Community Health Needs Assessment
FY 2016 - 2018
I. Introduction

The Community Health Needs Assessment (CHNA) is the result of a collaboration between Mercy Medical Center-Clinton (MMC-C) and various community stakeholder agencies to review and measure health status in our community. The goal of the collaboration was to produce a current profile of health status, wellness, health delivery and public-sourced options about health in Clinton, Jackson, Whiteside, and Carroll counties. The process used a compilation of the most recent local, state and national data, as well as the opinions of representatives from area human service health agencies and members of the community. The report that follows is to be understood as a summary of the findings and observations from all sources.

A CHNA is a process that describes the state of the local community, enables the identification of the major risk factors and causes of poor health, and enables the identification of the actions to address these. At its most basic level, a community needs assessment of this type is a valuable tool for planning. The information gathered during this process will enable MMC-C and other health and human services organizations to identify and prioritize problems for action. At a time when resources are becoming scarcer, a needs assessment of this type is needed to determine the most beneficial allocation of resources. This is in keeping with the mission of MMC-C as a member of the Trinity Health System.

A. Mission

We, Mercy Medical Center-Clinton and Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

Reverence: We honor the sacredness and dignity of every person.

Commitment to those who are poor: We stand with and serve those who are poor, especially the most vulnerable.

Justice: We foster right relationships to promote the common good, including sustainability of the Earth.

Stewardship: We honor our heritage and hold ourselves accountable for the human, financial and natural resources entrusted to our care.

Integrity: We are faithful to who we say we are.
We believe that this report will convey the perceptions, attitudes and beliefs regarding health status and health needs within the Mercy service area community. It encompasses both qualitative and quantitative data. Quantitative data tells only part of the story. Qualitative data tells the stories behind the numbers. Realizing this, Mercy strives to paint a fair and accurate picture of the community’s health status and health needs. This information can be used in a variety of ways to improve community health, including the development of new local programs, collaborative efforts among stakeholders to seek unified solutions, new services and assistance to donors who must make strategic investment decisions.

The community health needs assessment that is presented in this report is just the beginning of a dynamic, ongoing process and long-term goal of improving the community’s health. This data collection is the first step in the overall community needs assessment process, which includes the following steps: community profiling, deciding on priorities for action, planning public health and health care programs to address the priority issues, implementing the planned activities, and the evaluation of health outcomes. Community health needs assessments should be part of a continuous process that seeks to improve the health and well-being of the community.

In the upcoming year, the health issues identified in the report will be reviewed, prioritized, and incorporated into a new strategic action plan that will be used by MMC-C and others to target activities for investment and action over the course of the next three to five years.

The rest of this assessment is divided into 6 additional sections which include a review of the hospital’s previous community health needs assessment, a description of the geographic area that MMC-C serves, key public health data, key environmental health data, a summary of various community sources of input regarding area health issues and a summary of the priorities MMC-C plans to address as a result of this assessment.

B. Review of Previous CHNA

Key findings of the FY 12-14 community health needs assessment included issues pertaining to behavioral health services, drug abuse, access to care, and teenage pregnancy. Disparities in access to health services were reflected in mortality rates and behavior risk survey results, which were divided among social, economic, gender, racial and ethnic lines. Based on the information gathered, the areas that MMC-C focused on included: behavioral health needs (including substance abuse), access to care, chronic disease management, and teen pregnancy.

**Behavioral Health:** The need for inpatient behavioral health services in the community became a critical issue when the last psychiatrist in town with admitting privileges resigned. MMC-C was the first in the state to initiate an inpatient tele-psychiatric service which allowed individuals to remain in the community for treatment. Substance abuse issues are also mounting in the community, including prescription drug abuse.
MMC-C decided the most effective way to address this issue was to become a sponsor of the Gateway Impact (Substance Abuse) Council.

**Access to Care:** Access to care remains a pressing need in the community. Community Health Care, Inc., (CHC) based out Davenport, had plans to open a satellite clinic in Clinton in 2012. However, due to financial considerations, CHC announced that they would not build a clinic in Clinton. MMC-C and the Sisters of St. Francis then pledged the money needed by CHC to cover its anticipated initial large startup expenses. As a result, a CHC clinic will open in the summer of 2015.

**Chronic Disease Management:** The rate of chronic disease (diabetes, obesity, asthma, etc.) was on the rise in the community. MMC-C undertook several things to address this issue. First, it developed a health coach program to assist those with congestive heart failure and pneumonia. It is also looking to expand the health coach program to chronic obstructive lung disease. In addition, the hospital is also working on creating a clinically integrated network which will focus on diabetes early on. Education and community outreach efforts will also play a key role in mitigating these health issues. MMC-C recently reorganized its community health and wellness function to better address community education on diabetes management, nutrition and healthy lifestyles.

**Teen Pregnancy Prevention:** Teen pregnancy was high in MMC-C’s service area. However, it was the decision of the hospital that other organizations in the community were better suited to deal with pregnancy prevention and family planning issues. As a result, MMC-C selected to partner with other community agencies such as the Women’s Health Center and the Pregnancy Center in this area. MMC-C did focus on improving women and infant care through various educational and support programs.

**Written Comments on Prior CHNA and Implementation:** While copies of MMC-C’s CHNA have been used as background information for county and other community planning efforts, no specific written comments have been received regarding the hospital’s previous CHNA and Implementation Plans.

**C. Executive Summary**

**Population:** The four county population decreased by 2.0% between 2010 total and 2014. It is projected to decline by an additional 1.8% by 2019. The percentage of individuals 65 years or older is already higher than state and national averages. This age cohort will continue to grow at a significant rate. In 2014, the racial makeup of the service area was approximately 89.4% white Non-Hispanic, 1.8% Black Non-Hispanic, 6.5% Hispanic, and 2.3% considered multiple races or another race.

**Socio and Economic Environment:** The median household income for all four counties in 2014 was below both state and national averages. County unemployment was lower than the nation. All counties had a higher percentage of individuals with a high school level of education or higher than the nation as a whole.
Community Health Needs Assessment Planning Process

MMC-C used a variety of sources for input into the Community Health Needs Assessment process including: participation in the Clinton County Community Health Needs Assessment Planning process, a review of surrounding county health plans, a telephone survey of lower income individuals and African American and Hispanic focus groups. Prioritization was done by the hospital’s Community in Need Subcommittee of the Mission Council with the addition of the Executive Director of the Visiting Nursing Association/ County Health Department.

Significant Health Needs Identified

The major issues identified for MMC-C to address include:

Access to Care
Mental Health
Prescription Medications and Diabetes

D. CHNA Approval

MMC-C’s most recent CHNA was approved at the hospital’s April 24, 2015.
II. Community Served

A. Geographic Area Served
A. Definition of Service Area

MMC-C is located in Clinton, Iowa and serves 16 zip codes in four counties in Iowa and Illinois. The four counties include: Clinton (IA.), Jackson (IA.), Whiteside (IL.), and Carroll (IL.).

B. Population Demographics

Population: All four counties within the service area have seen declining populations since 2000. In 2000, the service area population was approximately 147,772. The population has since decreased in 2010 to 144,933 and again in 2014 to 141,996. The decreasing numbers in population from 2010 to 2014 range from a 1% decline in Jackson County to a 4% decline in Carroll County. In 2019, The Nielsen Company expects the service area population to be approximately 139,394, a 1.8% decrease from 2014. The largest counties within the service area, Clinton and Whiteside, are expected to decrease in population during this time by 1.4% and 2.1% respectively.

Age: In comparison with state and national data, the service area has a much higher 65 and over population. Over 19% of the 2014 service area population was 65 and older, significantly higher than the Iowa average of 15.8% and the national average of 14.2%. The service area also has a higher percentage of residents 55-64 (16.5%) than the national average of 12.6%. On the contrary, the 0-14, 15-17, 18-24, and 25-34 age group populations are all below the national averages. The child bearing female population was 16.7% in 2014, approximately 2% less than the Iowa average and 3% less than the national average.

By 2019, the 0-14, 15-17, and 35-54 age group populations are all expected to decrease in size. The 18-24 and 25-34 age groups are expected to increase by less than 1% and remain below the national averages for each age group. The 55-64 and 65+ age group populations are also expected to increase, creating a larger gap above the national averages. The child bearing female population is expected to decrease by 1.4% in 2019, falling further below national and state averages, which are both expected to increase. As the area continues to grow older, attracting and keeping the younger population is becoming increasingly more difficult.
Race: All four counties within the service area have populations that are predominantly white. Clinton and Jackson counties register 91.5% and 95.2% of residents, respectively, as white, while 93.5% of Carroll County residents and 84.6% of Whiteside County residents identify as white. Clinton County has the highest percentage of black or African-American population, at 2.8%. Jackson, Carroll, and Whiteside County all reported less than 2% of residents as black or African-American. Whiteside County has the highest percentage of Hispanic or Latino population, at 11.7%. Clinton County reports 2.9%, Carroll County reports 3.7%, and Jackson County reports 1.9% Hispanic or Latino.

English Proficiency: Approximately 1.5% of the service area population, aged 5 and older, speak a language other than English at home and speak English less than ‘very well’. The inability to speak English well can create a barrier to healthcare access. However, a limited English proficiency rate of 1.5% is below the Iowa average of 2.9% and well below the national average of 8.7%. Whiteside County has the highest percentage of residents in the service area with limited English proficiency, at 2.2%.

Free/Reduced Lunch: According to the National Center for Education Statistics, there were 23,245 total public school students enrolled during the 2010-11 school year. Of the 23,245 enrolled students, 43.26% (10,056) were eligible for free/reduced lunch. The percent eligible for free/reduced lunch is significantly higher than the Iowa average of 38.9%. Whiteside County had the highest percentage of eligible students at 44.65%, followed by Carroll County at 44.59%, Clinton County at 42.95%, and Jackson County at 39.52%. Free/reduced lunch data is significant because it helps identify vulnerable populations that are more likely to need healthcare access or additional social support.

Household Income: The median household income for all four counties in 2014 was below both state and national averages. The median household income for the entire service area was $50,115, while the Iowa median was $52,594 and the national median was $51,423. The median household income in Clinton County was the highest of all four counties in the service area, at $53,234. The median household income in Jackson County was $48,402. Whiteside County had a median household income of $48,748 and the median household income in Carroll County was $47,656.

According to the American Community Survey 2007-11 conducted by the U.S. Census Bureau, approximately 35% of families in the service area reported an annual income of over $75,000. In comparison, 42% of families in the U.S., 40% of families in Iowa, and 46% of families in Illinois have annual incomes of over $75,000. Clinton County had the most families reporting an annual income of over $75,000, with 39.4%. None of the other three counties in the service area had more than 33% of families reporting an annual income of over $75,000.

Poverty: Poverty is a critical factor in the health status of residents, as it creates barriers to services and food that promote healthy living. In the service area, 11.57% of individuals are living in households with income below the Federal Poverty Level (FPL). The national average of individuals living at the FPL is 14.3% and the state of Iowa average is 11.9%. In the service area, Carroll County has the highest percentage of population below
the FPL with 13.13% of its residents. Clinton County and Whiteside County have similar rates with 11.71% and 11.81% respectively. Jackson County has the lowest percentage of residents below the FPL with 9.38%.

In all four counties, women tend to have higher rates of individuals below the FPL. For the service area as a whole, 10.37% of men are living below the FPL, while 12.74% of women are living below the FPL. Carroll County has the highest percentage of men below the FPL at 12.4% and the highest percentage of women below the FPL at 13.85%.

In the service area, 31.84% if individuals are living in households with income below 200% of the Federal Poverty Line. The service area percentage of households with an income below 200% is consistent with the national average of 32.69%. Whiteside County had the largest percentage of residents at 200% of the FPL with 33.43%.

**Medicaid:** The percentage of service area population enrolled in Medicaid is considerably higher than the state average. According to the American Community Survey, 19.92% of service area residents are enrolled in Medicaid, over 3% more than the Iowa average of 16.46%. Whiteside County has the highest percentage of program enrollment, with 21.18% receiving Medicaid.

Residents aged 18 years and younger account for a large part of the enrollment, with 37.5% receiving Medicaid. Both Illinois counties, Carroll and Whiteside, have a high percentage of 18 and younger residents receiving Medicaid, with 38.5% and 40.8% respectively. Both Clinton County and Jackson County have less than 32% of 18 and younger residents receiving Medicaid, consistent with the state average of 31.9%.

**Uninsured:** The number of adults who did not have health insurance was lower than the national average (21.1%) in all four counties. Clinton County had the lowest population of uninsured (10.7%), while Jackson County was slightly higher at 13.8%. Carroll County and Whiteside County were significantly higher, at 16.7% and 15.9%, respectively.

**Education:** In 2014, the percentage of the service area population with a high school education or higher was 88.3%. Whiteside County had the lowest rate at 86.9%, while Clinton County had the highest rate at 89.5%. All four counties have a higher rate than the national average of 85.8%.

Although all four counties have a favorable rate of residents with at least a high school education, the percentage of residents with a bachelor's degree or higher is significantly lower than the national average. The national average for a bachelor's degree or higher is 28.4%, while the percentage of service area residents is only 15.9%. Clinton County has the highest percentage of residents with a bachelor's degree or higher education level at 16.5%.

**Violent Crime:** According to the Federal Bureau of Investigation, in 2012, there were 342 violent crimes reported in the service area. A violent crime includes homicide, rape, robbery, and aggravated assault. Of the 342, violent crimes, 222 were reported in Clinton County, creating a rate of 456 violent crimes per 100,000 residents. The Clinton County rate is significantly higher than both the Iowa average of 264 per 100,000 and the national average of 387 per 100,000. Both Carroll County and Jackson County had very
low violent crime rates with 0 and 86 per 100,000 residents, respectively. High violent crime rates throughout the service area make it difficult to attract potential residents, especially those with higher income levels or higher education levels.

**Unemployment:** In the 12 months leading up to June 2013, the service area unemployment rate remained constant around 7.0 until reaching its peak of 9.04 in January 2013. After January 2013, the unemployment rate experienced a steady monthly drop until the current June 2013 rate of 6.77.

In a comparison of unemployment rates from June 2013, the service area had a rate of unemployment consistent with the national average. In June 2013, the service area unemployment rate was 6.77, while the national average for the same time period was 6.62. While the service area unemployment rate is similar to the national average, 3 of the 4 counties had higher unemployment rates than their respective state average. Whiteside County had the highest unemployment rate of all four counties, with a rate of 9.30. The Whiteside County rate was higher than the Illinois average of 8.31. Both counties in Iowa had higher unemployment rates than the Iowa state average of 3.97. Clinton County had an unemployment rate of 4.70 and Jackson County had an unemployment rate of 4.30. The higher than average unemployment rates within the service area suggest that residents may have more financial insecurity and barriers to healthcare access than other residents throughout the state.

**Access to Primary Care:** Service area residents have considerably less primary care physicians available to them than other areas throughout the state and nation. In 2011, there were approximately 57.6 physicians per 100,000 individuals in the service area. This number is much lower than the Iowa average of 81.8 physicians per 100,000 individuals and the national average of 85.8 physicians per 100,000 individuals. Carroll County has the lowest primary care physician rate at 32.98 physicians per 100,000 individuals (5 physicians serving a population of 15,163).

Although the number of primary physicians remains low as compared to state and national averages, the service area has experienced a steady increase in physician access since 2002. From 2002 to 2011, the physician per 100,000 individuals' ratio has risen 10 points, from 47.1 to 57.6.

### III. Process and Methods

**A. Data Sources**

The Community Health Needs Assessment (CHNA) process included gathering both qualitative and quantitative data. It is important to note that, while most of this data is health specific, MMC-C acknowledges that many factors affect individual and population health. Most notably, the social determinants of health (poverty, education, employment, etc.) can have a significant impact on health status, and Mercy collected a wide variety of data that reflects these indicators. Together, the qualitative and the quantitative data will help the health system make decisions regarding short-term and long-term resource allocation. Information gathered by informal means can be used to
validate scientifically gathered quantitative information. In addition, differences between public and provider perceptions are often discovered, as well as new issues, as unmet needs may surface.

Market Expert, an analytical tool provided by The Nielsen Company, was used for much of the demographical and socio-economic data. Other demographic and socio-economic data was obtained from the U.S. Census Bureau American Community Survey 2011, the U.S. Census Decennial Census, and the Bureau of Labor Statistics.

B. Community Health Rankings

**Diabetes:** In 2010, according to the Centers for Disease Control and Prevention, approximately 8.16% of service area adults (aged 20 years or older) had been told by a doctor that they had diabetes. The prevalence of diabetes in the service area is slightly below the national average of 8.95%.

Approximately 8.4% of males and 7.7% of females in the service area had been told by a doctor that they had diabetes. All four counties have higher rates of diabetes in the male population than their respective state averages. Whiteside County had the highest rate of diabetes in males, with 9.5%. Female prevalence rates for all counties tended to fall in line with their respective state averages.

From 2004 to 2010, the service area has seen the prevalence rate for diabetes steadily climb from 6.82% in 2004 to 8.16% in 2010. The increase in prevalence is important because diabetic patients tend to have an increased risk for further health issues.

**Heart Disease:** Heart disease prevalence for adults (aged 18 years and older) in the service area is much higher than state and national averages. According to the CDC, approximately 6.9% of adults living in the service area had been told they have coronary heart disease or angina. The national and state averages are much lower at approximately 4.0%. This is important because coronary heart disease is the leading cause of death in the United States and is also related to other heart related issues. Both Illinois counties, Carroll and Whiteside, had prevalence rates that were almost 2 times the national average at 8.12% and 7.49%, respectively. Clinton County and Jackson County had lower rates (6.09% and 6.26% respectively) but were still considerably higher than national and state averages.

From 2006-2010, an average of 373 heart disease related deaths occurred annually within the service area. The age-adjusted death rate of 175 per 100,000 is significantly higher the national average of 135 and the Iowa average of 141. When compared to the Healthy People 2020 target rate of less than or equal to 100.8, the service area rate is again almost 2 times the target.

**Dental Care Utilization:** Low dental care utilization for adults aged 18 years and older is an issue in 3 of the 4 service area counties. Approximately, 28% of the service area has
not seen a dentist in the past year, although that is lower than the national average of 30%. Clinton County is significantly higher than the state of Iowa average (25.6%) with 34.7% of residents not seeing a dentist in the past year. Both Carroll County and Whiteside County are below the Illinois state average (30.8%) but still have rates over 27%.

Asthma: Asthma is a prevalent problem in the United States that is often exacerbated by poor environmental conditions. Both the Illinois and national averages are 13.2%, while the Iowa average is lower at 10.5%. Of the service area residents aged 18 years and older, approximately 11.7% have been told by a healthcare professional that they have asthma. Clinton County has the highest incidence rate within the service area at 14.6%. Carroll County also has a high incidence rate with 13.8%. Both Whiteside County and Jackson County have rates much lower than the national average at 10.3% and 7.4%, respectively.

Teen Births: According to the CDC, the teen birth rate for the service area in 2011 was 40.01 per 1000 teens aged 15-19. The service area rate is higher than the national average of 37.1. Both Carroll County and Jackson County had teen birth rates much lower than national and state averages, with 28.7 per 1000 and 24.8 per 1000, respectively. Clinton County and Whiteside County had much higher teen birth rates, with 44.4 per 1,000 and 44.2 per 1,000. This measure is relevant because teen parents often need social, economic, and health support services.

Immunizations: Pneumonia vaccinations for the 65 and older population were close to the national average (66.3%) with 65.6% of service area residents reporting they had received the vaccine. A data breakout by demographic group was not available for this measure. Preventative measures such as the pneumonia vaccination are important because they decrease the likelihood of developing future health problems. These measures are even more significant in a service area with a high proportion of residents over the age of 65.

Tobacco Use: In the service area, an estimated 25.1% of adults aged 18 years and older currently smoke cigarettes. This rate is much higher than the national average of 18.6% and the state of Iowa average of 18.4%. Both Clinton County and Whiteside County have noticeably high rates at 28.4% and 27.5%, respectively.

According to the CDC, an estimated 48.9% of adult smokers have attempted to quit for at least 1 day in the past year. 66% of adult smokers in Clinton County and Whiteside County have attempted to quit in the past year.

Low Birth Weight Babies: Infants born with a birth weight of under 2500g are considered to have a low birth weight are at high risk for further health problems. From 2003-2009, approximately 7.1% of the total live births in the service area involved a low weight baby. Clinton County had the highest low weight baby rate at 8.1%, which is considerably higher than the Iowa average of 6.8%. Carroll County also had a high prevalence rate at 7.8% of babies. Both Whiteside and Jackson County had low birth weight rates below 6.5%, much lower than the national average of 8.2%.
Sexually Transmitted Diseases: When compared to state and national averages, the service area tends to have much less incidence of Chlamydia and Gonorrhea. The service area incidence rate for Chlamydia in 2011 was 276.7 per 100,000, much lower than the national average of 452.2 per 100,000. Although the incidence rate has remained below the national average, it has risen steadily since 2003 when it was only 211.4 per 100,000. Clinton County has the highest incidence rate of Chlamydia with 344.8 per 100,000 residents.

The national average for the incidence of Gonorrhea per 100,000 people is 102.87 and the state of Iowa average is considerably lower at 63.03. In 2011, the incidence rate for the service area was 34.4 per 100,000. Since 2003, the rate has been up and down, ranging from a low of 18.4 in 2004 to a high of 40.9 in 2007. As was the case with Chlamydia, Clinton County also has the highest incidence rate of Gonorrhea at 57.1 per 100,000 residents.

HIV and AIDS: HIV prevalence within the service area in 2010 was only 44.56 per 100,000 residents. The service area prevalence rate is much lower than the Iowa average of 68 per 100,000, the Illinois average of 300 per 100,000, and the national average of 340 per 100,000. Clinton County had the highest HIV prevalence rate at 53.2 per 100,000.

Cancer: The rate of death due to malignant neoplasm (cancer) per 100,000 population was 183.6 for the service area. Carroll County had the highest mortality rate at 190.2, followed by Clinton County at 186.8 per 100,000. Whiteside County and Jackson County had lower mortality rates at 182.9 and 172.8, respectively. The Iowa average for cancer mortality was 175 and the Illinois average was 184.1. All counties within the service area had mortality rates significantly higher than the HP 2020 target of less than 160.0 per 100,000.

The incidence rate of breast cancer for the service area was also higher than average with 128.4 per 100,000 population. This is considerably higher than the national average of 119.7 and slightly higher than the state of Iowa average of 123.4 per 100,000. Whiteside County and Clinton County had the highest incidence of breast cancer in the service area with 134.6 and 128.9, respectively.

Alcohol Consumption:

Heavy alcohol consumption continues to be higher than state and national averages in the area. Heavy alcohol consumption is defined as more than two drinks per day for men and more than one drink per day for women. According to the CDC, in 2011, approximately 20.3% of service area residents self-reported heavy alcohol consumption. Jackson County had the highest rate of consumption at 27.9%, followed by Clinton County at 20.0%. The state of Iowa average was 19.2% and the national average was 15.0%.

Obesity: In 2010, 44.12% of service area adults, aged 18 years and older, had a body mass index between 25 and 30 (considered overweight). State and national averages for the overweight population tend to be around 36-37%. Both Iowa counties had rates consistent with state and national averages, however, both Illinois counties had rates
much higher. More than 50% (50.12) of adults living in Carroll County were considered overweight and 49.3% of Whiteside County adults were considered overweight.

All four counties within the service area have populations with high obesity rates. For the purposes of this data, obesity was defined as a body mass index greater than 30 and was measured on adults 20 years and older. According to the data obtained by the CDC, approximately 29% of the service area population was considered to be obese. Both Carroll County and Jackson County have rates over 30% with 30.1% and 30.3%, respectively. Iowa in general tends to have a higher obese population with a state average of 29%. The national average is 27.3%.

Additionally, 31% of males and 27% of females in the service area had a BMI of over 35. The percentage of population with a BMI of over 35 has steadily grown from 24.8% in 2004 to 29.0% in 2010. The steady growth of the obese population within the service area is worrisome because of the health risks that tend to be associated with obesity.

C. Environmental Health Factors

Air Quality: When compared to the National Ambient Air Quality Standard, only 0.45% of days exceeded emissions standards in the service area. The rate is higher than the Iowa average of 0.09% but much lower than the Illinois average of 1.08% and the national average of 1.19%.

Carroll County had the highest percentage of days that exceeded emissions standards with 0.56%, followed by Whiteside County with 0.50%. Clinton County had a slightly lower percentage at 0.43% and Jackson County had the lowest rate at 0.27%.

Motor Vehicle Accident Deaths: The rate of motor vehicle accident related deaths in the service area was higher than state and national averages. The overall service area age-adjusted death rate per 100,000 people was 16.20, much higher than the national average of 13.04 and the state of Iowa average of 13.84. Carroll County had the highest rate of age-adjusted deaths with 31.22 per 100,000, while Whiteside County had the lowest rate with 13.52 per 100,000 people. Clinton County and Jackson County had age-adjusted death rates of 14.55 and 16.43, respectively.

Suicide Incidence: Age-adjusted suicide rates within the service area are also higher than the national average of 11.57 and the Healthy People 2020 target of 10.2. Jackson County had the highest suicide rate with 15.65 per 100,000 people. Clinton County and Whiteside County had suicide rates of 14.17 and 13.13 per 100,000, respectively.

Low Food Access: According to the US Department of Agriculture, approximately 22.2% of the service area was considered to have low food access. Clinton County had the highest rate with almost 28% of the population with low food access. Whiteside County and Jackson County had rates of 21.3% and 17.7%, respectively. Carroll County had the lowest rate in the service area with 12.8%. The national average for low food access was 23.6%, while state averages for Illinois and Iowa were 20.4% and 22.7%, respectively.
Lead Poison Cases: According to the Iowa Department of Public Health, in 2012 approximately 4.4% of children in Jackson County aged 6 years and younger tested positive for lead levels ≥ 10 μg/dL. Clinton County had a slightly lower incidence rate at 4.0%. Both Iowa counties in the service area had higher rates than the state average of 2.7%.

The lead poisoning incidence rate in both Illinois counties was considerably lower than the two Iowa counties in the service area. According to the Illinois Department of Public Health, Whiteside County had an incidence rate of 1.3%, while Carroll County had a rate of 1.1%. The Illinois state average for the same time period was 1.4%.

Radon Poison Cases: Iowa has the highest average radon concentrations in the United States with much of the state having radon concentrations over the action level set by the EPA. The average indoor radon concentration level in the United States is 1.3 pCi/L and the EPA recommends a home be fixed if the radon concentration level reaches 4 pCi/L or higher.

According to radon test results obtained by Air Check, Inc, all four counties within the service area had radon concentration levels well above the recommended action level. Carroll County had the highest average indoor radon level at 7.1 pCi/L and approximately 56% of the results were over the 4 pCi/L action level. Jackson County had an average radon concentration level of 6.2 pCi/L and 52% of the results over the EPA action level. Clinton County also had a very high rate at 6.0 pCi/L and 48% of the test results over the EPA action level. Whiteside County had the lowest average concentration level at 5.1 pCi/L but still had nearly 50% of the results over the EPA action level of 4 pCi/L.

D. Health Facilities Owned and Operated by MMC-C

MMC-C is a single organization comprised of three distinct facilities all located in the city of Clinton, Iowa.

- Mercy Medical Center a 163 bed acute care hospital located at 1410 N. Fourth Street.
- Mercy Living Center –North an 86 bed skilled nursing facility located at 600 14th Avenue North, Clinton, Iowa.
- Mercy Living Center-South a 97 bed skilled nursing facility located at 638 Bluff Blvd., Clinton, Iowa.

E. Services Provided

MMC-C offers a variety of services at its various locations.

Mercy Medical Center-North
- State of Iowa Level IV Trauma / Emergency Services
- Contracted Ambulance Services (Medic)
- Radiation Oncology
- Mercy Specialty Clinic (GI and ENT)
- Acute Care Services
o Inpatient Medical / Surgical Services
  o Inpatient Progressive Care Unit
  o Intensive Care Unit (including Inpatient Dialysis)
  o Respiratory Services
  o Women’s and Children Services
    ▪ OB
    ▪ GYN
    ▪ Pediatrics
  o Perioperative Services
    ▪ Preadmission Services
    ▪ Same Day Surgery
    ▪ Surgery
    ▪ Anesthesia
    ▪ GI Lab
  o Inpatient Behavioral Health Unit
  o Rehabilitation Services
  o Inpatient and Outpatient Chemo Therapy and Infusion Therapy
  o Inpatient and Outpatient Cardiac and Pulmonary Diagnostics and Interventional Services
  o Inpatient and Outpatient Radiology Services
    ▪ X-ray
    ▪ CT
    ▪ MRI
    ▪ Pet CT
    ▪ Mammography
    ▪ Ultrasound
    ▪ Nuclear Medicine
  o Inpatient and Outpatient Laboratory Services
  o Inpatient and Outpatient Pharmacy

Mercy Living Center North
  • Long Term Care
  • Skilled Care

Mercy Medical Center – South and Mercy Living Center – South
  • Outpatient Rehabilitation
    o Physical Therapy
    o Occupational Therapy
    o Speech Therapy
  • Outpatient Renal Dialysis
  • Wound Center
  • Home Medical Equipment
  • Homecare and Hospice
  • Long Term Care
  • Skilled Care
  • Memory Loss Unit
IV. Community Input and Collaborative Partners

A. Input Methodology

Clinton County CHNA Process: MMC-C working in conjunction with the Genesis Visiting Nurses Association (VNA) and Genesis Medical Center-DeWitt held a series of meetings with various community agencies and elected officials to review data and prioritize local health issues. The VNA is the agency that Clinton County Iowa contracts with to handle most of its public health functions. As a result, the health issues identified as a part of this process will also become the priorities for Clinton County the geographic area where most of the population that MMC-C serves reside. The community health assessment process was conducted during three meetings which occurred on September 17, 2014, November 5, 2014 and March 4, 2015.

Surrounding Counties: Input from sought Jackson, Carroll and Whiteside counties was incorporated by reviewing county community health needs assessment material. Down load of information occurred during December of 2014.

Survey of the Poor: MMC-C retained the services of Vernon Research to conduct focus group research with the poor to make sure their voices were heard as a part of this process. However, due to the difficulty of getting this group to attend a focus group the process eventually turned into a series of telephone interviews. Actual surveying occurred during the month of October 2014 with the final report being received on November 14, 2014.

Minority Focus Groups: MMC-C also conducted focus groups with Hispanic and African American representative within the community. A local Catholic parish helped to identify potential individuals to interview. Representatives of the Martin Luther King Celebration Committee, associated with Clinton Community College, helped identify individuals for the African American focus group. The Hispanic focus group met on December 17, 2014. The African American group meeting was held on February 23, 2015.

B. Summary of Input

Clinton County Community Focus Group: As a way to gain insight into underserved population, Genesis VNA and Mercy convened a series of meetings with representatives from various organizations within the service area including:

- Bridgeview Community Mental Health Center
- Clinton County Board of Health
- Clinton County Board of Supervisors
- Clinton County Early Childhood of Iowa Program
- Clinton County Medical Society
- Eastern Iowa Community College – Clinton
- Gateway Impact (Substance Abuse) Council
- Genesis VNA
• Genesis Medical Center-DeWitt
• HyVee Grocery Store
• Iowa State Extension Service
• Iowa State Senate Office
• Lutheran Social Services
• MMC-Clinton
• United Way of Clinton County
• Visiting Nurses of Iowa (I-Smile) Dental Program
• YWCA

The purpose of pulling the group together was to help identify and prioritize perceived gaps in services. Previous plan priorities and demographic/health status information was shared before and at the beginning of the meeting to help stimulate thought. Participants were then asked a structured set of questions regarding strengths and weaknesses of current service offerings. The focus group identified the following priority areas for focus:

• Healthy Lifestyles  
  o Obesity both in children and adults  
  o Lack of physical activity  
  o Tobacco use  

• Mental Health, both community awareness and access to service.

• Substance abuse, including marijuana and prescription drug abuse

• Alcohol abuse with special focus on binge drinking

• Teen risky behavior  
  o Teen pregnancy reduction  
  o Suicide prevention  
  o Drug abuse

**Surrounding County Input:** Issues identified in the health improvement plans of Jackson, Carroll and Whiteside counties that were not called out in the Clinton County planning process were:

• Access to care

• Sexually transmitted diseases

• Elderly care, including fall prevention

• Domestic violence
Survey of the Poor: Only county residents living under the federal poverty guidelines for income were included in this study. Respondents were recruited via an online screener. Links to the online screener were sent via the Iowa Opinion Panel, posted on Facebook and disseminated through targeted online advertisements. Additional recruitment was done in-person and through advertisements and referrals from the Genesis VNA, doctors’ offices, clinics and emergency rooms within Clinton County. Potential respondents were pre-screened so that the qualitative sample would include a mix of genders, ages, income levels and education levels. Vernon Research Group conducted in-depth interviews with 24 residents of Clinton County. Interviews were conducted via phone, took place between September 11 and November 4, lasted between 11 and 26 minutes, and averaged 16 minutes. Data analysts recorded answers to close-ended questions as they performed the interviews. Once all interviews were conducted, a single data analyst listened to all recordings to confirm that data was coded correctly, as well as to transcribe any particularly meaningful or elucidating remarks made by the respondents. Unless specifically stated otherwise, all respondents were asked all questions.

Zero respondents indicated that they were in very poor health. A combined 71% of respondents indicated that their health was average or better.

Two-thirds of respondents currently utilize Medicaid as their primary health insurance. A quarter of respondents indicated that they had no health insurance. Another quarter of respondents had some combination of health insurances. Only two of the 24 respondents had privately purchased health insurance.

Over a third of respondents had, within the last year, needed health services from a medical doctor but chose not to seek care. A quarter of respondents had needed dental care but chose not to seek it.

The cost of health care, followed by having no insurance, were the two biggest reasons respondents chose not to seek health care services within the last year. A quarter of respondents also indicated that cost of prescriptions, emergency room wait times and long wait times to get appointments were impediments. Mercy Clinton’s emergency room and staff were singled out in the qualitative responses as being especially difficult to deal with.

Depression was the largest health issue indicated by the respondents, as well as the only health issue indicated by a majority of the respondents. Allergies, anxiety and being overweight were the next biggest issues. Over a quarter of respondents had arthritis, while a quarter had asthma and/or high blood pressure.

A majority of respondents indicated they had seen a doctor for a routine examination within the last year.

Respondents indicated that they follow their doctors’ recommendations 81% of the time.

Respondents indicated that they take medications as prescribed 97% of the time.
Taking into account responses likely representing exercising activities, the average respondent undertook less than four minutes of vigorous activities and less than 26 minutes of moderate activities each day. Over half of respondents reported engaging in no vigorous activities whatsoever, and several of these same respondents reported getting no moderate exercise whatsoever during a typical week.

Respondents rated improved water quality as the overall most important area in terms of making the residents of their community healthier. Education regarding health care issues and services, increased participation in physical activities and exercise programs, improvements to nutrition and eating habits, and improved water quality all rated closer to “extremely important” than “neutral.”

Respondents were more likely to have no medical debt ($0) if they had some insurance, and respondents were more likely to have substantial medical debt (over $5,000) if they had no insurance.

There were significantly more people living in households of uninsured respondents than in the households of insured respondents.

**Hispanic Focus Group:** According to the group the greatest barrier to healthcare for local Hispanics appears to be a lack of health insurance. This is a result of the high percentage of local Hispanic residents that are undocumented and lack either employer based coverage or access to government programs. As a result, care is often delayed until absolutely necessary and is paid for in cash. While most families in Clinton have resided in the community for a number of years and their households are bilingual, translation services are still an issue for some older members of the community.

**African American Focus Group:** Most of the community leaders interviewed for this process were employed in education, social services or health care. While they received their health insurance coverage through their employers, they felt a large number of the African American Community in Clinton relied on Medicaid and Medicare. They also expressed concern at the growing number of young adults, who while qualified for subsidized health insurance coverage through the federal exchanges, were going without coverage.

The group felt the lack of coverage by younger community members could be traced to several factors including a lack of awareness as to who the communities’ enrollment Navigators were and the perceived cost of the insurance when they don’t think they will need it. The group proposed a number of outreach initiatives using local churches or community events.

Specific health needs identified by the group included: obesity, diabetes, high blood pressure, heart disease, prescription medications, teenage pregnancy and domestic violence. While the identified issues are basically the same as those affecting the population as a whole, the group felt new outreach approaches using members of the local African American community may be necessary in order to successfully address these issues.
Another area of interest identified by the group is the evolving sub-segments of their community. First, there is a growing number of aging African Americans in MMC-C’s service area. While this group may possess health insurance coverage, they many times have difficulty with transportation and prescription medications. The other segment the group felt were the most challenging is the younger recent arrivals from places like Chicago. They typically don’t identify with existing institutions.

V. Significant Community Health Needs

A. Process for Identifying Needs to be Addressed by Mercy

Internal prioritization of the issues to be addressed by MMC-C was handled by the Community in Need Subcommittee of the hospital’s Mission Council plus several additional people. The council is comprised of the Vice President for Business Development/Chief Community Benefits Officer, Financial Analyst/Community Benefit Coordinator/Financial Contact, the Vice President for Quality, the Community Health and Wellness Coordinator, a Discharge Planner and Health Coach. Other individuals participating included MMC-C’s Vice President Patient Services (CNO), the Regional Vice President of Mission and the Executive Director of the Genesis VNA/County Health.

The prioritization process involved several steps. First, the hospital’s Chief Community Benefit Officer identified 24 community issues that were sourced from public health data, various county health department planning efforts, a survey of low income individuals, and minority focus groups. This list along with a rough draft of the Community Health Needs Assessment without recommendations was distributed to the group before meeting. On March 20, 2015 the group met to review and discuss the entire list. The list was then narrowed to 13 items that the group felt were appropriate for MMC-C to address. At this point the group was asked to force rank the list of 13 from most important to least important. The scores of all participants were then averaged to determine the top four priorities the hospital will focus on. It should be noted that MMC-C will probably continue to pursue the remaining 9 issues but without the same focus as the main priorities.

B. Description of Health Needs to be Addressed by Mercy

Major Priorities: In order of importance:

- Access to Care: There are two ways that MMC-C plans to support improved access to care. First, MMC-C and Trinity Health, the hospital’s parent organization, have committed $150,000 a year support for two years to assist Community Healthcare Inc. open a satellite federally qualified community health center clinic in Clinton. The hospital is also exploring ways to help its patients with financial needs pay for
transportation to and from the hospital or to other referral centers. This program is estimated to cost approximately $80,000 per year.

- **Mental Health Service:** The hospital plans to continue its support for Bridgeview Community Mental Health Center’s outpatient behavioral health services and its own inpatient mental health unit. Maintaining an inpatient unit was seen as critical since the next nearest unit is over 35 miles away and many of the chronically mentally ill have transportation issues. The annual rent subsidy that MMC-C offers Bridgeview ranges in value from about $100,000 to $500,000 per year depending upon whether market rate rent or Medicare cost report costs are used to calculate the value of the hospital’s support. The estimated annual subsidy to maintain the inpatient mental health unit is about $400,000. Half of this subsidy represents support for the actual inpatient unit and the other half support for the inpatient physician tele-psych service.

- **Prescription Assistance:** During FY 2015 MMC-C initiated the 'First Fill' program. The focus of the program was on making sure that Congestive Heart Failure patients discharged from the hospital had their needed prescriptions when they left the hospital. Starting in FY 2016 MMC-C plans to expand the program to a broader range of inpatients that have trouble affording their prescriptions. The estimated annual cost for this program is $15,000. The new federally qualified community health center which is to open the summer of 2015 will offer reduced cost prescriptions for its patients this should have a significant impact on low income ambulatory patients ability to afford their prescriptions.

- **Diabetes:** Diabetes is clearly a significant issue for service area residents. There are several ways that MMC-C plans to address this issue. First, the hospital has recently formed an Accountable Care Organization/Clinically Integrate Network (ACO/CIN) in conjunction with Medical Associates the major multispecialty medical provider in the region. It is also intended that membership in this organization will be expanded to include other area primary care providers. One of the first clinical areas of focus for this new organization will be use of health coaches to better manage these patients. In addition to ACO/CIN activities MMC-C’s Community Health and Wellness department has a priority to increase the amount of community education it will do on this issue.

- **Weight Loss and Physical Activity:** Based on the RWJ Foundation County Health Rankings, Clinton County has increased in adult obesity from 28% in 2010 to 30% in 2014. Clinton County went from a ranking of 90 out of 99 counties in Health Behaviors to 96 in 2014.

**Secondary Priorities:**

While not the top areas of focus for MMC-C’s Community Benefit Program, the hospital also plans to work on a variety of other health issues including: tobacco use, low food access, minority health insurance enrollment, exercise, heart disease/high blood pressure, senior services, cancer awareness/prevention and low birth weight babies.

**Issues not to be addressed by MMC-C:**
While 24 major issues were identified through the Community Health Needs Assessment process, the committee felt that only 13 were ones that MMC-C could realistically directly impact. The remaining 12 were thought to be better served through other organizations in the community. Listed below are the remaining issues and the corresponding alternative provider.

- **Alcohol/Substance Abuse:** It was felt that since MMC-C does not offer treatment in these areas service was best left to Gateway Impact Coalition and the Clinton Substance Abuse and Prevention Council. Mercy does provide the Gateway Impact Coalition with Financial Assistance.

- **Air Quality and Asthma:** Since MMC-C does not employ primary care physicians, it was felt best to leave this issue to be handled by local clinicians. The addition of a new federally qualified community health center in town should also reduce any access issues low income individuals might have seeking treatment.

- **Dental:** Access to dental care by low income individuals has been an identified issue in MMC-C’s service area for a long time. The opening of the new federally qualified community health center with dental facilities will go a long way to address this issue.

- **Domestic Violence:** MMC-C is an active reporter of domestic violence particularly of victims seen in the hospital’s emergency department. The YMCA has been the major provider of housing for domestic violence victims in MMC-C’s service area for a long time. However, YMCA programming has been very negatively impacted by recent state regionalization. As a result this is an area the Community in Need Subcommittee of the Mission Council should continue to monitor.

- **Immunization:** While initial rates look lower than state rate, by kindergarten they improve greatly. This was felt to be an educational effort best handled by public health and local providers.

- **Language:** The language issue identified during the Community Health Needs Assessment process was primarily a physician office issue. Since MMC-C owns few physician practices and the practices the hospital does own are located in the hospital, they can take advantage of the hospital’s language support systems.

- **Lead Poisoning:** This was clearly seen as a public health issue which the VNA/County Health is set up to address.

- **Radon:** This was also seen as a public health issue that was best addressed by the VNA/County Health.

- **Sexually Transmitted Diseases:** Women’s Health Services already does significant education in the high school on this issue. Both Women’s Health and VNA/County Health already offer testing.

- **Teen Births:** This issue identified through a variety of sources. All of the discussion focused on promotion of birth contraceptives which is a difficult thing for MMC-C to be involved with as a Catholic Organization. As a result, MMC-C plans to focus its efforts more on working with supporting young women after they become pregnant. Efforts here include the provision of affordable prenatal education and participation in a State of Iowa pilot program to reduce infant deaths through the provision of free cribs.
• **Water Quality:** This issue was identified through the low income resident surveys. No public health data supported this as an issue as a result MMC-C does not plan to address.