LAWRENCE COUNTY MEMORIAL HOSPITAL
LAWRENCEVILLE, ILLINOIS

2013 COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION PLAN

ADOPTED BY BOARD RESOLUTION (JUNE 5, 2013)[1]

QHR | Consulting Services

[1] Response to Schedule H (Form 990) Part V B 2 and section 501(r)1

QHR | Consulting Services

Dear Community Resident:

Lawrence County Memorial Hospital (LCMH) welcomes you to review this document as we strive to meet the health and medical needs in our community. All not-for-profit hospitals are required to develop this report in compliance with the Affordable Care Act.

The "2013 Community Health Needs Assessment" identifies local health and medical needs and provides a plan to indicate how LCMH will respond to such needs. This document suggests areas where other local organizations and agencies might work with us to achieve desired improvements and illustrates one way we, LCMH, are meeting our obligations to efficiently deliver medical services.

LCMH will conduct this effort at least once every three years. As you review this plan, please see if, in your opinion, we have identified the primary needs and if our intended response should make appropriate needed improvements.

We do not have adequate resources to solve all the problems identified. Some issues are beyond the mission of the hospital and action is best suited for a response by others. Some improvements will require personal actions by individuals rather than the response of an organization. We view this as a plan for how we, along with other organizations and agencies, can collaborate to bring the best each has to offer to address the more pressing, identified needs.

The report is a response to a federal requirement of not-for-profit hospitals to identify the community benefit it provides in responding to documented community need. Footnotes are provided to answer specific tax form questions. For most purposes, they may be ignored. Of greater importance, however, is the potential for this report to guide our actions and the efforts of others to make needed health and medical improvements.

Please think about how to help us improve the health and medical services our area needs. I invite your response to this report. We all live and work in this community together and our collective efforts can make living here more enjoyable and healthier.

Thank You

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Table of Contents

EXECUTIVE SUMMARY

Executive Summary

Lawrence County Memorial Hospital ("LCMH" or the "Hospital") is organized as a not-for-profit hospital. A Community Health Needs Assessment (CHNA) is part of the required hospital documentation of "Community Benefit" under the Affordable Care Act (ACA), required of all not-for-profit hospitals as a condition of retaining tax-exempt status. A CHNA assures LCMH identifies and responds to the primary health needs of its residents.

This study is designed to comply with standards required of a not-for-profit hospital[2]. Tax reporting citations in this report are superseded by the most recent 990 H filings, if any, made by the hospital.

In addition to completing a CHNA, and funding necessary improvements, a not-for-profit hospital must document the following:

- Financial assistance policy and policies relating to emergency medical care;
- Billing and collections; and
- Charges for medical care.

Further explanation and specific regulations are available from Health and Human Services (HHS), the Internal Revenue Service (IRS), and the U.S. Department of the Treasury[3].

Project Objectives

LCMH partnered with Quorum Health Resources (QHR) for the following[4]:

- Complete a CHNA report, compliant with Treasury – IRS;
- Provide the Hospital with information required to complete the IRS – 990h schedule; and
- Produce the information necessary for the Hospital to issue an assessment of community health needs and document its intended response.

Brief Overview of Community Health Needs Assessment

Typically, non-profit hospitals qualify for tax-exempt status as a Charitable Organization, described in Section 501(c) 3 of the Internal Revenue Code; however, the term 'Charitable Organization' is undefined. Prior to the passage of Medicare, charity was generally recognized as care provided to the

[2] Part 3 Treasury/IRS – 2011 – 52 Notice … Community Health Needs Assessment Requirements… and https://www.federalregister.gov/articles/2013/04/05/2013-07959/community-health-needs-assessments-for-charitable-hospitals
[3] As of the date of this report Notice of proposed rulemaking was published 6/26/2012 and available at http://federalregister.gov/a/2012-15537
[4] Part 3 Treasury/IRS – 2011 – 52 Section 3.03 (2) third party disclosure notice

less fortunate without means to pay. With the introduction of Medicare, the government met the burden of providing compensation for such care.

In response, IRS Revenue ruling 69-545 eliminated the Charitable Organization standard and established the Community Benefit Standard as the basis for tax-exemption. Community Benefit determines if hospitals promote the health of a broad class of individuals in the community, based on factors including:

- Emergency room open to all, regardless of ability to pay;
- Surplus funds used to improve patient care, expand facilities, train, etc.;
- Controlled by independent civic leaders; and
- All available and qualified physicians are privileged.

Specifically, the IRS requires:

- Effective on tax years beginning after March 23, 2012, each 501(c) (3) hospital facility is required to conduct a CHNA at least once every three taxable years and adopt an implementation strategy to meet the community needs identified through such assessment;
- The assessment may be based on current information collected by a public health agency or non-profit organization and may be conducted together with one or more other organizations, including related organizations;
- The assessment process 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 or expertise of public health issues;
- The hospital must disclose in its annual information report to the IRS (Form 990 and related schedules) how it is addressing the needs identified in the assessment, and, if all identified needs are not addressed, the reasons why (e.g., lack of financial or human resources);
- Each hospital facility is required to make the assessment widely available and ideally downloadable from the hospital web site;
- Failure to complete a CHNA in any applicable three-year period results in a penalty to the organization of $50,000. For example, if a facility does not complete a CHNA in taxable years one, two, or three, it is subject to the penalty in year three. If it then fails to complete a CHNA in year four, it is subject to another penalty in year four (for failing to satisfy the requirement during the three-year period beginning with taxable year two and ending with taxable year four); and
- An organization that fails to disclose how it is meeting needs identified in the assessment is subject to existing incomplete return penalties[5].

[5] Section 6652

- This report was developed under the guidance of IRS/Treasury 2011-52 as modified by the Draft Federal Regulations published in the April 5, 2013 Federal Register.

APPROACH

Approach

To complete a CHNA, the hospital must:

- Describe the processes and methods used to conduct the assessment;
    - Sources of data and dates retrieved;
    - Analytical methods applied;
    - Information gaps impacting ability to assess the needs; and
    - Identification of with whom the Hospital collaborated.
- The proposed regulations provide that a hospital facility's CHNA report will be considered to describe how the hospital facility took into account input if the CHNA report:
    1) Summarizes, in general terms, the input provided and how and over what time period such input was provided;
    2) Provides the names of organizations providing input and summarizes the nature and extent of the organization's input; and
    3) Describes the medically underserved, low income, or minority populations being represented by organizations or individuals providing input.
- Describe the process and criteria used in prioritizing health needs;
- Describe existing resources available to meet the community health needs; and
- Identify the programs and resources the hospital facility plans to commit to meeting each identified need, and the anticipated impact of those programs and resources on the health need.

QHR takes a comprehensive approach to assess community health needs. We perform several independent data analyses based on secondary source data, augment this with local survey data, and resolve any data inconsistency or discrepancies from the combined opinions formed from local experts. We rely on secondary source data, and most secondary sources use the county as the smallest unit of analysis. We asked our local expert area residents to note if they perceived the problems or needs identified by secondary sources to exist in their portion of the county[6].

[6] Response to Schedule H (Form 990) Part V B 1 i

Most data used in the analysis is available from public internet sources. Critical data needed to address specific regulations or developed by the individuals cooperating with us in this study is displayed in the report of the appendix. Data sources include[7]:

Web Site or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Lawrence County compared to all Illinois counties	May 2, 2013	2002 to 2010
www.communityhealth.hhs.gov	Assessment of health needs of Lawrence County compared to its national set of "peer counties"	May 2, 2013	1996 to 2009
Truven (formerly known as Thomson) Market Planner	Assess characteristics of the hospital's primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according to the contribution each group makes to the entire area; and, to access population size, trends, and socio-economic characteristics	May 2, 2013	2012
www.capc.org and www.getpalliativecare.org	To identify the availability of Palliative Care programs and services in the area	May 2, 2013	2012
www.caringinfo.org and iweb.nhpco.org	To identify the availability of hospice programs in the county	May 2, 2013	2012
www.healthmetricsandevaluation.org	To examine the prevalence of diabetic conditions and change in life expectancy	May 2, 2013	1989 through 2009
www.dataplace.org	To determine availability of specific health resources	May 2, 2013	2005
www.cdc.gov	To examine area trends for heart disease and stroke	May 2, 2013	2008 to 2010

[7] Response to Schedule H (Form 990) Part V B 1 d

Web Site or Data Source	Data Element	Date Accessed	Data Date
www.CHNA.org	To identify potential needs among a variety of resource and health need metrics	May 2, 2013	2003 to 2010
www.datawarehouse.hrsa.gov	To identify applicable manpower shortage designations	May 2, 2013	2013
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	May 2, 2013	2010 published 11/29/12

- In addition, we deployed a CHNA "Round 1" survey to our local expert advisors to gain local input as to local health needs and the needs of priority populations. Local expert advisors were local individuals selected to conform to the input required by the Federal guidelines and regulations[8].
- We received community input from 19 local expert advisors. Survey responses started Saturday, April 20, 2013 at 12:42 P.M. and ended with the last response on Monday, May 6, 2013 at 9:36 A.M.;
- Information analysis augmented by local opinions showed how Lawrence County relates to its peers in terms of primary and chronic needs and other issues of uninsured persons, low-income persons, and minority groups. Respondents commented on if they believe certain population groups (or people with certain situations) need help to improve their condition, and if so, who needs to do what[9].

When the analysis was complete, we put the information and summary conclusions before our local group of experts[10], who were asked to agree or disagree with the summary conclusions. They were free to augment potential conclusions with additional statements of need, and new needs did emerge from this exchange[11]. Consultation with 19 local experts occurred again via an internet-based survey (explained below) during the period beginning Friday, May 10, 2013 at 12:12 P.M. and ending Tuesday, May 28, 2013 at 2:04 P.M.

With the prior steps identifying potential community needs, the local experts participated in a structured communication technique called a Delphi method, originally developed as a systematic, interactive forecasting method that relies on a panel of experts. Experts answer questionnaires in a series of rounds. We contemplated and implemented one round as referenced during the above dates. After each round, we provided an anonymous summary of the experts' forecasts from the previous round, as well as reasons provided for their judgments. The process encouraged experts to revise their earlier answers in light of the replies of other members of their panel. Typically, this

[8] Response to Schedule H (Form 990) Part V B 1 h; complies with 501(r)(3)(B)(i)
[9] Response to Schedule H (Form 990) Part V B 1 f
[10] Part response to Schedule H (Form 990) Part V B 3
[11] Response to Schedule H (Form 990) Part V B 1 e

process decreases the range of answers and moves the expert opinions toward a consensus "correct" answer. The process stops when we identify the most pressing, highest priority, community needs.

In the LCMH process, each local expert allocated 100 points among all identified needs, having the opportunity to introduce needs previously unidentified and challenge conclusions developed from the data analysis. A rank order of priorities emerged, with some needs receiving none or virtually no support, and other needs receiving identical point allocations.

We dichotomized the rank order into two groups: high priority needs and low priority needs. The determination of the break point - high as opposed to low - was a qualitative interpretation by QHR and the LCMH executive team, where a reasonable break point in rank occurred, indicated by the amount of points each potential need received and the number of local experts allocating any points to the need. When presented to the LCMH executive team, the divided need rank order identified which needs the Hospital considered high responsibility to respond vs. low responsibility to respond. The result provided a matrix of needs and guided the Hospital in developing its implementation response[12].

The proposed regulations provide that, in order to assess the community it serves, a hospital facility must identify significant health needs of the community, prioritize them, and then identify potential measures and resources available to address them, such as programs, organizations, and facilities in the community[13]. The proposed regulations clarify a CHNA need only identify significant health needs, and need only prioritize, and otherwise assess, those significant identified health needs. A hospital facility may determine whether a health need is significant based on all of the facts and circumstances present in the community it serves[14]. By definition, the high priority needs are deemed "significant" needs as defined by the regulations.

[12] Response to Schedule H (Form 990) Part V Section B 6 g, h and Part V B 1 g
[13] Draft regulations page 30
[14] Draft regulations page 32

FINDINGS

Findings

Definition of Area Served by Lawrence County Memorial Hospital[15]

LCMH, in conjunction with QHR, defines its service area as Lawrence County in State, which includes the following zip codes:

62417 – Bridgeport

62439 – Lawrenceville

62460 – Saint Francisville

62466 - Sumner

In 2011, the Hospital received 89.2% of its patients from this area.[16]

[15] Responds to IRS Form 990 (h) Part V B 1 a
[16] Truven MEDPAR patient origin data for the hospital; Responds to IRS Form 990 (h) Part V B 1 a

Demographic of the Community[17]

The 2013 population for Lawrence County is estimated to be 16,112[18] and expected to decline at a rate of -1.4%. This is in contrast to the 3.3% national rate of growth and the Illinois growth rate of 0.9%. Lawrence County in 2018 anticipates a population of 15,892.

According to the population estimates utilized by Truven, provided by The Nielsen Company, the 2013 median age for the county is 40.6 years, which is older than the Illinois median age (37.1 years) and the national median age (37.5 years). The 2013 Median Household Income for the area is $37,811 which is lower than the Illinois median income of $53,462 and the national median income of $49,233. Median Household Wealth value is below the Illinois but exceeds the national value. The Median Home Values in Lawrence County $67,626 is considerably below the state value of $172,253 and the national median of $169,011. Lawrence's unemployment rate as of April 2013 is 6.8%[19], which is considerably lower than the 9.3% Illinois statewide rate, and also considerably lower than the national rate of 7.5%.

The portion of the population in the county over 65 is 16.5%, well above the Illinois average of 13.4%. The portion of the population of women of childbearing age is 14.6%, below the Illinois average of 20.1% and the national average of 19.8%. 4.0% of the population is Hispanic. The largest minority are Black Non-Hispanic at 11.9% of the population. The White Non-Hispanic population comprises 82.9% of the total.

2013 Benchmarks
Area: Lawrence CO
Level of Geography: ZIP Code

Area	2013-2018 % Population Change	Median Age	Population 65+ % of Total Population	Population 65+ % Change 2013-2018	Females 15-44 % of Total Population	Females 15-44 % Change 2013-2018	Median Household Income	Median Household Wealth	Median Home Value
USA	3.3%	37.5	13.9%	16.3%	19.8%	-0.1%	$49,233	$54,682	$169,011
Illinois	0.9%	37.1	13.4%	13.7%	20.1%	-2.4%	$53,462	$64,780	$172,253
Selected Area	-1.4%	40.6	16.5%	6.6%	14.6%	-3.1%	$37,811	$59,808	$67,626

Demographics Expert 2.7
DEMO0003.SQP

[17] Responds to IRS Form 990 (h) Part V B 1 b
[18] All population information, unless otherwise cited, sourced from Truven (formally Thomson) Market Planner
[19] http://research.stlouisfed.org/fred2/series/ILLWURN; http://research.stlouisfed.org/fred2/series/ILUR; http://research.stlouisfed.org/fred2/series/UNRATE

Demographics Expert 2.7
2013 Demographic Snapshot
Area: Lawrence CO
Level of Geography: ZIP Code

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA
2010 Total Population	16,285	308,745,538
2013 Total Population	16,112	314,861,807
2018 Total Population	15,892	325,322,277
% Change 2013 - 2018	-1.4%	3.3%
Average Household Income	$48,270	$69,637

	2013	2018	% Change
Total Male Population	9,057	8,966	-1.0%
Total Female Population	7,055	6,926	-1.8%
Females, Child Bearing Age (15-44)	2,357	2,283	-3.1%

POPULATION DISTRIBUTION

	Age Distribution				
Age Group	2013	% of Total	2018	% of Total	USA 2013 % of Total
0-14	2,540	15.8%	2,530	15.9%	19.6%
15-17	501	3.1%	459	2.9%	4.1%
18-24	1,651	10.2%	1,666	10.5%	10.0%
25-34	2,355	14.6%	2,320	14.6%	13.1%
35-54	4,446	27.6%	4,117	25.9%	26.9%
55-64	1,955	12.1%	1,961	12.3%	12.4%
65+	2,664	16.5%	2,839	17.9%	13.9%
Total	16,112	100.0%	15,892	100.0%	100.0%

HOUSEHOLD INCOME DISTRIBUTION

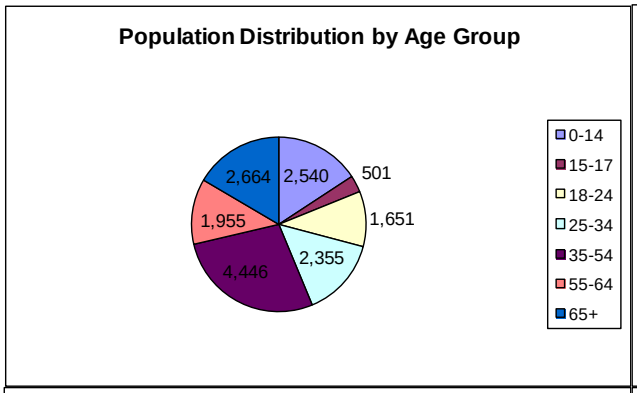
	Income Distribution		
2013 Household Income	HH Count	% of Total	USA % of Total
<$15K	1,134	22.0%	14.9%
$15-25K	192	3.7%	4.7%
$25-50K	1,661	32.3%	27.3%
$50-75K	1,100	21.4%	19.5%
$75-100K	441	8.6%	12.6%
Over $100K	615	12.0%	21.0%
Total	5,143	100.0%	100.0%

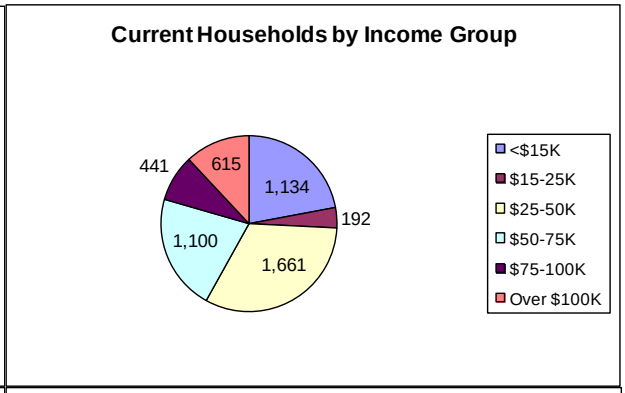
EDUCATION LEVEL

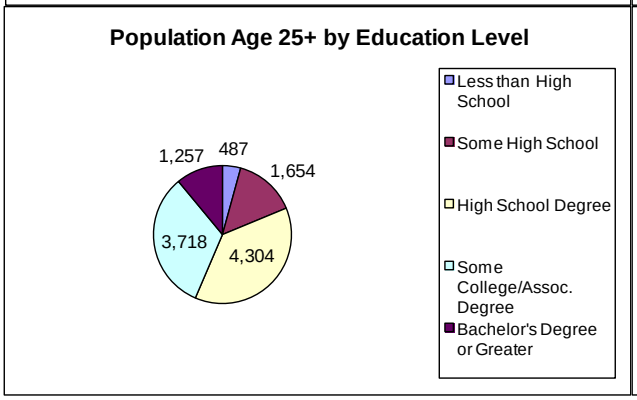
	Education Level Distribution		
2013 Adult Education Level	Pop Age 25+	% of Total	USA % of Total
Less than High School	487	4.3%	6.2%
Some High School	1,654	14.5%	8.4%
High School Degree	4,304	37.7%	28.4%
Some College/Assoc. Degree	3,718	32.6%	28.9%
Bachelor's Degree or Greater	1,257	11.0%	28.1%
Total	11,420	100.0%	100.0%

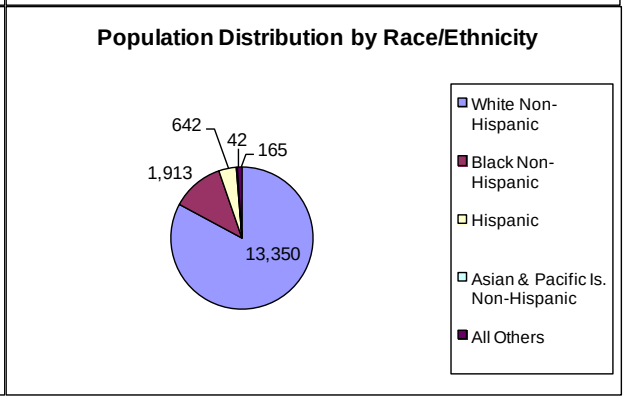
RACE/ETHNICITY

	Race/Ethnicity Distribution		
Race/Ethnicity	2013 Pop	% of Total	USA % of Total
White Non-Hispanic	13,350	82.9%	62.3%
Black Non-Hispanic	1,913	11.9%	12.3%
Hispanic	642	4.0%	17.3%
Asian & Pacific Is. Non-Hispanic	42	0.3%	5.1%
All Others	165	1.0%	2.9%
Total	16,112	100.0%	100.0%









The population also was examined according to characteristics presented in the Claritas Prizm customer segmentation data. This system segments the population into 66 demographically and

behaviorally distinct groups. Each group, based on annual survey data, is documented as exhibiting specific health behaviors. The makeup of the service area, according to the mix of Prizm segments and its characteristics, is contrasted to the national population averages to discern the following table of probable lifestyle and medical conditions present in the population. Items with red text are viewed as statistically important adverse potential findings. Items with blue text are viewed as statistically important potential beneficial findings. Items with black text are viewed as either not statistically different from the national normal situation or not being a favorable nor an unfavorable consideration in our use of the information.

Health Service Topic	Demand as % of National	% of Population Affected	Health Service Topic	Demand as % of National	% of Population Affected
Weight / Lifestyle			**Heart**		
BMI: Morbid/Obese	113.4%	29.0%	Routine Screen: Cardiac Stress 2yr	95.0%	14.8%
Vigorous Exercise	92.9%	47.1%	Chronic High Cholesterol	102.8%	22.9%
Chronic Diabetes	126.3%	13.1%	Routine Cholesterol Screening	90.5%	46.0%
Healthy Eating Habits	89.7%	26.5%	Chronic High Blood Pressure	124.4%	32.8%
Very Unhealthy Eating Habits	136.9%	3.8%	Chronic Heart Disease	129.2%	10.8%
Behavior			**Routine Services**		
I Will Travel to Obtain Medical Care	99.2%	29.4%	FP/GP: 1+ Visit	103.4%	91.2%
I Follow Treatment Recommendations	84.9%	34.3%	Used Midlevel in last 6 Months	106.4%	44.4%
I am Responsible for My Health	91.6%	57.7%	OB/Gyn 1+ Visit	84.3%	39.5%
Pulmonary			Ambulatory Surgery last 12 Months	102.8%	19.8%
Chronic COPD	116.5%	8.5%	**Internet Usage**		
Tobacco Use: Cigarettes	117.5%	30.4%	Use Internet to Talk to MD	74.7%	10.9%
Chronic Allergies	121.8%	22.4%	Facebook Opinions	84.6%	8.7%
Cancer			Looked for Provider Rating	82.1%	11.8%
Mammography in Past Yr	94.4%	42.8%	**Misc**		
Cancer Screen: Colorectal 2 yr	93.1%	23.5%	Charitable Contrib: Hosp/Hosp Sys	90.6%	21.6%
Cancer Screen: Pap/Cerv Test 2 yr	85.5%	51.4%	Charitable Contrib: Other Health Org	84.1%	32.7%
Routine Screen: Prostate 2 yr	95.4%	30.4%	HSA/FSA: Employer Offers	90.5%	47.2%
Orthopedic			**Emergency Service**		
Chronic Lower Back Pain	110.6%	24.9%	Emergency Room Use	108.4%	36.8%
Chronic Osteoporosis	117.9%	11.4%	Urgent Care Use	94.6%	22.3%

Leading Causes of Death

Cause of Death			Rank among all counties in IL	Rate of Death per 100,000 age adjusted		
IL Rank	Lawrence Co. Rank	Condition	(#1 rank = worst in state)	IL	Lawrence Co.	Observation
1	1	Heart Disease	47 of 102	183.2	223.0	As expected
2,10,13,14,18, 27,29,30,31,33, 34,35,37,40	2	Cancer	20 of 102	181.6	212.2	Higher than expected
3	3	Stroke	10 of 102	38.8	67.5	Higher than expected
4	4	Lung	20 of 102	40.2	55.4	Higher than expected
22, 25, 26	5	Accidents	26 of 102	30.2	51.3	Higher than expected
9	6	Diabetes	7 of 102	20.6	32.0	Higher than expected
6	6	Alzheimer's	14 of 102	20.8	32.0	Higher than expected
11	8	Flu - Pneumonia	39 of 102	17.7	22.7	As expected
8	9	Kidney	27 of 102	20.1	20.6	Higher than expected
12	10	Blood Poisoning	22 of 102	15.0	15.8	Higher than expected
19	11	Suicide	29 of 102	9.0	11.8	As expected
24	12	Parkinson's	13 of 101	6.7	9.4	Higher than expected
7	13	Hypertension	50 of 102	6.5	7.0	Lower than expected
21	14	Liver	73 of 102	8.2	5.7	Lower than expected
28	15	Homicide	59 of 81	6.8	1.7	Lower than expected

Primary and Chronic Disease Needs and Health Issues of Uninsured Persons, Low-Income Persons, and Minority Groups

Some information is available to describe the size and composition of various uninsured persons, low income persons, minority groups, and other vulnerable population segments. Specific studies identifying needs of such groups, distinct from the general population at a county unit of analysis, are not readily available from secondary sources.

The National Healthcare Disparities Report results from a Congressional directive to the Agency for Healthcare Research and Quality (AHRQ). This production is an annual report to track disparities related to "racial factors and socioeconomic factors in priority populations." The emphasis is on disparities related to race, ethnicity, and socioeconomic status. The directive includes a charge to examine disparities in "priority populations," which are groups with unique healthcare needs or issues that require special attention[20].

Nationally, this report observes the following trends:

- Measures for which Blacks were worse than Whites and are getting better:
  - Diabetes – Hospital admissions for short-term complications of diabetes per 100,000 population;
  - HIV and AIDS – New AIDS cases per 100,000 population age 13 and over; and
  - Functional Status Preservation and Rehabilitation. Female Medicare beneficiaries age 65 and over, who reported ever being screened for osteoporosis with a bone mass or bone density measurement.
- Measures for which Blacks were worse than Whites and staying the same:
  - Cancer – Breast cancer diagnosed at advanced stage per 100,000 women age 40 and over ; breast cancer deaths per 100,000 female population per year; adults age 50 and over who ever received colorectal cancer screening; colorectal cancer diagnosed at advanced stage per 100,000 population age 50 and over; colorectal cancer deaths per 100,000 population per year;
  - Diabetes – Hospital admissions for lower extremity amputations per 1,000 population age 18 and over with diabetes;
  - Maternal and Child Health – Children ages 2-17 who had a dental visit in the calendar year; Children ages 19-35 months who received all recommended vaccines;

[20] http://www.ahrq.gov/qual/nhdr10/Chap10.htm 2010

  - Mental Health and Substance Abuse – Adults with a major depressive episode in the last 12 months who received treatment for depression in the last 12 months; people age 12 and over treated for substance abuse who completed treatment course;
  - Respiratory Diseases – Adults age 65 and over who ever received pneumococcal vaccination; hospital patients with pneumonia who received recommended hospital care;
  - Supportive and Palliative Care – High-risk long-stay nursing home residents with pressure sores; short-stay nursing home residents with pressure sores; adult home health care patients who were admitted to the hospital; hospice patients who received the right amount of medicine for pain;
  - Timeliness – Adults who needed immediate care for an illness, injury, or condition in the last 12 months, who received care as soon as they wanted; emergency department visits where patients left without being seen; and
  - Access – People with a usual primary care provider; people with a specific source of ongoing care.
- Measures for which Asians were worse than Whites and getting better:
  - Cancer – Adults age 50 and over who ever received colorectal cancer screening; and
  - Patient Safety – Adult surgery patients who received appropriate timing of antibiotics.
- Measures for which Asians were worse than Whites and staying the same:
  - Respiratory Diseases – Adults age 65 and over who ever received pneumococcal vaccination; hospital patients with pneumonia who received recommended hospital care; and
  - Access – People with a usual primary care provider.
- Measures for which American Indians and Alaska Natives were worse than Whites for the most recent year and staying the same:
  - Heart Disease – Hospital patients with heart failure who received recommended hospital care;
  - HIV and AIDS – New AIDS cases per 100,000 population age 13 and over;
  - Respiratory Diseases – Hospital patients with pneumonia who received recommended hospital care;
  - Functional Status Preservation and Rehabilitation – Female Medicare beneficiaries age 65 and over who reported ever being screened for osteoporosis with a bone mass or bone density measurement;

  - Supportive and Palliative Care – Hospice patients who received the right amount of medicine for pain; high-risk, long-stay nursing home residents with pressure sores; adult home healthcare patients who were admitted to the hospital; and
  - Access – People under age 65 with health insurance.
- Measures for which American Indians and Alaska Natives were worse than Whites for the most recent year and getting worse:
  - Cancer – Adults age 50 and over who ever received colorectal cancer screening; and
  - Patient safety – Adult surgery patients who received appropriate timing of antibiotics.
- Measures for which Hispanics were worse than non-Hispanic Whites for the most recent year and getting better:
  - Maternal and Child Health – Children ages 2-17 who had a dental visit in the calendar year;
  - Lifestyle Modification – Adult current smokers with a checkup in the last 12 months who received advice to quit smoking; adults with obesity who ever received advice from a health provider about healthy eating; and
  - Functional Status Preservation and Rehabilitation – Female Medicare beneficiaries age 65 and over who reported ever being screened for osteoporosis with a bone mass or bone density measurement.
- Measures for which Hispanics were worse than non-Hispanic Whites for most recent year and staying the same:
  - Cancer – Women age 40 and over who received a mammogram in the last 2 years; adults age 50 and over who ever received colorectal cancer screening;
  - Diabetes – Adults age 40 and over with diagnosed diabetes who received all three recommended services for diabetes in the calendar year;
  - Heart Disease – Hospital patients with heart attack and left ventricular systolic dysfunction who were prescribed angiotensin-converting enzyme inhibitor or angiotensin receptor blocker at discharge; hospital patients with heart failure who received recommended hospital care;
  - HIV and AIDS – New AIDS cases per 100,000 population age 13 and over;
  - Mental Health and Substance Abuse – Adults with a major depressive episode in the last 12 months who received treatment for depression in the last 12 months;
  - Respiratory Disease – Adults age 65 and over who ever received pneumococcal vaccination; hospital patients with pneumonia who received recommended hospital care;

- Lifestyle Modification – Adults with obesity who ever received advice from a health provider to exercise more;
- Supportive and Palliative Care – Long-stay nursing home residents with physical restraints; high-risk, long-stay nursing home residents with pressure sores; short-stay nursing home residents with pressure sores; adult home health care patients who were admitted to the hospital; hospice patients who received the right amount of medicine for pain;
- Patient Safety – Adult surgery patients who received appropriate timing of antibiotics;
- Timeliness – Adults who needed care right away for an illness, injury, or condition in the last 12 months and got care as soon as wanted;
- Patient Centeredness – Adults with ambulatory visits who reported poor communication with health providers; children with ambulatory visits who reported poor communication with health providers; and
- Access – People under age 65 with health insurance; people under age 65 who were uninsured all year; people with a specific source of ongoing care; people with a usual primary care provider; people unable to get or delayed in getting needed care due to financial or insurance reasons

- Measures for which Hispanics were worse than non-Hispanic Whites for the most recent year and getting worse:
  - Maternal and Child Health – Children ages 3-6 who ever had their vision checked by a health provider.

We asked a specific question to our local expert advisors about unique needs of priority populations. We reviewed their responses to identify if any of the above trends were obvious in the service area. Accordingly, we place great reliance on the commentary received to identify unique population needs to which we should respond. Specific opinions from the local expert advisors are summarized as follows[21]:

- Low income community members (uninsured) have many needs
- Asthma, children needs and education are needed by the people
- Obesity, mental health, diabetes and cancer are a second tier of concerns where assistance is needed in keeping healthy

Statistical information about special populations follows:

[21] All comments and the analytical framework behind developing this summary appear in Appendix A.

Access to Care: Lawrence County, IL

In addition to use of services, access to care may be characterized by medical care coverage and service availability

Uninsured individuals (age under 65)[1]	**1,698**
Medicare beneficiaries[2]	
Elderly (Age 65+)	**2,654**
Disabled	**501**
Medicaid beneficiaries[2]	**3,671**
Primary care physicians per 100,000 pop[2]	**36.0**
Dentists per 100,000 pop[2]	**12.0**
Community/Migrant Health Centers[3]	**No**
Health Professional Shortage Area[3]	**No**

nda No data available.

[1] The Census Bureau. Small Area Health Insurance Estimates Program, 2006.
[2] HRSA. Area Resource File, 2008.
[3] HRSA. Geospatial Data Warehouse, 2009.

Data Details

Vulnerable Populations: Lawrence County, IL

Vulnerable populations may face unique health risks and barriers to care, requiring enhanced services and targeted strategies for outreach and case management.

Vulnerable Populations Include People Who[1]	
Have no high school diploma (among adults age 25 and older)	**2,249**
Are unemployed	**629**
Are severely work disabled	**510**
Have major depression	**887**
Are recent drug users (within past month)	**1,059**

nda No data available.

[1] The most current estimates of prevalence, obtained from various sources (see the Data Sources, Definitions, and Notes for details), were applied to 2008 mid-year county population figures.

Findings

Upon completion of the CHNA, QHR identified several issues within Lawrence County[22]:

Conclusions from Public Input to Community Health Needs Assessment

Our group of 20 Local Expert Advisors participated in an on-line survey to offer opinions about their perceptions of community health needs and potential needs of unique populations.

Responses were first obtained to the question: "What do you believe to be the most important health or medical issue confronting the residents of your County?" In summary, we receive the following commentary regarding the more important health or medical issues:

- Many health care needs due to a lack of resources in the County;
- The most mentioned issues included concerns about children issues, mental health issues and the affordability (insurance) of care;
- The next highest frequency mentions were specific service needs of nutritional needs and cancer; and
- A lower order of priority mentions included emergency services, prevention, physical activity and educational needs.

Responses were then obtained to the question: "Do you perceive there are any primary and/or chronic disease needs, as well as potential health issues, of uninsured persons, low-income persons, minority groups and/or other population groups (i.e. people with certain situations) which need help or assistance in order to improve? If you believe any situation as described exists, please also indicate who you think needs to do what?" In summary, we received the following commentary regarding the more important health or medical issues:

- Low income community members (uninsured) have many needs;
- Asthma, children needs and education are needed by the people; and
- Obesity, mental health, diabetes and cancer are a second tier of concerns where assistance is needed in keeping healthy.

[22] The Finding duplicate the material provided to the Local Expert Advisors to facilitate their role in the need identification process. The time between when the Local Expert Advisors were consulted and the time the report was produced results in some information being more current and presented in other parts of the document. Whenever facts are in conflict, the material in other sections of the report is the most current.

Summary of Observations from Lawrence County Compared to All Other Illinois Counties, in Terms of Community Health Needs

In general, Lawrence County residents are among the least healthy compared to the healthiest in Illinois.

- In a health status classification termed "Health Outcomes", Lawrence ranks number 89 among the 102 Illinois ranked counties (best being #1). Typifying the problem, Premature Death (deaths prior to age 75) is about 25% higher than average for Illinois and Illinois is slightly better than the national average. The Illinois and national Premature Death rates have been declining in contrast to the Lawrence rate which despite variation, remains virtually unchanged from its excessive rate of eleven years ago;
- Clinical conditions warranting investigation because of adverse values include the following:
    - Obesity – 29% of adults with increasing trend, faster than IL or US trend;
    - Motor Vehicle Crash Death Rate – 19 per 100,000, significantly higher than IL or US 90th percentile of all counties of 10;
    - Primary Care Physician to Population Ratio – 3,367 residents per physician which is significantly higher than IL average of 1,630:1 or the US benchmark of 90th percentile of all counties of 1,516:1;
    - Dentists to Population Ratio – 9,652 residents per physician which is significantly higher than the IL average of 1,630:1 or the US 90th Percentile of all counties of 1,516:1;
    - Preventable Hospital Stays – 110 hospital admissions per 1,000 Medicare enrollees which is significantly higher than the IL average of 75 or the US 90th percentile rate of 47, and, the Lawrence rate has remained virtually unchanged for the last seven years while IL and US 90th percentile rates declined; and
    - Diabetic Screening – 64% of diabetic Medicare enrollees which is significantly lower than the IL average of 84% and the US 90th percentile rate of 90%.
- High School Graduation – 80% which is significantly lower than the IL average of 82%;
- Some College – 44% of young adults have some college experience compared to the IL average of 66% or the US 90th percentile rate of 70%;
- Particulate Matter (air pollution) – 13.4 micrograms per cubic meter which is significantly higher than the IL average of 12.3 or the US 90th percentile rate of 8.8; and

- Drinking Water Safety – 5% of Lawrence County residents were/are exposed to water exceeding a violating limit in last year which is significantly higher than the IL average of 3% or the US 90th percentile benchmark of 0%.

Summary of Observations from Lawrence County Peer Comparisons

The federal government administers a process to allocate all counties into "peer" groups. County "peer" groups have similar social, economic, and demographic characteristics. Health and wellness observations when Lawrence County is compared to its national set of peer counties and compared to national rates make the following observations:

UNFAVORABLE - observations occurring at rates worse than national AND worse than among peers:

- Births to women under 18;
- Infant mortality;
- White non-Hispanic infant mortality;
- Post neonatal infant mortality;
- Breast cancer (female);
- Colon cancer;
- Lung cancer;
- Motor vehicle injuries; and
- Stroke.

SOMEWHAT A CONCERN - observations because occurrence is EITHER above national average OR above peer group average:

- Low birth weight (less than 2,500g);
- Births to unmarried women;
- Neonatal infant mortality;
- Coronary heart disease; and
- Suicide.

BETTER PERFORMANCE – better than peers and national rates:

- Unintentional injury;
- No care in first trimester;
- Very low birth weight (less than 1,500g);
- Births to women age 40 to 54; and

- Premature births.

Conclusions from the Demographic Analysis Comparing Lawrence County to National Averages

Lawrence County in 2012[23] comprises 16,433 residents. Since 2000 it has experienced population increase and anticipates continued growth faster than average for Illinois, but slower than the US average growth rate, through the next five years to achieve 16,856 residents. The population is 83.8% non-Hispanic White. Asian & Pacific Island non-Hispanics constitute 0.2% of the population. Hispanics comprise 3.8% of the population. Black non-Hispanics are the largest minority population at 11.1%.

24.8% of the population is age 65 or older. This is a considerably larger, double, the population segment than the elderly comprise elsewhere in Illinois (12.3%) or in comparison to the national average (12.9%). 14.8% of the women are in the childbirth population segment. This segment is considerably smaller than as elsewhere in Illinois (20.5%) or in comparison to the national average (20.1%). The median income, median home value and household wealth are below the Illinois and national averages.

The following areas were identified from a comparison of the county to national averages:

Metrics impacting more than 25% of the population and statistically significantly different from the national average include the following. All are considered adverse findings unless otherwise noted:

- I am responsible for my health 8% below average impacting 57% of the population;
- Obtained a Pap/Cervix test in last 2 years 15% below average impacting 51% of the population;
- Engage in Vigorous Exercise is 7% below average impacting 47% of the population;
- Obtain routine cholesterol screening is 10% below average impacting 46% of the population;
- Obtain Mammogram in last two years is 6% below average impacting 43% of the population;
- Had at least one OB/GYN visit in last year 16% below average impacting 40% of the population;
- Used Emergency Room in last year 8% above average impacting 37% of population;
- Follow treatment recommendations 15% below normal impacting 34% of the population;
- Chronic high blood pressure 25% above average impacting 33% of the population;
- Tobacco Use 18% above average impacting 30% of the population;

[23] This is the information considered by the Local Expert Advisors. Subsequently more recent data became available and is cited elsewhere in this report.

- Morbid obese 13% above average impacting 29% of the population;
- Healthy eating habits 10% below average impacting 26% of the population; and
- Chronic low back pain 11% above average impacting 25% of population.

Situations and Conditions statistically significantly different from the national average but impacting less than 25% of the population include the following. All are considered adverse findings unless otherwise noted:

- Cancer Screening 7% below average impacting 24% of the population;
- Chronic allergies 22% above average impacting 22% of the population;
- Routine cardiac stress testing in last 2 years 5% below average impacting 15% of population;
- Chronic Diabetes 26% above average impacting 15% of the population;
- Chronic Osteoporosis 18% above average impacting 11% of the population;
- Chronic Health Disease 29% above average impacting 11% of the population;
- Chronic COPD 16% above average impacting 8% of the population; and
- Very Unhealthy Eating Habits 37% above average impacting 4% of the population.

Key Conclusions from Consideration of the Other Statistical Data Examinations

Additional observations of Lawrence County found:

- Palliative Care (programs focused not on curative actions but designed to relieve disease symptoms pain and stress arising from serious illness) do not exist in the County. Hospice Care programs to provide comfort care during terminal stage of disease do not exist in the County but services are provided out of Olney; and
- Among the leading causes of death, Lawrence County has a significantly lower death rate in 3 of the 15 leading causes of death (Parkinson's 12th cause, Hypertension 13th cause and Homicide 15th cause) and a significantly higher death rate in 9 of the 15 leading causes of death. Ranking the causes of death in Lawrence County finds the leading causes to be the following (in descending order of occurrence):
    1) Heart Disease 223 (rate per 100,000) – County ranks 47th in IL (1st is worse in state) out of 102 counties, above IL average;
    2) Cancer 212 – significantly higher than expected, County ranks 20th in IL above IL average;
    3) Stroke 67.5 – significantly higher than expected, County ranks 10th in IL above IL average;

4) Lung Disease 55.4 – significantly higher than expected, County ranks 20th in IL above IL average;

5) Accidents 51.3 – County ranks 26th in IL above IL average;

6) (tie) Alzheimer's Disease 32 – significantly higher than expected, ranks 14th in IL above IL average;

6) (tie) Diabetes 32 – significantly higher than expected, ranks 7th in IL above IL average;

8) Flu – Pneumonia 22.7 – at expected death rate, ranks 39th in IL above IL average;

9) Kidney Disease 20.6 – significantly higher than expected, ranks 27th in IL basically at IL average rate of death; and

10) Blood Poisoning 15.8 – significantly higher than expected ranks 29th in IL basically at or little above IL average.

- According to the Center for Disease Control, the incident of Heart Disease Mortality during 2007 through 2009 for Lawrence County is 395.2, above about the national average (359.1). Disease by race is not available;
- The incident of Stroke deaths in Lawrence is 90.6 which is above the national average of 78.6. Again, death rates by race cannot be calculated;
- Life expectancy for both Men and Women has increased during the last 20 years; however, males have improved much better than females. Male life expectancy in 2009 was 7.8 years behind the top 10 best international country rates, a two year improvement. Life expectancy for Women is 6.3 years behind the 10 best international country rates, only an improvement of half a year;
- Lawrence is designated as a Health Professional Shortage Area (HPSA) for primary care based on total county population and upon low income criteria. It also is a HPSA for Dental Health and Mental Health. It also does quality as a Medically Underserved Area, making it eligible for some federal physician recruitment assistance;
- 16.2% of Lawrence County residents live in poverty, whereas 22.46% of children live in poverty. 8.47% of low income residents also have low food access (food store more than 1 mile in urban area or 10 miles in rural areas). This rate is almost double the IL average rate. In contrast, Liquor Store Access is three times the IL average (29.7 per 100,000 compared to IL avg. of 10.1);
- 40.3% of residents have not visited a dentist within the last year which greatly exceeds the IL average rate of 30.88%. Only 5% of residents do not have a regular doctor, which is greatly below (beneficial compared to) the IL average of 16.4%; and

- Expenditures for Cigarettes ranks Lawrence at the 91.18% percentile of all US counties.

EXISTING HEALTH CARE FACILITIES, RESOURCES AND IMPLEMENTATION PLAN

Significant Health Needs

We used the priority ranking of area health needs by the local expert advisors to organize the search for locally available resources as well as the response to the needs by LCMH[24]. The following list includes:

- Identifies the rank order of each identified Significant Need;
- Presents the factors considered in developing the ranking;
- Establishes a Problem Statement to specify the problem indicated by use of the Significant Need term;
- Identifies LCMH current efforts responding to the need;
- Establishes the Implementation Plan programs and resources LCMH will devote to attempt to achieve improvements;
- Documents the Leading Indicators LCMH will use to measure progress;
- Presents the Lagging Indicators LCMH believes the Leading Indicators will influence in a positive fashion; and
- Presents the locally available resources noted during the development of this report as believed to be currently available to respond to this need.

In general, LCMH is the major hospital in the service area. LCMH is a 25 bed critical access, acute care medical facility located in Lawrenceville, IL. The next closest facilities are outside the service area and include:

- Good Samaritan Hospital, a 232 bed acute care facility located in Vincennes, IN (10.8 miles, 17 minutes from LCMH);
- Richland Memorial Hospital, a 97 bed acute care facility located in Olney, IL (21.7 miles, 27 minutes from LCMH);
- Crawford Memorial Hospital, a 25 bed critical access facility located in Robinson, IL (24.6 miles, 35 minutes from LCMH); and
- Wabash General Hospital, a 25 bed critical access facility located in Mount Carmel, IL (23 miles, 28 minutes from LCMH).

All data items analyzed to determine significant needs are "Lagging Indicators", measures presenting results after a period of time, characterizing historical performance. Lagging Indicators tell you nothing about how the outcomes were achieved. In contrast the LCMH Implementation Plan

[24] Response to IRS Form 990 h Part V B 1 c

utilizes "Leading Indicators". Leading Indicators anticipate change in the Lagging Indicator. Leading Indicators focus on short-term performance, and if accurately selected, anticipate the broader achievement of desired change in the Lagging Indicator. In the QHR application Leading Indicators also must be within the ability of the hospital to influence and measure.

Significant Needs

1. OBESITY/OVERWEIGHT – Local experts cite nutritional and physical therapy needs; engage in vigorous exercise below average impacts 47% of population; morbid obese above average impacts 29% of population; very unhealthy eating habits impacts 4% of population; healthy eating habits below average impacts 26% of population; Obesity impacts 29% of adults and increasing faster than IL or US trend

Problem Statement: Increase awareness of maintaining a healthy weight and lifestyle.

LCMH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- LCMH will continue coordinating its efforts with diabetic reduction efforts formulating a multi-component obesity prevention intervention initiative;
- LCMH School programs/Dietician;
- LCMH Primary Care Clinic providers offer services to meet this need; and
- LCMH labels foods to show serving size and nutritional content: availability and awareness of nutritional information content may decrease calorie consumption.

LCMH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:[25]

- LCMH will continue its integrated approach to obesity by coordinating its efforts with diabetic reduction efforts formulating a multi-component obesity prevention intervention initiative;
- LCMH will lead by example by fostering employee involvement in a worksite prevention intervention;
- LCMH will continue to label foods to show serving size and nutritional content: availability and awareness of nutritional information content may decrease calorie consumption;
- LCMH will continue to make water available and promote consumption of water in place of sweetened beverages;
- LCMH will provide point-of-purchase prompts to highlight healthier alternatives such as fruits and vegetables; and
- Provide point-of-decision prompts for use of stairs: motivational signs placed on or near stairwells, elevators, encourage individuals to use stairs.

[25] This section in each need for which the hospital plans an implementation strategy responds to Schedule H (form 990) Part V Section B 6. a. and 6. b.

ANTICIPATED RESULTS FROM LCMH IMPLEMENTATION PLAN:

- LCMH anticipates a greater percentage of residents will no longer be obese.

LEADING INDICATOR LCMH WILL USE TO MEASURE PROGRESS:

- Annual enrollment in LCMH diabetes education program, 2012 = 31.

LAGGING INDICATOR LCMH WILL USE TO IDENTIFY IMPROVEMENT:

- Reduction in the percent of Lawrence County residents having an obesity value equal to or greater than 30 from 29%.

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
LHS Track	1802 Cedar St, Lawrenceville	618.943.2326
Red Hill High School Track	908 Chestnut St. Bridgeport, IL	618.945.2521
Curves for Women	1110 22nd Street Lawrenceville, IL	618.943.4772
Ryan's Total Fitness	720 11th Street Lawrenceville, IL	618.943.4606
Vincennes YMCA	2010 College Ave., Vincennes, IN	812.895.9622

2. CANCER – 2nd cause of death, significantly higher than expected, County ranks 20th in IL (1st is worst), death rate above IL average; Local experts cite cancer as a concern; Obtained Pap/Cervix test below average impacts 51% of population; Mammogram below average impacts 43% of population; Cancer Screening below average impacts 24% of population; Unfavorable rates worse than US AND Peers for Breast Cancer, Colon Cancer, Lung Cancer

Problem Statement: Cancer detection and screening services need greater participation

LCMH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- LCMH Diagnostic Imaging;
- LCMH Laboratory Services;
- LCMH screening colonoscopy;
- LCMH Primary Care Clinic and surgical clinic providers address this need by education and medical services; and
- LCMH screening programs at various community events.

LCMH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

- Continue the above services;

- Continue to coordinate efforts with the organizations listed below which offer resources responding to this need by identifying how LCMH services can benefit their initiatives. LCMH will initiate efforts by contacting each organization to establish a forum for effort collaboration;
- Continue to allocating resources to acquire educational material to distribute to patients receiving a cancer diagnosis or interested in the disease;
- Continue to provide a schedule of educational seminars to patients and interested residents; and
- Explore opportunities to deliver on site clinical oncology services.

ANTICIPATED RESULTS FROM LCMH IMPLEMENTATION PLAN:

- An increase in the use of screening and cancer detection services leading to earlier intervention and increased survival.

LEADING INDICATOR LCMH WILL USE TO MEASURE PROGRESS:

- Volume of colonoscopy and mammography exams should increase from 2012 volumes.
  - 2012 colonoscopy exams = 106; and
  - 2012 mammography exams = 623.

LAGGING INDICATOR LCMH WILL USE TO IDENTIFY IMPROVEMENT:

- Cancer death rate reduction from 212.2/100,000 and rank #20th in IL (first being worst).

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
Lawrence County Cancer Resource Center	Route 3 B414 P.O. Box 516 Lawrenceville	618.838.4651
Good Samaritan Hospital Cancer Pavilion	520 S. Seventh St., Vincennes, IN	812.885.3939
Evansville Tri-State Affiliate Komen Foundation Collaboration	4424 Vogel Rd., Suite 205, Evansville, IN 47715	812.962.2202

3. MENTAL HEALTH/SUICIDE/SUBSTANCE ABUSE – Suicide worse than US or Peer averages; federal manpower shortage designation; Local Experts cite mental health access issues; Liquor Store Access three times better than IL average (an adverse finding)

Problem Statement: Suicide death rate needs to decrease

LCMH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- LCMH focused on mental health referrals to appropriate community resource as identified below; and
- LCMH Primary Care Clinic provides medical services for mental health patients.

LCMH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

- Coordinating efforts with the organizations listed below which offer resources responding to this need by identifying how LCMH services can benefit their initiatives. LCMH will initiate efforts by contacting each organization to establish a forum for effort collaboration; and
- Establish a tracking system to identify mental health referrals.

ANTICIPATED RESULTS FROM LCMH IMPLEMENTATION PLAN:

- LCMH efforts can help address the symptoms of mental health problems and concerns.

LEADING INDICATOR LCMH WILL USE TO MEASURE PROGRESS:

- Mental Health Referrals in 2012 = 0.

LAGGING INDICATOR LCMH WILL USE TO IDENTIFY IMPROVEMENT:

- Suicide death rate reduction from 11.8/100,000 ranking it #29th in IL (first being worst).

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
Lawrence County Health Department Behavioral Health	RR1, P.O. Box 277 Lawrenceville, IL	618.943.3754
Southeast Illinois Counseling Center	1501 Olive Lawrenceville, IL	618.943.3451
Lawrence County DARE Program Lawrence County Sheriff Department	1306 Lexington Ave., Lawrenceville, IL	618.943.5766
Good Samaritan Hospital Samaritan Center	515 Bayou St., Vincennes, IN	812.886.6800
Harsha Behavioral Center	1420 East Crossing Blvd., Terre Haute, IN	812.298.8888
Richland Memorial Hospital Psychiatric Unit	800 East Locust, Olney, IL	618.392.3302

4. CORONARY HEART DISEASE – Leading cause of death, County ranks 47th in IL (1st is worst), death rate above IL average; deaths above US average; death rate worse than US or Peer average; Chronic Health Disease above average impacts 11% of pop.; Routine cardiac stress testing below average impacts 15% of population

Problem Statement: The death rate from coronary heart disease should decrease

LCMH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- LCMH Primary Care Clinic services;
- Visiting Cardiology Clinic in the Lawrence Medical Center;
- LCMH Diagnostic Imaging;
- LCMH Laboratory Services;
- Stress Test Services;
- Holter/Event Monitors; and
- LCMH Cardiac Rehab Program.

LCMH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

- LCMH will continue implementing its current efforts.

ANTICIPATED RESULTS FROM LCMH IMPLEMENTATION PLAN:

- LCMH efforts can help address the symptoms of and results of heart disease but it can do little to impact the underlying causes of this problem which stem from adverse lifestyle choices and other factors.
- LCMH efforts will increase awareness of disease and its risk factors. LCMH laboratory capabilities will supplement available public health resources.

LEADING INDICATOR LCMH WILL USE TO MEASURE PROGRESS:

- Provision of CHF discharge instructions:
  - 2012 percent (4th quarter) = 81%.

LAGGING INDICATOR LCMH WILL USE TO IDENTIFY IMPROVEMENT:

- Death rate from Coronary Heart Disease:
  - Lawrence County 2012 = 223/100,000 ranking it #47th in IL (first being worst).

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
Good Samaritan Hospital Dayson Heart Center	520 S. Seventh St., Vincennes, IN	812.885.3243

5. SMOKING/TOBACCO USE – Cigarette Expenditures at 91% US Counties; Tobacco Use above average impacts 30% of pop.

Problem Statement: Incident of adult smoking should not exceed the state average.

LCMH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- Smoking cessation education material provided to patients;
- Employees health insurance discount on premiums; and

- LCMH Primary Care Clinic medical services.

LCMH DOES NOT INTEND TO DEVELOP AN IMPLEMENTATION PLAN FOR THIS NEED FOR THE FOLLOWING REASON(S):

- Resource Constraints (LCMH recently is losing money from operations so no resources are available to devote to the need); and
- Need is addressed by other facility or organization.

ANTICIPATED RESULTS FROM LCMH IMPLEMENTATION PLAN:

- None

LEADING INDICATOR LCMH WILL USE TO MEASURE PROGRESS:

- None

LAGGING INDICATOR LCMH WILL USE TO IDENTIFY IMPROVEMENT:

- None

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
Lawrence County Health Department Tobacco Cessation Coordinator	RR3, Box 414 Lawrenceville, IL	618.943.3302

6. Affordability – Local Experts cite lack of access and affordability concerns

Problem Statement: Local residents should not be denied access to care because of limited payment ability

LCMH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- LCMH Financial Assistance Policy; and
- Grant funding for screening mammograms.

LCMH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

- Continue above efforts to proactively identify and approve those needing financial assistance; and
- Encourage enrollment in existing programs such as Medicaid via outreach/education and expedited enrollment.

ANTICIPATED RESULTS FROM LCMH IMPLEMENTATION PLAN:

- LCMH efforts can help address the symptoms of and results from problems of affordability and access but it can do little to impact the underlying causes of this problem which stem from unemployment, limited education, adverse lifestyle choices and other factors.

LEADING INDICATOR LCMH WILL USE TO MEASURE PROGRESS:

- Volume of patient financial assistance efforts should increase from 2012 volumes.
    - 2012 LCMH financial assistance policy funds = $98,000 per month.

LAGGING INDICATOR LCMH WILL USE TO IDENTIFY IMPROVEMENT:

- Number of County residents enrolled in Medicaid program = 3,284 in 2011[26].

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
Department of Health and Human Services	RR1 P.O. Box 418, Lawrenceville, IL	818.943.3302

7. STROKE – 3rd cause of death, significantly higher than expected, County ranks 10th in IL, death rate above IL average; deaths above US average; Unfavorable rates, worse than US AND Peers for incident of stroke patients

Problem Statement: The incident of death from Strokes needs to decline

LCMH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- LCMH Emergency service Stroke Protocols;
- LCMH Diagnostic Imaging;
- LCMH Laboratory Services; and
- LCMH Physical and Speech Therapy program for neurological impairments.

LCMH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

- LCMH will enhance efforts to make residents aware of stroke symptoms and benefits from rehabilitation; and
- Establish a tracking and monitoring system for documenting stroke patients.

ANTICIPATED RESULTS FROM LCMH IMPLEMENTATION PLAN:

- Patients having stroke related degenerative conditions would have enhanced restorative and coping skills; and
- Increased public awareness of stroke indications resulting in increased presentation of patients earlier in the condition onset where intervention is most effective.

LEADING INDICATOR LCMH WILL USE TO MEASURE PROGRESS:

[26] http://www2.illinois.gov/hfs/agency/Program%20Enrollment/Pages/lawrence.aspx

- Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival:
    - 2012 value not calculated.

LAGGING INDICATOR LCMH WILL USE TO IDENTIFY IMPROVEMENT:

- Improvement in the stroke death rate ranking of counties in Illinois so as to not exceed the state average (Lawrence value rank 10 of 102 with rate of 67.5 deaths per 100,000 [significantly high] compared to IL average death rate of 38.84).

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
Carle Foundation Hospital	611 West Park Street, Urbana, IL	1.800.451.4300
Deaconess Health System	600 Mary Street, Evansville, IN	1.877.348.7286

8. COMPLIANCE BEHAVIOR/PREDESPOSING CONDITIONS– Local experts cite education and prevention as needs; "I am responsible for my health" below average impacts 57% of population; "Follows treatments" below normal impacts 34% of population; High School Graduation significantly lower than IL average; Some College below IL average and US goal.

Problem Statement: Increase the number of residents engaged in treatment and compliant with treatment efforts.

LCMH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- LCMH's Primary Care Clinic.

LCMH DOES NOT INTEND TO DEVELOP AN IMPLEMENTATION PLAN FOR THIS NEED FOR THE FOLLOWING REASON(S):

- A lack of identified effective interventions to address the need.

LCMH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

- None

ANTICIPATED RESULTS FROM LCMH IMPLEMENTATION PLAN:

- None

LEADING INDICATOR LCMH WILL USE TO MEASURE PROGRESS:

- None

LAGGING INDICATOR LCMH WILL USE TO IDENTIFY IMPROVEMENT:

- None

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
Lawrence County Health Department Behavioral Health	RR1, P.O. Box 277, Lawrenceville, IL	618.943.3754

9. DENTISTS – 40.3% of residents had no dental visits in a year, exceeds 30.9% IL average; federal manpower shortage designation; Dentists to Population Ratio significantly higher (adverse) than IL average and US goal.

Problem Statement: Increase the Dentist to population ratio.

LCMH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- LCMH Emergency Services.

LCMH DOES NOT INTEND TO DEVELOP AN IMPLEMENTATION PLAN FOR THIS NEED FOR THE FOLLOWING REASON(S):

- Resource Constraints (LCMH recently lost money from operations so no resources to devote to the need);
- Lack of expertise of competency (i.e. certain professional credential required and no such individual is in area); and
- Need is addressed by other facility or organization.

IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

- None

ANTICIPATED RESULTS FROM LCMH IMPLEMENTATION PLAN:

- None

LEADING INDICATOR LCMH WILL USE TO MEASURE PROGRESS:

- None

LAGGING INDICATOR LCMH WILL USE TO IDENTIFY IMPROVEMENT:

- None

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
Douglas Kirk, DDS	2111 Lexington, Ave., Suite 7, Lawrenceville, IL	618.943.2637
Jerri Boughan, DDS	2300 James Street, Lawrenceville, IL	618.943.5664

10. Chronic COPD/(LUNG DISEASE)/PULMONARY – Lung Disease 4th cause of death, significantly higher than expected, County ranks 20th in IL (1st is worst), death rate above IL

average; Chronic COPD impacts 8% of population; Chronic allergies above average impacts 22% of population.

Problem Statement: Death rate from Lung and respiratory conditions needs to decline.

LCMH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- LCMH Primary Care provider resources in Lawrence County;
- Pulmonary Function Testing;
- LCMH Diagnostic Imaging; and
- LCMH Laboratory Services.

LCMH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

- Coordinating efforts with the organizations listed below which offer resources responding to this need by identifying how LCMH services can benefit their initiatives. LCMH will initiate efforts by contacting each organization to establish a forum for effort collaboration; and
- LCMH will focus on efforts from its primary care providers to meet this need

ANTICIPATED RESULTS FROM LCMH IMPLEMENTATION PLAN:

- LCMH efforts can help address the symptoms of and results from problems of affordability and access but it can do little to impact the underlying causes of this problem which stem from unemployment, limited education, adverse lifestyle choices and other factors.

LEADING INDICATOR LCMH WILL USE TO MEASURE PROGRESS:

- Number of pneumonia patients given the most appropriate initial antibiotic(s):
  - 2012 patients = 42.

LAGGING INDICATOR LCMH WILL USE TO IDENTIFY IMPROVEMENT:

- Reduce Lung Disease death rate per 100,000 for Lawrence County below its latest 55.4 ranking

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
Good Samaritan Hospital Pulmonologist	520 S. Seventh Street, Vincennes, IN	812.885.3215

11. Diabetes – 6th (tie) cause of death, significantly higher than expected, County ranks 7th in IL (1st is worst), death rate above IL average; Chronic Diabetes above average impacts 15% of population; screening rate significantly lower than IL average and US goal.

Problem Statement: Medical complications associated with the disease needs to be reduced.

LCMH SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- LCMH Diabetes education program;
- LCMH Dietician;
- LCMH outpatient therapeutic diets;
- LCMH laboratory services; and
- LCMH podiatry clinic.

LCMH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

- Coordinating efforts with the organizations listed below which offer resources responding to this need by identifying how LCMH services can benefit their initiatives. LCMH will initiate efforts by contacting each organization to establish a forum for effort collaboration; and
- LCMH will establish an integrated approach to Diabetes by coordinating its efforts with obesity reduction efforts formulating a multi-component obesity prevention intervention initiative.

ANTICIPATED RESULTS FROM LCMH IMPLEMENTATION PLAN:

- Increase in compliance with disease management initiatives.

LEADING INDICATOR LCMH WILL USE TO MEASURE PROGRESS:

- Volume of patient interactions should increase from 2012 volumes; and
    - 2012 diabetes education program participants = 31.

LAGGING INDICATOR LCMH WILL USE TO IDENTIFY IMPROVEMENT:

- Percent of adults aged 20 and above with diagnosed diabetes Lawrence County = 9%.

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
Good Samaritan Hospital Diebetologist	520 S. Seventh Street, Vincennes, IN	812.885.3215

Other Needs Identified During the CHNA Process

12. MATERNAL AND INFANT MEASURES – OB/GYN visit below avg. impacts 40% of pop.; Better than Peers and US rates No Care in First Trimester, Very Low Birth Weight, Births to Women Age 40 to 54, Premature Births; worse than US or Peer avg. Low Birth Weight, Births to Unmarried Women, Neonatal Infant Mortality; Unfavorable rates worse than US and> Peers for Births to Women Under 18, Infant Mortality, White non Hispanic Infant Mortality, Post Neonatal Infant Mortality.

Problem Statement: Additional emphasis is needed on initiating care during the first trimester.

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
Dr. Robert Walsh	LCMH Primary Care Clinic 2111 Lexington Ave. Lawrenceville	618.943.7214

13. PRIORITY POPULATIONS – 16.2% live in poverty, 22.46% of children live in poverty; 8.47% of low incomes have low food access (double IL avg.); local experts note low income and children have many needs including asthma, obesity, mental health, diabetes and cancer.

Problem Statement: Additional focus is needed to recognize unique needs of special populations.

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:
None Identified

14. CHOLESTEROL (HIGH) – Routine cholesterol screening below avg. impacts 46% of pop.

Problem Statement: Community awareness of problems from high cholesterol needs to increase.

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:
None Identified

15. BLOOD PRESSURE (High) – Hypertension 13th cause of deaths, death rate significantly below expectations; chronic high blood pressure above avg. impacts 33% of pop.

Problem Statement: Community awareness of problems from high blood pressure needs to increase.

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:
None Identified

16. PHYSICIANS inc. specialty physicians – only 5% have no regular doctor (beneficial compared to 16.4% IL avg.); federal manpower shortage designation; Primary Care Physician to Population Ratio significantly higher (adverse) than IL avg. and US goal.

Problem Statement: Additional physician services need to be available or accessible in Lawrence County.

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
LCMH web site physician directory	www.lcmhosp.org	

17. POLLUTION – Air particulate matter significantly higher than IL avg. and US goal; Water, drinking water safety significantly worse than IL avg. and US goal.

Problem Statement: Efforts to reduce pollution sources needs to be enhanced.

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:
None Identified

18. EMERGENCY SERVICES – lower priority need from local experts; Emergency Room use above avg. impacts 37% of pop.

Problem Statement: The public needs greater understanding of appropriate emergency service use.

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
LCMH Emergency Department	2200 State Street	618.943.1000

19. ALZHEIMER'S – 6th (tie) cause of death, significantly higher than expected, Co. ranks 14thin IL (1st is worst), death rate above IL avg.

Problem Statement: The death rate from Alzheimer's disease needs to decline.

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:
None Identified

20. PREVENTABLE HOSPITALIZATION – Preventable Hospital Stays significantly higher than IL avg. and US goal, virtually unchanged for 7 years while IL and US goals improved.

Problem Statement: Additional effort is needed to initiate treatment earlier in the disease process so unnecessary hospitalization is avoided.

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:
None Identified

21. ACCIDENTS – 5th cause of death, Co. ranks 26th in IL (1st is worst), death rate above IL avg.; death rates worse than US AND Peers for Motor Vehicle Injuries; Better than Peers and US rates for Unintentional Injury; Motor Vehicle Crash Death Rate significantly higher than IL or US goal.

Problem Statement: Deaths from accidents needs to decline.

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:
None Identified

22. LIFE EXPECTANCY/PREMATURE DEATH – Life expectancy increased but males improved much better than females; Premature Death 25% higher than IL avg. unchanged from excessive rate of eleven years ago.

Problem Statement: Additional efforts designed to prolong life need to be explored

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:
None Identified

23. KIDNEY DISEASE – 9th cause of death, significantly higher than expected, Co. ranks 27th in IL (1st is worst), death rate at IL avg.

Problem Statement: Deaths from kidney disease need to decline

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:
None Identified

24. PALLIATIVE CARE & HOSPICE – Programs do not exist in CO., Olney provides Hospice service.

Problem Statement: The feasibility of local palliative care programs needs to be determined

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:
None Identified

25. CHRONIC OSTEOPOROSIS (bone disease) – Chronic Osteoporosis above avg. impacts 11% of pop.

Problem Statement: Efforts to increase preventative services for osteoporosis need to be explored

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:
None Identified

26. FLU-PNEUMONIA – 8th cause of death, at expected death rate, Co ranks 39th in IL (1st is worst), death rate above IL avg.

Problem Statement: The death rate from Flu and Pneumonia needs to decline

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:
None Identified

27. LOW BACK PAIN (Chronic) – Chronic low back pain above avg. impacts 25% of pop.

Problem Statement: Back conservation education efforts need to be enhanced

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:
None Identified

28. BLOOD POISONING – 10th cause of death, significantly higher than expected Co. ranks 29th in IL (1st is worst), death rate a little above IL avg.

Problem Statement: The death rate from blood poisoning needs to decline

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:
None Identified

Overall Community Need Statement and Priority Ranking Score:

Significant Needs Where Hospital Has Implementation Responsibility

1. OBESITY/OVERWEIGHT;
2. CANCER;
3. MENTAL HEALTH/SUICIDE/SUBSTANCE ABUSE;
4. CORONARY HEART DISEASE;
6. AFFORDABILITY;
7. STROKE;
10. CHRONIC COPD/(LUNG DISEASE)/PULMONARY; and
11. DIABETES.

Significant Needs Where Hospital Did Not Develop Implementation Plan[27]

5. SMOKING/TOBACCO USE;
8. COMPLIANCE BEHAVIOR/PREDESPOSING CONDITIONS; and
9. DENTAL.

[27] Responds to IRS Schedule H (990) Part V B 7

Other Needs Where Hospital Developed Implementation Plan

None

Other Identified Needs Where Hospital Did Not Develop Implementation Plan

12. MATERNAL AND INFANT MEASURES;
13. PRIORITY POPULATIONS;
14. CHOLESTEROL (HIGH);
15. BLOOD PRESSURE (High);
16. PHYSICIANS inc. specialty physicians;
17. POLLUTION;
18. EMERGENCY SERVICES;
19. ALZHEIMER'S;
20. PREVENTABLE HOSPITALIZATION;
21. ACCIDENTS;
22. LIFE EXPECTANCY/PREMATURE DEATH;
23. KIDNEY DISEASE;
24. PALLIATIVE CARE & HOSPICE;
25. CHRONIC OSTEOPOROSIS;
26. FLU-PNEUMONIA;
27. LOW BACK PAIN (Chronic); and
28. BLOOD POISONING.

APPENDICES

Appendix A – Local Expert Advisor Opinion About Significant Needs

A total of 20 local expert advisors participated in an online survey offering opinions regarding their perceptions of community health needs. The following is an analysis of their responses:

The first question was open-ended. "What do you believe to be the most important health or medical issue confronting the residents of your County?" Answers were placed in a "Word Cloud" format for analysis and generated the following image:

Word Clouds are analytical tools, which give greater visual prominence to words appearing more frequently in the source text. This information visualization establishes a portrait of the aggregate responses, presenting the more frequently used terms with greater text size and distinction in the visual depiction. Common article word (i.e., "a," "the," etc.), non-contextual verbs (i.e., "is," "are," etc.) and similar words used when writing sentences are suppressed by this application.

Specific verbatim comments received were as follows:

- Access to health care, particularly for the elderly. Access to mental health care, especially for children. Lack of child care facilities, particularly no child care centers. Lack of jobs for non-skilled labor. Lack of education to fill the jobs that are out there. Need for parenting classes for young and poorly education parents.
- Affordable Health Care

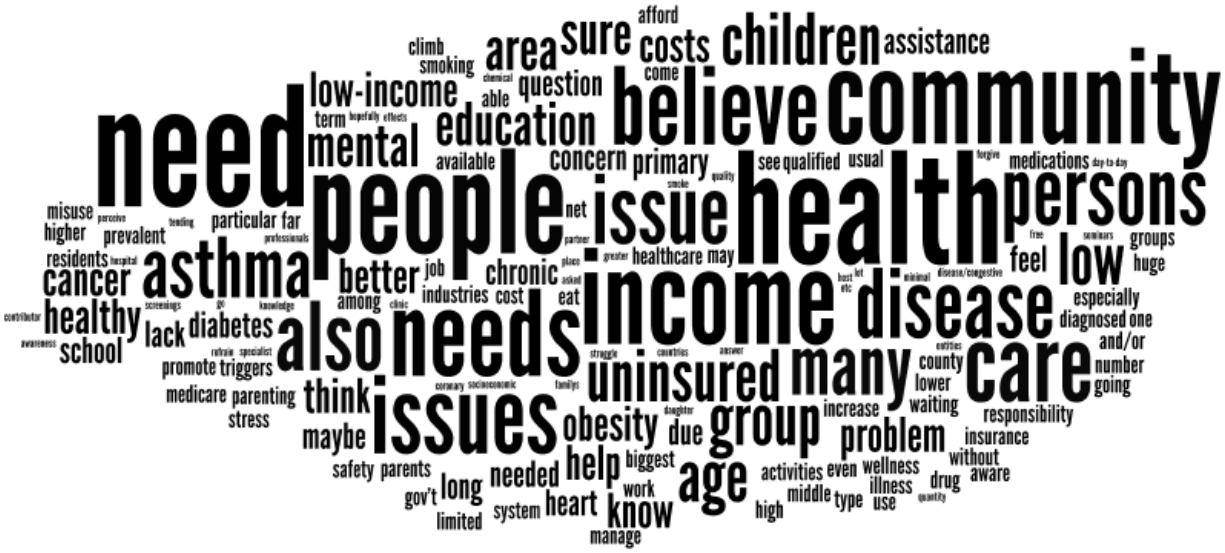
- Affordable preventive care.
- Distance from specialty care and the cost of time and finances, including mental health specialist, to travel to meet such needs.
- Health awareness, fire safety, smoking cessation, exercise and education about exercise for persons 18+
- High cost of healthcare; whether preventative, diagnostic, or as treatment. Especially for those who are middle class, healthcare is expensive. If they do have health insurance, then the cost can vary depending on premiums paid, deductibles paid, in addition to the expense paid by the individuals for the services obtained depending on if a provider is "in the network" or "out of network".
- I believe that nutrition is the most important health issue confronting residents of our county...especially the youth of our county. There many cases where adequate nutrition is the issue, but, in most cases, proper nutrition is the issue. I work with low-income children through Kids Shopping Day of Law Co. We see a lot of children who are overweight and many who are obese. I worry about the health issues that will inevitably plague these children throughout their lives as a result of poor nutrition now.
- I believe the most important health issue is cancer. I would also think diabetes & obesity.
- I feel behavioral health is a challenge for our County, especially substance abuse. Although the Law. Co Health Dept Behavioral Health and the Southeaster IL Counseling provide care, the individuals are not always satisfied with the medical supervision and choices available. I have heard of telemedicine being utilized in some rural areas like ours for this and other specialty needs.
- I feel that there are two important medical health issues for our community. First would be the availability of medical practitioners and the need for urgent care or later hours for all of the community and secondly would be quality emergency response and emergency care four our residence.
- In looking at the county as a whole, I believe our county has several and medical issues. To list a few I believe are of most importance: Cancer Heart related problems Nutrition Drug rehabilitation Mental illnesses Geriatric services Access to affordable healthcare.
- In my experience working with this community, I have assisted several individuals with crisis interventions. Individuals experienced mental illness symptoms and required inpatient hospitalization to a psychiatric unit, while others had no excess to refill medications because of transportation issues or lack of financial means. Most individuals did not where to go to receive help for loved ones extreme Mental Health issues. My agency has assisted with an average of 3 crisis calls a week.

- In my field, I have seen an increased amount of young adults that are demonstrating mental health issues. There appears to be a shortage of qualified professionals as many of our students must wait longer than a month to even get an intake meeting. This poses potential long term health risk for these young adults.
- In no particular order of importance: 1) primary care physicians for well care visits and non-emergent care of colds, injuries, illness; 2) secondary care services and diagnostics, i.e. minor surgeries and after care - arthroscopic, laparoscopic surgeries; 3) mental illness and counseling services; 4) better trauma, stabilization and emergency room services.
- It is hard to state just one issue. However, Cancer seems to be so prevalent among us. I have had family members come "back home" to visit fathers and mothers, and they are amazed at the number of people in our county who have cancer. So much so, that some of them have even seriously questioned the quality of our drinking water, etc., since they don't see as many people with cancer in the areas where they live.
- Just by looking around you can obviously see a large percentage of people are obese. The lack of physical activity and not eating healthy is a main cause. Obesity can lead to heart attacks, type 2 diabetes, elevated cholesterol, etc. Smoking is another main issue, this needs to be addressed and causes many health concerns.
- Poverty level, lack of physical activity, obesity, cheaper to eat unhealthy foods. Need to get physical activity back in schools.
- The large number of residents relying on the state to pay their health care bills.
- The most important issue is the increasing cost of health care. We need to seek the best way to offer insurance that is affordable to help detect any illness or sickness to recieve early attention. The rising cost of insurance is rising so rapid or limited on coverage several families are choosing to go without. This also affects the overall goals of caregivers.
- There is an apathy in this community to basic care for one's general health. There is no preventative or very little preventative efforts that I can see for people to be doing health life styles. In general, I hear many children talk about parents who still smoke cigarettes, drink alcohol and eat unhealthy. I hear children say that they are allowed to be on video games for many hours which prevents them from getting out and riding bikes, walking, etc. I also see many children who can't stay awake at school because they are awake late at night playing video games. It appears to me that it is a lack of knowledge of how to live healthy. It has caused an increase in children being overweight and they will have even more health problems than ever when they get older.

Our second question to the local experts was, “Do you perceive there are any primary and/or chronic disease needs, as well as potential health issues, of uninsured persons, low-income persons, minority groups and/or other population groups (i.e. people with certain situations), which need

help or assistance in order to improve? If you believe any situation as described exists, please also indicate who you think needs to do what."

The responses generated the following image:



Specific verbatim comments received were as follows:

- Again obesity is a huge problem. This seems to be more prevalent with lower income persons who may not know how to eat healthy. Also smoking is an issue, again more prevalent with lower income persons.
- Health needs of low income persons seem met adequately.
- I believe in our area there is higher than usual cancer cases in younger people and then a higher than usual cancer occurrence over all. I believe this is due to the long term environmental effects from the oil field/drilling and refinery industries in our area and the number of people who are and have been employed in those chemical heavy industries. Also, we do have a high number of people on gov't assistance either due to age (Medicare) or low income (Medicaid) and who many who are uninsured. I believe was also have many who misuse the system of gov't aide. A better safety net process for those in real need is needed. But also, a better safety net for the tax payers to keep those who misuse the system and drive up costs is needed too. I also believe many of the special needs community, especially, mental illness and/or learning disabled are under served.
- I believe that the dental needs of the uninsured and low income of our community is an issue that is affecting our residents. It is hard for me to place one entity who should be at the forefront of this issue but do know it is an issue which exists in our county.
- I do not perceive any health issues.

- I feel the community needs more mental health programs. Mental Health issues are increasing in this community due to economic stress: job loss, program cuts, lack of support. More children are being affected by parent/guardian stress which makes for an unstable home environment and greater need for services for families.
- I feel there is a need for assistance for the working middle income persons. Usually, low income persons are able to obtain a medical card to help with their healthcare costs and upper income persons are able to afford the costs. As far as who does what - it's a huge problem nationwide. Maybe we need to find out from other countries how their costs are minimal to clients without compromising the quality of care.
- I see an increase in mental/behavioral health issues facing young adults. I feel there needs to be a quantity of qualified professionals to treat these increase needs. We have students waiting in excess of a month to even get an intake meeting. Many negative health items can arise while waiting on qualified care.
- I think that low-income groups particularly but not exclusively have need for parenting educations. Maybe starting in high school? I know the LCHD does communicable disease and pregnancy prevention but not parenting as far as I know. I also saw a particular need for mental health assistance for pre-school children but there was nothing available for this age group in our area of the state. I am aware we are an elderly community and the LCHC has long provided care for this age group. However, recent rule changes to Medicare have limited visits to his age group. This may lead to a need for extra care in this age group.
- I truly believe there is a need for drug rehabilitation and more attention to mental illness, especially for low-income, uninsured people. I believe the responsibility of tending to the needs of this problem falls on a host of entities; the courts, corrections, hospital (primary care clinic), and health department.
- I will reiterate what I said in answer to the previous question. Obesity is an issue within our community that is a major contributor to a variety of health issues among our residents. While it is certainly not limited to people in a particular socioeconomic group, it is an issue among low-income families in our community. I am not sure 'who needs to do what', but education, or lack thereof, is an issue. Diabetes is also an area of concern. It affects so many people in our community...young and old, rich or poor. My daughter was diagnosed with Type 1 Diabetes at age 5. We have been fortunate enough to receive the very best education regarding her disease and the day-to-day management of it, so perhaps that it is why this issue is of such concern to me. I work with people all day and I am very involved in the community. I come into contact with so many people who deal with this disease...mostly Type 2 Diabetes...and are misinformed about their disease. The majority of people I talk to work with a general practitioner, not a specialist, to manage their care. Most of these doctors are not recommending education or providing it. I believe that education and access to it is vitally important.

- I'm sure there is but not that I'm aware of.
- In my position as a Minister, the biggest health issues of uninsured, low-income, minority groups that I observe are alcoholism, smoking, and drug/meth use. Obviously, the church needs to do a better job in reaching out to these people and helping them to change their lives. Beyond that, I'm not sure who should do what? I'm not sure if this is the kind of "primary and/or chronic disease need" being asked about in the question. Please forgive me if I did not approach the question in the way you desired.
- In our community a primary concern would be long term healthcare. We need to have the preventive care available in order to help with the health and wellness of this group. As insurance cost climb I am sure the amount of uninsured cost is going to climb putting more burden on all. For the potential disease needs in this area, I would say the top issues are the coronary disease/congestive heart failure, diabetes, depression, and cancer. I think all of these in our county could use some assistance-or better awareness.
- Middle income individuals struggle with insurance deductibles. Hopefully, Obama Care will help??? People cannot afford their medications and therefore go without and refrain from going to see their physician. Health issues, heart disease, cancers, obesity, teenage pregnancies, drug and alcohol issues. Solutions: Educate, free clinics, screenings.
- Obesity and Chronic health problems like heart disease & cancer. We all need to promote physical activities for children - senior citizens. We need to eat healthy and take responsibility for our own wellness. Lifestyle choices are all we can do to stay healthy. The community is already engaged in sports, 5K runs, and other activities that promote healthy living.
- One of the biggest chronic disease issues we have in school is Asthma. We have so many children with Asthma. I can't tell you why, but I believe we have more than the average school district. I think it is a combination of the children being overweight and low income. I don't think the Asthma gets managed as well as it could. Again...it is probably lack of knowledge. Also, I believe a lot of parents smoke around these children with Asthma and it triggers the Asthma. It would be awesome to have an Allergist come in and teach parents about Asthma triggers, etc. and how to manage Asthma. Maybe even partner up to have seminars at the schools.
- Substance abuse is significant resulting in uninsured, low income persons in our community since it blocks education and employment. When these people decide they need help to address the problem, they have difficulty obtaining the care they need.
- The inability of uninsured/low-income persons to pay for needed testing and medications for diagnosed illnesses.

Appendix B – Process to Identify and Prioritize Community Need[28]

Community Health Need Topic	Total Points Allocated	Number of Local Experts Allocating Points	Cumulative Percentage of Points	Break Point From Higher Need	Need Determination
1. OBESITY/OVERWEIGHT	145	16	8.06%		Significant Need
2. CANCER	140	16	15.83%	5	
3. MENTAL HEALTH / SUICIDE / SUBSTANCE ABUSE	132	16	23.17%	8	
4. CORONARY HEART DISEASE	120	17	29.83%	12	
5. SMOKING / TOBACCO USE	111	14	36.00%	9	
6. AFFORDABILITY	106	15	41.89%	5	
7. STROKE	93	16	47.06%	13	
8. COMPLIANCE BEHAVIOR / PREDESPOSING CONDITIONS	85	14	51.78%	8	
9. DENTAL	80	17	56.22%	5	
10. CHRONIC COPD / (LUNG DISEASE) / PULMONARY	80	15	60.67%	0	
11. DIABETES	78	15	65.00%	2	
12. MATERNAL AND INFANT MEASURES	62	14	68.44%	16	Other Identified Need
13. PRIORITY POPULATIONS	55	11	71.50%	7	
14. CHOLESTEROL (HIGH)	51	14	74.33%	4	
15. BLOOD PRESSURE (High)	49	14	77.06%	2	
16. PHYSICIANS inc. specialty physicians	47	12	79.67%	2	
17. POLLUTION	46	12	82.22%	1	
18. EMERGENCY SERVICES	45	10	84.72%	1	
19. ALZHEIMER'S	42	12	87.06%	3	
20. PREVENTABLE HOSPITALIZATION	41	12	89.33%	1	
21. ACCIDENTS	40	12	91.56%	1	
22. LIFE EXPECTANCY / PREMATURE DEATH	36	11	93.56%	4	
23. KIDNEY DISEASE	32	11	95.33%	4	
24. PALLIATIVE CARE & HOSPICE	20	11	96.44%	12	
25. CHRONIC OSTEOPOROSIS	20	10	97.56%	0	
26. FLU-PNEUMONIA	17	10	98.50%	3	
27. LOW BACK PAIN (Chronic)	16	9	99.39%	1	
28. BLOOD POISONING	10	7	99.94%	6	
29. POINTS RESERVED for Unknown need	1	1	100.00%	9	
	1800	17			

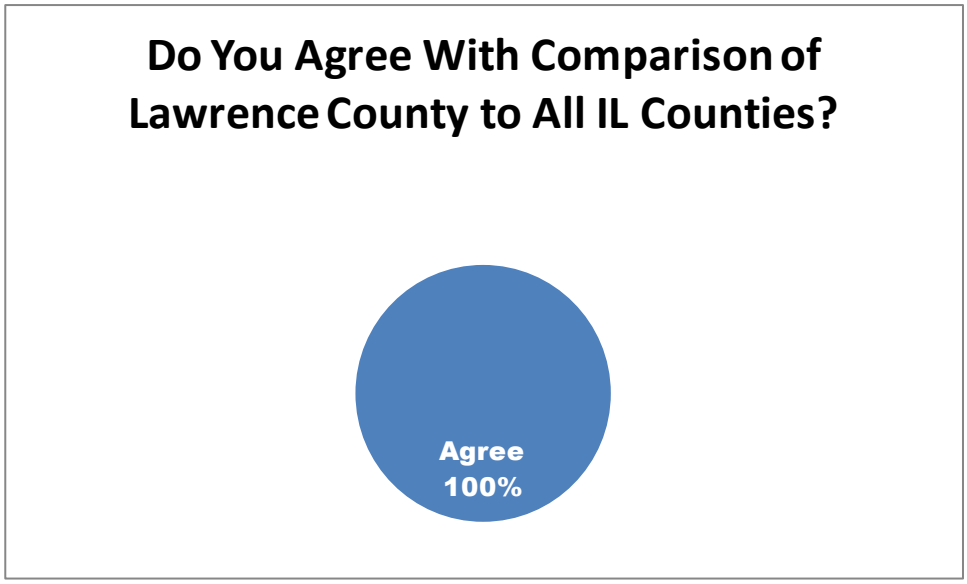
Individuals Participating as Local Expert Advisors[29]

[28] Responds to IRS Schedule H (990) Part V B 1. g. and V B 1. h.
[29] Responds to IRS Schedule H (990) Part V B 3

Company or Organization:	Title or Position	Area of Expertise
Lawrence County IDC & U of I Extension	Director/Educator	Economic Development
Lawrence County Health Dept.	RN-retired	Public Health-mostly elderly and children under 5
New Hope Christian Church	Senior Minister	
Cochran Insurance Agency, Inc.	owner	
Peoples State Bank	Assistant Vice President	Local businesswoman - serve on various charity
Red Hill CUSD #10	School Nurse	children
Red Hill CUSD #10	Nurse's for Red Hill School District	
Lawrence County Rural Health Clinic	Physician	long term physician
Red Hill CUSD #10	Principal	Education
retired from Community School Dist. #20	retired school nurse	retired school district in the local school after 32
Lawrence County Health Department	Mental Health Counselor/Case Manager	Mental Health
Red Hill CUSD #10	Superintendent	Education
Lawrence County Health Department	RN - WIC Coordinator	Public Health
Lawrence County Health Dept	Family Nurse Practitioner	Family Practice
Golden Rule Insurance	Facilities Manager	Employed by one of the largest employer in
Lawrence Unit #20	LHS Principal	
Lawrence County Chamber of Commerce	Executive Director	business
Lawrence County Health Department	Public Health Administrator	Public Health
Rucker's Candy	CSO / Owner	long term resident
Red Hill CUSD #10	Principal	long term area resident, work with the youth of the
New Hope Christian Church	Senior Minister	representative of a multi-aged church
shiloh baptist church	pastor	represent religious community

Advice Received from Local Experts

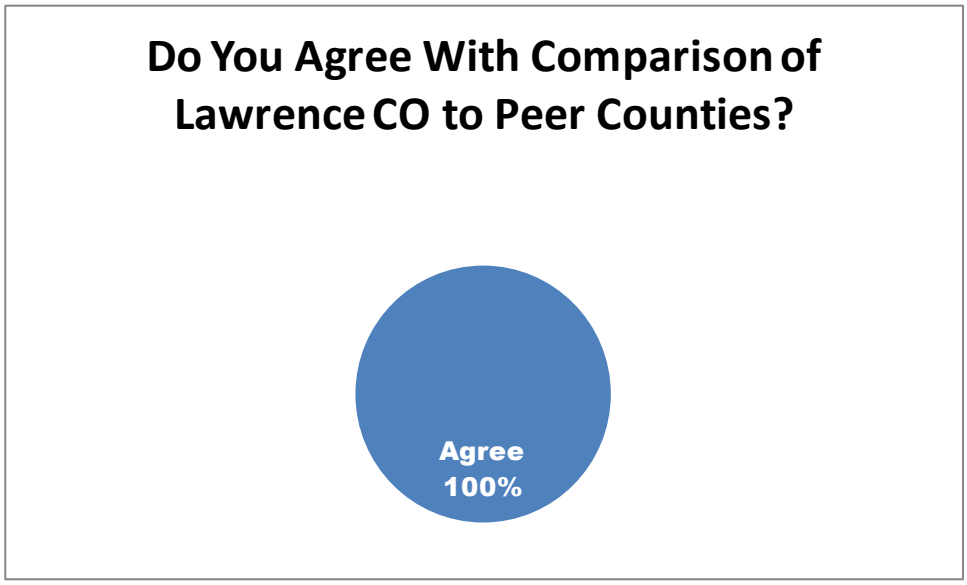
Q. Do you agree with the observations formed about the comparison of Lawrence County to all other Illinois counties?



- The fact that Lawrence County is comprised of low income and the elderly needs to be taken into consideration. The fact that our percentage of air and water pollution is significantly higher is very concerning to me. I think the oil and gas industry needs to be very closely monitored and be held responsible if found lacking in air and water quality safety. Diabetic screenings are available in our area. Perhaps our health care providers need to be more aware and remind their patients to participate.

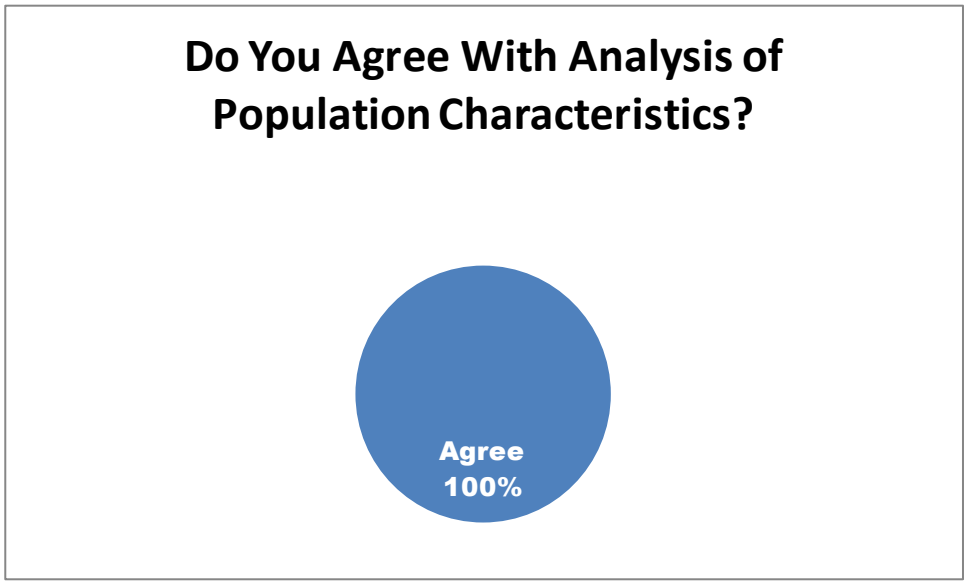
- Findings are consistent with county with large geriatric population and insufficient physicians. Also has large nursing home population,
- When referred to Lincoln ranks 89, is this supposed to be Lawrence County? (*Editorial NOTE: Yes it was inadvertent citation.*)
- Many of these statistics are consistent with the data we have had to use in various ways in the educational field.

Q. Do you agree with the observations formed about the comparison of Lawrence County to its peer counties?



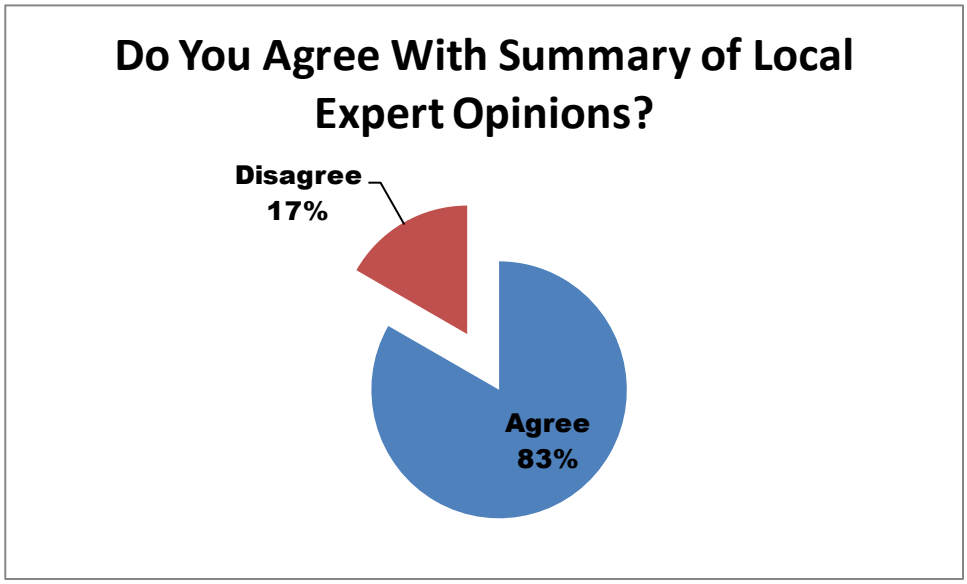
- I wonder if the higher cancer rates might be related to our poor air and water quality?? We are a poor and elderly county. I feel this contributes to a lot of these concerns.
- When referring to Halifax county this should be Lawrence county?
- Same as previous answer.

Q. Do you agree with the observations formed about the population characteristics of Lawrence County?



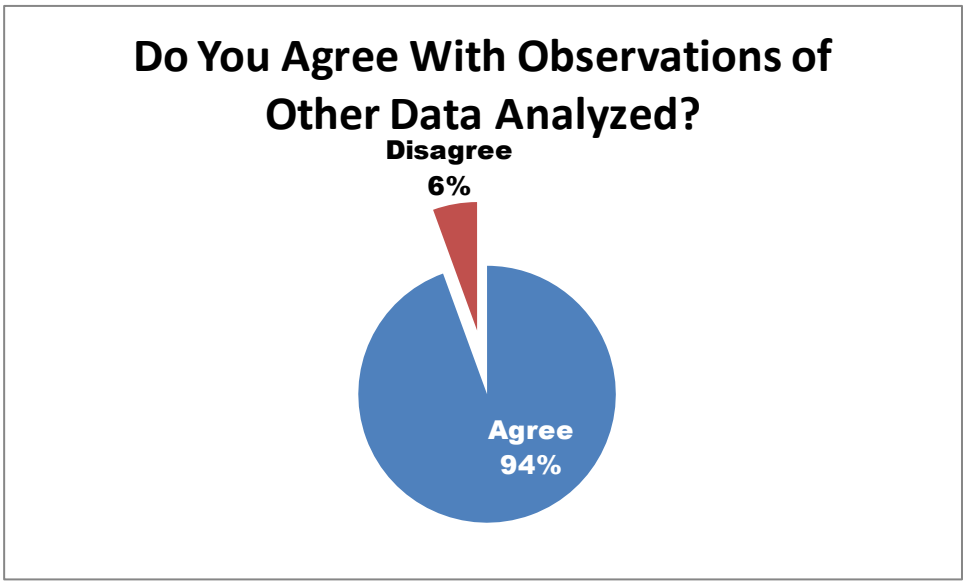
- For many of these findings to change, there have to be changes in peoples attitudes. Many of these need to start in childhood. Kids don't purchase their own foods, for example. It is very hard to change attitudes and habit in adult hood. If we could word with the children and get parent cooperation, it would be a great thing!

Q. Do you agree with the observations formed about the opinions from local residents?



- The only statement I would disagree with would be... Obesity, mental health, diabetes and cancer are a second tier of concerns where assistance is needed in keeping healthy. I believe this should be more of a top priority rather than a second tier of concern.
- I believe the observation is slightly incorrect concerning ranking "asthma, children needs, and education" higher than "obesity, mental health, diabetes, and cancer". The latter issues outweigh all the previous needs. Most of the latter needs lead to the previous needs (i.e. child needs, education, etc...). The health needs cause a lack of education and needs being met for children.
- Many residents of Lawrence County use the ER for acute care and never establish with provider. Thus no preventive care and consistent follow up for chronic problems. Illinois payment methods drive this behavior.
- There is a need for dental care providers to service patients that are on medicaid and those with a low income.
- I think it is not limited to the low income community members. It is also the middle income members because often there are some resources available for the lowest income members, but not for those considered in the middle, therefore causing care to be delayed or not taken care of at all.

Q. Do you agree with the observations formed about the additional data analyzed about Lawrence County?



- Do you think that having the Methodist Village here changes the statistics for Lawrence County?
- There is a Hospice office available through the Lawrence County Health Department. Also, there are 2 different food banks in Lawrence County, both centrally located in the county.

- Health and health care statistics are consistent with Lawrence County Poverty statistics.

Appendix C – Illustrative Schedule H (Form 990) Part V B Potential Response

Illustrative IRS Schedule H Part V Section B (form 990)[30]

Community Health Needs Assessment Answers

1. ***During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 9***

   Illustrative Answer – Yes

   If "Yes," indicate what the Needs Assessment describes (check all that apply):

   a. ***A definition of the community served by the hospital facility***
   b. ***Demographics of the community***
   c. ***Existing healthcare facilities and resources within the community that are available to respond to the health needs of the community***
   d. ***How the data was obtained***
   e. ***The health needs of the community***
   f. ***Primary and chronic disease needs and health issues of uninsured persons, low-income persons, and minority groups***
   g. ***The process for identifying and prioritizing community health needs and services to meet the community health needs***
   h. ***The process for consulting with persons representing the community's interests***
   i. ***Information gaps that limit the hospital facility's ability to assess the community's health needs***
   j. ***Other (describe in Part VI)***

   Illustrative Answer – check a. through i. Answers available in this report are found as follows:

   1. a. – See Footnotes #15 (page 10) & #16 (page 10)

   1. b. – See Footnotes #17 (page 11)

   1. c. – See Footnote #24 (page 28)

   1. d. – See Footnotes #7 (page 5)

[30] Questions are drawn from 2012 f990sh.pdf Forms and may change when the hospital is to make its 990 h filing

1. e. – See Footnotes #11 (page 7)

1. f. – See Footnotes #9 (page 7)

1. g. – See Footnote #12 (page 8) & #28 (page 52)

1. h. – See Footnote #8 (page 7) & #28 (page 52)

1. i. – See Footnote #6 (page 5)

1. j. – No response needed

2. ***Indicate the tax year the hospital facility last conducted a CHNA: 20 _ _***

   Illustrative Answer – 2013
   See Footnote #1 (Title page)

3. ***In conducting its most recent CHNA, did the hospital facility take into account input from representatives of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted***

   Illustrative Answer – Yes
   See Footnotes #10 (page 7), #29 (page 52)

4. ***Was the hospital facility's Need Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI.***

   Illustrative Answer – No

5. ***Did the hospital facility make its CHNA widely available to the public? If "Yes," indicate how the Needs Assessment was made widely available (check all that apply)***

   a. ***Hospital facility's website***
   b. ***Available upon request from the hospital facility***
   c. ***Other (describe in Part VI)***

   Illustrative Answer – check a. and b.
   The hospital will need to obtain Board approval of this report, document the date of approval, and then take action to make the report available as a download from its web site. It may also be prudent to place a notice in a paper of general circulation within the service area noting the report is available free upon request.

6. ***If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply to date):***

   a. ***Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA***
   b. ***Execution of an implementation strategy***

c. Participation in the development of a community-wide plan
d. Participation in the execution of a community-wide plan
e. Inclusion of a community benefit section in operational plans
f. Adoption of a budget for provision of services that address the needs identified in the CHNA
g. Prioritization of health needs in its community
h. Prioritization of services that the hospital facility will undertake to meet health needs in its community
i. Other (describe in Part VI)

Illustrative Answer – check a, b, g, and h.

6. a. – See footnote #25 (page 29)

6. b. – See footnote #25 (page 29)

6. g. – See footnote #12 (page 8)

6. h. – See footnote #12 (page 8)

7. Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs?

Illustrative Answer – No
Part VI suggested documentation – See Footnote #27 (page 43)

8. a. Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?
b. If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?
c. If "Yes" to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form4720 for all of its hospital facilities?

Illustrative Answers – 8 a, 8 b, 8 c – No