Community Health Needs Assessment

September 2013

Richland Memorial Hospital

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Executive Summary

Realizing the importance of and desiring to respond to the needs of the community by retaining our charitable hospital organization status, Richland Memorial Hospital is determined to combine the findings of this community health needs assessment with the vocalized needs of the community by creating a document that will serve as a key component to improve the overall health of our community. The findings of this project will also assist RMH leadership in stewarding the resources entrusted to them by providing services where assistance is most needed and where RMH is able to provide a strong leadership presence. In working through the requirements required by the Internal Revenue Service (IRS) and mandated by the federal Patient Protection and Affordable Care Act enacted March 23, 2010, RMH has identified three significant health needs in our defined community of Richland, Clay, Lawrence, Jasper and Edward's counties. These needs are identified and prioritized as follows:

- Health Need #1: Mental and Related Social Issues
- Health Need #2: Access to Health Services – Health Providers, Health Department
- Health Need #3: Chronic Disease

Over the next three years, Richland Memorial Hospital has committed to working closely with area organizations that treat mental illness and its related social issues by offering several collaborative educational outreach opportunities that address mental health needs and related social issues, as well as continue to be a part of the recruitment efforts for mental health providers. Outreach events and educational opportunities will also be used to focus on the need for chronic disease management skills in the community. Lastly, RMH continues to be committed to making healthcare accessible to all members of the community by fortifying its ongoing efforts to recruit a healthy supply of primary care physicians to the community, as well as the development of telemedicine options for treatment.

The Community Health Needs Assessment Committee

Members of the Richland Memorial Hospital Community Health Needs Assessment committee include the following:

David Allen, Chief Executive Officer, *Richland Memorial Hospital*

Mike Stoverink, Chief Financial Officer, *Richland Memorial Hospital*

Cindy Bailey, Chief Nursing Officer, *Richland Memorial Hospital*

Connie Waldrop, Director, *Richland and Clay County Department of Human Services*

Connie West, Executive Director, *Richland County Senior Citizens Center*

Debi Phillips, Marketing Officer, *Trustbank*

Ricardo Diaz, Vice President of Center Operations, *Southern Illinois Healthcare Foundation*

Marilyn Holt, Superintendent, *East Richland Community Unit School District #1*

Rick Bussard, Richland Memorial Hospital Board of Directors, *Blanks Insurance*

Robert Wesley, Executive Director, *Regional Medical Programs Office of External and Health Affairs – Southern Illinois University School of Medicine*

Liesl Wingert, Outreach Specialist (CHNA Project Coordinator), *Richland Memorial Hospital*

Members of the Community Health Needs Assessment committee were chosen according to guidelines put forth in IRS Notice 2011-52, Section 501(r) (3) as follows:

"The CHNA must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health" *(Department of the Treasury, Notice 2011-52).*

The committee includes those who work with and represent education, senior citizens, low-income and minority populations, healthcare services, medically underserved populations, corporate commerce, and public health experts. Their job was to assist in reviewing the data and giving guidance to Richland Memorial Hospital on the prioritization of the identified community health needs, as well contribute to the data that was gathered.

Introduction

Richland Memorial Hospital (RMH) is a 135 bed, not-for-profit healthcare facility with over 550 employees that is accredited through the Healthcare Facilities Accreditation Program (HFAP). As the provider of choice serving the southeastern counties of Illinois, RMH is dedicated to providing the highest quality of care possible. In order to do this, RMH endeavors to retain its tax-exempt status as a charitable hospital organization and comply with newly established requirements promulgated by the Internal Revenue Service (IRS) based on the federal Patient Protection and Affordable Care Act enacted on March 23, 2010 stating that all 501(c)(3) hospital organizations conduct a "community health needs assessment and prepare a corresponding implementation strategy once every three years". Performing a CHNA has allowed the hospital to identify the most pressing health issues in our community, set programming priorities, and align work efforts with community partners in order to meet these needs in the most effective manner possible.

Mission, Vision and Core Values of Richland Memorial Hospital

To lay the groundwork for this project, it is necessary to review the mission, vision, and core values of the Richland Memorial Hospital community. Richland Memorial Hospital is committed to providing excellent healthcare services to the community which can be seen in the mission, vision and core values of our medical community.

Mission

- To provide excellent healthcare, promote wellness, and educate patients, staff, and the community.

Vision

- To continue to be the major provider of educational, preventative, diagnostic, and therapeutic services in the area.

***RMH provides**:*

1. A medical staff of 30 primary and secondary care physicians who, in cooperation with hospital staff, provide care to patients;
2. A cadre of skilled and caring employees who represent more than 100 job categories and are recognized by their fellow citizens for their knowledge and commitment;
3. A range of services that appropriately addresses the educational, prevention, diagnostic and therapeutic needs of children, adults and elderly;
4. A patient-centered focus of care that seeks to identify, provide and continuously improve those services most appropriate for the individual patient; and
5. An on-going review of the healthcare needs of the residents of the area and the most appropriate modalities and delivery methods.

Core Values

The Core Values of Richland Memorial Hospital are those qualities and behaviors on which our organization stands and operates. These values are a reflection of our culture, our character, and our standards of behavior.

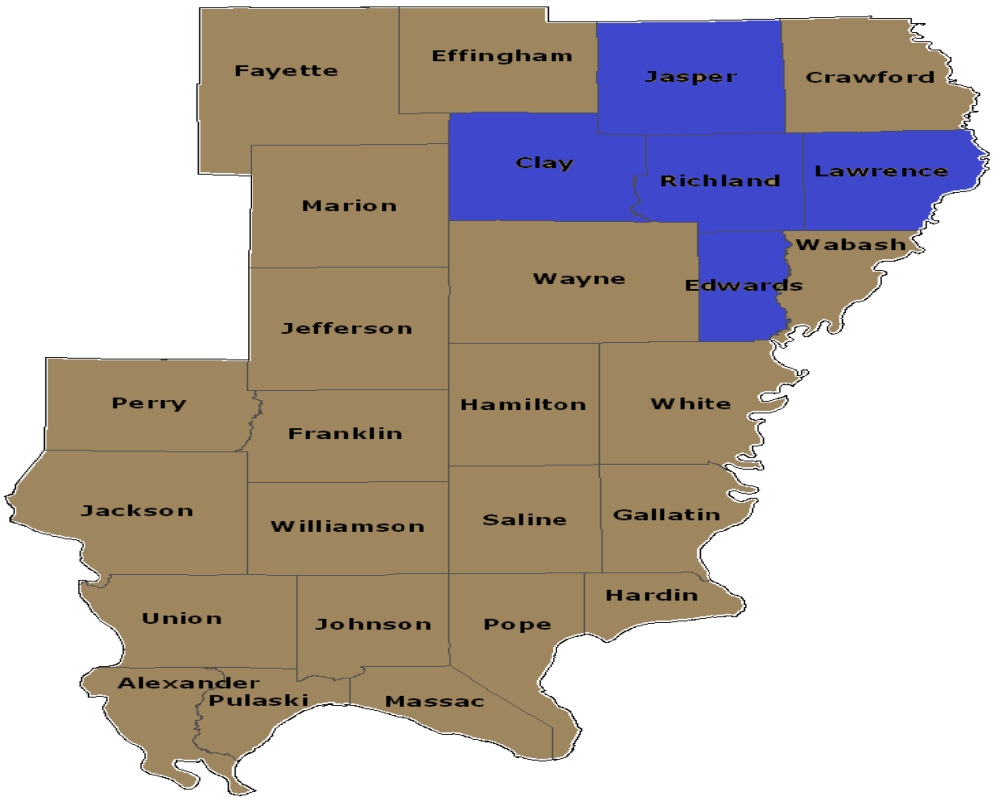
The following values are basic to quality and excellence in our facility:

- *Caring* for those entrusted to us and for one another with patience, kindness, compassion, and courtesy.
- *Trust* in our organization and belief in others while fostering a positive attitude, open-mindedness and confidence as we approach our daily work.
- *Respect* by recognizing and demonstrating the dignity and strength of each individual.
- *Competence* through the empowerment of our employees to seek personal and professional development to perform their respective duties in a skilled and proficient manner.
- *Communication* that that is open, honest, and thorough.

Community Served

Definition of the community served

The community that RMH serves was defined for the purpose of this community health needs assessment as those geographic areas/zip codes in which RMH performed at least 2% of the volume of healthcare services and captured at least 20% of the market share, and/or had a broad and reaching interest into that particular area. Per the results of a COMPdata survey and internal RMH data search, this was found to involve a five county area including Richland, Lawrence, Clay, Jasper and Edwards counties in the southeastern Illinois quadrant. The following map shows the area that includes the definition of the "community served":



Population characteristics and a specific description of medically underserved, low-income, and minority populations

According to the 2010 U.S. Census, the total population of the community served (Richland, Lawrence, Clay, Jasper and Edward's counties) is 63,300, with this number being very similar to the 2000 data from the U. S. Census. The most primary area served is located in Richland County, with a population of 16,233. The largest age category in the region includes those people between the ages of 20-64 years old, the smallest being those under the age of 5 years old. This data is stable when compared to the information from the 2000 U.S. Census. Tables 1 and 2 below show the distribution of ages by county based on data from the comparative U.S. Census:

Table 1: 2000 Population (Number and Percent)

2000 U. S. Census Population by Age[1] and County
(Number and Percent)

County	Population	Population Age Categories							
		Under Age 5		Aged 5-19		Aged 20-64		65 and Older	
		#	%	#	%	#	%	#	%
Clay	14,560	859	5.9%	2,997	20.6%	7,912	54.3%	2,792	19.2%
Edwards	6,971	394	5.7%	1,376	19.7%	3,911	56.1%	1,290	18.5%
Jasper	10,117	579	5.7%	2,338	23.1%	5,533	54.7%	1,667	16.5%
Lawrence	15,452	856	5.5%	3,054	19.8%	8,429	54.5%	3,113	20.1%
Richland	16,149	987	6.1%	3,417	21.2%	8,903	55.1%	2,842	17.6%
Total	63,249	3,675	5.8%	13,182	20.8%	34,688	54.8%	11,704	18.5%

Source: [1]United States Census Bureau. American Community Survey 2000.
Retrieved on December 13, 2012 from http://quickfacts.census.gov/qfd/maps/illinois_map.html

Table 2: 2010 Population (Number and Percent)

2010 U. S. Census Population by Age[1] and County
(Number and Percent)

County	Population Age Categories								
	Population	Under Age 5		Aged 5-19		Aged 20-64		65 and Older	
		#	%	#	%	#	%	#	%
Clay	13,815	852	6.2%	2,682	19.4%	7,813	56.6%	2,468	17.9%
Edwards	6,721	366	5.4%	1,349	20.1%	3,815	56.8%	1,191	17.7%
Jasper	9,698	555	5.7%	1,881	19.4%	5,573	57.5%	1,689	17.4%
Lawrence	16,833	874	5.2%	2,786	16.6%	10,490	62.3%	2,683	15.9%
Richland	16,233	974	6.0%	3,078	19.0%	9,071	55.9%	3,110	19.2%
Total	63,300	3,621	5.7%	11,776	18.6%	36,762	58.1%	11,141	17.6%

Source: [1]United States Census Bureau. American Community Survey 2010.
Retrieved on December 13, 2012 from http://quickfacts.census.gov/qfd/maps/illinois_map.html

Of the regional population (all five counties), it was found that 86.3% of adults under the age of 65 have some form of health insurance, and that 51.8% of the same group of adults have dental insurance *(United States Census Bureau, Small Area Health Insurance Estimates, 2012* and *Illinois Department of Public Health, Illinois Behavioral Risk Factors Surveillance System 2007-2009).* 24% of the population in the region who have health insurance utilize Medicaid. 20.8% utilize Medicare (United States Department of Health and Human Services, Community Health Status Indicators, 2009). The 2011 Community Profile published by the Greater Evansville Affiliate of the Susan G. Komen for the Cure Foundation estimates numbers as high as 25% to 30% of the population in this area are uninsured, indicating that basic preventive health measures as well as immediate health needs may be put off or ignored because of cost.

While health insurance, or lack thereof, is at the forefront of the healthcare battle, it is also important to note that many southern Illinois counties are dealing with a lack of primary care physicians, physician specialists, dentists, and mental health providers. This problem also plays into the issues that surround the medically underserved, in that often these patients will wait until a crisis point to seek medical attention because they do not have a regular physician. At that point, it is found that there is a definitive lack of providers to meet the medical need and the patient ends up in the local emergency room for treatment. This is a common theme across

both rural and urban America at this time. The Illinois Department of Public Health - Center for Rural Health indicates that most southern Illinois counties have a Federal HPSA (Health Professional Shortage Area) designation, with the low-income population being underserved. The five counties indicated in this CHNA are all included in that designation.

Richland Memorial Hospital would be remiss in its duties of conducting a thorough CHNA if it did not research and address the needs of minority and special populations. The following two tables (Table 3 and 4) show that overall, minority populations in the designated region make up 5.4% of the population, while "populations of interest" (veterans, developmentally disabled persons, and persons living below the poverty level) make up 24.2% of the population. Those persons living below the poverty level make up 13.8% of the population, a number that again indicates a substantial issue for the medically underserved.

Table 3: Minority Populations (Number and Percent)

2010 U. S. Census Minority Populations[1] by County
(Number and Percent)

County	Population	Minority Populations							
		Latino		Asian American		African American		Minority Total	
		#	%	#	%	#	%	#	%
Clay	13,815	180	1.3%	83	0.6%	69	0.5%	332	2.4%
Edwards	6,721	67	1.0%	20	0.3%	47	0.7%	134	2.0%
Jasper	9,698	87	0.9%	29	0.3%	29	0.3%	145	1.5%
Lawrence	16,833	589	3.5%	50	0.3%	1,683	10.0%	2,323	13.8%
Richland	16,233	227	1.4%	130	0.8%	114	0.7%	471	2.9%
Total	63,300	1,151	1.8%	313	0.5%	1,942	3.1%	3,405	5.4%

Source: [1]United States Census Bureau. American Community Survey 2010.
Retrieved on December 13, 2012 from http://quickfacts.census.gov/qfd/maps/illinois_map.html

Table 4: Populations of Interest

2010 Populations of Interest by County
(Number and Percent)

County	Population	Populations of Interest					
		Veterans[1]		Developmentally Disabled Persons[2]		Persons Below Poverty[3]	
		#	%	#	%	#	%
Clay	13,815	1,064	7.7%	262	1.9%	2,335	16.9%
Edwards	6,721	614	9.1%	125	1.9%	773	11.5%
Jasper	9,698	874	9.0%	182	1.9%	737	7.6%
Lawrence	16,833	1,379	8.2%	278	1.7%	2,727	16.2%
Richland	16,233	1,502	9.3%	291	1.8%	2,175	13.4%
Total	63,300	5,433	8.6%	1,138	1.8%	8,747	13.8%

Sources: [1]United States Census Bureau. American Community Survey 2010.
Retrieved on December 13, 2012 from http://quickfacts.census.gov/qfd/maps/illinois_map.html
[2]SIU School of Medicine. Direct communication with Illinois State Operated Developmental Centers 2010.
[3]United States Census Bureau. American Community Survey 2007-2011.
Retrieved on December 13, 2012 from http://quickfacts.census.gov/qfd/maps/illinois_map.html

While the above numbers alone indicate a need to reach out to the medically underserved, it is also prudent to look at income and education estimates for this region. It is common knowledge that higher income and educational attainment levels directly correlate with better medical care options. It is estimated that the average median annual income for Richland County is less than $42,000 *(United States Census Bureau, 2010),* with the other four counties closely following that same estimate. When factoring in educational attainment (see Table 5), only 14.3% of regional area residents aged 25 years or older have a Bachelor's Degree or higher education, and 37.4% have just a high school education. This data seems to correlate with the problematic issues surrounding the above numbers involving lack of adequate health insurance, income and education.

Table 5: Educational Attainment Levels

2007 - 2011 Estimated Educational Attainment: Adults Aged 25 Years or More[1] by County (Number and Percent)

County	Educational Attainment Among Adults Aged 25 Years or More								
	Population	Less Than HS		HS Diploma		Some College or AA Degree		BA Degree or Higher	
		#	%	#	%	#	%	#	%
Clay	9,614	1,348	14.0%	4,143	43.1%	2,811	29.2%	1,312	13.6%
Edwards	4,646	550	11.8%	1,574	33.9%	1,941	41.8%	581	12.5%
Jasper	6,793	697	10.3%	2,593	38.2%	2,479	36.5%	1,024	15.1%
Lawrence	11,784	2,444	20.7%	4,378	37.2%	3,723	31.6%	1,239	10.5%
Richland	11,318	1,215	10.7%	3,841	33.9%	4,119	36.4%	2,143	18.9%
Total	44,155	6,254	14.2%	16,529	37.4%	15,073	34.1%	6,299	14.3%

Source: [1]United States Census Bureau. American Community Survey 2007-2011.
Retrieved on December 13, 2012 from http://quickfacts.census.gov/qfd/maps/illinois_map.html
Note: Population based on persons aged 25 years or older according to the United States Census Bureau five year estimates.

Data Collection

Timeline for the CHNA

Preliminary preparation for this project began in September 2011 and continued through July 2012. The first meeting of the Community Health Needs Assessment committee was in August of 2012, and data collection began at that time, continuing through May 2013. In June of 2013, the Community Health Needs Assessment committee met to review and discuss the data, as well as identify and prioritize the findings from the data. The final report was completed in August 2013 and was presented to the Richland Memorial Hospital Board of Directors in September 2013 for final approval.

Federal requirements by the Patient Protection and Affordable Care Act state that the hospital must, during the data collection process, take into account input from persons who represent the broad interests of the community that is served by our hospital. This was done using several mechanisms of information gathering including private interviews, participation on the Community Health Needs Assessment committee (by invitation only), focus groups (qualitative data), written responses, as well as a data sweep of federal, state, internal and other secondary public data sources (quantitative data). As stated above, all data was acquired between the dates of August 2012 and May 2013. It should be noted that, though all of the data in this report is the most accurate and up-to-date available, it is typical for publicly available secondary data to be several years old. Every effort has been made to acquire the most up-to-date data available.

Qualitative Data: How RMH took into account input from persons who represent the broad interests of the community using a CHNA committee, focus groups, written responses, and private interviews

The Richland Memorial Hospital Community Health Needs Assessment committee put together a plan of action to conduct the CHNA that would address the requirement by the IRS to "take into account input from persons who represent the broad interests of the community" *(Department of the Treasury, Notice 2011-52).* The CHNA committee made the decision to not only acquire input from the committee members, but to also include input from participants by using focus groups, invited written responses, and private interviews.

CHNA committee members were chosen by Richland Memorial Hospital based on their ability to advocate/speak for those community members who are medically underserved, low-income, of a minority population, representative of the community at-large, representative of the healthcare community, representative of the business/corporate industry, or have a special knowledge of or expertise in public health. CHNA committee members were not paid for their time and participation, all involvement was completely voluntary. Private interviews were conducted with all CHNA committee members, with each interview including the same questions as were asked of the focus group participants (see Appendix A).

Seven *focus groups* were developed based on populations of critical priority identified by the CHNA committee. Participants were put into a group based on their area of expertise as it related to an area of priority, including healthcare, veterans, area clergy, senior citizens, education/children, low-income, and a "general" group that involved participants from a wide expanse of expertise. Participants representing various organizations throughout the five county region were invited to participate in the focus groups (see Table A, below). If an invited participant was unable to attend, *written responses* to the focus group questions were requested of those participants. As well, several community members with a special interest in the public health needs of the defined community were invited to present written responses to the determined set of questions.

All of the focus groups met during February and March of 2013 and were conducted by the Southern Illinois University Center for Rural Health and Social Service Development. Focus group participants were first contacted personally by phone by the Richland Memorial Hospital CHNA Project Manager to inquire of their willingness to participate. Two weeks prior to the designated meeting time, a letter was sent to the participants giving them specific guidelines for participation as well as the date and time that their group would be held (see Appendix B). Each focus group meeting met only one time at Richland Memorial Hospital and lasted one and a half hours. During the focus group meeting time, only the invited participants and the Southern Illinois University Center for Rural Health and Social Service Development team were allowed in the room. Focus group participants were not paid for their time and participation, all involvement was completely voluntary. In addition, participants were required to sign a

consent form for participation (see Appendix C), and were made fully aware that all discussion within the meeting time/room was considered confidential. Data was collected and analyzed by the Southern Illinois University Center for Rural Health and Social Service Development team and a summary of the data was presented to RMH in April 2013. There was a 90% participation rate by members of the focus groups, giving RMH a solid foundation of data from which to work with.

Finally, *private interviews* were conducted by the Project Coordinator with all of the CHNA committee members using the same designated set of questions that were used for the focus groups. In addition, several community members with a special interest in the public health needs of the defined community were invited to a private interview with the Project Coordinator in order to share their expertise on the health needs of our community.

Table 6 below shows the entire list of all of the organizations involved on/in the CHNA committee, focus groups, written responses, and interviews as well as the sector(s) of population that they represented and to what extent/how they were involved.

Table 6: Organizations represented in the Richland Memorial Hospital Community Health Needs Assessment and the nature of representation

Organization	Medically Underserved	Low-Income	Minority	Health Dept/Office	Expertise in Public Health	Other	CHNA Comm. Member	Focus Group	Interview
Richland Memorial Hospital	X	X	X		X	X	X	X	X
SIHF-WMC	X	X	X				X	X	X
Lawrence County EMS	X	X	X					X	
Jasper County Health Dept	X	X	X	X	X	X		X	
Southeastern IL Counseling Center	X	X	X			X		X	
Olney Central College		X	X			X		X	
ARC-CSS	X	X	X			X		X	
Richland County Chamber of Commerce						X		X	
Walmart DC		X				X		X	
Richland County Law Enforcement	X	X	X			X		X	
VFW	X	X	X			X		X	
American Legion	X	X	X			X		X	
Richland County Housing Authority	X	X	X			X		X	
Ministerial Association – Richland, Clay, Lawrence, Edwards and Jasper	X	X	X			X		X	
Southern Illinois University – School Of Medicine					X		X		X
Fox River Assisted Living	X	X	X			X		X	
Burgin Manor Nursing Home	X	X	X			X		X	
Birthright, Inc.	X	X	X					X	
East Richland Community Unit District #1 School System	X	X	X			X	X	X	X
Wes t Richland School System	X	X	X			X		X	

Upward Bound – TRIO Programs	X	X	X			X		X	
Edwards County School System	X	X	X			X		X	
SWAN – Homeless Shelter, Elder Abuse	X	X	X			X		X	
Master's Hand	X	X	X			X		X	
Department of Human Services – Richland, Clay	X	X	X		X	X	X	X	X
Richland County Health Office	X	X	X	X	X	X	X		X
Private Practice Mental Health Counselors	X					X		X	X
Edwards County Senior Citizens	X	X	X			X		X	
Richland County Senior Citizens	X	X	X			X	X	X	X
Trustbank						X	X		X
Lawrence County Health Department	X	X	X	X	X	X		X	
Blanks Insurance						X	X		X

**The category of "Other" denotes representation of corporate commerce, disabled, veterans, homeless, and mentally ill. It should be noted that there is duplication of the persons/needs listed in this category, as they often also apply to the other categories listed above.*

Quantitative Data: Publicly available and RMH internal data

In addition to qualitative data gathering activities, RMH was also involved in compiling data that is made publicly available (such as from the U.S. Census and the Illinois Department of Public Health), local school districts, as well as internal data from RMH systems. The Southern Illinois University School of Medicine – Office of External and Health Affairs was asked to complete a data sweep of federal, state, and other public sources that applied to the CHNA project. Their report was generated in May of 2013 and was pivotal in assisting the committee with the decisions made regarding what "significant health needs" were to be identified. Many of the tables in this CHNA are lifted directly from the actual report created for the committee. It was found that both the qualitative and quantitative data indicated the same foundations of concern that formulated the identification of the region's significant health needs by the CHNA committee. For the full report given by the Southern Illinois University School of Medicine – Office of External and Health Affairs, please reference Appendix D.

Summary of Findings

As stated above, there were several common themes that surfaced in both the qualitative and quantitative data. They were consistent enough among the different input sources that the community health needs picture was obvious to the committee when identifying the health needs that should be considered "significant". Using the process and criteria described in the next section, the following identified health needs were found to be the most significant to our community:

It is interesting to note that all three identified health needs are also Leading Health Indicators in the Healthy People 2020 report (*http://healthypeople.gov/2020/LHI/default.aspx*), and are considered to be "high priority health issues" in our nation (*http://healthypeople.gov/2020*). In other words, our five county region is very similar to the country as a whole in terms of health needs. While RMH has chosen to label the needs a bit differently, the underlying issues fit neatly into several of the Healthy People 2020 Leading Health Indicators. A more detailed discussion of these three significant health needs is addressed below, as well as the process and criteria that the CHNA committee used to identify and prioritize them.

Identified Significant Health Needs

Healthy People 2020 and Richland Memorial Hospital

It is important that a discussion of the Healthy People 2020 national project be included here (*http://healthypeople.gov/2020/about/default.aspx*), as hospitals are encouraged to compare the results of their CHNA with the goals put forth in this project. In addition, as hospitals are forming an implementation strategy to meet the identified significant health needs in their community, they are encouraged to use the goals and benchmarks indicated in Healthy People 2020 as a nationally consistent way to track the success of their programming and strategies. The tracking measures will then be available to the public as RMH conducts a new CHNA every three years for comparison, as required by the Patient Protection and Affordable Care Act and the Department of the Treasury.

What is Healthy People 2020?

Healthy People 2020 is a national plan for the United States that provides science-based national objectives for improving the health of all Americans over the course of ten years. For the past 3 decades, Healthy People has established benchmarks that enable collaborations across communities, as well as given individuals the information that provides the power for them to make informed health decisions. In addition, the Healthy People 2020 initiative acts to measure the impact of ongoing prevention activities across the United States. Thus, as you read through this report, you will occasionally see referenced for comparison the national data that is available to us from Healthy People 2020.

Process and criteria for identifying and prioritizing significant health needs

The process and criteria by which the CHNA committee identified and prioritized the most significant health needs to address was simple, straightforward, and common sense oriented. First, a complete list of the various health issues were identified from both the qualitative and quantitative data, and were compiled and reviewed. From that list, the issues were further narrowed down to the most common/frequently discussed ten health needs that arose from the data based on raw numbers (quantitative data) and discussion (qualitative data). The last step in the process found the CHNA committee evaluating the most commonly mentioned and obvious issues and applying the following discretionary methodology to each one in order to identify, label and prioritize those health issues that were deemed most significant:

- *Overall impact* – how much the issue affects health and quality life, or contributes to multiple health related issues
- *Magnitude of the problem* – how many lives are affected in our community, and how does our community compare to national benchmarks and goals
- *Severity* – the degree to which the issue leads to pre-mature morbidity and mortality
- *Ability and interest* of the community to effectively address the issue

Using the framework above allowed the committee to take into account all of the dynamics of the data that was presented to them, including both raw numbers as well as first person commentary. It was felt that this was a key point to the decision making process. As expected, there were no real surprises to the answers that arose from this way of looking at the data - the indications for prioritization became very obvious. In addition, it should be noted that the CHNA committee felt strongly about consideration being given to how deeply the various health needs affected the children in the region. Implementation strategies could then potentially be considered that would allow for positive changes in children's health, thus laying the framework for a healthier Southeastern Illinois community of the future.

Significant Health Needs – Discussion

Each identified health need listed below is intricately related to the others – none of them act on their own with no effect on the others. Therefore, prioritization of these specific needs was difficult. However, based on the sheer numbers and discussion threads that took place in the focus groups, committee meetings, and private interviews, it became obvious to the CHNA committee that our community has a strong need for a greater level of mental health services. The committee chose to include the "related social issues" such as homelessness, low-income, nutrition gaps, alcoholism, drug abuse, and teen pregnancy simply because they are so closely related to mental health issues. A more in-depth discussion follows regarding the significant health needs below.

Health Need #1: Mental Health and Related Social Issues

According to the Healthy People 2020 project, the definition of mental health is the "successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges" *(http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=28)*. It becomes obvious, then, that good mental health is essential to a person's basic well-being, as well as their family and interpersonal relationships. It is also a key point in the ability to contribute in a healthy manner to community or society. Good, stable mental health is the basis for a healthy working community of individuals. Mental illness is characterized by changes in thinking and mood that produce behaviors that are associated with distress and impaired functioning. Thus, it can be assumed that a community with a high proportion of mental illness will see an increase in negative social issues that contribute to many of the health problems that affect the local society.

According to the Healthy People project, the proportion of adults in 2010 aged 18 and over who experienced a major depressive episode (MDE) in the United States in the past 12 months was 6.8%. Most were females.

*(http://healthypeople.gov/2020/topicsobjectives2020/nationalsnapshot.aspx?topicId=28)

Local research shows an identical number for our region, as seen in Table 7 below (though not broken down by gender):

Table 7: Major Depression, Suicide, and Behavioral Health Resources (Number and Percent)

2009 Major Depression[1], Suicide[2], and Behavioral Health Resources[3] by County (Number and Percent)

County	Major Depression and Suicide				Behavioral Health Regional Resources	
	Adult Population	Have Major Depression[1]		Total Suicides[2] 1997-2006	Number of Psychiatrists[2]	Nearest Mental Health Center Location[3]
		#	%	#	#	
Clay	10,238	697	6.8%	13	0	Southeastern Illinois Counseling Center, Flora
Edwards	5,004	334	6.7%	6	0	Southeastern Illinois Counseling Center, Albion
Jasper	7,197	493	6.9%	6	0	Jasper County Health Department, Newton
Lawrence	12,947	887	6.9%	16	1	Lawrence County Health Dept., Lawrenceville
Richland	11,774	787	6.7%	16	1	Southeastern Illinois Counseling Center, Flora
Total	47,160	3,198	6.8%	57	2	n/a

Note: Regional Mental Health Facility: Region 5, South - Anna, Illinois

Note: State Psychiatric Hospitals: Alton Mental Health Center - Alton, Illinois
Choate Mental Health Center - Anna, Illinois

Source: [1]Department of Health and Human Services. Community Health Status Indicators 2009.
Retrieved on December 12, 2012 from http://www.communityhealth.hhs.gov/HomePage.aspx?GeogCD=&PeerStrat=&state=&county=

Note: Annual Averages Major depression prevalence by state for age 18 and older 2006-2007 from U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) Office of Applied Statistics as projected from state estimates

Note: Adult population aged 19 years or more

[2]American Medical Association.Physician Related Data Resources 2011.
Retrieved on February 12, 2013 from http://www.ama-assn.org/cgi-bin/sserver/datalist.cgi

Note: Does not indicate an FTE - data is self-reported by physicians to the AMA

[3]Illinois Department of Human Services 2012.
Mental Health Center Locator 2012.
Retrieved December 13, 2012 from http://www.dhs.state.il.us/page.aspx?module=12

During the focus group sessions, it was common for participants to state that local outpatient behavioral services were “ineffective”, and that the wait time for an appointment to see a counselor is 4-6 weeks due to a lack of mental health professionals in the area. During the discussions, it was clarified that the lack of professionals includes both psychiatric level providers as well as initial providers such as first level counselors. Richland Memorial Hospital has the only inpatient mental health/psychiatric units in the area with 10 inpatient beds available, all of which are often filled with a significant number of persons from out of the area. Post discharge arrangements are very difficult. Table 8 below shows the top five major

diagnostic categories at discharge for Richland Memorial Hospital, of which mental disease was in the top five for both 2011 and 2012.

Table 8: Top 5 Major Diagnostic Categories at Discharge – Richland Memorial Hospital

Richland Memorial Hospital
2011 and 2012 Top 5 Major Diagnostic Categories at Discharge by Year and Rank[1]
(Number of Inpatients and Percent of Total Inpatients)

2011 (Total Inpatients: n = 3,285)

Major Diagnostic Categories			Inpatients	
Rank	Description	Code	#	%
1	Mental Diseases and Disorders	19	573	17.4%
2	Pregnancy, Childbirth & Puerperium	14	352	10.7%
3	Respiratory System	4	323	9.8%
4	Newborn and Other Neonates	15	320	9.7%
5	Circulatory System	5	128	3.9%
n/a	Total	n/a	1,696	51.6%

2012 (Total Inpatients: n = 3,048)

Major Diagnostic Categories			Inpatients	
Rank	Description	Code	#	%
1	Mental Diseases and Disorders	19	505	16.6%
2	Pregnancy, Childbirth & Puerperium	14	338	11.1%
3	Newborn and Other Neonates	15	314	10.3%
4	Respiratory System	4	271	8.9%
5	Kidney and Urinary Tract	11	100	3.3%
n/a	Total	n/a	1,528	50.1%

Source: [1]Richland Memorial Hospital Medical Records Department. Provided to analysts on April 22, 2013. Provided both data and notes.

Note: Major Diagnostic Categories (MDC) are formed by assigning each principal diagnosis (from ICD-9-CM) to 1 of 25 mutually exclusive diagnostic areas. MDC codes, like DRG codes, are primarily a claims and administrative data element unique to the United States medical care reimbursement system. DRG codes also are mapped, or grouped, into MDC codes.

Note: The diagnoses in each MDC correspond to a single organ system or etiology and, in general, are associated with a particular medical specialty. MDC 1 to MDC 23 are grouped according to principal diagnoses. Patients with at least 2 significant trauma diagnosis codes (either as principal or secondary) from different body site categories are assigned to MDC 24 (Multiple Significant Trauma). Patients assigned to MDC 25 (HIV Infections) must have a principal diagnosis of an HIV Infection or a principal diagnosis of a significant HIV related condition and a secondary diagnosis of an HIV Infection.

Note: MDC 0, unlike the others, can be reached from a number of diagnosis/procedure situations related to transplants. This is due to the expense involved for the transplants so designated and because these transplants can be needed for a number of reasons which do not all come from one diagnosis domain. DRGs which reach MDC 0 are assigned to the MDC for the principal diagnosis instead of to the MDC associated with the designated DRG.

Both the focus groups as well as the CHNA committee felt that there was an exceptional lack of mental health service providers, which in turn leads to not only unaddressed mental illnesses, but also social issues such as poverty, suicide, violence, drug and alcohol abuse, food and housing insecurities, risky behaviors, and child abuse and neglect. Included in Tables 9 and 10 below, you can see some of the raw data regarding local numbers for children living in poverty as well as abuse and neglect. These numbers clearly coincide with information that came out of the focus groups and interviews that were conducted.

Table 9: Food Insecurity and Children Living in Poverty

2010 Food Insecurity[1] and Children Living in Poverty[2] by County (Number and Percent)

County	Population			Food Insecurity				Children Living in Poverty	
	Total Population	Children		Population		Children			
		#	%	#	%	#	%	#	%
Clay	13,961	3,727	26.7%	2,150	15.4%	790	21.2%	820	22.0%
Edwards	6,720	1,557	23.2%	840	12.5%	330	21.2%	265	17.0%
Jasper	9,744	2,217	22.8%	1,140	11.7%	430	19.4%	355	16.0%
Lawrence	16,846	3,213	19.1%	2,510	14.9%	800	24.9%	771	24.0%
Richland	16,148	3,589	22.2%	2,180	13.5%	750	20.9%	754	21.0%
Total	63,419	14,303	22.6%	8,820	13.9%	3,100	21.7%	2,964	20.7%

Sources: [1]Feeding America. Map the Meal Gap, Food Insecurity in Your County 2010.
Retrieved on December 12, 2012 from http://feedingamerica.org/hunger-in-america/hunger-studies/map-the-meal-gap.aspx.
[2]Robert Wood Johnson Foundation. County Health Rankings.
Retrieved on December 12, 2012 from http://www.countyhealthrankings.org/app/illinois/2012/rankings/outcomes/overall
Note: Total population based on information provided by Feeding America.

Table 10: Child Abuse/Neglect Rates

2010 Prevalence[1] of Child Abuse/Neglect and Rate by County (Number, Percent and Rate)

County	Abuse and Neglect Cases, Unduplicated Count and Rate				
	Population[2]	Cases	Unduplicated Count		Child Abuse per 1,000
		#	#	%	Rate
Clay	3,164	159	141	4.5%	40.8
Edwards	1,536	63	61	4.0%	38.3
Jasper	2,204	107	81	3.7%	30.8
Lawrence	3,207	239	207	6.5%	59.9
Richland	3,608	261	219	6.1%	55.5
Total	13,719	829	709	5.2%	51.5

Source: [1]Illinois Department of Child and Family Services. Child Abuse and Neglect Statistics 2011.
Retrieved on February 14, 2013 from http://www.state.il.us/DCFS/docs/CANTS2011.pdf.
[2]Population Aged 17 Years and Under as presented by United States Census Bureau 2010 data.
Note: Population was manually calculated by subtracting the population 18 and older from the total population.

When researching local homeless rates, it was found that there was a lack of comprehensive and clear data available that pertains to this issue. However, the school systems in the region are tracking the levels of homelessness within the families of their school children and the data is likely only the beginning of a larger regional issue that involves many more adults. Table 11 shows the data gathered from the school systems in the region. About 4.6% of the students in the region are considered homeless, with 10.3% of the students in Richland county struggling with this designation (please note: it is imperative that when discussing homelessness that a common definition be used across all data – the definition for homeless that was used for the purpose of this CHNA can be referenced in Table 11 below).

Table 11: Student Homelessness by County

2013 Student Enrollment and Homeless Students by County[1]
(Number and Percent)

County	Total Enrollment		Homeless Enrollment		
			Enrolled		Of Total
	#	%	#	%	%
Clay	2,464	25.7%	73	16.6%	3.0%
Edwards	955	9.9%	14	3.2%	1.5%
Jasper	1,405	14.6%	67	15.2%	4.8%
Lawrence	2,285	23.8%	29	6.6%	1.3%
Richland	2,491	25.9%	257	58.4%	10.3%
Total	9,600	100.0%	440	100.0%	4.6%

Sources: [1]Regional Office of Education and Richland Memorial Hospital. Based on student counts for the 2013 school year.
Note: Information based on enrollment reports provided to the Regional Office of Education by the following schools: Clay City CUSD # 10, Flora CUSD # 35, North Clay CUSD # 25, Jasper CUSD # 1, Lawrence County CUSD # 20, Red Hill CUSD # 10, Edwards County CUSD # 1, East Richland and West Richland CUSD schools.

Note: Homeless children are defined as: children and youth who lack a fixed, regular, and adequate nighttime residence, including children and youth who are: sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; living in motels, hotels, trailer parks, or camping grounds due to lack of alternative adequate accommodations; living in emergency or transitional shelters; abandoned in hospitals; awaiting foster care placement; children and youth who have a primary nighttime residence that is a public or private place not designed for, or ordinarily used as, a regular sleeping accommodations for human beings; children and youth who are living in cars, parks, public places, abandoned buildings, substandard housing, bus or train stations, or similar settings; and, migratory children who qualify as homeless because they are living in circumstances described above. (McKinney-Vento Act 725)

To add further to the discussion on mental health and children, the National Institute of Mental Health reports that in the U.S. today, one in ten children suffer from a mental disorder severe enough to cause some level of impairment. One of the most common elements of discussion in our focus groups, as well as the CHNA committee, was that of the increasing number of children in our region who are struggling with mental health issues. There is a severe lack of mental health providers in the area that have the necessary skills to work with pediatric mental illness, and educational funding for such providers within the school system (where often this is the first line of treatment for children) has been drastically cut leaving area school systems lacking for a referral source of help for their students. In order for children to receive adequate mental health services, these children must go out of the area for mental health care. Often this is a problem due to coordinating social issues such as lack of transportation, financial inability to afford to travel out of town for this type of medical care, lack of parental understanding of the seriousness of the issue and the need for consistency of treatment, and drug and alcohol abuse within the home environment that disallows good decision making processes as it pertains to the children. Thus, our children are often not getting the mental health care services that are needed.

Clearly, then, mental health and its associated social issues have come forth as an extremely pressing health need in our community. The lack of providers to address mental health needs in a timely and affordable manner, as well as the coinciding social issues that ensue from this problem, are significant. Both children and adults are affected in both direct and indirect manners. School systems are struggling with this issue on a daily basis, and the ability for our children to learn is getting more difficult each passing year. However, we also know that school-based preventive interventions aimed at improving social and emotional outcomes have the power improve academic outcomes. We also know that improving family functioning and positive parenting can have positive outcomes on mental health, reducing poverty-related risk *(http://www.iom.edu/Reports/2009/Preventing-Mental-Emotional-and-Behavioral-Disorders-Among-Young-People-Progress-and-Possibilities.aspx).* Addressing this significant health need will have to involve an interdisciplinary and interagency approach, as it will be impossible for one agency to effectively work with this problem.

Health Need #2: Access to Health Services – Health Providers, Health Department

Access to health services (or a lack thereof) affects both a person's health as well as their well-being. Prevention of disease and disability, detecting and treating health conditions and illnesses, increasing the quality of life, reducing the risk of premature death as well as increasing life expectancy levels are all affected by access to health services. The Richland Memorial Hospital community is blessed with both primary care and specialty providers, however as is true for most rural areas in the United States, there are not enough providers to adequately serve the area population. The table below shows the number and type of physician medical staff members that are affiliated with Richland Memorial Hospital (it should be noted that Clay and Lawrence county hospitals also have providers that serve areas that overlap the RMH service area, with basic numbers provided in Table 12 below):

Table 11: Richland Memorial Hospital 2013 Physician Medical Staff

Richland Memorial Hospital 2013 Physician Medical Staff by Type and Specialty[1]
(Number and Percent)

Medical Staff by Type and Specialty			Qualifications of Medical Staff by Type[2]
Active and Associate Staff	#	%	
Emergency Medicine	1	5.9%	Active Staff Qualifications: a) reside within 30 minutes of the Hospital (Psychiatrists, 60 minutes); b) know the community and Hospital medical needs; c) admit or be involved in the care of at least 12 patients/year; and, c) complete at least 1 year of satisfactory performance as Associate Staff.
Family Practice	2	11.8%	
General Practice	1	5.9%	
General Surgery	2	11.8%	
Internal Medicine	1	5.9%	
OB/GYN	3	17.6%	
Orthopedic Surgery**	1	5.9%	
Otolaryngology	1	5.9%	Associate Staff Qualifications: a) reside within 30 minutes of the Hospital; b) be qualified for advancement to Active Staff; c) participate in emergency room call schedule as appropriate, if requested; and, d) clinical performance reviewed as necessary during his/her Associate Staff status.
Pathology	1	5.9%	
Pediatrics	2	11.8%	
Psychiatry	1	5.9%	
Urology	1	5.9%	
Total Active/Associate Staff	17	100.0%	
Courtesy and Affiliated Staff	#	%	

Cardiology	35	29.2%	Courtesy Staff Qualifications: a) admit or provide service to fewer than 50 patients of the Hospital per year; b) reside within 45 minutes of the Hospital or arrange coverage with a similarly privileged Active or Associate Staff member of the Hospital for patient coverage; c) be an appointee of the Active or Associate Staff of another hospital accredited by the Joint Commission, the American Osteopathic Association, or the Healthcare Facilities Accreditation Program.
Clinical Radiologists	57	47.5%	
Dentistry	2	1.7%	
Emergency Medicine	10	8.3%	
General Surgery***	1	0.8%	
Hand Surgery	1	0.8%	
Neurology	2	1.7%	
Oncology	1	0.8%	
Opthalmology	2	1.7%	
Orthopedic Surgery	1	0.8%	Affiliated Staff Qualifications: specialists in the medical or dental professions who provide consultation, locum tenens or ER coverage or provide specific intermittent service (cardiology, neurology, pediatric cardiology, etc.) but are unable to hold a regular staff appointment due to distance or other reasons.
Pathology	2	1.7%	
Pediatric Cardiology	3	2.5%	
Podiatry	2	1.7%	
Psychiatry	1	0.8%	
Total Courtesy/Affiliated Staff	120	100.0%	

Source: [1]Richland Memorial Hospital. Medical Staff Services. Medical Records Department. 2013.
[2]Richland Memorial Hospital Medical Staff Bylaws.
**The Orthopedic Surgeon is an Associate Staff Member
***The General Surgeon is a Courtesy Staff Member

Table 12 shows how many physicians and dentists are available (as of 2009) in the region that is included in this CHNA:

Table 12: Physician and Dentist Count by County

2009 Number of Dentists[1], Dentist Utilization[2] and Physician Count[3] by County (Number and Percent)

County	Dentists, Dentist Utilization and Physicians				
	Population	Number of Dentists[1]	People Who Visit the Dentist Annually[2]		Current Physician Count[3]
		#	#	%	#
Clay	10,562	8	6,357	60.5%	13
Edwards	5,056	2	3,220	63.7%	0
Jasper	7,169	3	4,546	63.4%	2
Lawrence	12,239	3	7,938	65.0%	9
Richland	11,721	5	7,055	60.9%	39
Total	46,747	21	29,116	62.3%	63

Sources: [1]United States Department of Health and Human Services. Health Resources and Services Administration. Area Resource File 2011.

Note: Number of Board Certified Dentists

[2]Illinois Department of Public Health. Illinois Behavioral Risk Factors Surveillance System 2007-2009. Retrieved on December 12, 2012 from http://app.idph.state.il.us/brfss/countydata.asp .

Note: Estimate based upon a survey of households. As the data source is a survey, population numbers were weighted to account for the sampling technique used. Weighted population counts vary slightly depending upon the variable.

[3]American Medical Association. Physician Related Data Sources. Retrieved on March 7, 2013 from http://www.ama-assn.org/cgi-bin/sserver/datalist.cgi

One area of concern that was routinely brought up in all venues of data gathering was the lack of a health department. Two of the counties in the five county region (the defined community for this CHNA) do not have a health department – Richland and Edwards counties. Richland County has a County Health Nurse, but no politically defined department (there is a County Health Office, which is not afforded the same funding designations as a County Health Department). Edwards County is similar in that there is not a politically defined county health department, however they do have two county health nurses. It should also be noted that these two counties are the only two counties in the state that are lacking a health department. Since health departments provide a variety of health services, both direct (immunizations, health education, sexually transmitted disease testing, etc…) and indirect (various types of water testing, restaurant inspections, etc…), the lack of a health department becomes a critical missing piece of the health care puzzle.

In every step of the data gathering process, the issue of access to health services (medical providers) became apparent. This issue was brought up in every focus group that was conducted, with discussions centering on "the need for a healthcare system that is dynamic and able to meet the needs of the community, and is affordable for all" *(Richland Memorial Hospital Focus Group Report, April 15, 2013, Southern Illinois University Center for Rural Health and Social Service Development).* There were indications in the data that the emergency room is being utilized for primary care purposes due to the difficulty of acquiring a primary care appointment for urgent care issues which is due to the lack of the necessary amount of primary care providers in the area. In addition, it was felt that there was a lack of primary care evening and weekend appointments available which contributed to the use of the emergency room for primary care issues. Finally, it is becoming harder to find a physician that will provide services to public aid recipients (accepts Medicaid), especially specialty physicians. Oral health/dentistry is of particular concern, as there are no pediatric dentists that are available locally. "Traveling" dentists come to the schools at least one time per year, however these do not provide follow-up to the diagnoses, and the cost of treatment is prohibitive. Table 12, located above, indicates the number of dentists in the region. It is clearly not adequate for our five county area.

Healthy People 2020 lists "access to health services" as a leading health indicator, acknowledging the issue as a critical problem in the United States. It is a national health problem that our small community has not been able to avoid. While social, economic, and environmental factors all contribute toward the problems associated with not having enough primary care physicians, it is still worthy of our ongoing attention and efforts to address it.

Health Need #3: Chronic Disease

For the purposes of this CHNA, a simple definition of chronic disease is defined as "diseases of long duration and generally slow progression" *(Centers for Disease Control, 2013).* Chronic diseases tend to have the following common attributes:

- they have many causes but often share common risk factors (i.e. tobacco use, physical inactivity, unhealthy eating, and/or excessive alcohol use)
- usually begin slowly and develop gradually over time
- can occur at any age, most often in later life
- they have the ability to impact quality of life and limit daily activities
- require actions over the long-term to manage the disease, involving individuals, health care providers and the community
- in most cases can be prevented or controlled with healthy lifestyle changes

Chronic diseases impact the health of the population as well as the sustainability of the health care system, and many of our identified population live with more than one chronic disease as they are often intertwined. Diabetes, heart disease, lung disease, stroke, tobacco use, alcohol abuse, unhealthy eating habits, and obesity were the most commonly identified chronic diseases in our CHNA data.

There is a plethora of regional and national data surrounding the incidence of chronic disease. Please see the tables below that show the regional rates of chronic disease by diagnosis as they are broken down by county. The findings of the qualitative data (interviews and focus groups) indicate a strong perception that the communities involved in this CHNA struggle with all of these most common chronic diseases. Interestingly, this data came from both those who perform daily work in the medical community as well as those who work in non-medical fields.

Table 13: Risk Factors by County

2009 Health Risk Factors[1] Ranked by County
(Number and Percent)

County	Health Risk Factor Ranking									
	Factor #1	Factor #2	Factor #3	Factor #4	Factor #5	Factor #6	Factor #7	Factor #8	Factor #9	Factor #10
Clay	Inadequate fruit/veggie diet (89.1%)	Inadequate exercise (50.1%)	High Blood Pressure (41.9%)	High Cholesterol (39.4%	Arthritis (37.0%)	Obesity (31.3%)	Smoking (22.9%)	Asthma (14.0%)	Binge Drinking (12.9%)	Diabetes (12.3%)
Edwards	Inadequate fruit/veggie diet (85.1%)	Inadequate exercise (49.1%)	High blood pressure (38.7%)	Arthritis (34.5%)	High Cholesterol (31.6%)	Obesity (28.6%)	Smoking (19.3%)	Asthma (13.9%)	Diabetes (12.0%)	Binge Drinking (11.0%)
Jasper	Inadequate fruit/veggie diet (85.9%)	Inadequate exercise (41.5%)	High blood pressure (31.7%)	High cholesterol (28.3%)	Arthritis (28.4%)	Obesity (26.3%)	Binge Drinking (20.5%)	Smoking (16.3%)	Diabetes (10.3%)	Asthma (9.3%)
Lawrence	Inadequate fruit/veggie diet (86.5%)	Inadequate exercise (50.6%)	Arthritis (38.4%)	High Blood Pressure (34.8%)	High Cholesterol (33.4%)	Obesity (25.3%)	Smoking (20.0%)	Binge Drinking (14.6%)	Diabetes (13.2%)	Asthma (11.7%)
Richland	Inadequate fruit/veggie diet (85.9%)	Inadequate exercise (55.2%)	High cholesterol (36.7%)	High Blood Pressure (36.7%)	Arthritis (31.5%)	Obesity (29%)	Smoking (22.2%)	Binge Drinking (13.6%)	Diabetes (12.7%)	Asthma (11.4%)
Regional Modal Risk Factor	Inadequate fruit/veggie diet (86.7%)	Inadequate exercise (50.1%)	High Blood Pressure (36.8%)	High Cholesterol (34.6%)	Arthritis (31.4%)	Obesity (28.1%)	Smoking (20.6%)	Binge Drinking (14.5%)	Diabetes (12.3%)	Asthma (12.0%)

Source: [1]*Illinois Department of Public Health. Illinois Behavioral Risk Factors Surveillance System 2007-2009. Retrieved on December 12, 2012 from http://app.idph.state.il.us/brfss/countydata.asp .*

Note: Respondents are asked a variety of questions about their health status and behavioral and other characteristics related to health. The proportions above summarize their responses.

Table 14: Modifiable Health Risk Behavior

2009 Prevalence of Modifiable Health Risk Behaviors[1] by County (Number and Percent)

County	Population	Prevalence of Modifiable Health Risk Behavior									
		Inadequate Fruit/Vegetable Diet[2]		Inadequate Physical Activity[3]		Binge Drinking[4]		Obesity[5]		Smoking[6]	
		#	%	#	%	#	%	#	%	#	%
Clay	10,562	9,407	89.1%	5,296	50.1%	1,363	12.9%	3,309	31.3%	2,416	22.9%
Edwards	5,056	4,304	85.1%	2,485	49.1%	558	11.0%	1,444	28.6%	978	19.3%
Jasper	7,169	6,157	85.9%	2,974	41.5%	1,464	20.4%	1,884	26.3%	1,172	16.3%
Lawrence	12,239	10,589	86.5%	6,194	50.6%	1,787	14.6%	3,096	25.3%	2,446	20.0%
Richland	11,721	10,071	85.9%	6,467	55.2%	1,595	13.6%	3,403	29.0%	2,603	22.2%
Total	46,747	40,528	86.7%	23,416	50.1%	6,767	14.5%	13,136	28.1%	9,615	20.6%

Source: [1]Illinois Department of Public Health. Illinois Behavioral Risk Factors Surveillance System 2007-2009.
Retrieved on December 12, 2012 from http://app.idph.state.il.us/brfss/countydata.asp .
Note: Estimate based upon a survey of households. As the data source is a survey, population numbers were weighted to account for the sampling technique used. Weighted population counts vary slightly depending upon the variable.
Note: This information is based on the questions asked by the Illinois Behavioral Risk Factor Surveillance System:
[2]Consumed fewer than 5 fruits or veggies each day
[3]Did not meet physical activity guidelines.
[4] Engaged in binge drinking at least once in the past month
[5]Determined using self-reported weight and height measurements
[6]Current smoker who has smoked at least 100 cigarettes in one's lifetime

Table 15: Prevalence of Selected Chronic Diseases

2009 Prevalence of Selected Chronic Diseases[1] by County (Number and Percent)

County	Population	Prevalence of Selected Chronic Disease									
		Diabetes[2]		High Cholesterol[3]		Arthritis[4]		High Blood Pressure[5]		Ever Had Asthma[6]	
		#	%	#	%	#	%	#	%	#	%
Clay	10,562	1,304	12.3%	4,164	39.4%	3,913	37.0%	4,418	41.8%	1,483	14.0%
Edwards	5,056	607	12.0%	1,598	31.6%	1,742	34.5%	1,958	38.7%	703	13.9%

Jasper	7,169	741	10.3%	2,031	28.3%	2,036	28.4%	2,269	31.7%	670	9.3%
Lawrence	12,239	1,612	13.2%	4,090	33.4%	4,697	38.4%	4,259	34.8%	1,435	11.7%
Richland	11,721	1,491	12.7%	4,298	36.7%	3,693	31.5%	4,297	36.7%	1,332	11.4%
Total	46,747	5,755	12.3%	16,181	34.6%	16,081	34.4%	17,201	36.8%	5,623	12.0%

Source: [1]Illinois Department of Public Health. Illinois Behavioral Risk Factors Surveillance System (2007-2009). Retrieved on December 12, 2012 from http://app.idph.state.il.us/brfss/countydata.asp .

Note: Estimate based upon a survey of households. As the data source is a survey, population numbers were weighted to account for the sampling technique used. Weighted population counts vary slightly depending upon the variable.

Note: Questions asked by the Illinois Behavioral Risk Factor Surveillance System:

[2]Has a doctor ever told you that you had diabetes?

[3]Has a doctor ever told you that you have high cholesterol?

[4]Has a doctor ever told you that you have arthritis?

[5]Has a doctor ever told you that you have high blood pressure?

[6]Has a doctor ever told you that you have asthma?

There is a unique aspect to chronic disease management that is often understated – that of prevention. Of all of the chronic diseases mentioned, all are often preventable with a simple, healthy lifestyle. This indicates that with proper intervention and education (the earlier in life the better), many of the medical issues surrounding these disease processes can be completely avoided, thus reducing the physical and logistical burden on our emergency rooms and primary care providers. This in turn reduces medical expenses on all fronts, lowering the staggering financial debt on our medical care delivery system. Of course healthy living does not completely eliminate the issues – there are valid genetic, and often societal, components that feed the issues surrounding chronic disease in some people. However, it has been proven that with proper, early educational and physical interventions (such as screenings and annual physicals), the burden of chronic disease to society can be lessened.

Implementation Strategy

Addressing the identified significant health needs (action, resources, collaborative partners, impact, evaluation)

Health Need #1: Mental and related social issues

Recruitment: RMH will continue working with multiple recruitment agencies, as well as Southern Illinois Healthcare Foundation, with the goal of providing an increased number of mental health providers. The anticipated impact is an increase in the number of mental health providers, and evaluation of the impact will involve a comparison of the numbers of annual admissions that include a psychiatric diagnosis during this current CHNA with the next CHNA due in 2016.

Telemedicine Development: Compatible with the above goal of recruitment is the development of telemedicine opportunities that would allow mental health services/counseling to be provided through telemedicine access. Telemedicine equipment is in place and discussions are in progress with the Southern Illinois University School of Medicine in Springfield, IL to explore options for a child psychologist that would primarily serve children at risk in the local school systems. Currently, RMH is collaborating with the local school systems to work out a plan of service for the most at risk children. The anticipated impact of the successful initiation of telemedicine will include not only the actual use of telemedicine in a mental health capacity, but also the use of telemedicine into other specialty areas of medical practice. Evaluation of the impact will assess how many patients are being served by this type of care (compared with the non-utilization prior to the 2013 CHNA).

Mental Health Support Group: The Nurse Manager for the RMH Psychiatric Unit will oversee the development of a monthly Mental Health Support Group that will offer support, discussion and education surrounding various topics in the mental health field that are applicable to the involved group. The purpose of the group will be to offer a venue of support, encouragement, education, and resource networking for those who suffer from or have a family member with mental illness. Evaluation of the impact of this event will include feedback from group members and utilization numbers for the group events. Collaboration with all area mental health organizations, counselors, school systems, and other resources for education and referral will occur.

Drug Panel Discussion: The RMH Outreach Specialist will collaborate with the local school and mental health systems to coordinate a one evening “Drug Panel Discussion” that includes an educational venue to the public presented by professionals involved in the illegal drug field (state police, local police, Drug Enforcement Agency, mental health professionals, etc…). This

event will be used to educate the public about illegal drugs, what the side effects and long-term effects of the drugs are, what to look for when suspicion is in place for illegal drug use, and what resources are available to deal with them. The anticipated impact of this event will be a community-wide higher level of detailed education and awareness of illegal drugs. Measurement in the form of a questionnaire after the presentation will allow us to measure the level of knowledge prior to and after the event.

Health Need #2: Access to health services

Recruitment: RMH will continue the ongoing effort of recruitment that involves multiple recruiting firms with the goal of providing an increased number of medical providers to the area. It should be noted that hospitals in the state of Illinois are hindered by the restrictive Illinois rules as they pertain to Advanced Level Practitioners (ALP), as well as lagging recruitment possibilities due to the failing financial process in the state of Illinois, thus making it very difficult to attract all levels of quality medical providers. Despite these issues, the RMH recruitment process involves working jointly with the local Southern Illinois Healthcare Foundation to encourage recruitment opportunities for primary care providers, dental providers, as well as specialty providers. RMH will continue to have one staff member responsible for the recruitment process (Director of Physician Services). The anticipated impact is an increase in the number of medical providers at all levels, and evaluation of the impact will be a comparison of the numbers of medical providers available during the current CHNA compared to the next CHNA (due in 2016).

Medical School Tuition Assistance: RMH currently provides tuition assistance to those medical students who agree to establish their medical practice at RMH upon the successful completion of their medical education. The anticipated impact of this action is an increase in the number of medical students that agree to commit to practice within the RMH service area, and the evaluation of the impact will be the number of physicians that actually come to practice in the RMH service area as a result of this program.

Lack of a Health Department: RMH recognizes the lack of a health department in both Edwards and Richland counties, and also recognizes the high priority assigned to this issue according to the community data. When/if either of the appropriate officials listed in the counties above becomes interested in exploring the need for a health department, RMH will cooperate with county officials by facilitating the discussion and provide any other assistance as needed.

Health Need #3: Chronic disease management

MedAssist: RMH will be providing space twice per month to the Med*Assist* Program that is sponsored by Catholic Charities. This program provides patient assistance in the enrollment process for prescription medication provision (free or partially subsidized) through the various drug companies in order to assist people in need who have chronic conditions. This program works with both the patient and the physician, making it possible for "at risk" patients to acquire their needed medications. The anticipated impact of this program is an increase in the rate of patients who are able to acquire their appropriate medications, and the evaluation of such impact will be the successful numbers of patients who apply to the program and are adequately served.

Diabetes Education/Support Group: RMH will continue to provide a monthly support group for those community members who have been diagnosed with diabetes. The Diabetes Support Group is led and coordinated by the RMH Diabetes Educator, under the leadership of the Director of Staff Development. This support group has continued to grow in membership since its onset and it is assumed that it will continue to do so. Members of this group have been greatly impacted, as seen in the multiple patients who acquire a stable diabetic status during their participation which is the common goal among participants and physicians alike. Evaluation of continued impact will be measured by participant numbers, as well a bi-annual opinion questionnaire that will be administered by the facilitator.

In-Person Counselors: In collaboration with Southern Illinois Healthcare Foundation, RMH will support the "In-Person Counselor" program. This program will assist community members with enrolling in a healthcare plan, as mandated by the Affordable Care Act. In theory, when people have health insurance they will seek out proper primary medical care prior to an emergency/chronic issue arising. Thus, the impact of this program should be apparent in a healthier community overall. Evaluation of the impact will assess how many patients enroll in a health insurance plan through this program during the 3 year time period the 2013 CHNA and the 2016 CHNA.

Sodium Reduction Program: The Sodium Reduction Program began as a simple, short-term grant that was received by RMH. Due to the interest and success of the program, RMH will extend the program to the community. The RMH Dietitian will be made available to area organizations to discuss ways to reduce sodium levels in various venues. The RMH Dietitian will be collaborating with the local senior citizens center, as well as the local school systems to complete this task. The goal of this program is to lessen stroke risk and blood pressure levels in the participants, and evaluation of our success will be an overall report of nutrition

improvement in the food prepared by the participating organizations (to be reported by the RMH Dietitian).

Transitional Care Specialist: In order to prevent the risk of readmission, RMH has created a new position called the "Transition Care Specialist". This position is filled by a nurse who will prepare patients for discharge by addressing any medical and social needs that might keep a patient from healing properly. Included in this target population are those patients who have chronic disease issues that are not properly being addressed once home. As a result, the Transition Care Specialist will also do follow-up phone calls, education, and intervention after the patient has been discharged to home in order to give the patient the benefit of having a medical staff member to address issues with after they are home. The impact of this new position is anticipated to be a lower rate of readmissions due to preventable causes, and the measurement of such actions will be in the tracking of patient contacts by the Transition Care Specialist.

Smoking Cessation Program: RMH has instituted a Smoking Cessation Program for employees, patients, and community members. The Outreach Specialist meets one-on-one with participants to walk them through a behavioral-change based smoking cessation program. The length of the program is different for each participant and dependent on individual need and lifestyle. This program is also available using a group model for a corporate outreach tool, thus can be used throughout the community at/with any organization and is marketed through our Corporate Outreach Wellness Program. Evaluation of this project is completed by tracking how many participants utilize the program on an annual basis. Projected impact includes lower rates of lung and heart disease and lower hospital readmission rates for those participants.

Conclusion

Richland Memorial Hospital continues to be committed to offering quality healthcare services to the community in which it serves. This CHNA is one facet of that commitment, offering up a working plan of action to address the most pressing health needs of our community. No plan can address every health need identified nor can one single organization fix every problem in a community. However, with the appropriate data and a host of willing collaborative partners from the community, this CHNA has the power to provide a beginning framework from which our community can set goals and make continued changes that promote and encourage good health for every member of our community. It is the hope of Richland Memorial Hospital that this Community Health Needs Assessment will do just that.

Appendixes

Appendix A – Interview and Focus Group participant questions

Richland Memorial Hospital Community Needs Assessment

Focus Group Protocol

Facilitator Script:

"Welcome and thank you for participating in this focus group today. We appreciate your time and commitment to improving health issues in this community. We will ask the group to spend time identifying concerns for the community surrounding health care and other broad health issues. We would like you to think not only of issues directly related to the hospital, such as maternity care, breast cancer prevention, health screenings and education but also other health issues not directly related to the hospital, such as, drug and alcohol use, mental health needs, or safe environments. We will also spend time identifying resources which are currently available in the community which are successfully meeting the health needs of the community.

Your input is vital in helping to identify and prioritize needs, create solutions, and plan for services in the future. We will not be evaluating or judging any one person's opinions or experience, but rather we will capture the thinking of as many people as possible.

So let's begin with introductions…"

1. Introduction: Please say your name and what town you live in. Also, state what your experience has been with health care in the community or region.

2. What are the three most significant or critical health care needs in your community?
    a. Follow-up: Who is affected by these needs? (Which parts/ages/areas of the community are affected?)
    b. Follow-up: Would anyone like to add to the list previously mentioned?

3. What resources and services are currently available from the hospital or in the community?

4. What are the most preventable health-related diagnoses in your community?
    a. Probe: How many people agree with these concerns [as they are identified]

5. What new or currently unavailable actions, programs, and strategies do you think would make the biggest difference in your community? What solutions would help solve the problems and reduce/remove barriers discussed?

   Facilitators: [Summarize the main themes around concerns and potential solutions]
6. Summary question: Let's go around the room and make sure everyone has one last opportunity to state what they believe is the most important health need to be addressed in their community.

"Thank you for your time."

Appendix B – Letter to Focus Group participants

Dear Focus Group Participant,

Thank you so very much for your willingness to assist Richland Memorial Hospital with our

Community Health Needs Assessment. Here is your Focus Group participant information:

- ***DATE: XXXXXXX***
- ***LOCATION: Main Conference Room at Richland Memorial Hospital (please take the elevator to the lower level/basement floor and follow the signs to the Main Conference Room)***
- ***The Center for Rural Health and Social Service Development at Southern Illinois University-Carbondale will be conducting the Focus Group.***
- ***When you arrive, you will be required to sign a consent form for the session to be recorded. All recorded information is considered anonymous and confidentially protected. (If the consent form is not signed, you will not be allowed to participate).***
- ***The Southern Illinois University-Carbondale Center for Rural Health and Social Service Development consultants will provide RMH with a final aggregate report of the collected data by mid-April.***
- ***Light refreshments will be provided during the session***

Your participation in this community health needs assessment is completely voluntary. You may refuse to answer any question, and your responses will be kept completely confidential. If for some reason you are unable to attend your meeting time, please call me at 618.395.7340, ext. 4608.

The expertise and insight that you have regarding our community is highly valuable and we are grateful for the information that you share with us. Thank you again for your willingness to participate! If you have any questions, please feel free to call me.

Sincerely,

Liesl Wingert, Outreach Specialist

Richland Memorial Hospital

618.395.7340, ext. 4608

Appendix C – Letter of Consent for focus group participants

SIU CARBONDALE SOUTHERN ILLINOIS UNIVERSITY CENTER FOR RURAL HEALTH AND SOCIAL SERVICE DEVELOPMENT

RMH Richland Memorial Hospital

Richland Memorial Hospital Community Needs Assessment

Informed Consent to Participate

I (_____), agree to participate in this community needs assessment conducted by the Center for Rural Health and Social Services Development with Liesl Wingert, Outreach Specialist at Richland Memorial Hospital.

I understand the purpose of this study is to identify concerns for the community surrounding health care and other health issues. You will also be asked to identify resources which are currently available in the community.

I understand my participation is strictly voluntary and may refuse to answer any question without penalty. I am also informed that my participation will last 90 minutes.

I understand that my responses to the questions will be audio taped, and that these tapes will be transcribed/stored and kept for 90 days in a locked file cabinet. Afterward, these tapes will be destroyed.

I understand questions or concerns about this study are to be directed to Kim Sanders, 618-453-5545, ksanders@rural.siu.edu or Liesl Wingert, 618-395-2131 ext. 4608 or lwingert@richlandmemorial.com.

I have read the information above and any questions I asked have been answered to my satisfaction. I agree to participate in this activity and know my responses will be tape recorded. I understand a copy of this form will be made available to me for the relevant information and phone numbers.

"I agree _____ have my responses recorded on audio tape."

"I disagree _____to have my responses recorded on audio tape."

Participant signature Date

Appendix D – SIU-Office of External and Health Affairs Report

SIU School of Medicine

May 28, 2013

Ms. Liesl Wingert, BS, SCF, MHA
Outreach Specialist
Richland Memorial Hospital
800 East Locust Street
Olney, Illinois 62450

Dear Ms. Wingert,

The 39 tables, summary pages and bibliography enclosed with this letter constitute completion of a major effort on the part of SIU School of Medicine to respond to questions posed by Richland Memorial Hospital (RMH) in partial fulfillment of the triennial Community Needs Assessment required of not-for-profit hospitals by federal statute.

Most of the information presented in the enclosed tables is adapted from federal, state and other public sources. Though the base years vary somewhat, the information provided is the most recent available from secondary sources of data. Some tables are based upon primary data retrieved from local school districts and RMH records.

The information provided herein was compiled, under my direction, by two members of the SIU School of Medicine staff. Ms. Whitney Zahnd, MA, is a Clinical Research Specialist working within the SIU Center for Clinical Research of the Office of the Associate Dean for Research and Faculty Affairs. Mr. Joshua Sarver, MPA, is the Assistant Director for Regional Medical Programs of the Office of the Associate Provost for External and Health Affairs. Without the efforts of these two young professionals, this service would not have been available to RMH.

We are forwarding a great deal of information to RMH, probably more than you will need for the Community Needs Assessment. If the School can be of additional assistance in this effort, please don't hesitate to ask. My only request is that, should changes to the tables be necessary, you ask for our assistance in making those changes.

I look forward to meeting with you and the steering committee on June 28.

Sincerely,

Robert M. Wesley

Robert M. Wesley, MA
Executive Director, Regional Medical Programs

Office of External and Health Affairs
Southern Illinois University School of Medicine
PO Box 19604 | Springfield, Illinois 62794-9604
(217) 545-5770 | Fax: (217) 545-2024 | **www.siumed.edu**

Richland Memorial Hospital
Community Needs Assessment Summary – May 18, 2013

I. Demographics in the 5-County Region (Tables 1-7)

Table 1: 2000 U. S. Census Population by Age and County

1. Population: 63,249 (regional): range, 6,971 (Edwards) to 16,149 (Richland).
2. Largest category, 20-64 years: 54.8% (regional); range, 54.3% (Clay) to 56.1% (Edwards).
3. Smallest category, 0 - 5 years: 5.8% (regional); range, 5.5% (Lawrence) to 6.1% (Richland).

Richland Memorial Hospital Community Needs Assessment

Table 1: 2000 U. S. Census Population by Age[1] and County (Number and Percent)

County	Population	Population Age Categories							
		Under Age 5		Aged 5-19		Aged 20-64		65 and Older	
		#	%	#	%	#	%	#	%
Clay	14,560	859	5.9%	2,997	20.6%	7,912	54.3%	2,792	19.2%
Edwards	6,971	394	5.7%	1,376	19.7%	3,911	56.1%	1,290	18.5%
Jasper	10,117	579	5.7%	2,338	23.1%	5,533	54.7%	1,667	16.5%
Lawrence	15,452	856	5.5%	3,054	19.8%	8,429	54.5%	3,113	20.1%
Richland	16,149	987	6.1%	3,417	21.2%	8,903	55.1%	2,842	17.6%
Total	63,249	3,675	5.8%	13,182	20.8%	34,688	54.8%	11,704	18.5%

Source: [1]United States Census Bureau. American Community Survey 2000.
Retrieved on December 13, 2012 from http://quickfacts.census.gov/qfd/maps/illinois_map.html

Table 2: 2010 U. S. Census Population by Age and County

1. Population: 63,300 (regional): range, 6,721 (Edwards) to 16,833 (Lawrence).
2. Largest category, 20-64 years: 58.1% (regional); range, 55.9% (Richland) to 62.3% (Lawrence).
3. Smallest category, 0-5 years: 5.7% (regional); range, 5.2% (Lawrence) to 6.2% (Clay).

Richland Memorial Hospital Community Needs Assessment

Table 2: 2010 U. S. Census Population by Age[1] and County (Number and Percent)

County	Population	Population Age Categories							
		Under Age 5		Aged 5-19		Aged 20-64		65 and Older	
		#	%	#	%	#	%	#	%
Clay	13,815	852	6.2%	2,682	19.4%	7,813	56.6%	2,468	17.9%
Edwards	6,721	366	5.4%	1,349	20.1%	3,815	56.8%	1,191	17.7%
Jasper	9,698	555	5.7%	1,881	19.4%	5,573	57.5%	1,689	17.4%
Lawrence	16,833	874	5.2%	2,786	16.6%	10,490	62.3%	2,683	15.9%
Richland	16,233	974	6.0%	3,078	19.0%	9,071	55.9%	3,110	19.2%
Total	63,300	3,621	5.7%	11,776	18.6%	36,762	58.1%	11,141	17.6%

Source: [1]United States Census Bureau. American Community Survey 2010.
Retrieved on December 13, 2012 from http://quickfacts.census.gov/qfd/maps/illinois_map.html

Table 3: Proportionate Population Change, 2000 - 2010

1. The regional population grew by 51 persons (0.1%) over the 10-year period.
2. Population gains in Richland of 84 persons (0.5%) and Lawrence of 1,381 persons (8.9%).
3. The regional population grew in only one age category: 2,074 persons aged 20-64 years (6.0%).
4. Lawrence County saw a dramatic increase of 2,061 persons (24.5%) in the 20-64 age category.

Table 3: Proportionate Population Change, 2000 - 2010 Increase or Decrease (-) by Age Categories[1] and County

County	Total Population			Under Age 5			Aged 5 - 19			Aged 20 - 64			Aged 65 and Older		
	2000	2010	% Change	2000	2010	% Change	2000	2010	% Change	2000	2010	% Change	2000	2010	% Change
Clay	14,560	13,815	-5.1%	859	852	-0.8%	2,997	2,682	-10.5%	7,912	7,813	-1.3%	2,792	2,468	-11.6%
Edwards	6,971	6,721	-3.6%	394	366	-7.1%	1,376	1,349	-2.0%	3,911	3,815	-2.5%	1,290	1,191	-7.7%
Jasper	10,117	9,698	-4.1%	579	555	-4.1%	2,338	1,881	-19.5%	5,533	5,573	0.7%	1,667	1,689	1.3%
Lawrence	15,452	16,833	8.9%	856	874	2.1%	3,054	2,786	-8.8%	8,429	10,490	24.5%	3,113	2,683	-13.8%
Richland	16,149	16,233	0.5%	987	974	-1.3%	3,417	3,078	-9.9%	8,903	9,071	1.9%	2,842	3,110	9.4%
Total	63,249	63,300	0.1%	3,675	3,621	-1.5%	13,182	11,776	-10.7%	34,688	36,762	6.0%	11,704	11,141	-4.8%

Source: [1]United States Census Bureau. American Community Survey 2000 & 2010.
Retrieved on December 13, 2012 from http://quickfacts.census.gov/qfd/maps/illinois_map.html

Table 4: 2010 U. S. Census Minority Populations by County

1. The Latino, Asian American and African American population is 5.4% of the regional total.
2. Excepting Lawrence (10.0%), African Americans are less than 1.0% of each county's population.
3. Excepting Lawrence (3.5%), Latinos are 0.9% (Clay) to 1.4% (Richland) of the population.
4. Relative to the other four counties, Lawrence County's total minority population is high (13.8%).

Richland Memorial Hospital Community Needs Assessment

Table 4: 2010 U. S. Census Minority Populations[1] by County (Number and Percent)

County	Population	Minority Populations							
		Latino		Asian American		African American		Minority Total	
		#	%	#	%	#	%	#	%
Clay	13,815	180	1.3%	83	0.6%	69	0.5%	332	2.4%
Edwards	6,721	67	1.0%	20	0.3%	47	0.7%	134	2.0%
Jasper	9,698	87	0.9%	29	0.3%	29	0.3%	145	1.5%
Lawrence	16,833	589	3.5%	50	0.3%	1,683	10.0%	2,323	13.8%
Richland	16,233	227	1.4%	130	0.8%	114	0.7%	471	2.9%
Total	63,300	1,151	1.8%	313	0.5%	1,942	3.1%	3,405	5.4%

Source: [1]United States Census Bureau. American Community Survey 2010.
Retrieved on December 13, 2012 from http://quickfacts.census.gov/qfd/maps/illinois_map.html

Table 5: 2010 Populations of Interest by County

1. Veterans account for 8.6% of the region's total population and is evenly distributed.
2. Developmentally disabled persons account for 1.8% of the region's total and is evenly distributed.
3. Persons living below the federal poverty level account for 13.8% of the region's total population.
4. The population below poverty: range, 7.6% (Jasper) to 16.9% (Clay).

Table 5: 2010 Populations of Interest by County (Number and Percent)

County	Populations of Interest						
	Population	Veterans[1]		Developmentally Disabled Persons[2]		Persons Below Poverty[3]	
		#	%	#	%	#	%
Clay	13,815	1,064	7.7%	262	1.9%	2,335	16.9%
Edwards	6,721	614	9.1%	125	1.9%	773	11.5%
Jasper	9,698	874	9.0%	182	1.9%	737	7.6%
Lawrence	16,833	1,379	8.2%	278	1.7%	2,727	16.2%
Richland	16,233	1,502	9.3%	291	1.8%	2,175	13.4%
Total	63,300	5,433	8.6%	1,138	1.8%	8,747	13.8%

Sources: [1]United States Census Bureau. American Community Survey 2010.
Retrieved on December 13, 2012 from http://quickfacts.census.gov/qfd/maps/illinois_map.html
[2]SIU School of Medicine. Direct communication with Illinois State Operated Developmental Centers 2010.
[3]United States Census Bureau. American Community Survey 2007-2011.
Retrieved on December 13, 2012 from http://quickfacts.census.gov/qfd/maps/illinois_map.html

Table 6: 2007 – 2011 Estimated Educational Attainment: Adults Aged 25 Years or More by County

1. Regionally, 14.2% have less than a HS diploma: range, 10.3% (Jasper) to 20.7% Lawrence.
2. Regionally, 51.6% of adults aged 25+ years have a high school diploma or less.
3. Adults with a BA or higher degree range between 10.5% (Lawrence) and 18.9% (Richland).
4. Regionally, 48.4% of adults aged 25+ years have some college or a BA or higher degree.

Richland Memorial Hospital Community Needs Assessment

Table 6: 2007 - 2011 Estimated Educational Attainment: Adults Aged 25 Years or More[1] by County (Number and Percent)

County	Educational Attainment Among Adults Aged 25 Years or More								
	Population	Less Than HS		HS Diploma		Some College or AA Degree		BA Degree or Higher	
		#	%	#	%	#	%	#	%
Clay	9,614	1,348	14.0%	4,143	43.1%	2,811	29.2%	1,312	13.6%
Edwards	4,646	550	11.8%	1,574	33.9%	1,941	41.8%	581	12.5%
Jasper	6,793	697	10.3%	2,593	38.2%	2,479	36.5%	1,024	15.1%
Lawrence	11,784	2,444	20.7%	4,378	37.2%	3,723	31.6%	1,239	10.5%
Richland	11,318	1,215	10.7%	3,841	33.9%	4,119	36.4%	2,143	18.9%
Total	44,155	6,254	14.2%	16,529	37.4%	15,073	34.1%	6,299	14.3%

Source: [1]United States Census Bureau. American Community Survey 2007-2011.
Retrieved on December 13, 2012 from http://quickfacts.census.gov/qfd/maps/illinois_map.html
Note: Population based on persons aged 25 years or older according to the United States Census Bureau five year estimates.

Table 7: 2011 Estimated Civilian Employment by Ranked Industries and Unemployment by County

1. 5 industries employ 66.2% of the population (educ/health, manufacturing, retail, ag & construction).
2. The highest percentage of the population (23.7%) is employed in education and health services.
3. The regional unemployment rate (7.3%): range, 5.8% (Richland) and 9.5% (Clay).

Table 7: 2011 Estimated Civilian Employment by Ranked Industries and Unemployment[1] by County (Number and Percent)

County	Regional Civilian Employment by Ranked Industry														Unemployment		
	Education/ Health Services		Manufacturing		Retail		Agriculture		Construction		Other		Total Employed		Total Workforce	Unemployed	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	#	%
Clay	1,325	22.5%	1,249	21.2%	754	12.8%	383	6.5%	489	8.3%	1,690	28.7%	5,890	22.2%	6,507	617	9.5%
Edwards	498	16.2%	918	29.9%	347	11.3%	184	6.0%	165	5.4%	959	31.2%	3,071	11.6%	3,360	289	8.6%
Jasper	1,076	22.6%	748	15.7%	548	11.5%	495	10.4%	217	4.6%	1,679	35.3%	4,763	17.9%	5,162	399	7.7%
Lawrence	1,521	27.8%	739	13.5%	569	10.4%	235	4.3%	238	4.4%	2,169	39.6%	5,471	20.6%	5,814	343	5.9%
Richland	1,892	25.6%	1,197	16.2%	887	12.0%	480	6.5%	443	6.0%	2,491	33.7%	7,390	27.8%	7,848	458	5.8%
Total	6,312	23.7%	4,851	18.2%	3,105	11.7%	1,777	6.7%	1,552	5.8%	8,988	33.8%	26,585	100.0%	28,691	2,106	7.3%
Cumulative	6,312	23.7%	11,163	42.0%	14,268	53.7%	16,045	60.4%	17,597	66.2%	26,585	100.0%	n/a	n/a	n/a	n/a	n/a

Source: [1]United States Census Bureau. American Community Survey 2007-2011.

Retrieved on December 13, 2012 from http://quickfacts.census.gov/qfd/maps/illinois_map.html

Note: Population based on persons aged 25 years or older according to the United States Census Bureau five year estimates.

II. Births and Adult Mortality in the 5-County Region (Tables 8 and 9)

Table 8: 2007 – 2009 Births by Resident County

1. Total births, 2,081 (region): Richland (567) and Clay (512) residents accounted for 51.8%.
2. Three counties, Richland (567), Clay (512) and Lawrence (486) accounted for 75.2% of births.
3. Births in Lawrence County increased between 2007 & 2008 and between 2008 & 2009.
4. Births in Jasper County decreased between 2007 & 2008 and between 2008 & 2009.
5. Births in Clay, Edwards and Richland were varied as to increase and decrease.

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Table 8: 2007 - 2009, Births[1] by Resident County (Number and Percent)

County	2007		2008		2009		Total	
	#	%	#	%	#	%	#	%
Clay	170	25.6%	164	22.8%	178	25.5%	512	24.6%
Edwards	64	9.6%	70	9.7%	63	9.0%	197	9.5%
Jasper	115	17.3%	111	15.4%	93	13.3%	319	15.3%
Lawrence	142	21.4%	169	23.5%	175	25.1%	486	23.4%
Richland	173	26.1%	206	28.6%	188	27.0%	567	27.2%
Total	664	100.0%	720	100.0%	697	100.0%	2,081	100.0%

Sources: [1]Provided by Richland Memorial Hospital on April 29, 2013. (reports IDPH as primary source)

Table 9: 2009 Adult Mortality by Selected Causes and County

1. A regional total of 776 deaths from all causes were recorded in 2009.
2. County deaths as a proportion of regional deaths: range 9.5% (Edwards) to 29.8% (Lawrence).
3. Heart disease (26.8%) and malignant neoplasms (20.7%) were the two largest causes of death.
4. Heart disease, malignant neoplasms, stroke and diabetes cumulative percent was 55.2%.
5. Heart disease, malignant neoplasms and lower respiratory disease cumulative percent was 54.5%.

Table 9: 2009 Adult Mortality by Selected Causes[1] and County

County			Selected Causes of Death - Counts													
Name	Total Population[2]	Total Mortality	Heart Disease	Malignant Neoplasms	Lower Respiratory	Stroke	Accidents	Alzheimer Disease	Kidney Disease	Diabetes	Influenza and Pneumonia	Septicemia	Suicide	Liver Disease	All Other Causes
Clay	13,538	198	49	44	21	9	8	2	8	7	5	3	2	2	38
Edwards	6,444	74	22	14	5	3	6	0	2	1	0	3	0	1	17
Jasper	9,530	92	30	20	6	6	1	4	2	3	6	1	1	0	12
Lawrence	16,408	231	55	36	13	16	10	17	6	8	4	2	1	2	61
Richland	15,523	181	52	47	9	6	12	1	4	0	4	3	6	2	35
Total	61,443	776	208	161	54	40	37	24	22	19	19	12	10	7	163

County			Selected Causes of Death - Percents of Total Mortality												
County	Total Population[2]	Total Mortality	Heart Disease	Malignant Neoplasms	Lower Respiratory	Stroke	Accidents	Alzheimer Disease	Kidney Disease	Diabetes	Influenza and Pneumonia	Septicemia	Suicide	Liver Disease	All Other Causes
Clay	22.0%	25.5%	6.3%	5.7%	2.7%	1.2%	1.0%	0.3%	1.0%	0.9%	0.6%	0.4%	0.3%	0.3%	4.9%
Edwards	10.5%	9.5%	2.8%	1.8%	0.6%	0.4%	0.8%	0.0%	0.3%	0.1%	0.0%	0.4%	0.0%	0.1%	2.2%
Jasper	15.5%	11.9%	3.9%	2.6%	0.8%	0.8%	0.1%	0.5%	0.3%	0.4%	0.8%	0.1%	0.1%	0.0%	1.5%
Lawrence	26.7%	29.8%	7.1%	4.6%	1.7%	2.1%	1.3%	2.2%	0.8%	1.0%	0.5%	0.3%	0.1%	0.3%	7.9%
Richland	25.3%	23.3%	6.7%	6.1%	1.2%	0.8%	1.5%	0.1%	0.5%	0.0%	0.5%	0.4%	0.8%	0.3%	4.5%
Total	100.0%	100.0%	26.8%	20.7%	7.0%	5.2%	4.8%	3.1%	2.8%	2.4%	2.4%	1.5%	1.3%	0.9%	21.0%
Cumulative Percent			26.8%	47.6%	54.5%	59.7%	64.4%	67.5%	70.4%	72.8%	75.3%	76.8%	78.1%	79.0%	100.0%

Sources: [1]Illinois Department of Public Health. Health Statistics. Causes of Death by Resident County 2009.

Retrieved on December 12, 2012 from http://www.idph.state.il.us/health/bdmd/deathcauses_09.htm

Note: Adult mortality by selected causes of death includes death statistics for all ages, including as many as 15 individuals who were not adults. Persons under age 15 account for 6 deaths (3 in Edwards County, 3 in Lawrence County). Persons between ages 15 and 24 accounted for 9 deaths (3 in Edwards County, 2 in Jasper County, and 4 in Lawrence County). Cause of death for these persons is unknown as those data are unavailable. Consequently, there is error in the table to the extent of 15/776 = 2.0%.

[2]United States Census Bureau. Annual Estimates of the Resident Population for Counties:April 1, 2000 to July 1, 2009.

Retrieved on December 12, 2012 from http://www.census.gov/popest/data/counties/totals/2009/tables/CO-EST2009-01-17.xls

Causes of death specifically requested by Richland Memorial Hospital.

III. Health Insurance in the 5-County Region (Tables 10 and 11)

Table 10: 2009 Estimated Medicare and Medicaid Population by County

1. The regional Medicare population (20.8%): range, 18.9% (Lawrence) to 22.2% (Richland).
2. The regional Medicaid population (24.0%): range, 19.7% (Edwards) to 27.7% (Clay).
3. The total regional Medicare/Medicaid population (44.8%): range, 40.8% (Jasper) to 49.5% (Clay).

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Table 10: 2009 Estimated[1] Medicare and Medicaid Population by County (Number and Percent)

County	Medicare and Medicaid as Proportions of the Population								
	Population	Medicaid and Medicare Insured Population						Other or No Insurance	
		Medicaid		Medicare		Total Medicare/Medicaid			
		#	%	#	%	#	%	#	%
Clay	13,767	3,812	27.7%	3,005	21.8%	6,817	49.5%	6,950	50.5%
Edwards	6,501	1,282	19.7%	1,391	21.4%	2,673	41.1%	3,828	58.9%
Jasper	9,698	1,997	20.6%	1,956	20.2%	3,953	40.8%	5,745	59.2%
Lawrence	16,681	3,671	22.0%	3,155	18.9%	6,826	40.9%	9,855	59.1%
Richland	15,532	4,157	26.8%	3,451	22.2%	7,608	49.0%	7,924	51.0%
Total	62,179	14,919	24.0%	12,958	20.8%	27,877	44.8%	34,302	55.2%

Source: [1] United States Department of Health and Human Services. Community Health Status Indicators 2009.
Retrieved on December 12, 2012 from http://wwwn.cdc.gov/CommunityHealth/HomePage.aspx

Note: Population based on United States Census Bureau 2008 population estimate as reported by the United States Department of Health and Human Services Community Health Status Indicators 2009.

Table 11: 2010 Health and 2009 Dental Insurance: Adults Aged 64 and Under by County

1. Regionally, 86.3% of adults under age 65 have some form of health insurance.
2. Health insured adults under age 65: range, 85.7% (Lawrence) to 87.1% (Richland).
3. Regionally, 51.8% of adults under age 65 have dental insurance.
4. Dental insured adults under age 65: range, 43.4% (Jasper) to 56.3% (Clay).

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Table 11: 2010 Health[1] and 2009 Dental[2] Insurance: Adults Aged 64 and Under by County (Number and Percent)

County	Health and Dental Insurance					
	Adults Aged 64 Years and Under Health Insured in 2010			Dental Insured in 2009		
	Population	#	%	Population	#	%
Clay	11,261	9,702	86.2%	10,562	5,949	56.3%
Edwards	5,530	4,809	87.0%	5,056	2,547	50.4%
Jasper	7,975	6,860	86.0%	7,169	3,110	43.4%
Lawrence	11,793	10,101	85.7%	12,239	6,330	51.7%
Richland	13,025	11,339	87.1%	11,721	6,289	53.7%
Total	49,584	42,811	86.3%	46,747	24,225	51.8%

Sources: [1]United States Census Bureau. Small Area Health Insurance Estimates 2012.
Retrieved on December 13, 2012 from http://www.census.gov/did/www/sahie/data/interactive/
[2]Illinois Department of Public Health. Illinois Behavioral Risk Factors Surveillance System 2007-2009.
Retrieved on December 12, 2012 from http://app.idph.state.il.us/brfss/countydata.asp .

Note: Estimate based upon a survey of households. As the data source is a survey, population numbers were weighted to account for the sampling technique used. Weighted population counts vary slightly depending upon the variable.

IV. Health Risk Factors Among Children in the 5-County Region (Tables 12 - 16)

Table 12: 2009 High Risk Births and Infant/Pediatric Mortality by County

1. The proportion of preterm births: range, an estimated 7.5% (Jasper) to 13.7% (Lawrence).
2. 11.2% of births in the region are to teenage mothers: range, 8.6% (Jasper) to 17.5% (Edwards).
3. Ratio of infant deaths to infant births: 3 : 697.
4. 3 pediatric (aged 14 years or less) deaths were reported during 2009.

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Table 12: 2009 High Risk Births[1,2] and Infant/Pediatric Mortality[3,4] by County (Number, Ratio and Percent)

County	High Risk Births					Infant Mortality[5]	Pediatric Deaths
	Total Births	Preterm Births		Births to Teenage Mothers		Births:Deaths	Aged 14 Years and Less
		#	%	#	%	Ratio	#
Clay	178	20	11.2%	21	11.8%	0:178	0
Edwards	63	5	7.9%[6]	8	17.5%	1:63	2
Jasper	93	7	7.5%[6]	11	8.6%	0:93	0
Lawrence	175	24	13.7%	19	10.9%	2:175	1
Richland	188	25	13.3%	19	10.1%	0:188	0
Total	697	81	N/A	78	11.2%	3:697	3

Sources:
[1]Illinois Department of Public Health. Birth Characteristics by Resident County 2009.
Retrieved on December 12, 2012 from http://www.idph.state.il.us/health/bdmd/birthchar_09.htm
[2]Illinois Department of Public Health. Illinois Teen Births by County 2009.
Retrieved on December 12, 2012 from http://www.idph.state.il.us/health/teen/teen0809.htm
[3]Illinois Department of Public Health. Infant Mortality Numbers by County 2009.
Retrieved on December 12, 2012 from http://www.idph.state.il.us/health/infant/infmort0609.htm
[4]Illinois Department of Public Health. Death Demographics by County 2009.
Retrieved on February 14, 2013 from http://www.idph.state.il.us/health/bdmd/deathdemo_09.htm
[5]The infant mortality rate for these five counties did not meet standards for reliability and precision. Therefore, a ratio of infant deaths to births was used in lieu of the standard infant mortality rate.
[6]Rate or percentage does not meet standards of reliability (numerator <10 or denominator <100) used by IDPH, but percentage is listed

Table 13: 2010 Food Insecurity and Children Living in Poverty by County

1. 22.6% of the region's population are children: range, 19.1% (Lawrence) to 26.7% (Clay).
2. 13.9% of the regional population is food insecure: range, 11.7% (Jasper) to 15.4% (Clay).
3. 21.7% of the region's children are food insecure: range, 19.4% (Jasper) to 24.9% (Lawrence).
4. 20.7% of the region's children live in poverty: range, 16.0% (Jasper) to 24.0% (Lawrence).

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Table 13: 2010 Food Insecurity[1] and Children Living in Poverty[2] by County (Number and Percent)

County	Population			Food Insecurity				Children Living in Poverty	
	Total Population	Children		Population		Children			
		#	%	#	%	#	%	#	%
Clay	13,961	3,727	26.7%	2,150	15.4%	790	21.2%	820	22.0%
Edwards	6,720	1,557	23.2%	840	12.5%	330	21.2%	265	17.0%
Jasper	9,744	2,217	22.8%	1,140	11.7%	430	19.4%	355	16.0%
Lawrence	16,846	3,213	19.1%	2,510	14.9%	800	24.9%	771	24.0%
Richland	16,148	3,589	22.2%	2,180	13.5%	750	20.9%	754	21.0%
Total	63,419	14,303	22.6%	8,820	13.9%	3,100	21.7%	2,964	20.7%

Sources: [1]Feeding America. Map the Meal Gap, Food Insecurity in Your County 2010.
Retrieved on December 12, 2012 from http://feedingamerica.org/hunger-in-america/hunger-studies/map-the-meal-gap.aspx.
[2]Robert Wood Johnson Foundation. County Health Rankings.
Retrieved on December 12, 2012 from http://www.countyhealthrankings.org/app/illinois/2012/rankings/outcomes/overall
Note: Total population based on information provided by Feeding America.

Table 14: 2012 Students Eligible for Free or Reduced-Cost Lunch by County

1. 38.6% of the region's students are eligible for the school free lunch program.
2. Enrollment in the free lunch program: range, 27.3% (Edwards) to 42.9% (Clay and Lawrence).
3. An additional 9.8% of the region's students are eligible for the reduced cost lunch program.
4. Enrollment in the reduced lunch program: range, 7.3% (Edwards) to 11.5% (Lawrence).

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Table 14: 2012 Students Eligible for Free or Reduced-Cost Lunch[1] by County (Number and Percent)

County	Free or Reduced-Cost Lunch Eligibility						
	Total Enrollment	Free Lunch		Reduced-Cost		Total Eligible	
		#	%	#	%	#	%
Clay	2,314	993	42.9%	211	9.1%	1,204	52.0%
Edwards	934	255	27.3%	68	7.3%	323	34.6%
Jasper	1,483	490	33.0%	140	9.4%	630	42.5%
Lawrence	2,223	953	42.9%	256	11.5%	1,209	54.4%
Richland	2,619	1,003	38.3%	259	9.9%	1,262	48.2%
Total	9,573	3,694	38.6%	934	9.8%	4,628	48.3%

Source: [1]Illinois State Board of Education. Nutrition. Free Lunch Eligibility Listing 2012.
Retrieved on December 13, 2012 from http://www.isbe.net/nutrition/htmls/eligibility_listings.htm

Table 15: 2013 Student Enrollment and Homeless Students by County

1. 9,600 students are enrolled in the region: range, 955 (9.9%, Edwards) to 2,491 (25.9%, Richland).
2. Richland accounts for 257 (58.4%) of the total 440 homeless students in the 5-county region.
3. Within Richland, the 257 homeless students equal 10.3% of the county's total enrollment.

Table 15: 2013 Student Enrollment and Homeless Students by County[1] (Number and Percent)

County	Total Enrollment		Homeless Enrollment		
			Enrolled		Of Total
	#	%	#	%	%
Clay	2,464	25.7%	73	16.6%	3.0%
Edwards	955	9.9%	14	3.2%	1.5%
Jasper	1,405	14.6%	67	15.2%	4.8%
Lawrence	2,285	23.8%	29	6.6%	1.3%
Richland	2,491	25.9%	257	58.4%	10.3%
Total	9,600	100.0%	440	100.0%	4.6%

Sources: [1]Regional Office of Education and Richland Memorial Hospital. Based on student counts for the 2013 school year.

Note: Information based on enrollment reports provided to the Regional Office of Education by the following schools: Clay City CUSD # 10, Flora CUSD # 35, North Clay CUSD # 25, Jasper CUSD # 1, Lawrence County CUSD # 20, Red Hill CUSD # 10, Edwards County CUSD # 1, East Richland and West Richland CUSD schools.

Note: Homeless children are defined as: children and youth who lack a fixed, regular, and adequate nighttime residence, including children and youth who are: sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; living in motels, hotels, trailer parks, or camping grounds due to lack of alternative adequate accommodations; living in emergency or transitional shelters; abandoned in hospitals; awaiting foster care placement; children and youth who have a primary nighttime residence that is a public or private place not designed for, or ordinarily used as, a regular sleeping accommodations for human beings; children and youth who are living in cars, parks, public places, abandoned buildings, substandard housing, bus or train stations, or similar settings; and, migratory children who qualify as homeless because they are living in circumstances described above. (McKinney-Vento Act 725)

Table 16: 2010 Prevalence of Child Abuse/Neglect and Rate by County

1. Regionally, 5.2% of children (709 children, 829 cases) were either abused or neglected in 2010.
2. Abused or neglected children by county: range, 3.7% (Jasper) to 6.5% (Lawrence).
3. The regional rate per 1,000 of child abuse/neglect (51.5): range, 30.8 (Jasper) to 59.9 (Lawrence).

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Table 16: 2010 Prevalence[1] of Child Abuse/Neglect and Rate by County (Number, Percent and Rate)

County	Abuse and Neglect Cases, Unduplicated Count and Rate				
	Population[2]	Cases	Unduplicated Count		Child Abuse per 1,000
		#	#	%	Rate
Clay	3,164	159	141	4.5%	40.8
Edwards	1,536	63	61	4.0%	38.3
Jasper	2,204	107	81	3.7%	30.8
Lawrence	3,207	239	207	6.5%	59.9
Richland	3,608	261	219	6.1%	55.5
Total	13,719	829	709	5.2%	51.5

Source: [1]Illinois Department of Child and Family Services. Child Abuse and Neglect Statistics 2011. Retrieved on February 14, 2013 from http://www.state.il.us/DCFS/docs/CANTS2011.pdf.

[2]Population Aged 17 Years and Under as presented by United States Census Bureau 2010 data.

Note: Population was manually calculated by subtracting the population 18 and older from the total population.

V. General Health Risk Factors in the 5-County Region (Tables 17 – 23)

Table 17: 2009 Health Risk Factors Ranked by County

1. 86.7% of regional responses were consistent with inadequate fruit and vegetable intake.
2. 50.1% of regional responses were consistent with inadequate levels of exercise.
3. Regional indications of: high blood pressure (36.8%), high cholesterol (34.6%) & arthritis (31.4%).
4. Regional indications of obesity (28.1%), smoking (20.6%).
5. Regional indications of binge drinking (14.5%), diabetes (12.3%) and asthma (12.0%).

Table 17: 2009 Health Risk Factors[1] Ranked by County (Number and Percent)

County	Health Risk Factor Ranking									
	Factor #1	Factor #2	Factor #3	Factor #4	Factor #5	Factor #6	Factor #7	Factor #8	Factor #9	Factor #10
Clay	Inadequate fruit/veggie diet (89.1%)	Inadequate exercise (50.1%)	High Blood Pressure (41.9%)	High Cholesterol (39.4%	Arthritis (37.0%)	Obesity (31.3%)	Smoking (22.9%)	Asthma (14.0%)	Binge Drinking (12.9%)	Diabetes (12.3%)
Edwards	Inadequate fruit/veggie diet (85.1%)	Inadequate exercise (49.1%)	High blood pressure (38.7%)	Arthritis (34.5%)	High Cholesterol (31.6%)	Obesity (28.6%)	Smoking (19.3%)	Asthma (13.9%)	Diabetes (12.0%)	Binge Drinking (11.0%)
Jasper	Inadequate fruit/veggie diet (85.9%)	Inadequate exercise (41.5%)	High blood pressure (31.7%)	High cholesterol (28.3%)	Arthritis (28.4%)	Obesity (26.3%)	Binge Drinking (20.5%)	Smoking (16.3%)	Diabetes (10.3%)	Asthma (9.3%)
Lawrence	Inadequate fruit/veggie diet (86.5%)	Inadequate exercise (50.6%)	Arthritis (38.4%)	High Blood Pressure (34.8%)	High Cholesterol (33.4%)	Obesity (25.3%)	Smoking (20.0%)	Binge Drinking (14.6%)	Diabetes (13.2%)	Asthma (11.7%)
Richland	Inadequate fruit/veggie diet (85.9%)	Inadequate exercise (55.2%)	High cholesterol (36.7%)	High Blood Pressure (36.7%)	Arthritis (31.5%)	Obesity (29%)	Smoking (22.2%)	Binge Drinking (13.6%)	Diabetes (12.7%)	Asthma (11.4%)
Regional Modal Risk Factor	Inadequate fruit/veggie diet (86.7%)	Inadequate exercise (50.1%)	High Blood Pressure (36.8%)	High Cholesterol (34.6%)	Arthritis (31.4%)	Obesity (28.1%)	Smoking (20.6%)	Binge Drinking (14.5%)	Diabetes (12.3%)	Asthma (12.0%)

Source: [1]Illinois Department of Public Health. Illinois Behavioral Risk Factors Surveillance System 2007-2009.
Retrieved on December 12, 2012 from http://app.idph.state.il.us/brfss/countydata.asp .
Note: Respondents are asked a variety of questions about their health status and behavioral and other characteristics related to health. The proportions above summarize their responses.

Table 18: 2009 Prevalence of Modifiable Health Risk Behaviors by County

1. Indications of inadequate diet, 86.7% (region): range, 85.1% (Edwards) to 89.1% (Clay).
2. Indications of inadequate exercise, 50.1% (region): range 41.5% (Jasper) to 55.2% (Richland).
3. Indications of binge drinking, 14.5% (region): range, 11.0% (Edwards) and 20.4% (Jasper).
4. Indications of obesity, 28.1% (region): range 25.3% (Lawrence) to 31.3% (Clay).
5. Indications of smoking, 20.6% (region): range 16.3% (Jasper) to 22.9% (Clay).

Table 18: 2009 Prevalence of Modifiable Health Risk Behaviors[1] by County (Number and Percent)

County	Population	Prevalence of Modifiable Health Risk Behavior									
		Inadequate Fruit/Vegetable Diet[2]		Inadequate Physical Activity[3]		Binge Drinking[4]		Obesity[5]		Smoking[6]	
		#	%	#	%	#	%	#	%	#	%
Clay	10,562	9,407	89.1%	5,296	50.1%	1,363	12.9%	3,309	31.3%	2,416	22.9%
Edwards	5,056	4,304	85.1%	2,485	49.1%	558	11.0%	1,444	28.6%	978	19.3%
Jasper	7,169	6,157	85.9%	2,974	41.5%	1,464	20.4%	1,884	26.3%	1,172	16.3%
Lawrence	12,239	10,589	86.5%	6,194	50.6%	1,787	14.6%	3,096	25.3%	2,446	20.0%
Richland	11,721	10,071	85.9%	6,467	55.2%	1,595	13.6%	3,403	29.0%	2,603	22.2%
Total	46,747	40,528	86.7%	23,416	50.1%	6,767	14.5%	13,136	28.1%	9,615	20.6%

Source: [1]Illinois Department of Public Health. Illinois Behavioral Risk Factors Surveillance System 2007-2009.

Retrieved on December 12, 2012 from http://app.idph.state.il.us/brfss/countydata.asp .

Note: Estimate based upon a survey of households. As the data source is a survey, population numbers were weighted to account for the sampling technique used. Weighted population counts vary slightly depending upon the variable.

Note: This information is based on the questions asked by the Illinois Behavioral Risk Factor Surveillance System:

[2]Consumed fewer than 5 fruits or veggies each day

[3]Did not meet physical activity guidelines.

[4] Engaged in binge drinking at least once in the past month

[5]Determined using self-reported weight and height measurements

[6]Current smoker who has smoked at least 100 cigarettes in one's lifetime

Table 19: 2009 Adult Tobacco Use and High School Senior Tobacco and Drug Use by County

1. Regionally, 20.6% of responding adults use tobacco: range, 16.3% (Jasper) to 22.9% (Clay).
2. HS seniors using smokeless tobacco: 7% (Richland), 9% (Clay) and 16% (Lawrence).
3. HS seniors smoking tobacco: 16% (Richland), 17% (Clay) and 20% (Lawrence).
4. HS seniors alcohol use: 30% (Clay) to 37% (Lawrence and Richland).
5. HS seniors marijuana use: 3% (Clay), 10% (Richland) and 11% (Lawrence).

Table 19: 2009 Adult Tobacco Use[1] and High School Senior Tobacco and Drug Use[2] by County (Number and Percent)

County	Adult Tobacco Use[1]					HS Senior Tobacco Use[2]				HS Senior Drug Use[2]			
	Population	Adults Who Smoke[3]		Allow Home Smoking[4]		Respondents	Smokeless Tobacco[5]	Smoked Tobacco[5]	Parental Advice[6]	Alcohol[5]	Marijuana[5]	Meth[6]	Cocaine[6]
		#	%	#	%	#	%	%	%	%	%	%	%
Clay	10,562	2,419	22.9%	2,706	25.6%	69	9.0%	17.0%	28.0%	30%	3%	0%	2%
Edwards	5,056	981	19.4%	1,262	25.1%	dm**	dm**	dm**	dm**	dm**	dm**	dm**	dm**
Jasper	7,196	1,173	16.3%	dm**	dm**	dm**	dm**	dm**	dm**	dm**	dm**	dm**	dm**
Lawrence	12,239	2,448	20.0%	3,144	25.6%	134	16.0%	20.0%	33.0%	37%	11%	1%	6%
Richland	11,711	2,600	22.2%	2,865	24.4%	111	7.0%	16.0%	42.0%	37%	10%	0%	2%
Total	46,764	9,620	20.6%	dm**	dm**	dm**	dm**	dm**	dm**	dm**	dm**	dm**	dm**

Source: [1]Illinois Department of Public Health. Illinois Behavioral Risk Factors Surveillance System 2007-2009.

Retrieved on December 12, 2012 from http://app.idph.state.il.us/brfss/countydata.asp .

Note: Estimate based upon a survey of households. As the data source is a survey, population numbers were weighted to account for the sampling technique used. Weighted population counts vary slightly depending upon the variable.

[2]University of Illinois Center for Prevention Research and Development. Illinois Youth Survey County Reports.

Retrieved December 12, 2012 from http://iys.cprd.illinois.edu/results/county-reports

Note: Questions asked by the Illinois Behavioral Risk Factor Surveillance System:

[3]Survey participants indicated that they have smoked 100 cigarettes in their lifetime and currently smoke.

[4]Survey participants indicated that smoking is allowed anywhere or some places in their home or that they have no rules for smoking in their home

[5]Within the past month

[6]Within the past year

** Data missing. Incomplete or missing data at source.

Table 20: 2009 Prevalence of Selected Chronic Diseases by County

1. Prevalence of diabetes, 12.3% (region): range, 10.3% (Jasper) to 13.2% (Lawrence)
2. Prevalence of high cholesterol, 34.6% (region): range, 28.3% (Jasper) to 39.4% (Clay).
3. Prevalence of arthritis, 34.4% (region): range, 28.4% (Jasper) to 38.4% (Lawrence).
4. Prevalence of high blood pressure, 36,8% (region): range 31.7% (Jasper) and 41.8% (Clay).
5. Prevalence of asthma, 12.0% (region): range, 9.3% (Jasper) and 14.0% (Clay).

Table 20: 2009 Prevalence of Selected Chronic Diseases[1] by County (Number and Percent)

County	Population	Prevalence of Selected Chronic Disease									
		Diabetes[2]		High Cholesterol[3]		Arthritis[4]		High Blood Pressure[5]		Ever Had Asthma[6]	
		#	%	#	%	#	%	#	%	#	%
Clay	10,562	1,304	12.3%	4,164	39.4%	3,913	37.0%	4,418	41.8%	1,483	14.0%
Edwards	5,056	607	12.0%	1,598	31.6%	1,742	34.5%	1,958	38.7%	703	13.9%
Jasper	7,169	741	10.3%	2,031	28.3%	2,036	28.4%	2,269	31.7%	670	9.3%
Lawrence	12,239	1,612	13.2%	4,090	33.4%	4,697	38.4%	4,259	34.8%	1,435	11.7%
Richland	11,721	1,491	12.7%	4,298	36.7%	3,693	31.5%	4,297	36.7%	1,332	11.4%
Total	46,747	5,755	12.3%	16,181	34.6%	16,081	34.4%	17,201	36.8%	5,623	12.0%

Source: [1]Illinois Department of Public Health. Illinois Behavioral Risk Factors Surveillance System (2007-2009).

Retrieved on December 12, 2012 from http://app.idph.state.il.us/brfss/countydata.asp .

Note: Estimate based upon a survey of households. As the data source is a survey, population numbers were weighted to account for the sampling technique used. Weighted population counts vary slightly depending upon the variable.

Note: Questions asked by the Illinois Behavioral Risk Factor Surveillance System:

[2]Has a doctor ever told you that you had diabetes?

[3]Has a doctor ever told you that you have high cholesterol?

[4]Has a doctor ever told you that you have arthritis?

[5]Has a doctor ever told you that you have high blood pressure?

[6]Has a doctor ever told you that you have asthma?

Table 21: 2009 Adult Obesity and Associated Behavioral and Environmental Factors by County

1. 28.1% (region) of adults are obese: range, 27.0% (Edwards) to 30.0% (Richland).
2. 49.9% (region) of adults meet exercise guidelines: range, 44.8% (Richland) to 58.5% (Jasper).
3. Regionally, there are 59 recreational facilities per 100,000: range, 0 (Edwards) to 19 (Richland).
4. Regionally, 38.5% of zip codes have access to healthy food: range, 17% (Jasper) to 60% (Clay).

Table 21: 2009 Adult Obesity[1] and Associated Behavioral and Environmental Factors[1,2] by County
(Number and Percent)

County	Adult Obesity[1]			Associated Factors			
				People who meet exercise guidelines[2]		Recreational Facilities per 100,000[1]	Zip Codes with Access to Healthy Foods[1]
	Population	#	%	#	%	#	%
Clay	10,537	3,056	29.0%	5,242	49.7%	15	60.0%
Edwards	5,056	1,365	27.0%	2,571	50.9%	0	40.0%
Jasper	7,169	2,079	29.0%	4,195	58.5%	10	17.0%
Lawrence	12,239	3,549	29.0%	6,045	49.4%	15	50.0%
Richland	11,707	3,512	30.0%	5,240	44.8%	19	33.0%
Total	46,708	13,125	28.1%	23,293	49.9%	59	38.5%

Source: [1]Robert Wood Johnson Foundation. County Health Rankings.

Retrieved December 12, 2012 from http://www.countyhealthrankings.org/app/illinois/2012/rankings/outcomes/overall

[2]Illinois Department of Public Health. Illinois Behavioral Risk Factors Surveillance System 2007-2009.

Retrieved on December 12, 2012 from http://app.idph.state.il.us/brfss/countydata.asp

Note: Information provided by the Illinois Behavioral Risk Factor Surveillance System:

Met or exceeded regular and sustained physical activity guidelines based on calculations related to survey participant responses to a variety of questions.

Note: Estimate based upon a survey of households. As the data source is a survey, population numbers were weighted to account for the sampling technique used. Weighted population counts vary slightly depending upon the variable.

Table 22: 2009 Prevalence of Violence and Violent Crime Rate by County

1. Regionally, 4.3% of respondents reported being physically hurt by someone in the past 12 months.
2. Reports of being physically hurt by someone: range, 2.1% (Richland) and 6.6% (Clay).
3. Regional violent crime rate of 271.5 per 100,000 population: range, 148 (clay) to 497 (Edwards).

Table 22: 2009 Prevalence of Violence[1] and Violent Crime Rate[2] by County (Number, Percent and Rate)

County	Prevalence of Violence and Violent Crime			
	Population	Physically Hurt Past Year[1]		Violent Crime[2] per 100,000
		#	%	Rate
Clay	10,562	694	6.6%	148
Edwards	5,056	215	4.3%	497
Jasper	7,169	349	4.9%	395
Lawrence	12,239	517	4.2%	270
Richland	11,721	246	2.1%	211
Total	46,747	2,021	4.3%	271.5

Source: [1]Illinois Department of Public Health. Illinois Behavioral Risk Factors Surveillance System 2007-2009.
Retrieved on December 12, 2012 from http://app.idph.state.il.us/brfss/countydata.asp
Note: Question asked by the Illinois Behavioral Risk Factor Surveillance System:
In the past 12 months, were you physically hurt by someone?
Note: Estimate based upon a survey of households. As the data source is a survey, population numbers were weighted to account for the sampling technique used. Weighted population counts vary slightly depending upon the variable.
[2]Robert Wood Johnson Foundation. County Health Rankings.
Retrieved on December 12, 2012 from http://www.countyhealthrankings.org/app/illinois/2012/rankings/outcomes/overall
Note: Violent Crime includes rape, homicide, robbery and aggravated assault

Table 23: 2009 Incidence and Rates of Sexually Transmitted Disease by County

1. Chlamydia rates per 100,000, 97.7 (region): range, 43.0 (Edwards) to 137.4 (Clay).
2. HIV rates per 100,000, 4.9 (region): range, 0.0 (Edwards) to 11.3 (Lawrence).
3. Gonorrhea rates per 100,000, 4.9 (region): 6.2 (Richland) to 13.7 (Clay).
4. No cases of syphilis were reported in the region.

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Table 23: 2009 Incidence and Rates of Sexually Transmitted Disease[1,2] by County (Cases and Rates/100,000 Population)

County	Sexually Transmitted Disease Cases and Rates							
	Chlamydia[1]		HIV (2005 - 2011)[2]		Gonorrhea[1]		Syphilis[1]	
	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate
Clay	20	137.4	4	4.2	2	13.7	0	0.0
Edwards	3	43.0	0	0.0	0	0.0	0	0.0
Jasper	11	108.7	1	1.5	0	0.0	0	0.0
Lawrence	15	97.1	13	11.3	0	0.0	0	0.0
Richland	11	68.1	3	2.8	1	6.2	0	0.0
Total	60	97.7	21	4.9	3	4.9	0	0.0

Sources: [1]Illinois Department of Public Health. Illinois Department of Public Health Statistics.
Retrieved on December 12, 2012 from http://www.idph.state.il.us/health/statshome.htm
[2]Illinois Department of Public Health. Illinois Department of Public Health AIDS/HIV Monthly Surveillance Report December 2011.
Retrieved on December 12, 2012 from http://www.idph.state.il.us/aids/Surv_Report_1211.pdf
Note: Reported values are the 5-year running means.

VI. Dentists, Physicians and Social Services in the 5-County Region (Tables 24 – 27)

Table 24: 2009 Number of Dentists, Dentist Utilization and Physician Count by County

1. It is not clear whether the dentists and physicians reported practice in the region or reside there.
2. The 21 dentists in the region are unevenly distributed: range, 2 (Edwards) to 8 (Clay).
3. Regionally, more than 60% (62.3%) of citizens reported seeing the dentist annually.
4. The 63 physicians in the region are unevenly distributed: range, 0 (Edwards) to 39 (Richland).

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Table 24: 2009 Number of Dentists[1], Dentist Utilization[2] and Physician Count[3] by County (Number and Percent)

County	Dentists, Dentist Utilization and Physicians				
	Population	Number of Dentists[1]	People Who Visit the Dentist Annually[2]		Current Physician Count[3]
		#	#	%	#
Clay	10,562	8	6,357	60.5%	13
Edwards	5,056	2	3,220	63.7%	0
Jasper	7,169	3	4,546	63.4%	2
Lawrence	12,239	3	7,938	65.0%	9
Richland	11,721	5	7,055	60.9%	39
Total	46,747	21	29,116	62.3%	63

Sources:
[1]United States Department of Health and Human Services. Health Resources and Services Administration. Area Resource File 2011.

Note: Number of Board Certified Dentists

[2]Illinois Department of Public Health. Illinois Behavioral Risk Factors Surveillance System 2007-2009.

Retrieved on December 12, 2012 from http://app.idph.state.il.us/brfss/countydata.asp .

Note: Estimate based upon a survey of households. As the data source is a survey, population numbers were weighted to account for the sampling technique used. Weighted population counts vary slightly depending upon the variable.

[3]American Medical Association. Physician Related Data Sources.

Retrieved on March 7, 2013 from http://www.ama-assn.org/cgi-bin/sserver/datalist.cgi

Table 25: 2009 Major Depression, Suicide, and Behavioral Health Resources by County

1. Regionally, 6.8% of the population report major depression with little variation among the counties.
2. Regionally, a total of 57 suicides were reported over the 10-year period, 1997 – 2006.
3. Two psychiatrists are located in the region, 1 each in Richland and Lawrence.
4. Mental Health Counseling Centers are located in Clay and Edwards counties.
5. Health Departments are located in Jasper and Lawrence counties.

Table 25: 2009 Major Depression[1], Suicide[2], and Behavioral Health Resources[3] by County (Number and Percent)

County	Major Depression and Suicide				Behavioral Health Regional Resources	
	Adult Population	Have Major Depression[1]		Total Suicides[2] 1997-2006	Number of Psychiatrists[2]	Nearest Mental Health Center Location[3]
		#	%	#	#	
Clay	10,238	697	6.8%	13	0	Southeastern Illinois Counseling Center, Flora
Edwards	5,004	334	6.7%	6	0	Southeastern Illinois Counseling Center, Albion
Jasper	7,197	493	6.9%	6	0	Jasper County Health Department, Newton
Lawrence	12,947	887	6.9%	16	1	Lawrence County Health Dept., Lawrenceville
Richland	11,774	787	6.7%	16	1	Southeastern Illinois Counseling Center, Flora
Total	47,160	3,198	6.8%	57	2	n/a

Note: Regional Mental Health Facility: Region 5, South - Anna, Illinois

Note: State Psychiatric Hospitals: Alton Mental Health Center - Alton, Illinois

Choate Mental Health Center - Anna, Illinois

Source: [1]Department of Health and Human Services. Community Health Status Indicators 2009.

Retrieved on December 12, 2012 from http://www.communityhealth.hhs.gov/HomePage.aspx?GeogCD=&PeerStrat=&state=&county=

Note: Annual Averages Major depression prevalence by state for age 18 and older 2006-2007 from U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) Office of Applied Statistics as projected from state estimates

Note: Adult population aged 19 years or more

[2]American Medical Association.Physician Related Data Resources 2011.

Retrieved on February 12, 2013 from http://www.ama-assn.org/cgi-bin/sserver/datalist.cgi

Note: Does not indicate an FTE - data is self-reported by physicians to the AMA

[3]Illinois Department of Human Services 2012.

Mental Health Center Locator 2012.

Retrieved December 13, 2012 from http://www.dhs.state.il.us/page.aspx?module=12

Table 26: Social Service Organizations by County by Populations Served

1. 33 social service organizations serve 8 distinct sub-populations in 4 counties (minus Richland).
2. Many are community-based, however, state and county governments provide services as well.

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Table 26: Social Service Organizations by County by Populations Served[1]

County	Population Served	Agency Type	Agency Name	City
Clay	Caregivers	Community	Flora Public Library Caregiver Support Group	Flora
	Disabled	Assisted Living	Heritage Woods	
			Burge House	
		DD Facility	Chestnut Corners	Louisville
			Country View Terrace	
			Prairie Estates	Flora
	Elderly	Assisted Living	Burge House	
		Community	Senior Services for Clay County	
		Nursing Home	Flora Gardens Care Center	
			Flora Rehab and Healthcare Center	
		Senior Center	Clay County Senior Citizen Center	
	Families	Counseling	Clay Family Counseling Center	
	Residents	County	Clay County Health Department	
Edwards	Disabled	DD Facility	West Salem Manor	West Salem
	Elderly	Nursing Home	Rest Haven Manor	Albion
		Senior Center	Edwards County Senior Citizen Center	
			Grayville Senior Citizen Center	Grayville
			Shawnee Alliance for Seniors	Carterville
	Residents	Health Office	Edwards County Health Office	Albion
Jasper	Elderly	Nursing Home	Newton Rest Haven	Newton

		Senior Center	Effingham City-County Committee on Aging	Effingham
			Jasper County Senior Citizen Center	Newton
	Residents	County	Jasper County Health Department	
Lawrence	Caregivers	Hospital	Hospice of Southeastern Illinois	Lawrenceville
	Children	Public School	Special Education CUSD # 20	
	Elderly	Nursing Home	Lawrence Community Healthcare	Bridgeport
			United Methodist Village Main Campus	Lawrenceville
			United Methodist Village North Campus	
		Senior Center	Effingham City-County Committee on Aging	Flora
	Families	Counseling	Lawrence Family Counseling Center	Lawrenceville
	Residents	County	Lawrence County Health Department	
	Unemployed	Not for Profit	Chamber of Commerce	
	Veterans	State Agency	Illinois Department of Veterans Affairs	

Source: [1] Agency name, address, type and population served categories are based on information provided by Richland Memorial Hospital. Social Services Resource Book (Updated July, 2012).
Note: Agency type 'Community' is defined as a public or community agency providing services, such as support groups or home services, that are not the primary function of the organization (e.g. support groups sponsored by a public agency such as a library or local faith-based organization).

Table 27: Social Service Organizations in Olney, Richland County, Illinois by Populations Served

1. 13 social service organizations serve 13 distinct sub-populations in Richland County.
2. Many are community-based, however, state and county governments provide services as well.

Table 27: Social Service Organizations in Olney, Richland County, Illinois by Populations Served[1]

Population Served	Agency Type	Agency Name
Children	Community	Big Brothers Big Sisters
		KidZone
		Embarras River Basin Agency
	Public School	Southeastern Special Education East Richland High School
		Southeastern Special Education East Richland Elementary School
	State Agency	Specialized Care for Children in Richland County
Disabled	Assisted Living	Brookstone Estates
	Community	ARC Community Support System
	Nursing Home	Richland Manor
	State Agency	Division of Rehabilitation Services (DORS)
Domestic Violence	Community	SWAN (Stopping Women Abuse Now)
Elderly	Assisted Living	Emerald Glen
		Fox River Apartments
	Nursing Home	Burgin Manor
		Marks Sunset Manor
		Richland Manor
	Senior Center	Richland County Senior Citizens Center
Family	Community	One Hope United
	State Agency	Department of Child and Family Services
Food Insecure	Food Pantry	The Good Samaritan
		The Master's Hands
Home Health	Community	Advantage Home Health Service

Mental Health	Counseling	ARBORS Center
Pregant Women and Infants	Community	Birthright
Residents	Community	Salvation Army
	Health Office	Richland County Health Office
	Community College	Single Parent Displaced Homemaker Program
	Hospital	Richland Memorial Hospital
Substance Abuse	Community	First Church of Olney
		Free Methodist Church
	Counseling	Southeastern Counseling Center
Unemployed	Not for Profit	Chamber of Commerce
Women, Infants and Children	State Agency	Richland County WIC Office

Source: [1] Based on information provided by Richland Memorial Hospital Social Services Resource Book (Updated July, 2012).

Note: Agency type 'Community' is defined as a public or community agency providing services such as support groups or home services that are not the primary function of the organization.

VII. Hospitals in the 5-County Region (Tables 28 – 33)

General Information – No corresponding table.

1. The three hospitals in the region are located in Clay, Lawrence and Richland counties.
2. Richland Memorial Hospital (RMH) is a general hospital located in Olney, Illinois.
3. Lawrence County Hospital (LCH) is a Critical Access Hospital located in Lawrenceville, Illinois.
4. Clay County Hospital (CCH) is a Critical Access Hospital located in Flora, Illinois.

Table 28: 2011 Regional Hospital Service Utilization by Service and Hospital

1. Certificate of Need beds, 177 beds (region): 134 beds (RMH), 18 beds (CCH) & 25 beds (LCH).
2. RMH offers intensive care, obstetrics, mental health, pediatric, and long-term care services.
3. LCH and CCH offer general medical/surgical services but no specialty services offered by RMH.

Table 28: 2011 Regional Hospital Service Utilization by Service and Hospital[1] (Number and Percent)

Hospital Service by Hospital	CON Authorized Beds	Peak Beds Staffed	Peak Census	Admissions	Service Utilization Days			Average Length of Stay	Average Daily Census	Occupancy Rate	
					Inpatient	Observation	Total			CON Beds	Staffed Beds
	#	#	#	#	#	#	#	#	#	%	%
Intensive Care Total	8	5	5	74	130	0	130	1.8	0.4	4.5%	7.1%
Clay County Hospital	0	0	0	0	0	0	0	0.0	0.0	0.0%	0.0%
Lawrence County Hospital	0	0	0	0	0	0	0	0.0	0.0	0.0%	0.0%
Richland Memorial Hospital	8	5	5	74	130	0	130	1.8	0.4	4.5%	7.1%
Acute Mental Illness Total	16	10	10	593	2,663	12	2,675	4.5	7.3	45.8%	73.3%
Clay County Hospital	0	0	0	0	0	0	0	0.0	0.0	0.0%	0.0%
Lawrence County Hospital	0	0	0	0	0	0	0	0.0	0.0	0.0%	0.0%
Richland Memorial Hospital	16	10	10	593	2,663	12	2,675	4.5	7.3	45.8%	73.3%
Obstetrics/Gynecology Total	10	10	9	514	1,124	43	1,167	2.3	3.2	32.0%	32.0%
Clay County Hospital	0	0	0	0	0	0	0	0.0	0.0	0.0%	0.0%
Lawrence County Hospital	0	0	0	0	0	0	0	0.0	0.0	0.0%	0.0%
Richland Memorial Hospital	10	10	9	514	1,124	43	1,167	2.3	3.2	32.0%	32.0%
Pediatrics Total[2]	5	0	0	0	0	0	0	0.0	0.0	0.0%	0.0%
Clay County Hospital	0	0	0	0	0	0	0	0.0	0.0	0.0%	0.0%
Lawrence County Hospital	0	0	0	0	0	0	0	0.0	0.0	0.0%	0.0%
Richland Memorial Hospital	5	0	0	0	0	0	0	0.0	0.0	0.0%	0.0%

Long Term Care Total	34	34	34	211	3,175	0	3,175	15.0	8.7	25.6%	25.6%
Clay County Hospital	0	0	0	0	0	0	0	0.0	0.0	0.0%	0.0%
Lawrence County Hospital	0	0	0	0	0	0	0	0.0	0.0	0.0%	0.0%
Richland Memorial Hospital	34	34	34	211	3,175	0	3,175	15.0	8.7	25.6%	25.6%
Medical/Surgical Total	104	104	65	3,444	12,441	320	12,761	3.7	35.0	33.6%	33.6%
Clay County Hospital	18	18	18	1,069	4,289	64	4,353	4.1	11.9	66.3%	66.3%
Lawrence County Hospital	25	25	15	734	2,404	11	2,415	3.3	6.6	26.5%	26.5%
Richland Memorial Hospital	61	61	32	1,641	5,748	245	5,993	3.7	16.4	26.9%	26.9%
Total Utilization	177	n/a	n/a	4,844	20,109	375	20,484	4.2	56.1	31.7%	n/a
Clay County Hospital	18	n/a	n/a	1,069	4,289	64	4,353	4.1	11.9	66.3%	n/a
Lawrence County Hospital	25	n/a	n/a	846	3,203	11	3,214	3.8	8.8	35.2%	n/a
Richland Memorial Hospital	134	n/a	n/a	2,929	12,617	300	12,917	4.4	35.4	26.4%	n/a

Source: [1]Illinois Department of Public Health. Individual Hospital Profiles by Hospital Name. 2011
Retrieved March 18, 2013 from http://www.hfsrb.illinois.gov/pdf

[2]All "Pediatrics" utilization information, other than the number of CON beds, is included in the "Medical/Surgical" section below.

Table 29: 2011 Admissions and Inpatient Days by Patient Age Categories and Admitting Hospital

1. Hospital admissions, 3,444 (region): 47.6% (RMH), 31.0% (CCH), and 21.3% (LCH).
2. RMH accounted for 57.3% of admissions in the 0 – 14 years of age category.
3. RMH accounted for 53.7% of admissions in the 65 – 74 years of age category.
4. RMH accounted for the single largest proportion of admissions in the other 3 age categories.

Table 29: 2011 Admissions and Inpatient Days by Patient Age Categories and Admitting Hospital[1] (Number and Percent)

Hospital	Number of Patient Admissions and Inpatient Days by Age Categories											
	0 - 14 Years		15 - 44 Years		45 - 64 Years		65 - 74 Years		75+ Years		Total	
	Admissions	Inpatient Days	Admissions	Inpatient Days	Admissions	Inpatient Days	Admissions	Inpatient Days	Admissions	Inpatient Days	Admissions	Inpatient Days
Clay County Hospital	44	78	152	468	224	827	127	472	522	2,444	1,069	4,289
Lawrence County Hospital	17	38	97	185	141	388	113	370	366	1,423	734	2,404
Richland Memorial Hospital	82	179	164	450	328	1,056	278	1,028	789	3,035	1,641	5,748
Total	143	295	413	1,103	693	2,271	518	1,870	1,677	6,902	3,444	12,441

Hospital	Percent of Patient Admissions and Inpatient Days by Age Categories											
	0 - 14 Years		15 - 44 Years		45 - 64 Years		65 - 74 Years		75+ Years		Total	
	Admissions	Inpatient Days	Admissions	Inpatient Days	Admissions	Inpatient Days	Admissions	Inpatient Days	Admissions	Inpatient Days	Admissions	Inpatient Days
Clay County Hospital	30.8%	26.4%	36.8%	42.4%	32.3%	36.4%	24.5%	25.2%	31.1%	35.4%	31.0%	34.5%
Lawrence County Hospital	11.9%	12.9%	23.5%	16.8%	20.3%	17.1%	21.8%	19.8%	21.8%	20.6%	21.3%	19.3%
Richland Memorial Hospital	57.3%	60.7%	39.7%	40.8%	47.3%	46.5%	53.7%	55.0%	47.0%	44.0%	47.6%	46.2%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: [1]Illinois Department of Public Health. Individual Hospital Profiles by Hospital Name. 2011
Retrieved March 18, 2013 from
http://www.hfsrb.illinois.gov/pdf

Table 30: 2011 Laboratory, Diagnostic/Interventional and Imaging Service Utilization by Hospital

1. Regionally, RMH performed more than half the radiology (52.6%) ultrasound (55.3%) service.
2. Regionally, RMH performed close to half (49.7%) of the laboratory studies service.
3. Regionally, CCH performed 61.8% of the mammography service; LCH does not offer this service.
4. Regionally, RMH performed 45.9% and CCH performed 44.6% of the CAT Scan service.

Table 30: 2011 Laboratory, Diagnostic/Interventional and Imaging Service Utilization[1] by Hospital (Number)

Hospital	Number of Laboratory, Diagnostic/Interventional and Imaging Services Delivered						
	Lab Studies	General Radiography	Nuclear Medicine	Mammography	Ultrasound	CAT Scans	MRI
Clay County Hospital	97,571	7,610	828	2,406	1,899	2,885	424
Lawrence County Hospital	74,587	5,664	324	0	1,308	618	327
Richland Memorial Hospital	170,021	14,711	786	1,490	3,967	2,970	670
Total	342,179	27,985	1,938	3,896	7,174	6,473	1,421

Hospital	Percent of Laboratory, Diagnostic/Interventional and Imaging Services Delivered						
	Lab Studies	General Radiography	Nuclear Medicine	Mammography	Ultrasound	CAT Scans	MRI
Clay County Hospital	28.5%	27.2%	42.7%	61.8%	26.5%	44.6%	29.8%
Lawrence County Hospital	21.8%	20.2%	16.7%	0.0%	18.2%	9.5%	23.0%
Richland Memorial Hospital	49.7%	52.6%	40.6%	38.2%	55.3%	45.9%	47.1%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: [1]Illinois Department of Public Health. Individual Hospital Profiles by Hospital Name. 2011
Retrieved March 18, 2013 from http://www.hfsrb.illinois.gov/pdf
Note: Numbers and percents include inpatient, outpatient and contract studies and examinations.

Table 31: 2011 Surgery and Operating Room Utilization by Hospital

1. Regionally, 11 combined-function operating rooms are provided by RMH (5), LCH (4) and CCH (2).
2. Regionally, of the 3,470 total procedures reported, the majority (2,813) are outpatient procedures.
3. Procedures in general surgery (1,402) & gastroenterology (942) were performed most frequently.
4. Procedures in urology (238) and otolaryngology (390) were performed exclusively by RMH.
5. All 3 performed procedures in orthopedics (208), ophthalmology (251), & general surgery (1,402).

Table 31: 2011 Surgery and Operating Room Utilization[1] by Hospital (Number)

Surgical Specialty by Hospital	Operating Rooms				Surgical Cases			Surgical Hours			Mean Hours Per Case		
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Total	Inpatient	Outpatient	Total	Inpatient	Outpatient	Total
General Surgery Total	0	0	5	5	448	954	1,402	1,057	1,696	2,753	2.4	1.8	2.0
Clay County Hospital	0	0	2	2	80	278	358	134	373	507	1.7	1.3	1.4
Lawrence County Hospital	0	0	2	2	12	199	211	16	289	305	1.3	1.5	1.4
Richland Memorial Hospital	0	0	1	1	356	477	833	907	1,034	1,941	2.5	2.2	2.3
Gastroenterology Total	0	0	2	2	133	809	942	61	497	558	0.5	0.6	0.6
Clay County Hospital	0	0	0	0	122	589	711	49	272	321	0.4	0.5	0.5
Lawrence County Hospital	0	0	2	2	11	220	231	12	225	237	1.1	1.0	1.0
Richland Memorial Hospital	0	0	0	0	0	0	0	0	0	0	0.0	0.0	0.0
Obstetrics/Gynecology Total	0	0	0	0	0	19	19	0	22	22	0.0	1.2	1.2
Clay County Hospital	0	0	0	0	0	0	0	0	0	0	0.0	0.0	0.0
Lawrence County Hospital	0	0	0	0	0	19	19	0	22	22	0.0	1.2	1.2
Richland Memorial Hospital	0	0	0	0	0	0	0	0	0	0	0.0	0.0	0.0
Ophthalmology Total	0	0	1	1	0	251	251	0	182	182	0.0	0.7	0.7
Clay County Hospital	0	0	0	0	0	80	80	0	40	40	0.0	0.5	0.5
Lawrence County Hospital	0	0	0	0	0	37	37	0	38	38	0.0	1.0	1.0
Richland Memorial Hospital	0	0	1	1	0	134	134	0	104	104	0.0	1.0	0.8
Orthopedics Total	0	0	1	1	27	181	208	87	316	403	3.2	1.7	1.9
Clay County Hospital	0	0	0	0	0	40	40	0	30	30	0.0	0.8	0.8
Lawrence County Hospital	0	0	0	0	0	9	9	0	9	9	0.0	1.0	1.0
Richland Memorial Hospital	0	0	1	1	27	132	159	87	277	364	3.2	2.1	2.3
Otolaryngology Total	0	0	1	1	2	388	390	5	416	421	2.5	1.1	1.1

Clay County Hospital	0	0	0	0	0	0	0	0	0	0	0.0	0.0	0.0
Lawrence County Hospital	0	0	0	0	0	0	0	0	0	0	0.0	0.0	0.0
Richland Memorial Hospital	0	0	1	1	2	388	390	5	416	421	0.0	1.1	1.1
Podiatry Total	0	0	0	0	2	18	20	3	24	27	1.5	1.3	1.4
Clay County Hospital	0	0	0	0	2	18	20	3	24	27	1.5	1.3	1.4
Lawrence County Hospital	0	0	0	0	0	0	0	0	0	0	0.0	0.0	0.0
Richland Memorial Hospital	0	0	0	0	0	0	0	0	0	0	0.0	0.0	0.0
Urology Total	0	0	1	1	45	193	238	102	337	439	2.3	1.7	1.8
Clay County Hospital	0	0	0	0	0	0	0	0	0	0	0.0	0.0	0.0
Lawrence County Hospital	0	0	0	0	0	0	0	0	0	0	0.0	0.0	0.0
Richland Memorial Hospital	0	0	1	1	45	193	238	102	337	439	2.3	1.7	1.8
Surgical Specialties Total	0	0	11	11	657	2,813	3,470	1,315	3,490	4,805	2.0	1.2	1.4
Clay County Hospital	0	0	2	2	204	1,005	1,209	186	739	925	0.9	0.7	0.8
Lawrence County Hospital	0	0	4	4	23	484	507	28	583	611	1.2	1.2	1.2
Richland Memorial Hospital	0	0	5	5	430	1,324	1,754	1,101	2,168	3,269	2.6	1.6	1.9

Source: [1]Illinois Department of Public Health. Individual Hospital Profiles by Hospital Name. 2011
Retrieved March 18, 2013 from http://www.hfsrb.illinois.gov/pdf

Table 32: 2011 Revenues by Source and Value of Charity Care, by Patient Type and Hospital

1. Total revenues, $68.9 million (region); $37.7 M (RMH), 19.4 M (CCH), $11.8 M (LCH)
2. Total revenues, % of revenues, 100.0% (region): 54.8% (RMH), 28.1% (CCH), 17.1% (LCH).
3. Medicare/Medicaid revenues, $38.2 M (region): $19.6 M (RMH), $10.7 M (CCH), $7.8 M (LCH).
4. Medicare/Medicaid, % of revenues, 55.4% (region): 52.0% (RMH), 55.2% (CCH), 66.5% (LCH).
5. Private insurance revenues, $27.6 M (region): $16.8 M (RMH), $7.1 M (CCH), $3.7 M (LCH).
6. Private insurance, % of revenues, 40.0% (region): 44.4% (RMH), 36.6 % (CCH), 31.5% (LCH).
7. Private pay revenues, $3.1 M (region): $1.4 M (RMH), $1.6 M (CCH), $177,400 (LCH).
8. Private pay, % of revenues, 4.5% (region): 3.6% (RMH), 8.2% (CCH), 1.5% (LCH).
9. Value of charity care, $1.9 M (region): $1.1 M (RMH), $575,136 (CCH), $221,400 (LCH).
10. Charity care, % equivalent, 2.7% (region): 2.9% (RMH), 3.0% (CCH), 1.9% (LCH).

Table 32: 2011 Revenues by Source and Value of Charity Care, by Patient Type and Hospital[1] (Amount and Percent)

Patient Type by Hospital	Revenues by Source and Value of Charity Care													
	Medicare		Medicaid		Other Public Insurance		Private Insurance		Private Pay		Total Revenues		Value of Charity Care	
	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%
Total Inpatient Revenues	$13,421,187	54.4%	$3,806,321	15.4%	$11,500	0.0%	$6,047,398	24.5%	$1,399,301	5.7%	$24,685,707	100.0%	$481,518	2.0%
Clay County Hospital	$3,175,736	66.0%	$379,344	7.9%	$0	0.0%	$982,865	20.4%	$274,330	5.7%	$4,812,275	19.5%	$93,051	1.9%
Lawrence County Hospital	$2,583,930	80.1%	$135,450	4.2%	$11,500	0.4%	$470,800	14.6%	$24,750	0.8%	$3,226,430	13.1%	$27,950	0.9%
Richland Memorial Hospital	$7,661,521	46.0%	$3,291,527	19.8%	$0	0.0%	$4,593,733	27.6%	$1,100,221	6.6%	$16,647,002	67.4%	$360,517	2.2%
Total Outpatient Revenues	$14,167,426	32.0%	$6,775,201	15.3%	$48,200	0.1%	$21,510,622	48.6%	$1,730,945	3.9%	$44,232,394	100.0%	$1,407,495	3.2%
Clay County Hospital	$5,751,212	39.5%	$1,410,001	9.7%	$0	0.0%	$6,103,835	41.9%	$1,308,373	9.0%	$14,573,421	32.9%	$482,085	3.3%
Lawrence County Hospital	$3,511,170	41.1%	$1,597,350	18.7%	$48,200	0.6%	$3,235,500	37.9%	$152,650	1.8%	$8,544,870	19.3%	$193,450	2.3%
Richland Memorial Hospital	$4,905,044	23.2%	$3,767,850	17.8%	$0	0.0%	$12,171,287	57.6%	$269,922	1.3%	$21,114,103	47.7%	$731,960	3.5%
Total Revenues	$27,588,613	40.0%	$10,581,522	15.4%	$59,700	0.1%	$27,558,020	40.0%	$3,130,246	4.5%	$68,918,101	100.0%	$1,889,013	2.7%
Clay County Hospital	$8,926,948	46.0%	$1,789,345	9.2%	$0	0.0%	$7,086,700	36.6%	$1,582,703	8.2%	$19,385,696	28.1%	$575,136	3.0%
Lawrence County Hospital	$6,095,100	51.8%	$1,732,800	14.7%	$59,700	0.5%	$3,706,300	31.5%	$177,400	1.5%	$11,771,300	17.1%	$221,400	1.9%
Richland Memorial Hospital	$12,566,565	33.3%	$7,059,377	18.7%	$0	0.0%	$16,765,020	44.4%	$1,370,143	3.6%	$37,761,105	54.8%	$1,092,477	2.9%

Source: [1]Illinois Department of Public Health. Individual Hospital Profiles by Hospital Name. 2011
Retrieved March 18, 2013 from http://www.hfsrb.illinois.gov/pdf

Note: "Value of Charity Care" Amounts and Percents are not included in "Total Revenues" Amount and Percent.

Table 33: 2011 Patients Served by Revenue Source and Charity Care, by Patient Type and Hospital

1. Total patients served, 165,534 (region): 54,253 (RMH), 72,399 (CCH), 38,882 (LCH).
2. Total patients served, % of total, 100.0%, (region): 32.8% (RMH), 43.7% (CCH), 23.8% (LCH).
3. Medicaid/Medicaid patients, 106,466 (region): 33,861 (RMH), 47,797 (CCH), 24,808 (LCH).
4. Medicare/Medicaid % of patients, 65.4% (region): 64.4% (RMH), 66.3% (CCH), 64.9% (LCH).
5. Private insurance patients, 41,925 (region): 13,972 (RMH), 18,420 (CCH), 9,533 (LCH).
6. Private insurance % of patients, 25.7% (region): 26.6% (RMH), 25.6% (CCH), 25.0% (LCH).
7. Private pay patients, 14,256 (region): 4,757 (RMH), 6,868 (CCH), 1,631 (LCH).
8. Private pay % of patients, 8.8% (region): 9.0% (RMH), 8.1% (CCH), 9.5% (LCH).
9. Charity care patients, 2,673 (region): 1,663 (RMH), 314 (CCH), 696 (LCH).
10. Charity care % of patients, 1.6% (region): 3.1% (RMH), 0.4% (CCH), 1.8% (LCH).

Table 33: 2011 Patients Served by Revenue Source and Charity Care, by Patient Type and Hospital[1] (Number and Percent)

Patient Type by Hospital	Patients Served by Revenue Source and Value of Charity Care															
	Medicare		Medicaid		Other Public Insurance		Private Insurance		Private Pay		Total Paying Patients		Charity Care Provided		Total Patients	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Total Inpatients	2,876	61.8%	652	14.0%	3	0.1%	861	18.5%	259	5.6%	4,651	100.0%	193	4.0%	4,844	100.0%
Clay County Hospital	724	69.4%	150	14.4%	0	0.0%	141	13.5%	28	2.7%	1,043	22.4%	26	2.4%	1,069	22.1%
Lawrence County Hospital	631	75.5%	86	10.3%	3	0.4%	83	9.9%	33	3.9%	836	18.0%	10	1.2%	846	17.5%
Richland Memorial Hospital	1,521	54.9%	416	15.0%	0	0.0%	637	23.0%	198	7.1%	2,772	59.6%	157	5.4%	2,929	60.5%
Total Outpatients	65,835	41.6%	37,103	23.5%	211	0.1%	41,064	26.0%	13,997	8.8%	158,210	100.0%	2,480	1.5%	160,690	100.0%
Clay County Hospital	32,697	46.0%	14,226	20.0%	0	0.0%	18,279	25.7%	5,840	8.2%	71,042	44.9%	288	0.4%	71,330	44.4%
Lawrence County Hospital	13,241	35.5%	10,850	29.0%	211	0.6%	9,450	25.3%	3,598	9.6%	37,350	23.6%	686	1.8%	38,036	23.7%
Richland Memorial Hospital	19,897	39.9%	12,027	24.1%	0	0.0%	13,335	26.8%	4,559	9.2%	49,818	31.5%	1,506	2.9%	51,324	31.9%
Total Patients	68,711	42.2%	37,755	23.2%	214	0.1%	41,925	25.7%	14,256	8.8%	162,861	100.0%	2,673	1.6%	165,534	100.0%
Clay County Hospital	33,421	46.4%	14,376	19.9%	0	0.0%	18,420	25.6%	5,868	8.1%	72,085	44.3%	314	0.4%	72,399	43.7%
Lawrence County Hospital	13,872	36.3%	10,936	28.6%	214	0.6%	9,533	25.0%	3,631	9.5%	38,186	23.4%	696	1.8%	38,882	23.5%
Richland Memorial Hospital	21,418	40.7%	12,443	23.7%	0	0.0%	13,972	26.6%	4,757	9.0%	52,590	32.3%	1,663	3.1%	54,253	32.8%

Source: [1]Illinois Department of Public Health. Individual Hospital Profiles by Hospital Name. 2011
Retrieved March 18, 2013 from http://www.hfsrb.illinois.gov/pdf

VIII. Richland Memorial Hospital (Tables 34 – 39)

Table 34: Richland Memorial Hospital 2013 Physician Medical Staff by Type and Specialty

1. RMH reports 17 Active and Associate Staff physicians, accounting for 12 specialties.
2. The 17 physicians include 3 OB/GYN, 2 family physicians, 2 general surgeons and 2 pediatricians.
3. RMH reports 120 Courtesy and Affiliated Staff physicians, accounting for 14 specialties.
4. Clinical radiologists (57), cardiology (35) & emergency medicine (10) are the 3 largest specialties.

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Table 34: Richland Memorial Hospital 2013 Physician Medical Staff by Type and Specialty[1] (Number and Percent)

Medical Staff by Type and Specialty			Qualifications of Medical Staff by Type[2]
Active and Associate Staff	#	%	
Emergency Medicine	1	5.9%	Active Staff Qualifications: a) reside within 30 minutes of the Hospital (Psychiatrists, 60 minutes); b) know the community and Hospital medical needs; c) admit or be involved in the care of at least 12 patients/year; and, c) complete at least 1 year of satisfactory performance as Associate Staff.
Family Practice	2	11.8%	
General Practice	1	5.9%	
General Surgery	2	11.8%	
Internal Medicine	1	5.9%	
OB/GYN	3	17.6%	
Orthopedic Surgery**	1	5.9%	
Otolaryngology	1	5.9%	Associate Staff Qualifications: a) reside within 30 minutes of the Hospital; b) be qualified for advancement to Active Staff; c) participate in emergency room call schedule as appropriate, if requested; and, d) clinical performance reviewed as necessary during his/her Associate Staff status.
Pathology	1	5.9%	
Pediatrics	2	11.8%	
Psychiatry	1	5.9%	
Urology	1	5.9%	
Total Active/Associate Staff	17	100.0%	
Courtesy and Affiliated Staff	#	%	
Cardiology	35	29.2%	Courtesy Staff Qualifications: a) admit or provide service to fewer than 50 patients of the Hospital per year; b) reside within 45 minutes of the Hospital or arrange coverage with a similarly privileged Active or Associate Staff member of the Hospital for patient coverage; c) be an appointee of the Active or Associate Staff of another hospital accredited by the Joint Commission, the American Osteopathic Association, or the Healthcare Facilities Accreditation Program.
Clinical Radiologists	57	47.5%	
Dentistry	2	1.7%	
Emergency Medicine	10	8.3%	
General Surgery***	1	0.8%	
Hand Surgery	1	0.8%	
Neurology	2	1.7%	
Oncology	1	0.8%	

Opthalmology	2	1.7%	Affiliated Staff Qualifications: specialists in the medical or dental professions who provide consultation, locum tenens or ER coverage or provide specific intermittent service (cardiology, neurology, pediatric cardiology, etc.) but are unable to hold a regular staff appointment due to distance or other reasons.
Orthopedic Surgery	1	0.8%	
Pathology	2	1.7%	
Pediatric Cardiology	3	2.5%	
Podiatry	2	1.7%	
Psychiatry	1	0.8%	
Total Courtesy/Affiliated Staff	120	100.0%	

Source: [1]Richland Memorial Hospital. Medical Staff Services. Medical Records Department. 2013.
[2]Richland Memorial Hospital Medical Staff Bylaws.
[**]The Orthopedic Surgeon is an Associate Staff Member
[***]The General Surgeon is a Courtesy Staff Member

Table 35: RMH: 2011 & 2012 Top 5 Major Diagnostic Categories at Discharge by Year and Rank

1. 6 Major Diagnostic Categories accounted for more than half the discharge diagnoses over 2 years.
2. Between 2011 and 2012, kidney and urinary tract replaced circulatory system for the 5th diagnosis.
3. Mental disease, pregnancy, respiratory system, and neonates remained in the top 5 both years.
4. In both years, more than 25% of discharge diagnoses were due to mental diseases and pregnancy.

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Table 35: Richland Memorial Hospital
2011 and 2012 Top 5 Major Diagnostic Categories at Discharge by Year and Rank[1]
(Number of Inpatients and Percent of Total Inpatients)

2011 (Total Inpatients: n = 3,285)

Major Diagnostic Categories			Inpatients	
Rank	Description	Code	#	%
1	Mental Diseases and Disorders	19	573	17.4%
2	Pregnancy, Childbirth & Puerperium	14	352	10.7%
3	Respiratory System	4	323	9.8%
4	Newborn and Other Neonates	15	320	9.7%
5	Circulatory System	5	128	3.9%
n/a	Total	n/a	1,696	51.6%

2012 (Total Inpatients: n = 3,048)

Major Diagnostic Categories			Inpatients	
Rank	Description	Code	#	%
1	Mental Diseases and Disorders	19	505	16.6%
2	Pregnancy, Childbirth & Puerperium	14	338	11.1%
3	Newborn and Other Neonates	15	314	10.3%
4	Respiratory System	4	271	8.9%
5	Kidney and Urinary Tract	11	100	3.3%
n/a	Total	n/a	1,528	50.1%

Source: [1]Richland Memorial Hospital Medical Records Department. Provided to analysts on April 22, 2013. Provided both data and notes.

Note: Major Diagnostic Categories (MDC) are formed by assigning each principal diagnosis (from ICD-9-CM) to 1 of 25 mutually exclusive diagnostic areas. MDC codes, like DRG codes, are primarily a claims and administrative data element unique to the United States medical care reimbursement system. DRG codes also are mapped, or grouped, into MDC codes.

Note: The diagnoses in each MDC correspond to a single organ system or etiology and, in general, are associated with a particular medical specialty. MDC 1 to MDC 23 are grouped according to principal diagnoses. Patients with at least 2 significant trauma diagnosis codes (either as principal or secondary) from different body site categories are assigned to MDC 24 (Multiple Significant Trauma). Patients assigned to MDC 25 (HIV Infections) must have a principal diagnosis of an HIV Infection or a principal diagnosis of a significant HIV related condition and a secondary diagnosis of an HIV Infection.

Note: MDC 0, unlike the others, can be reached from a number of diagnosis/procedure situations related to transplants. This is due to the expense involved for the transplants so designated and because these transplants can be needed for a number of reasons which do not all come from one diagnosis domain. DRGs which reach MDC 0 are assigned to the MDC for the principal diagnosis instead of to the MDC associated with the designated DRG.

Table 36: RMH: 2011 & 2012 Top 5 Diagnosis Related Groups (DRGs) at Discharge by Year & Rank

1. In both 2011 and 2012, 25% or more of RMH discharge diagnoses fell within 3 DRGs.
2. By year: psychoses (13.6%, 13.9%), normal newborn (8.6%, 8.7%), vaginal delivery (5.7%, 5.5%).
3. 915 of 3,285 (2011) & 860 of 3,048 (2012) RMH discharge diagnoses fell within these 3 DRGs.
4. The top 5 RMH DRGs accounted for 35.0% (2011) and 34.4% (2012) of all discharge diagnoses.

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Table 36: Richland Memorial Hospital
2011 and 2012 Top 5 Diagnosis Related Groups at Discharge by Year and Rank[1]
(Number of Inpatients and Percent of Total Inpatients)

2011 (Total Inpatients: n = 3,285)

Diagnosis Related Groups			Inpatients	
Rank	Diagnosis	Code	#	%
1	Psychoses	885	446	13.6%
2	Normal Newborn	795	282	8.6%
3	Vaginal Delivery	775	187	5.7%
4	Depressive Disorder	881	127	3.9%
5	Simple Pneumonia & Pleurisy	195	108	3.3%
n/a	Total	n/a	1,150	35.0%

2012 (Total Inpatients: n = 3,048)

Diagnosis Related Groups			Inpatients	
Rank	Diagnosis	Code	#	%
1	Psychoses	885	425	13.9%
2	Normal Newborn	795	266	8.7%
3	Vaginal Delivery	775	169	5.5%
4	Esophagitis, Gastroenteritis, Digestive Disorder	392	100	3.3%
5	Kidney and Urinary Tract Infections	690	89	2.9%
n/a	Total	n/a	1,049	34.4%

Source: [1]Richland Memorial Hospital Medical Records Department. Provided to analysts on April 22, 2013. Provided both data and notes.

Note: Richland Memorial Hospital decreased the number of staffed psychiatry beds from 16 to 10 on March 30, 2011.

Note: The assignment of the principal diagnosis must be based on the Uniform Hospital Discharge Data Set (UHDDS) definition which is "the condition established after study that occasioned the admission to the hospital." The principal diagnosis code assignment must also be supported by the physician documentation in the medical record.

Table 37: 2011 Birthing Data and Newborn Nursing Service Utilization by Hospital

1. RMH serves as a birthing center for the region and offers 6 labor and delivery rooms.
2. In 2011, RMH provided service for a total of 354 births of which 351 were live births.
3. Neither CCH nor LCH provide birthing services.

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Table 37: 2011 Birthing Data and Newborn Nursing Service Utilization[1] by Hospital (Numbers)

Hospital	Birthing Data				Newborn Nursing Patient Days			
	Deliveries	Live Births	Labor Rooms	C-Sections	Level 1 Days	Level 2 Days	Level 2+ Days	Total Days
Clay County Hospital	0	0	0	0	0	0	0	0
Lawrence County Hospital	0	0	0	0	0	0	0	0
Richland Memorial Hospital	354	351	6	114	643	11	0	654
Total	354	351	6	114	643	11	0	654

Source: [1]Illinois Department of Public Health. Individual Hospital Profiles by Hospital Name. 2011 Retrieved March 18, 2013 from http://www.hfsrb.illinois.gov/pdf

Note: "Labor Rooms" above includes Labor, Delivery, Recovery, and Postpartum utilization.

Table 38: Richland Memorial Hospital 2007 – 2010 Birthings by Year and Resident County

1. Between 2007 and 2010, a total of 1,190 babies were delivered at Richland Memorial Hospital.
2. In the same period, RMH delivered 398 (or 70.2%) of babies born to Richland County residents.
3. In the same period, RMH delivered 671 (56.4%) of babies born to residents of the other 4 counties.

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Table 38: Richland Memorial Hospital 2007 - 2010 Birthings by Year and Resident County[1]

Year	Richland Memorial Hospital (RMH) Birthings						
	Richland County Resident Birthings				# RMH Birthings from Other Counties	Total RMH Birthings	% RMH Birthings from Other Counties
	Delivered at RMH	Delivered Elsewhere[2]	Total[2]	% Delivered at RMH[2]			
2007	124	49	173	71.7%	136	260	52.3%
2008	147	59	206	71.4%	169	316	53.5%
2009	127	61	188	67.6%	187	314	59.6%
2010	121	dm	dm	dm	179	300	59.7%
Total	398	169	567	70.2%	671	1,190	56.4%

Sources: [1]Richland Memorial Hospital on April 29, 2013 (Reports US Census, Illinois Department of Public Health and RMH internal Data Records as primary sources).
[2]Data for Richland County resident babies born elsewhere were not available. Consequently, totals for these sections of the table are based upon 2007 - 2009 data.

Table 39: RMH 2011 & 2012 Patient Transfers by Year, Diagnosis, Method and Destination

1. In this period, RMH admitted 25,835 patients of which 1,058 (4.1%) were transferred for care.
2. 71.0% were transferred to other facilities for medical (38.0%) or cardiac (32.0%) diagnoses.
3. 73.0% were transferred by ambulance with an additional 18.1% transferred by helicopter.
4. 47.1% of transfers to Evansville: Deaconess Hospital (31.6%) or Deaconess Gateway (15.5%).

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Table 39: Richland Memorial Hospital 2011 & 2012 Patient Transfers by Year, Diagnosis, Method and Destination[1]

Transfer Patient Characteristics	Calendar Year					
	2011		2012		Total	
	#	%	#	%	#	%
Total Admitted	13,466	100.0%	12,369	100.0%	25,835	100.0%
Total Transferred	508	3.8%	550	4.4%	1,058	4.1%
Transfer Diagnosis						
Medical	193	38.0%	215	39.0%	408	38.5%
Cardiac	163	32.0%	182	33.0%	344	32.5%
Trauma	56	11.0%	88	16.0%	144	13.6%
Pediatric	46	9.0%	0	0.0%	46	4.3%
Other	51	10.0%	66	12.0%	117	11.0%
Total	508	100.0%	550	100.0%	1,058	100.0%
Transport Method						
Ambulance	371	73.0%	402	73.0%	772	73.0%
Helicopter	76	15.0%	116	21.0%	192	18.1%
Private Auto	25	5.0%	27	4.9%	52	4.9%
Other	36	7.0%	6	1.1%	42	3.9%
Total	508	100.0%	550	100.0%	1,058	100.0%
Transfer Destination						
Deaconess	142	28.0%	193	35.0%	335	31.6%
Deaconess Gateway	76	15.0%	88	16.0%	164	15.5%
St. Mary's - Evansville	50	9.8%	0	0.0%	50	4.7%
Good Samaritan - Vincennes IN	0	0.0%	72	13.0%	72	6.8%
Other	240	47.2%	198	36.0%	438	41.4%
Total	508	100.0%	550	100.0%	1,058	100.0%

Source: [1]Richland Memorial Hospital Transfer Data Sheets, 2011 and 2012 (Emergency Department.

Note: "Medical" includes pneumonia, CVA/TIA, vascular, renal failure, sepsis, COPD, electrolytes.

Note: "Trauma" includes fracture, head injury, chest injury, soft tissue, abdominal

Note: "Ambulance" refers to transfer by any ambulance service including but not limited to RMH.

Appendix E – SIU-Center for Rural Health and Social Service Development Report

Richland Memorial Hospital

Focus Group Report

For the purpose of a Community Needs Assessment

April 15, 2013

Submitted by

Center for Rural Health and Social Service Development

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Focus groups were conducted and content analyzed to aid the community needs assessment of Richland Memorial Hospital. The goal of this project was to identify needs within the community which the hospital may address. Individuals from the surrounding communities were invited to seven focus groups held over a two week period. The participants were chosen to represent a variety of community interests. Participants were asked to answer questions including what are the 1) three most significant health care needs, 2) currently available resources and services in the community, 3) most preventable health-related diagnoses, and 4) new or currently unavailable programs which would make the biggest difference in the community. The focus group protocol and participant informed consent are listed in Appendix A and B. From these groups, transcriptions were created which were analyzed using the qualitative analysis software Atlas.ti. This program assisted us in developing the primary themes which participants identified and discussed throughout the groups.

Needs

Significant or Critical Healthcare Needs (*focus group participant quotes in italics*):

Mental Health Care and Treatment

Mental and behavioral health care and treatment was consistently identified as a significant health care need by all focus groups. The poor economy and inadequate funding of the behavioral healthcare system was identified as contributing factors for the increased demand for mental health services. Participants identified untreated mental health conditions such as, stress, anxiety, and depression, and substance abuse such as, methamphetamine, and prescription drug abuse. Outpatient behavioral health services where characterized as ineffective. There is only one human service agency in Richland County and not enough psychiatrists and counselors. The wait time for an appointment to see a counselor is 4 – 6 weeks, and a patient cannot see a psychiatrist until they have seen a counselor. This process may take 3 months. Persons seeking immediate help may go to the emergency department and be placed into a higher level of care in order to receive services. Richland Memorial Hospital has 10 inpatient mental health beds. They are filled with a significant number of persons from out of area and post discharge placement is often difficult.

- Outpatient Behavioral Health Services
  - There is a shortage of psychiatrists and counselors
  - The wait time for an appointment is too long 4 – 6 weeks
  - Patients may wait 3 months to see a psychiatrist
  - Persons seeking immediate treatment go to the emergency department
  - Patients may be placed into a higher level of care (inpatient) in order to receive services
  - Patients run out of medication due to delays in seeing a psychiatrist
  - Patients receiving inpatient mental health care may be from out of area and placement is difficult following discharge.

What I noticed is that the economy has gotten worse; the influx of people needing services has gone up and resources have gone down.

…there are people who desperately need help with mental issues, and it's sad that there's not a lot of help out there for them…

I think we need a larger mental health system that can cover all the age ranges, younger and older.

It can take a month or more just to get your initial visit and for the psychiatrist it can take three months.

I think we need more counselors, but it's difficult to get them to come to a small town to live and practice, and hospital beds for psychiatrics.

People we see, once you know their story, goes back with sex abuse since 7 yrs old. Goes back to the counseling. If not dealt with just a repeated cycle if no one shows them how to turn around.

We get psych patients from all over the area, and it's really difficult to get them back home, or they are homeless, so the psych unit is serving outside the community more than locals.

…and I've been helping do the jail visits, and I would say a good portion of those are in there because of mental health issues, and we always said if they didn't get the proper help they need or medicine they need we're going to see them elsewhere.

Substance abuse, illegal drugs, methamphetamine, and prescription drug abuse was identified as prevalent in the area. People are "doctor jumping" and using the emergency department to obtain prescription medication for their own use or to sell. Parents are also taking their children's medication for their own use.

- Substance Abuse
  - Prevalence of substance abuse, illegal drugs, methamphetamine and prescription drug abuse
  - People are "doctor jumping" and using the emergency department to obtain prescription medication
  - Parents may be taking their children's medication for their own use.

I say we have a problem of abuse with illegal drugs, its outs there. We have a county

that is the state high for meth.

Richland County is one of the largest meth counties so that does say something to the health needs.

In addition to substance abuse, focus on abuse of prescription meds. Seeing not just kids but parents. Parents not giving meds to kids, parents are abusing it.

We see a lot of prescription med abuse. This is big lately. People coming to ED with issues that are not true and asking for something, with a "toothache", also doctor jumping.

They have counselors for substance abuse but they can't see them enough to have effective treatment.

Children's mental health services were also identified as a critical need. Schools are trying to fill the gaps but they have experienced funding cuts and do not have enough counselors. Children in need of services are not being identified and there are not enough early intervention programs. Children have difficulty getting an appointment with the psychiatrist and they are running out of medication. Children discharged from residential placement need continuity of care and are having difficulty with obtaining needed follow-up.

- Children's Mental Health Services
  - Schools are trying to fill gaps in services due to the shortage of counselors and psychiatrists
  - Schools have experienced funding cuts and do not have enough counselors
  - Children in need of services are not being identified
  - There are not enough early intervention programs
  - Children are running out of medication due to inability to see psychiatrist
  - Children discharged from residential placement are having difficulty obtaining needed follow-up care

…you can identify at that young of an age that that child needs help. But there are not the funding resources to get it done even in the schools. We have 2 counselors for a

thousand kids, it just doesn't happen.

Pregnancy issue 3 years ago…Goes along with mental health. No self esteem.

Early intervention types of programs for mental health and lifestyle choices. For children, starting with positive role models, health focus, activities, and a whole range of things for early interventions. Maybe strengthening the existing programs.

I agree with whole aspect Mental Health. Difficult to find appropriate service for our children.

Kids run out of medicine, doctor not there as often. He comes from Terre Haute.

Continuity of care – if they come back from residential placement it is hard to continue with medication - lapse time to find another provider or if they have mandated counseling. The teachers are trying to manage and teach this child that can't focus.

Health Care and Services

The need for health care and services was also mentioned in each focus group. Discussion focused on the need for a healthcare system that is dynamic and able to meet the needs of the community; and is affordable for all.

Primary care was an area of concern. There was an expressed need for more primary care providers, family practice and pediatricians, as well as specialists. The emergency department is being utilized for primary care because of the difficulty in getting primary care appointments for urgent care, and the unavailability of primary care after hours and on weekends. There were repeated comments that the "culture" is to go to the emergency room for all healthcare. Not all providers will accept Medicaid. The Southern Illinois Healthcare Foundation clinic was identified as actively recruiting new providers and welcomed for offering a sliding scale/FQHC clinic. A school based health clinic was

mentioned as needed. The shortage of providers is negatively impacting the need for care coordination for patients transitioning from different levels of care and those patients receiving home health services.

- Primary care
  - Shortage of primary care providers, family practice and pediatricians, and specialists
  - The emergency department is being utilized for primary care
    - Timely/acute primary care appointments not available
    - Primary care not available after hours and on weekends
    - The "culture" is to use the emergency room for all health care
    - Providers may not be accepting persons on Medicaid
    - A school based health clinic was identified as needed
  - Care coordination is needed for patients transitioning from different levels of care

Well, we have a great need for more family practice doctors, at least 2 more; we have only 2 that are just overworked. It is really hard to get in.

Because we don't have a lot of doctors to choose from and so many people, Medicaid, private, etc. People aren't getting the time needed spent with them. You can see all the patients waiting.

But it's hard to get a physician to follow-up with tests; and doctors that come are seen as temporary and it's hard to get established with them because they are very overworked.

…with the Medicaid it is hard to find a provider that will take a new patient that is on medical assistance, ….if they need a specialist it is hard to find a specialist that you can refer them to that is any closer than Champaign sometimes.

Need other than emergency department – is there another option that is more affordable?

Medicaid may need to have healthcare maybe outside of the emergency room.

What do you do when you don't feel sick enough to go to the emergency room but you need to see a doctor on the weekends? I see the greatest need for a place on the weekends.

The populations we deal with they just overuse the ED. If they get a cold they just go to ED because they don't have to pay for it.

They go to the ER because they may not be able to get into a medical clinic; they may not have insurance or money. Many citizens are in that situation because there is no where that they can get services until they can get back on their feet. No outpatient clinic that I am aware of.

Part of the problem is the availability of physicians, primary care, to see patients so they come to the ER. The ER is used as a physician's office because they've made multiple calls to the doctor's office and they can't get in so they come to the ER and its expensive and time consuming and bogs the ER down that they can't see patients that need to be seen.

Another need for the area that I have experienced myself is chronic back pain. I have to travel to Indiana for pain management, if there was something closer it would be more convenient. A friend of mine travels just to get a shot.

…and we're discussing right now opening a school based center which would be helpful in meeting that need.

Specialists from other areas do provide services locally; however, specialty care for many conditions is only available out-of-area. Travelling to Evansville, Vincennes, St. Louis, or Chicago is physically tiring and expensive. Services mentioned not available in the area were pain management, cancer treatment and pediatric dentistry. It was noted that Flora Hospital does not offer OB services. Telehealth services would help alleviate the shortage of specialty providers. It was noted that there is only one vision care provider.

- Specialty care for many conditions is only available out-of-area

- Out of area travel is physically tiring and expensive
- Services not available in area include pain management, cancer treatment and pediatric dentistry
- Telehealth services are needed to alleviate the shortage of specialty providers

Sometimes I worry about specialties. I know some doctors that come down but in other aspects, we don't have people for some health issues that are a bit more difficult.

I think with the limited obstetricians that are around puts a real burden on things.

Couple years ago talked about telemedicine for specialist. Need to go to St. Louis. I go to Kentucky, to go back for frequent visits, that is a burden.

Sports medicine doctor those kids can see or get in. That would service surrounding community.

One provider for vision

Oral health was identified as another need. There are not enough dentists and available dentists do not always accept a "medical card". Dentists may require payment "up front" even when a patient has insurance. Routine dental cleanings appointments are only available yearly. Children must go out-of-area for a pediatric dentist. A "traveling" dentist comes to the schools, but there are no dentists to refer children to for follow-up and often the cost of treatment is prohibitive. A concern expressed was that oral health care is greatly needed for children but not a priority for parents in this area; even persons with dental coverage do not receive preventive dental care.

- Oral health
  - Shortage of dentists
    - No pediatric dentist
    - Dentists do not always accept a "medical card"
  - Routine dental cleanings appointments are only available yearly
  - Dentists may require payment "up front" even when a patient has insurance
  - A "traveling" dentist comes to the schools, but there are no dentists to refer children to for follow-up and often the cost of treatment is prohibitive
  - Preventive dental care is needed

- Oral health care is greatly needed for children but not a priority for parents

We do have a good dentist in our area. But the quantity of people that need the service is great. Dentists don't have room. Cleaning only once a year because that is all they can schedule.

Well they can't afford a dentist because most of the dentists in the area will not take Medicaid so it's really hard to place those patients somewhere.

For kids with medical card, to get dental, or eye glasses, teeth cleaned or cavity they have to drive a good distance. It is not a good situation.

…it is filled with pediatric that need a special peds dentist; they have to go to St. Louis or Chicago.

Traveling dentist. Problem is they don't do follow up. They find the problem. Last year just gave out a referral to local dentist that doesn't take a medical card and that was their answer to you having 10 cavities.

Dental is a serious problem and it amazed me that a person with a medical card and access - how many don't utilize.

Medical transportation is provided through the "RIDES" program. This program was viewed positively; however there are access and cost limitations. For the most part, routine local services are available. The RIDES program requires 24 hour advance scheduling and is not available after hours or on weekends. There are no services for urgent transportation needs. Locating transportation for out-of-area medical appointments is difficult. There is a need for responsive emergency medical services in the most rural areas. There are resources to help with the cost of transportation for certain groups; however, RIDES is not affordable for others such as, low income and elderly.

- Medical transportation
  - RIDES program has access and cost limitations
    - Routine local services are available but the program requires advance scheduling and unavailable after hours and on weekends
    - RIDES not available for out-of –area transportation

        - RIDES is not always affordable for low income and elderly
    - There is a need for responsive emergency medical services in some of the most rural areas

My wish is there would be emergency transportation. No 24 hours scheduling that is the biggest problem, after hours and weekend. That is when things happen.

It is hard to find out of town. Locally it is not an issue, but when you get where you have to go to Springfield or Evansville that takes a day.

Transportation to medical appointment is huge issue for low income people and elderly, really anyone. There are a lot of people that don't have a reliable vehicle or the money to pay for RIDES mass transit.

RIDES transit charges extra for some people to go outside the route; some people really cannot afford that. A lot of my seniors are not on Medicaid where they can get these extra services for free.

An expressed significant health need is that Richland and Edwards counties are the only two counties in Illinois without a health department and the area is missing out on funded programs for this reason. Richland County has a county health nurse; however, funding and hours are limited. There was confusion expressed about where to obtain immunizations. It was mentioned that local doctors will only administer immunizations to their patients and people travel out of area to obtain immunizations. It was mentioned that people go to the county health department; however, Richland County does not have one. The cost of immunizations is prohibitive for the underinsured and uninsured.

- Health Department
    - Richland and Edwards counties are the only two counties in Illinois without a Health Department
        - The area is missing out on funded programs for this reason
        - Richland County health nurse has limited funding and hours
    - Immunizations
        - Local doctors will only administer immunizations to their patients
        - County health departments provide immunizations; however, Richland County does not have a health department
        - People travel out of area to obtain immunizations
        - The cost of immunizations is prohibitive for the underinsured and uninsured

Richland and Edwards counties do not have an actual health department and we are the only two in the state that don't actually have a funded health department. Which brings up a lot of other programs, we miss out on a lot of other programs that other counties have.

We do have a need for a county health department. A tremendous need that would cover lot of areas.

Now we do have a county nurse but she is kind of limited in funds and hours.

There's not a lot of insurance that cover immunizations.

And some doctors won't give vaccinations unless you are a regular patient of the office.

Right now the only places you can get immunizations are county health departments.

Special Populations Healthcare Needs and Services

In addition to medical, dental and mental/behavioral healthcare needs, focus group participants discussed the needs of special groups such as, children, families, elderly, and other vulnerable groups.

The need for children's mental health services has been discussed. Additional needs for children focused on aspects of parental nurturing, learning life skills, and having basic needs met. Many children were described as experiencing anxiety and depression, and having no one to reach out to at home. Some parents were described as unconcerned and in need of education on how to parent effectively. A concern was that children are not being exposed to and taught how to live successfully. Many children

depend on donated food from local food pantries, churches, and schools. Schools are trying to support children and fill in the gaps; however, they have limited programming resources and many programs are grant funded. A frustration expressed was that when parenting programs are offered, attendance is often poor. Teen pregnancy was identified as a concern and although some educational programming on growth and development is being offered in the elementary, middle and high schools, more is needed. In addition to needed life skills education, children have a need to learn healthy living (nutrition, smoking prevention, internet safety). An additional request was for a week end sports medicine clinic where students can be seen for sports injuries.

- Children
  - Many children do not have basic needs met – food, safety, hygiene
  - Many children have ineffective parents
    - Many children are not receiving life skills education at home
    - Many children need to see what is possible for them to achieve
    - Concern expressed about the number of teen pregnancies

No one to talk to in the home. We find our afterschool tutorial sessions which are intended to academically prepare are used for counseling. We are their rock and support. Three hours a week is all they have.

The struggle, with students we can develop the passion in them, with parents it may be too late. …And tell them if you want to break the cycle, you don't have to live like this but this is what you need to do.

I know there was a big increase in teen pregnancy last year in Richland County.

Pregnancy issue 3 years ago, 28 students in Richland County.

In high school so many teen pregnancies.

You can change the school lunch guidelines. That is part of the problem, kids go to after school and they are hungry. They don't get food at home unless it is a donut or starch or sugar. Then they come to school and we have to hold back

We send backpacks home on weekend with food.

There are more young people smoking today than there was years ago.

Families, especially young families, have a need for parenting and child care programs and support groups. Poor families may be unaware of resources available in the community and may not understand the complexities of how to manage their own resources. Programs are also needed for chronic disease management and preventive health care education. Diabetes management and programs to support healthy living, such as, nutrition, exercise, smoking cessation, and weight management were identified. It was suggested that programs are designed so there is no stigma associated with attending the program and that programs are offered in locations that reach out to the intended audience. There was an expressed concern about internet pornography and the need for STD prevention programs.

- Families
  - Need for life skills education
    - Parenting
    - Child care - breastfeeding
  - Need for chronic disease and preventive health care education
    - Healthy living – nutrition, exercise, smoking cessation, weight management
    - Chronic diseases – diabetes

…education for young parents and parents.

I definitely agree with that, because my wife sees people that have no clue about parenting.

There's a really good program at the grade school, but you can't make them come.

The people I deal with are the ones the community doesn't want to deal with. We don't go on the south side of the tracks. Well you need to go on the south side. Until you love these people they will never change.

Offering education at different venues is a strategy for this community.

Tying education into other community events.

Don't believe in preventative, will only deal with the problem when it happens.

The first thing my brain screams is smoking, it's the number one preventable, but it can be the most difficult thing to kick.

Preventable health issue, obesity. Lot of people in poverty eat foods not good for them. They are not eating healthy food.

Goes along with that, people in poverty don't exercise.

Nutrition, everybody needs, nutrition is a huge thing.

…hearing about STIs and STDs. There is definitely a need for ongoing education about safety and prevention of that type of disease.

Diabetes, early onset from not proper care, not maintaining properly, and multiple complications from unmanaged diabetes.

I have heard that we are one of top counties in Illinois for cancer.

Many elderly were described as lonely and in need of home and/or community activities to stay busy. It was mentioned that the Senior Center needs someone to lead exercise programs and that a VSP program (Very Special Persons) is needed. The elderly have transportation needs. They need someone

to assist them with getting to and from medical appointments and shopping. They may not be able to ambulate independently enough to get on and off RIDES transportation. Elderly may need assistance with managing their finances and obtaining available community resources. There is a need for a provider who specializes in geriatrics.

- Elderly
  - Many elderly are lonely and need home and/or community activities
  - Elderly need someone to assist them when using public transportation
  - Elderly may need financial counseling
  - Need a provider with a geriatric specialty

Elders also need activities to keep them busy...right now we are having trouble finding someone to do exercises at the senior centers.

I wish we had a VSP program, I doubt Edwards County has one. I think that it stands for Various Specials Persons actually but it is grant funded.

I wish there was some education for these people about how important it is to spend that money for the care that you need.

Getting people out the house could help; but how do you get them out of the house?

Other vulnerable groups include the working poor who are in need of affordable health insurance. Many veterans experience mental health issues post deployment and they were described as unlikely to reach out to others. Some veterans turn to alcohol and are looked down upon. Veterans need outreach programs both in the community and in veteran's facilities. A need for a women's shelter (those who don't quality for SWAN) and a homeless shelter for males or sex offenders was expressed.

- Other vulnerable
  - 40 - 60 year olds need affordable health insurance
  - Need a woman's shelter (those who don't qualify for SWAN) and homeless shelter for males or sex offenders

- Veterans may experience mental health issues post deployment and they need outreach programs both in the community and in veterans facilities

Veterans

So I wish there was more education to veterans - as far as, what is available and why you need to register.

We need to reach out to them but they need to reach out to us.

We need to put an article in the paper so that people know that we are here for them, cable, internet, or word of mouth. We need programs to offer to these individuals.

Other Vulnerable

..women's shelter for those who don't qualify for SWAN.

We don't have a homeless shelter, especially for males, or for sex offenders.

…people who are young and disabled. They need similar to assisted living. For younger in 30s and mentally able and only physical issues… there is a hole here, no help.

Potential Solutions

The solutions mentioned by participants ranged from resources in the realm of mental health, broader community, seniors, health services, schools, and government. These solutions as well as those identified from the critical needs are those that would serve greatly serve the community.

Mental Health

- Mental health providers for adults & children

  I think it needs to be more availability for follow-up appointments and regular appointment services, between the crisis and the next appointment

  And therapist to go with it, can't just have the medicine giver without the treatment

  Increased investment in the mental health resources that we already have for more counselors so that it doesn't take a month to get an appointment and they can see more people

- Mental health inpatient services for children

  When we try to get a student diagnosed, they have to go to Springfield. We have students that may need to be identified but they don't have the resources. The closest place is Springfield. On top of that, once diagnosed, we don't have resources to help parents after school. Parents don't have resources at home.

  Goes along with something as simple as ADHD. We have a physician that will do that, but never get a full evaluation. We do parent checklist, but never interview teacher, student.

  If we had counseling or an outreach person that could visit the school. We need counselors to talk to and some children may avoid medication

Community

- Life skills courses

- Free physical/recreational programs

  I think there is a need for additional free recreational programs or some type of physical activity recreational programs

  If we get together we could get a YMCA in Olney. Money was a big issue in the past with creating a YMCA.

- Veterans Services
- Community resource center

  A community resource center that can organize the resources, and advertise for all of the resources

- Health department
- More job opportunities

  There need to be options for people who want a job

- Yellow dot program

<u>Seniors</u>

- Education for seniors
- End of life care education

  I think a series of seminars where professionals talk about end of life care issues for adult and children.

- Grandparenting classes

Health Services

- Extended hours clinic

  I think some type of immediate care like Saturday and Sunday

- Primary care doctors

  More primary doctors, we keep hearing that we will get more but there needs to be access to doctor care. For hospital doctors and general practice.

Schools

- School mentoring programs

  Mentoring programs are good in the schools because it shows the children that there's a different person out there, that maybe the way they're growing up isn't the only way, more positive role models for parents to associate with, that truly care about them.

  A good positive presence in the kid's life, having policemen and adults that they can have a relationship with.

- After school program

  Another county has an after school program that picks up the kids after school and brings them to the track and have a workout and snack

- Career days

Regular career days that might encourage kids go to trade school, or to get their GED or go to college would be helpful

- Retention specialist at OCC

Government

- DCFS funding
- Drug tests & education for LINK cards

Resources

Although the list of resources in the community is long, there was concern expressed that the list of resources should be centralized so that community organizations can reach out to each other and provide assistance. Participants also showed interest in seeing many of these programs receive increased support so that they can continue to serve the community.

Charity

- Catholic Charities
- Masters Hands
    - Kids backpack program

Community

- Chamber of Commerce Job Assistance
- School Community Resource Guide
- County Health Office
- Medicaid Office
- Richland County Recreation Counsel
- RIDES Mass Transit
- Veterans of Foreign Wars and American Legion

- Olney Central College Nursing Program
- CPR classes
- DOORS
- Low Income Home Energy Assistance Program (LIHEAP)
- Opportunities for Access (OFA)
- Stopping Women's Abuse Now (SWAN)

Healthcare

- Diabetes Organization
- Flu Shots
- Health Screenings
- Komen for the Cure Mammography Grant
- Providers: Athletic trainers, Orthopedist
- Southern Illinois Healthcare Foundation/Weber Medical Clinic
    - Sliding Fee Scale
- Sports Medicine
- Ambulance Service

Hospital

- Cholesterol Screenings
- Diabetes Education
- Financial Assistance
- Mammography
- Physical Therapy
- Teen Pregnancy Prevention & STD Education
- Life Flight

Mental Health

- Alcoholics Anonymous
- Southeastern Illinois Counseling Center
    - Crisis line
- Substance Use Life Recovery Program
- Veterans Affairs Crisis Line
- Screening, Assessment and Support Services (SASS)

Parents

- Birth to Three program
- Breast Feeding Classes
- Parenting Classes
- Women, Infants, and Children (WIC)

Schools/Children

- After School Programs
- Autism Assistance for Parents
- Big Brothers/Big Sisters
- Elementary Schools
    - Puberty Education
    - Good touch/bad touch
    - Flags for First Graders
- Middle School
    - Career day
    - Sexual education
    - Physical Education with Play60
- High School
    - Dating Violence program
    - Job Shadowing
    - Male mentoring
    - Teen parenting
- Illinois Kids Care
- Latch Key program
- Transitional Youth Expo
- TRIO program

Seniors

- Home Health
- Hospice
- Medication Assistance
- Silver Sneakers
- Community of Care Program

Summary

The needs, solutions, and resources presented in this report reflect the opinions of the community members in the focus groups. The researchers attempted to report the views and opinions of the focus groups' participants in a way which would aid Richland Memorial Hospital Community Needs Assessment. Although effort was taken in obtaining a wide variety of opinions, these views may not reflect all possible needs and solutions within the community. The quotes were presented in a manner to ensure participant anonymity and describe the themes which were discussed.

(Appendix A)

Richland Memorial Hospital Community Needs Assessment

Focus Group Protocol

Facilitator Script:

"Welcome and thank you for participating in this focus group today. We appreciate your time and commitment to improving health issues in this community. We will ask the group to spend time identifying concerns for the community surrounding health care and other broad health issues. We would like you to think not only of issues directly related to the hospital, such as maternity care, breast cancer prevention, health screenings and education but also other health issues not directly related to the hospital, such as, drug and alcohol use, mental health needs, or safe environments. We will also spend time identifying resources which are currently available in the community which are successfully meeting the health needs of the community.

Your input is vital in helping to identify and prioritize needs, create solutions, and plan for services in the future. We will not be evaluating or judging any one person's opinions or experience, but rather we will capture the thinking of as many people as possible.

So let's begin with introductions…"

7. Introduction: Please say your name and what town you live in. Also, state what your experience has been with health care in the community or region.

8. What are the three most significant or critical health care needs in your community?
    a. Follow-up: Who is affected by these needs? (Which parts/ages/areas of the community are affected?)
    b. Follow-up: Would anyone like to add to the list previously mentioned?

9. What resources and services are currently available from the hospital or in the community?

10. What are the most preventable health-related diagnoses in your community?
    a. Probe: How many people agree with these concerns [as they are identified]

11. What new or currently unavailable actions, programs, and strategies do you think would make the biggest difference in your community? What solutions would help solve the problems and reduce/remove barriers discussed?

    Facilitators: [Summarize the main themes around concerns and potential solutions]
12. Summary question: Let's go around the room and make sure everyone has one last opportunity to state what they believe is the most important health need to be addressed in their community.

"Thank you for your time."

(Appendix B)

SIU SOUTHERN ILLINOIS UNIVERSITY CARBONDALE
CENTER FOR RURAL HEALTH AND SOCIAL SERVICE DEVELOPMENT

RMH Richland Memorial Hospital

Richland Memorial Hospital Community Needs Assessment

Informed Consent to Participate

I (_____), agree to participate in this community needs assessment conducted by the Center for Rural Health and Social Services Development with Liesl Wingert, Outreach Specialist at Richland Memorial Hospital.

I understand the purpose of this study is to identify concerns for the community surrounding health care and other health issues. You will also be asked to identify resources which are currently available in the community.

I understand my participation is strictly voluntary and may refuse to answer any question without penalty. I am also informed that my participation will last 90 minutes.

I understand that my responses to the questions will be audio taped, and that these tapes will be transcribed/stored and kept for 90 days in a locked file cabinet. Afterward, these tapes will be destroyed.

I understand questions or concerns about this study are to be directed to Kim Sanders, 618-453-5545, ksanders@rural.siu.edu or Liesl Wingert, 618-395-2131 ext. 4608 or lwingert@richlandmemorial.com.

I have read the information above and any questions I asked have been answered to my satisfaction. I agree to participate in this activity and know my responses will be tape recorded. I understand a copy of this form will be made available to me for the relevant information and phone numbers.

"I agree _____ have my responses recorded on audio tape."

"I disagree _____to have my responses recorded on audio tape."

Participant signature Date