Franciscan
ST. ELIZABETH HEALTH
Crawfordsville

Franciscan St. Elizabeth Health - Crawfordsville
Community Health Needs Assessment
2012-2013

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INTRODUCTION

In the first quarter of 2012, Franciscan St. Elizabeth Health-Crawfordsville (FSEH-CR) embarked on a comprehensive Community Health Needs Assessment (CHNA) process for its Crawfordsville hospital to identify and address the key health issues for our community. FSEH-CR is part of Franciscan Alliance (formerly Sisters of St. Francis Health Services), one of the largest Catholic health care systems in the Midwest with 13 hospitals and a number of nationally recognized Centers of Health Care Excellence serving patients in Indiana, Illinois and Michigan. FSEH-CR is a not-for-profit, 103 (licensed)/42 (staffed) bed campus hospital serving Montgomery County in Western Central Indiana. With 249 employees, FSEH-CR provides services primarily to residents of Montgomery County, but also serves those in neighboring communities and counties. Since the vast majority of people served reside in Montgomery County, this assessment focused on needs within that county. FSEH-CR is accredited by the Healthcare Facilities Accreditation Program (HFAP). Seventy-nine (79) percent of Crawfordsville patients are from Montgomery County.

The doctors and employees of FSEH-CR, along with other Franciscan Alliance hospitals, work to live our hospital's mission: Continuing Christ's Ministry in Our Franciscan Tradition. In following our mission we live and work by a set of common values that include the respect for life, fidelity to our mission, compassionate concern, joyful service and Christian stewardship. FSEH-CR provides the following services:

- Behavioral Health
- Cancer care
- Emergency Medicine
- Hospitalists
- Imaging
- Intensive Care Unit
- Laboratory Services
- Primary Care Physicians
- Rehabilitative Services
- Sleep Center
- Surgical Services (inpatient and outpatient)

FSEH's Regional Board's Mission/HR Committee (Mission/HR Committee) is dedicated to addressing its outreach objectives of serving the entire community, not only those who come through its doors. It tracks this information through our Community Benefit Program. The purpose of that plan is to distinguish and identify the major goals, objectives, strategies, and tactics of each of the following: Community Health Needs Assessment, Access to Programs and Services, Tracking, and Reporting. Building on a long tradition of service, the Mission Committee utilizes hospital strengths alongside those of other newly formed and well-established community partners. Specifically, a major determinant of success for any hospital-based Community Benefit program lies in its ability to being fully able to identify the health needs of its service area. To that end, the Mission Committee is responsible for addressing the requirements of CHNA. The members of the Mission Committee come from various sectors of the Greater Lafayette community, as well as representation from Crawfordsville and Montgomery County, and give their input to FSEH's Senior Management Team with the goal of better understanding and reaching the most vulnerable sectors of the community, while meeting pressing healthcare needs. The goal is to improve the community's health status by empowering citizens to make healthy life choices.

CHNA PURPOSE

The purpose of the CHNA is to provide an understanding of the current health status and needs of the FSEH-CR service area which is Montgomery County. The primary service area of Montgomery County was determined by identifying the origin of more than 79% of patients served. This information will be used to prioritize the identified needs, and to plan and act upon these health needs. The CHNA also will recognize community strengths, assets, and potential resources to address those needs.

Beyond the educational and informative aspect - the CHNA is a newly required legal document for tax-exempt health care organizations around the country. The CHNA must be conducted in order to be compliant with the new Affordable Care Act (ACA) requirements. The Internal Revenue Service (IRS) has drafted guidelines of what must be included in the assessment. These guidelines state:

- A CHNA must be conducted every 3 years
    - Take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health.
    - Be made widely available to the public.
- Adopt an implementation strategy to meet the community health needs identified through the assessment.
- Report how addressing the needs identified in the CHNA and a description of needs that are not being addressed with the reason why such needs are not being addressed.

OBJECTIVES

1. Develop a comprehensive profile of health status, quality of care, and care management indicators overall for Montgomery County.
2. Identify the priority health needs (public health and healthcare) within the FSEH-CR service area.
3. Serve as a foundation for developing subsequent detailed recommendations on implementation strategies that can be utilized by healthcare providers, communities, and policy makers in order to improve the health status of the FSEH-CR service area.
4. Supply public access to the CHNA results in order to inform the community and provide assistance to those invested in the transformation to the community's healthcare network.
5. Improve access to health services, enhance population health, advance general knowledge, and relieve or reduce the burden of government to improve health of the FSEH-CR service area.

METHODOLOGY

This assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research via a survey produced by the CHNA advisory committee and secondary research (vital statistics and other existing health-related data); these quantitative components allow for comparison to benchmark data at state and national levels.

Analytic Methods

The CHNA survey was prepared in early 2012 and first launched in the spring of 2012. It consisted of 33 questions that centered on Community Issues, Community Services, Health Issues and Health Related Services.

This CHNA is the first of its kind in Montgomery County. The primary data collection was performed and led by Pauline Shen, MPH, an epidemiologist with the Tippecanoe County Health Department with assistance from select members of the Mission/HR Committee from FSEH-CR, representing the local hospital. This effort was sponsored by FSEH-CR and Montgomery County Health Department. The survey was available online and in paper, in both English and Spanish. The assessment was launched on March 21, 2012 with a press conference that included the mayor of Crawfordsville and a county commissioner. Local news and radio slots were also done. The local papers carried several articles through the summer updating the public about the progress.

Paper copies (3,000) were mailed to residences randomly throughout the community. Paper copies were distributed by local Health Coalition members, Mission team members and others to as many locations as possible. Schools and businesses were contacted to ask if they would send the online link to their employees and they were on all the sponsors' websites. The local churches helped with getting survey results from the Hispanic population in Crawfordsville. The final number of surveys received for this assessment was 1,244. Of that, 107 surveys were submitted by area Hispanic residents. More than 65% of the surveys collected were paper surveys. Gathering data from the low social-economic population was of upmost importance because this population is rarely sampled and often has the heaviest users of the community services. Therefore food pantries, mobile food panties, homeless shelters, and other locations had readily available paper surveys in both English and Spanish. Hard copies were available at all FSEH-CR sites, in the local newspaper and several local Churches.

The Hispanic sample was small (n=107) and thus, barely large enough to have statistical significance. It is not significant compared to the general population; therefore the Hispanic percent response is shown when it is different from the general population percent response.

All the data collected was analyzed by Pauline Shen, MPH, with the support of a Wabash College student intern. On January 25, 2013, a meeting was held with local community leaders and organizations to review some of the results of the survey and see how collaboration could begin to happen. At this meeting of nineteen (19), a short survey was completed by sixteen (16) of these leaders asking them to identify the needs in which the hospital should take the lead. This survey was used to help in considering the prioritization of community needs identified.

Data Sources

In order to better understand the health of our community, it is important that we understand the environment in which we live. National, state and local governments have developed health priorities with the intention of increasing the health of Americans and Hoosiers, respectively. These priorities are set in order to observe, measure, gauge, analyze and identify the current communities' health needs.

Priorities set at the national level are identified and outlined in Healthy People 2020 by the U.S. Department of Health and Human Services. The goals are evidence-based and are created in 10-year increments for improving the health of all Americans. Healthy People 2020 priorities are based on four foundation health measures that include general health status, health-related quality of life and well-being, determinants of health, and disparities. Specifically, these priorities will provide measureable objectives and goals for the community to strive towards.

The Indiana State Department of Health has also identified statewide health priorities in a 5-year, Indiana State Health Improvement Plan (I-SHIP). This plan was partly developed on the basis of the Centers for Disease Control

and Prevention "Winnable Battles"—conditions or diseases that have large health impacts **and** known, effective strategies to address them. I-SHIP is focused on six main health priorities (below) along with key system improvements. The detailed I-SHIP document can be viewed here.
http://www.state.in.us/isdh/files/Indiana_State_Health_Plan_FINAL_6_23_11.pdf

1. Assure Food Safety
2. Reduce Healthcare Associated Infections
3. Reduce the burden of HIV, Sexually Transmitted Diseases and Viral Hepatitis
4. Reduce Infant Mortality
5. Decrease prevalence of Obesity
6. Decrease Tobacco Usage

In addition to these national and statewide priorities, a variety of existing (secondary) data sources was consulted to complement the research quality of this CHNA. Specifically, the newly adapted Healthy Communities Institute (HCI) helped to aggregate and report data at county-level. Additional information was obtained from a variety of sources (specific citations are included in the CHNA report), such as:

- Indiana State Department of Health
- Healthy Communities Institute (HCI)
- Healthy People 2020
- County Health Rankings.org
- US Census Bureau
- State & County QuickFacts

Healthy Communities Institute (HCI)

Healthy Communities Institute (HCI) is a third-party resource that Franciscan Alliance purchased in order to better understand and address the health of our communities. This resource aggregates national, state and county data into one convenient area that allows its' users and their community to understand the environment in which they live. HCI has been recently recognized by the Health Data Initiative Forum III in Washington, D.C. and awarded the Best Community Health App. This resource allows its users to measure community health, share best practices, identify new funding sources while improving community health. One of the visually appealing aspects of HCI is their use of the colored gauge. The colored gauge, as defined by HCI, "gives a visual representation of how our community is doing in comparison to other communities. The three-colored dial represents the distribution of values from the reporting regions (e.g. counties in the state) ordered from those doing the best to those doing the worst (sometimes lower values are better and in other cases higher values are better). From that distribution, the green represents the top 50th percentile, the yellow represents the 25th to 50th percentile, and the red represents the "worst" quartile."

Information Gaps/Vulnerable Populations

The CHNA analysis and report yielded a wealth of information about the health status, behaviors and needs for our population. A distinct advantage of the primary quantitative (survey) research are findings by geographic,

demographic and health characteristics to identify the primary and chronic disease needs and other health issues of vulnerable populations, such as uninsured persons, low-income persons, and racial/ethnic minority groups.

While this CHNA is quite comprehensive and the sample size closely approximated the adult population of Montgomery County, FSEH-CR recognizes that it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest.

Given the Hispanic sample was small, it must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs. However, paper-and-pencil surveys were utilized in order to target specific populations.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly a great number of medical conditions that are not specifically addressed. To attempt to close the information gap, FSEH-CR conducted a brief survey with fifty-three (53) Opinion Leaders in the community.

The CHNA survey was distributed only in Montgomery County. In tandem with the survey completion, FSEH-CR determined to add two more pieces to the assessment. In the summer of 2012, some fifty-three (53) Opinion Leaders representing various governmental and outreach services within Montgomery County received an electronic survey, asking for their input into a more focused look at the healthcare concerns of Montgomery County. The response rate was 47% (25 people). Upon review of both surveys, the input from various political, business, non-profit, community and school leaders who attended the sharing of the results and review of the opinion leader survey, noted those needs which the hospital should consider taking the lead. These survey results were included in considering possible programs to be addressed in the Implementation Plan. Review and input occurred from the FSEH-CR Internal Team on March 22, 2013 and by the Mission/HR committee on September 12, 2013 and the FSEH Regional Board on September 26, 2013.

Collaborating Organizations

The CHNA template was reviewed and leadership received input from a CHNA Committee, which was comprised of representatives from hospital departments/committees chosen for their relevant experience and interests and select outside organizations including the Montgomery Health Department and Christian Nursing Services, which operates the Dr. Mary Ludwig Free Clinic. In addition, FSEH-CR sought input from other organizations and agencies in conducting this needs assessment. Feedback was sought from various community organizations which included the following: the chair of the ministerial association, the mayor of Crawfordsville, and the executive directors of the Youth Service Bureau, (an organization which helps youth through delinquency prevention, community education, youth advocacy, direct services and referrals), the Montgomery County Community Foundation, the Chamber of Commerce and MUFFY, the Montgomery County United Fund for You.

Public Dissemination

This CHNA is available to the public using the following URL:
http://www.franciscanalliance.org/hospitals/crawfordsville/Documents/mont-cty-chna.pdf

The Healthy Communities Institute (HCI) is a web-based product that measures community health, shares best practices, identifies new funding sources and drives

improved community health. This site can be found at the following link for each of the hospitals and their specific service areas within the Franciscan Alliance system: http://www.franciscanalliance.org/community/community-needs-assessment/Pages/default.aspx

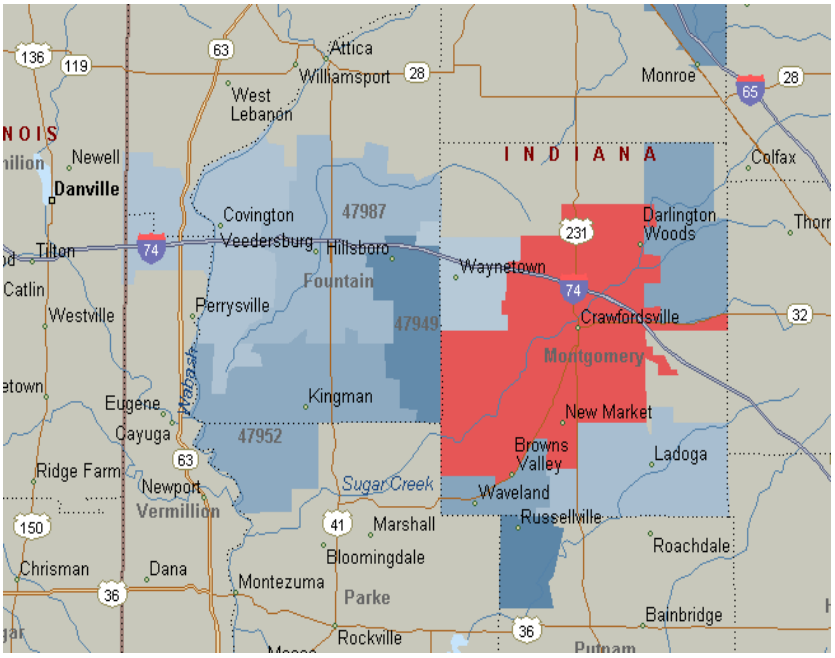
This site:

- Informs readers that the CHNA report is available and provides instructions for downloading it;
- Offers the CHNA report document in a format that, when accessed, downloaded, viewed, and printed in hard copy, exactly reproduces the image of the report;
- Grants access to download, view, and print the document without special computer hardware or software required for that format (other than software that is readily available to members of the public without payment of any fee) and without payment of a fee to the hospital organization or facility or to another entity maintaining the website.

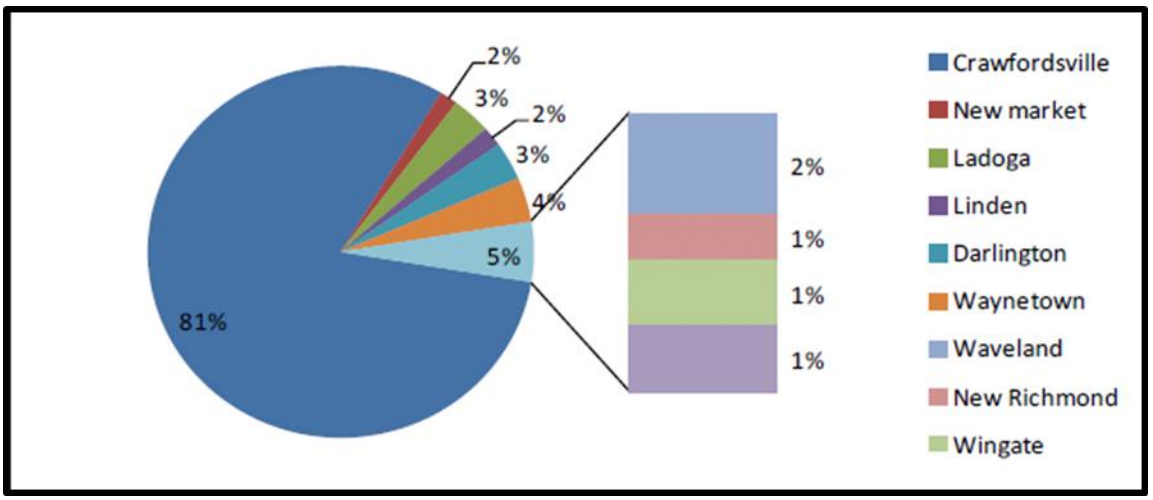
FSEH-CR will provide any individual requesting a copy of the written report with the direct website address, or URL, where the document can be accessed. FSEH-CR will also maintain at its facilities a hardcopy of the CHNA report that may be viewed by any who request it.

Definition of the Community served

The primary FSEH-CR service area, as defined for the purposes of the CHNA, was Montgomery County as it is the source of 79% of all the patients served at FSEH-CR. The primary service and secondary service area are shown on the following page. The county is shown in the context of this geographic description is illustrated in the following map. The health resources of FSEH-CR are also used by a much smaller number of people from a number of other counties included in the secondary service area: Fountain, Putnam, Parke, Warren and Vermillion.



Sample by Zip code



Secondary Data Assessment

Overview: Demographics of the Community Served

People Quick Facts	Montgomery County	Indiana
Population, 2012 estimate	38,254	6,537,334
Population, 2010 (April 1) estimates base	38,124	6,483,800
Population, percent change, April 1, 2010 to July 1, 2012	0.3%	0.8%
Population, 2010	38,124	6,483,802
Persons under 5 years, percent, 2012	6.4%	6.5%
Persons under 18 years, percent, 2012	23.5%	24.3%
Persons 65 years and over, percent, 2012	16.1%	13.6%
Female persons, percent, 2012	49.6%	50.8%
White alone, percent, 2012 (a)	96.7%	86.6%
Black or African American alone, percent, 2012 (a)	1.1%	9.4%
American Indian and Alaska Native alone, percent, 2012 (a)	0.4%	0.4%
Asian alone, percent, 2012 (a)	0.6%	1.8%
Native Hawaiian and Other Pacific Islander alone, percent, 2012 (a)	Z	0.1%
Two or More Races, percent, 2012	1.2%	1.8%
Hispanic or Latino, percent, 2012 (b)	4.7%	6.3%
White alone, not Hispanic or Latino, percent, 2012	92.5%	81.0%
Living in same house 1 year & over, percent, 2007-2011	85.3%	84.4%
Foreign born persons, percent, 2007-2011	3.1%	4.5%
Language other than English spoken at home, percent age 5+, 2007-2011	4.9%	7.9%
High school graduate or higher, percent of persons age 25+, 2007-2011	87.4%	86.6%
Bachelor's degree or higher, percent of persons age 25+, 2007-2011	18.0%	22.7%
Veterans, 2007-2011	3,240	478,030
Mean travel time to work (minutes), workers age 16+, 2007-2011	20.7	23.1
Housing units, 2011	16,510	2,800,614
Homeownership rate, 2007-2011	72.6%	71.1%
Housing units in multi-unit structures, percent, 2007-2011	15.4%	18.5%
Median value of owner-occupied housing units, 2007-2011	$109,500	$123,300
Households, 2007-2011	14,446	2,472,870

Persons per household, 2007-2011	2.56	2.53
Per capita money income in the past 12 months (2011 dollars), 2007-2011	$23,322	$24,497
Median household income, 2007-2011	$47,929	$48,393
Persons below poverty level, percent, 2007-2011	13.1%	14.1%
Geography QuickFacts	Montgomery County	Indiana

(a) Includes persons reporting only one race

(b) Hispanics may be of any race, so also are included in applicable race categories

(c) Value greater than zero but less than half unit of measure shown

Additional Demographics (source HCI website)

1. Estimated 38,805 individuals live in Montgomery County, IN.
2. Race/Ethnicity Makeup:
    - 94.78% White (5.28% of which are Hispanic/Latino)
    - 0.88% Black/ African American
    - 0.26% Am Indian/Alaska Native
    - 0.59% Asian
    - 0.01% Native HI/PI
    - 2.11% Some other Race
    - 1.36% 2+Races
3. Income Distribution
    - $38,083 is the median income for Montgomery County residents in 2013.
    - 8.5% of households live below the federal poverty level (FPL) in 2013. (See Figure 2 below)

HEALTH OUTCOMES

DEMOGRAPHICS

County Health Rankings & Roadmaps
A Healthier Nation, County by County

8/18/13	Montgomery County	Error Margin	Indiana	National Benchmark*	Trend	Rank (of 92)
Health Outcomes						45
Mortality						39
Premature death	7,156	6,203-8,108	7,520	5,317		
Morbidity						58
Poor or fair health	16%	12-21%	16%	10%		
Poor physical health days	3.9	2.9-4.9	3.6	2.6		
Poor mental health days	4.0	2.4-5.7	3.6	2.3		
Low birthweight	8.2%	7.3-9.1%	8.3%	6.0%		
Health Factors						48
Health Behaviors						58
Adult smoking	25%	19-32%	24%	13%		
Adult obesity	31%	26-37%	31%	25%		
Physical inactivity	31%	26-37%	27%	21%		

8/18/13	Montgomery County	Error Margin	Indiana	National Benchmark*	Trend	Rank (of 92)
Excessive drinking	14%	10-20%	16%	7%		
Motor vehicle crash death rate	24	18-30	13	10		
Sexually transmitted infections	150		351	92		
Teen birth rate	50	46-55	41	21		
Clinical Care						43
Uninsured	17%	15-19%	17%	11%		
Primary care physicians**	2,005:1		1,557:1	1,067:1		
Dentists**	2,310:1		2,165:1	1,516:1		
Preventable hospital stays	88	79-97	76	47		
Diabetic screening	83%	76-91%	83%	90%		
Mammography screening	65%	57-73%	64%	73%		
Social & Economic Factors						49
High school graduation**	93%		86%			
Some college	48%	43-52%	59%	70%		
Unemployment	8.8%		9.0%	5.0%		
Children in poverty	24%	20-29%	23%	14%		
Inadequate social support		20%	14-28%	20%	14%	
Children in single-parent households		28%	22-33%	32%	20%	
Violent crime rate		183		327	66	
Physical Environment						39
Daily fine particulate matter		12.9	12.7-13.1	13.0	8.8	
Drinking water safety		0%		2%	0%	
Access to recreational facilities		5		9	16	
Limited access to healthy foods**		4%		6%	1%	
Fast food restaurants		45%		50%	27%	

2013
* 90th percentile, i.e., only 10% are better.

** Data should not be compared with prior years due to changes in definition.
Note: Blank values reflect unreliable or missing data

HEALTHY COMMUNITIES INSTITUTE INDICATORS

The following chart describes those conditions that were found to be the farthest from the Health Population 2020 Goals. If the arrow is at the line between green and yellow it means that in Montgomery County the condition is at the 2020 Goal for the time period applicable. By going to the URL: http://www.franciscanalliance.org/community/community-needs-assessment/Pages/default.aspx supporting detail can be viewed.

Indicators for County: Montgomery, IN[i]

View the Legend

Health		
Babies with Low Birth Weight MAP	Comparison: IN Counties	
Preterm Births MAP	Comparison: IN Counties	
Age-Adjusted Hospitalization Rate due to Uncontrolled Diabetes NEW MAP	Comparison: IN Counties	
Mothers who Smoked During Pregnancy MAP	Comparison: IN Counties	
Age-Adjusted Death Rate due to Suicide MAP	Comparison: U.S. Counties	
Age-Adjusted ER Rate due to Adult Asthma NEW MAP	Comparison: IN Counties	
Age-Adjusted Death Rate due to Lung Cancer NEW MAP	Comparison: U.S. Counties	
Lung and Bronchus Cancer Incidence Rate NEW MAP	Comparison: U.S. Counties	
Age-Adjusted ER Rate due to Urinary Tract Infections NEW MAP	Comparison: IN Counties	
Age-Adjusted ER Rate due to Asthma NEW MAP	Comparison: IN Counties	
Age-Adjusted ER Rate due to Pediatric Asthma NEW MAP	Comparison: IN Counties	
Adults who Smoke MAP	Comparison: U.S. Counties	
Preventable Hospital Stays MAP	Comparison: U.S. Counties	
Age-Adjusted ER Rate due to Diabetes NEW MAP	Comparison: IN Counties	
Age-Adjusted ER Rate due to Long-Term Complications of Diabetes NEW MAP	Comparison: IN Counties	

Age-Adjusted ER Rate due to Short-Term Complications of Diabetes NEW MAP	Comparison: IN Counties	
Adults who are Sedentary MAP	Comparison: IN Counties	
Low-Income Preschool Obesity MAP	Comparison: U.S. Counties	
Age-Adjusted ER Rate due to Hepatitis NEW MAP	Comparison: IN Counties	
Mothers who Received Early Prenatal Care MAP	Comparison: IN Counties	
Poor Mental Health Days MAP	Comparison: U.S. Counties	
Age-Adjusted ER Rate due to COPD NEW MAP	Comparison: IN Counties	
Age-Adjusted ER Rate due to Alcohol Abuse NEW MAP	Comparison: IN Counties	
Primary Care Provider Rate MAP	Comparison: U.S. Counties	
Colorectal Cancer Incidence Rate NEW MAP	Comparison: U.S. Counties	
Health Behaviors Ranking MAP	Comparison: IN Counties	
Morbidity Ranking MAP	Comparison: IN Counties	
Social and Economic Factors Ranking MAP	Comparison: IN Counties	
Adults with Diabetes MAP	Comparison: U.S. Counties	
Age-Adjusted Death Rate due to Diabetes MAP	Comparison: U.S. Counties	
Age-Adjusted Hospitalization Rate due to Diabetes NEW MAP	Comparison: IN Counties	
Age-Adjusted Hospitalization Rate due to Long-Term Complications of Diabetes NEW MAP	Comparison: IN Counties	
Diabetic Screening: Medicare Population MAP	Comparison: U.S. Counties	
Adults who are Obese MAP	Comparison: IN Counties	
Age-Adjusted Death Rate due to Coronary Heart Disease MAP	Comparison: U.S. Counties	
Age-Adjusted Hospitalization Rate due to Heart Failure NEW MAP	Comparison: IN Counties	
Age-Adjusted ER Rate due to Bacterial Pneumonia NEW MAP	Comparison: IN Counties	
Age-Adjusted Death Rate due to Alzheimer's Disease MAP	Comparison: U.S. Counties	
Age-Adjusted ER Rate due to Dehydration NEW MAP	Comparison: IN Counties	

Age-Adjusted Hospitalization Rate due to Urinary Tract Infections NEW MAP	Comparison: IN Counties	
Age-Adjusted Hospitalization Rate due to Adult Asthma NEW MAP	Comparison: IN Counties	
Age-Adjusted Hospitalization Rate due to Asthma NEW MAP	Comparison: IN Counties	
Age-Adjusted Hospitalization Rate due to COPD NEW MAP	Comparison: IN Counties	
Poor Physical Health Days MAP	Comparison: U.S. Counties	
Self-Reported General Health Assessment: Poor or Fair MAP	Comparison: U.S. Counties	
Salmonella Incidence Rate NEW	Comparison: IN State Value	
Infant Mortality Rate NEW	Comparison: IN State Value	

Existing Healthcare Facilities & Resources

FSEH-CR recognizes that there are many existing healthcare facilities and resources within the Montgomery County community that are available to respond to the health needs of residents. These organizations include, but are not limited to, the following:

Hospitals

Franciscan St. Elizabeth Health – Crawfordsville

Nursing Homes/Adult Care

Bickford of Crawfordsville - Bickford Senior Living
The Lane House
Ben Hur Nursing Home
Hickory Creek at Crawfordsville
Whitlock House
Williamsburg Health & Rehab (not in Montgomery County)
Wellbrooke of Crawfordsville

Mental Health Services

Child and Family Counseling, LLC
Cummins Mental Health Center – Outpatient referral source and provider and Emergency Detention Order provider
Families United, Inc.
Franciscan St. Elizabeth Health – Generations Unit – onsite FSEH treatment unit
Wabash Valley Outpatient Services Outpatient referral source and provider and Emergency Detention Order provider

Emergency Medical Services

STAR Ambulance: City of Crawfordsville – service provider for many of the patient transfers.

Home Healthcare

Indiana Home Care Plus
SouthernCare
St. Elizabeth Home Health Care - FSEH Home Care agency.

Hospice Care

St. Elizabeth Hospice
Hospice care available in select nursing homes

Other Community – based Resources

Mary Ludwig Free Clinic – Collaborative partner in the survey development and one of our leaders sits on the Mary Ludwig Free Clinic Board.

FPN Neighborhood Family Medicine Clinic – a clinic in the Franciscan Physician Network (FPN), a physician's network associated with Franciscan Alliance.

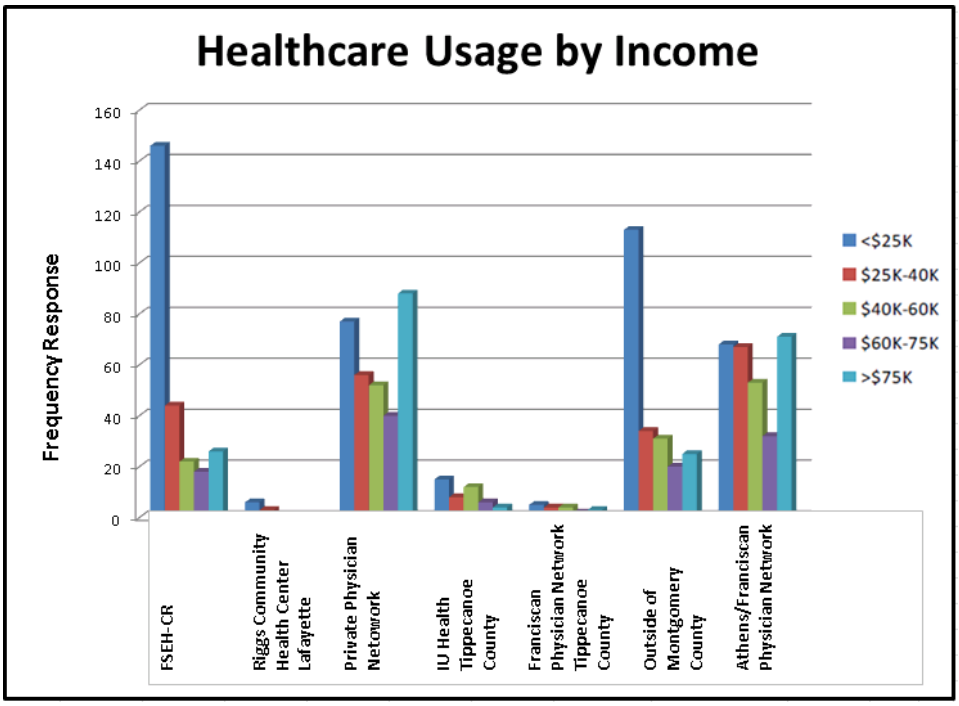
Public Health Departments

Montgomery County Health Department – collaborative partner in developing this survey.

There are three major players in the healthcare market in Montgomery County, the Private Physician Network, the Franciscan Physician Network (formerly Athens Medical Group), and FSEH-CR. Three of every four residents use one of these three resources/facilities. However, close to one in five leaves the county for some of their healthcare service. (Pages 26-7, Montgomery County Community Health Needs Assessment {CHNA} at http://www.franciscanalliance.org/hospitals/crawfordsville/Documents/mont-cty-chna.pdf)

For those that can afford the services, >$75K, the Private Physician Network, or Franciscan Physician Network is the preferred choice. However the households <$25K are the heaviest users of FSEH-CR. The second choice for this lower income segment is to leave Montgomery County, which is probably a hardship. It is unknown where *{or if}* they receive their healthcare. (Page 17, CHNA) The figures below reference information considered for the specific initiatives identified.

Figure 1: Healthcare Usage by Income



Review of Other Community Health Need Assessments

While this assessment is the first of its kind in Montgomery County, collaboration before and after will continue with key agencies and groups.

PRIMARY DATA ASSESSMENT

Primary data collection began in March 2012 and proceeded until August 2012. During this 5 month span, 1,244 community participants within the FSEH-CR service area answered our thirty-three (33) -question survey via online and paper format. In addition, fifty-three (53) general and hospital opinion leaders within the FSEH-CR community were invited to answer a 20- question online survey that focused more on their community assessment rather than personal assessment. Twenty-five (25) people responded. This was followed by a community sharing with nineteen (19) key leaders with political, business, non-profit, community and school responsibilities to assess their reaction to the results and then another survey was completed by sixteen (16) of these leaders to help us prioritize our focus. However, this primary data analysis coupled and compared with secondary data helped to gain a better awareness of the environment around us.

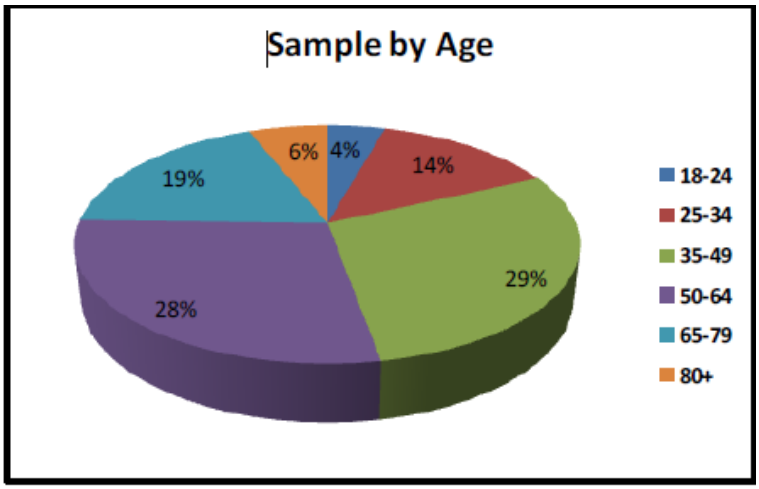
The CHNA survey highlighted various personal needs such as dental care, eye care, preventive screenings and help with paying for medications. Similarly, community needs identified include: child abuse, substance abuse, teen pregnancy and youth programs. Traditionally the top four chronic health indicators in Montgomery are the same in Indiana and the nation. They may be in a different order. Among the Hispanic population diabetes is close to the third chronic health indicator along with depression. Underlying all in this particular survey was a need that was presumed and not measured in this CHNA: access and affordability of healthcare. (See graph of Opinion Leader Survey, Figure five {5} of this report) The complete detail of the County-wide survey can be viewed at: http://www.franciscanalliance.org/hospitals/crawfordsville/Documents/mont-cty-chna.pdf.

Results from Community Survey

The primary data collection was supported by the Crawfordsville Team of the FSEH-CR, representing the local hospital. The effort was overseen by Pauline Shen, MPH, an epidemiologist at the Tippecanoe County Health Department. This effort was sponsored by: FSEH-CR and the Montgomery County Health Department. The link to the full Needs Assessment Survey results is:
http://www.franciscanalliance.org/hospitals/crawfordsville/Documents/mont-cty-chna.pdf

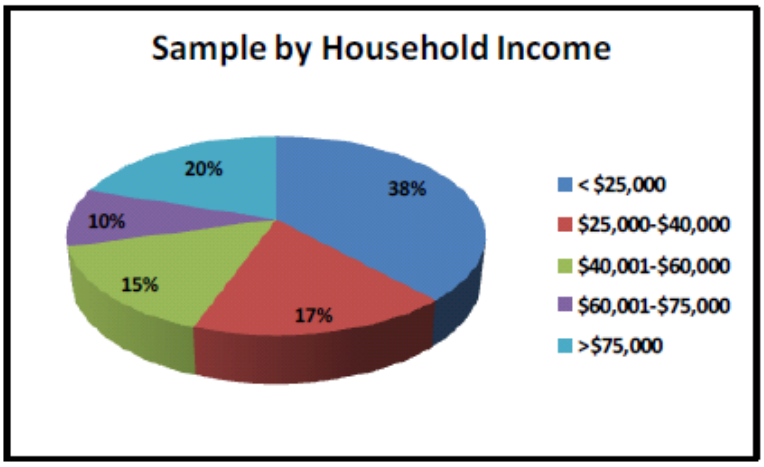
Among the respondents 75% were female and 25% men. This is not even, but very typical of survey data. With a large enough sample size, information can still be analyzed for males, but with less significance. (CHNA, Page 7)

Figure 1: Sample by Age



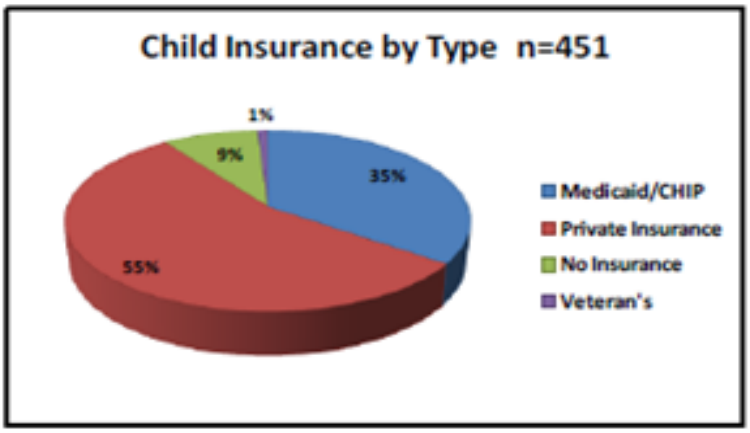
The low socio economic comprised the largest segment of the sample. They are slightly oversampled to assure their representation. The lowest and highest income segments make up over half of the sample.

Figure 2: Sample by household Income



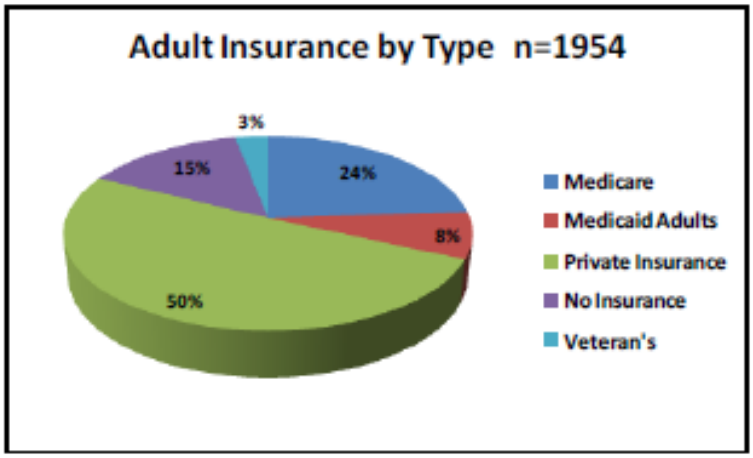
In the chart below, “N” represents each household, which may include more than one child. Thus, according to this survey more than a third of children in the county are on Medicaid and 9% have no insurance or at least 850 children have no insurance.[ii]

Figure 3: Child Insurance Status



According to this survey 15% of adults do not have healthcare insurance. In real terms this means approximately 4400 adults in Montgomery County do not have insurance.[iii] In the chart below, “N” represents the number of adults as the respondents could also indicate the status of other adults in the household.

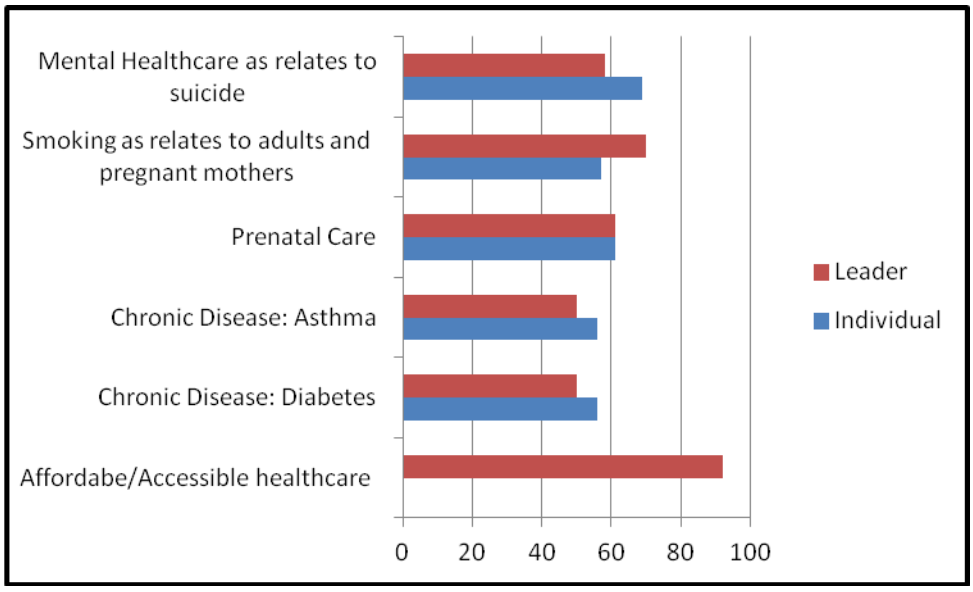
Figure 4: Adult Insurance Status



Individual and Opinion Leader Comparison

The Opinion Leaders Survey and the Individual Survey both asked questions about ranking needed health-related services within Montgomery County. However, the statements were phrased a little differently so a direct comparison is not possible. Also, please note the individual survey did not query on perceptions regarding affordable/accessible healthcare. Below shows some the overlapping concepts:

Figure 5: Individual and Opinion Leader Comparison by Percent of Respondents



AREAS OF OPPORTUNITY

IDENTIFICATION OF PERSONS PROVIDING INPUT

Individuals with various backgrounds were sought to give input into the creation and dissemination of the three survey levels. The Mission/HR Committee is comprised of members of the FSEH Regional Board, physicians, community leaders representing education, social services, and directors from Lafayette and Crawfordsville. The online opinion leaders' survey was sent to the leadership of various agencies in the County. On January 25, 2013 a meeting was held with local organizations to review all of the results of the survey and see how collaboration could begin to happen. At this meeting a short survey was completed by sixteen (16) of the nineteen (19) leaders who attended to identify those needs which the hospital should take the lead. This survey was used to help in considering the prioritization of community needs identified.

PRIORITIZATION PROCESS

After reviewing the CHNA findings, both the Mission/HR Committee, and Senior Leadership gave input in determining the health needs to be prioritized for action in FY2014-FY2016. During the a detailed presentation of the CHNA findings, steering committee members and Senior Leaders talked through a process of understanding key local data findings (Areas of Opportunity) and identified health issues against the following uniform criteria:

- **Magnitude**. The number of persons affected, also taking into account variance from benchmark data and Healthy People targets.
- **Impact/Seriousness**. The degree to which the issue affects or exacerbates other quality of life and health-related issues.
- **Feasibility**. The ability to reasonably impact the issue, given available resources.
- **Consequences of Inaction**. The risk of not addressing the problem at the earliest opportunity

This survey results reflect respondents' opinions whereas the other supporting data reflect objective findings. When this distinction is applied, some of the concerns of respondents are not supported by objective data.

IDENTIFIED PRIORITIES OF COMMUNITY HEALTH IMPROVEMENT

The following "health priorities" represent recommended areas of possible intervention, based on the data gathered through this CHNA and the guidelines set forth in *Healthy People 2020*. From these data, opportunities for health improvement exist in the county with regard to the following areas as confirmed by objective data noted:

	Areas of Opportunity relative to Montgomery County data	
1	Affordable/Accessible Healthcare	Number of uninsured is above national benchmark; access to primary care physicians (ratio of providers to population) is higher than state and nation. (County Health Rankings accessed 9-22)
2	Chronic Disease: • Diabetes	Increased ER rate due to Diabetes (HCI)
	• Asthma	Increased ER rate due to asthma (HCI)
3	Prenatal Health	Low percentage of mothers receiving Early Prenatal Care (HCI)
4	Smoking as relates to adults and pregnant mothers	High rate of Adults who smoke as compared to the nation; high rate of pregnant mothers who smoke as compared to the state average and high rate of lung cancer (HCI)
5	Mental Healthcare as relates to suicide	Above national average for poor mental health days; high death rate due to suicide as compared the nation (HCI)

COLLABORATION EFFORTS

FSEH-CR will continue to network with key agencies in the community as this plan unfolds. With the revision of the FPN Neighborhood Family Medicine and the 2013 opening of the Mary Ludwig Free Clinic, a future goal for a more seamless safety net for various community members in need will unfold over time.

FY2013-FY2016 Implementation Strategy

FSEH-CR has served the Crawfordsville/Montgomery County community for more than 100 years under various ownership models. It was purchased in 1999 and became part of what now is Franciscan Alliance, a system of 13 hospitals across Indiana and South Suburban Chicago in Illinois.

This document outlines FSEH-CR's Implementation Strategy to address our community's health needs by 1) sustaining efforts operating within a targeted health priority area; 2) developing new programs and initiatives to address identified health needs; and 3) promoting an understanding of these health needs among other community organizations within the public itself.

Hospital-Level Community Benefit Planning

Priority Health Issues to be Addressed

In consideration of the top health priorities identified through the CHNA process, and taking into account hospital resources and overall alignment with the hospital's mission, goals, and strategic priorities, it was determined that FSEH-CR would focus on developing and/or supporting strategies and initiatives to improve:

- Affordable/accessible healthcare- "According to this CHNA 15% of adults do not have healthcare insurance. In real terms this means approximately 4400 adults in Montgomery County do not have insurance." Further, "more than a third of children in the county are on Medicaid and 9% have no insurance or at least 850 children have no insurance.[iv]
  (CHNA, Page 9)
- Chronic disease management of Diabetes - In Indiana, an estimated $4 billion dollars in health care costs are associated with diabetes. 26.9% of the population 65 years and older have diabetes. 17.2% of Hoosier adults ages 55-64 and 21% of adults 65 years of age and older have been diagnosed with diabetes.[v] The FSEH-CR's service area has an *Age-Adjusted ER Rate due to Diabetes* of 28.3compared to Indiana at 22.3.[vi]

Integration with Operational Planning

The CHNA plan and the health issues being addressed are incorporated into overall hospital plans.

Priority Health issues that Will Not be Addressed & Why

In acknowledging the wide range of priority health issues that emerged from the CHNA process, FSEH-CR determined that it could effectively focus on those which it deemed most pressing, most under-addressed, and most within its ability to influence. Upon review of the various identified health needs (above data health priorities), the following were determined not to be our major focus at this time:

1. Prenatal care –our Franciscan St. Elizabeth Health – Lafayette East campus in Lafayette targets this need, given the location of the Obstetrics department (FSEH-CR no longer provides obstetric services.) Various OB/Gyn medical providers have weekly clinic days in Crawfordsville; in addition a family nurse practitioner has been added recently at the FPN Neighborhood Family Medicine Clinic to do adult and pediatric care.
2. Asthma – our specialists are from another hospital system and thus our ability to influence is limited.
3. Smoking – plans on addressing were tabled as our major collaborator underwent a leadership change.

4. Lung cancer – plans on addressing were tabled as our major collaborator underwent a leadership change.
5. Pediatric asthma – we have added another practitioner who sees pediatric patients; we do not have a pediatric unit.
6. In addition, there are other community needs that may impact some aspects of health such as transportation, public education, environmental issues, air quality, crime, etc. Challenges such as these that fall outside the hospital's area of knowledge, which are the appropriate responsibility of other public bodies and require levels of funding not possible at the hospital, were not selected as possible programs for implementation.

By working on affordable/accessible care we hope to favorably impact many of these other health issues by getting more people into an ongoing regimen of care and education

Implementation Strategies & Action Plans

The following outlines FSEH-CR's plan to address those priority health issues chosen for action in the FY2013-FY-2016 period.

	Diabetes Self-Management
Reason for Program	In Indiana, an estimated $4 billion dollars in health care costs are associated with diabetes. 26.9% of the population 65 years and older have diabetes. 17.2% of Hoosier adults ages 55-64 and 21% of adults 65 years of age and older have been diagnosed with diabetes.[vii] The FSEH-CR's service area has an *Age-Adjusted ER Rate due to Diabetes* of 28.3 compared to Indiana at 22.3.[viii] Structure a *Shared Medical (Homogenous Model) Appointment*. This is a visit for an established set of patients grouped by diagnosis to facilitate diabetic self-management. Early anecdotal reports identified an increase in physician productivity with DIGMAs[ix] [x]
Potential Community Partners / Planned Collaboration	Franciscan Physicians Network (FPN), a physician's network associated with Franciscan Alliance, Internal Medicine and Surgical Specialist • WIR Diabetes Center • Consider other FPN locations after a one year evaluation is completed i.e. FPN Neighborhood Family Medicine
Goal	• To teach and achieve actual application of self-management to prevent further complications. • Target patients from the emergency department for either this program or channel into next educational class held at the FPN Neighborhood Family Medicine
Timeframe	2014-2016

Scope	Establish and conduct a pilot program in one FPN office. Currently (9) diabetic patients are enrolled in shared medical appointments.
Strategies & Objectives	**Objective**: Reduce complications caused by the mismanagement of diabetes **Strategies** 1. Notify targeted patients of the opportunity to enroll in the program 2. Register participants, conduct routine screening evaluation and complete assessment screening including glucose, lipid profile, BMI, Biometrics, Blood pressure, foot screening 3. Provide education for prevention of complications which will include the ADA Screening Standards of Medical Care for Diabetes. i.e. use of the standard self-care behaviors (see number 4 below) 4. Evaluate participants progress with follow up of the same standards: document the results and expect these to move towards these standards • HgA1C<7% • Blood pressure < 130/80 • LDL < 100 mg/dl • HDL Male >40 mg/dl • HDL Female >50 mg/dl • Triglycerides <150 mg/dl
Financial Commitment	Models require extra personnel, but enough patients are seen to cover this extra cost.
Anticipated Impact	• Better access to care i.e. backlog will be relieved to some extent • Enhanced diabetes management • More education • Improved productivity / or neutral with current cost
Plan to Evaluate Impact	Use ADA Screening Standards of Medical Care for Diabetes. Document the results and expect individual results to move toward these standards: • HgA1C<7% • Blood pressure < 130/80 • LDL < 100 mg/dl • HDL Male >40 mg/dl • HDL Female >50 mg/dl • Triglycerides <150 mg/dl

	Expect daily self-monitoring blood sugar to move closer to targets: • Fasting blood sugar <120 • Postprandial (2 hrs. after meal) <180
Results	*Pending*

Affordable/Accessible Healthcare	
Reason for Program	A survey of 53 local opinion leaders, representing various governmental and outreach services within Montgomery County was surveyed in July 2012. The electronic survey was sent out in July of 2012 with a response rate of 47% (25 responses). Affordable (92%) and accessible (70%) healthcare was at the top of that listing. According to this survey (CHNA) 15% of adults do not have healthcare insurance. In real terms this means approximately 4,400 adults in Montgomery County do not have insurance. The Mary Ludwig Free Clinic, a newly opened free clinic (a separate non-profit) will help address those who meet the guidelines of 200% of poverty level; this clinic also requires application for admittance and will not accept Medicaid. The FPN Neighborhood Family Medicine had been under capacity in the Medicaid population it served. In the very recent past, the FPN clinic has added another provider and opened its population served to any patient with various insurance products or lack thereof. Conceivably, patients may still have immediate needs and be served at the FPN Neighborhood Family Medicine; should they meet guidelines for the free clinic referrals will be made. Similarly, patients without access to a provider who may be post hospitalization or appear at various other non-profits for assistance can be referred to this FPN clinic.
Community Partners / Planned Collaboration	• FPN Neighborhood Family Medicine • Mary Ludwig Free clinic (in time evaluate ways to provide a more seamless safety net for various community members in need.)
Goal	• Progress towards capacity in serving targeted population. (3,450 office visits annually in 2014) • Assess if more capacity is needed (August 2014)
Timeframe	FY October 2013 – 2016
Scope	Due to various issues over the past few years, the FPN Neighborhood

	Family Medicine, which had served the Medicaid population, has been underutilized. Scope of this initiative in 2013-2014 is to increase capacity thru assessment and the addition of a practitioner and consideration of expanded hours and population served.
Strategies & Objectives	1. Assess need for marketing and target various Medicaid providers re services 2. After hours clinic 3. In second year, assess synergies with free clinic (This clinic opened August, 2013) 4. Evaluate the back log in requests for appointment and assess if more capacity is needed. 5. Reassess capacity at end of the first quarter 2014 (i.e. compare last quarter of 2013 to end of first quarter statistics)
Financial Commitment	2014 fiscal Budget of $173,000
Anticipated Impact	Expand capacity towards peak volume when at capacity Increase the number of people getting regular care
Plan to Evaluate Impact	Measure baseline usage at height of volume and follow up stats.
Results	*Pending*

ENDNOTES

[i] Retrieved on 9-22-13

[ii] These statistics are based on multiplying these percents by the census as reported in this CHNA,

[iii] Respondents could also respond as the insurance coverage of their spouse.

[iv] These statistics are based on multiplying these percents by the census as reported in this CHNA,

[v] http://www.in.gov/isdh/24966.htm

[vi] HCI Website

[vii] http://www.in.gov/isdh/24966.htm

[viii] HCI Website

[ix] E. B. Noffsinger, "Benefits of Drop-In Group Medical Appointments (DIGMAs) to Physicians and Patients," *Group Practice Journal* 48 (March 1999): 214, 26–28.

[x] E. B. Noffsinger, "Will Drop-In Group Medical Appointments (DIGMAs) Work In Practice?" *The Permanente Journal* 3 (1999): 58–67.

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