Community Health Needs Assessment

September 2016

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 (RMH) 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: **Behavioral health**
- Health Need #2: **Increasing access to healthcare services**
- Health Need #3: **Chronic disease**

Over the next three years, Richland Memorial Hospital is committed to working closely with area organizations that work within the behavioral health field by contributing to the discussion regarding expanded options for care that would serve not only the patient but the involved family unit as well. In addition, RMH recognizes that increasing access to all types of healthcare will have a lasting effect on the general health of our community. In order to address this, RMH will explore several opportunities that involve convenient care options, case management, telemedicine, and continued recruitment of both primary care and specialty providers. Lastly, utilizing ongoing efforts as well as future growth opportunities, RMH will strive to be involved in outreach events and educational venues that encourage the prevention, proper treatment, and management of chronic disease in our community.

Community Health Needs Assessment Committee

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

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

Gina Thomas, Chief Nursing Officer & Director of Patient Care Services, *Richland Memorial Hospital*

Eric Toliver, Director of Organizational and Community Development and Volunteer Services, *Richland Memorial Hospital*

Jennifer Emmons, Director of Physician Practices & Physician Recruiting, *Richland Memorial Hospital*

Connie Waldrop, Local Office Administrator, Richland County Family Community Resource Center- *Department of Human Services (Richland, Clay, Lawrence)*

Debi Phillips, Marketing Officer, *Trustbank*

Chris Simpson, Assistant Superintendent, *Richland County Community Unit School District #1*

Carol Schafer, Member – Board of Directors, *Richland Memorial Hospital*

Vaneta Andrews, Executive Director, *Brookstone Estates and Emerald Glen Assisted Living Facilities*

Nancy Mink, Health Center Manager, *Weber Medical Clinic – Southern Illinois Healthcare Foundation*

Jennifer Hendricks-Kaufmann, Public Relations Manager, *Carle Foundation Hospital*

Brent Todd, Assistant Director, *Regional Medical Programs and Rural Health – Office of Community Health and Service, Southern Illinois University School of Medicine*

Liesl Wingert, Outreach Specialist (CHNA Project Manager), *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, identifying the most pressing community health needs, and prioritizing the identified community health needs, as well as to contribute to the data that was gathered.

Introduction

Richland Memorial Hospital (RMH) is a 134 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 continues to be 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".

The first Community Health Needs Assessment (CHNA) was completed and published in September of 2013, and both the 2013 and 2016 CHNA reports are available on the RMH website at www.richlandmemorial.com. Performing the CHNA every three years allows the hospital to not only identify the most current pressing health issues in our community, set programming priorities, and align work efforts with community partners in order to meet these needs, it also allows for long range trending analysis that is based on solid biostatistics and qualitative data, as well as the identification of the progress toward the goals that are set within the Implementation Strategy. The CHNA continues to prove that it is one of many valuable tools that can be used to achieve the overall goal that RMH has of providing excellent healthcare based on the needs of the community that it serves.

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 health care, 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 both 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.

Progress Report

for the

2013 Community Health Needs Assessment

Health Need #1: Mental health and related social issues

1. ***Recruitment:*** RMH continues its ongoing recruitment for a full time on-staff psychiatrist. Due to a limited supply of psychiatrists, this continues to be a difficult task as this specialty is not favorable toward moving to a small, rural community.
2. ***Telemedicine:*** The exploration of the use of telemedicine opportunities continues, being directly affected by state and federal reimbursement issues.
3. ***Mental health support group:*** RMH is still in the process of exploring options for a mental health support group.
4. ***Drug panel discussion:*** The creation of a community drug panel discussion was directly affected by the absence of an Illinois state budget and thus created a lack of education funding that affected the school system's ability to collaborate on this project. This task was not completed due to these issues.

Health Need #2: Access to health services

1. ***Recruitment:*** RMH has made strides in its access to health services since 2013. RMH has added the following providers to its staff:

2 Pediatricians

2 CRNA's

1 Pediatric NP (Newton)

1 Family Practice NP (West Salem)

1 Family Practice Physician

1 Convenient Care NP

1 part time Convenient Care NP

3 Hospitalists – Weekend coverage only

2 athletic trainers (Flora and Newton)

Recruitment of other specialties as well as primary care providers is ongoing.

2. ***Medical school tuition assistance:*** Related to this is the continued support from the RMH Foundation in its financial contributions and support of 4 medical students that have committed to return to the area to practice medicine. Currently, there is one student in training for Family Practice, one student in training for Internal Medicine and 2 students that are yet undecided. Two of these students are within 2 years of completing their education and residency and will be ready for community practice.
3. ***Lack of a health department:*** RMH continues to recognize the movement for a local health department, however due to the Illinois state budget, funding that would allow for a community to establish a health department is not easily available. During the past three years, RMH has contributed to the ongoing conversation surrounding the creation of a health department and has collaborated with the appropriate people through data acquisition and explanation.

Health Need #3: Chronic Disease Management

1. ***MedAssist:*** The Med*Assist* program is still operational, however it is no longer being housed on the RMH property twice per month due to Illinois state budget cuts. To access the program, potential patients must call the central office (located in Effingham). Contact information is given to patients in their admission packet that they receive upon admission. The Discharge Planner is also available upon request in order to facilitate contact with the program providers.
2. ***Diabetes Education/Support Group:*** RMH has addressed the chronic disease management issue from a variety of directions. The Diabetic Support Group continues and has an average attendance of between 15-30 people each month. The director has acquired her Certified Diabetic Educator designation and has continued to increase her numbers of one-one-one outpatient visits each year. Currently, she has met with 91 patients for education (Jan-through Aug of 2016). In 2015, she met with 79 patients total for the year. The program is on target to finish out 2016 with a strong improvement in numbers.

   In 2016, RMH formed a COPD Support Group that is led by the Director of Respiratory Therapy. This group is still in its infancy but has a strong following that allows for referrals for more supportive services as well as education and support.

3. ***In Person Counselors:*** Southern Illinois Healthcare Foundation provides an In Person Counselor for all community members who are in need of assistance with enrolling in a healthcare plan, as mandated by the Affordable Care Act. The data from the current Community Health Needs Assessment shows that there is an increase in the number of community members with healthcare coverage.
4. ***Sodium Reduction Program:*** The Sodium Reduction Program that was headed by the RMH Dietitian produced several community changes. The dietitian was able to collaborate with the local Senior Citizens Center to evaluate their food program and offer education and options for lowering sodium levels in the food program. In addition, patients and staff at RMH were given extensive education regarding sodium and the cafeteria offerings were given a makeover to lessen the sodium levels overall.

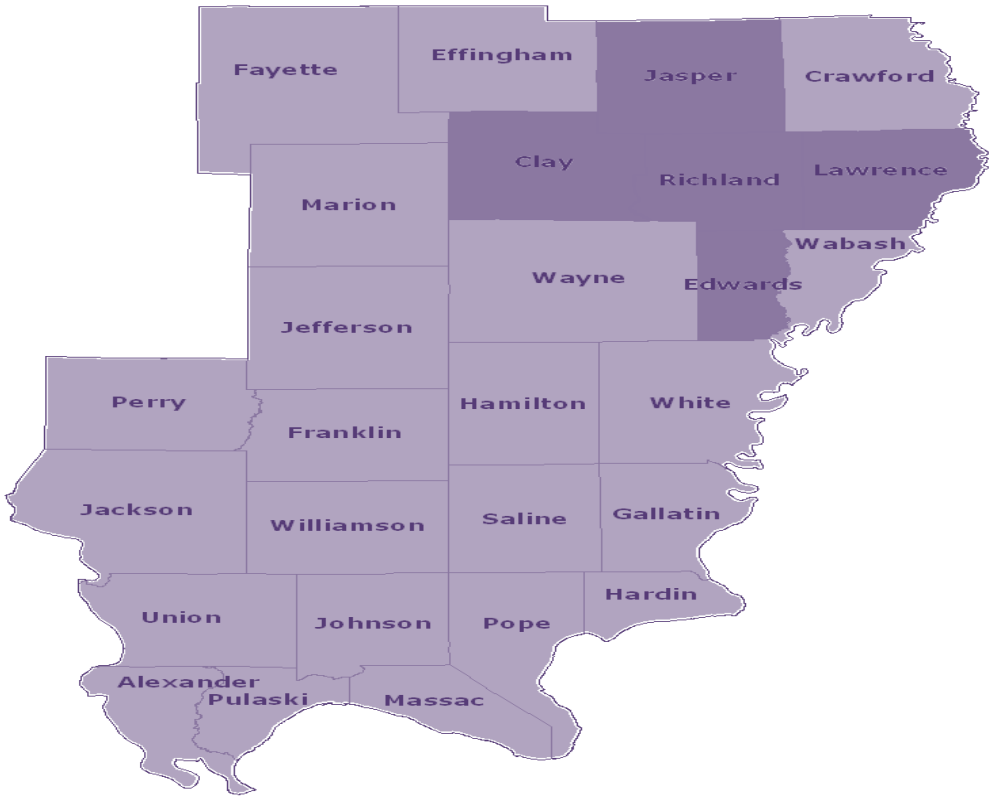
5. ***Transitional Care Specialist:*** RMH created a Transition Care Specialist nursing position who assists those patients who have a chronic disease. The majority of these patients have a potentially manageable chronic disease and are in need of more intensive follow up and guidance after their diagnosis and hospital stay. Numbers showing the success of this program are just now coming available and show favorable results.
6. ***Smoking Cessation Program:*** The RMH Smoking Cessation Program continues to see patients and employees upon the request of either the patient or the attending physician. Due to success in these tasks, permission was granted to allow the Smoking Cessation Facilitator to meet with community members as needed for smoking cessation counseling (do not have to be patients of RMH to be seen, and there is no cost to the service).

Community Served

Definition of the community served

Richland Memorial Hospital's primary service area has not changed since the 2013 Community Health Needs Assessment report, and includes portions of eight Southeastern Illinois counties with a total patient population of about 60,000. Counties within the hospital's primary service area include Clay, Crawford, Edwards, Jasper, Lawrence, Richland, Wabash and Wayne. RMH further extends home health and hospice services to individuals living in Clark, Cumberland, Effingham, Hamilton and White Counties.

For the purpose of this community health needs assessment, the 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, are the surveyed areas that will be discussed in this Community Health Needs Assessment (CHNA) report. Per the results of COMPdata information and an internal RMH data evaluation, this was found to involve a five county area including Richland, Lawrence, Clay, Jasper and Edwards counties in the southeastern Illinois quadrant (dark purple shaded area). The following map shows the area that includes the definition of the "community served":



Population characteristics and a specific description of low-income, minority, and other populations of interest

According to the 2014 U.S. Census estimate, the total population of the community served (Richland, Lawrence, Clay, Jasper and Edward's counties) is 62,890, with this number being very similar to the 2000 and 2010 data from the U. S. Census (though the estimate shows a slight decrease). As expected, the most primary area served is located in Richland County, with an estimated population of 16,144. The largest age category in the region continues to include those people between the ages of 20-64 years old, the smallest being those under the age of 5 years old. This data is similar when compared to the information from the 2000 and 2010 U.S. Census. Table 1 below shows the estimated distribution of ages by county:

Table 1: 2014 U.S. Census Population Estimate by Age and County[1]

(Number and Percent)

	Population Age Categories								
	2014 Estimated Population	Under Age 5		Aged 5-19		Aged 20-64		65 and Older	
		#	%	#	%	#	%	#	%
Clay	13,675	840	6.1	2,637	19.3	7,714	56.4	2,484	18.2
Edwards	6,687	424	6.3	1,281	19.2	3,754	56.1	1,228	18.4
Jasper	9,658	559	5.8	1,781	18.4	5,633	58.3	1,685	17.4
Lawrence	16,726	857	5.1	2,425	14.5	10,697	64.0	2,747	16.4
Richland	16,144	966	6.0	2,982	18.5	9,031	55.9	3,165	19.6
Total	**62,890**	**3,646**	**5.8**	**11,106**	**17.7**	**36,829**	**58.6**	**11,309**	**18.0**

Sources

[1]U.S. Census Bureau, 2010-2014 American Community Survey, Demographic and Housing Estimates. Retrieved on July 11, 2016 from factfinder.census.gov.

Of the regional population (all five counties), it was found that compared to 2010, the general surveyed area as a whole experienced slight population loss (total 0.8%), with Edwards county experiencing the largest growth at 17.8% in the "Under Age 5" population. Comparing the 2013 CHNA data with the most current data, the number of insured adults rose from 86.3% to 91.3%, and those with dental insurance remained

stable at 51.8%. The population covered by Medicaid rose slightly from 24% to 25.7%, most likely due to the advent of the Affordable Care Act and its insurance requirements. Those covered by Medicare (20.8%) stayed the same. Finally, those with no insurance coverage decreased slightly from 55.2% to 53.6%, again indicative of the Affordable Care Act insurance requirements.

Table 2: 2015 Estimated Medicare and Medicaid Population by County

(Number and Percent)

	Medicare and Medicaid as Proportions of the Population								
	Estimated 2014 Population[1]	Medicaid and Medicare Insured Population						Other or No Insurance[1]	
		Medicaid[2]		Medicare[3]		Total Medicare and Medicaid[a]			
		#	%	#	%	#	%	#	%
Clay	13,675	4,054	29.6%	2,968	21.7%	7,022	51.3%	6,653	48.7%
Edwards	6,687	1,729	25.9%	1,380	20.6%	3,109	46.5%	3,578	53.5%
Jasper	9,658	1,968	20.4%	1,867	19.3%	3,835	39.7%	5,823	60.3%
Lawrence	16,726	3,920	23.4%	3,105	18.6%	7,025	42.0%	9,701	58.0%
Richland	16,144	4,478	27.7%	3,743	23.2%	8,221	50.9%	7,923	49.1%
Total	**62,890**	**16,149**	**25.7%**	**13,063**	**20.8%**	**29,212**	**46.4%**	**33,678**	**53.6%**

Sources

[1]U.S. Census Bureau, 2010-2014 American Community Survey, Demographic and Housing Estimates. Retrieved on June 24, 2016 from factfinder.census.gov.

[2]Illinois Department of Healthcare and Family Services Program Enrollment as of June 30, 2015. Retrieved from http://www.illinois.gov/hfs/info/factsfigures/Program%20Enrollment/Pages/default.aspx.

Medicaid beneficiaries include total enrollees participating in comprehensive and those participating in partial benefit program.

[3]Centers for Medicare and Medicaid Services, Medicare Enrollment Reports: Medicare Aged and Disabled by State and County as of July 1, 2015. Retrieved on June 30. 2016 from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/Dashboard.html.

Notes

[a]The "Total Medicaid and Medicare" column may include dual beneficiaries.

Table 3: 2014 Health and 2009 Dental Insurance: Adults Aged 64 and Under by County (Number and Percent)

	Health and Dental Insurance					
	Adults Aged 64 Years and Under Health Insured in 2014			Dental Insured in 2009[a]		
	Population[1]	#[2]	%	Population[3]	#[3]	%
Clay	11,191	10,206	91.2	10,562	5,949	56.3
Edwards	5,459	4,968	91.0	5,056	2,547	50.4
Jasper	7,973	7,271	91.2	7,169	3,110	43.4
Lawrence	13,979	12,735	91.1	12,239	6,330	51.7
Richland	12,979	11,902	91.7	11,721	6,289	53.7
Total	**51,581**	**47,082**	**91.3**	**46,747**	**24,225**	**51.8**

Sources

[1]U.S. Census Bureau, 2006-2010 American Community Survey, Demographic and Housing Estimates. Retrieved on July 11, 2016 from factfinder.census.gov.

[2]United States Census Bureau. Small Area Health Insurance Estimates 2014. Retrieved on July 1, 2016 from http://www.census.gov/did/www/sahie/data/interactive/.

[3]Illinois Department of Public Health. Illinois Behavioral Risk Factors Surveillance System 2007-2009. Retrieved July 1, 2016 from http://app.idph.state.il.us/brfss/countydata.asp.

Notes

[a]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.

With the goal of conducting a thorough CHNA, RMH reviewed the data from the 2010-2014 U.S. Census Bureau regarding minority and other special populations of interest (see Tables 4 and 5 below). Per the data, the largest minority group is African American at 5.8% of the population, with Latinos being the second largest group at 2.4%. Lawrence County accounted for the largest number of both minorities within the five surveyed

counties, with 20.9% of their population being African American and 5.3% being Latino. Looking at the total number, 9.3% of the five county area claims to be of a minority population.

Other populations of interest that arose in the data included veterans, those with disabilities, and persons living below the poverty level. Of these special interest populations, it is interesting to note that the largest group is the disabled population at 15.1% of the population within the five county area. The rates of disabled in each county is relatively equal, thus no county stands out as unique. The next highest population of interest is persons who live below the poverty level, at 12.7%. There is a distinct difference in the rate of this group for Jasper county, at 6.6%, which is the lowest rate. All other counties for this group are nearer to the average, with Richland county having the highest rate at 15%.

Table 4: 2014 U.S. Census Minority Populations Estimate by County[1]

(Number and Percent)

		Minority Populations									
	2014 Estimated Population	Latino		Asian American		African American		Other[a]		Minority Total	
		#	%	#	%	#	%	#	%	#	%
Clay	13,675	179	1.3%	17	0.1%	55	0.4%	94	0.7%	345	2.5%
Edwards	6,687	78	1.2%	15	0.2%	38	0.6%	0	0.0%	131	2.0%
Jasper	9,658	110	1.1%	13	0.1%	16	0.2%	98	1.0%	237	2.5%
Lawrence	16,726	894	5.3%	25	0.1%	3,491	20.9%	338	2.0%	4,748	28.4%
Richland	16,144	221	1.4%	86	0.5%	69	0.4%	37	0.2%	413	2.6%
Total	**62,890**	**1,482**	**2.4%**	**156**	**0.2%**	**3,669**	**5.8%**	**567**	**0.9%**	**5,874**	**9.3%**

Sources

[1]U.S. Census Bureau, 2010-2014 American Community Survey, Demographic and Housing Estimates. Retrieved on July 11, 2016 from factfinder.census.gov.

Notes

[a]Other includes American Indian and Alaska Native, Native Hawaiian and Other Pacific, and Some other race.

Table 5: 2014 Populations of Interest by County (Number and Percent)							
County	Populations of Interest						
	2014 Population Estimate[1]	Veterans[2]		Civilian Noninstitutionalized Population with a Disability[2]		Persons Below Poverty[3]	
		#	%	#	%	#	%
Clay	13,675	911	6.7%	2,318	11.4%	1,901	13.9%
Edwards	6,687	531	7.9%	1,042	10.5%	836	12.5%
Jasper	9,658	670	6.9%	1,338	9.1%	637	6.6%
Lawrence	16,726	1,230	7.4%	2,053	12.9%	2,174	13.0%
Richland	16,144	1,431	8.9%	2,769	11.7%	2,422	15.0%
Total	**62,890**	**4,773**	**7.6%**	**9,520**	**15.1%**	**7,970**	**12.7%**

Sources

[1]U.S. Census Bureau, 2010-2014 American Community Survey, Demographic and Housing Estimates. Retrieved on July 11, 2016 from factfinder.census.gov.

[2]U.S. Census Bureau, 2010-2014 American Community Survey, Selected Social Characteristics. Retrieved on July 11, 2016 from factfinder.census.gov.

[3]U.S. Census Bureau, 2010-2014 American Community Survey, Selected Economic Characteristics Retrieved on July 11, 2016 from factfinder.census.gov.

While taking into consideration the numbers of minorities and other populations of interest when looking at population health factors, of which these groups make up roughly an average of 10% of the area population, it is also necessary to look at income and educational level estimates for this region in order to gain a clearer view of the population as a whole. Higher income and educational attainment levels directly correlate with better medical care and health education understanding. According to the most recent data collected by the Illinois Department of Employment Security (July of 2016), the average unemployment rate for the five county area is 6.24% (Lawrence county having the highest with a rate of 7.5% and Edwards county having the lowest with 5.3%), much on par with the state average at 7%. Data from the Labor Market Statistics website indicates that the average annual wage for this area is around $30,000, with the median household income estimated at

$40,000. According to Table 6 that uses data from the U.S. Census Bureau, the majority of community members who are employed work in education, healthcare and social assistance (23.9%). The next largest group is manufacturing with 17.5%.

Table 6: 2014 Estimated Civilian Employment by Ranked Industries and Unemployment by County[1] (Number and Percent)

	Regional Civilian Employment by Ranked Industry															
	Education, Health Care, & Social Assistance		Manufacturing		Retail Trade		Agriculture, Forestry, Fishing, & Mining		Transportation Warehousing& Utilities		Arts, Entertainment, Recreation, Accommodation & Food Services		Other Services		Professional, Scientific, Management, Admin & Waste Mgt. Svs	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Clay	1,305	21.6	1,279	28.9	689	24.2	641	32.6	365	22.9	388	26.9	349	26.5	226	18.1
Edwards	558	9.2	778	17.6	287	10.1	201	10.2	104	6.5	135	9.3	170	12.9	182	14.6
Jasper	1,010	16.7	699	15.8	562	19.7	433	22.0	442	27.8	234	16.2	205	15.6	352	28.2
Lawrence	1,329	22.0	591	13.3	379	13.3	236	12.0	242	15.2	291	20.2	198	15.0	143	11.5
Richland	1,835	30.4	1,086	24.5	931	32.7	455	23.1	439	27.6	396	27.4	394	29.9	344	27.6
Total	**6,037**	**23.9**	**4,433**	**17.5**	**2,848**	**11.3**	**1,966**	**7.8**	**1,592**	**6.3**	**1,444**	**5.7**	**1,316**	**5.2**	**1,247**	**4.9**

	(Regional Civilian Employment by Ranked Industry cont.)												Unemployment		
	Construction		Finance, Insurance, Real Estate, Rental, and Leasing		Public Administration		Wholesale Trade		Information		Total Employed		Total Workforce	Unemployed	
	#	%	#	%	#	%	#	%	#	%	#	%	#	#	%
Clay	322	26.5	146	12.6	242	22.9	140	21.9	109	34.5	6,201	24.5	6,698	497	7.4
Edwards	144	11.8	94	8.1	81	7.7	94	14.7	13	4.1	2,841	11.2	3,146	305	9.7
Jasper	258	21.2	273	23.6	171	16.2	136	21.3	58	18.4	4,833	19.1	5,114	281	5.5
Lawrence	190	15.6	395	34.1	148	14.0	105	16.4	15	4.7	4,262	16.9	4,507	245	5.4
Richland	303	24.9	249	21.5	413	39.1	165	25.8	121	38.3	7,131	28.2	7,652	521	6.8
Total	**1,217**	**4.8**	**1,157**	**4.6**	**1,055**	**4.2**	**640**	**2.5**	**316**	**1.3**	**25,268**	**100**	**27,117**	**1,849**	**6.8**

Sources

[1]U.S. Census Bureau, 2010-2014 American Community Survey, Selected Economic Characteristics Retrieved on July 11, 2016 from factfinder.census.gov.

Educational attainment levels shown in Table 7 indicate that the largest portion of adults aged twenty-five or older have either a high school diploma (36.1%) or some college/Associate Degree (35.1%), together equaling 71.2% of the area population. The county with the largest number of adults who have attained a higher level of education is Richland county, with 21.3% of the population having a Bachelor's Degree or higher. Jasper county was second in this line item with 18.4%. Comparing the data from the 2013 CHNA, it should be noted that there is a significant drop in the number of those with less than a high school diploma, as the number went from 14.2% to 7.8%. Lawrence and Richland counties account for the largest drop in this number. These same two counties also saw an increase in percentage points of those who attained a Bachelor's degree or higher.

Table 7: 2014 Estimated Educational Attainment: Adults Aged 25 Years or More by County[1]

(Number and Percent)

	Educational Attainment Among Adults Aged 25 Years or More								
	2014 Population 25+ Years of Age	Less Than High School Diploma		High School Diploma		Some College or Associate Degree		Bachelor Degree or Higher	
		#	%	#	%	#	%	#	%
Clay	9,366	1,186	12.7	3,752	40.1	3,167	33.8	1,261	13.5
Edwards	4,632	579	12.5	1,664	35.9	1,917	41.4	472	10.2
Jasper	6,793	626	9.2	2,599	38.3	2,320	34.2	1,248	18.4
Lawrence	12,232	628	5.1	4,262	34.8	4,135	33.8	1,142	9.3
Richland	11,248	448	4.0	3,718	33.1	3,983	35.4	2,393	21.3
Total	**44,271**	**3,467**	**7.8**	**15,995**	**36.1**	**15,522**	**35.1**	**6,516**	**14.7**

Sources

[1]U.S. Census Bureau, 2010-2014 American Community Survey, Selected Social Characteristics. Retrieved on July 11, 2016 from factfinder.census.gov.

Designation of Federal Health Professional Shortage Area

Of continued concern to many southern Illinois counties is the need for an increased number of primary care physicians, physician specialists, dentists, and mental health providers. The Illinois Department of Public Health - Center for Rural Health indicates that most southern Illinois counties have a Federal Health Professional Shortage Area (HPSA) designation, indicating that those people who live in these areas continue to be underserved. All five counties surveyed for this CHNA have a HPSA designation. Recruitment of providers in all areas of healthcare is constantly ongoing, and healthcare issues regarding the imbalance between the increasing numbers of insured patients vs. the inadequate number of available providers continues to be a driving force that surrounds decision-makers at the top levels of medical administration. Thus, recruitment is of primary concern in many rural communities.

When discussing the need for medical providers, it is prudent to discuss the unique situation that surrounds the use of the emergency department. It was noted several times in the focus group sessions that there is a lack of education regarding the proper use of emergency department services, an issue that has been ongoing even prior to the onset of the Affordable Care Act. Due to the lack of primary care providers, patients in medically underserved areas will often wait until a crisis point to seek medical attention and then do so by using the emergency department, often when the medical issue could have been more appropriately handled in a less expensive setting if it had been properly treated in a more timely manner using a primary care provider. However, when there is a shortage of primary care providers, the emergency department then becomes the default treatment center at the point of crisis. This has been found to be a common theme across both rural and urban hospitals, and thus is not unique to this area. It is simply another facet of the entire medical scenario that must be taken into consideration when planning for the adequate healthcare of a community.

It should be noted that RMH believes that the recruitment of providers is an ongoing prioritized endeavor that has as its goal to adequately provide for the medical needs of our entire service area. Administration is continually evaluating the need for primary care providers as well as specialty services that the data show would be a valuable asset to the community. Table 8 below shows the current number and types of medical staff that are employed by, or affiliated with, RMH as of April of 2016. Since the 2013 CHNA, RMH has recruited the following new providers:

- 2 Pediatricians
- 2 CRNA's
- 1 Pediatric NP (Newton)
- 1 Family Practice NP (West Salem)
- 1 Family Practice Physician
- 1 Convenient Care NP
- 3 Hospitalists (weekend coverage only)
- 2 athletic trainers (Flora and Newton)
- 1 part time Convenient Care NP

Table 8: Richland Memorial Hospital 2016 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	0	0.0%	**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	3	20.0%	
General Practice	0	0.0%	
General Surgery	2	13.3%	
Internal Medicine	1	6.7%	
OB/GYN	2	13.3%	
Orthopedic Surgery	1	6.7%	
Otolaryngology	1	6.7%	**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	6.7%	
Pediatrics	2	13.3%	
Psychiatry	1	6.7%	
Urology	1	6.7%	
Total Active/Associate Staff	**15**	**100.0%**	
Courtesy and Affiliated Staff	#	%	
Cardiology	33	24.1%	**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	76	55.5%	
Dentistry	2	1.5%	
Emergency Medicine	11	8.0%	
General Surgery	1	0.7%	
Hand Surgery	1	0.7%	
Internal Medicine (Hospitalist)	3	2.2%	
Neurology	1	0.7%	
Oncology	1	0.7%	
Opthalmology	1	0.7%	
Pathology	1	0.7%	**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.
Pediatric Cardiology	4	2.9%	
Podiatry	1	0.7%	
Psychiatry	1	0.7%	
Total Courtesy/Affiliated Staff	**137**	**100.0%**	

Sources
[1]**Richland Memorial Hospital. Medical Staff Services. Medical Records Department. Provided on April 15, 2016.**
[2]**Richland Memorial Hospital Medical Staff Bylaws.**

Data Collection

Timeline for the CHNA

The first CHNA was published in September 2013, however preparation actually began in September of 2011. As this is a required task of the federal Patient Protection and Affordable Care Act enacted March 23, 2010, which states that not-for-profit hospitals must conduct a Community Health Needs Assessment every three years, the project is seen as an ongoing, continual task of the hospital. The first meeting of the current Community Health Needs Assessment committee was in September of 2015, and data collection began at that time, continuing through August of 2016. In July of 2016, 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 September of 2016 and was presented to the Richland Memorial Hospital Board of Directors in September of 2016 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. Similar to the way this was completed for the 2013 CHNA, this was done using several mechanisms 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 September 2015 and August 2016. 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).* RMH made the decision to not only acquire input from the CHNA 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. New to the CHNA committee for 2016 was an invitation to Carle Foundation Hospital to send a representative participant in order to give a voice to those providers who serve a number of our more critical/specialty patients. CHNA committee members were not paid for their time and participation. 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. Participants were put into a group based on their area of expertise as it related to an area of priority, including senior citizens, schools/children, low income, healthcare, the ministerial profession, behavioral health, and a "general" group that involved participants from a wide expanse of expertise. A wide variety of organizations and businesses from the five county area were represented on the focus groups (see Table 9 below). Participation was by invitation only, in which 90% of those invited chose to attend.

All of the focus groups met during March of 2016 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 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. In addition, also new to the CHNA process, focus group participant demographic data was collected (see Appendix F for compiled demographic data). After the focus groups were performed, all acquired data was 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 2016. With a 90% participation rate within the focus groups, it was felt that RMH was given a solid foundation of data from which to work with.

In addition to focus groups, *private interviews* were conducted by the Project Manager with 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 present written responses to the determined set of questions.

Finally, new to the 2016 CHNA process was the *private interview process* of a variety of providers, both primary care and specialty. Although providers have always been included/invited to participate during the 2013 CHNA, a concerted effort was made to include more providers with a variety of backgrounds and specialties in the 2016 CHNA data. Primary care, pediatric, emergency department, urology, obstetrical, dental, and public health providers (all local) made themselves available to contribute to the data set for 2016. In addition, the Carle Foundation Hospital representative was able to conduct similar reviews of the focus group questions with several providers that have a working relationship with a fair amount of patients in the area, which gave yet another perspective on community healthcare issues. The opinions and insights gathered from this part of the process was invaluable.

Table 9 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 9: 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	X
Clay County Health Dept	X	X	X	X	X	X		X	
Clay County Hospital	X	X	X		X	X		X	
Carle Foundation Hospital	X	X	X		X	X	X		X
Olney Central College	X	X	X			X		X	
Private practice counseling	X	X	X			X		X	
Richland County Chamber of Commerce						X		X	
Walmart DC		X				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	
Veterans Administration	X	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
Burgin Manor Nursing Home	X	X	X			X		X	
Heritage Woods	X	X	X			X		X	
Emerald Glen/Brookstone Asst. Living	X	X	X			X	X	X	X
Birthright, Inc.	X	X	X					X	
Clay County Housing Authority	X	X	X			X		X	
CAISA	X	X	X			X		X	
Richland County Community Unit District #1 School System	X	X	X			X	X	X	X
TRIO Programs	X	X	X			X		X	
Jasper County Community Unit School District #1	X	X	X			X	X		X
Red Hill Community Unit School District #10	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, Lawrence	X	X	X		X	X	X	X	X
Richland County Health Office	X	X	X	X	X	X	X		X
Trustbank						X	X		X
AM Transport						X		X	
Richland County Development Corporation	X	X	X			X		X	
Division of Specialized Care for Children	X	X	X		X	X		X	
Lazy 8 Body Shop						X		X	
Lawrence County Health Department	X	X	X	X	X	X		X	
Blanks Insurance						X	X		X

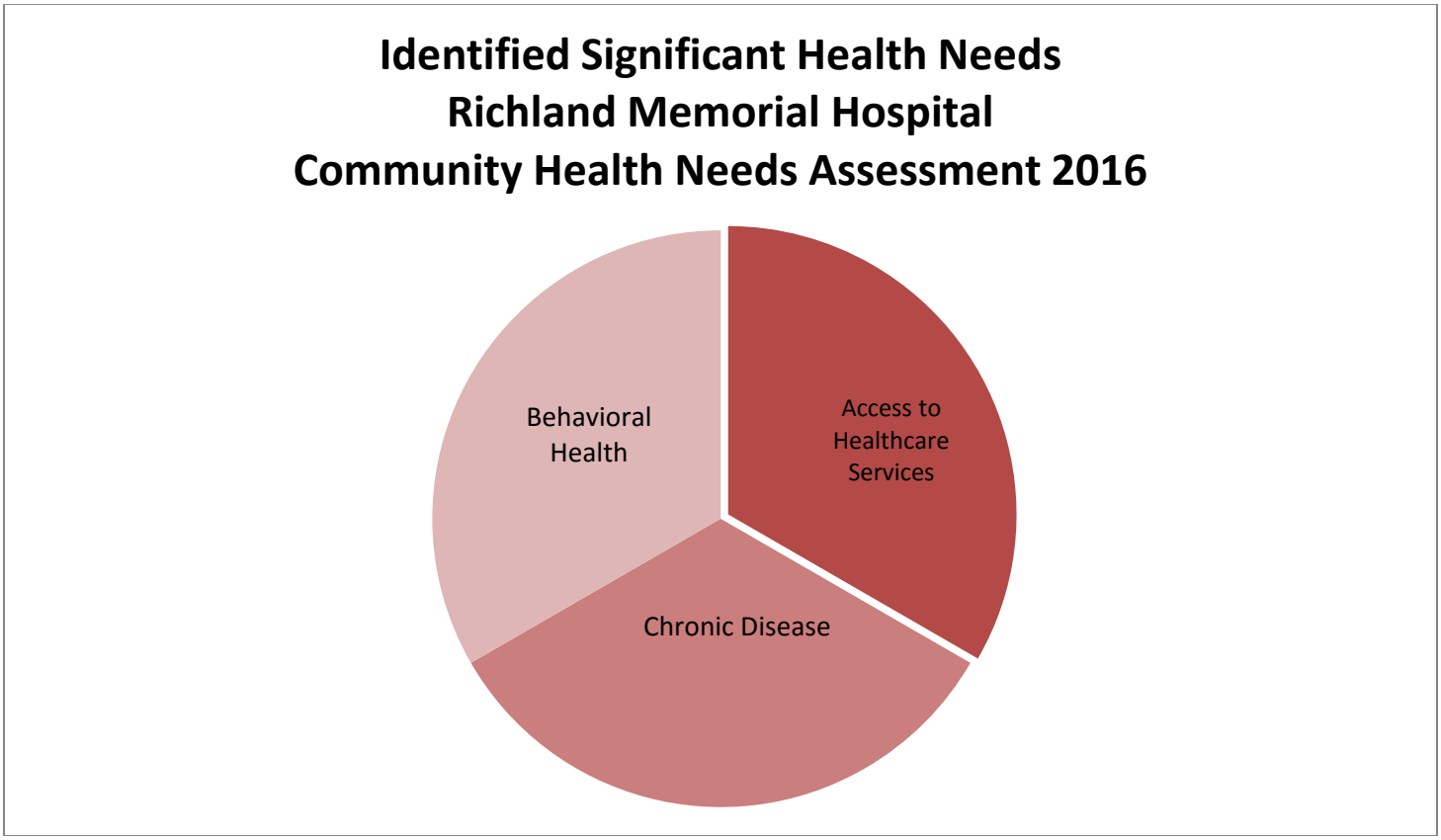
**The category of "Other" denotes representation of corporate commerce, disabled, veterans, homeless, and mentally ill. It should be noted that there is duplication of the persons/needs listed in this category, as they often also apply to the other categories listed above.*

Quantitative Data: Publicly available and RMH internal data

In addition to qualitative data, 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 Community Health and Service was asked to complete a data sweep of federal, state, and other public sources that applied to the CHNA project. Their report was finalized in July of 2016 and was pivotal in assisting the committee with the decisions made regarding what "significant health needs" were to be identified. Most 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 Community Health and Service, please reference Appendix E.

Summary of Findings

Several common themes surfaced in both the qualitative and quantitative data. They were consistent enough among the different data sources that the community health needs picture was quickly identified by the committee when deciding which health needs 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:



Not surprisingly, 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. Also interesting to note is that compared to the 2013 CHNA, the identified needs are the same, and ranked in the same order. 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. As per the federal guidelines, RMH will conduct a new CHNA every three years and make it publicly available on the RMH website located at www.richlandmemorial.com . Each CHNA will be posted (up to the three most recent ones since the first one published in 2013) in order to allow for comparisons between each CHNA, 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 health needs that arose from the data based on raw numbers (quantitative data) and discussion (qualitative data). The last step in the process involved having the CHNA committee evaluate 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
- *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. As expected, the indications for prioritization became very obvious with Behavioral Health emerging as the top community

health need, and Access to Healthcare Services and Chronic Disease coming in closely behind as second and third. It is interesting to note that a significant portion of the discussion involved how the implementation of various models of case management might affect patient outcomes for each of these topics in not only the inpatient setting, but also the outpatient setting. While in 2013, there was a large focus on children's health, the 2016 CHNA committee spent time discussing issues and reviewing strategies that might affect family health as a whole (not just the patient). Within each of the identified needs, this was a common thread of discussion as it specifically related to "overall impact" and how much of the issue affects health and quality of life.

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 is difficult. However, based on discussion threads that took place in the focus groups, committee meetings, and private interviews, as well as quantitative data, it became obvious to the 2016 CHNA committee that the following prioritized health needs were identified:

1. Behavioral health
2. Increasing access to healthcare services
3. Chronic disease

Health Need #1: Behavioral health

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)*. As stated in the 2013 CHNA report, 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 2020 project (https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Mental-Health/data#MHMD-1) , mental health is named as a Leading Health Indicator, and both suicide rates and major depressive episodes are used as markers. The national suicide rate increased 18.2% from 2004 to 2014. Females tend to have a lower suicide rate than males, with males having more than 3.5 times the rate as females. Those people over the age of 65 years old have the highest rate of suicide. Data regarding major depressive episodes states that females (16.2%) have three times the major depressive episodes than males (5.3%). The Illinois state average of adults between 2010-2013 aged 18 and over who experienced a major depressive episode (MDE) was 5.6% according to the National Survey on Drug Use and Health (NSDUH), SAMHSA. Although the CHNA data tables from 2013 and 2016 cannot be compared (the 2016 data for "Have Major Depression" is taken from Medicare Fee-for Service data, which will only apply

to those adults over the age of 65 whereas the 2013 table involved all adults over the age of 18), depression and suicide as indicators of mental health were matters of discussion within the 2016 CHNA committee, as well as the lack of adequate number of psychiatrists to service the five county area (see Tables 10 and 10b below for local data).

Table 10: Major Depression – Older Adults

COUNTY	Population Age 65 Years or Older[1]			Prevalence of Older Adult Depression (Medicare Fee-For-Service Beneficiaries with Depression)[2]					
				2012		2013		2014	
	2012	2013	2014	#[a]	%	#	%	#	%
Clay	2,486	2,495	2,485	375	15.1%	354	14.2%	350	14.1%
Edwards	1,217	1,225	1,228	105	8.6%	100	8.2%	104	8.5%
Jasper	1,663	1,676	1,685	201	12.1%	204	12.2%	233	13.8%
Lawrence	2,689	2,670	2,747	347	12.9%	326	12.2%	354	12.9%
Richland	3,161	3,170	3,165	335	10.6%	358	11.3%	377	11.9%
TOTAL	**11,216**	**11,236**	**11,310**	**1,363**	**12.2%**	**1,343**	**12.0%**	**1,418**	**12.5%**

Sources

[1]U.S. Census Bureau, 2010-2014 American Community Survey, Demographic and Housing Estimates. Retrieved on September 7, 2016 from factfinder.census.gov.

[2]Centers for Medicare & Medicaid Services. Prevalence State/County Level: All Beneficiaries by Age, 2007-2014. Retrieved September 7, 2016 from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/CC_Main.html.

[3]Illinois Department of Public Health, Center for Health Statistics, Mortality Data, 2003-2012. Suicides Deaths by Resident County 2003-2012 Aggregated. Retrieved on July 13, 2016 from http://www.dph.illinois.gov/sites/default/files/publications/il-suicide-deaths-bycounty-2003-2012-050216.pdf.

[4]Health Resource and Service Administration. Area Health Resource File. Retrieved on July 13, 2016 from http://ahrf.hrsa.gov/download.htm.

[5]Provided by Richland Memorial Hospital via personal communication on July 7, 2016.

[6]Illinois Department of Human Services, Mental Health Office Locator. Retrieved on July 13, 2016 from www.dhs.state.il.us/page.aspx?module=12.

Table 10b: Total Number of Suicides and Psychiatrists

	Total Suicides[3] 2003-2012	Number of Psychiatrists[4]
	#	#
Clay	22	0
Edwards	7	0
Jasper	19	0
Lawrence	23	1
Richland	15	1
	86	2

Sources

[1]U.S. Census Bureau, 2010-2014 American Community Survey, Demographic and Housing Estimates. Retrieved on September 7, 2016 from factfinder.census.gov.

[2]Centers for Medicare & Medicaid Services. Prevalence State/County Level: All Beneficiaries by Age, 2007-2014. Retrieved September 7, 2016 from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/CC_Main.html.

[3]Illinois Department of Public Health, Center for Health Statistics, Mortality Data, 2003-2012. Suicides Deaths by Resident County 2003-2012 Aggregated. Retrieved on July 13, 2016 from http://www.dph.illinois.gov/sites/default/files/publications/il-suicide-deaths-bycounty-2003-2012-050216.pdf.

[4]Health Resource and Service Administration. Area Health Resource File. Retrieved on July 13, 2016 from http://ahrf.hrsa.gov/download.htm.

[5]Provided by Richland Memorial Hospital via personal communication on July 7, 2016.

[6]Illinois Department of Human Services, Mental Health Office Locator. Retrieved on July 13, 2016 from www.dhs.state.il.us/page.aspx?module=12.

RMH is the only hospital in the assessed area which has an inpatient psychiatric unit and as such, when internal RMH data is further reviewed, it shows that the top Major Diagnostic Category (MDC) for both 2014 and 2015 is Mental Diseases and Disorders. In addition, the top Diagnosis Related Group (DRG) at Discharge for both 2014 and 2015 is Psychoses (see Tables 11 and 12 below).

Table 11: Richland Memorial Hospital

2014 and 2015 Top 5 Major Diagnostic Categories at Discharge by Year and Rank[1]

(Number of Inpatients and Percent of Top Five Categories)

2014						2015				
Major Diagnostic Categories[a]			Inpatients			Major Diagnostic Categories[a]			Inpatients	
Rank	Description	Code	#	%		Rank	Description	Code	#	%
1	Mental Diseases & Disorders	19	469	30.0%		1	Mental Diseases & Disorders	19	504	35.2%
2	Newborn & Neonates	15	338	21.6%		2	Newborn & Neonates	15	284	19.8%
3	Pregnancy; Childbirth	14	312	20.0%		3	Pregnancy; Childbirth	14	274	19.1%
4	Respiratory System	4	242	15.5%		4	Respiratory System	4	217	15.2%
5	Factors Influencing Health Status and Other Contacts with Health Services	23	201	12.9%		5	Factors Influencing Health Status and Other Contacts with Health Services	23	152	10.6%
n/a	**Total**	**n/a**	**1,562**	**100%**		**n/a**	**Total**	**n/a**	**1,431**	**100%**

Sources

[1]Data provided by Richland Memorial Hospital Medical Records Department on April 15, 2016.

Notes

[a]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.

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.

Table 12: Richland Memorial Hospital

2014 and 2015 Top 5 Diagnosis Related Groups at Discharge by Year and Rank[1]

(Number of Inpatients and Percent of Top Five Categories)

2014						2015				
Diagnosis Related Groups			Inpatients			Diagnosis Related Groups			Inpatients	
Rank	Diagnosis[a]	Code	#	%		Rank	Diagnosis[a]	Code	#	%
1	Psychoses	885	380	35.0%		1	Psychoses	885	422	41.2%
2	Normal Newborn	795	279	25.7%		2	Normal Newborn	795	253	24.7%
3	Vaginal Delivery	775	198	18.2%		3	Vaginal Delivery	775	158	15.4%
4	Rehabilitation w/ CC/MCC	945	139	12.8%		4	Rehabilitation w/ CC/MCC	945	110	10.7%
5	Depressive Disorder	881	89	8.2%		5	Depressive Neuroses	881	82	8.0%
n/a	**Total**	n/a	1,085	100%		n/a	**Total**	n/a	1,025	100%

Sources

[1]Data provided by Richland Memorial Hospital Medical Records Department on April 15, 2016.

Notes

[a]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.

In all discussions within the focus groups, private interviews, as well as the CHNA committee, it was felt that there continues to be an inadequate number of mental health service providers (see Table 10b), which in turn leads to not only unaddressed mental illnesses, but also social issues such as poverty (Table 13, 14 and 15), suicide (see Table 10b), violence (see Table 18), drug and alcohol abuse/risky behaviors (Table 17), food and housing insecurities (Tables 13, 14, and 15), and child abuse and neglect (Table 16). The data in Tables 13-18 clearly coincide with the discussions that were had in the focus groups and interviews.

Table 13: 2014 Food Insecurity and Children Living in Poverty by County (Number and Percent)

County	Population[1]			Food Insecurity[2]				Children Living in Poverty[3]	
	2014 Population Estimates	Children		Population		Children			
		#	%	#	%	#	%	#	%
Clay	13,675	3,193	23.3%	1,709	12.5%	773	24.2%	702	22.0%
Edwards	6,687	1,572	23.5%	756	11.3%	333	21.2%	252	16.0%
Jasper	9,658	2,158	22.3%	889	9.2%	395	18.3%	367	17.0%
Lawrence	16,726	3,182	19.0%	2,425	14.5%	725	22.8%	764	24.0%
Richland	16,144	3,623	22.4%	2,018	12.5%	804	22.2%	761	21.0%
Total	**62,890**	13,728	21.8%	**7,797**	**12.4%**	**3,031**	**22.1%**	**2,845**	**20.7%**

Sources

[1]U.S Census Bureau, 2006-2010 American Community Survey, Demographic and Housing Estimates. Retrieved on July 11, 2016 from factfinder.census.gov.

[2]Feeding America. Map the Meal Gap, Food Insecurity in Your County 2014. Retrieved on June 24, 2016 from http://feedingamerica.org/hunger-in-america/hunger-studies/map-the-meal-gap.aspx.

[3]Robert Wood Johnson Foundation. County Health Rankings. Retrieved on June 24, 2016 from http://www.countyhealthrankings.org/app/illinois/2014/rankings/outcomes/overall.

Table 14: 2016 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	2,204	906	41.1%	207	9.4%	1,113	50.5%
Edwards	916	266	29.0%	69	7.5%	335	36.6%
Jasper	1,455	465	32.0%	121	8.3%	586	40.3%
Lawrence	2,094	978	46.7%	219	10.5%	1,197	57.2%
Richland	2,561	910	35.5%	238	9.3%	1,148	44.8%
Total	**9,230**	**3,525**	**38.2%**	**854**	**9.3%**	**4,379**	**47.4%**

Source

[1]**Illinois State Board of Education. Nutrition. Free Lunch Eligibility Listing FY2016. Retrieved on June 27, 2016 from http://www.isbe.net/nutrition/htmls/eligibility_listings.htm.**

Table 15: 2014 and 2015 Student Enrollment and Homeless Students by County (Number and Percent)

County	School Districts	Total Enrollment				Homeless Enrollment[a]				Homeless (% of Total)	
		2014[1]		2015[2]		2014[3]		2015[4]		2014	2015
		#	%	#	%	#[1]	%	#[2]	%	%	%
Clay	Clay City, District 10	331	3.5%	314	3.4%	17	5.0%	9	3.0%	3.7%	3.0%
	North Clay, District 25	651	6.9%	645	6.9%	33	5.0%	45	7.0%	7.3%	14.2%
	Flora, District 35	1,373	14.5%	1,391	14.9%	27	2.0%	28	2.0%	6.1%	8.7%
Edwards	Edwards County, District 1	939	9.9%	924	9.9%	19	2.0%	18	2.0%	4.2%	5.8%
Jasper	Jasper County, District 1	1,422	15.1%	1,387	14.8%	28	2.0%	42	3.0%	6.4%	13.1%
Lawrence	Lawrence County, District 20	1,232	13.0%	1,229	13.1%	12	1.0%	12	1.0%	2.8%	3.9%
	Red Hill, District 10	1,047	11.1%	1,052	11.2%	42	4.0%	42	4.0%	9.4%	13.2%
Richland	Richland County, District 1	2,451	25.9%	2,423	25.9%	270	11.0%	121	5.0%	60.2%	38.1%
Total	**Total**	**9,446**	**100.0%**	**9,365**	**100.0%**	**448**	**4.7%**	**318**	**3.4%**	**100.0%**	**100.0%**

Sources

[1]Illinois State Board of Education, 2014-15 Home District Enrollment Report, Fall Enrollment Counts; Retrieved on June 27, 2016 from http://isbe.state.il.us/research/htmls/fall_housing.htm.

[2]Illinois State Board of Education, 2015-16 Home District Enrollment Report, Fall Enrollment Counts; Retrieved on June 27, 2016 from http://isbe.state.il.us/research/htmls/fall_housing.htm.

[3]Regional Office of Education and Richland Memorial Hospital. Based on student counts in fall semester of the 2014-15 academic year.

[4]Regional Office of Education and Richland Memorial Hospital. Based on student counts in fall semester of the 2015-16 academic year.

Notes

[a]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: 2015 Prevalence of Child Abuse/Neglect and Rate by County (Number, Percent, and Rate)

County	Abuse and Neglect Cases, Unduplicated Count and Rate				
	Population Aged 17 Years and Under[1,a]	Cases[2]	Unduplicated Count[2]		Child Abuse Rate (Cases/1,000 Children[2])
		#	#	%	
Clay	3,193	218	166	5.2%	52.5
Edwards	1,572	62	52	3.3%	33.9
Jasper	2,158	94	81	3.8%	36.8
Lawrence	3,182	212	184	5.8%	57.4
Richland	3,623	339	276	7.6%	76.5
Total	**13,728**	**925**	**759**	**5.5%**	**51.4**

Sources

[1]Population Aged 17 Years and Under as presented by United States Census Bureau 2014 estimates.

[2]Illinois Department of Child and Family Services. Child Abuse and Neglect Statistics FY2015. Retrieved on June 27, 2016 from illinois.gov/dcfs.

Notes

[a]Population was manually calculated by subtracting the population 18 and older from the total population.

Table 17: 2012 or 2014 High School Senior Tobacco and Drug Use by County[a]

(Numbers and Percents)

County	Respondents	HS Senior Tobacco Use			HS Senior Drug Use			
		Cigarettes	Smokeless Tobacco	Smoking Tobacco (not cigarettes)	Alcohol	Inhalants	Marijuana	Prescription Drugs (to get high)
	#	%	%	%	%	%	%	%
Clay[1]	100	14%	13%	5%	26%	0%	4%	1%
Edwards	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Jasper	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Lawrence[1]	69	16%	12%	12%	36%	3%	19%	4%
Richland[2]	111	16%	7%	12%	37%	2%	10%	3%
Total	**280**	**46%**	**32%**	**29%**	**33%**	**2%**	**11%**	**3%**

Sources

[1]University of Illinois, Center for Prevention Research and Development. Illinois Youth Survey, 2014 County Report. Retrieved on July 13, 2016 from https://iys.cprd.illinois.edu/results/county.

[2]University of Illinois, Center for Prevention Research and Development. Illinois Youth Survey, 2012 County Report. Retrieved on July 13, 2016 from https://iys.cprd.illinois.edu/results/county.

Notes

[a]Responses indicate participating in the activity within the past 30 days.

Table 18: 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,a]		Violent Crime[2,c] per 100,000
		#[b]	%	Rate
Clay	10,482	694	6.6%	148
Edwards	5,115	215	4.2%	497
Jasper	7,500	349	4.7%	395
Lawrence	13,544	517	3.8%	270
Richland	12,521	246	2.0%	211
Total	**49,162**	**2,021**	**4.1%**	**271.5**

Sources

1Illinois 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.

[2]Robert Wood Johnson Foundation. County Health Rankings. Retrieved on December 12, 2012 from http://www.countyhealthrankings.org/app/illinois/2012/rankings/outcomes/overall.

Notes

[a]Question asked by the Illinois Behavioral Risk Factor Surveillance System:

In the past 12 months, were you physically hurt by someone?

[b]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.

[c]Violent Crime includes rape, homicide, robbery, and aggravated assault.

Local homeless rates/data continues to come from the school system, as they are the only organization that is consistently tracking this phenomenon in the area. However, it must be pointed out that these numbers only include families with school children, thus making it an incomplete picture of this particular situation. It would be reasonable to assume that the data is showing only a portion of what is likely a larger regional issue that involves many more adults. About 3.4% of the students in the region are considered homeless (this number is down from the 2013 CHNA data), with Richland county carrying a little over 38% of the students that are homeless in the five county area. (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 15 above).

To add further to the discussion on mental health, the National Institute of Mental Health reports that in the U.S. today, one in five children (20%) either currently or at some point during their life, have had a seriously debilitating mental disorder. In the 2013 CHNA, it was found that "one in ten children suffer from a mental disorder severe enough to cause some level of impairment". Even though the definitions are not the same, it becomes clear that an increasing number of children require some amount of behavioral health care at some point in their lives. Similar to 2013, a common element of discussion in the focus groups and the CHNA committee was that of the large 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) continues to be 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. Children, adults and the elderly are all affected in both direct and indirect manners. School systems are struggling with this issue on a daily basis, and the ability of 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).* The 2016 CHNA committee discussed at length the need to address and treat not only the patient, whether they are a child or an adult, but the entire patient-family unit in order to adequately and fully address the mental health issue. Actively targeting 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: Increasing access to healthcare services

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. Table 19 below shows the number and type of physician medical staff members that are affiliated with Richland Memorial Hospital, and Table 20 shows how many physicians and dentists are available (as of 2013) in the region that is included in this CHNA.

. Since the 2013 CHNA, a total of 14 new providers of varying levels have been added to RMH due to the excellent recruitment program conducted by the Director of Physician Practices and Chief Executive Officer.

Table 19: Richland Memorial Hospital 2016 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	0	0.0%	**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	3	20.0%	
General Practice	0	0.0%	
General Surgery	2	13.3%	
Internal Medicine	1	6.7%	
OB/GYN	2	13.3%	
Orthopedic Surgery	1	6.7%	
Otolaryngology	1	6.7%	**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	6.7%	
Pediatrics	2	13.3%	
Psychiatry	1	6.7%	
Urology	1	6.7%	
Total Active/Associate Staff	**15**	**100.0%**	
Courtesy and Affiliated Staff	#	%	
Cardiology	33	24.1%	**Courtesy Staff Qualifications:** a) admit or provide service to fewer

Clinical Radiologists	76	55.5%	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.
Dentistry	2	1.5%	
Emergency Medicine	11	8.0%	
General Surgery	1	0.7%	
Hand Surgery	1	0.7%	
Internal Medicine (Hospitalist)	3	2.2%	
Neurology	1	0.7%	
Oncology	1	0.7%	
Opthalmology	1	0.7%	
Pathology	1	0.7%	**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.
Pediatric Cardiology	4	2.9%	
Podiatry	1	0.7%	
Psychiatry	1	0.7%	
Total Courtesy/Affiliated Staff	**137**	**100.0%**	

Sources

[1]**Richland Memorial Hospital. Medical Staff Services. Medical Records Department. Provided on April 15, 2016.**

[2]**Richland Memorial Hospital Medical Staff Bylaws.**

Table 20: 2010-2013 Number of Dentists and Physician Count by County (Number and Percent)		
County	**Dentists, Dentist Utilization and Physicians**	
	2014 Population Estimate[1]	**Number of Dentists[2]**	**Current Physician Count[2]**
		#	#
Clay	13,675	6	8
Edwards	6,687	2	1
Jasper	9,658	2	0
Lawrence	16,726	2	5
Richland	16,144	4	19
Total	**62,890**	**16**	**33**

Sources

[1]U.S. Census Bureau, 2010-2014 American Community Survey, Demographic and Housing Estimates. Retrieved on July 11, 2016 from factfinder.census.gov.

[2]Health Resource and Service Administration. Area Health Resource File. Retrieved on July 13, 2016 from http://ahrf.hrsa.gov/download.htm.

Of continued concern in all discussions was the lack of a health department. In fact, this topic appeared in every one of the focus group discussions. Two of the counties in the five county region (the defined community for this CHNA) continue to 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 actually 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. However, the Illinois budget inevitably affects this problem thus continuing to negate the option for either community to pursue such an endeavor at this time.

In six out of the seven focus groups, when discussing access to healthcare, it was brought up that there is a need for the RMH Convenient Care Clinic to have more expanded hours. The clinic earned “universal praise” from the participants, however comments focused on the need for evening and weekend hours. There are other area walk-in clinics located in Lawrenceville, Effingham, Mt. Carmel and Effingham who do have evening

and weekend hours and it was stated in various discussions that although these are good options, it would be much more convenient to have such a service in Richland county.

Dental care continues to be of concern. Southern Illinois Healthcare Foundation secured the services of a public aid pediatric dentist for a short time (as of October 14, 2016 he will no longer be in practice in Olney), however there has been no other growth in area dental services. Southern Illinois Healthcare Foundation continues recruitment activities for another pediatric dentist to replace the one who is leaving in October. "Traveling" dentists for school children 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 may be prohibitive to some families. Adult dentists continue to be in demand, especially those who will accept a medical card. Table 20 above indicates the number of dentists in the region, the number clearly continuing to not be adequate for the 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, though RMH has consistently shown attention to this need by the outgoing recruitment efforts and obvious increase in providers for the area. While social, economic, and environmental factors all contribute toward the problems associated with not having proper, affordable and easily attainable access to healthcare services, it is still worthy of our ongoing attention and efforts to address it.

Health Need #3: Chronic Disease

The Illinois Department of Public Health defines chronic disease as "disease that persists over a long period of time" and "can be prevented or controlled through regular participation in physical activity, eating healthy, not smoking, and avoiding excessive alcohol consumption" (*http://www.idph.state.il.us/idhp/idhp_ChronicDisease.htm*). According to the CDC, "chronic diseases and conditions…are among the most common, costly, and preventable of all health problems", and "about one-half of all adults in the United States have a chronic health condition" *(Centers for Disease Control, 2016)*. 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 disease impacts 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. According to the CDC, one of four adults have two or more chronic health conditions (*http://www.cdc.gov/chronicdisease/overview/index.htm*).

The 2016 CHNA committee identified both heart disease (which includes hypertension, high cholesterol, coronary heart disease, stroke, and heart attack) and obesity as the most commonly identified chronic diseases in our CHNA data (see Tables 21-25 below). Of note, when looking at Table 24 below, it shows that in all counties, heart disease (high cholesterol, hypertension, and coronary heart disease) together make up 87.4% of the prevalence of selected chronic diseases in total. Of another interesting note regarding this particular data table, it also shows that compared to comparable 2013 CHNA data, the prevalence of diabetes has decreased in most of the five county area. It should be noted that the data in this table is fairly recent, having been gathered from 2010-2014 through the Illinois Department of Public Health, Illinois Behavioral Risk Factor Surveillance System.

Table 21: 2011 Adult Mortality by Selected Causes[1] and County

County			Selected Causes of Death (Counts)												
Name	Total Population[2]	Total Mortality	Malignant Neoplasms	Heart Disease	Lower Respiratory	Stroke	Accidents	Influenza and Pneumonia	Diabetes	Alzheimer Disease	Septicemia	Kidney Disease	Liver Disease	Suicide	All Other Causes
Clay	13,675	176	45	33	16	14	11	9	1	1	2	4	1	2	37
Edw	6,687	67	21	22	4	1	3	1	0	0	1	2	1	0	11
Jasper	9,658	97	17	29	3	5	2	4	2	1	3	1	1	2	27
Law	16,726	221	40	37	15	13	11	8	12	16	5	6	1	0	57
Rich	16,144	180	44	39	12	8	6	4	4	0	4	1	2	0	56
Total	**62,890**	**741**	**167**	**160**	**50**	**41**	**33**	**26**	**19**	**18**	**15**	**14**	**6**	**4**	**188**

County			Selected Causes of Death (Percent)												
County	Total Population[2]	Total Mortality	Malignant Neoplasms	Heart Disease	Lower Respiratory	Stroke	Accidents	Influenza and Pneumonia	Diabetes	Alzheimer Disease	Septicemia	Kidney Disease	Liver Disease	Suicide	All Other Causes
Clay	21.7%	23.8%	6.1%	4.5%	2.2%	1.9%	1.5%	1.2%	0.1%	0.1%	0.3%	0.5%	0.1%	0.3%	5.0%
Edw	10.6%	9.0%	2.8%	3.0%	0.5%	0.1%	0.4%	0.1%	0.0%	0.0%	0.1%	0.3%	0.1%	0.0%	1.5%
Jasper	15.4%	13.1%	2.3%	3.9%	0.4%	0.7%	0.3%	0.5%	0.3%	0.1%	0.4%	0.1%	0.1%	0.3%	3.6%
Law	26.6%	29.8%	5.4%	5.0%	2.0%	1.8%	1.5%	1.1%	1.6%	2.2%	0.7%	0.8%	0.1%	0.0%	7.7%
Rich	25.7%	24.3%	5.9%	5.3%	1.6%	1.1%	0.8%	0.5%	0.5%	0.0%	0.5%	0.1%	0.3%	0.0%	7.6%
Total	**100.0%**	**100.0%**	**22.5%**	**21.6%**	**6.7%**	**5.5%**	**4.5%**	**3.5%**	**2.6%**	**2.4%**	**2.0%**	**1.9%**	**0.8%**	**0.5%**	**25.4%**

Sources

[1]Illinois Department of Public Health. Health Statistics. Causes of Death by Resident County 2011. Retrieved on June 24, 2016 from www.idph.state.il.us/health/bdmd/deathcauses_11.htm.

[2]U.S. Census Bureau, 2010-2014 American Community Survey, Demographic and Housing Estimates. Retrieved on June 17, 2016 from factfinder.census.gov.

Table 22: 2010-2014 Health Risk Factors[1] Ranked by County

County	Health Risk Factor Ranking[a]																		
	Pneumonia vaccinations[b]	Flu vaccinations[c]	High cholesterol[d]	Hypertension[e]	Infrequent checkups[f]	Obesity[g]	Inactivity[h]	Seatbelts[i]	Smoking[j]	Accute or binge drinking[k]	No primary care provider[l]	No health care coverage[m]	Diabetes[n]	Cost of healthcare[o]	Heart attack[p]	COPD[q]	Asthma[r]	Coronary heart disease[s]	Stroke[t]
Clay	69.9%	59.2%	48.2%	37.2%	36.9%	30.0%	24.3%	24.1%	24.3%	19.6%	14.6%	11.6%	10.7%	8.9%	9.0%	9.5%	5.2%	9.1%	3.4%
Edw	71.5%	52.1%	45.4%	33.6%	34.6%	33.8%	28.4%	21.3%	14.6%	12.6%	14.0%	12.5%	9.0%	9.0%	8.3%	4.7%	6.3%	5.8%	2.9%
Jasp	70.4%	53.8%	41.0%	33.9%	32.7%	29.1%	27.5%	27.5%	13.9%	24.8%	12.8%	9.2%	9.9%	6.0%	5.8%	3.4%	7.3%	3.5%	3.1%
Law	70.3%	50.7%	44.4%	38.0%	34.8%	30.1%	33.9%	28.5%	22.9%	11.8%	10.8%	13.8%	13.9%	14.6%	8.3%	9.4%	8.2%	7.7%	3.4%
Rich	64.8%	50.9%	45.7%	36.2%	34.5%	26.8%	23.8%	17.6%	15.7%	11.4%	11.8%	14.0%	11.6%	8.8%	6.8%	8.6%	6.9%	7.3%	4.1%
Avg	**69.4%**	**53.3%**	**44.9%**	**35.8%**	**34.7%**	**30.0%**	**27.6%**	**23.8%**	**18.3%**	**16.0%**	**12.8%**	**12.2%**	**11.0%**	**9.5%**	**7.6%**	**7.1%**	**6.8%**	**6.7%**	**3.4%**

Sources

[1]Illinois Department of Public Health. Illinois Behavioral Risk Factors Surveillance System 2010-2014. Retrieved on July 1, 2016 from http://app.idph.state.il.us/brfss/countydata.asp.

Notes

[a]Respondents are asked a variety of questions about their health status and behavioral and other characteristics related to health. The percentages above summarize their responses. Additional information about health risk factors, including the questions asked of the participants, are included below:

Table 23: 2010-2014 Prevalence of Modifiable Health Risk Behaviors[1] by County (Number and Percent)

County	Never had a pneumonia vaccination	No flu vaccination in past year	Infrequent checkups	Obesity	Inactivity	No seatbelts	Smoking	Accute or binge drinking	No primary care provider	No health care coverage
	%	%	%	%	%	%	%	%	%	%
Clay	69.9%	59.2%	36.9%	30.0%	24.3%	24.1%	24.3%	19.6%	14.6%	11.6%
Edw	71.5%	52.1%	34.6%	33.8%	28.4%	21.3%	14.6%	12.6%	14.0%	12.5%
Jasper	70.4%	53.8%	32.7%	29.1%	27.5%	27.5%	13.9%	24.8%	12.8%	9.2%
Law	70.3%	50.7%	34.8%	30.1%	33.9%	28.5%	22.9%	11.8%	10.8%	13.8%
Rich	64.8%	50.9%	34.5%	26.8%	23.8%	17.6%	15.7%	11.4%	11.8%	14.0%
Total	**69.4%**	**53.3%**	**34.7%**	**30.0%**	**27.6%**	**23.8%**	**18.3%**	**16.0%**	**12.8%**	**12.2%**
	7	9	4	7	5	10	11	13	4	5

Sources

[1]Illinois Department of Public Health. Illinois Behavioral Risk Factors Surveillance System 2010-2014. Retrieved on July 1, 2016 from http://app.idph.state.il.us/brfss/countydata.asp.

Notes

[a]This information is based upon questions asked by the Illinois Behavioral Risk Factor Surveillance System. Estimates are 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 24: 2010-2014 Prevalence of Selected Chronic Diseases[1] by County (Number and Percent)

County	Prevalence of Selected Chronic Disease[a]						
	High Cholesterol	Hypertension	Diabetes	COPD	Asthma	Coronary Heart Disease	Stroke
	%	%	%	%	%	%	%
Clay	48.2%	37.2%	10.7%	9.5%	5.2%	9.1%	3.4%
Edwards	45.4%	33.6%	9.0%	4.7%	6.3%	5.8%	2.9%
Jasper	41.0%	33.9%	9.9%	3.4%	7.3%	3.5%	3.1%
Lawrence	44.4%	38.0%	13.9%	9.4%	8.2%	7.7%	3.4%
Richland	45.7%	36.2%	11.6%	8.6%	6.9%	7.3%	4.1%
Total	**44.9%**	**35.8%**	**11.0%**	**7.1%**	**6.8%**	**6.7%**	**3.4%**

Sources

[1]Illinois Department of Public Health. Illinois Behavioral Risk Factors Surveillance System (2010-2014). Retrieved on July 6, 2016 from http://app.idph.state.il.us/brfss/countydata.asp.

Notes

[a]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 25: 2013 Adult Obesity and Associated Behavioral and Environmental Factors[1] by County

County	Adult Obesity[a]		Associated Factors			
			Physical Inactivity Prevalence[b]		Access to Exercise Opportunities[c]	Limited Access to Healthy Foods[d]
	#	%	#	%	%	%
Clay	3,158	31.0%	2,932	28.8%	52%	5%
Edw	1,568	31.3%	1,233	24.6%	n/a	4%
Jasper	2,178	30.2%	1,752	24.3%	42%	5%
Law	3,796	28.9%	3,159	24.0%	44%	5%
Rich	3,524	28.8%	3,281	26.8%	65%	2%
Total	**14,224**	**30.0%**	**12,357**	**25.7%**	**51%**	**4%**

Sources

[1]Robert Wood Johnson Foundation. County Health Rankings. Retrieved on July 13, 2016 from http://www.countyhealthrankings.org/app/illinois/2014/rankings/outcomes/overall.

Notes

[a]Adult Obesity is the percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m^2.

[b]Physical Inactivity is the percentage of adults aged 20 and over reporting no leisure-time physical activity.

[c]Access to Exercise Opportunities measures the percentage of individuals in a county who live reasonable close to a location for physical activity.

[d]Limited access to healthy foods estimates the percentage of the population who are low income and do not live close to a grocery store. In rural areas, this means living less than 10 miles from a grocery store.

The data above is quantitative data only. It should be mentioned that the findings of the qualitative data (both private interviews and focus groups) seem to indicate a strong perception that the communities involved in this CHNA struggle with chronic disease, sometimes in a multigenerational manner due to inadequate education, poverty, and addiction. The qualitative data, as has already been mentioned, is perception-based that comes from both those who perform daily work in the medical community as well as those who work in non-medical fields.

Chronic disease is unique in the medical field in that it has the capability of being prevented, usually with a simple, healthy lifestyle. With proper intervention and education (beginning in childhood), many of the medical issues that surround these disease processes can be completely avoided. When avoided, they reduce the physical and financial burden on not only emergency departments and providers, but also the patient and

the patient family. 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 and early educational and physical interventions, the burden of chronic disease to society has the unique potential to be lessened.

Implementation Strategy

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

Health Need #1: Behavioral Health

Continued recruitment of providers*:* RMH will continue with the goal of increasing the number of mental health providers at various levels, including Master's level counselors/therapists as well as psychiatrists. The utilization of telemedicine will continue to be explored within this relationship.

- Impact: Increased number of mental health providers.
- Evaluation: A comparison of the numbers of mental health providers across our service area from 2016-2019.

Improved access: RMH will review the use of a model of care that involves the treatment of the involved family system (in addition to the patient), as resources are available. Due to the instability and volatility of the Illinois budget, this will only be a feasible goal as other local agencies are able to secure funding for the appropriate programming in the outpatient setting. Through several area Interagency Coalitions, of which RMH is an active participatory member, these collaborating organizations will be encouraged and provided as needed with appropriate available data from the RMH Community Health Needs Assessment as they endeavor to secure funding for their programming and meet the outpatient needs of our behavioral health patients upon discharge.

RMH will continue to explore options for care regarding the increasing need for "dual diagnosis" services – those behavioral health patients who present with not only a mental health diagnosis but also a substance abuse disorder (and a need for detoxification treatment services). Currently, RMH does not have the resources to provide a detox program for substance abuse patients, referring those particular patients to other facilities that are better equipped to handle the diagnosis. However, with the substantial growth of this group of patients and the lack of inpatient behavioral health facilities in the area, RMH recognizes this need and will continue to assess their ability to provide this service.

RMH recognizes the continued growth in behavioral health telemedicine services, and will continue to explore opportunities within this service. Areas that will be investigated for this service are behavioral health medication management, inpatient and outpatient counseling, and emergency services.

- Impact: Access to mental health care will improve due to an increase in both inpatient and outpatient provider services, including treatment of the patient as well as involved family members.
- Evaluation: Evaluation of the number of patients that are treated for behavioral health diagnoses, as well as behavioral health readmission rates.

Education/outreach and prevention: Educational venues in the form of health fairs, programs within the local school system, the use of social media, and corporate wellness programming partnerships will continue to be developed and expanded in order to prevent and recognize the devastating effects of various forms of mental illness. RMH will continue to develop and utilize these relationships in order to educate and attempt to link potential patients to appropriate services within our community. This action will prove to be vital to the healthy function of this community.

- Impact: Higher level of health education and understanding regarding the prevention, recognition and treatment options for various types of mental illness among area community members.
- Evaluation: Evaluation of the number of educational venues that RMH participates in that address behavioral health issues.

Health Need #2: Increasing access to health care services

Increase access to "convenient care": Participants of the focus groups as well as private interviews consistently noted that there is a need for an increase in convenient care services (for those medical crises that do not warrant an emergency room visit). The need is greatest for weekend and evening hours. Within the next three years, RMH will look to expand the Convenient Care Clinic hours to provide for this need.

- Impact: Ability for patients to access non-emergency medical care during extended hours.
- Evaluation: Comparison from 2016-2019 of number of convenient care clinic hours and providers available.

Case management: A prominent discussion among the CHNA committee members was the need for case management, specifically at the RMH outpatient clinic sites (inpatient case coordinators and discharge planners are already in place as members of the Quality Assessment and Improvement department). RMH will explore the feasibility of making available a case coordinator to each outpatient site/physician practice. This act would encourage a coordinated and thorough access to community resources for all patients (not just hospital inpatients). This will also allow for more efficient provider-patient time for appropriate medical services while allowing the case coordinator to address all other patient issues that may affect patient health.

Cardiology: RMH will continue the ongoing recruitment for an on-site full time cardiologist.

- Impact: RMH will acquire the ability to immediately and appropriately address cardiology needs by having a cardiologist on-site without having to send patients to another facility or face an extended waiting period to see a cardiologist.
- Evaluation: Comparison of 2016-2019 numbers of cardiologists on staff and on-site at RMH.

Foundational support of medical students: RMH Foundation will continue to financially support local medical school students in their endeavor to complete their medical education, with the goal of returning to the immediate area to practice medicine upon the completion of their education. Currently, the RMH Foundation is supporting 4 medical students through this program – one in family practice, one in internal medicine, and

two that are undecided. Of these four, two are within two years away from educational completion and will be ready to practice.

- Impact: To create an increase in the number of primary care providers in the RMH service area.
- Evaluation: Comparison of the 2016-2019 numbers of primary care providers in the area.

Health Need #3: Chronic disease

Case management: RMH will explore the expansion of a chronic disease management program that would involve case coordination similar to that which has previously been discussed for the outpatient clinical sites, however this program would be specific to chronic disease. The specific goal of the chronic disease case manager would be to connect patients to outpatient services (physical, social, financial, medical) in order to enhance their healing process and long term health goals within appropriate time parameters.

- Impact: Patients will have a designated person that helps them navigate the medical system and available resources to assist with the acquisition of optimal health goals in a timely and appropriate manner.
- Evaluation: Continued decline of readmission rates from 2016-2019.

Education and Prevention: RMH is actively addressing the need for a heart/cardiovascular health with the recruitment of an in-house cardiologist that would be on staff full-time.

RMH will take steps to address the obesity epidemic preventatively by utilizing outreach opportunities that promote a healthy lifestyle. Collaborating with school administrators will offer the opportunity to directly affect rates of diabetes and cardiovascular issues for both the student age population as well as the adult population. In addition, RMH will continue to collaborate with and support community activity planning that encourages exercise and healthy activities for all individuals (family bicycle rides, 5k runs, etc…).

RMH will continue to provide a monthly support group for those community members who have been diagnosed with diabetes in order to prevent worsening cases and offer management techniques to those affected. Members of this support group continue to be greatly impacted, as seen in the consistent numbers of participants (up to 30 patients per group) and multiple positive comments from the CHNA focus group participants. RMH will evaluate the productivity of working towards completion of becoming a certified diabetes education program. Evaluation of continued impact will be measured by participant numbers, as well as IDPH and BRFSS data for prevalence of diabetes in our service area (please refer to Table 24 for 2010-2014 data).

RMH will continue to provide a monthly support group for those community members who have been diagnosed with COPD in order to prevent worsening cases and offer management techniques to those

affected. Evaluation of continued impact will be measured by participant numbers, as well as IDPH and BRFSS data for prevalence of COPD in our service area (please refer to Table 24 for 2010-2014 data).

RMH will explore the opportunity to engage the community in a health awareness project that includes a "community health theme". The primary focus of this project would be to create an opportunity to engage a variety of businesses and/or not-for-profit organizations using a focused health theme that promotes total person wellness and education about the prevention of the most prominent chronic diseases that affect a person's well being. Such a project would utilize all aspects of outreach including (but not limited to) radio, newspaper, newsletters, social media, on-site lunch-and-learn opportunities, health fairs, and other appropriate collaborative venues. The creation of such a project will be able to contribute to many of the health implementation strategies that have been already been discussed in this CHNA.

- Impact: Patients, patient families, caregivers and community members will have increased access to multiple educational and preventive opportunities in the community setting in order to prevent and/or increase their health literacy regarding chronic diseases.
- Evaluation: An increase in the number of community benefit hours and participants will be seen from 2016-2019, as well as a decrease in the number of readmissions for those patients diagnosed with a chronic disease.

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

Focus group script and question

"Welcome and thank you for participating in this focus group meeting today.

We appreciate your time and commitment to improving the health of your community.

We will spend some time today identifying the health care concerns of the community and discussing the factors that influence people's health.

During our discussion, we would like you to consider not only those aspects of health care that are directly related to hospital's mission, such as maternity care, breast cancer prevention, health screenings and education, but also other important health concerns that are not directly related to the hospital, such as, drug and alcohol use, mental health needs, or safe environments in our homes, workplaces and community.

We will also spend some time today identifying those resources that are available to address the health needs of the community.

The purpose of the meeting today is not to judge or evaluate anyone's opinions or experience, but is rather to collect input from a broad range of community members in order to see if there is some general consensus on the most important health problems in the community and perhaps ways to address these problems.

Your input will be used to help to identify and prioritize needs, create solutions, and plan for services in the future.

So let's begin with introductions…"

1) Please tell us who you are, the name of the town that you live in, and one reason why you really like living in your community.

2) What would you say are the most pressing health needs in your community?

What do you think are the three most serious health care *needs* in your community?

Which members of the community have these needs?

(Which parts/ages/areas of the community are affected?)

3) What health-related problems in your community could be prevented?

How?

4) What resources and services are available in the community to address these needs?

What role does Richland Memorial Hospital play in addressing the health care needs that have been identified (in Questions #2 & #3)?

During the previous (2013) RMH CHNA the three most pressing health care needs identified by community members were:

Mental health - especially in terms of the lack of access to psychiatric services, such as outpatient medication management and behavioral treatment for children and families, as well as the social impacts of untreated mental illness, such as substance abuse, poverty, homelessness, and child abuse and neglect;

Lack of access to health services – particularly the need for more primary care providers, specialty medical services that are closer to home, and dental services, as well as many of the public services that are often provided by public health departments, which do not exist in Edwards or Richland County;

And

Chronic disease – particularly those health conditions that are of long duration and slow progression that can be prevented or controlled by healthy life-style changes (such as diabetes, high cholesterol, high blood pressure)

5) Can you think of any programs or services that have been initiated by Richland Memorial Hospital in the past 3 years that are addressing these health care priorities? (repeat: mental health, access to services, and chronic disease)

Facilitators: [Summarize the main themes around concerns and potential solutions].

Ask for agreement and comments from focus group participants.

Supplemental wrap up question (if time allows):

Thinking about the discussion that we have had here today …

What is your vision of a healthy community?

What does a healthy community and the people who live there look like?

"Thank you for your time."

Appendix B – Letter to Focus Group participants

(insert date) , 2016

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: (insert date, time)***
- ***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-May.***
- ***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

LWingert@richlandmemorial.com

Appendix C – Informed Consent to Participate (Focus Groups)

Richland Memorial Hospital Community Needs Assessment

Informed Consent to Participate

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

I understand that the purpose of this study is concerns of the community about health care services and other health issues, and to also identify resources which are currently available in the community.

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

I understand that my responses will be digitally recorded, and that these digital files will be transcribed and stored with the transcriptions in a locked file cabinet. After 90 days, these files will be destroyed.

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

I have read the information above, and any questions that I have asked have been answered to my satisfaction. I agree to participate in this activity and know my responses will be digitally recorded. I understand that a copy of this form is available to all participants upon request.

_____ "I agree have my focus group responses digitally recorded." ***(please check)***

_____ _____

Participant signature Date

Appendix D – Participant Survey

Thank you for volunteering to assist Richland Memorial Hospital with its Community Health Needs Assessment.

We are asking each participant to complete this brief survey. The purpose of this survey is to ensure that our analysis includes input from a broad representation of community members. Your responses are completely confidential and these surveys will be destroyed as soon as summary statistics from all the focus groups have been compiled.

Please circle the categories below that are most applicable to you.

Gender:

Male

Female

Year you were born:

Before 1940

Between 1940 and 1950

Between 1951 and 1975

Between 1976 and 1985

After 1985

What county(ies) would you say you represent as a focus group participant:

Clay

Edwards

Jasper

Lawrence

Richland

Other *(name)*_____

How would you describe your race/ethnicity:

White

Black

Asian

Native American

More than one

Other *(specify)*_____

How would you describe your level of formal education:

Some HS

HS grad

Some college

Finished college (AA/BA/BS)

Some graduate school

Finished graduate school

Other *(describe)*_____

The category that best describes your current occupation is:

Business/finance/banking

Clerical

Education

Medical

Mining and/or manufacturing

Retail/wholesale

Trades

Retired

Currently not working, but not retired

Other *(describe)*_____

Thank you!

Appendix E – Southern Illinois University School of Medicine – Office of Community Health and Service

(Quantitative Data Tables)

Table 1: 2010 U.S. Census Population by Age and County[1]

(Number and Percent)

County	Population	Population Age Categories							
		Under Age 5		Aged 5-19		Aged 20-64		65 and Older	
		#	%	#	%	#	%	#	%
Clay	13,927	909	6.5%	2,699	19.4%	7,827	56.2%	2,492	17.9%
Edwards	6,707	360	5.4%	1,369	20.4%	3,780	56.4%	1,198	17.9%
Jasper	9,752	576	5.9%	1,894	19.4%	5,634	57.8%	1,648	16.9%
Lawrence	16,849	897	5.3%	2,877	17.1%	10,295	61.1%	2,780	16.5%
Richland	16,166	971	6.0%	3,035	18.8%	9,101	56.3%	3,059	18.9%
Total	**63,401**	**3,713**	**5.9%**	**11,874**	**18.7%**	**36,637**	**57.8%**	**11,177**	**17.6%**

Sources

[1]U.S. Census Bureau, 2006-2010 American Community Survey, Demographic and Housing Estimates. Retrieved on July 11, 2016 from factfinder.census.gov.

Table 2: 2014 U.S. Census Population Estimate by Age and County[1]

(Number and Percent)

County	Population Age Categories								
	2014 Estimated Population	Under Age 5		Aged 5-19		Aged 20-64		65 and Older	
		#	%	#	%	#	%	#	%
Clay	13,675	840	6.1%	2,637	19.3%	7,714	56.4%	2,484	18.2%
Edwards	6,687	424	6.3%	1,281	19.2%	3,754	56.1%	1,228	18.4%
Jasper	9,658	559	5.8%	1,781	18.4%	5,633	58.3%	1,685	17.4%
Lawrence	16,726	857	5.1%	2,425	14.5%	10,697	64.0%	2,747	16.4%
Richland	16,144	966	6.0%	2,982	18.5%	9,031	55.9%	3,165	19.6%
Total	**62,890**	**3,646**	**5.8%**	**11,106**	**17.7%**	**36,829**	**58.6%**	**11,309**	**18.0%**

Sources

[1]U.S. Census Bureau, 2010-2014 American Community Survey, Demographic and Housing Estimates. Retrieved on July 11, 2016 from factfinder.census.gov.

Table 3: Proportionate Estimated Population Change from 2010[1] to 2014[2]

Increase (+) or Decrease (-) by Age Categories[1] and County

County	Total Population			Population Age Categories											
				Under Age 5			Aged 5 - 19			Aged 20 - 64			Aged 65 and Older		
	2010	2014	% Change	2010	2014	% Change	2010	2014	% Change	2010	2014	% Change	2010	2014	% Change
Clay	13,927	13,675	-1.8%	909	840	-7.6%	2,699	2,637	-2.3%	7,827	7,714	-1.4%	2,492	2,484	-0.3%
Edwards	6,707	6,687	-0.3%	360	424	17.8%	1,369	1,281	-6.4%	3,780	3,754	-0.7%	1,198	1,228	2.5%
Jasper	9,752	9,658	-1.0%	576	559	-3.0%	1,894	1,781	-6.0%	5,634	5,633	0.0%	1,648	1,685	2.2%
Lawrence	16,849	16,726	-0.7%	897	857	-4.5%	2,877	2,425	-15.7%	10,295	10,697	3.9%	2,780	2,747	-1.2%
Richland	16,166	16,144	-0.1%	971	966	-0.5%	3,035	2,982	-1.7%	9,101	9,031	-0.8%	3,059	3,165	3.5%
Total	**63,401**	**62,890**	**-0.8%**	**3,713**	**3,646**	**-1.8%**	**11,874**	**11,106**	**-6.5%**	**36,637**	**36,829**	**0.5%**	**11,177**	**11,309**	**1.2%**

Sources

[1]U.S. Census Bureau, 2006-2010 American Community Survey, Demographic and Housing Estimates. Retrieved on July 11, 2016 from factfinder.census.gov.

[2]U.S. Census Bureau, 2010-2014 American Community Survey, Demographic and Housing Estimates. Retrieved on July 11, 2016 from factfinder.census.gov.

Table 4: 2014 U.S. Census Minority Populations Estimate by County[1]

(Number and Percent)

County	2014 Estimated Population	Minority Populations									
		Latino		Asian American		African American		Other[a]		Minority Total	
		#	%	#	%	#	%	#	%	#	%
Clay	13,675	179	1.3%	17	0.1%	55	0.4%	94	0.7%	345	2.5%
Edwards	6,687	78	1.2%	15	0.2%	38	0.6%	0	0.0%	131	2.0%
Jasper	9,658	110	1.1%	13	0.1%	16	0.2%	98	1.0%	237	2.5%
Lawrence	16,726	894	5.3%	25	0.1%	3,491	20.9%	338	2.0%	4,748	28.4%
Richland	16,144	221	1.4%	86	0.5%	69	0.4%	37	0.2%	413	2.6%
Total	**62,890**	**1,482**	**2.4%**	**156**	**0.2%**	**3,669**	**5.8%**	**567**	**0.9%**	**5,874**	**9.3%**

Sources

[1]U.S. Census Bureau, 2010-2014 American Community Survey, Demographic and Housing Estimates. Retrieved on July 11, 2016 from factfinder.census.gov.

Table 5: 2014 Populations of Interest by County

(Number and Percent)

County	2014 Population Estimate[1]	Populations of Interest					
		Veterans[2]		Civilian Noninstitutionalized Population with a Disability[2]		Persons Below Poverty[3]	
		#	%	#	%	#	%
Clay	13,675	911	6.7%	2,318	11.4%	1,901	13.9%
Edwards	6,687	531	7.9%	1,042	10.5%	836	12.5%
Jasper	9,658	670	6.9%	1,338	9.1%	637	6.6%
Lawrence	16,726	1,230	7.4%	2,053	12.9%	2,174	13.0%
Richland	16,144	1,431	8.9%	2,769	11.7%	2,422	15.0%
Total	**62,890**	**4,773**	**7.6%**	**9,520**	**15.1%**	**7,970**	**12.7%**

Sources

[1]U.S. Census Bureau, 2010-2014 American Community Survey, Demographic and Housing Estimates. Retrieved on July 11, 2016 from factfinder.census.gov.

[2]U.S. Census Bureau, 2010-2014 American Community Survey, Selected Social Characteristics. Retrieved on July 11, 2016 from factfinder.census.gov.

[3]U.S. Census Bureau, 2010-2014 American Community Survey, Selected Economic Characteristics Retrieved on July 11, 2016 from factfinder.census.gov.

Table 6: 2014 Estimated Educational Attainment: Adults Aged 25 Years or More by County[1] (Number and Percent)

County	Educational Attainment Among Adults Aged 25 Years or More								
	2014 Population 25+ Years of Age	Less Than High School Diploma		High School Diploma		Some College or Associate Degree		Bachelor Degree or Higher	
		#	%	#	%	#	%	#	%
Clay	9,366	1,186	12.7%	3,752	40.1%	3,167	33.8%	1,261	13.5%
Edwards	4,632	579	12.5%	1,664	35.9%	1,917	41.4%	472	10.2%
Jasper	6,793	626	9.2%	2,599	38.3%	2,320	34.2%	1,248	18.4%
Lawrence	12,232	628	5.1%	4,262	34.8%	4,135	33.8%	1,142	9.3%
Richland	11,248	448	4.0%	3,718	33.1%	3,983	35.4%	2,393	21.3%
Total	**44,271**	**3,467**	**7.8%**	**15,995**	**36.1%**	**15,522**	**35.1%**	**6,516**	**14.7%**

Sources

[1]U.S. Census Bureau, 2010-2014 American Community Survey, Selected Social Characteristics. Retrieved on July 11, 2016 from factfinder.census.gov.

Table 7: 2014 Estimated Civilian Employment by Ranked Industries and Unemployment by County[1] (Number and Percent)

County	Regional Civilian Employment by Ranked Industry…															
	Education, Health Care, & Social Assistance		Manufacturing		Retail Trade		Agriculture, Forestry, Fishing, & Mining		Transportation, Warehousing, & Utilities		Arts, Entertainment, Recreation, Accommodation & Food Services		Other Services		Professional, Scientific, Management, Administrative & Waste Mgt. Svs	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Clay	1,305	21.6%	1,279	28.9%	689	24.2%	641	32.6%	365	22.9%	388	26.9%	349	26.5%	226	18.1%
Edwards	558	9.2%	778	17.6%	287	10.1%	201	10.2%	104	6.5%	135	9.3%	170	12.9%	182	14.6%
Jasper	1,010	16.7%	699	15.8%	562	19.7%	433	22.0%	442	27.8%	234	16.2%	205	15.6%	352	28.2%
Lawrence	1,329	22.0%	591	13.3%	379	13.3%	236	12.0%	242	15.2%	291	20.2%	198	15.0%	143	11.5%
Richland	1,835	30.4%	1,086	24.5%	931	32.7%	455	23.1%	439	27.6%	396	27.4%	394	29.9%	344	27.6%
Total	**6,037**	**23.9%**	**4,433**	**17.5%**	**2,848**	**11.3%**	**1,966**	**7.8%**	**1,592**	**6.3%**	**1,444**	**5.7%**	**1316**	**5.2%**	**1,247**	**4.9%**

County	Regional Civilian Employment by Ranked Industry (cont.)												Unemployment		
	Construction		Finance, Insurance, Real Estate, Rental, and Leasing		Public Administration		Wholesale Trade		Information		Total Employed		Total Workforce	Unemployed	
	#	%	#	%	#	%	#	%	#	%	#	%	#	#	%
Clay	322	26.5%	146	12.6%	242	22.9%	140	21.9%	109	34.5%	6,201	24.5%	6,698	497	7.4%
Edwards	144	11.8%	94	8.1%	81	7.7%	94	14.7%	13	4.1%	2,841	11.2%	3,146	305	9.7%
Jasper	258	21.2%	273	23.6%	171	16.2%	136	21.3%	58	18.4%	4,833	19.1%	5,114	281	5.5%
Lawrence	190	15.6%	395	34.1%	148	14.0%	105	16.4%	15	4.7%	4,262	16.9%	4,507	245	5.4%
Richland	303	24.9%	249	21.5%	413	39.1%	165	25.8%	121	38.3%	7,131	28.2%	7,652	521	6.8%
Total	**1,217**	**4.8%**	**1,157**	**4.6%**	**1,055**	**4.2%**	**640**	**2.5%**	**316**	**1.3%**	**25,268**	**100.0%**	**27,117**	**1,849**	**6.8%**

Sources

[1]U.S. Census Bureau, 2010-2014 American Community Survey, Selected Economic Characteristics Retrieved on July 11, 2016 from factfinder.census.gov.

Table 8: 2010-2014 Births by Resident County[1]

(Number and Percent)

County	Births											
	2010		2011		2012		2013		2014		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
Clay	166	23.1%	147	20.4%	192	26.1%	144	20.1%	163	21.9%	812	22.3%
Edwards	66	9.2%	86	11.9%	72	9.8%	80	11.2%	80	10.8%	384	10.6%
Jasper	136	18.9%	111	15.4%	114	15.5%	114	15.9%	110	14.8%	585	16.1%
Lawrence	160	22.3%	168	23.3%	173	23.5%	176	24.6%	185	24.9%	862	23.7%
Richland	190	26.5%	210	29.1%	186	25.2%	201	28.1%	206	27.7%	993	27.3%
Total	**718**	**100.0%**	**722**	**100.0%**	**737**	**100.0%**	**715**	**100.0%**	**744**	**100.0%**	**3,636**	**100.0%**

Sources

[1]Illinois Department of Public Health. Births by County of Residence 2010-2019. Retrieved on July 1, 2016 from http://www.dph.illinois.gov/data-statistics/vital-statistics/birth-statistics.

Table 9: 2011 Adult Mortality by Selected Causes[1] and County

County			Selected Causes of Death (Counts)												
Name	Total Population[2]	Total Mortality	Malignant Neoplasms	Heart Disease	Lower Respiratory	Stroke	Accidents	Influenza and Pneumonia	Diabetes	Alzheimer Disease	Septicemia	Kidney Disease	Liver Disease	Suicide	All Other Causes
Clay	13,675	176	45	33	16	14	11	9	1	1	2	4	1	2	37
Edwards	6,687	67	21	22	4	1	3	1	0	0	1	2	1	0	11
Jasper	9,658	97	17	29	3	5	2	4	2	1	3	1	1	2	27
Lawrence	16,726	221	40	37	15	13	11	8	12	16	5	6	1	0	57
Richland	16,144	180	44	39	12	8	6	4	4	0	4	1	2	0	56
Total	**62,890**	**741**	**167**	**160**	**50**	**41**	**33**	**26**	**19**	**18**	**15**	**14**	**6**	**4**	**188**

County			Selected Causes of Death (Percent)												
County	Total Population[2]	Total Mortality	Malignant Neoplasms	Heart Disease	Lower Respiratory	Stroke	Accidents	Influenza and Pneumonia	Diabetes	Alzheimer Disease	Septicemia	Kidney Disease	Liver Disease	Suicide	All Other Causes
Clay	21.7%	23.8%	6.1%	4.5%	2.2%	1.9%	1.5%	1.2%	0.1%	0.1%	0.3%	0.5%	0.1%	0.3%	5.0%
Edwards	10.6%	9.0%	2.8%	3.0%	0.5%	0.1%	0.4%	0.1%	0.0%	0.0%	0.1%	0.3%	0.1%	0.0%	1.5%
Jasper	15.4%	13.1%	2.3%	3.9%	0.4%	0.7%	0.3%	0.5%	0.3%	0.1%	0.4%	0.1%	0.1%	0.3%	3.6%
Lawrence	26.6%	29.8%	5.4%	5.0%	2.0%	1.8%	1.5%	1.1%	1.6%	2.2%	0.7%	0.8%	0.1%	0.0%	7.7%
Richland	25.7%	24.3%	5.9%	5.3%	1.6%	1.1%	0.8%	0.5%	0.5%	0.0%	0.5%	0.1%	0.3%	0.0%	7.6%
Total	**100.0%**	**100.0%**	**22.5%**	**21.6%**	**6.7%**	**5.5%**	**4.5%**	**3.5%**	**2.6%**	**2.4%**	**2.0%**	**1.9%**	**0.8%**	**0.5%**	**25.4%**

Sources

[1]Illinois Department of Public Health. Health Statistics. Causes of Death by Resident County 2011. Retrieved on June 24, 2016 from www.idph.state.il.us/health/bdmd/deathcauses_11.htm.

[2]U.S. Census Bureau, 2010-2014 American Community Survey, Demographic and Housing Estimates. Retrieved on June 17, 2016 from factfinder.census.gov.

Table 10: 2015 Estimated Medicare and Medicaid Population by County (Number and Percent)

County	Medicare and Medicaid as Proportions of the Population								
	Estimated 2014 Population[1]	Medicaid and Medicare Insured Population						Other or No Insurance[1]	
		Medicaid[2]		Medicare[3]		Total Medicare and Medicaid[a]			
		#	%	#	%	#	%	#	%
Clay	13,675	4,054	29.6%	2,968	21.7%	7,022	51.3%	6,653	48.7%
Edwards	6,687	1,729	25.9%	1,380	20.6%	3,109	46.5%	3,578	53.5%
Jasper	9,658	1,968	20.4%	1,867	19.3%	3,835	39.7%	5,823	60.3%
Lawrence	16,726	3,920	23.4%	3,105	18.6%	7,025	42.0%	9,701	58.0%
Richland	16,144	4,478	27.7%	3,743	23.2%	8,221	50.9%	7,923	49.1%
Total	**62,890**	**16,149**	**25.7%**	**13,063**	**20.8%**	**29,212**	**46.4%**	**33,678**	**53.6%**

Sources

[1]U.S. Census Bureau, 2010-2014 American Community Survey, Demographic and Housing Estimates. Retrieved on June 24, 2016 from factfinder.census.gov.

[2]Illinois Department of Healthcare and Family Services Program Enrollment as of June 30, 2015. Retrieved from http://www.illinois.gov/hfs/info/factsfigures/Program%20Enrollment/Pages/default.aspx.

Medicaid beneficiaries include total enrollees participating in comprehensive and those participating in partial benefit program.

[3]Centers for Medicare and Medicaid Services, Medicare Enrollment Reports: Medicare Aged and Disabled by State and County as of July 1, 2015. Retrieved on June 30. 2016 from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/Dashboard.html.

Notes

[a]The "Total Medicaid and Medicare" column may include dual beneficiaries.

Table 11: 2014 Health and 2009 Dental 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 2014			Dental Insured in 2009[a]		
	Population[1]	#[2]	%	Population[3]	#[3]	%
Clay	11,191	10,206	91.2%	10,562	5,949	56.3%
Edwards	5,459	4,968	91.0%	5,056	2,547	50.4%
Jasper	7,973	7,271	91.2%	7,169	3,110	43.4%
Lawrence	13,979	12,735	91.1%	12,239	6,330	51.7%
Richland	12,979	11,902	91.7%	11,721	6,289	53.7%
Total	**51,581**	**47,082**	**91.3%**	**46,747**	**24,225**	**51.8%**

Sources

[1]U.S. Census Bureau, 2006-2010 American Community Survey, Demographic and Housing Estimates. Retrieved on July 11, 2016 from factfinder.census.gov.

[2]United States Census Bureau. Small Area Health Insurance Estimates 2014. Retrieved on July 1, 2016 from http://www.census.gov/did/www/sahie/data/interactive/.

[3]Illinois Department of Public Health. Illinois Behavioral Risk Factors Surveillance System 2007-2009. Retrieved July 1, 2016 from http://app.idph.state.il.us/brfss/countydata.asp.

Notes

[a]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 12: 2014 High Risk Births and Infant/Pediatric Mortality by County (Number and Percent)

County	High Risk Births					Infant Mortality[4]	Pediatric Deaths[4]
	Total Births[1]	Preterm Births[2]		Births to Teenage Mothers[3]		Deaths of Age <1	Deaths Aged 1-14 Years
		#	%	#	%	#	#
Clay	163	17	10.4%	14	8.6%	0	0
Edwards	80	8	10.0%	7	8.8%	0	1
Jasper	110	9	8.2%	3	2.7%	0	0
Lawrence	185	25	13.5%	17	9.2%	2	0
Richland	206	14	6.8%	15	7.3%	2	2
Total	**744**	**73**	**9.8%**	**56**	**7.5%**	**4**	**3**

Sources

[1]Illinois Department of Public Health. Birth Characteristics by Resident County, 2014. Retrieved on July 1, 2016 from http://www.dph.illinois.gov/sites/default/files/publications/Birth-characteristics-2014-061616.pdf.

[2]Illinois Department of Public Health. Infant Mortality Numbers by County 2014. Retrieved on July 1, 2016 from http://www.dph.illinois.gov/sites/default/files/publications/death-demographics-resident-county-2014.pdf.

[3]illinois Department of Public Health. Illinois Teen Births by County, 2013-2014. Retrieved on July 1, 2006 from http://www.dph.illinois.gov/sites/default/files/publications/Teen-Births-2014-061616.pdf

[4]Illinois Department of Public Health. Death Demographics by Resident County, 2014. Retrieved on July 1, 2016 from http://www.dph.illinois.gov/sites/default/files/publications/death-demographics-resident-county-2014.pdf.

Table 13: 2014 Food Insecurity and Children Living in Poverty by County (Number and Percent)

County	Population[1]			Food Insecurity[2]				Children Living in Poverty[3]	
	2014 Population Estimates	Children		Population		Children			
		#	%	#	%	#	%	#	%
Clay	13,675	3,193	23.3%	1,709	12.5%	773	24.2%	702	22.0%
Edwards	6,687	1,572	23.5%	756	11.3%	333	21.2%	252	16.0%
Jasper	9,658	2,158	22.3%	889	9.2%	395	18.3%	367	17.0%
Lawrence	16,726	3,182	19.0%	2,425	14.5%	725	22.8%	764	24.0%
Richland	16,144	3,623	22.4%	2,018	12.5%	804	22.2%	761	21.0%
Total	**62,890**	**13,728**	**21.8%**	**7,797**	**12.4%**	**3,031**	**22.1%**	**2,845**	**20.7%**

Sources

[1]U.S Census Bureau, 2006-2010 American Community Survey, Demographic and Housing Estimates. Retrieved on July 11, 2016 from factfinder.census.gov.

[2]Feeding America. Map the Meal Gap, Food Insecurity in Your County 2014. Retrieved on June 24, 2016 from http://feedingamerica.org/hunger-in-america/hunger-studies/map-the-meal-gap.aspx.

[3]Robert Wood Johnson Foundation. County Health Rankings. Retrieved on June 24, 2016 from http://www.countyhealthrankings.org/app/illinois/2014/rankings/outcomes/overall.

Table 14: 2016 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	2,204	906	41.1%	207	9.4%	1,113	50.5%
Edwards	916	266	29.0%	69	7.5%	335	36.6%
Jasper	1,455	465	32.0%	121	8.3%	586	40.3%
Lawrence	2,094	978	46.7%	219	10.5%	1,197	57.2%
Richland	2,561	910	35.5%	238	9.3%	1,148	44.8%
Total	**9,230**	**3,525**	**38.2%**	**854**	**9.3%**	**4,379**	**47.4%**

Source

[1]Illinois State Board of Education. Nutrition. Free Lunch Eligibility Listing FY2016. Retrieved on June 27, 2016 from http://www.isbe.net/nutrition/htmls/eligibility_listings.htm.

Table 15: 2014 and 2015 Student Enrollment and Homeless Students by County (Number and Percent)

County	School Districts	Total Enrollment				Homeless Enrollment[a]				Homeless (% of Total)	
		2014[1]		2015[2]		2014[3]		2015[4]		2014	2015
		#	%	#	%	#[1]	%	#[2]	%	%	%
Clay	Clay City, District 10	331	3.5%	314	3.4%	17	5.0%	9	3.0%	3.7%	3.0%
	North Clay, District 25	651	6.9%	645	6.9%	33	5.0%	45	7.0%	7.3%	14.2%
	Flora, District 35	1,373	14.5%	1,391	14.9%	27	2.0%	28	2.0%	6.1%	8.7%
Edwards	Edwards County, District 1	939	9.9%	924	9.9%	19	2.0%	18	2.0%	4.2%	5.8%
Jasper	Jasper County, District 1	1,422	15.1%	1,387	14.8%	28	2.0%	42	3.0%	6.4%	13.1%
Lawrence	Lawrence County, District 20	1,232	13.0%	1,229	13.1%	12	1.0%	12	1.0%	2.8%	3.9%
	Red Hill, District 10	1,047	11.1%	1,052	11.2%	42	4.0%	42	4.0%	9.4%	13.2%
Richland	Richland County, District 1	2,451	25.9%	2,423	25.9%	270	11.0%	121	5.0%	60.2%	38.1%
Total	**Total**	**9,446**	**100.0%**	**9,365**	**100.0%**	**448**	**4.7%**	**318**	**3.4%**	**100.0%**	**100.0%**

Sources

[1]Illinois State Board of Education, 2014-15 Home District Enrollment Report, Fall Enrollment Counts; Retrieved on June 27, 2016 from http://isbe.state.il.us/research/htmls/fall_housing.htm.

[2]Illinois State Board of Education, 2015-16 Home District Enrollment Report, Fall Enrollment Counts; Retrieved on June 27, 2016 from http://isbe.state.il.us/research/htmls/fall_housing.htm.

[3]Regional Office of Education and Richland Memorial Hospital. Based on student counts in fall semester of the 2014-15 academic year.

[4]Regional Office of Education and Richland Memorial Hospital. Based on student counts in fall semester of the 2015-16 academic year.

Notes

[a]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: 2015 Prevalence of Child Abuse/Neglect and Rate by County (Number, Percent, and Rate)

County	Abuse and Neglect Cases, Unduplicated Count and Rate				
	Population Aged 17 Years and Under[1,a]	Cases[2]	Unduplicated Count[2]		Child Abuse Rate (Cases/1,000 Children[2])
		#	#	%	
Clay	3,193	218	166	5.2%	52.5
Edwards	1,572	62	52	3.3%	33.9
Jasper	2,158	94	81	3.8%	36.8
Lawrence	3,182	212	184	5.8%	57.4
Richland	3,623	339	276	7.6%	76.5
Total	**13,728**	**925**	**759**	**5.5%**	**51.4**

Sources

[1]Population Aged 17 Years and Under as presented by United States Census Bureau 2014 estimates.

[2]Illinois Department of Child and Family Services. Child Abuse and Neglect Statistics FY2015. Retrieved on June 27, 2016 from illinois.gov/dcfs.

Notes

[a]Population was manually calculated by subtracting the population 18 and older from the total population.

Table 17: 2010-2014 Health Risk Factors[1] Ranked by County

County	Health Risk Factor Ranking[a]																	
	Pneumonia vaccinations[b]	Flu vaccinations[c]	High cholesterol[d]	Hypertension[e]	Infrequent checkups[f]	Obesity[g]	Inactivity[h]	Seatbelts[i]	Smoking[j]	Accute or binge drinking[k]	No primary care provider[l]	No health care coverage[m]	Diabetes[n]	Cost of healthcare[o]	Heart attack[p]	COPD[q]	Asthma[r]	Coronary heart disease[s]	Stroke[t]
Clay	69.9%	59.2%	48.2%	37.2%	36.9%	30.0%	24.3%	24.1%	24.3%	19.6%	14.6%	11.6%	10.7%	8.9%	9.0%	9.5%	5.2%	9.1%	3.4%
Edw	71.5%	52.1%	45.4%	33.6%	34.6%	33.8%	28.4%	21.3%	14.6%	12.6%	14.0%	12.5%	9.0%	9.0%	8.3%	4.7%	6.3%	5.8%	2.9%
Jasp	70.4%	53.8%	41.0%	33.9%	32.7%	29.1%	27.5%	27.5%	13.9%	24.8%	12.8%	9.2%	9.9%	6.0%	5.8%	3.4%	7.3%	3.5%	3.1%
Law	70.3%	50.7%	44.4%	38.0%	34.8%	30.1%	33.9%	28.5%	22.9%	11.8%	10.8%	13.8%	13.9%	14.6%	8.3%	9.4%	8.2%	7.7%	3.4%
Rich	64.8%	50.9%	45.7%	36.2%	34.5%	26.8%	23.8%	17.6%	15.7%	11.4%	11.8%	14.0%	11.6%	8.8%	6.8%	8.6%	6.9%	7.3%	4.1%
Avg	**69.4%**	**53.3%**	**44.9%**	**35.8%**	**34.7%**	**30.0%**	**27.6%**	**23.8%**	**18.3%**	**16.0%**	**12.8%**	**12.2%**	**11.0%**	**9.5%**	**7.6%**	**7.1%**	**6.8%**	**6.7%**	**3.4%**

Sources

[1]Illinois Department of Public Health. Illinois Behavioral Risk Factors Surveillance System 2010-2014. Retrieved on July 1, 2016 from http://app.idph.state.il.us/brfss/countydata.asp.

Notes

[a]Respondents are asked a variety of questions about their health status and behavioral and other characteristics related to health. The percentages above summarize their responses. Additional information about health risk

factors, including the questions asked of the participants, are included below:

Table 18: 2010-2014 Prevalence of Modifiable Health Risk Behaviors[1] by County (Number and Percent)

County	Never had a pneumonia vaccination %	No flu vaccination in past year %	Infrequent checkups %	Obesity %	Inactivity %	No seatbelts %	Smoking %	Accute or binge drinking %	No primary care provider %	No health care coverage %
Clay	69.9%	59.2%	36.9%	30.0%	24.3%	24.1%	24.3%	19.6%	14.6%	11.6%
Edw	71.5%	52.1%	34.6%	33.8%	28.4%	21.3%	14.6%	12.6%	14.0%	12.5%
Jasper	70.4%	53.8%	32.7%	29.1%	27.5%	27.5%	13.9%	24.8%	12.8%	9.2%
Law	70.3%	50.7%	34.8%	30.1%	33.9%	28.5%	22.9%	11.8%	10.8%	13.8%
Rich	64.8%	50.9%	34.5%	26.8%	23.8%	17.6%	15.7%	11.4%	11.8%	14.0%
Total	**69.4%**	**53.3%**	**34.7%**	**30.0%**	**27.6%**	**23.8%**	**18.3%**	**16.0%**	**12.8%**	**12.2%**
	7	9	4	7	5	10	11	13	4	5

Sources

[1]Illinois Department of Public Health. Illinois Behavioral Risk Factors Surveillance System 2010-2014. Retrieved on July 1, 2016 from http://app.idph.state.il.us/brfss/countydata.asp.

Notes

[a]This information is based upon questions asked by the Illinois Behavioral Risk Factor Surveillance System. Estimates are 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 19: 2010-2014 Adult Tobacco Use by County (Number and Percent)

County	Adult Tobacco Use[1]									
	18-24		25-44		45-64		65+		Total	
	#	%	#	%	#	%	#	%	#	%
Clay	dm**	dm**	1,185	30.7%	664	20.1%	255	26.2%	2,104	25.9%
Edwards	dm**	dm**	300	7.8%	327	9.9%	71	7.3%	698	8.6%
Jasper	dm**	dm**	341	8.8%	469	14.2%	72	7.4%	882	10.9%
Lawrence	dm**	dm**	1,205	31.3%	1,204	36.5%	315	32.4%	2,724	33.5%
Richland	dm**	dm**	824	21.4%	633	19.2%	260	26.7%	1,717	21.1%
Total	**dm****	**dm****	**3,855**	**100.0%**	**3,297**	**100.0%**	**973**	**100.0%**	**8,125**	**100.0%**

Sources

[1]Illinois Department of Public Health. Illinois Behavioral Risk Factors Surveillance System 2010-2014.

Retrieved on July 6, 2016 from from http://app.idph.state.il.us/brfss/countydata.asp .

Notes

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.

dm**: Data missing; Incomplete or missing data at source.

Table 19b: 2012 or 2014 High School Senior Tobacco and Drug Use by County[a]

(Numbers and Percents)

County	Respondents	HS Senior Tobacco Use			HS Senior Drug Use			
		Cigarettes	Smokeless Tobacco	Smoking Tobacco (not cigarettes)	Alcohol	Inhalants	Marijuana	Prescription Drugs (to get high)
	#	%	%	%	%	%	%	%
Clay[1]	100	14%	13%	5%	26%	0%	4%	1%
Edwards	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Jasper	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Lawrence[1]	69	16%	12%	12%	36%	3%	19%	4%
Richland[2]	111	16%	7%	12%	37%	2%	10%	3%
Total	**280**	**46%**	**32%**	**29%**	**33%**	**2%**	**11%**	**3%**

Sources

[1]University of Illinois, Center for Prevention Research and Development. Illinois Youth Survey, 2014 County Report. Retrieved on July 13, 2016 from https://iys.cprd.illinois.edu/results/county.
[2]University of Illinois, Center for Prevention Research and Development. Illinois Youth Survey, 2012 County Report. Retrieved on July 13, 2016 from https://iys.cprd.illinois.edu/results/county.

Notes

[a]Responses indicate participating in the activity within the past 30 days.

Table 20: 2010-2014 Prevalence of Selected Chronic Diseases[1] by County (Number and Percent)

County	Prevalence of Selected Chronic Disease[a]						
	High Cholesterol %	Hypertension %	Diabetes %	COPD %	Asthma %	Coronary Heart Disease %	Stroke %
Clay	48.2%	37.2%	10.7%	9.5%	5.2%	9.1%	3.4%
Edwards	45.4%	33.6%	9.0%	4.7%	6.3%	5.8%	2.9%
Jasper	41.0%	33.9%	9.9%	3.4%	7.3%	3.5%	3.1%
Lawrence	44.4%	38.0%	13.9%	9.4%	8.2%	7.7%	3.4%
Richland	45.7%	36.2%	11.6%	8.6%	6.9%	7.3%	4.1%
Total	**44.9%**	**35.8%**	**11.0%**	**7.1%**	**6.8%**	**6.7%**	**3.4%**

Sources

[1]Illinois Department of Public Health. Illinois Behavioral Risk Factors Surveillance System (2010-2014). Retrieved on July 6, 2016 from http://app.idph.state.il.us/brfss/countydata.asp.

Notes

[a]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 21: 2013 Adult Obesity and Associated Behavioral and Environmental Factors[1] by County

County	Adult Obesity[a]		Associated Factors			
			Physical Inactivity Prevalence[b]		Access to Exercise Opportunities[c]	Limited Access to Healthy Foods[d]
	#	%	#	%	%	%
Clay	3,158	31.0%	2,932	28.8%	52%	5%
Edw	1,568	31.3%	1,233	24.6%	n/a	4%
Jasper	2,178	30.2%	1,752	24.3%	42%	5%
Law	3,796	28.9%	3,159	24.0%	44%	5%
Rich	3,524	28.8%	3,281	26.8%	65%	2%
Total	**14,224**	**30.0%**	**12,357**	**25.7%**	**51%**	**4%**

Sources

[1]Robert Wood Johnson Foundation. County Health Rankings. Retrieved on July 13, 2016 from http://www.countyhealthrankings.org/app/illinois/2014/rankings/outcomes/overall.

Notes

[a]Adult Obesity is the percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m^2.

[b]Physical Inactivity is the percentage of adults aged 20 and over reporting no leisure-time physical activity.

[c]Access to Exercise Opportunities measures the percentage of individuals in a county who live reasonable close to a location for physical activity.

[d]Limited access to healthy foods estimates the percentage of the population who are low income and do not live close to a grocery store. In rural areas, this means living less than 10 miles from a grocery store.

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,a]		Violent Crime[2,c] per 100,000
		#[b]	%	Rate
Clay	10,482	694	6.6%	148
Edwards	5,115	215	4.2%	497
Jasper	7,500	349	4.7%	395
Lawrence	13,544	517	3.8%	270
Richland	12,521	246	2.0%	211
Total	**49,162**	**2,021**	**4.1%**	**271.5**

Sources

1Illinois 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.

[2]Robert Wood Johnson Foundation. County Health Rankings. Retrieved on December 12, 2012 from http://www.countyhealthrankings.org/app/illinois/2012/rankings/outcomes/overall.

Notes

[a]Question asked by the Illinois Behavioral Risk Factor Surveillance System:

In the past 12 months, were you physically hurt by someone?

[b]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.

[c]Violent Crime includes rape, homicide, robbery, and aggravated assault.

Table 23: 2013 and 2014 Incidence of Sexually Transmitted Diseases by County (Cases and Rates/100,000 Residents)

County	Population[1]		Sexually Transmitted Disease Cases and Rates																			
			Bacterial Diseases												Viral Diseases							
			Chlamydia[2]				Gonorrhea[2]				Syphilis[2]				HIV (2006-2013)[3]				Hepatitis C[2]			
	2013	2014	2013		2014		2013		2014		2013		2014		2013		2014[b]		2013		2014	
	#	#	#	Rate[a]	#	Rate[a]	#	Rate[a]	#	Rate[a]	#	Rate[a]	#	Rate[a]	#	Rate	#	Rate	#	Rate[a]	#	Rate[a]
Clay	13,553	13,463	29	214	35	260	1	7	1	7	0	0	0	0	3	3	N/A	N/A	5	37	10	74
Edwards	6,675	6,621	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	N/A	N/A	N/A	N/A	N/A	N/A
Effingham	34,319	34,321	83	242	81	236	5	146	5	15	2	6	0	0	4	2	N/A	N/A	10	29	12	35
Jasper	9,564	9,619	17	178	24	250	0	0	1	10	2	21	0	0	1	1	N/A	N/A	0	0	6	62
Lawrence	16,736	16,596	40	239	35	211	3	18	1	6	0	0	0	0	14	11	N/A	N/A	16	96	23	139
Richland	16,092	16,103	51	317	47	292	6	37	6	37	0	0	0	0	2	2	N/A	N/A	3	19	5	31
Wayne	16,597	16,515	24	145	37	224	5	30	0	0	1	6	0	0	2	2	N/A	N/A	5	30	9	54
Total	**113,536**	**113,238**	**244**	**215**	**259**	**229**	**20**	**18**	**14**	**12**	**5**	**4**	**0**	**0**	**26**	**3**	**N/A**	**N/A**	**39**	**34**	**65**	**57**

Sources

[1]Annual estimates of the resident population: April 1, 2010 to July 1, 2015. U.S. Census Bureau, Population Division. Retrieved from http://factfinder.census.gov on June 29, 2016.

[2]Data provided to Richland Memorial Hospital by the Richland County Health Office on January 13, 2006.

[3]Illinois Department of Public Health. Illinois Department of Public Health AIDS/HIV Monthly Surveillance Report December 2013. Retrieved on June 29, 2016 from http://www.idph.state.il.us/aids/Surv_Report_1213.pdf.

Notes

[a]Rates/100,000 population for each county are calculated as follows: (Number of Cases/County Population) x 100,000.

[b]Data not available as of June 29, 2016.

Table 23b: 2013 and 2014 Food Borne Illnesses by County

(Cases and Rates/100,000 Population)

County	Population		Food Borne Disease Cases and Rates			
			Salmonellosis[3]			
	2013[1]	2014[2]	2013		2014	
	#	#	#	Rate[a]	#	Rate[a]
Clay	13,744	13,675	4	29.1	2	14.6
Edwards	6,695	6,687	N/A	N/A	N/A	N/A
Effingham	34,274	34,280	4	11.7	5	14.6
Jasper	9,680	9,658	0	0.0	3	31.1
Lawrence	16,702	16,726	5	29.9	3	17.9
Richland	16,213	16,144	1	6.2	2	12.4
Wayne	16,674	16,627	6	36.0	5	30.1
Total	**113,982**	**113,797**	**20**	**17.5**	**20**	**17.6**

Sources

[1]U.S. Census Bureau, 2009-2013 American Community Survey 5-Year Estimates, Demographic and Housing Estimates. Retrieved on July 13, 2016 from factfinder.census.gov.

[2]U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates, Demographic and Housing Estimates. Retrieved on July 13, 2016 from factfinder.census.gov

[3]Data provided to Richland Memorial Hospital by the Richland County Health Office on January 13, 2016.

Notes

[a]Rates/100,000 population for each county are calculated as follows: (Number of Cases/County Population) x 100,000.

Table 24: 2010-2013 Number of Dentists and Physician Count by County (Number and Percent)

County	Dentists, Dentist Utilization and Physicians		
	2014 Population Estimate[1]	Number of Dentists[2]	Current Physician Count[2]
		#	#
Clay	13,675	6	8
Edwards	6,687	2	1
Jasper	9,658	2	0
Lawrence	16,726	2	5
Richland	16,144	4	19
Total	**62,890**	**16**	**33**

Sources

[1]U.S. Census Bureau, 2010-2014 American Community Survey, Demographic and Housing Estimates. Retrieved on July 11, 2016 from factfinder.census.gov.

[2]Health Resource and Service Administration. Area Health Resource File. Retrieved on July 13, 2016 from http://ahrf.hrsa.gov/download.htm.

Table 25: Major Depression – Older Adults

COUNTY	Population Age 65 Years or Older[1]			Prevalence of Older Adult Depression (Medicare Fee-For-Service Beneficiaries with Depression)[2]					
	2012	2013	2014	2012		2013		2014	
				#[a]	%	#	%	#	%
Clay	2,486	2,495	2,485	375	15.1%	354	14.2%	350	14.1%
Edwards	1,217	1,225	1,228	105	8.6%	100	8.2%	104	8.5%
Jasper	1,663	1,676	1,685	201	12.1%	204	12.2%	233	13.8%
Lawrence	2,689	2,670	2,747	347	12.9%	326	12.2%	354	12.9%
Richland	3,161	3,170	3,165	335	10.6%	358	11.3%	377	11.9%
TOTAL	**11,216**	**11,236**	**11,310**	**1,363**	**12.2%**	**1,343**	**12.0%**	**1,418**	**12.5%**

Table 25b: Total Number of Suicides and Psychiatrists

	Total Suicides[3] 2003-2012	Number of Psychiatrists[4]
	#	#
Clay	22	0
Edwards	7	0
Jasper	19	0
Lawrence	23	1
Richland	15	1
	86	**2**

Sources

[1]U.S. Census Bureau, 2010-2014 American Community Survey, Demographic and Housing Estimates. Retrieved on September 7, 2016 from factfinder.census.gov.

[2]Centers for Medicare & Medicaid Services. Prevalence State/County Level: All Beneficiaries by Age, 2007-2014. Retrieved September 7, 2016 from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/CC_Main.html.

[3]Illinois Department of Public Health, Center for Health Statistics, Mortality Data, 2003-2012. Suicides Deaths by Resident County 2003-2012 Aggregated. Retrieved on July 13, 2016 from http://www.dph.illinois.gov/sites/default/files/publications/il-suicide-deaths-bycounty-2003-2012-050216.pdf.

[4]Health Resource and Service Administration. Area Health Resource File. Retrieved on July 13, 2016 from http://ahrf.hrsa.gov/download.htm.

[5]Provided by Richland Memorial Hospital via personal communication on July 7, 2016.

[6]Illinois Department of Human Services, Mental Health Office Locator. Retrieved on July 13, 2016 from www.dhs.state.il.us/page.aspx?module=12.

Table 26: 2014 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	Utilization			Average Length of Stay	Average Daily Census	Occupancy Rate	
					Inpatient	Observation	Total			CON Beds	Staffed Beds
	#	#	#	#	#	#	#	#	#	%	%
Intensive Care Total	**8**	**8**	**5**	**194**	**329**	**293**	**622**	**3.2**	**1.7**	**21.3%**	**21.3%**
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	8	8	5	194	329	293	622	3.2	1.7	21.3%	21.3%
Acute Mental Illness Total	**16**	**10**	**10**	**516**	**2,185**	**0**	**2,185**	**4.2**	**6.0**	**37.4%**	**59.9%**
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	516	2,185	0	2,185	4.2	6.0	37.4%	59.9%
Obstetrics/Gynecology Total	**10**	**10**	**7**	**440**	**791**	**61**	**852**	**1.9**	**2.3**	**23.3%**	**23.3%**
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	10	10	7	440	791	61	852	1.9	2.3	23.3%	23.3%
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**	**175**	**3,269**	**0**	**3,269**	**18.7**	**9.0**	**26.3%**	**26.3%**
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	34	34	34	175	3,269	0	3,269	18.7	9.0	26.3%	26.3%
Medical/Surgical Total	**104**	**73**	**53**	**2,564**	**9,903**	**765**	**10,668**	**4.2**	**29.2**	**28.1%**	**40.0%**
Clay County Hospital	18	18	10	810	3,050	166	3,216	4.0	8.8	48.9%	48.9%
Lawrence County Hospital	25	25	13	616	2,124	21	2,145	3.5	5.9	23.5%	23.5%
Richland Memorial Hospital	61	30	30	1,138	4,729	578	5,307	4.7	14.5	23.8%	48.5%
Total Utilization	**177**	**n/a**	**n/a**	**4,072**	**7,837**	**1,119**	**8,956**	**2.2**	**24.5**	**13.9%**	**n/a**
Clay County Hospital	18	n/a	n/a	928	4,058	166	4,224	4.6	11.6	64.3%	n/a
Lawrence County Hospital	25	n/a	n/a	714	2,676	21	2,697	3.8	7.4	29.6%	n/a
Richland Memorial Hospital	134	n/a	n/a	2,430	1,103	932	2,035	5.0	33.5	25.0%	n/a

Sources

[1]Health Facilities & Services Review Board. Individual Hospital Profiles by Hospital Name, 2014 PDF. Retrieved on July 1, 2016 from http://www.illinois.gov/sites/hfsrb/InventoriesData/FacilityProfiles/Pages/default.aspx.

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

Table 27: 2014 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	
	Inpatient Admissions	Inpatient Days	Inpatient Admissions	Inpatient Days	Inpatient Admissions	Inpatient Days	Inpatient Admissions	Inpatient Days	Inpatient Admissions	Inpatient Days	Inpatient Admissions	Inpatient Days
Clay County Hospital	10	21	122	373	214	756	127	536	337	1,364	810	3,050
Lawrence County Hospital	7	24	88	228	166	554	108	371	247	947	616	2,124
Richland Memorial Hospital	40	87	80	255	272	1,078	203	881	543	2,428	1,138	4,729
Total	**57**	**132**	**290**	**856**	**652**	**2,388**	**438**	**1,788**	**1,127**	**4,739**	**2,564**	**9,903**

Hospital	Percent of Inpatient Patient Admissions and Inpatient Days by Age Categories											
	0 - 14 Years		15 - 44 Years		45 - 64 Years		65 - 74 Years		75+ Years		Total	
	Inpatient Admissions	Inpatient Days	Inpatient Admissions	Inpatient Days	Inpatient Admissions	Inpatient Days	Inpatient Admissions	Inpatient Days	Inpatient Admissions	Inpatient Days	Inpatient Admissions	Inpatient Days
Clay County Hospital	17.5%	15.9%	42.1%	43.6%	32.8%	31.7%	29.0%	30.0%	29.9%	28.8%	31.6%	30.8%
Lawrence County Hospital	12.3%	18.2%	30.3%	26.6%	25.5%	23.2%	24.7%	20.7%	21.9%	20.0%	24.0%	21.4%
Richland Memorial Hospital	70.2%	65.9%	27.6%	29.8%	41.7%	45.1%	46.3%	49.3%	48.2%	51.2%	44.4%	47.8%
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 %**

Sources

[1]Health Facilities & Services Review Board. Individual Hospital Profiles by Hospital Name, 2014 PDF. Retrieved oon July 1, 2016 from

http://www.illinois.gov/sites/hfsrb/InventoriesData/FacilityProfiles/Pages/default.aspx.

Table 28: 2013-2015 Immunization Coverage and Payment Sources by Age Group[1]

Type	Immunization Counts																	
	2013						2014						2015					
	Ages <1	Ages 1-6	Ages 7-12	Ages 13-18	Total #	Total %	Ages <1	Ages 1-6	Ages 7-12	Ages 13-18	Total #	Total %	Ages <1	Ages 1-6	Ages 7-12	Ages 13-18	Total #	Total %
Insured	25	81	45	33	184	13.2%	51	105	62	43	261	19.2%	43	174	144	180	541	36.1%
Medicaid	94	348	185	133	760	54.7%	104	302	197	116	719	52.9%	85	306	172	191	754	50.3%
Underinsured	37	153	115	73	378	27.2%	8	124	98	81	311	22.9%	5	39	30	60	134	8.9%
No Insurance	4	30	20	13	67	4.8%	4	23	23	17	67	4.9%	1	16	27	25	69	4.6%
Total	**160**	**612**	**365**	**252**	**1,389**	**100%**	**167**	**554**	**380**	**257**	**1,358**	**100%**	**134**	**535**	**373**	**456**	**1,498**	**100%**

Sources

[1]Information provided to Richland Memorial Hospital by the Richland County Health Office on January 13, 2016.

Table 29: 2014 Laboratory, Diagnostic/Interventional and Imaging Service Utilization[1] by Hospital (Number)[a]

Hospital	Number of Laboratory, Diagnostic/Interventional and Imaging Services Delivered						
	Lab Studies	General Radiography	Nuclear Medicine	Mammography	Ultrasound	CAT Scans	MRI
Clay County Hospital	107,184	7,525	752	2,021	2,063	3,417	626
Lawrence County Hospital	88,602	6,003	168	1	1,286	1,424	355
Richland Memorial Hospital	189,944	11,037	607	1,916	4,238	4,021	809
Total	**385,730**	**24,565**	**1,527**	**3,938**	**7,587**	**8,862**	**1,790**

Hospital	Percent of Laboratory, Diagnostic/Interventional and Imaging Services Delivered						
	Lab Studies	General Radiography	Nuclear Medicine	Mammography	Ultrasound	CAT Scans	MRI
Clay County Hospital	27.8%	30.6%	49.2%	51.3%	27.2%	38.6%	35.0%
Lawrence County Hospital	23.0%	24.4%	11.0%	0.0%	17.0%	16.1%	19.8%
Richland Memorial Hospital	49.2%	44.9%	39.8%	48.7%	55.9%	45.4%	45.2%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Sources

[1]Health Facilities & Services Review Board. Individual Hospital Profiles by Hospital Name. 2014 PDF. Retrieved July 1, 2016 from http://www.illinois.gov/sites/hfsrb/InventoriesData/FacilityProfiles/Pages/default.aspx.

Notes

[a]Numbers and percents include inpatient, outpatient and contract studies and examinations.

Table 30: 2014 Surgery and Operating Room Utilization[1] by Hospital (Number)

Surgical Specialty by Hospital	Operating Rooms				Surgical Cases			Surgical Hours			Mean Hours Per Case		
		Outpatient	Combined	Total[a]	Inpatient	Inpatient	Total[a]	Inpatient	Outpatient	Total[a]	Inpatient	Outpatient	Total[a]
General Surgery Total	**0**	**0**	**3**	**3**	**267**	**1,002**	**1,269**	**540**	**1,436**	**1,976**	**2.0**	**1.4**	**1.6**
Clay County Hospital	0	0	2	2	78	410	488	125	441	566	1.6	1.1	1.2
Lawrence County Hospital	0	0	0	0	80	295	375	143	361	504	1.8	1.2	1.3
Richland Memorial Hospital	0	0	1	1	109	297	406	272	634	906	2.5	2.1	2.2
Gastroenterology Total	**0**	**0**	**0**	**0**	**139**	**786**	**925**	**75**	**450**	**525**	**0.5**	**0.6**	**0.6**
Clay County Hospital	0	0	0	0	108	594	702	44	257	301	0.4	0.4	0.4
Lawrence County Hospital	0	0	0	0	31	192	223	31	193	224	1.0	1.0	1.0
Richland Memorial Hospital	0	0	0	0	0	0	0	0	0	0	0.0	0.0	0.0
OB/GYN Total	**0**	**0**	**1**	**1**	**229**	**176**	**405**	**510**	**310**	**820**	**2.2**	**1.8**	**2.0**
Clay County Hospital	0	0	0	0	0	9	9	0	8	8	0.0	0.9	0.9
Lawrence County Hospital	0	0	0	0	1	24	25	3	26	29	3.0	1.1	1.2
Richland Memorial Hospital	0	0	1	1	228	143	371	507	276	783	2.2	1.9	2.1
Ophthalmology Total	**0**	**0**	**1**	**1**	**1**	**405**	**406**	**1**	**309**	**310**	**1.0**	**0.8**	**0.8**
Clay County Hospital	0	0	0	0	0	82	82	0	46	46	0.0	0.6	0.6
Lawrence County Hospital	0	0	0	0	0	163	163	0	164	164	0.0	1.0	1.0
Richland Memorial Hospital	0	0	1	1	1	160	161	1	99	100	1.0	0.6	0.6
Orthopedics Total	**0**	**0**	**1**	**1**	**76**	**249**	**325**	**409**	**581**	**990**	**5.4**	**2.3**	**3.0**
Clay County Hospital	0	0	0	0	0	25	25	0	17	17	0.0	0.7	0.7
Lawrence County Hospital	0	0	0	0	0	45	45	0	68	68	0.0	1.5	1.5
Richland Memorial Hospital	0	0	1	1	76	179	255	409	496	905	5.4	2.8	3.5
Otolaryngology Total	**0**	**0**	**1**	**1**	**2**	**311**	**313**	**3**	**336**	**339**	**1.5**	**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	311	313	3	336	339	1.5	1.1	1.1
Podiatry Total	**0**	**0**	**0**	**0**	**0**	**18**	**18**	**0**	**23**	**23**	**0.0**	**1.3**	**1.3**
Clay County Hospital	0	0	0	0	0	18	18	0	23	23	0.0	1.3	1.3

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**	**168**	**213**	**96**	**265**	**361**	**2.1**	**1.6**	**1.7**
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	168	213	96	265	361	2.1	1.6	1.7
Surgical Specialties Total	**0**	**0**	**11**	**11**	**657**	**2,813**	**3,470**	**1,315**	**3,490**	**4,805**	**7.3**	**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

Sources

[1]Health Facilities & Services Review Board. 2014 AHQ Data Spreadsheet - Excel Format Revised November 19, 2015. Retrieved July 1, 2016 from http://www.illinois.gov/sites/hfsrb/InventoriesData/FacilityProfiles/Pages/default.aspx.

Notes

[a]"Value of Charity Care" Amounts and Percents are not included in "Total Revenues" Amount and Percent.

Table 31: 2014 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[a]		Private Insurance		Private Pay		Total Revenues[b]		Value of Charity Care[b]	
	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%
Total Inpatient Revenues	**$10,098,102**	**49.3%**	**$2,474,807**	**12.1%**	**$0**	**0.0%**	**$7,715,725**	**37.7%**	**$175,139**	**0.9%**	**$20,463,773**	**100.0%**	**$542,621**	**2.7%**
Clay County Hospital	$2,284,456	62.1%	$280,950	7.6%	$0	0.0%	$1,068,747	29.0%	$45,558	1.2%	$3,679,711	18.0%	$64,400	1.8%
Lawrence County Hospital	$2,260,432	74.8%	$228,273	7.6%	$0	0.0%	$516,840	17.1%	$15,995	0.5%	$3,021,540	14.8%	$103,749	3.4%
Richland Memorial Hospital	$5,553,214	40.4%	$1,965,584	14.3%	$0	0.0%	$6,130,138	44.5%	$113,586	0.8%	$13,762,522	67.3%	$374,472	2.7%
Total Outpatient Revenues	**$21,005,043**	**36.3%**	**$9,392,461**	**16.2%**	**$0**	**0.0%**	**$25,975,762**	**44.9%**	**$1,463,705**	**2.5%**	**$57,836,971**	**100.0%**	**$2,143,575**	**3.7%**
Clay County Hospital	$4,542,449	25.8%	$2,427,486	13.8%	$0	0.0%	$9,555,336	54.2%	$1,108,859	6.3%	$17,634,130	30.5%	$650,960	3.7%
Lawrence County Hospital	$4,102,216	42.9%	$2,589,965	27.1%	$0	0.0%	$2,775,926	29.0%	$102,027	1.1%	$9,570,134	16.5%	$659,113	6.9%
Richland Memorial Hospital	$12,360,378	40.4%	$4,375,010	14.3%	$0	0.0%	$13,644,500	44.5%	$252,819	0.8%	$30,632,707	53.0%	$833,502	2.7%
Total Revenues	**$31,103,145**	**39.7%**	**$11,867,268**	**15.2%**	**$0**	**0.0%**	**$33,691,487**	**43.0%**	**$1,638,844**	**2.1%**	**$78,300,744**	**100.0%**	**$2,686,196**	**3.4%**
Clay County Hospital	$6,826,905	32.0%	$2,708,436	12.7%	$0	0.0%	$10,624,083	49.8%	$1,154,417	5.4%	$21,313,841	27.2%	$715,360	3.4%
Lawrence County Hospital	$6,362,648	50.5%	$2,818,238	22.4%	$0	0.0%	$3,292,766	26.2%	$118,022	0.9%	$12,591,674	16.1%	$762,862	6.1%
Richland Memorial Hospital	$17,913,592	40.4%	$6,340,594	14.3%	$0	0.0%	$19,774,638	44.5%	$366,405	0.8%	$44,395,229	56.7%	$1,207,974	2.7%

Sources

[1]Health Facilities & Services Review Board. 2014 AHQ Data Spreadsheet - Excel Format Revised November 19, 2015. Retrieved July 1, 2016 from http://www.illinois.gov/sites/hfsrb/InventoriesData/FacilityProfiles/Pages/default.aspx.

Notes

[a]"Other Public Insurance" includes all forms of direct public payment, excluding Medicare and Medicaid. DMH/DD and Veterans Administration funds and other public funds paid directly to a facility are recorded as "other public."

[b]"Value of Charity Care" amounts and percents are not included in "Total Revenues" amount and percent.

Table 32: 2014 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	**2,354**	**60.2%**	**907**	**23.2%**	**1**	**0.0%**	**566**	**14.5%**	**85**	**2.2%**	**3,913**	**100.0%**	**170**	**4.2%**	**4,083**	**100.0%**
Clay County Hospital	626	68.6%	117	12.8%	0	0.0%	150	16.4%	20	2.2%	913	23.3%	26	2.8%	939	23.0%
Lawrence County Hospital	483	73.9%	111	17.0%	1	0.2%	48	7.3%	11	1.7%	654	16.7%	60	8.4%	714	17.5%
Richland Memorial Hospital	1,245	53.1%	679	28.9%	0	0.0%	368	15.7%	54	2.3%	2,346	60.0%	84	3.5%	2,430	59.5%
Total Outpatients	**62,009**	**40.9%**	**41,246**	**27.2%**	**89**	**0.1%**	**38,771**	**25.6%**	**9,450**	**6.2%**	**151,565**	**100.0%**	**3,745**	**2.4%**	**155,310**	**100.0%**
Clay County Hospital	23,331	43.2%	15,364	28.4%	0	0.0%	14,226	26.3%	1,138	2.1%	54,059	35.7%	227	0.4%	54,286	35.0%
Lawrence County Hospital	13,821	34.5%	12,909	32.2%	89	0.2%	9,461	23.6%	3,818	9.5%	40,098	26.5%	2,352	5.5%	42,450	27.3%
Richland Memorial Hospital	24,857	43.3%	12,973	22.6%	0	0.0%	15,084	26.3%	4,494	7.8%	57,408	37.9%	1,166	2.0%	58,574	37.7%
Total Patients	**64,363**	**41.4%**	**42,153**	**27.1%**	**90**	**0.1%**	**39,337**	**25.3%**	**9,535**	**6.1%**	**155,478**	**100.0%**	**3,915**	**2.5%**	**159,393**	**100.0%**
Clay County Hospital	23,957	43.6%	15,481	28.2%	0	0.0%	14,376	26.2%	1,158	2.1%	54,972	35.4%	253	0.5%	55,225	34.6%
Lawrence County Hospital	14,304	35.1%	13,020	31.9%	90	0.2%	9,509	23.3%	3,829	9.4%	40,752	26.2%	2,412	5.6%	43,164	27.1%
Richland Memorial Hospital	26,102	43.7%	13,652	22.8%	0	0.0%	15,452	25.9%	4,548	7.6%	59,754	38.4%	1,250	2.0%	61,004	38.3%

Sources

[1]Health Facilities & Services Review Board. 2014 AHQ Data Spreadsheet - Excel Format Revised November 19, 2015. Retrieved July 1, 2016 from http://www.illinois.gov/sites/hfsrb/InventoriesData/FacilityProfiles/Pages/default.aspx.

Table 33: 2013-2015 Payer Mix Utilization at Richland Memorial Hospital

	Percent Payer Mix Utilization by Fiscal Year			
	2013	2014	2015	Average
Entity Wide	**100%**	**100%**	**100%**	**100%**
Medicare	49.7%	49.9%	48.0%	49%
Medicaid	17.3%	19.7%	21.6%	20%
Commercial	26.0%	25.0%	26.4%	26%
Private Pay	7.0%	5.5%	4.0%	6%
Emergency Room	**100%**	**100%**	**100%**	**100%**
Medicare	31.6%	29.9%	30.7%	31%
Medicaid	31.0%	35.5%	37.5%	35%
Commercial	25.2%	26.0%	25.9%	26%
Private Pay	12.2%	8.6%	5.9%	9%
Inpatient Psych	**100%**	**100%**	**100%**	**100%**
Medicare	27.0%	26.9%	25.5%	26%
Medicaid	29.6%	45.0%	54.9%	43%
Commercial	16.5%	13.0%	10.9%	13%
Private Pay	26.9%	15.1%	8.7%	17%
Convenient Care	**100.0%**	**100.0%**	**100.0%**	**100%**
Medicare	6.4%	7.2%	5.2%	6%
Medicaid	29.1%	34.9%	35.4%	33%
Commercial	54.1%	47.9%	49.9%	51%
Private Pay	10.4%	10.0%	9.5%	10%

Sources

[1]Richland Memorial Hospital Payer Mix Utilization, Fiscal Years 2013/2014/2015. Provided by the Office of the Chief Financial Officer on April 29, 2016.

Table 34: Richland Memorial Hospital 2016 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	0	0.0%	**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	3	20.0%	
General Practice	0	0.0%	
General Surgery	2	13.3%	
Internal Medicine	1	6.7%	
OB/GYN	2	13.3%	**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.
Orthopedic Surgery	1	6.7%	
Otolaryngology	1	6.7%	
Pathology	1	6.7%	
Pediatrics	2	13.3%	
Psychiatry	1	6.7%	
Urology	1	6.7%	
Total Active/Associate Staff	**15**	**100.0%**	
Courtesy and Affiliated Staff	#	%	
Cardiology	33	24.1%	**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	76	55.5%	
Dentistry	2	1.5%	
Emergency Medicine	11	8.0%	
General Surgery	1	0.7%	
Hand Surgery	1	0.7%	
Internal Medicine (Hospitalist)	3	2.2%	
Neurology	1	0.7%	
Oncology	1	0.7%	**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.
Opthalmology	1	0.7%	
Pathology	1	0.7%	
Pediatric Cardiology	4	2.9%	
Podiatry	1	0.7%	
Psychiatry	1	0.7%	
Total Courtesy/Affiliated Staff	**137**	**100.0%**	

Sources

[1]Richland Memorial Hospital. Medical Staff Services. Medical Records Department. Provided on April 15, 2016.

[2]Richland Memorial Hospital Medical Staff Bylaws.

Table 35: Richland Memorial Hospital
2014 and 2015 Top 5 Major Diagnostic Categories at Discharge by Year and Rank[1]
(Number of Inpatients and Percent of Top Five Categories)

2014

Major Diagnostic Categories[a]			Inpatients	
Rank	Description	Code	#	%
1	Mental Diseases & Disorders	19	469	30.0%
2	Newborn & Neonates	15	338	21.6%
3	Pregnancy; Childbirth	14	312	20.0%
4	Respiratory System	4	242	15.5%
5	Factors Influencing Health Status and Other Contacts with Health Services	23	201	12.9%
n/a	**Total**	**n/a**	**1,562**	**100%**

2015

Major Diagnostic Categories[a]			Inpatients	
Rank	Description	Code	#	%
1	Mental Diseases & Disorders	19	504	35.2%
2	Newborn & Neonates	15	284	19.8%
3	Pregnancy; Childbirth	14	274	19.1%
4	Respiratory System	4	217	15.2%
5	Factors Influencing Health Status and Other Contacts with Health Services	23	152	10.6%
n/a	**Total**	**n/a**	**1,431**	**100%**

Sources

[1]Data provided by Richland Memorial Hospital Medical Records Department on April 15, 2016.

Notes

[a]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.

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.

Table 36: Richland Memorial Hospital
2014 and 2015 Top 5 Diagnosis Related Groups at Discharge by Year and Rank[1]
(Number of Inpatients and Percent of Top Five Categories)

2014

Diagnosis Related Groups			Inpatients	
Rank	Diagnosis[a]	Code	#	%
1	Psychoses	885	380	35.0%
2	Normal Newborn	795	279	25.7%
3	Vaginal Delivery	775	198	18.2%
4	Rehabilitation w/ CC/MCC	945	139	12.8%
5	Depressive Disorder	881	89	8.2%
n/a	**Total**	**n/a**	**1,085**	**100%**

2015

Diagnosis Related Groups			Inpatients	
Rank	Diagnosis[a]	Code	#	%
1	Psychoses	885	422	41.2%
2	Normal Newborn	795	253	24.7%
3	Vaginal Delivery	775	158	15.4%
4	Rehabilitation w/ CC/MCC	945	110	10.7%
5	Depressive Neuroses	881	82	8.0%
n/a	**Total**	**n/a**	**1,025**	**100%**

Sources

[1]Data provided by Richland Memorial Hospital Medical Records Department on April 15, 2016.

Notes

[a]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: 2014 Birthing Data and Newborn Nursing Service Utilization[1] by Hospital (Numbers)

Hospital	Birthing Data				Newborn Nursing Patient Days			
	Deliveries	Live Births	Labor Rooms[a]	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	366	363	6	113	640	16	0	656
Total	**366**	**363**	**6**	**113**	**640**	**16**	**0**	**656**

Sources

[1]Illinois Department of Public Health. Individual Hospital Profiles by Hospital Name, 2014. Retrieved July 13, 2016 from http://www.illinois.gov/sites/hfsrb/InventoriesData/FacilityProfiles/Pages/default.aspx

Notes

[a]"Labor Rooms" above includes Labor, Delivery, Recovery, and Postpartum utilization.

Table 37b: 2011-2015 Birthing Data for Richland Memorial Hospital (Numbers)

Year	Birthing Data							
	Maternal Age at Delivery		Live Births	Total Fetal Deaths		C-Sections		Breastfeeding at Discharge
	14-16	17-19		> 20 weeks	< 20 weeks	Primary	Repeat	
2011	8	50	351	3	0	66	48	201
2012	4	34	341	3	0	65	43	219
2013	6	32	333	0	0	58	56	236
2014	4	31	363	3	1	56	56	236
2015	2	28	309	0	3	37	47	209
Total	**24**	**175**	**1,697**	**9**	**4**	**282**	**250**	**1,101**
Average	**5**	**35**	**339**	**2**	**1**	**56**	**50**	**220**

Sources

Richland Memorial Hospital. Family Maternal Services Department. Received April 5, 2016.

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

Year	Richland Memorial Hospital (RMH) Births						
	Richland County Resident Births				# RMH Births from Other Counties	Total RMH Births	% RMH Births 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: Richland Memorial Hospital 2013-2015 Patient Transfers by Year, Diagnosis, Method and Destination[1]

Transfer Patient Characteristics	Calendar Year							
	2013		2014		2015		Total	
	#	%	#	%	#	%	#	%
Total Admitted	**60,272**	**100.0%**	**61,420**	**100.0%**	**62,405**	**100.0%**	**184,097**	**100.0%**
Total Transferred	**553**	**0.9%**	**562**	**0.9%**	**636**	**1.0%**	**1,751**	**1.0%**
Transfer Diagnosis								
Medical[a]	302	47.2%	278	53.0%	302	47.2%	882	48.9%
Cardiac	190	29.7%	119	22.7%	190	29.7%	499	27.6%
Trauma[b]	69	10.8%	52	9.9%	69	10.8%	190	10.5%
Pediatric	47	7.3%	26	5.0%	47	7.3%	120	6.6%
Psych	32	5.0%	50	9.5%	32	5.0%	114	6.3%
Total	**640**	**100.0%**	**525**	**100.0%**	**640**	**100.0%**	**1,805**	**100.0%**
Transport Method								
Ambulance[c]	417	77.8%	431	78.2%	439	69.7%	1,287	75.0%
Helicopter	89	16.6%	91	16.5%	162	25.7%	342	19.9%
Private Auto	28	5.2%	29	5.3%	21	3.3%	78	4.5%
Other	2	0.4%	0	0.0%	8	1.3%	10	0.6%
Total	**536**	**100.0%**	**551**	**100.0%**	**630**	**100.0%**	**1,717**	**100.0%**
Transfer Destination								
Deaconess	164	36.2%	201	41.1%	214	36.5%	579	37.9%
Deaconess Gateway	69	15.2%	46	9.4%	89	15.2%	204	13.4%
St. Mary's - Evansville	47	10.4%	36	7.4%	35	6.0%	118	7.7%
Good Samaritan - Vincennes IN	100	22.1%	100	20.4%	93	15.9%	293	19.2%
Carle	6	1.3%	26	5.3%	71	12.1%	103	6.7%
St. Louis Children's Hospital	21	4.6%	23	4.7%	30	5.1%	74	4.8%
Other	46	10.2%	57	11.7%	54	9.2%	157	10.3%
Total	**453**	**100.0%**	**489**	**100.0%**	**586**	**100.0%**	**1,528**	**100.0%**

Sources

[1]Richland Memorial Hospital. Retrieved on April 28, 2016.

Notes

[a]"Medical" includes pneumonia, CVA/TIA, vascular, renal failure, sepsis, COPD, electrolytes.

[b]"Trauma" includes fracture, head injury, chest injury, soft tissue, abdominal

[c]"Ambulance" refers to transfer by any ambulance service including but not limited to RMH.

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

RICHLAND MEMORIAL HOSPITAL COMMUNITY HEALTH NEEDS ASSESSMENT

FOCUS GROUP REPORT

APRIL 2016

PREPARED BY:

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Richland Memorial Hospital - Community Health Needs Assessment

Focus Group Report – April 2016

Executive Summary

A series of seven focus group meetings were conducted in March, 2016 to collect community input for the *2017-2020 Richland Memorial Hospital (RMH) Community Health Needs Assessment*.

The primary task assigned to the focus group participants was to identify the most pressing community health needs in the RMH service area. The focus groups were also tasked with identifying community resources and RMH initiatives that responded to community health needs. A wide variety of topics were discussed during the focus group sessions. Analysis of the session transcripts revealed several themes that dominated the discussion of community health needs in every group.

- Mental health and substance abuse – The discussion of community mental health needs overwhelmed all of the other topics discussed in the focus group sessions. The greatest concern was the shortage of mental health professionals and treatment resources to respond to all types of mental health and addiction needs (acute, chronic, child, adult, students, seniors, etc.).

- Expansion of ambulatory care treatment resources – The RMH "Convenient Care" facility was highly praised by focus group participants, but was also described as a victim of its own success, and is now overcrowded and understaffed. Discussion focused on the need to expand the availability of ambulatory care services in the community, particularly the number of days/hours of service.

- Public transportation – While participants value the public transportation agency that serves the community, they also expressed a strong need to expand the access to affordable, convenient public transportation. Longer hours of service and more convenient trip alternatives are needed, not only to access medical services, but also to buy food and medicine, and to get to jobs.

- Public Health Department Services – There was a strong, although not unanimous, expression of the need for all of the services, and centralization of service delivery, that are traditionally provided by a public health department.

- Housing and homelessness – Participants described the dominance of overcrowded and inadequate rental housing in the region, and the need to provide more safe and affordable low-income housing. Discussion also focused on the institutional and funding issues that complicate the process of providing housing for individuals who have financial, legal, mental health issues, and the severe health consequences of the inadequate housing and homelessness.

- Comprehensive coordination and improved awareness of local resources – Discussion in every focus group session pointed to the need to take maximum advantage of the health-related resources that are available in the region by creating a greater awareness of these services, and the coordination of service providers, in order to improve the efficiency of service delivery in the region.

Numerous obstacles to addressing these needs were also considered by focus group participants.

The lack of adequate funding, particularly the absence of state funding during the current state budget stalemate, was described as a major obstacle in responding to every major health need in the region. Multigenerational poverty and self-destructive health behaviors were also discussed as another major obstacle to improving community health.

Focus group participants identified numerous organizations, institutions and other resources in the region that are working to improve regional health, as well as a considerable number of innovative programs from RMH that are being used to respond to the health needs of the community.

INTRODUCTION

As a not-for-profit hospital, Richland Memorial Hospital is required to prepare a Community Health Needs Assessment (CHNA) every three years, and is currently in the process of preparing its 2017 - 2020 Assessment.

The purpose of this Community Health Needs Assessment is to identify the "significant health needs" in the hospital's defined service area (Richland, Clay, Lawrence, Jasper and Edward counties), through a review of information collected from community members and available data sources, in order to guide RMH leadership in directing resources to where they are needed the most in order to improve the overall health of the entire community.

As part of the effort to collect information from community members, seven focus groups were conducted over the course of three days, early in March 2016. Fifty-eight volunteers from throughout the region participated in the group sessions. These individuals were representative of various constituent groups in the community and were knowledgeable about the hospital's defined service area and its needs.

The purpose of the focus group discussion was to collect community feedback on the following topics:

- The most important health care needs facing the community
- The most preventable health-related conditions in the community
- The resources that are available (or needed) in the community to address health care needs
- Community awareness of programs and services that Richland Memorial Hospital is currently providing to respond to health care needs in the region

ANALYSIS AND REPORTING

The focus group discussions were recorded and the recordings were transcribed. Analysis began by reviewing the transcripts and coding the participants' statements, based upon the topical categories of information that were needed to inform the CHNA process. Major themes in the discussion were identified by assessing the extent to which each topic occurred during the focus group sessions.

A brief summary of each of these themes is presented below, followed by a bulleted list of the details that were reported by focus group participants that related to each theme. Because of the interconnected nature of the focus group topics, there is some overlap in the contents of the themes. Representative quotations (edited to ensure readability and anonymity) are also included (*italics*) to provide insight into the discussion, and to reflect both the seriousness of the issues that were discussed, and the desire of community participants to bring attention to, and find ways to address, the needs of their community.

The focus group protocol, questions, participant demographics, and other associated documents appear in an Appendix section at the end of this report.

ACKNOWLEDGEMENT

The focus group sponsor and analysts would like to acknowledge the efforts of the community-minded

individuals who willingly took the time out from their busy day to sit down and discuss the health needs

of their community. Their frank and often passionate assessment of community needs provided the data that was used to produce this report.

COMMUNITY HEALTH NEEDS

Participants identified a large number of health care needs in the community. Six major areas of health-related needs were identified by the analysis: mental health and substance abuse, expansion of ambulatory care and public transportation, delivery of public health services, improvements to low-income housing, and the need for increased coordination and awareness of existing health services.

MENTAL HEALTH/SUBSTANCE ABUSE/ADDICTION

... we're finding a high number of chronically mentally ill patients suddenly without any kind of treatment or medication because of state budget cuts ... our community health providers are leaving us ... (we) lack capacity for our in-patient psych services because (we) cover such a large (service area) ... (we're) full all the time.

Identifying students who need help or assistance isn't a problem. We can walk down the hallway and identify who they are. (But) we don't have any assistance until they get into crisis mode. We have zero options to what we can do with them.

... and DCFS is pretty strapped (financially) so they can't investigate all those (child abuse cases) as thoroughly as they need to. I've talked to some of the people that go out and investigate and they are just swamped, they can't even do it justice. We see a lot of people on our psychiatric unit as adults that have dealt with that issue for years and years and years. Probably 80% of our people, don't you think?

... but there is a lack of resources and the counseling center would say that they are full and we can't see your child. You have to go so many times, or have so many appointments scheduled and go to them before you can get medication. So this child was without medication and of course went back into the hospital, which is more state money for (a) hospital stay that should not happen because the child wasn't getting the continued care that he needed. Having medication is one thing, but having counseling is important as well to help (learn) coping strategies, and he was not receiving that.

Mental health and substance abuse/dependency issues were the first topic of discussion in 6 of the 7 group sessions (and were the second topic discussed in the 7th group) and occupied the majority of the discussion in every session. The group discussions focused primarily on the prevalence of mental health issues in the region, the inadequacy of treatment funding, professionals and services, and the multigenerational nature of mental illness and substance abuse.

Participants also described the impact of mental illness on community health and welfare and how delays in prompt treatment (including medications) eventually result in more complex and expensive social problems (incarceration, self-medication, addiction).

Numerous aspects of the need for mental health and substance abuse treatment in the community were discussed during the focus group sessions:

Access Issues

- **Need more inpatient and outpatient services for all groups**
  - **All ages, students, veterans, sex offenders, Medicaid recipients and uninsured**
- **Inadequate staff and services**
  - **Insufficient number and types of providers**
  - **Need more professionals who can prescribe psychotropic medicines**
  - **Pediatric psychiatrists, especially in Richland County**
  - **Need psychiatric telehealth**
  - **Inappropriately long wait times (many cannot wait for treatment – now/never)**
  - **Need prompt, local emergency psych interventions for youth**
  - **Need suicide intervention/prevention**
- **Need coherent mental health professional recruitment programs**
- **Need counseling centers at schools for early intervention**

Substance Abuse/Addiction

- **Need more treatment services for substance abuse**
- **Need more substance abuse specialists**
- **Need physicians who can provide medication assisted treatment (MAT)**
- **No detox facilities**

Transportation issues

- **Local mental health facilities too far out of town to walk to**
- **Only access to timely services may be at distant facilities (e.g., Centralia) Inadequate funding for mental health services**
- **Declining since 2007**
- **No salaries for staff at several agencies**
- **Intermittent and greatly reduced services from providers**
- **Loss of school counselor position due to budget cuts**
- **State delays in payment for services impacting all behavioral health providers Cascading problems resulting from a lack of prompt access to care**
- **Long delays (as long as 3 months for students) and/or lack of access for uninsured results in worsening mental health and more expensive treatment**
- **Mental health plays a key role in physical health – people with mental health problems often are unable to attend to their needs and their physical health quickly declines**
- **Need opportunities for group therapy to quickly address needs of multiple individuals – especially in student populations**

Need to address the "cyclical/multigenerational" nature of mental illness

- **Untreated child/sexual abuse contributes to teen/adult mental illness/crime/addiction**
- **Link between inadequate basic needs (food/meds/housing) and poor health/mental health**
- **Link between inadequate parental care and children's mental health issues Other Mental Health needs and issues**
- **Health education needed for families of mentally ill**

- Control of prescription medications to avoid diversion/abuse
- Continuity of care (ability to discharge patients into supportive environment)
- Stigma of seeking mental health treatment in a small town or school system ○ Causes people to avoid treatment or to travel long distances to avoid community censure

AMBULATORY CARE CLINIC

I think the Convenient Care has been so successful ... that it is so full, (that) you have to make an appointment ... It's not really Convenient Care anymore now.

I know that the outpatient clinic here provides a lot of those services but they are … overbooked completely. I have children at home and just trying to get them an appointment we're looking (at) 2-3 weeks out ... and if they have strep (throat) you know I don't (want to wait) that long … it's just very overbooked and under staffed.

Ambulatory care plays a major role in health maintenance and in reducing the likelihood that small problems will become big problems that require more intensive and expensive treatment, such as emergency room care.

The "Convenient Care" walk-in clinic operated by the Richland Memorial Hospital was discussed in six of the seven sessions, and earned universal praise from focus group participants for the important role it plays in the health of their communities. However, the many comments focused on the need for expansions in the hours/days of services, staffing, and types of services available.

The ambulatory care clinic was described as:

- Invaluable
- Necessary alternative to emergency room care
- Overcrowded
- Overbooked and understaffed

The ambulatory care clinic needs:

- More staff, perhaps mid-level professionals
- Longer daily hours, especially for working people
- Weekend hours
- Dental care provider and access to emergency oral surgery

PUBLIC TRANSPORTATION

We have limited resources ... we see a lot of our people that go to Wabash or Fairfield, or up here (Olney) for services ... the thing that we struggle with the most is the transportation. You are looking at 15-25 mile drive for most. They can't drive 5 miles (let) alone 15 or 20.

... there's something that still could be focused on and that's transportation. Transportation to doctors' appointments. We have RIDES (public transit) which is wonderful but they operate on a schedule. They drop you off at this time and you may be done with your doctors' appointment in thirty minutes but they're not gonna be back to pick you up for maybe another forty-five minutes to an hour. So while we have transportation, (and) that's a good thing, I think it's something that we could improve on.

... one segment that hasn't been mentioned is the unemployed single mom who needs to get to some service agency and they have no transportation ... unfortunately we're located on the (far) end of town ... (and) we have people pushing a stroller in very inclement weather simply because no one in their group of people that they're familiar with, has a vehicle ... I read about the taxi, I thought that's wonderful ... but they don't have the money to buy a can of formula, how are they going to come up with five dollars to bring them out here?

Transportation is a huge issue.

The role of public transportation in relation to community health was discussed by participants in every session. For those who cannot drive, or afford to operate a vehicle, transportation has a direct relationship to health because it determines their ability to attend doctor's appointments, shop for groceries and medicines, or be able to get to their jobs and earn a living.

Participants reported that subsidized public transportation services were available from RIDES Mass Transit District, which offers regular daily routes, as well as door-to-door services for medical appointments, when scheduled 24 hours in advance. While group participants had many positive comments about the services provided by RIDES, they also expressed the need for more extensive public transportation services. Participants also reported that there is also a (relatively new) private taxi service in the community which charges $6 per trip (in town).

Several types of transportation needs were reported in the community that had direct and indirect health impacts.

- Medical transportation needed
    - Especially for medical and dental appointments
    - Specific groups that are particularly in need of transportation services include : elderly, unemployed, single moms, veterans
- Non-medical transportation needed
    - Food/medicine shopping
        - To jobs

Public Mass Transit was valued by participants, but:

- Needs to be more "convenient"
    - Need longer hours, especially for transportation to job sites
    - Need to be more responsive to appointment needs; especially return trips
    - More spontaneous (too hard to reserve a day in advance)
    - Difficult to schedule timely transportation to other towns/counties

- Need to find ways to be accessible to all community members
    - Needs to be affordable to those without a payment source
    - Needs to be accessible for those who do not have phones or cannot communicate well over the phone
    - Not used by those who think there is a stigma connected to public transportation use
    - Public transportation currently not available for sex offenders, even though they have health needs

Public taxis were viewed as a welcome addition to the community

- But are not affordable for frequent use, especially by the very poor

The discussion of transportation needs also included several suggestions for ways to help address transportation problems:

- Address the lack of convenient services by:
    - Coordinated effort by local churches to provide volunteer drivers to assist with transportation for needy individuals
    - RIDES administration has been responsive to past community needs and should be engaged in discussion of how to address the need for expanded services
- Encourage community leaders (such as teachers) to use public transportation to reduce the stigma associated with its use

PUBLIC HEALTH DEPARTMENT SERVICES AND SERVICE COORDINATION

… I think a health department … would be good to have everyone under one umbrella. Because right now we're kind of scattered all across the county or counties to refer services. And it would be nice if we could just put it all under one roof and say go here and you can get skills training, medical, (apply for) WIC, or you can see the doctors. You know, I think we need that here. But instead, we've got providers all over the place and some people don't even know where these providers are or that you can refer to them because it's just so many different locations.

… they (other county) have a wonderful health department (with) coordinated services (and) all the extra programs … WIC, immunizations, etc. …To be able to go to one place … one-stop shopping where they don't have to get 10 different appointments to get 10 different things done.

Richland County does not have a public health department, and the need for a health department and the services that could be provided by a health department were discussed in every focus group session. While there appeared to be a general consensus that a health department would be beneficial to community health (was needed), some participants stated that most of the services provided by health departments were already available either locally or from other providers in the region. There was also a discussion of the difficulty of providing funding for a health department at a time when health departments in neighboring counties were reducing staff and services due to a lack of state funding support. Several groups discussed the potential for developing a multi-county public health department as has been done in other regions of the state.

Participants identified needed services that could be provided by a local health department:

- Vaccinations/immunizations
- TB clinic
- Food/sanitation inspection
- Pest/vermin education and control
    - Bedbugs and head lice
    - Mosquito habitat regulation/enforcement
- Sex education, family planning services, STD testing/prevention
- Tobacco Quitline; smoking cessation
- Regulation/code enforcement for garbage, onsite wastewater, other environmental threats
- Health education for chronic health conditions
- Sewage/wastewater regulation/inspection/enforcement
- Regulation/inspection of rental housing
- Regulation/inspection of food safety in restaurants
- WIC program – food distribution, breast feeding assistance, new mom mentoring

Discussion also focused on the central role of public health facilities:

- Many services under the same roof; more effective "one-stop-shopping", especially for those who have multiple health care and social service needs, and/or lack personal transportation
- Health departments often play a coordinating role in optimizing services across sectors and regions

HOUSING AND HOMELESSNESS

We <u>had</u> a homeless shelter ... that served 8 counties but now because of funding is only open for domestic abuse individuals. No housing, no homeless program, so we get a lot of people who, their symptoms get worse because of the stress of that. And (because) it's better than being on the streets, they come to the hospital ... because they are going to get 3 hot (meals) and a cot and it's a good safe place to be. You can't say "You're lying to me", or whatever, and then when they leave, it's like, where do they go? And if they aren't on disability they can't go to a group home or a shelter care home.

... a lot of the people don't even have ovens or stoves; they may only have a microwave or electric skillet, the poverty level is beyond belief unless you've been in there to see it.

We have identified at least one-hundred and forty kids (in the school district) for the year so far and by the end of the school year we will be probably be close to two-hundred students that are identified as homeless.

Housing is a problem with low income families ... I talked to a girl yesterday ... they have a bug issue, live in a trailer park and the landlord is not going to fix it ... we have a family who's attic caught on fire ... He (landlord) boarded up the attic and they were still living in the home. They had space heaters and it was a very cold winter ... All of the plumbing froze. So trying to get

resources to help that family. What you hear is that I'm sorry, they wrote down that the land lord is not responsible. They end up moving and then the land lord patches things back up and then rents out to the next person. It irritates me.

Group discussions of housing needs centered on two different topics. The first focused on those issues related to the obstacles to providing housing to those who are homeless, mentally ill, unemployed and/or in financial distress. The second topic of discussion was the need to improve the poor quality of the low-income rental property in the region, and the connections between inadequate housing and health and mental health in the community.

The lack of safe, affordable low-cost housing was a serious concern and was discussed at length in most of the groups. The rental housing stock was described as unregulated, unsafe, and operated by "slum lords". Problems with housing included: overcrowding (multiple families in one house/trailer), infestation of bedbugs and other pests, contamination from past drug activities, and over-charging. The impact of inadequate housing or homelessness, on students, the mentally ill and those just released from treatment and incarceration was described as a major obstacle to improved health.

Housing issues that were discussed included:
Shortage of affordable, low-income housing

- Low-income market is dominated by "slumlords"
- Inadequate access to rent and utility assistance programs
- Homeless students at high school and community college
- No public housing for convicted felons and drug users (complicating rehabilitation)
- 12 month waiting list for senior housing

Unsafe Low-income housing

- Rental housing is (reportedly) unregulated in Richland County
- County does not have housing inspectors
- Infestations of bedbugs, mosquitos and other pests
- Lack adequate heating/cooling systems

Inadequate housing has serious health implications

- Inadequate utilities result in poor sanitation and nutrition
- Increased stress on vulnerable populations; worsens existing health/mental health problems
- Mold and filth contribute to asthma
- Stigma of homelessness has mental health and social welfare implications

COMPREHENSIVE COORDINATION

AND IMPROVED AWARENESS OF LOCAL RESOURCES

I feel like part of the problem is, there are so many resources out there (and) I'm in healthcare and even I don't know (that) we have these resources ... it's like the word just doesn't get out ... if people just knew (about) these resources and what they are ... (they could use them).

We want to go to where we can get the biggest bang, the shortest amount of time, quickly get in there, all the resources we could possibly get ... one of the things we need to think about as a community is how can we combine our services so that it would be a one-stop shop for some of these services. Instead of having to go here and there ... (for example) with the new moms, they go for their well-baby visit and ... (they could also get) education (on how to be a) new mom, breast feeding support, whatever (else) they need.

... an idea that the ministerial association has just been throwing around recently and ... that really wouldn't cost any money, is more collaboration of the non-profit organizations in town .... I think that would go a long way to solving a lot of these problems or at least acknowledging the problems that exist and coming up with solutions for them.

I think a way to address the needs is to have a resource coordinator, because we do have resources. Someone that can say here is the issue, we can talk about it, here is this (resource).

All of the focus group sessions included a discussion of the need to create greater awareness of the many resources that already exist in the region (*see Resources section below*). Several participants expressed surprise about the availability of some of resources that were discussed during the focus group sessions.

There was also an insistence that the community could benefit greatly from the collaboration of the numerous agencies, organizations, and resources in the region. Participants offered suggestions on the kinds of interactions and alliances that might be possible, as well as on the potential benefits of new/collaborative organizations. The importance of this desire for more collaboration was observed by the length of time that many of the participants remained in the room following the conclusion of the focus group session so that they could continue their discussions. In one group, several participants thanked the focus group team for creating the opportunity for community dialogue.

Observations and suggestions in regard to the need for resource coordination/collaboration included:

- Monthly meetings of resource agencies to discuss and address issues, and to make community members aware of the many services that are available in the area
- Ministerial alliance could improve coordination and interactions between parishes and community agencies/organizations
- Improved networking between county-level organizations; explore potential for a multi-county public health organization to provide services to counties without health departments
- Explore the use of a “case management” approach by health providers/agencies to the application of resources to address health/community problems
- Greater coordination of health and social welfare providers to create a full range of comprehensive services (i.e., from disease prevention to treatment to post-care follow-up) as well as the benefits of providing all these services at a single, easy to access, location
- Networking of regional health care providers to share needed services (especially psychiatric care providers) across the region

- Collaboration of health care and regional employers with public transportation managers to coordinate transit services and provide timely transportation of patients and employees to appointments and employment sites throughout the region throughout the day
- Need to develop a community mission statement and goals through interaction of all community resource providers

OTHER HEALTH NEEDS/ISSUES

Numerous other topics were discussed during the focus groups sessions that, while important, did not rise to the level of major themes. However, two other topics received considerable attention, and while not included with the major themes (above) also merited attention in the discussion of community health needs.

FUNDING SUPPORT

Our critical need (issue)... is the state funding cuts. We have many ... chronic(ly) mentally ill patients that are suddenly without any kind of planning, (and) without a provider, so they are going without refills on their medication ... without their medication it's causing an overflow into the court system ... Every county around here has lost their providers.

The one thing I would like to mention is the state of the affairs in Illinois, and the lack of a budget ... you have agencies that are operating at minimal capacity, (with a) skeleton crew, so it is completely effecting every aspect of social services, medical care, everything.

I don't think the counseling situation will be solved with the state's budget. This has been going on for a long time. It started (in) 2007. It (is) just slowly dying and (has) gotten worse.

The impacts of inadequate funding, and in particular, the current lack of a state budget, were discussed in all of the sessions. Focus group participants cited numerous examples of health, mental health/substance abuse, education, housing and social welfare programs and agencies that had been forced to close or reduce staff. The effect of these reductions on community health and welfare were also a topic of discussion in several of the group sessions.

Examples of the impacts of inadequate funding cited during group discussion included:

- Reductions in staff and services at specific organizations
    - Southeastern Illinois Counseling Center
    - Stopping Woman Abuse Now, Inc. (SWAN)
    - County health departments
- Funding cuts to specific programs
    - Sexual Assault and Family Emergencies (SAFE) program
    - WIC - Special Supplemental Nutrition Program for Women, Infants, and Children
    - Tobacco cessation programs
    - Mental health services (generally)
    - Illinois Early Intervention Program

    - Community college programs for low-income students
- No funding source for specific needs
    - Medication funding assistance for the poor
    - No funds available to establish health department

ORAL HEALTH/DENTAL CARE

We are finding now (that) dental is a big, big problem.

… 4-5 patients a week show up in the RMH Convenient Care, adults who are underinsured or (have) state insurance, adults with abscessed teeth, rotting teeth, that cannot go anywhere, there is nowhere for them to go so they are coming … (into the) clinic, just because of the pain … just to get an antibiotic. Then (the) staff is spending an hour or so on the phone calling (other providers) just trying to find someone who will take them.

Discussions focused on the inadequate number of dental care providers in the region, including specialist providers, such as oral surgeons and pediatric dentists; the lack of understanding of good dental hygiene by residents of many communities; the problems of finding access to dental services and payment sources for the poor; and the health and financial implications of poor dental health for individuals and the community.

Need better awareness of dental hygiene

- Complete lack of awareness of hygiene among some parts of the population
- Impact on oral health of cigarette and methamphetamine use

Access to care

- Too few local dentists
- No affordable care for poor/public aid
- No access to emergency oral surgeon
- No local access for “special needs” children
- Need “walk-in” care at ambulatory clinic

Consequences of poor dental care

- Self-medication of dental pain with drugs/alcohol
- Poor dental health impacts general health (infection, nutrition, etc.)
- Lack of routine dental care results in more expensive emergency room care

“PREVENTABLE” COMMUNITY HEALTH CONDITIONS

I think we are overweight. America is overweight … This is preventable. That’s education and … social issues. Its marketing and fast foods and schedules and busy-ness and convenience. It’s a matter of refocusing on the concept of what a healthy lifestyle is and what quality of life is. That is something that could easily be addressed.

... good jobs are extremely important to a healthy community. It provides ... the individual with a sense of value, provides you a way to provide ... for your family. I think that's important.

The parents need to be educated better so that they can educate their children. I think it is ... a trickledown effect ... if the parents aren't educated, then their children start falling into their footsteps. ... There is no one to help them with homework. There are second graders ... that are already above their parent's level of learning. How do you help with that?

Why are they not parenting well? Because they are drug addicted, alcohol addicted. They were teen parents and now their children are old enough to be left on their own and they are forcing them to be more independent when they shouldn't be independent. And making choices that they shouldn't be making. How do you go back from that? What causes them to be drug dependent or alcohol dependent? Where did that start? You just keep following the circle.

... a lot of these people ... are the product of multiple generations with the same thought that this is what their life is supposed to be. ... you talk to some of these kids and you say what do you want to do when you grow up, what do you want to be, and what do you want to do in 5 years, and their goal is just for the next day, not for a year from now ... they know there is no one that cares about them. They voice that there is no one that cares about them so why should they care about themselves.

Anything tobacco related. COPD. There needs to be more tobacco education.

Following the discussion of the health needs of the community, focus group participants were asked to identify those health conditions in their communities that would respond to preventive strategies. Discussion in most of the groups focused on familiar "chronic disease" conditions and the difficulty of educating and motivating those suffering from these conditions to alter their behavior in order to improve their health.

Two other themes emerged in regard to prevention. There was considerable discussion in all of the focus groups about the cyclical and multigenerational nature of poverty, addiction, poor health and inadequate education. Participants acknowledged the extreme difficulty in breaking this cycle of multigenerational behavior to prevent its continued impact on health and social welfare conditions in the community.

The second common theme throughout all of the sessions was the need to develop health care resources that can respond to problems in a timely manner, preventing the worsening of health conditions, or even the accumulation of other health problems. This was most frequently discussed in reference to mental health treatment, where early intervention efforts can prevent increasingly severe symptoms, more expensive treatment, and interactions with law enforcement and the court system.

Focus group participants identified many conditions that could be addressed through "preventive"

means as well as some of the socioeconomic factors that contribute to poor health:

- Asthma

- Child neglect
- Substance abuse/addiction (drugs/alcohol)
- Communicable diseases, especially in children
- Congestive heart failure
- Diabetes
- Smoking and smoking-related diseases (COPD, emphysema, bronchitis)
- Obesity and childhood obesity
- Unplanned pregnancies, teen pregnancies, STDs
- Food borne illness
- Acute mental health crises
- Health issues caused by inadequate housing (and exposure to mold, bedbugs, head lice, etc.)
- Deterioration of health issues caused by treatment delays linked to the lack of medical transportation
- Inadequate knowledge of most basic health literacy and behaviors (e.g., dental hygiene, child care, addiction, etc.)
- Health and mental health issues worsened by poverty and the lack of economic opportunity

The prevention discussion also noted opportunities to implement prevention activities:

- Health education programs
    - Smoking cessation
    - Dietary and medication compliance
    - Sexuality education and parenting classes
- Health department (or other agency) intervention
    - Vaccinations/immunizations
    - Housing regulation, inspection, and enforcement programs
- Psychiatric care
    - Medication management to ensure correct administration and guaranteed access
    - Prompt intervention using telehealth connection to providers
- Transportation alternatives
    - Volunteer drivers from local churches
    - Organized effort to better communicate medical transportation needs to regional public transit provider

COMMUNITY RESOURCES

… people come to this county for healthcare … There are (other) good resources as well, such as, extra-curricular activities. If you want to do something, if your kids want to do something, you can be busy every night. If there is an issue with a family, the community pulls together. It's got a good community/support system. There's a lot of positives.

I don't think people know what's out there … we tend to focus on all the negatives of, we've got kids who are doing this, we've got adults who are doing this, we've got repeat offenders, but yet

we've got the services out there. Let's focus on what we've got and get those people into those programs. I'm not saying that we can't improve but I just think there's lack of knowledge (about resources).

I think we have a great college system and I think we have a great hospital here. Like everyone

else, I think we have an excellent school district.

I think the best thing about living here is for a small community we do have a lot of resources available and its' a very close knit community.

During the introductory statements to the focus groups session, many of the participants noted that the region had an abundance of good will and community health resources. This was borne out during the discussions, as participants identified a large number of organizations, programs, interventions, and services in the immediate region. There was considerable consistency in the reporting of resources across groups, and many of the resources listed below were mentioned in every session.

These resources focus on a wide variety of community needs—access to health and specialist care, health education, health and mental health screenings and referrals, feeding and food assistance programs, family and parenting education, child care and after school programs, housing and financial assistance.

A considerable number of the community resources that were identified were based at Richland Memorial Hospital or were part of hospital outreach services. Other programs are provided by local schools, faith-based and community groups, and government and grant-funded organizations.

The discussion of community resources in all of the groups also invariably included concerns that many of these resources were in danger of being suspended or discontinued because of the loss of their sources of funding. The Illinois State budget standoff that was occurring at the time the groups were being conducted was of particular concern and was discussed in each of the focus group sessions.

Group participants identified a considerable number of health-related resources:

RICHLAND MEMORIAL HOSPITAL-BASED RESOURCES

- **"Convenient Care" ambulatory clinic**
- **Inpatient mental health services**
- **Home Health services**
- **Visiting "specialist" physicians from other hospitals**
    - **Cardiologists**
    - **Podiatrist**
- **Pulmonary rehabilitation**
- **Cancer care and chemotherapy**
- **Health screenings combined with health education**
- **"Transitional care", appointment scheduling and follow up services that ensure continuity of care**

- **Physician tuition reimbursement program to attract local students to become medical professionals and remain in the community**
- **Created internet access for students by paying for and sharing the high-speed cable brought into meet hospital data access needs**

RICHLAND MEMORIAL HOSPITAL OUTREACH RESOURCES

- **Health education**
    - **Community seminars**
    - **Tobacco cessation program**
    - **Sexuality education in the schools**
- **Support groups**
- **Outpatient outreach for the elderly**

COMMUNITY PROGRAMS/SERVICES

- **ABC early childhood intervention program (0-3 year old) (in conjunction with Head Start)**
- **Big Brothers/Big Sisters – approximately 130 mentors**
- **Birthright – adoption service; mentoring for young mothers**
- **"Family Matters" (Effingham-based) – deals with special population education issues**
- **"Fifth Block" after school program (healthy food/physical activities/skill development)**
- **"Safe Link" cell phone service for the poor**
- **Screening Assessment Support Services (SASS) mental health program for adolescents**
- **Sexual Assault and Family Emergencies (SAFE) program**
- **"Senior Renewal" outpatient psychiatric care for elderly (in another county)**
- **Tobacco quit line**
- **WIC - Special Supplemental Nutrition Program for Women, Infants, and Children (through other County Health Department)**
- **Walmart program to donate clothes and gift cards to students**

OTHER COMMUNITY HEALTH RESOURCES AGENCIES AND ORGANIZATIONS

- **Good Samaritan - food pantry and financial assistance**
- **One Hope United – housing assistance, case management**
- **Embarras River Basin Agency**
- **Hospice – bereavement programs**
- **Marion Eye Center – assist with eye care and glasses**
- **Masters Hands:**
    - **Food pantry/"back-pack" food program for students/summer feeding program**
    - **AA/NA programs**
- **Stopping Woman Abuse Now, Inc. (SWAN) domestic violence resource center; legal help; group counseling**
- **Southeastern Illinois Agency on Aging (other county)**
- **SIU School of Medicine – telemedicine/psychiatric services in other county**
- **Southeastern Illinois Counseling Center**
- **Sheriff's Department**

- Veteran's Administration
    - Home health services for veterans
    - Telemedicine services between Marion VA and Vincennes Clinic
    - "Millennium Bill" (financial assistance to help veterans pay medical bills at non-VA facilities)
- Weber Medical Clinic (FQHC)
    - Licensed social work counselor at FQHC who takes public aid payment sources
    - Pediatric dentist (public aid only)
- Specialized children's medical care (through UIC clinic)

SCHOOL BASED/RELATED RESOURCES

- Local schools
    - School feeding programs (60% eligible)
    - Clothes for homeless/needy students: "Fall Kids Ball"
    - Backpacks (Title 1 schools)
    - Health education
    - School supplies from Regional Office of Education
    - School nurses and counselors
    - Parental education programs through the elementary schools
    - "Sky Work" education program
    - Illinois State Board of Education, "Prevention Initiative" program/grant
    - Illinois Early Intervention Program - provides services in the home to children with disabilities, birth to age 3]
- Olney Community College
    - Serves as a link to educational and social service resources for students and community members
    - Training local students for health careers, including nursing

VOLUTEER RESOURCES FROM LOCAL CHURCHES

- Food, clothing, soaps/shampoo for needy
- Volunteer transportation services

TRANSPORTATION

- RIDES Mass Transit District
    - Provides scheduled and on-demand services
    - Used to get to jobs, medical appointments and shopping
- New private taxi service in Olney

PUBLICATIONS

- 2010 Richland County Resource Directory (possibly out-of-date) (available online at: http://www.ercu1.net/common/pages/DisplayFile.aspx?itemId=771112)

Our hospital ... started a program where we're trying to recruit within so to speak and we have local people that we've offered tuition assistance for them agreeing to come back and work for us ... we've tried to keep some of our talent that we already have here and as we know the human connections, well I'll go to this person because he went to school with my brother or my son or what you know ... as far as building that trust, rapport, very important with creating a compliance atmosphere for our young and for our old.

... they work with us in providing some sex-education programs ... RMH s(staff) will come in and

present (education on) that (topic) ... we are trying to be proactive at preventing ... teenage pregnancy and disease.

... they bring cardiologists from Evansville ...they have two or three. They have more providers that come out.

... our residents (people) don't use the ER nearly as much as they used to because they're utilizing the Convenient Care.

We offer meals from the hospital to patients who can't cook or don't know what they need to cook or whatever. They can come pick up pre-made meals ... the dietician works with the patients who are on special diets. Our department helps coordinate that effort.

...from working at 4 different hospitals, (over many years), I can honestly say RMH is more involved in the community than most. I really can.

They have the health fair. I know it's well-attended. It helps to educate and inform.

... I know that (RMH is) very active with provider recruitment and also ... has entered into a clinical affiliation agreement with (another health care provider) and that should eventually help expand the provider base that we have here at the hospital ... (RMH has) been very good over the last several years with recruitment of new physicians.

We have initiated several outreach efforts in the past few recent years. Especially we were already talking about what we do in the school in regards to teen pregnancy prevention and that type of thing. We also go in to industry and businesses in the community and we offer lab work, screenings for them for their employees also. Educational programs that they are interested in having providers come and speak with them about different types of health issues.

We are involved in several health fairs or health initiatives that business industry and also even the school district has for their employees where we go in and that we are involved in that. We also try and sponsor any type of activities in the community that help promote health related goals like triathlons, 5ks, anything where we can provide financial resources to help sustain those types of programs to support healthy living. .... The hospital provides a lot of volunteers for

that. And through those efforts, the community has been able to build new sidewalks and bike paths. The hospital is very active in that.

… (RMH is) running a chronic disease management program … So that was COPD, CHF, diabetes, and that … now (they've) started going into the home … (it is for) those patients who don't qualify for home health but need someone to walk in and open your cabinet doors and say, "Hey you know those Ramen noodles are high in sodium" That kind of thing because they don't know. So it's on a small scale right now, but we are just in the very early, early stages … it's been really successful so far, … it's really fun right now and it's really been effective … the COPD (and) diabetes education group … just started … they meet monthly with area diabetics and COPD patients. And clinicians can refer patients.

The final goal of the focus group sessions was to assess the awareness of the programs and services that Richland Memorial Hospital has developed to respond to community health needs. While the original intent of the discussion was to specifically identify programs that responded to the needs that had been identified during the previous Community Health Needs Assessment (2013-2016), participants appeared to take great satisfaction in describing all of the RMH health-related initiatives that they could.

Some of the most frequently mentioned Hospital initiatives were the development of an ambulatory care, "Convenient Care ", facility, the development of the Chronic Disease Management program, and the large variety of health education programs and activities the hospital staff conduct in the schools and in the community.

Richland Memorial Hospital programs and services identified by focus group participants included:

IMPROVED ACCESS TO HEALTH CARE FACILITIES AND SERVICES

- RMH Convenient Care Clinic
    - Very needed and highly valued community health care resource
    - Community desires expansion of access and services
- Agreements with other hospitals/organizations to bring specialty physicians to the region on a regular basis, including heart specialists
- Pulmonary rehab center
- Inpatient mental health services
- Relationship with Clinics in Newton and West Salem
- "Health Desk" & "Transition Care" scheduling and follow-up appointment program to ensure continuity of care

OUTREACH PROGRAMS

- Business and industry workplace screening/education programs
- In-home COPD program
- Promotion of city bike and walking paths
    - Support/promote healthy living activities in the community (runs/walks) Both financial support & volunteer time

- Role of RMH and outreach staff in providing health screenings and community health education information
    - Health seminars
    - Health Fairs
    - Programs at local businesses
        - Lab work
        - Screening
        - Health education programs
    - Staff development programs
    - Chronic Disease Management Program – Diabetic (and other) support groups
    - Health education in schools
        - Sexuality education (including STD prevention)
        - Pregnancy prevention
        - Screenings/education for District employees
- RMH helped bring school counselors to Lawrence Co. school (removed when they lost funding)

SUMMARY

The information 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 the Richland Memorial Hospital Community Health Needs Assessment. Although effort was taken in obtaining a wide variety of opinions, these views may not reflect all possible needs, solutions and resources within the community. The quotes were presented in a manner to ensure participant anonymity and describe the themes which were discussed.

APPENDIX

Four documents are included in the appendix:

1) **Focus Group Script and Questions**
2) **Participant Consent Form**
3) **Participant Survey Form**
4) **Participant Demographics Table**

FOCUS GROUP SCRIPT AND QUESTIONS

"Welcome and thank you for participating in this focus group meeting today.

We appreciate your time and commitment to improving the health of your community.

We will spend some time today identifying the health care concerns of the community and discussing the factors that influence people's health.

During our discussion, we would like you to consider not only those aspects of health care that are directly related to hospital's mission, such as maternity care, breast cancer prevention, health screenings and education, but also other important health concerns that are not directly related to the hospital, such as, drug and alcohol use, mental health needs, or safe environments in our homes, workplaces and community.

We will also spend some time today identifying those resources that are available to address the health needs of the community.

The purpose of the meeting today is not to judge or evaluate anyone's opinions or experience, but is rather to collect input from a broad range of community members in order to see if there is some general consensus on the most important health problems in the community and perhaps ways to address these problems.

Your input will be used to help to identify and prioritize needs, create solutions, and plan for services in the future.

So let's begin with introductions..."

1) **Please tell us who you are, the name of the town that you live in, and one reason why you really like living in your community.**

2) **What would you say are the most pressing health needs in your community?**
   What do you think are the three most serious health care *needs* in your community?
   Which members of the community have these needs?

3) **What health-related problems in your community could be prevented?**
   How?

4) **What resources and services are available in the community to address these needs?**
   What role does Richland Memorial Hospital play in addressing the health care needs that have been identified (in Questions #2 & #3)?

During the previous (2013) RMH CHNA the three most pressing health care needs identified by community members were:

Mental health - especially in terms of the lack of access to psychiatric services, such as outpatient medication management and behavioral treatment for children and families, as well as the social impacts of untreated mental illness, such as substance abuse, poverty, homelessness, and child abuse and neglect;

Lack of access to health services – particularly the need for more primary care providers, specialty medical services that are closer to home, and dental services, as well as many of the public services that are often provided by public health departments, which do not exist in Edwards or Richland County;

And

Chronic disease – particularly those health conditions that are of long duration and slow progression that can be prevented or controlled by healthy life-style changes (such as diabetes, high cholesterol, high blood pressure)

5) Can you think of any programs or services that have been initiated by Richland Memorial Hospital in the past 3 years that are addressing these health care priorities? (repeat: mental health, access to services, and chronic disease)

Facilitators: [Summarize the main themes around concerns and potential solutions]. Ask for agreement and comments from focus group participants.

Wrap up question:

Thinking about the discussion that we have had here today ...

What is your vision of a healthy community?

What does a healthy community and the people who live there look like?

"Thank you for your time."

Richland Memorial Hospital Community Needs Assessment

Informed Consent to Participate

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

I understand that the purpose of this study is to collect information about the concerns of the community related to health care services and other health issues, and also to identify resources which are currently available in the community.

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

I understand that my responses will be digitally recorded, and that these digital files will be transcribed and stored, along with the transcriptions, in a locked file cabinet. After 90 days, these files and transcriptions will be destroyed.

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

I have read the information above, and any questions that I have asked have been answered to my satisfaction. I agree to participate in this activity and know my responses will be digitally recorded. I understand that a copy of this form is available to all participants upon request.

_____ "I agree to have my focus group responses digitally recorded." ***(please check)***

Participant signature Date

_____ _____

Participant Survey

Thank you for volunteering to assist Richland Memorial Hospital with its Community Health Needs Assessment.

We are asking each participant to complete this brief survey. The purpose of this survey is to ensure that our analysis includes input from a broad representation of community members. Your responses are completely confidential. These surveys will be destroyed as soon as summary statistics from all of the focus groups have been collected.

Please circle the categories below that are most applicable to you.

Gender:

Male
Female

Year you were born:

Before 1951

Between 1951 and 1975
Between 1976 and 1985
Between 1986 and 1995
After 1995

What county (ies) would you say you represent as a focus group participant:

Clay

Edwards
Jasper

Lawrence
Richland

Other *(name)*

How would you describe your race/ethnicity:

White

Black

Asian

Hispanic

Native American

More than one

Other *(specify)*

How would you describe your level of formal education:

Some HS

HS grad

Some college

Finished college (AA/BA/BS)

Some graduate school

Finished graduate school

Other *(describe)*

The category that best describes your current occupation is:

Business/finance/banking

Clerical

Education

Medical

Mining and/or manufacturing

Retail/wholesale

Trades

Retired

Currently not working, but not retired

Other *(describe)*

Thank you!

PARTICIPANT DEMOGRAPHICS SURVEY SUMMARY TABLE

Characteristic	*Number*	*Percent*
Gender		
Male	19	33%
Female	38	67%
Age Group		
65+	7	12%
41-64	38	67%
31-40	9	16%
21-30	3	5%
<21	0	0%
County (can have multiple)		
Clay	12	21%
Edwards	7	12%
Jasper	7	12%
Lawrence	9	16%
Richland	52	91%
Other * (*See notes below)*	4	7%
Race/Ethnicity		
White	57	100%
Black	0	0%
Asian	0	0%
Hispanic	0	0%
Native American	1	2%
More than one	0	0%
Other	0	0%
Education		
Some HS	0	0%
HS grad	4	7%
Some college	6	11%
Finished college (AA/BA/BS)	24	42%
Some graduate school	2	4%
Finished graduate school	21	37%
Other	0	0%
Occupation		
Business/finance/banking	4	7%
Clerical	3	5%
Education	9	16%
Medical	20	35%
Mining and/or manufacturing	0	0%
Retail/wholesale	0	0%
Trades	0	0%
Retired	4	7%
Currently not working, but not retired	1	2%
Other ** (*See notes below)*	18	32%

Notes: 57 of the 58 participants filled out the survey. Some categories may not sum to 100% because of multiple responses. *44 work primarily in one county, 12 work in multiple counties, one did not respond, “Other” counties that were listed include: Edgar, Effingham, Fayette, Marion, Shelby, Wabash, Wayne, and “Others”

** Other occupational categories included: Assisted living professional, Clergy/ministry/pastor (5); Housing professional (2); Law enforcement; Social work/social services (5); School nurse; Transportation professional; SX/AS/AD; VA