Ascension St. Vincent Heart Center

2024 Community Health Needs Assessment

Hamilton County, Indiana

Conducted May 1, 2024, to June 30, 2025

Ascension

The goal of this report is to offer a meaningful understanding of the most significant health needs across Hamilton County with emphasis on identifying the barriers to health equity for all people, as well as to inform planning efforts to respond to those needs. Special attention has been given to the needs of individuals and communities who are at increased risk for poor health outcomes or experiencing social factors that place them at risk. Findings from this report can be used to identify, develop, and focus hospital, health system, and community initiatives and programming to better serve the health and wellness needs of the community.

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The 2024 Community Health Needs Assessment report was approved by the Ascension St. Vincent Heart Center Board of Directors on May 29, 2025 (2024 tax year), and applies to the following three-year cycle: July 2025 to June 2028 (FY 2026 - FY 2028). This report, as well as the previous report, can be found at our public website.

We value the community's voice and welcome feedback on this report. Please visit our public website (https://healthcare.ascension.org/chna) to submit your comments.

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Acknowledgements

The 2024 Community Health Needs Assessment (CHNA) represents a true collaborative effort to gain a meaningful understanding of the most pressing health needs across Hamilton County. Ascension St. Vincent Heart Center is exceedingly thankful to the many community organizations and individuals who shared their views, knowledge, expertise and skills with us. A complete description of community partner contributions is included in this report. We look forward to our continued collaborative work to promote a healthier, more equitable place to live, work and play.

We would also like to thank you for reading this report, and your interest and commitment to improving the health and well-being of Hamilton County.

Executive Summary

The goal of the 2024 Community Health Needs Assessment report is to offer a meaningful understanding of the most significant health needs across Hamilton County. Findings from this report can be used to identify, develop, and focus hospital, health system, and community initiatives and programming to better serve the health and wellness needs of the community.

Purpose of the CHNA

As part of the Patient Protection and Affordable Care Act of 2010, all not-for-profit hospitals are required to conduct a community health needs assessment (CHNA) and adopt an implementation strategy (IS) every three years. The purpose of the CHNA is to understand the health needs and priorities, with an emphasis on identifying the barriers to health equity, for all people who live and/or work in the communities served by the hospital, with the goal of responding to those needs through the development of an implementation strategy plan.

Community Served

Although Ascension St. Vincent Heart Center serves Hamilton County in addition to the surrounding areas, Ascension St. Vincent Heart Center has defined its “community served” as Hamilton County for the 2024 CHNA. Hamilton County was selected as Ascension St. Vincent Heart Center’s community served because it is our primary service area as well as our partners' primary service area. Additionally, community health data is readily available at the county level.

Data Analysis Methodology

The 2024 CHNA was conducted from May 2024 through June 2025, and utilized a process which incorporated data from both primary and secondary sources. Primary data sources included information provided by groups/individuals, e.g., community members, health care consumers, health care professionals, community stakeholders, and multi-sector representatives. Special attention was given to the needs of individuals and populations who are more marginalized and to unmet health needs or gaps in services. During 2024, two community input meetings were held and five key stakeholder interviews were conducted. Secondary data was compiled and reviewed to understand the health status of the community. Measures reviewed included chronic disease, social and economic factors, and healthcare access and utilization trends in the community and were gathered from reputable and reliable sources.

Community Needs

Ascension St. Vincent Heart Center, with contracted assistance from Verité Healthcare Consulting, analyzed secondary data and gathered community input through interviews and community input sessions to identify the needs of Hamilton County. In collaboration with community partners, Ascension St. Vincent Heart Center used a phased prioritization approach to determine the most crucial needs for community stakeholders to address. The significant needs identified through this process are as follows:

- Access to Care
- Mental Health Status and Access to Mental Health Services
- Services for Older Adults
- Social Drivers of Health, including:
    - Poverty
    - Affordable Housing
    - Food Insecurity
    - Transportation
- Substance Use Disorders, including Alcohol and Nicotine

Next Steps and Conclusion

The 2024 CHNA was presented to the Ascension St. Vincent Heart Center Board of Directors for approval and adoption on May 29, 2025. Following approval of the CHNA, Ascension St. Vincent Heart Center will complete a prioritization matrix and develop an implementation strategy. The implementation strategy will focus on all or a subset of the significant needs, and will describe how the hospital intends to respond to those prioritized needs throughout the same three-year CHNA cycle: July 2025 to June 2024.

Ascension St. Vincent Heart Center hopes this report offers a meaningful and comprehensive understanding of the most significant needs of Hamilton County members. The hospital values the community's voice and welcomes feedback on this report; comments or questions can be submitted via Ascension's public website (https://healthcare.ascension.org/chna).

About Ascension

As one of the leading non-profit and Catholic health systems in the United States, Ascension is committed to delivering compassionate, personalized care to all, with special attention to individuals and communities who are at increased risk for poor health outcomes or affected by experiencing social factors that impact health that place them at risk.

Ascension

Ascension is one of the nation's leading non-profit and Catholic health systems, with a Mission of delivering compassionate, personalized care to all with special attention to those most vulnerable and persons living in poverty. In FY 2024, Ascension provided $2.1 billion in care of persons living in poverty and other community benefit programs. Ascension includes approximately 131,000 associates, 37,000 affiliated providers and 136 hospitals, serving communities in 18 states and the District of Columbia.

Ascension's Mission provides a strong framework and guidance for the work done to meet the needs of communities across the U.S. It is foundational to transform health care and express priorities when providing care and services, particularly to those most in need.

> **Mission:** Rooted in the loving ministry of Jesus as healer, we commit ourselves to serving all persons with special attention to those who are poor and vulnerable. Our Catholic health ministry is dedicated to spiritually-centered, holistic care which sustains and improves the health of individuals and communities. We are advocates for a compassionate and just society through our actions and our words.

For more information about Ascension, visit https://www.ascension.org.

Ascension St. Vincent Indiana

Ascension St. Vincent operates 19 hospitals in addition to a comprehensive network of affiliated joint ventures, medical practices and clinics serving Indiana and employs more than 13,000 associates. In Fiscal Year 2024, Ascension St. Vincent provided more than $357 million in community benefit and care of persons living in poverty throughout the state.

Ascension St. Vincent Heart Center

As a Ministry of the Catholic Church, Ascension St. Vincent Heart Center is a non-profit hospital governed by a local board of trustees represented by community members, medical staff, and sister sponsorships. For many years, the hospital has provided medical care for the residents of Hamilton County, Indiana and neighboring areas.

In 2006, St. Vincent and the Heart Center of Indiana formed a 50/50 joint venture, renaming the facility the St. Vincent Heart Center of Indiana. The 80-bed, specialized licensed hospital focuses on

cardiovascular care, providing a wide range of related services, including emergency medicine, interventional radiology, laboratory services, medical imaging, nutrition support, rehabilitation services, respiratory care, sleep disorder treatment, spiritual care, cardiac surgery, and women's health. Located in Hamilton County, central Indiana, the ASV Heart Center serves patients from across the state.

For more information about the Ascension St. Vincent Heart Center, visit

https://healthcare.ascension.org/locations/indiana/inasc/carmel-ascension-st-vincent-heart-center

About the Community Health Needs Assessment

A community health needs assessment is essential for community building, health improvement efforts, and directing resources where they are most needed. CHNAs can be powerful tools with the potential to be catalysts for immense community change.

Purpose of the CHNA

A CHNA is defined as "a systematic process involving the community that identifies and analyzes community health needs and assets to plan and act upon priority community health needs."[1] The process serves as a foundation for promoting the health and well-being of the community by identifying the most pressing needs, leveraging existing assets and resources, developing strategic plans, and mobilizing hospital programs and community partners to work together. This community-driven approach aligns with Ascension St. Vincent Heart Center's commitment to offer programs designed to respond to the health needs of a community, with special attention to persons who are medically underserved and at risk for poorer health outcomes because of social factors that put them at increased risk.

Advancing Health Equity

Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health.[2] Progress toward achieving health equity can be measured by reducing health disparities. Health disparities are particular health differences closely linked with economic, social, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced such obstacles to health based on their race or ethnicity; religion; socioeconomic status; gender identity; sexual orientation; age; cognitive, sensory, or physical disability; geographic location; or other characteristics historically linked to discrimination or exclusion.[3]

Focusing on the root causes that have perpetuated these differences contributes to the advancement of health equity. By identifying the conditions, practices, and policies that perpetuate differences in health outcomes, we can better respond to root causes when pursuing health equity.

Ascension acknowledges that health disparities in our communities go beyond individual health behaviors. Ascension's Mission calls us to be "advocates for a compassionate and just society through our actions and words"; therefore, health equity is a matter of great importance to Ascension.

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[1] Catholic Health Association of the United States. (2022). *A guide for planning and reporting community benefit, 2022 (p.146)*.

[2] National Center for Chronic Disease Prevention and Health Promotion. (2023, January 4). *Advancing health equity in chronic disease prevention and management*. Center for Disease Control and Prevention (CDC). Retrieved October 11, 2023, from https://www.cdc.gov/chronicdisease/healthequity/index.htm

[3] Braveman, P. (2014). What are health disparities and health equity? We need to be clear. *Public Health Reports*, *129*(Suppl 2), 5-8. https://doi.org/10.1177/00333549141291S203

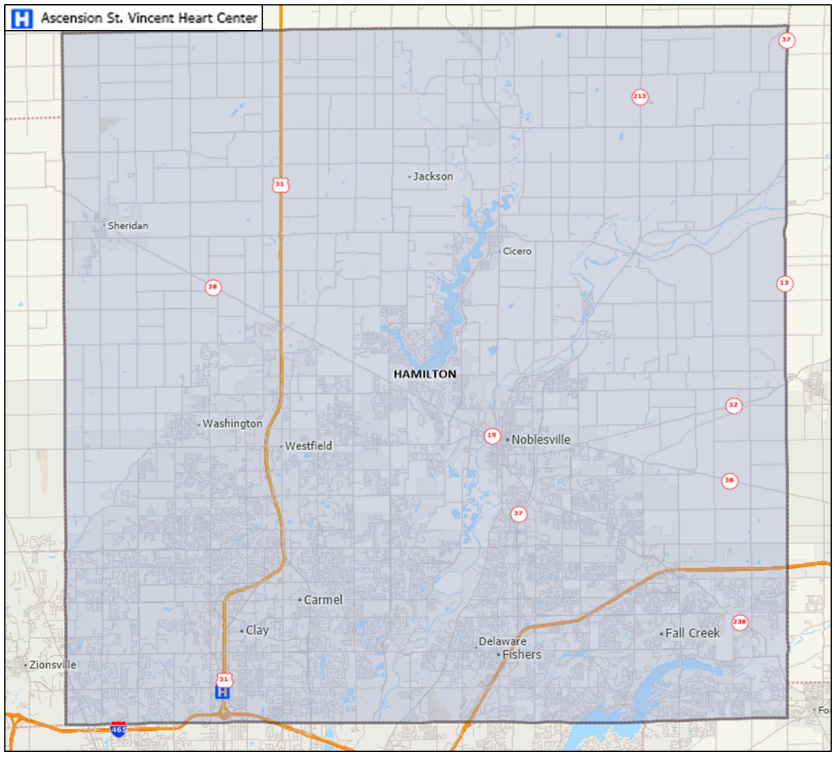
IRS 501(r)(3) and Form 990 Schedule H Compliance

The CHNA also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection and Affordable Care Act of 2010, more commonly known as the Affordable Care Act (ACA). As part of the ACA, all not-for-profit hospitals are required to conduct a CHNA and adopt an implementation strategy every three years. Requirements for 501(c)(3) hospitals under the ACA are described in Code Section 501(r)(3), and include making both current and previous CHNA and implementation strategy reports widely available to the public. In accordance with this requirement, electronic versions of these reports can be accessed at https://healthcare.ascension.org/CHNA, and paper versions can be requested at Ascension St. Vincent Heart Center's Information Desk in the main lobby.

Community Served and Demographics

Community Served

For the purpose of the 2024 CHNA, Ascension St. Vincent Heart Center has defined its community served as Hamilton County. Although Ascension St. Vincent Heart Center serves the surrounding areas, the "community served" was defined as such because (a) most of our service area is in the county; (b) most of our assessment partners define their service area at the county level; and (c) most community health data is available at the county level. The map below portrays the community that was assessed.



Demographic Data

Located in Indiana, Hamilton County has a population of 364,921 and is the fourth most populous county in the state. Below are demographic data highlights for Hamilton County.

- 14.0 percent of the community members of Hamilton County are 65 or older, compared to 16.9 percent in Indiana
- 95.1 percent of community members are non-Hispanic; 4.9 percent are Hispanic or Latino (any race)
- 80.7 percent of community members are non-Hispanic white; 7.3 percent are Asian; 0.2 percent are American Indian or Alaska Native, and 4.9 percent are non-Hispanic Black or African American
- The total population is projected to increase from 2025 to 2030 is 8.6 percent, with the 65 and older population expected to increase by 22.7 percent
- The median household income is 75.3 percent above the state median income ($117,100 for Hamilton County; $66,800 for Indiana)
- The percent of all ages of people in poverty was lower than the state (5.0 percent for Hamilton County; 12.6 percent for Indiana)
- The uninsured rate for Hamilton County is lower than the state (5 percent for Hamilton County; 9 percent for Indiana)

Description of the Community

Demographic Highlights			
Population			
Indicator	**Hamilton County**	**Indiana**	**Description**
Percentage living in rural communities	5.7%	28.8%	
Percentage below 18 years of age	25.0%	23.0%	
Percentage 65 years of age and over	14.0%	16.9%	
Percentage Asian	7.3%	2.8%	
Percentage American Indian or Alaska Native	0.1%	0.1%	
Percentage Hispanic	4.9%	7.9%	
Percentage non-Hispanic Black	4.9%	9.9%	
Percentage non-Hispanic White	80.7%	77.0%	
Social and Community Context			
English proficiency	1.3%	1.4%	Proportion of community members who speak English “less than well”
Median household income	$117,068	$66,768	Income level at which half of households in a county earn more and half of households earn less
Percentage of children in poverty	4.0%	15.4%	Percentage of people under age 18 in poverty
Percentage of uninsured	5%	9%	Percentage of population under age 65 without health insurance
Percentage of educational attainment	97.2%	90.0%	Percentage of adults ages 25 and over with a high school diploma or equivalent
Percentage of unemployment	2.1%	3.0%	Percentage of population ages 16 and older unemployed but seeking work

Source: County Health Rankings, 2024

To view community demographic data in their entirety, see Appendix B (Page 31).

Process and Methods Used

Ascension St. Vincent Heart Center is committed to using national best practices in conducting the CHNA. Health needs and assets for Hamilton County were determined using a combination of data collection and analysis for both secondary and primary data, as well as community input on the identified and significant needs.

Collaborators and/or Consultants

With the contracted assistance of Verité Healthcare Consulting, Ascension St. Vincent Heart Center completed its 2024 CHNA in collaboration with the following organizations:

- Dobson DaVanzo & Associates
- Community Health Network
- Indiana University Health
- Riverview Health
- Hamilton County Health Department
- Other Ascension St. Vincent hospitals

Key stakeholder interviews and community input sessions were conducted as a collaborative effort with the organizations listed above.

Data Collection Methodology

Primary data were gathered through community input sessions with a range of public health and social service providers that represent the broad interests of community members. A concerted effort was made to ensure that the individuals and organizations represented the needs and perspectives of 1) public health practice and research; 2) individuals who are medically underserved, are low-income, or considered among the minority populations served by the hospital; and 3) the broader community at large and those who represent the broad interests and needs of the community served.

Secondary data were gathered from credible sources of reliable metrics. These metrics included a variety of community health indicators for the community, which were benchmarked against Indiana and U.S. averages.

Identified needs were determined to be “significant” if both of the following conditions were met:

- Community Importance - Stakeholders who participated in community input sessions identified the issue as problematic; and
- Unfavorable to Benchmarks - Metrics for the community from secondary data compared unfavorably to metrics for Indiana and/or the U.S.

Summary of Community Input

Community input, also referred to as "primary data," is an integral part of a community health needs assessment (CHNA) and is meant to reflect the voice of the community. This input is invaluable for efforts to accurately assess a community's health needs. As noted previously, a concerted effort was made to ensure that the individuals and organizations represented the needs and perspectives of 1) public health practice and research; 2) individuals who are medically underserved, low-income, or considered among the minority populations served by the hospital; and 3) the broader community at large and those who represent the broad interests and needs of the community served.

Multiple methods were used to gather community input, including five key stakeholder interviews and two community input sessions. These methods provided additional perspectives on selecting and responding to top health issues facing Hamilton County. A summary of the process and results is outlined below.

Community Input Sessions

Two focus groups were conducted to gather feedback from the community on the health needs and assets of Hamilton County. Thirty-eight individuals participated in the focus groups, held in May 2024. Sectors represented by participants included community-based organizations, first responders, faith-based organizations, health care systems & providers, the Hamilton County Public Health Department.

Community Focus Groups
Key Summary Points
• **Access to healthcare services** is challenging for numerous reasons, including cost, insurance restrictions, limited health literacy and understanding, and language and/or cultural barriers. • Service barriers are exacerbated by **shortages of providers**, especially mental health therapists, geriatricians, psychiatrists. • **Workforce development** is stymied by licensing and education requirements, low wages relative to costs of living for some positions, and lack of transportation. • **Substance use disorders**, including use of alcohol and tobacco, impact many residents and is evidenced by overdoses within the community, yet there is a lack of inpatient treatment options. • **Mental health** is an issue for everyone, but many mental health providers do not accept insurance, and residents may be unable to afford to pay for behavioral health services out-of-pocket. • Access to services and health outcomes are related to **social drivers of health**, especially transportation. • **Insecurities with basic needs** of food, housing, and safety are experienced by many community members, especially racial/ethnic minorities, low-income residents, immigrants, ALICE (Asset Limited, Income Constrained, Employed) families, and, increasingly, older adults.

Sectors Represented	Common Themes
• Community Based Organizations • First Responders • Faith-based Organizations • Health Care Systems & Providers • Hamilton County Public Health • Local Government • Philanthropic Organizations • Veterans	• Housing and healthcare needs are increasing and exceed current capacity. • Wages are stagnant but the cost of living is increasing. • Resources are available, but many individuals aren't aware of the services available due, in part, to language barriers. • Substance use disorder includes new emerging substances, such as fentanyl and Delta 8, in addition to alcohol, tobacco, and opioids. • There are not enough behavioral health services, and some residents must leave the community for services.

Meaningful Quotes

- More than half of our patients state that when they leave the clinic, they worry about having food for their family.
- Many individuals aren't aware of the services available in the community.
- Children are now more open to talking about mental health issues, but there's a stigma that these types of issues don't happen in Hamilton County whereas they undoubtedly do.
- Older adults are getting priced out of communities that they've lived in for their entire lives.
- Housing affordability is an issue in the county. There are many apartments, but none are affordable.
- Patients will forego medical treatment if they need to spend their money on necessities, such as housing and food.

Key Stakeholder Interviews

Five key informant interviews were conducted to gather feedback from key informants on the health needs and assets of the State of Indiana and Hamilton County. Ten representatives from five different organizations and agencies participated in the interviews, held in July 2024. Sectors represented by participants included an advocacy group, the Fishers Health Department, the Hamilton County Health Department, the Indiana Department of Health, and a state minority health organization.

Key Stakeholder Interviews

Key Summary Points

- **Poor health behaviors**, illustrated by rates of obesity across the community and smoking/vaping among young adults, continue to be pervasive and are reflected in health outcomes, including a decrease in life expectancy.
- **Social drivers of health**, notably transportation, have a direct impact on health outcomes.
- **Safe and affordable housing** is critical to healthy outcomes, including its role in workforce development.
- **Substance use disorder**, including vaping, and **poor mental health** are big issues, yet services are limited.
- **Workforce shortages**, including dental health providers, impedes access to health care.
- **Access to health care services**, illustrated with access to maternal and infant health, do not meet community members' needs when limited to the standard workday.
- **Isolation** was widely experienced and recognized during the COVID pandemic and it remains a hidden issue for many community members, especially older adults.
- **Navigating community resources** is challenging, especially for immigrant community members.

Sectors Represented	Common Themes
• Advocacy Group • Fishers Department of Health • Hamilton County Health Department • Indiana Department of Health • State Government	• Basic needs insecurity, including access to food and medication, is impacting more community residents, including older adults with depleted resources. • Poor health status and outcomes continue to be an issue, especially among racial/ethnic minority residents. • Many community members have problems with accessing healthy options, such as grocery stores. • Substance use disorder and poor mental health continue to impact many residents and both are increasing.
Meaningful Quotes	
• I want to acknowledge the loneliness epidemic – isolation is a huge issue, and we should encourage socialization. • We need all the data possible to identify emerging issues. • Private/public partnerships were really one of the biggest bright spots during COVID and we need to be continued. • Key social drivers of health influencing community members' well-being are transportation and housing. • Housing is becoming a greater and greater crisis everywhere and definitely a larger issue for populations of color. • We need more social services for formerly incarcerated residents – and Indiana has a very high incarceration rate. • There is a need for training and mentoring to address the steep learning curve when providers transition from the academic environment to practice.	

To view community input data in its entirety, see Appendix C (Page 34).

Summary of Secondary Data

Secondary data is data that has already been collected and published by another party. Both governmental and non-governmental agencies routinely collect secondary data reflective of the population's health status at the state and county levels through surveys and surveillance systems. Secondary data for this report was compiled from various reputable and reliable sources.

Health indicators in the following categories were reviewed:

- Health outcomes
- Social and Economic Factors
- Physical environment
- Clinical care
- Health Behaviors
- Disparities

The total population of Hamilton County is projected to increase by 8.6 percent between 2025 and 2030 to approximately 417,426 persons. The 65+ population is projected to grow 22.7 percent.

Overall, secondary data indicate that Hamilton County is comparatively healthy.

Data from County Health Rankings and Roadmaps indicate that some community health issues are problematic in Hamilton County because the county's data are particularly unfavorable in comparison with overall Indiana and/or overall U.S. measures. The Hamilton County indicators below are comparatively worse than Indiana and/or U.S. averages.

- The number of membership (social) associations per 10,000 persons
- Air pollution, as measured by particulate matter
- The per-capita supply of mental health providers
- The percent of driving deaths with alcohol involvement

Additional details are below.

- There are no food deserts, Medically Underserved Areas, or Medically Underserved Populations that have been designated by the federal government in Hamilton County.
- Census blocks in throughout Hamilton County are identified as areas with high levels of socioeconomic disadvantage
- A census tract in Hamilton County has been identified as a low-income area.

To view the secondary data and sources in their entirety, see Appendices B, D1, and D2 (Page 31, 35 & 42).

Written Comments on Previous CHNA and Implementation Strategy

Ascension St. Vincent Heart Center's previous CHNA and implementation strategy was made available to the public and open for public comment via the website: https://healthcare.ascension.org/chna. No comments were received from the public on the previous CHNA or implementation strategy.

Data Limitations and Information Gaps

Although it is quite comprehensive, this assessment cannot measure all possible aspects of health and cannot represent every possible population within Hamilton County. This constraint limits the ability to assess all the community's needs fully.

For this assessment, three types of limitations were identified:

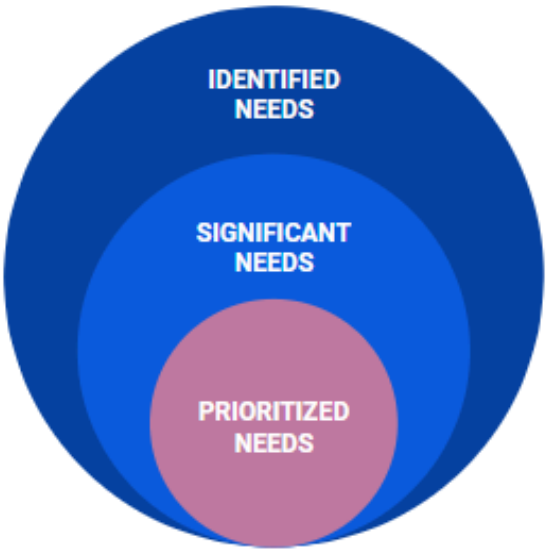
- Some groups of individuals may not have been adequately represented through the community input process. For example, these groups may include individuals who are transient, who speak a language other than English, or who are members of the lesbian/gay/bisexual/transgender+ community.
- Secondary data is limited in a number of ways, including timeliness, reach, and ability to fully reflect the health conditions of all populations within the community.

- An acute community concern may significantly impact a hospital's ability to conduct portions of the CHNA assessment. An acute community concern is defined by Ascension as an event or situation that may be severe and sudden in onset or newly affects a community. Such an event or situation may impact the ability to collect community input, may not be captured in secondary data, and/or can present in the middle of the three-year CHNA cycle. For the 2024 CHNA, no acute community concerns were identified.

Despite the data limitations, Ascension St. Vincent Heart Center is confident of the overarching themes and health needs represented through the assessment data. This is based on the fact that the data collection included multiple qualitative and quantitative methods, and engaged the hospital and participants from the community.

Community Needs

Ascension St. Vincent Heart Center, with contracted assistance from Verité Healthcare Consulting, analyzed secondary data of numerous indicators and gathered community input through <community input meetings with community representatives, hospital staff members, and key Stakeholders to identify the needs in Hamilton County. In collaboration with community partners, Ascension St. Vincent Heart Center used a phased prioritization approach to identify the needs.



- First phase: Determine the broader set of **identified needs**.
- Second phase: Narrow identified needs to a set of **significant needs**.
- Third phase (following CHNA completion): Narrow the significant needs to a set of **prioritized needs** to be addressed in the implementation strategy plan.

Following the completion of the CHNA assessment, Ascension St. Vincent Heart Center will select all, or a subset, of the significant needs as the hospital's **prioritized needs** to develop a three-year implementation strategy. Although the hospital may respond to many needs, the prioritized needs will be at the center of a formal CHNA implementation strategy and corresponding tracking and reporting. The image above portrays the relationship between the needs categories.

Identified Needs

The first phase was to determine the broader set of **identified needs**. Ascension has defined "identified needs" as the health outcomes or related conditions (e.g., social determinants of health) impacting the health status of Hamilton County. The identified needs were categorized into health behaviors, social determinants of health, length of life, quality of life, clinical care, and systemic issues to develop better measures and evidence-based interventions that respond to the determined condition.

Significant Needs

In the second phase, identified needs were then narrowed to a set of "significant needs" determined most crucial for community stakeholders to address. In collaboration with various community partners, Ascension St. Vincent Heart Center synthesized and analyzed the data to determine which of the identified needs were most significant. Ascension has defined **significant needs** as the identified needs deemed most significant to respond to based on established criteria and/or prioritization methods. Identified needs were determined to be "significant" if both of the following conditions were met:

- Community Importance - Stakeholders who participated in community input sessions identified the issue as problematic; and
- Unfavorable to Benchmarks - Metrics for the community from secondary data compared unfavorable to metrics for Indiana and/or the U.S.

Based on the synthesis and analysis of the data, the significant needs for the 2024 CHNA are as follows:

- Access to Care
- Mental Health Status and Access to Mental Health Services
- Services for Older Adults
- Social Drivers of Health, including:
    - Poverty
    - Affordable Housing
    - Food Insecurity
    - Transportation
- Substance Use Disorders, including Alcohol and Nicotine
    - Alcohol Misuse

To view healthcare facilities and community resources available to respond to the significant needs, please see Appendix E (Page 49).

The following pages contain a description (including data highlights, community challenges and perceptions, and local assets and resources) of each significant need.

Access to Care	
Significance	**Populations Most Impacted**
When barriers to accessing health care services are present, community health suffers. A wide array of factors can affect access, including provider supply, transportation, language and cultural competency, cost, availability of needed specialty services, limited insurance benefits, limited education regarding available services and how to use them, and others.	• Immigrants • LGBTQ residents • Low-income persons • Racial and ethnic minorities • Older adults
Community Input Highlights	
• Access to healthcare services is challenging for numerous reasons, including cost, insurance restrictions, limited health literacy and understanding, and language and/or cultural barriers. • Service barriers are exacerbated by shortages of providers, especially mental health therapists, geriatricians, psychiatrists. • Workforce shortages, including dental health providers, impedes access to health care. • Poor health behaviors, illustrated by rates of obesity across the community and smoking/vaping among young adults, continue to be pervasive and are reflected in health outcomes, including a decrease in life expectancy.	
Secondary Data Highlights	
• Overall population growth in Hamilton County, expected to be 8.6 percent between 2025 and 2030, will increase demand for health care services. • Hamilton County's 65 years and older population is projected to grow 22.7 percent between 2025 and 2030. Population growth will increase need and demand for access to health care services.	

Mental Health Status and Access to Mental Health Services	
Significance	**Populations Most Impacted**
Mental disorders are among the top causes of disability and disease burdens. Mental health and physical health are closely connected.	• Community members with limited financial resources or without mental health insurance benefits have additional difficulties accessing services. • Older adults and other community members who have been experiencing isolation also are particularly vulnerable to poor mental health status.
Community Input Highlights	
• Mental health is an issue for everyone, but many mental health providers do not accept insurance, and residents may be unable to afford to pay for behavioral health services out-of-pocket. • Substance use disorder, including vaping, and poor mental health are big issues, yet services are limited. • Isolation was widely experienced and recognized during the COVID pandemic and it remains a hidden issue for many community members, especially older adults.	
Secondary Data Highlights	
• The ratio of the population to mental healthcare providers is higher in Hamilton County than Indiana and U.S. ratios.	

Services for Older Adults	
Significance	**Populations Most Impacted**
The older adult population (65+ years of age) is projected to grow rapidly in Hamilton County. This trend will increase needs and demands for health care and social services.	• Hamilton County's 65 years and older population • Caregivers
Community Input Highlights	
• Insecurities with basic needs of food, housing, and safety are experienced by many community members, especially racial/ethnic minorities, low-income residents, immigrants, ALICE (Asset Limited, Income Constrained, Employed) families, and, increasingly, older adults. • Older adults are getting priced out of communities that they've lived in for their entire lives. • Isolation was widely experienced and recognized during the COVID pandemic and it remains a hidden issue for many community members, especially older adults.	
Secondary Data Highlights	
• Hamilton County's 65 years and older population is projected to grow 22.7 percent between 2025 and 2030. Population growth will increase need and demand for access to health care services. • The mortality rate from Parkinson' Disease is higher than Indiana and U.S. rates.	

Social Drivers of Health, including Poverty, Affordable Housing, Food Insecurity, and Transportation	
Significance	**Populations Most Impacted**
Contributors to health outcomes include access to social and economic opportunities, such as community resources, school quality, environment conditions, and social interactions.	• Children and youth • Low-income community members • New neighbors • Older populations • People living in rural areas • Racial and ethnic minorities • Veterans
Community Input Highlights	
• Access to services and health outcomes are related to social drivers of health, especially transportation. • Insecurities with basic needs of food, housing, and safety are experienced by many community members, especially racial/ethnic minorities, low-income residents, immigrants, ALICE (Asset Limited, Income Constrained, Employed) families, and, increasingly, older adults. • Housing and healthcare needs are increasing and exceed current capacity • Social drivers of health, notably transportation, have a direct impact on health outcomes. • Safe and affordable housing is critical to healthy outcomes, including its role in workforce development. • Navigating community resources is challenging, especially for immigrant community members.	
Secondary Data Highlights	
• The percentage of households in Hamilton County experiencing severe housing cost burden is higher than the overall U.S. percentage. • The percentage of households in Hamilton County experiencing severe housing problems is higher than the overall U.S. percentage • Census blocks in Hamilton County are identified as areas with high levels of socioeconomic disadvantage • A census tract in Hamilton County has been identified as a low-income area.	

Substance Use Disorders, including Alcohol and Nicotine	
Significance	**Populations Most Impacted**
Substance use disorders have a significant impact on individuals, families, and communities. Impacts are cumulative and result in costly social, physical, mental, and public health issues.	• According to the CDC, smoking is most prevalent for the following categories of adults: men, people 45-64 years of age, non-Hispanic American Indiana/Alaska Native, adults with a disability, people with severe generalized anxiety disorder, and people with severe depression[4] • People with untreated mental health conditions.
Community Input Highlights	
• Substance use disorders, including use of alcohol and tobacco, impact many residents and is evidenced by overdoses within the community, yet there is a lack of inpatient treatment options. • Substance use disorder includes new emerging substances, such as fentanyl and Delta 8, in addition to alcohol, tobacco, and opioids. • Substance use disorder, including vaping, and poor mental health are big issues, yet services are limited. • Substance use disorder and poor mental health continue to impact many residents and both are increasing.	
Secondary Data Highlights	
• The percentage of alcohol-impaired driving deaths is higher in Hamilton County than the overall Indiana percentage, 21 percent and 18 percent, respectively. • The overdose death rate by any opioids per 100,000 persons is higher in Hamilton County than the overall rates of Indiana and the U.S., 59, 34, and 27 opioid-related deaths by state per 100,000 persons, respectively.	

[4] Tobacco Product Use Among Adults— United States, 2022; 2022 National Health Interview Survey (NHIS) Highlight, Centers for Disease Control and Prevention; 2024. See https://www.cdc.gov/tobacco/media/pdfs/2024/09/cdc-osh-ncis-data-report-508.pdf.

Next Steps

In the third phase, which will take place following the completion of the community health needs assessment as outlined in this report, Ascension St. Vincent Heart Center will narrow the significant needs to a set of prioritized needs. Ascension defines “prioritized needs” as the significant needs that the hospital has prioritized to respond to through the three-year CHNA implementation strategy. The implementation strategy will detail how Ascension St. Vincent Heart Center will respond to the prioritized needs throughout the three-year CHNA cycle: July 2025 to June 2028. The implementation strategy will also describe why certain significant needs were not selected as prioritized needs to be addressed by the hospital.

Summary of Impact of the Previous CHNA Implementation Strategy

An important piece of the three-year CHNA cycle is revisiting the progress made on priority needs set forth in the preceding CHNA. By reviewing the actions taken to respond to the prioritized needs and evaluating the impact those actions have made in the community, it is possible to better target resources and efforts during the next CHNA cycle.

Ascension St. Vincent Heart Center's 2021 CHNA Implementation Strategy responded to the following priority health needs: access to care; mental health; and substance use disorder. Additionally, a community engagement initiative was incorporated throughout all strategies.

Highlights from Ascension St. Vincent Heart Center's 2021 CHNA Implementation Strategy include:

- The Community Health Workers exceeded their goal by increasing the number of completed Medical Home Pathways from 6 in FY23 to 13 in FY24, despite a shortage of providers, for a 117% increase in individuals they assisted with securing a primary care provider.
- The Community Health Workers exceeded their goal by increasing the number of completed Enrollment Pathways from 14 in FY23 to 45 in FY24, for a 221% increase in individuals they assisted with obtaining health insurance.
- The hospital hosted a QPR session for the community, with approximately 30 individuals in attendance. The training was in a hybrid format (option to be in person or virtual) and was widely promoted to the general community.

Written input received from the community and a report on the actions taken to respond to the significant health needs prioritized in the 2021 CHNA implementation strategy can be found in Appendix F (Page 51).

Approval by Ascension St. Vincent Heart Center Board of Directors

To ensure Ascension St. Vincent Heart Center's efforts meet the needs of the community and have a lasting and meaningful impact, the 2024 CHNA was presented to the Ascension St. Vincent Heart Center Board of Directors for approval and adoption on May 29, 2025. Although an authorized body of the hospital must adopt the CHNA and implementation strategy reports to be compliant with the provisions in the Affordable Care Act, adoption of the reports also demonstrates that the board is aware of the findings from the CHNA, endorses the health needs identified, and supports the strategies developed to respond to those needs.

Conclusion

Ascension St. Vincent Heart Center hopes this report offers a meaningful and comprehensive understanding of the most significant needs of Hamilton County. This report will be used by internal stakeholders, nonprofit organizations, government agencies, and other Ascension St. Vincent Heart Center community partners to guide the implementation strategies and community health improvement efforts as required by the Affordable Care Act. The 2024 CHNA will also be available to the broader community as a useful resource for further health improvement efforts.

As a Catholic health ministry, Ascension St. Vincent Heart Center is dedicated to spiritually centered, holistic care that sustains and improves the health of not only individuals but the communities it serves. With special attention to those who are underserved and marginalized, we are advocates for a compassionate and just society through our actions and words. Ascension St. Vincent Heart Center is dedicated to serving patients with compassionate care and medical excellence, making a difference in every life we touch. The hospital values the community's voice and welcomes feedback on this report. Please visit Ascension's public website (https://healthcare.ascension.org/chna) to submit any comments or questions.

Appendices

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Appendix A: Definitions and Terms

Catholic Health Association of United States (CHA) "is recognized nationally as a leader in community benefit planning and reporting."[55] The definitions in Appendix A are from the CHA guide *Assessing and Addressing Community Needs, 2015 Edition II,* which can be found at chausa.org.

Community Input
Federal law (P.L. 111-148) requires that an assessment must take into account "input from persons who represent the broad interests of the community serviced by the hospital facility, including those with special knowledge of or expertise in public health." The proposed rule indicates that in order to meet this requirement the CHNA must at a minimum, take into account input from:

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.

The proposed regulations also provide:

1. That input from persons representing the broad interests of the community includes, but is not limited to, input on any financial and other barriers to access to care in the community and
2. That a hospital facility may take into account input from a broad range of persons located in or serving its community who may have special knowledge of or expertise in public health, including, but not limited to, health care consumers and consumer advocates, nonprofit and community-based organizations, academic experts, local government officials, local school districts, health care providers and community health centers, health insurance and managed care organizations, private businesses, and labor and workforce representatives.

Demographics

Population characteristics of your community. Sources of information may include population size, age structure, racial and ethnic composition, population growth, and density.

[5] Catholic Health Association of the United States. (2015). Assessing & Addressing Community Health Needs, 2015 Edition II.

Key Stakeholder Interviews

A method of obtaining input from community leaders and public health experts one-on-one. Interviews can be conducted in person or over the telephone (including computer/video calls). In structured interviews, questions are prepared and standardized prior to the interview to ensure consistent information is solicited on specific topics. In less structured interviews, open-ended questions are asked to elicit a full range of responses. Key Stakeholders may include leaders of community organizations, service providers, and elected officials. Individuals with special knowledge or expertise in public health may include representatives from your state or local health department, faculty from schools of public health, and providers with a background in public health.

Medically Underserved Populations

Medically underserved populations include populations experiencing health disparities or that are at risk of not receiving adequate medical care because of being uninsured or underinsured or due to geographic, language, financial, or other barriers. Populations with language barriers include those with limited English proficiency. Medically underserved populations also include those living within a hospital facility's service area but not receiving adequate medical care from the facility because of cost, transportation difficulties, stigma, or other barriers.

Surveys

Used to collect information from community members, stakeholders, providers, and public health experts for the purpose of understanding community perception of needs. Surveys can be administered in person, over the telephone, or using a web-based program. Surveys can consist of both forced-choice and open-ended questions.

Appendix B: Community Demographic Data and Sources

The tables below provide further information on the community's demographics. The descriptions of the data's importance are largely drawn from the County Health Rankings & Roadmaps website.

Table 1: Population

Why it is important: The composition of a population, including related trends, is important for understanding the community context and informing community planning.

Population	Hamilton County	Indiana	U.S.
Total	364,921	6,833,037	333,287,557
Male	49.4%	49.7%	49.6%
Female	50.6%	50.3%	50.4%

Source: County Health Rankings, 2024

Table 2: Population by Race and Ethnicity

Why it is important: The racial and ethnic composition of a population is important in understanding the cultural context of a community. The information can also be used to better identify and understand health disparities.

Race or ethnicity	Hamilton County	Indiana	U.S.
Asian	7.3%	2.8%	6.3%
Non-Hispanic Black / African American	4.9%	9.9%	12.6%
Hispanic / Latino	4.9%	7.9%	19.1%
American Indian or Alaska Native	0.2%	0.4%	1.3%
Non-Hispanic White	80.7%	77.0%	58.9%

Source: County Health Rankings, 2024

Table 3: Population by Age

Why it is important: The age structure of a population is important in planning for the future of a community, particularly for schools, community centers, healthcare, and child care. A population with more youths will have greater education and childcare needs, while an older population may have greater healthcare needs.

Age	Hamilton County	Indiana	U.S.
Median age	37.8	38.0	38.5
Ages 0-17	25.0%	23.0%	21.7%
Ages 18-64	61.0%	60.1%	61.0%
Ages 65+	14.0%	16.9%	17.3%

Source: County Health Rankings, 2024

Table 4: Income

Why it is important: Median household income and the percentage of children living in poverty, which can compromise physical and mental health, are well-recognized indicators. People with higher incomes tend to live longer than people with lower incomes. In addition to affecting access to health insurance, income affects access to healthy choices, safe housing, safe neighborhoods, and quality schools. Chronic stress related to not having enough money can have an impact on mental and physical health as well. ALICE, an acronym for Asset Limited, Income Constrained, Employed, are households that earn more than the U.S. poverty level but less than the basic cost of living for the county. Combined, the number of poverty and ALICE households equals the total population struggling to afford basic needs.

Income	Hamilton County	Indiana	U.S.
Median household income	$117,100	$66,800	$74,800
Per capita income	$56,943	$35,578	$41,261
People with incomes below the federal poverty guideline	5.0%	12.6%	12.8%
ALICE households	20.1%	27.0%	28.6%

Source: County Health Rankings, 2024; U.S. Census; 2024; United for Alice, 2024

Table 5: Education

Why is it important: There is a strong relationship between health, lifespan, and education. In general, as income increases, so does lifespan. The relationship between more schooling, higher income, job opportunities (e.g., pay, safe work environment), and social support helps create opportunities for healthier choices.

Education	Hamilton County	Indiana	U.S.
High school diploma or higher	97%	90%	89%
Bachelor's degree or higher	61%	28%	34%

Source: County Health Rankings, 2024; U.S. Census, 2024

Table 6: Insured/Uninsured

Why it is important: Lack of health insurance can have serious health consequences due to lack of preventive care and delays in care that can lead to serious illness or other health problems.

Insurance	Hamilton County	Indiana	U.S.
Uninsured	5%	9%	10%
Medicaid Participation, not Eligible	7.3%	20.7%	21.2%

Source: County Health Rankings, 2024; U.S. Census, 2024

Appendix C: Community Input Data and Sources

Community Input Sessions and Key Stakeholder Interviews

The questions below are examples of questions discussed with participants of community community input sessions.

- Are any of the significant needs identified in 2021 still the most significant in the community in 2024?
- Have any of these areas gotten worse? Better?
- Do you agree or disagree with any of the issues seen in the data?
- What needs are missing from the preliminary ?
- Are any communities or part of the community particularly vulnerable for one or more of the issues we have discussed so far?
- Are there resources and organizations to address some of these needs? Do community members have difficulty finding any specific services or aid?
- If you could make one major change to improve the health and wellbeing of your com-munity members, what would that change be?

Appendix D1: Secondary Data and Sources

The tables below are based on data vetted, compiled, and made available on the County Health Rankings and Roadmaps (CHRR) website (https://www.countyhealthrankings.org/). The site is maintained by the University of Wisconsin Population Health Institute, School of Medicine and Public Health, with funding from the Robert Wood Johnson Foundation. CHRR obtains and cites data from other public sources that are reliable. CHRR also shares trending data on some indicators.

CHRR compiles new data annually and shares it with the public. The data below is from the 2024 publication. It is important to understand that reliable data is generally two to three years behind due to the importance of careful analysis.

How to Read These Charts

Why they are important: Explains why we monitor and track these measures in a community and how it relates to health. The descriptions for "why they are important" are largely drawn from the CHRR website.

County vs. state: Describes how the county's most recent data for the health issue compares to the state average.

Trends: CHRR provides a calculation for some measures to explain if a measure is worsening or improving.

- ☒ The measure is worsening in this county.
- ▲ The measure has no significant trend.
- ✅ The measure is improving in this county.
- N/A There is no data trend to share, or the measure has remained the same.

United States (U.S.): Describes how the county's most recent data for the health issue compares to the U.S.

Description: Explains what the indicator measures, how it is measured, and who is included in the measure.

N/A: Not available or not applicable. There might not be available data for the community on every measure. Some measures will not be comparable.

Table 7: Health Outcomes

Why they are important: Health outcomes reflect how healthy a county is right now. They reflect the physical and mental well-being of members within a community.

Indicators	Trend	Hamilton County	Indiana	U.S.	Description
Length of Life					
Premature death	▲	4,700	9,300	8,000	Years of potential life lost before age 75 per 100,000 population (age-adjusted)
Life expectancy	N/A	81.0	75.6	77.6	How long the average person is expected to live
Infant mortality	N/A	5	7	6	Number of all infant deaths (within one year) per 1,000 live births
Physical Health					
Poor or fair health	N/A	10%	16%	14%	Percentage of adults reporting fair or poor health
Poor physical health days	N/A	2.5	3.5	3.3	Average number of physically unhealthy days reported in the past 30 days (age-adjusted)
Frequent physical distress	N/A	8%	11%	10%	Percentage of adults with 14 or more days of poor physical health per month
Low birth weight	N/A				Percentage of babies born too small (less than 2,500 grams or 5 lbs. 8 oz.)
Falls 65+ (by state)	N/A	7%	8%	8%	Older adult falls reported by state, 2021
Fall fatalities 65+ (by state)	N/A	N/A	30.8%	27.6%	Number of injury deaths due to falls among those 65 years of age and over per 100,000 population, 2021
Mental Health					
Poor mental health days	N/A	4.2	5.2	4.8	Average number of mentally unhealthy days reported in the past 30 days
Frequent mental distress	N/A	13%	17%	15%	Percentage of adults reporting 14 or more days of poor mental health per month
Suicide	N/A	11	16	14	Number of deaths due to suicide per 100,000
Morbidity					
Diabetes prevalence	N/A	8%	11%	10%	Percentage of adults ages 20 and above with diagnosed diabetes
Cancer deaths (by state)	N/A	125.7	166.7	149.4	Average annual cancer death rate per 100,000
Communicable Disease					
HIV prevalence	N/A	95	217	382	Number of people ages 13 years and over with a diagnosis of HIV per 100,000
Sexually transmitted infections	☒	208.0	510.7	495.5	Number of newly diagnosed chlamydia cases per 100,000

Sources: County Health Rankings, 2024; Centers for Disease Control and Prevention, 2024

Table 8: Social and Economic Factors

Why they are important: These factors have a significant effect on our health. They affect our ability to make healthy decisions, afford medical care, afford housing and food, manage stress, and more.

Indicator	Trend	Hamilton County	Indiana	U.S.	Description
Economic Stability					
Median household income	N/A	$117,100	$66,800	$74,800	The income where half of households in a county earn more and half of households earn less
Unemployment	▲	2%	3%	4%	Percentage of population ages 16 and older unemployed but seeking work
Poverty	N/A	5.0%	12.6%	12.8%	Percentage of population living below the federal poverty line
Childhood poverty	▲	4%	15%	16%	Percentage of people under age 18 in poverty
Educational Attainment					
High school completion	N/A	97%	90%	89%	Percentage of adults ages 25 and over with a high school diploma or equivalent
Some college	N/A	87%	63%	68%	Percentage of adults ages 25-44 with some post-secondary education
Social/Community					
Children in single-parent homes	N/A	13%	24%	25%	Percentage of children who live in a household headed by a single parent
Social associations	N/A	9.8	11.8	9.1	Number of membership associations per 10,000 population
Disconnected youth	N/A	4%	6%	7%	Percentage of teens and young adults ages 16-19 who are neither working nor in school
Violent crime	N/A	N/A	306.2	369.8	Number of reported violent crime offenses per 100,000 population
Access to Healthy Foods					
Food environment index	N/A	9.0	6.8	7.7	Index of factors that contribute to a healthy food environment (0 = worst, 10 = best)
Food insecurity	N/A	6%	11%	10%	Percentage of the population who lack adequate access to food
Limited access to healthy foods	N/A	5%	9%	6%	Percentage of the population who are low-income and do not live close to a grocery store

Sources: County Health Rankings, 2024; United for Alice, 2024; Federal Bureau of Investigation, 2024

Table 9: Physical Environment

Why they are important: The physical environment is where people live, learn, work, and play. The physical environment impacts our air, water, housing, and transportation to work or school. Poor physical environment can affect our ability and that of our families and neighbors to live long and healthy lives.

Indicator	Trend	Hamilton County	Indiana	U.S.	Description
Physical Environment					
Severe housing cost burden	7%	11%	14%	7%	Percentage of households that spend 50 percent or more of their household income on housing
Severe housing problems	8%	12%	17%	8%	Percentage of households with at least one of four housing problems: overcrowding, high housing costs, lack of kitchen facilities, and/or lack of plumbing facilities
Air pollution: particulate matter	10.2	8.8	7.4	10.2	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)
Home ownership	76%	70%	65%	76%	Percentage of occupied housing units that are owned

Source: County Health Rankings, 2024

Table 10: Clinical Care

Why it is important: Access to affordable, quality care can help detect issues sooner and prevent disease. This can help individuals live longer and have healthier lives.

Indicator	Trend	Hamilton County	Indiana	U.S.	Description
Healthcare Access					
Uninsured	✅	5%	9%	10%	Percentage of population under age 65 without health insurance
Uninsured adults	✅	6%	10%	12%	Percentage of adults under age 65 without health insurance
Uninsured children	✅	4%	6%	5%	Percentage of children under age 19 without health insurance
Primary care physicians	▲	720:1	1,520:1	1,330:1	Ratio of the population to primary care physicians
Mental healthcare providers	N/A	540:1	500:1	320:1	Ratio of the population to mental healthcare providers
Hospital Utilization					
Preventable hospital stays	✅	2,105	3,135	2,681	Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees
Preventive Healthcare					
Flu vaccinations	✅	60%	50%	46%	Percentage of fee-for-service Medicare enrollees who had an annual flu vaccination
Mammography screenings	✅	53%	45%	43%	Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening

Source: County Health Rankings, 2024

Table 11: Health Behaviors

Why they are important: Health behaviors are actions individuals take that can affect their health. These actions can lead to positive health outcomes or they can increase someone's risk of disease and premature death. It is important to understand that not all people have the same opportunities to engage in healthier behaviors.

Indicator	Trend	Hamilton County	Indiana	U.S.	Description
Healthy Lifestyle					
Adult obesity	N/A	29%	37%	34%	Percentage of the adult population (ages 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2
Physical inactivity	N/A	17%	25%	23%	Percentage of adults ages 20 and over reporting no leisure-time physical activity
Access to exercise opportunities	N/A	92%	77%	84%	Percentage of population with adequate access to locations for physical activity
Insufficient sleep	N/A	27%	36%	33%	Percentage of adults who report fewer than seven hours of sleep on average
Motor vehicle crash deaths	N/A	5	13	12	Number of motor vehicle crash deaths per 100,000 population
Teen births	N/A	4	20	17	Number of births per 1,000 female population ages 15-19
Substance Misuse					
Adult smoking	N/A	10%	18%	15%	Percentage of adults who are current smokers
Excessive drinking	N/A	17%	18%	18%	Percentage of adults reporting binge or heavy alcohol drinking
Alcohol-impaired driving deaths	✅	21%	18%	26%	Alcohol-impaired driving deaths
Overdose deaths: any opioids by state	N/A	13	34	27	Rate of opioid-related deaths by state per 100,000 persons

Source: County Health Rankings, 2024

Table 12: Disparities

Why they are important: Differences in access to opportunities that affect health can create differences between groups of people in the community. A focus on equity is important to improve health for everyone in the community.

Indicator	Population	Measure
Health Disparities		
Premature death: Years of potential life lost before age 75 per 100,000 population (age-adjusted)	**Overall**	**4,661 per 100,000**
	Asian	3,156 per 100,000
	Non-Hispanic Black / African American	7,255 per 100,000
	Hispanic / Latino	2,421 per 100,000
	American Indian or Alaska Native	N/A
	Non-Hispanic White	4,766 per 100,000
Low birthweight: Percentage of live births with low birthweight (< 2,500 grams or 5 lbs 8 oz)	**Overall**	**6.6%**
	Asian	10.4%
	Non-Hispanic Black / African American	11.8%
	Hispanic / Latino	7.2%
	American Indian or Alaska Native	0.0%
	Non-Hispanic White	5.9%

Source: County Health Rankings, 2024

Appendix D2: Additional Secondary Data

Appendix D2 presents and discusses additional, relevant secondary data for Hamilton County, Indiana, and the United States. All data presented are from credible sources.

Community-Specific Secondary Data

The following section includes community-specific secondary data identified below.

- Projected population growth
- Mortality, Age-Adjusted Rates Per 100,000
- Cancer Mortality, Crude Rates Per 100,000
- Locations of Medically Underserved Areas and Populations (MUAs/MUPs)
- Area Deprivation Index for Census Blocks
- Low-income and Low-access Census tracts and Low-income Census tracts

Projected Population Growth, 2019-2025

Hamilton County				Indiana			
Age Cohort	2025	2030	Change	Age Cohort	2025	2030	Change
0 to 24	123,393	124,944	1.3%	0 to 24	2,229,462	2,207,899	-1.0%
25 to 44	105,391	117,000	11.0%	25 to 44	1,802,599	1,839,566	2.1%
45 to 64	97,445	104,082	6.8%	45 to 64	1,640,993	1,619,183	-1.3%
65 and older	58,172	71,400	22.7%	65 and older	1,233,963	1,346,861	9.1%
Total	384,401	417,426	8.6%	Total	6,907,017	7,013,509	1.5%

Source: STATS Indiana, 2024

Description. This table portrays population growth in Hamilton County and Indiana.

Observation. The total population of Hamilton County is projected to increase by 8.6 percent between 2025 and 2030 to approximately 417,426 persons. The 65+ population is projected to grow 22.7 percent.

Mortality, Age-Adjusted Rates Per 100,000, 2016-2020

Cause	Hamilton County	Indiana	United States
Major cardiovascular diseases	174.5	239.1	217.7
Diseases of heart	129.8	181.4	164.8
Malignant neoplasms	125.7	166.7	149.4
All other diseases (Residual)	97.2	110.5	88.7
Ischemic heart diseases	73.6	98.1	91.5
Other heart diseases	45.2	69.6	56.8
Other forms of chronic ischemic heart disease	54.7	61.3	63.3
Accidents (unintentional injuries)	31.2	57.7	50.4
Chronic lower respiratory diseases	34.8	55.3	39.1
All other forms of chronic ischemic heart disease	42.1	53.2	46.8
Other chronic lower respiratory diseases	31.8	51.2	36.2
Malignant neoplasms of trachea, bronchus and lung	25.0	44.9	34.9
Nontransport accidents	26.0	44.1	37.6
All other forms of heart disease	25.0	44.0	35.5
Cerebrovascular diseases	32.7	40.2	37.6
Acute myocardial infarction	18.6	35.8	27.1
Alzheimer disease	27.9	33.9	30.8
Accidental poisoning and exposure to noxious substances	13.0	26.9	21.0
Diabetes mellitus	16.5	26.6	22.1
Heart failure	19.5	24.9	20.6
Other and unspecified infectious and parasitic diseases and their sequelae	20.9	23.6	19.9
COVID-19	18.6	21.3	17.7
All other and unspecified malignant neoplasms	14.9	19.6	18.5
Nephritis, nephrotic syndrome and nephrosis	13.0	17.8	12.9
Renal failure	12.8	17.5	12.6
Malignant neoplasms of lymphoid, hematopoietic and related tissue	14.6	16.0	14.6
Intentional self-harm (suicide)	11.3	15.4	13.8
Malignant neoplasms of colon, rectum and anus	10.8	14.9	13.4
Septicemia	8.3	14.9	10.1
Other diseases of respiratory system	8.9	14.2	10.8.
Transport accidents	5.1	13.6	12.7
Motor vehicle accidents	4.7	13.0	12.0
Influenza and pneumonia	7.0	12.9	13.6
Chronic liver disease and cirrhosis	8.3	12.4	11.5
Malignant neoplasm of pancreas	11.5	11.9	11.1
Malignant neoplasm of breast	9.4	11.4	10.8
Pneumonia	5.6	10.8	11.9
Hypertensive heart disease	8.7	10.4	13.3
Essential hypertension and hypertensive renal disease	5.9	10.3	9.1
Parkinson disease	13.1	9.8	8.8
Intentional self-harm (suicide) by discharge of firearms	6.2	8.5	6.9
Atherosclerotic cardiovascular disease, so described	12.6	8.1	16.5
Other and unspecified nontransport accidents and their sequelae	5.9	8.0	5.0
Malignant neoplasm of prostate	7.1	7.9	7.8
Assault (homicide)	1.5	7.8	6.4

Source: Centers for Disease Control and Prevention, 2024

Description. This table provides age-adjusted mortality rates in Hamilton County and Indiana. Light grey shading highlights rates that were above the U.S. average; dark grey shading highlights rates more than 50 percent above average.

Observations. In Hamilton County, mortality rates for causes that were higher than overall U.S.rates include COVID-19; nephritis, nephrotic syndrome and nephrosis; renal failure; malignant neoplasm of pancreas; and Parkinson disease.

Cancer Mortality, Crude Rates Per 100,000, 2016-2020

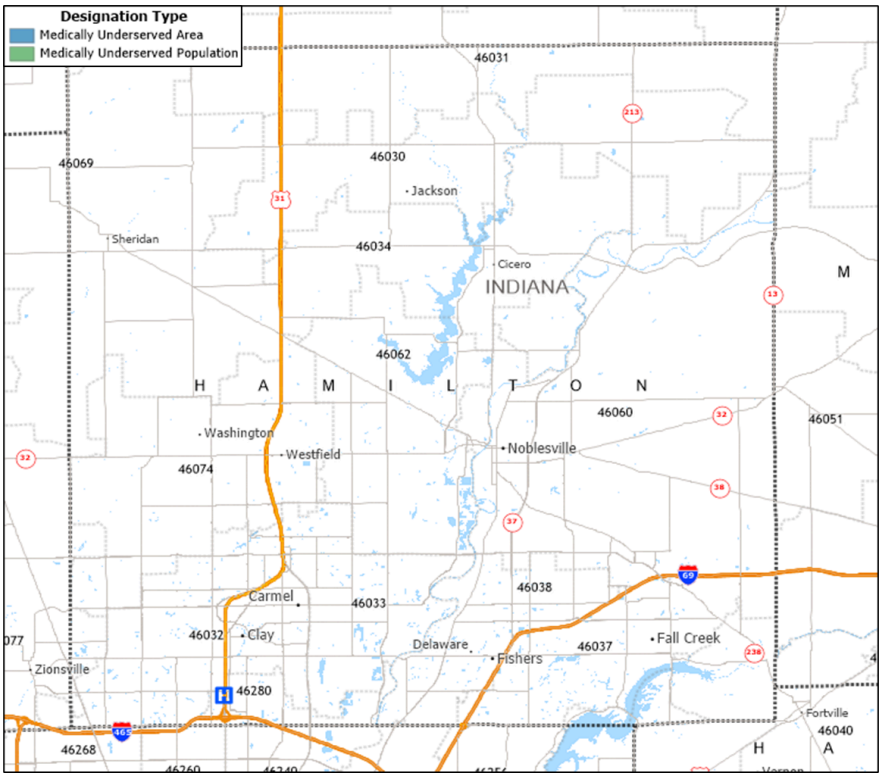
Type of Cancer	Hamilton County	Indiana	United States
All Cancer Sites Combined	125.2	202.3	182.5
Lung and Bronchus	24.1	53.1	41.4
Female Breast	20.7	26.4	25.3
Prostate	12.9	20.1	19.8
Colon and Rectum	9.0	17.6	15.8
Pancreas	12.9	15.2	14.2
Leukemias	6.4	7.6	7.1
Liver and Intrahepatic Bile Duct	4.6	8.0	8.6
Ovary	5.8	7.8	8.1
Non-Hodgkin Lymphoma	4.1	6.7	6.1
Corpus and Uterus, NOS	5.1	7.4	7.2
Esophagus	2.7	6.0	4.8
Urinary Bladder	3.7	5.7	5.1
Brain and Other Nervous System	5.5	5.3	5.3
Kidney and Renal Pelvis	3.3	4.9	4.3
Myeloma	3.0	3.7	3.7
Oral Cavity and Pharynx	2.0	3.5	3.3
Cervix	N/A	3.0	2.5
Melanomas of the Skin	2.8	2.7	2.5
Stomach	2.1	2.7	3.3
Larynx	N/A	1.4	1.2
Mesothelioma	N/A	0.8	0.7
Thyroid	N/A	0.7	0.6
Hodgkin Lymphoma	N/A	0.4	0.3
Testis	N/A	0.3	0.3

Source: Centers for Disease Control and Prevention, 2024

Description. This table provides crude cancer mortality rates in Hamilton County and Indiana. Light grey shading highlights rates that were above the U.S. average; dark grey shading highlights rates more than 50 percent above average.

Observations. In Hamilton County, cancer mortality rates for Brain and Other Nervous System, as well as melanomas of the skin were higher than overall U.S. rates. Numerous causes for Indiana were higher than overall U.S.rates.

Locations of Medically Underserved Areas and Populations, 2024

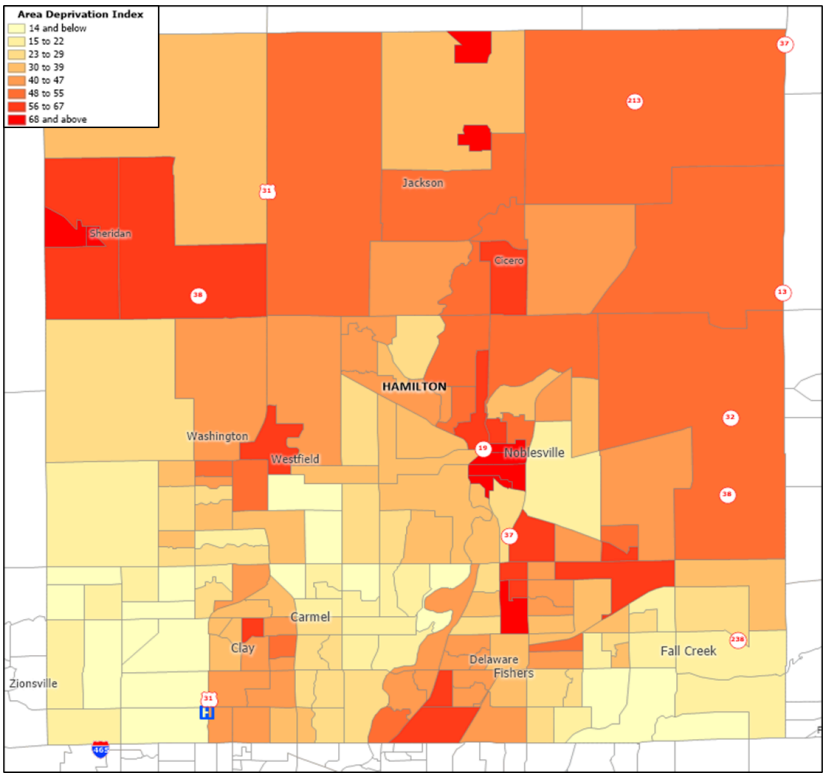


Source: Health Resources and Services Administration, 2024, and Caliper Maptitude.

Description. Medically Underserved Areas and Populations (MUA/Ps) are designated by the Health Resources and Services Administration (HRSA) based on an "Index of Medical Underservice." The index is based on the ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over. Areas with a score of 62 or less are considered medically underserved. MUAs and MUPs also may be assigned by HRSA leadership and state government officials.

Observations. No census tract in Hamilton County is designated as a MUA or MUP.

Area Deprivation Index for Census Blocks, 2024

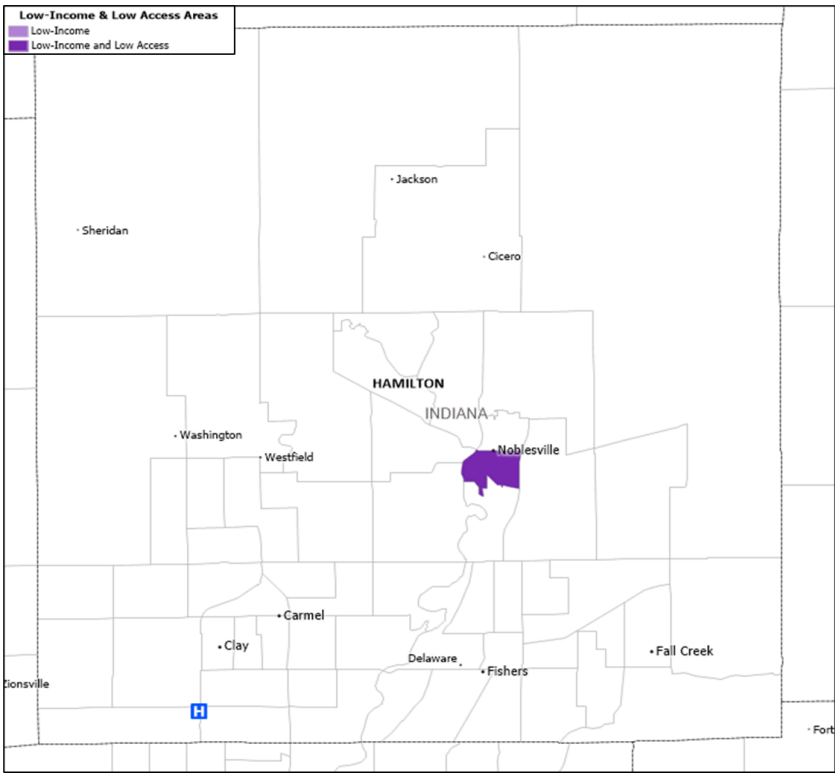


Source: University of Wisconsin School of Medicine and Public Health, 2024, and Caliper Maptitude.

Description. The Area Deprivation Index (ADI) ranks neighborhoods at the Census block by level of socioeconomic disadvantage and includes factors for income, education, employment, and housing quality. ADI is produced by the University of Wisconsin, School of Medicine and Public Health, Center for Health Disparities Research. ADIs are calculated for census block groups in national percentile rankings from 1 to 100. A block group ranking of 1 indicates the lowest level of disadvantage within the nation and an ADI ranking of 100 indicates the highest level of disadvantage.

Observation. Census blocks throughout Hamilton County have high levels of socioeconomic disadvantage.

Low-income and Low-access Census tracts and Low-income Census tracts



Source: Source: U.S. Department of Agriculture, 2021, and Caliper Maptitude, 2024.

Description. The U.S. Department of Agriculture's Economic Research Service identifies low-income census tracts with low-access to a supermarket. For urban areas, low-access is defined as more than one mile from a supermarket or large grocery store, and more than 10 miles from a supermarket or large grocery store in a rural area. These census tracts are colloquially referenced as "food deserts." Many government-led initiatives aim to increase the availability of nutritious and affordable foods to people living in these areas.

Observations. A Noblesville census tract has been identified as a low-income area. No census tract in Hamilton County has been identified as a food desert.

Appendix E: Health Care Facilities and Community Resources

As part of the CHNA process, Ascension St. Vincent Heart Center has cataloged resources available in Hamilton County that respond to the significant needs identified in this CHNA. Resources may include acute care facilities (hospitals), primary and specialty care clinics and practices, mental health providers, and other non-profit services. State and national resources can also provide information regarding programs that can better serve the needs of a person experiencing a specific problem.

The resources listed are not intended to be exhaustive.

Organization	Phone	Website
Hospitals		
Ascension St Vincent Carmel	317-582-7901	https://healthcare.ascension.org/locations/indiana/inasc/carmel-ascension-st-vincent-carmel
Ascension St Vincent Fishers	317-415-9000	https://healthcare.ascension.org/locations/indiana/inasc/fishers-ascension-st-vincent-fishers
Ascension St Vincent Heart Center	317-583-5000	https://healthcare.ascension.org/locations/indiana/inasc/carmel-ascension-st-vincent-heart-center
Community Fairbanks Recovery Center	317-849-8222	https://www.ecommunity.com/locations/community-fairbanks-recovery-center
Community Health Network Rehabilitation Hospital	317-585-5400	https://www.ecommunity.com/locations/community-rehabilitation-hospital-north
Community Hospital North	317-621-5335	https://www.ecommunity.com/locations/community-hospital-north
Franciscan Health Orthopedic Hospital Carmel	574-256-3935	https://www.franciscanhealth.org/find-a-location/franciscan-health-orthopedic-hospital-carmel-290744
Indiana Spine Hospital, LLC	317-795-2000	https://indianaspinehospital.com/
Indiana University Health North Hospital	317-688-2000	https://iuhealth.org/find-locations/iu-health-north-hospital
Indianapolis Rehabilitation Hospital, LLC	463-333-9110	https://www.indianapolis-rehabhospital.com/
Kindred Hospital Indianapolis North	317-813-8900	https://www.kindredhospitals.com/locations/ltac/kindred-hospital-indianapolis-north
Riverview Health	317-773-0760	https://riverview.org/
Catholic Charities		
Catholic Charities Indianapolis	317-236-1500	https://helpcreatehope.org/

Information and Referral		
Indiana 211 Can Help	Dial 2-1-1 or 1-866-211-9966	https://in211.communityos.org/
Neighborhood Resource by Ascension	N/A	https://neighborhoodresource.findhelp.com/
Federally Qualified Health Centers (FQHCs)		
IHC Hamilton County WIC	317-776-3445	https://indianahealthonline.org/locations/hamilton-county-wic/
Aspire Indiana Health - Noblesville	877-574-1254	https://www.aspireindiana.org/noblesville-office
Aspire Indiana Health - Carmel	877-574-1254	https://www.aspireindiana.org/carmel-office

Sources: Indiana Department of Health; Catholic Charities USA; Neighborhood Resource; Indiana 211; HRSA

Appendix F: Evaluation of Impact from the Previous CHNA Implementation Strategy

Ascension St. Vincent Heart Center's previous CHNA implementation strategy responded to the following priority health needs: access to care, mental health and substance use disorders.

The table below describes the actions taken during fiscal years 2023-2025 (July 1, 2022-June 30, 2025) CHNA implementation strategy cycle to respond to each priority need.

Note: At the time of the report publication, the third year of the cycle will not be complete. The hospital will accommodate for that variable; results from the last year of this cycle will be reported and attached to the 2025 IRS Form 990/Schedule H.

PRIORITY NEED	**Access to Care**
SMART GOAL	1. By June 30, 2025, Ascension St. Vincent Heart Center will increase the number of patients established with a medical home by 2.0% each year, amongst individuals who complete a Medical Home Pathway, from baseline established in FY2023.
ACTIONS	**STATUS OF RESULTS**
Community Health Workers (CHWs) assess and address barriers to establishing a medical home, refer patients to a medical home, educate, assist with scheduling, confirm attendance at appointment, and follow up for ongoing concerns to complete the Medical Home Pathway.	**FY23 - Year 1: Baseline Set** ● The CHWs assisted 6 individuals with connecting to a medical home through the completion of a Medical Home Pathway. **FY24 - Year 2: Met Goal** ● The CHWs assisted 13 individuals with connecting to a medical home through the completion of a Medical Home Pathway (FY24 goal = 6). **FY25 - Year 3: In Progress** ● The results from the last year of this cycle will be reported and attached to the 2025 IRS Form 990/Schedule H.

PRIORITY NEED	Access to Care
SMART GOAL	2. By June 30, 2025, Ascension St. Vincent Heart Center and Care Continuity, will increase the number of self-pay/charity Emergency Department patients connected with a provider by 5.0%, from baseline established in FY2023.
ACTIONS	**STATUS OF RESULTS**
ED Concierge team members receive a referral from an Emergency Department provider. Care Continuity ED Concierge team members engage patients, assist with scheduling doctor appointments, arrange transportation and follow up with appointment reminders and confirmation.	**FY23 - Year 1: Baseline Set** ● The ED Concierges assisted 173 ED self-pay/charity patients with connecting to a provider. **FY24 - Year 2: On Track** ● The ED Concierges assisted 138 ED self-pay/charity patients with connecting to provider (2-year goal from baseline = 182) **FY25 - Year 3: In Progress** ● The results from the last year of this cycle will be reported and attached to the 2025 IRS Form 990/Schedule H.

PRIORITY NEED	Access to Care
SMART GOAL	3. By June 30, 2025, Ascension St. Vincent Heart Center will increase the number of people enrolled in a health insurance plan by 5.0% each year, amongst individuals who complete an enrollment pathway, from baseline established in FY2023.
ACTIONS	**STATUS OF RESULTS**
Community Health Workers verify appropriate application is completed, review referrals for social determinants of health (SDOH), assess and address barriers, monitor patient progress, and provide ongoing management to complete the Enrollment Pathway.	**FY23 - Year 1: Baseline Set** ● The CHWs assisted 13 individuals with obtaining health insurance through completion of an Enrollment Pathway. **FY24 - Year 2: Met Goal** ● The CHWs assisted 45 individuals with obtaining health insurance through completion of an Enrollment Pathway (FY24 goal=14). **FY25 - Year 3: In Progress** ● The results from the last year of this cycle will be reported and attached to the 2025 IRS Form 990/Schedule H.

PRIORITY NEED	Mental Health
SMART GOAL	By June 30, 2025, Ascension St. Vincent Heart Center, in collaboration with the Stress Center, will provide at least one session of QPR (Question, Persuade, Refer) Training for community members.
ACTIONS	**STATUS OF RESULTS**
Identify a hospital lead, identify partners, and develop a resource list. Plan promotion activities. Promote and offer the event. Obtain applicable outputs and/or outcomes	**FY23 - Year 1: Planning Year** ● The hospital completed the following planning steps: identified a lead, determined individual roles and expectations and updated resource lists from the previous I.S. cycle to reflect possible collaborating organization. **FY24 - Year 2: Met Goal** ● The hospital hosted a QPR session for the community, with approximately 30 individuals in attendance. The training was in a hybrid format (option to be in person or virtual) and was widely promoted to the general community. **FY25 - Year 3: In Progress** ● The results from the last year of this cycle will be reported and attached to the 2025 IRS Form 990/Schedule H.

PRIORITY NEED	Substance Use Disorder (SUD)
SMART GOAL	By June 30, 2025, Ascension St. Vincent Heart Center will develop a process to partner with community providers to enhance care coordination for persons with mental health and substance use disorder.
ACTIONS	**STATUS OF RESULTS**
Identify lead and assemble planning committee including community providers. Develop a plan to standardize a process for collaborating with community providers. Implement standardization process. Regional	**FY23 - Year 1: Planning Year** ● The hospital completed the following planning steps: identified a lead, determined individual roles and expectations, identified existing external committees and internal experts to serve in an advisory role and identified an evidence-based tool to support the objective.

Director of Behavioral Health Services.	**FY24 - Year 2: Behind Schedule** ● The SMART Medical Clearance Form, an evidenced-based tool designed to simplify and standardize the Medical Clearance Process when individuals present in the ED in a behavioral health crisis, was implemented in the pilot hospitals' ED, with plans to expand to other North Region hospitals, including Ascension St. Vincent Heart Center and the Heart Center. ● Implementation was interrupted when a system-wide cybersecurity event in May of 2024 caused a disruption in the standardized use of the tool. Efforts are underway to reinforce consistent use of the tool in the first two pilot hospitals before expanding. ● Education about the use of the new tool and how it will enhance care coordination for persons with mental health and substance use disorder is underway with community providers and partners. ● As a board member of the Madison County Mental Health and Addiction Coalition, the President of ASV Anderson and Regional Behavioral Health Director, hosted the coalition meeting at the Anderson Center to share their services and processes and tour the facility. **FY25 - Year 3: In Progress** ● The results from the last year of this cycle will be reported and attached to the 2025 IRS Form 990/Schedule H.

PRIORITY NEED	Community Engagement
SMART GOAL	By June 30, 2025, Ascension St. Vincent Heart Center will strengthen community engagement to expand the reach of evidence-based programs, advocacy, and/or services through financial support, facilitation, and/or promotion.
ACTIONS TAKEN	**STATUS OF RESULTS**
Identify a lead, assemble a workstream and identify or develop an assessment tool. Assess, identify opportunities, and make recommendations for strengthening community engagement: Develop strategy for community engagement.	**FY23 - Year 1: Planning Year** ● A market-wide workstream was developed with regional leads, individual roles and expectations were determined and an existing assessment tool (survey) was identified. **FY24 - Year 2: On Track** ● The associate community engagement survey was adapted to the Indiana market and was emailed to all associates on numerous occasions throughout August of 2023, with 13% of associates responding. ● The results were analyzed and presented to the market-wide workstream and regional leaders. ● Plans were interrupted due to a system-wide cybersecurity event in May of 2024. Due to the cybersecurity recovery, the timeline for hospitals to conduct a brainstorming session to assess their survey results and identify FY25 opportunities was adjusted to take place in Q1 of FY25. **FY25 - Year 3: In Progress** ● The results from the last year of this cycle will be reported and attached to the 2025 IRS Form 990/Schedule H.