Deaconess Health System

CHNA 2019

Community Health Needs Assessment

Vanderburgh County, Indiana

2019-2021

TABLE OF CONTENTS

For questions regarding the Community Health Needs Assessment, please contact:

Deaconess Marketing Department, 600 Mary Street, Evansville, IN 47747

812-450-5000

CHNA@deaconess.com

An electronic version of the Community Health Needs Assessment is publicly available at www.deaconess.com/CHNA. Paper copies of the CHNA are available at zero cost. Email CHNA@deaconess.com to request a copy.

VANDERBURGH COUNTY

Introduction

This report provides a comprehensive overview of the 2018 Community Health Needs Assessment (CHNA) conducted collaboratively by Deaconess Health System, St. Vincent Evansville Hospital, ECHO Community Healthcare, Vanderburgh County Health Department, United Way of Southwestern Indiana, and the Welborn Baptist Foundation. This represents the third community health needs assessment completed as a collaborative effort.

The chapters of this report provide an overview of the methods used to conduct the CHNA, summaries of existing health indicator data that was reviewed, primary data that was collected for purposes of the CHNA, and a description of the process and outcomes of a prioritization process to establish the health priorities that will drive the hospital's activities in the subsequent years.

About the Service Area

For the CHNA, the hospitals established the service area as being all zip codes in Vanderburgh County and all people living in the county at the time the CHNA was conducted.

Source: Indiana Business Research Center, ESRI data and March 2010 ZIP code boundaries from Tele Atlas

About Deaconess Health System

Deaconess Health System is the premier provider of health care services to 26 counties in three states (IN, IL, and KY). The system consists of seven hospitals located in southern Indiana: Deaconess Midtown Hospital, Deaconess Gateway Hospital, The Women's Hospital, The Heart Hospital, The Orthopedic and Neuroscience Hospital, Deaconess Cross Pointe, and Encompass Health Deaconess Rehabilitation Hospital.

Deaconess Clinic, a fully integrated multispecialty group featuring primary care physicians as well as top specialty doctors, provides patients with consistent and convenient care. Additional components include a freestanding cancer center, urgent care facilities, a network of preferred hospitals and doctors, more than 30 care sites, and multiple partnerships with other regional health care providers.

Deaconess Midtown Hospital is the anchor and largest hospital in the Deaconess Health System. Located in Evansville, Indiana, the campus remains in the same city block as the original Protestant Deaconess Hospital built in 1899. Vanderburgh County is also home to multiple Deaconess physician and specialty clinics as well as home care, palliative care and hospice services.

About St. Vincent Evansville

In 1872, Sister Marie Voelker, DC, and three other Daughters of Charity arrived in Evansville to start a healthcare facility located on the banks of the Ohio River in a former marine hospital which was used during the Civil War. In 1894, the second location was at the corner of First Avenue and Columbia Street. In 1956, the formerly St. Mary's Medical Center relocated to Washington Street where it resides today. In 2017, the hospital changed its official name to St. Vincent Evansville for recognition purposes throughout the state of Indiana.

St. Vincent Evansville Hospital is a 508-bed acute care facility and offers the following services: bariatric services, cancer, cardiovascular services, diabetes care, maternity services, medical imaging, mental & behavioral health, orthopedics, pediatrics, rehabilitation services, respiratory care, senior services, surgery, wellness medicine, women's health, and wound treatment. St. Vincent Evansville's primary service area is Vanderburgh County which is in southern Indiana.

EXECUTIVE SUMMARY

To ensure insights into the health needs of communities within its service area and to provide guidance to the development of health promoting programs and services, St. Vincent Evansville and Deaconess Midtown Hospital conducted the 2018 Community Health Needs Assessment (CHNA). This report provides a comprehensive overview of the methods used to conduct the CHNA, summaries of data that were considered, and a description of the process and outcomes of a prioritization process to establish the health priorities that will drive the hospital's activities in subsequent years.

To conduct the CHNA, the hospitals pursued a diverse and comprehensive range of activities to collect and consider data that provided valuable insights for decision making. A foundational activity included the review of existing data that provided insights into the most pressing health needs of the hospitals' service area and the social, economic, and demographic characteristics of those living in the service area. Additionally, to ensure the consideration of community member insights into the health issues impacting their communities, the hospitals conducted a detailed survey among the general population and also among those participating in care and services throughout Indiana. Lastly, the hospitals conducted a series of focus groups that included community members and stakeholders representing organizations that provide services on the front lines of public health in their communities.

Subsequent to the collection of data, the hospitals conducted a prioritization process that involved the consideration of the insights gained during the CHNA activities and that resulted in the selection of local health priorities. **For Vanderburgh County, those priorities include:**

- **Substance Abuse and Alcohol Abuse**
- **Mental Health**
- **Food Insecurity and Food Access**
- **Chronic Health Conditions**
- **Poverty**

These five priorities provide an issue-oriented roadmap for the development of local programs, services, and initiatives that seek to improve the health of the local community. They are based upon an extensive and comprehensive CHNA process that considered data from a range of sources, that utilized a rigorous scientific process, and that was conducted in a participatory manner throughout that sought to include the voices of community members, stakeholders, and hospital leaders.

PRECEDING CHNA EFFORTS

2016-2018

In 2015, Deaconess Health System joined five other local health-related organizations, ECHO Community Healthcare, St. Mary's Health, United Way of Southwestern Indiana, the Vanderburgh County Health Department, and Welborn Baptist Foundation to plan for and administer a Community Health Needs Assessment (CHNA). Conducting a CHNA is a required component of the Affordable Care Act and serves as a way to evaluate the overall health of the community. The assessment identifies recurring causes of poor health then focuses resources to support and drive positive change in the identified behaviors.

Data was gathered in May and June 2015 from 12 focus groups, 17 "key informant interviews" and publicly reportable data such as community demographics, health behaviors, and health outcomes. Representation included social service agencies, education, law enforcement, public service, business and industry, government, non-profit organizations, and health care related organizations from both Vanderburgh and Warrick County.

After reviewing the data, our collaborative identified four main issues:

- Behavioral Health (including substance abuse, tobacco use, and mental health) – both counties
- Exercise, Weight, and Nutrition – both counties
- Maternal Child Health – only Vanderburgh County
- Cancer (specifically breast and prostate) – only Warrick County

Plans to address these causes of poor health included:

- Behavioral health services mapping and local survey
- 3-year grant initiative—Youth Mental Health First Aid training
- Coordinate area diabetes classes, grant projects, and activities
- Advocate for built environment features in local government
- Work with early childhood providers to educate parents on nutritious food for their toddlers and pre-school age children
- Coordinate messaging for use throughout the community regarding nutrition/nutritious choices for toddlers and pre-school age children
- Support and continue the work of the Child Abuse Task Force
- Use three existing community collaborations to reduce infant mortality rates in Vanderburgh County

The complete action plan and yearly progress reports related to the 2016 CHNA can be found on www.deaconess.com/CHNA.

SURVEY PROCESS AND METHODS

CHNA Overview: To conduct a comprehensive Community Health Needs Assessment (CHNA), the hospitals worked with a range of community and academic partners. The purpose of the assessment is to identify the significant health needs in the community and gaps that may exist in services provided. It also provides the community with information to assess essential health care, preventive care, and treatment services. This endeavor represents efforts to share information that can lead to improved access to care and quality of care available to the community, while reinforcing and augmenting the existing infrastructure of services and providers.

CHNA Activities and Methods

The CHNA began in 2017 and was completed in 2018, the results of which are reflected in this report. Table 1 provides an overview of the overall process and specific methods related to each CHNA activity. Within each respective section of this report, additional details regarding methods, participants, and measures are provided.

CHNA Partners

Conducting the CHNA necessitated collaboration with a wide range of public health and social service partners to ensure that diverse scientific and community-based insights were included throughout the process. Of particular importance was the inclusion of individuals who directly or indirectly represented the needs of three important groups: 1) those with particular expertise in public health practice and research, 2) those who are medically underserved, low-income, or considered among the minority populations served by the hospital, and 3) the broader community at large and those who represent the broad interests and needs of the community served.

Key partner organizations included:

- **The University of Evansville**. Faculty, staff, and students in public health areas collaborated with the hospital on the data-oriented aspects of the project.
- **Indiana University School of Public Health**. Faculty and students collaborated with the hospital throughout the survey process.
- **Indiana University Center for Survey Research**. Faculty and staff provided in-depth technical assistance and guidance throughout the survey process, and worked closely with the hospitals and the University of Evansville to field the community health survey.

Survey Process and Methods Continued

Key partner organizations cont.

- **Measures Matter, LLC**. Measures Matter is a community-based research consulting firm based in Bloomington, Indiana and Palm Springs, California. Measures Matter conducted an independent analysis of the survey data and also facilitated the prioritization process with the hospital and its partners.
- **County Health Departments**. Representatives of the Vanderburgh County Health Department were partners in the larger network of organizations and hospitals that worked to enhance consistency in statewide CHNA activities, particularly the CHNA Community Survey and focus groups. Additionally, given that the survey process was coordinated in conjunction with multiple other hospital systems and local organizations throughout the state, other health departments involved in the process included those from Tippecanoe, Clay, Fountain, Warren, Howard, Jennings, Lawrence, Madison, Randolph, Washington, Warrick, Hamilton, and Marion Counties.
- **Community Health and Social Service Organizations**. A wide range of community-based health and social service organizations collaborated throughout the CHNA process to consider data from the CHNA, make decisions regarding health priorities, and initiate considerations of subsequent actions based on the CHNA. Listings of those community partners are included in the Appendices section of this report (Appendix B) and also listed in the Prioritization Process section as applicable (Section 6).

Table 1. Description of CHNA Activities

CHNA ACTIVITIES	DESCRIPTION OF ACTIVITIES
Identification of the Service Population	Hospital staff worked together to identify the community served through a review of patient-related data and other geographic boundaries related to the hospital's service area.
Review of Existing Health Indicator Data	In collaboration with public health researchers, the hospital conducted a review of existing data and indicators relevant to this assessment. Subsequent to this review of data, key insights were incorporated into subsequent CHNA activities and considered during the selection of health priorities.
Community Health Survey	In collaboration with nine other hospital systems, health department representatives, community organizations, and faculty researchers from the University of Evansville and Indiana University Bloomington, a survey was developed and conducted to collect data from residents in the specific hospital's service area. The survey process included; a) a random sample that recruited proportionately from all zip codes in the service area and b) a convenience sample survey that sought to collect the same data from individuals seeking care and services at organizations.
Community Focus Group Discussions	Six community focus group discussions were held in the service area. The purpose of these focus group was to: a) discuss insights from the work of those in health and social service organizations, b) discuss the factors associated with ongoing health issues identified in their work, and c) to gather other local community input relevant to a comprehensive consideration of the health needs of those counties and the service area on the whole.
Health Needs Prioritization Session	Hospital staff held a meeting of key stakeholders and local organizational leadership in order to review data from all activities conducted for the CHNA. Subsequent to a formal presentation and discussion of the data, attendees in the meeting participated in a nominal group process to identify the top health needs that would inform the development of the implementation plan.
Review of Resources and Partners	Based upon the results of the CHNA activities, a list of local resources and partnerships was reviewed and revised that would be relevant to addressing the needs identified via the CHNA and the subsequent implementation plan.

REVIEW OF EXISTING HEALTH INDICATORS

Introduction

This section of the report provides an overview of existing data and indicators that offer insight into the health and social issues of the service area. These data were used in a range of ways throughout the CHNA process, including:

- to inform the development of issues that would be further explored in the 2018 CHNA Community Survey,
- to guide specific analyses of data from the 2018 CHNA Community Survey,
- to provide data summaries and other insights to community members, organizational stakeholders, and hospital staff during CHNA related meetings and discussions, and
- as a foundation for the review of ongoing efforts and key decisions about the services offered by the hospitals.

Data Sources

To ensure consistency throughout the CHNA process of the hospitals in the service area, the review of existing data included the most recently available data related to the following community indicators:

- demographic characteristics of residents in the service area,
- social and economic characteristics of the service area,
- leading health outcomes,
- clinical characteristics of the service area, with a focus on access to care,
- quality of life indicators, and
- health-related behaviors and associated factors.

Data presented in this section of the report were sourced from the 2018 version of County Health Rankings & Roadmaps, a project of the Population Health Institute of the University of Wisconsin that is supported by the Robert Wood Johnson Foundation. Data also included those from the Indiana State Department of Health.

Throughout these data, indicators are presented for the county of interest, the state of Indiana, and the Top U.S. Performers (indicators that represent the top 10% best performing counties in the country). While comparisons across these data are valuable for identifying areas in a particular county where improvements can be made, such comparisons should always be made within the context of the vast differences that exist across the counties in the country.

Population Characteristics

Demographic characteristics of a particular region provide important insights for the development and delivery of health-related services and programs. Vanderburgh County is more diverse than much of the state in terms of racial and ethnicity characteristics, evenly split with regard to gender, with the majority of individuals living in areas considered urban. Vanderburgh County's population of 181,721 persons is summarized in Table 2.

Table 2. Characteristics of Vanderburgh County's Population

County Population Characteristics	Vanderburgh County	Indiana
Population Size	181,721	6,633,053
% Below 18 years of age	21.8%	23.8%
% 65 and older	15.8%	14.9%
% Non-Hispanic African American	9.4%	9.3%
% American Indian and Alaskan Native	0.3%	0.4%
% Asian	1.4%	2.2%
% Native Hawaiian/Other Pacific Islander	0.1%	0.1%
% Hispanic	2.6%	6.8%
% Non-Hispanic white	84.0%	79.6%
% Not proficient in English	1%	2%
% Females	51.6%	50.7%
% Rural	9.20%	27.6%

Social and Economic Characteristics

Social and economic factors are well established as important determinants of health and well-being. For purposes of the CHNA, these factors provide valuable insight into the context of health and well-being indicators and offer a foundation for considering the manner in which a hospital's programs are connected to a wider social services network. Educational attainment in the county is below the top U.S. performing geographic areas and high school graduation rates are lower in the county compared to the state. The county is also similar to the state's average regarding the indicators that are closely associated with health outcomes, although rates of childhood poverty are slightly elevated compared to the state and significantly higher than top U.S. performing areas. Table 3 provides a summary of primary social and economic factors in Vanderburgh County.

Table 3. Social and Economic Factors, Vanderburgh County

Social and Economic Factors	Vanderburgh County	Top US Performers	Indiana
High school graduation	78%	95%	87%
Some college	65%	72%	62%
Unemployment	4.10%	3.20%	4.40%
Children in poverty	23%	12%	19%
Income inequality	4.4	3.7	4.4
Children in single-parent households	40%	20%	34%
Social associations	14.4	22.1	12.3
Violent crime (per 100,000)	385	62	356
Injury deaths (per 100,000)	82	55	70

Quality of Life Indicators

Self-reported rankings of overall health status, and the number of days in a given month individuals would rate their physical and mental health as being poor, offer important insights into the factors that often influence individuals to seek care or support, and share well documented associations with care outcomes. Additionally, low birthweight is commonly used as a gauge for the existence of multi-faceted public health problems. Vanderburgh County performs at levels similar to the state on each of these important indicators, yet worse than top U.S. areas, as is summarized in Table 4.

Table 4. Quality of Life Indicators

Quality of Life Indicators	Vanderburgh County	Top US Performers	Indiana
Poor or fair health	20%	12%	18%
Poor physical health days	4.2	3	3.9
Poor mental health days	4.5	3.1	4.3
Low birthweight	9%	6%	8%

Health Outcomes

Common health indicators that provide insight into the general health state of a community include premature mortality, infant mortality, chronic disease (diabetes), infectious disease (HIV) and both physical and mental distress. On these indicators, Vanderburgh county largely mirrors the averages for the state of Indiana. However, while these values place Vanderburgh County within the middle quartiles of the state on most indicators, both the state and county have health outcomes that indicate a level of health worse than the top U.S. performing regions. Table 5 provides an overview of these leading health indicators for Vanderburgh County.

Table 5. Health Outcome Indicators, Vanderburgh County

Health Outcome Indicators	Vanderburgh County	Top US Performers	Indiana
Premature age-adjusted mortality (per 100,000)	440	270	390
Child mortality (per 100,000)	70	40	60
Infant mortality (per 100,000)	8	4	7
Frequent physical distress	12%	9%	12%
Frequent mental distress	13%	10%	13%
Diabetes prevalence	11%	8%	11%
HIV prevalence (per 100,000)	182	49	196

Clinical Characteristics

Of particular importance to the hospital were data that help to assess and consider issues closely aligned with the nation's objectives of improving access to care, reducing health care costs, and improving both the proportion of the population that has health insurance (particularly children) and adherence to preventive screenings and chronic disease monitoring. Uninsured rates in Vanderburgh County, while similar to the state average, are well above the top performing areas of the U.S.

Vanderburgh County, based on the availability of health care providers, ranks among the best counties in the state. Other indicators related to preventive screening and chronic disease management are found within the top ranges of both the state and nation. Table 6 provides a summary of these clinical characteristics of Vanderburgh County.

Table 6. Clinical Care Characteristics, Vanderburgh County

Clinical Characteristics	Vanderburgh County	Top US Performers	Indiana
Uninsured	10%	6%	11%
Uninsured adults	12%	7%	13%
Uninsured children	5%	3%	7%
Primary care physicians	1,130:1	1,030:1	1,500:1
Dentists	1,450:1	1,280:1	1,850:1
Mental health providers	530:1	330:1	700:1
Other primary care providers	845:1	782:01	1,367:1
Preventable hospital stays (per 100,000)	65	35	57
Diabetes monitoring	87%	91%	85%
Mammography screening	71%	71%	62%
Health care costs	$10,585		$9,992

Leading Causes of Mortality

An examination of the leading causes of mortality provides valuable insight into the major health issues facing a community. Presented in terms of the rates of disease-specific death by 100,000 members of a population, these data serve as an indicator of the issues most likely to require significant attention from hospitals and other health and social service organizations.

While these data are mortality-specific, they also serve as an indicator of a community's morbidity given that many individuals live with these diseases for extended periods of time. They also provide a helpful guide to prevention-focused programs given that behavioral determinants of these leading health issues are fairly understood. *Table 3 provides a summary of these indicators.*

Table 7. Mortality Indicators for Vanderburgh County, 2016

ICD 10 Description of Mortality Causes	Rates per 100,000 Population (Age-Adjusted)
ALL CAUSES	**850.45**
Malignant neoplasms (cancer)	**165.06**
Malignant neoplasm of stomach	2.58
Malignant neoplasms of colon, rectum and anus	12.97
Malignant neoplasm of pancreas	11.71
Malignant neoplasms of trachea, bronchus and lung	49.94
Malignant neoplasm of breast	10.2
Malignant neoplasms of cervix uteri, corpus uteri and ovary	5.86
Malignant neoplasm of prostate	8.64
Malignant neoplasms of urinary tract	12.31
Non-Hodgkin's lymphoma	2.84
Leukemia	6.55
Other malignant neoplasms	**41.46**
Diabetes mellitus	**30.39**
Alzheimer's disease	**38.15**
Major cardiovascular diseases	**228.38**
Diseases of heart	174.81
Hypertensive heart disease with or without renal disease	10.59
Ischemic heart diseases	98.7
Other diseases of heart	65.51
Essential hypertension and hypertensive renal disease	15.27
Cerebrovascular diseases (stroke)	27.1
Atherosclerosis	5.33
Other diseases of circulatory system	5.88

Table 7. Mortality Indicators for Vanderburgh County, 2016 - continued

Influenza and pneumonia	**11.86**
Chronic lower respiratory diseases	**56.92**
Peptic ulcer	**0.34**
Chronic liver disease and cirrhosis	**13.13**
Nephritis, nephrotic syndrome and nephrosis (kidney disease)	**20.03**
Pregnancy, childbirth and the puerperium	**0**
Certain conditions originating in the perinatal period	**3.11**
Congenital malformations, deformations and chromosomal abnormalities	**3.64**
Sudden infant death syndrome (SIDS)	**0**
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (excluding SIDS)	**5.86**
All other diseases	**194.97**
Motor vehicle accidents	**6.83**
All other and unspecified accidents and adverse effects	**51.12**
Intentional self-harm (suicide)	**16.1**
Assault (homicide)	**3.14**
All other external causes	**1.4**

Behavioral Factors

For purposes of the CHNA, a range of leading health behavior indicators were assessed. Each of the selected indicators share important associations with leading causes of morbidity and mortality in the country. Table 8 provides an overview of the leading health behaviors that not only offer insights into the social/behavioral determinants of leading health challenges in Vanderburgh County but also provide opportunities for the ongoing development and implementation of health and social service programs.

Table 8. Health Behaviors and Behavioral Outcomes, Vanderburgh County

Health Behaviors	Vanderburgh County	Top US Performers	Indiana
Adult smoking	22%	14%	21%
Adult obesity	34%	26%	32%
Food environment index	7.6	8.6	7
Physical inactivity	28%	20%	27%
Access to exercise opportunities	90%	91%	77%
Excessive drinking	18%	13%	19%
Alcohol-impaired driving deaths	22%	13%	22%
Sexually transmitted infections	572.0	145.1	437.9
Teen births	35	15	30

Table 9 also provides an overview of additional behavioral factors that are important for the context of the CHNA activities.

Table 9. Other Behavioral Factors, Vanderburgh County

Other Behavioral Factors	Vanderburgh County	Top US Performers	Indiana
Food insecurity	16%	10%	14%
Limited access to healthy foods	4%	2%	7%
Drug overdose deaths (per 100,000)	24	10	20
Motor vehicle crash deaths (per 100,000)	9	9	12
Insufficient sleep	34%	27%	36%

SUMMARY

A review of leading indicators related to the health and well-being of a community provides an important foundation for the remaining CHNA activities. These data offer insights into the factors underlying the health issues that are perceived by providers, organizational stakeholders, and community members as being among those needing priority attention. These data summaries were used during subsequent CHNA activities, receiving particular attention during the prioritization process that is described later in this report.

SURVEY METHODS

Purpose of the Survey

To collect primary data from residents of communities in the service area of Vanderburgh County, a survey was designed, fielded, and analyzed. This section of the report includes a description of the survey methods and a summary of participants' responses to the survey.

Survey Development

To develop the survey used for the CHNA, the hospitals partnered with faculty from Indiana-based universities who had particular expertise in community-based survey research. Dr. William McConnell of the University of Evansville served as the lead researcher on the project, in partnership with Dr. Michael Reece and Dr. Catherine Sherwood-Laughlin (both of the Indiana University School of Public Health). The University of Evansville contracted with the Center for Survey Research (CSR) at Indiana University to administer this survey in two phases: phase I was conducted as a paper survey mailed to a random address-based sample and phase II was conducted as a paper survey administered by the hospitals to a convenience sample of their choosing. The survey was conducted with approval of the Institutional Review Board (IRB) of the University of Evansville.

Planning and development for the survey began in the winter of 2017. The university faculty joined a collaborative of eight major hospital systems that served populations in Indiana and Illinois. A goal of the collaborative was to align survey activities in order to increase cost-efficiency and to work toward the development of a data infrastructure that would be useful across the systems and also of enhanced utility to the health and social service organizations with which those hospitals partner on initiatives to improve health in their respective local communities.

Using a construct-based approach that identified the leading areas to be included on the survey, the hospitals and faculty developed a survey. The survey included measures that had been validated for use in similar projects by other researchers and additional measures that were developed by the partners for specific needs of this CHNA. The survey covered ten major areas. Table 10 provides an overview of the constructs covered in the survey and a description of the measures associated with each construct. A copy of the survey is included as Appendix A.

Table 10. Survey Constructs and Measures

Survey Constructs	Description of Measures
Demographics	This section included measures related to the socio-demographics of the survey participants, including: county of residence, age, gender, ethnicity, race, education, household income, employment, and number of adults and children in household.
Perceived Health and Well-Being	This section included a revised version of the U.S. Centers for Disease Control and Prevention's Health-Related Quality of Life measure. Items included the single-item HRQOL assessment of perceived overall health and additional assessments of physical health, mental health, and social well-being. Also included was a measure of overall life satisfaction and a measure of current level of stress.
Health Care Coverage and Relationships	This section included a single measure of whether the participant had health insurance or some other type of coverage for health care and a single measure of whether they had a current personal health care provider.
Health Care Engagement	This section included a measure related to the types of care with which the participant had engaged in the previous 12 months. A total of 14 specific types of health care engagement were assessed.
Health-Related Behaviors	This section included a measure that asked participants to self-report their participation in a range of health-related behaviors. A total of 11 health behaviors were assessed.
Health Care Resource Challenges	This section included measures related to the extent to which participants had found themselves in need of avoiding care due to a lack of fiscal resources. Specifically assessed was the extent to which participants had to forego three types of health care, including seeing a medical provider, filling a prescription, and securing transportation for a health purpose or appointment.
Felt Social Determinants	This section included measures to assess the extent to which participants felt the impact of 10 specific social determinants, including economics, education, community cohesion, policy, environment, housing, psychosocial, transportation, social, ecological, and employment.
Perceived Priority Health Needs	This section included a measure to assess participants' perceptions of the importance of 21 health issues to their local community.
Perceived Resource Allocation Priorities	This section included a measure to assess participants' perceptions of the extent to which 21 health issues were of priority for the allocation of resources in their local community.
Perceived Importance of Social and Health Services	This section included a measure to assess the extent to which participants perceived 20 different health and social service programs to be of importance to their community.

Sample Development

To collect data, two separate samples were accessed. One sample, described below, included a random sample of individuals representative of the service area. Additionally, the hospitals collaborated with health and social service organization partners to form a convenience sample that included those engaged in services.

Phase One Random Sample

The target population for Phase I of the 2018 Community Health Needs Assessment Survey consisted of noninstitutionalized adult residents, aged 18 years or older, in the catchment areas of the participating hospitals. Sampling was performed on a household basis using an address-based sample.

The faculty collaborated with the hospitals to determine catchment areas using county and zip code boundaries. Geographic areas that were shared between hospitals were reduced such that each geographic area was sampled one time.

Sampling was determined using a multistage sampling design. At the first stage, sample units were drawn randomly from an address-based sampling frame of each area. Sample frames were limited to residential addresses excluding P.O. boxes (unless marked in the sample frame as 'only way to get mail'), seasonal, vacant, throwback, and drop-off point addresses. At the second stage, a within-household respondent was selected by asking the adult with the most recent birthday to complete the survey.

To develop the sample area, a set of 2,223 address-based records representing the service population were purchased from Marketing Systems Group (MSG). MSG used proprietary sampling methods and provided assurance of appropriate and accurate coverage for the target population. The sample list delivered by MSG included postal address information, FIPS code (county designator), and appended demographic information for age, gender, Hispanic surname, Asian surname, number of adults at address, number of children at address, household income class, marital status, ethnicity, and home ownership status. Upon receipt of the sample, it was stored in a secure database created and maintained by the CSR and was reviewed and corrected for any clerical errors. Using these records, a recruitment sample was constructed for the hospital's service population.

Phase Two Convenience Sample

A phase two sample was also constructed by the hospitals and their community-based partners for purposes of collecting data from those likely to be missed in address-based recruitment. St. Vincent and Deaconess are committed to serving all persons, with special attention to those who are poor and vulnerable. For the CHNA, there was a concerted effort to reach experts in public health, professionals with special knowledge of the community health needs and those who can be the voice of the medically underserved and vulnerable populations. To reach these individuals, the community resource list from the 2016 CHNA was updated (Appendix B) and used as a reference to identify relevant organizations. Once identified, surveys were sent either electronically or by mail, to reach the target population.

Data Collection

Phase One Random Sample

The questionnaire was printed as a four-page booklet on a single 11" x 17" sheet with a fold in the center. Each questionnaire was printed with a unique, numeric survey identifier that matched a record in the sample. A separate sheet was folded over the questionnaire and printed with a cover letter, study information sheet, and return mailing instructions. The questionnaire packet was assembled in a 9" x 12" windowed envelope and included an 8¾" x 11½" postage-paid, business reply envelope for survey returns.

The field period for the 2018 Community Health Needs Assessment Survey was April 2, 2018, through June 29, 2018. Each sampled address received up to two questionnaire attempts. The addresses were divided into four batches based on USPS pre-sort, and each batch was mailed one at a time over the course of a two-week period. The second questionnaire for each address was mailed approximately 4 weeks after the first questionnaire. The addresses of returned questionnaires were excluded from the lists for the second questionnaire attempt.

After the second questionnaire attempt, a postcard follow-up was reintroduced in hopes of increasing response. In addition to reminding people to mail in their completed questionnaires, the postcard also provided a website address that allowed people to take the survey online as a member of the secondary convenience sample.

Paper questionnaires were returned to CSR in postage-paid, business reply envelopes provided in the questionnaire packet. Completed survey returns were counted, checked for unclear marks, batched in groups of 50 surveys, and scanned into ABBYY FlexiCapture OCR software for data processing. CSR's scanning partner, DataForce (dba MJT, US), received the scanned survey images electronically and reviewed the data via ABBYY FlexiCapture data verification software to ensure quality control. Missing responses and multiple responses to a single item were flagged. The compiled data was transmitted back to CSR via a secure file transfer protocol (SFTP) server.

Phase Two Convenience Sample

The collection of data in the convenience sample phase utilized the same survey used in the random sample. For this phase of data collection the survey was available both in English and Spanish. Survey data for the convenience sample were collected between June 15 - July 6, 2018. All data from returned surveys, both online and paper versions, were sent directly to the IU Center for Survey Research in Bloomington, Indiana. Additionally, an online version of the questionnaire was programmed in the Qualtrics survey platform. During data collection at community-based organizations, the hospitals had the choice to use the online version of the survey (using a phone or tablet) or the paper-based survey. Once collected, data were shipped to CSR for scanning.

After the data collection period ended for the convenience sample, it was determined that a meaningful analysis of this county-level survey data was not possible given low numbers from specific counties. Therefore, data were considered in the aggregate from all counties in which surveys were returned. Throughout the results section, insights and comparisons from the convenience sample are included.

Data Management

All surveys were returned to CSR for scanning and organization. Data files were stored by CSR on a secure file server and processed using R statistical programming software. Respondent-provided counties and zip codes were cross-checked against the sample file. Discrepancies and misspellings were verified against the original scanned image of the response and, if reasonably similar, corrected prior to final data submission.

After data processing, identifiers to allow filtering by catchment area and weighting variables were added (only for the random sample). The final dataset was converted to a format for analysis in STATA statistical analysis software and transmitted to the researchers via Slashtmp, Indiana University's secure file transfer system.

Weighting of Samples

Weighting activities for the 2018 Community Health Needs Assessment apply only to the random sample. Two weighting adjustments were made to enhance consistency between the survey sample and the characteristics of the service population. The first adjustment was a base weight adjustment to account for unequal probabilities of selection within household. The second was a post-stratification adjustment to U.S. Census Bureau 2012-2016 American Community Survey five-year population estimates. The two weighting adjustments were multiplied to calculate a preliminary final weight for each catchment area. These preliminary weights were then trimmed and scaled so that the final weights summed to the number of respondents in each catchment area. Finally, we discuss incorporating weights in analysis of the survey data. Dataset preparation and weighting activities were conducted using SAS Versions 13.1 and 14.1 and Excel. American Community Survey data were obtained using American FactFinder (https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml).

Survey Response Patterns

Regarding the random sample, of the 2,223 address-based records received during sample construction, 2,123 were deemed eligible for participation in the survey and received recruitment materials by mail. Of those households, a total of 260 returned a completed survey. The response rate for Vanderburgh County was thus 12.2%. Table 11 provides an overview of survey responses by zip codes included in the service population.

County/Zip	Count of Respondent Households	Count of Households Assumed Eligible	Response Rate
Vanderburgh	**260**	**2132**	**12.20%**
47612	0	1	0.00%
47639	2	4	50.00%
47708	2	8	25.00%
47710	25	222	11.26%
47711	43	358	12.01%
47712	29	240	12.08%
47713	13	121	10.74%
47714	41	394	10.41%
47715	59	391	15.09%
47720	21	195	10.77%
47725	25	198	12.63%
Total	**260**	**2132**	**12.20%**

Data Analyses

Data analyses were conducted by Measures Matter, LLC, a research consulting group with expertise in community-based participatory research. Prior to analyses, Measures Matter staff consulted with the hospitals to develop a preliminary plan for the analysis of data and the presentation of results.

To retain the integrity of the phase one random sample and the methodological rigor offered by that sample, analyses were conducted separately for the phase one random sample and the phase two convenience sample.

SURVEY RESULTS

The summary of the survey results primarily reflects the phase one random sample unless otherwise stated. Throughout the summary, comparisons to the phase two convenience sample (at the statewide aggregate level) are also included where appropriate.

Description of Participants

A total of 260 participants returned a completed survey from the phase one random sample. In this section of the survey, the primary presentation of results includes these 260 individuals from the random sample.

Additionally, a total of 324 individuals completed a survey during the convenience sample phase. Given that analyses by county were not possible given limited data from certain counties, these data were analyzed to offer comparisons between the county-specific random sample and the convenience data collected across multiple counties statewide. In and where appropriate, commentary is provided in each section to highlight similarities and differences between the random and convenience sample data.

County of Residence. Of the 260 participants, 97.6% (n=254) indicated that their primary residence was located in Vanderburgh County. Although all households receiving the survey were located in Vanderburgh County, some participants (2.4%, n=6) refused to provide their county of residence or indicated that it was located in an adjacent county. Figure 1 provides an overview of the participants' reported county of residence.

Adults and Children in Household. Participants were asked to indicate the number of adults (18 years and over) and children (under 18 years) who lived in their household. Of the participants, 81.1% (n = 211) indicated that two or fewer adults lived in the household. Of those providing a response to the question about children in the household, the majority (61.0%, n = 159) indicated no children under the age of 18 years in the home. Some participants did report children in the home, with most (31.7%, n = 82) indicating two or fewer children and the remainder (3.4%, n = 9) reporting three or more children in the home.

A larger proportion of individuals (> 25%) in the convenience sample indicated the presence of three or more adults in the home and 17.9% indicated the presence of three or more children in the home. Participants in the convenience sample were largely women (80%).

Gender. Participants were asked to report their gender. More women participated in the survey than did men, and few refused to respond to the question about gender. Figure 2 provides an overview of participant gender. Most participants in the convenience sample were also women.

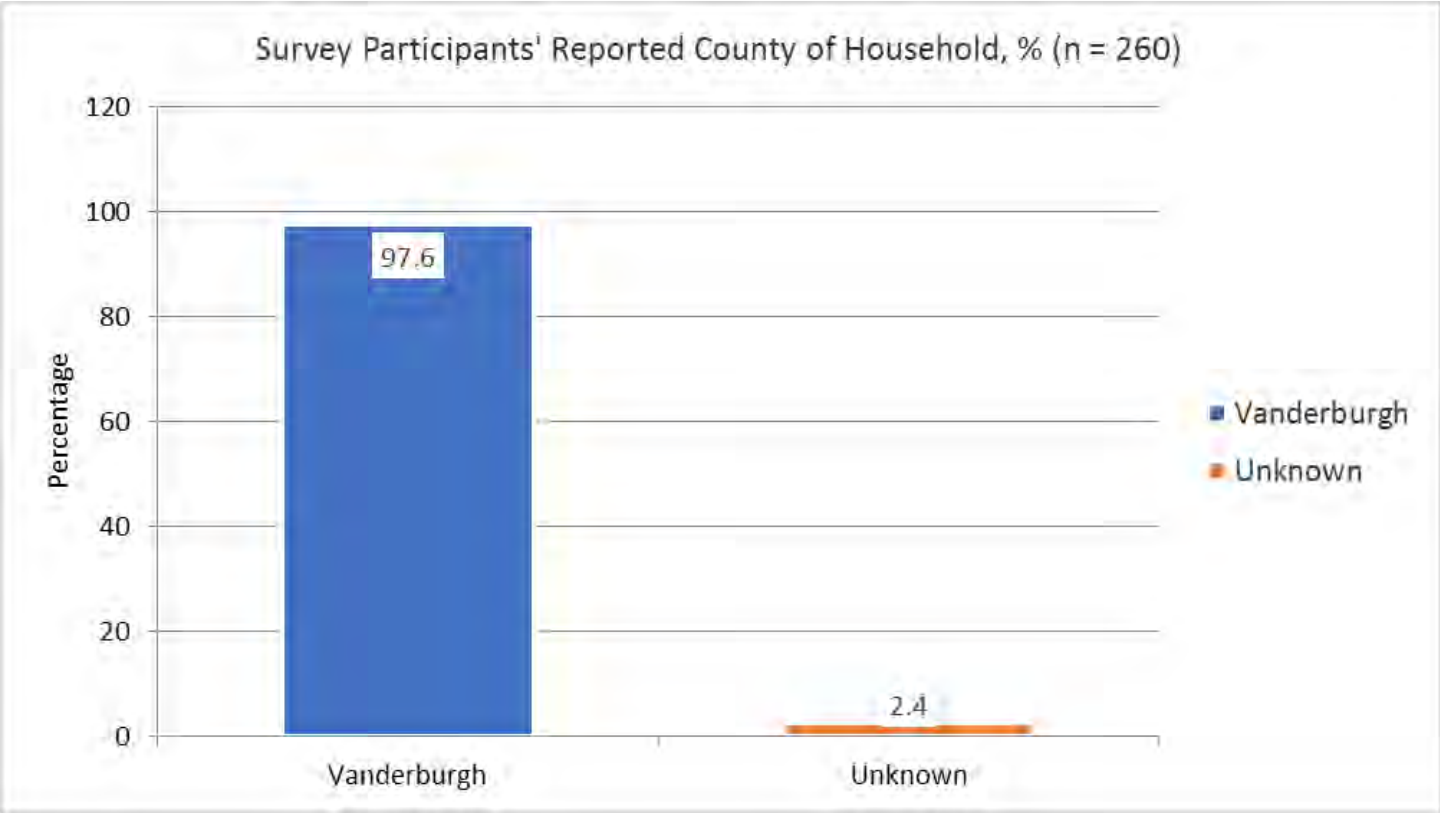


Figure 1. Participants' Reported County of Residence, by % of Participants

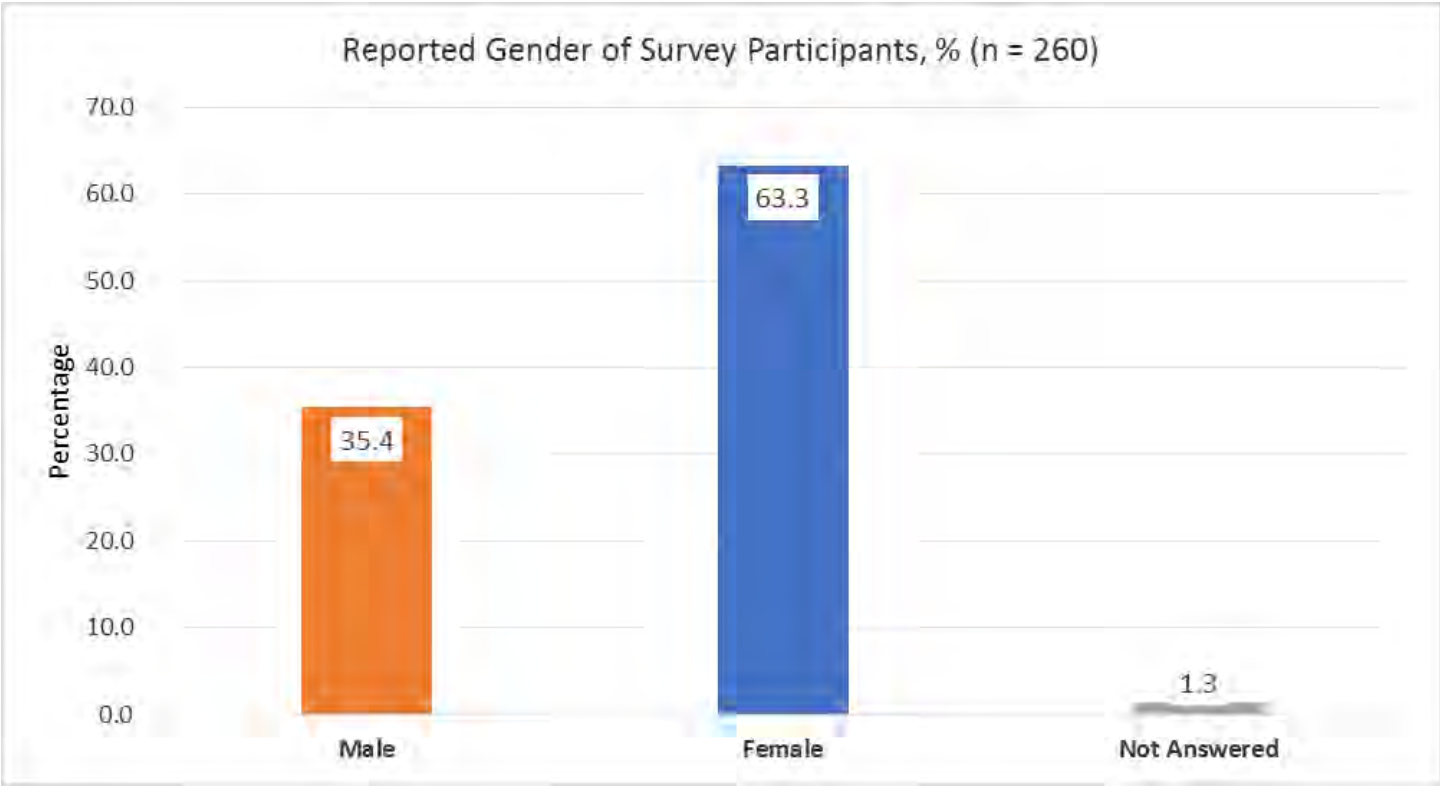


Figure 2. Reported Gender of Survey Participants, by % of Participants

Age. Participants were asked to provide the year in which they were born. Those data were then analyzed to compute the estimated age of the individual at the time the survey was returned. Figure 3 provides a categorical overview of the age of participants.

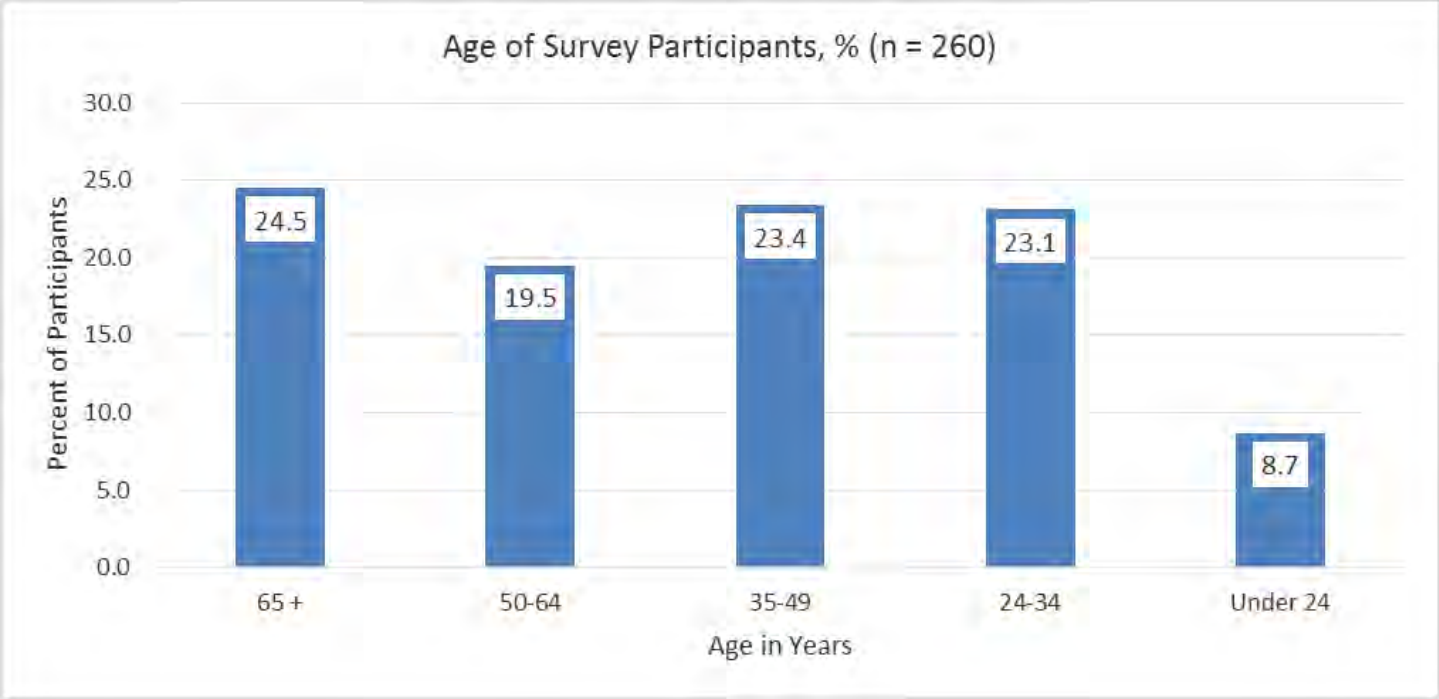


Figure 3. Reported Age of Participants, by % in Years

Race. Participants were asked to respond to a question regarding the race with which they identify. Participants were invited to select more than one race. The vast majority (90.1%, n = 234) indicated that they were of "Caucasian/White" race, with an additional 6.2% (n = 16) responding that they were "Black or African American." Figure 4 provides an overview of the race characteristics and those indicating their ethnicity as Hispanic.

Ethnicity. Participants were asked whether they were of Hispanic, Latino, or Spanish origin. Less than one percent of participants responded in the affirmative.

Participants in the convenience sample were more diverse with regard to ethnicity and race, with approximately 6% reporting their ethnicity as Hispanic and 30.6% reporting their race as Black or African-American. Participants in the convenience sample reported incomes at levels indicating poverty, with over 50% reporting total household income of less than $25,000 and 31.5% reporting income of less than $15,000.

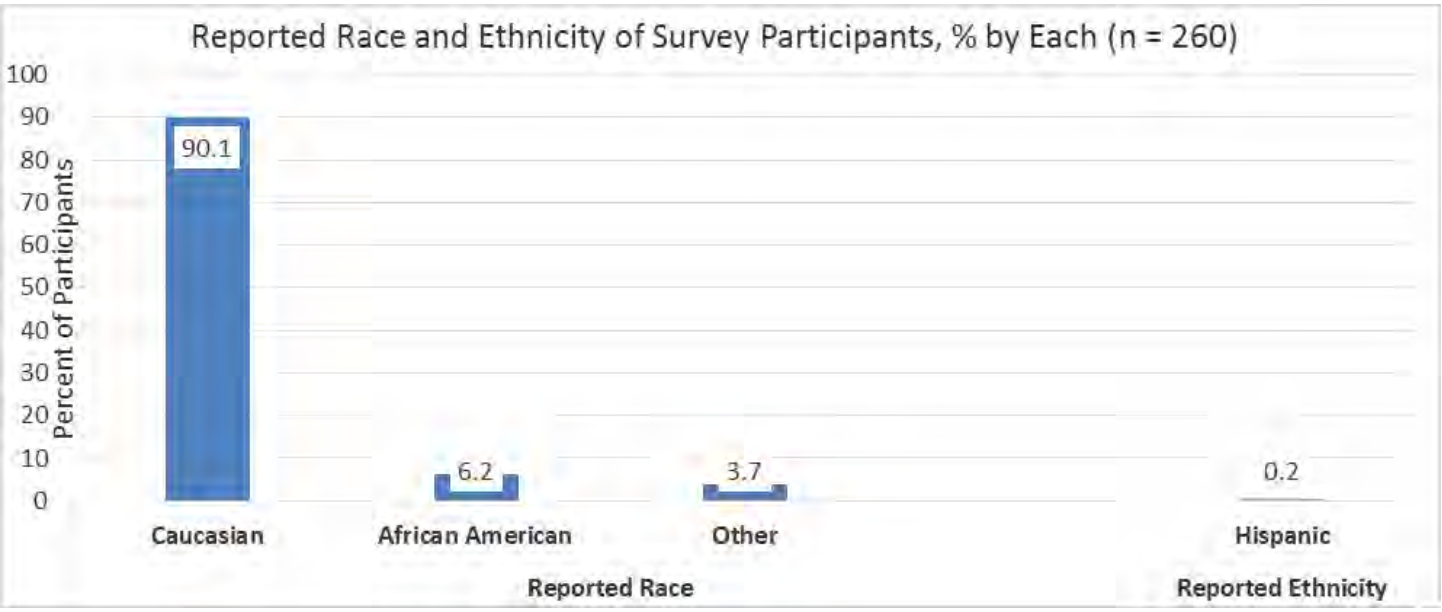


Figure 4. Reported Race and Ethnicity of Participants, by Category %

Household Income. Participants were asked to respond to a question regarding the total income of the household in which they lived (including all sources). Eight participants did not provide a response to this question. Approximately one-fourth (24.2%, n = 63) reported total household income of less than $35,000, slightly over one-third (37.5%, n = 98) reported income of between $35,000 and $74,999, with the remaining one-third of participants (35.2%, n = 91) reporting total household income of over $75,000. Figure 5 provides a categorical summary of participants' reported household income.

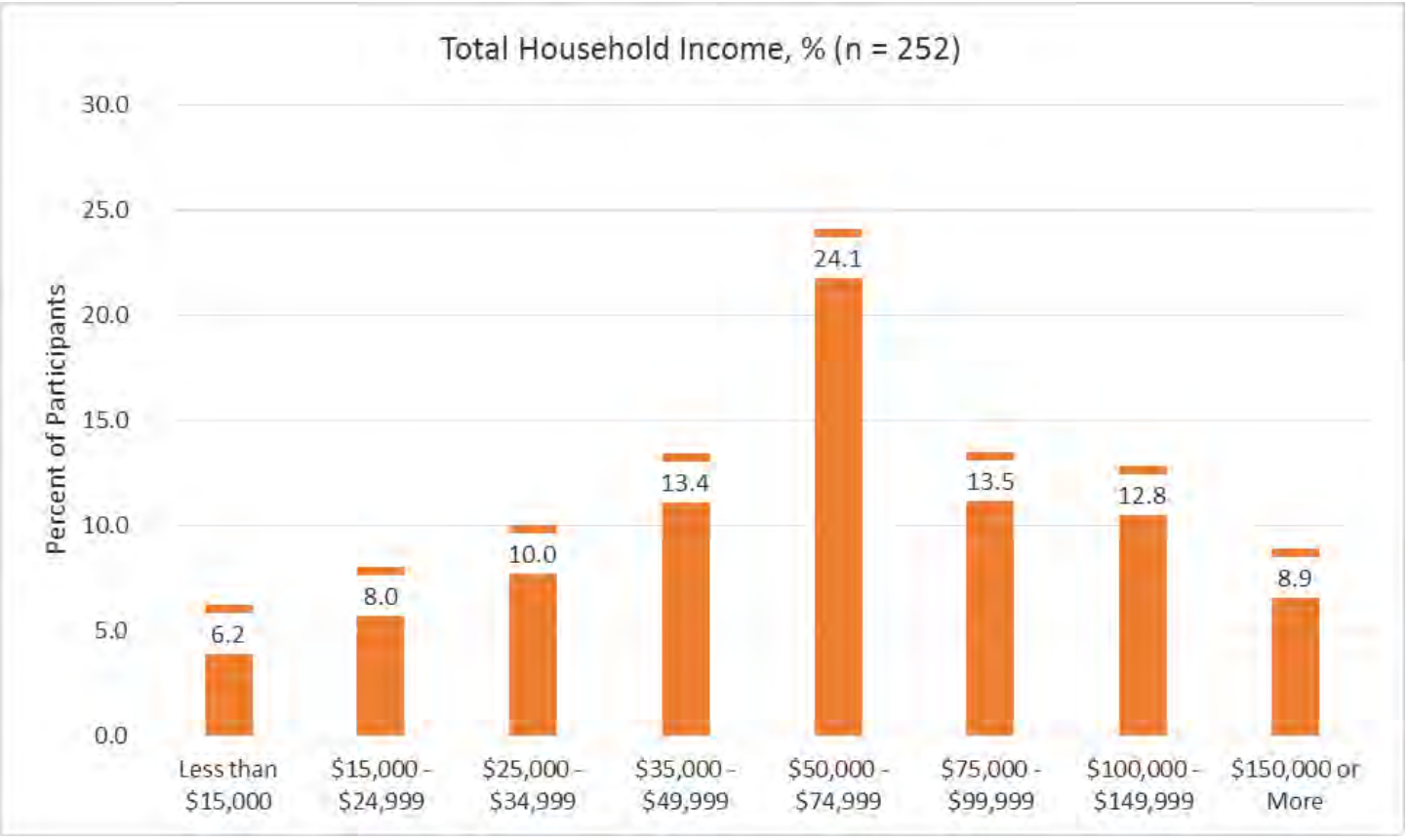


Figure 5. Reported Total Household Income, by Category %

Level of Education. Participants were asked to report their highest level of education based on specific categories. Approximately one-third of participants (38.0%, n = 99) reported having completed an associate's or bachelor's degree from a college or university and 19.3% (n = 50) reported having attained a graduate or professional degree. Approximately one-fourth of participants (21.0%, n = 54) indicated that they had a diploma or certificate from a technical or vocational school or that they had completed some college. In similar proportions, 16.8% (n = 44) reported having received a high school diploma or GED, and only 2.1% (n = 5) reported that they had some high school education but had not graduated. Seven individuals (1.4%) chose "other" without clarification and one individual chose not to provide a response to this question.

Employment. Participants were asked to describe their employment status. Most were employed full-time or part-time (61.5%, n = 160) and only 5.8% (n = 15) described themselves as being unemployed. Approximately one-fourth (23.1%, n = 60) were retired and 2.9% (n = 8) reported being students.

Participants' Perceptions of Health and Well-Being

Participants were asked to respond to four questions that sought to capture their perceptions of their current health status. Participants were asked to provide an assessment of their overall health, their physical health, their mental health, and their social well-being. Additionally, participants were asked about their overall life satisfaction and their level of stress. While responses to each area assessed are described below, Figures 6, 7, and 8 provide a summary of the participant responses.

Overall Health. Participants were asked "Would you say that in general, your overall health is…" with five response options ranging from poor to excellent. One participant did not respond to this question (0.5%). The vast majority of participants rated their overall health as very good (36.0%, n = 94), excellent (10.9%, n = 28), or good (38.1%, n = 99). The remainder assessed their overall health as being fair (10.2%, n = 27) or poor (4.3%, n = 11).

Physical Health. Participants were asked "Would you say that in general, your physical health is…" with five response options ranging from poor to excellent. Despite the vast majority who reported their overall health as being very good or positive, participants differentiated their level of health more when being specific to their physical health. Less than half of individuals collectively rated their physical health as very good (16.5%, n = 43) or excellent (2.8%, n = 7). Larger proportions of participants rated their health as good (39.1%, n = 102), or fair (30.9%, n = 80), with the remainder rating their physical health as poor (10.8%, n = 28).

Mental Health. Participants were asked "Would you say that in general, your mental health is…" with five response options ranging from poor to excellent. The majority of participants rated their overall mental health as very good (36.9%, n = 96), excellent (21.8%, n = 57), or good (29.9%, n = 78). The remainder assessed their overall mental health as being fair (8.6%, n = 22) or poor (2.6%, n = 7).

Social Well-Being. Participants were asked "Would you say that in general, your social well-being is…" with five response options ranging from poor to excellent. The majority of participants perceived their overall social well-being as less than good, with the largest proportion of all participants responding fair (41.1%, n = 107) and approximately one-fifth of participants (20.6%, n = 54) responding with poor. Approximately one-third of participants rated their social well-being as good (27.5%, n = 72), with the remainder responding with very good (8.0%, n = 21) or excellent (2.3%, n = 6).

Participants in the convenience sample largely perceived their overall health and physical health as being "good to excellent" in higher than anticipated proportions, with over 75% reporting such. In terms of those expressing poor or fair levels on the specific indicators of health, over 20% rated their physical health as such, 14.2% rated their mental health as such, and 31.1% rated their social well-being as poor or fair.

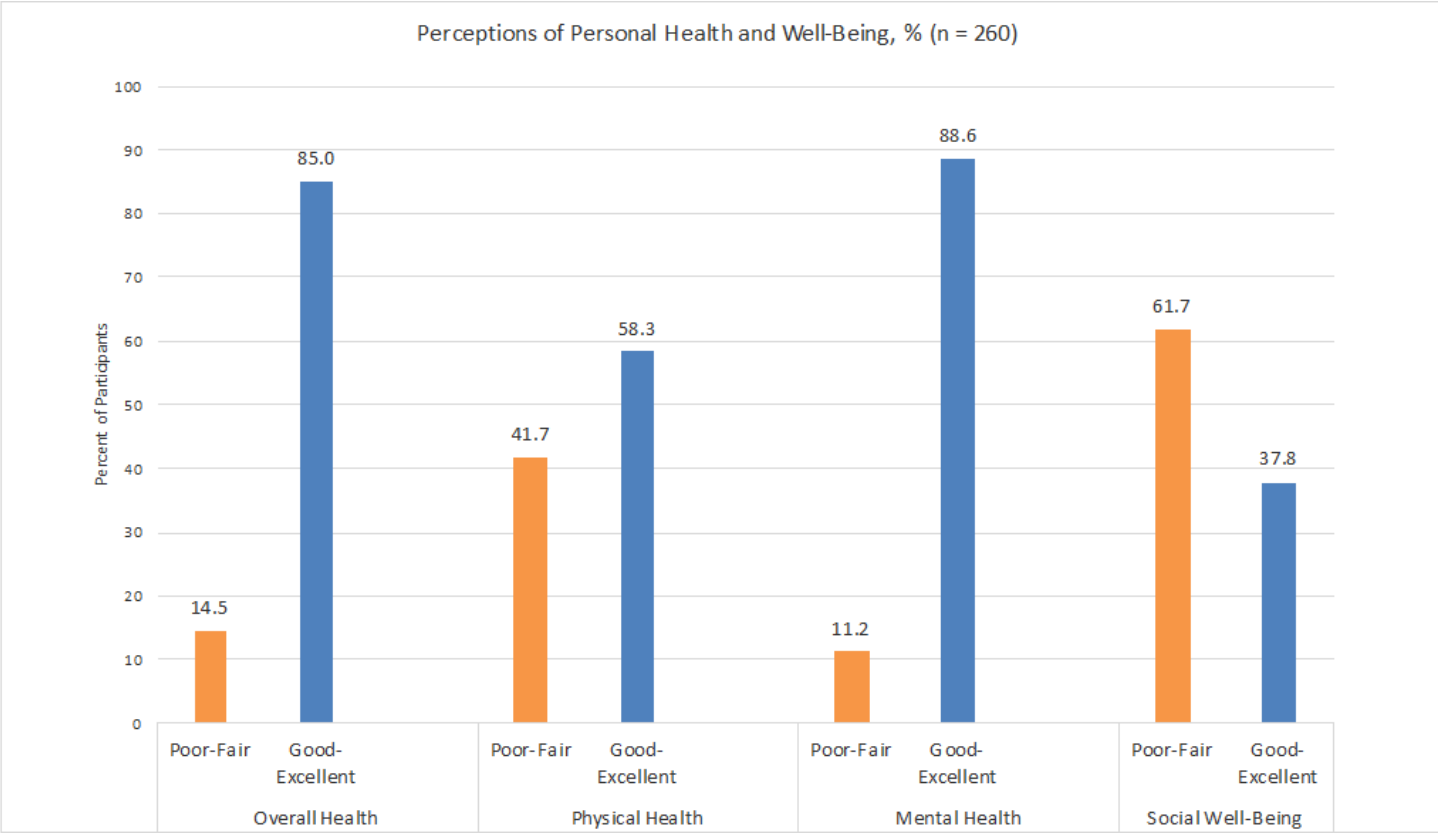


Figure 6. Participants' Perceptions of Health and Well-Being

Overall Life Satisfaction. Participants were asked to respond to a single question "overall I am satisfied with my life" with five response options ranging from strongly disagree to strongly agree. Figure 7 provides an overview of responses to this item.

Level of Life Stress. Participants were asked to rank their current level of life stress by responding to a single item "Please rank yourself on a scale of 1 to 10 where 1 means you have "little or no stress" and 10 means you have "a great deal of stress." Figure 7 provides responses of respondents who ranked themselves on this measure.

Participants in the convenience sample tended to report higher levels of stress, with 29.9% describing their stress as being in the top levels (greater than 8 on scale of 1-10). Regarding life satisfaction, 20.2% of those in the convenience sample disagreed with the statement "overall I am satisfied with my life."

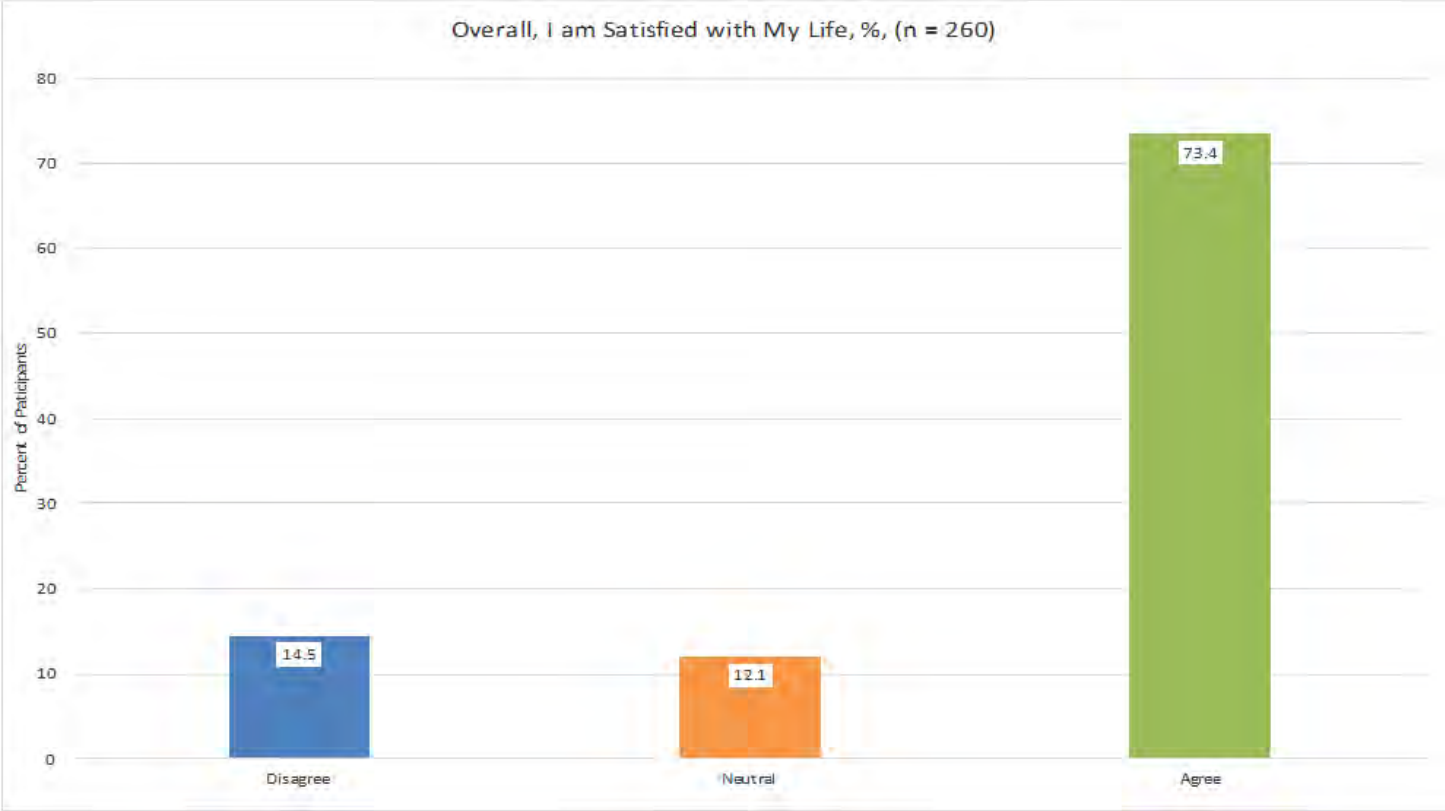


Figure 7. Participants' Agreement with Life Satisfaction Item

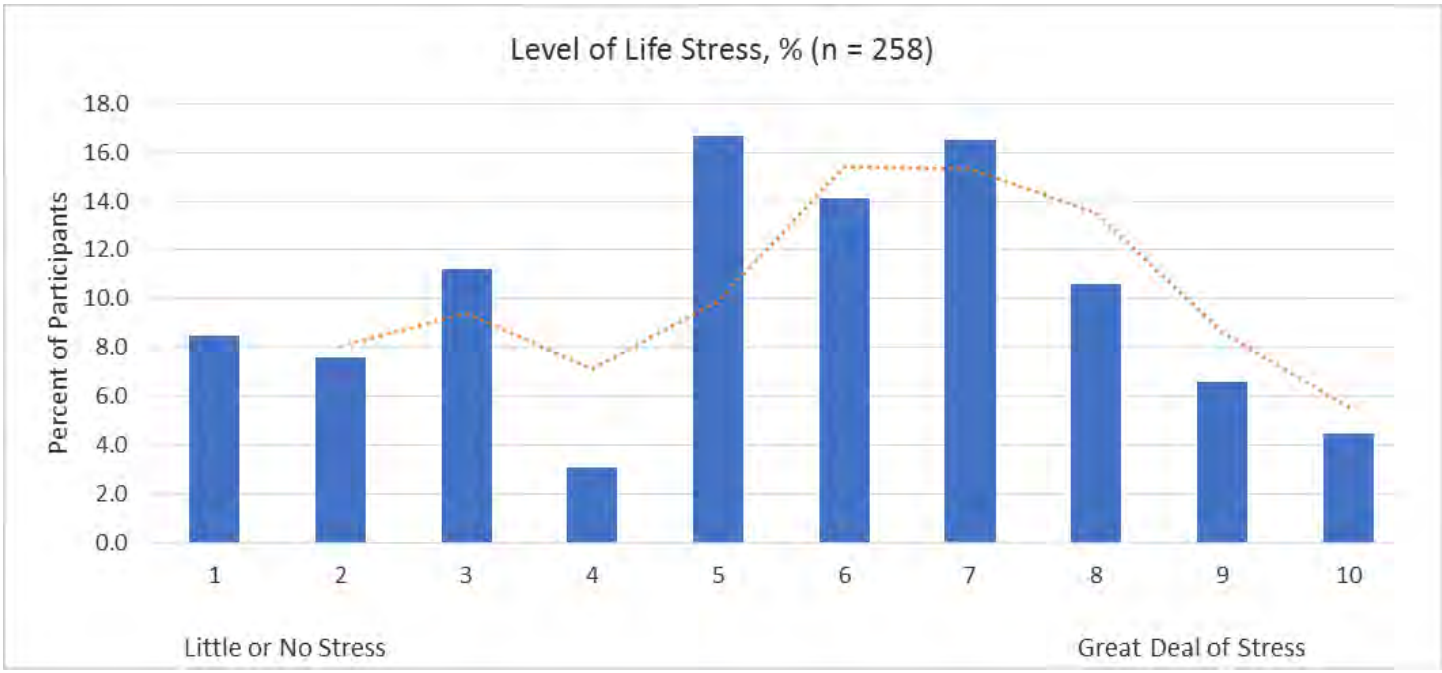


Figure 8. Ranking of Level of Life Stress

Health Care Access and Engagement

Participants were asked to respond to a range of questions related to their current level of health care coverage and also asked to describe the types of engagement they had with the health care system in their community within the 12 months prior to the survey. Also assessed was whether participants had found themselves in situations within the past year that made it necessary to forego some level of health care based on a lack of financial resources or because they had to prioritize other matters.

Insurance or Health Care Coverage. Participants were asked "do you currently have insurance or coverage that helps with your health care costs?" Of the participants, the vast majority (95.5% n = 248) reported that they did have such coverage or insurance, while 2.6% (n = 7) responded "no" and three participants (1.0%) indicated that they were "unsure" about such coverage.

Current Personal Provider. Participants were asked "do you currently have someone that you think of as your personal doctor or personal health care provider?" Most participants indicated that they did have such a personal provider (83.2%, n = 216), while 15.4% (n = 40) responded "no."

Figure 9 provides an overview of the responses to the questions about insurance or health care coverage and the presence of a personal health care provider.

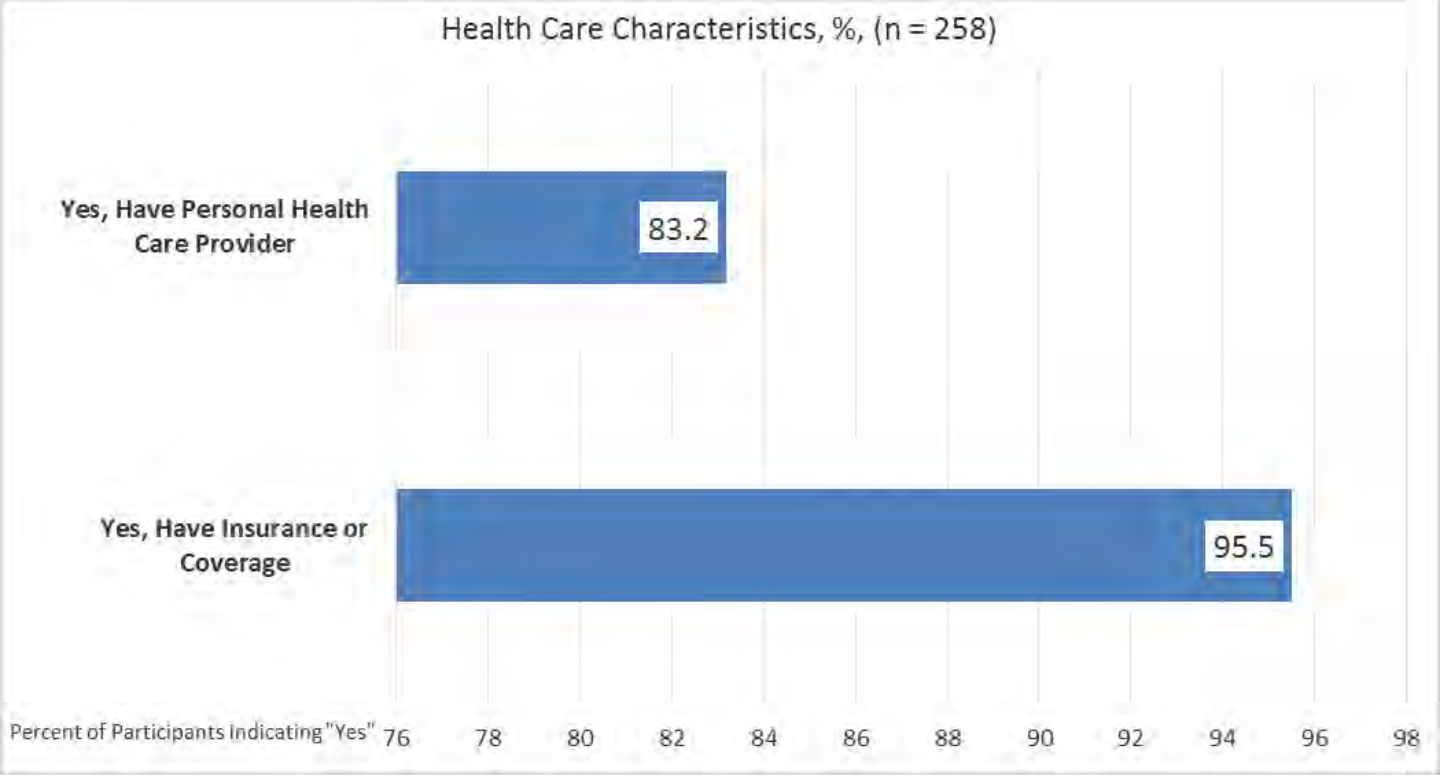


Figure 9. Participants' Reported Insurance and Personal Provider Characteristics

Of those participating in the convenience sample, 22.2% reported a lack of health insurance and 17.6% reported a lack of a personal provider.

Health Care Engagement. Participants were provided with a list of 14 health-related services and types of health care engagement and asked whether they had received or utilized each of those within the past 12 months. Table 12 provides a summary of the participants' responses, ordered from the highest to lowest levels of care engagement.

Type of Health Care Engagement	Received Past 12 Months (%)	Did Not Receive Past 12 Months (%)
Filled a Prescription	70.1	29.9
Received a Routine Physical Exam	64.1	35.9
Received Dental Care	61.3	38.7
Received Immunizations or other Preventive Care	45.3	54.7
Received Acute Care, Like for an Infection or Injury	30.1	69.9
Received Care at an Urgent Care Facility	22.1	77.9
Received Care for Chronic Disease	15.9	84.1
Received Treatment for a Mental Health Diagnosis	12	88.0
Received Care at a Hospital Emergency Room	10.2	89.8
Received a Screening for Anxiety or Depression by a Medical Provider	9.7	90.3
Received Inpatient Care at a Hospital	8.9	91.1
Received Prenatal or Well-Baby Care	5.5	94.5
Received Care Related to Family Planning	5.3	94.7
Received Treatment for Addiction	2.9	97.1

Participants in the convenience sample reported different patterns of health care engagement than did the random sample, in key areas. Rates of engagement in the convenience sample included: immunizations or preventive care (18.5%), routine physical exam (37.3%), using emergency rooms (15.4%), acute care (16.7%), chronic care (19.1%), emergency room treatment (15.4%), urgent care use (11.4%), dental care (38.3%), and filling a prescription (52.2%). Only 2.2% reported receiving treatment for addiction, and 6.5 percent reported receiving treatment for a mental health diagnosis, yet 12.7% reported being screened for depression by a medical provider.

Resources and Health Care Engagement. Participants were provided a list of three types of health care engagement needs including seeing a provider, filling a prescription, and finding transportation for care and asked to indicate whether there had been a time within the past 12 months that they could not act upon that need because "they couldn't afford it or had to prioritize spending money on something else." Less than 25% of participants indicated that it had been the case that they prioritized something over their health care across the three types assessed. Figure 10 summarizes this data.

Regarding **seeing a medical provider**, 17.1% of participants (n = 45) indicated that they had a need to see a provider but did not due to other needs. Most participants (78.8%, n = 205) reported that they had not found themselves in a situation to avoid seeing a provider and a small number of participants (4.1%, n = 11) chose not to provide a response to this question.

Regarding **needing to fill a prescription**, 20.2%, (n = 53) indicated that that they had a need to avoid filling a prescription due to other needs and a small number (1.2%, n = 3) indicated that there were unsure whether that had been their situation. Most participants (76.5%, n = 199) reported that they had not found themselves in a situation to avoid filling prescription due to a lack of resources and a small number of participants (2.0%, n = 5) chose not to provide a response to this question.

Regarding **needing transportation for health care**, 8.8% of participants (n = 23) indicated that they had not been able to access transportation due to other needs and one person (0.2%,) indicated that they were unsure. The vast majority of participants (88.2%, n = 229) reported that they had not found themselves in this situation while 1.8% of participants (n = 5) chose not to provide a response to this question.

Across all three areas, participants in the convenience sample reported fairly elevated levels of incidence of needing to forego care due to the need to prioritize other resources. Of those, 27.2% reported foregoing seeing a provider, 27.2% reported not filling a prescription, and 17.6% reported foregoing transportation for care due to other needs.

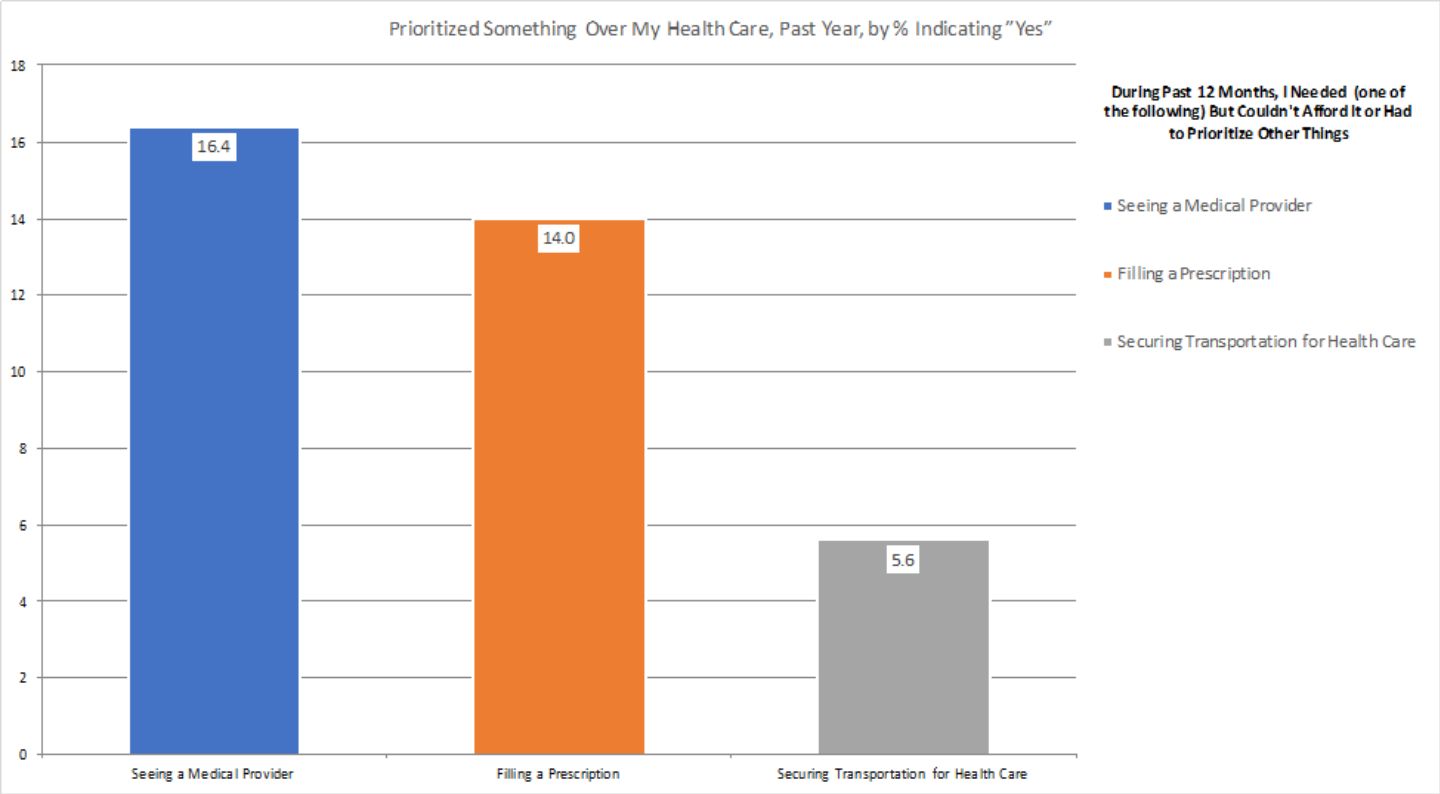


Figure 10. Participants' Reports of Resource Challenges and Health Care

Personal Health-Related Behaviors

Also of interest was understanding the extent to which participants had participated in certain behaviors within the past 30 days. Considered were behaviors that were conceptualized as health promoting (e.g., behaviors perceived by the hospitals to be supportive of one's health and well-being) or health challenging (e.g., behaviors perceived by the hospitals to be challenging to one's health and well-being). Table 13 provides a summary of participants' self-reported behaviors.

In the convenience sample, the most frequently reported health promoting behaviors were getting plenty of sleep (43.2%), eating a healthy balanced diet (42.9%), and having blood pressure checked (38.3%). The most frequently reported challenging behavior was using tobacco (23.1%) and 8.3% reported the use of a prescribed opioid.

Health Promoting Behaviors	% Reporting Behavior
Being Physically Active	52.0
Getting Plenty of Sleep	57.1
Eating Balanced Diet	50.9
Checked Blood Pressure	43.7
Tried to Reduce Stress	27.9
Took Prescription for Mental Health	20.3
Health Challenging Behaviors	**% Reporting Behavior**
Used Tobacco	17.0
Took Opioid Prescribed to Me	6.1
Driving Intoxicated	1.6
Took Opioid Not Prescribed to Me	0.9

Table 13. Participants' Self-Reported Health Behaviors Past 30 Days (n = 260)

Social Determinants of Health

Those conducting the CHNA were particularly interested in a better understanding of whether or not participants perceived that certain social issues (often considered to be determinants of health status) were impacting their lives. Participants were provided with a list of 10 statements and asked to report the extent to which that statement applied to them. Each statement reflected a particular social determinant of health.

The purpose of these items was to assess the extent to which participants "felt" specific characteristics of social factors known to influence health outcomes. To assess these, some items were worded in a positive way. For example, "I feel safe in the place where I live" is a positively worded item and those reporting "never" or "seldom" to that item are among those who have identified a social factor that could be acted upon in the health and social services infrastructure to work with an individual who has concerns about his or her housing situation. Negatively worded items like "I worry about being able to pay my rent or mortgage" are considered at the other end of the response options, with those responding "sometimes," "often," or "always" being among those who might benefit most from economic or employment assistance as ways to reduce health impacts.

Consistently across these items, there were six participants who did not respond to each item and those participants were not included in the summary provided. Table 14 provides an overview of the extent to which participants perceived those statements to be among those that applied to them.

Highlighted in this table are the social determinants with endorsement of 10% or greater that, in a typical social service setting, would indicate a need for further consideration, discussion, or triage.

Social Determinant	Item Assessed	Total Sample Responses
Positively Worded Social Determinant Items		**Percent Reporting "Never" or "Seldom" Applies to Me**
Social Ecology (n = 517)	I feel those around me are healthy	5.8
Education (n = 502)	I am satisfied with my education	11.7
Community Cohesion (n = 508)	I make efforts to get involved in my community	34.3
Policy (n = 504)	I vote when there is an election in my town	16.1
Environment (n = 509)	I feel that my town's environment is healthy (air, water, etc)	34.7
Housing (n = 509)	I feel safe in the place where I live	4.7
Psychosocial (n = 499)	I try to spend time with others outside of work	15.0
Transportation (n = 510)	I have access to safe and reliable transportation	1.7
Negatively Worded Social Determinant Items		**Percent Reporting "Sometimes," "Often" or "Always" Applies to Me**
Economy (n = 506)	I worry about my utilities being turned off for non-payment	8.0
Employment (n = 510)	I worry about being able to pay my rent or mortgage	12.7

Table 14. Participants' Reports of Felt Social Determinants

In the convenience sample, participants were strikingly similar in their responses to the positively worded items as those in the random sample. However, those in the convenience sample were more likely to report worry about the economic and employment items, with 32.4% reporting worry about utilities being turned off for non-payment and 34.6% indicating worry about being able to pay rent or mortgage.

Importance of Community-Based Health and Social Service Programs

Participants were asked to provide perspective on the extent to which health and social service programs are important to their local community. During the survey, participants were provided with a list of 20 different programs that are often present in many communities. Participants were inconsistent with regard to the extent to which they provided an assessment of each program type. As a result, results from participants were used to calculate rankings of program endorsement.

Of the 20 programs, all were ranked as being either moderately or very important by more than 65% of participants. While these results do provide some insight into the types of programs perceived as most important in their local community, across the board these data suggest that in general most community members perceive the general network of health and social service programs to be important on the whole.

However, considering these data in terms of those services that participants ranked as "very" important does provide valuable insights into those most valued. Table 15 provides a list of the extent to which participants rated a program type as "moderately" or "very" important, presented in order of highest to lowest endorsement. In this table, highlighted separately are those services ranked as "very" important by more than 50% or 60%.

Community Programs	Moderately/Very Important %	Moderately Important %	Very Important %
Substance Abuse Prevention & Treatment (n = 254)	93.7	25.2	68.5
Mental Health Counseling (n = 254)	93.2	29.6	63.6
Physical Activity (n = 257)	91.7	40.6	51.1
Food Pantries (n = 255)	90.7	36.2	54.5
Services for Women, Infants, Children (n = 255)	90.4	36.1	54.3
Aging Services (n = 259)	89.9	37.5	52.4
Free/Emergency Childcare (n = 255)	87.3	24.8	62.5
Job Training/Employment Assistance (n = 253)	87.2	40.9	46.3
Gun Safety Education (n = 255)	85.9	37.2	48.7
Housing Assistance (n = 258)	85.6	44.3	41.3
Health Insurance Assistance (n = 258)	84.2	32.8	51.4
Nutrition Education (n = 257)	80.3	44.7	35.6
Financial Assistance (n = 256)	80.2	44.3	35.9
Walking Trails/Outdoor Space (n = 254)	79.8	36.6	43.2
Food Stamps/SNAP (n = 256)	79.0	43.1	35.9
Family Planning (n= 254)	78.6	50.7	27.9
Transportation Assistance (n = 254)	74.9	35.4	39.5
Prescription Assistance (n =258)	71.6	40.2	31.4
Legal Assistance (n = 258)	69.4	42.1	27.3
Needle Exchange (n = 252)	67.8	36.6	31.2

Table 15. Endorsement of Importance of Community Programs

Participants in the convenience sample were equally supportive of the importance of community-based social services, with over 50% of participants endorsing all services as important. However, particularly with services such as mental health counseling, substance abuse treatment, and assistance with housing and finances, participants in the convenience sample more strongly endorsed the needs for services with more than 50% endorsing them as "very" important.

Community Perceptions of Priority Health Needs

Important to development of the CHNA and its subsequent Implementation Plan was to assess the local health issues which community members perceived to be of importance. The hospitals developed a list of 21 different health needs that are common in many communities similar to Vanderburgh County. Survey participants were asked to select five of those community health issues that they perceived to be among the most important for the hospitals and their partners to address.

Accompanying the list of health issues was a statement that guided survey participants in the selection process. The statement read "Below is a list of health issues present in many communities. Please pick the five that you think pose the greatest health concern for people living in your community." Table 16 provides a summary of the extent to which each health issue was selected as one of the top five issues by survey participants.

Table 16. Priority Health Issues Selected by Participants as Being Among the Top 5 Most in Need of Attention in Vanderburgh County (n = 260)

Health Issue	% Selecting Issue as One of Top 5 Needing Attention
Substance use or abuse	64.7
Obesity	53.3
Mental health	40.0
Chronic diseases (diabetes, cancer, and heart disease)	38.0
Assault, violent crime, and domestic violence	35.6
Child neglect and abuse	32.8
Poverty	29.8
Homelessness	29.8
Environmental issues	24.4
Tobacco use	22.6
Alcohol use or abuse	21.9
Food access, affordability, and safety	16.8
Suicide	12.8
Disability needs	11.0
Sexual violence, assault, rape, or human trafficking	9.8
Dental care	8.2
Injuries and accidents	6.0
Infectious diseases like HIV, STDs, and hepatitis	5.6
Aging and older adult needs	4.4
Infant mortality	3.3
Reproductive health and family planning	2.7

Community Perceptions of Priority Health Needs Continued

While participants were able to select from the full list of 21 health issues during the survey, it was decided to narrow down the priority issues to the top 50% during the community prioritization session. Figure 11 provides a graphical presentation of the top health issues shared during community meetings for purposes of informing future initiatives.

"Below are some issues present in many communities. Please pick FIVE that you think pose the greatest health concern for people who live in your community."

Local community health needs selected as a top 5 issue, % (n=260). Data reflects Top 12 issues from total list of 21 possible.

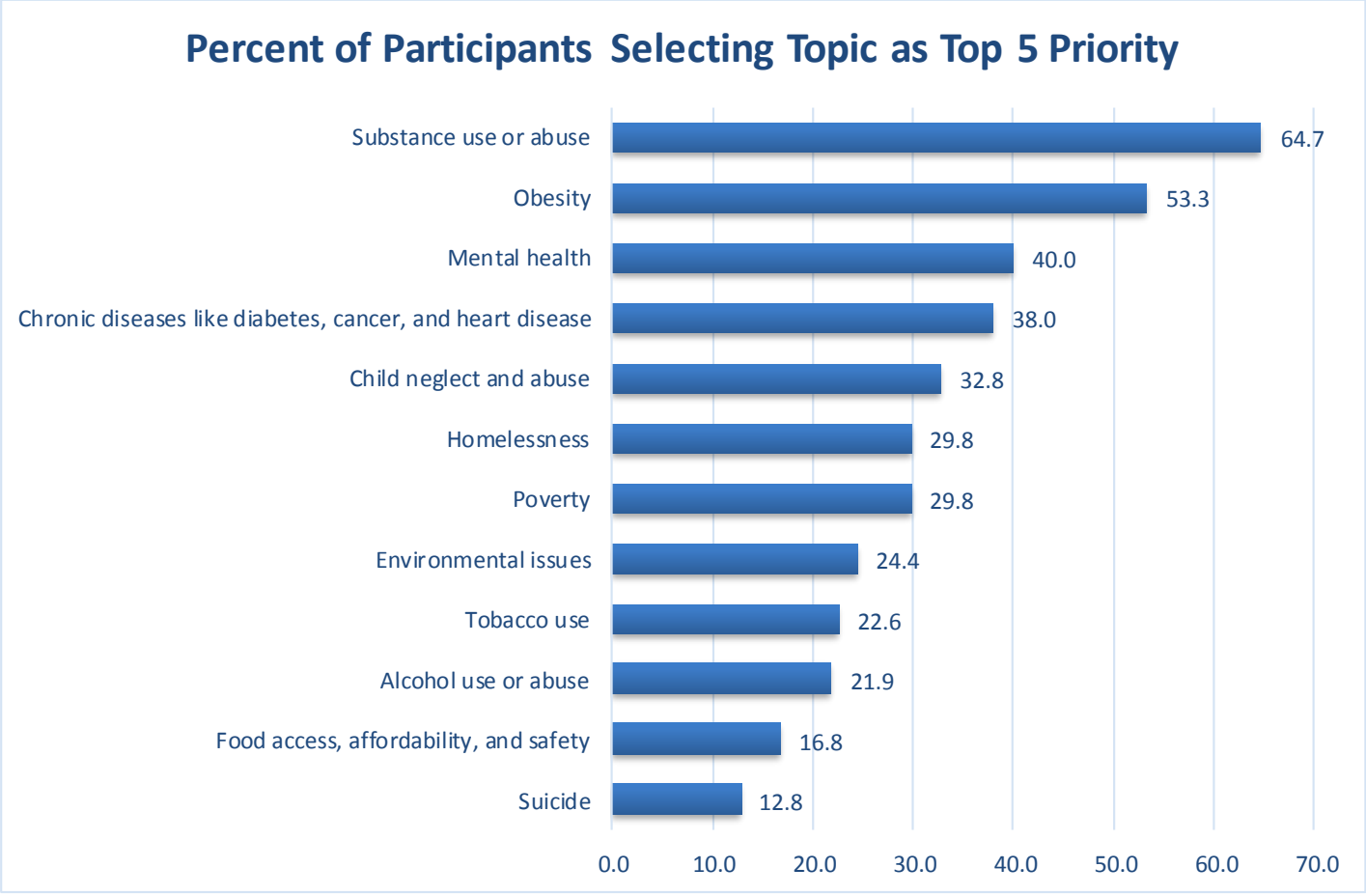


Figure 11. Most Frequently Endorsed Health Issues as Priority for Action

In the convenience sample, the top 10 issues reported as priority needs included: substance abuse (49.4%), food access (42.3%), mental health (31.2%), poverty (30.2%), chronic disease (28.4%), alcohol use (28.1%), obesity (27.5%), homelessness (25.6%), assault and violence (25.0%), and child neglect and abuse (21.6%).

Community Perceptions of Health Issues Needing Priority Resource Allocation

In addition to assessing the extent to which participants perceived specific needs as being among the most important for action in their community, participants were also asked to provide their perceptions of the extent to which those same 21 issues were also priorities for the allocation of resources in the local community. Participants were given a statement to consider prior to indicating their perceptions. The statement read "Previously you were asked to pick issues that pose the greatest health concern in your community. If you had $3 and could give $1 to help solve some of these, which are the three to which you would give $1?"

As was the case with the health issues selected as priorities for action, it was decided to narrow down the priority issues to the top 50% during the community prioritization session. Figure 12 provides a graphical presentation of the top ranked issues that survey participants selected as priorities for the allocation of resources.

Previously you were asked to pick issues that pose the greatest health concern in your community. If you had $3 and could give $1 to help solve some of these, which are the THREE to which you would give $1?

Top 10 Health Issues Selected as Priority for Resource Allocation, % (n=253)

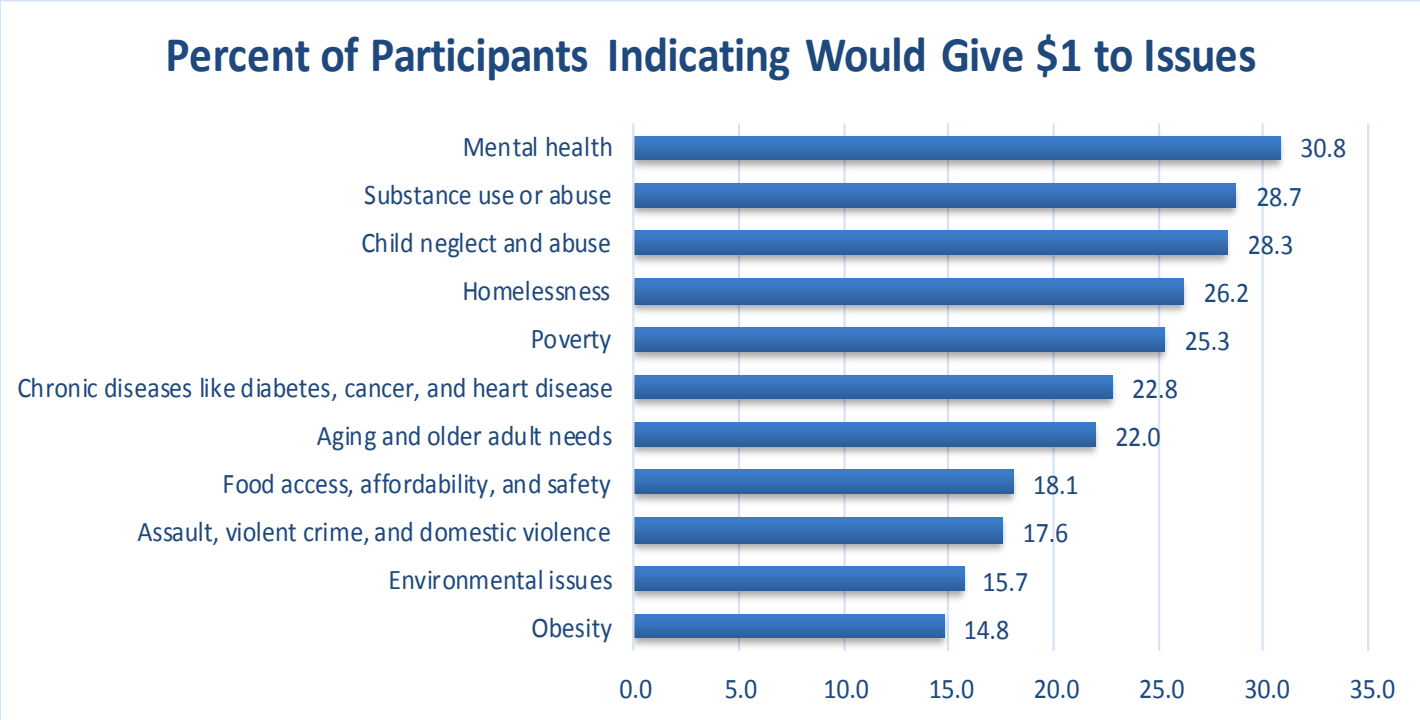


Figure 12. Most Frequently Endorsed Health Issues as Priority for Resource Allocation

In the convenience sample, the top 10 issues reported as resource allocation priorities were highly consistent with their rankings of needs, except that aging was perceived as a top 10 priority for resources but not in the top 10 needs (the opposite was the case with alcohol use which was a need but not in the top 10 for allocation). The top 10 issues for resource allocation included: food access (31.8%), obesity (27.5%), substance abuse (25.6%), homelessness (23.5%), mental health (24.1%), poverty (21.0%), child neglect and abuse (19.8%), chronic disease (16.0%), aging needs (16.0%), and assault and violence (15.7%).

Comparison of Needs and Resource Priorities

While participants were asked to provide an assessment of priority needs and priorities for resource allocation as separate survey items, a comparison of those priority rankings provides helpful insights into the extent to which there is consistency between the two. Figure 13 provides such a comparison and highlights inconsistency between health issues that community members believed were a priority needing addressed and those that they believe should be a priority for the allocation of resources.

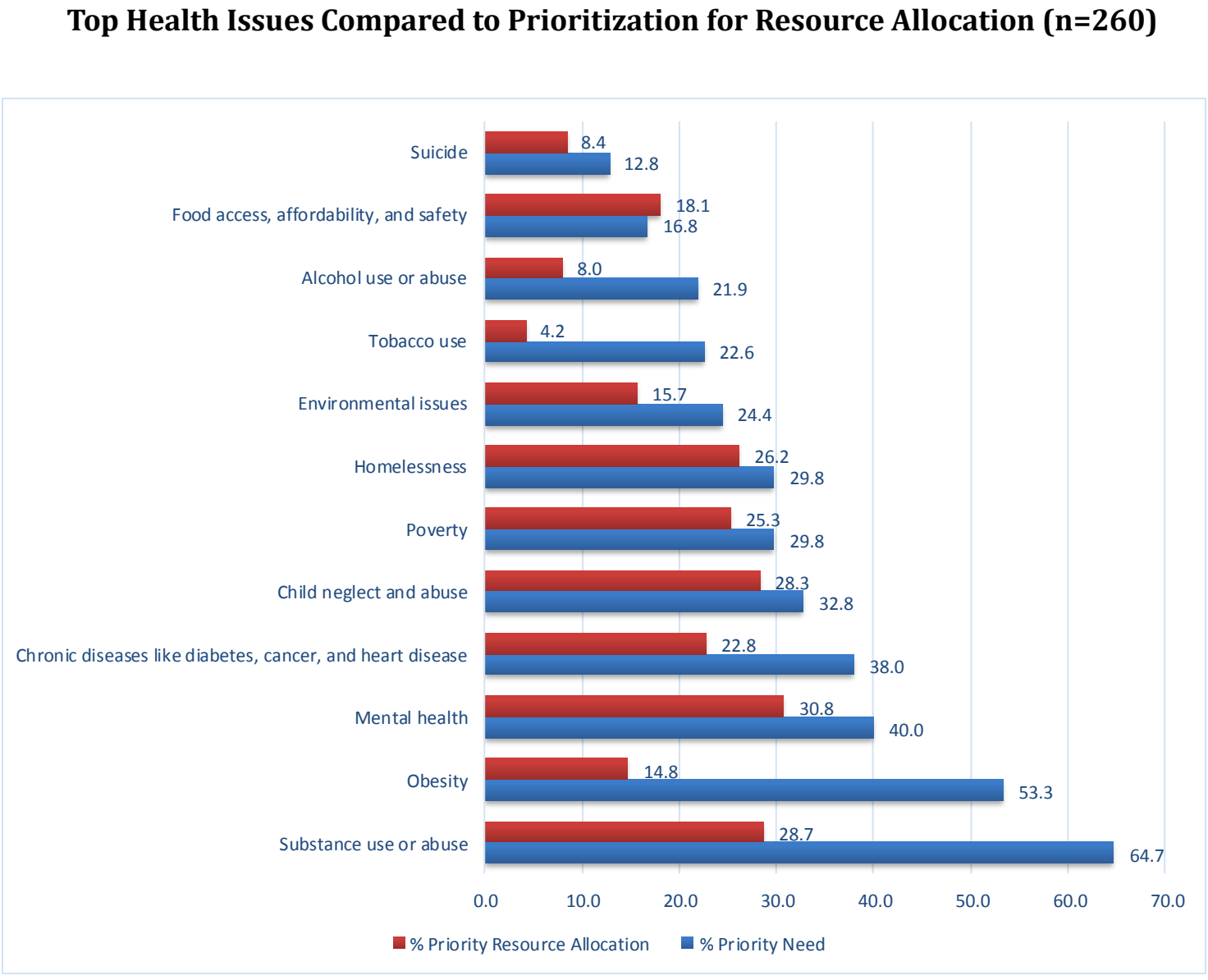


Figure 13. Comparison of Priority Needs and Resource Priorities

COMMUNITY CHNA FOCUS GROUPS

To provide for additional opportunities for community members to provide valuable insights into the decisions made during the 2018 CHNA process, the hospitals, in collaboration with other partner organizations and hospitals, held a series of focus group discussions.

These focus group discussions provided opportunities to gather community members, providers of local health and social services, and other stakeholders to review information, have open conversations about local health needs, and to offer suggestions for priority health topics that should be considered as the hospitals make decisions about their priorities and subsequent implementation plan.

This section provides an overview of the focus group discussions and the recommendations emerging from those discussions. Appendix B includes a listing of those participating in the focus groups.

Focus Groups

On two different dates in August 2018, August 27 and 28, six focus group discussions were held. Those discussions included participants from Warrick and Vanderburgh Counties. To ensure that broad perspectives were collected, each focus group included participants from a specific sector of the community's health and social services infrastructure. Those groups included: medical organizations, public service organizations, social service organizations (2 focus groups), businesses and corporations, and educational institutions.

Participants

A total of 65 community members participated in the focus group discussions. Additionally, each focus group included observers and facilitators from the hospitals and other organizations convening the meetings. Below is a summary of the number of participants for each focus group discussion, by the nature of the organizations they represented.

Focus Groups by Organizational Type	# of Community Members Participating
Medical	21
Public Service	2
Social Services	29 (14 and 15 per group)
Business	6
Education	7

Focus Group Methods

To conduct the focus group discussions, the facilitators applied a great deal of consistency in both the approach, process, and types of information shared with the community members. The process for the focus group discussions included the following activities:

- Introductions
- A description of the purpose of the discussion and ground rules
- A discussion of health issues within the county from the perspective of the community members
- The development of a list of health needs that the community members perceived as priorities based upon the discussion
- A voting process that sought to provide insight into the relative priority of each of the health issues from the perception of community members
- A voting process to indicate the priorities for which resources should be allocated

Outcomes

Figure 14 provides an overview of the priority health issues endorsed by the participants. These data are presented by topic and by the nature of each focus group's participants.

Figure 15 provides an overview of the level of endorsement for resource allocation by the participants. These data are presented by topic and by the nature of each focus group's participants.

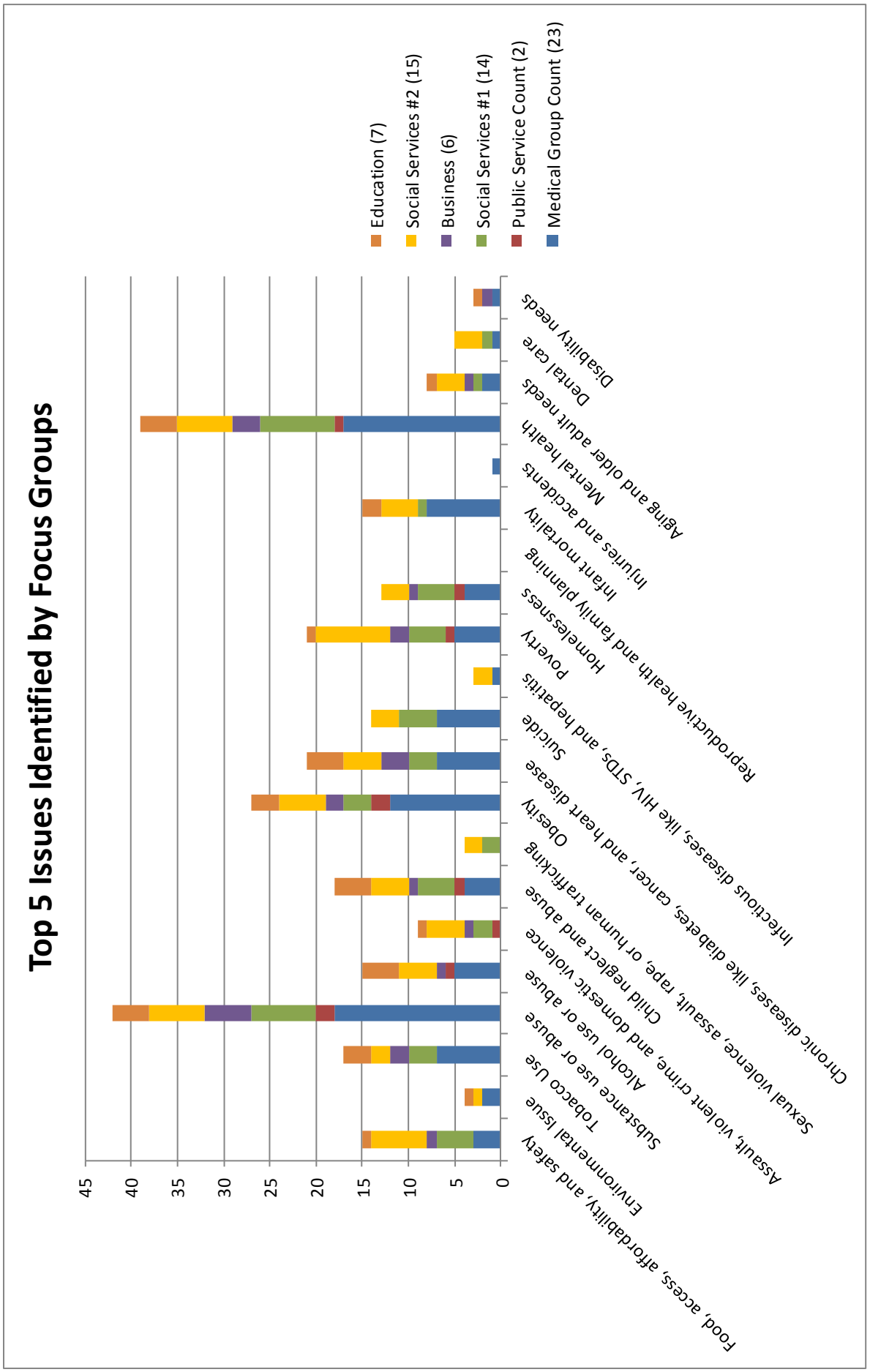


Figure 14. Priority Health Issues Endorsed by Focus Group Participants

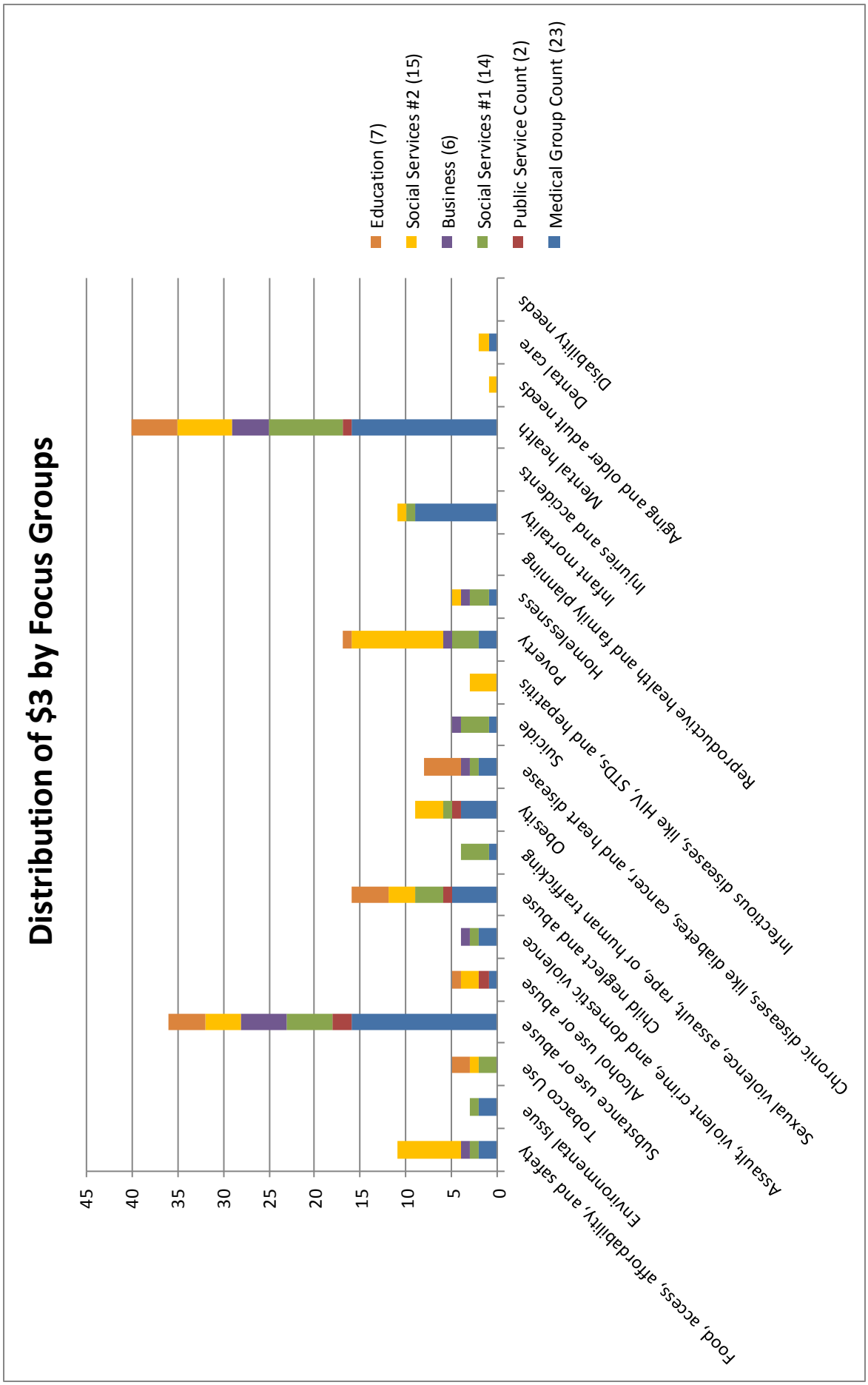


Figure 15. Resource Allocation Endorsements by Focus Group Participants

PRIORITIZATION PROCESS

To consider the CHNA data and to identify the most urgent health issues that would guide the hospital's future priority areas, a comprehensive prioritization process was conducted. Representatives of several community health organizations in the service area, including hospital staff, participated in a meeting to review data collected for the CHNA. A list of organizations from which representatives participated is included later in this section. A copy of the slides used during the presentation of data is included as Appendix C.

The session included the following activities:

- A review of the purpose of conducting the CHNA and reflections on decisions and actions taken in response to the 2015 CHNA.

- A review of data was presented by a representative of Measures Matter, LLC. It included a summary of existing health indicators, data from the CHNA survey, and data from the five focus groups.

- A nominal group process facilitated by Measures Matter, LLC to facilitate the group's selection of priority health issues for the 2018 CHNA. That process was conducted in the following way:
    - Participants were provided with the list of health topics that emerged as among those having the most support from existing indicators, survey data, and focus groups. That list of health topics is provided in Figure 16.
    - Participants were given the opportunity to add additional topics.
    - Participants were each provided with 5 "sticky dots" and asked to place their dots on the issues that they each felt were most in need of prioritization.
    - The "dots" on each topic were tallied and a discussion about the topics and any special considerations for each was held.

<u>Participating Organizations</u>

In addition to the two staff from St. Vincent Health and Deaconess Health who coordinated the session and the facilitator, 17 individuals participated in the session representing*:

Vanderburgh County Health Department	ECHO Community Healthcare
United Way of Southwestern Indiana	St. Vincent Health (7 participants)
Welborn Baptist Foundation	Deaconess Health System (6 participants)

** unless indicated, each organization had one representative participating*

Resulting Priorities

As a result of both phases of the prioritization process, five issues received endorsement for prioritization for Vanderburgh County.

Those issues included:

- Substance Abuse and Alcohol Abuse
- Mental Health
- Food Insecurity and Food Access
- Chronic Health Conditions
- Poverty

A list of available community health resources was also reviewed as part of the process and the potential partners for addressing these needs is included as Appendix E.

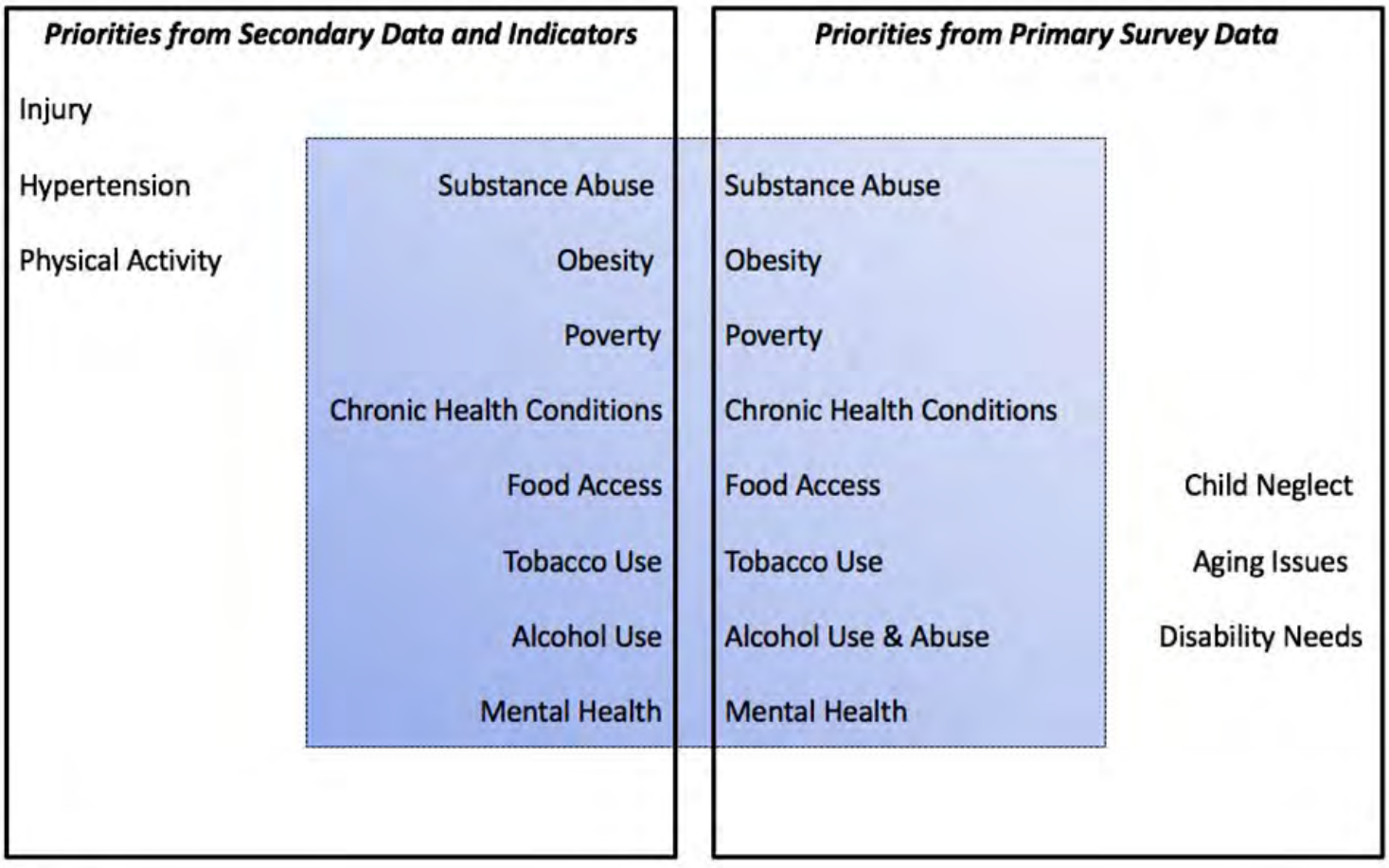


Figure 16. Overlapping health issues that emerged from secondary data and the CHNA survey.

IMPLEMENTATION PLAN

Mental Health, Substance Abuse, Food Insecurity

From the five endorsed issues identified for prioritization, the group selected mental health, substance abuse, and food insecurity as our primary points of focus for the next CHNA period. Improvement in chronic health conditions should be a by-product of successful work in the other three areas and "poverty" consists of more variables than this group can address.

The broad categories of **mental health**, **substance abuse**, and **food insecurity** were subsequently narrowed down to the following, more specific, action items. Subject experts and groups currently conducting work in these fields will come together by the end of calendar year 2019 to identify metrics and outcome measures as well as assign tasks for the three-year CHNA period.

Additionally, activities in these identified priority areas will coordinate with and support initiatives from the Indiana State Department of Health, Indiana Chamber of Commerce, Healthy Communities Partnership, Promise Zone, and local economic development and government institutions.

Mental Health

Create and conduct a public relations campaign with the following message: talk therapy is the best way to address mental health issues/concerns/conditions/illnesses. Work will include:

- Creation and public distribution of educational materials related to the different kinds of mental health providers and what they can and cannot treat
- Admission criteria for inpatient psychiatric care
- Ways to sustain or improve mental health while waiting for a scheduled treatment appointment

Mental health specific education for primary care physicians related to:

- Signs and symptoms of common mental illnesses/conditions
- Recommended medications
- Appropriate referrals for treatment
- Adverse Childhood Experiences (ACE) and their relationship to future health

Current partnering agencies/groups include:

Deaconess, St. Vincent Evansville, Southwestern Behavioral Health, ECHO Healthcare, Vanderburgh County Health Department, Brentwood Springs, Evansville State Hospital, Evansville Psychiatric Children's Center, Mental Health America Vanderburgh County, Youth First, Mayor's Mental Health Commission, Lampion Center, Evansville Central Library, Community Patient Safety Coalition, Vanderburgh County Medical Society, CAPE: Minority Health Coalition, USI, Southwest Indiana AHEC, Ivy Tech Community College, EVSC, Resilient Evansville, IU School of Medicine, Crisis Intervention Teams (law enforcement), and Evansville Catholic Schools.

IMPLEMENTATION PLAN

Mental Health, Substance Abuse, Food Insecurity

Substance Abuse

- Deaconess (The Women's Hospital) and St. Vincent Evansville (Hospital for Women and Children) will participate in the Indiana Perinatal Network's pilot program for perinatal substance use screening. The goal is to reduce the number of babies born with Neonatal Abstinence Syndrome (NAS) and decrease days in the NICU for babies born with NAS.
- Investigate the use of SBIRT (Screening, Brief Intervention, Referral to Treatment) as a drug and alcohol screening tool in primary care offices.
- Support the work of the Mayor's Substance Abuse Task Force.

Current partnering agencies/groups include:

Deaconess, St. Vincent Evansville, ECHO Healthcare, Southwestern Behavioral Health, Vanderburgh County Health Department, Brentwood Springs, Mayor's Substance Abuse Task Force, and Vanderburgh County Substance Abuse Council.

Food Insecurity/Food Access

- Use programs and projects such as farmer's markets, pop-up markets, a bulk food buying club, and the grocery store trolley to increase the availability of healthy food options in "healthy food priority areas" formerly called food deserts.
- With support from local partners, focus specific efforts on providing school-age children with nutritious food year-round.

Current partnering agencies/groups include:

Healthy Communities Partnership, Promise Zone subcommittee on food access, Vanderburgh County Health Department, Deaconess, St. Vincent Evansville, Welborn Baptist Foundation, Urban Seeds, Seton Harvest, Junior League of Evansville, Market Wagon and Newburgh Farmers Market, Purdue Extension – Vanderburgh County, USI, and Evansville Area Food Council.

APPENDIX

Appendix A: Community Health Needs Assessment, Participant Survey

Appendix B: Focus Group Participants and Notes

Appendix C: Prioritization Session Slides/Presentation and Notes

Appendix D: Vanderburgh County Resource List

Appendix E: Secondary Data Report

Appendix A: CHNA Participant Survey

MY Community Health Needs Assessment

Because a Healthier Community Means a Healthier Me

Who should fill out this questionnaire? We ask that the **adult (18 years of age or older) in your household who had the most recent birthday** complete this questionnaire.

Instructions: Please mark your answers clearly in the boxes using pencil or dark pen. Examples: ■ ☒

1 **In which county do you live?**
(Please print one letter in each box.)

2 **What is the zip code of your residence?**
(Please print one number in each box.)

3 **How many adults (18 years or older) live in your household, INCLUDING YOURSELF?**

INCLUDE everyone who is living or staying here for more than 2 months. DO NOT include anyone who is living somewhere else for more than 2 months, such as a college student living away or someone in the Armed Forces on deployment.

4 **How many children younger than 18 years of age live in your household?**

5 **What is your gender?** (Select only one.)

☐ Male ☐ Female

6 **In what year were you born?** (Please print a 4-digit year.)

Please answer both Question 7 about Hispanic origin and Question 8 about race.

7 **Are you of Hispanic, Latino, or Spanish origin?**

☐ Yes ☐ No

8 **What is your race?** (Select all that apply.)

☐ White
☐ Black or African-American
☐ American Indian or Alaska Native
☐ Asian
☐ Native Hawaiian or other Pacific Islander
☐ Other, please specify:

9 **Considering all sources, which of the following best describes your total household income before taxes for 2017?** (Select only one.)

☐ Less than $15,000
☐ $15,000-$24,999
☐ $25,000-$34,999
☐ $35,000-$49,999
☐ $50,000-$74,999
☐ $75,000-$99,999
☐ $100,000-$149,999
☐ $150,000 or more

10 **Which of the following best describes your current employment status?** (Select only one.)

☐ Employed full time
☐ Employed part time
☐ Unemployed looking for work
☐ Unemployed not looking for work
☐ Unable to work due to disability
☐ Homemaker
☐ Retired
☐ Student

11 **Which of the following best describes the highest level of education you completed?** (Select only one.)

☐ Some high school
☐ High school diploma or GED
☐ Some college
☐ Technical or vocational school diploma or certificate
☐ Associate's degree
☐ Bachelor's degree
☐ Graduate or professional degree or beyond
☐ Other, please specify:

12 **Would you say that in general:** (Select only one.)

	Excellent	Very good	Good	Fair	Poor
Your overall health is...	☐	☐	☐	☐	☐

13 **Regarding different areas of your health and life, you would say that in general:** (Select one answer for EACH row.)

	Excellent	Very good	Good	Fair	Poor
Your physical health is...	☐	☐	☐	☐	☐
Your mental health is...	☐	☐	☐	☐	☐
Your social well-being is...	☐	☐	☐	☐	☐

14 **How much do you agree or disagree with the following statement: "In general, I am satisfied with my life."** (Select only one.)

- ☐ Strongly disagree
- ☐ Somewhat disagree
- ☐ Neither agree nor disagree
- ☐ Somewhat agree
- ☐ Strongly agree

15 **On a scale of 01 to 10 where 01 means you have "little or no stress" and 10 means you have "a great deal of stress," how would you rate your average level of stress during the past month?** (Please print a 0 in the first box for numbers less than 10.)

☐☐

16 **Do you currently have insurance or coverage that helps with your healthcare costs (including private or employer-sponsored insurance or public coverage like Medicare or Medicaid)?** (Select only one.)

☐ Yes ☐ No ☐ Do not know

17 **Do you currently have someone that you think of as your personal doctor or personal healthcare provider?** (Select only one.)

☐ Yes ☐ No ☐ Do not know

18 **Within the past 12 months, which of the following health services have you received?** (Select all that apply.)

- ☐ Chronic care for a disease like diabetes or a disability
- ☐ Acute care, like for an infection or injury
- ☐ Immunizations or other preventive care
- ☐ Routine physical exam
- ☐ Prenatal or well-baby care
- ☐ Care related to family planning
- ☐ Care at a hospital emergency room
- ☐ Care at an urgent care facility
- ☐ Inpatient care at a hospital
- ☐ Filling a prescription
- ☐ Dental care
- ☐ Screening for anxiety or depression by a medical provider
- ☐ Treatment for a mental health diagnosis
- ☐ Treatment for addiction

19 **Thinking about the past month, which of the following behaviors have you participated in regularly (at least 3 days per week on average)?** (Select all that apply.)

- ☐ I smoked cigarettes or used other tobacco
- ☐ I was physically active on a regular basis
- ☐ I ate a healthy balanced diet
- ☐ I got plenty of sleep
- ☐ I took an opioid or narcotic that was prescribed to me
- ☐ I took an opioid or narcotic that was NOT prescribed to me
- ☐ I took a medication for anxiety, depression, or other mental health challenge that was prescribed to me
- ☐ I had my blood pressure checked
- ☐ I drank alcohol to the point of intoxication
- ☐ I drove while under the influence of alcohol or drugs
- ☐ I took steps to reduce my level of stress

20 **During the past 12 months, was there ever a time that you or the family members you live with needed one of the following but couldn't afford it or had to prioritize spending money on something else?** (Select one answer for EACH row.)

	Yes	No	Do not know
Seeing a medical provider	☐	☐	☐
Filling a prescription	☐	☐	☐
Transportation for a health purpose or appointment	☐	☐	☐

21 **How often would you say that the following statements apply to you?** (Select one answer for EACH row.)

	Never	Seldom	Sometimes	Often	Always
I feel those around me are healthy (family, friends, and co-workers)	☐	☐	☐	☐	☐
I worry about my utilities being turned off for non-payment	☐	☐	☐	☐	☐
I feel satisfied with my education	☐	☐	☐	☐	☐
I make efforts to get involved in my community	☐	☐	☐	☐	☐
I vote when there is an election in my town	☐	☐	☐	☐	☐
I feel that my town's environment is healthy (air, water, etc.)	☐	☐	☐	☐	☐
I feel safe in the place where I live	☐	☐	☐	☐	☐
I try to spend time with others outside of work	☐	☐	☐	☐	☐
I have access to safe and reliable transportation	☐	☐	☐	☐	☐
I worry about being able to pay my rent or mortgage	☐	☐	☐	☐	☐

22 **Below are some issues present in many communities. Please pick FIVE that you think pose the greatest health concern for people who live in your community.** (Select only five out of all options 1 - 21.)

1 ☐ Food access, affordability, and safety
2 ☐ Environmental issues
3 ☐ Tobacco use
4 ☐ Substance use or abuse
5 ☐ Alcohol use or abuse
6 ☐ Assault, violent crime, and domestic violence
7 ☐ Child neglect and abuse
8 ☐ Sexual violence, assault, rape, or human trafficking
9 ☐ Obesity
10 ☐ Chronic diseases, like diabetes, cancer, and heart disease
11 ☐ Suicide
12 ☐ Infectious diseases, like HIV, STDs, and hepatitis
13 ☐ Poverty
14 ☐ Homelessness
15 ☐ Reproductive health and family planning
16 ☐ Infant mortality
17 ☐ Injuries and accidents
18 ☐ Mental health
19 ☐ Aging and older adult needs
20 ☐ Dental care
21 ☐ Disability needs

23 **Previously, you were asked to pick issues that pose the greatest health concern in your community. If you had $3 and could give $1 each to help solve some of these, which are the THREE to which you would give $1.** (Select only three out of all options 1 - 21.)

1 ☐ Food access, affordability, and safety
2 ☐ Environmental issues
3 ☐ Tobacco use
4 ☐ Substance use or abuse
5 ☐ Alcohol use or abuse
6 ☐ Assault, violent crime, and domestic violence
7 ☐ Child neglect and abuse
8 ☐ Sexual violence, assault, rape, or human trafficking
9 ☐ Obesity
10 ☐ Chronic diseases, like diabetes, cancer, and heart disease
11 ☐ Suicide
12 ☐ Infectious diseases, like HIV, STDs, and hepatitis
13 ☐ Poverty
14 ☐ Homelessness
15 ☐ Reproductive health and family planning
16 ☐ Infant mortality
17 ☐ Injuries and accidents
18 ☐ Mental health
19 ☐ Aging and older adult needs
20 ☐ Dental care
21 ☐ Disability needs

24 Below is a list of programs or services in many communities. Please mark how important these programs or services are for your community. (Select one answer for EACH row.)

	Not at all important for my community	Not very important for my community	Moderately important for my community	Very Important for my community
Nutrition education, like healthy cooking classes	☐	☐	☐	☐
Physical activity programs	☐	☐	☐	☐
Substance abuse prevention and treatment	☐	☐	☐	☐
Needle exchange programs	☐	☐	☐	☐
Mental health counseling and support	☐	☐	☐	☐
Gun safety education	☐	☐	☐	☐
Family planning services	☐	☐	☐	☐
Walking trails and other outdoor spaces	☐	☐	☐	☐
Aging and older adult services	☐	☐	☐	☐
Assistance with filling a prescription	☐	☐	☐	☐
Housing assistance	☐	☐	☐	☐
Financial assistance	☐	☐	☐	☐
Legal assistance	☐	☐	☐	☐
Help getting health insurance	☐	☐	☐	☐
Job training or employment assistance	☐	☐	☐	☐
Transportation assistance	☐	☐	☐	☐
Services for women, infants, and children (WIC)	☐	☐	☐	☐
Food stamps or SNAP	☐	☐	☐	☐
Food pantries	☐	☐	☐	☐
Free or emergency child care	☐	☐	☐	☐

Evaluación de las necesidades de salud de mi comunidad

Mi comunidad es más saludable y por eso yo soy más saludable

¿Quién debe completar este cuestionario? Pedimos que el **adulto (18 años de edad o mayor) del domicilio que cumplió años más recientemente** llene este formulario.

Instrucciones: Por favor, use un lápiz o un bolígrafo de tinta oscura para indicar sus respuestas claramente en las casillas. Ejemplos: ■ ☒

1. ¿En qué condado vive usted?
(Escriba una letra en cada casilla.)

2. ¿Cuál es el código postal de su lugar de domicilio?
(Por favor escriba una letra en cada casilla.)

3. ¿Cuántos adultos (18 años o mayor) viven en su domicilio, INCLUYÉNDOSE A SÍ MISMO?
INCLUYA a todos quienes viven o han estado aquí por más de 2 meses. NO INCLUYA a quienes viven en otro lugar por más de 2 meses, como un estudiante universitario que vive en otro lugar o alguien que está en las Fuerzas Armadas en despliegue militar.

4. ¿Cuántos niños menores de 18 años viven en su domicilio?

5. ¿Cuál es su género? (Elija una sola opción)

☐ Hombre ☐ Mujer

6. ¿En qué año nació? (Escriba un año de 4 dígitos.)

Por favor, conteste tanto la Pregunta 7 sobre origen como la Pregunta 8 sobre raza.

7. ¿Ud. es de origen latino o español?

☐ Sí ☐ No

8. ¿Cuál es su raza o etnicidad? (Elija todas las opciones que se apliquen.)

- ☐ Blanco
- ☐ Negro, afro-estadounidense o afro-latino
- ☐ Asiático
- ☐ Indígena estadounidense, Indígena-latino o Nativo de Alaska
- ☐ Nativo de Hawái o de otra isla del Pacífico
- ☐ Otro, por favor especifique:

_____

9. Considerando todas las fuentes, ¿cuál de las siguientes opciones mejor describe sus ingresos totales para el 2017 antes de los impuestos? (Elija una sola opción)

- ☐ Menos de $15,000
- ☐ $15,000-$24,999
- ☐ $25,000-$34,999
- ☐ $35,000-$49,999
- ☐ $50,000-$74,999
- ☐ $75,000-$99,999
- ☐ $100,000-$149,999
- ☐ $150,000 o más

10. ¿Cuál de las siguientes opciones mejor describe su estado de empleo actual? (Elija una sola opción)

- ☐ Empleado de tiempo completo
- ☐ Empleado de tiempo parcial
- ☐ Desempleado buscando trabajo
- ☐ Desempleado no buscando trabajo
- ☐ Incapaz de trabajar debido a discapacidad
- ☐ Amo(a) de casa
- ☐ Jubilado
- ☐ Estudiante

11. ¿Cuál de las siguientes opciones mejor describe el nivel más alto de educación que Ud. ha completado? (Elija una sola opción)

- ☐ Alguna educación secundaria
- ☐ Diploma de secundaria o GED
- ☐ Alguna educación universitaria
- ☐ Diploma o certificado de instituto técnico o de formación profesional
- ☐ Grado de asociado
- ☐ Título de licenciatura
- ☐ Posgrado o título profesional o más
- ☐ Otro, por favor especifique:

_____

12. ¿Diría que por lo general: (Elija una sola opción)

	Excelente	Muy Buena	Buena	Regular	Mala
Su salud en general es…	☐	☐	☐	☐	☐

13. Con respecto a las diferentes áreas de su salud y su vida, Ud. diría que en general: (Elija una respuesta para CADA fila.)

	Excelente	Muy Buena	Buena	Regular	Mala
Su salud física es…	☐	☐	☐	☐	☐
Su salud mental es…	☐	☐	☐	☐	☐
Su bienestar social es…	☐	☐	☐	☐	☐

14. ¿Qué tanto está de acuerdo o en desacuerdo con la siguiente declaración: "En general, yo estoy satisfecho con mi vida." (Elija una sola opción)

- ☐ Completamente en desacuerdo
- ☐ No del todo de acuerdo
- ☐ No de acuerdo ni en desacuerdo
- ☐ De acuerdo en parte
- ☐ Completamente de acuerdo

15. En una escala de 01 a 10 en que 01 significa que Ud. tiene "poco o nada de estrés" y 10 significa que tiene "una gran cantidad de estrés," ¿cómo clasificaría su nivel promedio de estrés durante el último mes? (Por favor escriba un 0 en la primera casilla para números inferiores a 10.)

☐☐

16. ¿Actualmente tiene seguro o cobertura que le ayude con sus gastos de servicios médicos (incluyendo seguro privado o patrocinado por el empleador o cobertura pública como Medicare o Medicaid)? (Elija una sola opción)

☐ Sí ☐ No ☐ No sé

17. ¿Actualmente tiene a alguien que considere su doctor personal o su proveedor de servicios médicos personal? (Elija una sola opción)

☐ Sí ☐ No ☐ No sé

18. Durante los últimos 12 meses, ¿cuál de los servicios siguientes médicos ha recibido Ud.? (Elija todas las opciones que se apliquen)

- ☐ Atención crónica para una enfermedad como la diabetes o una discapacidad
- ☐ Atención aguda, como para una infección o una lesión
- ☐ Inmunización u otra atención preventiva
- ☐ Chequeo físico de rutina
- ☐ Atención prenatal o control de niño sano
- ☐ Atención de planificación familiar
- ☐ Atención de sala de emergencia en un hospital
- ☐ Atención en una instalación de atención de urgencias
- ☐ Atención de hospitalización en un hospital
- ☐ Comprar medicamentos recetados
- ☐ Atención odontológica
- ☐ Consulta para ansiedad o depresión por parte de un proveedor médico
- ☐ Tratamiento para diagnóstico de salud mental
- ☐ Tratamiento para adicción

19. Pensando en el último mes, ¿en cuáles de los siguientes comportamientos ha participado con regularidad (por lo menos 3 veces al día por semana en promedio)? (Elija todas las opciones que se apliquen)

- ☐ Fumé cigarrillos o usé otro tabaco
- ☐ Fui físicamente activo con regularidad
- ☐ Tuve una dieta sana y equilibrada
- ☐ Dormí bastante
- ☐ Tomé un opioide o un narcótico que me fue recetado
- ☐ Tomé un opioide o un narcótico que NO me fue recetado
- ☐ Tomé un medicamento que me fue recetado para la ansiedad, la depresión u otro reto de salud mental
- ☐ Me mandé chequear la presión arterial
- ☐ Tomé alcohol hasta embriagarme
- ☐ Conduje bajo efectos del alcohol o de drogas
- ☐ Tomé pasos para reducir mi nivel de estrés

20. Durante los últimos 12 meses, hubo algún momento en el que Ud. o los miembros de su familia con los que vive necesitaron uno de los siguientes, pero no le estaba al alcance o tenía otras prioridades de gastos. (Elija una respuesta para CADA fila.)

	Sí	No	No sé
Consultar a un proveedor médico	☐	☐	☐
Comprar medicamentos recetados	☐	☐	☐
Transporte por razón de salud o para una consulta médica	☐	☐	☐

21. ¿Con qué frecuencia diría que las siguientes declaraciones se le aplican a Ud.? (Elija un respuesta para CADA fila.)

	Nunca	Raramente	A veces	A menudo	Siempre
Siento que las personas a mi alrededor están saludables (familia, amigos y compañeros de trabajo)	☐	☐	☐	☐	☐
Me preocupa que desconecten mis servicios públicos por no pagar	☐	☐	☐	☐	☐
Me siento satisfecho con mi educación	☐	☐	☐	☐	☐
Me esfuerzo por involucrarme en mi comunidad	☐	☐	☐	☐	☐
Voto cuando hay elecciones en mi ciudad	☐	☐	☐	☐	☐
Siento que el ambiente de mi ciudad es saludable (aire, agua, etc.)	☐	☐	☐	☐	☐
Me siento seguro en el lugar donde vivo	☐	☐	☐	☐	☐
Trato de pasar tiempo con otras personas fuera del trabajo	☐	☐	☐	☐	☐
Tengo acceso a transporte seguro y fiable	☐	☐	☐	☐	☐
Me preocupa poder pagar el arriendo o la hipoteca	☐	☐	☐	☐	☐

22. A continuación hay asuntos que están presentes en muchas comunidades. Por favor elija CINCO preocupaciones de salud que Ud. crea que sean las mayores para la gente de su comunidad. (Elija solo cinco de todas las opciones 1-21)

1 ☐	Acceso a comida, precios razonables y seguridad alimenticia	8 ☐	Violencia sexual, asalto, violación y tráfico humano	15 ☐	Salud reproductiva y planificación familiar
2 ☐	Cuestiones ambientales	9 ☐	Obesidad	16 ☐	Mortalidad infantil
3 ☐	Uso de tabaco	10 ☐	Enfermedades crónicas como diabetes, cáncer y enfermedad del corazón	17 ☐	Heridas y accidentes
4 ☐	Uso o abuso de sustancias	11 ☐	Suicidio	18 ☐	Salud mental
5 ☐	Use o abuso de alcohol	12 ☐	Enfermedades contagiosas, como VIH, enfermedad de transmisión sexual y hepatitis	19 ☐	Envegecimiento y necesidades de adultos mayores
6 ☐	Asalto, delito violento, crimen y violencia doméstica	13 ☐	Pobreza	20 ☐	Atención odontológica
7 ☐	Abuso y negligencia de menores	14 ☐	No tener hogar	21 ☐	Necesidades de discapacidad

23 Arriba se le pidió que eligiera los asuntos de salud que más le preocupan en su comunidad. Si tuviera $3 y pudiera dar $1 para ayudar a solucionar algunos de estos asuntos, ¿a cuáles de los TRES le daría $1? (Elija solo tres de todas las opciones 1-21)

1 ☐	Acceso a comida, precios razonables y seguridad alimenticia	8 ☐	Violencia sexual, asalto, violación y tráfico humano	15 ☐	Salud reproductiva y planificación familiar
2 ☐	Cuestiones ambientales	9 ☐	Obesidad	16 ☐	Mortalidad infantil
3 ☐	Uso de tabaco	10 ☐	Enfermedades crónicas como diabetes, cáncer y enfermedad del corazón	17 ☐	Heridas y accidentes
4 ☐	Uso o abuso de sustancias	11 ☐	Suicidio	18 ☐	Salud mental
5 ☐	Use o abuso de alcohol	12 ☐	Enfermedades contagiosas, como VIH, enfermedad de transmisión sexual y hepatitis	19 ☐	Envegecimiento y necesidades de adultos mayores
6 ☐	Asalto, delito violento, crimen y violencia doméstica	13 ☐	Pobreza	20 ☐	Atención odontológica
7 ☐	Abuso y negligencia de menores	14 ☐	No tener hogar	21 ☐	Necesidades de discapacidad

21. A continuación hay una lista de programas o servicios que existen en muchas comunidades. Por favor indique cuáles de los programas considera importantes en su comunidad, ya sea para otras personas o para Ud. mismo. (Elija todas las opciones que se apliquen para CADA fila O indique "Este programa o servicio no me importa a mí.")

	Este programa o servicio es importante para mí porque afecta la salud y el bienestar de OTROS en mi comunidad.	Este programa o servicio es importante para mí porque afecta MI salud y bienestar PERSONAL.	Este programa o servicio no es importante para mí.
Educación alimenticia, como clases de cocina saludable	☐	☐	☐
Programas de actividad física	☐	☐	☐
Prevención y tratamiento de abuso de sustancias	☐	☐	☐
Programas de intercambio de agujas	☐	☐	☐
Consejería y apoyo de salud mental	☐	☐	☐
Educación de seguridad de armas de fuego	☐	☐	☐
Servicios de planificación familiar	☐	☐	☐
Senderos y otros espacios para ejercicio al aire libre	☐	☐	☐
Servicios sobre envejecimiento y para adultos mayores	☐	☐	☐
Ayuda para obtener medicamentos recetados	☐	☐	☐
Ayuda de vivienda	☐	☐	☐
Ayuda financiera	☐	☐	☐
Ayuda legal	☐	☐	☐
Ayuda para conseguir seguro de salud	☐	☐	☐
Capacitación laboral o asistencia profesional o laboral	☐	☐	☐
Ayuda de transporte	☐	☐	☐
Servicios para mujeres, bebés y niños (WIC)	☐	☐	☐
Cupones de alimentos o ayuda suplementaria (SNAP)	☐	☐	☐
Despensa de alimentos	☐	☐	☐
Cuidado infantil gratuito o de emergencia	☐	☐	☐

Monday, August 27, 2018

7:30 - 9 AM

Session 1 - Medical Organizations

Dr. Gina Huhnke	Deaconess	Chief Med Officer, ED doctor
Marlene Waller	Deaconess	Director E.D.
Scott Branam	Deaconess Cross Pointe	Chief Admin Officer
Chris Ryan	The Women's Hospital	CEO
Mark Puckett	Brentwood Springs	CEO
Beverly Walton	Comm Pt Safety Coalition	Director
Donna Culley	Southwestern Behavioral Healthcare, Inc.	Director Child and Family
Faren Levell	Southwestern Behavioral Healthcare, Inc.	CEO
Katy Adams	Southwestern Behavioral Healthcare, Inc.	Director, Addiction Services
Dr. Maria Del Rio Hoover	St. Vincent EVV	Medical Director - Peds
Dr. Brent Cochran	St. Vincent EVV	Pediatrician
Sister Jane McConnell	St. Vincent EVV	
Julie Newton	St. Vincent EVV	Director of Medical Group
Farrah Allen	St. Vincent EVV	Women/Child Outreach and Transport Coordinator
Nancy McCleary	St. Vincent EVV	Director of ED
Michelle Parks	St. Vincent EVV	Director Strategic Operations
Lisa Myer	St. Vincent EVV	Community Relations
Dr. Ken Spear	Vanderburgh Co Health Dept	Health Officer
Sandee Strader-McMillan	ECHO Community Healthcare	CEO
Gene Schadler	Evansville State Hospital	Superintendent
Pamela Ford	IU School of Dentistry	Director of Dental Assisting

10 - 11:30 AM

Session 2 - Public Service

Allie Cole	Dept of Child Services Vanderburgh Co	Family Case Mgr Supervisor
Mike Connelly	Evansville Fire Dept	Fire Chief

1 - 2:30 PM

Session 3 - Social Services (group 1)

Courtney Horning	Smokefree Communities	
Kim Litkenheg	Smokefree Communities	
Chris Metz	ECHO Housing	Executive Director
Emily Reidford	Mental Health America Vanderburgh Co	
Davi Stein-Kiley	Youth First	VP Social Work
Suzanne Draper	CASA Vanderburgh County	Executive Director
Marge Gianopoulos	Warrick County Cares	Ast. Dir of Programs
Tracy Gander	Catholic Charities	Comm Outreach Services
Helen Azarian	EVV Public Library	Librarian of Practice, Comm Health
Rebecca Sawyer	Albion Fellows Bacon Center	
Kayla McCay	Albion Fellows Bacon Center	
Lacy Wilson	Purdue Extension	Nutrition Education Program
Lynn Kyle	Lampion Center	Executive Director
Sandee Strader-McMillan	ECHO Community Healthcare	CEO

Tuesday, August 28, 2018

8 - 9:30 AM

Session 4 - Business/Corporation

Tim Hayden	SWIN Chamber of Commerce	VP and COO
Susie Traylor	The Women's Hospital	Director of HR
Sara Garrett	Vectren	Human Resources
Mary Scheller	Old National Bank	Human Resources
Katie Burnett	Deaconess	Human Resources
Lisa Chapman	EVV Public Library	Human Resources

10 - 11:30 AM

Session 5 - Social Services (group 2)

Jennifer Jerger	Matthew 25 AIDS Resource	Medical Case Manager EVV
Amy DeVries	CAJE	Lead Organizer
Molly Elfreich	Holly's House	Forensic Interviewer
Ron Ryan	Boys and Girls Club	Executive Director
RaShawnda Bonds	CAPE	Head of Minority Health Coalition
Jaime Allen	CAPE	student intern from USI
Carmen Vasquez	CAPE	Hispanic/Latino Outreach
Abraham Brown	Evansville Latino Center	
Tiffani Sinn Trulock	Little Lambs	
Katie Reineke	EVV Public Library	
John Boggeman	Evansville Christian Life Center	Health Clinic
Monica Spencer	SWIRCA and More	Development Director
John Phillips	Hope Central	
Derrick Stewart	YMCA	Executive Director
Alex Rahman	Salvation Army	

1 - 2:30 PM

Session 6 - Education

Cindy Moore	Ivy Tech Community College	Dean, Health Sciences
Gail Lindsay	Ivy Tech Community College	Dean, School of Nursing
Ann Feldhaus	Easter Seals, Milestones Child Development	Dir of Children's Programs
Diana Butler	EVV/Vanderburgh Co School Corp	Dir of Health Services
Aleisha Sheridan	4C of Southern Indiana	Executive Director
Alysia Rhinefort	4C of Southern Indiana	Outreach Specialist
Kathy Riedford	University of Southern Indiana	School of Nursing

CHNA Focus Group Highlights - August 2018

Medical Group

Core issue – Trauma and unstable lifestyle lead to poor choices with lifelong health and societal impact.

Important notes:

- People assume they need medication. They ask their family doctor or pediatrician to prescribe medication when therapy is really the best choice. Only 30% of patients at Southwest Behavioral Health need meds. Local emergency departments report that everyone is on a pill to fix something.
- Legalizing marijuana in other states is affecting patients and staff who work in mental health. Therapists and doctors can't say it's illegal anymore. People come from other places where it is legal. Colorado is experiencing higher levels of psychosis in the years after legalization.
- 50% of patients at ECHO Health have a primary diagnosis of substance abuse with mental illness.
- Lack of public health spending in Indiana is a serious problem. The VCHD receives 1% of its total budget from the state of Indiana.
- STDs – Syphilis has increased 500% in the past couple of years. So has TB, Hep A, and others.
- Obesity – trauma and an unstable lifestyle contribute to being overweight. Fast food is cheap. Losing weight is not a priority because they are in crisis and trying to survive.
- Pregnant women who are addicted to drugs and/or alcohol are hard to identify (huge stigma attached to being pregnant and using drugs). Once they get in treatment, they are very successful.

Public Service Group

Core issue – System is not equipped to help all the people who need help. Generates responder fatigue.

Important notes:

- Evansville Fire Department has "lift assist." When dispatched by AMR ambulance service, firefighters go to a home to physically lift a 400+ pound person from the floor or other location into an ambulance. They have 10-15 lift assists per month. These are emergency medical situations only. The EFD put a stop to lift assist in non-emergent situations because those calls were impeding the ability to respond to fires.
- Infant fatalities are 95% due to unsafe sleep conditions. Almost all of those conditions involve a parent who is passed out or incapacitated from drugs and/or alcohol. Marijuana is the most common drug.

Public Service Group Continued

- People revived with Narcan by the fire department refuse to go to the hospital. Once they wake up, they claim to be fine and leave.
- Seeing the same people overdose, need lift assist, have DCS called to their homes, listening to the people continue to be in denial about substance abuse issues leads to responder fatigue. The fire fighters, police, and other public service workers don't feel like they are making a difference any-more. They lose compassion and are frustrated.
- Vanderburgh County Department of Child Services removed 550 children from their homes in 2017. Drugs and/or alcohol contributed to 62% of those removals.
- DCS had 873 active cases in Vanderburgh County on August 27, 2018. They have 20 assessment workers handling 300 requested assessments. They need 30 workers but cannot get people to stay.

Social Services #1 Group

Core issue – Poverty

Important notes:

- Suicide disparity – In our region, middle-age white men are by far the most likely to die by suicide. Those aged 70+ are the second most likely group to die by suicide.
- Homelessness definitions – the way we account for homeless people varies by social or community organization. Example: ECHO Housing uses Category 1 Homelessness (street homeless) while ECHO Health and the Evansville Vanderburgh School Corporation use McKinney-Vento guidelines to define homelessness. This categorization counts living in a hotel, motel, car, shelter, campground, and with other families in a "doubled-up" situation as homeless.
- The majority of street homeless people are men.
- Caregiver fatigue – The turnover rate for clinicians working with the poor/disenfranchised/ underserved population is very high.
- Alcohol and marijuana are socially acceptable at some level. More parents, especially younger parents, are self-medicating with alcohol and marijuana. (This relates to unsafe sleep deaths.)
- Teenagers think smoking cigarettes is gross and most aren't interested in vaping. The cool thing now is Juul. "With its unique satisfaction profile, simple interface, flavor variety and lack of lingering smell, JUUL stands out as the vapor alternative." (Source, www.juul.com)

Business/Corporations Group

Core issue: Can't hire or retain enough quality workers to meet job openings/available positions

Important notes:

- Thousands of manufacturing jobs are available in the region but companies are struggling to get qualified workers. Some are considering waiving a marijuana drug screen because they need workers and the people applying can't pass the drug screen.
- Sitting at desks and doing repetitive manufacturing work leads to trouble with weight. Neither option generates aerobic exercise. It also causes overuse injuries.
- Diabetes, hypertension, and heart disease are prevalent in the work force.
- Middle-age women are taking FMLA the most. Reasons include caring for elderly parents, and/or a sick child or spouse. This age group also takes leave to manage anxiety, depression, and other stress-induced conditions.
- Many companies have employees who are retirement age and want to retire but can't because they need the company insurance, have to pay for raising grandchildren, or some other family situation.
- There are various levels of substance use and abuse in the work place – throughout all education and salary ranges. This creates unsafe conditions, attendance issues, and morale problems.

Social Services #2 Group

Core issue: Lack of life skills and social support keep people in poverty.

Important notes:

- Many first generation Latino adults come to this region from very rural places. Most only have a second grade education from their home country. Learning English when you don't have a solid foundation in your native language is extremely difficult.
- Food is a serious need. So many families struggle with hunger and food insecurity. This is usually a result of poverty and low-paying jobs.
- Lots of elderly people struggle with food and nutrition.
- There are zero (Spanish) bilingual mental health providers in the area. (ECHO has bilingual doctors and nurses but not mental health technicians, psychologists, etc.)
- Senior/elder population needs guidance and social support to navigate all systems – health care, social services, food, medicine, etc. Increase in opioid use and addiction in the elderly because they have so many doctors and specialists who prescribe medicine and they just take it because the doctor told them to take it.

Social Services #2 Group Continued

- Medicaid/Medicare will not cover dentures.
- Families in crisis cannot consistently make good decisions. The focus is on right now and 1 hour from now.
- Criminal history, no matter how minor, adversely affects people, especially those living in poverty. The existence of a criminal record keeps people from securing safe housing, employment, etc.
- The only type of sex education allowed in public schools is abstinence. State law (IC 20-30-5-13), concerning human sexuality or sexually transmitted diseases at accredited schools, requires educators to teach:
- Abstinence outside of marriage for all school age children
- Instill that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases and other health problems
- Be sure to teach the best way to avoid any sexually transmitted diseases or other associated health problems is to establish a marriage that is a "mutually faithful monogamous relationship."
- Abstinence only rules make it difficult for social service groups to educate kids on healthy relationships, "good touch, bad touch", sexual assault, molestation, and sexually transmitted diseases. Kids must have written permission from a parent/guardian to attend a presentation on anything related to sexuality.

Education Group

Core issue: Fragmented families are the root of poverty and its related outcomes.

Important notes:

- Child neglect is a bigger issue than child abuse.
- There are increasing rates of type 2 Diabetes in children, teachers, staff, and college students. It is difficult to find resources to help pay for supplies and teach the person how to manage their disease. Sometimes supplies are so expensive that people just don't treat their diabetes.
- Intervention is needed for children less than age 5. Trauma in the first 3 years of life can alter formation of the brain.
- A lot of older students, including college, who are referred for mental health counseling do not attend. They are afraid of the associated stigma and decide to self-medicate instead of get treatment.
- Indiana regulations related to abstinence only sex education and the requirement of a signed permission slip for outside agency presentations disproportionally affect the students who need this education the most. Students in challenging lifestyles are the least likely to return a signed permission slip.

Education Group Continued

- When you are in a crisis, you are in survival mode. Navigating multiple complex systems is too hard.
- Children need stability. Without it, they suffer the most.
- More social support is needed for kids, adults, and the elderly.
- There are so many family models (grandparents/relatives raising kids, parents in jail, single mom, generational poverty, foster homes, step-families, multiple children from multiple partners, etc.) that one type of support will not work for everyone.
- Pediatricians and family doctors need more training on how to recognize trauma (and its lingering effects) in children. Also, parents aren't always honest with the doctor.
- Children who are prescribed medication, usually for a behavioral issue, experience weight gain. The doctor prescribing the medicine is generally not a mental health specialist and inadvertently starts an obesity cycle.
- We need to meet people where they are. Get employees who look like and relate to the target audience. Build trust.

Appendix C: Power Point Presentation from Prioritization Session

Community Health Needs Assessment Prioritization Meeting

VANDERBURGH COUNTY

September 12, 2018

Welcome, Introductions, and Reflection

Purpose of Prioritization Session

Review of 2016 CHNA

Introduction to the CHNA Data

Types of Data We Will Consider Today:

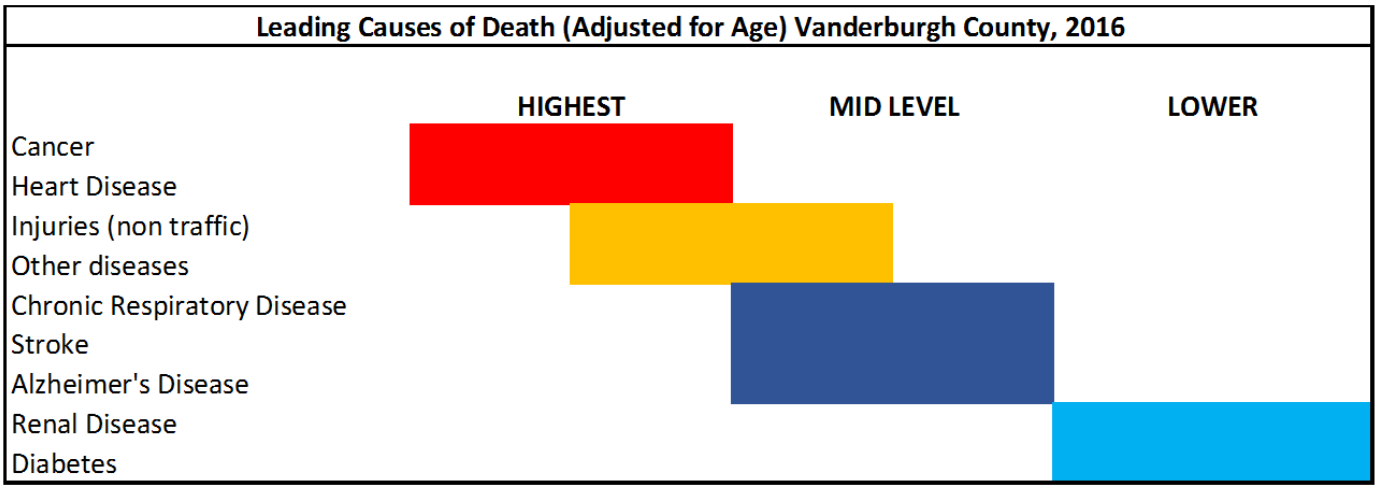
- Existing Data About our Community (e.g., city, county, regional health data)
- New Data Collected from Residents of our Community
  - 2018 CHNA Survey
  - Focus Group Data

Collectively, these data provide important information about the health of our community that will help us to make recommendations about the services and programs of St. Vincent Evansville and Deaconess Midtown.

Brief Overview of Existing Health Data in Vanderburgh County

What Do We Know about Health in Vanderburgh County?

Leading Causes of Death (Adjusted for Age) Vanderburgh County, 2016



Vanderburgh County ranks in the bottom half of the state for life expectancy among both women and men.

Challenging Health Issues in Vanderburgh County

- ***Obesity***. While obesity is high among individuals of all ages, it is particularly of concern for pre-adolescent children and lower income individuals.
- ***Hypertension***. Vanderburgh County continues to exceed national averages for adults.
- ***Low Birth Weight.*** Remains of concern in Vanderburgh County.
- ***Smoking***. Vanderburgh County continues to have a higher smoking rate, with continuing concerns about smoking during pregnancy.
- ***Child Abuse***. The child abuse rate for Vanderburgh County is among the worst in the state.
- ***Substance Abuse***. Vanderburgh County is among those in Indiana continuing to experience significant challenges due to substance abuse and its contributions to both mortality and morbidity.

Health Care Delivery Issues in Vanderburgh County

- Access to Health Care
  - Uninsured rate is lower in Vanderburgh than Indiana as a state.
  - Vanderburgh County ranks among the best in the state for availability of primary care providers.
  - Vanderburgh County ranks among the best in the state for availability of dental care providers.
- Preventable hospital stays: Vanderburgh County is slightly above the state average.
- Positive trends in the county for indicators such as diabetes monitoring and mammography screening.

Other Social Service and Public Health Issues in Vanderburgh County

Issues Related to the Social and Public Health Infrastructure:

- Availability of mental health providers remains high in Vanderburgh County. Poor mental health days among residents exceed state average and true access issues to mental health remain of concern.
- Access to recreational and physical activity facilities (natural and built) is high in Vanderburgh County, yet reported physical activity remains low.
- County mirrors other urban areas with regard to sexual and reproductive health, with elevated rates of STI and teen births.
- Data suggests ongoing challenges related to alcohol use (e.g., DUI arrests, impaired driving deaths, adults reporting excessive alcohol use).

Overview of the 2018 Vanderburgh County CHNA Survey

2018 CHNA Survey

- Survey conducted by St. Vincent and Deaconess in collaboration with other hospitals throughout Indiana.
- Researchers from Indiana University Bloomington and the University of Evansville helped to design the survey and the survey process.
- Data were collected in early 2018 by the IU Bloomington Center for Survey Research.

2018 CHNA Survey

In early 2018:

- Approximately 2,000 households in Vanderburgh County were randomly selected.
- Each household received a survey in the mail.
  - Asked to be completed by adult (18 or over) who had most recent birthday.
  - Mail back to IU Bloomington in postage-paid envelope.
- Households that did not respond received a second survey.
- Vanderburgh County received a total of 260 completed surveys.

Additionally, Deaconess and St. Vincent collected data via the survey from individuals seeking services in community-based settings. Those will be shared as well in a broad summary.

Community-Based Data Collection

- Additional surveys collected from 324 individuals throughout the state.
- Collected in both English and Spanish.
- Collected in a range of venues that serve disenfranchised community members and that provide valuable social and health services.
- In some sections of this presentation we will reference points from this data.

2018 CHNA Survey

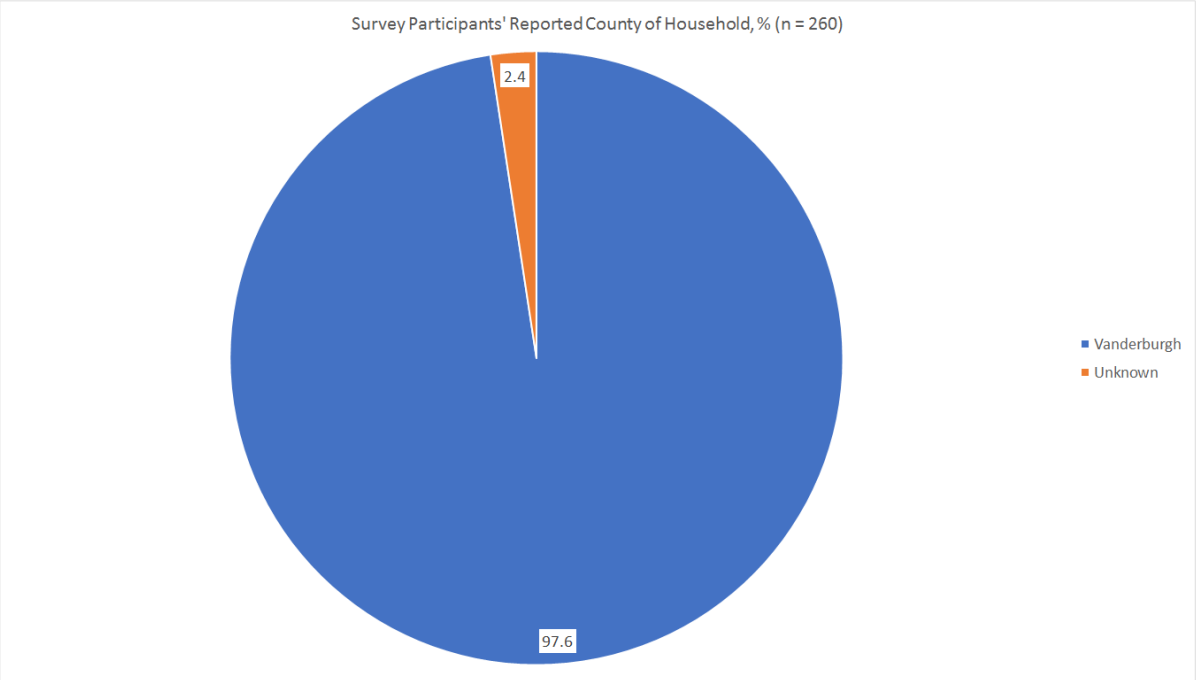
The survey asked participants to provide information related to 9 major areas:

1. Their demographic characteristics and characteristics of their household.
2. Perceptions of their health and well-being.
3. Their health care coverage and relationships with the healthcare system.
4. Types of health services they received over the previous year.
5. Characteristics of their health-related behaviors over the previous month.
6. Their perceptions of the social factors that challenge their well-being.
7. Health issues that they perceive as a priority for their community.
8. Health issues that they perceive as important for the allocation of resources.
9. The types of programs and services they think are important to their community.

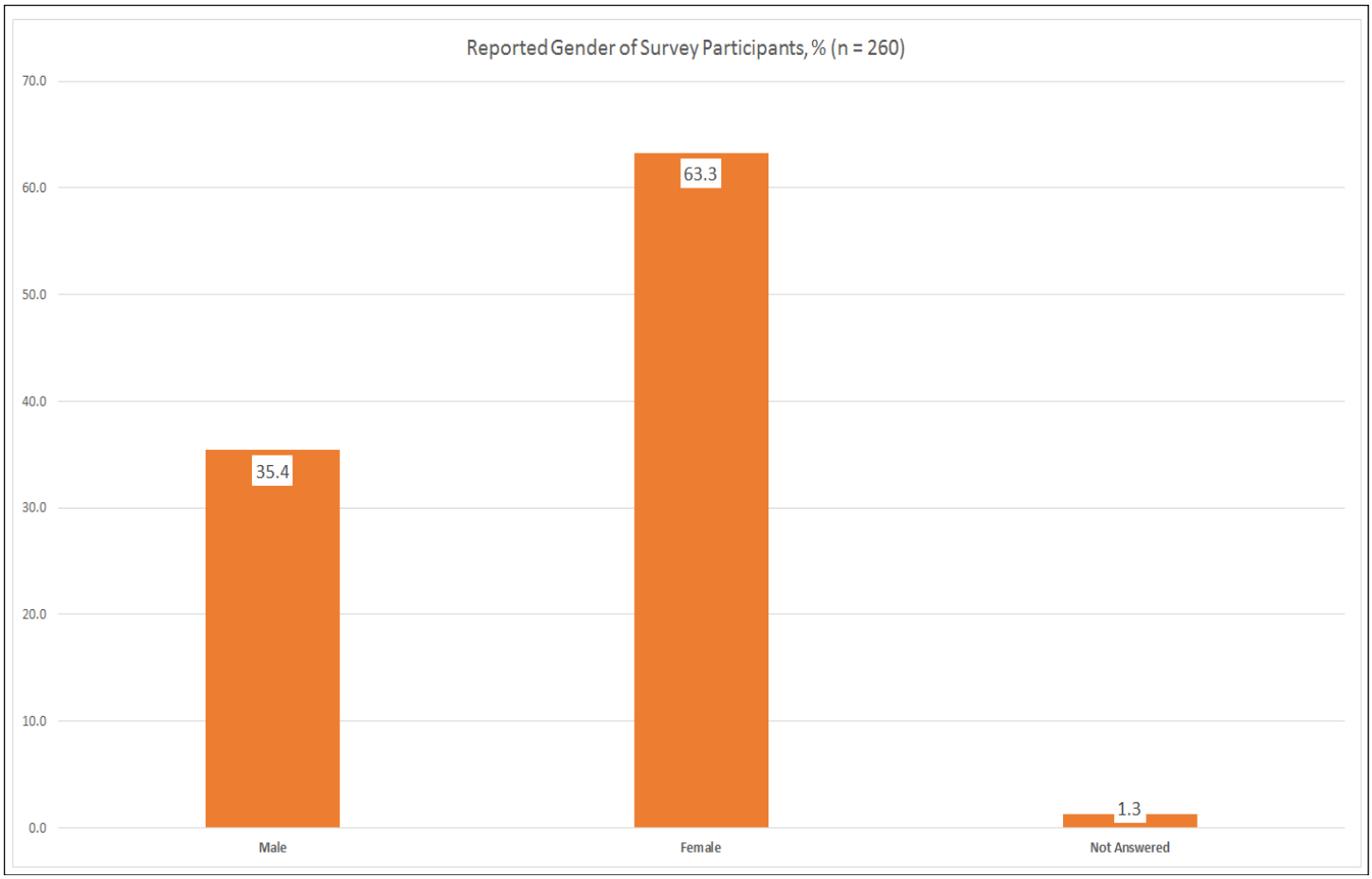
Brief Overview of the Survey Results

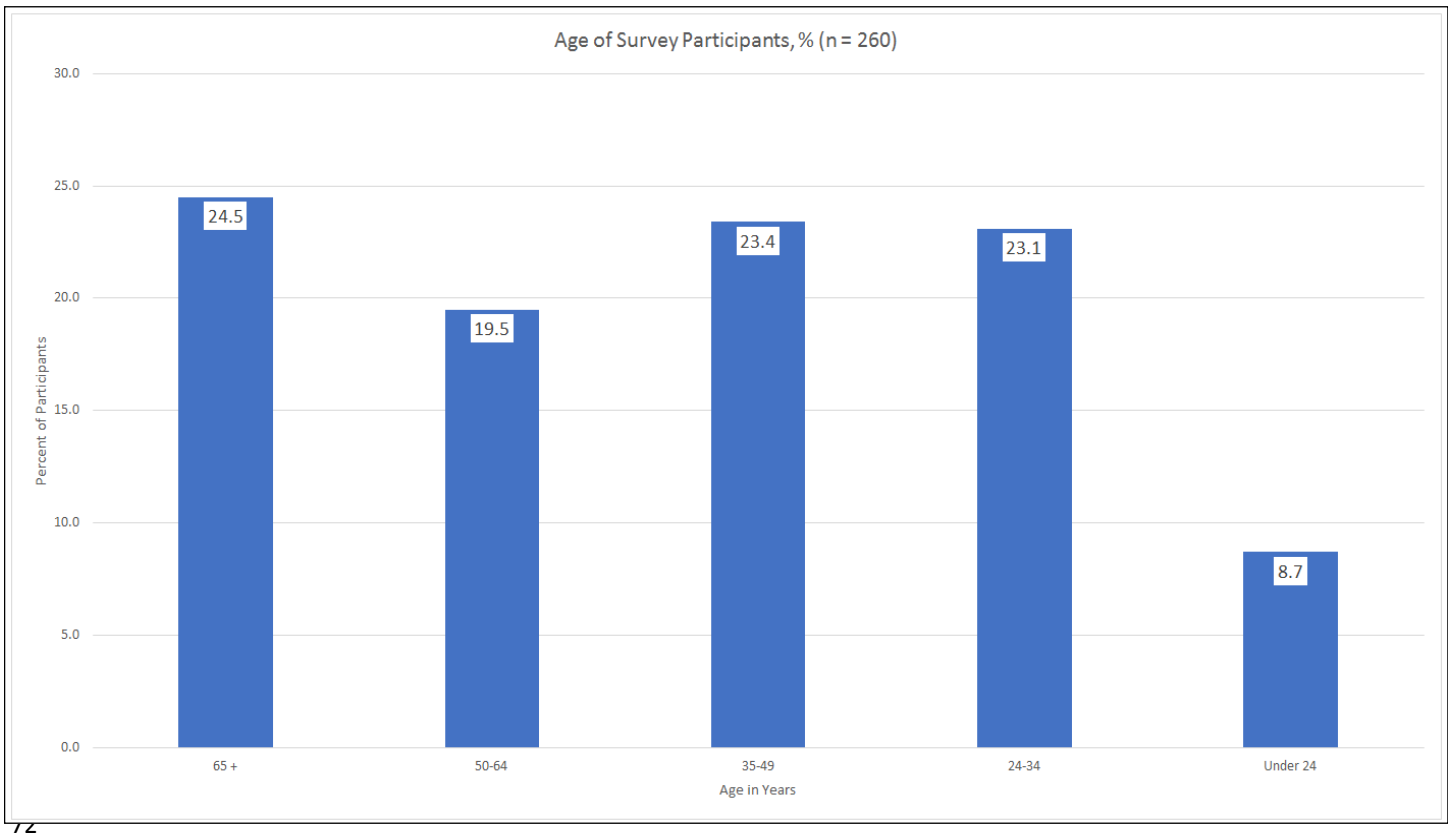
Full Results of the Survey Will Be Available Online Once CHNA Report is Completed

About the survey participants

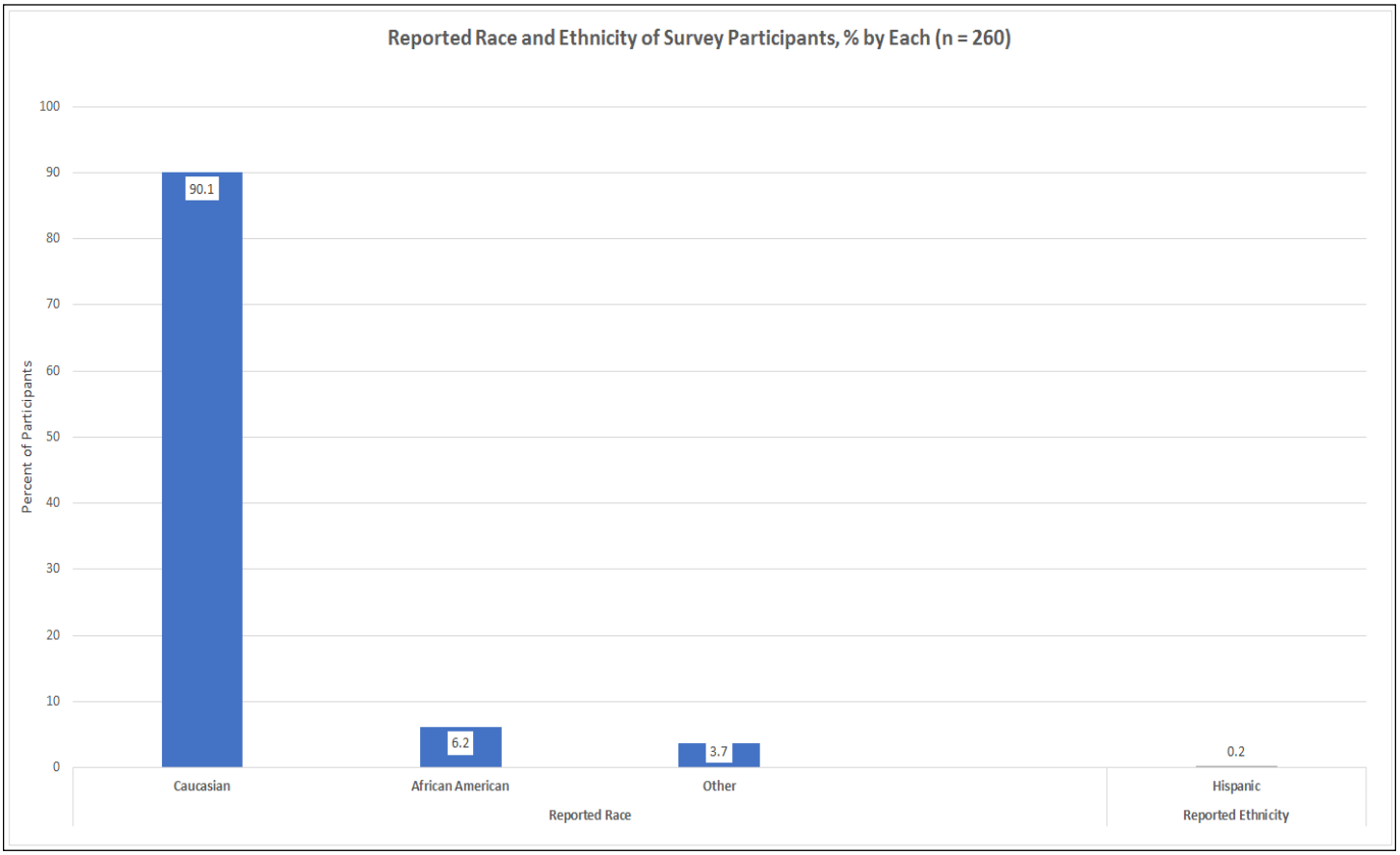


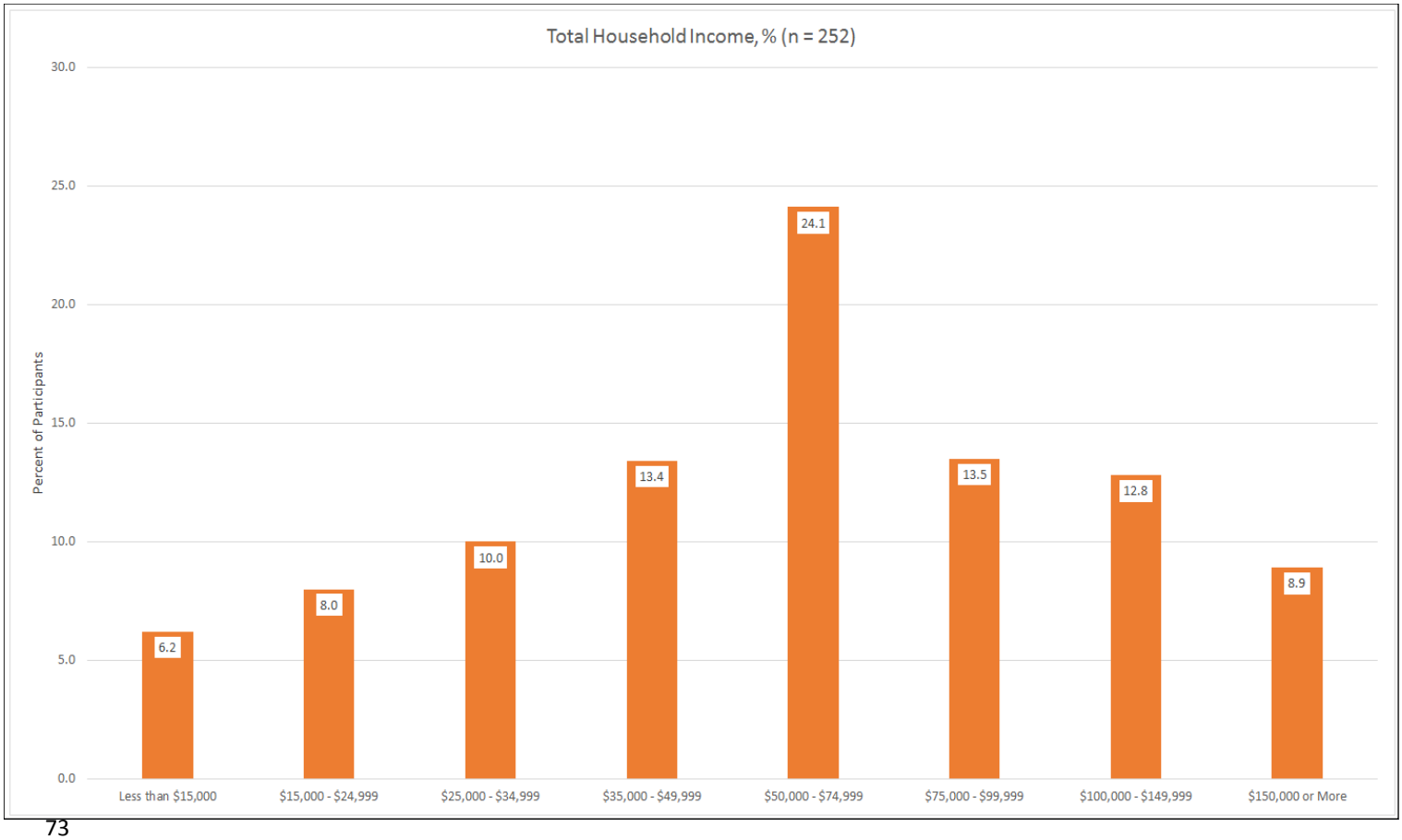
About the survey participants

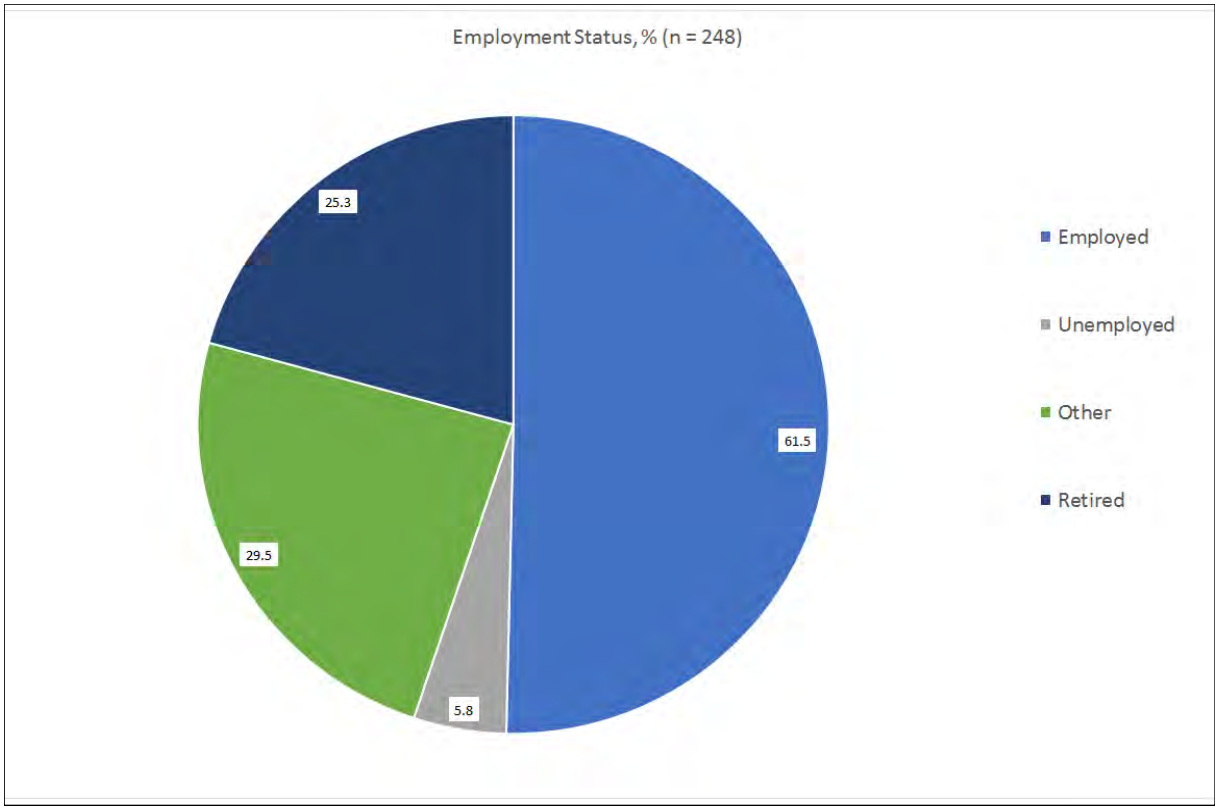




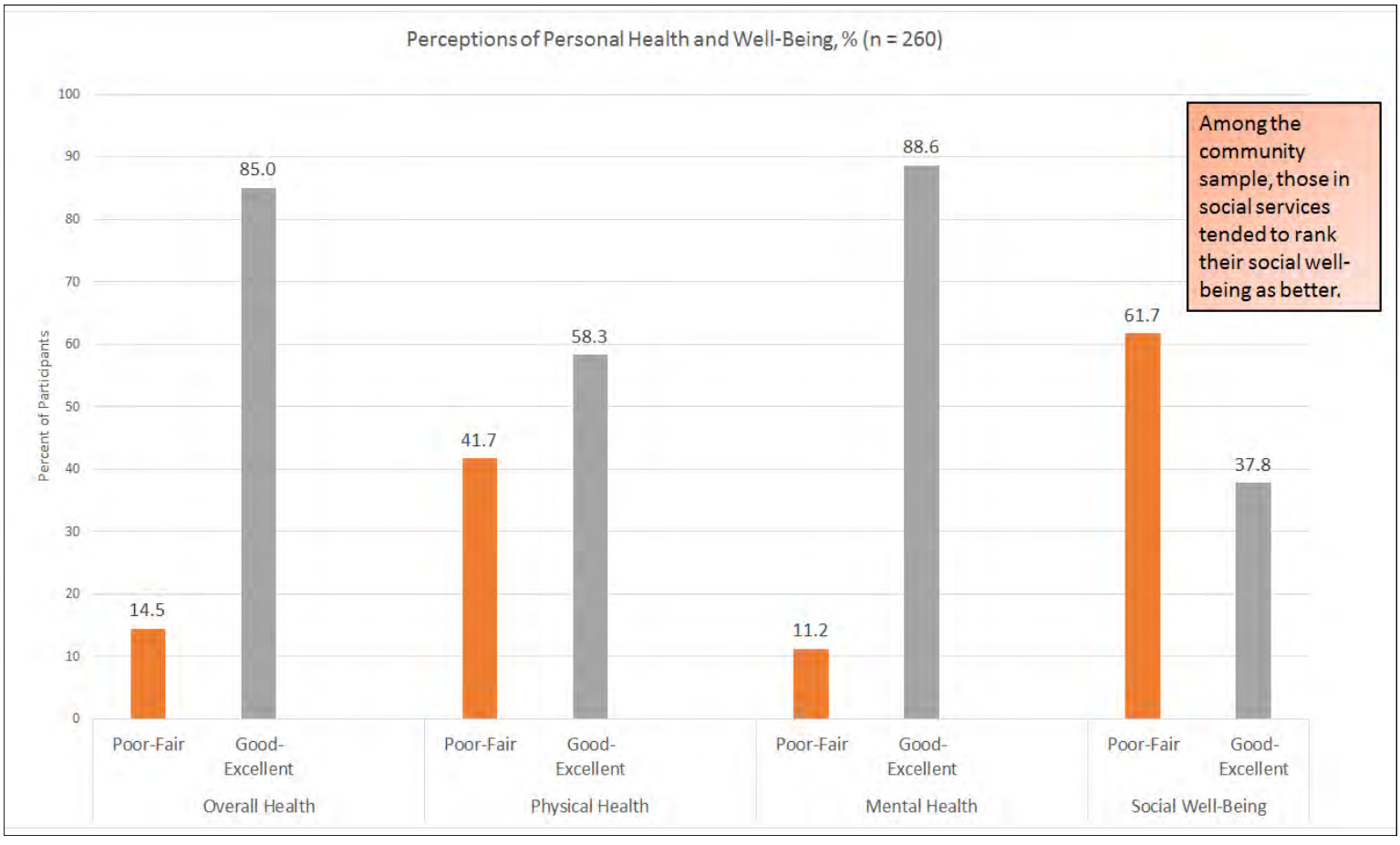
About the survey participants

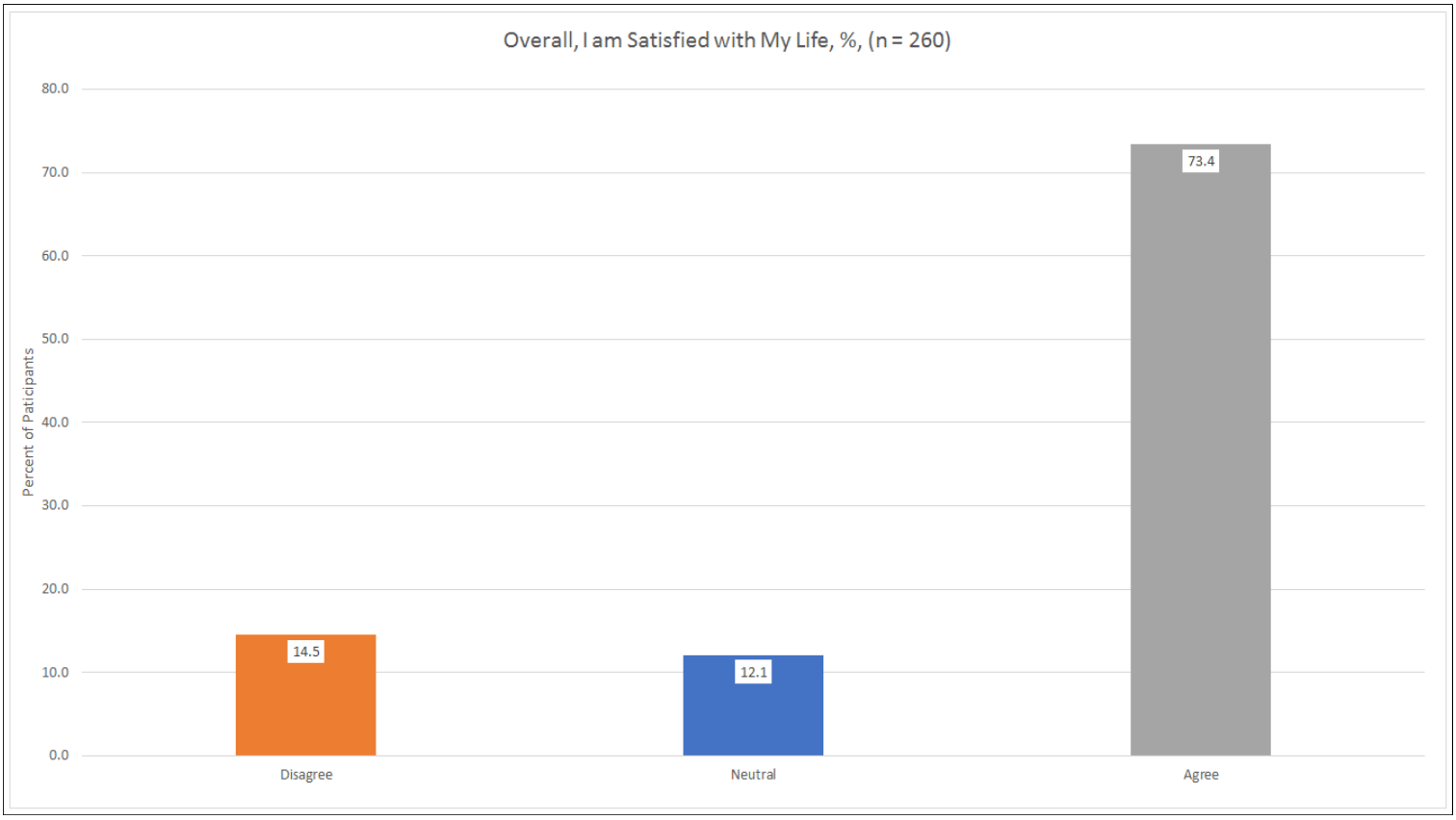


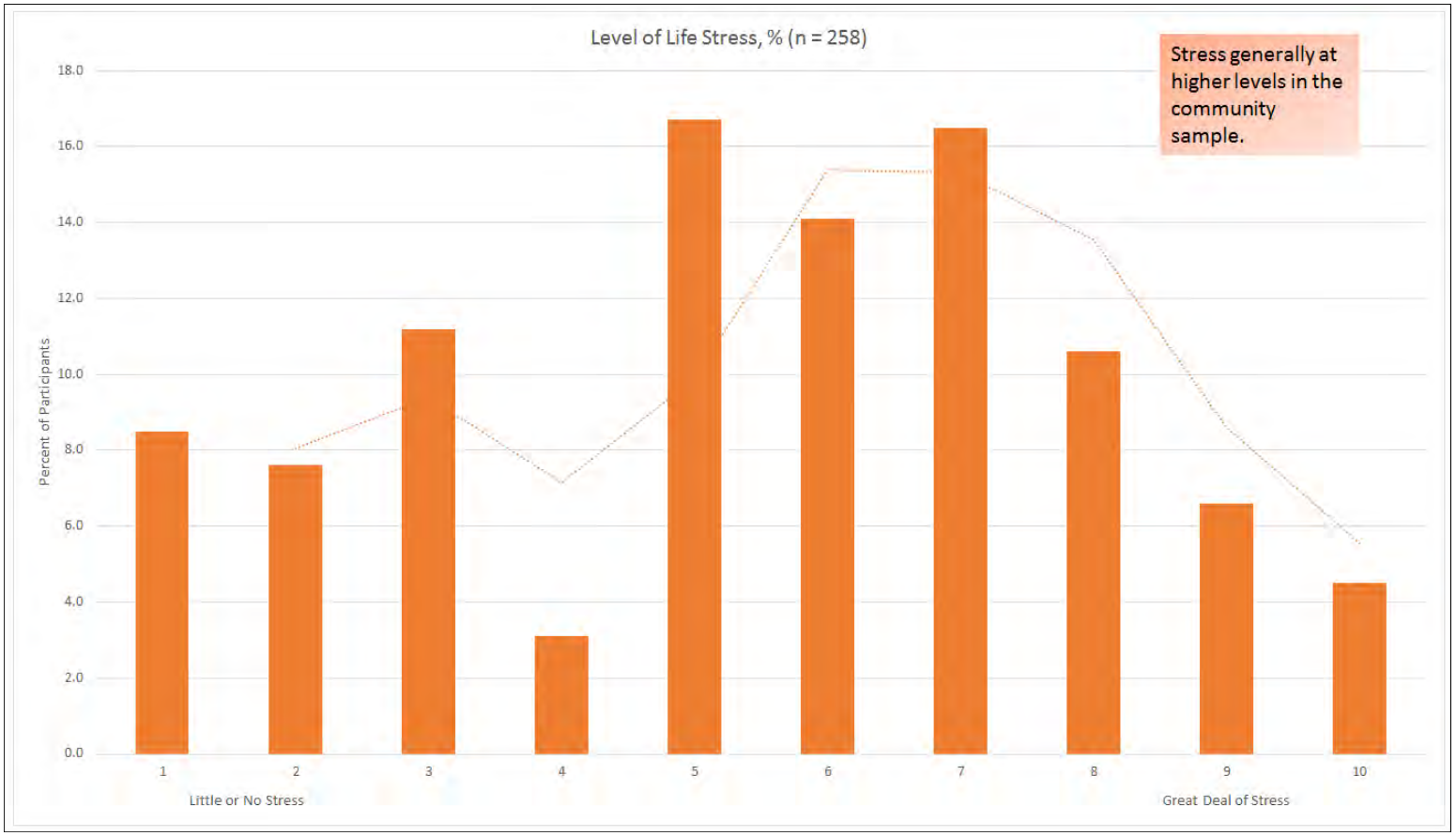




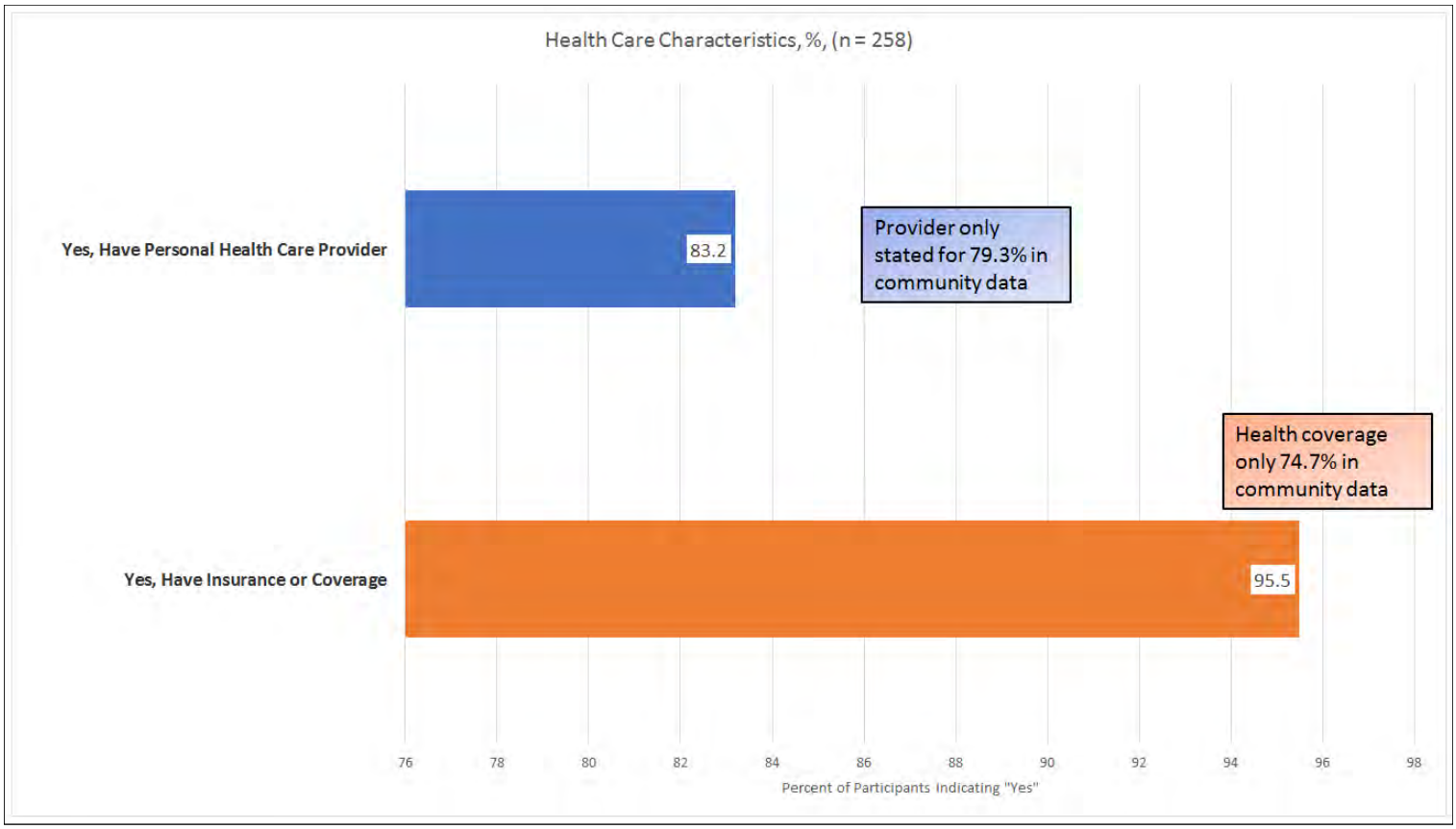
About Their Health and Well-Being

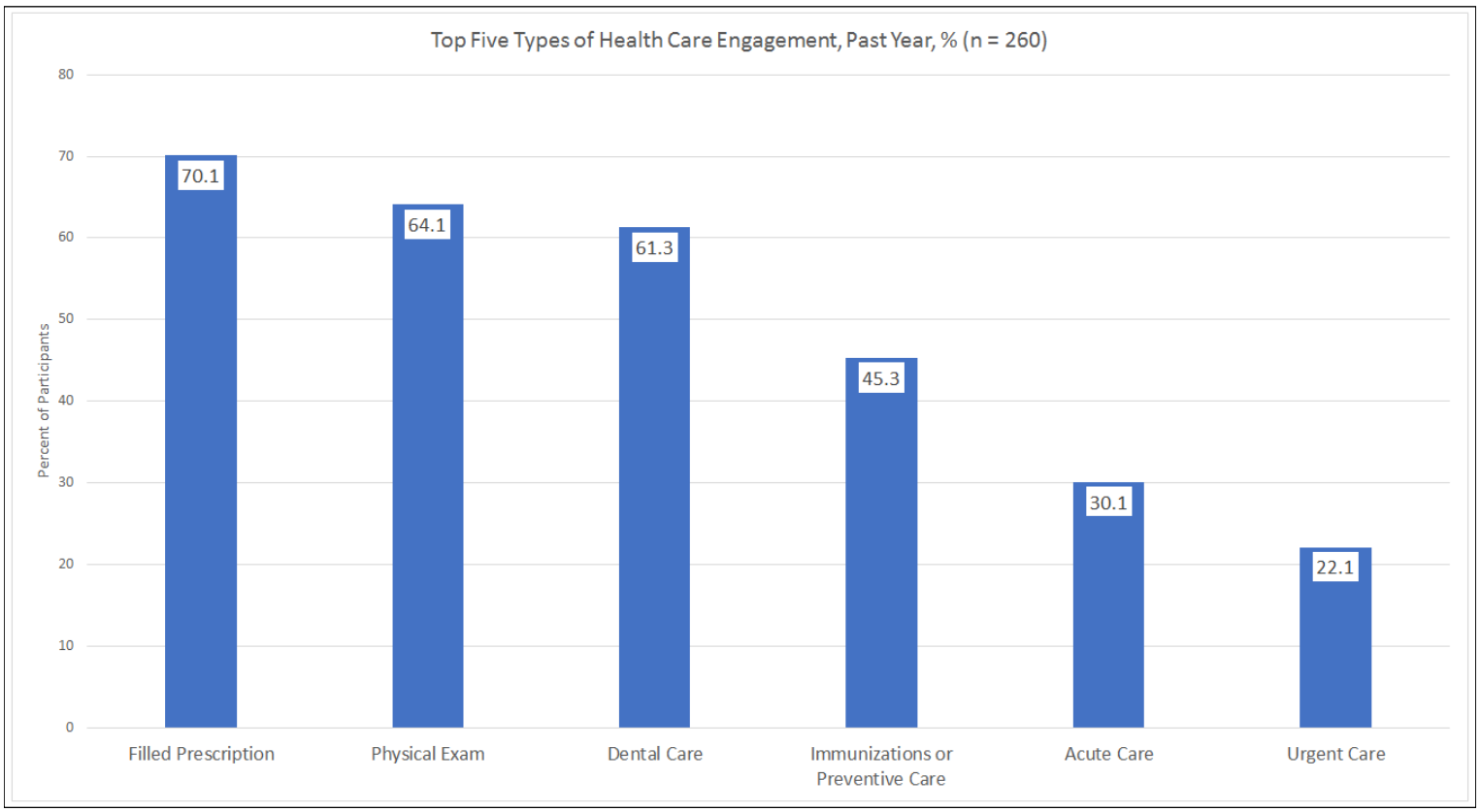


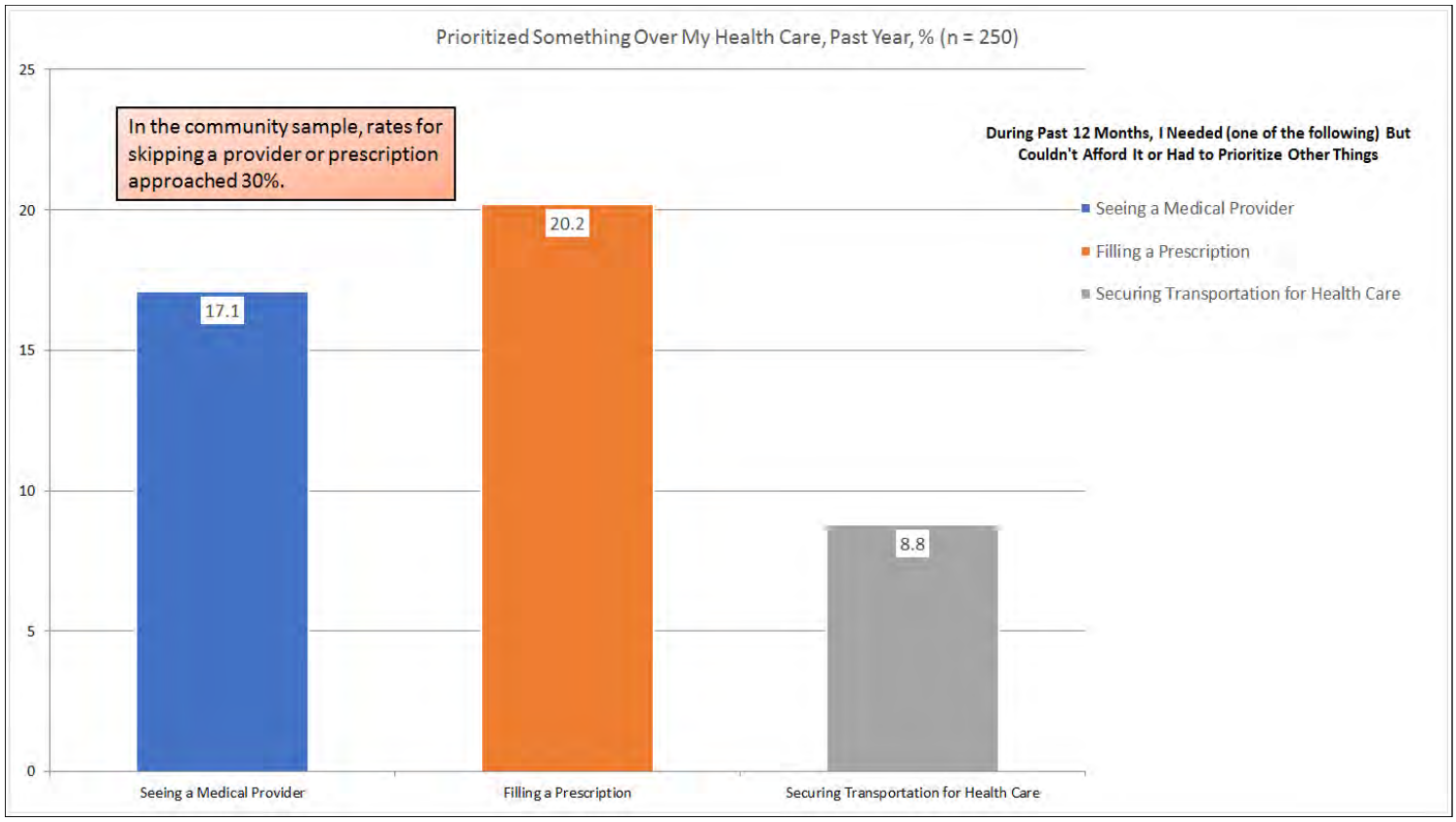

Overall, I am Satisfied with My Life, %, (n = 260)
Percent of Paticipants
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
14.5
12.1
73.4
Disagree
Neutral
Agree


Level of Life Stress, % (n = 258)
Stress generally at higher levels in the community sample.
Percent of Participants
18.0
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
1
2
3
4
5
6
7
8
9
10
Little or No Stress
Great Deal of Stress

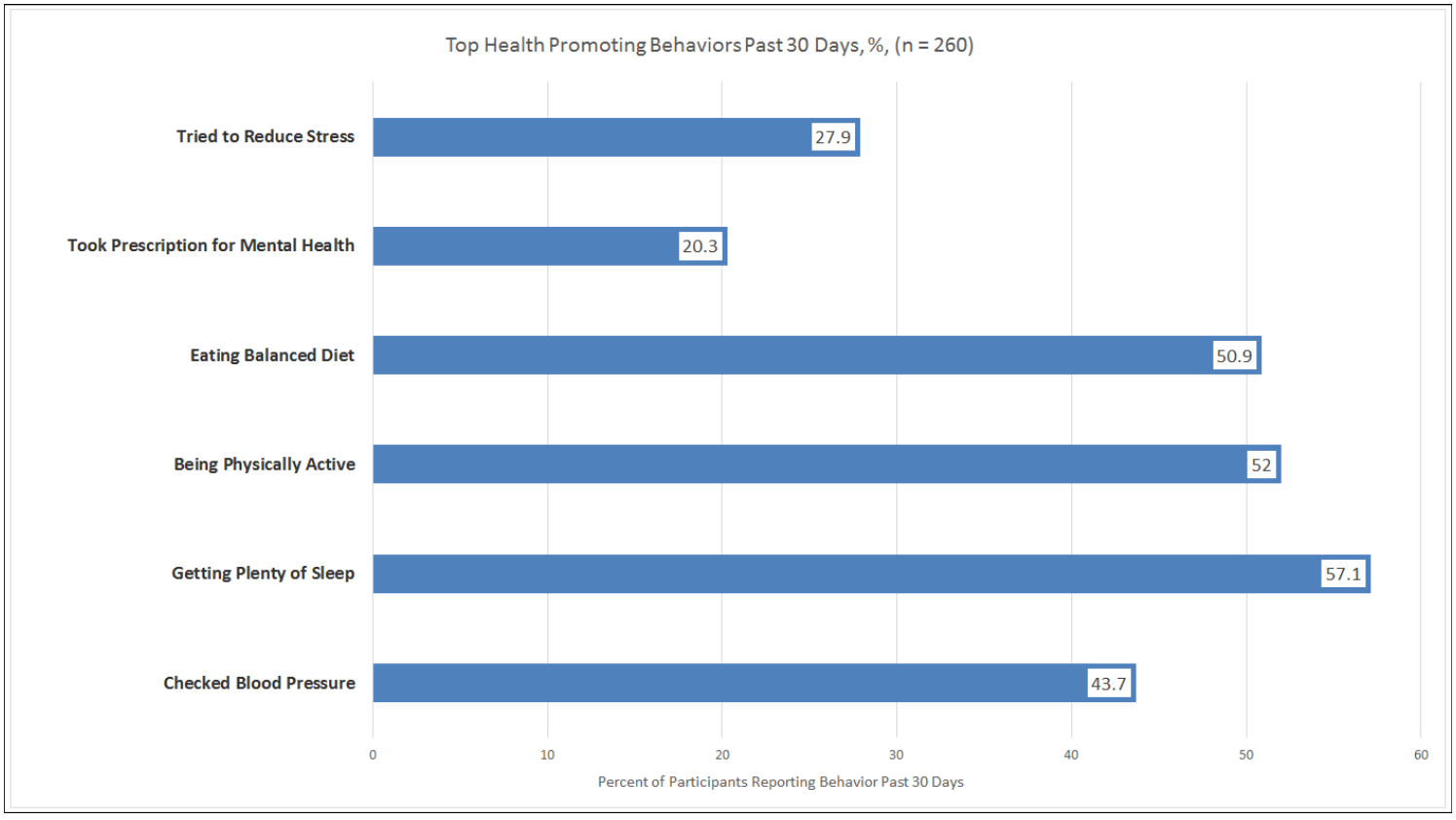
About Their Health Care Coverage and Access

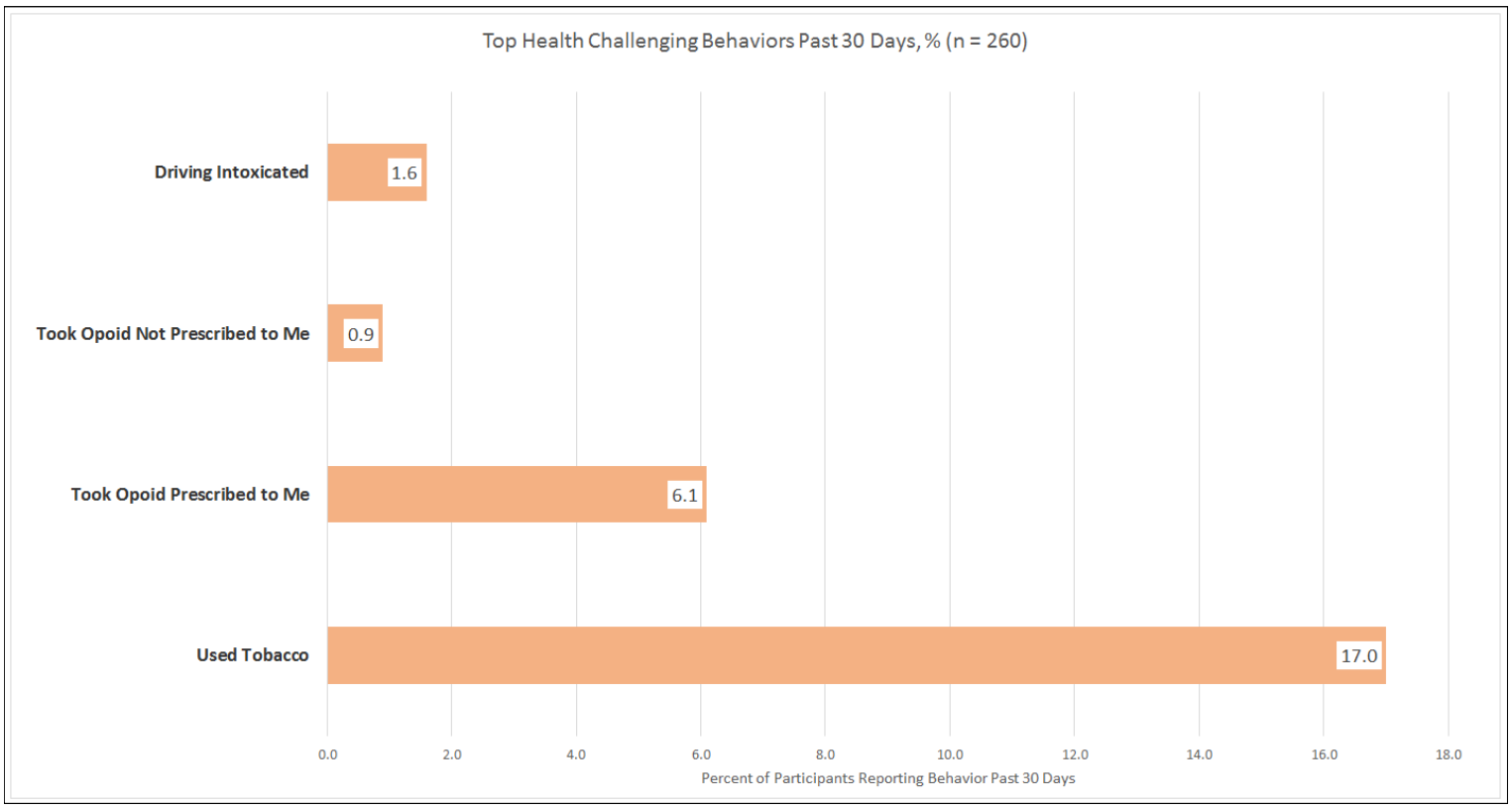


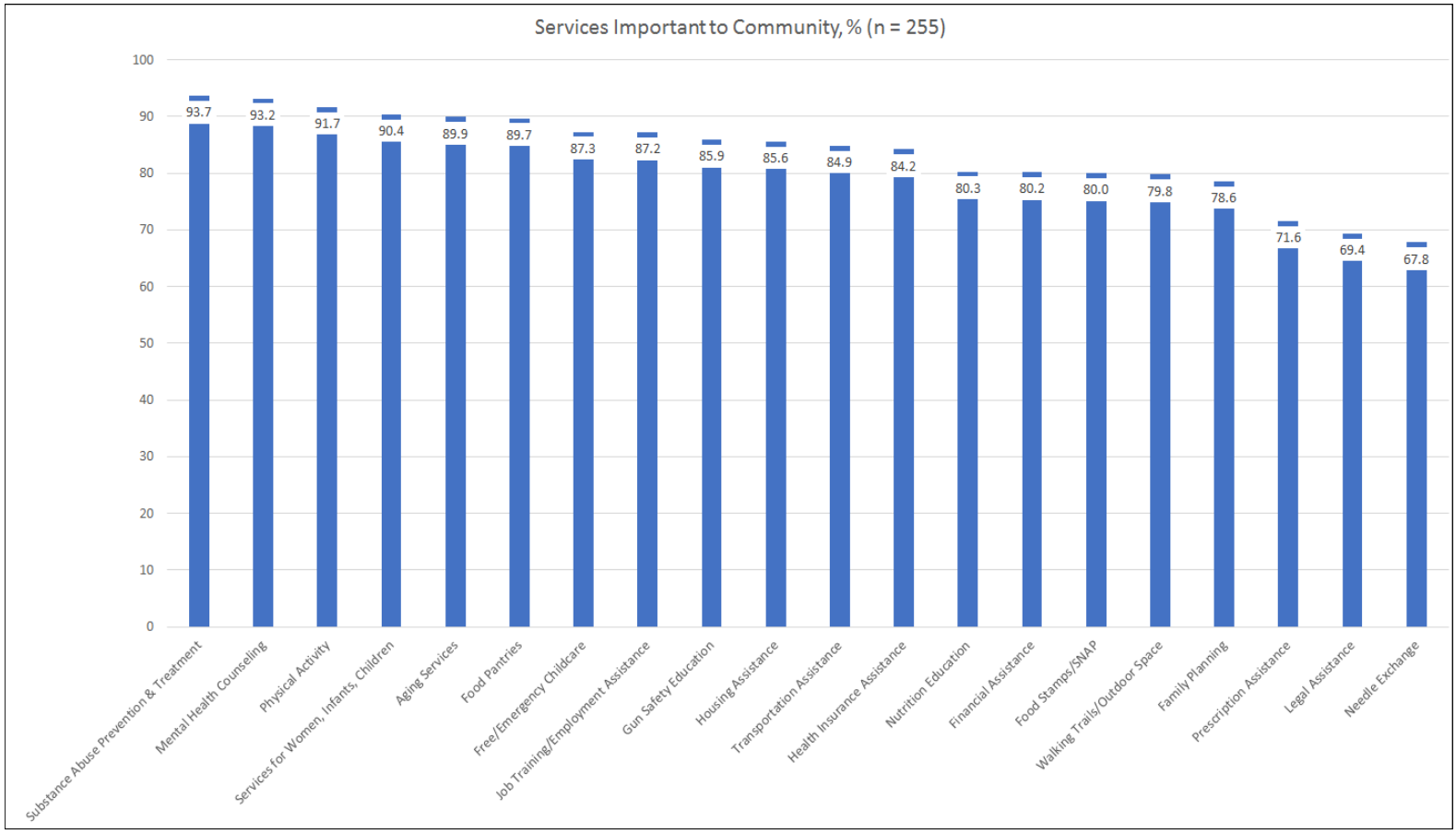




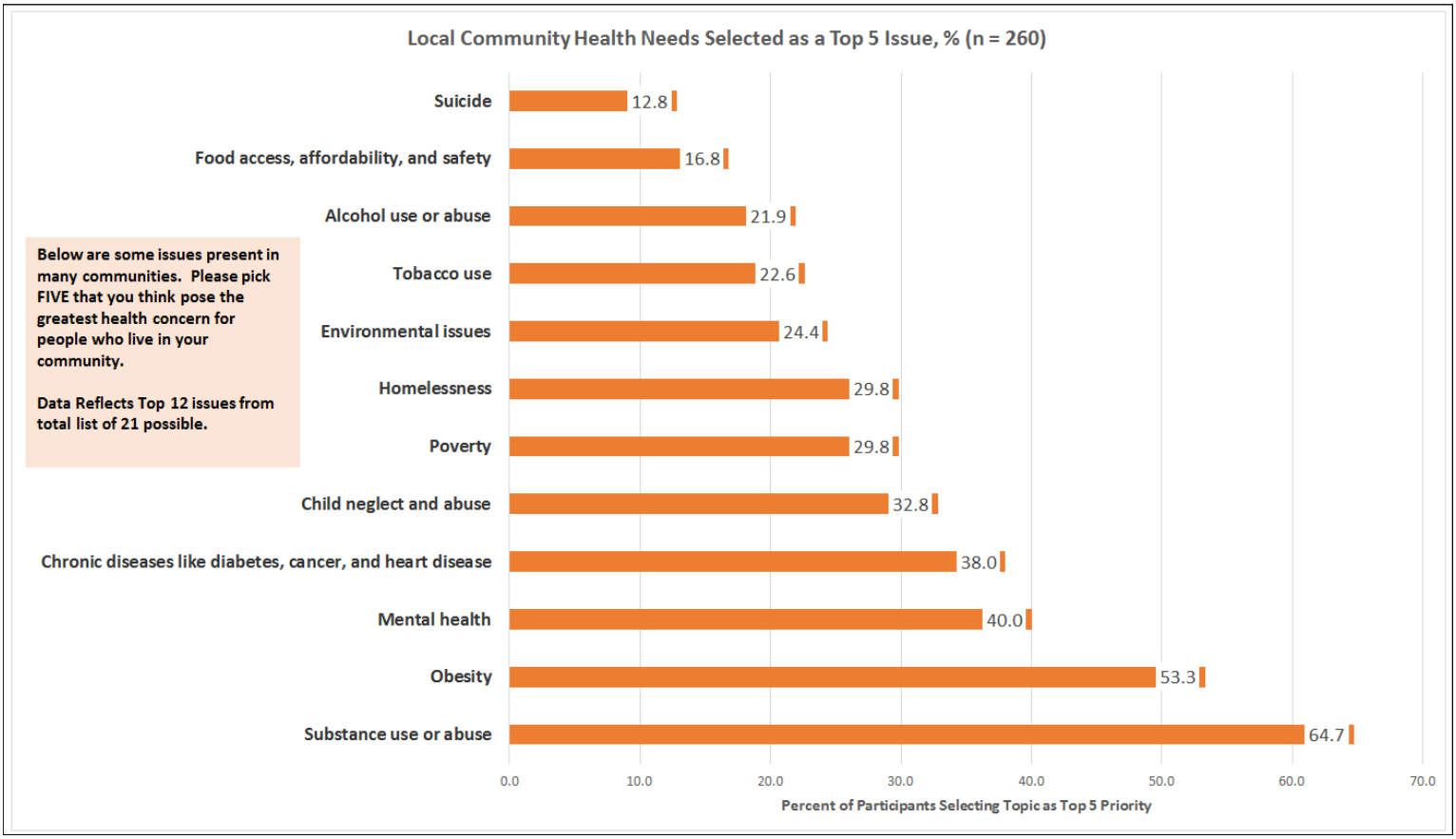
About Their Health Behaviors

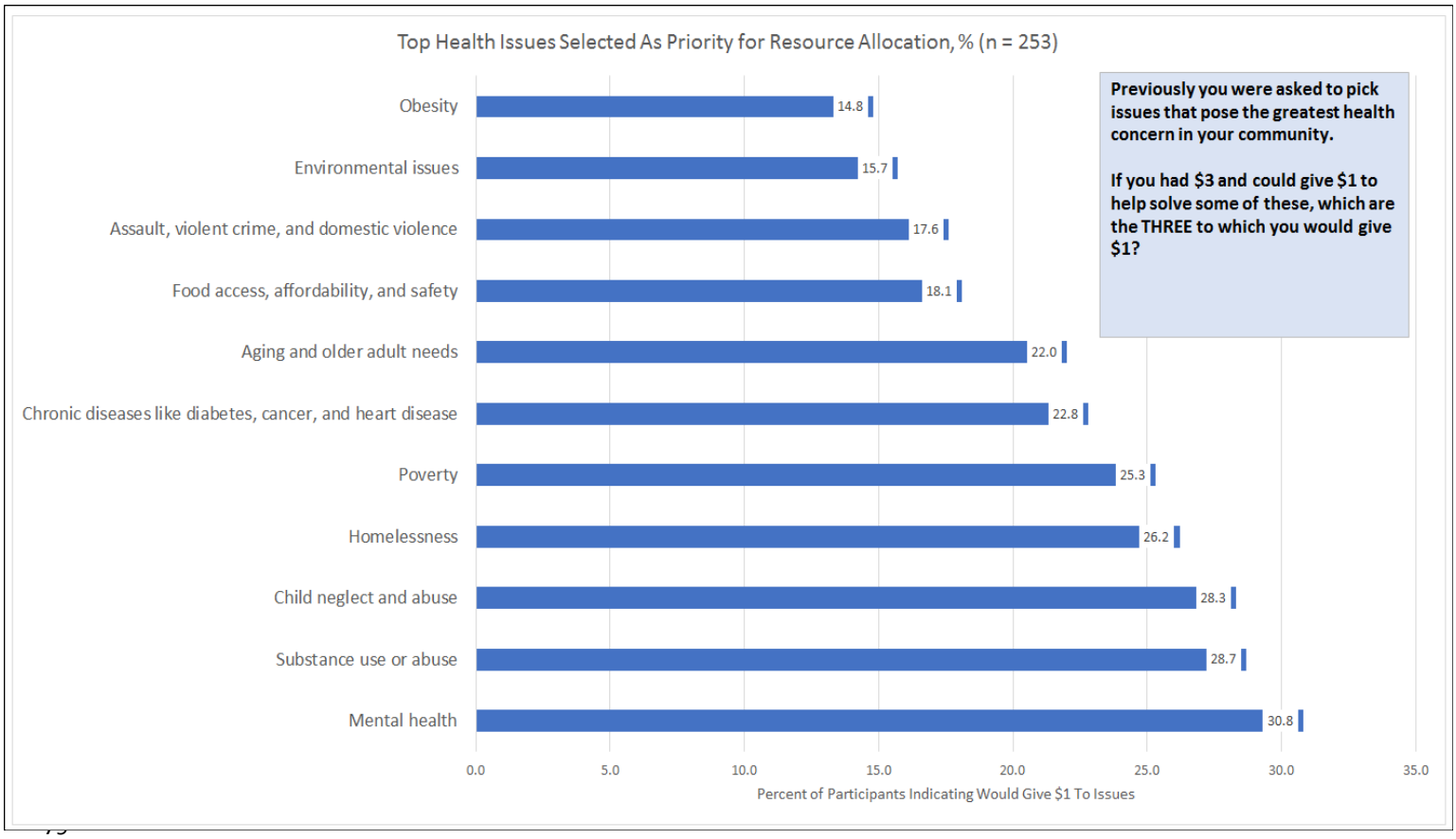



Top Health Challenging Behaviors Past 30 Days, % (n = 260)
Driving Intoxicated
1.6
Took Opoid Not Prescribed to Me
0.9
Took Opoid Prescribed to Me
6.1
Used Tobacco
17.0
0.0
2.0
4.0
6.0
8.0
10.0
12.0
14.0
16.0
18.0
Percent of Participants Reporting Behavior Past 30 Days


Services Important to Community, % (n = 255)
100
90
80
70
60
50
40
30
20
10
0
93.7
93.2
91.7
90.4
89.9
89.7
87.3
87.2
85.9
85.6
84.9
84.2
80.3
80.2
80.0
79.8
78.6
71.6
69.4
67.8
Substance Abuse Prevention & Treatment
Mental Health Counseling
Physical Activity
Services for Women, Infants, Children
Aging Services
Food Pantries
Free/Emergency Childcare
Job Training/Employment Assistance
Gun Safety Education
Housing Assistance
Transportation Assistance
Health Insurance Assistance
Nutrition Education
Financial Assistance
Food Stamps/SNAP
Walking Trails/Outdoor Space
Family Planning
Prescription Assistance
Legal Assistance
Needle Exchange

Perceptions of Priority Health Needs





Convenience Sample Priorities

- Common priority needs between the main survey and the community-based data.

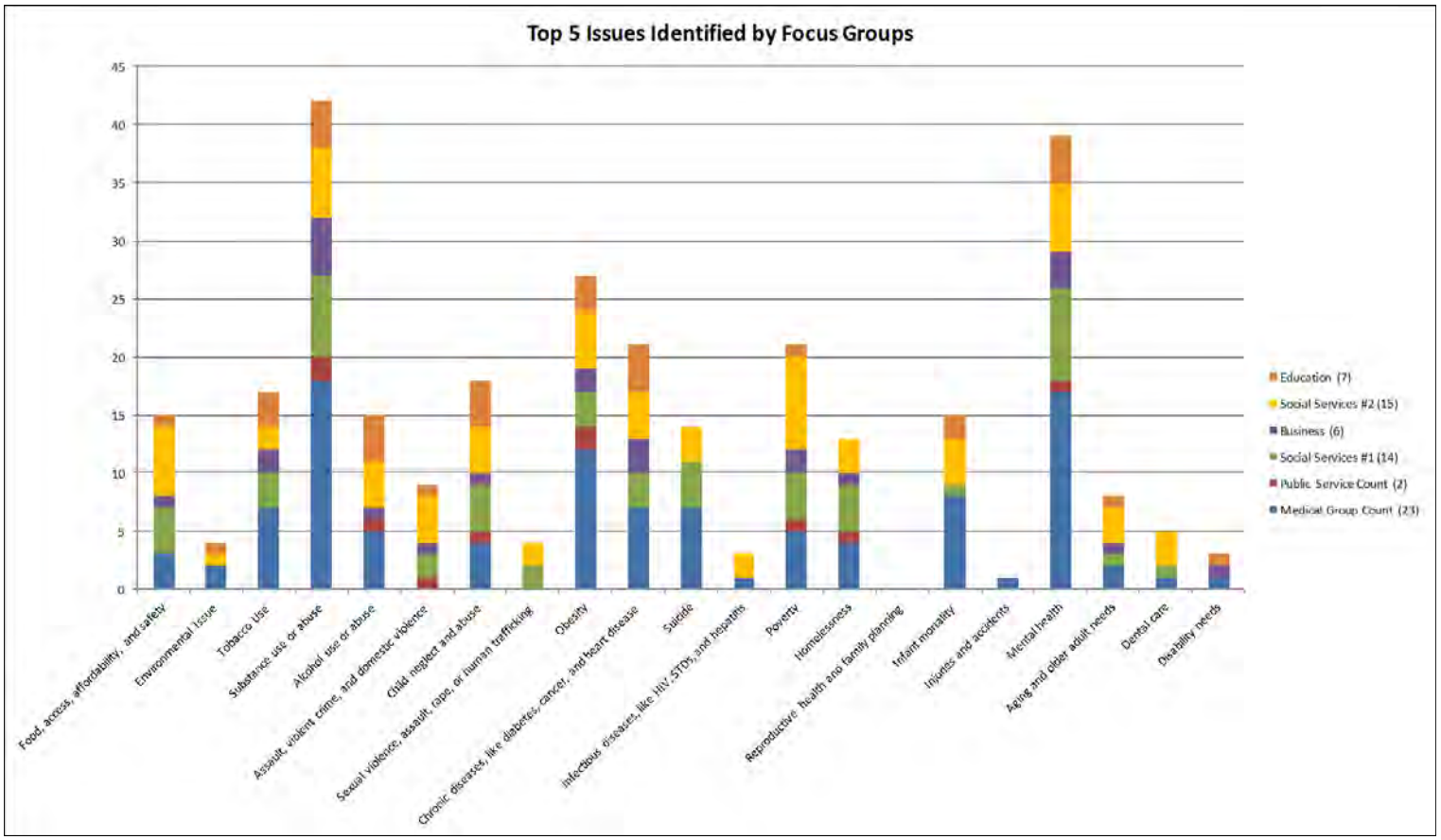
- Community-Based Needs and Priority Resource Allocations Included in Top 10:

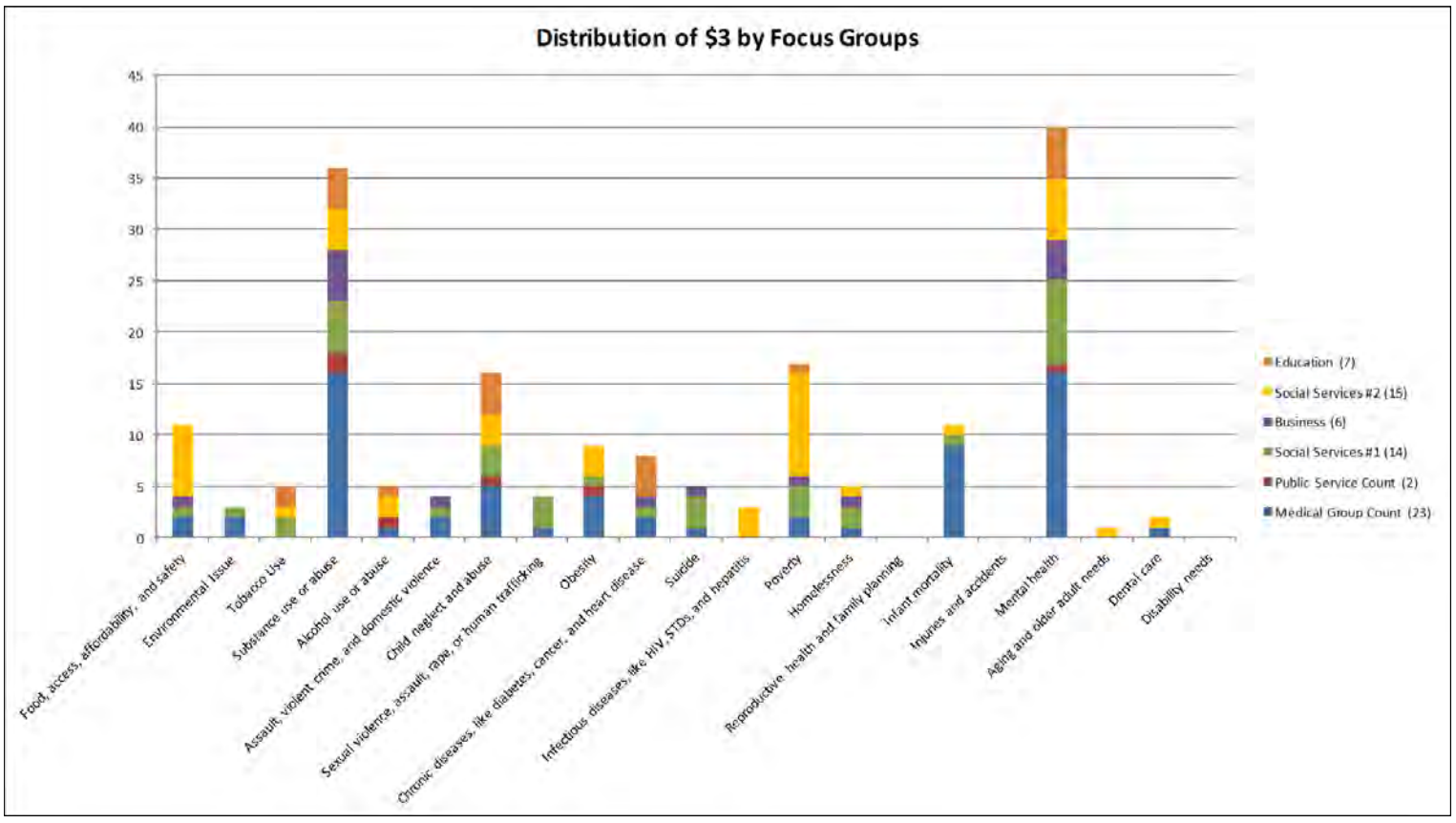
  - Homelessness
  - Assault, Violent Crime, Domestic Violence
  - Higher Ranks for Mental Health

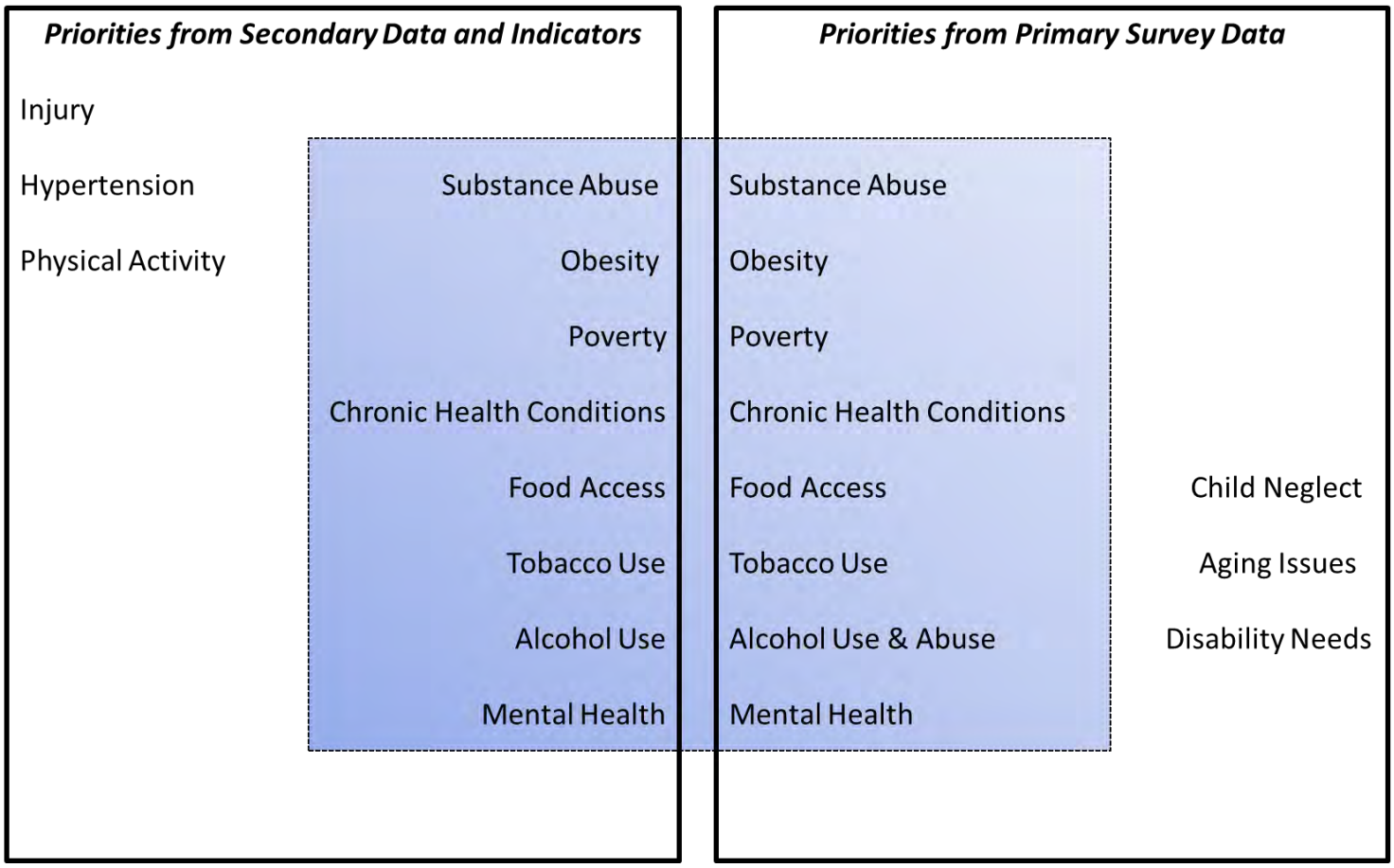
  - Food Availability Highest Priority for Resource Allocation

Community Focus Group Input on Priorities

Deaconess and St. Vincent conducted focus group meetings to collect additional community member perceptions of community health priorities.







Questions and Answers

Prioritization Process

Goal: Select the FIVE health issues that you think are the highest priority for Vanderburgh County.

1. 5-10 minutes: Brainstorm and listing of NEW potential priority issues (based on data and your own insights). *We will write those on flipcharts along with the ones already highlighted.*

2. *5 minutes: Apply priority dots (5 per person) to the issues YOU perceive as highest priority.*

3. *10 minutes: Discussion of the top 5 and listing of considerations for each.*

Next Steps

CHNA Prioritization Process

September 12, 2018 in Room 107A of St. Vincent Evansville Medical Arts Building

Attendees:

Lisa Maish, Deaconess

Lisa Myer, St. Vincent EVV

Ashley Tenbarge, St. Vincent EVV

Lori Grimm, Deaconess The Women's Hospital

Dr. Ken Spear, Vanderburgh County Health Department

Jill Buttry, Deaconess

Andrea Hays, Welborn Baptist Foundation

Amy Canterbury, United Way of SWI

Dr. Chad Perkins, St. Vincent EVV

Sandee Strader-McMillen, ECHO Health

Pam Hight, Deaconess

Janet Raisor, St. Vincent EVV

Dr. Maria Del Rio Hoover, St. Vincent EVV

Sabrina Jones, St. Vincent EVV

Scott Branam, Deaconess Cross Pointe

Ashley Johnson, Deaconess

Jenna Alvia, St. Vincent Warrick

Dr. Carrie Ann Lawrence, IU School of Public Health – Facilitator

Top 3 identified health needs for Vanderburgh County

Substance use/abuse, mental health, poverty (emphasis on food insecurity)

Top 3 identified health needs for Warrick County

Mental health, substance use/abuse, access to care (specifically transportation)

ST. VINCENT EVANSVILLE HOSPITAL CHNA PRIORITIZATION SESSION

NO.	NAME (PRINT)	PHONE	ORGANIZATION	DEPARTMENT	SIGNATURE
1	Lisa Maisu	(812)426 9753	Deaconess clinic	Administration	Lisa M
2	Risa Myer	812 485-1504	ST. Vincent	Community Relations	
3	Ashley Tenbarge	812-485-4691	St. Vincent	Community Relations	
4	Lori Grimm	812-461-8435	The Women's Hospital	Perinatal Services	
5	Ken Spear MD	812-435 2400	VC HD	Health Dept	
6	Jill Buttry	812-430-4962	Deaconess	Nursing Admin	
7	Andrea Hays	812-437-8260	Welborn Baptist Fam.	Healthy Eating & Active Living / Community Engagement	
8	Amy Canterbury	812.421.7480	United Way SWI	Pres & CEO	
9	Chad Perkins	812 305 4069	SVEMS	Admin	
10	Sandee Strader McMillen	812-436-0215	ECHO	Admin	
11	Pam Hyt	812-450-7571	Deaconess	PL/Marketing	
12	Janet Raisor	812 485 5603	St V	Community Relations	
13	Maria Del Pilar Hoover	812 485-7397	St Vincent	Center for Children Peds Service Line	

COMMUNITY DEVELOPMENT & HEALTH IMPROVEMENT
CHNA Prioritization Session

TIME
8:30a – 10:30a

EVENT DATE
September 12

LOCATION
SV-Evansville – Medical Arts Build

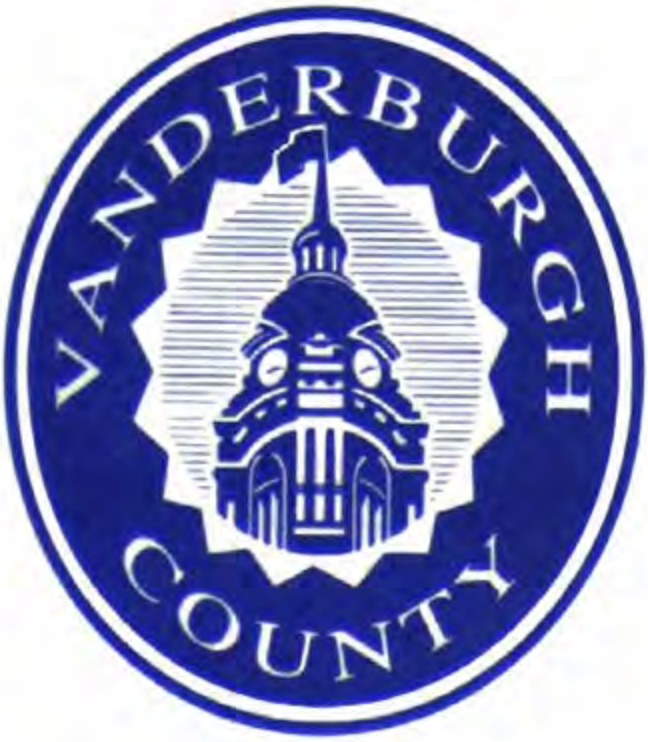
NO.	NAME (PRINT)	PHONE	ORGANIZATION	DEPARTMENT	SIGNATURE
14	Sabrina Jones	812-485-5719	St. Vincent	Marketing	
15	Scott Branam	812-471-4524	Cross Pointe	Rich health	
16	Ashley Johnson		Deaconess	Marketing	
17	~~Jenna Alvig~~		St. vincent	Women's Clinical Operations	
18	*Did not attend SV Evansville session				
19					
20					
21					
22					
23					
24					
25					

Appendix D: Resource List

Resource Name	Local Address	Phone Number	Website	Topic Area
Adult Protective Services	Civic Center Complex, Admin. Bld. Rm 108, Evansville, IN 47708	812-435-5190	www.vanderburghprosecutor.org	Older Adults
AIDS Resource Group	101 NW 1st St., Suite 213 Evansville, IN 47708	812-421-0059	www.argevansville.org	Immunization and Infectious Disease
Albion Fellows Bacon Center		812- 422-9372	www.albionfellowsbacon.org	Injury and Violence Prevention
ARC of Evansville	615 W Virginia St, Evansville, IN 47710	812-428-4500	www.arcofevansville.org	Disability and Health
CAPE Minority Health Coalition	401 SE 6th Street, Suite 101 Evansville, IN 47713	812-492-3938	www.capeevansville.org	Access to Health Services
Crisis Intervention Team—EPD	15 N.W. M.L. King Jr. Blvd. Evansville, IN 47708	812-436-7896	www.evansvillepolice.com/specialized-assignments/crisis-intervention-team	Injury and Violence Prevention
Deaconess Health System	600 Mary Street Evansville, IN 47747	812-450-5000	www.deaconess.com	Access to Health Services
Easterseals Rehabilitation Center	3701 Bellemeade Ave, Evansville, IN 47714	812-479-1411	www.easterseals.com/in-sw/	Disability and Health
ECHO Community Healthcare	315 Mulberry Street Evansville, IN 47713	812-492–8310	www.echochc.org	Access to Health Services
Evansville Christian Health Clinic	265 Bellemeade Ave, Evansville, IN 47713	812-426-6152	https://evansvillehealthclinic.com/	Access to Health Services
Evansville Psychiatric Children's Center	3300 E Morgan Ave, Evansville, IN 47715	812-477-6436	https://www.in.gov/fssa/dmha/3080.htm	Mental Health and Mental Disorders
Evansville State Hospital	3400 Lincoln Ave, Evansville, IN 47714	812-469-6800	https://www.in.gov/fssa/dmha/3058.htm	Mental Health and Mental Disorders
Holly's House	750 N Park Dr. Evansville, IN 47710	812-437-7233	www.hollyshouse.org	Injury and Violence Prevention
Matthew 25 AIDS Services	101 NW 1st St, Suite 215 Evansville, IN 47713	(812) 437-5192	www.matthew25clinic.org	Immunization and Infectious Disease
Mental Health America	410 Mulberry St, Evansville, IN 47713	812-426-2640	http://www.mhavanderburgh.org	Mental Health and Mental Disorders
METS	601 John St Evansville, IN 47713	812-435-6166	www.evansvillegov.org/city/department	Social Determi-nants of Health
Patchwork Central	100 Washington Ave, Evansville, IN 47713	812-424-2735	http://patchwork.org/	Access to Health Services
Southwestern Behavioral Healthcare	415 Mulberry Street Evansville, IN 47713	812-423-7791	www.southwestern.org	Mental Health and Mental Disorders
St. Vincent Evansville Hospital	3700 Washington Ave. Evansville, IN 47714	812-485-4000	www.stvincent.org/Locations/Hospitals/Evansville	Access to Health Services
SWIRCA and More	16 W. Virginia St. Evansville, IN 47710	812- 464-7800	www.swirca.org	Older Adults
United Way of SWI	501 NW 4th St, Evansville, IN 47708	812- 422-4100	www.unitedwayswi.org	Social Determi-nants of Health
Vanderburgh County Health Department	420 Mulberry St. Evansville, IN 47713	812-435-2400	http://health.vanderburghcounty.in.gov	Access to Health Services

Appendix E: Secondary Data Report

Vanderburgh County
Health Assessment

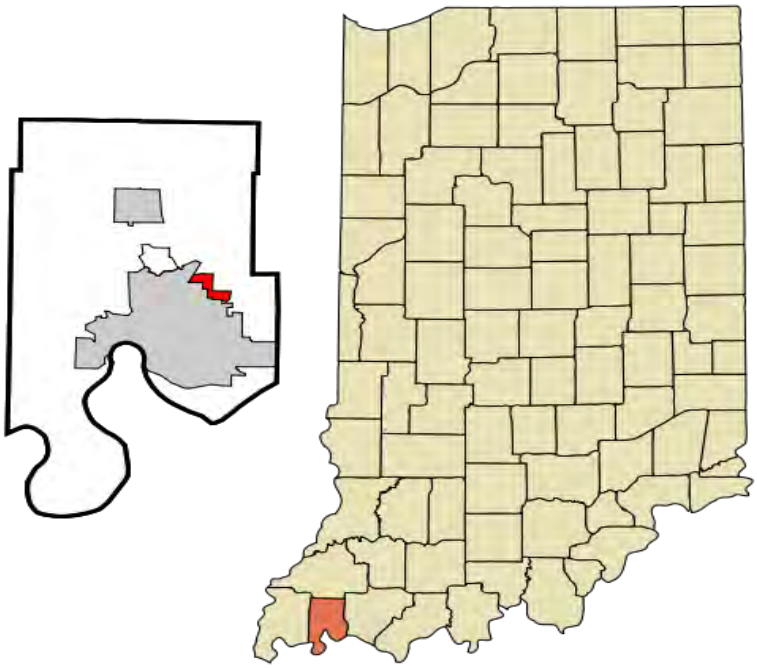


University of Evansville
Sadaf Jawad

Table of contents

Vanderburgh County

Located in southwestern Indiana, Vanderburgh County is a thriving community serving as the commercial, medical, educational and cultural hub for the Indiana/Kentucky/Illinois tristate region. The County seat is in Evansville. With eight townships and a population of 181,877 Vanderburgh County is the seventh largest county out of total 92 counties of Indiana. This beautiful “River City” attracts many tourists and is a center of cultural activities in the tristate region. Adjacent counties are Gibson County, Henderson County, Posey County and Warrick County.



The Ohio river is no doubt the city’s most magnificent physical feature. Evansville has a unique opportunity to assert itself as the heart of the tristate region. The heart of a city is the downtown. It’s a cultural hub. Two major universities UE and USI. Major hospitals in Evansville. A person is as healthy as the environment he lives in. Unfortunately the Downtown has continued to decline with more families moving to suburban areas. Poor access and circulation of traffic leads to barriers in accessibility to healthcare and recreational activities.

Historical Facts

The city of Evansville has a rich historical background. Few of us realize that Evansville is near the center of a region in which are remains of a very primitive culture. The Ohio valley was once well populated by a race of mound building Indians. These mound builders are estimated to have lived from 900 A.D to 1600 A.D. Angel mounds is an excellent example of a defensive effort of a peaceful sedentary people against invasion. With the collapse of the chiefdom in 1450 the Angel people relocated and groups of Shawnee, Miami and other tribes moved into the area. The city of Evansville was founded in 1812 by Hugh McGary. Commemoration of the past adds new interest in our environment. Today the Downtown Evansville Master Plan Update identifies priorities for downtown improvements, policies and actions for next five-to- seven-year investment cycle. In 1927 the first comprehensive master plan was completed. The old city's grid was laid out at right angles to the river. As the city grew in 1870's a new grid was laid out with Indiana's north-south grid which was at 45 degrees angle to the old city's grid. This has been both a curse and a blessing. The curse is that the newer streets still run into the old grid with confusing intersections and awkward pieces of land. The blessing is that because of the change in grid downtown is geographically identifiable with most of its historic heritage intact. Several fine historic buildings remain. The Old Post Office, the Old Courthouse, the Old Jail and Sheriff's Residence, the Memorial Coliseum, and the Willard Library are the much celebrated historical structures. Under the modernization of commercial buildings on Main Street are historic shop fronts. The rich heritage of Evansville needs to be revitalized with new investment and development.

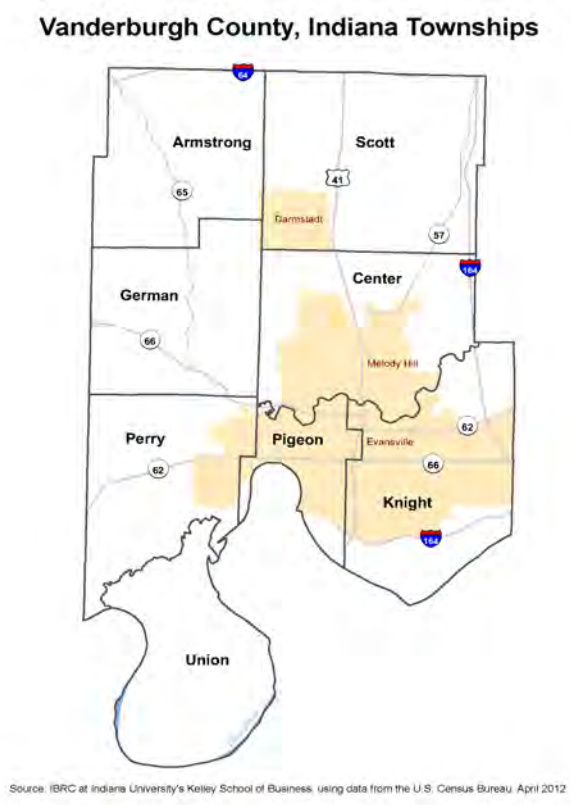
Unemployment

The unemployment rate in Vanderburgh county ranges from 2.0% to 14.4%, with an overall county value of 7.0%. Zip codes 47708 and 47722 have the highest unemployment rates in the county. The males in Vanderburgh County have a higher unemployment rate than females, but are better than the overall Indiana state unemployment rate for males.

Demographics

The population of Vanderburgh County is 181,877 making it the third largest city in the state of Indiana. According to the County Health Rankings 2015, Vanderburgh County ranks 78th out of 92 Indiana Counties in health outcomes. About 10.5% of the population is living in poverty. The median household income in Vanderburgh County is $44,396 which is about $5,000 lower than the state average. It has been recognized that zip codes 47708 and 47713 are socioeconomically the most needy and dependent. (HCI's SocioNeeds)

The population that is below 18 years of age is 21.9% while 65 and older is 15.8%. Population of Non-Hispanic Whites is 84.2% which is similar to the statewide population. Percentage of population that is American Indian or Alaskan Native is 0.3%. Asian population is 1.3%. While Native Hawaiian or other Pacific Islander is only 0.1%. Hispanic population is 2.6%.With just 1% population not proficient in English Vanderburgh County is largely English speaking. Out of the whole population 51.7% are female. The Vanderburgh County is largely an urban area, with rural population only 9.2%.



Selected Demographic Information

Geographical Areas of Highest Need

Social and economic factors are well known to be strong determinants of health outcomes. The HCI SocioNeeds Index® summarizes multiple socioeconomic indicators, ranging from poverty to education, which may impact health or access to care. All zip codes in the United States are given an Index value from 0 (low need) to 100 (high need). Within Vanderburgh County, zip codes are ranked based on their Index value (see Table 3). These ranks are used to identify the relative level of need within the county.

Geographically, there are parts of Vanderburgh County for which quality of life issues are of greater concern. The Index shows that zip codes **47713** and **47708** are the communities with the highest socioeconomic need within Vanderburgh County and are more likely to be affected by poor health outcomes. It should be noted that these zip codes were also cited as having the lowest median household incomes, highest poverty rates, highest percentages of households without a vehicle, and lowest levels of educational attainment.

Cultural Characteristics

Vanderburgh County is a popular tourist destination. Tropicana Evansville is the state's first casino and draws large number of crowds. Mesker Park Zoo and Botanical gardens are home to large species of animals and plants. Public School District of Vanderburgh County is Evansville-Vanderburgh School Corporation (EVSC). Signature school is a nationally ranked charter school that has made its mark. The Vanderburgh County has two major universities, the University of Evansville and the University of Southern Indiana. Entertainment venues include the Historic Bosse Field, the Ford Center and the Old National Events Plaza. The Victory Theater that is home to Evansville Philharmonic Orchestra attracts large crowds for it concerts and plays every year.

Summary of Indicators and Secondary Data:

Infant Mortality

The Infant Mortality rate of Indiana is 7.2 per 1,000 live births and that for Vanderburgh County is 11 per 1,000 live births. These values are much higher than the Healthy People target of 6 per 1,000 live births.

	Vanderburgh	**Indiana**	**Healthy People target**
Infant Mortality Rate*	7.2	11	6

*IMF: Number of infant deaths per 1,000.

Children's Health

With the knowledge that the health trajectory of a person is established early on in life all children should have the access to health services. Children should be given the opportunity to participate in educational programs that establish positive health and emotional behaviors. Indiana ranks 32nd in the nation's

Leading cause of injury death

Drug overdose deaths are the leading cause of injury death in the United States, with over 100 drug overdose deaths occurring every day. With 23.6 deaths per 100,000 population, Vanderburgh County ranks in the worst quartile in the US and Indiana counties for Death Rate due to Drug Poisoning.

Mortality

Mortality reports are published annually by the Indiana State Department of Health. According to the 2016 mortality report of Vanderburgh County heart disease is the leading cause of death in both males and females. It is closely followed by Cancer.

According to the county health rankings Vanderburgh County ranks 60th with 8,500 premature deaths. Premature deaths are the years of potential life lost before age 75 per 100,000 population (Age Adjusted).

In 2015 the total deaths in Vanderburgh County due to all causes was 2,030.

Mortality data for Vanderburgh County by STATS Indiana (2015)

Mortality Indicator	Number of deaths
Total deaths	2,030
Tuberculosis	0
Syphilis	0
HIV	1
Malignant Neoplasm	439
Diabetes Mellitus	54
Alzheimer Disease	111
Heart Disease	519
Influenza and Pneumonia	38
Chronic Lower Respiratory Disease	175
Peptic Ulcer	4
Chronic Liver Disease and Cirrhosis	51
Kidney Disease	41
Pregnancy Childbirth and Puerperium	0
Certain conditions originating in the perinatal period	6
Congenital malformations deformations and chromosomal abnormalities	6
Symptoms signs and abnormal clinical and laboratory findings not elsewhere classified	12
SIDS	0
Motor Vehicle Accidents	22
All other accidents(Non motor vehicle)	89
Suicide	32
Homicide	6
Other external causes	0
All other Disease	424
Diseases of the Heart	402
Cerebrovascular Diseases	82

Causes of Death and Mortality Rates per 100,000 for Vanderburgh County

Vanderburgh County	All Races			
	Age Adjusted	Total	Male	Female
Malignant neoplasms (cancer)	337.47	748	412	336
Diabetes mellitus	21.57	49	24	25
Alzheimer's disease	31.4	77	19	58
Major cardiovascular diseases	255.82	579	300	279
Diseases of heart	408.76	920	504	416
Essential hypertension and hypertensive renal disease	5.12	12	7	5
Cerebrovascular diseases (stroke)	36.31	84	29	55
Atherosclerosis	0.48	1	0	1
Other diseases of circulatory system	9.53	22	12	10
Influenza and pneumonia	13.04	30	9	21
Chronic lower respiratory diseases	48.39	107	48	59
Peptic ulcer	0.88	2	1	1
Chronic liver and kidney diseases	37.88	83	47	36
All other diseases	176.12	397	191	206
Motor vehicle accidents	8.57	17	14	3
All other and unspecified accidents and adverse effects	45.49	89	46	43
Intentional self-harm (suicide)	20.15	37	25	12
Assault (homicide)	5.11	9	4	5
All other external causes	0.37	1	1	0

Source: Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team.

Deaths from Tuberculosis, Syphilis, and HIV are included in All Other Diseases to maintain confidentiality.

Infant Mortality

		Vanderburgh County	Indiana
Live Births	**Total**	11,163	420,004
White		9,645	368,580
Black		1,320	44,697
Other Non-White		150	5,908
Unknown		48	819
Infant Deaths	**Total**	99	3,396
White		85	2576
Black		14	761
Other Non-White		0	41
Unknown		0	18
Infant Death Rates	**Total**	8.9	8.1
White		8.8	7.0
Black		10.6	17.0
Other Non-White		0.0	6.9

Source: Indiana State Department of Health, 2002-2011 data - Epidemiology Resource Center, Data Analysis Team

Overall Health

The population of Vanderburgh County experiences 20% Fair/Poor health days, which is higher than the state average (16%) and double that of the national average (10%).

	2014 Vanderburgh	2014 Indiana	2014 National
Fair/Poor Physical Health Days	20%	16%	10%
Poor Physical Health Days	4.7	3.6	2.5

Source: County Health Rankings at www.countyhealthrankings.com

Obesity

Vanderburgh County, Indiana, is tackling obesity throughout the community. Child and adult obesity was identified by this community of 179,703 residents as an issue of high importance, but one that was not being addressed adequately. Now, obesity is considered one of Vanderburgh County's priority health challenges, as 28% of Vanderburgh County adults are obese. Further, nearly 30% of youth aged 10-17 in Indiana are obese or overweight, and less than 20% of county adults eat the recommended daily amount of fruits and vegetables. These factors contribute to the prevalence of obesity-related diseases. For example, Vanderburgh County adults exceed the national averages for those affected by hypertension and type 2 diabetes. Source: (https://www.cdc.gov/nccdphp/dch/programs/communitiesputtingpreventiontowork/communities/profiles/obesity-in_vanderburgh-county.htm)

	2014 Vanderburgh	2014 Indiana	2014 National
Adult Obesity	32%	31%	25%
Childhood Obesity (Ages 2-17)	18%	n/a	n/a

Source: County Health Rankings at www.countyhealthrankings.com

Tobacco Use and Smoking

According to the data provided by Indiana government the Adult Smoking Rate in Vanderburgh County is 28%, with a total number of adult smokers 37,000. Out of the total population of Vanderburgh 19% women smoke during pregnancy, which results in 512 smoking-affected births per year. The lung cancer Incidence (2003-2007) was 87.0 per 100,000 and lung cancer mortality (2003-2007) was 69.1 per 100,000.

	2017 Vanderburgh	2017 Indiana	2015 National
Current Adult Smokers	25%	23%	14%
Current Youth Smokers	*No Data Provided	11%	7%

Mental Health

According to the Behavioral Health's Poorest Performing Indicators and Rankings Vanderburgh County ranks in the worst quartile in the US and Indiana counties for Depression in the Medicare Population. The suicide rate in Vanderburgh County is 21.6 deaths per 100,000 population. More than 33,000 people kill themselves each year according to the Centers for Disease Control and Prevention, but suicide deaths only account for part of the problem. An estimated 25 attempted suicides occur per every suicide death, and those who survive suicide may have serious injuries, in addition to having depression and other behavioral conditions. The Healthy People 2020 national health target is to reduce the suicide rate to 10.2 deaths per 100,000 population.

	2014 Vanderburgh County	2014 Indiana	2014 National
Poor Mental Health Days	4.2	3.7	2.4
Child Neglect	15.7%	17.2%	n/a
Child Physical Abuse	12.0%	9.6%	n/a
Child Sexual Abuse	23.8%	18.8%	n/a

Source: (County Health rankings, Kids Count at www.iyi.org/datacenter)

Addiction

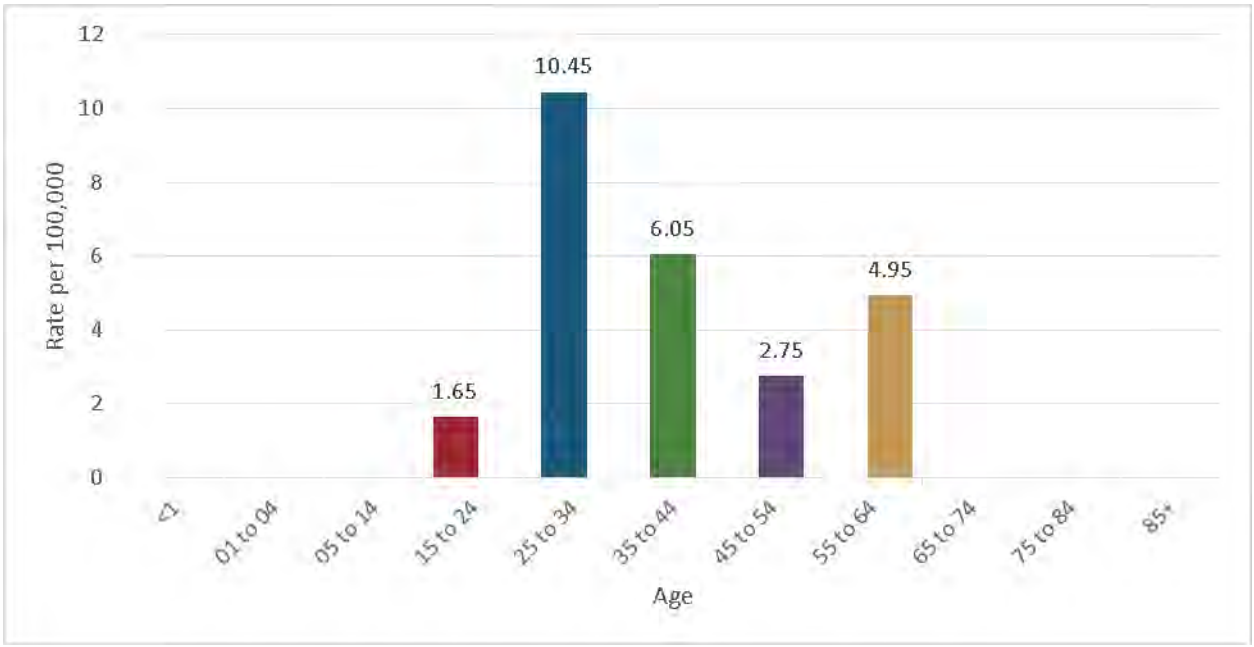
With 23.6 deaths per 100,000 population, Vanderburgh County ranks in the worst quartile in the US and Indiana counties for Death Rate due to Drug Poisoning. Drug overdose deaths are the leading cause of injury death in the United States, with over 100 drug overdose deaths occurring every day. Mental Health & Mental Disorders and Substance Abuse are a pressing health concern in Vanderburgh County. There are many concerns with respect to Behavioral Health, including a shortage of providers, stigma around seeking treatment for mental health issues, rising suicide rates, and the relationship between substance abuse and mental health. The other aspect of substance abuse is that of tobacco abuse and the attendant costs in Loss of Productive life Years, increased medical costs and longer term chronic illness and cancer.

Substance Abuse Indicators

Indicator	Vanderburgh County Value	Indiana State Value
Death Rate Due to Drug Poisoning [b]	23.6	13.6
Age-Adjusted ER Rate due to Alcohol Abuse [e]	46.3	29.4
Age- Adjusted Hospitalization rate due to Alcohol Abuse [d]	22	9.9
Adults who Smoke	25.1%	22.8%
Liquor Store Density [c]	12.8	12.1
Mothers Who Smoked During Pregnancy	20.7%	15.7%
Health Behaviors Ranking [a]	64	
Alcohol-Impaired Driving Deaths	25.3	25.6
Adults who Drink Excessively	14.9%	15.9%

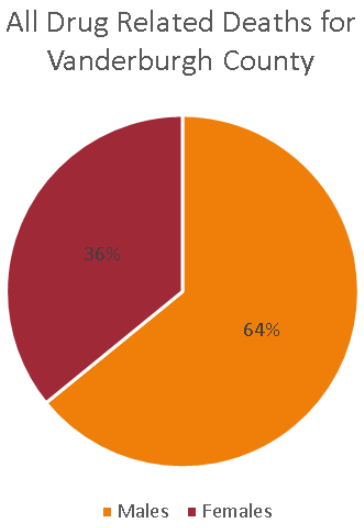
[a] Value represents Vanderburgh County's rank out of 92 Indiana Counties
[b] Value represents the number of deaths per 100,000 population
[c] Value represents the number of stores per 100,000 population
[d] Value represents the number of hospitalizations per 10,000 population ages 18+
[e] Value represents the number of ER visits per 10,000 population ages 18+

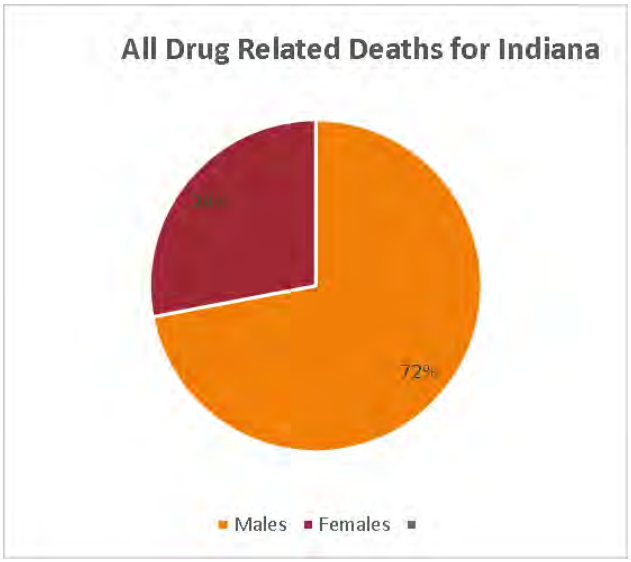
All Drug Deaths by Age, Vanderburgh County



Drug Overdoses

The 2016 fatal drug overdose demographics for Indiana show that 63% of deaths were of males and 37% were females, in Vanderburgh County the deaths were 72% for males and 28% for females. The Crude rate 6.80 per 100,000 was highest for ages 25-34 in Indiana, while in Vanderburgh County it was highest for 25-34 age category at 10.45 per 100,000.





2016 Fatal Drug Overdose Breakdown by Drug for Vanderburgh County

Drug Category	Rate per 100,0000	Count
All Drug Poisoning	25.86	47
Opioid Involved	18.71	34
Heroin Involved	11.55	21
Unspecified Substance	14.30	26

Notes: 55% of all drug poisoning deaths in Vanderburgh County contain an unspecified substance.

Homelessness

On average, there are 445 individuals in shelter or transitional housing on any given night in Evansville. During a single night in the cold month of January, 532 individuals in Vanderburgh County were identified as being homeless. (Point-in-time count, Vanderburgh County 2012) In Vanderburgh County, the number of single homeless individuals decreased from 2011 to 2012, while the number of families increased. Furthermore there are around 50-60 uncounted individuals living in places not meant for habitation in Vanderburgh.

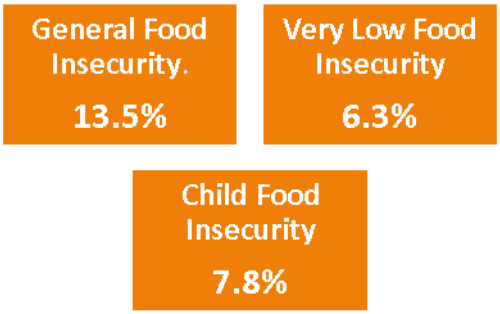
The collective barriers to obtaining a rented apartment in Vanderburgh are the inability to pay rent, extreme poverty conditions and lack of government and social support. The Fair Market Rent in 2o13 for a 1BR apartment in Evansville was $583.00. An individual receiving SSI ($674/month) can only afford a monthly rent of no more $202 based on HUD's affordability standard. ("Out of Reach Report," National Low Income Housing Coalition, 2009) A minimum wage earner ($7.25/hour) can afford rent of no more than $377 per month. ("Out of Reach Report," National Low Income Housing Coalition, 2012). In Vanderburgh County, 35% of individuals are renters. A worker must earn $13.43 an hour or work 74 hours a week at minimum wage to afford a 2BR apartment. ("Out of Reach Report," National Low Income Housing Coalition, 2012). As of 2011, 15.5% of Vanderburgh County residents live below the poverty line, compared with the state level of 14.1%. (United States Census Bureau)

In Indiana, 180,900 low-income renter households pay more than half their monthly cash income for housing costs. About 15% of these severely cost burdened renter households are headed by people who are elderly, 22% have disabilities, while 30% are other families with children. (Center on Budget and Policy Priorities, Indiana Federal Rental Assistance Facts, 2012). Approximately 6,196 homeless individuals reside in Indiana. (Spotlight on Poverty). More than 91,000 low-income households receive federal rental assistance. (Center on Budget and Policy Priorities, Indiana Federal Rental Assistance Facts, 2012)

Family shelters in Evansville remain at full occupancy and often must turn families away. This widening gap between housing costs and income is a threat to our community, with more families at risk of becoming homeless in the future. Source: (http://auroraevansville.org/files/2013-Fact-sheet-on-Homelessness.pdf)

Food Insecurity and Food Matters

The USDA defines three types of food insecurity:



Food Insecurity in Indiana

	Food Insecurity Rate	Estimated number food insecure individuals	% below 130% poverty (SNAP, WIC, free school meals, CSFP, TEFAP)	% between 130% and 185% poverty (WIC, reduced price school meals)	% above 185% poverty (charitable response)
Vanderburgh County	15.5%	28,000	58%	17%	25%
Indiana	14.4%	950,000	53.8%	17.2%	29.1%

Food insecure households are unable, at times during the year, to provide adequate food for one or more household members because the household lacked money and other resources for food. For most **food insecure** households, inadequacy was in quality and variety of foods.

Households with Food-Insecure children were unable, at times during the year, to provide adequate food for one or more child because the household lacked money and other resources for food. For most of these households, inadequacy was in quality and variety of foods; for about one in ten, amounts of food provided were also inadequate. The percentage of food insecure children in Indiana is 7.8%. Source (With With a population of **171,922** people in 2010, **Vanderburgh County** had a total expenditure of **$3,178,132.90** on Food Stamps in 2010. With a population of **171,922** people in 2010, **Vanderburgh County** had a total expenditure of **$3,178,132.90** on Food Stamps in 2010. http://food-access.healthgrove.com/l/2632/Vanderburgh-County-Indiana#Farms&s=2xrk75, Feeding America, Map The Meal Gap 2017, http://www.feedingamerica.org/research/map-the-meal-gap/2015/MMG_AllCounties_CDs_MMG_2015_1/IN_AllCounties_CDs_MMG_2015.pdf)

Resources

http://www.kff.org/statedata/?state=IN

http://www.in.gov/laboroflove/files/2012_Hospital_District_Data.pdf

Annie E. Casey Foundation, Kids Count Data Center (2016) Retrieved from http://datacenter.kidscount.org/

Healthy People 2020 (www.healthypeople.gov

http://food-access.healthgrove.com/l/2632/Vanderburgh-County-Indiana#Farms&s=2xrk75

https://www.kff.org/other/state-indicator/death-rate-by-gender/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

http://www.in.gov/isdh/18375.htm

http://www.in.gov/isdh/reports/mortality/2012/table05/tbl05_82.htm

http://www.in.gov/isdh/tpc/files/VANDERBURGH_COUNTY.pdf

www.countyhealthrankings.com

Kids Count at www.iyi.org/datacenter