River Bend Hospital

Community Health Needs Assessment

NCHS

CPAs / ADVISORS

blue

August 2015

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LETTER FROM THE CEO

To Our Community Members:

River Bend Hospital is committed to addressing acute inpatient psychiatric care, and to enhancing the quality of life for individuals, families, and communities in our ten-county service area. Our goal for the attached Needs Assessment is to better understand the range of issues affecting community health needs. River Bend Hospital is pleased to present this comprehensive assessment of mental health care needs in our community. We look forward to working with you to optimize community health and continue meeting the River Bend mission through high-quality mental health services.

Additionally, North Central Health Services (NCHS) provides financial support primarily for capital grants to not-for-profit organizations who share our commitment to health and the development of healthy communities. It was our privilege this year to witness the implementation of new and ambitious community-driven projects; the expansion of established, high-impact programs; and the realization of NCHS-initiated special projects. In 2014 alone, NCHS awarded grants to 35 organizations totaling more than $2 million, bringing total NCHS grantmaking since 1999 to over $48 million. To highlight a few grants, Mental Health America (MHA) of Tippecanoe County was awarded a grant for building renovation and equipment to assist in the MHA of Tippecanoe merge with the Lafayette Crisis Center. MHA also received funds to present a Child Psychiatric Conference designed for professionals who care for children, including including physicians, nurses, school personnel, juvenile justice personnel, and therapists. Historic Five Points Fire Station Educational Center, Inc. received continued funding for an NCHS-initiated project to provide equipment for the Tippecanoe County smoke detector outreach program to reduce fire deaths and injuries associated with residential fires, particularly in underserved areas and for vulnerable populations. The United Way of Lafayette was the recipient of an NCHS Food and Family Request for Proposals grant to launch 15 Born Learning Academies, a collaborative program to provide family skills training to 1,500 families, including nutrition education and parent education.

The significance of better understanding our community's needs was highlighted by the Patient Protection and Affordable Care Act requirements passed in March 2010. New requirements for tax-exempt hospitals were added to the Internal Revenue Code, mandating hospitals to conduct a community health needs assessment and to adopt an implementation strategy to address at least some of the applicable needs detected during the assessment process.

During 2015, a Community Health Needs Assessment was conducted by River Bend Hospital for the residents of Benton, Carroll, Clinton, Fountain, Jasper, Montgomery, Newton, Tippecanoe, Warren, and White counties. River Bend Hospital has developed an implementation strategy based upon the applicable needs identified in the assessment – the results are summarized in the attached report.

Stephanie Long, FACHE
Chief Executive Officer

August 2015

RIVER BEND HOSPITAL'S MISSION

River Bend Hospital exists to make available acute inpatient psychiatric care to the adult population of Mid-North Indiana. We are committed to achieving this purpose in a therapeutic environment with appropriate facilities and valued staff. Expertise, compassion, and professionalism are the cornerstones of our purpose and success.

EXECUTIVE SUMMARY

On behalf of River Bend Hospital (the Hospital) and North Central Health Services, Inc. (NCHS), a community health needs assessment (CHNA) was conducted in 2015 primarily to identify the major mental health needs, both met and unmet, within the surrounding community. The community's geographic area is comprised of the following 10 counties: Benton, Carroll, Clinton, Fountain, Jasper, Montgomery, Newton, Tippecanoe, Warren, and White. The chief objectives of the CHNA were to: 1) identify major behavioral health needs within the community in an effort to ultimately improve the health of the area's residents and facilitate collaboration among mental health providers, and 2) voluntarily satisfy the federal guidelines within the Patient Protection and Affordable Care Act (PPACA) of 2010.

Data for this CHNA was collected from primary and secondary data sources to identify key findings and gaps that may exist between mental health needs and services provided within the community. Three methods of collection for primary data were used: 1) online survey, 2) focus groups, and 3) personal interviews. Several secondary data sources were reviewed to identify key findings with strategic implications and for benchmarking of the Hospital's service area.

Highlighted subsequently are important findings identified through the data collection, analysis, and assessment process:

- Access to mental health services is limited, particularly for various at-risk populations; therefore, the offering of new or expanded mental health services is needed to more effectively reach selected at-risk populations.
- The community suffers from a shortage of mental health professionals, particularly qualified psychiatrists, psychologists, social workers and primary mental health care providers.
- The delivery of mental health services in the community is fragmented, with minimal coordination and collaboration among providers.
- Financial resources and funding for mental health and related social services are significantly limited, thus inhibiting providers from meeting most, if not all, of the identified unmet mental health needs in the community.
- There are increased efforts being made to break the cycle of homelessness in the community, and this is viewed very positively. However, the perception is that homelessness leads to behavioral issues and increases the need for mental health, alcohol and addiction care.
- There continues to be a stigma about mental illness, including care and treatment, though it has improved somewhat over the past several decades.
- The deinstitutionalization of the chronically mentally ill/seriously mentally ill (SMI) population in the state has placed significant strains on existing community resources.
- There are lengthy wait times, in some cases up to several months, in order to see a provider for initial and renewal medication prescriptions, as well as for diagnosis and treatment services.

Finally, it is important to note that our data collection did not include a statistically representative sample of the community, in that members of disadvantaged populations were less likely to participate via a web-based survey. These individuals may include immigrants, refugees, the homeless, as well as individuals with low education attainment and income levels. Focus groups were conducted with community leaders and others who work directly with members of disadvantaged populations in order to consider broad interests of the community served.

ORGANIZATIONAL BACKGROUND

North Central Health Services, Inc.

NCHS was incorporated as a not-for-profit organization in 1984 under the laws of the State of Indiana and is a not-for-profit organization as defined by Section 501(c)(3) of the Internal Revenue Code. It is governed by a volunteer board of individuals and has a long tradition of successfully providing medical services, originally via Lafayette Home Hospital. In January 2010, its primary responsibilities became the ownership and operation of Wabash Valley Hospital in West Lafayette, Indiana. The private inpatient psychiatric hospital, licensed and certified by the Indiana Department of Mental Health, was then renamed River Bend Hospital.

River Bend Hospital

The Hospital provides inpatient care to adults by behavioral medicine specialists including psychiatrists, psychologists, social workers, activity therapists and nurse professionals. They are well supported by others in the health profession and together create a therapeutic environment designed for short-term intervention and mental health enhancement. The hospital is committed to pursuing its mission, addressing acute inpatient psychiatric care, and enhancing the quality of life for individuals, families, and communities in its 10-county service area. The Hospital accepts patients throughout North Central Indiana and works cooperatively with others in behavioral health organizations to create a competent, caring environment for improving and restoring the mental health of our community and its citizens.

NCHS and the Hospital support not-for-profit organizations and agencies that share a similar commitment to health and healthy communities, primarily through grants for capital projects. The understanding of complex delivery systems, and recognizing opportunities to enhance and further develop those systems, continues to drive our objectives to provide and award grants to other organizations that provide services of high quality in an efficient and cost-conscious manner. NCHS and the Hospital prefer to fund projects that have significant potential for positive impact on the community.

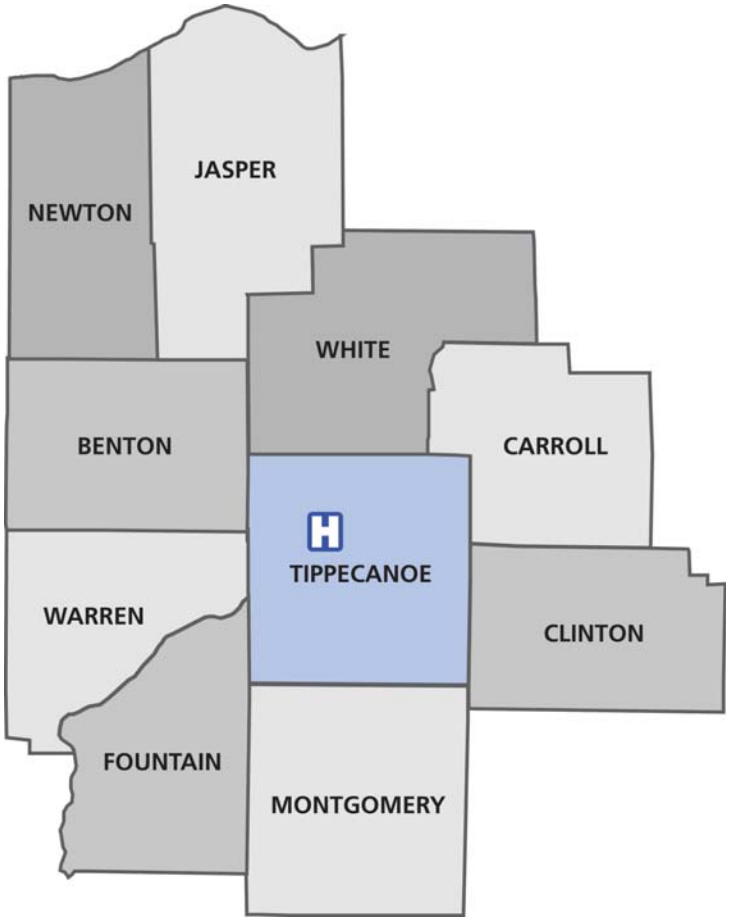
SERVICE AREA

SERVICE AREA AND COMMUNITY OF THE HOSPITAL

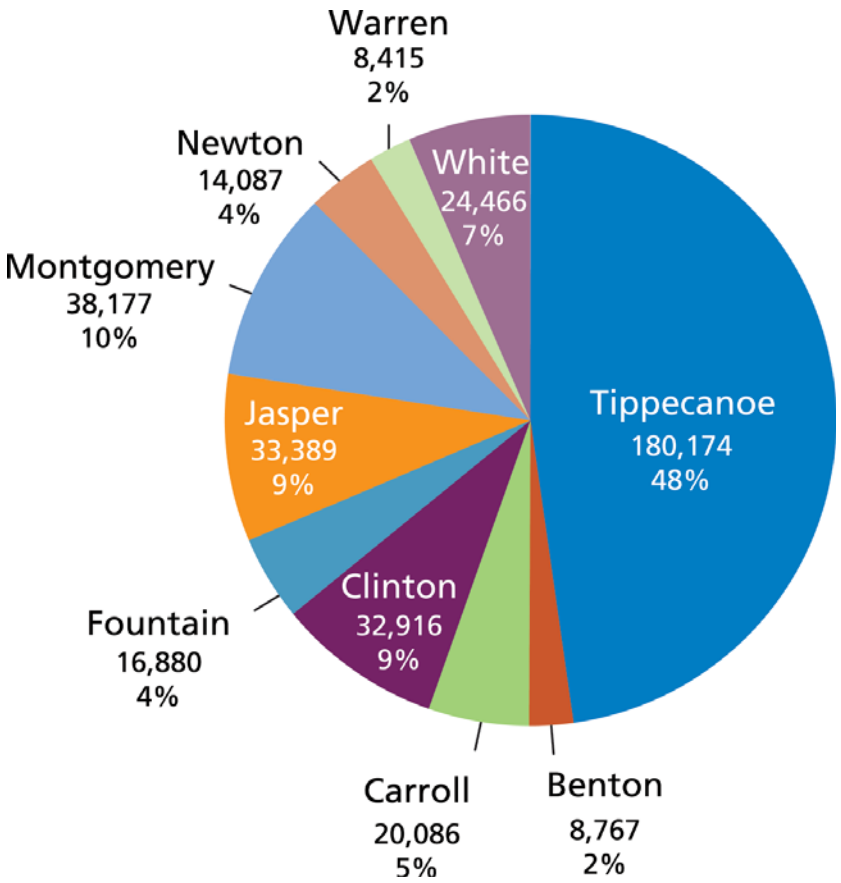
During 2015, the CHNA was conducted by the Hospital for the 377,357 residents of Benton, Carroll, Clinton, Fountain, Jasper, Montgomery, Newton, Tippecanoe, Warren, and White counties located in Indiana.

The Hospital's service area includes both urban and rural areas covering over 4,400 square miles, with the local economy and surrounding areas focused on agriculture, industrial, and academic activities of the local university. Population per square mile is significantly lower when compared to Indiana's average population per square mile (approximately 86 per mile vs. 183 per mile, respectively). Tippecanoe County represents 48% of the total service area population. Median age in the service area is 37.4 years, with 9% of the population non-white and 50% female. Approximately 12% of the service area population lives below the poverty level, while the unemployment rate is 4.6% as of June 2015. Persons from age 45 to 64 represent the largest population range (26.4%) for the service area. The smallest age range is children under the age of four, comprising 5.95% of the service area population.

SERVICE AREA MAP



SERVICE AREA POPULATION BREAKDOWN BY COUNTY



CONDUCTING THE ASSESSMENT

OVERVIEW

NCHS contracted Blue & Co., LLC (Blue) to assist the Hospital in conducting a CHNA and analyzing the data for the CHNA requirements set forth in section 9007 of the Patient Protection and Affordable Care Act (PPACA) of 2010. Blue is a Certified Public Accounting firm that provides, among other services, tax consulting and compliance to the healthcare industry. The Hospital provided all of the financial support for the assessment process.

The CHNA requirements were effective starting taxable years beginning after March 23, 2012. On December 29, 2014 the Treasury Department and the IRS published the final regulations for section 501(r) located in 26 CFR parts 1, 53, and 602. The Hospital is licensed by the Indiana Department of Mental Health and not licensed, registered or recognized by the state of Indiana as a hospital facility. River Bend is a private psychiatric facility that provides inpatient care to adults by behavioral medicine specialists including psychiatrics, psychologists, social workers, activity therapists and nurse professionals. The organization is not required to comply with Internal Revenue Code 501(r) per the definition defined in section 501(r)(2)(A)(i) for Hospital facility. The Indiana Administrative Code Section 16-18-2-179(b) specifically excludes from the definition of Hospital "institutions included to diagnose, care, and treat individuals with a mental illness." However in the best interest of the community, River Bend's management wanted to have an assessment conducted in a good faith effort to support and improve the health of the community it serves.

The assessment was developed to identify the significant mental health needs in the community and gaps that may exist in services provided. It was also developed to provide the community with information to assess essential mental health care, preventive care, and treatment services. This endeavor represents NCHS's and the Hospital's efforts to share information that can lead to improved mental health care and quality of care available to the community, while reinforcing and augmenting the existing infrastructure of services and providers.

COMMUNITY HEALTH NEEDS ASSESSMENT GOALS

The assessment had several goals which included identification and documentation of:

- Community health needs, specifically relating to mental health,
- Mental health services offered in the Hospital's service area,
- Significant gaps in mental health needs and services offered, and
- Barriers to meeting any needs that may exist.

Other goals of the assessment were:

- Strengthen relationships with local community leaders, healthcare leaders and providers, other health service organizations, and the community at large, and
- Provide quantitative and qualitative data to help guide future policy, business, and clinical programming decisions.

INFORMATION GAPS

The data collection process did not include a statistically representative sample of the community, in that members of disadvantaged populations were less likely to participate via a web-based survey. Blue was able to speak with community leaders and others who work directly with members of disadvantaged populations. In addition, participant responses provided can contain biases due to individuals' views. Finally, a challenge encountered was the inconsistency in years available for statistical data collection. The most current statistical data has been used where available and the years available have been documented throughout the report.

PROCESS & METHODOLOGY

Documenting the mental health care needs of a community allows healthcare organizations to design and implement cost-effective strategies that improve the mental health of the population served. A comprehensive data-focused assessment process can uncover key health needs and concerns related to education, prevention, detection, diagnosis, and treatment. Blue used an assessment process focused on collection of primary and secondary data sources to identify key areas of concern.

Blue conducted focus group conversations with community leaders as well as medical, social services, clinical and professional staff. Blue also obtained input from local physicians, hospital employees, mental health professionals, public health experts, and community leaders and officials. In addition, online surveys were used to solicit feedback from various members of the community. The community outreach data collection strategy was targeted at engaging a cross-section of residents from the community as discussed above.

Once data had been collected and analyzed, meetings with hospital leadership were held to discuss key findings as well as refine and prioritize the comprehensive list of community needs, services and potential gaps.

PRIMARY DATA COLLECTION METHODS

The primary data was collected, analyzed, and presented with the assistance of Blue. Focus groups were facilitated by Blue personnel. The Hospital provided listings with contact information of local officials, public health experts, mental health providers, and other key informants.

Three methods of collection for primary data were used: 1) online survey, 2) focus groups, and 3) personal interviews.

Online Survey

An online survey was developed and used as a method to solicit perceptions, insights and general understanding from community members and special expertise regarding mental health. The online "Community Input 2015" survey (see Attachment C) was made available on the website of NCHS (www.nchsi.com). A total of 70 surveys were completed.

The survey comprised nineteen questions total. The first ten questions related to the current and previously conducted community health needs assessment; the last nine regarded demographics. Community members were asked to identify the top five health needs, top three mental health needs, top three social issues, and top three healthcare challenges in the community. The top five health needs and top three mental health needs questions provided eleven topics to identify from highest to lowest priority. The top three social issues and top three healthcare challenge questions provided nine topics to identify from highest to lowest priority. Each question provided the option to write in issues that were not listed. Participants were also asked to identify the primary transportation used to attend a doctor's appointment and primary source for obtaining information about healthcare. The results of the survey can be found in the Key Findings section of the report.

In addition to soliciting comments regarding the current needs of the community, participants were asked to comment on the most recently conducted CHNA and most recently adopted implementation strategy, which were conducted in 2012. The responses received are provided in the Survey Results section.

Focus Groups

Two focus groups were conducted by Blue, with 7 and 11 participants attending the sessions. Each session lasted approximately one hour. These focus groups were conducted with members representing the communities being served by the Hospital including community leaders, health experts, public officials, physicians, hospital employees, and mental health professionals including those associated with the Hospital. The primary objective of the focus groups was to solicit perceptions regarding behavioral health and substance abuse needs and services offered in the community, along with any opportunities or barriers that may exist to satisfy needs. The individuals participating in the meetings were able to provide insight regarding members of disadvantaged populations.

Personal Interviews

Personal interviews were conducted face-to-face and via telephone with two key individuals in the community using a structured questionnaire (See Attachment C for content).

Secondary Data Sources

Blue reviewed secondary data sources including the American Hospital Association 2015 Environmental Scan and Deloitte 2012 Survey of Health Care Consumers in the United States to identify health factors with strategic implications. The health factors identified were supported with information from additional sources including: America's Health Rankings United Health Foundation; Behavioral Health Barometer; Centers for Disease Control and Prevention (MMWR); County Health Rankings; Indiana Coalition Against Domestic Violence; Indiana Drug Control Update; Indiana Housing & Community Development Authority (IHCDA); Indiana National Alliance on Mental Illness; Indiana State Department of Health; National Mental Health Services Survey (N-MHSS); Suicide in Indiana Report; and Substance Abuse and Mental Health Services Administration (SAMHSA) data. (See Attachment D for a complete list of citations.)

KEY FINDINGS

AREAS OF CONCERN

The following represent key responses obtained from the data collection and analysis process.

Access to Mental Health Services

Access to mental health services is limited, particularly for various at-risk populations; therefore, the offering of new or expanded mental health services is needed to more effectively reach selected at-risk populations.

- Although services are provided for at-risk populations, these services are limited. This is especially true as it relates to services for the SMI (seriously mentally ill/chronically mentally ill), detox, adult alcohol and drug abuse, co-occurring disorders, geriatric, child and adolescent psychiatric, and child and adolescent alcohol and drug abuse populations.
- Hospital emergency departments are viewed as a less-than-ideal entry point, are not well-equipped to handle mental health emergencies, and are overused to access mental health services. Hospital emergency rooms were indicated as significant points of entry during mental health crises with limited numbers of beds and professional resources available. A better entry or access point with abilities to prescribe and provide medications and evaluations, such as a psychiatric emergency room, could be equipped to reach at-risk populations and reduce the burden faced by traditional hospital emergency departments.
- Although the Lafayette community boasts an outstanding bus system for mass transportation, significant limitations in transportation for mental health services still exist, particularly in the more rural communities of the 10-county service area.
- There are differing opinions as to the adequacy of mental health services available for the Hispanic population, including the effect that language may have on access.
- Determining the entry point into the mental health system can be confusing for potential clients, particularly for low-income/at-risk populations. Waiting periods for appointments and services were noted as a barrier to access.

Community Perception of Accessibility of Mental Health Providers

There is a perception the community suffers from a shortage of mental health professionals, particularly psychiatrists, psychologists, social workers and primary mental health care providers.

- Attempts to employ and maintain well-trained, educated, mental health professionals in the community are limited by funding resources and the overall inadequate supply locally, in the state, and nationally.
- There is a perceived high turnover rate weakening reliability and trust in mental health professionals. Some professionals do not provide notice to the public, patients, healthcare providers or other organizations prior to their departure from the community.
- Patients experience lengthy wait times, up to several months, in order to see a prescriber for diagnosis, initial and renewal medication prescriptions, and other treatment.

Delivery of Mental Health Services

The delivery of mental health services in the community is, overall, fragmented, with limited coordination and collaboration among providers.

- There is a sense that greater coordination and collaboration among providers could produce a more efficient and effective use of limited resources.
- There is a perceived need for greater provider collaboration to improve discharge planning, after-care, referral, and the continuum of care provided.
- There is a sense that most mental health providers are not knowledgeable about available resources from other organizations and providers, including their service capabilities, policies, and practices; this leads to redundancies, inefficiencies and fragmentation in providing mental health services.
- Social services and mental health treatment services are closely linked for a segment of the low-income, at-risk population. Greater coordination and collaboration of services and service providers may enhance service delivery efficiency and effectiveness.
- There is perceived difficulty in communication among providers who use automated menu phone systems. Individuals, family members, and other healthcare practitioners and providers are unable to contact professionals in times of emergency.

Financial Resources and Funding

Financial resources and funding for mental health and related social services are significantly limited, inhibiting providers from meeting most, if not all, of the identified unmet mental health needs in the community.

- Governmental health insurance programs are viewed as being unrealistically restrictive and inadequate.
- Inadequate Medicaid reimbursement is a principal driver of the underfunding of mental health services.
- Patients with private insurance have access to private mental health services in the community and therefore are able to meet their mental health treatment needs more often than those without private insurance. However, restrictions and limitations with private health insurance coverage and reimbursement does have a limiting effect on access to treatment for those privately insured.
- The indigent population is significantly at risk for not having access to mental health care or alcohol and addiction care treatment services.
- An expansion of access and addition of mental health care services for at-risk populations is perceived to only create greater financial burdens, subsidies and potential insolvency within the mental health provider community.
- Mental health services needed may be terminated (i.e. Crisis Intervention Team, housing, Assertive Community Treatment, access to psychiatric medications and crisis services) due to the discontinuance of funding.

- Certain transportation, specifically for individuals amidst mental crisis, is vital, however, is provided by police department personnel at the risk of depleting department financial resources and officers' service availability.
- Not all mental health providers have a sliding-fee scale based upon the patient's ability to pay for services rendered.
- It is common for mental health treatment services, including medication treatments, to be skipped or even stopped completely when private or public funding sources cease.

Efforts Made to Break the Cycle of Homelessness in the Community

There are increased efforts to break the cycle of homelessness in the community; this is viewed very positively. However, there is a perception that homelessness leads to behavioral issues and increases the needs for mental health, alcohol and addiction care services.

- Homeless shelter services are viewed as underfunded, as a result of the closure of the Mental Health America day shelter.
- There is a perceived need for additional transitional housing for mental health and recovering patients, with a greater need for more collaborative efforts among community providers.
- There is a need for temporary placement for individuals in crisis. There is a high usage of jails as temporary holding cells for individuals better cared for with supervision by a mental health provider.

Mental Illness Awareness and Education

There continues to be a stigma about mental illness care and treatment, despite improvement over the past several decades.

- Attempts to promote mental health education and awareness in the community are limited and fragmented. There is a general belief that additional emphasis on education and awareness might be better achieved through a collaborative, community-wide initiative.
- Additional resources are needed to teach coping skills as an alternative to medication in less severe mental health diagnoses.
- There is a perceived need for adolescent suicide awareness and prevention.

Deinstitutionalization of the Chronically Mentally Ill/SMI Population

The deinstitutionalization of the chronically mentally ill/SMI population in the state has placed significant strains on existing community resources.

- There is a common perception that it is unrealistic to expect that all SMI patients can function independently or even be treated appropriately or effectively in the community versus institutionalization.There is no assisted housing available for chronically mentally ill individuals in the community.
- SMI populations heavily rely on family support; however, families are not adequately equipped to provide the necessary support. There is a need for educational classes and support for families providing care to SMI patients.
- Homeless shelter services are viewed as inadequate and underfunded.
- There is a perceived need for additional transitional housing for mental health and recovering patients.
- There is a need for temporary placement for individuals in crisis. There is a high usage of jails as temporary holding cells for individuals better cared for with supervision by a mental health provider.

SURVEY RESULTS

The following represent the responses obtained during the data collection and analysis process.

Top Five Health Needs in the Community

Participants were instructed to select the top five most significant health needs in the community, with one (1) being the most important and five (5) being the least important, from the topics listed, with the option to provide a write-in response. The responses were given a weighted score and rank. The top five ranked responses are considered primary needs; the remainder of the needs are considered secondary.

NEEDS IN THE COMMUNITY - TOP 5 HEALTH NEEDS	
Primary Needs Based on Response Percentage	**Percent of Responses**
Programs and resources for mental health improvements	25%
Programs and resources for substance abuse	19%
Access to healthcare	19%
Programs and resources for obesity prevention	9%
Programs and resources for chronic disease	8%
Secondary Needs	
Access to dental/oral healthcare	6%
Access to prenatal healthcare	4%
Other*	3%
Resources for hearing/vision issues	2%
Programs and resources for infant mortality prevention	2%
Resources for injury prevention	1%
Programs and resources for Asthma awareness and prevention	1%

* Participants were given the opportunity to specify other needs not listed. Other responses included:

- All of these needs especially for the low income/working poor
- Availability of public health services
- Child/adolescent mental health
- Children's health resources; dietary consulting
- Coverage for care
- Diabetes
- Emergency mental health assessment
- Facility for patients who don't "fit" in a nursing home, group home, etc.
- Low cost exercise and nutrition counseling
- Mental health
- Mental health help, treatment, inpatient services

- Mental health, nutrition counseling, physical therapy, exercise options
- More community based in-home case management programs for mental illness
- Programs and resources for senior living
- Programs and resources to support incarcerated individuals get back on their feet
- Programs for primary or secondary trauma-child witness to crime, sexual assault and domestic long-term trauma
- Wellness and nutrition

Top Three Mental Health Needs in the Community

Participants were instructed to select the three most significant mental health needs in the community, with one (1) being the most important and three (3) being the least important, from the topics listed, with the option to provide a write-in response. The responses were given a weighted score and rank. The top three ranked responses are considered primary needs; the remainder of the needs are considered secondary.

NEEDS IN THE COMMUNITY - TOP 3 MENTAL HEALTH NEEDS	
Primary Needs Based on Response Percentage	**Percent of Responses**
Increase number of treatment facilities	15%
Increase continued care and collaboration with after care treatment plans	15%
Increase awareness for mental health services and resources	14%
Secondary Needs	
Increase substance abuse programs and resources	14%
Increase mental health screenings by doctors	9%
Increase programs for depression prevention and awareness	8%
Increase programs for other mental health prevention and awareness	8%
Increase programs for suicide prevention and awareness	7%
Increase programs for domestic abuse prevention and awareness	4%
Increase programs for anxiety prevention and awareness	4%
Other*	4%

* Participants were given the opportunity to specify other needs not listed. Other responses included:

- Availability of emergency care for mental health crisis
- Give mental health/substance abuse services to those who can't afford it
- Housing for mentally ill; emergency psych services; access to psychiatrists
- Programs for youth suicide prevention
- Psychiatric ER; better psych services in the ER
- More treatment options midway between outpatient and inpatient; group homes, supervised apartments; adolescent/child mental healthcare

Top Three Social Issues in the Community

Participants were instructed to select the three most significant social issues in the community, with one (1) being the most important and three (3) being the least important, from the topics listed, with the option to provide a write-in response. The responses were given a weighted score and rank. The top three ranked responses are considered primary needs; the remainder of the needs are considered secondary.

NEEDS IN THE COMMUNITY – TOP 3 SOCIAL ISSUES	
Primary Needs Based on Response Percentage	**Percent of Responses**
Poverty	24%
Health	18%
Public safety	11%
Secondary Needs	
Housing	10%
Transportation	10%
Hunger	10%
Education	8%
Other*	6.5%
Environment	2%
Pollution (clean, safe air quality)	0.5%

* Participants were given the opportunity to specify other needs not listed. Other responses included:

- Drug abuse prevention and education
- Drug prevention programs and treatment centers
- Gangs; social pressures
- Homelessness
- Initiative to want to work and hold a job
- Lack of mental health institutions; substance abuse and alcohol abuse
- Life skills so that people are employable
- Local veteran's resources

Top Three Healthcare Challenges in the Community

Participants were instructed to select the three most significant healthcare challenges in the community, with one (1) being the most important and three (3) being the least important, from the topics listed, with the option to provide a write-in response. The responses were given a weighted score and rank. The top three ranked responses are considered primary; the remainder of the needs are considered secondary. There was a significant number of responses (41%) that selected "do not have any challenges receiving healthcare" which has been listed as the last item.

NEEDS IN THE COMMUNITY - TOP 3 HEALTHCARE CHALLENGES	
Primary Needs Based on Response Percentage	**Percent of Responses**
Limited hours at doctors' offices / clinics	15%
Co-pay costs	15%
Other*	9%
Secondary Needs	
Lack of doctors who accept specific insurance	7%
Lack of insurance	4%
Unable to find a specialist	4%
Unable to find a doctor	3%
Language barriers	1%
Lack of transportation	1%
Do not have any challenges receiving healthcare	41%

* Participants were given the opportunity to specify other needs not listed. Other responses included:

- Access to care is available, but with long waits for [primary care physicians] and specialists
- Coordination of care; each [medical doctor] is [compartmentalized]
- Have to go out of county for services
- Home assistance for aging parents and the elderly
- Lack of quality specialized providers in community
- Length of time for doctor's appointments
- Measure of quality; availability
- My health insurance incentivizes me to go out of my county for health[care]
- Specialist over an hour away from residence
- Understanding Medicare

Primary Transportation Taken to Doctor's Appointments and Other Healthcare Treatment

Participants were instructed to select the primary transportation from the following: *personal vehicle, public transportation, taxi, family/friend, walk, I am unable to make it to appointments due to lack of transportation, or other transportation*. Of the responses, 99% used a personal vehicle, while only 1% responded *friend*.

Primary Source for Information About Healthcare

Participants were instructed to select the primary source for information about healthcare from the following: *doctor's office or clinic; family, friend, co-workers, or neighbor; school clinic or nurse; community center; church; internet; media (radio, TV, magazines, newspapers); I do not receive information about healthcare; or other sources*. Of the responses, 60% received information from the doctor's office or clinic; 24% used the internet; 6% received information from family, friends, co-workers, or neighbors; 4% used media i.e. radio, TV, magazines, or newspapers; 4% used other sources; and only 1% did not receive information about healthcare.

General Comments: Current Needs, 2012 Solicited Comments, and River Bend Hospital (RBH) Awareness

Participants were asked to provide any additional comments regarding needs in the community. The following comments were received.

- Access to any kind of service is always an issue in Warren County. The only "public transportation" is MAC Van, which is only available to a portion of our population.
- Access to healthcare for the underinsured.
- Affordable mental health counseling and just psychiatrists period.
- All decent doctors are booked and not accepting new patients.
- Am I correct in that there are no longer any counselors available in our local schools? Particularly at the elementary and middle school levels, counselors provided a vital link between the school and available mental health services. Are case workers still involved in the schools? I've been involved in a mentoring program for the past six years (have followed the same student) and have seen and heard more horror stories from elementary students -- parents in jail, bullying, total lack of physical and emotional support, just to name a few -- than I could ever imagine. Resources are key!
- I believe there are a lot of governmental, non-profit and individual people that have help for those in need and many people don't know who or how to contact them. A website would be great outlining all of the social services that are offered in a community. A one stop shop that each organization can update daily.
- I think the community needs to continue to invest in education, health, and wellness programs and facilities to help fuel our growth. In very short order, our existing facilities can become maxed out without strategic investment today.

- In Fowler we try to provide a network of drivers who will take patients to appointments in Lafayette, but sometimes that still is a problem.
- Increasing incidence of drug use and crime.
- Mental health services is low everywhere. As an employee of a hospital, we spend hours trying to find [inpatient] help and bed [availability] for our patients that come to our Emergency Department.
- More access to psychiatrists and therapists without such long waits.
- Our community needs a facility that can care for mentally ill patients and provide them with emotional support. Patients should not be told that they have to be treated in the ED to be admitted to the facility of their choice.
- People who struggle with substance abuse and mental disorders need better access to treatment and housing.
- [River] Bend could work closely with other mental [health providers] to assist more people.
- The community needs easier access to inpatient treatment facilities for mental health and addictions.
- There is a huge need for people who slip through the cracks. There aren't enough case managers to help new folks, unless they are DCS cases. We don't have a good place to house & care for folks that are not self-sufficient, need more help than a group home, but still have mental illness & don't qualify for nursing home care. Others who have been hard to place: traumatic brain injury, borderline personality disorder, Alzheimer's patients. Indiana, specifically the [Lafayette]/[West Lafayette] area, really doesn't have adequate facilities for them. Could definitely use a borderline program in this area. Also seeing lots of meth & heroin use. Need more help addressing that issue.
- There is an overall lack of continuity of care for behavioral healthcare. The outpatient isn't coordinated with inpatient, and there is no communication with family practice physicians.
- We are grateful to have access to the information.

Participants were asked to respond to the following question: "How do you characterize the community's overall awareness of River Bend Hospital and its services? Is there anything that could be done to improve awareness about the contributions the Hospital is making to the community?" The following comments were received.

- A majority of people in our community have never heard of River Bend and the services provided at the facility.
- A representative needs to visit the community and speak at civic organizations, non-profits, churches, governmental boards and other community needs organizations.
- Above average.
- Advertisement. More community involvement.
- As a community I'm not certain there is full understanding or awareness of services offered by River Bend to [patients]. Is there any collaboration between River [Bend] and Sycamore Springs? What is collaboration between River Bend and [primary care physicians] or specialists?

- Because of my job I know what River Bend does, however, I'm not sure that the population I serve (low income) is always aware of services offered.
- Community awareness is low. Unless you used the facility and [are] aware of its ability to help others and the [community].
- Community awareness of what services, number of beds, number of social workers in the field, etc. would be useful for River Bend's image.
- First I've heard of it.
- General lack of awareness by general population; much more so by health care provider population and those clients within the mental health system
- General public not aware of the resources and the value added by this hospital source. Many assume it serves only those "in trouble" with law, etc.
- Generally there is not a positive perspective of River Bend's services.
- Honestly, I have never heard of any services reaching out to Warren County. Having said that, I am not in the mental health field, but I still think there is a lack of awareness.
- I am aware of River Bend, but do not see it as part of [our] community in Crawfordsville.
- I am not exactly sure what River Bend does - have seen commercials. Would be interested in knowing more about what they can do, where they are located and what they cannot handle.
- I am only aware of their services because of our work with NCHS.
- I believe an awareness campaign is needed by River Bend to assist the community in understanding the services and increase the awareness of the resources available at River Bend.
- I believe that overall the community is unaware of River Bend and its services. For those who are aware, I think there is a good perception.
- I believe that River Bend is well known in the community for the inpatient side of things - but I think more information and media attention to outpatient services would help.
- I don't know what it is. I doubt that people even know it exists and what services [are] offered.
- I don't think our community knows anything about River Bend. I know very little about it. Maybe social media, or attend community events.
- I don't think people know that there is more care than just "hospitalization." Advocates/case workers need to be publicized so the community knows there are many levels of care available.
- I don't think the community fully understands what River Bend offers. It seems like mental health should somehow be added to the title or tagline.
- I doubt that any people at all in [Benton] County are aware of your services. I am a member of Rotary, and anyone who would like to be a guest at our meeting and make a presentation would be warmly welcomed!

- I feel the community doesn't understand mental health as a biological illness, therefore doesn't understand the contributions River Bend gives to the healthcare of our community members. Promoting awareness of mental health conditions, symptoms and how common the disorders are is needed.
- I have not heard anything negative regarding River Bend Hospital and/or the services provided.
- I know the community is aware of [River Bend] hospital, however the Hospital doesn't have a good reputation with patients after treatment. [M]any of the [people] I have taken care of request not to return to River Bend for additional treatment after discharge.
- I only know what I hear from the media regarding River Bend Hospital.... Not in my community.
- I see the overall awareness as a Hospital that serves a purpose in the community, but needs to advertise its existence more.
- I think the community is on a learning curve about the difference between RBH [River Bend Hospital] and Wabash Valley, often thinking they are the same. RBH is still struggling under a bad impression left by Wabash Valley -- formerly the dumping ground of several counties.
- I think there is limited awareness and lack of understanding of the important role River Bend Hospital plays in the region. Connecting with area primary health care providers could help.
- I think there is very little knowledge among the general population regarding River Bend Hospital. Billboards, radio, and television ads would help. Mailings to local provider practices and brochures that can be left with providers would be helpful. Sponsoring educational programs for the general public at different locales and times within Montgomery County could also assist in improving knowledge of RBH.
- I work in healthcare and am not sure of all the services that are provided. I think you could start by ensuring that local healthcare is aware of your services and how to make referrals and why some of our patients are refused or not eligible for treatment.
- I would suggest that very few people in Benton County, outside of those who have visited/been treated at River Bend, are aware of its services. Increasing awareness could be most likely be attained through newspaper articles in our local paper, direct mail, involvement in community events and networks.
- In general there is a lack of awareness. The assumption is that River Bend is a last resort facility, but very few even know it exists, primarily because of location and lack of widespread advertising.
- In my 6 months in Greater Lafayette, I have heard a lot about River Bend Hospital.
- It seems to be well known. Not everyone knows the new name.
- Limited access to care. I don't believe the general public knows of River Bend services. More likely to know it as an emergency mental health option.
- Limited inpatient services.

- Living in a community outside of Lafayette, I don't honestly think most people are aware of River Bend -- how someone might make contact, what services it provides, etc. We only know it as we drive along River Rd and see it up on the hill...isolated. Are there outreach programs in the counties surrounding Tippecanoe? If so, they are not well known.
- Low. Maybe advertising.
- Many individuals believe River Bend is Wabash Valley Alliance.
- More media/advertisement. Many people still refer to the hospital as Wabash Valley or are unaware of us in general.
- No awareness, any advertisement.
- Not aware. How about getting a regular mental health spot on the noon or evening news? They do adopt a pet; surely mental health issues/ substance abuse are more important.
- Not sure they are aware of the services offered. Limited awareness.
- Not very aware, gets confused with WVA [Wabash Valley Alliance].
- Not very aware.
- Overall the community is not well informed to the limitations that the hospital has.
- Pass out brochures to agencies.
- People believe River Bend is still Wabash Valley Hospital. In addition, the community believes RBH has a legal obligation to accept every patient that is referred.
- People do not know where they are located or what services they provide. They need to be out in the public more: fairs, health wellness events, etc.
- Promote to the doctors' offices more.
- River Bend is known in the community as a psych hospital. Advertisement might help improve awareness.
- Still confused with WVH [Wabash Valley Hospital] and WVA [Wabash Valley Alliance]. Still not aware that we are no longer state subsidized. Maybe more involvement in community forums.
- Still much confusion over RBH versus the old WVH and how things are different—not just a different name.
- Still totally confused with WVA. Still seen as a "public" agency and not a private concern. Need to continue to clarify the separation, lack of direct government funding.
- Stressing the collaborations that exist and how these can be used together to address current and future needs.
- The public knows about River Bend but is not quite sure of their services.

- The biggest barrier I see with River Bend is the hurry up and wait. I have not made a referral there in a while and process may have changed but I had patients not wanting to go and sit waiting in line. They preferred an appointment. I do realize likely there are significant no shows but maybe a combination of the two would work.
- The community believes that River Bend helps all persons that have severe mental illness--which is not the case.
- The community does not know about River Bend Hospital. I have lived here locally all my life and never knew about River Bend until applying. Marketing could increase community awareness.
- The community does not understand that we are no longer part of Wabash Valley, that we are acute care and that we cannot solve housing problems-more PR [public relations].
- The community has limited awareness of River Bend Hospital partly due to its "recent" name change.
- The community seems to be aware of RBH and its purpose from what I have experienced.
- There is confusion about services provided at River Bend, ie, inpatient or outpatient.
- Unaware of River Bend Hospital.
- Within healthcare relatively well known but not always fully understood as far as devices available. In the community not positive the resources are known or understood. More marketing?

Of the responses received, 49% of the participants were aware the 2012 Community Health Needs Assessment was available to the public. Participants were given the opportunity to provide comments, questions, and any changing circumstances for the 2012 Community Health Needs Assessment (available at http://www.nchsi.com/communityhealthneedassessment.cfm) and the following comments were received.

- Ever increasing need for outpatient and eldercare services.
- Have not read 2012 assessment. However, there are new and expanding opportunities to partner with homeless services and housing programs--both for intake and exit planning.
- Many more low income, poor that need help, both mental & substance.
- Planned opening of additional outpatient behavioral healthcare services.
- Since 2012 the Montgomery County Free Clinic has opened and HIP 2.0 has taken effect, both with improved access to health care for our poorest citizens. In general though, health care in this community is too expensive, even for those with insurance.
- The needs seem very similar.

NATIONAL, STATE AND COUNTY TRENDS

NATIONAL HEALTHCARE TRENDS SYNOPSIS

Healthcare spending continued to slowly grow at the national level from 2011 to 2013. The following data was obtained from the National Health Expenditures 2013 Highlights provided from the Center for Medicare & Medicaid Services.

2011 Health Expenditures

- Total health expenditures increased 3.9% to $2.7 trillion from 2010.
- Healthcare represents 17.4% of the Gross Domestic Product (GDP).
- Health expenditures reached $8,428 per capita.

2012 Health Expenditures

- Total health expenditures increased 4.1% to $2.8 trillion from 2011.
- Healthcare represents 17.4% of the Gross Domestic Product (GDP).
- Health expenditures reached $8,996 per capita.

2013 Health Expenditures

- Total health expenditures increased 3.6% to $2.9 trillion from 2012.
- Healthcare represents 17.4% of the Gross Domestic Product (GDP).
- Health expenditures reached $9,255 per capita.

As a nation, there has been a strong awareness on the impact our lifestyles have on our health. The following data obtained from America's Health Rankings 2014 Edition highlights the improvements and challenges in healthcare factors for 2014 from the past year.

2014 National Health Improvements

- Smoking has decreased 3% for those who smoke regularly.
- Immunization coverage among adolescents has increased 5%.
- Infant mortality has decreased 4%.

2014 National Health Challenges

- Infectious disease, specifically Pertussis (whooping cough), has increased 154%.
- Adult obesity has increased from 7% to 29.4%.
- Deaths due to drugs have increased 7% to 13.0 deaths per 100,000 population.
- Physical inactivity increased 3% to 23.5% of adults.

In Indiana, the overall health ranking has steadily declined in the American's Health Ranking report over the past several years to 41st as reported in the 2014 report. The strengths for the state are low incidence of infectious disease, low percentage of children in poverty, and high immunization coverage among teens. The challenges faced by the Indiana population are high prevalence of obesity and physical inactivity, and high levels of air pollution.

2014 Indiana Improvements

- Smoking has decreased by 14% in the past two years to 21.9% of adults.
- Binge drinking decreased by 6% in the past year to 15.0% of adults.
- Children in poverty decreased by 40% in the past year to 14.7% of children.

2014 Indiana Challenges

- 31.8% of adults are obese.
- 15.1 drug deaths per 100,000 population.
- 28.3% of adults are physically inactive.
- 11.7 particles per cubic meter ranking Indiana 48th among the nation in high levels of air pollution.

Deloitte Center for Health Solutions provided the following national health related data:

Consumers & Health Care System 2012 Survey Results

- 62% of consumers believed that 50% or more of the money spent on health care was wasted.
- 25% felt that the best value was obtained for the money spent in health care.
- 80% of consumers reported having a primary care provider.
- 75% of consumers sought medical care in the last year.
- Overall satisfaction with their primary care providers was 76%.
- More than 40% had received care at a hospital in the last year, with 23% outpatient, 19% ER, and 8% inpatient.
- 35% of consumers having received care at a hospital were dissatisfied with the care, reporting the causes of dissatisfaction as cost-related, customer services issues, and access/availability issues.
- 88% of prescription medication users believe they are aware of how their medicine works, 87% believe they understand the risks and side effects, and 86% have confidence in the effectiveness of their medicine.
- 14% of people stated they switched medications in the last year because of ineffectiveness or side effects.
- 34% of those using prescription medicines switched to generics.
- 80% reported almost always taking prescription medications per their doctor's instruction.
- 31% reported that their household's spending on health care as a proportion of total household spending increased in comparison with the previous year.
- 46% of people who did not seek care from their doctor when sick or injured did so because of cost related reasons.
- 14% used social media to discuss prescription side effects and to learn more about prescription medications.
- 26% would be interested in utilizing a smart phone app that would remind them to take medication at the right time and in the right dose.
- 32% of consumers say they would choose an innovative treatment (with greater chance in working but less tested) over a standard treatment.
- 58% would be willing to take a cost-free diagnostic test that could predict the likelihood of developing certain diseases.
- 57% of people would like to customize their health plan knowing that cost will reflect the benefits and features they chose.
- 46% are open to seeing a nurse practitioner or physician assistant if the MD is unavailable.

- 26% reported preferring providers that utilize alternative approaches and natural therapies.
- Healthcare is viewed as being intensely personal by consumers.
- Consumers are increasingly concerned with the costs for which they are responsible.
- Approximately one third of adults are not comfortable with safeguards for personal information; security and privacy issues are a main concern regarding personal health information.
- Many do not feel they understand what impact the Affordable Care Act will have, with most concern being expressed by seniors.

HEALTHY PEOPLE 2020

HealthyPeople.gov provides 10-year national objectives for improving the health of all Americans by 2020. The topics are the result of a multi-year process with input from a diverse group of individuals and organizations. Eighteen federal agencies with the most relevant scientific expertise developed health objectives to promote a society in which all people live long, healthy lives.

The 2020 topics are organized into 39 areas with measurable and developmental objectives maintained by the Office of Disease Prevention and Health Promotion within the U.S. Department of Health and Human Services. Two objectives related to mental health care include improving mental health status and expansion of treatment services. The objectives are to increase prevention and access to appropriate, quality mental health services with an overall 10% improvement goal for the following:

- Reduce the suicide rate.
- Reduce suicide attempts.
- Reduce the proportion of adolescents who engage in disordered eating behaviors in an attempt to control their weight.
- Reduce the proportion of persons who experience major depressive episodes.
- Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral.
- Increase the proportion of children who receive treatment of their mental health problems.
- Increase the proportion of juvenile residential facilities that screen admissions for mental health problems.
- Increase the proportion of persons who receive treatment for co-occurring substance abuse and mental disorders.
- Increase depression screening by primary care providers.
- Increase the proportion of homeless adults who receive mental health services for their mental health problems.

STATE HEALTHCARE TRENDS SYNOPSIS

State Mental Health Funding

Funding varies from year to year for mental health services; however, budgeted funding for Mental Health and Addiction Services in Indiana remained static between fiscal year 2012 and 2013. For fiscal year 2014, there is a budgeted decrease in appropriations of approximately $8 million from the general fund. Funding reductions provide a challenge each year for mental health providers across the state. Lack of financial resources and funding for mental health services is one of the most prevalent findings from our primary data collection process. Lack of funding continues to be a significant barrier to meeting the needs of the community.

Community and Social Services Occupational Employment

According to historical data from the Indiana Department of Workforce Development for May 2014 and 2013, the total individuals employed in community and social service occupations for the United States were 1,930,750 and 1,890,410, respectively. Indiana comprises nearly 2% of the total. Indiana's service category shows an increase between years; substance abuse and behavior disorder counselors decreased 18% while mental health and substance abuse social workers increased 25%.

COMMUNITY AND SOCIAL SERVICE OCCUPATIONS	2014	2013
Total Community and Social Services Occupations in Indiana	32,910	31,360
Substance Abuse and Behavioral Disorder Counselors	1,070	1,260
Educational, Vocational, and School Counselors	3,820	4,240
Marriage and Family Therapists	680	660
Mental Health Counselors	1,690	1,210
Rehabilitation Counselors	1,020	1,190
Counselors, All Other	180	170
Child, Family, and School Social Workers	5,320	4,920
Medical and Public Health Social Workers	3,830	2,990
Mental Health and Substance Abuse Social Workers	2,010	1,600
Social Workers, All Other	600	760
Health Educators	1,520	1,640
Probation Officers and Correctional Treatment Specialists	2,370	2,310
Social and Human Service Assistants	4,990	4,580
Community Health Workers	1,190	1,040
Community and Social Service Specialists, All Other	1,240	1,410
Clergy	940	930
Directors, Religious Activities and Education	300	300
Religious Workers, All Other	130	150

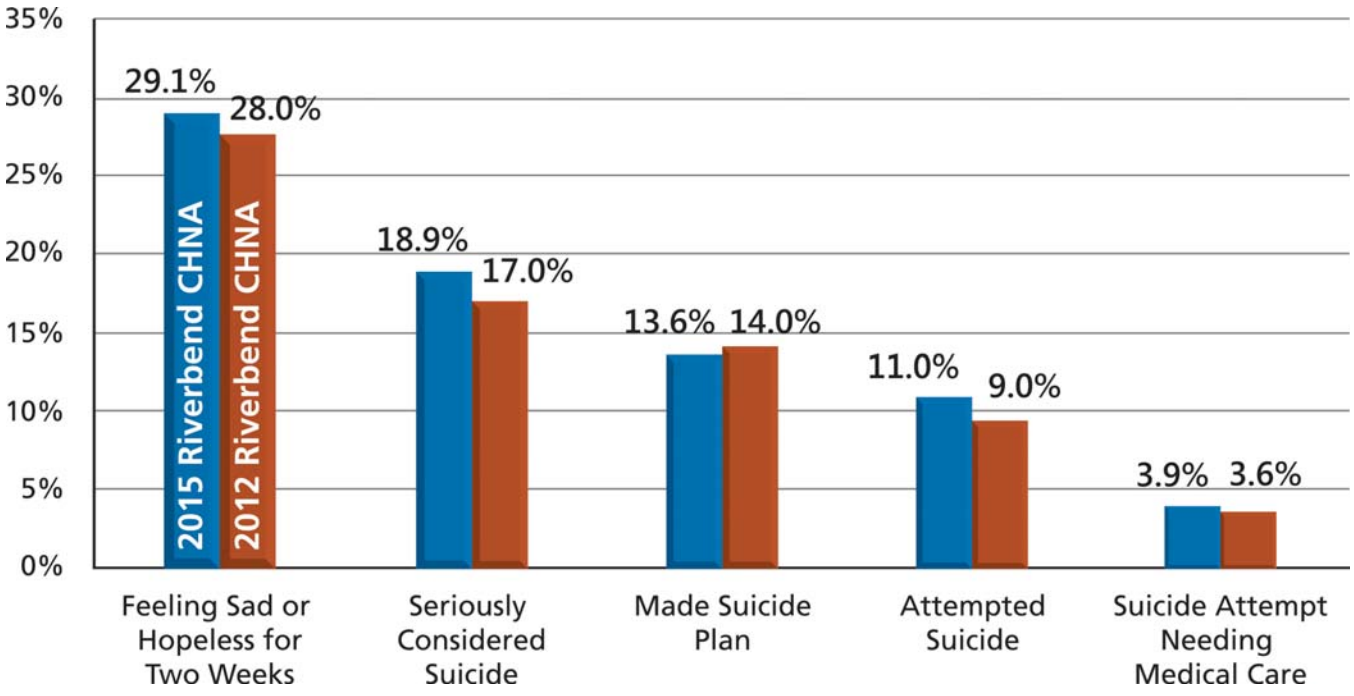
Source: Indiana Department of Workforce Development - Research and Analysis, 2015.

EPIDEMIOLOGIC SYNOPSIS: HEALTH, MENTAL HEALTH AND ADDICTIONS CARE

Mental Health

In Indiana, approximately 5.3% or 264,000 adults live with serious mental illness (SMI), which translates into approximately 15,300 adults being affected in the service area. This is a 1.75% increase since 2010. About 398,000 adults suffer with any mental illness (AMI). However, only 41.8% of those 398,000 received treatment in the last year. In 2013, 47,644 children and adolescents used public mental health services. Approximately 12% of children in Indiana (164,911) have emotional behavioral developmental issues, ranking it the 6th highest state in the United States.

The Indiana State Department of Health reported an increase of 1% of Indiana students in grades 9 through 12 reporting they felt sad or hopeless almost every day for at least two weeks during the past 12 months in 2011. The report indicated there was a 3% increase in Indiana adolescents that had attempted suicide to 11%, compared to 9% in 2009. Furthermore, this report found that 19% of Indiana adolescents thought seriously about suicide, a 2% increase over the past 3 years.



Source: Indiana State Department of Health, 2013.

Substance Abuse

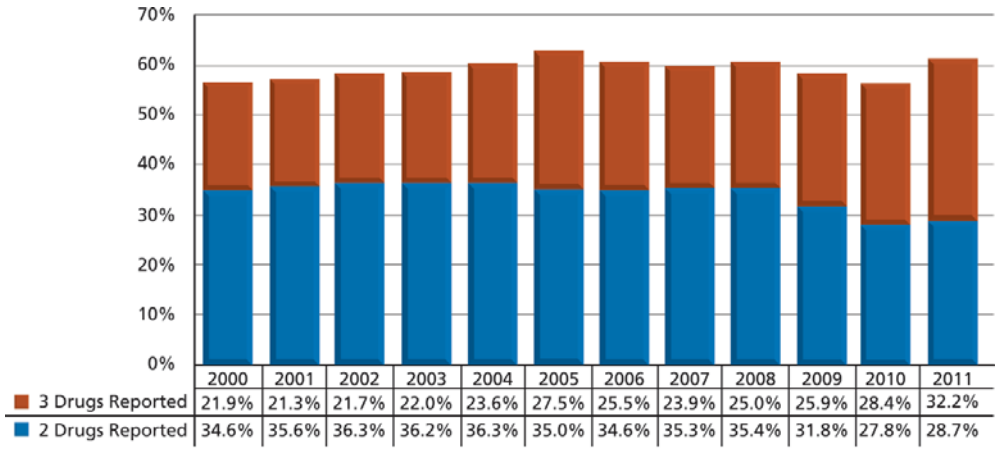
Alcohol is the most frequently used substance in Indiana; nearly half of all Hoosiers 12 years and older report current alcohol use in the past month. Of those, nearly a quarter engaged in binge drinking. The age range with the highest rates of current alcohol use in Indiana is 18 to 25 years, with nearly 6 out of 10 young adults reporting usage. Of those reporting, slightly over 40% reported binge drinking. However, rates for heavy drinking in Indiana were nearly 1% below the US average. Binge and heavy drinking are consumption patterns that have been proven problematic in many ways. Another concern in Indiana is underage drinking. Approximately 33% of Indiana high school students currently drink alcohol, while nearly 20% engaged in binge drinking. In Indiana, a little over 38% of substance abuse related admissions are due to alcohol, which is 1% less than the national average.

The prevalence rate for current illicit drug use in Indiana is almost 8%. The 18-to-25-year-old group displays the highest rate of use, slightly over 18%. Marijuana is the most frequently consumed illicit substance; about 6.2% Hoosiers that are 12 years and older reported current use. Of those Hoosiers that reported use, over 16.8% are 18 to 25 years old (Substance Abuse and Mental Health Services Administration, 2013). Among Indiana high school students, 20% report currently using marijuana, 2.3% state current use of cocaine, 2.8% used heroin once, and 3.9% reported using methamphetamine at least once during the student's lifespan.

The three most commonly abused types of prescription medicines are pain relievers (opioids), central nervous system depressants (sedatives, tranquilizers, hypnotics), and stimulants (for attention deficit disorder, narcolepsy, and weight loss) (Substance Abuse and Mental Health Services Administration, 2013). Among Hoosiers 12 years old or older, 2.7% reported current abuse of prescription drugs while 7.6% abused them in the past year, and 20.7% abused them at least once in their life.

Polysubstance abuse is a pattern of using two or more drugs at a time. Among the Indiana treatment population, 60.9% reported use of two or more drugs (Substance Abuse and Mental Health Services Administration, 2013). The most common drug combinations in Indiana are alcohol and marijuana; alcohol and a drug; or alcohol, cocaine, and marijuana. The diagram below shows that the polysubstance abuse of three substances has increased over the last few years.

Percentage of Indiana Treatment Episodes with Reported Use of Two Substances and Three Substances (Treatment Episodes Data Set, 2000-2011)



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
3 Drugs Reported	21.9%	21.3%	21.7%	22.0%	23.6%	27.5%	25.5%	23.9%	25.0%	25.9%	28.4%	32.2%
2 Drugs Reported	34.6%	35.6%	36.3%	36.2%	36.3%	35.0%	34.6%	35.3%	35.4%	31.8%	27.8%	28.7%

Source: Substance Abuse & Mental Health Data Archive. 2011

Co-occurring Disorders

Roughly half of individuals who are seriously mentally ill (SMI) are affected by substance abuse; 37% of alcohol abusers and 53% of drug abusers also have at least one serious mental illness. Of all people diagnosed as mentally ill, 29% abuse either alcohol or drugs (National Alliance on Mental Illness, 2003). Approximately 8.4 million adults in the United States have co-occurring disorders. Individuals with co-occurring disorders tend to have multiple health and social problems, and many are at increased risk for homelessness and incarceration. However, co-occurring disorders may be difficult to diagnose and treat. In many cases, one disorder is addressed while the other disorder remains untreated (SAMHSA National Survey on Drug Use and Health, 2012).

The prevalence among adults with SMI and a co-occurring disorder, i.e., SMI and chronic addiction, is estimated to be 23.2% in Indiana, which equates to approximately 4,666 individuals 18 years and older affected in the Hospital's service area (Indiana Family and Social Services Administration, n.d.)

SECONDARY SOURCE HEALTH DATA: HEALTH FACTORS

Population Synopsis

The citizens of the Hospital's service area are predominantly white (91%), with a median age of 41.3. The median age is almost 4 years greater than the state average of 37.4. The ten-county service area's combined high school graduation rate is 91.0%, slightly higher than Indiana's 87.0%, with 35.7% of Tippecanoe County residents holding a bachelors and/or a master's degree. The service area's residents with higher education degrees is 15.8%, considerably less than the state's average of 23.8% and national average of 31.96%. The median household income for the service area is $50,104, above the state level of $47,508 and only slightly below the national median of $51,474. The service area reported 18% of the children in poverty versus 22% in Indiana and 13% nationally. Children in the service area living in single-parent households is 27% versus 33% in Indiana and 20% nationally. Approximately 12% of the service area population lives below the poverty level. The unemployment rate is 4.6% as of June 2015.

Health Status Synopsis

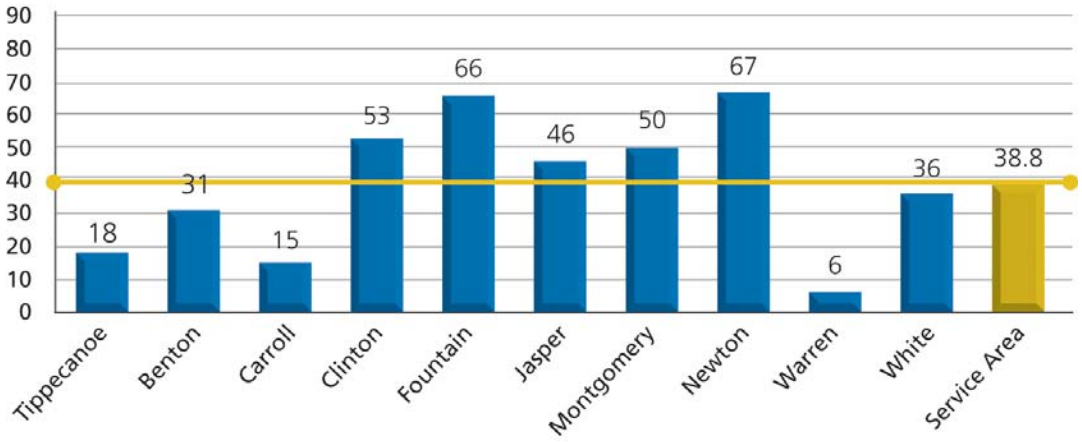
After reviewing secondary data for the service area, it was noted that the area's Health Outcomes ranking has not changed. The median county ranking in Indiana is 46; the service area ranks in the upper half of the 92 counties, at 39. The Health Factors ranking has slightly increased to 37 from two years ago and it remains in the top half of the median of Indiana counties at 37. On average, the national and state benchmark data is still better than the service area.

SERVICE AREA ANALYSIS			
	Service Area (Average)	State of Indiana	National Benchmark
Health Outcomes			
Length of Life			
Premature Death	7,627	7,528	5,200
Quality of Life			
Poor/Fair Health	17%	16%	10%
Poor physical health days	3.9	3.6	2.5
Poor mental health days	3.8	3.7	2.3
Low birth weight	6.72%	8.20%	5.9%
Health Factors			
Health Behaviors			
Adult smoking	25%	23%	14%
Adult obesity	32%	31%	25%
Physical inactivity	28%	27%	20%
Excessive drinking	16%	16%	10%
Sexually transmitted infections	266	451	138
Teen birth rate	38	39	20
Clinical Care			
Uninsured adults	17%	17%	11%
Primary care physicians	4,634:1	1,518;1	1,045:1
Preventable hospital stays	75.3	70	41
Diabetic screening	85%	84%	90%
Mammography screening	63%	61.4%	70.7%

(Source: www.countyhealthrankings.org)

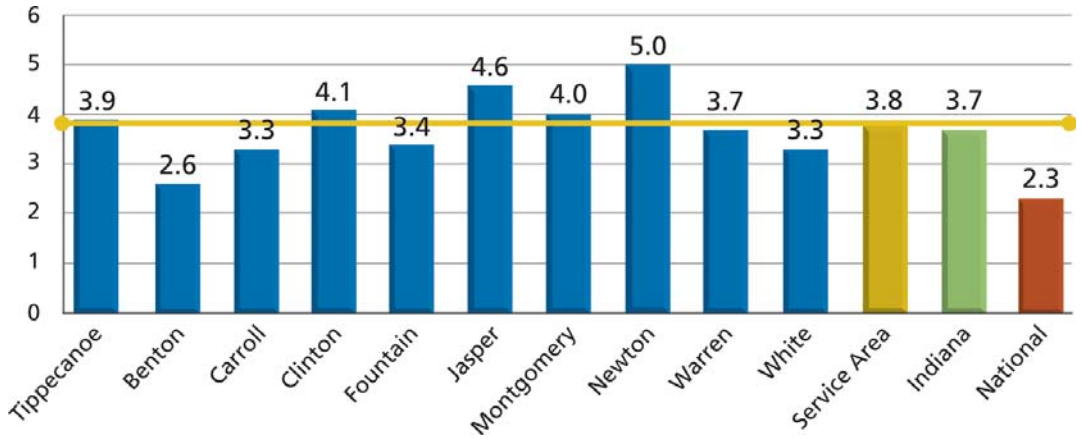
HEALTH OUTCOMES (COUNTY HEALTH RANKING 2015 DATA)

Illustrated below is the county ranking for the overall health outcome. The 92 counties in Indiana have been ranked from 1 to 92, with 1 representing the best and 92 representing the least healthy county. Health outcomes represent the health of the county by measuring the years people live and how healthy people feel. Data is provided on premature death, poor health, poor physical health days, poor mental health days, and low birth weight. Overall, the service area contains five counties ranked in the top half above the median rank of 46. Additionally the overall service area ranks in the top best of the counties at 39. (See Appendix B).



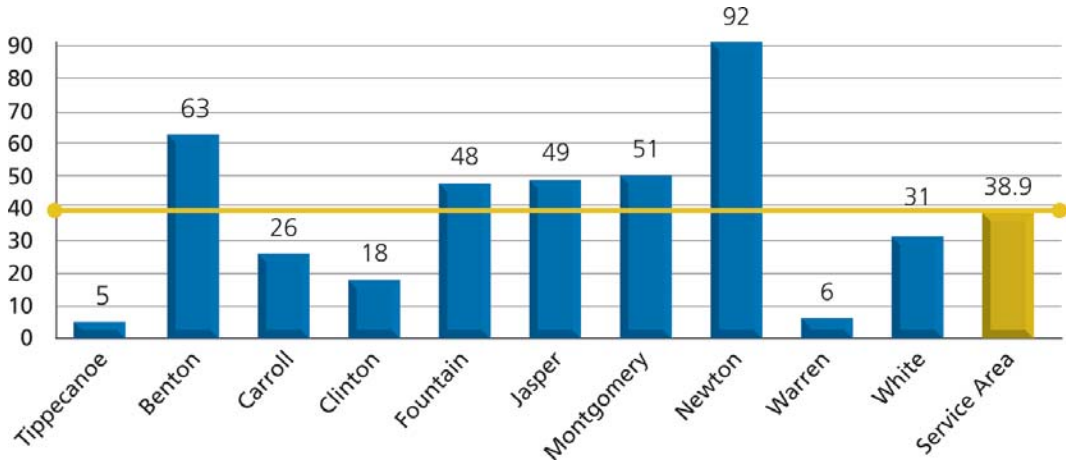
POOR MENTAL HEALTH DAYS (COUNTY HEALTH RANKING 2015 DATA)

Illustrated below is the number of days on average an adult reported their mental health was not good. The poor mental health days represent the number of responses to the question, "Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past thirty days was your mental health not good?" Overall, the 10-county area reports poor mental health approximately 13% of the month (3.8 days out of 30) versus 12% in Indiana and 8% nationally. (See Appendix B).



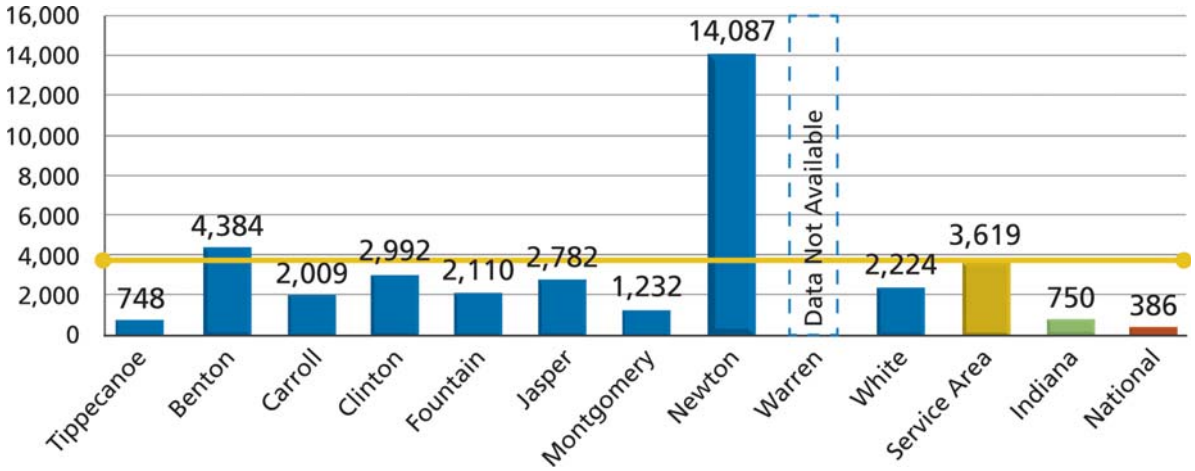
HEALTH BEHAVIORS (COUNTY HEALTH RANKING 2015 DATA)

Illustrated below is the county ranking for overall health behaviors. The 92 counties in Indiana have been ranked from 1 to 92, with 1 representing the best and 92 representing the county with the least healthy influences. Health factors represent how the county's health is influenced by health behaviors, clinical care, social and economic factors, and physical factors. Data is provided on tobacco use, sexual activity, diet and exercise, alcohol use, quality of care and access to care. Overall, the service area contains five counties ranked in the top half above the median rank of 46. Additionally, the service area ranks in the best counties at 39 with Tippecanoe ranked at 5. (See Appendix B).



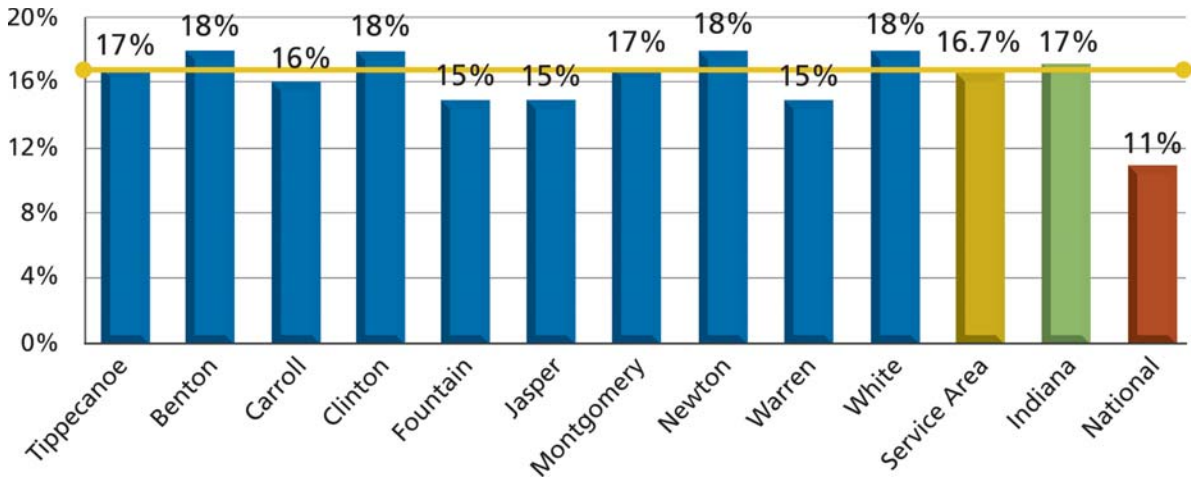
MENTAL HEALTH PROVIDER (COUNTY HEALTH RANKING 2015 DATA)

Illustrated below is the population per mental health provider. The providers include psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists who meet certain qualifications and certifications. Overall, the 10-county area has on average 3,619 people per mental health provider — significantly higher than Indiana overall and the national average. (See Appendix B).



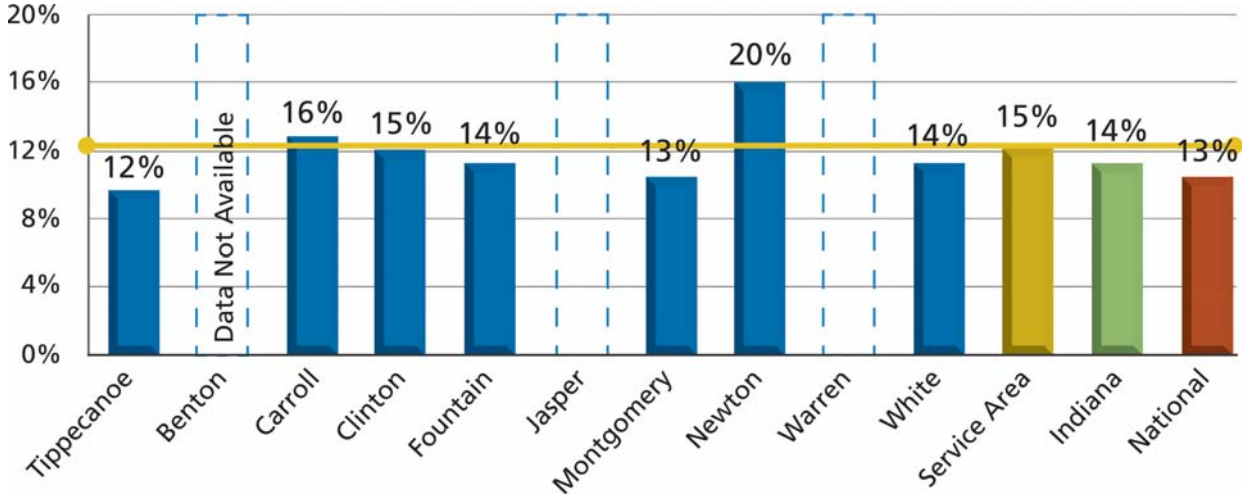
UNINSURED (COUNTY HEALTH RANKING 2015 DATA)

Illustrated below is the percentage of adults under age 65 without health insurance coverage. Approximately 17% of the 10-county area is uninsured, slightly above the national average. (See Appendix B).



COULD NOT SEE DOCTOR DUE TO COST (COUNTY HEALTH RANKING 2015 DATA)

Illustrated below is the percentage of adults unable to see a doctor due to the cost for services. The percentage represents the number of adults who reported in the past 12 months they needed to see a doctor but could not due to cost. Approximately 15% of the 10-county area could not see a doctor due to the cost. (See Appendix B).



CONCLUSION

COMMUNITY RESOURCES IDENTIFIED

The assessment identified a number of strong community assets (see Attachment A) including the Hospital and its community benefit programs.

In addition to the Hospital, community resources identified were a community clinic, primary care physicians, a public school system with active home and school associations, and numerous religious congregations.

OVERALL OBSERVATION

Priorities for the key areas will be assessed by the NCHS Board of Directors and documented in the implementation strategy report.

Overall priorities determined to be significant:

- Expanding/increasing inpatient mental health and substance abuse inpatient capacity and services,
- Increasing substance abuse prevention services,
- Increasing mental health educational awareness programs,
- Increasing the number of mental health care providers and professionals,
- Increasing/expanding collaboration among mental health organizations and providers,
- Improving access to mental health care for uninsured and under-insured.

CONTACT

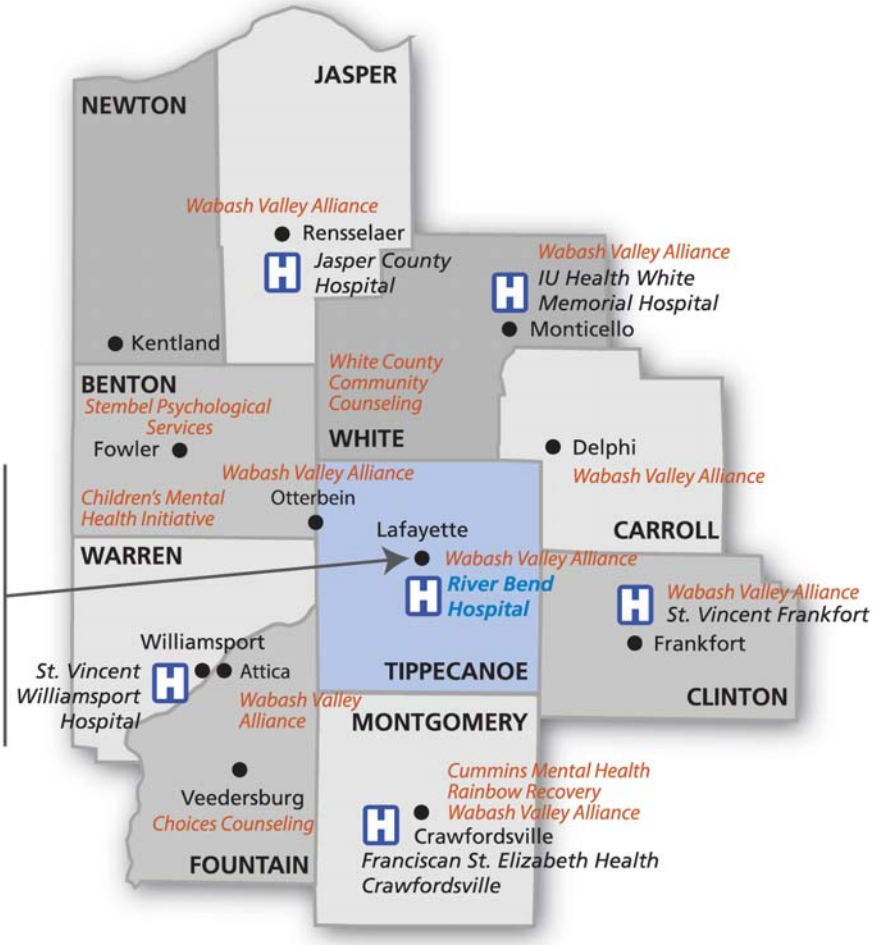
This assessment summary is published on the website of River Bend Hospital, www.nchsi.com. A copy may also be obtained by contacting the Hospital's Administrative Office at (765) 423-1604.

ATTACHMENTS

ATTACHMENT A: AVAILABLE COMMUNITY RESOURCES

Other Lafayette Area Hospitals
IU Health Arnett Hospital
Franciscan St. Elizabeth Health

Other Lafayette Area Mental Health
Alpine Clinic
Buck Black Mental Health Services
Franciscan St. Elizabeth Health
Heartland Clinic
Olive Tree Place
Raj Clinic
Sycamore Springs



ATTACHMENT B: DEMOGRAPHIC DATA

SERVICE AREA ANALYSIS

	Tippecanoe	Benton	Carroll	Clinton	Fountain
Health Outcomes (State Rank)	**18**	**31**	**15**	**53**	**66**
Length of Life	16	56	6	59	87
Premature death	6,380	8,084	5,937	8,115	9,848
Quality of Life	26	12	36	48	18
Poor or fair health	16%	18%	20%	15%	15%
Poor physical health days	3.2	5.1	3.5	3.9	4.0
Poor mental health days	3.9	2.6	3.3	4.1	3.4
Low birthweight	0.07	0.051	0.072	0.075	0.065
Health Factors (State Rank)	**11**	**37**	**18**	**34**	**66**
Health Behaviors	5	63	26	18	48
Adult smoking	15.0%	28.0%	26.0%	19.0%	27.0%
Adult obesity	26.0%	34.0%	31.0%	29.0%	31.0%
Food environment index	6.4	8.2	8.3	8.1	8.2
Physical inactivity	25%	34%	28%	30%	32%
Access to exercise opportunities	73%	56%	71%	63%	62%
Excessive drinking	17%		15%	12%	13%
Alcohol-impaired driving deaths	32%	9%	17%	29%	13%
Sexually transmitted infections	497	227	169	297	257
Teen births	25	33	27	49	47
Clinical Care	18	63	33	50	79
Uninsured	0.17	0.18	0.16	0.18	0.15
Primary care physicians*	1,479	2,935	5,024	3,669	4,280
Dentists*	2,310	4,384	2,511	2,743	4,220
Mental health providers*	748	4,384	2,009	2,992	2,110
Preventable hospital stays	65	74	58	64	107
Diabetic monitoring	85%	85%	84%	87%	81%
Mammography screening	64.8%	62.9%	65.7%	64.1%	66.7%

This chart displays demographic data and other related characteristics of the population in each county of the Hospital's service area, as compared to the total service area and state of Indiana. See pages 50-81 for graphical depictions and additional explanation of select charted data above. (Sources: http:quickfactscensus.gov and http:county healthrankings.org)

Jasper	Montgomery	Newton	Warren	White	Service Area	Indiana	National
46	**50**	**67**	**6**	**36**	**38.8**		
57	**52**	**80**	**3**	**36**	**45.2**		
8,099	7,953	9,038	5,327	7,493	7,627	7,528	5,200
32	**51**	**49**	**19**	**33**	**32.4**		
15%	16%	24%	19%	14%	17%	16%	10%
	3.5	4.1	4	3.7	3.9	3.6	2.5
4.6	4	5	3.7	3.3	3.79	3.7	2.3
0.067	0.078	0.058	0.059	0.077	0.0672	0.082	0.059
43	**31**	**85**	**14**	**35**	**37.4**		
49	**51**	**92**	**6**	**31**	**38.9**		
27.0%	23.0%	42.0%	19.0%	22.0%	24.8%	23.0%	14.0%
33.0%	35.0%	36.0%	29.0%	32.0%	31.6%	31.0%	25.0%
8.3	7.5	8.2	8.5	8.0	7.97	7.2	8.4
26%	25%	28%	26%	27%	28%	27%	20%
56%	63%	57%	41%	37%	58%	75%	92%
15%	16%	25%		11%	16%	16%	10%
30%	20%	18%	9%	14%	19%	26%	14%
188	280	185	216	344	266	451	138
34	46	36	33	47	37.7	39	20
66	**24**	**80**	**38**	**71**	**52.2**		
0.15	0.17	0.18	0.15	0.18	0.167	0.17	0.11
2,091	2,250	14,044	8,342	2,221	4,634	1,518	1,045
3,710	2,246	14,087	8,415	3,058	4,768	1,973	1,377
2,782	1,232	14,087		2,224	3,619	750	386
84	63	73	79	86	75.3	70	41
83%	87%	85%	87%	87%	85%	84%	90%
53.0%	65.5%	57.7%	71.6%	59.6%	63.2%	61.4%	70.7%

* Ratio to 1 healthcare provider

	Tippecanoe	Benton	Carroll	Clinton	Fountain
Social & Economic Factors	36	20	16	53	67
High school graduation	86.0%	98.0%	93.0%	89.0%	92.0%
Some college	70.6%	51.0%	52.7%	43.6%	52.4%
Unemployment	6.8%	7.5%	7.1%	7.1%	9.7%
Children in poverty	19.0%	18.0%	16.0%	21.0%	19.0%
Income inequality	5.3	3.8	3.8	3.9	3.7
Children in single-parent households	30%	22%	24%	33%	28%
Social associations	10.1	18.2	14.9	14.5	13.4
Violent crime	274		87	210	
Injury deaths	44	73	58	64	80
Physical Environment	50	8	24	33	39
Air pollution - particulate matter	13.5	13.5	13.5	13.5	13.6
Drinking water violations	0%	0%	0%	0%	3%
Severe housing problems	20%	9%	10%	13%	10%
Driving alone to work	76%	79%	82%	81%	81%
Long commute - driving alone	13%	33%	48%	30%	39%
Demographics					
Population	180,174	8,767	20,086	32,916	16,880
% below 18 years of age	20.60%	24.80%	23.60%	26.00%	23.10%
% 65 and older	10.20%	15.90%	17.20%	15.40%	18.70%
% Non-Hispanic African American	4.50%	0.70%	0.40%	0.50%	0.30%
% American Indian and Alaskan Native	0.40%	0.20%	0.30%	0.40%	0.30%
% Asian	6.80%	0.20%	0.20%	0.30%	0.30%
% Native Hawaiian/Other Pacific Islander	0.10%	0.00%	0.00%	0.00%	0.10%
% Hispanic	7.90%	5.40%	4.00%	14.50%	2.50%
% Non-Hispanic white	78.90%	92.70%	94.40%	83.90%	95.60%
% not proficient in English	2.10%	0.90%	1.40%	3.80%	0.70%
% Females	48.90%	50.40%	50.00%	50.80%	50.10%
% Rural	14.50%	100.00%	81.40%	49.80%	66.00%

Jasper	Montgomery	Newton	Warren	White	Service Area	Indiana	National
31	30	66	32	33	38.4		
90.0%	98.0%	83.0%	93.0%	88.0%	91.0%	87.0%	
56.2%	48.6%	50.6%	50.6%	56.7%	53.3%	60.2%	71.0%
8.2%	7.2%	8.4%	7.6%	7.1%	7.7%	7.5%	4.0%
15.0%	19.0%	17.0%	16.0%	19.0%	17.9%	22.0%	13.0%
3.2	3.9	3.7	3.7	3.6	3.86	4.3	3.7
25%	28%	29%	21%	28%	27%	33%	20%
16.4	14.4	11.4	9.6	14.3	13.72	12.7	22
	168	131		129	166.5	334	59
74	77	90	64	70	69.4	62	50
26	20	36	18	25	27.9		
13.3	13.6	13.4	13.6	13.4	13.49	13.5	9.5
1%	0%	0%	0%	0%	0%	4%	0%
11%	10%	11%	8%	12%	11%	14%	9%
85%	83%	85%	85%	83%	82%	83%	71%
42%	27%	45%	32%	32%	34%	30%	15%
33,389	38,177	14,087	8,415	24,466	377,357	6,570,902	316,128,839
24.80%	23.20%	22.30%	22.20%	23.60%	23.42%	24.10%	23.10%
15.30%	16.30%	17.30%	18.30%	18.40%	16.30%	13.90%	14.40%
0.80%	0.90%	0.60%	0.30%	0.40%	0.94%	9.20%	11.00%
0.30%	0.40%	0.40%	0.20%	0.60%	0.35%	0.40%	1.90%
0.40%	0.60%	0.30%	0.50%	0.40%	1.00%	1.90%	4.00%
0.10%	0.00%	0.10%	0.10%	0.10%	0.06%	0.10%	0.40%
5.70%	4.70%	5.80%	1.20%	7.70%	5.94%	6.40%	11.20%
92.00%	92.50%	92.30%	97.10%	90.20%	90.96%	80.70%	69.70%
0.50%	1.20%	0.50%	0.00%	1.40%	1.25%	1.60%	2.80%
50.10%	49.70%	49.30%	50.20%	50.40%	49.99%	50.70%	50.60%
68.00%	52.80%	100.00%	77.10%	68.00%	67.76%	27.60%	25.90%

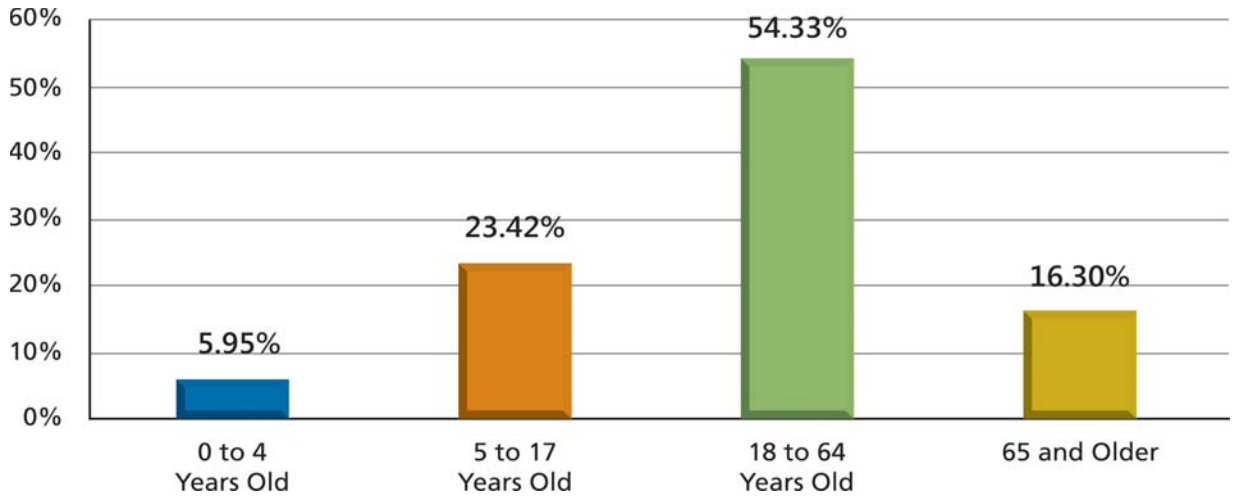
	Tippecanoe	Benton	Carroll	Clinton	Fountain
Health Outcomes					
Diabetes	9.0%	13.0%	11.0%	13.0%	13.0%
HIV prevalence	73	81		65	34
Premature age-adjusted mortality	333.6	401.8	317	409.8	461
Infant mortality	6.9	—	—	6.7	—
Child mortality	48.7	—	—	65.2	79
Health Behaviors					
Food insecurity	17%	13%	12%	13%	13%
Limited access to healthy foods	10%	0%	2%	1%	1%
Motor vehicle crash deaths	8	31	13	17	30
Drug poisoning deaths	11	—	10	14	9
Health Care					
Uninsured adults	19.0%	22.0%	20.0%	22.0%	18.0%
Uninsured children	8.0%	10.0%	9.0%	11.0%	8.0%
Health care costs	$9,667	$9,660	$10,394	$9,488	$10,163
Could not see doctor due to cost	12%	—	16%	15%	14%
Other primary care providers *	1,917	4,384	5,022	10,972	8,440
Social & Economic Factors					
Median household income	$47,808	$49,318	$52,587	$47,279	$42,732
Children eligible for free lunch	37%	37%	35%	43%	36%
Homicides	1				

* Ratio to 1 healthcare provider

Jasper	Montgomery	Newton	Warren	White	Service Area	Indiana	National
12.0%	12.0%	12.0%	12.0%	11.0%	11.8%	11.0%	9.6%
61	101	—	—	78	70	159	289
377.7	387.3	420.3	283.5	385.4	377.7	380.8	343.7
—	7.3	—	—	—	7.0	7.7	6.8
56.1	68.4	—	—	67.8	64.2	60.1	55.7
12%	15%	14%	12%	13%	13.4%	16%	15.2%
2%	4%	0%	1%	3%	2.4%	6%	6.2%
22	15	34	20	21	21.1	12	13.4
12	24	—	—	12	13	14	12.9
18.0%	20.0%	20.0%	17.0%	21.0%	19.7%	20.0%	19.00%
8.0%	9.0%	10.0%	8.0%	11.0%	9.2%	9.0%	6.9%
$10,698	$9,337	$9,507	$10,001	$10,269	$9,918	$10,079	$9,108
—	13%	20%	—	14%	15%	14%	13%
2,385	3,471	2,817	8,415	3,495	5,132	1,840	1,635
$53,757	$50,889	$53,715	$53,623	$48,581	$50,104	$47,508	$51,474
31%	38%	38%	29%	36%	36%	40%	40%
					1	5	5.26

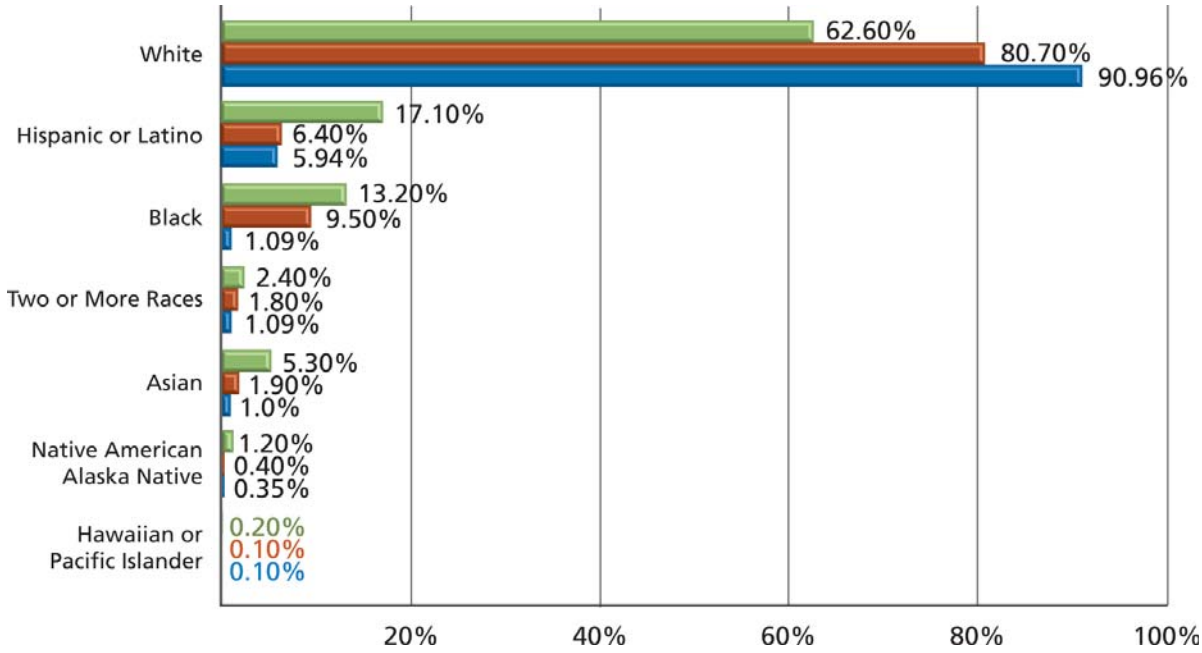
This chart displays data relating to the general healthcare status of the population and several factors impacting it by county as compared to the Hospital's total service area and the state of Indiana. See pages 50 - 81 for graphical depictions and additional explanation of selected charted data above. (Sources: http://quickfacts.census.gov and http://www.countyhealthrankings.org)

2015 Population Distribution by Age



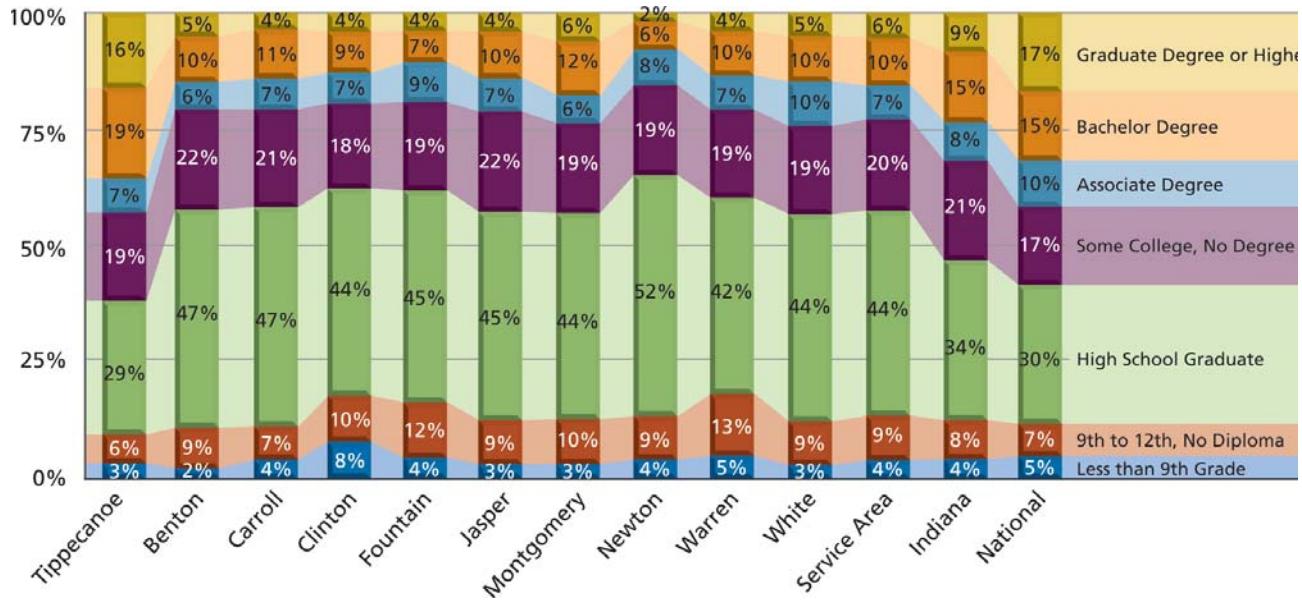
This graph displays the total population of the Hospital's service area by age cohort. (http://quickfacts.census.gov)

2015 Population Estimates by Race



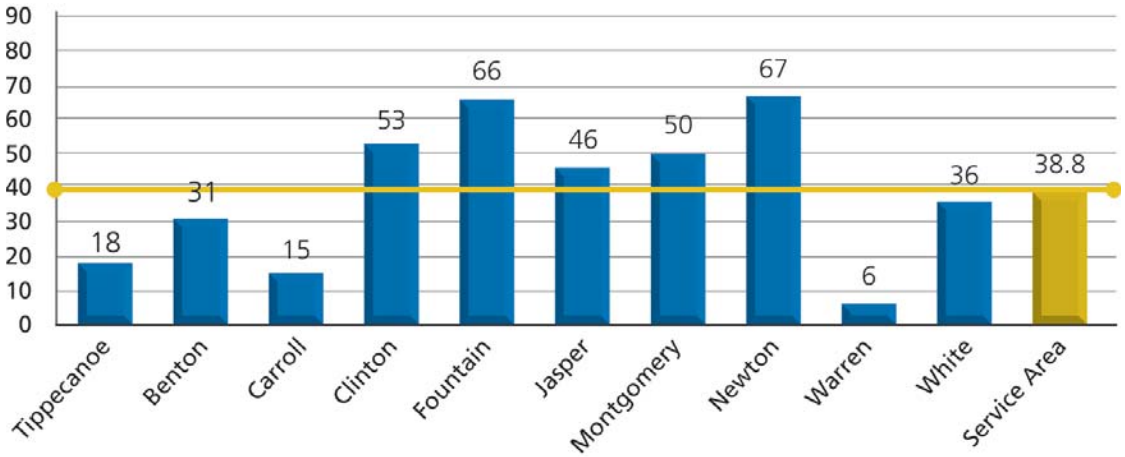
This graph displays the total population of the Hospital's service area by race. (http://quickfacts.census.gov)

2015 Educational Attainment



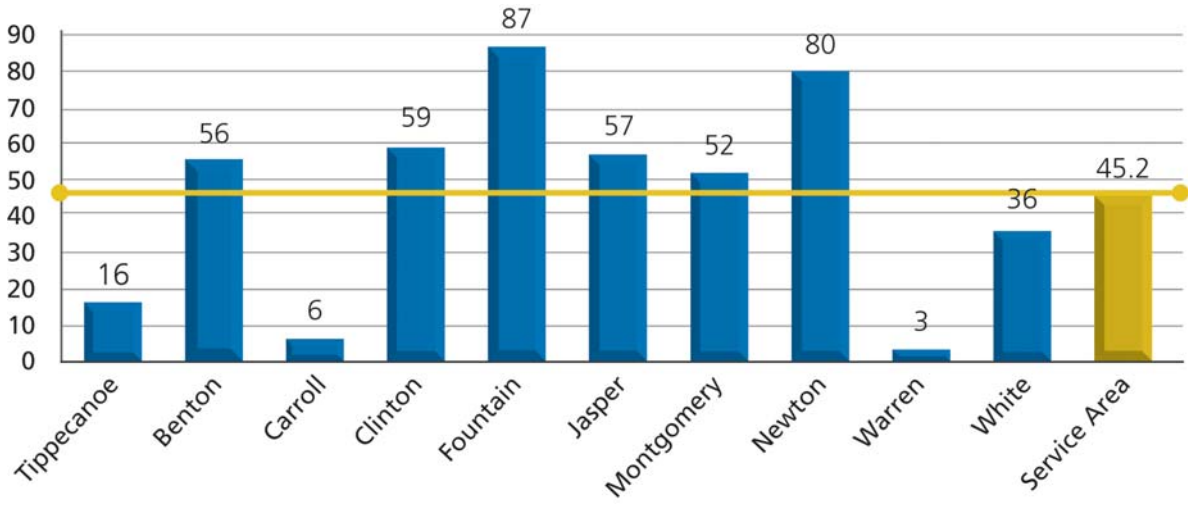
This graph displays the highest level of educational attainment of the population in each county in the Hospital's service area as compared to the total service area and state of Indiana. (http://quickfacts.census.gov)

2015 HEALTH OUTCOMES



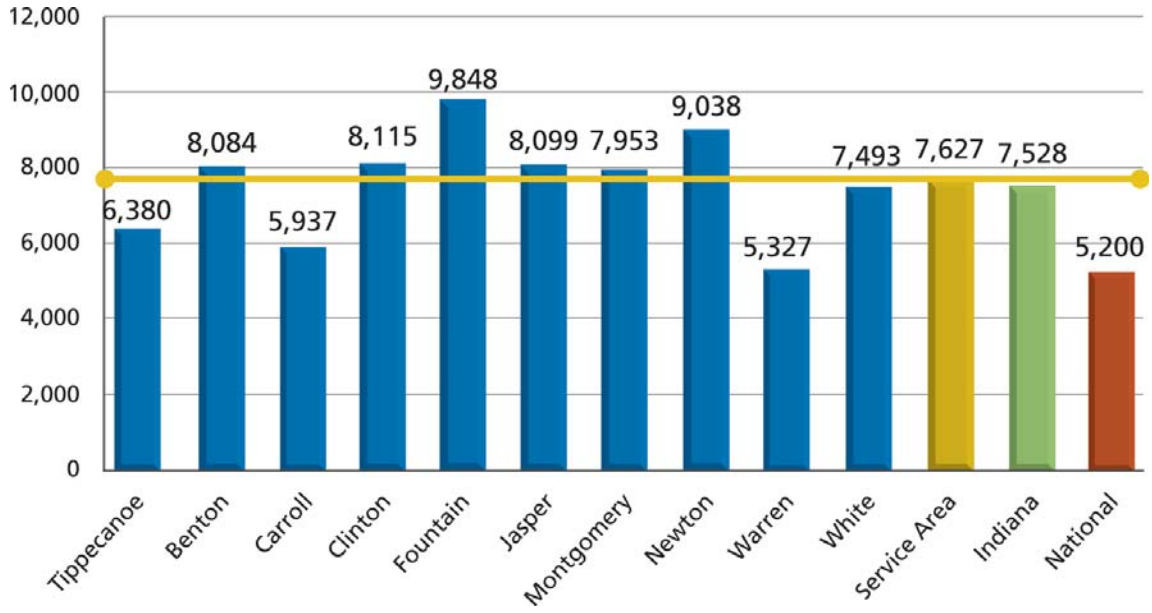
Health Outcomes is a *County Health Ranking* representing how long people live and how healthy people feel while alive. The health outcomes represent the health of the county by measuring the length and quality of life within each county. 92 counties in Indiana have been ranked from 1 to 92, with 1 representing the best and 92 representing the least health county. (Source: www.countyhealthrankings.org)

2015 LENGTH OF LIFE



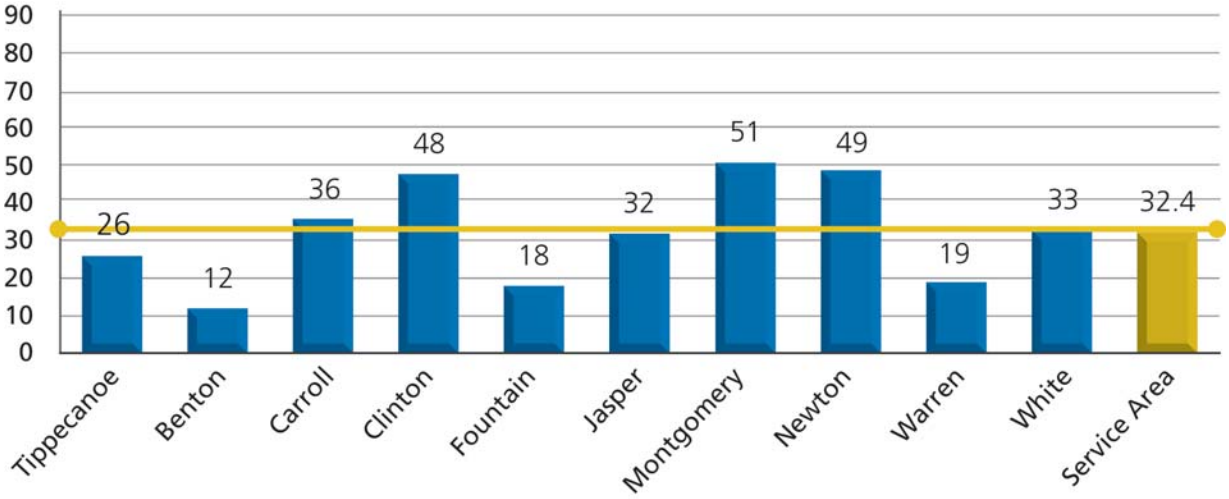
The length of life ranking is the first of two weighted scores used in calculating a county's overall health outcomes. (Source: www.countyhealthrankings.org)

2015 Premature Death



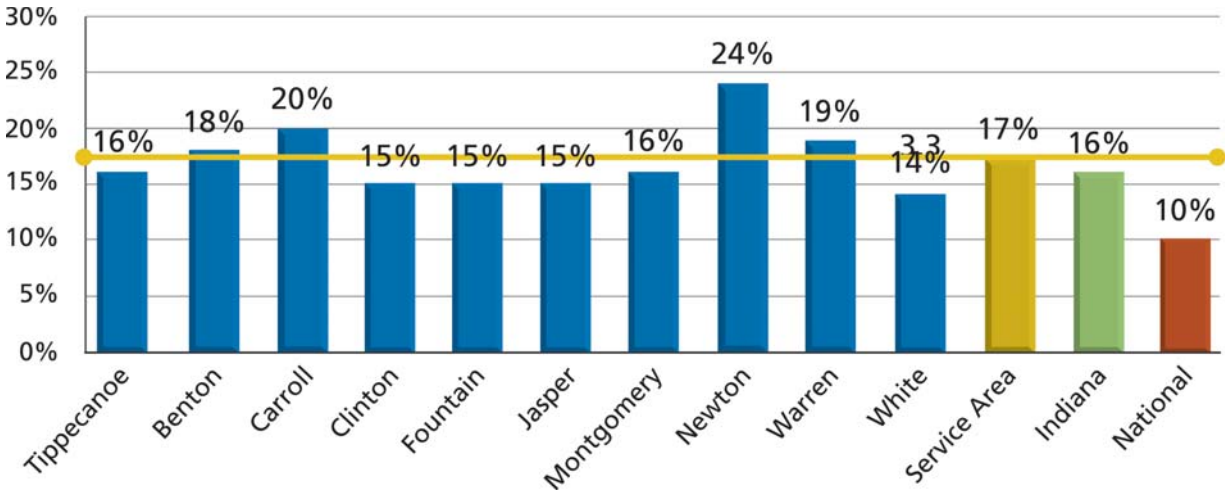
The premature death ranking measures the years of potential life lost before age 75 per 100,000 population. It is the only measure which goes into the (Source: www.countyhealthrankings.org)

2015 QUALITY OF LIFE



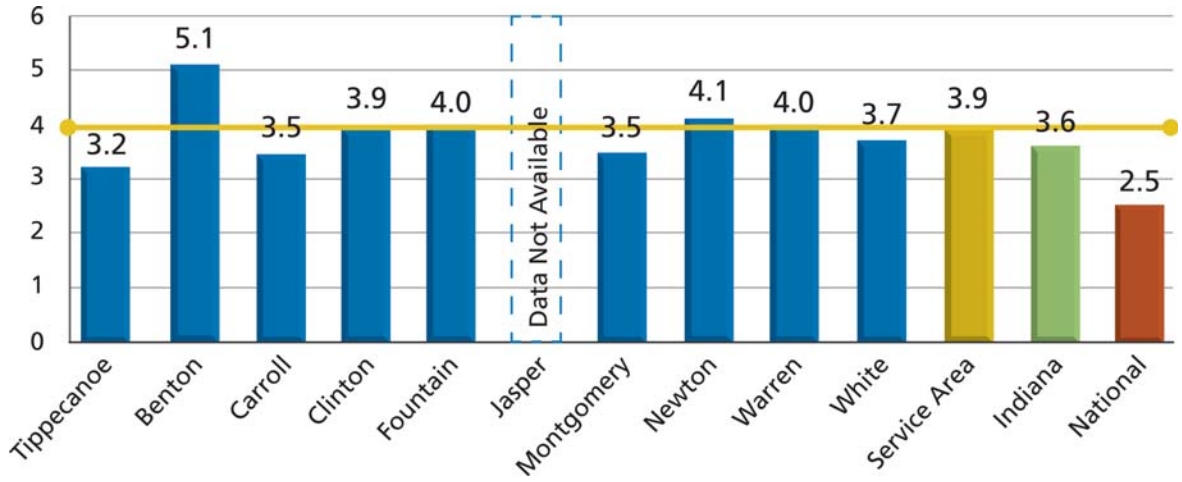
The quality of life is made up of Poor or fair health, poor physical health days, poor mental health days and low birthweight measures. The 92 counties in Indiana have been ranked from 1 to 92, with 1 representing the best quality of life and 92 representing the worst quality of life. (Source: www.countyhealthrankings.org)

2015 Poor or Fair Health



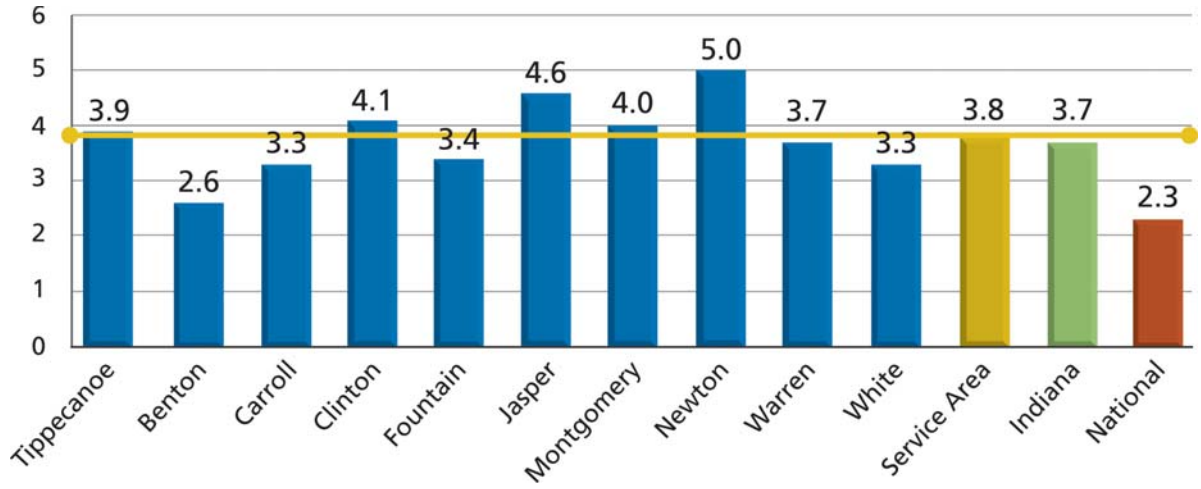
The poor or fair health (overall health) represents self-reported health status based on survey responses to the question, "In general, would you say that your health is excellent, very good, good, fair, or poor?" The value reported for each county is the percent percentage of adults reporting poor or fair health. (Source: www.countyhealthrankings.org)

2015 Poor Physical Health Days



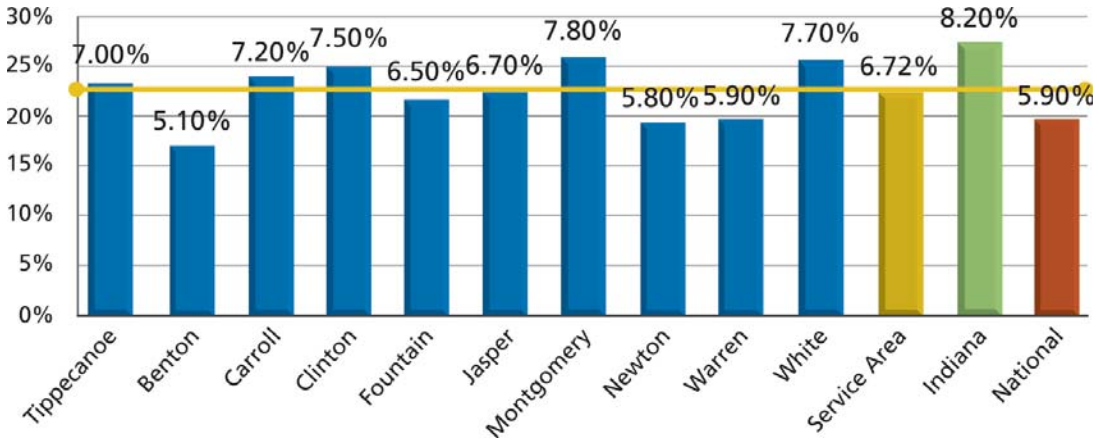
The poor physical health days represents self-reported health status based on survey responses to the question, "Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?. The value reported for each county is the average number of days adult respondents report their physical health was not good. (Source: www.countyhealthrankings.org)

2015 Poor Mental Health Days



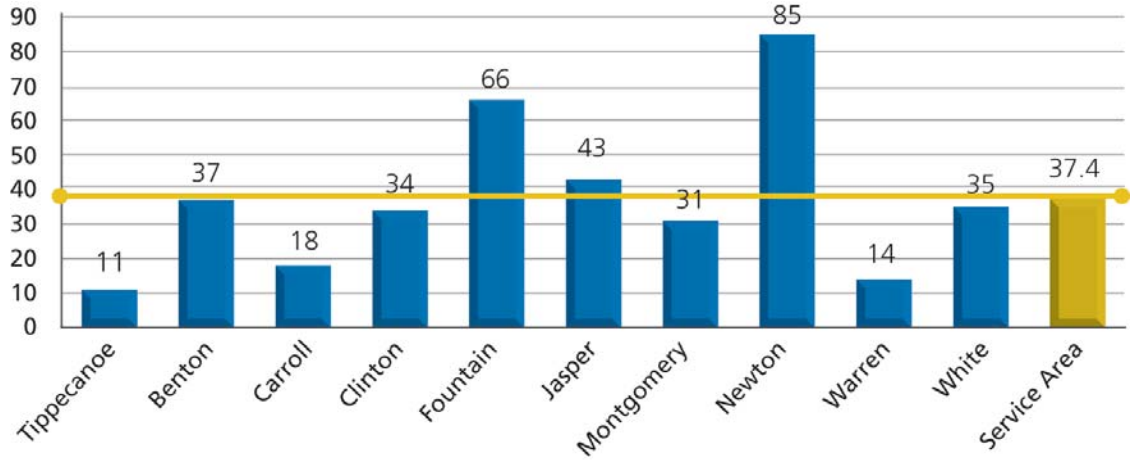
The poor mental health days represents self-reported health status based on survey responses to the question, "Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" The value reported for each county is the average number of days adult respondents reported that their mental health was not good. (Source: www.countyhealthrankings.org)

2015 Low Birthweight



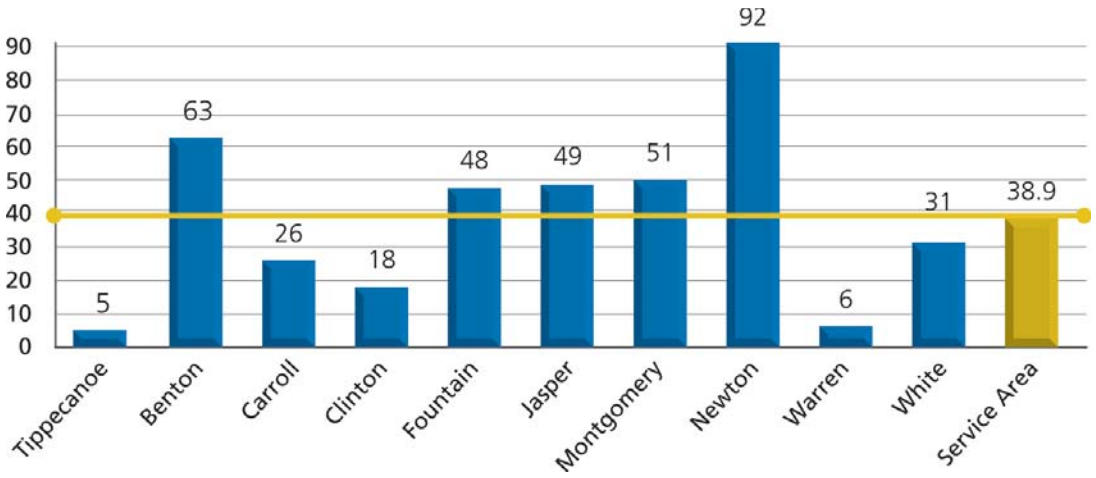
Low birthweight (LBW) represents maternal exposure to health risks and an infant's current and future morbidity which is an indcator for premature mortality and/or morbidity. The value reported for each county is the percent of live births with LBW (<2,500 grams). (Source: www.countyhealthrankings.org)

2015 HEALTH FACTORS



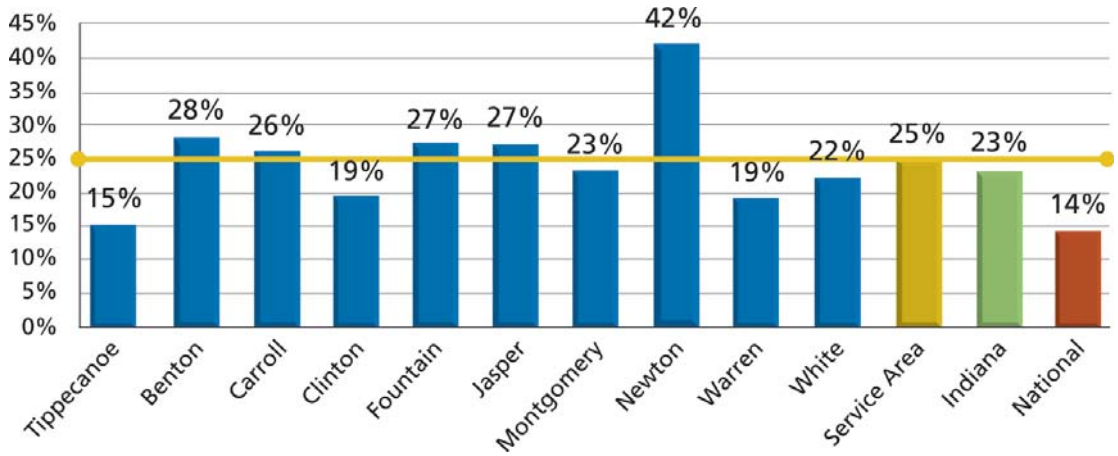
Health Factors is a County Health Ranking representing what influences the health of a county. The health factors are weighted measures of health behaviors, clinical care, socal and economic, and physical environment factors within each county. The 92 counties in Indiana have been ranked from 1 to 92, with 1 representing the best health factors and 92 representing the lowest composite score. (Source: www.countyhealthrankings.org)

2015 HEALTH BEHAVIORS



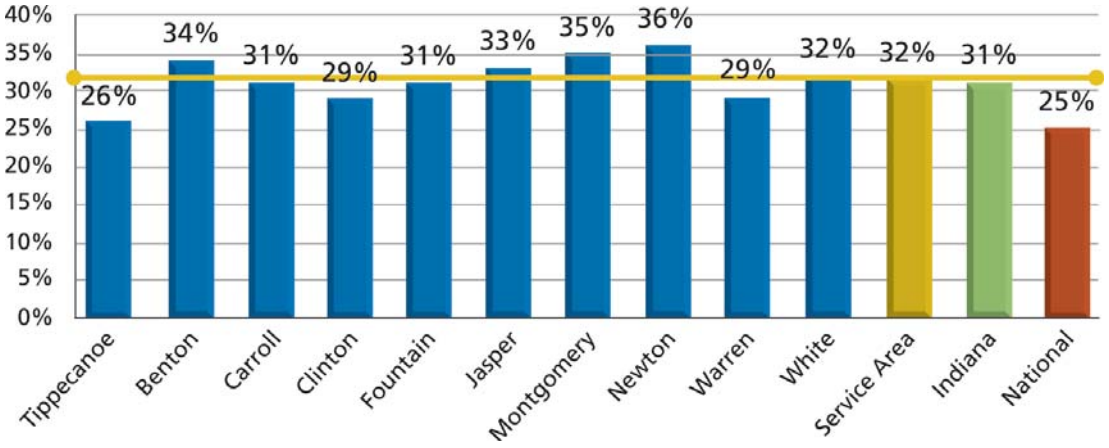
Health behavior consists of the following weighted factors for each county: smoking (10%), diet and exercise (10% - made up of adult obesity at 7.5% and physical inactivity at 2.5%), alcohol use (5% - excessive drinking 2.5%; motor vehicle crash death rate 2.5%), and sexual activity (5% - sexually transmitted infections 2.5%; teen birth rate 2.5%). 92 counties in Indiana have been ranked from 1 to 92, with 1 representing the highest and 92 representing the lowest composite score. (Source: www.countyhealthrankings.org)

2015 Adult Smoking



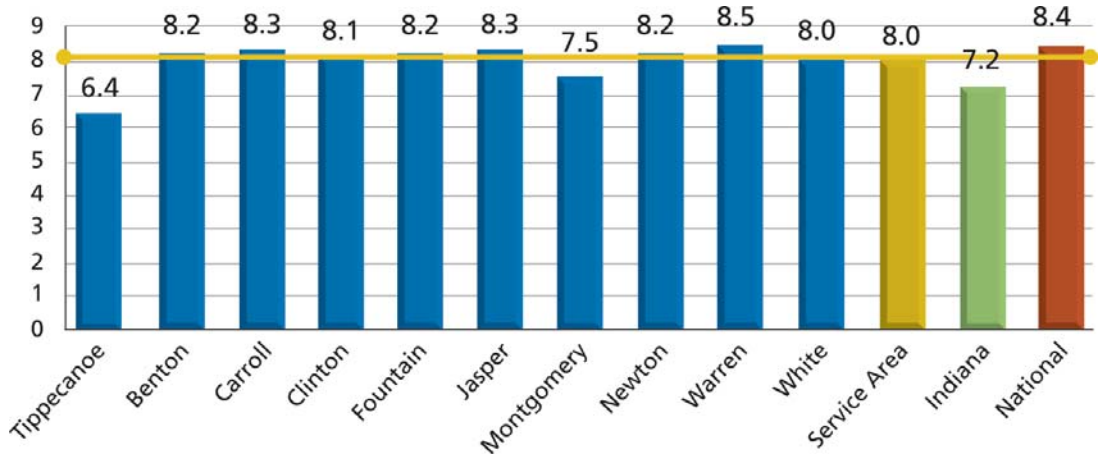
Adult smoking represents the extent of health risk in each county related to tobacco use and is an indicator of adverse health outcomes. The value reported for each county is the estimated percent based on the adult population that currently smokes every day or "most days" and has smoked at least 100 cigarettes in their lifetime. Adult smoking rate is one of four factors with a weight of 10% in calculating a county's overall health behavior ranking. (Source: www.countyhealthrankings.org)

2015 Adult Obesity



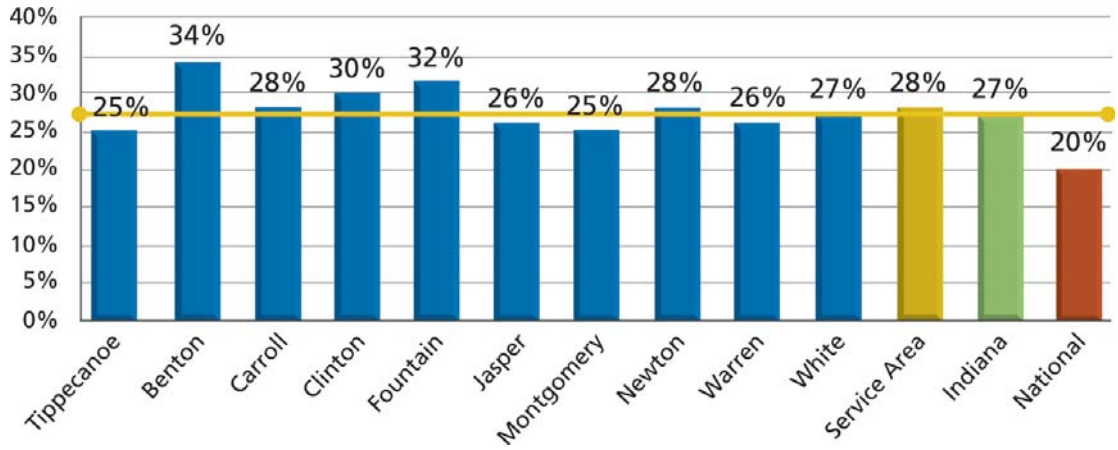
Adult obesity represents the increased risk in each county for health conditions linked to being overweight or obese such as coronary heart disease, type 2 diabetes, cancer, hypertension, dyslipidemia, stroke, liver and gallbladder disease, sleep apnea and respiratory problems, and osteoarthritis. The value reported for each county is the percent of adults who report a body mass index (BMI) greater than or equal to 30 kg/m2. Adult obesity rate is a proportion of the diet and exercise factor with a weight of 5% in calculating a county's overall health behavior ranking. (Source: www.countyhealthrankings.org)

2015 Food Environment Index



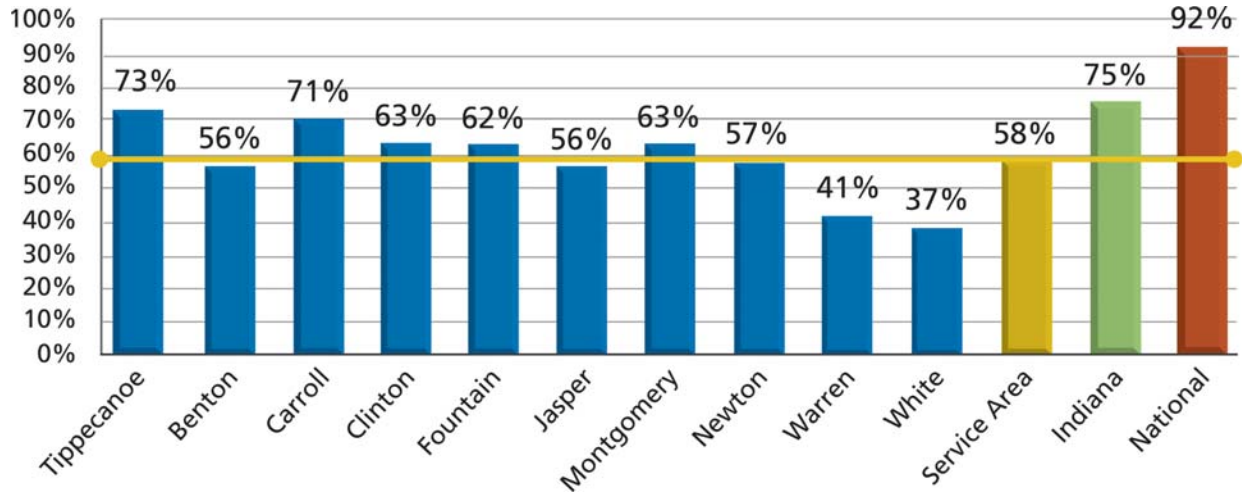
The food environment index categorizes the factors that contribute to a healthy food environment with) being the worst and 10 the best. The index is a portion of the diet and exercise factor with a weight of 2% in calculating a county's overall health behavior ranking. (Source: www.countyhealthrankings.org)

2015 Physical Inactivity



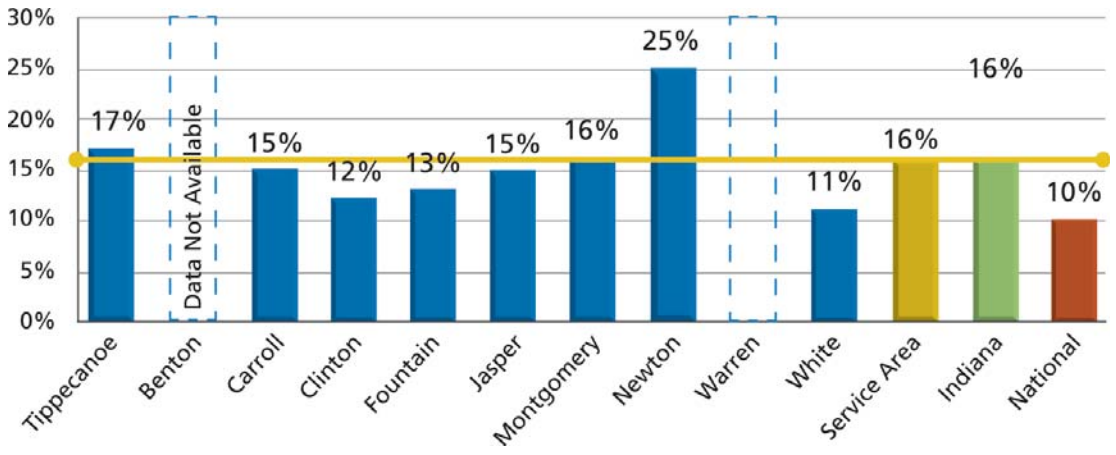
Physical inactivity represents the increased risk in each county for health conditions such as type 2 diabetes, cancer, stroke, hypertension, cardiovascular disease, and premature mortality. The value reported for each county is the percent of adults aged 20 and older reporting no leisure-time physical activity. Physical inactivity is a portion of the diet and exercise factor with a weight of 2% in calculating a county's overall health behavior ranking. (Source: www.countyhealthrankings.org)

2015 Access to Exercise Opportunities



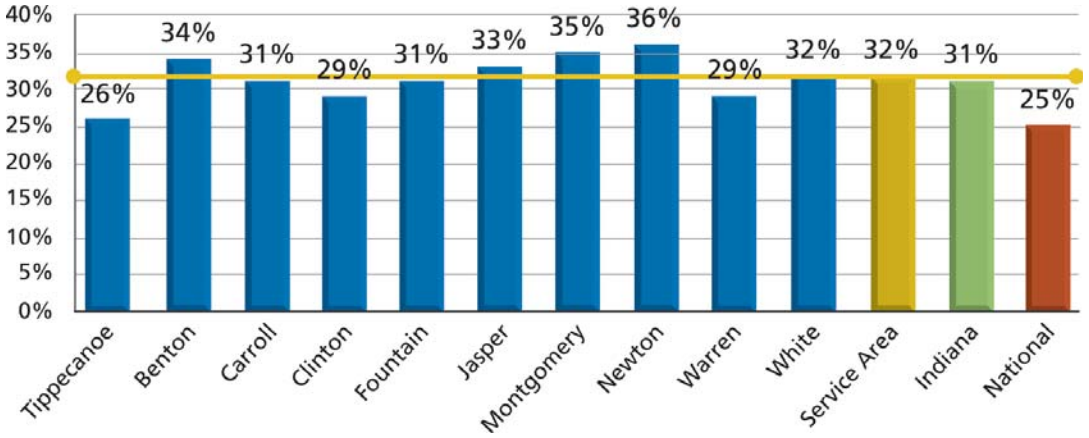
Access to exercise opportunities represents the percentage of the population with adequate access to locations for physical activity. Access to exercise opportunities is a portion of the diet and exercise factor with a weight of 1% in calculating the health behavior ranking. (Source: www.countyhealthrankings.org)

2015 Excessive Drinking



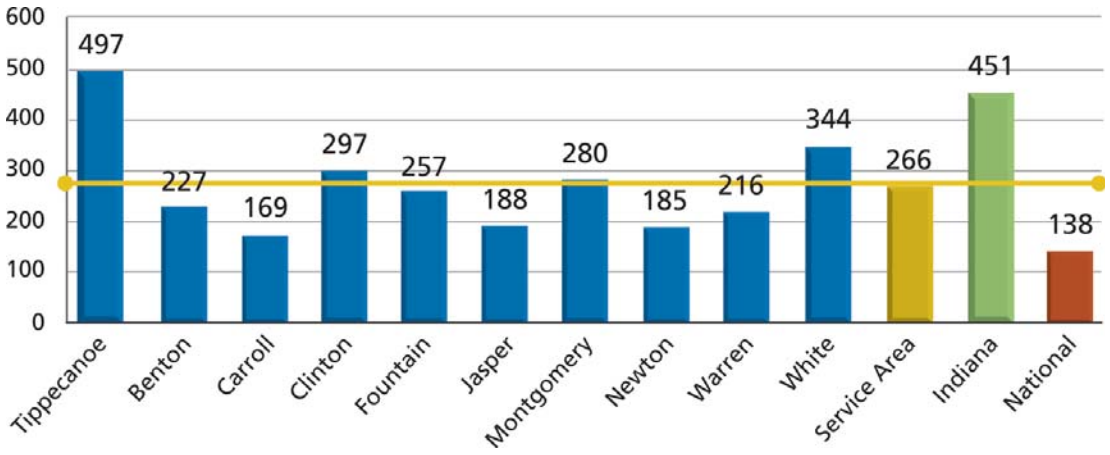
Excessive drinking represents the increased risk in each county for adverse health outcomes due to excessive alcohol use. The value reported for each county is the percent of the adult population that reports either binge drinking (consuming more than 4 [women] or 5 [men] alcoholic beverages on a single occasion in the past 30 days) or heavy drinking (more than 2 [women] or 2 [men] drinks per day on average). Excessive drinking rate is a portion of the alcohol use factor with a weight of 2.5% in calculating a county's overall health behavior ranking. (Source: www.countyhealthrankings.org)

2015 Alcohol-impaired Driving Deaths



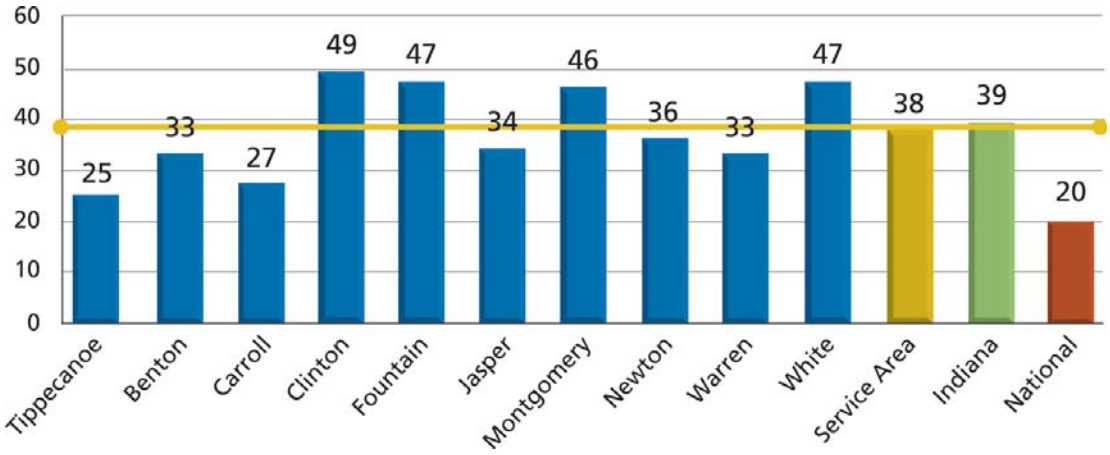
The alcohol-impaired driving deaths parameter measures the percentage of deaths while driving with alcohol involvement. This percentage is a portion of the alcohol and drug use factor with a weight of 2.5% in calculating a county's overall health behavior ranking. (Source: www.countyhealthrankings.org)

2015 Sexually Transmitted Infections



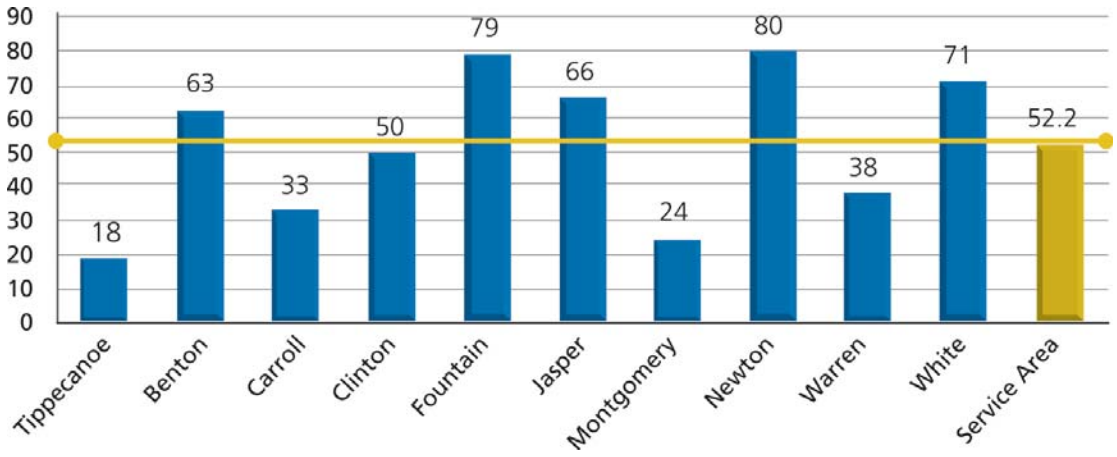
Sexually transmitted infections (STI) represents the increased risk in each county of morbidity and mortality due to cervical cancer, involuntary infertility, and premature death. The value reported for each county is the number of newly diagnosed chlamydia cases per 100,000 population. STI is a portion of the sexual activity factor with a weight of 2.5% in calculating a county's overall health behavior ranking. (Source: www.countyhealthrankings.org)

2015 Teen Births



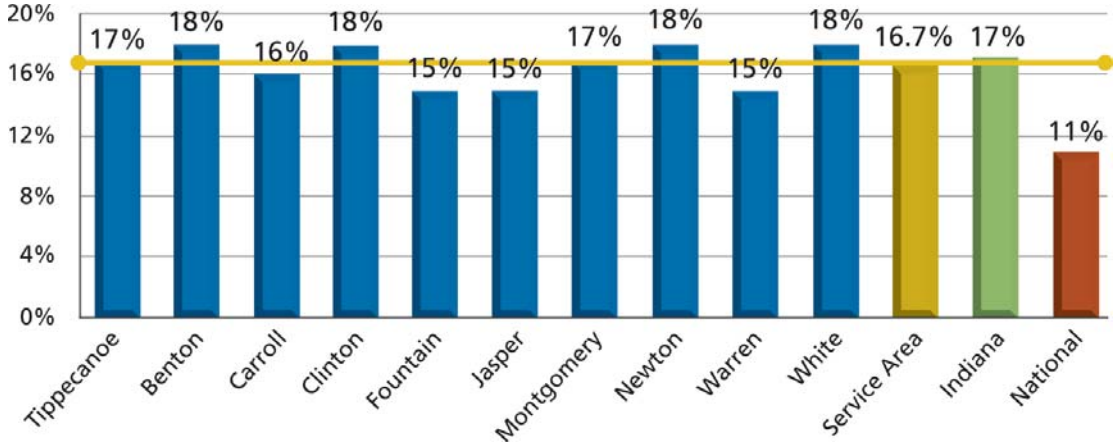
Teen birth rate represents the increased risk in each county for poor prenatal care and pre-term delivery due to late or no prenatal care, gestational hypertension and anemia, and poor maternal weight gain. The value reported for each county is the number of teen births per 1,000 female population ages 15-19. Teen birth rate is a portion of the sexual activity factor with a weight of 2.5% in calculating a county's overall health behavior ranking. (Source: www.countyhealthrankings.org)

2015 CLINICAL CARE



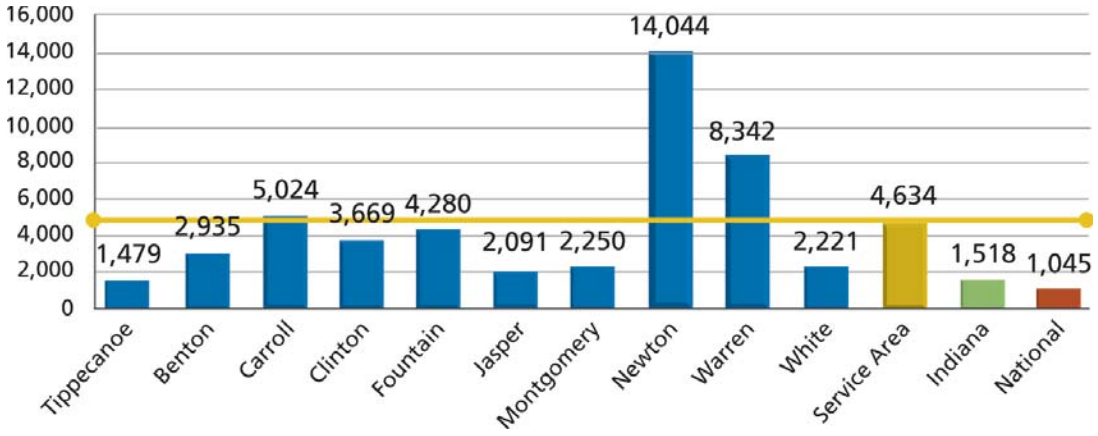
Clinical care consists of the following weighted factors for each county: access to care and quality of care. 92 counties in Indiana have been ranked from 1 to 92, with 1 representing the highest and 92 representing the lowest composite score. The clinical care score is the second of four factors with a weight of 20% in calculating a county's overall health factor ranking. (Source: www.countyhealthrankings.org)

2015 Uninsured



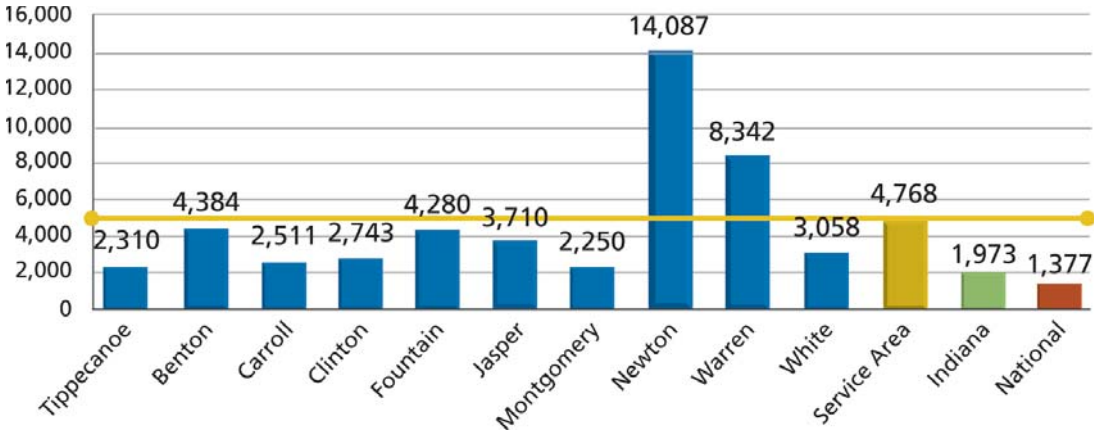
Uninsured represents a significant barrier to accessing needed health care due to lack of health insurance coverage that continues to increase. The value reported for each county is the estimated percent of the population under age 65 without health insurance coverage. The uninsured percentage is a portion of the access to care factor with a weight of 2.5% in calculating a county's overall critical care ranking. (Source: www.countyhealthrankings.org)

2015 Primary Care Physicians



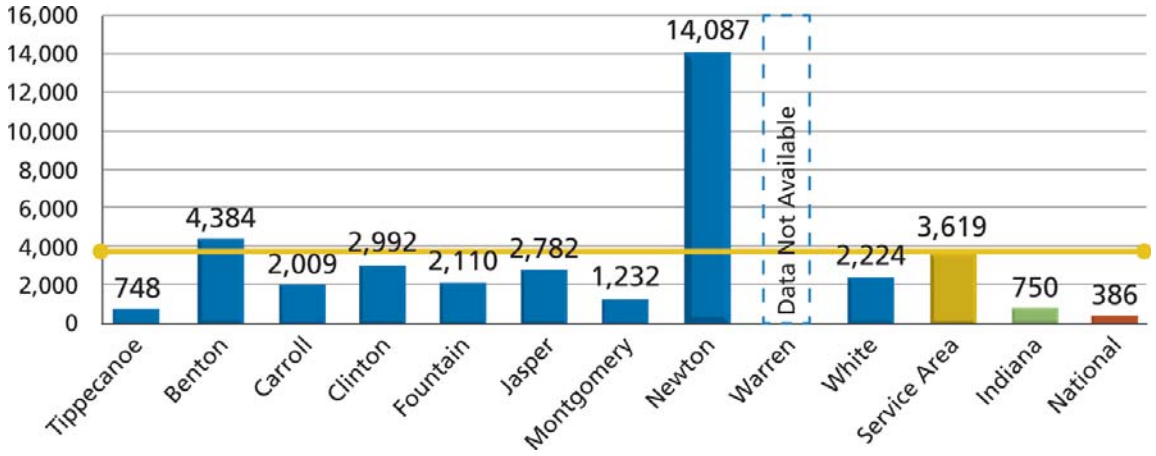
The primary care physicians parameter represents the rate of availability for the population to obtain essential access to preventive and primary care with appropriate referrals to specialty care. The value reported is the population per provider including practicing physicians specializing in general practice medicine, family medicine, internal medicine, pediatrics, and obstetrics/gynecology. The rate depicted is a portion of the access to care factor with a weight of 3% in calculating a county's overall critical care ranking. (Source: www.countyhealthrankings.org)

2015 Dentists



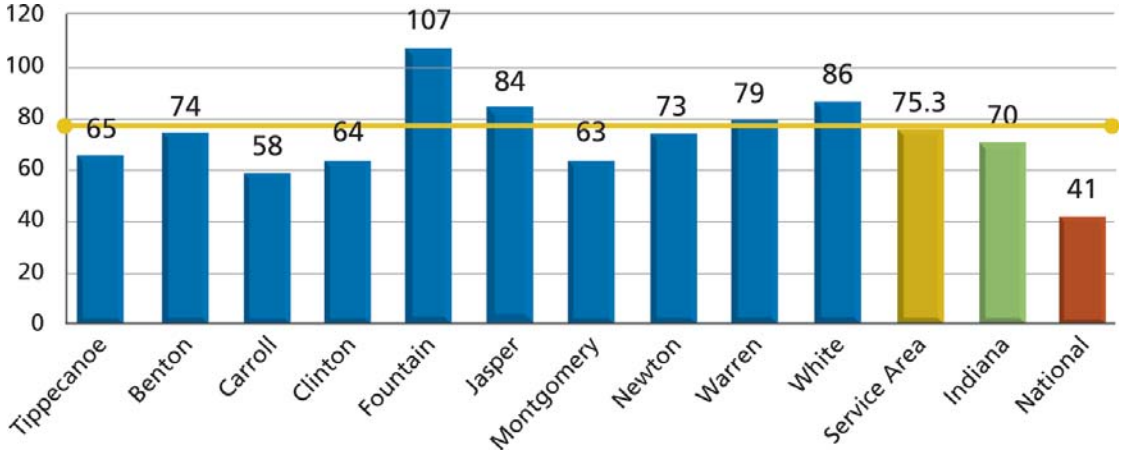
The dentists parameter represents the rate of availability for the population to obtain essential access to preventive and restorative dental care. The value reported is the population per dentist. The rate depicted is a portion of the access to care factor with a weight of 1% in calculating a county's overall critical care ranking. (Source: www.countyhealthrankings.org)

2015 Mental Health Providers



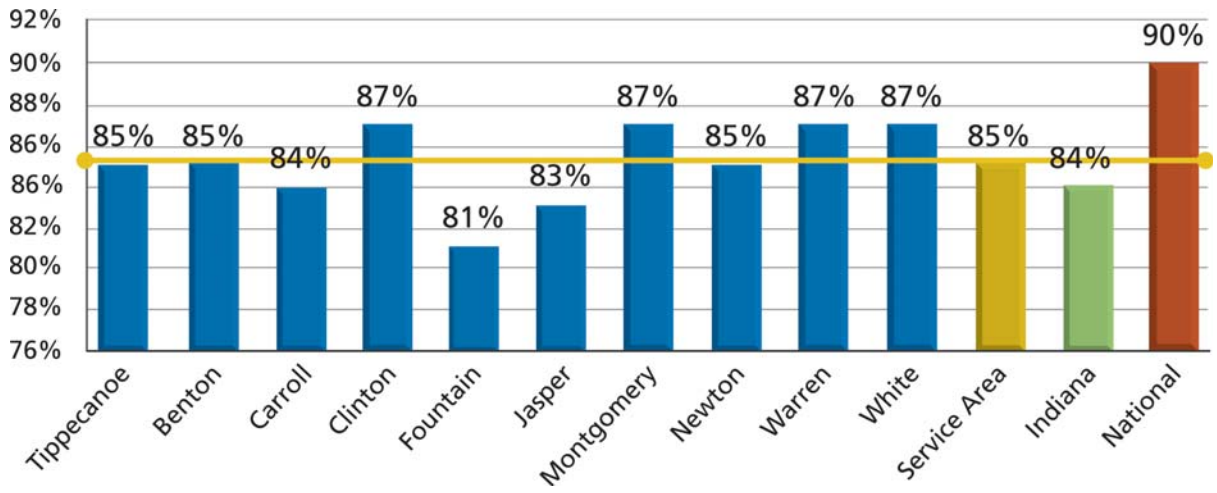
The mental health providers parameter measures the ratio of population to mental health providers. (Source: www.countyhealthrankings.org)

2015 Preventable Hospital Stays



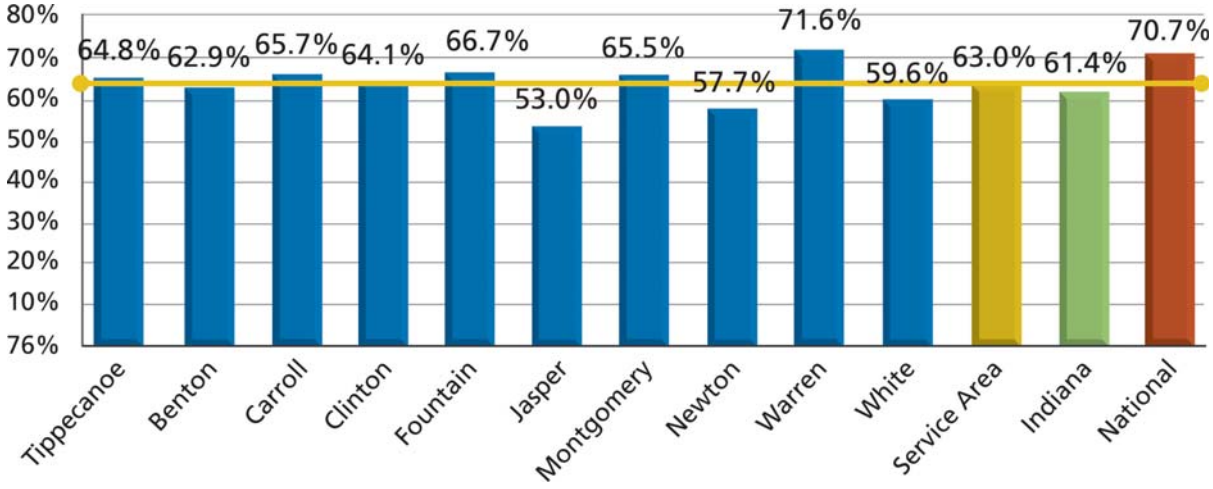
The preventable hospital stays parameter measures the number of hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees. (Source: www.countyhealthrankings.org)

2015 Diabetic Monitoring



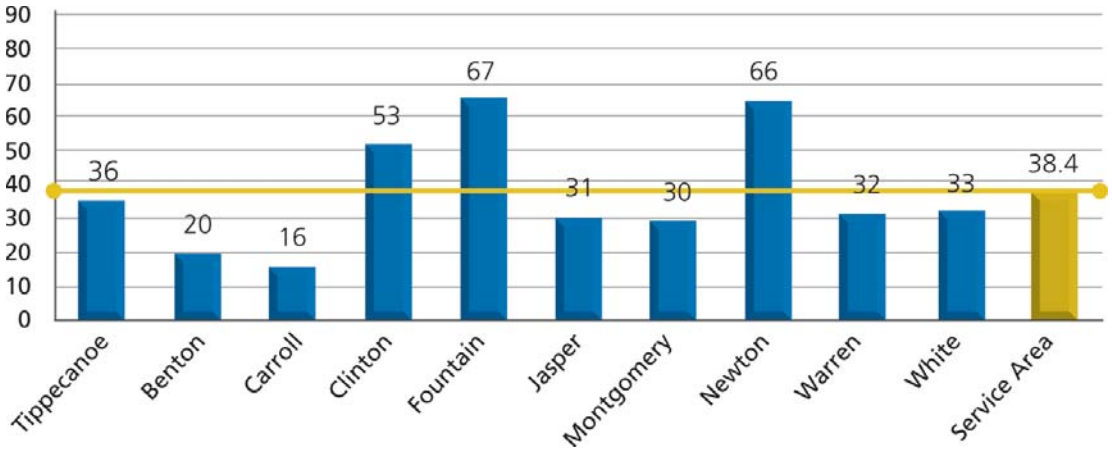
The diabetic monitoring measures the percentage of diabetic Medicare enrollees ages 65 to 75 that receive HbA1c monitoring. Diabetic Monitoring is a portion of the quality of care factor with a weight of 2.5% in calculating the county's overall Clinical Care ranking. (Source: www.countyhealthrankings.org)

2015 Mammography Screening



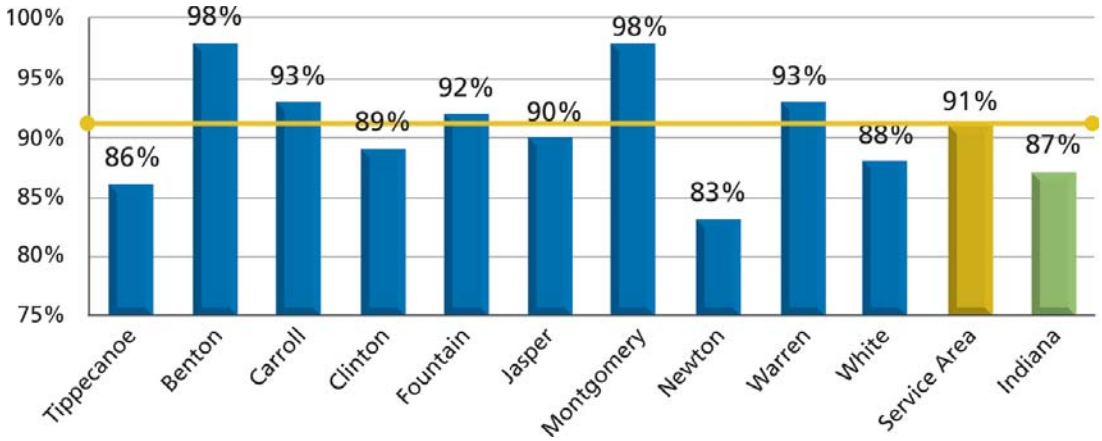
The mammography screening measures the percentage of female Medicare enrollees ages 67-69 that receive mammography screening. Mammography screening is a portion of the quality of care factor with a weight of 2.5% in calculating the county's overall clinical care ranking. (Source: www.countyhealthrankings.org)

2015 SOCIAL& ECONOMIC FACTORS



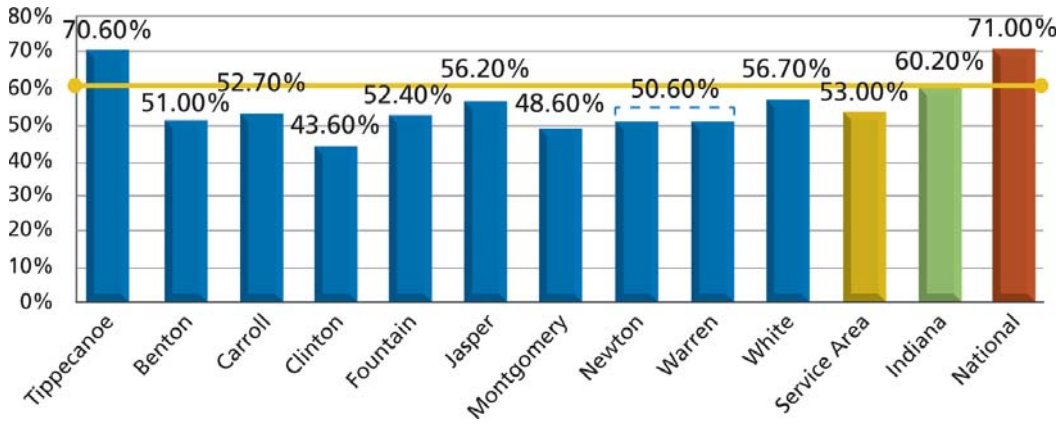
Social & Economic factors consists of the following weighted factors for each county: education (10% - comprises high school graduation, 5% and those with some college 5%), Employment (10%), and family and social support (5% - inadequate social support 2.5%; children in single-parent households 2.5%) factors within each county. 92 counties in Indiana have been ranked from 1 to 92, with 1 representing the highest and 92 representing the lowest composite score. The social & economic score is the third of four factors with a weight of 40% in calculating a county's overall health factor ranking. (Source: www.countyhealthrankings.org)

2015 High School Graduation



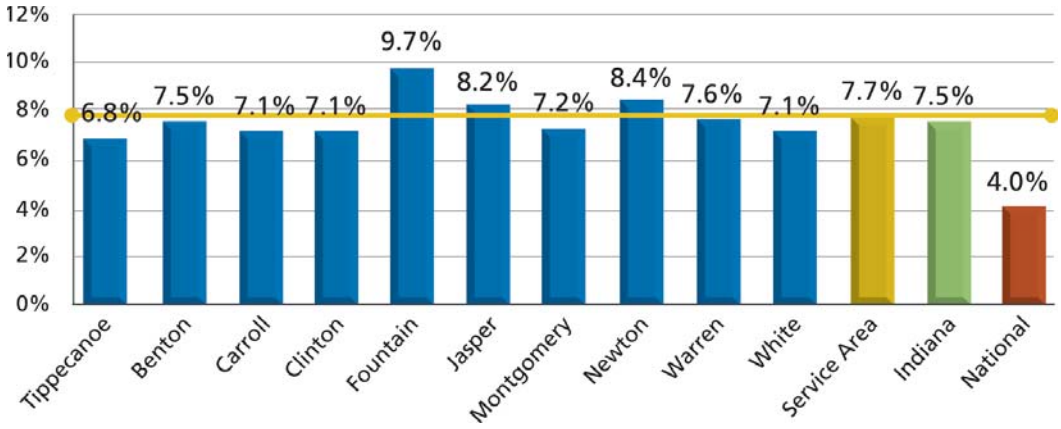
High school graduation represents a correlation between education attainment and improved health through improved work and economic opportunities, reduced psychosocial stress, and healthier lifestyles. The value reported is the percent of ninth-grade cohorts in public schools that graduate in 4 years. High school graduation percentage is a portion of the education factor with a weight of 5% in calculating a county's overall social and economic ranking. (Source: www.countyhealthrankings.org)

2015 Some College



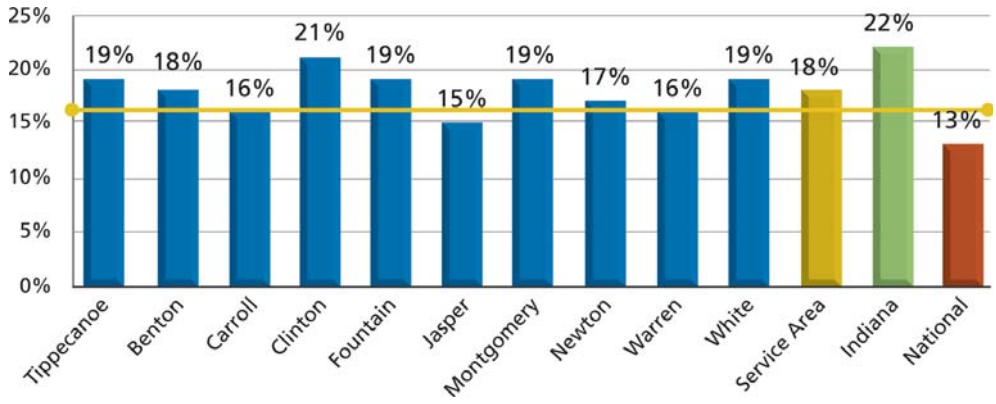
Some college represents a correlation between higher education attainment and improved health through improved work and economic opportunities, reduced psychosocial stress, and healthier lifestyles. The value reported is the percent population, ages 25 to 44 years, with some post-secondary education, such as enrollment at vocational/technical schools, junior colleges, four-year colleges including pursing post-secondary education without receiving a degree. Some college percentage is a portion of the education factor with a weight of 5% in calculating a county's overall social and economic ranking. (Source: www.countyhealthrankings.org)

2015 Unemployment



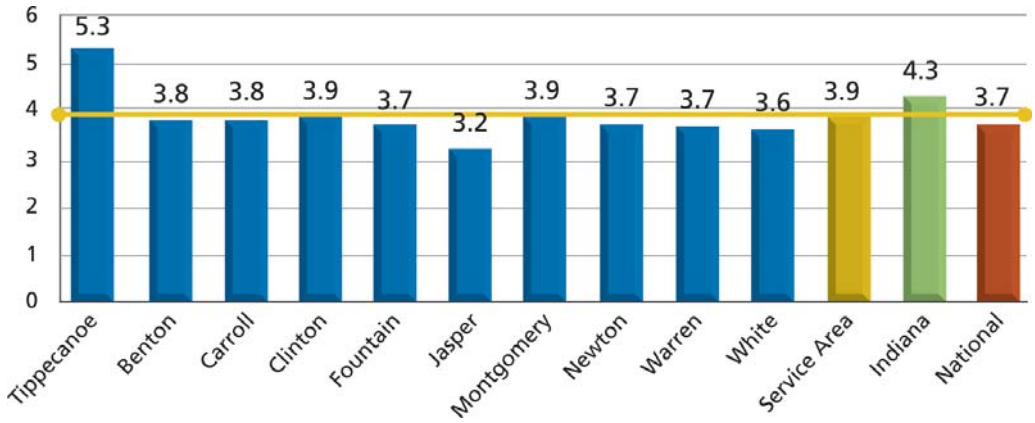
Unemployment represents the population that may be at risk for various health concerns associated with unemployment that can lead to physical health responses ranging from self-reported physical illness to mortality, especially suicide. The value reported for each county is the percent of the civilian labor force, 16 years or older, who is unemployed but seeking work. Unemployment percentage is the second of nine factors with a weight of 10% in calculating a county's overall social and economic ranking. (Source: www.countyhealthrankings.org)

2015 Children in Poverty



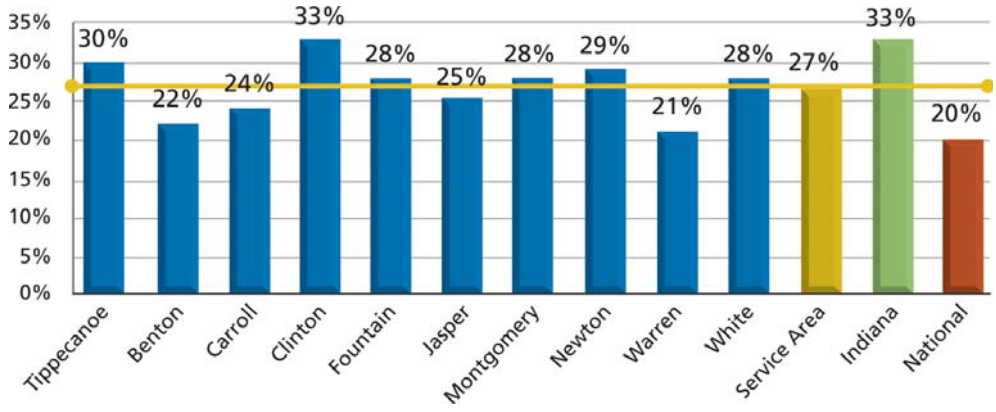
Children in poverty (income factor) represent increased risk in children of morbidity and mortality due to risk of accidental injury and lack of health care access. Poverty can result in negative health consequences, such as increased prevalence of medical conditions and disease incidence, depression, intimate partner violence, and poor health behaviors. The value reported for each county is the percent of children under age 18 living below the Federal Poverty Line. Children in poverty percentage is the third of nine factors with a weight of 7.5% in calculating a county's overall social and economic ranking. (Source: www.countyhealthrankings.org)

2015 Income Inequality



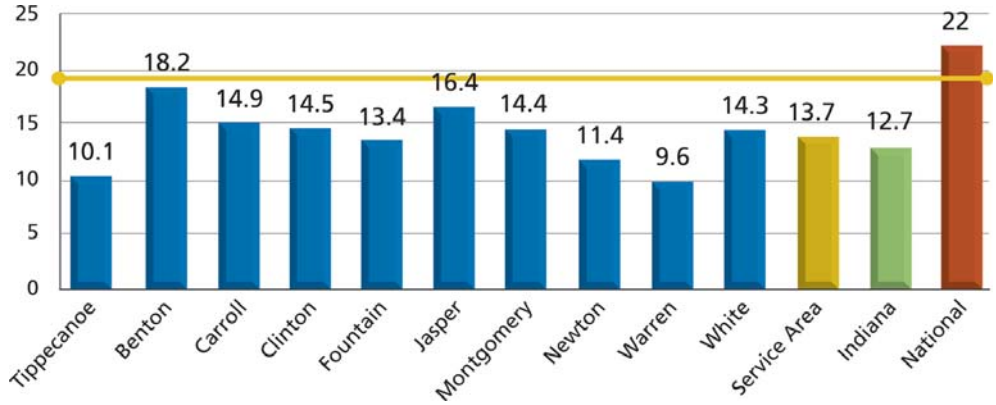
Income inequality represents the ratio of household income at the 80th percentile to income a the 20th percentile. Income inequality is the fourth of nine factors with a weight of 2.5% in calculating a county's overall social and economic ranking. (Source: www.countyhealthrankings.org)

2015 Children in Single-Parent Households



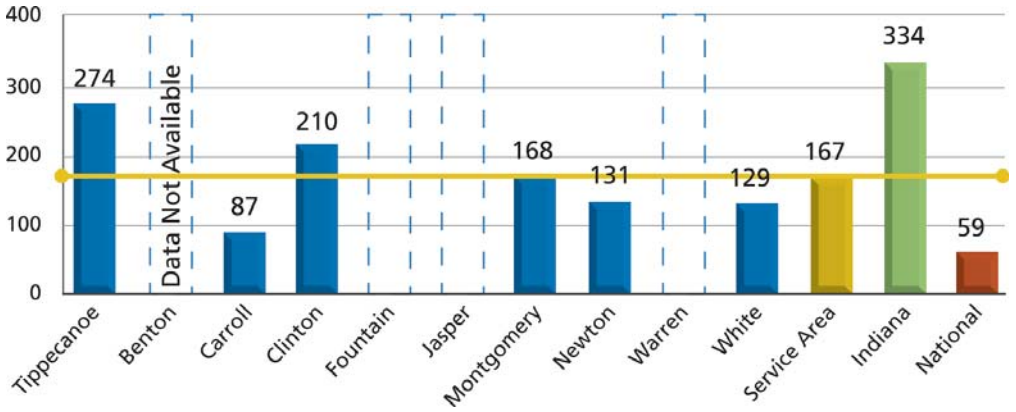
Children in single-parent households represent the percentage of children in family households that live in a household headed by a single parent without a spouse living in the home. Children in single-parent households are at increased risk of negative health outcomes such as mental health problems (such as substance abuse, depression and suicide) and developing unhealthy behaviors such as excessive alcohol use and smoking. Children in single-parent households is the sixth of nine factors with a weight of 2.5% in calculating a county's overall social and economic ranking. (Source: www.countyhealthrankings.org)

2015 Social Associations



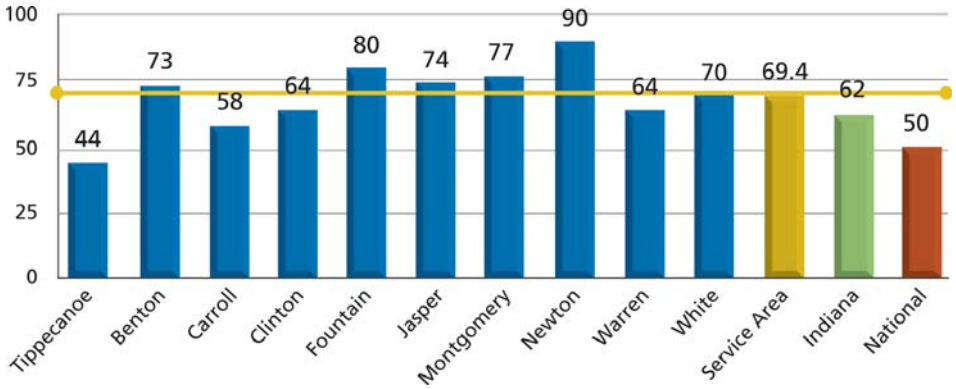
Social Associations represents the number of membership associations per 10,000 population. These include memberships to civic, political, religious, sports, professional organizations as well as golf clubs and fitness centers and other types of membership associations. This parameter was included because those with poor family support, minimal social contact and limited involvement in community life are associated with increased morbidity and early mortality. Income inequality is the seventh of nine factors with a weight of 2.5% in calculating a county's overall social and economic ranking. (Source: www.countyhealthrankings.org)

2015 Violent Crime



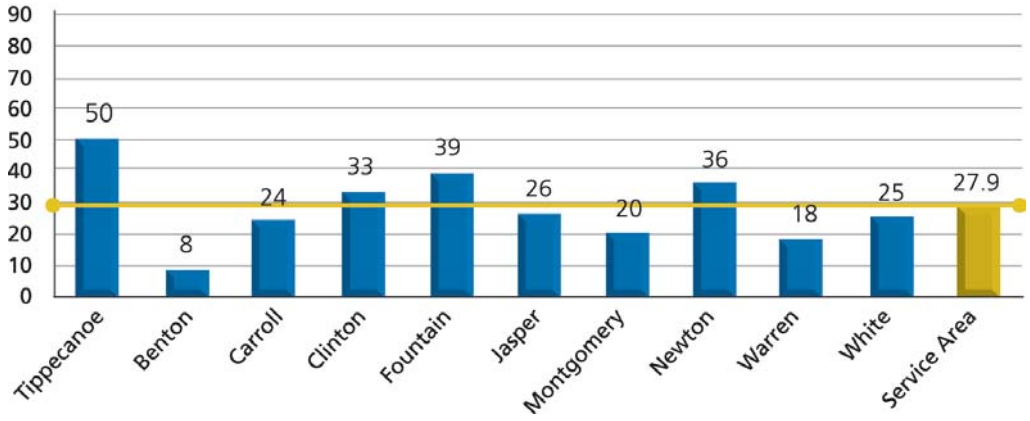
Violent crime represents the number of violent crime offenses reported per 100,000 population. Violent crime is defined as face-to-face offences between victims and their perpetrators. These include rape, robbery, aggravated assault and homicide. High levels of violent crime negatively affects a persons physical safety and psychological well-being and can negatively impact the pursuit of healthy behaviors. Violent crime is the eighth of nine factors with a weight of 2.5% in calculating a county's overall social and economic ranking. (Source: www.countyhealthrankings.org)

2015 Injury Deaths



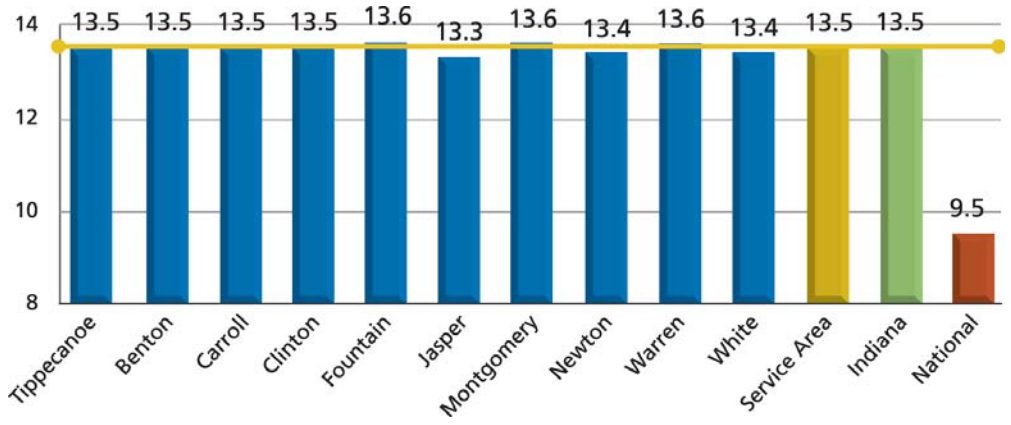
Injury deaths represents the number of deaths due to both intentional and accidental injury per 100,000 population. Injury is a leading cause of death with unintentional and intentional injury as the 5th and 10th leading causes respectively. The most common causes being motor vehicle, poisoning and falls, as well as suicide firearm, homicide firearm and suicide suffocation. This parameter was included because those with poor family support, minimal social contact and limited involvement in community life are associated with increased morbidity and early mortality. Income inequality is the ninth of nine factors with a weight of 2.5% in calculating a county's overall social and economic ranking. (Source: www.countyhealthrankings.org)

2015 PHYSICAL ENVIRONMENT



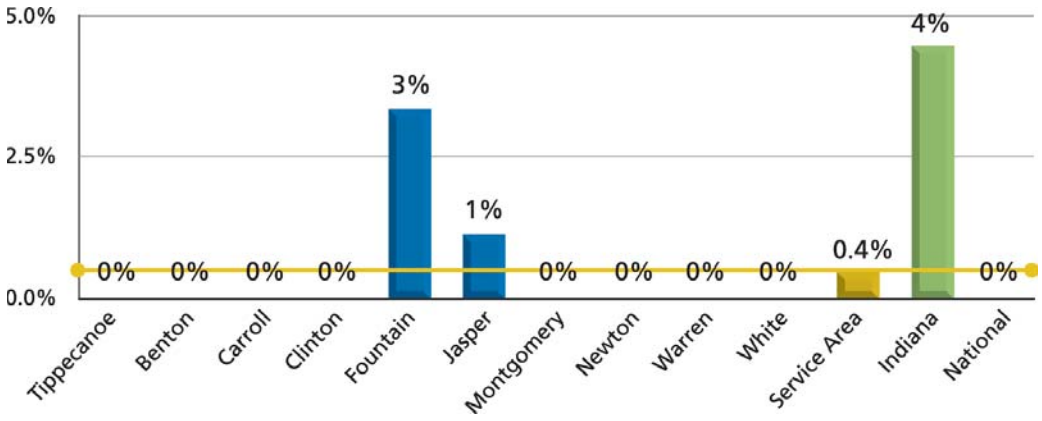
Physical Environment consists of the following weighted factors for each county: air pollution (2.5%), drinking water violations (2.5%), severe housing problems (2%), driving alone to work (2%), and long commute - driving alone (1%) factors within each county. 92 counties in Indiana have been ranked from 1 to 92, with 1 representing the highest and 92 representing the lowest composite score. The physical environment score is the fourth of four factors with a weight of 40% in calculating a county's overall health factor ranking. (Source: www.countyhealthrankings.org)

2015 Air Pollution - Particulate Matter



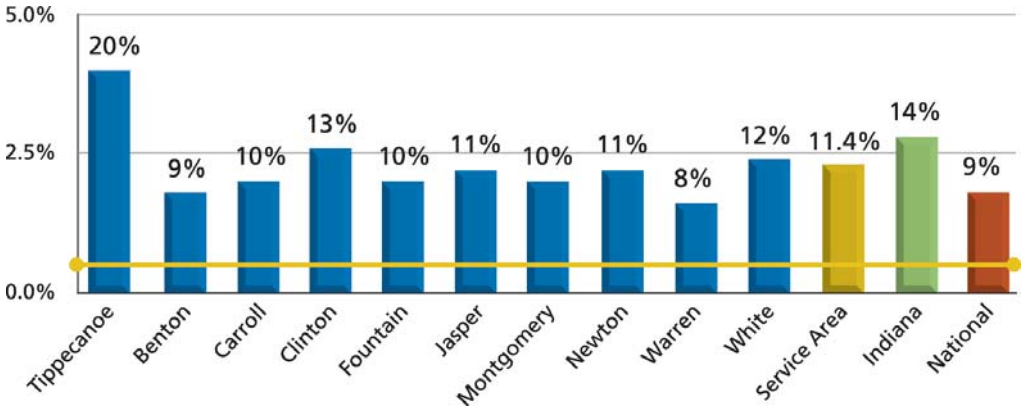
Air Pollution - particulate matter represents the average daily density of fine particulate matter in micrograms per cubic meter (PM2.5). A negative correlation between decreased lung function, chronic bronchitis, asthma and other pulmonary health problems has been linked to increased air pollution due to particulate matter being inhaled. The air pollution - particulate matter score carries a weight of 2.5% in calculating a county's overall health factors ranking. (Source: www.countyhealthrankings.org)

2015 Drinking Water Violations



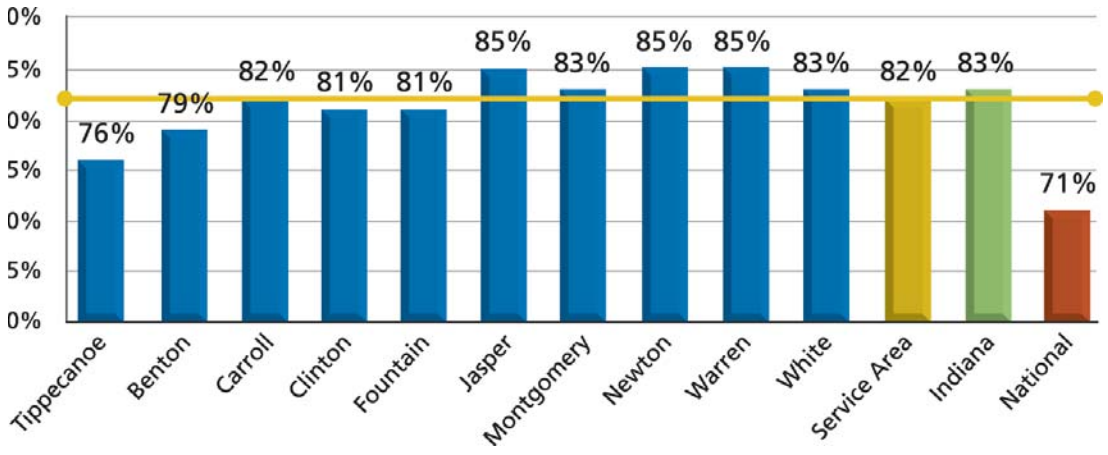
Drinking water violations is the percentage of the population obtaining their water from public water systems where at least one health-based violation has occurred during the reporting period. These violations may include maximum containment level, maximum residual disinfectant level and treatment technique violations. Although the state of Indiana had score of 4%, River Bend Hospital's 10 county service area was significantly lower at 0.4%. All counties in the service area had a score of 0%, except for Fountain (3%) and Jasper (1%). Drinking water violations is the second of five factors with a weight of 2.5% in calculating the overall health factor ranking. (Source: www.countyhealthrankings.org)

2015 Severe Housing Problems



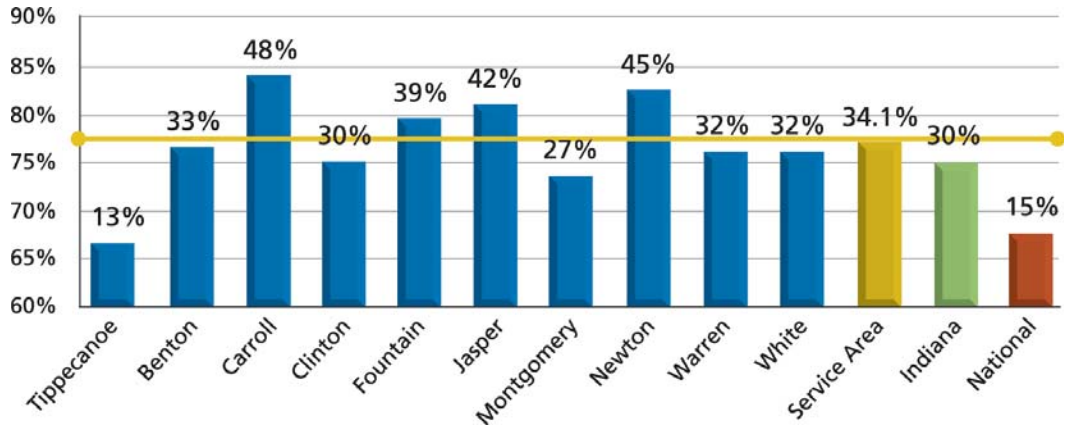
Sever housing problems consist of homes reported to have incomplete kitchen, plumbing, severely overcrowded (more than 1.5 persons per room) or cost burdened household (housing cost exceeds 50% of income). This parameter was included because severe housing problems contribute to chronic and infectious diseases, increased injury and poor childhood development. Sever housing problems is the third of five factors with a weight of 2% in calculating a county's overall health factors ranking. (Source: www.countyhealthrankings.org)

2015 Driving Alone to Work



Driving alone to work is the percentage of the employed population who regularly drives to work alone. Transportation impacts the overall health of the community through air quality, traffic accidents and active living. The score impacts the housing and transit portion of the overall health factors ranking with a weight of 2%. (Source: www.countyhealthrankings.org)

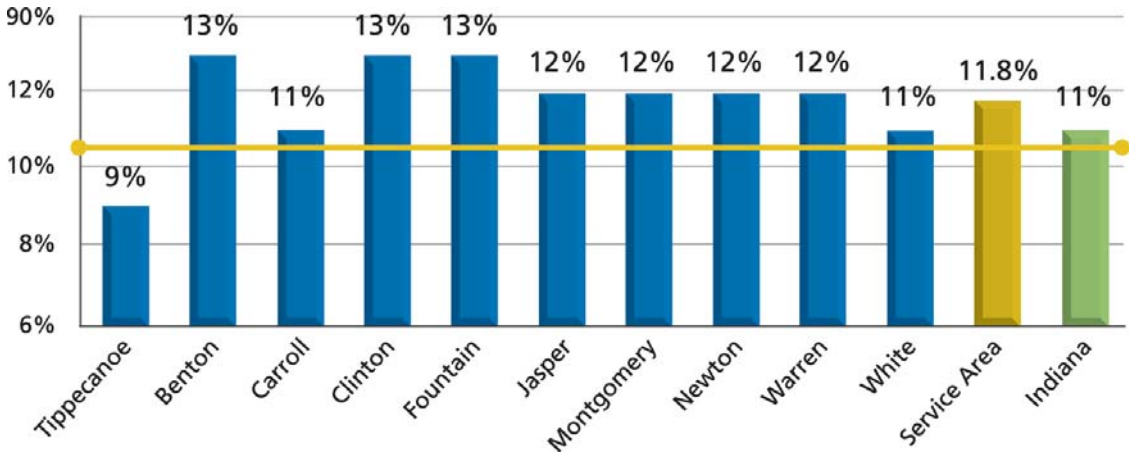
2015 Long Commute - Driving Alone



Long commute - driving alone parameter is the percentage of those whose commute to work takes longer than 30 minutes each day. This ranking is the result of a 2012 study published in the American Journal of Preventative Medicine which found the farther people commute by vehicle, the higher their BMI (body mass index) and their blood pressure. Additionally, the longer the commute, the less physical activity the individual participated in. The long commute - driving alone score is the fifth of five factors with a weight of 1% in calculating the housing and transit portion of a county's overall health factors ranking. (Source: www.countyhealthrankings.org)

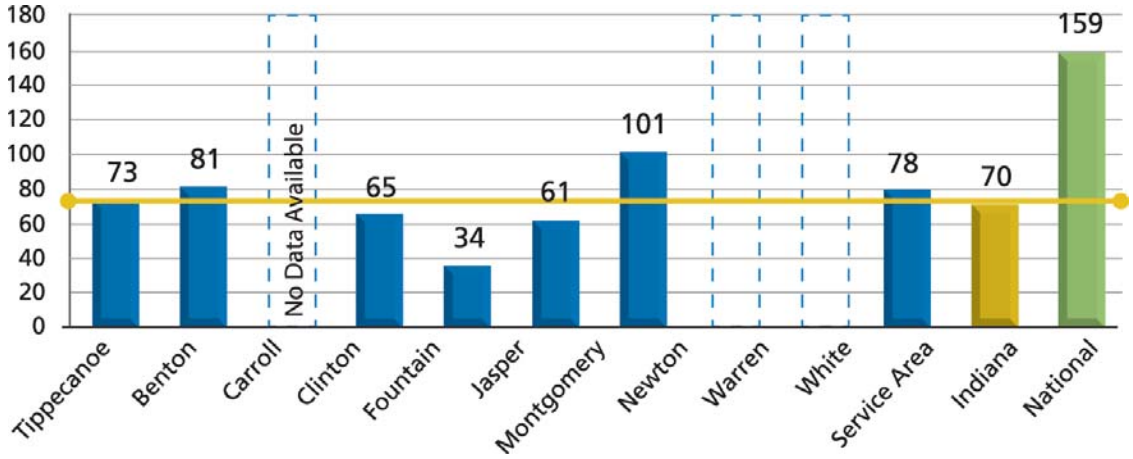
2015 ADDITIONAL MEASURES - HEALTH OUTCOMES

2015 Diabetes



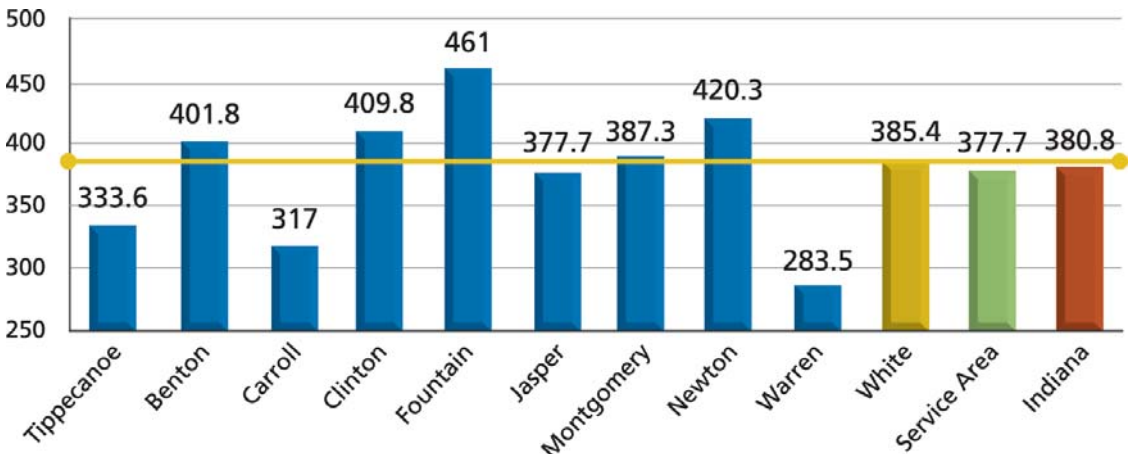
Diabetes score is the percentage of adults 20 years or older who have been diagnosed as having diabetes. (Source: www.countyhealthrankings.org)

2015 HIV Prevalence



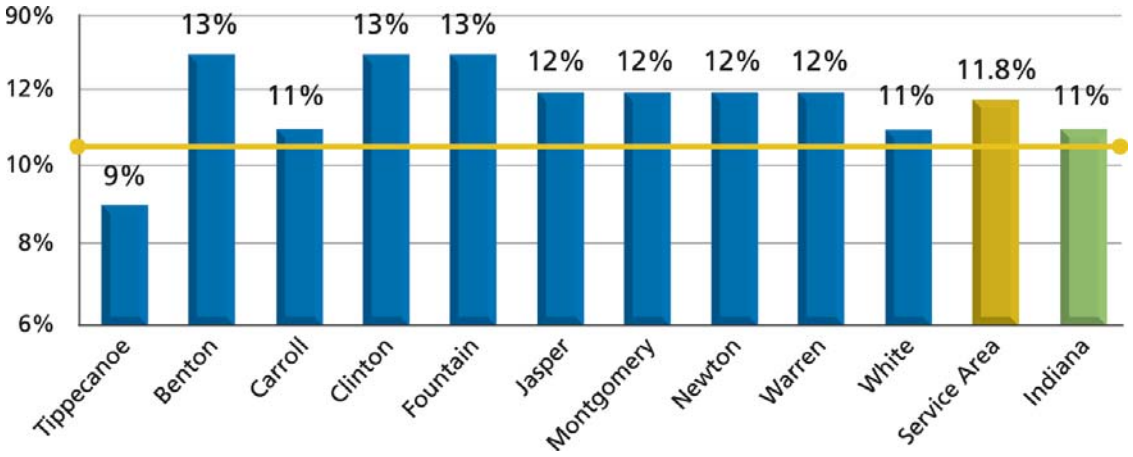
HIV Prevalence score is the number of people who have been diagnosed as being infected with the human immunodeficiency virus (HIV) per 100,000 population. (Source: www.countyhealthrankings.org)

2015 Premature Age-Adjusted Mortality



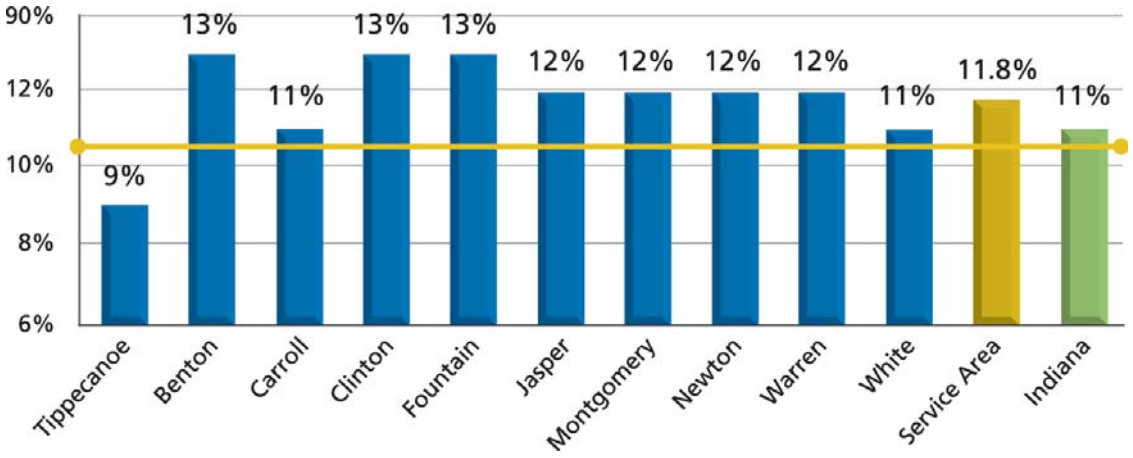
Premature age-adjusted mortality score is the number people (per 100,000 population) under the age of 75 who have died. (Source: www.countyhealthrankings.org)

2015 Infant Mortality



Infant mortality is the number of infants (within one year of birth) who have died per 1,000 live births. (Source: www.countyhealthrankings.org)

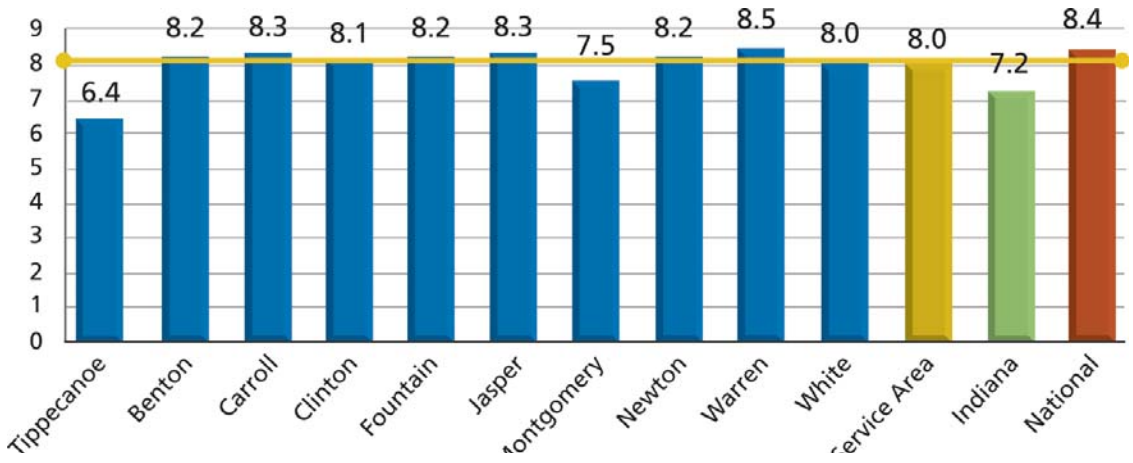
2015 Child Mortality



Child Mortality is the number of children (under the age of 18) who have died per 100,000 population. (Source: www.countyhealthrankings.org)

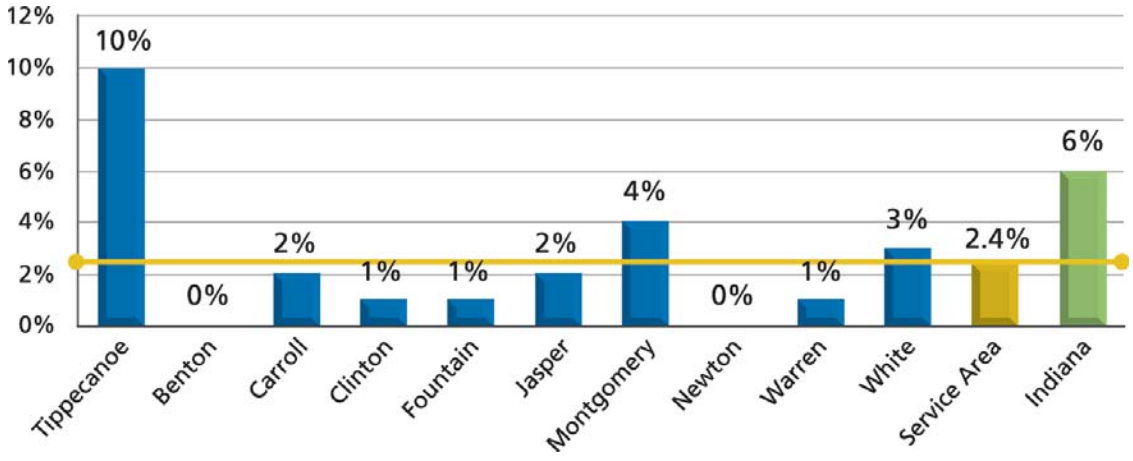
2015 ADDITIONAL MEASURES - HEALTH BEHAVIORS

2015 Food Insecurity



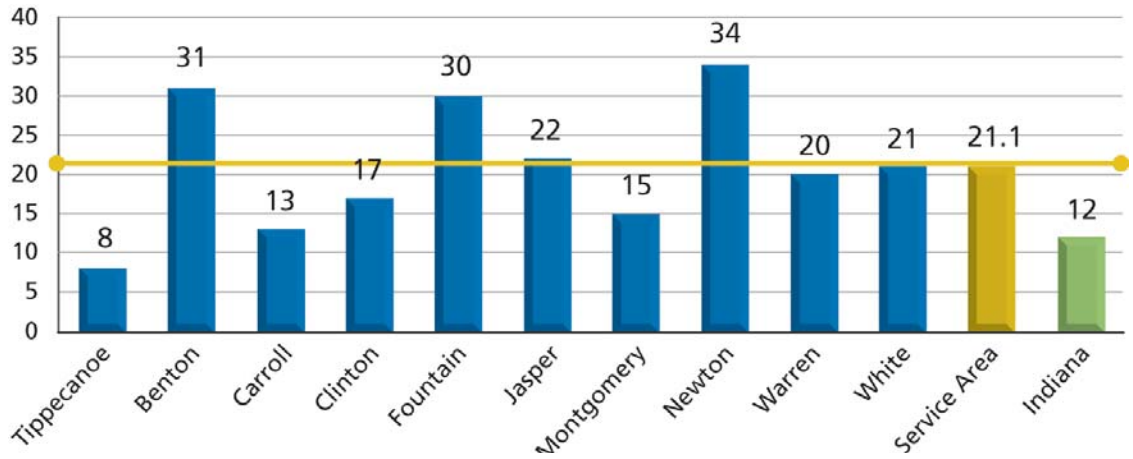
Food insecurity is the percentage of the population who do not have sufficient access to food. (Source: www.countyhealthrankings.org)

2015 Limited Access to Healthy Foods



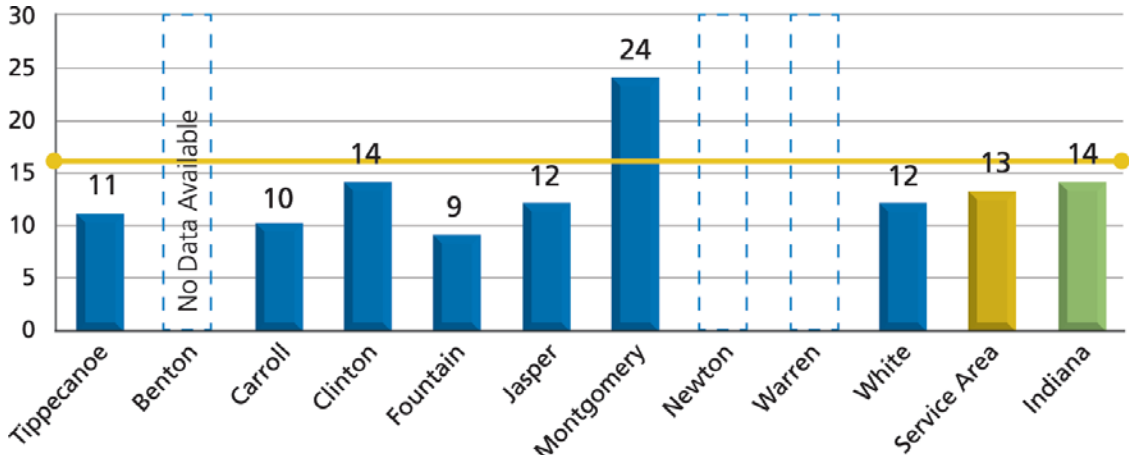
The limited access to healthy foods score is the percentage of the low-income population who does not live close to a grocery store. (Source: www.countyhealthrankings.org)

2015 Motor Vehicle Crash Deaths



The Motor vehicle crash deaths score is the number of people who have died in motor vehicle crashes per 100,000 population. (Source: www.countyhealthrankings.org)

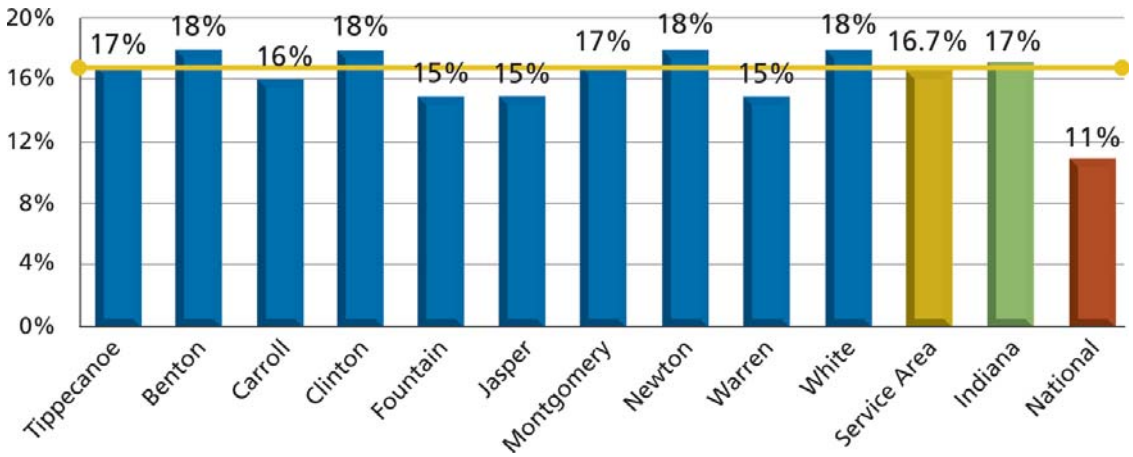
2015 Drug Poisoning Deaths



The drug poisoning deaths score is the number of people who have died as a result of drug poisoning per 100,000 population. (Source: www.countyhealthrankings.org)

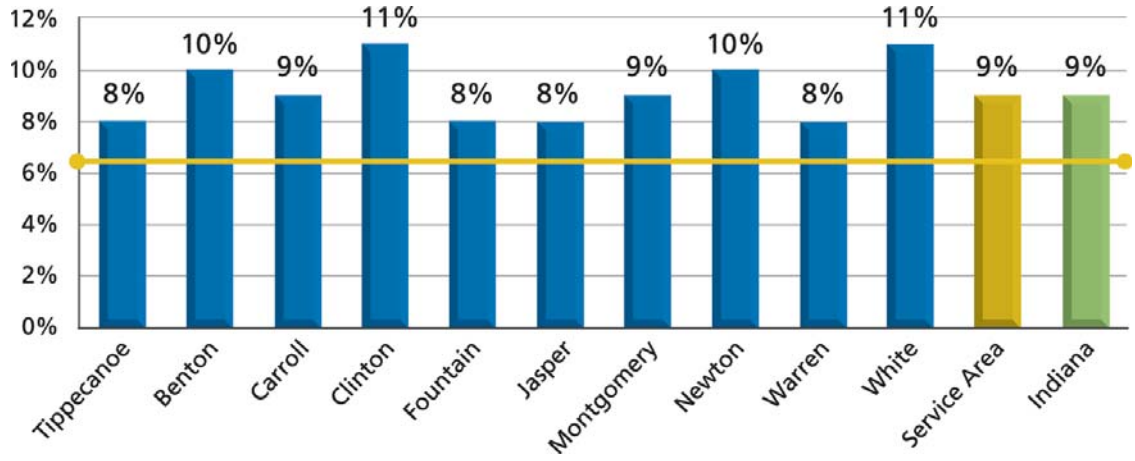
2015 ADDITIONAL MEASURES - HEALTH CARE

2015 Uninsured Adults



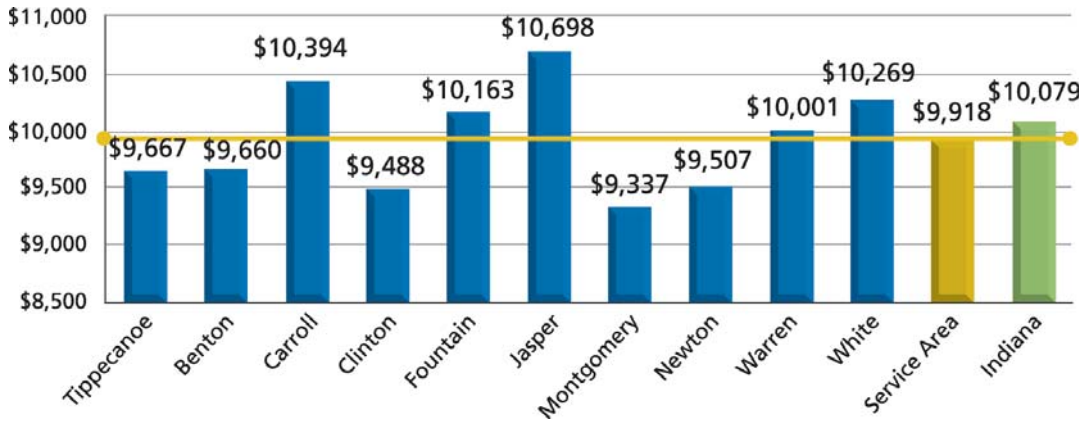
Uninsured adults is the percentage of adults, 18 to 64 years old, who do not have health insurance. (Source: www.countyhealthrankings.org)

2015 Uninsured Children



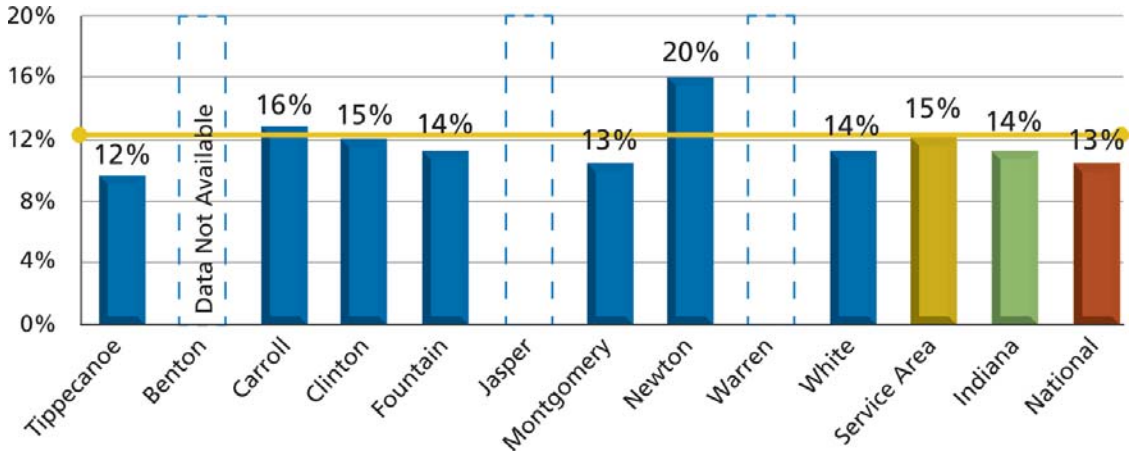
Uninsured children is the percentage of the population under the age of 19 without health insurance coverage. (Source: www.countyhealthrankings.org)

2015 Health Care Costs



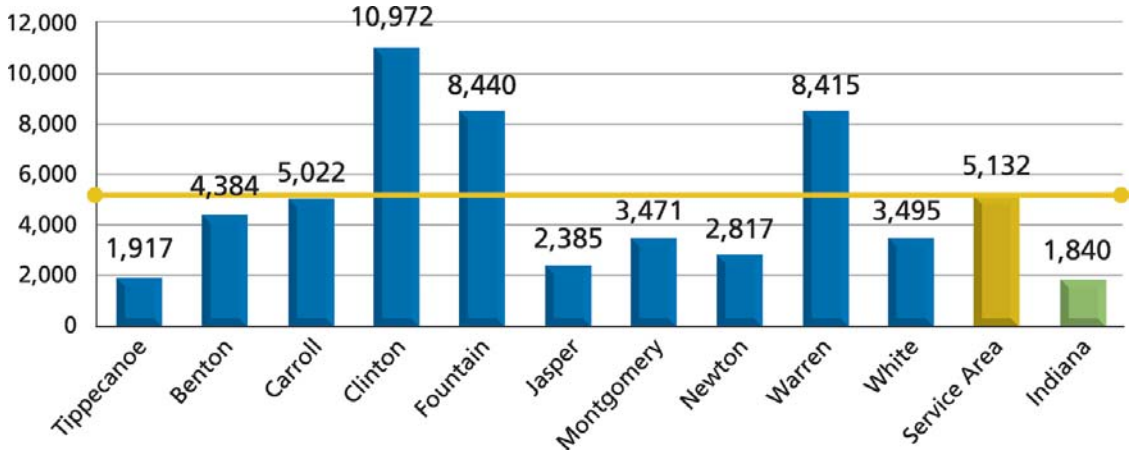
Health Care Costs is the price-adjusted Medicare reimbursement amount per Medicare enrollee. (Source: www.countyhealthrankings.org)

2015 Could Not See a Doctor Due to Cost



Could not see a doctor due to cost score is the percentage of adults who could not see a doctor in the previous 12 months because of the cost. (Source: www.countyhealthrankings.org)

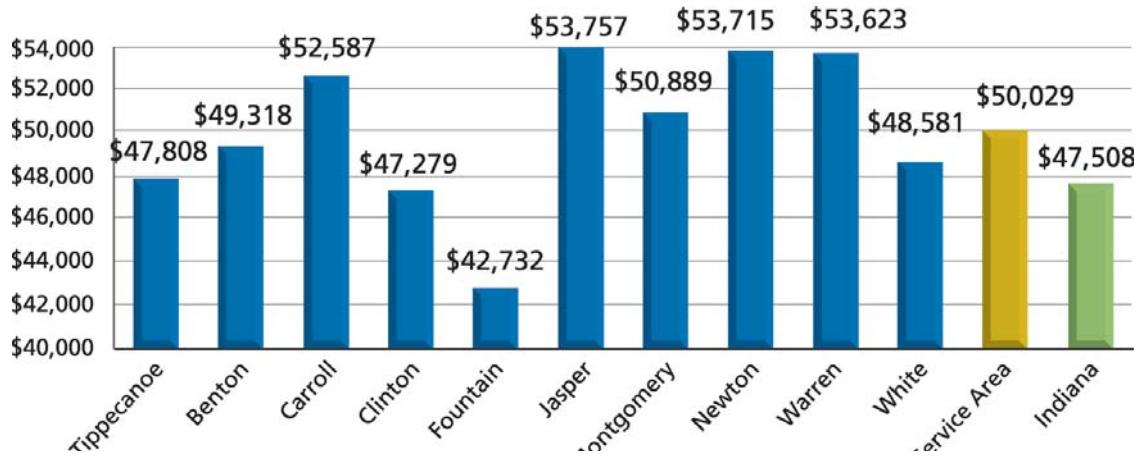
2015 Other Primary Care Providers



Other primary care providers score is a ratio of the number of people in the county to one primary care provider other than physicians. Other primary care providers include nurse practitioners (NPs), physician assistants and clinical nurse specialists. (Source: www.countyhealthrankings.org)

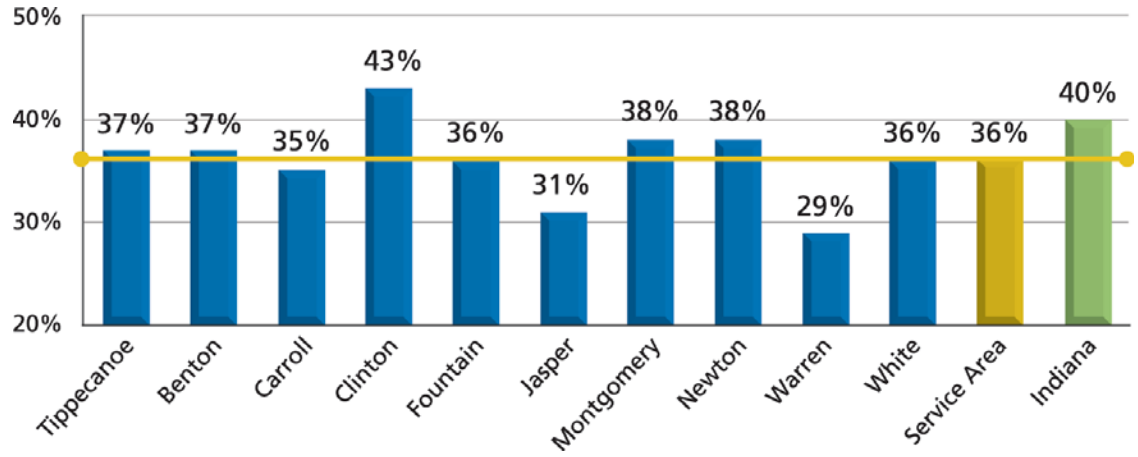
2015 ADDITIONAL MEASURES - SOCIAL & ECONOMIC FACTORS

2015 Median Household Income



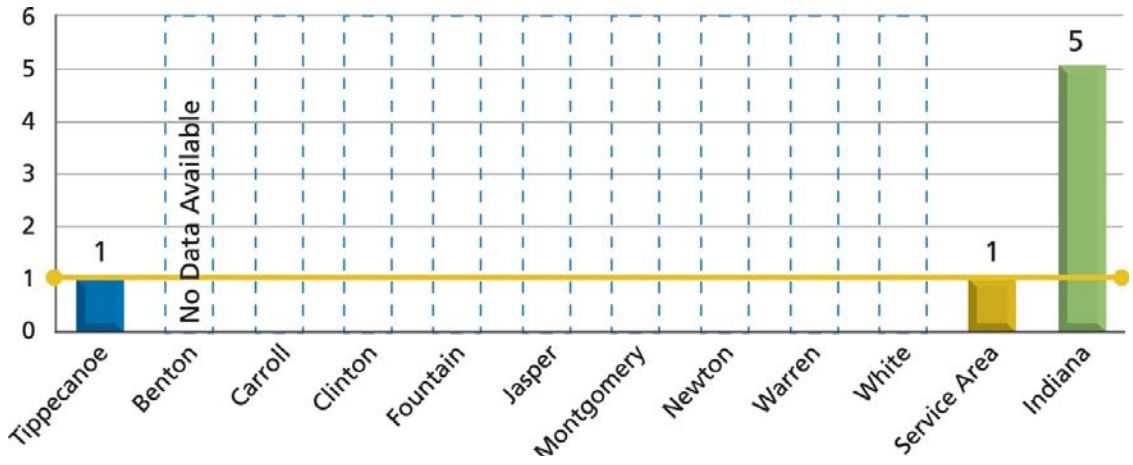
The median household income is the income at which is halfway between the highest earning household income and the lowest earning household income. (Source: www.countyhealthrankings.org)

2015 Children Eligible for Free Lunch



Children eligible for free lunch is the percentage of school age children enrolled in public schools who are eligible for free lunch. (Source: www.countyhealthrankings.org)

2015 Homicides



Homicides is the number of homicide deaths per 100,000 population. (Source: www.countyhealthrankings.org)

ATTACHMENT C: SURVEY QUESTIONS

ONLINE SURVEY

Community Health Needs Assessment

River Bend Hospital: 2900 North River Road, West Lafayette, IN 47906

Community Input 2015

Welcome!

River Bend Hospital is conducting this survey as a method to solicit perceptions, insights and general understandings from community members as part of a Community Health Needs Assessment. This survey is confidential and has only 19 questions. The feedback you provide will help River Bend Hospital assess the health needs in our community and what gaps may exist in services offered to meet those needs.

We would appreciate receiving your feedback through July 31, 2015.

Goals for the survey:

1. To understand perceptions and expectations about health services, including education and prevention services that are issues or critical ***needs of the community***.
2. To understand perceptions and expectations about health services, including education and prevention services, offered and provided in the community, including ***services not offered and provided but needed***.
3. To receive feedback regarding the previous 2012 Community Health Needs Assessment available.

Please complete the survey and click the "Submit" button at the bottom of the page when finished.

Note: Please tab through the form questions; clicking "Enter" on your keyboard will submit the form.

The questions marked with an asterisk (*) require a response.

Part A. Community Member Needs

River Bend Hospital is interested in learning more about its community members' perceptions, insight and opinions regarding healthcare needs as part of a Community Health Needs Assessment. The feedback you provide will help the hospital determine what healthcare services are needed in this community and what gaps may exist in services offered to meet those needs.

Email

1. Select the top 5 health needs in the community: *

	1	2	3	4	5
Access to healthcare	☐	☐	☐	☐	☐
Programs and resources for mental health improvement	☐	☐	☐	☐	☐
Programs and resources for substance abuse	☐	☐	☐	☐	☐
Access to prenatal healthcare	☐	☐	☐	☐	☐
Access to dental/oral healthcare	☐	☐	☐	☐	☐
Resources for hearing/vision issues	☐	☐	☐	☐	☐
Programs and resources for obesity prevention	☐	☐	☐	☐	☐
Programs and resources for chronic disease (cancer, heart disease)	☐	☐	☐	☐	☐
Programs and resources for Asthma awareness and prevention	☐	☐	☐	☐	☐
Resources for injury prevention	☐	☐	☐	☐	☐
Programs and resources for infant mortality prevention	☐	☐	☐	☐	☐
Other health needs	☐	☐	☐	☐	☐

Select one choice per column, beginning with 1 as your most important health need.

1a. List other health needs:

2. Select the top 3 mental health improvements the community needs: *

	1	2	3
Increase programs for depression prevention and awareness	☐	☐	☐
Increase programs for anxiety prevention and awareness	☐	☐	☐
Increase programs for suicide prevention and awareness	☐	☐	☐
Increase programs for other mental health prevention and awareness	☐	☐	☐
Increase awareness for mental health services and resources	☐	☐	☐
Increase programs for domestic abuse prevention and awareness	☐	☐	☐
Increase number of treatment facilities	☐	☐	☐
Increase substance abuse programs and resources	☐	☐	☐
Increase mental health screenings from doctors	☐	☐	☐
Increased continued care and collaboration with after care treatment plans	☐	☐	☐
Mental Health in the community does not need to be improved	☐	☐	☐
Other mental health improvements	☐	☐	☐

Select one choice per column, beginning with 1 as your most important mental health improvement need.

2a. List other mental health improvements:

3. Select the top 3 social issues in the community: *

	1	2	3
Public safety	☐	☐	☐
Hunger	☐	☐	☐
Health	☐	☐	☐
Transportation	☐	☐	☐

Poverty	☐	☐	☐
Housing	☐	☐	☐
Education	☐	☐	☐
Environment (parks, sidewalks, roads, bike paths)	☐	☐	☐
Pollution (clean, safe air quality)	☐	☐	☐
Other social issues	☐	☐	☐

Select one choice per column, beginning with 1 as your most important social issue.

3a. List other social issues:

4. Select the top 3 healthcare challenges your household faces: *

	1	2	3
Lack of transportation	☐	☐	☐
Lack of insurance	☐	☐	☐
Co-pay costs	☐	☐	☐
Limited hours at doctors' offices/clinics	☐	☐	☐
Unable to find a doctor	☐	☐	☐
Unable to find a specialist	☐	☐	☐
Lack of doctors who accept my insurance	☐	☐	☐
Language barriers	☐	☐	☐
Do not have any challenges receiving healthcare	☐	☐	☐
Other challenges	☐	☐	☐

Select one choice per column, beginning with 1 as your most important healthcare challenge.

4a. List other challenges:

5. Select the primary transportation taken to doctor's appointments and other healthcare treatment: *

- ○ Personal vehicle
- ○ Public transportation
- ○ Taxi
- ○ Family or friend
- ○ Walk

- ○ I am unable to make it to appointments due to lack of transportation
- ○ Other transportation

Select one

5a. List other transportation:

6. Select the primary source for information about healthcare: *

- ○ Doctor's office or clinic
- ○ Family/Friends/Co-workers/Neighbors
- ○ School clinic or nurse
- ○ Community Center
- ○ Church
- ○ Internet
- ○ Media (radio, TV, magazines, newspaper)
- ○ I do not receive information about healthcare
- ○ Other sources

Select one

6a. List other sources:

7. How do you characterize the community's overall awareness of River Bend Hospital and its services? Is there anything that could be done to improve awareness about the contributions the Hospital is making to the community? *

8. Please provide any additional comments regarding the needs in the community:

9. Were you aware the 2012 Community Health Needs Assessment was available? *

○ Yes ○ No

10. Please provide comments, questions, changing circumstances for the 2012 Community Health Needs Assessment (available at http://www.nchsi.com/communityhealthneedassessment.cfm):

11. What is your zip code? *

12. What is your county of residence? *

Benton

12a. If you chose "Other" for #12 above, please specify below:

13. How many years have you resided in the community? *

Part B. OPTIONAL

River Bend Hospital is interested in learning more about its community members. This will be helpful for the hospital to understand the community members it is serving.

14. What is your gender?

○ Male ○ Female

Select one

15. What is your age?

○ 18 to 29
○ 30 to 39
○ 40 to 49
○ 50 to 59

○ 60 to 69
○ 70 to 79
○ 80+

Select one

16. What is the highest level of education you have attained?

○ Middle school
○ High school
○ Trade school/Technical school
○ Some college
○ Associate's degree
○ Bachelor's degree
○ Graduate school
○ Other

Select one

16a. If you chose "Other" for #16 above, please specify below:

17. What is your race?

○ African-American
○ Latino/Spanish
○ Asian
○ Native American
○ Caucasian
○ Other

Select one

17a. If you chose "Other" for #17 above, please specify below:

18. How many persons are in your family/household?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9+

Select one

19. What is your gross annual income?

○ $0 - $11,170
○ $11,171 – 15,130
○ $15,131 – 19,090
○ $19,091 – 23,050
○ $23,051 – 27,010
○ $27,011 – 30,970
○ $30,971 – 34,930
○ $34,931 – 38,890

- ○ $38,891 – 50,130
- ○ $50,131 - $75,090
- ○ $75,091 – 90,050
- ○ $90,051+

Select one

Thank you for participating!

Submit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FOCUS GROUP STRUCTURED QUESTIONS FOR FACILITATION

1. Are you aware of or familiar with the CHNA that was completed by River Bend Hospital not quite 3 years?
2. Are you aware of or familiar with any of the strategies or action steps taken by River Bend Hospital, or any other healthcare or social service organization as a direct result of the past CHNA?
3. Describe access to healthcare services in this community.
4. Does access to healthcare vary between primary care and specialty care service? If so, how?
5. Does access to healthcare vary between medical care and mental health care? If so, how?
6. What are the obstacles to people accessing needed medical and mental health care in this community?
7. Are there any barriers that exist in the general community, public health community, or healthcare provider community that prevents us from creating a healthier community?
8. What are the biggest healthcare needs, including mental healthcare and addiction care needs, in this community?
9. What healthcare needs are currently being met and what healthcare needs are currently not being met adequately? For those needs that are unmet, what reasons exist for them not being met?
10. What are the biggest healthcare, mental health or addiction care education or prevention needs in this community?
11. Are there unmet social service needs impacting access to healthcare services in the community? If so, what are they?
12. Are there healthcare education and prevention needs currently being met? If not, which needs are unmet and to what extent are they not being met?
13. Describe your perception of how well healthcare providers work together and coordinate care across the continuum in this community.
14. Describe your perception of how well healthcare providers and organizations work together with social service organizations in the community.
15. Are there any special one-time projects that exist where one-time funding would help meet a healthcare or related need that is currently unmet?
16. Name 2 or 3 improvements you would like to see made in healthcare services in this community and why.
17. Is this community adequately prepared to prevent injury, as well as prevent disease & epidemics, and prevent or respond to environmental hazards and emergency situations? If not, how could the community infrastructure be improved so that we are more adequately prepared?
18. Do you have any other thoughts, comments or suggestions about healthcare, mental health, addiction care, or health education and prevention that we haven't discussed today?

ATTACHMENT D: CITATIONS

2015 REPORT

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