2019 Community Health Needs Assessment

Good Samaritan

CPAs / ADVISORS

blue

September 2019

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LETTER FROM THE CEO

To Our Community Members:

Good Samaritan Hospital is committed to providing high quality healthcare and exemplary customer services. The hospital is a community based hospital located in the heart of Vincennes, Indiana. A board governs the hospital and ensures that the strategic direction of the hospital is met. The organization consistently meets the health care needs of the community and the people in which it serves.

Our goal with the attached Community Health Needs Assessment (CHNA) is to better understand the range of issues affecting community health needs including local healthcare services provided and any gaps that may exist in meeting those needs. Moreover, through this assessment process, report and subsequent actions, we hope to strengthen the understanding and working relationships among and between the hospital and the other various health care, social service, and community providers that all play a role in shaping the health status of our community. In the new era of population health management, it will be imperative that various providers and organizations work together in a collaborative fashion to better serve patients and provide care and service that is more focused on prevention, health promotion and wellness.

The significance of better understanding our community's needs was highlighted with the Patient Protection and Affordable Care Act requirements passed on March 23, 2010. New requirements for tax-exempt hospitals were added to the Internal Revenue Code mandating hospitals to conduct a community health needs assessment every three years and to adopt an implementation strategy to address applicable needs detected during the assessment process.

During 2019, a CHNA was conducted by Good Samaritan Hospital for the region we serve. We will be developing an implementation strategy for the applicable needs addressed and the results will be summarized in a separate report approved by Good Samaritan Hospital and its Governing Board.

We are pleased to present this comprehensive CHNA which represents a comprehensive assessment of health care needs in our community. We look forward to working with you and others in the community to optimize community health and continue meeting Good Samaritan mission of providing excellent health care by promoting wellness, education and healing through trusting relationships.

Chief Executive Officer

September 2019

GOOD SAMARITAN HOSPITAL'S:

Mission: Provide excellent health care by promoting wellness, education and healing through trusting relationships.

Vision: To be the regional center of excellence in health care to support the communities we serve.

P.R.I.D.E. Values: Patient • Respect • Integrity • Dignity • Excellence

Promise: We promise to treat you like family by delivering compassionate, high-quality care throughout your journey.

**Community Health
Needs Assessment**

EXECUTIVE SUMMARY

On behalf of Good Samaritan Hospital (the "Hospital"), a community health needs assessment (CHNA) was conducted in 2019 primarily to identify the major health needs, both met and unmet, within the surrounding community. The community's geographic area is comprised primarily of Knox County (Pop. 37,508), including the town of Vincennes, IN. The primary service area of the Hospital is Knox County, and its neighboring counties of Daviess, Gibson, Greene, Pike and Sullivan and the Illinois counties of Crawford, Lawrence, Richland, and Wabash.

The primary objectives of the CHNA were to: 1) identify major health needs within the community in an effort to improve the health of the area's residents and facilitate collaboration among local healthcare providers, and 2) satisfy the federal guidelines within the Patient Protection and Affordable Care Act (PPACA) of 2010.

Data for this CHNA was collected from primary and secondary sources to identify key findings and gaps that may exist between health needs and services provided within the community. The method of collection for primary data were personal interviews. Several secondary data sources were reviewed and analyzed to identify key findings with strategic implications and for benchmarking of the Hospital's service area.

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

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

- Increasing substance abuse prevention, treatment and educational awareness,

- Increasing primary care physicians (Internal Medicine and Pediatrics) and specialty physicians,

- Improving Affordable Healthcare,

- Increasing the number of mental healthcare providers and professionals in the community, and

- Expanding transportation services to/from treatment services

Good Samaritan Hospital has identified the above needs for its community and prioritized them based on the order above. The section later in this report titled "KEY FINDINGS" will go through all of the health needs identified during the CHNA process.

ORGANIZATIONAL BACKGROUND

Good Samaritan Hospital

For more than 100 years, Good Samaritan has been a health care leader in Southwestern Indiana and Southeastern Illinois. Located in historic Vincennes, Good Samaritan is a 232-bed community health-care facility with over 1,900 employees and a commitment to delivering exceptional patient care.

History

In 1908, Good Samaritan opens its doors on February 8th. The 25-bed facility is the first county hospital in Indiana. Edith Willis became the Hospital's first superintendent starting in 1908 through 1944. Her staff included an assistant superintendent, a student nurse, a janitor and a cook.

In 1958, major renovations brought the number of patient beds to 221 and added state-of-the-art facilities for a laboratory and other services including physical medicine, radiology, and rehabilitation. Just three years later, The Knox County Hospital Association is founded and to this day, continues to play an integral role in the hospital's growth and development.

In 1984, Columbian Tower West is completed, bringing the number of patient beds to 342 and adding a new cardiology department and a modernized emergency room. 11 years after the completion of the Columbian Tower, the five-story Health Pavilion opens with the latest outpatient technology and a Women's and Infants Center.

As the county continues to grow, it is found that more renovations are needed, and in 2004, the two-story, 30,000-square-foot Same Day Surgery Center opens. It streamlines outpatient services and specializes in quick, less invasive surgical procedures. In the 100 years since its opening, Good Samaritan has continued to innovate, grow, and change. For its centennial celebration in 2008, the 25,000-square-foot Cancer Pavilion is completed. It centralizes a full spectrum of cancer care including radiation and infusion therapy in a patient-focused atmosphere.

In 2012 the groundbreaking for the BEACON Project (Building Excellence Around Communities, Opportunities, and Needs) is held and encompasses a 120-bed, five-story inpatient tower – a redesign of key health care service areas and an upgrade to the Hospital's engineering systems.

Since its opening in 1908, the Hospital's single building has become many to respond to the community's changing medical needs and the area's growth. But one thing has never changed — the Hospital's mission to serve. It is put into action every day by dedicated health-care professionals, employees, and volunteers.

Community Health Needs Assessment

Services

In partnership with area physicians, the Hospital provides a full range of medical services to meet the healthcare needs of the community it proudly serves. Services offered by the Hospital include:

- Behavioral Health
- Breast Care Center
- Cancer Care
- Cardiology
- Center for Wound Healing
- Community Health Services
- Convenient Care Clinic
- Diabetes/Welch Diabetic Education
- Ear, Nose, Throat
- Emergency Department
- Endoscopy
- Home Care Services
- Hospice
- Individual Membership Program
- Industrial Health
- Inpatient Oncology
- Laboratory
- Neurology
- Occupational Health and Acute Care Clinic
- Occupational Therapy
- Orthopedics
- Physical Therapy
- Podiatry
- Primary Care
- Primary Care Clinic / Patient Centered Medical Home
- Pulmonology
- Rehabilitation
- Respiratory
- Sleep Disorder Center
- Speech Therapy
- Surgery
- Trauma
- Urology
- Vascular and Thoracic Surgery
- Weight Loss Clinic
- Women's Health

SERVICE AREA

SERVICE AREA AND COMMUNITY OF THE HOSPITAL

The CHNA was conducted by the Hospital during 2019 on behalf of the approximately 37,508 (2017 US Census) residents of Knox County, as well as the patients served by the Hospital from neighboring communities. Additionally, the Hospital provides services to members of the bordering counties of Daviess (33,113), Gibson (33,576), Greene (32,177), Pike (12,365) and Sullivan (20,746) and the Illinois counties of Crawford I18,961), Lawrence (16,168), Richland (15,901), and Wabash (11,489). The total population of Knox County and the 10-county service area is just over 230,000.

The Hospital's primary service area includes Knox County which covers roughly 516 square miles, with the local economy and surrounding areas focused on education, transportation, and health services.

2017 Census data also reports that the median age in Knox County is 38.1. The median age for the United States is 37.4 years. The number of persons per household in Knox County is 2.36. The U.S. average number of persons per household is 2.6. Race in Knox County is as follows: 94.4% of residents are white, 3.0% are black, and 2.2% claim Hispanic Ethnicity.

There are 1,180 to 1 primary care physicians in Knox County. The Indiana average is 1,500 to 1. There are 1,856 to 1 primary care physicians in the entire Good Samaritan Hospital Service Area. The Indiana average is 1,505 to 1 and the Illinois average is 1,230 to 1.

The defined communities served within this report did not exclude the medically underserved, low-income, or minority populations who live in the below geographic areas. In addition, the report did not exclude patients based on whether (or how much) they or their insurers pay for the care received or whether they are eligible for assistance under the hospital facility's financial assistance policy.

**Community Health
Needs Assessment**

SERVICE AREA MAPS

The following map geographically illustrates the Hospital's community by showing the community zip codes shaded by number of inpatient discharges. The map below displays the Hospital's geographic relationship to the community, as well as significant roads and highways. Knox County (dark blue shade) has a total area of 516 square miles.
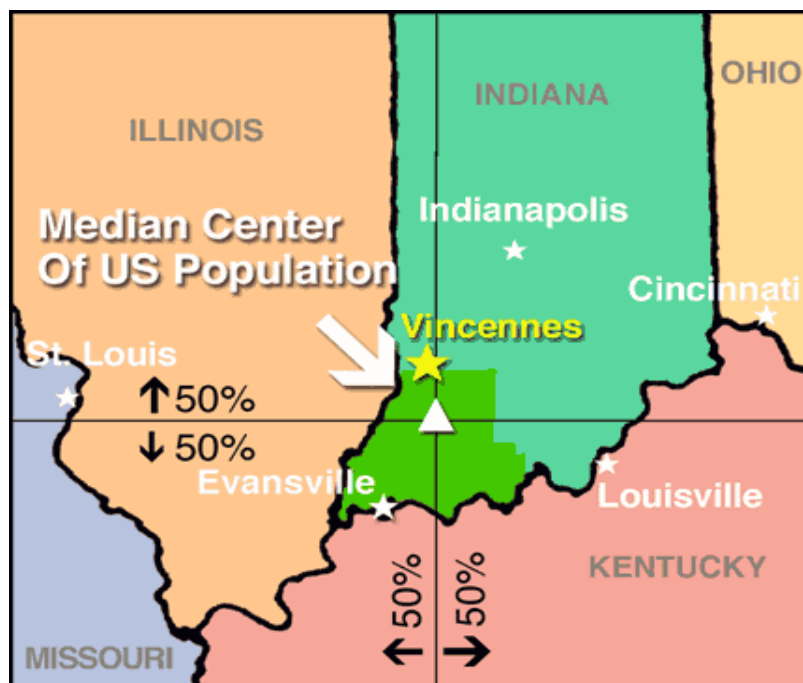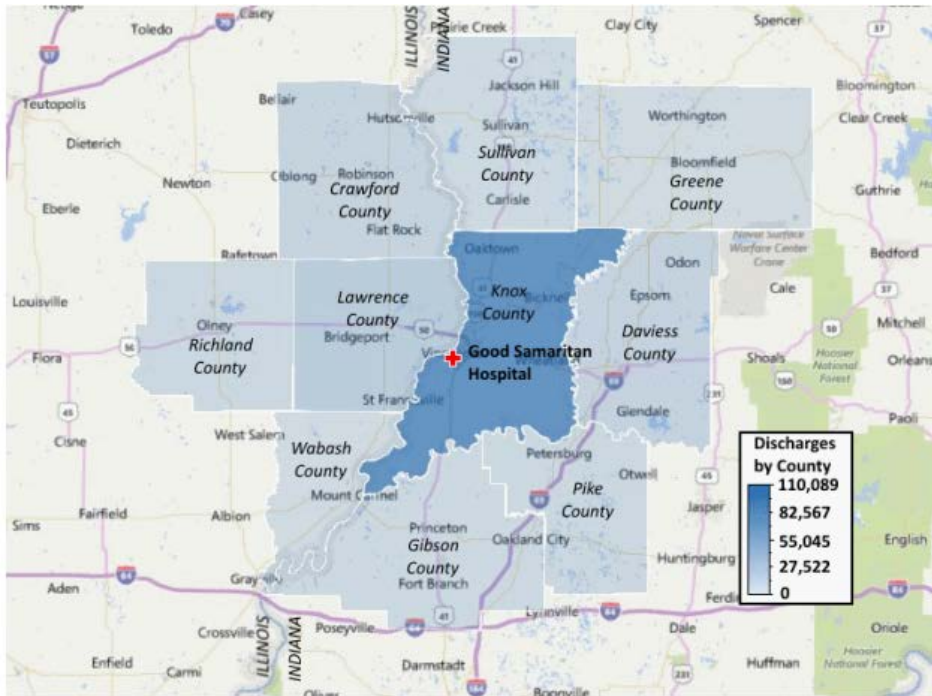
CONDUCTING THE ASSESSMENT

OVERVIEW

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

The CHNA requirements were effective starting taxable years beginning after March 23, 2002. On December 29, 2014, the Treasury Department and the IRS published final regulations for section 501(r) located in 26 CFR part 1, 53, and 602. The Hospital is licensed by the Indiana State Department of Health as a hospital facility. The hospital is also accredited by the Joint Commission, it is a verified Level III Trauma Center and Medicare Certified.).

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

COMMUNITY HEALTH NEEDS ASSESSMENT GOALS

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

- Community health needs,
- Quantitative analysis of needed physicians by specialty in the service area,
- Health services offered in the Hospital's service area,
- Significant gaps in health needs and services offered, and
- Barriers to meeting any needs that may exist.

Other goals of the assessment were:

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

EVALUATION OF 2016 CHNA

The list below provides some of the identified needs from the Good Samaritan Hospital's 2016 CHNA. An evaluation of the impact of actions that were taken, since the hospital facility finished conducting its 2016 CHNA, to address the significant health needs identified in the 2016 CHNA. Some of the results of the hospital's activities are listed below:

- **Adult Obesity / Diabetes / Cancer**

Good Samaritan also had Adult Obesity as a goal to be addressed in the 2019 CHNA. Subsequently, the hospital developed a food voucher program with the local Farmers Market and the Primary Care Clinic. Patients are able to redeem the vouchers for fresh produce at the Farmers Market each Saturday. Last year, in 2018 over $300 dollars of fresh fruit and vegetables were bought using vouchers. The program continued again this year in 2019.

Also, the "Walk with a Doc" program was developed and continues every Saturday at Gregg Park from 9am-10am. This is an opportunity for members of the community to meet with and discuss health related questions and concerns with Good Samaritan medical providers each weekend. During the winter months, the walkers go to Vincennes University Sports complex indoor track. The number of walkers varies anywhere from 6-25 each weekend.

Additionally, Good Samaritan has developed a "Weight Loss" challenge in collaboration with the Local YMCA and Community Health that is having a good impact on members in the community who are interested in understanding how important weight loss can be to their health.

- **Lack of Health Knowledge**

Good Samaritan had a goal to increase both access and awareness of health information and resources in order to enhance and expand educating their community. They have been successful in developing an evidence-based PowerPoint presentation on Heart Disease and Stroke. The action plan was to target a more diverse age group by partnering with Faith-Based organizations in the community. This will give the hospital an opportunity to educate 30, 40, and 50 year old persons on how they can lower their risk for heart disease, stroke, and diabetes.

Additionally, this also has raised awareness in in the service area, of the many services and free screenings provided by Good Samaritan Community Health. The hospital reaches people in all 9 counties of our region offering free health screenings from blood pressures to free lab draws for Hemoglobin A1c, lipids, PSA's, GFR/Creatinine, and more

The hospital has and continues to provide community education programming at both public and private organizations.

- **Drug Abuse**

As part of the goal to "Create Strategic Partnerships with Community Organizations", Good Samaritan was successful in partnering with area school systems to provide additional health and safety educational opportunities for students. In particular, they restarted the FATAL VISION impaired driving program at area high schools prior to their proms. The hospital has completed sixteen classes (324 students) at Lincoln High School, North Knox High School, and at Rivet High school. Also conducted a student survey to measure impact.

- **Physical Inactivity**

Good Samaritan had a goal to initiate and support both hospital-based and community-based programs which encourage physical activity. The following are programs that are given support:

- Active Living Workshop (State funded plan) has recently met and reviewed the Action Plan. Committees were selected to develop and implement the plan. The committees are comprised of representatives of the area Parks (city, county, Federal parks), area schools, Vincennes University, local YMCAs, Good Samaritan, the City of Vincennes, Vincennes Urban Enterprise Association.

- Plans include; walkable maps, signage to promote walking, artistic crosswalks and sidewalks, and Lester Square Park plan.

- Good Samaritan was also successful in partnering with the Vincennes Community School Corporation's Wellness Committee whose focus is to promote physical activity. The school system's Wellness Coordinator has invited a representative of the hospital to be on the School Health Advisory Council and they are working together.

• Poverty/Children in Poverty and Children in Single-Parent Households

- As part of the goal to "Create Strategic Partnerships with Community Organizations", Good Samaritan was successful in partnering with area FIT KIDS is a program teaching healthy eating and nutrition, plus the importance of physical activity. The program starts at the third grade level and continues with 5th graders, 7th graders, and 9th graders using age appropriate curriculum. It is an interactive program with many hands-on activities, games, and visual aids. Every school in Knox County participates in the FIT KIDS program. Community Health receives positive feedback regarding this program from students and staff alike.

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INFORMATION GAPS

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

The service area includes Knox and surrounding counties in Indiana and Illinois; the Indiana health ranking data for Knox County shows it ranks 65th in Health Outcomes and 62nd in Health Factors out of the 92 counties in Indiana. The surrounding county rankings are listed in Exhibit B on pages 37 – 42.

PROCESS & METHODOLOGY

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

Blue developed interview questions and a survey that would be the tools to gather information from key stakeholders in the community. Blue then conducted the conversations with community leaders as well as members of the hospital's medical staff or sent surveys that could be completed online or by paper. The community outreach data collection strategy was targeted at engaging a cross-section of residents from the community as discussed below. Once data had been collected and analyzed, meetings with hospital leadership were held to discuss key findings as well as refine and prioritize the comprehensive list of community needs, services and potential gaps.

PRIMARY DATA COLLECTION METHODS

The primary data was collected, analyzed, and presented with the assistance of Blue. Two methods of collection for primary data were used: 1) surveys and 2) personal interviews.

SURVEYS

A survey was developed by Blue and used as a method to solicit perceptions, insights and general understanding from community members who represent the broad interests of the community, including those with special knowledge of or expertise in public health. These individuals also represented the interests of the medically underserved, low-income, and minority populations of the community served. The survey "Community Input 2019" (see Attachment D) was made available via an online tool and in PDF format for multiple members of service area. A total of Eleven (11) surveys were returned for inclusion in this document.

The survey comprised ten questions in total. Community members were asked to identify the top three most significant health needs in the community. They were asked about their perception on the availability, health status, provider coordination, and barriers that exist. Additionally, the participants were given the opportunity to write in issues that were not listed. The results of the survey can be found in the Key Findings section of the report.

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PERSONAL INTERVIEWS

Personal interviews were conducted by Blue with a total of Eight (8) participants during August 2019, with each session lasting approximately 30 minutes each. These sessions were conducted with members from the communities being served by the Hospital including community leaders, health experts, public officials, physicians, hospital employees, and other health professionals and providers including those associated with the Hospital. Input was also received from the City of Vincennes, Knox County Drug and Alcohol Program, Community Senior Center, PACE Community Action Agency, and Knox County Health Department. The primary objective was to solicit perceptions regarding health needs and services offered in the community, along with any opportunities or barriers that may exist to satisfy needs. The Interview questions can be found in Attachment D of the report.

SECONDARY DATA SOURCES

Blue reviewed secondary statistical data sources including: Deloitte 2018 Survey of Health Care Consumers in the United States to identify health factors with strategic implications. The health factors identified w e r e supported with information from additional sources including US Census Quick Facts, County Health Rankings, and the Indiana Department of Health. In addition, hospital-specific data provided by the Hospital was reviewed. (See Attachment E for a complete list of citations.)

KEY FINDINGS

The following represents key findings generated from the data collection and analysis process:

PERSONAL INTERVIEW RESULTS

Responses to "Health and Quality of Life in Knox County"

- Good
- Good
- Good
- Fair
- Fair
- Fair
- Fair

Responses to "Has health and quality of life improved, stayed the same, or declined in past few years?"

All participants agreed that Knox County has improved to some degree. They all point to lack of primary care, substance abuse, and the need for more preventative measures as to how things can get even better.

- Declined
- Improved
- Improved
- Improved
- Improved
- Improved
- Declined

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Responses to "Are there people or groups of people in Knox County whose health or quality of life may not be as good as others?"

Due to different income levels and Insurance barriers, all participants agree that those in who are considered to be in poverty, have a lower quality of life.

- Yes
- Yes
- Yes
- Yes
- Yes
- Yes
- Yes

Responses to "What are the most critical health and quality of life issues?"

- Mental Health and Substance Abuse
- Improving nutrition – This helps in so many areas, such as; Obesity, Cardiovascular disease, etc. Can create healthier minds and bodies.
- Drug Abuse
- Cardiac Issues
- Meth Addictions and Diabetes
- Unsure/Chose not to answer
- Obesity/Opioid Abuse

Responses to "Has access to health improved in last few years?"

- No, has declined in recent years
- Improved; It's better due to Good Samaritan's efforts, ER wait times are down significantly, dialysis Center in the community, and the cancer Center in the community
- Yes. Due to Good Samaritan's efforts with community health offerings, new facilities and new equipment.
- Yes, several different clinics opening up with free offerings for the community.
- Yes, focused intervention with social media, free programs, and Community outreach.
- Yes
- Declined, Due to access of care and underinsured being reluctant to pay deductibles

Responses to "Are you familiar with with the outreach efforts of Good Samaritan Hospital regarding Heart Disease, Cancer, and Stroke?"

- Very familiar with the efforts; Hospital has a good community education program. Hospital's involved in the community with education and awareness. Bloodwork clinics for screening is a great service

- Hospital provides community health services and education to many in the community. Hospital comes to the Senior Center for education, etc. They would like to see a blood work screening at locations like this.

- Very aware of these services; the hospital is involved in many community related health activities. Local "clinics" free blood work, walk with a Doc, and outside exercise equipment in parks

- Very Familiar

- Very familiar and currently working with local clinics to provide better outreach.

- Familiar and they do a good job with having continuous improvement.

- Familiar with what we do, but we can do more in terms of outreach

Responses to "What insights and observations do you have in regards to health behaviors in the community surrounding obesity, physical inactivity, drug abuse, and tobacco use?"

- Drugs, Alcohol Abuse and Mental Health are not improving, need more education, more awareness at all ages and levels in the community, and better access to services.

- These behaviors are worse than ever in our community, especially drug use. Law enforcement is working very hard. No dedicated drug "Rehab" center in the community

- Yes, there have been improvements. The city and the hospital are both involved in many programs/activities such as Drug Abuse Awareness. Parks and Exercise programs and Inactivity and Obesity is still a problem – providing vouchers for healthy food options is a good start (Good Samaritan).

- Not aware of any organizations, but still believes obesity and physical activity is still a huge problem in the community.

- Good Sam has really focused on Heart and weight Management & College has incentives for health screenings as well as not smoking.

- Unsure of any programs

- We have done re-training for local MDs for Opioids prescribing policies Walk with a Doc for Obesity, NP Andrea Miller has her own weight loss program.

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Responses to "What is the most important issue the Hospital should address in next 3-5 years?"

- Staffing… In particular, address the shortage of primary care physicians in the community and nurses at the hospital.

- "An inpatient" Rehab Facility for addiction

- Not aware of any organizations, but still believes obesity and physical activity is still a huge problem in the community.

- More primary care physicians in the community to improve access to care, more specific cardiology services, and keep the Residency program strong.

- Heart Health Programs

- Opening Lines of communication between employees.

- No Answer

- Access to primary care and improving the relationship with local health department in getting vaccinations done.

COMMUNITY SURVEY RESULTS

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

Identify the top three most significant health care prevention, treatment, and awareness needs in the community.

Participants were instructed to provide the top three most significant health care prevention, treatment, and awareness needs in the community. In the table below, each need that was provided as an option is listed on the left. The percentages represent how often a need was chosen

Need	Percentage
FOOD AND NUTRITION EDUCATION	10%
FINANCIAL ISSUES	10%
GENERAL HEALTH EDUCATION LACKING	20%
MENTAL HEALTH EDUCATION LACKING	20%
MENTAL HEALTH SERVICES AVAILABILITY	20%
SPECIALTY CARE PROVIDER AVAILABILITY	40%
PRIMARY CARE PROVIDER AVAILABILITY	40%
ADDICTION CARE SERVICE AVALABILITY	40%
AFFORDABLE HEALTH INSURANCE	40%
AFFORDABLE HEALTH CARE	50%

Responses for Awareness of Health Care Services Available in the Community

Participants were instructed to respond to the following statement, "Are you aware of the health care services available in your community?" The participants were given three choices (completely aware, somewhat aware, and not aware) to select from with over half of the respondents somewhat aware of the health care services available in the community, and over a third of the respondents were completely aware of the health care services available in the community.
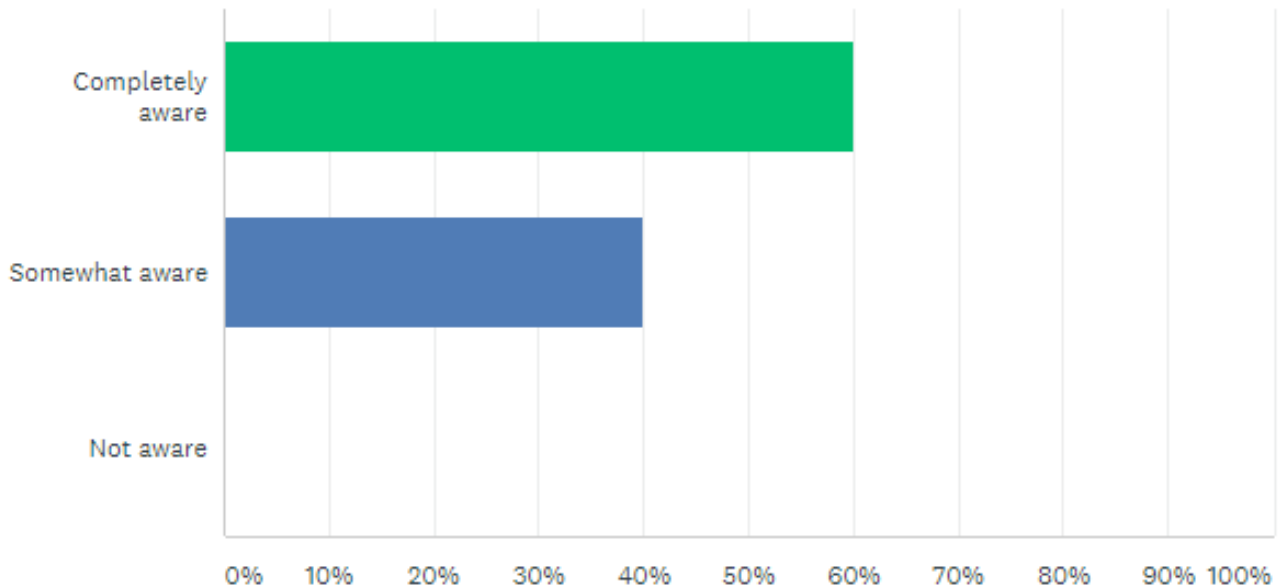
Responses for General HealthStatus

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

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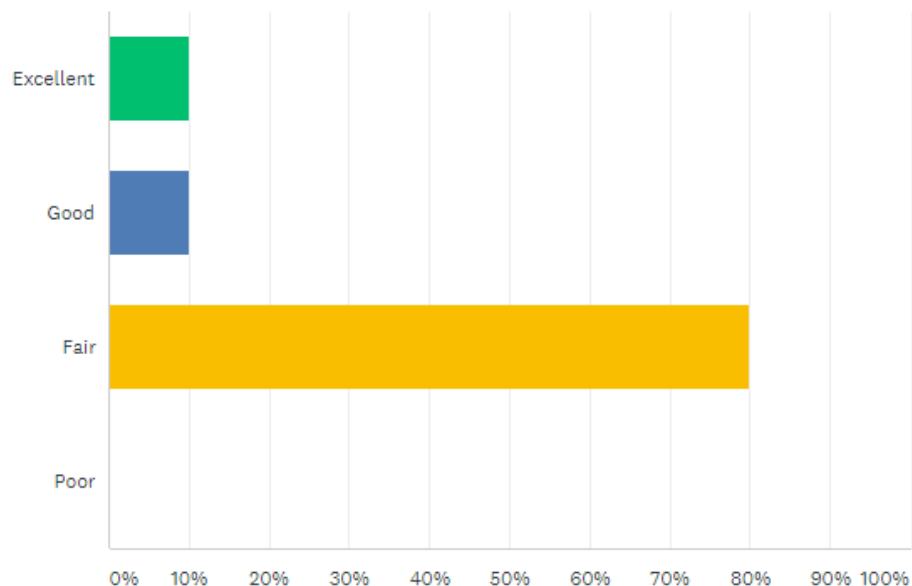
Responses for Health Needs Status

Participants were instructed to respond to the following question, "Are the health care needs currently being met in your community?" The participants were given four choices (completely agree, somewhat agree, somewhat disagree, and completely disagree) to select from. Over half of the respondents agreed that the health care needs of the community are being met.
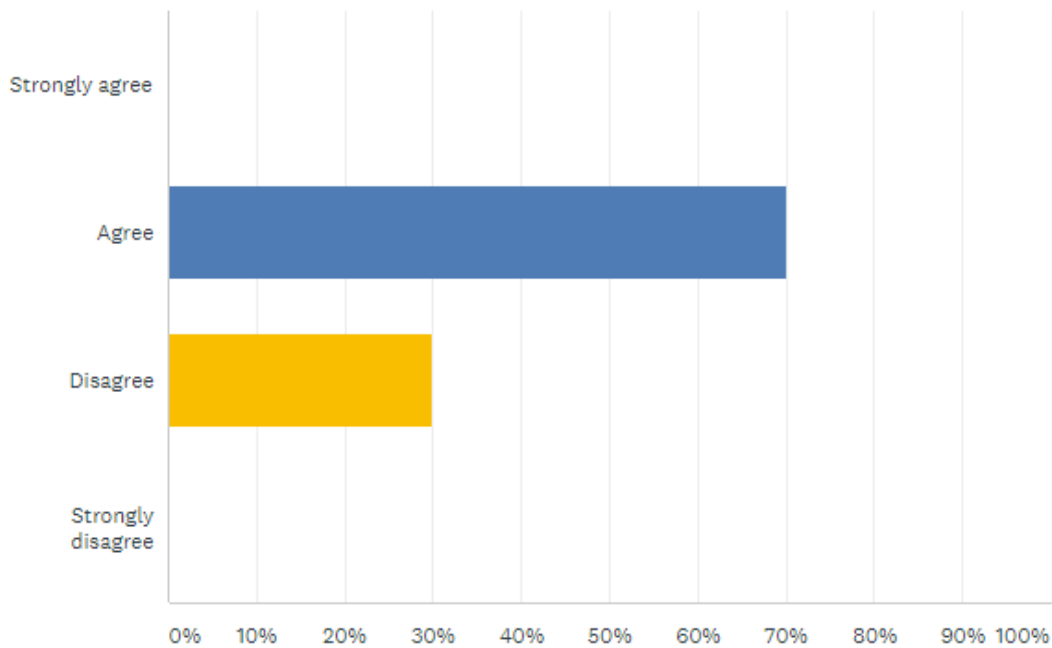
Participants were also given the opportunity to share any health care needs of the community that they feel are not being met. Below are the responses received:

• More education on the effects of smoking, and alcohol. Affordable wellness opportunities for the less fortunate. Education to them about staying healthy.

• Smoking cessation, obesity

• It does appear that so many people in our community goes out of town for some services. Therefore on # 5, I posted agree but I also disagree

• I hear so many individuals speak of the difficulty in getting into a primary care provider, especially when a practice is closed.

• Substance Abuse Treatment and Prevention

Responses for Coordination of Care in the Community
Participants were instructed to respond to the following statement, "Health care providers work well together and coordinate care in this community." The participants were given four choices (completely agree, somewhat agree, somewhat disagree, and completely disagree) to select from with over half of   the respondents in agreement that the health providers do work well together and coordinate care in the community while the remainder of respondents somewhat disagreed or completely disagreed.
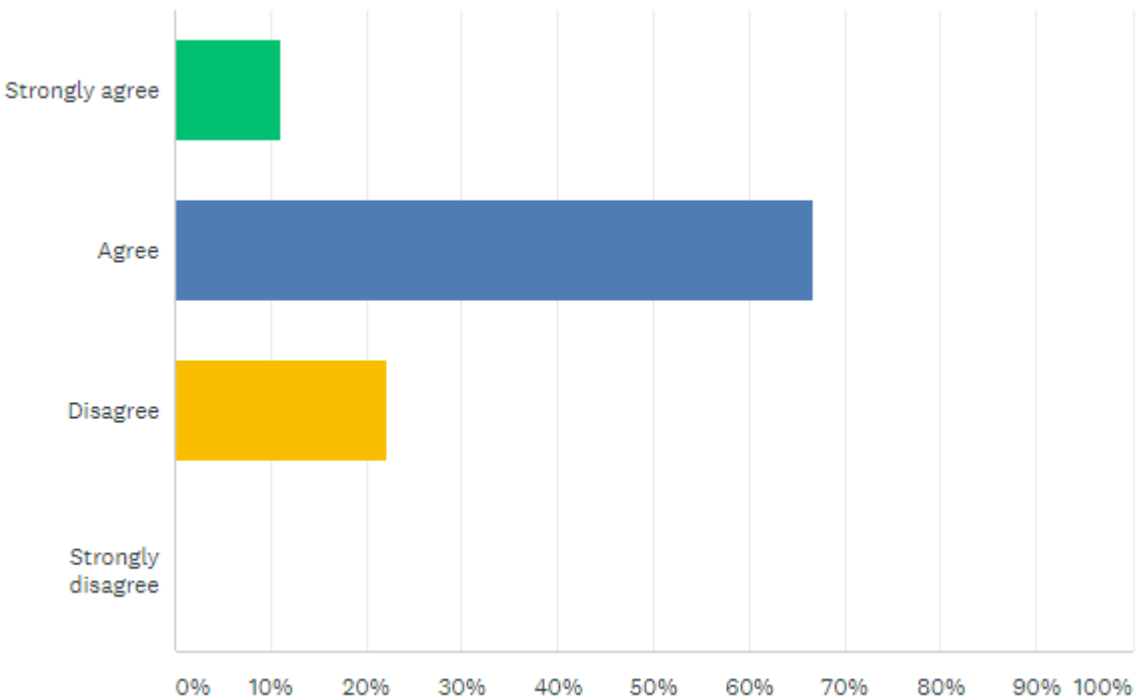
Responses for Barriers Existing to Preventing a Healthier Community

Participants were instructed to respond to the following statement, "There are barriers that exist in government, the general community, public health community, or health care provider community that prevent us from creating a healthier community." The participants were given four choices (completely agree, somewhat agree, somewhat disagree, and completely disagree) to select from with the majority of the respondents agreeing there are barriers that exist which keep the community from becoming healthier and the remainder of respondents somewhat disagreed or completely disagreed with the statement.
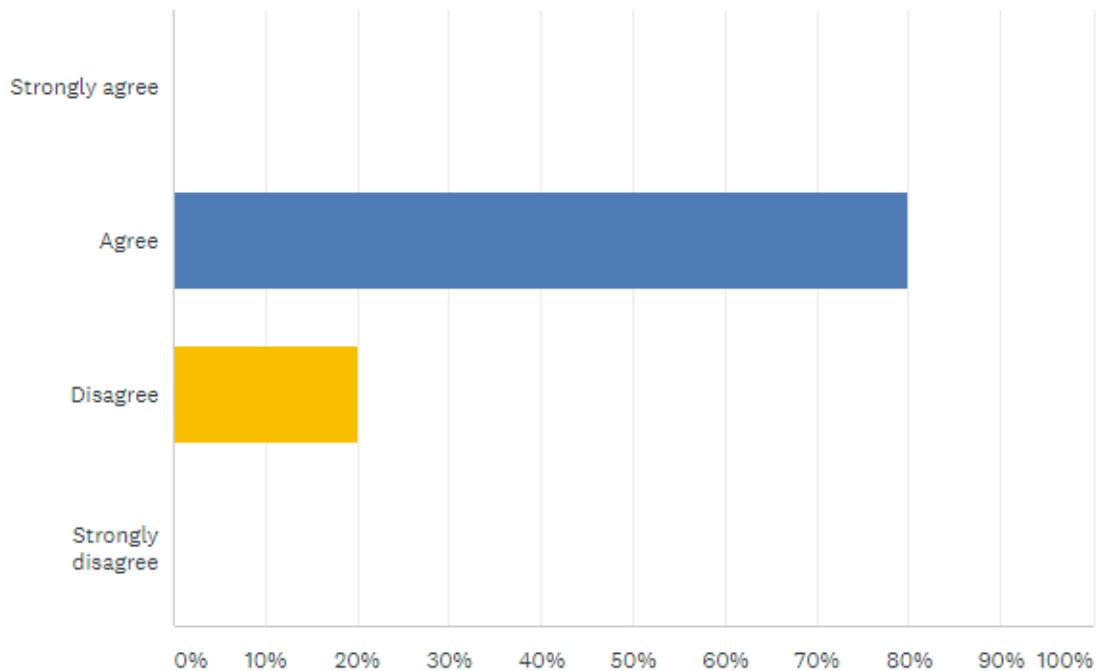
Participants were given the opportunity to share any barriers that exist in government, the general community, public health community, or health care provider community that prevent creating a healthier community. Below are the responses received:

- Control over what the insurance companies do, they dictate too much by their lack of service -- causing people to just not go to the doctor as needed

- Too much bureaucracy and red tape for insurance and government reimbursements to health care providers. More Doc/patient time and less Doc/computer time would be helpful.

- We do not need county commissioners serving on the hospital board. They have no health experience that is helpful to the hospital. Need term limits for Board Members. Sharing patient info from one doctor to another.

- The biggest barrier to general community health is the multi-generational lack of interest in changing habits

Additional Community Comments Received

At the end of the survey participants were given the opportunity to share any general comments. Below are the general comments received:

- GSH does an outstanding job given the current state of our national health care system.

- In general, I feel that we are moving forward and do a good job with screening and increased awareness.

- We have a great hospital with some great personnel. I follow the info in the local paper that says what services are available at other locations during each week. So many people do not take the paper anymore and don't do Facebook. We need to find a way to get this info out because so many people would use these services that do not qualify or have insurance. We need our doctors (not all doctors) to listen and observe our seniors and listen to what they are saying or asking. I talk to so many seniors that are confused and don't know why they are going to this doctor one week and another doctor the next week. And then they don't understand the reports. I am one of the lucky ones. I have a good doctor and I ask my questions. Thanks.

- With the payer mix in this community, I believe the ability to draw people into wellness checks is important. Statistically it has been proven that a higher percentage of individuals in lower income brackets tend to have more co-morbidities. This is likely due to lack of funds for fitness clubs and the overall lack of initiative to strive for better health.

- Our biggest need is to bridge the socio-economic gap in attitude toward healthy lifestyles.

NATIONAL, STATE, AND COUNTY TRENDS

NATIONAL HEALTHCARE TRENDS SYNOPSIS

Healthcare spending continues to slowly grow at the national level each year. The following data describes the recent trends in national healthcare, and was obtained from the Centers for Medicare & Medicaid Services, the American Health Rankings 2018 Edition, the United States Census Bureau, and the Deloitte 2018 Survey of Health Care Consumers in the United States, the American Hospital Association 2018 Environmental Scan, and Healthy People 2020.

2017 Health Expenditures

- Total health expenditures increased 3.9% to $3.5 trillion from 2016.
- Healthcare represents 17.9% of the Gross Domestic Product (GDP).
- Health expenditures reached $10,739 per capita.

As a nation, there has been a strong awareness on the impact our lifestyles have on our health. The following data obtained from America's Health Rankings 2018 Edition represents the improvements and challenges in healthcare factors for 2018.

2018 National Health Highlights

- In the past three years, drug deaths increased 25% from 13.5 to 16.9 deaths per 100,000 population

- In the past year, obesity increased 5% from 29.9% to 31.3% of adults

- In the past 15 years, air pollution decreased 36% from 13.2 to 8.4 micrograms of fine particles per cubic meter

- In the past year, HPV immunization among males aged 13 to 17 increased 18% from 37.5% to 44.3%

- In the past five years, children in poverty decreased 19% from 22.6% to 18.4% of children aged 0 to 17

- In the past year, mental health providers increased 8% from 218.0 to 234.7 per 100,000 population

- In the past two years, primary care physicians increased 8% from 145.3 to 156.7 per 100,000 population

- In the past three years, cardiovascular deaths increased 2% from 250.8 to 256.8 deaths per 100,000 population

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2018 National Health Highlights (continued)

- In the past two years, frequent mental distress increased 7% from 11.2% to 12.0% of adults

- In the past five years, premature death increased 6% from 6,981 to 7,432 years lost before age 75 per 100,000 population

The Deloitte Center for Health Solutions' report titled *2018 Survey of Health Care Consumers in the United States: The performance of the health care system and health care reform* provided the following national health related data:

Deloitte Consumers & Health Care System 2018 Survey Results

- 53 percent said they were likely to use a tool to look up quality ratings for specific physicians or hospitals, but only 23 percent did so in the past year, and though 50 percent said they were likely to use a tool to look up pricing in the future, only 27 percent did so in the past year.

- 35 percent of Participants were interested in using a virtual assistant to identify symptoms and direct them to a physician or nurse.

- 31 percent were interested in connecting with a live health coach that offers 24/7 text messaging for nutrition, exercise, sleep, and stress management.

- 29 percent were interested in using an app that uses voice-recognition software to recognize depression or anxiety from changes in the tone of voice.

- 51 percent are comfortable using an at-home test to diagnose infections (such as strep throat and urinary tract infection) before going to the doctor for treatment.

- 45 percent are comfortable using an at-home genetic test to identify existing or future health risks.

- 44 percent are comfortable using an at-home blood test (a quick prick with a fine needle) that connects to an app to track overall health trends (for instance, cholesterol, fasting blood glucose, inflammation, triglycerides).

- 41 percent are comfortable sending/mailing a stool sample to a laboratory service that identifies gut bacteria, which in turn can help guide nutritional choices.

- Slightly more than half of consumers are willing to share health data for emergency situations (to alert either family members or emergency responders).

- 40 percent are willing to share their data for health care research or to improve the device.

**Community Health
Needs Assessment**

Deloitte Consumers & Health Care System 2018 Survey Results (continued)

- Across the board, chronically ill consumers are more willing to share their tracked health information.

- Consumers vary in their interest in and use of tools. Care providers and technology/software developers should recognize the importance of targeting different segments, not only by age, but also by health condition and perceived health status.

- Organizations should facilitate the use of consumer information (for example, from fitness devices) that goes to physicians and care teams. Technology/software developers should make it easy for care teams to use the data, and organizations may need to train consumers and professionals on how to use the tools and interpret the data. Physician adoption of new technologies could depend on the company's ability to convince them of the tool's efficiency or cost-effectiveness and whether it is integrated with providers' EHR systems and workflows.

- Different users/customers seek different benefits: Consumers seek convenience, health improvements, and cost savings, with variation based on consumer segments.

- Physicians want ease of use/simplification of workflow and/or improvement in outcomes and efficiency of care, and accuracy and reliability of data from these devices.

- Health systems look for efficiency of care, lower cost, cybersecurity, and ease of integration with HIT systems.

- The growth of at-home diagnostic tests and genetic tests, coupled with increasing use of wearables and tools to measure health and fitness goals, can provide a wealth of consumer-generated information that can be used to better understand the patient journey. This data can support discovery, development, and commercialization.

- All stakeholders have an opportunity to build trust through transparency, efficiency, and delivery of value. In addition, partnerships with physicians and health systems may help overcome consumers' lack of trust for organizations who have low levels of trust.

- Organizations should pay attention to the areas where consumers are asking for advocates the most and how they can consider digital means or other tools to support those needs.

- All stakeholders developing tools should provide meaningful and easy-to-understand data and access to care and care support such that consumers can recognize the benefit of technology engagement.

- There will be a growing expectation for physicians and health systems to take in all these additional data streams and determine what to do with them. Partnerships with technology companies (including EHR vendors) could potentially help this effort. There also may be additional opportunities for health plans to be data brokers/data aggregators.

CPAs / ADVISORS

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American Hospital Association (AHA) Environmental Scan (2018)

The 2018 American Hospital Association Environmental Scan provides insight and information about market forces that have a high probability of affecting the healthcare field. It was designed to help hospitals and health system leaders better understand the healthcare landscape and the critical issues and emerging trends their organizations will likely face in the future. The Scan provided the following information:

Access: Coverage

- In 2016, 28.1 million people were uninsured, and the uninsured rate fell to a record low of 8.8%.

- 20.5 million People have gained health insurance since 2010.

- About 12 million people bought health insurance through the ACA's insurance markets for 2017, and 7 million of them (58%) qualified for Cost Sharing Reduction payments.

Economic Forces

- Total annual spending on prescription drugs has reached $309 billion, the fastest growing segment of the U.S. health care economy. The price of drugs, not utilization, is the predominant contributor to the increase.

- 38.7% growth in inpatient drug spending on a per admission basis over a two-year period.

- More than 90% of hospitals said spending on pharmaceuticals was of moderate or severe concern.

- Four in 10 (43%) adults with health insurance say they have difficulty affording their deductible, and roughly a third say they have trouble affording their premiums and other cost sharing; all shares have increased since 2015.

- Three in 10 (29%) Americans report problems paying medical bills. Of this group, seven in 10 (73%) report cutting back spending on food, clothing or basic household items.

- Half of the public says they are at least somewhat worried they will not be able to afford needed health care services.

Physicians

- The nation faces a shortage of between 40,800 and 104,900 physicians by 2030.

- First-year enrollment at U.S. medical schools has increased by 28% since 2002, with 22 new schools accounting for nearly 40% of the growth.

- ACGME-accredited, entry-level residency positions are continuing to grow at a rate of about 1% per year. Federal caps on Medicare-funded residency training positions remain effectively frozen at 1996 levels.

- 49% of physicians often or always experience feelings of burnout.

**Community Health
Needs Assessment**

Healthy People 2020

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

Goals for Healthy People 2020

- Eliminate preventable disease, disability, injury, and premature death.

    - Emphasize the importance of prevention and health promotion.

    - Address "all hazards" preparedness as a public health issue.

    - Create a multi-sectoral approach with a strong public health workforce and infrastructure.

- Achieve health equity, eliminate disparities, and improve the health of all groups.

    - Achieve health equity and eliminate health disparities.

    - Measure health equity and health disparities over time.

- Create social and physical environments that promote good health for all.

    - Create an ecological approach to health promotion.

    - Address the social and physical environments effecting health.

- Promote healthy development and healthy behaviors across every stage of life.

    - Recognize the importance of life stages and developmental stages to health.

    - Tailor a clustering of life stages and population metrics for healthy development.

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The 2020 topics are organized into 42 areas with measurable and developmental objectives maintained by the Office of Disease Prevention and Health Promotion within the U.S. Department of Health and Human Services. The objectives relevant for this assessment are as follows:

Healthy People 2020 Objectives

Adolescent Health

- Increase educational achievement of adolescents and young adults.
- Reduce the proportion of adolescents who have been offered, sold, or given an illegal drug on school property.
- Increase the proportion of adolescents whose parents consider them safe at school.

Access to Health Services

- Increase the proportion of persons with health insurance.
- Increase the proportion of persons with a usual primary care provider.
- Increase the number of practicing primary care providers.
- Increase the proportion of persons who have a specific source of ongoing care.
- Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines.

Education

- Increase the proportion of preschool Early Head Start and Head Start programs that provide health education to prevent health problems in the following areas: unintentional injury; violence; tobacco use and addiction; alcohol or other drug use; unhealthy dietary patterns; and inadequate physical activity, dental health and safety.
- Increase the proportion of elementary, middle, and senior high schools that provide comprehensive school health education to prevent health problems in the following areas: unintentional injury; violence; suicide; tobacco use and addiction; alcohol or other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; and inadequate physical activity.
- Increase the proportion of elementary, middle, and senior high schools that have health education goals or objectives which address the knowledge and skills articulated in the National Health Education Standards (high school, middle, and elementary).

- Increase the proportion of elementary, middle, and senior high schools that provide school health education to promote personal health and wellness in the following areas: hand washing or hand hygiene; oral health; growth and development; sun safety and skin cancer prevention; benefits of rest and sleep; ways to prevent vision and hearing loss; and the importance of health screenings and checkups.

- Increase the proportion of worksites that offer an employee health promotion program to their employees.

- Increase the number of community-based organizations providing population-based primary prevention services.

Health Communication and Health Information Technology

- Improve the health literacy of the population.

- Increase the proportion of patients whose doctor recommends personalized health information resources to help them manage their health.

- Increase individuals' access to the Internet.

- Increase social marketing in health promotion and disease prevention.

Immunization & Infectious Disease

- Reduce, eliminate, or maintain elimination of cases of vaccine-preventable diseases.

- Achieve and maintain effective vaccination coverage levels for universally recommended vaccines among young children.

- Increase the percentage of children and adults who are vaccinated annually against seasonal influenza.

- Increase the percentage of providers who have had vaccination coverage levels among children in their practice population measured within the past year.

Injury & Violence Prevention

- Reduce physical violence by current or former intimate partners.

- Reduce sexual violence by current or former intimate partners.

- Reduce psychological abuse by current or former intimate partners.

- Reduce children's exposure to violence.

- Increase the number of States and the District of Columbia that link data on violent deaths from death certificates, law enforcement, and coroner and medical examiner reports to inform prevention efforts at the State and local levels.

Mental Health

- Increase the proportion of children who receive treatment of their mental health problems.

- Increase the proportion of juvenile residential facilities that screen admissions for mental health problems.

- Increase the portion of persons who receive treatment for co-occurring substance abuse and mental disorders.

- Increase depression screening by primary care   providers.

- Increase the proportion of homeless adults who receive mental health services for their mental health problems.

- Reduce the proportion of adolescents aged 12 to 17 years who experience major depressive episodes (MDEs).

Substance Abuse

- Reduce average alcohol consumption.

- Decrease the rate of alcohol-impaired driving.

- Reduce steroid use among adolescents.

- Reduce past-year nonmedical use of prescription drugs.

- Reduce the number of deaths attributable to alcohol.

- Reduce the proportion of adolescents who use inhalants.

STATE HEALTHCARE TRENDS SYNOPSIS

In Indiana, the overall health ranking reported in the 2018 America's Health Ranking was 41 out of 50 decreasing from 38th in 2017. The strengths for the state are high Tetanus Diphtheria and Pertussis (Tdap) immunization, coverage among adolescents, low incidence of pertussis, and high percentage of high school graduation. The challenges faced by the Indiana are high prevalence of smoking (increased 6% in past two years), high prevalence of mental distress, and high cancer death rate.

2018 Indiana Highlights
- In the past two years, smoking increased 6% from 20.6% to 21.8% of adults
- In the past three years, air pollution decreased 23% from 11.3 to 8.7 micrograms of fine particles per cubic meter
- In the past six years, children in poverty decreased 20% from 23.0% to 18.4% of children aged 0 to 17
- In the past year, HPV immunization among males aged 13 to 17 increased 36% from 24.7% to 33.5%
- In the past five years, cancer deaths increased 2% from 207.0 to 210.5 deaths per 100,000 population
- In the past years, frequent mental distress increased 11% from 13.2% to 14.7% of adults

2018 Illinois Highlights
- Leading cause of death is Heart Disease followed by Cancer.
- Firearm deaths are the leading mortality death.
- Chlamydia is the most commonly reported STD in the state of Illinois
- Drug overdoses is the 3rd leading cause of death outside of health reasons
- In 2017, 15.5% of adults smoked. Nationally, the rate was 17.1%.
- In 2017, 7.6% of high school students in Illinois smoked cigarettes on at least one day in the past 30 days. Nationally, the rate was 8.8%.

COUNTY HEALTH CARE TRENDS SYNOPSIS

According to County Health Rankings, the citizens of the service area are predominantly white (92.5%) and made up of 49.4% female. The age of Knox County population is older compared to the state of Indiana, with 17.2% of Knox County population 65 and older compared to 15.4% for the state of Indiana. Knox County is 36.2% of rural area which is higher than the state at 27.6 %. Roughly 61% of residents have some level of college education; similar to the state of Indiana at 62%. The median household income of $44,837 is marginally higher than the state level of $35,449. The state of Indiana had reported an unemployment rate of 3.3%, and Knox County is slightly lower at a 2.8 % unemployment rate. The percentage of children living in poverty in Knox County is 24% which is higher than the state at 18%. Children in Knox County living in single-parent households is 34% which is on par with the state at 34%. Approximately 53% of the children residing in Knox County are eligible for a free school lunch, compared to 49% in the state of Indiana.

Approximately 9% of the population in Knox County does not have health insurance, which is the same in the state of Indiana. The number of people in relation to the number of dentists in Knox County is 2,080 to one dentist, compared to the state of Indiana of 1,260 to one. The number of people in relation to the number of mental health providers in Knox County is 680 to one compared to 670 to one in the state of Indiana. The ratio for population to primary care physicians in Knox County is approximately 1,180 individuals to one primary care physician; compared to 1,500 to one in the state of Indiana.

The percentage of adults who are obese is at 34% in Knox County versus 33% in the state of Indiana. The percentage of teen births in Knox County is higher at 32% compared to the state of Indiana at 28%. There is less access to physical exercise equipment, facilities and other opportunities for physical exercise in Knox County (67%) vs. the state of Indiana at 75%. The percentage of residents that are physically inactive is 30% versus 25% in the state of Indiana. The percentage of drug related deaths is 20.2% compared to the state of 33%.

The number of preventable hospital stays, which is the number of hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees in the county is 6,833 versus 5,023 for Indiana. Life expectancy in Knox County is 79.2 years which is virtually the same as the state at 80.0. Premature death is defined as the years of potential life lost before age 75 per 100,000 population (age-adjusted).

Health Status Synopsis

After reviewing secondary data for Knox County and surrounding counties, it was noted that the Health Outcomes ranking is at the lower third ranking at 65 out of 92 counties (Daviess is 36, Gibson is 42, Greene is 57, Pike is 60 and Sullivan is 71).

County Health Rankings & Roadmaps
Building a Culture of Health, County by County

	Indiana	Knox		Daviess	Gibson	Greene	Pike	Sullivan
Health Outcomes		65		36	42	57	60	71
Length of Life		69		42	48	46	60	75
Premature death	8,200	9,500		8,000	8,400	8,200	9,100	9,800
Quality of Life		61		26	34	73	56	63
Poor or fair health	18%	17%		17%	15%	17%	15%	18%
Poor physical health days	3.9	3.8		3.8	3.6	3.9	3.8	4.1
Poor mental health days	4.3	4.0		4.1	3.9	4.2	3.9	4.2
Low birthweight	8%	8%		6%	8%	8%	9%	7%
Health Factors		62		61	14	76	35	89
Health Behaviors		73		65	19	81	24	76
Adult smoking	21%	20%		20%	19%	22%	18%	21%
Adult obesity**	33%	34%		35%	31%	34%	38%	33%
Food environment index**	7.1	7.6		8.2	8.5	7.7	8.5	7.8
Physical inactivity**	25%	30%		32%	26%	32%	29%	31%
Access to exercise opportunities	75%	67%		56%	69%	48%	76%	50%
Excessive drinking	19%	18%		18%	18%	17%	17%	17%
Alcohol-impaired driving deaths	21%	37%		18%	11%	32%	7%	33%
Sexually transmitted infections**	466.0	424.5		224.9	272.4	262.0	190.6	229.4
Teen births	28	32		30	35	35	35	41
Clinical Care		48		91	11	80	76	87
Uninsured	9%	9%		18%	7%	10%	9%	9%
Primary care physicians	1,500:1	1,180:1		1,940:1	3,740:1	3,580:1	12,430:1	1,730:1
Dentists	1,810:1	2,080:1		3,680:1	1,870:1	2,300:1	12,370:1	4,150:1
Mental health providers	670:01	680:01		1,230:1	4,800:1	1,610:1	2,470:1	2,960:1
Preventable hospital stays	5,023	6,833		4,622	4,752	5,824	4,820	6,944
Diabetes monitoring	40%	42%		42%	47%	37%	4%	27%
Mammography screening	47%	48%		30%	54%	39%	30%	40%

Years of potential life lost before age 75 per 100,000 population (age-adjusted)
**Number of hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees*

🟥 Worse than State of Indiana

🟩 Better than State of Indiana
Source: www.countyhealthrankings.org

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CONCLUSION

COMMUNITY RESOURCES IDENTIFIED

The assessment identified community assets (See Attachment A) including the Hospital and its community benefit programs.

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

OVERALL OBSERVATION

Priorities for the key areas will be assessed by the Hospital's Board of Governors and documented in the implementation strategy report.

Overall priorities determined to be significant:

1. Increasing substance abuse prevention, treatment and educational awareness.

2. Increasing primary care physicians (Internal Medicine and Pediatrics) and specialty physicians.

3. Improving Affordable Healthcare.

4. Increasing the number of mental healthcare providers and professionals in the community.

5. Expanding transportation services to/from treatment services.

CONTACT

This assessment summary is published on the website of Good Samaritan (www.gshvin.org). Additionally a copy may be obtained by contacting the Hospital's Administration office at 812-882-5220.

ATTACHMENT A:
AVAILABLE COMMUNITY RESOURCES

(Knox County) Vincennes Indiana (Population in County 33,305)

- Advanced Pain Care Clinic
- BridgePointe Health Campus
- Gentlecare of Vincennes
- Health Connection
- Knox County Health Department
- Lodge of the Wabash
- Luking Family Practice, L.L.C.
- Medical Center of Vincennes: Keyes Scott MD
- Medical Center of Vincennes: Miller Andrea L
- Pro Rehab
- Riverfront Counseling Center
- Riverside Family Clinic
- Samaritan Center
- Vincennes Clinic
- Willow Manor

(Daviess County) Washington, Indiana (Population in County 33,113)

- Care Center Consulting Services
- Cullen Medical Pro Corporation
- DCH CORE Center
- Dahl Family Medicine
- Daviess Community Hospital
- Daviess County Health Department
- Memorial Health Washington
- New Skin Appeal LLC
- Pregnancy Care Center
- Rescare Homecare
- Samaritan Center
- Samaritan Center
- Senior & Family Services Inc.
- Southwest Medical Services Inc.
- Williams Bros. Health Care Pharmacy

(Gibson County) Princeton, Indiana (Population in County 33,576)

- Deaconess Health Care
- Deaconess Radiology EXPRESS – Princeton
- Gibson General Deaconess Clinic EXPRESS Princeton
- Gibson General Hospital
- Gibson Home Health Services
- Princeton Clinic
- Tulip Tree Health Services
- Umali Melissa M Psychology
- Williams Bros Health Care Pharmacy

(Pike County), Petersburg, Indiana (Population in County 12,365)

- Amber Manor Care Center
- Deaconess Clinic Petersburg
- Golden LivingCenter – Petersburg
- Petersburg Family Medicine
- Petersburg Medical Clinic
- Samaritan Center
- Trilogy Health Services

(Sullivan County), Sullivan, Indiana (Population in County 20,076)

- Family Practice Associates
- Family Practice Associates of Sullivan County
- Hamilton Center, Inc.
- Healthy Families
- Miller's Merry Manor
- Quick Care Clinic
- Scarc Industries
- Sullivan County Community Hospital
- WellnessFirst of Sullivan

(Crawford County) Robinson , Illinois (Population in County 18,961)

- CMH Medical Cosmetic Services
- CMH Rural Health Clinic
- Cotillion Ridge: Therapy & Senior Care – Robinson
- Crawford Memorial Hospital
- Help At Home Inc
- South Haven
- Wabash Valley Occupational Health and Acute Medical Care

(Lawrence County) Lawrenceville, Illinois (Population in County 16,168)

- Lawrence County Health Department Behavior Health
- Lawrence County Health Department Psychosocial Rehabilitation
- Lawrence County Memorial Hospital
- Primary Care Clinic

(Richland County) Olney, Illinois (Population in County 15,091)

- Arbors Center/Richland county counseling center
- Carle Richland Memorial Hospital Orthopaedic Clinic
- Carle Richland Memorial Hospital-Convenient Care Clinic
- Colwell Counseling & Consulting Services, Inc.
- Home Health Services
- Jack A. Cole PhD, Clinical Psychologist
- Market Street Medical, LLC
- Miller Chiropractic
- SIHF Healthcare – Olney
- Thrifty Home Medical
- Weber Medical Clinic
- Whole Family Health Medical Clinic, S.C

(Wabash County), Mt. Carmel, Illinois (Population in County 11,489)

- Addus HomeCare
- Depot Counseling
- Help At Home
- Hope Pregnancy Center
- Oakview Nursing & Rehabilitation
- Rehab Care Group
- River Oaks
- Southeastern Illinois Center
- WGH Orthopaedics & Sports Medicine
- Wabash County Public Aid Department
- Wabash General Hospital
- Wabash General Hospital: Ferguson Thimjon C MD

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ATTACHMENT B: DEMOGRAPHIC DATA

EXPLANATIONS & DEFINITIONS FOR SELECTED CHARTS/GRAPHS THAT FOLLOW

TITLE OF CHART/GRAPH	EXPLANATIONS & DEFINITIONS
Health Outcomes	Health Outcomes ranking is based upon the length of life and quality of life rates.
Length of Life	Length of Life ranking is based on the premature death rate.
Premature Death	Years of potential life lost before age 75 per 100,000 population (age adjusted)
Quality of Life	Indicates poor health and the prevalence of disease in 4 separate categories which include poor or fair health, poor physical health days, poor mental health days and low birth weight.
Poor or Fair Health	Percent of adults reporting fair or poor health (age adjusted) by county.
Poor Physical Health Days	Average number of physically unhealthy days reported in past 30 days (age adjusted).
Poor Mental Health Days	Average number of mentally unhealthy days reported in past 30 Days (age adjusted).
Low Birth Weight	Percent of live births with low birth weights (<2,500 grams).
Health Factors	Weighted measures of health behaviors, clinical care, social and economic and physical environment factors within each county.
Health Behaviors	An aggregate of a number of variables that include adult smoking, adult obesity, food environment index, physical inactivity, access to exercise opportunities, excessive drinking, alcohol-impaired driving deaths, sexually transmitted infections and teen births.
Life Expectancy	Average number of years a person is expected to live.
Adult Smoking	Percent of adults who report smoking >= 100 cigarettes and are currently smoking.
Adult Obesity	Percent of adults who report a Body Mass Index (BMI) >= 30.
Food Environment Index	Index of factors that contribute to a healthy food environment by weighing two indicators equally, one being the access to healthy foods by of low income and the other being the food insecurity of the population.
Physical Inactivity	Percent of adults 20 years or older reporting no leisure time physical activity.
Access to Exercise Opportunities	Percent of the population with adequate access locations where they can engage in physical activity.
Excessive Drinking	Includes both binge and heavy drinking.
Alcohol-Impaired Driving Deaths	Percent of driving deaths caused by alcohol
Sexually Transmitted Infections	Chlamydia rate per 100,000 population.

TITLE OF CHART/GRAPH	EXPLANATIONS & DEFINITIONS
Teen Birth Rate	Teen birth rate per 1,000 female population, ages 15 to 19.
Clinical Care	Aggregate of several variables including percentage of uninsured, primary care physicians-to-population, preventable hospital days; diabetic screening, and mammography screening.
Uninsured	Percentage of the population under age 65 used in the clinical care factors ranking.
Primary Care Physicians	Ratio of population to Primary Care Physicians.
Dentists	Ratio of population to Dentists.
Mental Health Providers	Ratio of population to Mental Health Provider.
Preventable Hospital Stays	Number of hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees.
Diabetic Monitoring	Percent of diabetic Medicare enrollees who receive HbA1c monitoring.
Mammography Screening	Percent of female Medicare enrollees who receive mammography screening.
Social & Economic Factors	Aggregate of factors including education level, unemployment rate, children in poverty, inadequate social support, children in single parent households, and violent crime rate.
High School Graduation	Percent of ninth graders who graduate in 4 years.
Some College	Percent of adults age 25 to 44 years with some post-secondary education.
Unemployment	Percent of population 16+ unemployed but seeking work.
Children in Poverty	Percent of children under age 18 in poverty.
Income Inequality	Ratio of income at the 80th percentile to the 20th percentile.
Children in Single-Parent Households	Percent of children who live in a household headed by a single parent.
Social Associations	Number of membership associations per 10,000 population.
Violent Crime Rate	Annual crimes per 100,000 in population.
Injury Deaths	Number of deaths caused from injuries per 100,000 population.
Physical Environment	Aggregate of several weighted variables including air pollution, drinking water violations, severe housing problems, driving alone to work and long commute - driving alone.
Air Pollution - Particulate Matter	Average density of fine particulate matter in micrograms per cubic meter per day.
Drinking Water Violations	Percent of population who may be exposed to water that does not meet safe drinking water standards.
Severe Housing Problems	Percent of households with at least one of the following problems: overcrowding, high housing costs, lack of kitchen or plumbing.

Source: www.countyhealthrankings.org

TITLE OF CHART/GRAPH	EXPLANATIONS & DEFINITIONS
Driving Alone to Work	Percent of workforce that drives to work alone
Long Commute - Driving Alone	Percent of the workforce whose commute exceeds 30 minutes.
Additional Measures	Additional parameters identified in each category. These parameters are included as a valuable source of data to help gain a better understanding of the community. These measures are not used to determine the ranking of each category unless no other data is available.
Population	Number of individuals who reside in a county.
% Below 18 Years of Age	Percentage of the population who are younger than 18 years of age.
% 65 and Older	Percentage of the population who are 65 or older.
% Non-Hispanic African American	Percentage of the population who are not Hispanic African American.
% American Indian & Alaskan Native	Percentage of the population who are of American Indian and Alaskan Native descent.
% Asian	Percentage of the population who are of Asian descent.
% Native Hawaiian/Other Pacific Islander	Percentage of the population who are of Native Hawaiian or other Pacific Island descent.
% Hispanic	Percent of the population who are Hispanic.
% Non-Hispanic White	Percent of the population who are white and not of Hispanic descent.
% Not Proficient in English	Percent of the population, age 5 or older, who report as not speaking English "well".
% Females	The percent of the population that are female.
% Rural	Percentage of the population living in a rural area.
Diabetes	Percentage of adults aged 20 or older who have been diagnosed with having diabetes.
HIV Prevalence	Number of people per 100,000 population diagnosed with HIV.
Premature Age-Adjusted Mortality	Number of deaths under 75 years old per 100,000 population (age-adjusted).
Infant Mortality	Number of babies who died within 1 year of birth per 1,000 live births.
Child Mortality	Number of children (under age 18) who died per 100,000.
Food Insecurity	Percent of population who lack adequate access to food.
Limited Access to Healthy Foods	Percent of population who are low income and do not live close to a grocery store.
Motor Vehicle Crash Deaths	Number of deaths caused by motor vehicle crashes per 100,000 population.
Drug Poisoning Deaths	Number of deaths caused by drug overdose per 100,000 population.
Uninsured Adults	Percent of the population under age 65 without health insurance.

TITLE OF CHART/GRAPH	EXPLANATIONS & DEFINITIONS
Uninsured Children	Percent of the population under the age of 18 without health insurance.
Healthcare Costs	The amount of price-adjusted Medicare reimbursements per enrollee.
Could Not See Doctor Due to Cost	Percent of the population who were unable to see a doctor because of cost.
Other Primary Care Providers	Ratio of population per primary care providers other than physicians.
Median Household Income	The income at which half the households earn more and half earn less.
Children Eligible for Free Lunch	Percentage of children enrolled in public schools that are eligible for free lunch.
Homicides	Number of deaths caused by assault per 100,000 population.

Source: www.countyhealthrankings.org

KNOX COUNTY ANALYSIS

		Knox County	Trend ⓘ	Error Margin	Top U.S. Performers ⓘ	Indiana	Rank (of 92) ⓘ
Health Outcomes							65
Length of Life							69
Premature death	ⓘ	9,500	〰	8,300-10,600	5,400	8,200	
Quality of Life							61
Poor or fair health	ⓘ	17%		17-18%	12%	18%	
Poor physical health days	ⓘ	3.8		3.6-4.0	3.0	3.9	
Poor mental health days	ⓘ	4.0		3.8-4.2	3.1	4.3	
Low birthweight		8%		7-9%	6%	8%	

Additional Health Outcomes (not included in overall ranking) **+**

		Knox County	Trend ⓘ	Error Margin	Top U.S. Performers ⓘ	Indiana	Rank (of 92) ⓘ
Health Factors							62
Health Behaviors							73
Adult smoking	ⓘ	20%		19-21%	14%	21%	
Adult obesity		34%	〰	28-41%	26%	33%	
Food environment index		7.6			8.7	7.1	
Physical inactivity		30%	〰	24-36%	19%	25%	
Access to exercise opportunities		67%			91%	75%	
Excessive drinking	ⓘ	18%		17-19%	13%	19%	

KNOX COUNTY ANALYSIS (continued)

Alcohol-impaired driving deaths	37%	~	27-47%	13%	21%
Sexually transmitted infections	424.5	~		152.8	466.0
Teen births	32		28-35	14	28

Additional Health Behaviors (not included in overall ranking) +

Clinical Care 48

Uninsured	9%	~	8-10%	6%	9%
Primary care physicians	1,180:1	~		1,050:1	1,500:1
Dentists	2,080:1	~		1,260:1	1,810:1
Mental health providers	680:1			310:1	670:1
Preventable hospital stays	6,833	~		2,765	5,023
Mammography screening	42%	~		49%	40%
Flu vaccinations	48%	~		52%	47%

Social & Economic Factors 50

High school graduation	97%			96%	84%
Some college	61%		55-68%	73%	62%
Unemployment	3.4%	~		2.9%	3.5%
Children in poverty	24%	~	18-30%	11%	18%
Income inequality	4.2		3.8-4.7	3.7	4.4
Children in single-parent households	34%		28-40%	20%	34%
Social associations	18.5			21.9	12.3
Violent crime	109			63	385
Injury deaths	85		72-98	57	74

Indiana Overall Health Outcomes and Health Factors (by Rank, in order)
(Source: www.countyhealthrankings.org)

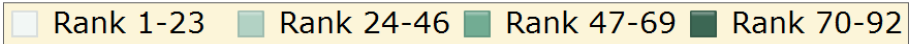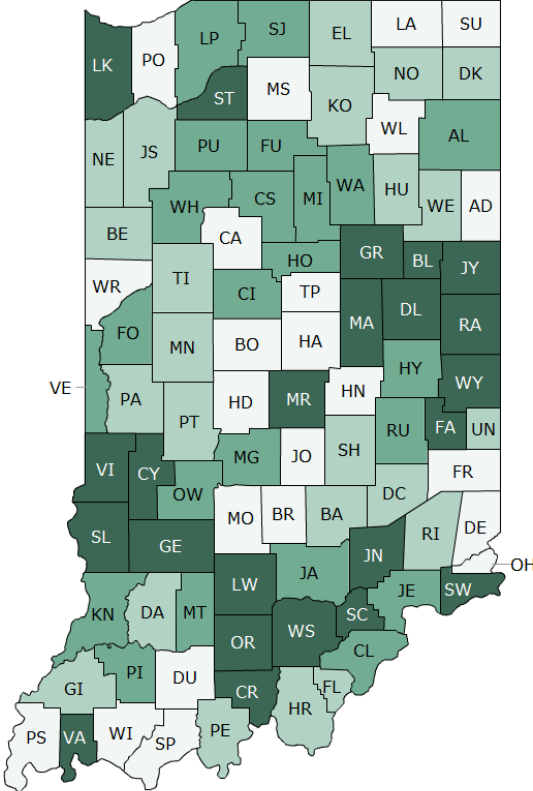| County	Health Outcomes	Health Factors		County	Health Outcomes	Health Factors		County	Health Outcomes	Health Factors		County	Health Outcomes	Health Factors
Adams	17	47		Franklin	9	19		Lawrence	70	70		Rush	51	58
Allen	47	37		Fulton	67	53		Madison	89	82		Scott	91	87
Bartholomew	42	11		Gibson →	40	15		Marion	75	92		Shelby	46	46
Benton	32	17		Grant	90	71		Marshall	15	25		Spencer	10	9
Blackford	86	73		Greene →	71	83		Martin	48	39		St. Joseph	59	57
Boone	4	2		Hamilton	1	1		Miami	54	78		Starke	79	86
Brown	5	23		Hancock	7	5		Monroe	18	16		Steuben	16	38
Carroll	19	14		Harrison	38	41		Montgomery	27	22		Sullivan →	77	91
Cass	64	68		Hendricks	2	3		Morgan	55	32		Switzerland	83	80
Clark	62	62		Henry	61	59		Newton	37	81		Tippecanoe	24	18
Clay	72	60		Howard	66	74		Noble	26	51		Tipton	11	10
Clinton	58	50		Huntington	33	36		Ohio	20	30		Union	31	48
Crawford	88	90		Jackson	57	21		Orange	76	75		Vanderburgh	80	67
Daviess →	44	56		Jasper	36	40		Owen	56	69		Vermillion	63	66
Dearborn	22	31		Jay	84	54		Parke	34	77		Vigo	81	79
Decatur	45	34		Jefferson	65	65		Perry	41	52		Wabash	52	27
DeKalb	25	29		Jennings	82	76		Pike →	60	35		Warren	3	26
Delaware	85	55		Johnson	8	7		Porter	21	28		Warrick	12	6
Dubois	23	4		Knox →	68	64		Posey	13	13		Washington	73	84
Elkhart	30	45		Kosciusko	29	24		Pulaski	53	49		Wayne	87	72
Fayette	92	85		LaGrange	6	44		Putnam	39	42		Wells	28	8
Floyd	43	20		Lake	74	89		Randolph	78	63		White	49	33
Fountain	50	61		LaPorte	69	88		Ripley	35	43		Whitley	14	12

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

The overall rankings in *health outcomes* represent how healthy counties are within the state. The ranks are based on two types of measures: how long people live and how healthy people feel while alive. Hamilton and Hendricks Counties are #1 and #2, while Scott and Fayette Counties are #91 and #92 respectively. The Hospital service area counties are identified with and arrow and their state rank.

The overall rankings in *health factors* represent what influences the health of a county. They are an estimate of the future health of counties as compared to other counties within a state. The ranks are based on four types of measures: health behaviors, clinical care, social and economic, and physical environment factors. Hamilton and Boone Counties are #1 and #2, while Sullivan and Marion Counties are #91 and #92 respectively. The Hospital service area counties are identified with and arrow and their state rank.

Community Health
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Indiana Overall Health Outcomes (County rank by color code)

(Source: www.countyhealthrankings.org)

Rank 1-23   Rank 24-46   Rank 47-69   Rank 70-92

Indiana Overall Health Factors (County rank by color code)
(Source: www.countyhealthrankings.org)
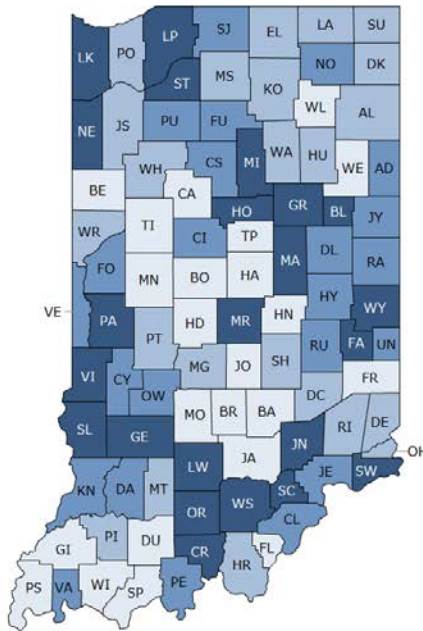
Rank 1-23 ■ Rank 24-46 ■ Rank 47-69 ■ Rank 70-92
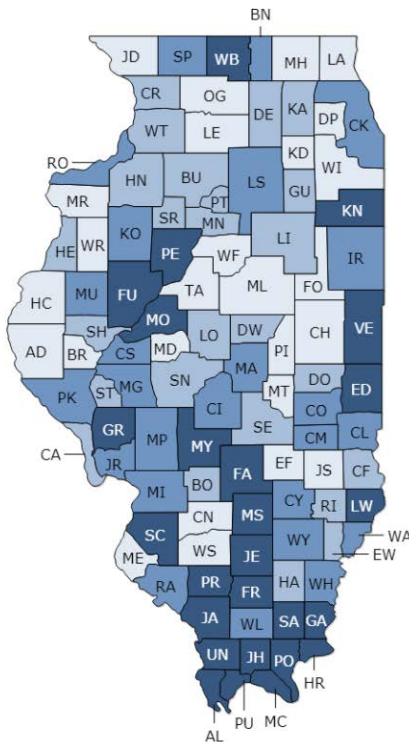
Rank 1-26 ■ Rank 27-51 ■ Rank 52-76 ■ Rank 77-102

Poor to Fair Health Outcomes Overall Rank in Indiana
(Source: www.countyhealthrankings.org)

Poor or Fair Health

Percentage of adults reporting fair or poor health (age-adjusted). Reason for Ranking Self-reported health status is a general measure of health-related quality of life (HRQoL) in a population. Measuring HRQoL helps characterize the burden of disabilities and chronic diseases in a population. Self-reported health status is a widely used measure of people's health-related quality of life. In addition to measuring how long people live, it is important to also include measures that consider how healthy people are while alive.

2019 Health Outcomes – Premature Death
(Source: www.countyhealthrankings.org)

BEST | WORST | MISSING
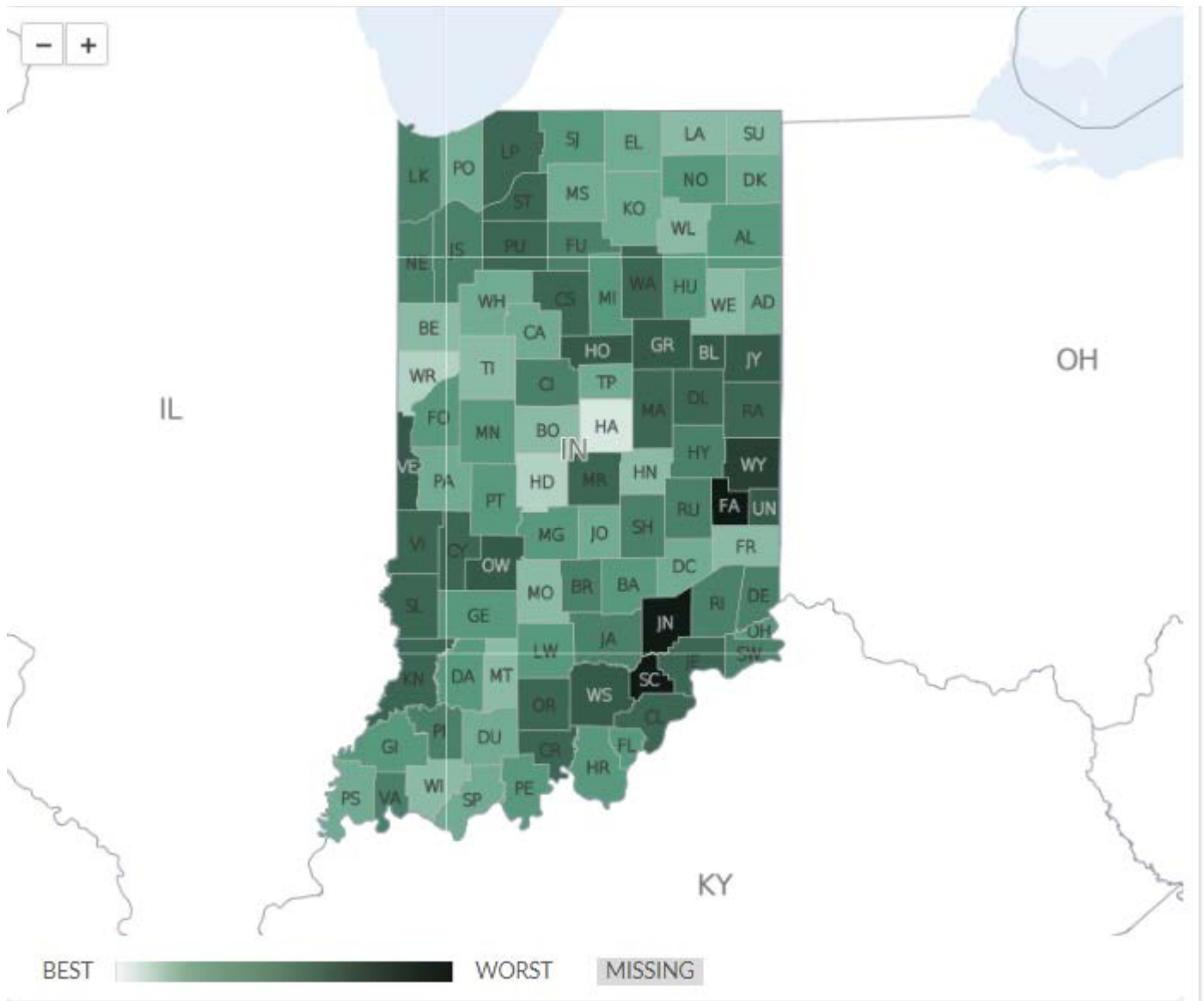
Premature Death

Years of Potential Life Lost (YPLL) is a widely used measure of the rate and distribution of premature mortality. Measuring premature mortality, rather than overall mortality, reflects the County Health Rankings' intent to focus attention on deaths that could have been prevented. YPLL emphasizes deaths of younger persons, whereas statistics that include all mortality are dominated by deaths of the elderly.[1] For example, using YPLL-75, a death at age 55 counts twice as much as a death at age 65, and a death at age 35 counts eight times as much as a death at age 70.

(Source: www.countyhealthrankings.org)

**Community Health
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2018 Health Factors – Uninsured

(Source: www.countyhealthrankings.org)
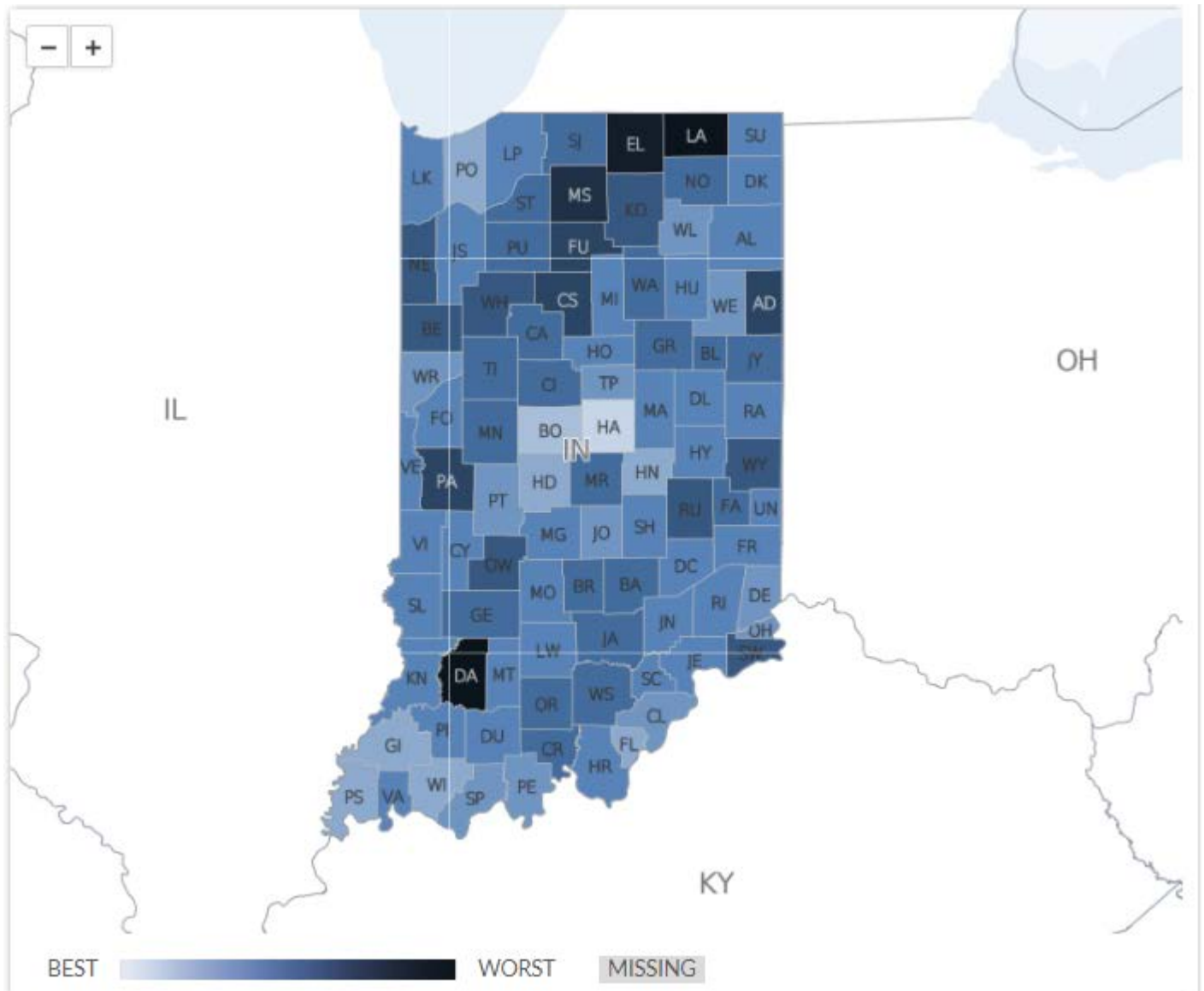
Lack of health insurance coverage is a significant barrier to accessing needed health care and to maintaining financial security. One key finding from the Kaiser Family Foundation report on access to healthcare is that, "Going without coverage can have serious health consequences for the uninsured because they receive less preventative care, and delayed care often results in serious illness or other health problems. Being uninsured can also have serious financial consequences, with many unable to pay their medical bills, resulting in medical debt."

SPECIALTIES	CURRENT NUMBER OF PHYSICANS WITHIN PRIMARY SERVICE AREA	SURPLUS (SHORTAGE) IN PRIMARY SERVICE AREA	Population of 100,000					POPULATION BASED UPON HOSPITAL PRIMARY SERVICE AREA: POPULATION OF 232,004
			GMENAC	GOODMAN	HICKS & GLENN	SOLUCIENT	AVERAGE	
Primary Care								
Family Practice	81.00	31.56	25.20	N/A	16.20	22.53	21.31	49.44
Internal Medicine	29.00	(16.71)	28.80	N/A	11.30	19.01	19.70	45.71
Pediatrics	15.00	(11.53)	12.80	N/A	7.60	13.90	11.43	26.53
Total Primary Care	125.00	3.32	66.80	N/A	35.10	55.44	52.45	121.68
Medical Specialties								
Allergy/Immunology	2.00	(0.95)	0.80	1.30	N/A	1.72	1.27	2.95
Cardiology	8.00	0.57	3.20	3.60	2.60	3.41	3.20	7.43
Dermatology	3.00	(2.09)	2.90	1.40	2.10	2.38	2.20	5.09
Endocrinology	1.00	(0.86)	0.80	N/A	N/A	0.80	0.80	1.86
Gastroenterology	3.00	(2.03)	2.70	1.30	N/A	2.50	2.17	5.03
Hematology/Oncology	5.00	(0.33)	3.70	1.20	N/A	1.99	2.30	5.33
Infectious Disease	0.00	(2.09)	0.90	N/A	N/A	0.90	0.90	2.09
Nephrology	3.00	0.66	1.10	N/A	N/A	0.92	1.01	2.34
Neurology	3.00	(1.47)	2.30	2.10	1.40	1.90	1.93	4.47
Psychiatry	12.00	(8.40)	15.90	7.20	3.90	8.18	8.80	20.40
Pulmonology	2.00	(1.33)	1.50	1.40	N/A	1.40	1.43	3.33
Rheumatology	1.00	(0.48)	0.70	0.40	N/A	0.81	0.64	1.48
Physical Medicine & Rehab	1.00	(2.13)	1.30	N/A	N/A	1.40	1.35	3.13
Other Medical Specialties	0.00	(4.66)	N/A	N/A	N/A	2.01	2.01	4.66
Surgical Specialties								
General Surgery	26.00	8.88	9.70	9.70	4.10	6.01	7.38	17.12
Cardio/Thoracic Surgery	1.00	(0.62)	N/A	0.70	N/A	N/A	0.70	1.62
Neurosurgery	1.00	(1.09)	1.10	0.70	N/A	N/A	0.90	2.09
OB/GYN	20.00	(1.15)	9.90	8.40	8.00	10.17	9.12	21.15
Ophthalmology	10.00	0.60	4.80	3.50	3.20	4.71	4.05	9.40
Orthopedic Surgery	17.00	4.00	6.20	5.90	4.20	6.12	5.61	13.00
Otolaryngology	7.00	0.43	3.30	2.40	N/A	2.8	2.83	6.57
Plastic Surgery	1.00	(2.90)	1.10	1.10	2.30	2.22	1.68	3.90
Urology	7.00	0.88	3.20	2.60	1.90	2.86	2.64	6.12
Other Surgical Specialties	0.00	(5.10)	N/A	N/A	N/A	2.20	2.20	5.10
Hospital-based								
Emergency	28.00	9.75	8.50	2.70	N/A	12.40	7.87	18.25
Anesthesiology	13.00	(4.75)	8.30	7.00	N/A	N/A	7.65	17.75
Radiology	7.00	(12.60)	8.90	8.00	N/A	N/A	8.45	19.60
Pathology	0.00	(11.25)	5.60	4.10	N/A	N/A	4.85	11.25
Pediatric Cardiology	0.00	(0.46)	N/A	N/A	N/A	0.20	0.20	0.46
Pediatric Neurology	0.00	(0.28)	N/A	N/A	N/A	0.12	0.12	0.28
Pediatric Psychiatry	2.00	0.96	N/A	N/A	N/A	0.45	0.45	1.04
Other Pediatric Subspecialties	0.00	(2.06)	0.89	N/A	N/A	N/A	0.89	2.06
TOTALS	**309.00**	-39.06						348.06

Physician Needs Assessment Analysis

A quantitative physician needs assessment analysis was completed for Knox County and the entire service area that includes the bordering counties. The physician needs assessment analysis uses a nationally-recognized quantitative methodology to determine the need for physicians by physician specialty for a given geographic population area being assessed. This need for physicians by specialty is then compared to the current supply of physicians practicing in that given geographic population. For purposes of this CHNA, the service area population of 232,004 was analyzed by physician need vs. supply by physician specialty. Gaps of physician supply vs. needs were then identified.

It should be noted there are a myriad of qualitative factors that impact the need, supply and gaps for physicians by specialty in any particular geographic region. These needs include, but are not limited to, the age of current practicing physicians; quality or service issues with a given physician or practice; the number of practicing mid-level providers; full time vs. part time availability expressed in terms of a full time equivalent (FTE); hospital emergency department coverage; coverage for vacations, continuing medical education, or personal time off; patient outmigration; the geographical referral area for the given specialty; waiting times for appointments; insurance plans accepted by the physician practice; the growing national shortage of physicians; the length of time it can take to successfully recruit a physician to the community and begin practicing; and other important qualitative factors.

For purposes of additional analysis, the physician needs assessment analysis of the service area only reveals a need for physicians in a variety of specialties, and are discussed below. The primary qualitative factor accounted for in this analysis was the age of the practicing physicians in the service area, and the identification of any physician considered to be in the "retirement zone", or 63 years of age or older. It was assumed that any physician in the retirement zone could retire from his/her medical practice at any time and therefore that position must be considered as one possibly needing to be replaced and part of any physician recruitment plan for the future.

Based on the quantitative physician needs assessment analysis completed, the top six physician needs in the service area by specialty are as follows:

- Internal Medicine – 16.71
- Pediatrics – 11.53
- Psychiatrist – 8.40
- Radiology – 12.60

Qualitative Factors to be assessed

1. Age of current physicians practicing in the service—by specialty. For those at age 60 and above it should be assumed they are in the possible retirement zone and their position should be accounted for in recruitment planning. This is especially true given the length of time successful recruitment can take.
2. Quality or service issues that may cause the physician to be asked to leave or be replaced.
3. Waiting times for new patient appointments.
4. Full-time vs. part-time status (FTE count).
5. Emergency department call coverage and any gaps that may exist.
6. Coverage for vacations, continuing medical education time off, personal time off, etc.
7. The specialty of "Hospitalist" is a newer specialty, and therefore the four national physician need models do not account for this specialty.
8. Patient outmigration by specialty.
9. Patient satisfaction by physician.
10. Size of individual physician practices/approximate patient counts and patients seen per day on average.

ATTACHMENT D: COMMUNITY INPUT

Good Samaritan Medical Center

2019 Community Health Needs Assessment – Survey

Dear valued member of the Knox County community:

My name is _____ I am with Blue & Co. We are assisting Good Samaritan Hospital in completing their Community Health Needs Assessment for 2019. The goal of this project is to gather local data and feedback as part of developing a plan to improve health and quality of life in Knox County. A combination of surveys and interviews are being used to engage community members. You have been selected for survey because of your knowledge, insight, and familiarity with the community. The themes that emerge from these interviews will be summarized and made available to the public; however, individual survey answers will be kept strictly confidential.

We anticipate that this survey will take you less than 20 minutes to complete and we certainly appreciate you taking time out of your busy day to participate.

---

1. Please enter the following information:

    i. Name: _____

    ii. County of Residence _____

    iii. Number of Years Lived in the County _____

2. Identify the top three most significant health care prevention, treatment, and awareness needs in the community (circle three).

   Affordable health insurance   Health promotion services lacking

   Affordable health care prices   Mental health education lacking

   Mental health services availability   Places to exercise lacking

blue

Addiction care service availability

Primary care provider availability

Specialty care provider Availability

Healthy food availability

Financial issues

Food and nutrition education

General health education lacking

Community events lacking

Lack of community interests

Other:_____

3. Are you aware of the health care services available in your community?
   i. Completely aware
   ii. Somewhat aware
   iii. Not aware

4. How do you generally describe the health status of your community?
   i. Excellent
   ii. Good
   iii. Fair
   iv. Poor

5. Are the health care needs currently being met in your community?
   i. Completely agree
   ii. Somewhat agree
   iii. Somewhat disagree
   iv. Completely disagree

6. Please share any health care needs of the community that are not being met.

   _____

   _____

7. Health care providers work well together and coordinate care in this community.
   i. Completely agree
   ii. Somewhat agree
   iii. Somewhat disagree
   iv. Completely disagree

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8. There are barriers that exist in government, the general community, public health community, or health care provider community that prevents us from creating a healthier community.
    i. Completely agree
    ii. Somewhat agree
    iii. Somewhat disagree
    iv. Completely disagree

9. Please share any barriers that exist in government, the general community, public health community, or health care provider community that prevents creating a healthier community.

    _____

    _____

10. Please share any general comments about the Health Needs in the Community.

    _____

    _____

blue

KEY INFORMANT INTERVIEW – RESULTS for ANALYSIS

Community Health Needs Assessment for Good Samaritan Hospital, Vincennes, Indiana:

Interviewer's Initials:_____

Date:_____ Start Time: _____ End Time:_____

Name of Person Interviewed: _____ Title:_____

Agency/Organization: _____

# of years living in: _____ County: _____

# of years in current position: _____

Questions:
1. In general, how would you rate health and quality of life in Knox County?

2. In your opinion, has health and quality of life in <u>Knox</u> County improved, stayed the same, or declined over the past few years?

a. Why do you think it has (based on answer from previous question: improved, declined, or stayed the same)?

b. What other factors have contributed to the (based on answer to question 2: improvement, decline **or** to health and quality of life staying the same)?

3. Are there people or groups of people in Knox County whose health or quality of life may not be as good as others?

a. Who are these persons or groups (whose health or quality of life is not as good as others)?

c. Why do you think their health/quality of life is not as good as others?

4. What barriers, if any, exist to improving health and quality of life in Knox County?

5. In your opinion, what are the most critical health and quality of life issues in <u>Knox</u> County?

a. What needs to be done to address these issues?

6. Do you think access to Health Services has improved over the last 3 years? Why or why not?

7. What is your familiarity with various outreach efforts of Good Samaritan Hospital regarding Heart Disease, Cancer and Stroke? Do you think the outreach is helpful and effective? Do you have any suggestions for additional outreach opportunities?

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8. Please provide insight and observations regarding certain health behaviors in the community surrounding obesity, physical inactivity, drug abuse and tobacco use. Have any noticeable improvements been made in these areas during the last three years?   What organizations are addressing these issues and what are they doing? What do you think is the best way to change behaviors in these areas?

9. What is the most important issue the hospital should address in the next 3-5 years?

Is there anything you would like to add?

ATTACHMENT E: CITATIONS

2018 REPORT

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**Community Health
Needs Assessment**