Community Health Needs Assessment

prepared for River Bend Hospital

August 2012

River Bend Hospital has completed a comprehensive assessment of the current mental health care needs and resources available in the community as a complimentary and fundamental overall community effort.

Additionally, this report outlines potential mental health service disparities, and needed community actions to create an optimal environment for improving and restoring the mental health of the community and its citizens.

River Bend Hospital

NCHS

CPAs / ADVISORS

blue

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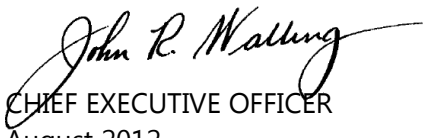
Letter from the CEO

To Our Community Members:

River Bend Hospital is committed to addressing acute and immediate inpatient psychiatric care, and to enhancing the quality of life for individuals, families, and communities we serve in our ten county service area. Our goal with 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 desired in our community. We look forward to working with you to optimize community health and continue meeting the River Bend mission through complementary quality mental health services offered to those in the community.

The significance of better understanding our community's needs was highlighted with 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 applicable needs detected during the assessment process.

During 2012, 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 was able to develop an implementation strategy for the applicable needs addressed in the report – the results are summarized in the attached report.



CHIEF EXECUTIVE OFFICER
August 2012

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. Providing expertise, compassion, and professionalism are the centerpiece 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 2012 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) satisfy the federal guidelines within the Patient Protection and Affordable Care Act (PPACA) of 2010 as well as IRS Notice 2011-52.

Data for this CHNA was collected from primary and statistical data sources to identify key findings and gaps that may exist between mental health needs and services provided within the community. Four methods of collection for primary data were used: 1) on-line survey, 2) written survey selectively distributed, 3) focus groups, and 3) personal interviews conducted face-to-face and via telephone. Several statistical 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:

- 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 services are significantly limited, thus inhibiting providers from meeting most, if not all, of the identified unmet mental health needs in the community.
- 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 meet these needs.
- There continues to be a stigma about mental illness, including care and treatment, although 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 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 addition care.
- The community suffers from a shortage of mental health professionals, particularly qualified psychiatrists, psychologists and primary mental health care providers.
- There are lengthy wait times, in some cases up to several months, in order to see a provider for initial and renewal medication prescriptions.

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, as well as individuals with low education and income levels. Interviews 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 pursuant to its mission 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 a significant potential for positive impact on the community.

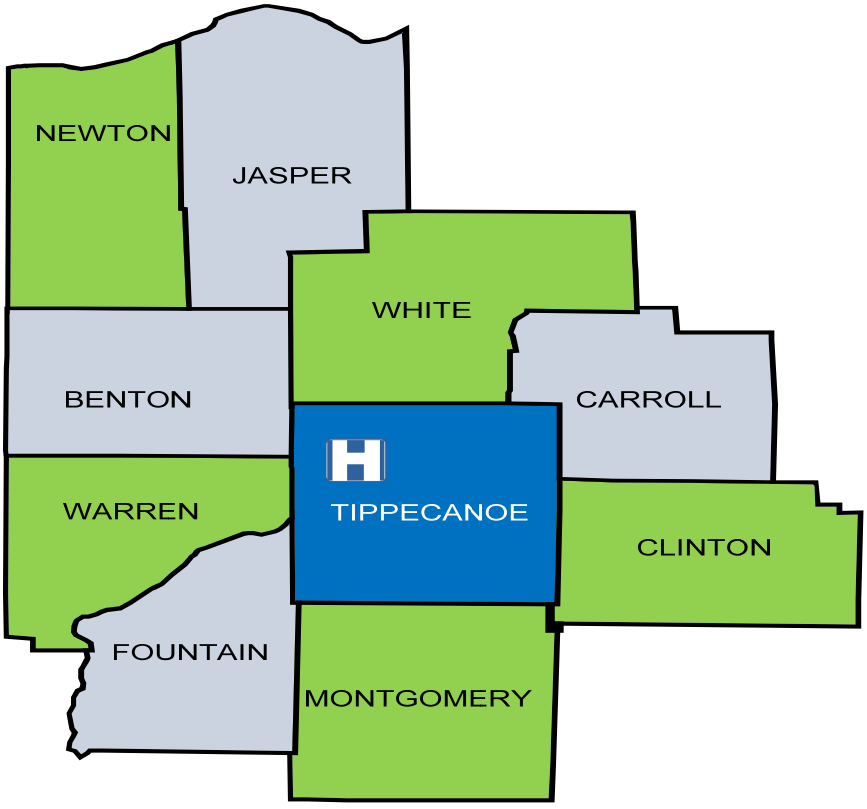
Service Area

SERVICES AREA AND COMMUNITY OF THE HOSPITAL

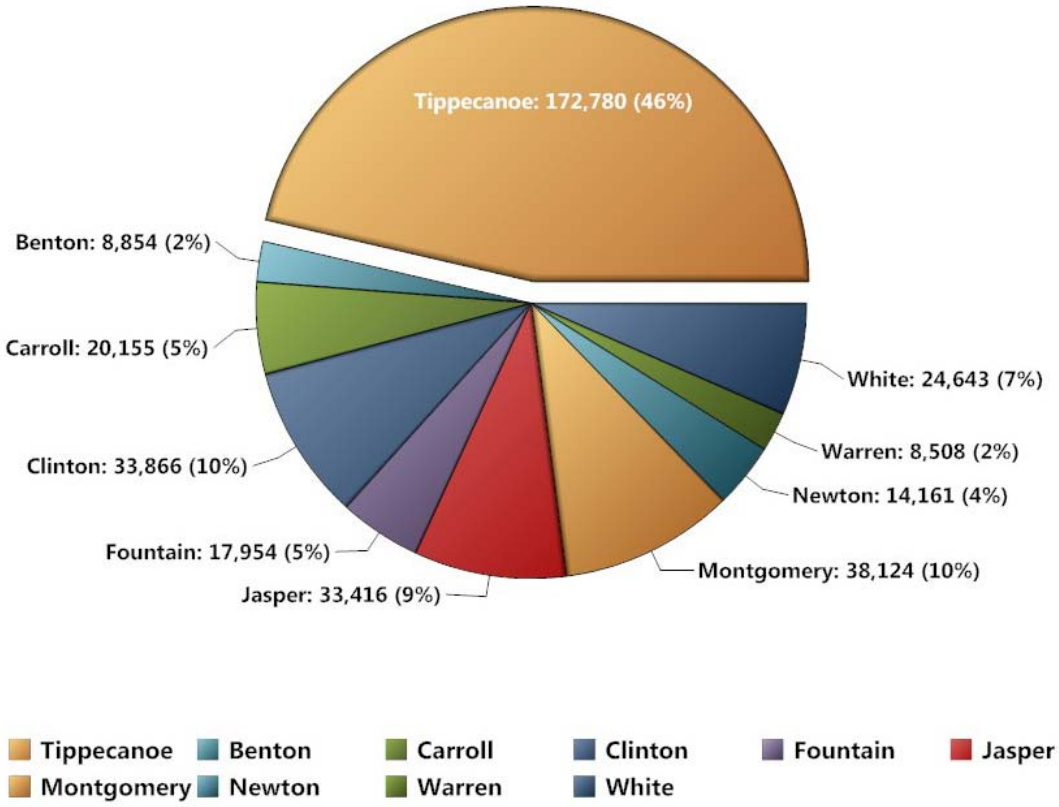
During 2012, the CHNA was conducted by the Hospital for the 372,461 (2010 US Census) residents of Benton, Carroll, Clinton, Fountain, Jasper, Montgomery, Newton, Tippecanoe, Warren, and White counties located in Indiana.

The Hospital's service area includes both urban and rural areas which covers over 4,400 square miles, with the local economy and surrounding areas focused on agriculture and the academic and industrial activities of the local university. Population per square mile is significantly lower when compared to Indiana's population per square mile (78 per mile vs. 180 per mile, respectively). Tippecanoe County represents 46% of the total service area population of 372,461. Median age in the service area is 39.2 years, with 6.6% of the population non-white and 51% female. Approximately 11.55% of the service area population lives below the poverty level, while the unemployment rate is 8.6% (as of February 2012). Persons from age 25 to 44 represent the largest population range (26.3%) for the service area. The smallest age range is children under the age of four, this range composed 6.6% of the service area.

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 and IRS Notice 2011-52. 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 are effective starting taxable years beginning after March 23, 2012. The United States Treasury and Internal Revenue Service published Notice 2011-52 in order to provide preliminary guidance for hospitals to start preparing assessments and implementation strategies prior to the effective date. NCHS and the Hospital are relying on the anticipated regulatory provisions provided in IRS Notice 2011-52 to conduct the following CHNA.

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' 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 encouraging 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 most significant information gaps impacting the ability to assess needs of the community served were primarily a low response to online survey requests, and low response from at-risk populations. 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 prevention, detection, diagnosis, and treatment. Blue used an assessment process focused on collection of primary and statistical data sources to identify key areas of concern.

Blue conducted personal interviews 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, written and online surveys were also 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, initial 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, collated, analyzed, and presented with the assistance of Blue. Interviews and 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.

Four methods of collection for primary data were used: 1) on-line survey, 2) written surveys, 3) focus groups, and 4) personal interviews.

On-Line Survey

Two versions of on-line surveys were developed and used as a method to solicit perceptions, insights and general understanding from community members and special expertise regarding mental health. The on-line "Community Input 2012" survey (see Attachment B) was made available on the website of NCHS. The on-line "Special Expertise Questionnaire 2012" survey (see Attachment B) was sent to specific special expertise participants unavailable for in-person interviews. Desired participation was not received, as there were a total of 20 surveys completed online.

The community members were asked six general questions regarding the participant's awareness of the community's needs for inpatient mental health care services. The participants were to select the top three mental health care needs in the community and note if he/she completely agrees, somewhat agrees, somewhat disagrees, or completely disagrees with the statements provided regarding mental health care services in the community. The general community member services were made available on NCHS' website (www.nchsi.com).

The special expertise participants were asked 26 questions regarding the Hospital and the mental health care in the community. The participants noted opportunities and inadequacies of the hospitals constraints, needs in the community, and general awareness about healthcare related topics.

Written Surveys

Written surveys were provided to community participants via a community transitional housing center and outpatient addiction center. The survey was a printed version of the "Community Input 2012" survey for solicitation of community members perceptions, insights and general understanding of inpatient mental health care needs in the community. There were a total of 6 surveys completed and returned.

Focus Groups

Two focus groups were conducted by Blue with 6 participants in each group. 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.

Personal Interviews

Personal interviews were conducted face-to-face and via telephone using a structured special expertise questionnaire (See Attachment B for questionnaire content and Attachment C for special expertise participants). A total of 27 people participated. Interviewees were invited based upon a list provided by the Hospital that included lay members of the community; representatives from community health service organizations; community leaders; health experts; physicians, mental health professionals, and other healthcare service providers; legal and education professionals; and other civic organization officials.

STATISTICAL DATA SOURCES

Blue reviewed statistical data sources including: American Hospital Association *2011 Environmental Scan* and Deloitte *2011 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 County Health Rankings, Indiana National Alliance on Mental Illness, Indiana State Department of Health, Internet Mental Health, National Alliance on Mental Illness (NAMI), National Institute of Mental Health (NIMH), Substance Abuse and Mental Health Services Administration (SAMHSA), West Central Indiana and National Alliance on Mental Illness. In addition, hospital-specific data provided by the Hospital was reviewed. (See Attachment F for a complete list of citations.)

The Hospital provided a number of documents used for purposes of the report including patient origin data. Other reports provided and reviewed included the 2007 Mental Health and Addiction Services Needs Assessment Report conducted by the Center for Health Policy, the February 2009 and December 2011 Community Health Needs Assessment for Tippecanoe County by Pauline Shen, 2011 Inpatient Improvement Survey Results, and 2011 IHA Patient Discharge Study.

Key Findings

PERSONAL INTERVIEW AREAS OF CONCERN

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

Delivery of Mental Health Services

The delivery of mental health services in the community is, by-and-large, fragmented with minimal 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 being provided.
- There is a sense that most mental health providers really are not as knowledgeable about what other organizations and providers are doing, including what their service capabilities are, as well as their policies and practices; this leads to redundancies, inefficiencies and fragmentation in the "mental health system."
- 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 services are significantly limited, thus 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 principle driver of the underfunding of mental health services.
- People with private insurance have access to private mental health services in the community and therefore are able to meet their mental health treatment needs much more 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.
- Funding for certain types of transportation, specifically for individuals amidst mental crisis, are managed through the use of the police department personnel which depletes 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.

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 meet these needs.

- Although numerous services are being provided for at-risk populations, these services are limited. This is especially true as it relates to services for the SMI, detox, adult alcohol and drug abuse, co-occurring disorders, geriatric, child and adolescent psychiatric, and child and adolescent alcohol and drug abuse populations.
- Waiting periods for appointments and services were noted as a barrier to access.
- 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. This includes the barrier that language has on access.
- Determining the entry-point into the mental health system can be confusing for potential clients, particularly for low income/at-risk populations. The hospital emergency department is viewed as a less-than-ideal entry point.
- The hospital emergency room was noted as a point of entry during mental health crises with limited amounts of beds and professional resources.

Mental Illness Stigma

There continues to be a stigma about mental illness care and treatment, although it has improved somewhat 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.
- There is a perceived need for adolescent suicide awareness and prevention even if acknowledgment of a potential problem is difficult.

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 perception that it is unrealistic to think some 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.
- 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 the families providing the care.

Efforts Made to Break the Cycle of Homelessness in the Community

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

- 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 temporarily holding cells for individuals better suited in custody of a mental health professional.

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 and primary mental health care providers.

- Attempts to employ and maintain well-trained, educated, professionals in the community are limited by funding resources.
- There is a perceived high turnover rate weakening reliability and trust in the professionals. Some professionals do not even provide notice to the public, patients, healthcare providers or other organizations in the community.

- There are lengthy wait times, up to several months, in order to see a prescriber for initial and renewal medication scripts.

SPECIAL EXPERTISE QUESTIONNAIRE

The following represent the responses obtained during the data collection and analysis process. During interviews with special expertise participants, they were asked about the community's overall mental health and issues relating to mental health in the community.

SPECIAL EXPERTISE QUESTIONNAIRE RESULTS				
	Completely agree	Somewhat agree	Somewhat disagree	Completely disagree
Funding for mental health care is too limited to meet the needs of the community.	75%	25%	0%	0%
Some members of the community do not have access to mental health care because they do not have health insurance or their insurance does not provide mental health care coverage and they cannot pay for services.	64%	32%	0%	4%
It is crucial to establish more mental health care services in the community.	54%	39%	7%	0%
There are not enough mental health care professionals in the community to successfully manage the mental health care issues.	61%	29%	10%	0%
There is a need for transportation to and from treatment services for individuals seeking treatment.	43%	36%	3%	18%
Additional collaboration is needed among individual mental health care services providers and organizations in the community.	50%	18%	32%	0%
There is a need to expand/establish Hispanic services in the community.	25%	57%	18%	0%
Educational programs and campaigns to increase awareness about mental health care issues in the general public are needed.	54%	32%	11%	3%

SPECIAL EXPERTISE QUESTIONNAIRE RESULTS				
	Very Important	Important	Somewhat Important	Not Important
How important is it to increase funding for mental health care services in the community?	64%	32%	4%	0%
How important is it to increase access to mental health care by providing some type of payment source or assistance to clients in the community?	54%	36%	7%	3%
How important is it to establish more or expand existing mental health care services in the community?	46%	25%	25%	4%
How important is it to increase the number of mental health care professionals in the community?	54%	25%	18%	3%
How important is it to provide transportation services in the community?	32%	40%	14%	14%
How important is it to improve collaboration in the community?	40%	46%	14%	0%
How important is it to establish/expand Hispanic services in the community?	14%	43%	39%	4%
How important is it to provide educational programs to increase awareness of mental health care issues amoung the general public in the community?	39%	29%	21%	11%
How important is it to increase funding for mental health care services in the community?	64%	32%	4%	0%

ONLINE SURVEY RESULTS

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

Top Prevention, Treatment and Awareness Needs in the Community

Participants were instructed to provide the top three most significant mental health prevention, treatment, and awareness needs in the community.

NEEDS IN THE COMMUNITY	
Prevention, treatment, and awareness	**Percent of Responses from listed needs**
Drug abuse	18%
Alcohol abuse	17%
Depression	14%
Mental disorder	14%
Suicide	9%
Violent/Abuse behaviors	5%
Child abuse	3%
Domestic violence	3%
Tobacco abuse	3%
Binge drinking	1%
Other*	1%
Eating disorder	0%

*Participants were given the opportunity to specify other needs not listed. Other response provided was a need for hospitals to admit court ordered patients.

Responses for General Mental Health Status

Participants were instructed to respond to the following question, "How do you generally describe the mental health status of your community?" The participants were given four choices (excellent, good, fair, or poor) to select from. Nearly half of the respondents measured the community's mental health as fair and the remainder of respondents generally described the status as good.

MENTAL HEALTH STATUS OF THE COMMUNITY	
Responses	**Percent of Responses from listed needs**
Excellent	0%
Good	39%
Fair	42%
Poor	19%

Responses for Mental Health Needs Status

Participants were instructed to respond to the following question, "Are the mental health care needs currently being met in your community?" The participants were given four choices (completely agree, somewhat agree, somewhat disagree, and completely disagree) to select from. Nearly half of the respondents somewhat agreed that the needs of the community are being meet while the majority of the remainder of respondents somewhat disagreed with that statement.

COMMUNITY NEEDS BEING MET	
Responses	**Percent of Responses from listed needs**
Completely agree	12%
Somewhat agree	42%
Somewhat disagree	31%
Completely disagree	15%

Responses for Coordination of Care in the Community

Participants were instructed to respond to the following question, "Do you believe the mental health providers work well together and coordinate care in this community?" The participants were given four choices (completely agree, somewhat agree, somewhat disagree, and completely disagree) to select from with half of the respondents in somewhat agreement that the mental health providers do work well together and coordinate care in the community while the remainder of respondents were split between completely agreeing and somewhat disagreeing with that statement.

COORDINATION OF CARE	
Responses	**Percent of Responses from listed needs**
Completely agree	19%
Somewhat agree	50%
Somewhat disagree	19%
Completely disagree	12%

Responses for Barriers Existing to Preventing a Healthier Community

Participants were instructed to respond to the following question, "Do you believe there are barriers that exist in government, the general community, public health community, or mental health provider community that prevents us from creating a healthier community?" The participants were given four choices (completely agree, somewhat agree, somewhat disagree, and completely disagree) to select from with over half of the respondents completely agreeing there are barriers that exist keeping the community from becoming healthier and the remainder of respondents somewhat agree with the statement.

EXISTING BARRIERS	
Responses	**Percent of Responses from listed needs**
Completely agree	54%
Somewhat agree	35%
Somewhat disagree	8%
Completely disagree	3%

National, State and County Trends

NATIONAL HEALTHCARE TRENDS SYNOPSIS

Healthcare spending continues to grow at the national level each year. The following data, obtained from the United States Census Bureau, represents the level of healthcare spending and expenditures in the United States for 2009 and 2010:

2009 Health Expenditures

- Total health expenditures increased 4.0% to $2.5 trillion.
- Healthcare represents 17.6% of the Gross Domestic Product (GDP).
- Health expenditures reached $8,086 per capita.

2010 Health Expenditures

- Total health expenditures increased 3.9% to $2.6 trillion.
- Healthcare represents 17.9% of the Gross Domestic Product (GDP).
- Health expenditures reached $8,402 per capita.

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

Consumers & Demographics

- Depression is the single biggest reason for productivity loss among workers.
- 18% report treating a health problem with an alternative approach or natural therapy.
- 19% report seeking care for non-emergency health reasons at a walk-in clinic.
- 25% say they decided not to see a doctor when sick or injured.
- 28% report searching on-line for quality-related information.
- Child obesity is growing 3 times faster than adult obesity.
- 35% of people stated they had relied on home remedies or over-the-counter drugs instead of going to see a doctor in the past 12 months.
- 40% of the uninsured are likely to postpone care when sick or injured.
- 57% of adults use prescription medications.
- Nearly 60% of all individuals receive healthcare coverage through private, employer-based health insurance.
- 76% of consumers feel they do not have a strong understanding of how the healthcare system works.
- 76% have visited a physician or other health professional in the past year for a routine check-up: the uninsured are half as likely to do so.
- Nearly 80% of all workers have at least one chronic condition, while 55% have more than one.
- 82% report taking vitamins, minerals or herbal supplements.
- 82% report having a doctor, nurse practitioner or other healthcare professional as their primary care provider.
- 90% believe they are in good health overall.

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 multiyear 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 portion 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 Cuts

Funding varies from year to year for mental health services. From 2011 to 2012, the Indiana State Mental Health budget decreased by $24.7 million. For fiscal year 2012, the estimated loss of enhanced Federal Medicaid Match is $239 million. As such, this provides a challenge each year for mental health providers across the state. *Lack of financial resources and funding for mental health services* was 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 2011 and 2010, the total individuals employed in community and social service occupations for the United States were 1,890,410 and 1,901,180, respectively. Indiana comprises nearly 2% of the total. Indiana's service category shows an increase between years; however, substance abuse and behavior disorder counselors decreased 10% while mental health and substance abuse social workers decreased 30%.

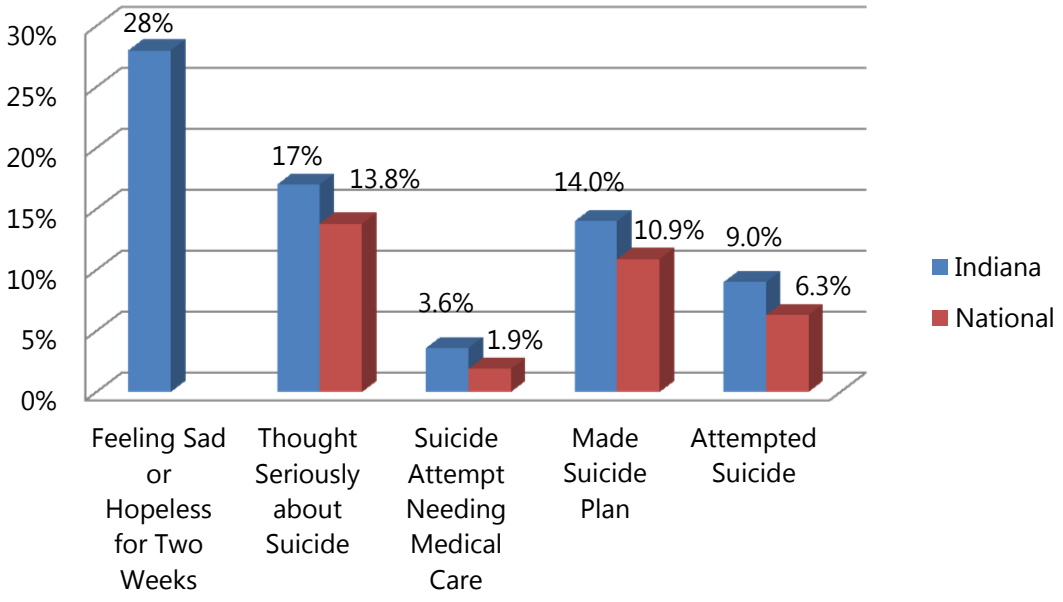
COMMUNITY AND SOCIAL SERVICE OCCUPATIONS	2010	2011
Total Community and Social Services Occupations in Indiana	**28,990**	**29,360**
Substance Abuse and Behavioral Disorder Counselors	1,190	1,080
Educational, Vocational, and School Counselors	4,550	4,370
Marriage and Family Therapists	550	500
Mental Health Counselors	930	860
Rehabilitation Counselors	1,060	1,180
Counselors, All Other	60	100
Child, Family, and School Social Workers	5,130	5,160
Medical and Public Health Social Workers	2,320	2,520
Mental Health and Substance Abuse Social Workers	2,030	1,570
Social Workers, All Other	750	840
Health Educators	970	1,240
Probation Officers and Correctional Treatment Specialists	2,150	2,160
Social and Human Service Assistants	4,430	4,490
Community and Social Service Specialists, All Other	1,740	2,160
Clergy	890	830
Directors, Religious Activities and Education	180	220
Religious Workers, All Other	60	80

EPIDEMIOLOGIC SYNOPSIS: HEALTH, MENTAL HEALTH AND ADDICTIONS CARE

Mental Health

In Indiana, approximately 3.55% or 227,000 adults live with serious mental illness (SMI), which translates into approximately 9,996 adults being affected in the service area. It is estimated 8 out of 10 children ages 9 to 17 in this service area have a serious emotional disturbance (SED) and a Global Assessment of Functioning (GAF) Scale of less than 50 – this equates to approximately 3,536 children. Twelve percent or 5,304 children in this Hospital's service area scored less than 50 on the GAF Scale, per Indiana Family and Social Services Administration, n.d.

The 2009 Youth Risk Behavior Survey reported a little over a quarter of Indiana students in grades 9 through 12 reported they felt sad or hopeless almost every day for at least two weeks during the past 12 months. This study further found Indiana adolescents were more likely to have attempted suicide resulting in injury, poisoning, or overdose that had to be treated by a doctor or nurse; rising from previously reported 2.9% to 3.6%. Furthermore, this report found that 17% of Indiana adolescents thought seriously about suicide; 14% had made a suicide plan; and 9% reported attempted suicide, much higher than national results for these same indicators of 13.8%, 10.9%, and 6.3%, respectively.



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 2% 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. Almost 40% of Indiana high school students currently drink alcohol, while nearly a quarter engaged in binge drinking (*Centers for Disease Control and Prevention*, 2007). In Indiana, a little over 47% of substance abuse related admissions are due to alcohol, which is 6% more than the National average.

The prevalence rate for current illicit drug use in Indiana is slightly over 7%. 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 5% Hoosiers reporting current use. Of those Hoosiers that reported use, over 14% are 18 to 25 years old (*Substance Abuse and Mental Health Services Administration*, 2007). Among Indiana high school students, 18.9% report currently using marijuana, 3.0% state current use of cocaine, and 7% reported using methamphetamine at least once during the student's lifespan (*Centers for Disease Control and Prevention*, 2009).

The service area's estimated prevalence rates of chronic addiction vary by age group. At nearly a quarter of all young adults, 18 to 25 year olds have the highest rate. The rate of those aged 12 to 17 is nearly 11% (slightly under 3,000 children) and for individuals 26 years and older, it is about 7.5% (almost 17,300 adults (*Indiana Family and Social Services Administration*, n.d.). Hoosiers in the community receiving treatment for substance use/abuse disorders predominantly report alcohol as their primary drug at the time of admission (47.1%), followed by marijuana/hashish (31.1%), and cocaine/crack (6.8%). Over half of the individuals in treatment use more than one substance or polysubstance use (53.4%) (*Indiana Division of Mental Health and Addiction*, 2005). Furthermore, data shows treatment needs of some individuals are not being met: 2.59% of Hoosiers 12 years and older are in need of but do not receive treatment for illicit drug use and 7.52% for alcohol use (*Substance Abuse and Mental Health Services Administration*, 2007).

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) (*NIDA*, 2005). Among Hoosiers 12 years old or older, 2.7% reported current abuse of psychotherapeutics while 7.6% abused them in the past year.

Co-occurring Disorder

Individuals who suffer from both mental illness and a substance use/abuse disorder are said to have a co-occurring disorder. According to reports in the Journal of the American Medical Association (JAMA), co-occurring disorders are very common. 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; and of all people diagnosed as mentally ill, 29% abuse either alcohol or drugs (*National Alliance on Mental Illness*, 2003). Individuals with co-occurring disorder tend to have multiple health and social problems, and many are at increased risk for homelessness and incarceration (*National Association of State Mental Health Program Directors*, 1998). Research strongly suggests that to recover from the disorder, treatment for both mental illness and addiction is necessary (*National Alliance on Mental Illness*, 2003).

The prevalence among adults with SMI to have 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.).

STATISTICAL SOURCE HEALTH DATA: HEALTH FACTORS

Population Synopsis

The citizens of the service area are predominantly white (94.4%), with a median age of 39.2. The median age is more than 2 years greater than the state average of 37.0. The ten-county service area's combined high school graduation rate is 87.0% slightly higher than Indiana's 84.0%. Tippecanoe County residents boast a 33.2% holding a bachelors and or a master's degree. The service area's residents with higher education degrees, 15.4%, is considerably less than the states number of 22.4%. The region's median household income of $47,526 is consistent with the state level of $47,697. The service area reported 18% of the children in poverty versus 22% in Indiana and 13% nationally. Furthermore, children living in single-parent households is 26% versus 32% in Indiana and 20% nationally. Approximately 11.5% of the service area population lives below the poverty level. Conversely, the unemployment rate is 8.6% as of February 2012.

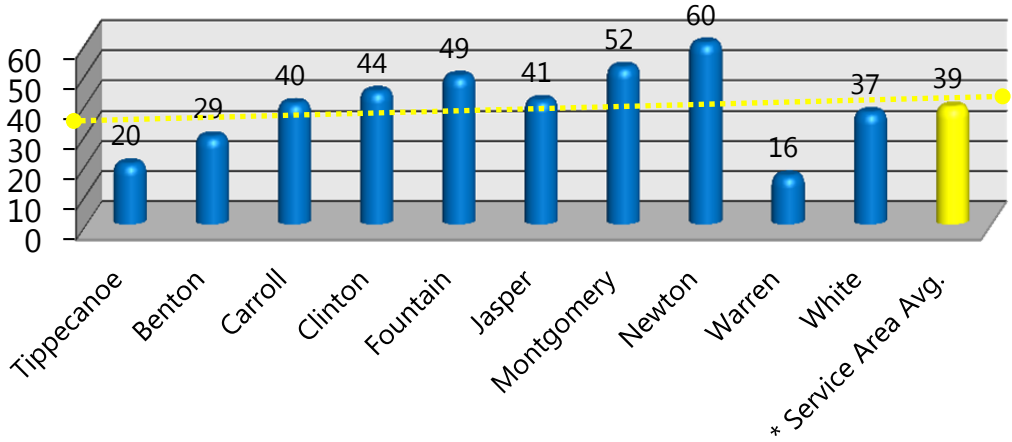
Health Status Synopsis

After reviewing statistical data for the service area, it was noted that the community is not the healthiest community in Indiana; however, it is not the unhealthiest area either. On average, the national and state benchmark data is better than the community.

SERVICE AREA ANALYSIS			
	Service Area (Average)	State of Indiana	National Benchmark
Health Outcomes			
Poor/Fair Health	16%	16%	10%
Poor physical health days	3.9	3.6	2.6
Poor mental health days	3.5	3.6	2.3
Low birth weight	6.8%	8.1%	6.0%
Health Factors			
Adult smoking	24%	24%	14%
Adult obesity	31%	31%	25%
Physical inactivity	29%	27%	21%
Excessive drinking	12%	16%	8%
Sexually transmitted infections	152.3	341	84
Teen birth rate	40.4	44	22
Clinical Care			
Uninsured adults	17%	16%	11%
Primary care physicians	944.1:1	889.1:1	631.1:1
Preventable hospital stays	81.9	78	49
Diabetic screening	84%	82%	89%
Mammography screening	61%	64%	74%

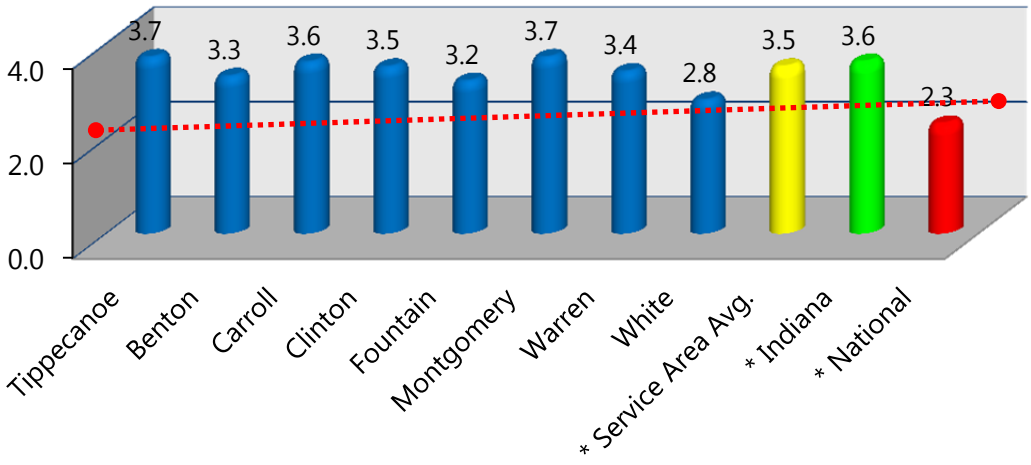
HEALTH OUTCOMES (COUNTY HEALTH RANKING 2012 DATA)

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 length people live and how healthy people feel. Examined is data on premature death, poor health, poor physical health days, poor mental health days, and low birth weight. Overall, the 10-county area has 2 counties ranked in the top 20 counties while the other 8 counties rank from 29 to 60.



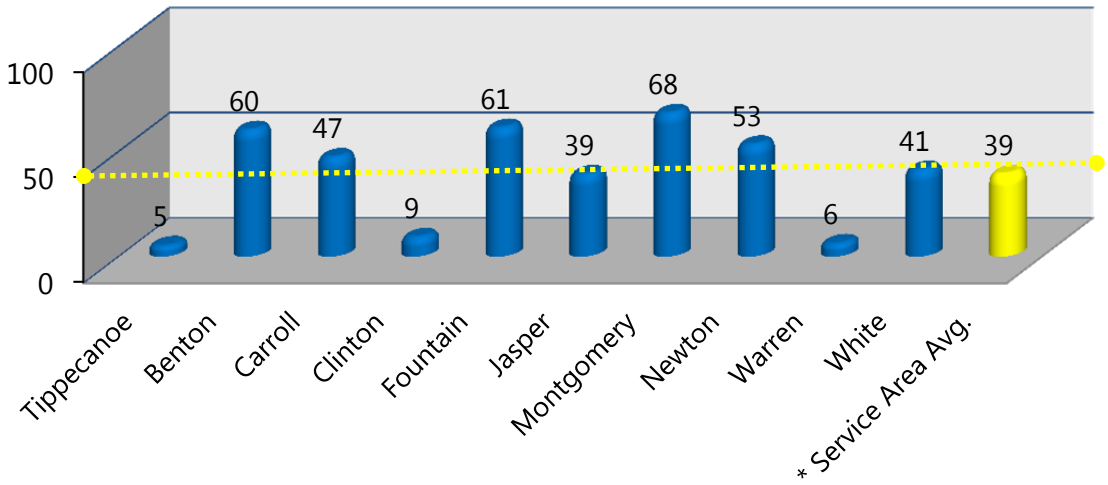
POOR MENTAL HEALTH DAYS (COUNTY HEALTH RANKING 2012 DATA)

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 11% of the month (3.5 days out of 30) vs. 12% in Indiana and 7% nationally.



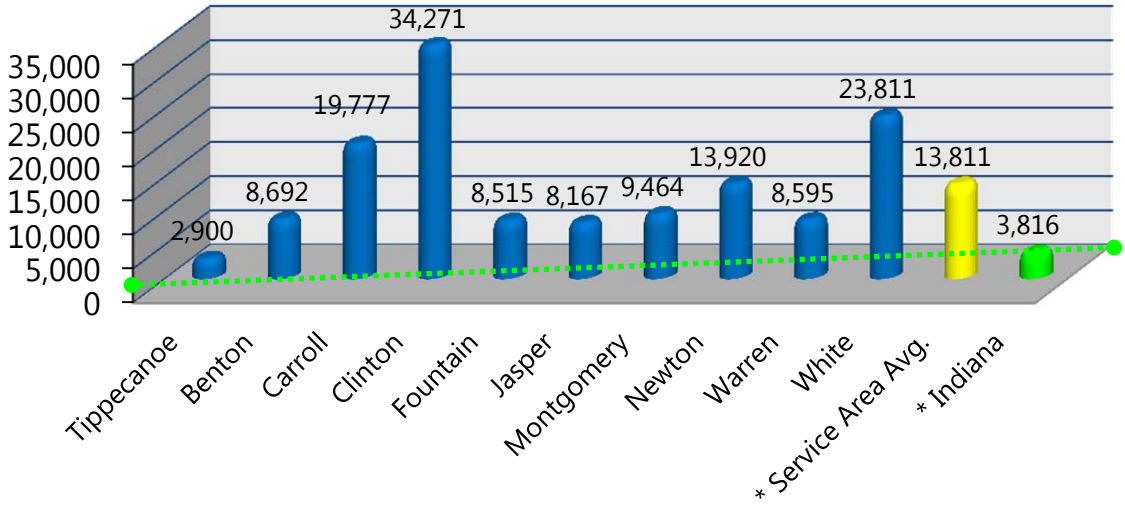
HEALTH BEHAVIORS (COUNTY HEALTH RANKING 2012 DATA)

Illustrated below is the county ranking for the 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 measuring factors on health behaviors, clinical care, social and economic factors, and physical factors. Examined is data on tobacco use, sexual activity, diet and exercise, alcohol use, quality of care and access to care. Overall, the 10-county area has 3 counties ranked in the top 10 counties while the other 7 counties rank from 39 to 68.

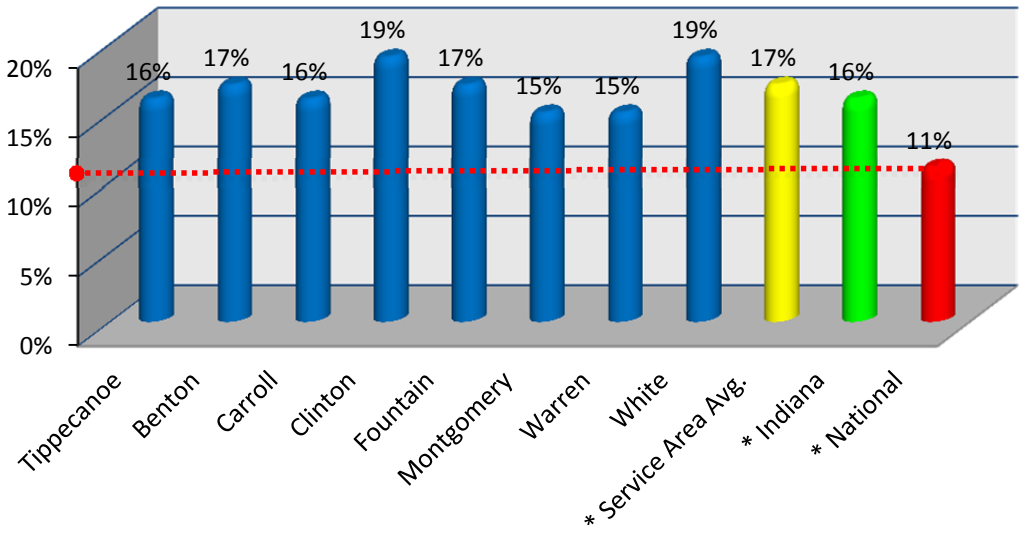


MENTAL HEALTH PROVIDER (COUNTY HEALTH RANKING 2012 DATA)

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 approximately 13,811 people per mental health provider.

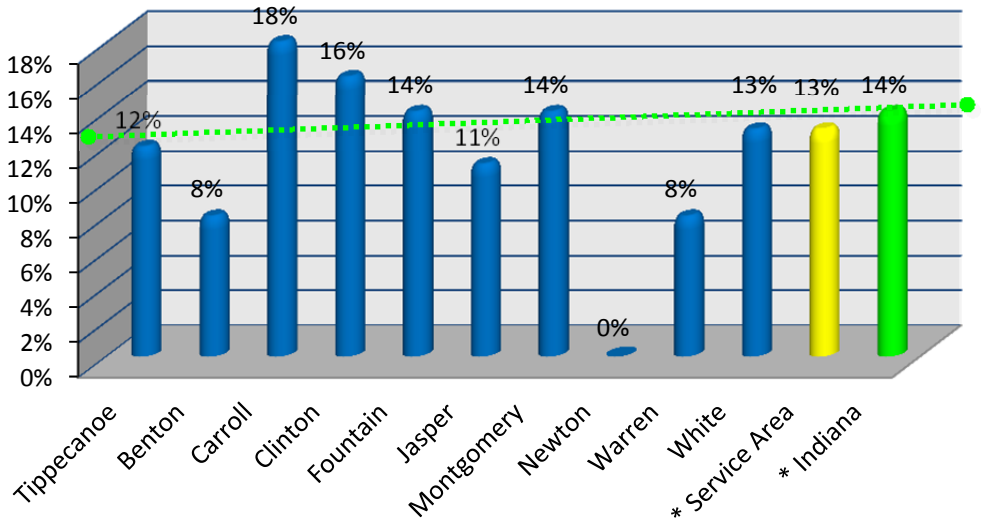


Illustrated below is the percentage of adults under age 65 without health insurance coverage. Approximately, 17% of the 10-county area is uninsured.



COULD NOT SEE DOCTOR DUE TO COST (COUNTY HEALTH RANKING 2012 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 a need to see a doctor but could not due to cost. Approximately 13% of the 10-county area could not see a doctor due to the cost.



Conclusion

COMMUNITY RESOURCES IDENTIFIED

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

The assessment also identified a community clinic, an adequate supply of 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 board of directors and documented in the implementation strategy report.

Overall priorities determined to be significant:

- Increasing educational awareness programs,
- Expansion/Increase in inpatient mental health and substance abuse beds,
- Increasing the number of mental health care providers and professionals,
- Substance abuse prevention,
- Access to mental health care for uninsured and under-insured,
- Increase/Expand collaboration,
- Expanding transportation to/from treatment services, and
- Expanding Hispanic services.

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.

Implementation Strategy

After careful and thoughtful review, analysis and discussion about the River Bend CHNA Report and the information and findings it contains, the Board of Directors of North Central Health Systems believes the following Implementation Strategy is the optimum action step to take at this time. This Implementation Strategy considers the financial constraints and limitations posed by reimbursement sources for mental health services, including Indiana Medicaid; the changing healthcare operating environment; Healthcare Reform and its many changes and challenges; River Bend Hospital's mission; and the goal of continued operation of the North Central Health System and River Bend Hospital in a way that is prudent and therefore sustainable.

ACTION ITEM

Organize a meeting of local mental health and service organizations, healthcare leaders and professionals, providers, public health experts, government officials, and community leaders targeted for the 2nd quarter of 2013 for purposes of promoting education, awareness and collaboration within the mental health community regarding important topics, issues and opportunities in mental health.

ACTION ITEM OBJECTIVES

1. Increase awareness and understanding of important mental health and related community issues and opportunities.
2. Heighten the understanding, appreciation and working relationship among mental health providers, organizations and local community leadership.
3. Enhance the continuity of patient care by streamlining proper patient referral where appropriate.
4. Strengthen working relationships and identify opportunities for collaboration around the provision of mental health education and service delivery.
5. Discuss strategies for mental health promotion and wellness.

Attachments

EXPLANATIONS & DEFINITIONS FOR SELECTED CHARTS/GRAPHS THAT FOLLOW

TITLE OF CHART/GRAPH	PAGE #	EXPLANATIONS & DEFINITIONS
Health Outcomes	41	Healthy Outcomes ranking is based upon mortality & morbidity rates.
Mortality	42	Years of potential life lost before age 75 per 100,000 population (age adjusted)
Morbidity	43	Indicates poor health and the prevalence of disease in 4 separate categories.
Poor or Fair Health	44	Percent of adults reporting fair or poor health (age adjusted) by county.
Poor Physical Health Days	45	Average number of physically unhealthy days reported in past 30 days (age adjusted).
Poor Mental Health Days	46	Average number of mentally unhealthy days reported in past 30 days (age adjusted).
Low Birthweight	47	Percent of live births with low birthweights (<2,500 grams).
Health Behaviors	49	An aggregate of a number of variables that include healthy behaviors, clinical care, socio-economic factors, and physical environment factors.
Adult Smoking	50	Percent of adults who report smoking >= 100 cigarettes and are currently smoking.
Adult Obesity	51	Percent of adults who report a Body Mass Index (BMI) >= 30.
Physical Inactivity	52	Percent of adults 20 years or older reporting no leisure time physical activity.
Excessive Drinking	53	Includes both binge and heavy drinking.
Sexually Transmitted Infections	54	Clamydia rate per 100,000 population.
Teen Birth Rate	55	Teen birth rate per 1,000 female populations, ages 15 to 19.
Clinical Care	56	Aggregate of several variables including percentage of uninsured; primary care physicians-to-population; preventable hospital days; diabetic screening; and mammography screening.

TITLE OF CHART/GRAPH	PAGE #	EXPLANATIONS & DEFINITIONS
Uninsured Adults	57	Percent of the population under age 65 without health insurance.
Population per Primary Care Physician	58	Ratio of population to Primary Care Physicians
Preventable Hospital Stays	59	Hospital rate for ambulatory-sensitive conditions per 1,000 Medicare enrollees.
Diabetic Screening	60	Percent of diabetic Medicare enrollees that receive HbA1c screening.
Mammography Screening	61	Percent of female Medicare enrollees that receive mammography screening.
Socioeconomic Factors	62	Aggregate of factors including education level; unemployment rate; children in poverty; inadequate social support; children in single parent households; and violent crime rate.
High School Graduation	63	Percent of ninth grade cohort that graduates in 4 years.
Some College	64	Percent of adults age 25 to 44 years with some post-secondary education.
Unemployment	65	Percent of population 16+ unemployed but seeking work.
Children in Poverty	66	Percent of children under 18 in poverty.
Inadequate Social Support	67	Percent of adults without emotional/ social support.
Children in Single-Parent Household	68	Percent of children that live in a household headed by a single parent.

Source: www.countyhealthrankings.org

SERVICE AREA ANALYSIS

	Tippecanoe	Benton	Carroll	Clinton	Fountain	Jasper	Montgomery	Newton	Warren	White	Total Service Area	State of Indiana
Population 2010	172,780	8,854	20,155	33,866	17,954	33,416	38,124	14,161	8,508	24,643	372,461	6,483,802
0 to 4 years	6.4%	7.0%	6.1%	7.5%	5.9%	6.5%	6.5%	5.7%	5.8%	6.0%	6.6%	6.7%
5 to 17 years	14.3%	18.8%	18.5%	19.1%	18.3%	19.2%	17.5%	17.3%	17.7%	18.2%	17.8%	18.1%
18 to 24 years	24.6%	7.1%	7.3%	8.3%	7.2%	9.2%	9.7%	7.3%	7.2%	7.0%	10.0%	10.0%
25 to 44 years	25.1%	23.7%	23.2%	24.4%	23.0%	24.0%	23.6%	23.0%	23.0%	22.6%	26.3%	25.7%
45 to 64 years	20.1%	27.6%	29.1%	26.2%	27.9%	27.1%	27.2%	30.1%	29.8%	29.1%	23.1%	26.5%
65 years and more	9.5%	15.7%	15.8%	14.4%	17.7%	14.0%	15.5%	16.6%	16.6%	17.2%	12.5%	13.0%
Median Age	**27.7**	**40.1**	**40.9**	**37.5**	**41.6**	**38.0**	**39.4**	**42.4**	**42.4**	**41.9**	**39.2**	**37.0**
Female persons	48.7%	50.4%	49.9%	50.6%	50.5%	50.2%	49.6%	50.2%	49.8%	50.8%	51.0%	50.8%
Non-white population	16.0%	4.1%	3.2%	9.0%	3.7%	4.2%	4.8%	3.8%	2.2%	6.1%	6.6%	15.7%
Educational Attainment												
No high school diploma	12.2%	10.2%	11.4%	18.6%	16.8%	12.4%	13.1%	14.3%	16.8%	13.3%	13.9%	13.8%
High school graduate or equivalent	30.5%	50.3%	48.4%	43.6%	45.6%	45.2%	44.8%	46.8%	44.1%	44.0%	44.3%	36.2%
Some college, no degree	18.7%	19.5%	19.7%	18.2%	17.8%	20.7%	19.1%	21.2%	18.6%	19.8%	19.3%	20.3%
Associate degree	5.4%	6.2%	5.6%	6.6%	9.0%	7.5%	5.5%	8.3%	7.5%	8.4%	7.0%	7.3%
Bachelor's degree	18.1%	8.7%	11.3%	8.7%	6.4%	10.1%	11.2%	6.7%	8.9%	9.2%	9.9%	14.3%
Master's degree or higher	15.1%	5.1%	3.6%	4.3%	4.4%	4.1%	6.3%	2.7%	4.1%	5.3%	5.5%	8.1%
Socioeconomic												
Median household income	$42,632	$42,994	$48,055	$47,229	$43,947	$55,267	$47,694	$50,712	$50,841	$45,891	$47,526	$47,697
Homeownership rate	55.8%	78.7%	79.6%	73.4%	79.2%	78.8%	73.6%	81.9%	77.7%	77.6%	75.6%	71.5%
Median value of owner-occupied housing	$128,900	$85,200	$107,400	$98,700	$87,600	$142,200	$107,100	$109,600	$102,600	$111,000	$108,030	$123,000
Persons below poverty level	20.0%	10.0%	9.4%	11.7%	13.2%	9.5%	12.2%	11.1%	8.8%	9.5%	11.5%	13.5%
Civilian labor force	82,345	4,206	9,674	16,437	8,338	15,256	18,763	6,621	4,568	12,205	178,413	3,142,265
Unemployment rate (2010)	9.1%	10.3%	9.5%	10.3%	11.8%	10.3%	10.0%	11.0%	9.4%	10.7%	10.2%	10.2%
Unemployment rate (February 2012)	7.3%	9.0%	7.8%	8.8%	9.0%	9.5%	8.5%	10.4%	6.5%	9.1%	8.6%	8.8%
Persons per square mile	336	21.8	54.1	82.0	43.6	59.8	75.6	35.2	23.1	48.9	78.0	180.8
Land Area (square miles)	500.0	406.4	372.2	405.1	395.7	559.9	504.5	401.8	364.9	505.2	4,415.7	35,826.1

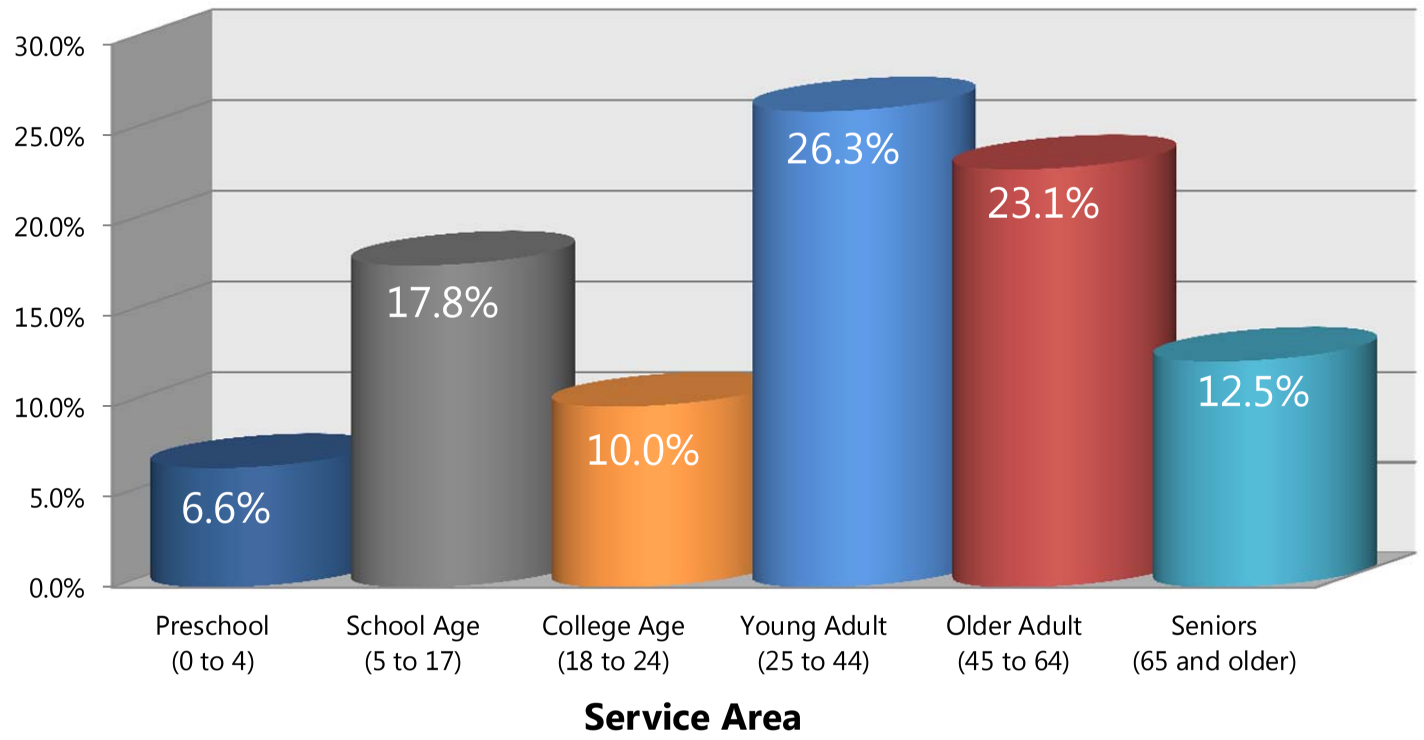
This chart displays demographic data and other related characteristics of the population in each county of the Hospital's service area, as compared to the total service area and state of Indiana. See pages 38 – 40 for graphical depictions and additional explanation of select charted data above. (Source: http://quickfacts.census.gov)

SERVICE AREA ANALYSIS (CONTINUED)

	Tippecanoe	Benton	Carroll	Clinton	Fountain	Jasper	Montgomery	Newton	Warren	White	Service Area (Avg.)	State of Indiana	National Benchmark
Health Outcomes (State Rank)	20	29	40	44	49	41	52	60	16	37	39	-	-
Mortality	15	36	47	42	53	60	55	66	25	50	45	-	-
Morbidity	27	28	32	51	41	12	48	44	6	22	31	-	-
Poor or fair health	15%	17%	19%	16%	17%	13%	16%	-	-	17%	16%	16%	10%
Poor physical health days	3.3	5.6	3.4	4.2	4.6	3.3	3.8	2.9	3.8	4.2	3.9	3.6	2.6
Poor mental health days	3.7	3.3	3.6	3.5	3.2	4.2	3.7	4.0	3.4	2.8	3.5	3.6	2.3
Low birthweight	7.0%	5.4%	6.7%	7.7%	7.1%	6.3%	7.7%	7.9%	5.3%	6.6%	6.8%	8.1%	6.0%
HealthFactors (State Rank)	10.0	35.0	23.0	32.0	66.0	41.0	37.0	64.0	15.0	45.0	36.8	-	-
Health Behaviors	**5.0**	**60.0**	**47.0**	**9.0**	**61.0**	**39.0**	**68.0**	**53.0**	**6.0**	**41.0**	**38.9**	-	-
Adult smoking	20%	-	28%	21%	29%	-	27%	-	20%	21%	24%	24%	14%
Adult obesity	28%	33%	32%	29%	29%	32%	31%	31%	30%	34%	31%	31%	25%
Physical inactivity	24%	34%	27%	27%	30%	30%	31%	30%	31%	29%	29%	27%	21%
Excessive drinking	18%	11%	10%	10%	15%	12%	13%	16%	6%	11%	12%	16%	8%
Sexually transmitted infections	343	114	131	191	188	123	214	93	0	126	152.3	341	84
Teen birth rate	26	41	31	58	47	36	55	34	30	46	40.4	44	22
Clinical Care (State Rank)	17	70	24	48	82	29	25	88	52	72	50.7	-	-
Uninsured adults	16%	17%	16%	19%	17%	15%	15%	18%	15%	19%	17%	16%	11%
Primary care physicians	944.1	4,346:1	1,236:1	1,318:1	3,406:1	1,054:1	1,183:1	6,960:1	2,149:1	1,323:1	944.1	889.1	631.1
Preventable hospital stays	67	64	61	75	96	89	75	107	92	93	81.9	78	49
Diabetic screening	84%	83%	82%	87%	84%	86%	82%	82%	83%	84%	84%	82%	89%
Mammography screeening	67%	52%	65%	64%	54%	64%	64%	56%	64%	63%	61%	64%	74%
Socioeconomic Factors (State Rank)	23	16	17	56	57	58	39	52	18	44	38.0	-	-
High school graduation	83%	90%	89%	85%	88%	87%	94%	76%	96%	83%	87%	84%	-
Some college	69%	50%	51%	43%	52%	54%	48%	50%	43%	51%	51%	58%	68%
Unemployment	9.1%	10.3%	9.5%	10.3%	11.8%	10.3%	10.0%	11.0%	9.4%	10.7%	10.2%	10.2%	5.4%
Children in poverty	20%	18%	16%	22%	20%	14%	23%	17%	16%	18%	18%	22%	13%
Inadequate social support	15%	10%	23%	16%	16%	20%	20%	-	-	20%	17.5%	20%	14%
Children in single-parent households	30%	22%	15%	31%	30%	30%	26%	22%	29.0%	28.0%	26.3%	32.0%	20.0%
Physical Environment (State Rank)	27	81	50	69	47	46	25	14	13	31	40.3	-	-
Air pollution-particulate matter days	0	1	2.0	2.0	1.0	1.0	1.0	1.0	1.0	2.0	1.2	2.0	0.0
Air pollution-ozone days	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	3.0	-
Limited access to healthy foods	10%	15%	14%	0%	3%	17%	1%	17%	1%	1%	7.9%	7%	0%
Access to recreational facilities	8	0	15	0	0	12	5	22	0	4	6.6	10	16

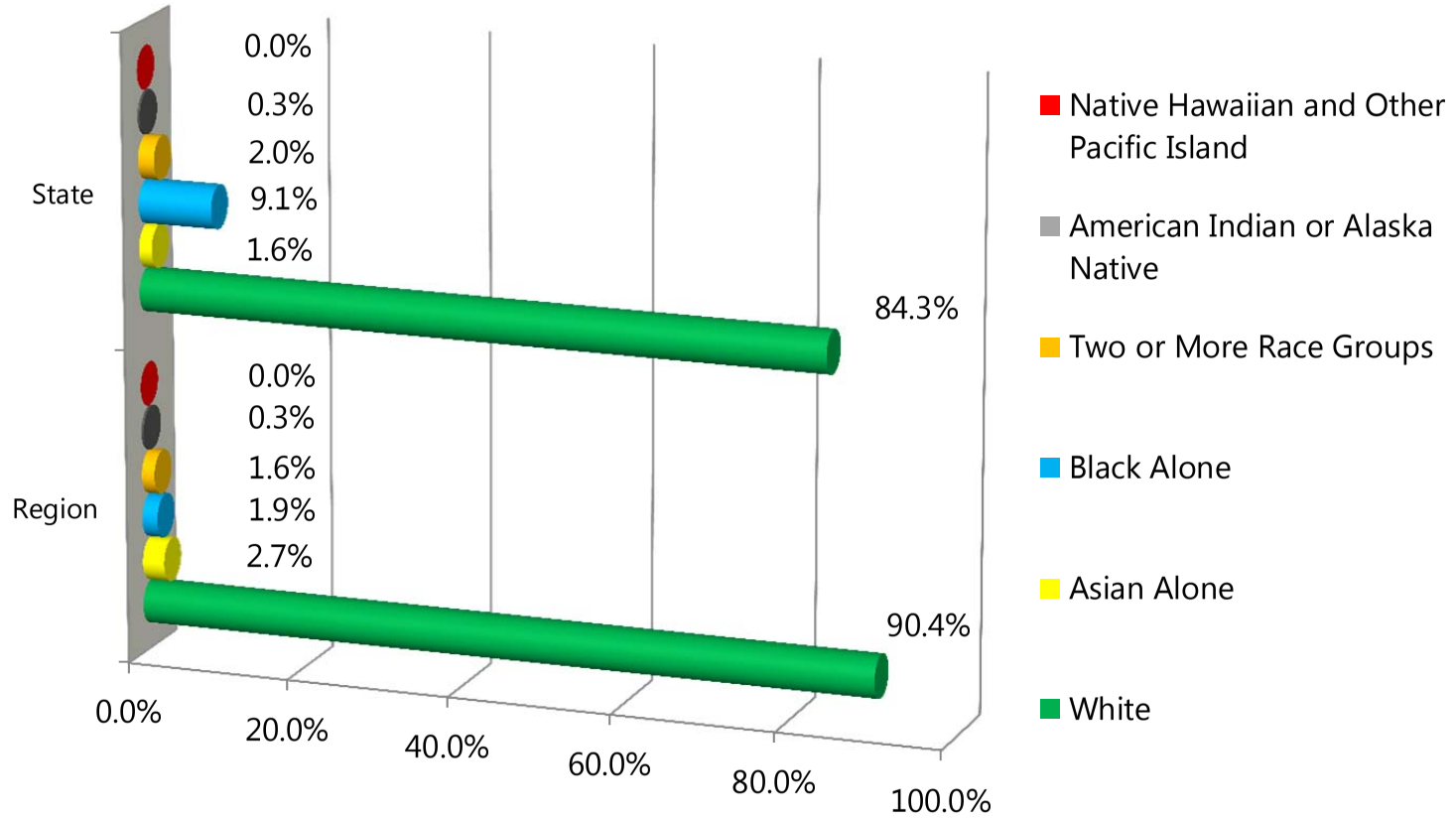
This chart displays data relating to the general healthcare status of the population and several factors impacting it by county as compared to the Hospital's total service area and the state of Indiana. See pages 41 – 68 for graphical depictions and additional explanation of select charted data above. (Source: http://quickfacts.census.gov)

2012 POPULATION DISTRIBUTION BY AGE



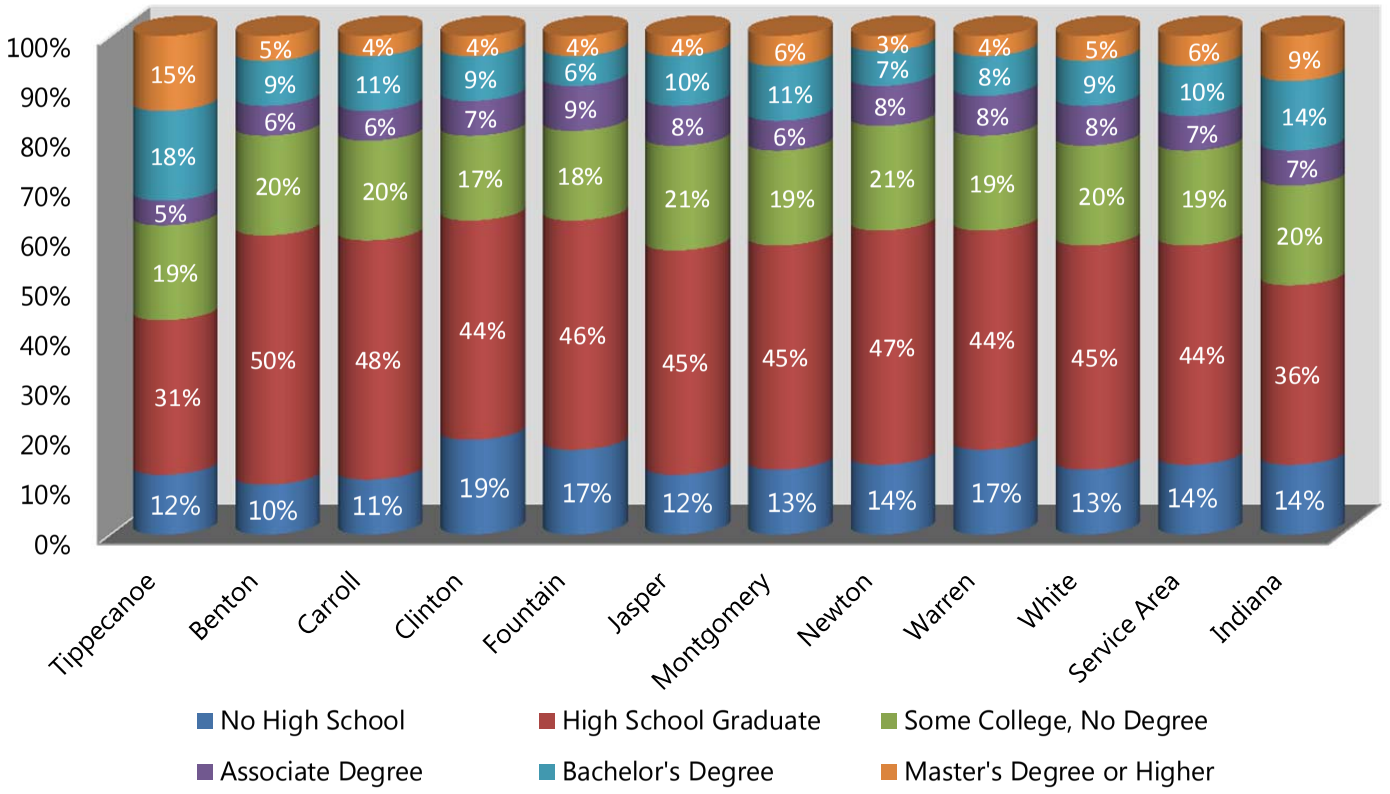
This graph displays the total population of the Hospital's service area by age cohort. (Source: http://quickfacts.census.gov)

2012 POPULATION ESTIMATES BY RACE



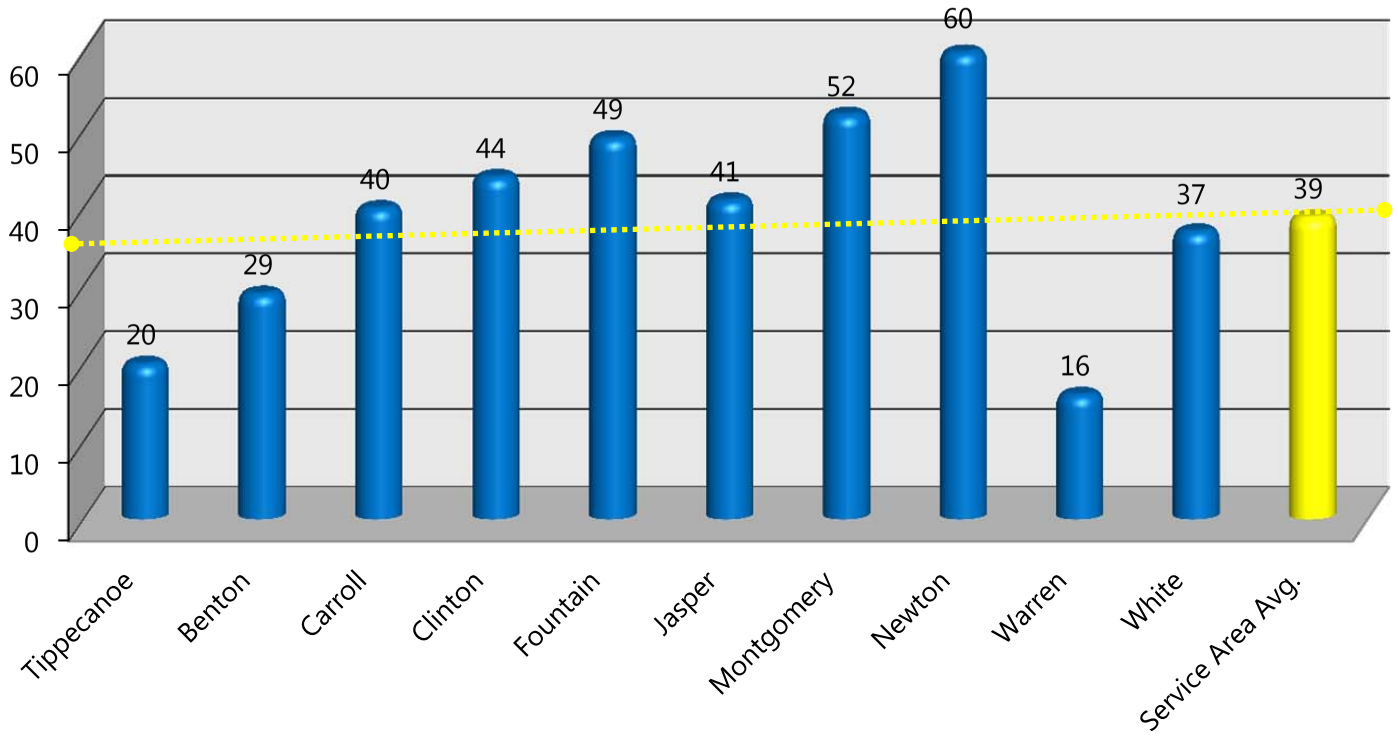
This graph displays the total population of the Hospital's service area by race. (Source: http://quickfacts.census.gov)

2012 EDUCATIONAL ATTAINMENT



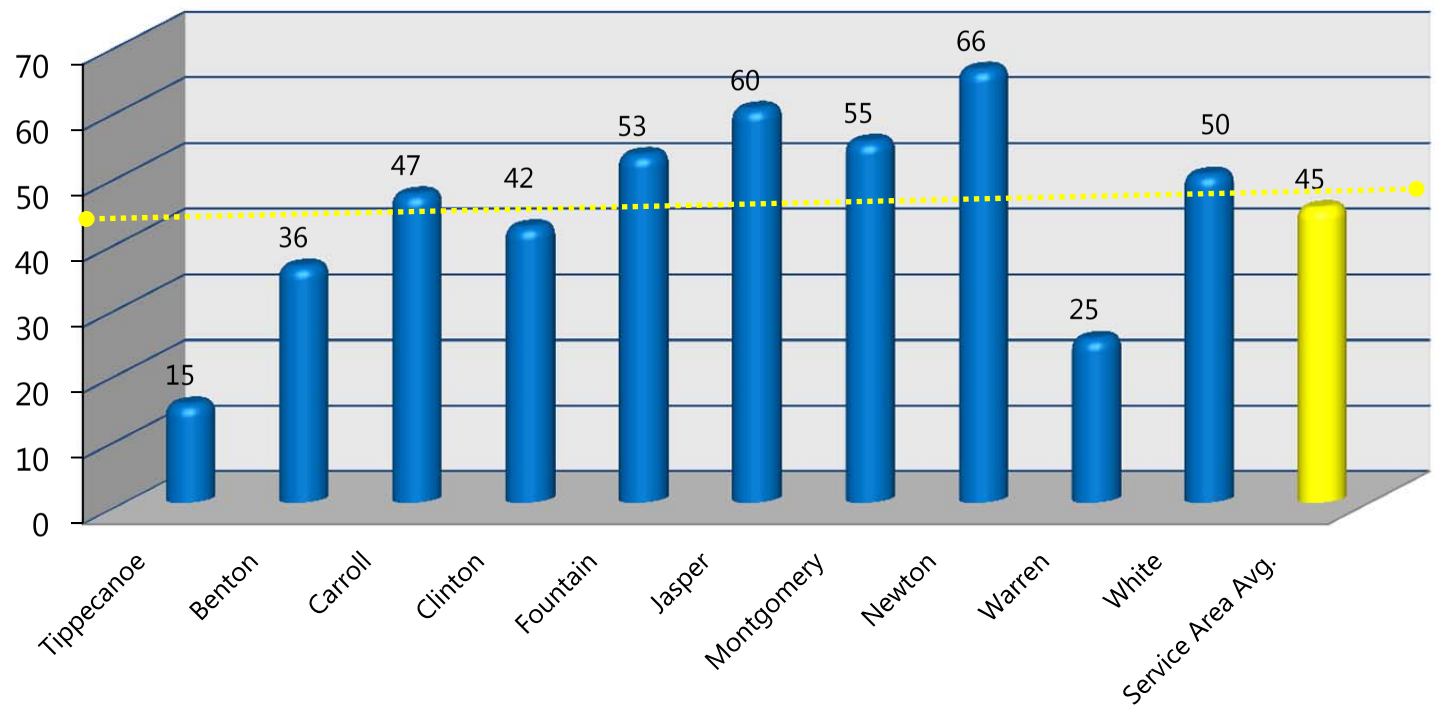
This graph displays the highest level of educational attainment of the population in each county in the Hospital's service area as compared to the total service area and state of Indiana. (Source: http://quickfacts.census.gov)

2012 HEALTH OUTCOMES



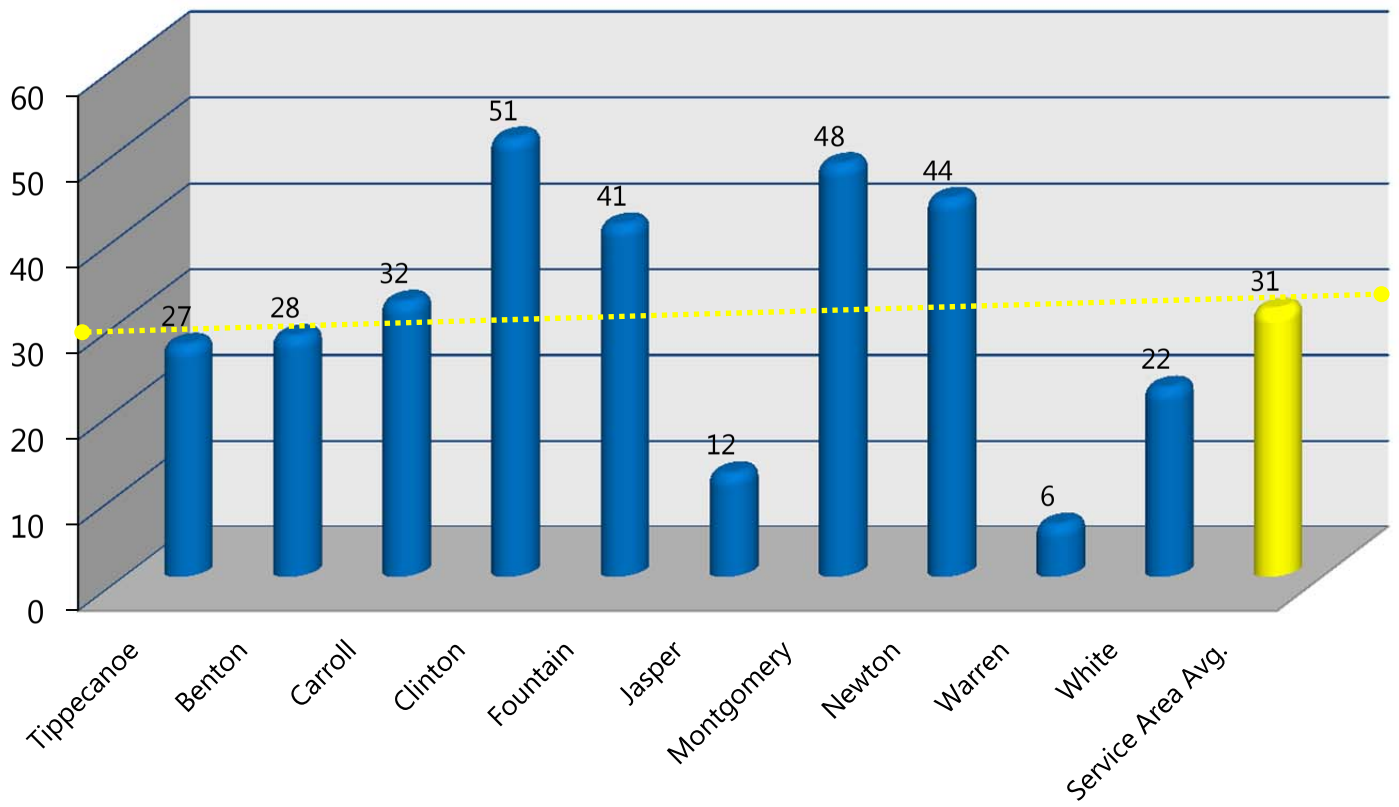
Health Outcomes is a *County Health Ranking* representing how long people live and how healthy people feel while alive. The health outcomes represent the health of the county by measuring the mortality and morbidity within each county. 92 counties in Indiana have been ranked from 1 to 92, with 1 representing the best and 92 representing the least healthy county. Refer to page 28 for additional health status synopsis for the service area. (Source: www.countyhealthrankings.org)

2012 MORTALITY



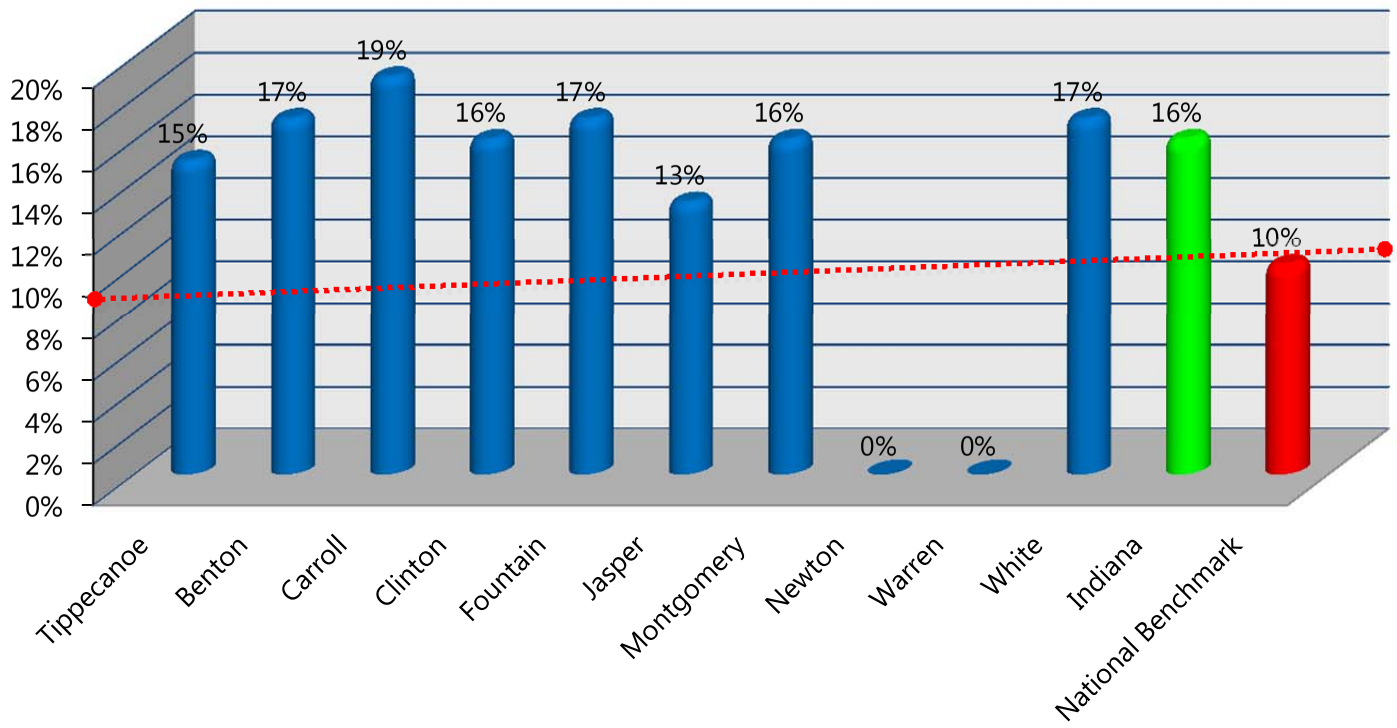
The mortality ranking measurers what is known about deaths before age 75 (premature deaths) to determine how long people are living. The 92 counties in Indiana have been ranked from 1 to 92, with 1 representing the least amount of premature deaths and 92 representing the county with the most number of premature deaths. (Source: www.countyhealthrankings.org)

2012 MORBIDITY



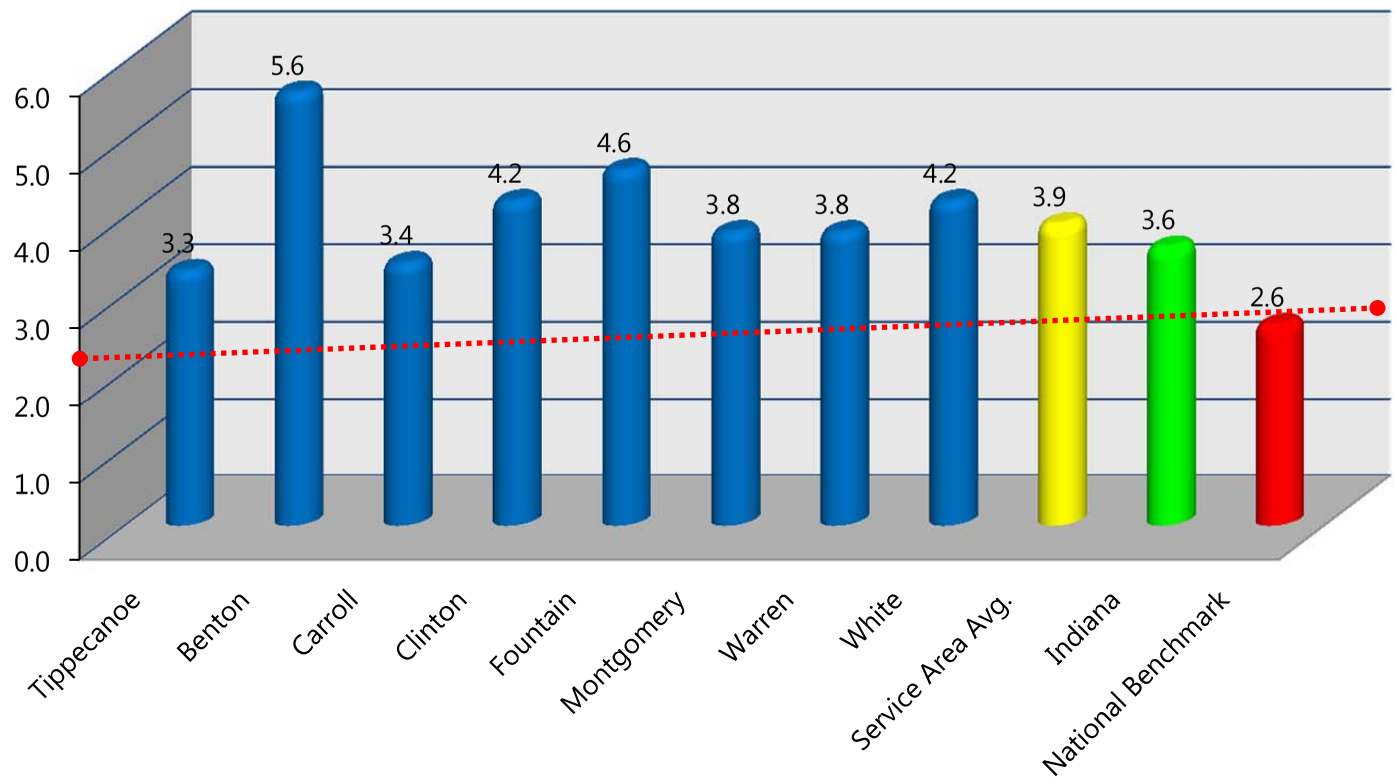
The morbidity ranking reports a combined measure of individuals' self-reported overall health, physical health days, mental health days, and low birth weight (LBW) to provide a rank for quality of life. The 92 counties in Indiana have been ranked from 1 to 92, with 1 representing the best ranked quality of life and 92 representing the county with least ranked quality of life. See pages 44 – 47 for explanation of morbidity factors. (Source: www.countyhealthrankings.org)

2012 POOR OR FAIR HEALTH



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 of adult respondents who rate their health "fair" or "poor". Poor or fair health is one of four factors with a weight of 10% in calculating a county's overall morbidity ranking. (Source: www.countyhealthrankings.org)

2012 POOR PHYSICAL HEALTH DAYS



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 that their physical health was not good. Poor physical health days is the second of four factors with a weight of 10% in calculating a county's overall morbidity ranking. (Source: www.countyhealthrankings.org)

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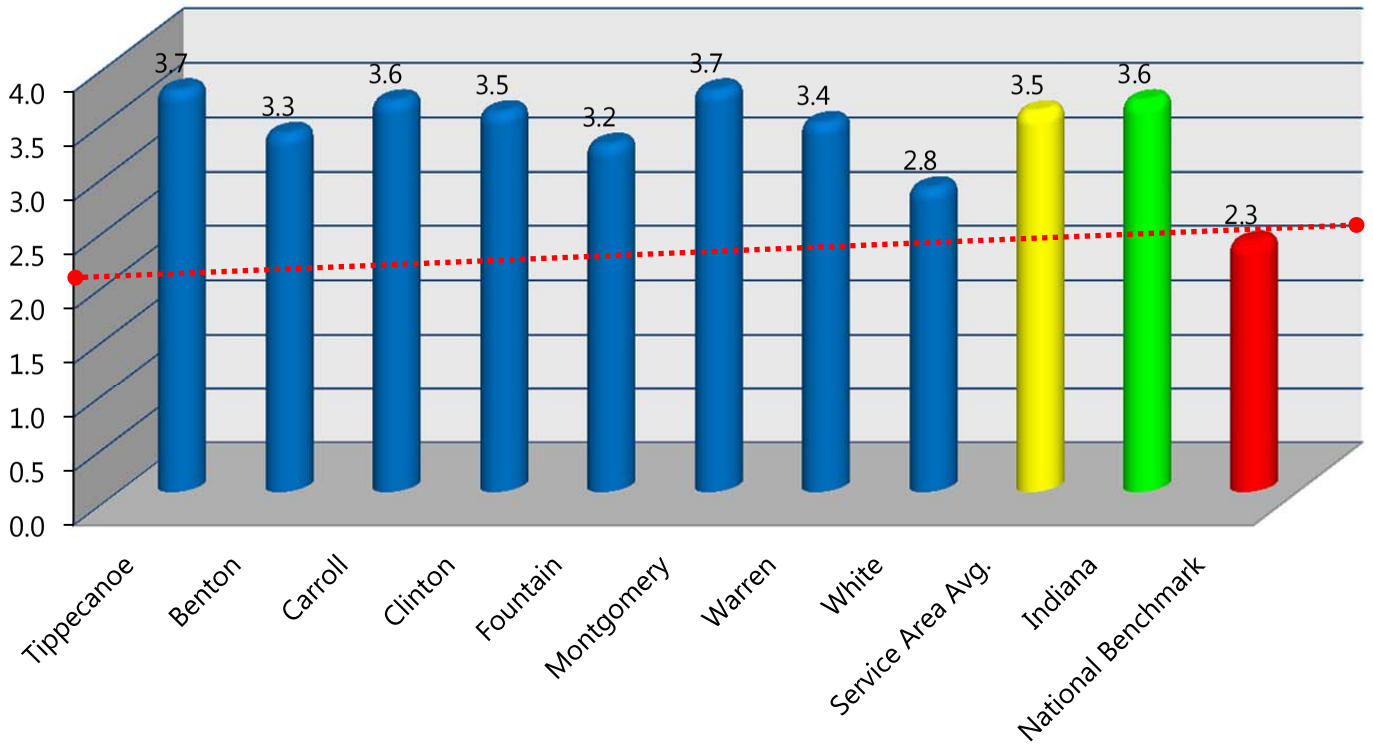
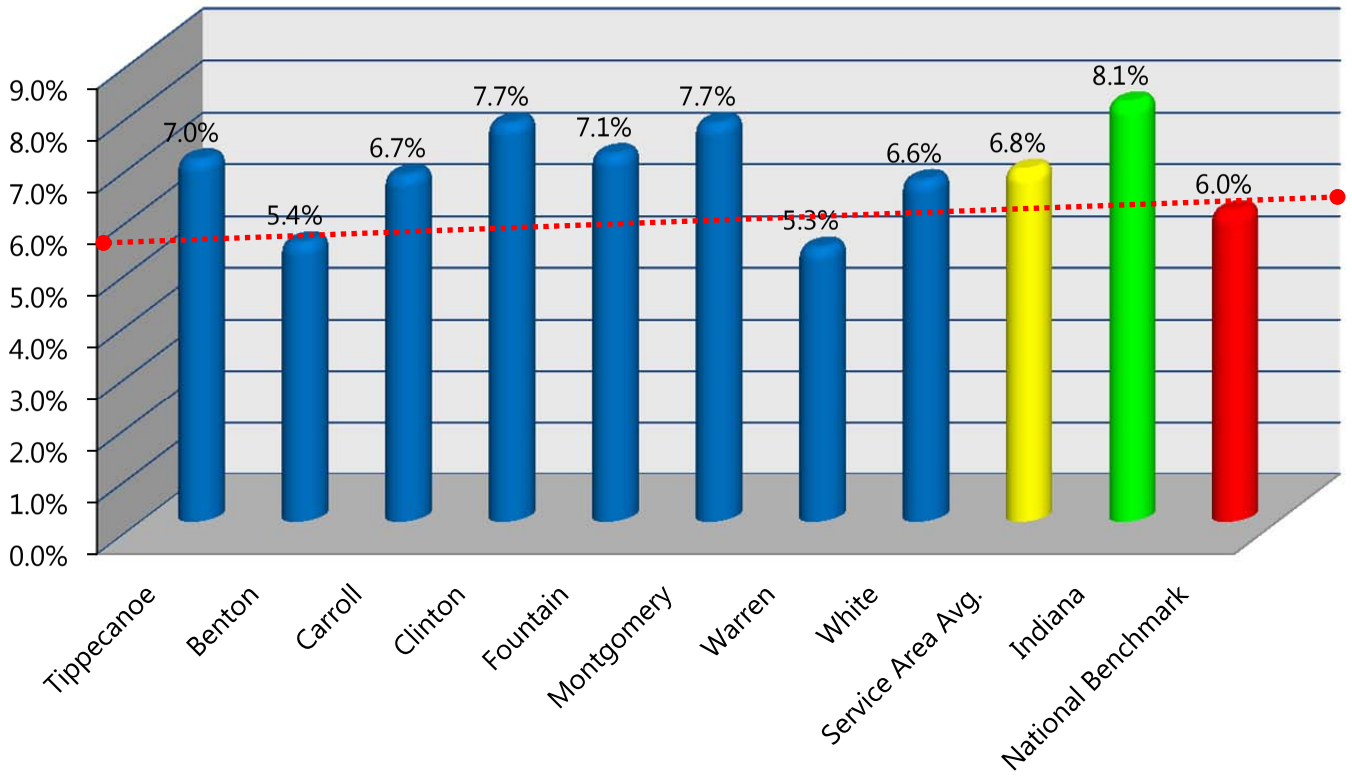
2012 POOR MENTAL HEALTH DAYS



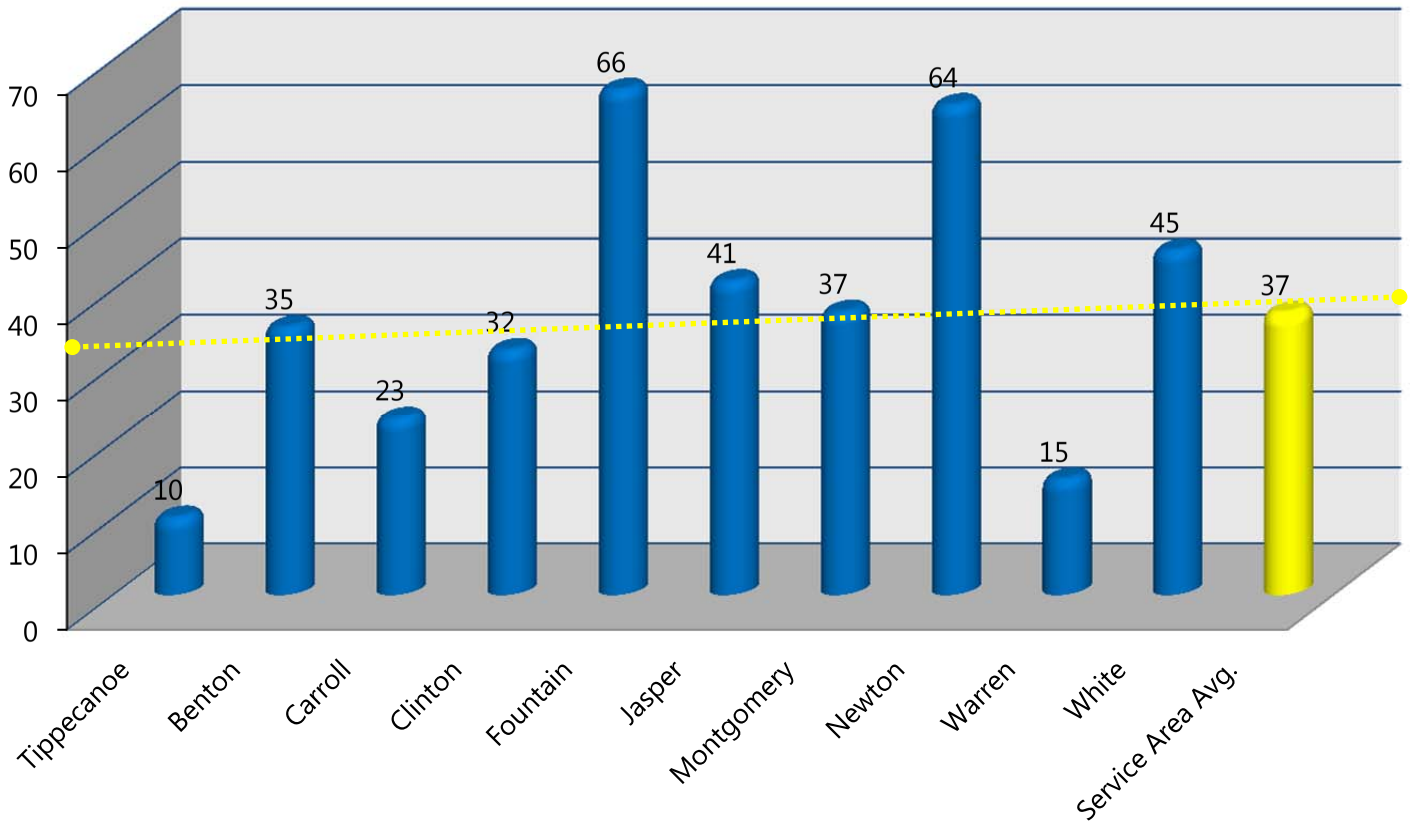
Poor mental health days represents self-reported health status based on survey responses to the question, "Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" The value reported for each county is the average number of days adult respondents report that their mental health was not good. Poor mental health days is the third of four factors with a weight of 10% in calculating a county's overall morbidity ranking. (Source: www.countyhealthrankings.org)

2012 LOW BIRTHWEIGHT



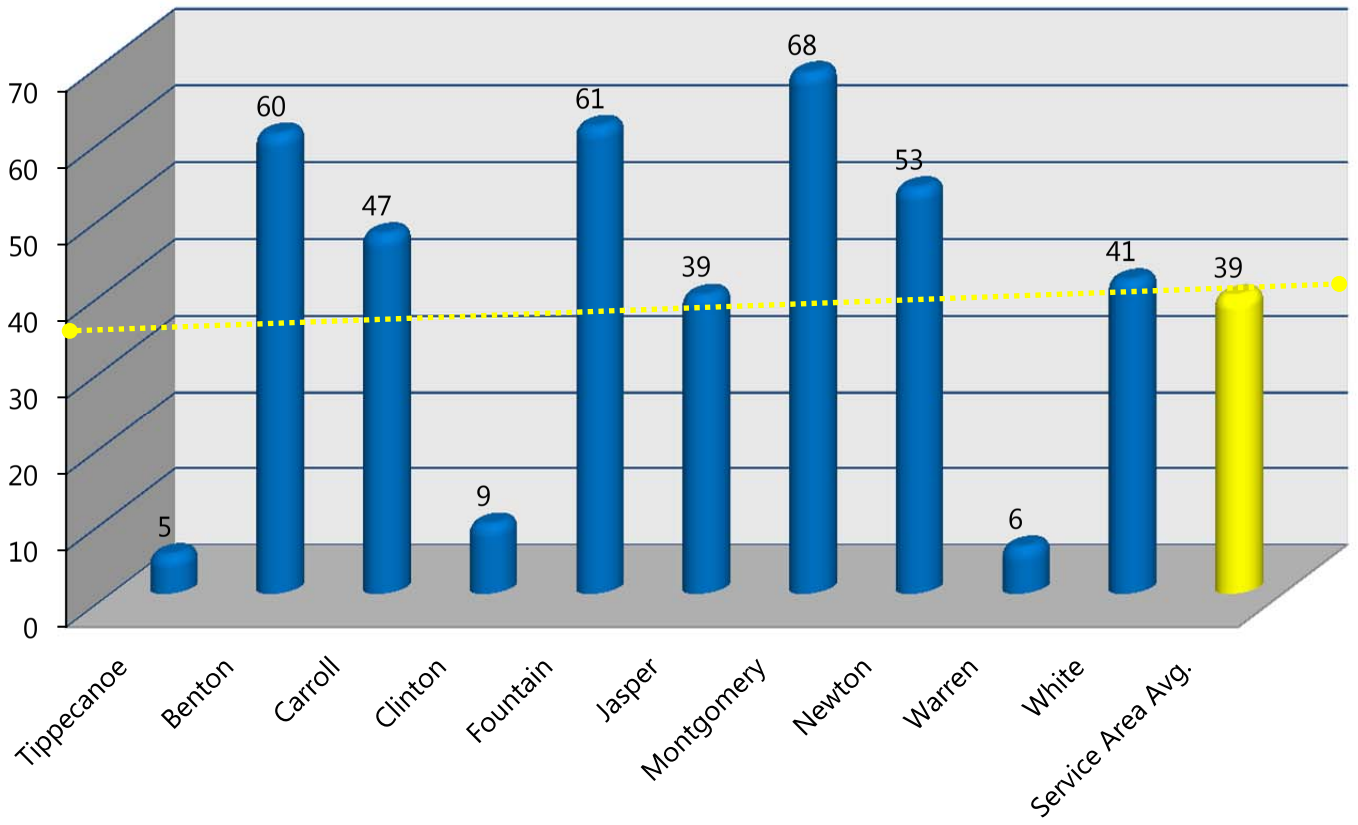
Low birthweight (LBW) represents maternal exposure to health risks and an infant's current and future morbidity which is an indicator for premature mortality and/or morbidity. The value reported for each county is the percent of live births with LBW (<2500 grams). LBW is the last of four factors with a weight of 20% in calculating a county's overall morbidity ranking.
(Source: www.countyhealthrankings.org)

2012 HEALTH FACTORS



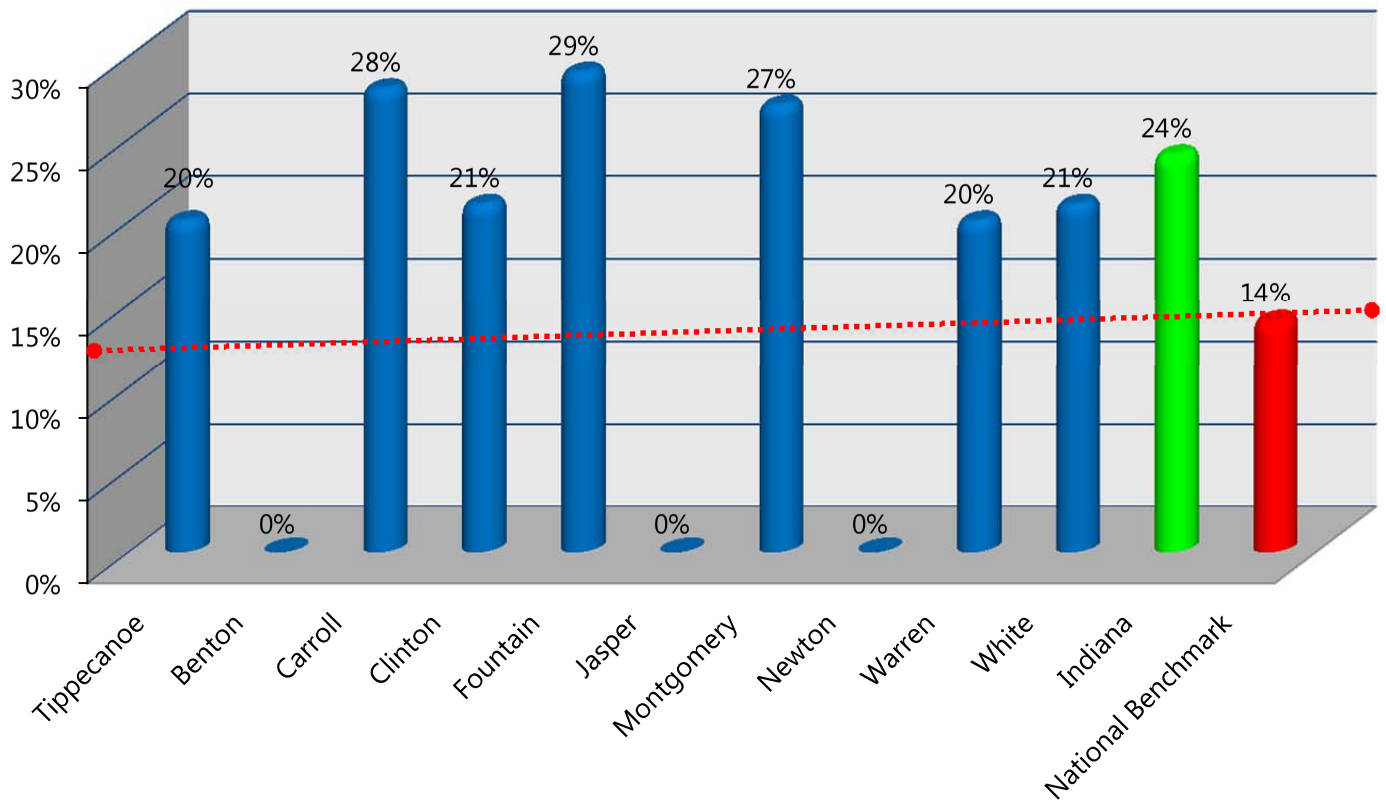
Health Factors is a *County Health Ranking* representing what influences the health of a county. The health factors are weighted measures of health behaviors, clinical care, social and economic, and physical environment factors within each county. 92 counties in Indiana have been ranked from 1 to 92, with 1 representing the highest and 92 representing the lowest composite score. Refer to page 28 for additional health status synopsis for the service area. (Source: www.countyhealthrankings.org)

2012 HEALTH BEHAVIORS



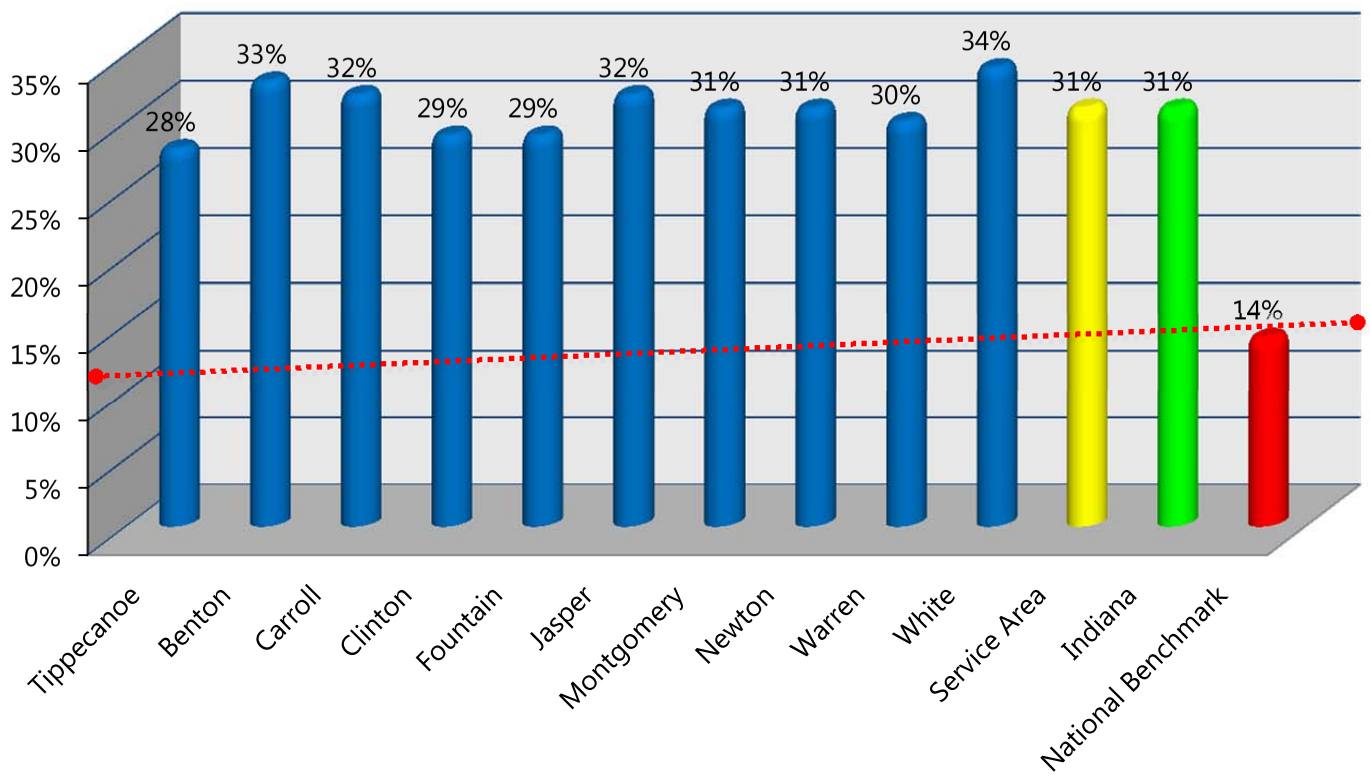
Health behavior consists of the following weighted factors for each county: smoking (10%), diet and exercise (10% - made up of adult obesity at 7.5% and physical inactivity at 2.5%), alcohol use (5% - excessive drinking 2.5%; motor vehicle crash death rate 2.5%), and sexual activity (5% - sexually transmitted 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. The health behavior score is one of four factors with a weight of 30% in calculating a county's overall health factor ranking. See pages 50 – 55 for explanation of health behavior factors. (Source: www.countyhealthrankings.org)

2012 ADULT SMOKING



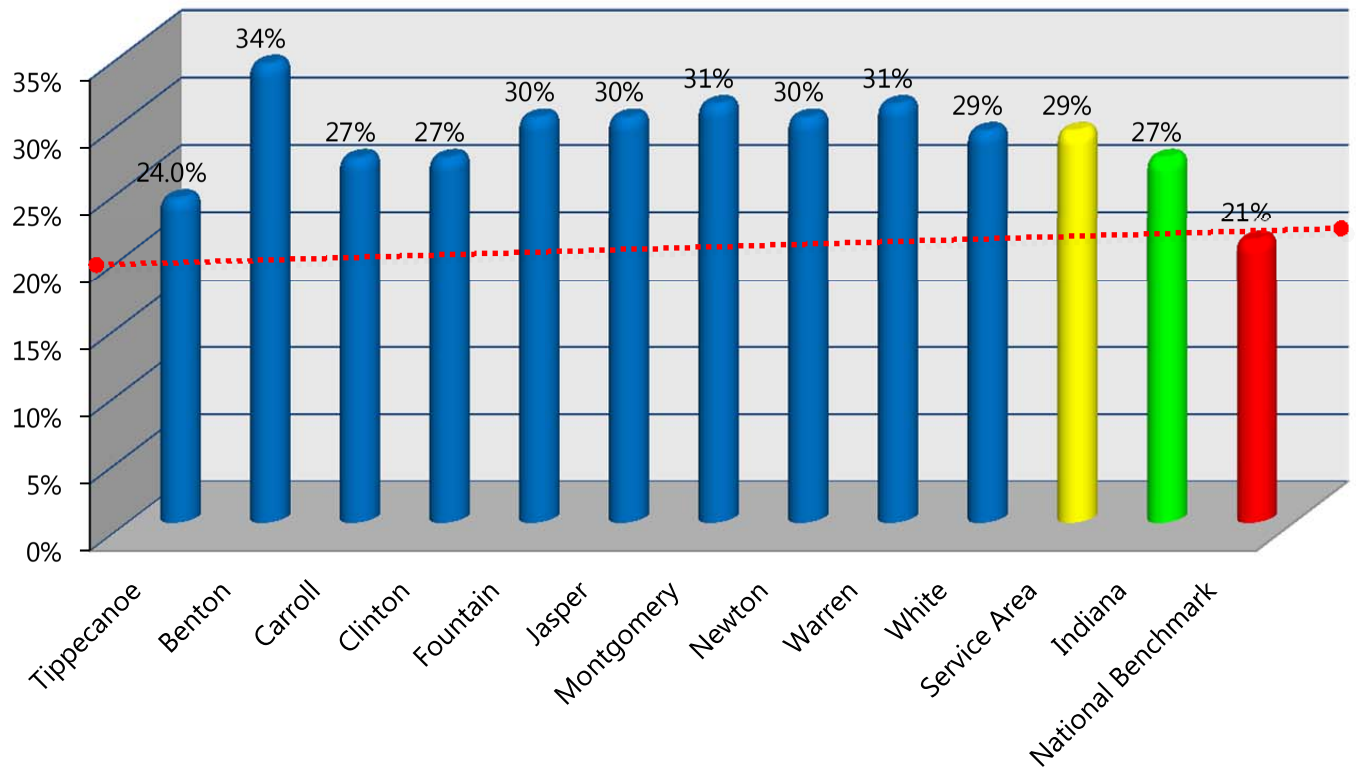
Adult smoking represents the extent of health risk in each county related to tobacco use and is an indicator of adverse health outcomes. The value reported for each county is the estimated percent based on the adult population that currently smokes every day or "most days" and has smoked at least 100 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)

2012 ADULT OBESITY



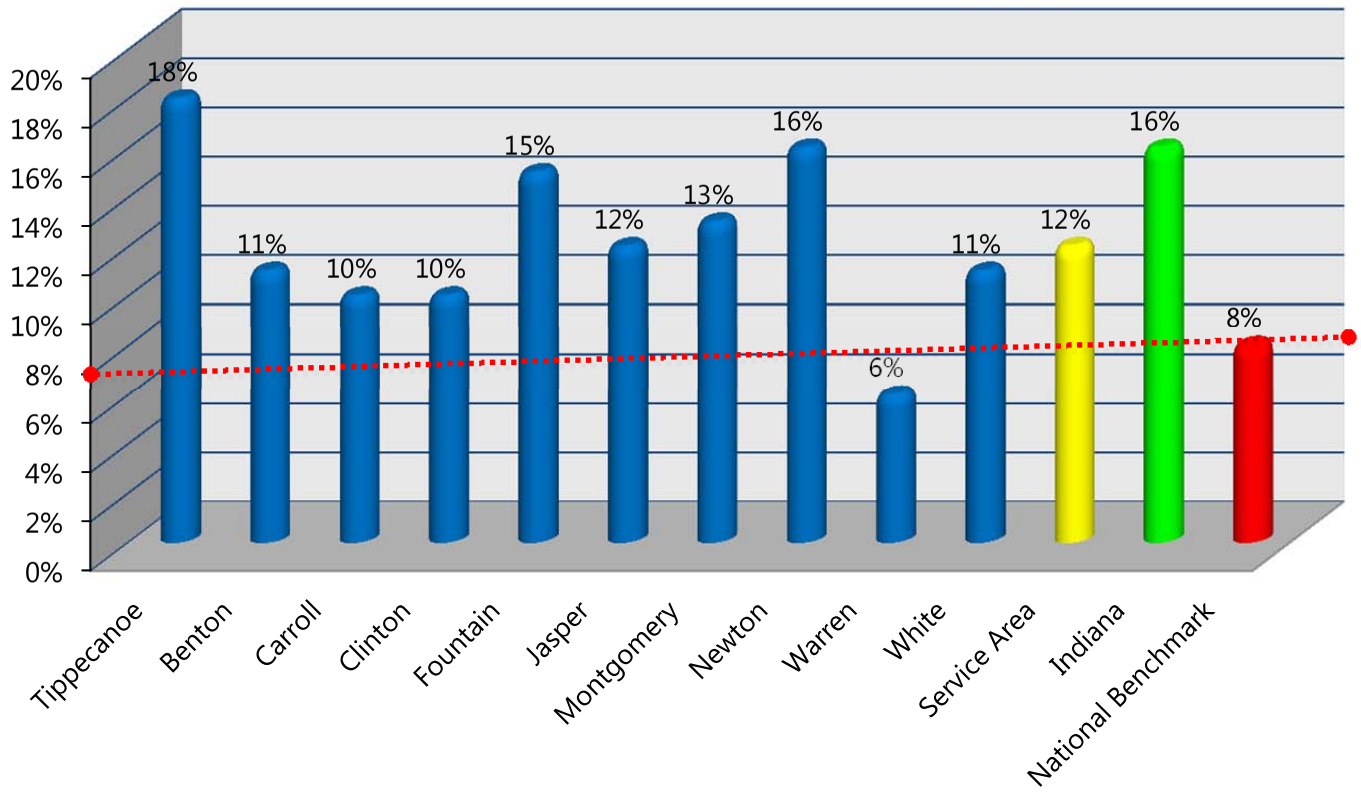
Adult obesity represents the increased risk in each county for health conditions linked to being overweight or obese such as coronary heart disease, type 2 diabetes, cancer, hypertension, dyslipidemia, stroke, liver and gallbladder disease, sleep apnea and respiratory problems, and osteoarthritis. The 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 portion of the diet and exercise factor with a weight of 7.5% in calculating a county's overall health behavior ranking. (Source: www.countyhealthrankings.org)

2012 PHYSICAL INACTIVITY



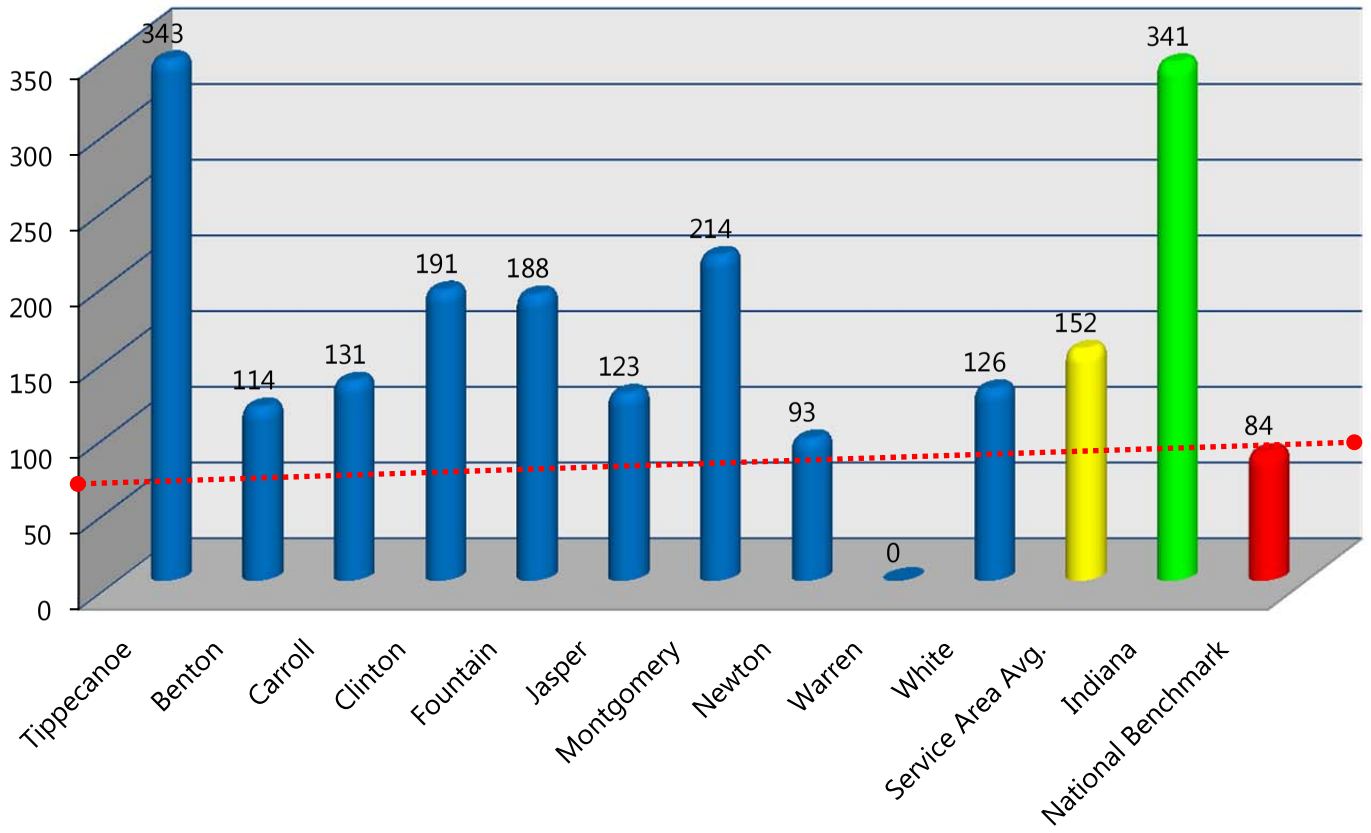
Physical inactivity represents the increased risk in each county for health conditions such as type 2 diabetes, cancer, stroke, hypertension, cardiovascular disease, and premature mortality. The value reported for each county is the percent of adults age 20 and older reporting no leisure time physical activity. Physical inactivity rate is a portion of the diet and exercise factor with a weight of 2.5% in calculating a county's overall health behavior ranking. (Source: www.countyhealthrankings.org)

2012 EXCESSIVE DRINKING



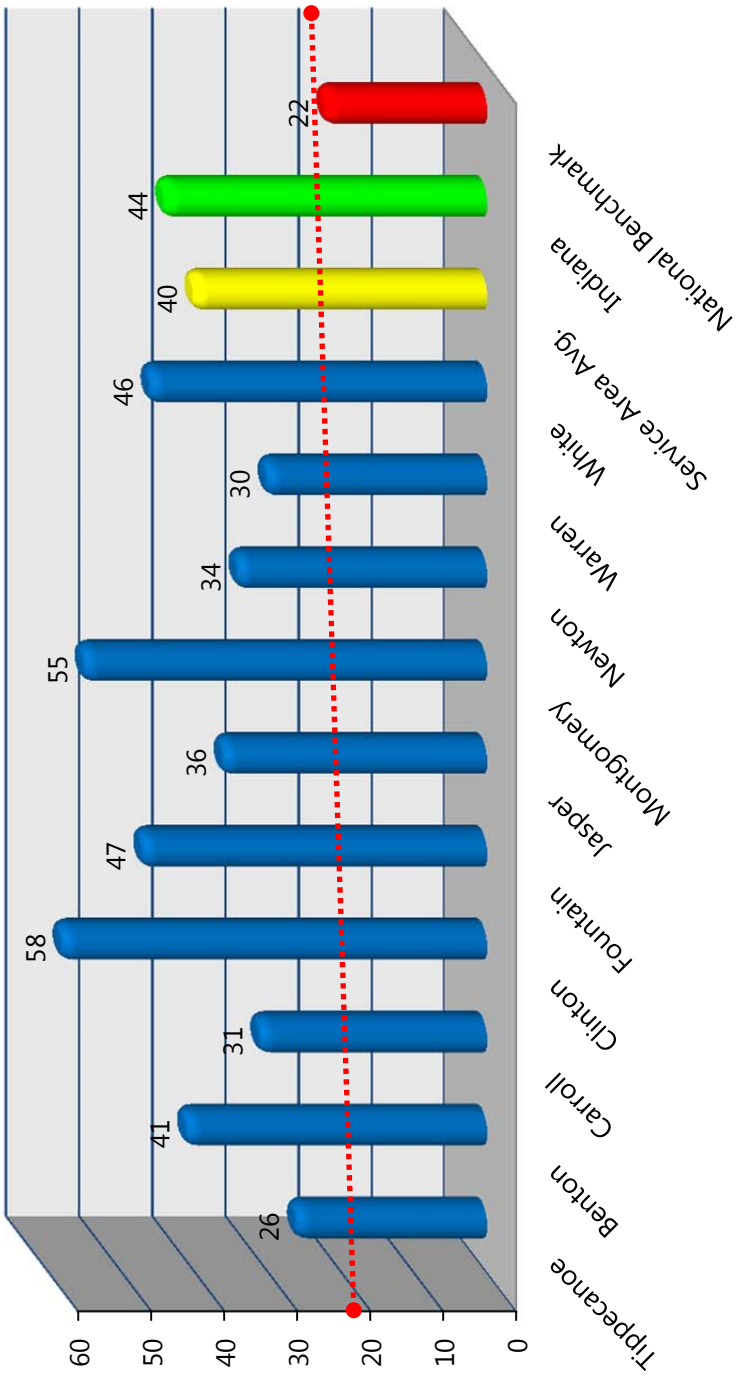
Excessive drinking represents the increased risk in each county for adverse health outcomes due to excessive alcohol use. The value reported for each county is the percent of the adult population that reports either binge drinking (consuming more than 4 [women] or 5 [men] alcoholic beverages on a single occasion in the past 30 days) or heavy drinking (more than 1 [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)

2012 SEXUALLY TRANSMITTED INFECTIONS



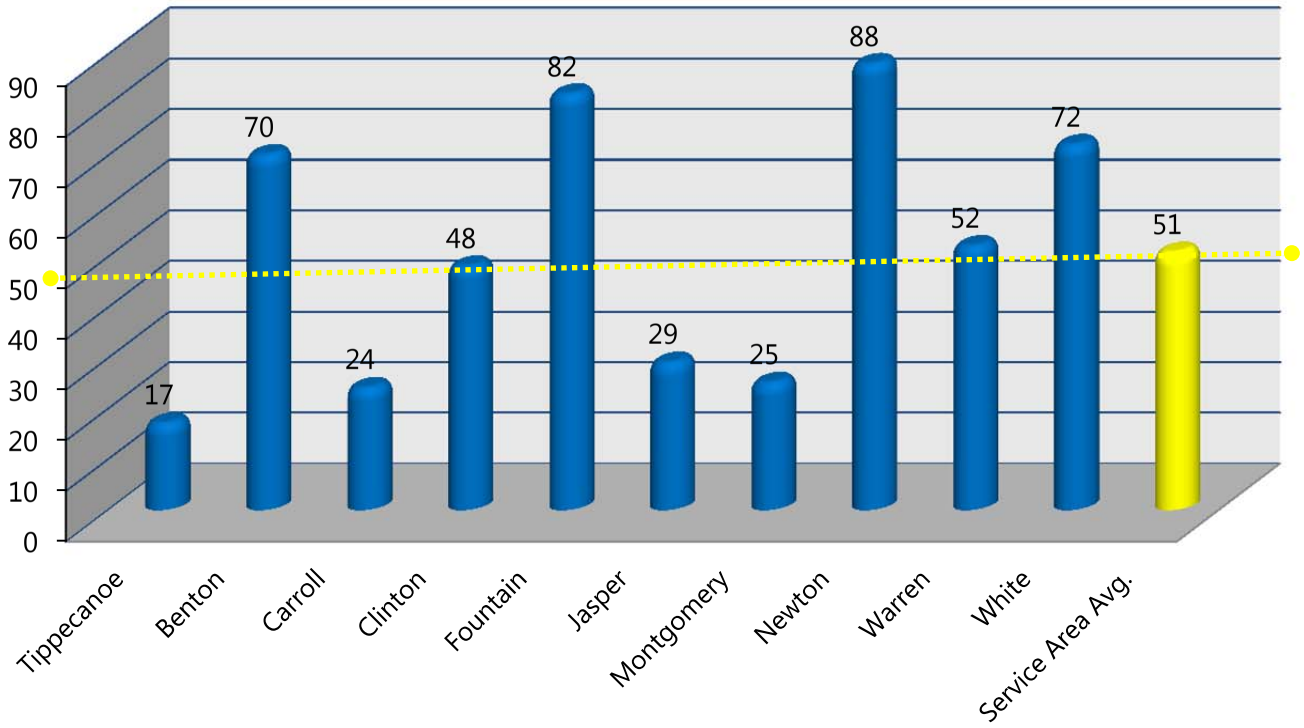
Sexually transmitted infections (STI) represent the increased risk in each county of morbidity and mortality due to cervical cancer, involuntary infertility, and premature death. The value reported for each county is the number of new cases of chlamydia reported per 100,000 population. STI is a portion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

2012 TEEN BIRTH RATE



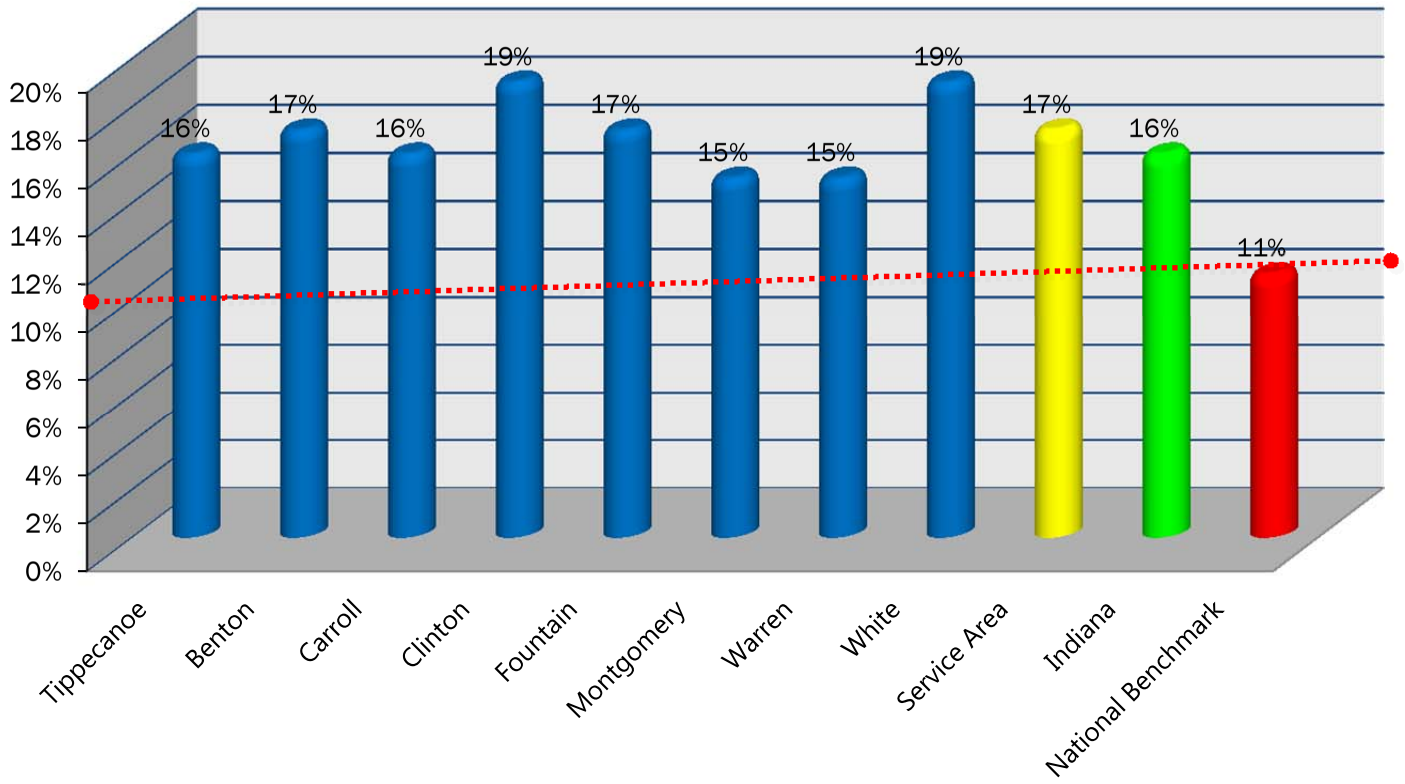
Teen birth rate represents the increased risk in each county for poor prenatal care and pre-term delivery due to late or no prenatal care, gestational hypertension and anemia, and poor maternal weight gain. The value reported for each county is the number of teen births per 1,000 female population, ages 15 to 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)

2012 CLINICAL CARE



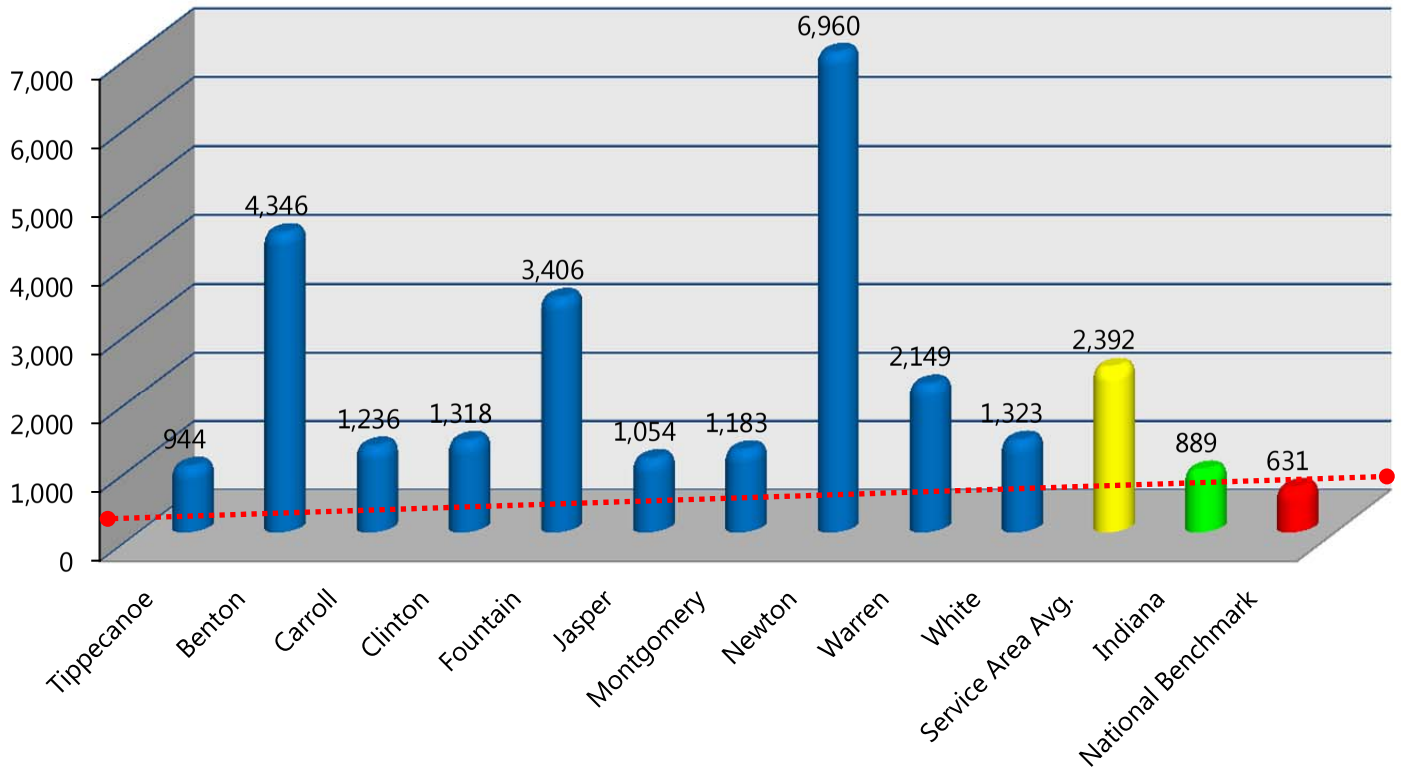
Clinical care consists of the following weighted factors for each county: access to care (10% - made up of uninsured at 5% and primary care physicians at 5%) and quality of care (10% - preventable hospital stays 5%; diabetic screening 2.5%; mammography screening 2.5%). 92 counties in Indiana have been ranked from 1 to 92, with 1 representing the highest and 92 representing the lowest composite score. The clinical care score is the second of four factors with a weight of 20% in calculating a county's overall health factor ranking. See pages 57 – 61 for an explanation of clinical care factors. (Source: www.countyhealthrankings.org)

2012 UNINSURED ADULTS



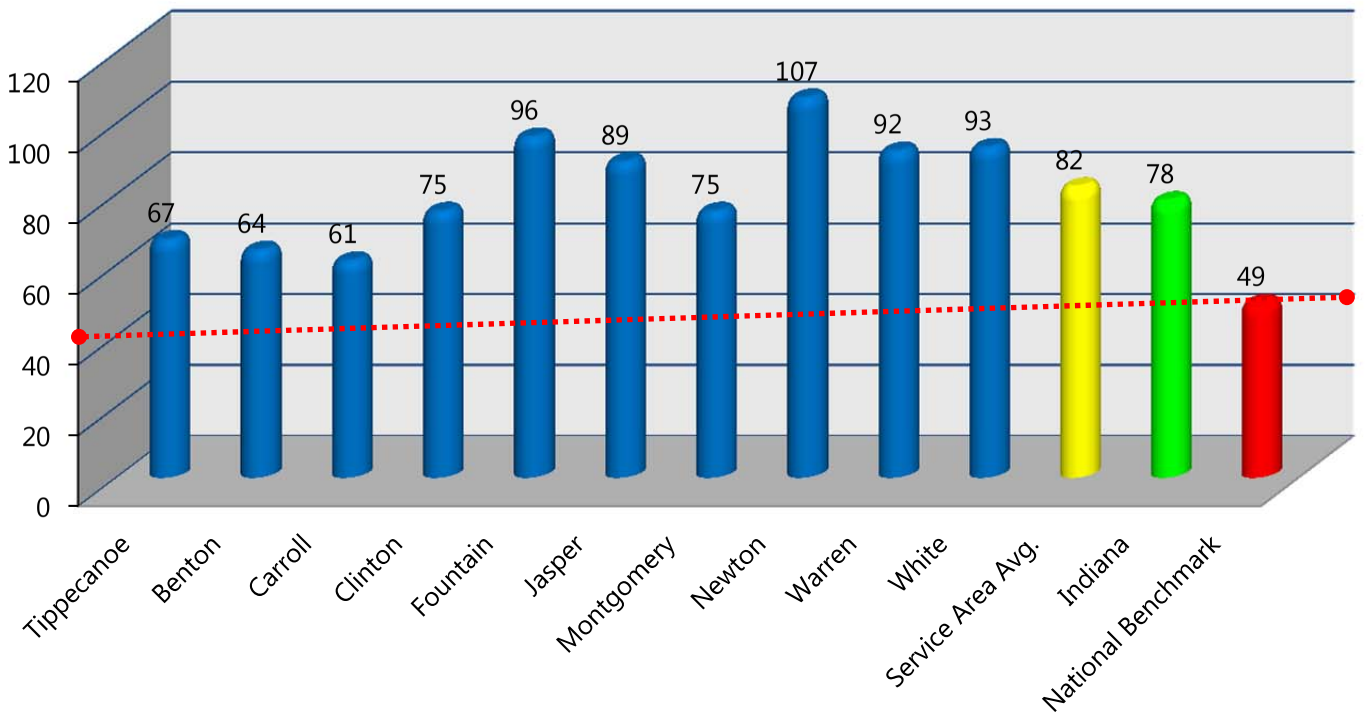
Uninsured adults represents a significant barrier to accessing needed health care due to lack of health insurance coverage that continues to increase. The value reported for each county is the estimated percent of the population under age 65 without health insurance coverage. The uninsured adults percentage 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)

2012 POPULATION PER PRIMARY CARE PHYSICIAN



Population per primary care physicians 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 2.5% in calculating a county's overall critical care ranking. (Source: www.countyhealthrankings.org)

2012 PREVENTABLE HOSPITAL STAYS



Preventable hospital stays represents the population's effectiveness and accessibility of primary healthcare. The value reported for each county is the number of Medicare enrollees discharged for ambulatory care sensitive conditions per 1,000 Medicare enrollees. Preventable hospital stays is a portion of the quality of care factor with a weight of 5% in calculating a county's overall critical care ranking. (Source: www.countyhealthrankings.org)

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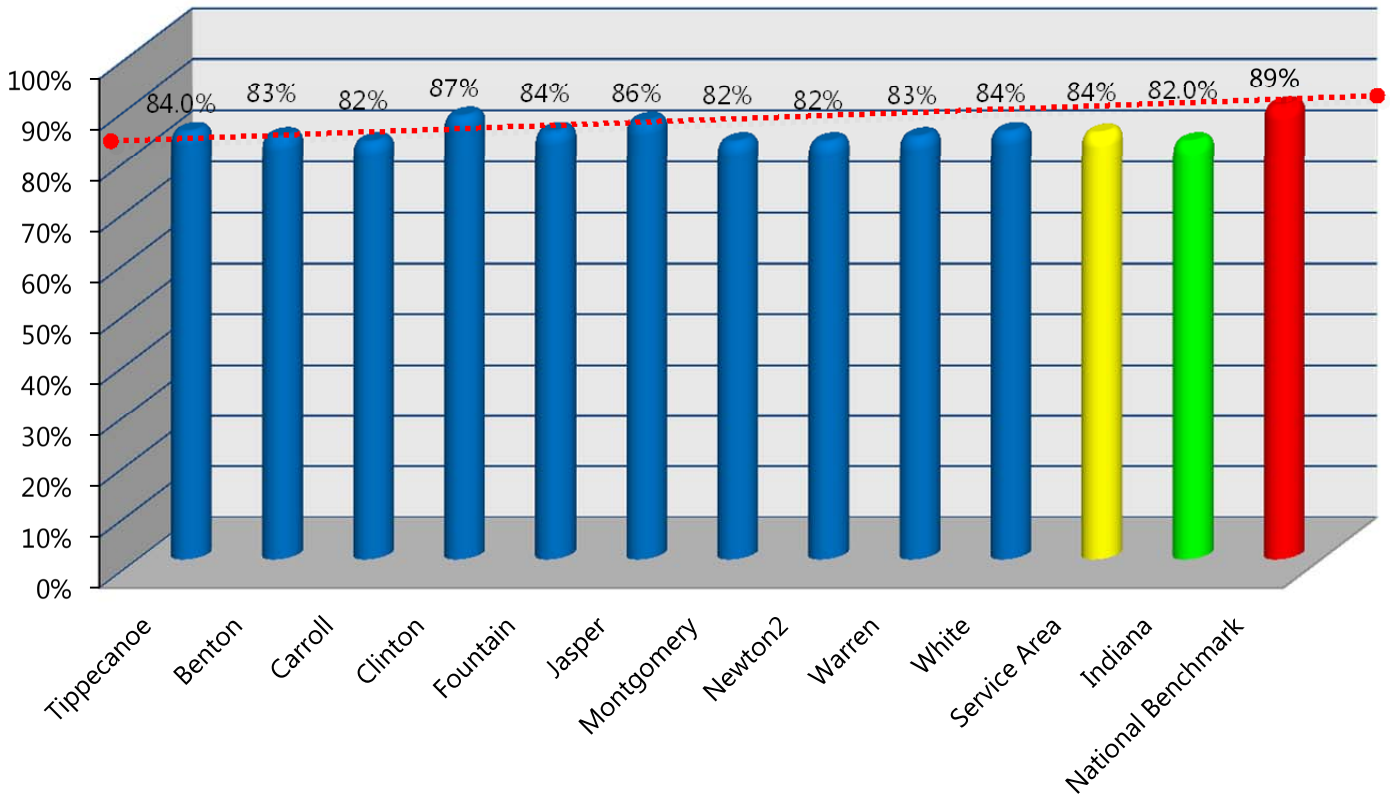
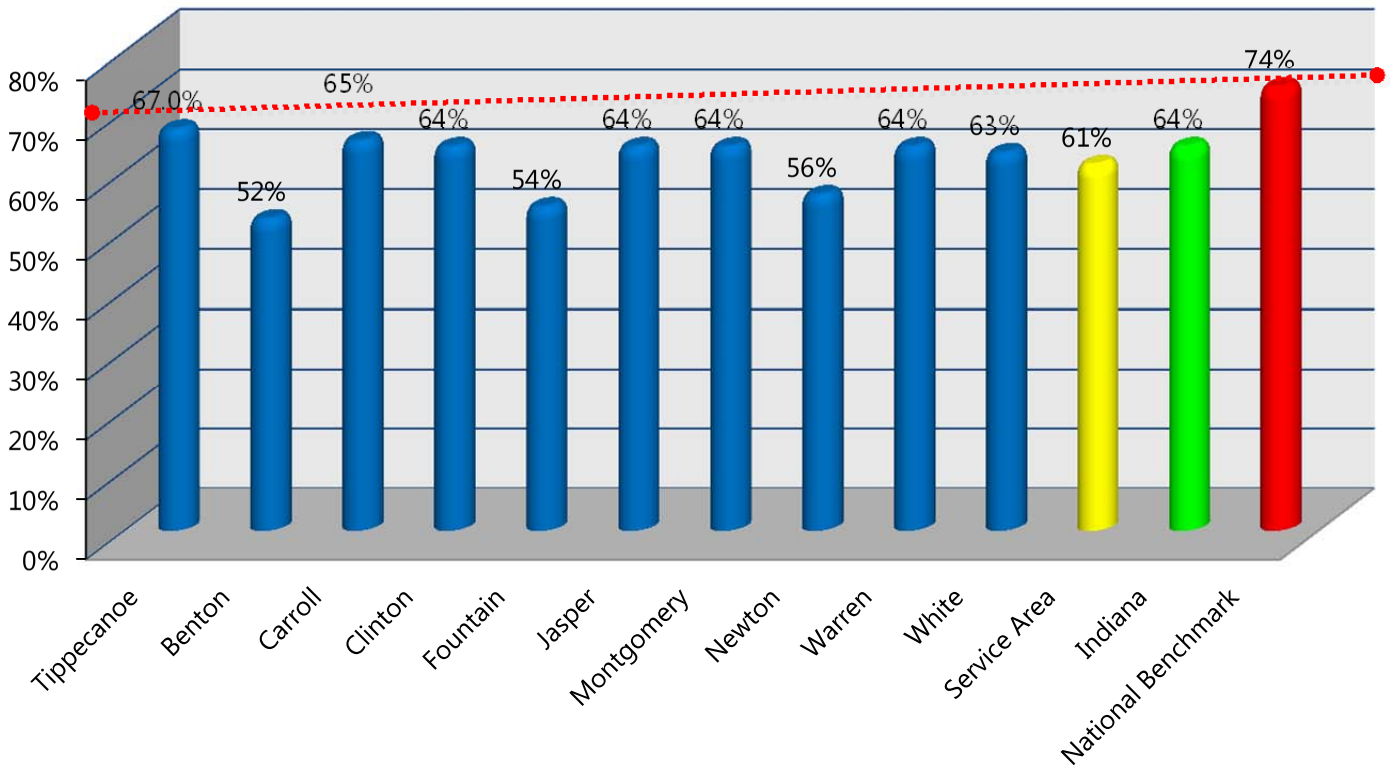
2012 DIABETIC SCREENING



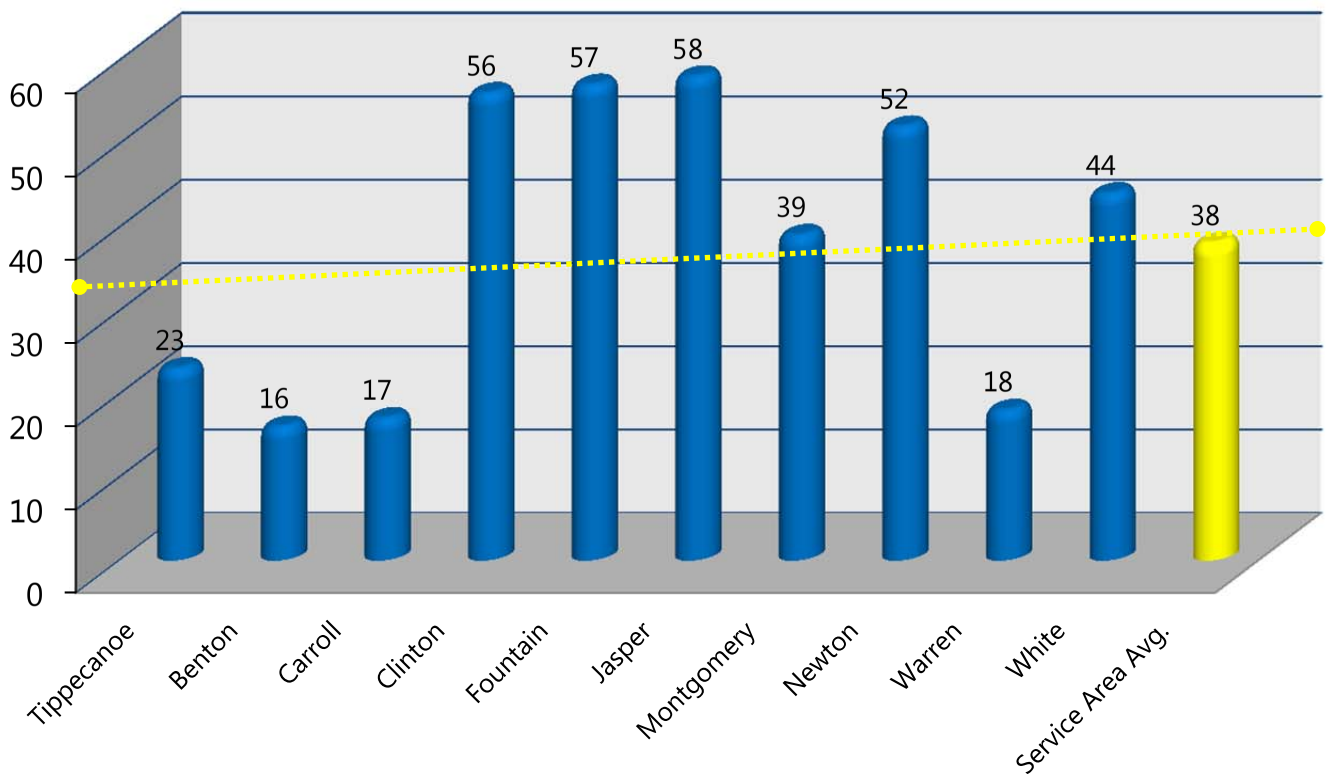
Diabetic screening represents the standard of care by assessing the management of diabetes over the long term through an estimate of how well a patient has managed his or her diabetes with increased management programs helping improve quality of care. The value reported is the percent of diabetic Medicare enrollees whose blood sugar control was screened in the past year using a test of their glycated hemoglobin (HbA1c) levels. The diabetic screening percentage is a portion of the quality of care factor with a weight of 2.5% in calculating a county's overall critical care ranking. (Source: www.countyhealthrankings.org)

2012 MAMMOGRAPHY SCREENING



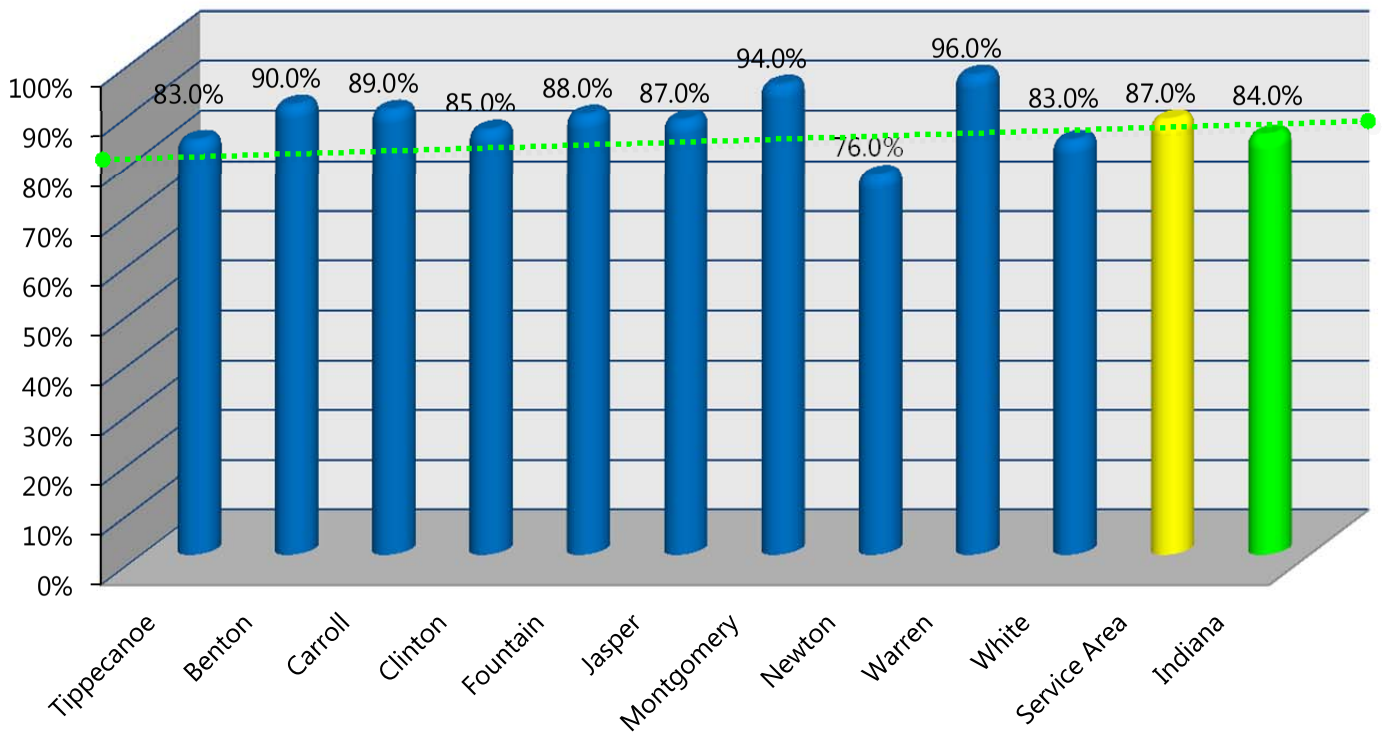
Mammography screening represents improvement in quality of care due to suggested evidence that screenings reduced breast cancer mortality, especially amount older women. The value reported is the percent of female Medicare enrollees age 67 – 69 that receive at least one mammography screening over a two-year period. The mammography screening percentage is a portion of the quality of care factor with a weight of 2.5% in calculating a county's overall critical care ranking. (Source: www.countyhealthrankings.org)

2012 SOCIOECONOMIC FACTORS



Socioeconomic 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%), Income (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 socioeconomic score is the third of four factors with a weight of 40% in calculating a county's overall health factor ranking. See pages 63 – 68 for explanation of selected socioeconomic factors. (Source: www.countyhealthrankings.org)

2012 HIGH SCHOOL GRADUATION



High school graduation represents a correlation between educational 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)

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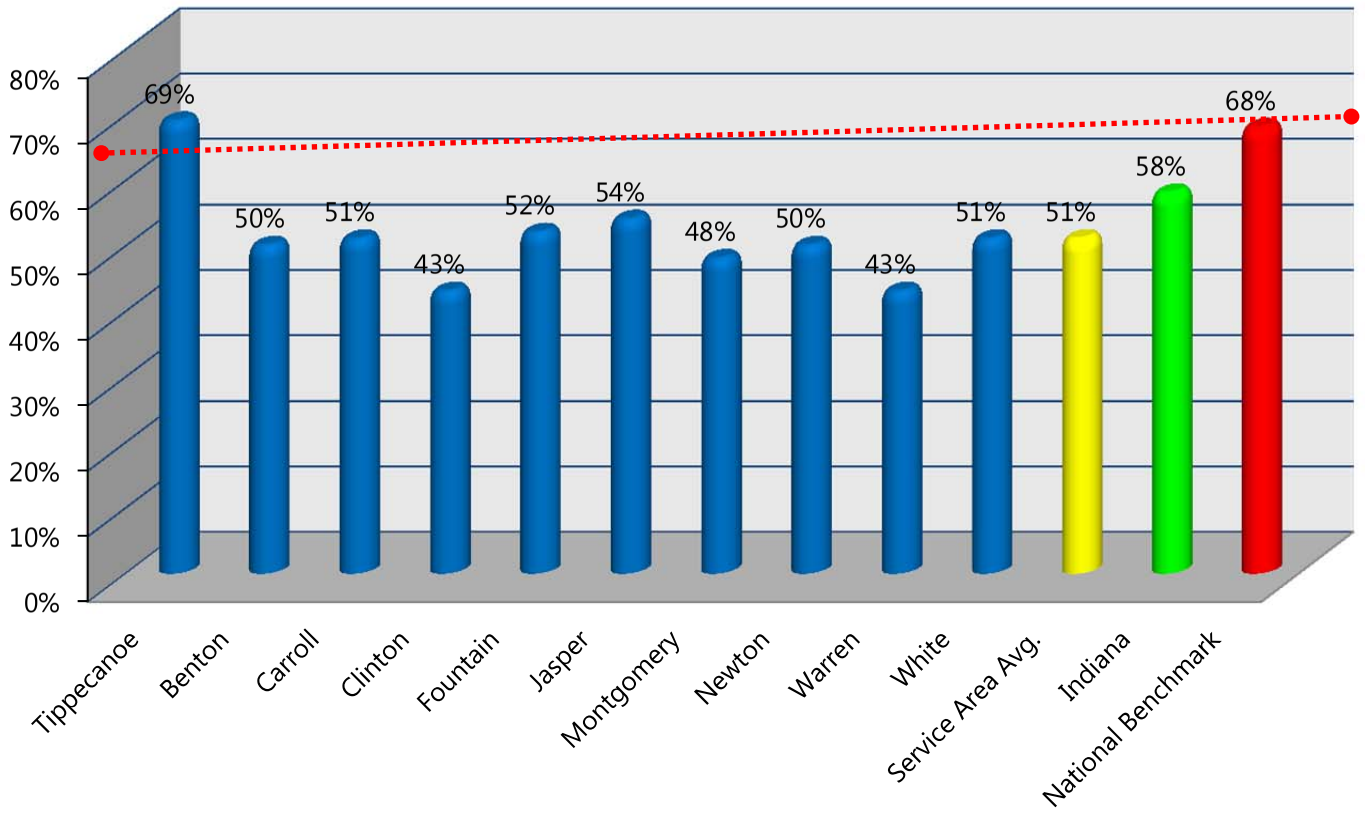
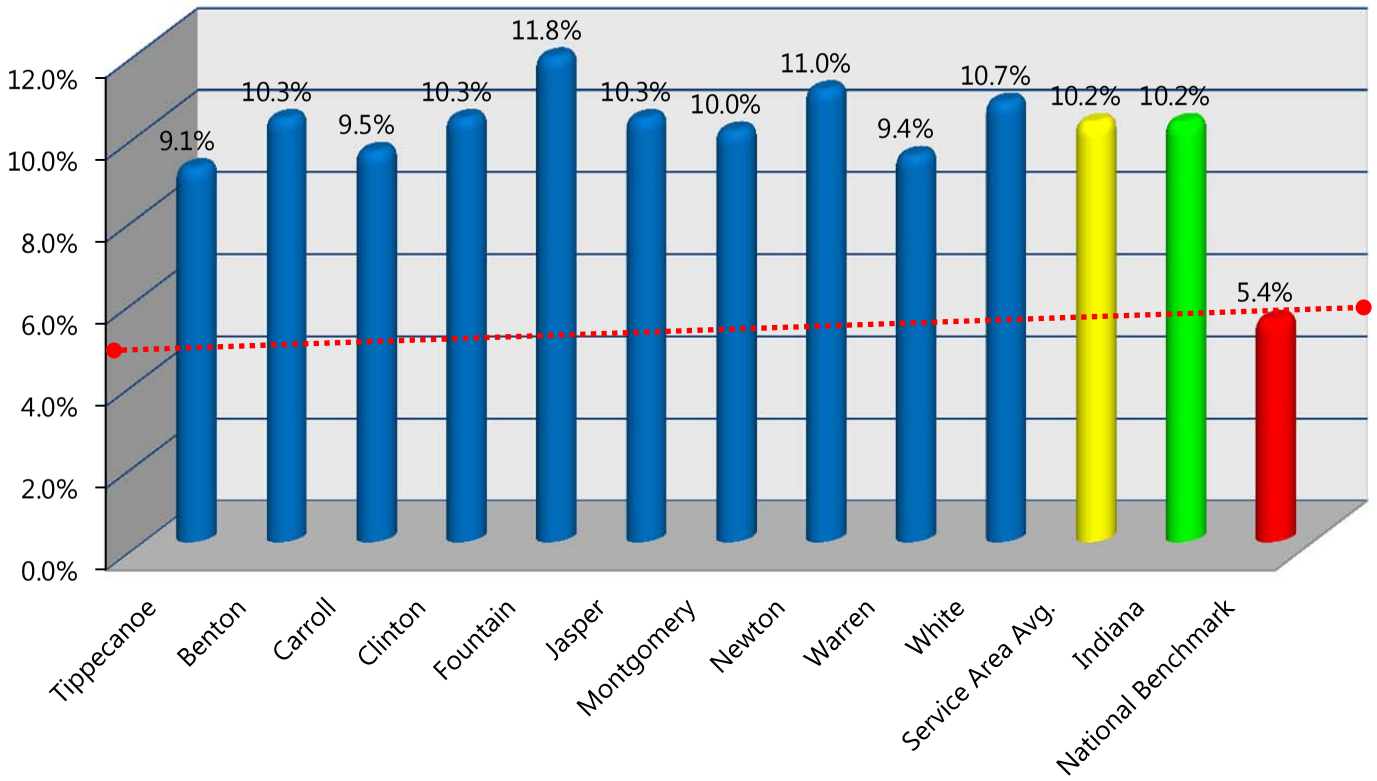
2012 SOME COLLEGE



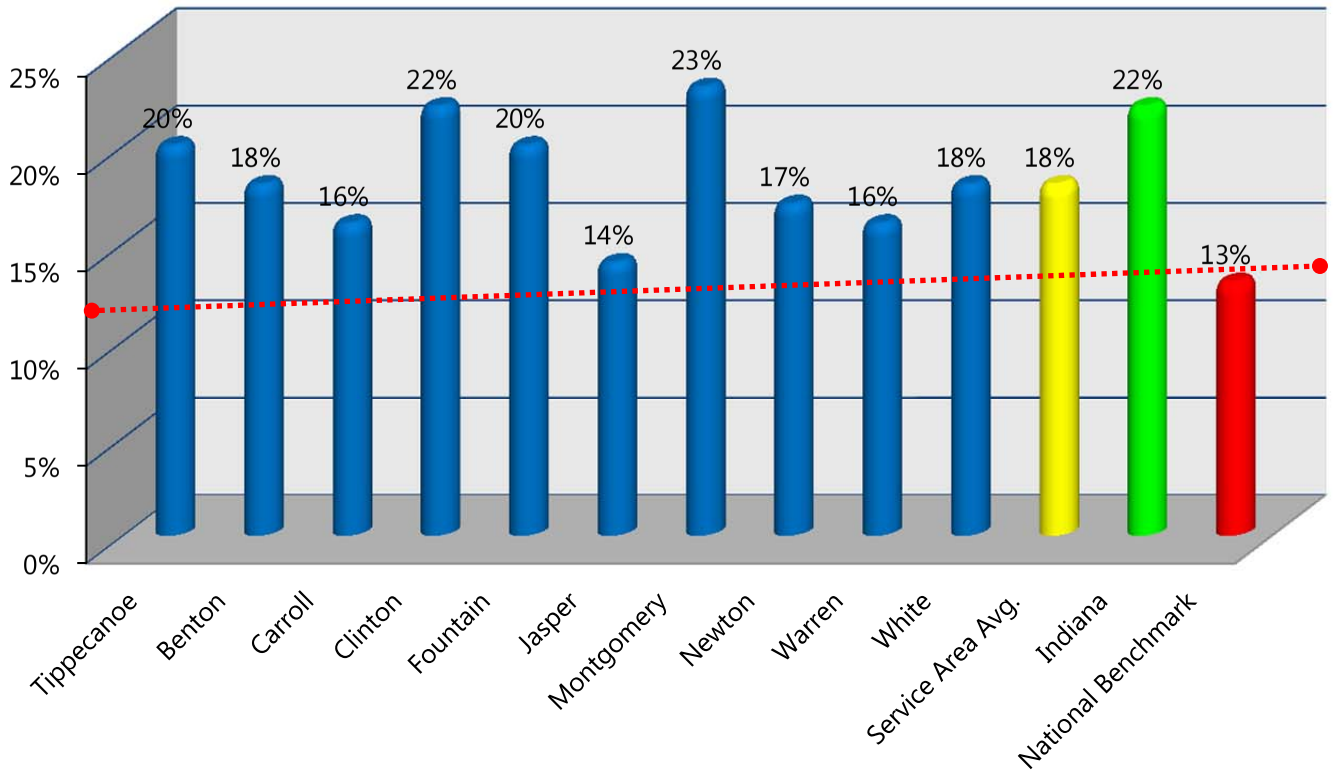
Some college represents a correlation between higher educational attainment and improved health through improved work and economic opportunities, reduced psychosocial stress, and healthier lifestyles. The value reported is the percent of population, ages 25 to 44 years, with some post-secondary education, such as enrollment at vocational/technical schools, junior colleges, four-year colleges including individuals 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)

2012 UNEMPLOYMENT



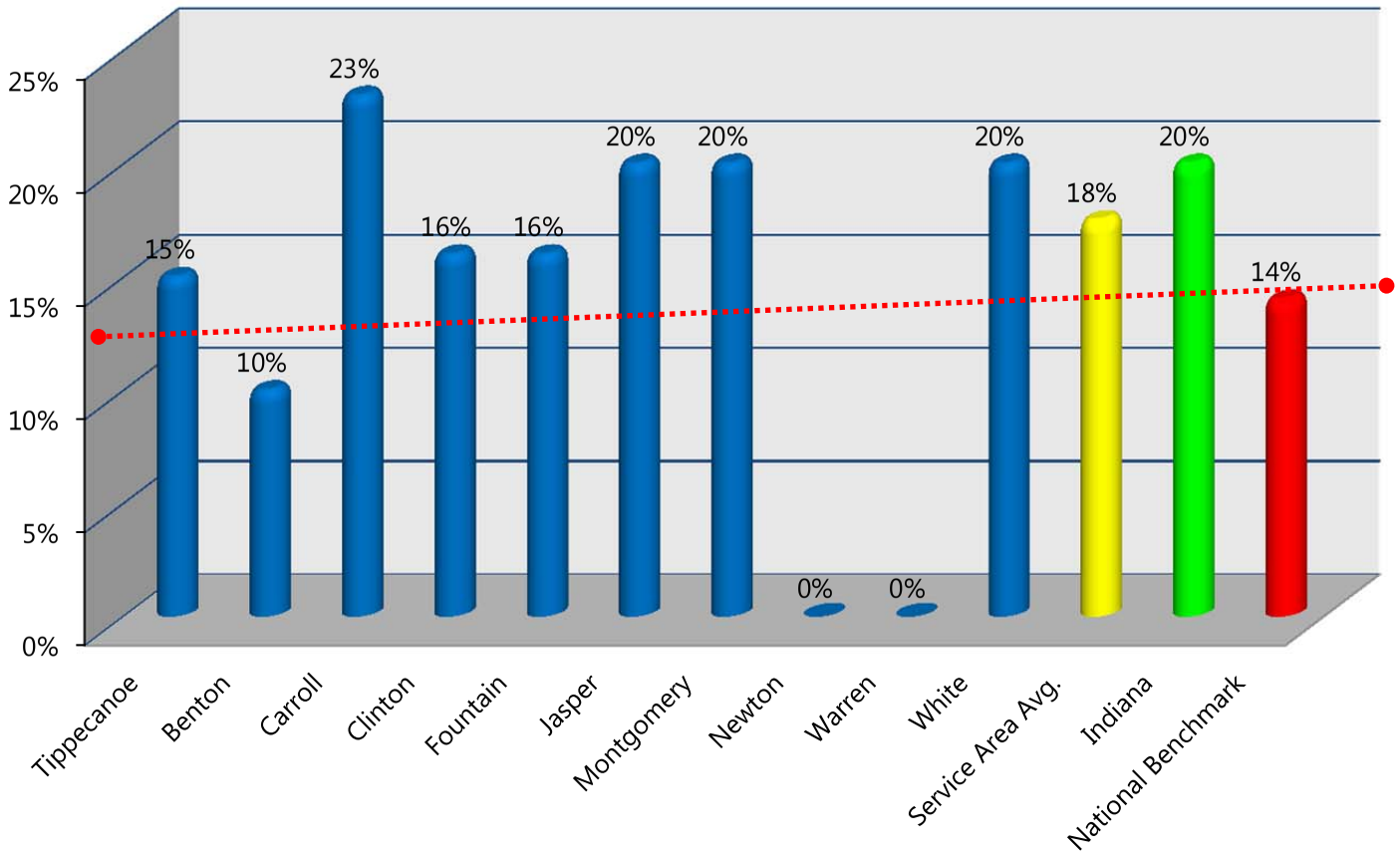
Unemployment represents the population that may be at risk for various health concerns associated with unemployment that can lead to physical health responses ranging from self-reported physical illness to mortality, especially suicide. The value reported for each county is the percent of the civilian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

2012 CHILDREN IN PROVERTY



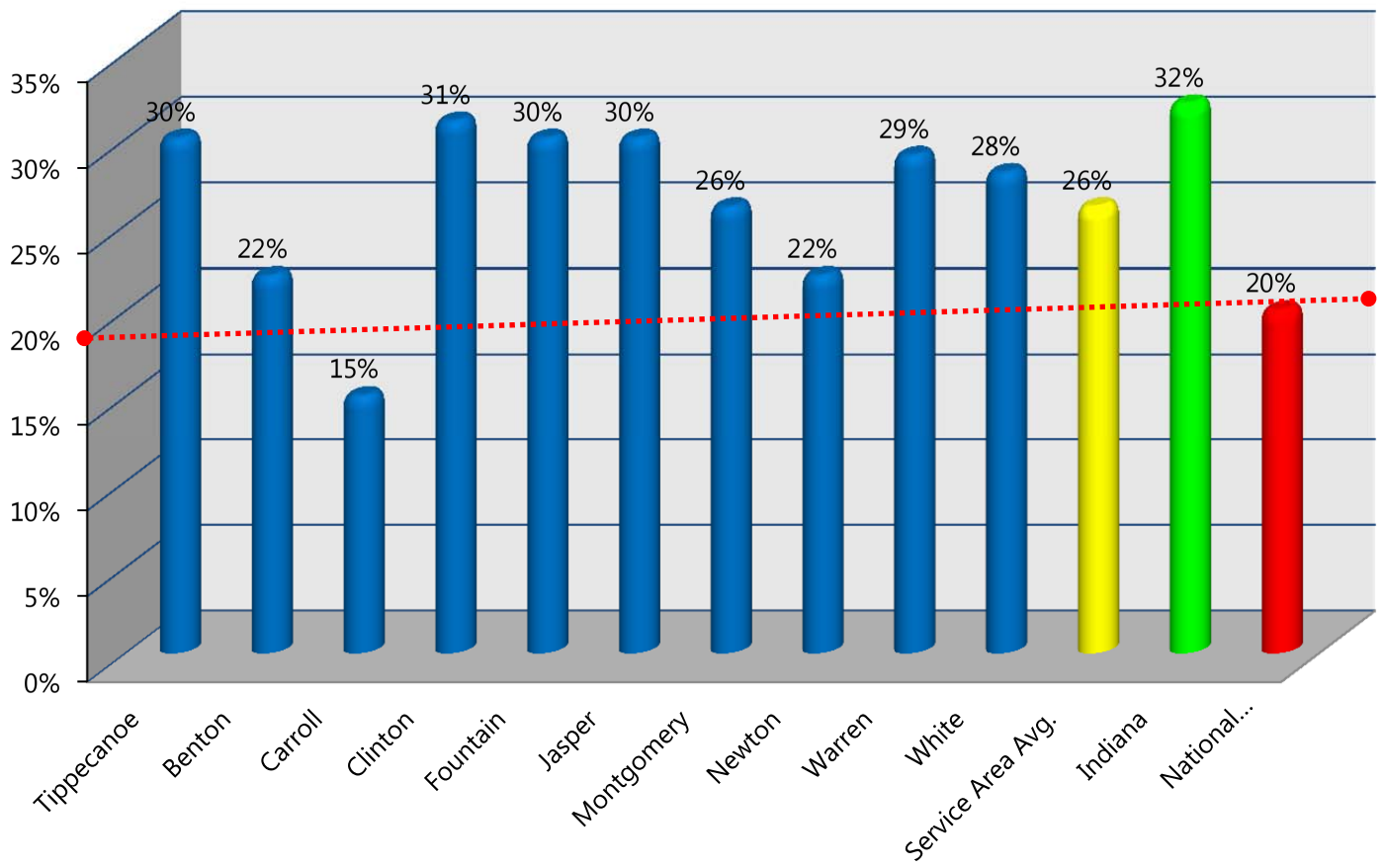
Children in poverty (income factor) represent increased risk in children of morbidity and mortality due to risk of accidental injury and lack of health care access. Poverty can result in negative health consequences, such as increased prevalence of medical conditions and disease incidence, depression, 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 five factors with a weight of 10% in calculating a county's overall social and economic ranking. (Source: www.countyhealthrankings.org)

2012 INADEQUATE SOCIAL SUPPORT



Inadequate social support represents increased morbidity and early mortality for individuals without a strong social network. The social and emotional support measure is based on survey responses to the question, "How often do you get the social and emotional support you need?" The value reported for each county is the percent of adult population that responds that they "never", "rarely," or "sometimes" get the support they need. Inadequate social support percentage is a portion of the family and social support factor with a weight of 2.5% in calculating a county's overall social and economic ranking. (Source: www.countyhealthrankings.org)

2012 CHILDREN IN SINGLE-PARENT HOUSEHOLDS



Children in single parent household factor represents adults and children at risk for adverse health outcomes such as substance abuse, depression, and suicide and unhealthy behaviors such as smoking and excessive alcohol use. The value reported for each county is the percent of all children in family households that live in a household headed by a single parent. Children in single parent households percentage is a portion of the family and social support factor with a weight of 2.5% in calculating a county's overall social and economic ranking. (Source: www.countyhealthrankings.org)

Attachment B: Questionnaires

Community Health Needs Assessment

River bend Hospital

Special Expertise Questionnaire 2012

Name: **Date:** **Title:**

Interview type:

- ☐ Phone ☐ Focus group ☐ Written correspondence
- ☐ Individual meeting ☐ Survey ☐ Other:

Special Knowledge/Expertise:

Affiliation (Organization/ Department/ Agency):

Which of the following roles do you provide to River Bend Hospital (the Hospital)?

(Mark all that apply)

- ☐ Board Directors/Trustee
- ☐ Organization Officer, leader, or management member
- ☐ Person with special knowledge of or expertise in public health
- ☐ Representative of Federal, tribal, regional, State or local health department
- ☐ Representative of other department or agency with current relevant health needs data
- ☐ Community leader or representative
- ☐ Member of medically underserved, low income, minority population

May we disclose your name, title, special knowledge and affiliation in our report?

☐ Yes ☐ No

1. What are the top 3 strengths of River Bend Hospital?

a.

b.

c.

2. What has the hospital done well in the last three (3) years?

Community Health Needs Assessment

River bend Hospital

Special Expertise Questionnaire 2012

3. Are there any suggested improvements/ gaps the Hospital should consider improving?

4. Where do you want to see the Hospital in 10 years?

5. Is there anything currently the Hospital is or is not doing to be successful in 10 years and beyond?

6. How do you characterize the community's overall awareness of River Bend Hospital and its services?

Community Health Needs Assessment

River bend Hospital

Special Expertise Questionnaire 2012

7. Funding for mental healthcare services is too limited to meet the needs of the community.

☐ Completely agree ☐ Somewhat agree ☐ Somewhat disagree ☐ Completely disagree

8 How important is it to increase funding for mental healthcare services in the community?

☐ Very Important ☐ Important ☐ Somewhat important ☐ Not important

9. Some members of the community do not have access to mental healthcare because they do not have health insurance or their insurance does not provide mental healthcare coverage and they cannot pay for services.

☐ Completely agree ☐ Somewhat agree ☐ Somewhat disagree ☐ Completely disagree

10. How important is it to increase access to mental healthcare by providing some type of payment source or assistance to clients in the community?

☐ Very Important ☐ Important ☐ Somewhat important ☐ Not Important

11. It is crucial to establish more mental healthcare services in the community.

☐ Completely agree ☐ Somewhat agree ☐ Somewhat disagree ☐ Completely disagree

12. How important is it to establish more or expand existing mental healthcare services in the community?

☐ Very Important ☐ Important ☐ Somewhat important ☐ Not important

13. If important, what types of services are needed in the community?

_____

_____

14. There are not enough mental healthcare professionals in the community to successfully manage the mental healthcare issues.

☐ Completely agree ☐ Somewhat agree ☐ Somewhat disagree ☐ Completely disagree

15. How important is it to increase the number of mental healthcare professionals in the community?

☐ Very Important ☐ Important ☐ Somewhat important ☐ Not Important

16. There is a need for transportation to and from treatment services for individuals seeking treatment.

☐ Completely agree ☐ Somewhat agree ☐ Somewhat disagree ☐ Completely disagree

17. How important is it to provide transportation services in the community?

☐ Very Important ☐ Important ☐ Somewhat important ☐ Not Important

Community Health Needs Assessment

River bend Hospital

Special Expertise Questionnaire 2012

18. Additional collaboration is needed among individual mental healthcare services providers and organizations in the community.

☐ Completely agree ☐ Somewhat agree ☐ Somewhat disagree ☐ Completely disagree

19. How important is it to improve collaboration in the community?

☐ Very Important ☐ Important ☐ Somewhat important ☐ Not Important

20. There is a need to expand/establish Hispanic services in the community.

☐ Completely agree ☐ Somewhat agree ☐ Somewhat disagree ☐ Completely disagree

21. How important is it to establish/expand Hispanic services in the community

☐ Very Important ☐ Important ☐ Somewhat important ☐ Not Important

22. Educational programs and campaigns to increase awareness about mental healthcare issues in the general public are needed.

☐ Completely agree ☐ Somewhat agree ☐ Somewhat disagree ☐ Completely disagree

23. How important is it to provide educational programs to increase awareness of mental healthcare issues amount the general public in the community?

☐ Very Important ☐ Important ☐ Somewhat important ☐ Not Important

24. What topics and types of educational programs or campaigns on mental health are needed?

25. Are there any other gaps in the local services system you have identified?

26. Comments for any of the issues/ other comments?

4

Community Health Needs Assessment

River Bend Hospital: 2900 North River Road, West Lafayette, IN 47906
Focus Group 2012

River Bend Hospital

Part A. Perception, insight and general understanding

1. List the first inpatient mental healthcare hospital that comes to mind.

Name: _____

2. What inpatient mental healthcare hospital is located closest to where you live?

Name: _____

3. What hospital do you think of for providing the following?

Attribute	Name
Care that is conveniently located:	
High quality care:	
Friendly, compassionate, personal care:	
Excellent physicians:	
Services that promote health education, wellness and prevention:	
Inpatient mental healthcare:	
Outpatient mental health or addiction care counseling:	
Physician clinics:	

4. Are you aware of the mental healthcare services available in your community? (Check one)

☐ Completely aware ☐ Somewhat aware ☐ Not aware

5. How do you generally describe the mental health status of your community? (Check one)

☐ Excellent ☐ Good ☐ Fair ☐ Poor

6. Do you have a primary healthcare provider? (Check one)

☐ Yes ☐ No

7. What are the most significant mental healthcare issues in this community? (Check up to 3 in each category)

Access Issues

- ☐ Affordable health insurance
- ☐ Affordable healthcare prices
- ☐ Mental health services availability
- ☐ Addiction care service availability
- ☐ Primary care provider availability
- ☐ Specialty care provider availability
- ☐ Healthy food availability
- ☐ Financial issues

Lifestyle/ Health Information

- ☐ Health promotion services lacking
- ☐ Mental health education lacking
- ☐ Places to exercise lacking
- ☐ General health education lacking
- ☐ Community events lacking
- ☐ Lack of community interest
- ☐ Other: _____

NCHS

Community Health Needs Assessment
River Bend Hospital: 2900 North River Road, West Lafayette, IN 47906
Focus Group 2012

River Bend Hospital

8. What types of communication medium do you find the most credible for hospital information as well as education on mental healthcare topics including prevention and wellness? (Check all that apply)

- ☐ Television
- ☐ Radio
- ☐ Newspaper
- ☐ Billboards
- ☐ Other:
- ☐ Direct mail
- ☐ Newsletter
- ☐ Seminars
- ☐ Social media
- ☐ Community programs
- ☐ Internet
- ☐ Brochures

9. What is your county of residence and years you have resided in the community?

- ☐ Benton
- ☐ Carroll
- ☐ Clinton
- ☐ Other:
- ☐ Fountain
- ☐ Jasper
- ☐ Montgomery
- ☐ Newton
- ☐ Tippecanoe
- ☐ Warren
- ☐ White

Years:

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.

10. What is your gender? ☐ Male ☐ Female

11. What is your age?

- ☐ 18 to 29
- ☐ 30 to 39
- ☐ 40 to 49
- ☐ 50 to 59
- ☐ 60 to 69
- ☐ 70 to 79
- ☐ 80+

12. What is the highest level of education you have attended?

- ☐ Middle school
- ☐ High school
- ☐ Trade/ Technical School
- ☐ Other:
- ☐ Some college
- ☐ Associate's degree
- ☐ Bachelor's degree
- ☐ Graduate school

13. What is your race?

- ☐ African-American
- ☐ Latino/Spanish
- ☐ Other:
- ☐ Asian
- ☐ Native American
- ☐ Caucasian

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

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 8+

15. 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+

NCHS

2

Community Health Needs Assessment

River Bend Hospital: 2900 North River Road, West Lafayette, IN 47906
Community Input 2012

River Bend Hospital

Part A. Community Member Needs – River Bend Hospital (formally Wabash Valley Hospital) is interested in learning more about its community members' perceptions, insight and opinions regarding mental healthcare needs as part of a Community Health Needs Assessment. The feedback you provide will help the hospital determine what mental healthcare services are needed in this community and what gaps may exist in services offered to meet those needs. (Please complete this survey and return to our surveyors, Blue & Co., LLC, or complete online at www.nchsi.com.)

1. Are you aware of the inpatient mental health care services available in your community? (Check one)

☐ Completely aware ☐ Somewhat aware ☐ Not aware

2. How do you generally describe the mental health status of your community? (Check one)

☐ Excellent ☐ Good ☐ Fair ☐ Poor

3. What are the three (3) most significant mental health care prevention, treatment and/ or awareness needs in this community? (Check up to 3)

☐ Alcohol abuse	☐ Domestic violence	☐ Mental disorder
☐ Binge drinking	☐ Drug abuse	☐ Suicide
☐ Child abuse	☐ Eating disorder	☐ Tobacco abuse
☐ Depression	☐ Mental health	☐ Violent/ abuse behaviors
☐ Other:		

4. Are the mental health care needs currently being met in your community? (Check one)

☐ Completely agree ☐ Somewhat agree ☐ Somewhat disagree ☐ Completely disagree

5. Please share any needs:

6. Do you believe the mental healthcare providers work well together and coordinate care in this community? (Check one)

☐ Completely agree ☐ Somewhat agree ☐ Somewhat disagree ☐ Completely disagree

7. Do you believe there are barriers that exist in government, the general community, public health community, or mental healthcare provider community that prevents us from creating a healthier community? (Check one)

☐ Completely agree ☐ Somewhat agree ☐ Somewhat disagree ☐ Completely disagree

8. Please share any barriers:

9. Please share any general comments:

NCHS

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Community Health Needs Assessment
River Bend Hospital: 2900 North River Road, West Lafayette, IN 47906
Community Input 2012

10. What is your county of residence?

☐ Benton	☐ Fountain	☐ Newton	☐ White
☐ Carroll	☐ Jasper	☐ Tippecanoe	
☐ Clinton	☐ Montgomery	☐ Warren	
☐ Other:			

11. How many years have you resided in the community?

12. What is your Zip Code?

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.

13. What is your gender? ☐ Male ☐ Female

14. What is your age?

☐ 18 to 29	☐ 40 to 49	☐ 60 to 69	☐ 80+
☐ 30 to 39	☐ 50 to 59	☐ 70 to 79	

15. What is the highest level of education you have attended?

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

16. What is your race?

☐ African-American	☐ Asian	☐ Caucasian
☐ Latino/Spanish	☐ Native American	
☐ Other:		

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

☐ 1	☐ 3	☐ 5	☐ 7	☐ 8+
☐ 2	☐ 4	☐ 6	☐ 8	

18. What is your gross annual income?

☐ $0 - $11,170	☐ $23,051 – 27,010	☐ $38,891 – 50,130
☐ $11,171 – 15,130	☐ $27,011 – 30,970	☐ $50,131 - $75,090
☐ $15,131 – 19,090	☐ $30,971 – 34,930	☐ $75,091 – 90,050
☐ $19,091 – 23,050	☐ $34,931 – 38,890	☐ $90,051+

Thank you for participating!

Please return the survey to Blue & Co., LLC
One American Square, Ste 2200| Indianapolis, IN 46282

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Attachment C: Special Expertise Participants

Special Expertise Interviews

Name, Title, Affiliation	Date Participated	Expertise
Mayor Tony Rosworski Lafayette Mayor	June 12th	Community Leader
Mayor John Dennis West Lafayette Mayor	June 12th	Community Leader
Ron Louks, MD Riggs Community Health Center	June 12th	Person with special knowledge of and expertise in public health
Jennifer Flora, CEO Mental Health American of Tippecanoe County	June 12th	Community Leader and Representative of other agency with current relevant health needs data
James Taylor, Executive Director United Way of Greater Lafayette	June 13th	Community Leader
Joseph (Joe) Seaman, President & CEO Greater Lafayette Commerce	June 13th	Community Leader
Rick Crawley, CEO River Bend Hospital	June 13th	Community Leader, Representative of medically underserved, and person with special knowledge of and expertise in public health
Chief Dan Rousch Lafayette Police Department	June 13th	Community Leader and Representative of low income and minority
Sargent Jay Rosen Lafayette Police Department	June 13th	Community Leader and Representative of low income and minority
Veronique LaBlonk, CEO Riggs Community Health Center	June 13th	Community leader, Representative of medically underserved and person with special knowledge of and expertise in public health
John Werment, M.D. Riggs Community Health Center	June 19th	Person with special knowledge of and expertise in public health

Alisson Everman Adult Probation Officer	June 19th	Representative of other agency with current relevant health needs data
Gilbert Smith, Manager Dept. of Child Services	June 19th	Representative of other agency with current relevant health needs data
Richard Rohdert, Medical Director River Bend Hospital	June 20th	Special Expert with public health data and Community Leader
Coleen Harmick, Executive Director CASA Program Tipp County	June 20th	Community Leader
Ashley Bice, Executive Director Benton Community Foundation	June 20th	Community Leader
Dr. Steven Berger, psychiatrist St. Vincent Medical Group	June 21st	Person with special knowledge of and expertise in public health
Aaron Johnson, Juvenile Probation Tippecanoe County	June 21st	Representative of other agency with current relevant health needs data
Joe Buser, Prosecutor	June 21st	Community Leader
Bob Cook, Executive Director ASI	June 21st	Community Leader
Jennifer Shook, ASI	June 21st	Community Leader
Angela Smith Grossman, Manager DCS Tippecanoe County Office	June 25th	Representative of other agency with current relevant health needs data
Jennifer Layton, Executive Director Howarth Center	June 27th	Community Leader and Representative of low income
Karen Combs, Director of Elementary Ed Lafayette School Corp	June 27th	Community Leader
Karen Branch, Executive Director Montgomery County Youth Service Bureau	June 27th	Community Leader
Barb Salmon, Director of Social Work River Bend Hospital	July 5th	Person with special knowledge and expertise in public health
Tom Gilliom, COO River Bend Hospital	July 23rd	Community leader, Person with special knowledge and expertise in public health

Attachment D: Existing Resources

Available resources representative of the majority health services in the community:

TREATMENT CENTERS

Alpine Counseling Center
Anisa Counseling Group
Bartlett Counseling Services
Boone County Health Center
Community Howard Regional Health, Inc.
Cummins Behavioral Health System, Inc.
Family Services, Inc.
Families United, Inc.
Heartland Clinic
Regional Mental Health Center, Inc.
River Bend Hospital
Stembel Psychological Services
St. Elizabeth
Sycamore Springs Health
Turning Point Counseling, Inc.
Wabash Valley Alliance

COMMUNITY RESOURCES IDENTIFIED

Lafayette Crisis Center
Mental Health America
NAMI-West Central Indiana

Attachment E: CHNA Team

RIVER BEND HOSPITAL TEAM MEMBERS

John Walling, CEO, River Bend Hospital
Gail Summers, Quality Improvement Director, River Bend Hospital

BLUE & CO., LLC

Steven B. Reed, FACHE, President, Magellan Management Group, LLC
Dean Mazdai, Consultant, Magellan Management Group, LLC
Angela L. Zirkelbach, CPA, Director
Amber Kocher, CPA, Accountant
Lindsey Ladyman, Accountant

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