able and willing to use Zoom with your camera on during the focus group?

- ○ Yes (1)
- ○ No (2)

Q5 Are you able to meet virtually before the focus group to go over important information?

- ○ Yes (1)
- ○ No (2)

Q6 Please provide the following information:

- Name: (1) _____
- Email: (2) _____
- Phone Number: (3) _____

Q7 How do you wish to be contacted?

- Telephone (1)
- Email (2)

Q8 What is your County of Residence?

- Elkhart County (1)
- Marshall County (2)
- St. Joseph County (3)

Q9 What is your gender?

- Male (1)
- Female (2)
- Prefer not to answer (3)
- Other: (4) _____

Q10 What is your race or ethnic background?

- White or Caucasian (1)
- Hispanic or Latinx (2)
- Black or African American (3)
- American Indian, Alaska Native, Native Peoples (4)
- Asian or Pacific Islander (5)
- Other (6) _____

Q11 What is your age?

- ○ 18-24 (1)
- ○ 25-64 (2)
- ○ 65+ (3)

Q12 Do you have children under the age of 18?

- ○ Yes (1)
- ○ No (2)

Q13 How did you find out about this focus group?

- ○ Friend or family member (1)
- ○ Referred by a local organization: (2) _____
- ○ Beacon associate (3)
- ○ Beacon webpage (4)

Q14 All individuals who complete the focus group will receive a $30 gift card. Which of the following do you prefer?

- ○ I opt to receive mine virtually using the email address provided. (1)
- ○ I would like to receive a physical copy of the gift card. (2)
- ○ I do not wish to receive a gift card. (3)

Q15 Community Health Needs Assessment 2022-2024 Focus Groups
Purpose You have been invited to participate in a focus group sponsored by Beacon Health System's Community Impact Department under the direction of Lauren Squires. The purpose of this focus group is to better understand the current health needs of our three county region (Elkhart, Marshall, and St. Joseph Counties). The information learned in this focus group will be used to determine appropriate community health programming for 2022-2024.

Procedure As part of this study, you will be placed in a group of 6 – 12 adult individuals. A moderator will ask you several questions while facilitating the discussion. As approved through Beacon Health System's Review Board, this focus group will be audio-recorded and a note-taker will be present. However, your name will not be associated with any of your responses. NO names will be included in the final report. You can choose whether or not to participate in the focus group, and you may stop at any time during the course of the study. Please note that there are no right or wrong answers to focus group questions. Beacon Community Impact wants to hear the many varying viewpoints

and would like for everyone to contribute their thoughts. Out of respect, please refrain from interrupting others. However, feel free to be honest even when your responses counter those of other group members.

Benefits and Risks Your participation may benefit you and other community members in Elkhart, Marshall, and St. Joseph Counties through improved community health programming. However, no risks are anticipated beyond those experienced during an average conversation.

Confidentiality Should you choose to participate, you will be asked to respect the privacy of other focus group members by not disclosing any content discussed during the study. Researchers within Beacon Community Impact will analyze the data, but—as stated above—NO names will be included in any reports.

Contact If you have any questions about your rights as a participant in this study, you may contact the Beacon Institutional Review Board office at 574-296-6505. I understand this information, certify that I am 18 years or older, and agree to participate fully under the conditions stated above.

Spanish

Le agradecemos por elegir participar en la Evaluación de necesidades de salud comunitaria de Beacon Health System 2021. Durante este verano, nuestro equipo organizará grupos de sondeo con miembros de la comunidad para comprender cómo podemos apoyar mejor a la comunidad. Las siguientes preguntas determinarán si reúne los requisitos para participar. En caso de que reúna los requisitos, nuestro equipo se comunicará con usted para darle más información.

Q3 ¿Desea participar en el grupo de sondeo de la Evaluación de necesidades de salud comunitaria?

- ○ Si (1)
- ○ No (2)

Q4 ¿Puede y desea utilizar Zoom con la cámara encendida mientras conversa con el grupo de sondeo?

- ○ Si (1)
- ○ No (2)

Q5 ¿Puede reunirse virtualmente antes de la charla con el grupo de sondeo para repasar información importante?

- ○ Si (1)
- ○ No (2)

Q6 Le agradecemos que nos brinde la siguiente información:

- ○ Nombre: (1) _____
- ○ Correo electrónico: (2) _____
- ○ Número de teléfono: (3) _____

Q7 ¿Cómo le gustaría que nos comuniquemos con usted?

- ○ Teléfono (1)
- ○ Correo electrónico (2)

Q8 ¿En qué condado reside?

- ○ Condado de Elkhart (1)
- ○ Condado de Marshall (2)
- ○ Condado de St. Joseph (3)

Q9 ¿Cuál es su género?

- ○ Masculino (1)
- ○ Femenino (2)
- ○ Prefiere no responder (3)
- ○ Otro: (4) _____

Q10 ¿Cuál es su raza u origen étnico?

- ○ Blanco o caucásico (1)
- ○ Hispano o latino (2)
- ○ Negro o afroamericano (3)
- ○ Indio americano, nativo de Alaska, pueblos nativos (4)
- ○ Isleño asiático o del Pacífico (5)
- ○ Otro: (6) _____

Q11 ¿Cuál es su edad?

- ○ 18 - 24 (1)
- ○ 25 - 64 (2)
- ○ 65 + (3)

Q12 ¿Tienes hijos menores de 18 años?

- ○ Si (1)
- ○ No (2)

Q13 ¿Cómo se enteró de este grupo de sondeo?

- ○ Amigo o familiar (1)
- ○ Derivado por una organización local: (2) _____
- ○ Asociado a Beacon (3)
- ○ Página web de Beacon (4)

Q14 Todas las personas que completen el grupo de sondeo recibirán una tarjeta de regalo de $30. De las siguientes opciones, ¿qué prefiere?

- ○ Elijo recibir la mía virtualmente, utilizando la dirección de correo electrónico proporcionada. (1)
- ○ Me gustaría recibir una copia física de mi tarjeta de regalo. (2)
- ○ No deseo recibir una tarjeta de regalo. (3)

Q15
Evaluación de las necesidades de salud de la comunidad 2022-2024

Grupos de sondeo

Propósito

Ha recibido una invitación para participar en un grupo de sondeo patrocinado por el departamento de Impacto Comunitario de Beacon Health System, bajo la dirección de Lauren Squires. El propósito de este grupo de sondeo es comprender mejor las necesidades de salud actuales en nuestra región de tres condados (los condados de Elkhart, Marshall y St. Joseph). La información obtenida de este grupo de sondeo se utilizará para determinar la programación de salud comunitaria adecuada para 2022-2024.

Procedimiento

Como parte de este estudio, lo colocaremos en un grupo de entre 6 y 12 personas. Un moderador le hará varias preguntas, al tiempo que facilita la conversación. Según lo aprobado a través de la Junta de Revisión de Beacon Health System, la charla con este grupo de sondeo se grabará en audio; además, estará presente una persona que tome notas. No obstante eso, su nombre no se asociará a ninguna de sus respuestas. El informe final NO incluirá nombres.

Usted puede decidir si participa o no en el grupo de sondeo, y puede desistir en cualquier momento durante el transcurso del estudio.

Tenga en cuenta que las preguntas al grupo de sondeo no tienen respuestas correctas o incorrectas. Impacto Comunitario de Beacon quiere escuchar los diferentes puntos de vista y desearía que todos contribuyan con sus pensamientos. Por respeto, absténgase de interrumpir a los demás. Sin embargo, siéntase libre de hablar con sinceridad incluso cuando sus respuestas sean contrarias a las de otros miembros del grupo.

Beneficios y riesgos

Su participación puede beneficiarlo a usted y a otros miembros de la comunidad en los condados de Elkhart, Marshall y St. Joseph a través de programas mejorados de salud comunitaria. Por otra parte, no se anticipan riesgos más allá de aquellos que se experimentan durante una conversación normal.

Confidencialidad

Si decide participar, se le pedirá que respete la privacidad de los demás miembros del grupo de sondeo al no revelar el contenido que se analiza durante el estudio. Los investigadores de Impacto Comunitario de Beacon analizarán la información pero, tal como se afirmó anteriormente, NO se incluirán nombres en los informes.

Contacto

Si tiene preguntas acerca de sus derechos como participante de este estudio, puede comunicarse con la oficina de la Junta de revisión institucional de Beacon llamando al 574-296-6505.

Comprendo esta información, certifico que tengo 18 años o más de edad y acepto participar plenamente en las condiciones indicadas anteriormente.

Focus Groups with Beacon Health System's community-at-large (Elkhart, Marshall, and St. Joseph County Residents)

Introduction – 6 mins

- Welcome and thanks
- What the project is about:
    - Beacon Health System's Community Health Needs Assessment
    - Identifying unmet health needs in our community
    - Ultimately, to plan on how to address health needs now and in future
- Confidentiality:
    - Would like to record so that we can be sure to get your words right.
    - We will only use first names here to preserve your anonymity.
    - Transcripts will go to hospitals if that is OK with you.
    - Transcripts will be transcribed using the professional transcription service, Rev.com.
    - When we are finished with all of the focus groups, we will look at all of the transcripts, code them, and summarize the things we learn. We also will pull out some quotes so that the hospitals can hear your own words. We will not use your name or any identifying information when we give them those quotes.
- What we'll do with the information you tell us today:
    - Hospitals will report the assessment to the IRS
    - Hospitals will use information for planning future investments
- Logistics
    - We will end at : .
    - It is my job to move us along to stay on time. I may interrupt you; I don't mean any disrespect, but it is important to get to all of the questions and get you out in time. I may also ask clarifying questions.
    - Cell phones: On vibrate; please take calls outside.
    - Bathroom: Bathrooms are located [insert directions].

- If ZOOM: please leave cameras on, if possible, for the entire session. It may be easiest to have your microphone on mute when not speaking to reduce noise overlap.
- Guidelines: It's OK to disagree, but be respectful. We want to hear from everyone. Please speak up!

Health Needs Prioritization – 10 mins.

You are here to share your experience as a member of the [insert county] community.

Part of our task today is to find out which health needs you think are most important. This document has a list of the health needs that the community came up with when we did the Community Health Needs Assessment in 2016. Additionally you will see a list of priorities identified by the Key Informant's surveyed earlier this year.

[Read aloud from document and define (e.g. "Access and Delivery" means insurance, having a primary care physician, preventive care instead of Emergency Department, being treated with dignity and respect, wait times, etc.).]

*Discuss COVID and how it may have excacerbated these issues/brought to light new gaps.

1. Are there any that should be added to the list?

2. Please think about the three from the list you believe are the most important to address here in the next few years.

- Face-to-face: take the three sticky dots you have and use them to vote for three health needs that you think are the most important to address in the next 3-4 years. The idea is to vote on the things that you think may not be well- addressed now. In other words, some health needs may have a lot of people working on them, and plenty of treatments and medicines to address them. Others we may not understand as well, or there may not be enough doctors or facilities out there to help people. Then we will discuss the results of your votes looking specifically at the identified top three.
- Virtual: I will call on each person in the focus group to identify the three greatest health needs. We will then tally up the votes and discuss the three items with the most votes. In case of a tie, will will discuss the top 4 or 5.

3. Summarize voting results. Explain that we will spend the rest of our time reflecting on these top priorities.

Understanding the Needs – 15 mins

4. When you think about [health need1]…
- What are people struggling with?
- What barriers exist to people getting healthy or staying healthy?

[Repeat this question for the remaining two identified priorities.]

5. What about healthcare access?
- Is everyone able to get health insurance for their needs?
- Is everyone able to afford to pay for health services and medication?
- Is everyone able to get to the doctors they need when they need to?
- Do people mostly have a primary care doctor, or do they mostly use urgent care or the ER instead? [If the latter: Why?]

6. What about mental health? Mental health was one of the top health needs last time.

(By mental health, we mean everything ranging from stress, substance use disorder to mental illness.)

a. In your opinion, what are the specific mental health needs in our community? Prompt:

Conditions like stress or depression, outcomes like suicide, concerns about stigma

b. Do you think that people who are struggling with mental health issues are doing worse than others when it comes to these other health issues we have listed? If so, how? (Drivers)

7. Do you think that things have been getting better, stayed the same, or gotten worse, in the last three years or so? [If things have changed: How?]

Equity & Cultural Competency – 15 mins

8. Do you think that everyone in our community is getting the same health care, and has the same access to care? If not, what are the barriers for them? Prompt: Think about all of the people in our community… some have different ethnicities, languages, sexual orientations, and religions. They may be disabled or be low-income or be experiencing homelessness.

Suggestions / Improvements / Solutions – 5-10 mins

In addition to what we have already talked about…

9. What types of services, if any, does the community need more of?
Prompt: Preventative care? Deep-end services? Workforce changes?

10. What kinds of changes could those in charge here in EC, MC, or SJC make to help all of us stay healthy?

Closing – 5 mins

- Thank you
- Repeat - What we will do with the information
- Incentives – after you turn in the demographic survey

Spanish

Grupos de sondeo de toda la comunidad de Beacon Health System (residentes de los condados de Elkhart, Marshall y St. Joseph)

Introducción – 6 min.

- Bienvenido y gracias
- Los objetivos del proyecto:
  - Evaluación de las necesidades de salud de la comunidad de Beacon Health System
  - Identificar las necesidades de salud insatisfechas en nuestra comunidad
  - En última instancia, planificar cómo abordar las necesidades de salud actuales y futuras
- Confidencialidad:
  - Nos gustaría grabar para que podamos estar seguros de captar correctamente sus palabras.
  - Aquí solo usaremos nombres de pila para preservar su anonimato.
  - Si usted está de acuerdo, las transcripciones irán a los hospitales.
  - Las transcripciones se harán utilizando el servicio de transcripción profesional Rev.com.
  - Cuando hayamos terminado con todos los grupos de sondeo, veremos todas las transcripciones, las codificaremos y resumiremos lo que aprendemos. También extraeremos algunas citas para que los hospitales puedan escuchar sus propias palabras. Al brindar esas citas, no utilizaremos su nombre ni otra información que lo identifique.
- Lo que haremos con la información que nos brinde hoy:

- Los hospitales informarán al Servicio de Impuestos Internos (IRS) acerca de la evaluación
- Los hospitales utilizarán la información para planificar futuras inversiones

- Logística
  - Terminaremos a las : .
  - Mi trabajo es avanzar con usted para mantener la puntualidad. Tal vez lo interrumpa. No quiero faltarle el respeto, pero es importante responder todas las preguntas y terminar a tiempo. También puedo hacer preguntas para aclarar.
  - Teléfonos celulares: En modo de vibración. Por favor, atienda las llamadas afuera.
  - Baño: Los baños están ubicados en [colocar indicaciones].
  - Si es vía ZOOM: de ser posible, deje las cámaras encendidas durante toda la sesión. Puede ser más fácil tener el micrófono en silencio cuando no está hablando para reducir la superposición de ruidos.
  - Indicaciones: Está bien no estar de acuerdo, pero sea respetuoso. Queremos escucharlos a todos. ¡Por favor, hable!

Priorización de las necesidades de salud – 10 min

Usted está aquí para compartir su experiencia como miembro de la comunidad de [colocar condado].

Parte de nuestra tarea de hoy es averiguar qué necesidades de salud cree que son las más importantes.

Este documento tiene una lista de las necesidades de salud que surgieron de la comunidad cuando hicimos la Evaluación de necesidades de salud de la comunidad en 2016. Además, verá una lista de prioridades identificadas por los informantes clave encuestados a principios de este año.

[Lea en voz alta el documento y defina (por ej., "Acceso y prestación" se refiere a un seguro, tener un médico de atención primaria, atención preventiva en lugar del Departamento de emergencias, ser tratado con dignidad y respeto, tiempos de espera, etc.)].

*Hable de la COVID y de cómo puede haber exacerbado estos problemas o sacado a la luz nuevas brechas.

1. ¿Hay alguna que deberíamos agregar a la lista?
2. Piense en las tres de la lista que cree que son las más importantes para abordar aquí en los próximos años.
   a. Cara a cara: tome los tres puntos adhesivos que tiene y utilícelos para votar por tres necesidades de salud que cree que son las más importantes para abordar en los próximos 3-4 años. La idea es que vote sobre las cosas que cree que pueden no estar bien contempladas ahora. En otras palabras, algunas necesidades de salud pueden tener a muchas personas trabajando en ellas, y muchos tratamientos y medicamentos para abordarlas. Es posible que haya otras que no comprendamos tan bien, o que no haya suficientes médicos o instalaciones para ayudar a las personas. Luego, analizaremos los resultados de sus votos prestando atención específicamente a los tres primeros que se identificaron.
   b. Virtual: llamaré a cada persona del grupo de sondeo para que identifique las tres necesidades de salud más importantes. Luego contaremos los votos y analizaremos los tres puntos con más votos. En caso de un empate, analizaremos los primeros 4 o 5.
3. Resumen de los resultados de la votación. Explique que dedicaremos el resto de nuestro tiempo a reflexionar sobre estas prioridades principales.

Comprender las necesidades – 15 min

4. Cuando piensa acerca de [necesidad de salud1]...
   - ¿Con qué tiene dificultades la gente?

- ¿Qué barreras encuentra la gente para recuperarse o mantenerse saludable? [Repita esta pregunta para las otras dos prioridades que se identificaron].

5. ¿Qué ocurre con el acceso a la atención médica?
   - ¿Todos pueden obtener un seguro médico para sus necesidades?
   - ¿Todos pueden pagar los servicios de salud y los medicamentos?
   - ¿Todos pueden acceder a los médicos que necesitan cuando los necesitan?
   - ¿Las personas tienen en su mayoría un médico de atención primaria o, en su lugar, utilizan la atención de urgencia o de la sala de emergencias? [Si es esto último: ¿Por qué?]

6. ¿Qué sucede con la salud mental? La salud mental fue una de las principales necesidades de salud identificadas la última vez.

   (Por salud mental, nos referimos a todo, desde el estrés o el trastorno por consumo de sustancias hasta las enfermedades mentales).

   a. En su opinión, ¿cuáles son las necesidades específicas de salud mental en nuestra comunidad? Entrada: Afecciones como el estrés o la depresión, resultados como el suicidio, preocupaciones sobre la estigmatización

   b. ¿Cree que las personas que luchan con problemas de salud mental están peor que otras cuando se trata de estos otros problemas de salud que hemos enumerado? En caso afirmativo, ¿cómo? (Claves)

7. ¿Cree que las cosas han mejorado, se han mantenido igual o han empeorado alrededor de los últimos tres años? [Si las cosas han cambiado: ¿Cómo?]

Igualdad y capacidad cultural – 15 min.

8. ¿Cree que todos en nuestra comunidad reciben la misma atención médica y tienen el mismo acceso a la atención? En caso negativo, ¿cuáles son las barreras que enfrentan?
   Entrada: Piense en todas las personas de nuestra comunidad... algunas tienen diferentes etnias, idiomas, orientaciones sexuales y religiones. Pueden estar discapacitados o tener bajos ingresos o estar sin hogar.

Sugerencias/mejoras/soluciones – 5-10 min.

Más allá de lo que hablamos hasta ahora...

9. ¿Qué tipo de servicios necesita más la comunidad, si los hay?
   Entrada: Atención preventiva Servicios intensivos Cambios en la fuerza laboral

10. ¿Qué tipo de cambios podrían hacer los responsables aquí en EC, MC o SJC para ayudarnos a todos a mantenernos saludables?

Cierre – 5 min

- Gracias
- Repetir – Qué haremos con la información
- Incentivos – después de entregar la encuesta demográfica

Priority Areas for Question 1 in English and Spanish	
Chronic disease support (Diabetes, Cancer, etc.)	Apoyo a enfermedades crónicas (diabetes, cáncer, etc.)
Economic Stability (Job Placement, Continuing Education Opportunities, etc.)	Estabilidad económica (colocación laboral, oportunidades de educación continua, etc.)
Environmental Issues (lead exposure, air quality, water quality, etc.)	Problemas ambientales (exposición al plomo, calidad del aire, calidad del agua, etc.)
Educational Achievement/Child and Adolescent Development	Logro educativo / Desarrollo infantil y adolescente
Food Access	Acceso a comida
Healthcare Access/Literacy/Insurance	Acceso a servicios de salud/ Educacion en salud/ Seguro medico
Housing	Vivienda
Immunization and Infectious Disease(non COVID-19)	Vacunas y enfermedades infecciosas (no COVID-19)
Injury and Violence Prevention	Heridas y prevencion de violencia
Maternal/Infant Health	Cuidado durante el embarazo / Salud de los bebes
Mental Health/Suicide/Adverse Childhood Experiences	Salud Mental
Overweight/Obesity/Physical Exercise/Healthy Eating	Sobre peso/obesidad/Ejercicio/Nutricion
Racism/Implicit Bias	Racismo
Sexually Transmitted Diseases (Health, Education, etc.)	Enfermedades de Transmision Sexual (Salud, Educacion, etc)
Substance Abuse(Drugs, Alcohol, Tobacco)	Abuso de sustancias (Alcohol, drogas, Tabaco)

Appendix 6: IRS Requirements Checklist

CHNA Requirements per IRS Section 501-R	
Federal Requirements Checklist	**Report Reference**
Be conducted every 3 years	Section 2
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, and	Section 2
Be made widely available to the public.	https://impact.beaconhealthsystem.org/chna/
Conducting a CHNA	
1. Define the community it serves.	Section 3 & 4
2. Assess the health needs of that community.	Section 3

	3. In assessing the community's health needs, solicit and take into account input received from persons who represent the broad interests of that community, including those with special knowledge of or expertise in public health.	Section 3
	4. Document the CHNA in a written report (CHNA report) that is adopted for the hospital facility by an authorized body of the hospital facility.	Section 1
	5. Make the CHNA report widely available to the public.	https://impact.beaconhealthsystem.org/chna/
Community Served		
	The geographic area served by the hospital facility,	Section 3
	Target populations served, such as children, women, or the aged, and	Section 3
	Principal functions, such as a focus on a particular specialty area or targeted disease.	Section 3
Assessing Community Health Needs		
	To assess the health needs of its community, a hospital facility must identify the significant health needs of the community.	Section 5
	It must also prioritize those health needs,	Section 5
	as well as identify resources potentially available to address them.	Section 6 & Appendix 2
A hospital facility may determine whether a health need is significant based on all the facts and circumstances present in the community it serves. Additionally, a hospital facility may use any criteria to prioritize the significant health needs it identifies, including, but not limited to the:		
	Burden, scope, severity, or urgency of the health need,	Section 5
	Estimated feasibility and effectiveness of possible interventions,	Section 6
	Health disparities associated with the need, or	Section 5
	Importance the community places on addressing the need.	Section 5
Input Representing the Broad Interests of the Community		
	1. At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency), or a State Office of Rural Health described in Section 338J of the Public Health Services Act, with knowledge, information, or expertise relevant to the health needs of the community.	Section 3

	2. Members of medically underserved, low-income, and minority populations in the community served by the hospital facility, or individuals or organizations serving or representing the interests of these populations.	Section 3
	3. Written comments received on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy	Section 2
Documentation of a CHNA		
	A hospital facility must document its CHNA in a report that is adopted by an authorized body of the hospital facility.	Section 1
	A definition of the community served by the hospital facility and a description of how the community was determined.	Section 3
	A description of the process and methods used to conduct the CHNA.	Section 3
	A description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves.	Section 3
	A prioritized description of the significant health needs of the community identified through the CHNA. This includes a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs.	Section 5
	A description of resources potentially available to address the significant health needs identified through the CHNA.	Section 6 & Appendix 2
	An evaluation of the impact of any actions that were taken to address the significant health needs identified in the immediately preceding CHNA,	Appendix 1
A CHNA report will be considered to describe the process and methods used to conduct the CHNA report if it:		
	Describes the data and other information used in the assessment,	Appendix 4
	Describes the methods of collecting and analyzing this data and information,	Section 5
	Identifies any parties with whom the hospital facility collaborated or contracted for assistance in conducting the CHNA.	Section 3
	A hospital facility may rely on (and the CHNA report may describe) external source material in conducting its CHNA. In such cases, the hospital	Appendix 4

	facility may simply cite the source material rather than describe the methods of collecting the data.	
A hospital facility's CHNA report must describe how the hospital facility took into account input received from persons who represent the broad interests of the community it serves. The CHNA report should:		
	Summarize, in general terms, the input provided by such persons,	Section 3
	Describe how and over what time period such input was provided (for example, whether through meetings, focus groups, interviews, surveys, or written comments and between what approximate dates),	Section 3
	Provide the names of any organizations providing input and summarizes the nature and extent of the organization's input, and	Section 3
	Describe the medically underserved, low-income, or minority populations being represented by organizations or individuals that provided input.	Section 3
	If a hospital facility solicits, but cannot obtain, input from a required source representing the broad interests of the community, the hospital facility's CHNA report must describe the hospital facility's efforts to solicit the input from such source.	N/A
	Collaborating hospital facilities may produce a joint CHNA report as long as all of the collaborating hospital facilities define their community to be the same and the joint CHNA report contains all of the same basic information that separate CHNA reports must contain. Additionally, the joint CHNA report must be clearly identified as applying to the hospital facility.	Sections 1 & 3
CHNA Report: Widely Available		
	A hospital facility must make its CHNA report widely available to the public. This must be done by making the CHNA report widely available on a Web site and by making a paper copy of the CHNA report available for public inspection upon request and without charge at the hospital facility.	https://impact.beaconhealthsystem.org/chna/

	Prior CHNA reports must remain widely available to the public, both on a Web site and in paper, until the hospital facility has made two subsequent CHNA reports widely available to the public.	https://impact.beaconhealthsystem.org/chna/

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beaconhealthsystem.org/community-impact