2024 Community Needs Assessment

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Background

Purpose

This Community Needs Assessment (CNA) focuses on mental health and substance use service needs in Vanderburgh, Warrick, Gibson, and Posey Counties in Southern Indiana. This document, funded by a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), will be used to meet SAMHSA grantee attestation requirements and Certified Community Behavioral Health Center (CCBHC) certification requirements for the Indiana Department of Mental Health and Addiction (DMHA).

At Southwestern Behavioral Healthcare (Southwestern), this CNA will be used for agency strategic planning and Continuous Quality Improvement (CQI) efforts over the next three years. We are also using this report to further educate our staff and governance on the launch of CCBHC as a Medicaid program replacing the Community Mental Health Center model and what that means for our community and service lines. Our hope is that our partner agencies will utilize any part of this report for their own funding applications.

Introduction and Overview

What is the definition and purpose of a Community Needs Assessment?

> ***"The overarching purpose of the community needs assessment is to understand what needs exist in your community and what your CCBHC can do to address them."***

Source: National Council for Mental Wellbeing, 2024

A community needs assessment is defined, by SAMHSA, as a process involving the collection of data and the conducting of interviews with stakeholders [which may more easily be understood as a person, group, or organization with an interest or concern in the decision making and planning of an individual, group, or organization[i]] with the purpose of understanding gaps in services and identifying strengths and assets available within the community. CNAs can be conducted to meet Federal and State regulations, make decisions on program planning, address everchanging priorities and policies, respond to trends and changes in the local community, mobilize community resources, and increase community partnerships. This comprehensive approach ensures that services provided are tailored to the specific needs of the communities being served.[ii] The findings of this CNA will be used as the basis for Southwestern's Continuous Quality Improvement (CQI) plan, Key Performance Indicator (KPI) outcome measures selection, clinical training plans, and outreach initiatives.

In 2023, Southwestern Behavioral Healthcare, Inc. provided mental health, substance use disorder, and/or primary care services to 7,836 individuals and families in a service region that includes Vanderburgh, Warrick, Gibson, and Posey Counties in Southern Indiana. Since 1971, Southwestern has been a leader in providing a wide range of programs and services to meet the mental health and substance use disorder treatment needs in our region as a Community Mental Health Center (CMHC). Southwestern engaged in a state and national systems transformation initiative and is seeking Certified Community Behavioral Health Clinic status through the Indiana Department of Mental Health and Addiction. As part of this process Southwestern will conduct a Community Needs Assessment (CNA) every three years to guide agency planning and fulfill SAMHSA and DMHA requirements.

What is a CCBHC and how will it impact the Southwestern Indiana region?

A CCBHC is a new Medicaid provider type, established by the Excellence in Mental Health Act and Addiction Treatment Act (S. 2069/H.R. 4323). Some key features of a CCBHC include:

- **Comprehensive Services**: CCBHCs are designed to provide a comprehensive range of mental health and substance use disorder services to vulnerable individuals. This includes developmentally appropriate care for children and youth.
- **Access to Care**: CCBHCs are required to serve anyone who requests care for mental health or substance use, regardless of their ability to pay, place of residence, or age.
- **Quick Service**: CCBHCs must meet standards for the range of services they provide and are required to quickly establish people into care. In established CCBHC demonstration states, 93% of individuals requesting services are seen within 10 days versus the national average wait of 48 days.[iii]
- **Crisis Services**: The CCBHC model requires crisis services to be available 24/7/365. Southwestern has implemented a full crisis continuum, including crisis call line, mobile crisis response team, and crisis receiving and stabilization services.
- **Care Coordination**: Care coordination is provided to help people navigate behavioral health care, physical health care, social services, and other systems with which they are involved.
- **Enhanced Reimbursement**: In return for providing these comprehensive services, CCBHCs receive an enhanced Medicaid reimbursement rate based on their anticipated costs of expanding services to meet the needs of these complex populations. This enhanced reimbursement rate is under a prospective payment system (PPS), like that used by Federally Qualified Health Centers (FQHC).[iv]

Southwestern's efforts toward CCBHC certification readiness began in 2021 with the award of a SAMHSA CCBHC Expansion grant to develop and implement a community crisis services continuum and establish mental health primary care integration in Vanderburgh County; both service lines are now fully operational. Simultaneously, CCBHC attestation criterion were being operationalized into policy and practice across all Southwestern programs and service locations. Southwestern was awarded a SAMHSA CCBHC Innovation and Advancement grant for the 2022-2026 fiscal years to continue working towards certification readiness.

In 2024, the Indiana Division of Mental Health and Addiction (DMHA) was selected as a CCBHC demonstration state by SAMHSA and the Center for Medicare and Medicaid Services (CMS). Southwestern was subsequently selected as a CCBHC pilot-site by the Indiana DMHA and will be a fully certified CCBHC effective January 1, 2025.

Southwestern Service Area Description and CCBHC Sites

A. Geographic description of service area

The community needs assessment includes Vanderburgh, Warrick, Gibson, and Posey counties. These counties are all included in the Evansville-IN-KY Metropolitan Statistical Area (MSA). The general concept of an MSA is that of a core area containing a substantial population nucleus, together with adjacent communities having a high degree of economic and social integration with that core.[v]

An MSA is typically centered around a city, in this case Evansville, and the surrounding areas. This MSA covers a 2,063 square mile region of Southern Indiana.

Location	Total Population
Vanderburgh	179,900
Warrick	64,065
Gibson	33,006
Posey	25,226
Area Total	302,197
Indiana	6,784,403

Source: 2022 ACS 5-Year Estimate: Table DP05

VANDERBURGH COUNTY

Source: Vanderburgh County Quick Facts: United States Census Bureau[vi]

Vanderburgh County is the largest of the four counties in the Southwestern service area; the Evansville metropolitan area fully spans the county's geographic borders. The county covers an area of 236 square miles and has a population of 179,900, with a population density of 770 people per square mile.[vii] Vanderburgh is bordered by Gibson County to the north, Posey County to the West, Warrick County to the East, and Henderson County, Kentucky to the South. It is located along the Ohio River, as are Posey and Warrick Counties. Evansville serves as the hub for commerce and services received across our region.

Vanderburgh County is one of two designated Federal Promise Zones (PZ) in Indiana. This designation is given by the U.S. government to high-poverty communities; 22,250 people live within the Promise Zone (PZ), approximately 1/8 of Vanderburgh County's total population. The poverty rate within the PZ totals 39%; Southwestern Behavioral Healthcare is located within the Promise Zone.

Data provided by the two hospital systems located within Vanderburgh County provides a larger picture of local mental health. In 2023, Deaconess Health System reported 3,954 psychiatric evaluations took place in their emergency rooms with the top 20 mental health utilizers having 216 admissions. In 2023, Ascension Health System reported that 1,631 psychiatric assessments were conducted in their emergency room with 527 admissions to their adult inpatient mental health unit. There were 418 referrals for geriatric psychiatric assessments via the emergency room (ER) and 418 admissions to their geropsychiatric unit.

In 2022, the Evansville Police Department provided data reporting 3,954 law enforcement mental health contacts and 692 EPD Crisis Intervention Team (CIT) interventions. In 2023, 4,054 mental health contacts and 637 CIT contacts occurred. During the first full year (2023) of Southwestern's mobile crisis co-response with the Evansville Police Department, there were 154 coordinated crisis responses in the community[viii].

Additional population health data for Vanderburgh County includes:

- Vanderburgh County's overall poverty rate is 15.6%, about 25% higher than the state average of 12.6%.[ix]
- The 2022 Homeless Point in Time (PIT) Count was 364 individuals; with 75 chronically homeless persons identified.[x]
- One out of five residents report having a depressive disorder, and nearly one in four reports having an anxiety disorder.[xi]
- Children in the region have a reported incidence of 18% ADD/ADHD, 15% anxiety, 7% depression, 6% behavioral or conduct disorders, and 3% autism.[xii]
- Vanderburgh County has the highest alcohol abuse rate in the state.[xiii] One out of four residents drink to excess, nearly twice the state and national rates.
- Around a third of binge drinkers report co-morbid depression (30%) and/or anxiety (28%).
- The occurrence of death from intentional self-harm in Vanderburgh County is 21.0 per 100,000 population, exceeding the state rate of 15.9 per 100,000.[xiv]
- In 2023, there were 66 accidental overdose deaths in Vanderburgh County, with 35 of these deaths involving opioids; 27 of these deaths resulted from accidental overdose of Fentanyl.[xv]
- In 2023, population health surveillance by the Indiana State Department of Health (ISDH) reports 385 hospitalizations or emergency room visits for drug overdoses in the region.
- In 2023, Vanderburgh County had 79 overdose ER visits where the individuals were under 14 years of age.[xvi]
- Opioid prescription rates for Vanderburgh County were 228 per 1,000.[xvii]

WARRICK COUNTY

Source: Warrick County Comprehensive Plan 2045

Warrick County covers an area of 385 square miles and has a population of 64,065 residents, with a population density of 169 people per square mile. Warrick County is one of the 10 fastest growing counties in Indiana and reports a higher median household income than most of the state. A high-density residential portion of Warrick County adjoins Evansville's commercial and health services corridor, while the remainder of the county consists of rural towns, agricultural land, and natural recreation areas.

In a recent Warrick County Needs Assessment, mental health and substance use treatment were identified as the top needs with perceived barriers identified as accessing services, knowledge of conditions, and stigma.[xviii]

During 2020, 25% of driving deaths in Warrick County involved alcohol impairment. This rate is 6% higher than the state average (19%), 10% higher than Gibson County, 14% higher than Vanderburgh County, and 17% higher than Posey County. [xix]

Additional population health data for Warrick County includes:

- The poverty rate in Warrick County is 5.64%.
- In 2020, there were 10 deaths from intentional self-harm (suicide), slightly higher than the state average.[xx]
- In 2019, there were 26 hospital ER visits for opioid overdose.
- Warrick County's age adjusted overdose rate was 34% lower than the statewide rate.[xxi]
- Opioid prescription rates were and 176 per 1,000 residents in Warrick County.[xxii]
- During the 2022-2023 school year, there were 162 suspensions/expulsions related to alcohol, tobacco, and drug use.[xxiii]

GIBSON COUNTY

Source: Southern Indiana Road Trip: The Country Roads of Gibson County: southernindiana.org

Gibson County is a 499 square mile area with a population of 33,006 residents, and population density of 68 people per square mile.[xxiv] The county is primarily agricultural and industrial.

A 2023, a Gibson County community needs assessment ranked access to mental health, substance use, and primary care services as the highest identified needs. Access to care for members of underserved communities and transportation were also identified.[xxv] The 35-minute minimum drive from Gibson County to services available in Vanderburgh County presents a barrier to care.

A significant barrier to Southwestern's Promoting Integration of Primary and Behavioral Health Care (PIPBHC) grant at the Gibson County office is the limited number of primary care providers in the county. Southwestern offers primary care services via telehealth with our family practice APN within our healthcare integration program.

Additional population health data for Gibson County includes:

- Gibson County has a poverty rate of 9%.
- In 2022, There were 10 deaths from intentional self-harm (suicide) in Gibson County, and 3 deaths by unintentional overdose.[xxvi]
- The ratio of Gibson County residents to primary care providers is 3,080 to1.
- The ratio of Gibson County residents to mental health providers is 2,740 to 1.[xxvii]
- In 2023, there were 54 drug related ER visits and 4 overdose deaths in the county. [xxviii]
- During the 2022-2023 school year, 71 students were suspended or expelled related to alcohol, tobacco, or drug use.[xxix]
- 711 opioid prescriptions were dispensed per 1,000 residents of Gibson County in 2022.[xxx]

POSEY COUNTY


Source Image 1and3: Explore Historic Posey County: southernindiana.org Source Image 2: Gallery: visitposeycounty.com

Posey County is a 409 square mile area with a population of 25,226, and population density of 61 people per square mile.

A 2023 community action plan identified substance use disorder and mental health treatment access as primary community needs and identified methamphetamine as a primary substance of concern.[xxxi]

Additional population health data for Posey County includes:

- In 2022, there were 8 deaths from intentional self-harm (suicide) in Posey County and 7 deaths by unintentional overdose. [xxxii]
- Posey County has the highest disparity ratio of county residents to primary care providers in the region at 3,160 residents to 1 primary care provider.
- The ratio of residents to mental health care providers in Posey County is 8,370 residents to 1 mental health care provider.[xxxiii] Southwestern is the only provider of mental health services identified in the Posey County comprehensive community plan. [xxxiv]

B. Description of Southwestern Sites and Programming

Southwestern Behavioral Healthcare provides the nine core CCBHC services to our regional communities including:

1. **Crisis Services**: Available 24/7, including mobile crisis teams, emergency crisis intervention, and crisis stabilization.
2. **Outpatient Mental Health and Substance Use Services**: Comprehensive outpatient care for mental health and substance use disorders.
3. **Person- and Family-Centered Treatment Planning**: Individualized treatment planning that involves the person and their family.
4. **Community-Based Mental Health Care for Veterans**: Specialized mental health services for veterans.
5. **Peer, Family Support, and Counselor Services**: Support services provided by peers and counselors.
6. **Targeted Case Management**: Assistance in coordinating care and navigating various health and social services.
7. **Outpatient Primary Care Screening and Monitoring**: Screening and monitoring of key health indicators and risks.
8. **Psychiatric Rehabilitation Services**: Services aimed at helping individuals with mental health conditions to live independently.
9. **Screening, Diagnosis, and Risk Assessment**: Comprehensive assessment and diagnosis, including risk assessments.

SERVICE DESCRIPTIONS:

Outpatient Services: Located in Evansville, IN offers individual and group therapy for adults, children, and families. Psychiatric assessment and medication management services are available. Care coordination is provided to integrate care across multiple providers or access resources. They provide collaborative treatment-based approaches, evidence-based therapy interventions, parenting education, supported employment services, coordinated referrals for more intensive services, outpatient substance use services, and tobacco cessation services.

Gibson County Regional Services: Located in Princeton, IN offers outpatient behavioral services for adults, children, and families. They provide collaborative treatment-based approaches, evidence-based therapy interventions, and psychiatric evaluation and medication management for both adults and children. They also offer parenting education, referrals for more intensive services, substance use services, and referrals to residential services, as well as tobacco recovery services. PIPBHC grant has allowed Gibson office to offer added support to individuals who have co-occurring mental health and primary care needs. The agency has piloted a system for seeking out individuals with high need and is working with those individuals to address their needs and the barriers that impede their ability to meet their combined health needs. By treating the whole person and addressing the needs of the individuals seeking services, we aid them in addressing all concerns that, unchecked, could lead to less desirable outcomes.

Posey County Regional Services: Located in Mt. Vernon, IN offers outpatient behavioral services for adults, children, and families. They provide collaborative treatment-based approaches, evidence-based therapy interventions, and psychiatric evaluation and medication management for both adults and children. They also offer parenting education, referrals for more intensive services, substance use services, referrals to residential services, and tobacco recovery services.

Warrick County Regional Services: Located in Boonville, IN and offers outpatient behavioral services for adults, children, and families. They provide collaborative treatment-based approaches, evidence-based therapy interventions, and psychiatric evaluation and medication management for both adults and children. They also offer parenting education, referrals for more intensive services, substance use services, referrals to residential services, and tobacco recovery services.

Stepping Stone: Located in Evansville, IN, provides a full continuum of residential and outpatient services for substance use and co-occurring concerns; Evidence Based Practices (EBPs) in use at Stepping Stone include Seeking Safety, Living in Balance, Thinking for a Change, Relapse Prevention Program, My Ongoing Recovery Experience, Mapping Your Steps: Evidence Based Practice Series, Matrix, Helping Women Recover, Helping Men Recover, Healing Trauma, Exploring Trauma, Motivational Interviewing, Moral Reconation Therapy, Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, and 12-Step Facilitation.

Stepping Stone Outpatient Services, ASAM 1: Located in Evansville, IN and offers skills training, individual, group, and family therapy with specialty groups meeting from 1 to 3 times per week. ASAM 1.0 Outpatient services are offered at all county offices.

Stepping Forward ASAM 3.1: Located in Evansville, IN, offers ASAM 3.1 clinically managed low intensity residential programs for women. Stepping Forward is a structured three phase program which provides 24-hour support coupled with intensive treatment tailored to the client's individual needs. Priority admission is given to pregnant women who can stay during their pregnancy, and after birth, with their newborn. Timeframe depends on demonstrated need, with the goal of eventual transition to independent living. Stepping Forward is also a certified recovery residence through DMHA.

Stepping Stone Residential, ASAM 3.5: Located in Evansville, IN, offers Clinically Managed High-Intensity treatment– minimum of 20 hours of clinical services per week. Medications for opioid use disorder when applicable, therapy (individual, group, and family), psychoeducational classes, peer support, case management, medication management, skills training, primary care. The SMART Recovery toolbox will soon be introduced into our residential curriculum. Program offers gender specific programming with separate units for women and men. The typical stay is 21-28 days.

Crisis and Outreach Services: Services include crisis lines, mobile crisis co-response, and a Crisis Stabilization Unit. The crisis lines provide support and assistance to individuals in crisis, including those experiencing suicidal ideation. Calls to the crisis line are answered by trained professionals who assess the level of risk and provide appropriate interventions. This work involves answering calls in a professional and supportive manner, assessing the level of risk, and working with callers to ensure their safety. This work also requires facilitating hospital calls which can involve sharing necessary information with hospitals for coordinated care, such as confirming client status and treatment plans. Mobile crisis response involves responding to crisis situations in emergency rooms and community settings, assessing the situation, and providing appropriate interventions, such as arranging for follow-up services or accompanying individuals to the crisis stabilization unit. Mobile Responses can also occur alongside law enforcement to avoid legal intervention. The Crisis Stabilization Unit (CSU) is a 5-bed/4 living room chair hybrid facility that provides temporary respite and treatment to individuals experiencing acute crisis. CSU admission is voluntary, and individuals may stay in the unit for up to 23 hours before follow-up services begin. Referrals to the CSU can come from various sources, and when contacted by an external referral source, two Crisis Team staff members will assess the situation and determine the best care coordination for the individual. The CSU provides a safe and supportive environment for individuals in crisis, offering temporary respite and

treatment until follow-up services can be arranged. The CSU offers a range of services, including medication management, therapy, counseling, and assistance with developing coping skills and safety plans. The CSU works closely with community resources and providers to ensure a smooth transition and continuity of care for individuals after their stay in the unit.

Child and Family Services: Provides a range of mental health services to children and families in the community for the four-county region. They have a multidisciplinary team of experts who offer comprehensive assessments, individual therapy, group therapy, family therapy, skills training and development, case management, psychiatric services, high fidelity wraparound services, and parent training. These services can be delivered in clinic, home, school, or other community settings. Services rendered in clinic provide a safe environment to address various challenges impacting youth, while home-based family centered therapy focuses on promoting healthy functioning within the family unit. Care Coordination services are offered to link families to community resources, and skills training is provided to enhance parenting skills, social skills, and other life skills. High Fidelity Wraparound is an offered Evidence Based Practice (EBP); it is a team-based planning process that provides coordinated care for youth involved with multiple systems. Additionally, school-based services are available to students experiencing behavioral and emotional difficulties.

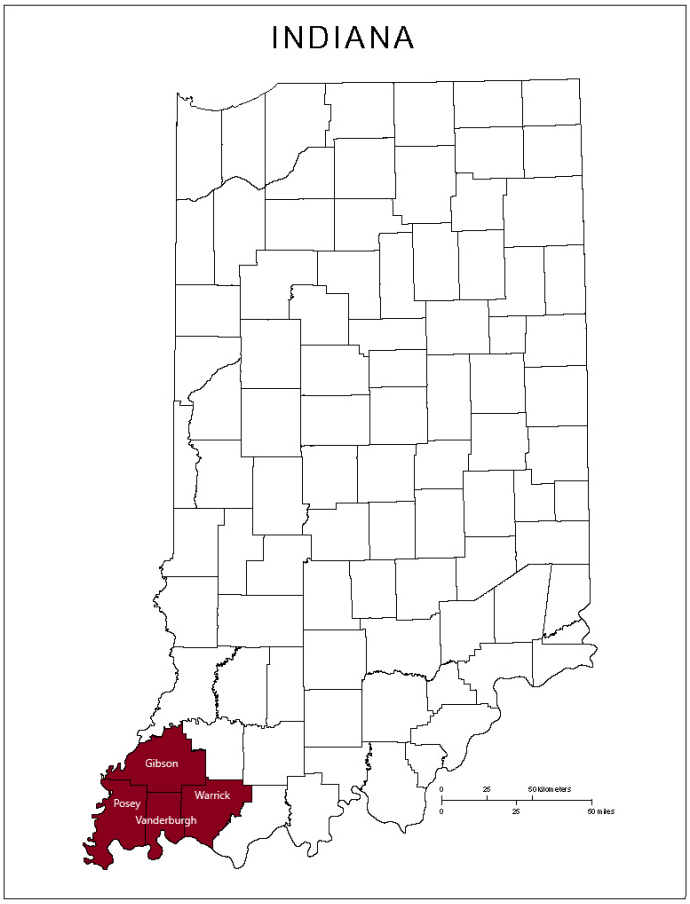
The Neurodevelopmental Center (NDC): A collaboration between Southwestern Behavioral Healthcare and Easterseals Rehabilitation Center, providing integrated care for youth in Indiana with the complex needs of intellectual and Developmental Disabilities (IDD) as well as mental health concerns. The NDC offers comprehensive assessments with a multidisciplinary team, including psychology, psychiatry, mental health services, physical therapy, occupational therapy, speech therapy, nutritional services, and audiology. They also provide care coordination, medication follow-up visits, nutrition and wellness counseling, and connection to community resources and support. EBPs offered include Parent Child Interaction Therapy, Nurturing Parenting, and Brief Strategic Family Therapy. The NDC received the 2024 Indiana Council of Community Health Centers Innovative Collaboration of the year award.

Supervised Group Living (SGL): A residential program that was designed to provide individuals who have severe and persistent mental illness with an environment in which they can develop the skills needed for independent living in the community. There are currently two group homes in Evansville each of these homes consisting of 10 bedrooms, two full and one-half baths, a laundry room, living room, kitchen/dining area, and a staff office and bathroom. Each of these homes can house and care for 10 residents through the provision of 24 hours a day, seven days a week staffing.

Community Support Services: Offers a full range of clinical, housing, health, supported employment, and life skills services to adults with serious mental illness and co-occurring mental illness. Services are provided by integrated skills coaches, integrated skills assistants, master's level therapists, nursing staff, nurse practitioners, and psychiatrists. In addition, services are offered within the jail, including collaboration with the mental health court and the Jail Based Competency Restoration Program.;

Evansville Rescue Mission: Serves a diverse population, primarily comprised of individuals experiencing homelessness and those in need of emergency shelter and support services. This population includes men facing various challenges such as poverty, unemployment, mental health issues, and substance abuse. We offer a variety of clinic-based individual and group therapy, care coordination, supported employment, skills training and case management services, and primary care at this site.

C. Demographics of the Region



Source Image: https://alabamamaps.ua.edu/contemporarymaps/usa/states/Indiana_co_lines.jpg

As part of the requirements established by the State of Indiana and SAMHSA, this Comprehensive Needs Assessment (CNA) aims to describe the region's geographic and demographic composition. This requirement provides an opportunity to present an overview of the geography and unique characteristics of the people living in our region. It is important to note that this is a brief overview and does not exhaustively detail all aspects of these communities. The unique culture of a region cannot be fully captured through this reductive reporting process. Demographics often give the impression that each population described is a monolithic community, which is far from reality.

In addition to the demographic data provided by the U.S. Census, the region also includes unique subpopulations. The area not only contains a federally recognized Promise Zone facing poverty but is also home to more affluent communities. From the river flood plains and miles of fields to the cities and towns, there are many vibrant pockets of cultural, racial, and ethnic diversity that are not fully captured in the raw numbers of demographic statistics. As we begin reviewing the demographics of the region, it is important to recognize that these pockets of diversity often experience unmet behavioral health needs. Later in this report, we will introduce focus group feedback to provide a more comprehensive discussion.

THE REGIONAL DEMOGRAPHIC PROFILE

The four county Southwestern service region (Vanderburgh, Warrick, Gibson, and Posey Counites, IN) consists of 302,197 people, of which 179,900 are residents in Vanderburgh County. Racial breakdown of the region is 86.9% White, 6.5% Black or African American, 2.6% two or more races, 1.6% identified as some other race, and 1.4% are Asian. 3.5% are of Hispanic or Latinx ethnicity.

Vanderburgh County is the most diverse county in the region. Warrick, Gibson, and Posey Counties racial demographics are 91% to 95% white, 1.3 to 2.1% Black or African American, and less than 1.4% Asian. Also of note is that compared to Indiana as a State, Gibson County has a slightly higher percentage of children under the age of 18, while nearly 1 in 5 of Posey County residents are over the age of 65. All counties in the region have higher percentages of individuals over the age of 65 than the state average.

The following tables present the breakdown of publicly available data describing the regional demographic composition:

Race (% of Total Population)						
Location	White	Black or African American	Asian	Some Other Race	Two or More Races	Total Population
Vanderburgh	83.3%	9.8%	1.4%	1.5%	4.0%	179,900
Warrick	91.5%	2.1%	2.4%	1.2%	2.9%	64,065
Gibson	91.5%	1.8%	0.5%	2.6%	3.7%	33,006
Posey	95.2%	1.3%	0.4%	1.3%	1.8%	25,226
Area Total	86.9%	6.5%	1.4%	1.6%	3.5%	302,197
Indiana	80.0%	9.4%	2.5%	3.0%	5.1%	6,784,403

Ethnicity (% of Total Population)		
Location	Hispanic	Total Population
Vanderburgh	3.0%	179,900
Warrick	2.1%	64,065
Gibson	2.0%	33,006
Posey	1.3%	25,226
Area Total	2.6%	302,197
Indiana	7.5%	6,784,403

Sex (% of Total Population)			
Location	Female	Male	Total Population
Vanderburgh	51.1%	48.9%	179,900
Warrick	50.8%	49.2%	64,065
Gibson	49.3%	50.7%	33,006
Posey	49.5%	50.5%	25,226
Area Total	50.7%	49.3%	302,197
Indiana	50.4%	49.6%	6,784,403

Age Groups (% of Total Population)				
Location	Under 18	18-64	65+	Total Population
Vanderburgh	21.5%	60.8%	17.6%	179,900
Warrick	23.4%	58.4%	18.2%	64,065
Gibson	23.9%	58.6%	17.4%	33,006
Posey	21.9%	58.4%	19.8%	25,226
Area Total	22.2%	59.9%	17.9%	302,197
Indiana	23.3%	60.6%	16.2%	6,784,403

Source: 2022 ACS 5-Year Estimate: Table DP05

A DEMOGRAPHIC OVERVIEW OF INDIVIDUALS and FAMILIES RECEIVING SOUTHWESTERN SERVICES

In the following comparative analysis, we seek to explore the following questions:

- Who are the clients of Southwestern Behavioral Healthcare?
- In which county do we need more services for children, substance use, and mental health?
- Do the demographics of Southwestern clients, staff, and leadership resemble the demographics of the communities we serve?

Southwestern has 4,809 active clients in Vanderburgh County, 1,223 clients in Warrick County, 849 clients in Gibson County, and 608 clients in Posey County.

Southwestern clients aggregate racial composition is 79.1% White, 10.1% Black/African American, 4.9% two or more races, 5.6% of some other race, and 0.3% Asian. Southwestern client ethnicity indicates 3% of Southwestern clients are of Hispanic or Latinx ethnicity.

- The client racial characteristic of Vanderburgh County is 74.1% White, 13.9% Black/African American, and 5.8% Some other Race.
- The client racial characteristics of Warrick, Gibson, and Posey County combined is 82.6% to 90% White, 2.6 to 3.3% Black or African American, and less than 0.4% Asian.
    - Also of note is that compared to the rest of Indiana, Posey County has a higher percentage of clients identifying as Some Other Race (11.5%).

COMPARATIVE DEMOGRAPHIC PROFILE OF SOUTHWESTERN CLIENTS AS COMPARED TO THE SERVICE REGION

Race (% of Total In Treatment)						
Location	White	Black or African American	Asian	Some Other Race	Two or More	Client Population
Vanderburgh	74.1%	13.9%	0.4%	5.8%	5.8%	4,809
Warrick	90.0%	3.3%	0.4%	3.3%	3.0%	1,223
Gibson	89.4%	3.9%	0.0%	3.1%	3.7%	849
Posey	82.6%	2.6%	0.2%	11.5%	3.1%	608
Region	79.1%	10.1%	0.3%	5.6%	4.9%	7,489
Indiana	80.0%	9.4%	2.5%	3.0%	5.1%	6,784,403

Ethnicity (% of Total In Treatment)		
Location	Hispanic	Client Population
Vanderburgh	3.0%	4,715
Warrick	2.0%	1,208
Gibson	3.0%	837
Posey	2.0%	576
Region	3.0%	7,336
Indiana	7.5%	6,784,403

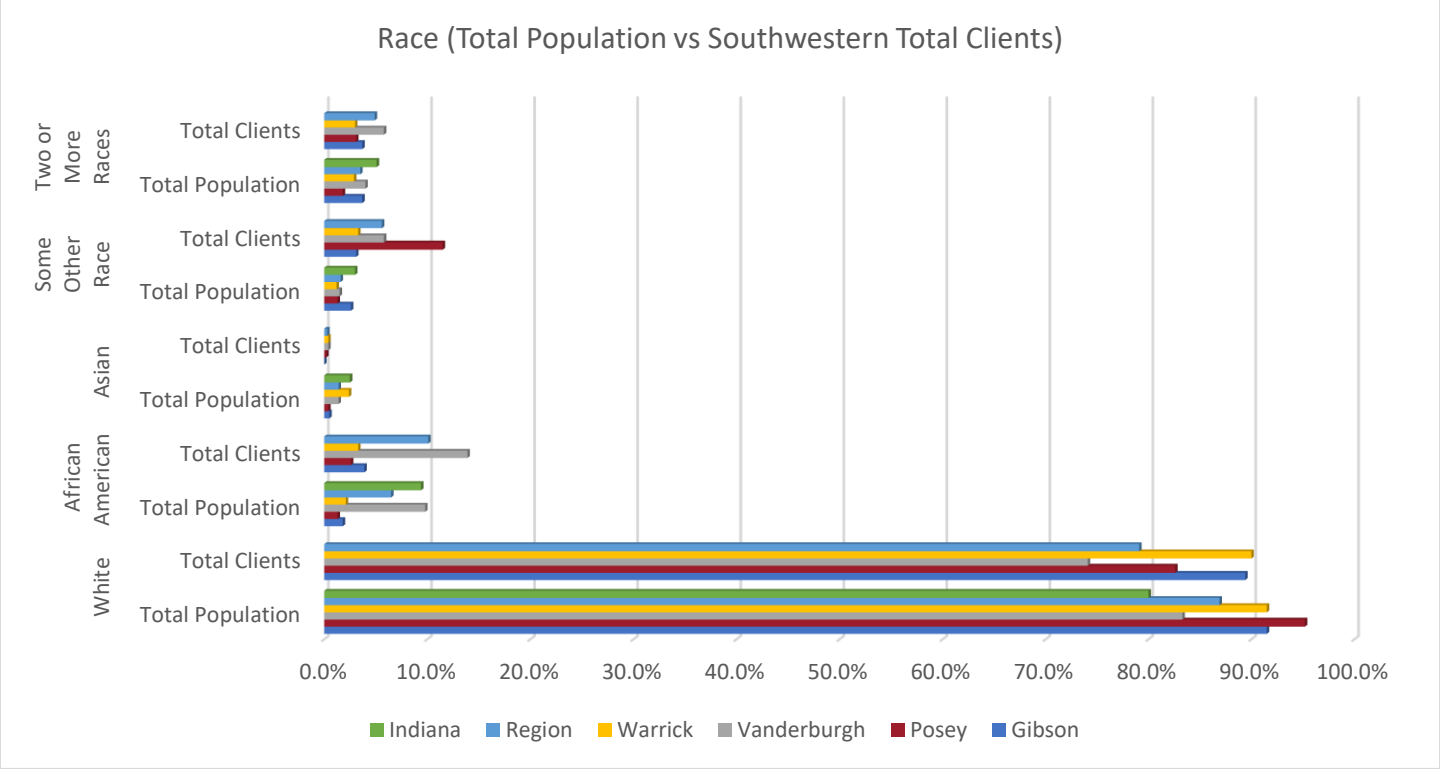
Sex (% of Total In Treatment)			
Location	Female	Male	Total Population
Vanderburgh	50.8%	49.2%	4,770
Warrick	54.7%	45.3%	1,218
Gibson	54.8%	45.2%	837
Posey	53.0%	47.0%	604
Region	52.1%	47.9%	7,429
Indiana	50.4%	49.6%	6,784,403

Age (% of Total In Treatment)				
Location	Under 18	18-64	65+	Total Population
Vanderburgh	30.9%	63.3%	5.8%	4,807
Warrick	47.5%	47.6%	4.9%	1,222
Gibson	33.0%	62.5%	4.5%	849
Posey	28.0%	67.1%	4.9%	608
Region	33.6%	61.0%	5.4%	7,486
Indiana	23.3%	60.6%	16.2%	6,784,403

COMPARISON BETWEEN REGIONAL POPULATION AND INDIVIDUALS/FAMILIES IN TREATMENT AT SOUTHWESTERN

One measure of CCBHC success is demographic alignment between regional demographics and the demographics of our client base, staff, leadership, and governing board members. The resulting comparison is provided in the tables below.

Race (% of Total Population) vs % of Total Southwestern Clients



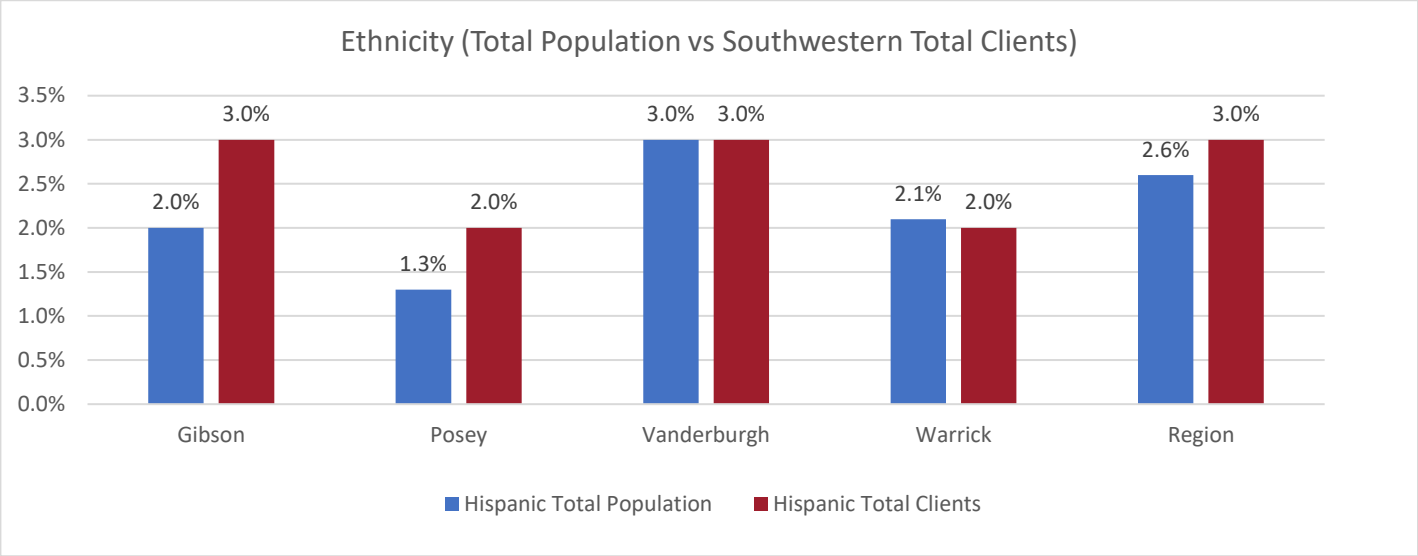
Source: 2022 ACS 5-Year Estimate: Table DP05

Regional Demographic Comparison by County and Southwestern Client Race

Location	White	Black or African American	Asian	Some Other Race	Two or More Races	Total Population / Client Population
Vanderburgh	83.3% / 74.1%	9.8% / 13.9%	1.4% / 0.4%	1.5% / 5.8%	4.0% / 5.8%	179,900 / 4,809
Warrick	91.5% / 90.0%	2.1% / 3.3%	2.4% / 0.4%	1.2% / 3.3%	2.9% / 3.0%	64,065 / 1,223
Gibson	91.5% / 89.4%	1.8% / 3.9%	0.5% / 0.0%	2.6% / 3.1%	3.7% / 3.7%	33,006 / 849
Posey	95.2% / 82.6%	1.3% / 2.6%	0.4% / 0.2%	1.3% / 11.5%	1.8% / 3.1%	25,226 / 608
Region	86.9% / 79.1%	6.5% / 10.1%	1.4% / 0.3%	1.6% / 5.6%	3.5% / 4.9%	302,197 / 7,489
Indiana	80.0%	9.4%	2.5%	3.0%	5.1%	6,784,403

*Clients in an active episode of service as of May 2024

Ethnicity (% of Total Population) vs % of Total Clients



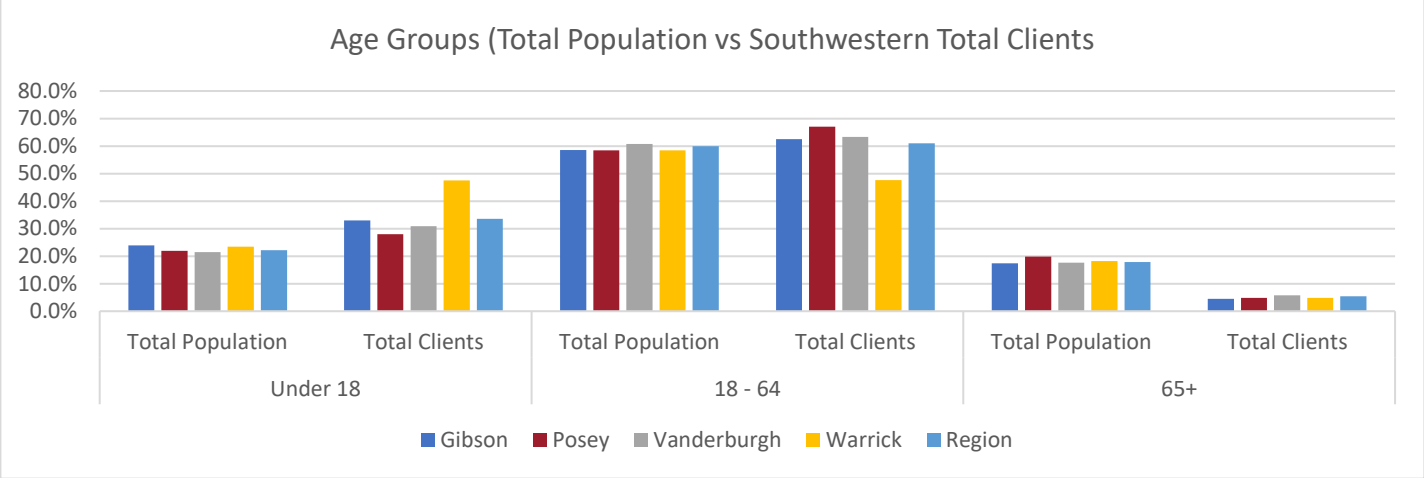
Location	Hispanic	Total Population / Client Population
Vanderburgh	3.0% / 3.0%	179,900 / 4,715
Warrick	2.1% / 2.0%	64,065 / 1,208
Gibson	2.0% / 3.0%	33,006 / 837
Posey	1.3% / 2.0%	25,226 / 576
Region	2.6% / 3.0%	302,197 / 7,336
Indiana	7.5%	6,784,403

Source: 2022 ACS 5-Year Estimate: Table DP0

Sex (% of Total Population) vs % of Total Clients

Location	Female	Male	Total Population
Vanderburgh	51.1% / 50.8%	48.9% / 49.2%	179,900 / 4,770
Warrick	50.8% / 54.7%	49.2% / 45.3%	64,065 / 1,218
Gibson	49.3% / 54.8%	50.7% / 45.2%	33,006 / 837
Posey	49.5% / 53.0%	50.5% / 47.0%	25,226 / 604
Region	50.7% / 52.1%	49.3% / 47.9%	302,197 / 7,429
Indiana	50.4%	49.6%	6,784,403

Age Groups (% of Total Population) vs % of Total Clients



Source: 2022 ACS 5-Year Estimate: Table DP05

Location	Under 18	18-64	65+	Total Population
Vanderburgh	21.5% / 30.9%	60.8% / 63.3%	17.6% / 5.8%	179,900 / 4,807
Warrick	23.4% / 47.5%	58.4% / 47.6%	18.2% / 4.9%	64,065 / 1,222
Gibson	23.9% / 33.0%	58.6% / 62.5%	17.4% / 4.5%	33,006 / 849
Posey	21.9% / 28.0%	58.4% / 67.1%	19.8% / 4.9%	25,226 / 608
Region	22.2% / 33.6%	59.9% / 61.0%	17.9% / 5.4%	302,197 / 7,486
Indiana	23.3%	60.6%	16.2%	6,784,403

Source: 2022 ACS 5-Year Estimate: Table DP05

Comparative Demographics

	Southwestern Regional	Southwestern Clients	Southwestern Staff	Southwestern Board
Sex				
Male	47.9%	46.1%	16.1%	31.3%
Female	52.1%	52.7%	83.9%	68.8%
Race				
Asian	0.3%	0.3%	1.2%	6.3%
Black	10.1%	10.0%	7.9%	6.3%
White	79.1%	79.5%	86.4%	87.5%
Ethnicity				
Hispanic or Latino	3.0%	2.7%	2.5%	0.0%
Not Hispanic or Latino	97.0%	94.9%	93.0%	81.3%
Gender Identity				
Male/Cisgender	-	42.1%	14.1%	31.3%
Female/Cisgender	-	47.5%	79.3%	68.8%
Non-binary/Gender Fluid	-	1.8%	2.1%	0.0%
Transgender (Male to Female)	-	0.1%	0.0%	0.0%
Transgender (Female to Male)	-	0.5%	0.4%	0.0%
Sexual Orientation				
Heterosexual/Straight	-	70.7%	79.3%	93.8%
Not Sure/Questioning	-	2.4%	0.8%	0.0%
Not Heterosexual	-	12.9%	17.4%	0.0%

SUMMARY FROM POPULATION DEMOGRAPHICS

Southwestern Behavioral Healthcare serves a diverse clientele across Vanderburgh, Warrick, Gibson, and Posey counties, with the highest number of clients in Vanderburgh County (4,809). The racial composition of Southwestern's clients is predominantly White (79.1%), with notable percentages of Black/African American (10.1%) and individuals of other races.

The demographic profiles of the four counties in the southwest corner of Indiana differ significantly. Southwestern is one of many service providers in Vanderburgh County but the only provider in Posey County. Regional demographic comparisons between residents and Southwestern clients indicate that the services are utilized by a representative sample of residents. A demographic comparison of individuals currently in treatment at Southwestern by race reflects the regional variances between the more urban Vanderburgh County and the three rural counties.

Clients identifying as White are represented at a higher percentage (79%) than the regional average of 87%. Active Southwestern clients identifying as Black/African American are represented at higher rates (10.1%) than in the broader community (6.5%). Asians are under-represented among Southwestern clients by less than 1%, with regional demographic rates also low at 1.4%. Individuals identifying as more than two races or some other race account for 10.5% of Southwestern clients compared to the regional average of 5.1%.

Ethnic diversity includes those identifying as Hispanic. Southwestern clients reported Hispanic ethnicity at 3% compared to 2.6% for the region. Females represent 52% of Southwestern clients compared to 48% males, which is the reverse of the regional demographic composition. This small (4%) difference indicates that males are nearly as likely to seek services as females. The largest representative age group of clients is 18-64 years, except in Warrick County, where children under 18 are the largest age group served. Compared to Indiana as a whole, Gibson County has a slightly higher percentage of children under 18, while nearly 1 in 5 Posey County residents are over 65. All counties in the region have higher percentages of individuals over 65 than the state average of 16.2%.

D. Regional Populations of Interest

The U.S. Center for Disease Control and Prevention (CDC) defines health disparities as "preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations." [xxxv] SAMHSA expects CCBHCs will focus their efforts on specific groups facing health disparities. The CDC expresses that "health disparities result from multiple factors, including poverty, environmental threats, inadequate access to health care, individual and behavioral factors, and educational inequalities. Populations can be defined by factors such as race or ethnicity, gender, education or income, disability, geographic location (e.g., rural or urban), or sexual orientation." [xxxvi]

The demographics of who Southwestern is serving in our region has been identified and discussed, however as a CCBHC, who we are *not* treating is of equal concern. Intentional outreach to unserved or underserved populations who experience health disparities is a core component of the CCBHC model. Due to guidance given by the National Council for Mental Wellbeing, SAMHSA, and through the demographic data available in both the public domain and Southwestern's EHR, the following are recognized as populations of focus based on our regional and client demographic analyses.

- People experiencing homelessness
- Individuals with co-occurring mental health/substance use conditions
- Individuals with co-occurring developmental/physical disabilities
- LGBTQ+ youth
- Veterans
- Individuals with disabilities
- Individuals with substance use concerns

In the following section we will review the data available concerning these populations.

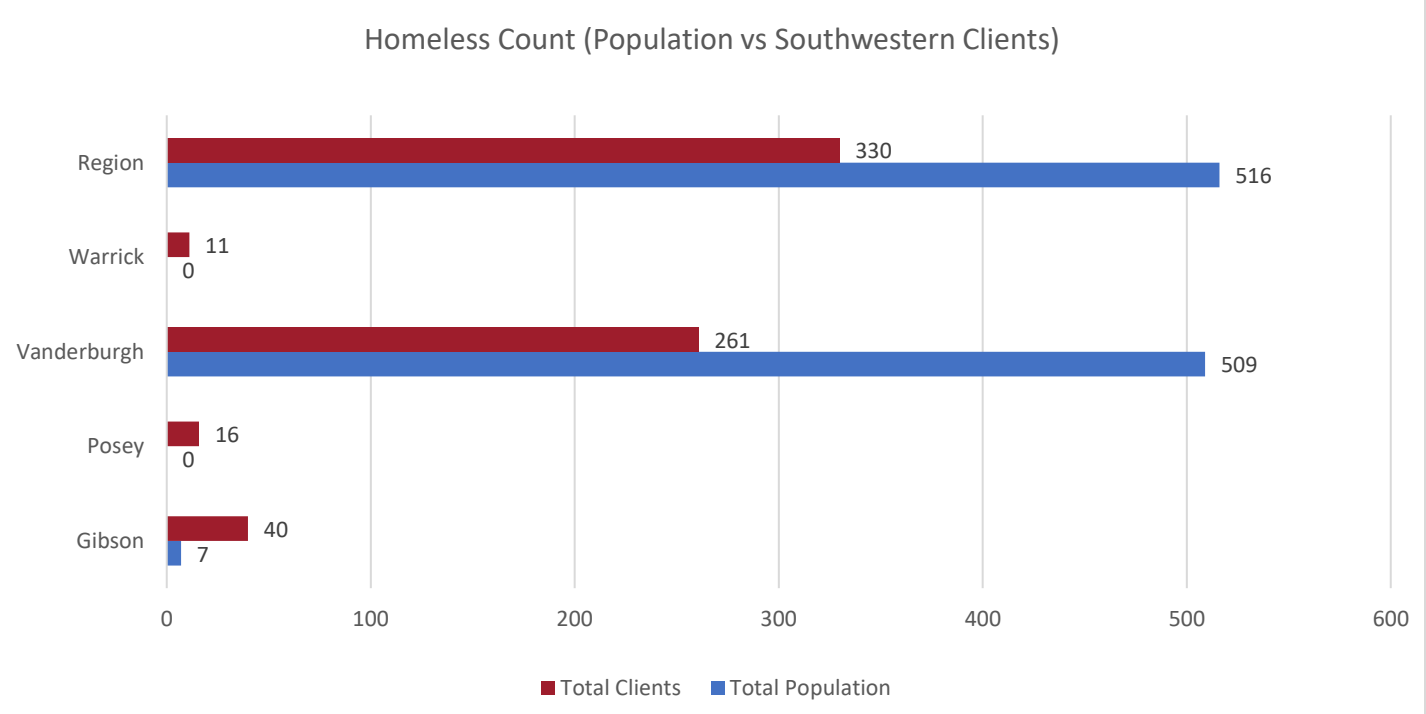
HOMELESSNESS IN THE REGION

Evansville is often the destination for individuals who are experiencing homelessness across the tri-state region, as the rural surrounding counties lack services and shelters. Individuals experiencing homelessness frequently arrive in Evansville needing assistance beyond shelter. Vanderburgh County has an active collaboration of agencies serving, feeding, sheltering, and housing individuals experiencing housing and food instability. A strength identified in Vanderburgh County is the strong network and collaboration among these agencies.

Southwestern collects many demographic categories through its comprehensive evaluation including data on housing stability of the individuals we serve. In the chart below, we have compared our internal count of homelessness with those of the 2023 Indiana Housing and Community Development Authority Point-in-Time (PIT) Count Data. The comparison is provided to compare client-based data with the community snapshot.

Point in Time Homeless Count			
Location	Number of Persons Experiencing Homelessness	Sheltered %	Unsheltered %
Gibson	7	0%	100%
Posey	0	--	--
Vanderburgh	509	79.6%	20.4%
Warrick	0	--	--
Area Total	516	78.5%	21.5%
Indiana	4,398	81.7%	18.3%

Source: 2023 Indiana Housing and Community Development Authority Point-in-Time (PIT) Count Data.



Individuals receiving services at the Warrick and Posey County offices reported no incidence of homelessness, contrasting with the Southwestern community snapshot (PIT Count) which recorded 11 homeless individuals in Warrick County and 16 in Posey County. In Gibson County, 7 unhoused individuals were receiving services at Southwestern, while the 2023 PIT count was 40. This discrepancy suggests that additional outreach and support for the homeless population may be warranted.

It is important to note that PIT values are a snapshot metric, collected annually on one day, whereas Southwestern's data is continuously updated. Therefore, the comparison is not one-to-one. PIT data helps to understand chronic homelessness, while Southwestern's data can account for day-to-day occurrences of unstable housing. Using both metrics provides a more comprehensive understanding of regional homelessness.

Homeless Clients		
Location	**Homeless Clients**	**Total Clients with Known Living Arrangements**
Vanderburgh	6.1%	4,272
Warrick	1.0%	1,110
Gibson	5.1%	781
Posey	2.8%	567
All Clients	4.9%	6,730

Source: 2022 ACS 5-Year Estimate: Table S2101

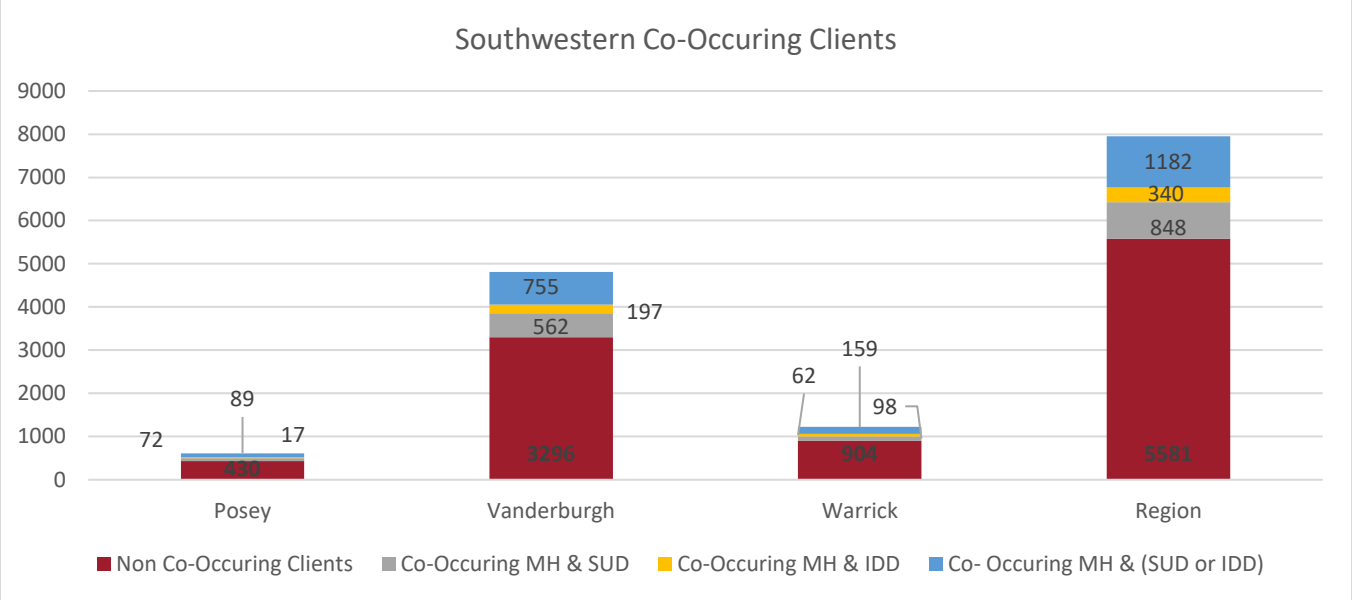
CO-OCCURRING DIAGNOSES

Co-occurring disorders, or comorbidity, refers to the simultaneous presence of two or more of the following diagnosed conditions: mental health, substance use, IDD, or a physical health condition. Comorbidity also implies that interactions between these diagnoses can worsen the course of both. Certain mental health conditions place individuals at higher risk for developing comorbid medical conditions. Certain medical problems place individuals at higher risk for comorbid substance misuse or exacerbation of existing mental health conditions.[xxxvii] Individuals and families needing integrated care of comorbid conditions have often struggled receiving access to such care, as the symptoms of one condition often resulted in not meeting admission criteria for either service.

Data around co-occurrence of mental health issues, substance use, and/or physical disabilities is limited for general and regional populations; however, Southwestern enters both physical and mental health diagnoses into our electronic health record (EHR) system as part of our healthcare integration initiative. Co-occurrence among Southwestern clients is presented in the table below, with the understanding that these rates are the best available proxy for rates of co-occurrence within the community.

The graphics below illustrate the prevalence of comorbid diagnostic issues of the Southwestern client base. Nearly 15% of the individuals and families we serve are experiencing more than one diagnosis that requires concurrent treatment. 10.7% of Southwestern clients are experiencing both mental health and substance use issues. Of those receiving services, 4.3% are addressing issues related to an intellectual or developmental disability in addition to an active mental health and/or substance use diagnosis.

Individuals with Co-Occurring Disorders (Individuals in treatment with Southwestern)



Location	Rate of Co-Occurrence (MH and SUD)	Rate of Co-Occurrence (MH and IDD)	Rate of Co-Occurrence (MH and SUD or IDD)
Vanderburgh	11.7% (562/4810)	4.1% (197/4810)	15.7% (755/4810)
Warrick	8.0% (98/1223)	5.1% (62/1223)	13.0% (159/1223)
Gibson	11.0% (93/849)	5.3% (45/849)	16.1% (137/849)
Posey	11.8% (72/608)	2.8% (17/608)	14.6% (89/608)
All Clients	10.7% (848/7951)	4.3% (340/7951)	14.9% (1182/7951)

THE LGBTQ+ COMMUNITY

The LGBTQ+ population of coupled households was identified in the 2020 Census and the counts range from 2% in Vanderburgh County to 0.6% in Posey County. This measure is only those LGBTQ+ individuals who are coupled in a relationship, omitting uncoupled individuals, resulting in an under representation of the total population of LGBTQ+ individuals in the region. The LGBTQ+ population is identified by SAMHSA and through research available through The Trevor Project as at higher risk of negative life outcomes. Individuals in this population often hesitate to seek needed behavioral and primary health services. These factors identify this population as underserved.[xxxviii]

In a 2021 survey by the Trevor Project, 45% of LGBTQ+ youth seriously considered suicide in the past year, while 60% who sought mental health care were not able to get it. LGBTQ+ adults experience higher rates of binge drinking, substance use disorder, generalized anxiety disorder, and depression. Higher rates of cancer, heart disease, diabetes, chronic pulmonary obstructive disease, diabetes, and asthma are also observed within this population.[xxxix] Identified risk factors include LGBTQ+ based discrimination, victimization, and stigma.[xl]

While SOGI (Sexual Orientation Gender Identity) data collected in our medical records is very granular, the categories used for the demographic categories below consist of heterosexual and LGBTQ+ individuals. These two categories are split into two categories. One includes all clients who identify as heterosexual, or heterosexual but questioning, this group were counted as heterosexual. Whereas the LGBTQ+ category is comprised of clients who indicated they did not identify as heterosexual.

The following tables represent regional U.S. Census Bureau statistics on same sex couples and Indiana profiles from the Trevor project on LGBTQ+ youth suicide risk and reasons for not seeking mental health treatment.

Sexual Orientation (% of Total Clients)

Location	Heterosexual	LGBTQ+	Total Clients with Known Orientation
Vanderburgh	85.3%	14.7%	3,906
Warrick	89.4%	9.8%	988
Gibson	94.3%	6.4%	809
Posey	88.6%	10.4%	558
All Clients	87.3%	12.7%	6,261

Same-Sex Couples (Regional Population)

Location	% of Coupled Households that are Same-Sex Couples (Married and Unmarried)	Total Number of Coupled Households
Vanderburgh	2.0%	37,179
Warrick	1.0%	15,936
Gibson	0.90%	7,707
Posey	0.60%	6,360
Region Total	1.5%	67,182
Indiana	1.4%	1,445,955

Source: 2020 Decennial Census: Table PCT15

LGBTQ+ Youth Mental Health Measures in Indiana (Data Reflects Youth Experience in 2021)

	Vanderburgh	Warrick	Gibson	Posey	Region	Indiana
LGBTQ+ Youth Who Seriously Considered Suicide	470	182	96	67	815	19,350
LGBTQ+ Youth Who Attempted Suicide	157	61	32	22	272	6,450
LGBTQ+ Youth Who Experienced Symptoms of Anxiety	783	304	160	112	1,359	32,250
LGBTQ+ Youth Who Experienced Symptoms of Depression	606	235	124	87	1,051	24,940
LGBTQ+ Youth Who Wanted Mental Healthcare but were unable to get it	647	251	132	92	1,123	26,660

Sources: The Trevor Project: 2022 National Survey on LGBTQ+ Youth Mental Health Indiana Report[xli]

Top Identified Reasons Why LGBTQ+ Youth Who Wanted Mental Healthcare Were Unable to Receive Care

	Vanderburgh	Warrick	Gibson	Posey	Region	Indiana
I was afraid to talk about my mental health concerns with someone else	501	194	102	72	869	20,640
I could not afford it	470	182	96	67	815	19,350
I was afraid I wouldn't be taken seriously	460	178	94	66	797	18,920
I did not want to have to get my parent's / caregiver's permission	439	170	89	63	761	18,060
I was afraid it wouldn't work	386	150	79	55	670	15,910

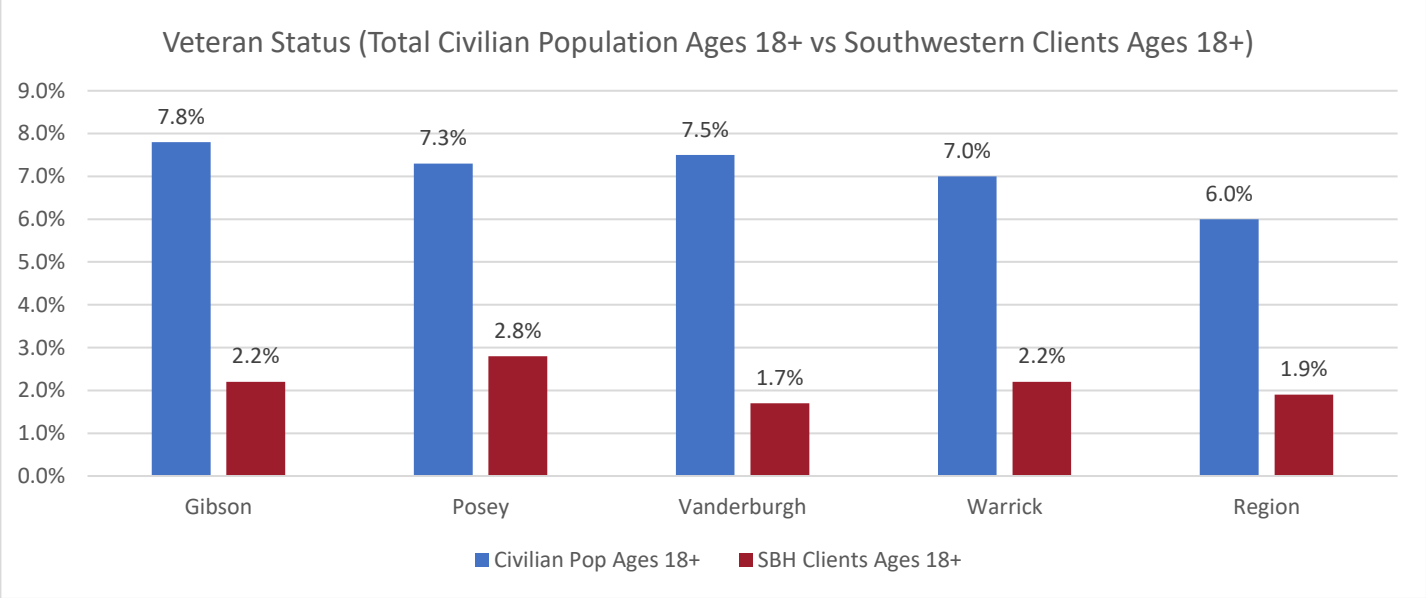
Sources: The Trevor Project: 2022 National Survey on LGBTQ+ Youth Mental Health Indiana Report and Williams Institute of the UCLA School of Law on LGBT Youth Population in the United States[xlii]

VETERANS

Veterans are a protected class under HHS guidelines and represent 1 in 15 individuals within Southwestern's service area. Veterans are an underserved population within the mental health center system across Indiana. [xliii] The Evansville Veterans Administration Health Care Center and the Evansville VET Center are both located in Evansville and provide a significant number of services to Veterans across the region. The Evansville VA Health Care Center provides outpatient mental health and psychiatric services.

Given the disproportionately high suicide rates within the Veteran population, linking Veterans to VA care and benefits is part of our CCBHC mandate. Providing comprehensive treatment to Veterans and active-duty military personnel who chose not to utilize VA services, regardless of their reason, is also a CCBHC priority.

Veteran Status (% of Total Civilian Population Over 18 Years Old) vs Client Population Over Age 18



Location County	Veterans	Total Civilian Population Over 18
Vanderburgh	7.5% / 1.7%	177,361 / 3,322
Warrick	7.0% / 2.2%	63,237 / 642
Gibson	7.8% / 2.2%	25,113 / 569
Posey	7.3% / 2.8%	24,980 / 438
Region	6.0% / 1.9%	290,691 / 4,971
Indiana	6.8%	5,202,053

Source: 2022 ACS 5-Year Estimate: Table S2101

INDIVIDUALS LIVING WITH DISABILITY

The disability rate among individuals served at Southwestern is 15.8% compared with the regional disability rate average of 14.4%. The differential between regional and agency disability demographics in Warrick County may reflect some transportation barriers and the lack of public transportation faced by the rural counties in our region.

Location	People with a Disability		Total Population with Disability Status Determined	Southwestern Clients
	Screened Population	Southwestern Clients		
Vanderburgh	15.4%	18.5%	177,361	2,373
Warrick	12.1%	9.2%	63,237	578
Gibson	15.7%	10.1%	32,448	397
Posey	12.1%	15.2%	24,980	315
Region	14.4%	15.8%	298,026	3,663
Indiana	13.7%		6,687,996	

Source: 2022 ACS 5-Year Estimate: Table S1810

INDIVIDUALS WHO USE SUBSTANCES

Regional Substance Use Treatment Episodes

Location	Alcohol Admissions	Marijuana Admissions	Cocaine Admissions	Heroin Admissions	Methamphetamine Admissions	Prescription Opioid Admissions	Total Number of Treatment Episodes
Vanderburgh	52.8% (n=603)	63.7% (n=727)	5.0% (n=57)	7.2% (n=82)	47.5% (n=542)	12.1% (n=138)	1,142
Warrick	51.7% (n=109)	63.5% (n=134)	--	5.7% (n=12)	49.8% (n=105)	11.8% (n=25)	211
Gibson	51.1% (n=89)	56.9% (n=99)	2.9% (n=5)	--	58.0% (n=101)	13.8% (n=24)	174
Posey	46.1% (n=47)	59.8% (n=61)	--	5.9% (n=6)	44.1% (n=45)	16.7% (n=17)	102
Total Area	52.1% (n=848)	62.7% (n=1,021)	3.8% (n=62)	6.1% (n=100)	48.7% (n=793)	12.5% (n=204)	1,692
Indiana	43.4% (n=10,228)	47.1% (n=11,102)	10.3% (n=5,402)	22.9% (n=5,402)	41.3% (n=9,746)	16.1% (n=3,788)	23,573

Source: Indiana Family and Social Services Administration, Division of Mental Health and Addiction, 2021. Accessed via IU Prevention Insights County Profiles:

Individuals seeking substance use treatment within the region make up just under 1% of the region's total population. Most individuals seeking treatment are addressing the use of methamphetamine, alcohol, or cannabis. 1 in 6 individuals seeking treatment are seeking treatment for opioid use. Substance use impacts a significant portion of the community, impacting all members of the family system.

Current Cigarette Smokers

	Vanderburgh	Warrick	Gibson	Posey	Indiana
% Current Cigarette Smokers[1]	21.2%	17.5%	21.3%	20.1%	20.2%

Sources: [1]BRFSS, 2020 Defined as: The adult population who both report that they currently smoke every day or some days and have smoked at least 100 cigarettes in their lifetime.

The regional smoking rate aligns with the Indiana state average of 20% and correlates with the most prevalent smoking related health issues including heart disease, cancer, and chronic lower respiratory disease.

Alcohol Measures

	Vanderburgh	Warrick	Gibson	Posey	Indiana
% Excessive Drinking[1]	19.3%	19.3%	18.5%	19.0%	18.4%
% of Driving Deaths Involving Alcohol Impairment[2]	10.8%	25.0%	14.6%	7.7%	19.0%

[1]BRFSS, 2020 Defined as: The percentage of adult respondents reporting either binge drinking (Women: >4 Drinks, Men: >5 Drinks on one occasion) or heavy drinking (Women: >1 drink per day, Men: >2 drinks per day); [2]Fatality Analysis Reporting System, 2016-2020.

The overall percentage of driving deaths involving alcohol impairment in Indiana is 19.0%. In Warrick County, 1 out of 4 traffic fatalities involved alcohol impairment, while the other regional counties experienced much lower rates, with Posey County the lowest at 7.7%. All four counties in the region reported binge drinking at levels higher than the state average.

Drug Overdoses					
	Vanderburgh	Warrick	Gibson	Posey	Indiana
Drug Overdose Deaths per 100,000[1]	22.8	16.4	9.9	--	28.0
Non-Fatal ER Visits Involving any Opioid Overdose per 100,000[2]	47.9	41.3	26.7	35.4	75.2

[1]National Center for Health Statistics – Mortality Files, 2018-2020; [2]Indiana State Department of Health, Division of Trauma and Injury, 2019. Accessed via IU Prevention Insights County Profiles Data

Fatal and non-fatal opioid overdose is a regional and national health crisis. Indiana's average overdose related death rate is 28 per 100,000 people. Comparatively, regional statistics illustrate lower percentages than the state average but are indiscriminate regarding years of potential life lost. Non-fatal overdose rates in the reporting counties indicate our region is experiencing less non-fatal overdoses than the state average. The region continues to require active prevention and intervention efforts.

SUMMARY OF POPULATIONS OF INTEREST

Populations of interest as defined within this CNA are at higher risk for being underserved due to lack of access to food, housing and transportation; or an established history of being unable to access behavioral health services.

Vanderburgh is the only county in our region providing services to individuals experiencing homelessness. It is common for hospitals or facilities in adjacent states and counties to provide transportation to Evansville, as part of a post-hospitalization discharge plan. When coordinated well, it is a good plan; the individual can then access food, shelter, clothing, and possibilities. When not coordinated, the person may arrive to a city they have never been and dropped at a shelter that only takes men. Crisis services work with local homeless shelters is often an individual's first point of contact with Southwestern.

Co-occurring or Comorbid conditions are two health conditions that occur together and may worsen the outcomes of both conditions, such as anxiety and hypertension. Historically individuals diagnosed with an intellectual or developmental disability were not treated in the mental health center system and mental health issues were not treated in the Bureau of Disability agencies; families were at a loss and struggled to get adequate care from either system. Co-occurring mental health and substance use disorders need concurrent treatment which can be accessed through the CCBHC model.

Regional data on the LGBTQ+ community is limited. The county data for LGBTQ+ youth indicate a significant gap in desire for care and the ability to access it. Local youth who participated in the survey noted fear in talking to someone about their mental health concerns, not being taken seriously, and not wanting to get a parent or caregiver's permission to engage in treatment services, as the main barriers to care. They also indicated suicidal ideations or attempts and untreated depression and anxiety.

Veterans who are not receiving care through the local VA system may not know what benefits they are entitled to or choose not to receive services through the VA system of care. The CCBHC model provides Veteran-centered care pathways to assure Veterans or members of the Armed Forces receive care from the most appropriate provider of their choosing.

Individuals with disabilities make up 14% of Southwestern's client base. Ongoing care coordination to address potential transportation barriers to treatment may be key to accessing services.

Substance use disorders are prevalent in our region and identified by all counties as a priority concern within their own community needs assessment reports. Alcohol and methamphetamine use were identified as the communities' primary concerns. Marijuana treatment episodes are also prominent. As neighboring states legalize cannabis, the impact on treatment episode data may be impacted.

Methodology of the Community Needs Assessment

Southwestern began the CNA process with our CCBHC-E grant in 2021; this was then updated upon writing of the Disparity Impact Statement (DIS) for the CCBHC-IA grant in 2023. As planning for the 3-year CNA update began, Southwestern reached out to Diehl Consulting Group (DCG) to seek assistance in conducting an in-depth update to the original CNA. A Scope of Work (SOW) was proposed by DCG. The SOW laid out the basic structure of data collection of both primary and secondary sources and determined the roles of each party within the research and writing process.

It was determined that Southwestern's CNA would follow the processes outlined in the National Council for Mental Wellbeing's CCBHC Community Needs Assessment Toolkit and updated CNA attestation definitions provided by SAMHSA (May 2024).

A. Guiding questions

The following three questions were the foundation for this Community Needs Assessment. Methods and processes are described later in the assessment.

1. What are the community needs and barriers to mental health and substance use care?
2. To what extent are Southwestern's current staffing and services responsive to these community needs?
3. How can Southwestern strategically partner with other community providers to meet these community needs?

B. Methodology

PREPARING FOR THE NEEDS ASSESSMENT

Southwestern completed an initial CNA in 2021. This needs assessment began in fall 2023; the process will extend into August of 2024. Preparation involved mapping the requirements of SAMHSA and the state of Indiana against goals and expectations of internal stakeholders. The following individuals were critical to the preparation process.

Name	Role	Organization
Melissa Duneghy	Continuous Improvement Manager	Southwestern Behavioral Healthcare
Shawn Edwards	Data Analyst	Southwestern Behavioral Healthcare
Aaron Scott	Grants Program Evaluator	Southwestern Behavioral Healthcare
Lisa Withrow	CCBHC-IA Project Director	Southwestern Behavioral Healthcare
Doug Berry	Evaluation Consultant	Diehl Consulting Group

COLLECTING QUANTITATIVE AND QUALITATIVE INFORMATION

Quantitative data was collected throughout the needs assessment process. Population data was collected on demographics of the service region and characteristics of the population. This information was collected from external sources; findings are presented in tables throughout the report and data sources are found in the endnotes. Priority was placed on data that were a) available at the county-level for the service region and b) had state and/or national comparison data available. Complementing the external population data were Southwestern's internal data points around individuals receiving services. This information was extracted from the Electronic Health Record (EHR) and allows for meaningful comparisons to the population data.

Qualitative data was collected from a variety of sources, including a) a survey of Southwestern leadership, b) a survey of Southwestern partners c) focus groups with community representatives, and d) focus groups with Southwestern clients.

ENGAGING COMMUNITY AND PARTNERS

Qualitative Data Source	Date(s)	Participation	Recruitment
Southwestern Leadership Survey	Week of February 26, 2024	Participants were invited to describe up to three things Southwestern does well and up to three opportunities for improvement. 126 comments were provided for things going well and 122 for opportunities for improvement.	All staff members who are supervisors or above were invited to complete the survey.
Southwestern Partner Survey	March 10, 2024, through March 31, 2024	26 partner organizations participated (at least partially) in the survey.	Southwestern staff identified contact information for partner organizations with an MOU. Then Southwestern directors added any organizations and/or contacts not already identified.
Focus Group—Community-At-Large	February 20, 2024	7 participants representing Evansville's African American museum, various youth serving organizations (and mentorship for LGBTQ+ youth), Veteran's issues, and lower-income health providers	Southwestern staff personally invited individuals representing historically underserved populations. Participants received gift cards in appreciation of their participation.
Focus Group—Community Leaders	March 8, 2024	6 participants in leadership roles within community organizations serving marginalized populations of focus (e.g., NAACP, Haitian Outreach Center), including two health care providers that specialize in LGBTQ+ care for the community.	Southwestern staff personally invited individuals representing historically underserved populations. As a note, this focus group was conducted virtually. Participants received gift cards in appreciation of their participation.
Focus Group—Parents of Youth Clients	March 5, 2024	5 parents/caregivers of youth participating in a regularly scheduled group.	This group of parents/caregivers meets regularly at a Southwestern site while their children participate in a group. The adults are accustomed to sharing with one another and often use the time to receive parenting guidance from Southwestern staff. Refreshments were provided in appreciation of their participation.
Focus Group—SUD Clients	March 6, 2024	Approximately 10 males and 10 females receiving residential SUD services at Stepping Stone	Southwestern staff coordinated times for the residential clients to participate in focus group discussions. Males and females were separated into two concurrent focus groups. Refreshments were provided in appreciation of their participation.

Needs Assessment Findings

Behavioral Health in the Service Region

BEHAVIORAL HEALTH IN THE REGION

Behavioral Health has been identified as a significantly needed service within each county's independent needs assessment reports. The regional community is known to have a high rate of substance use, a high rate of mental health conditions such as depression and anxiety, and each county within the region is also known to have a HRSA designation as a behavioral health provider shortage area. We must also consider the regional opioid overdose mortality rate which is alarmingly high; a fact even more concerning when the young age at which most opioid-related deaths occur. The regional prevalence of mental health issues illustrates the impact that mental health can have on a population.

Mental Health

	Vanderburgh	Warrick	Gibson	Posey	Indiana
Average Number of Mentally Unhealthy Days in the Past Month[1]	5.3	4.5	4.8	4.9	4.9
% Experiencing Frequent Mental Distress (14+ Mentally Unhealthy Days in the Past Month)[2]	17.0%	14.6%	16.20%	15.90%	15.8%
Mental Health Provider Ratio[3]	417:1	1402:1	2744:1	8372:1	529:1
Suicide Rate per 100,000[4]	19.7	14.4	20	18.5	15.4

Source: [1]BRFSS, 2020; [2]BRFSS, 2020 Defined as: The percentage of adults who reported that their mental health was not good for 14 or more days in the past 30 days.

The mental health provider ratio across our counties often results in 30+ minutes in travel time for residents to receive behavioral care (and other specialty care) in Evansville; this requires owning or accessing a car. Primary care providers in rural counties are often not available. In Posey County, IN, Southwestern is the only behavioral health service provider.

Warrick County has a suicide rate slightly below the state average. Gibson County, with an 8372 to 1 mental health provider ratio, has the highest suicide rate of 20 deaths per 100,000. Vanderburgh and Posey Counties near 20 suicide deaths per 100,000, higher than the state norm.

Top Ten Southwestern Client Diagnoses Rankings per County

Diagnoses	Vanderburgh	Warrick	Gibson	Posey	Region
Generalized anxiety disorder	1st	1st	1st	1st	1st
Post-traumatic stress disorder	2nd	3rd	2nd	2nd	2nd
Nicotine dependence	3rd	2nd	3rd	3rd	3rd
Cannabis dependence	4th	4th	4th	4th	4th
Attention-deficit hyperactivity disorder	5th	5th	5th	6th	5th
Other stimulant dependence, uncomplicated	7th	6th	6th	5th	6th
Major depressive disorder, recurrent	6th	10th	8th	7th	7th
Alcohol dependence, uncomplicated	9th	7th	7th	10th	8th
Oppositional defiant disorder	8th	8th	9th	8th	9th
Personal history of physical and sexual abuse in childhood	10th	9th	10th	9th	10th

Source: Southwestern EHR. Any diagnoses listed in Diagnosis Table, July 2024

For individuals and families receiving services at Southwestern, the most prevalent diagnosis is Generalized Anxiety Disorder; Post-Traumatic Stress Disorder ranks second. Nicotine Dependence holds the third position; quitting smoking can be incredibly challenging due to both physical and psychological dependence. Aligned with concerns expressed in the county profiles, substance use disorder (SUD) diagnoses of Stimulant, Alcohol, and Cannabis dependence are represented. Attention Deficit Hyperactivity Disorder and Oppositional Defiant Disorder diagnoses may impact our children and youth services. Major Depressive Disorder (MDD) is ranked sixth overall.

The tenth leading diagnosis is 'personal history of physical or sexual abuse in childhood.' Not unlike nicotine dependence, this diagnosis is often co-occurring with another diagnosis on this list. Each diagnosis impacts the other, possibly worsening the course of both.

Top Ten Client Diagnoses Prevalence per County by Percentage

Diagnoses	Vanderburgh (4,810 Clients)	Warrick (1,223 Clients)	Gibson (849 Clients)	Posey (608 Clients)	Area Total (7,490 Clients)
Generalized anxiety disorder	33.6%	37.3%	33.6%	36.5%	34.7%
Post-traumatic stress disorder	27.4%	21.4%	36.2%	26.5%	26.4%
Nicotine dependence	25.2%	26.7%	27.7%	23.5%	25.2%
Cannabis dependence	20.2%	19.7%	23.9%	18.4%	20.1%
Attention-deficit hyperactivity disorder	19.0%	15.7%	21.3%	16.8%	18.2%
Other stimulant dependence, uncomplicated	16.1%	14.9%	18.4%	17.6%	16.2%
Major depressive disorder, recurrent	17.0%	12.3%	17.4%	16.6%	16.0%
Alcohol dependence, uncomplicated	13.7%	14.9%	15.3%	13.8%	14.1%
Oppositional defiant disorder	13.7%	12.8%	15.5%	15.6%	13.8%
Personal history of physical and sexual abuse in childhood	12.7%	12.4%	14.3%	14.0%	12.8%

Across the service area, 77.8% of Southwestern clients have at least one diagnosis related to mental health needs, 31.3% have at least one diagnosis related to substance use disorders, and 11.0% have co-occurring mental health needs and substance use disorders.

While in some cases, the relative order of these diagnoses varies across the region, it should be noted that the same ten diagnoses are present in almost all counties, with the exception to this finding being the rate of borderline personality disorder diagnoses (12.7% of all clients) in Warrick County.

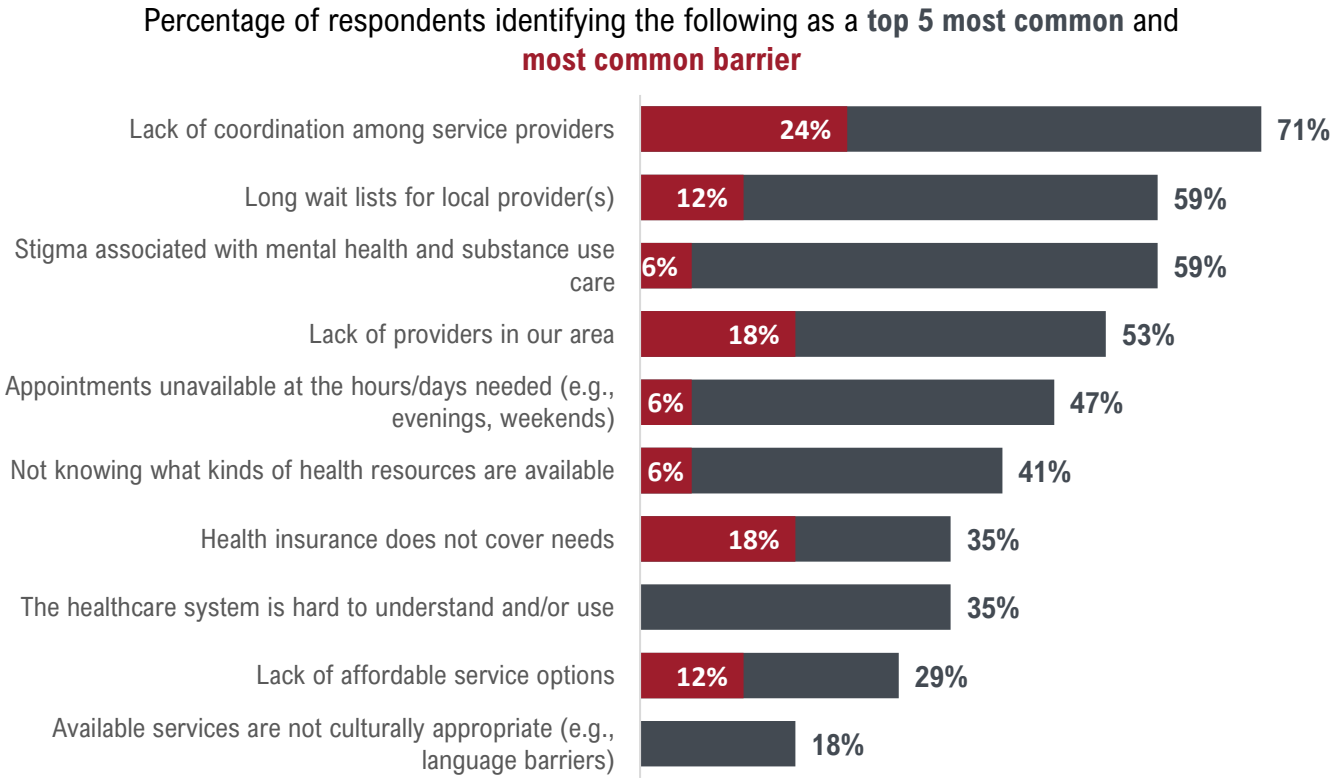
An alternative look at diagnosis prevalence focuses only on the *primary diagnosis* for each client. While it is important to consider co-occurrence of diagnoses, the exploration of *primary diagnoses* highlights the most salient needs present in the community. As shown below, the ten most common *primary diagnoses* include much of the same list that comprises the ten most common *total diagnoses* (though not necessarily in the same order). Exceptions to this finding involve nicotine dependence and personal history of physical and sexual abuse in childhood. While these diagnoses are common among Southwestern clients, they are not often the *primary* reason services are received. In contrast, borderline personality disorder and opioid dependence are included among the ten most common *primary diagnoses* but not the ten most common *total diagnoses*. While these diagnoses may not be as prevalent as others on the total list, they tend to be the *primary diagnosis* when someone is requesting services.

Top Ten Southwestern Client PRIMARY Diagnoses Prevalence per County					
Diagnoses	**Vanderburgh (4,697 Clients)**	**Warrick (1,211 Clients)**	**Gibson (838 Clients)**	**Posey (603 Clients)**	**Area Total (7,349 Clients)**
Generalized anxiety disorder	10.6%	14.9%	14.3%	8.1%	11.5%
Post-traumatic stress disorder	7.8%	10.0%	8.4%	15.8%	8.9%
Other stimulant dependence, uncomplicated	9.6%	3.9%	6.8%	9.0%	8.3%
Major depressive disorder, recurrent	6.5%	7.3%	12.3%	9.0%	7.5%
Alcohol dependence, uncomplicated	7.7%	4.5%	3.6%	5.8%	6.6%
Attention-deficit hyperactivity disorder	6.0%	7.7%	3.6%	2.8%	5.8%
Oppositional defiant disorder	2.7%	4.7%	6.1%	1.7%	3.3%
Cannabis dependence, uncomplicated	3.8%	2.0%	1.6%	4.6%	3.3%
Borderline personality disorder	2.9%	2.3%	3.0%	3.6%	2.9%
Opioid dependence, uncomplicated	3.1%	2.1%	0.8%	1.2%	2.5%

Respondents to the Southwestern Partner Survey[xliv] were asked to describe prevalent mental health and substance use issues and concerns in the community—as well as provide suggestions for improving these concerns. A summary of the top themes is included below:

Prevalent Issues and Concerns	Suggestions for Addressing
Lack of Access to Care and Resources *"Continued struggle with access to care particularly for children and families. Also access to quality assessments for cognitive disorders such as ADD, autism, dementia. Current innovative treatment approaches using technology like AI"* *"Although access to care is improving, psychiatric assessments and psychological testing can still take a long time to get into."*	**Increase Government Funding** *"I've always felt SWBH does all it can but is constrained by State and local funding."* **Expand Resources and services** *"Bring in more providers"* *"Expand wrap around services for families and individuals."*
Housing/Homelessness *"A large proportion of our chronically homeless individuals in the family are lacking consistent care from a mental health and substance abuse standpoint."* *"Lack of housing options for those with chronic mental health or substance use concerns"*	**Community Partnerships and Outreach** *"Greater focus on outreach efforts for these services in regard to the unhoused population."* *"Develop close partnerships with Aurora and ECHO Housing. Make health appointment attendance a priority when working with patients on improving living skills."*
Youth Mental Health *"Child and adolescent mental health issues."* *"Adolescent mental health"*	**Resource and Service Expansion** *"Continue the neurodevelopmental clinic"* *"IOP for adolescents"*

Partners were also asked to describe barriers to mental health and substance use care in the community. A full breakdown of barriers shared by partners follows:



Focus Group Feedback on Community Mental Health and Substance Use Treatment Needs	
Focus Group	**Summary of Relevant Feedback**
Community-At-Large	• Mental health and addiction needs are interrelated. Participants cited incarcerated populations and suggested that mental health struggles are often the root cause of substance-related offenses. • Children experiencing Adverse Childhood Experiences (ACEs) experience mental struggles. Further, recent developments (e.g., COVID-19 pandemic, increased screen time and access to technology in general) have heightened the stress and anxiety many in the community (including youth) may face. • Older adults in the community struggle with feelings of social isolation as they lose loved ones and experience mobility constraints. At the same time, this population may experience the added stress of caring for grandchildren.
Community Leaders	• Not everyone is prepared to stop using substances. Based on this reality, there is a need in the community to expand harm reduction strategies (e.g., needle exchange programs). • Vaping among youth and perceptions of societal approval of marijuana use has created concerns among participants; specifically, youth do not understand the long-term impacts of these behaviors when they begin. There is a need for more parental involvement in drug prevention.

MENTAL HEALTH AND SUBSTANCE USE SERVICE NEEDS AMONG THE PEOPLE WE SERVE

Focus Group Feedback on Community Mental Health and Addiction Needs	
Focus Group	**Summary of Relevant Feedback**
Parents of Youth Clients	• Substance use is often related to mental health issues such as anxiety. Further, the co-occurrence of obsessive disorders, ADHD, autism spectrum disorders, etc. makes it difficult to access comprehensive treatment. • Medication access is a problem for families, particularly due to costs. For example, a single parent struggles to pay for monthly medication but may still earn too much money to qualify for assistance. Further, concerns emerged that medication may be overprescribed. One participant described that her child had been on five different medications by the time s/he was seven years old. There is also a concern that medication use as a child may lead to substance misuse as an adult. Finally, participants questioned the effects of different medications on food allergies. Speaking about prescribed medications, one participant shared "It is a disservice to these children." • Inadequate options exist for addressing crisis situations as well as longer-term treatment. Participants described seeking services in Bloomington, Terre Haute, and other locations across the state only to be denied.
SUD Clients	• Related to partnerships (described later in the report), participants identified the need for Stepping Stone to follow up with other mental health providers serving the same clients, the court system, and providers of assistance programs clients are applying for. • Overall, participants described the need for help preparing for the outside world. As one participant stated, "Being in treatment is like pausing your life, but nothing on the outside has paused."

Focus Group Feedback on Unmet Mental Health and Substance Use Service Needs	
Focus Group	**Summary of Relevant Feedback**
Community-At-Large	• Care coordination/management is critical, especially for populations unable to navigate the system of care on their own (e.g., elderly population). • In some cases, services that were "paused" during the COVID-19 pandemic have not yet resumed. • There is a perception that some providers assume people are "out to abuse the system," which delays or inhibits their ability to provide necessary care. • There is a lack of oral surgeons who accept Medicaid in Indiana. • More training around trauma-informed care and social emotional learning is needed in the community overall—and especially for teachers and other professionals interacting with youth. • Specific populations perceived to be underserved include incarcerated individuals, individuals with co-occurring mental health and/or substance use or IDD diagnoses, aging populations, and LGBTQ+ youth
Community Leaders	• The African American community is reluctant to seek help for mental health issues. Groups are breaking down this barrier through community education offered through sororities, churches, etc., but the barrier remains. • Similarly, mental health care does not really exist in Haiti, so the Haitian community is not accustomed to these services being available. • Further, all immigrant populations may experience a language barrier when seeking and receiving services.
Parents of Youth Clients	• While it was noted that Southwestern accepts Medicaid, participants described a socioeconomic level at which services are less accessible. Specifically, for individuals who earn too much income to qualify for different assistance programs but still struggle to cover the costs of medications and/or other treatment options, services can become unattainable.
SUD Clients	• Participants described their inability to book therapy appointments while pursuing residential treatment for substance use. A suggestion was offered to allow outside therapists to come to Stepping Stone. • Similarly, while in treatment, participants noted the desire to be able to attend court dates and outside appointments that were previously scheduled. In one case, a client gave birth prior to treatment and felt unable to attend postnatal appointments. • Treatment plans that incorporate the entire family are perceived as lacking. In some cases, the only treatment options available isolate the client from his or her family (e.g., limited visits and phone calls).

BEHAVIORAL HEALTH INTEGRATION WITH PRIMARY CARE

Primary Care is an integral part of whole person health. As we look deeper into the individuals who need mental health treatment, we will find that these individuals are more likely to have negative primary health outcomes. We know that individuals with high Adverse Childhood Experiences (ACE) scores are significantly more likely to experience greater all-causes negative health consequences as are individuals who are diagnosed with severe mental illness.[xlv] [xlvi] As we examine the demographic and population data and consider the need for behavioral health, we also must recognize that part of health care is making sure the individual has physical health condition under control or under management. Co-occurring primary health diagnoses are a strong likelihood. Given this, a compelling case can be made to incorporate care coordination and primary health screening within the behavioral health space.

Below is a brief overview of the regional public health data available on Primary Health:

Physical Health Measures					
	Vanderburgh	Warrick	Gibson	Posey	Indiana
% Reporting Poor or Fair Health[1]	15.7%	11.7%	14.8%	13.3%	15.0%
Average Number of Physically Unhealthy Days in the Past 30 Days[1]	3.6	2.9	3.4	3.2	3.3
Frequent Physical Distress[2]	11.1	8.7	10.4	9.8	10.0
Life Expectancy[3]	75.5	77.4	77	79	76.5

Sources: [1]Behavioral Risk Factor Surveillance System (BRFSS), 2020; [2]BRFSS, 2020 Defined as: The percentage of adults who reported that their physical health was not good for 14 or more days in the past 30 days. [3]Nation Center for Health Statistics – Mortality Files, 2018-2020.

Life expectancy rates in our region vary from 79 years in Posey County to 75.5 years in Vanderburgh County. The counties in our region reflect state norms, except for one. Posey County has the highest rate of older adults in the region residing there and life expectancy is up to 3.5 years longer than the state average.

Physical Activity					
	Vanderburgh	Warrick	Gibson	Posey	Indiana
% Reporting No Physical Activity in the Past 30 Days[1]	26.1%	21.6%	25.7%	23.8%	25.6%
% Access to Exercise Opportunities[2]	82.6%	78.0%	66.7%	27.1%	76.8%

Sources: [1]Behavioral Risk Factor Surveillance System (BRFSS), 2020; [2]2023 County Health Rankings (Calculated using multiple data sources)

Over 25% residents in our region reported no physical activity in the past month with Warrick and Posey counties faring somewhat better than region and state averages.

Cause of Death Rankings (Age-Adjusted Rate)						
	Vanderburgh	Warrick	Gibson	Posey	Region	Indiana
Heart Disease	1st	1st	1st	2nd	1st	1st
Cancer	2nd	2nd	2nd	1st	2nd	2nd
Chronic Lower Respiratory Disease	4th	3rd	3rd	3rd	4th	3rd
Accidents and Adverse Effects	3rd	5th	4th	4th	3rd	4th
Alzheimer's Disease	5th	4th	6th	5th	6th	5th
Cerebrovascular Diseases	6th	6th	5th	6th	5th	6th
Diabetes Mellitus	7th	7th	7th	8th	7th	7th
Suicide and Self-Inflicted Injury	8th	9th	8th	7th	9th	8th
Kidney Disease	8th	8th	9th	9th	8th	9th
Chronic Liver Disease and Cirrhosis	10th	11th	10th	10th	11th	10th
Septicemia	11th	10th	11th	11th	10th	11th
Pneumonia	12th	12th	12th		12th	12th
Homicide and Legal Intervention	13th				13th	13th
Influenza	14th				14th	14th

Source: National Institute on Minority Health and Health Disparities: HD Pulse Data Portal. Age-Adjusted to the 2000 US Standard Population Death Rate, deaths per 100,000, 2016-2020

The number one age-adjusted cause of death in the region is heart disease. Suicide ranks between 7 and 9th as leading causes of death in the regional counties. Homicide is noted as the 13th cause of death in Vanderburgh County and does not appear as a leading cause of death in the surrounding rural counties.

When looking at co-occurring health disorders we can connect the dots between alcohol use disorder and cirrhosis and link chronic lower respiratory disease to smoking.

Cause of Death Per 100,000 (Age-Adjusted Rate)					
	Vanderburgh	Warrick	Gibson	Posey	Indiana
All Deaths	898.6	827.2	879	737.9	863.5
Accidents and Adverse Effects	59.1	46.3	55	42.1	57.7
Alzheimer's Disease	42.9	51.2	38.7	37.9	34
Cancer	171.6	151.4	160.6	159.5	166.9
Cerebrovascular Diseases	39.5	33.1	41.2	32.2	40.3
Chronic Lower Respiratory Disease	57	59	55.1	51	55.5
Chronic Liver Disease and Cirrhosis	15.1	12.3	14.7	13.5	12.4
Diabetes Mellitus	28.5	20.3	26.6	17.8	26.7
Heart Disease	177.4	181.4	199.8	153	181.7
Homicide and Legal Intervention	9.5	--	--	--	8
Influenza	2.4	--	--	--	2
Kidney Disease	19.7	15.2	16	16.9	17.9
Pneumonia	12.4	11.3	9.8	--	10.9
Septicemia	14.6	13.4	13.9	11.6	14.9
Suicide and Self-Inflicted Injury	19.7	14.3	19.8	18.4	15.4

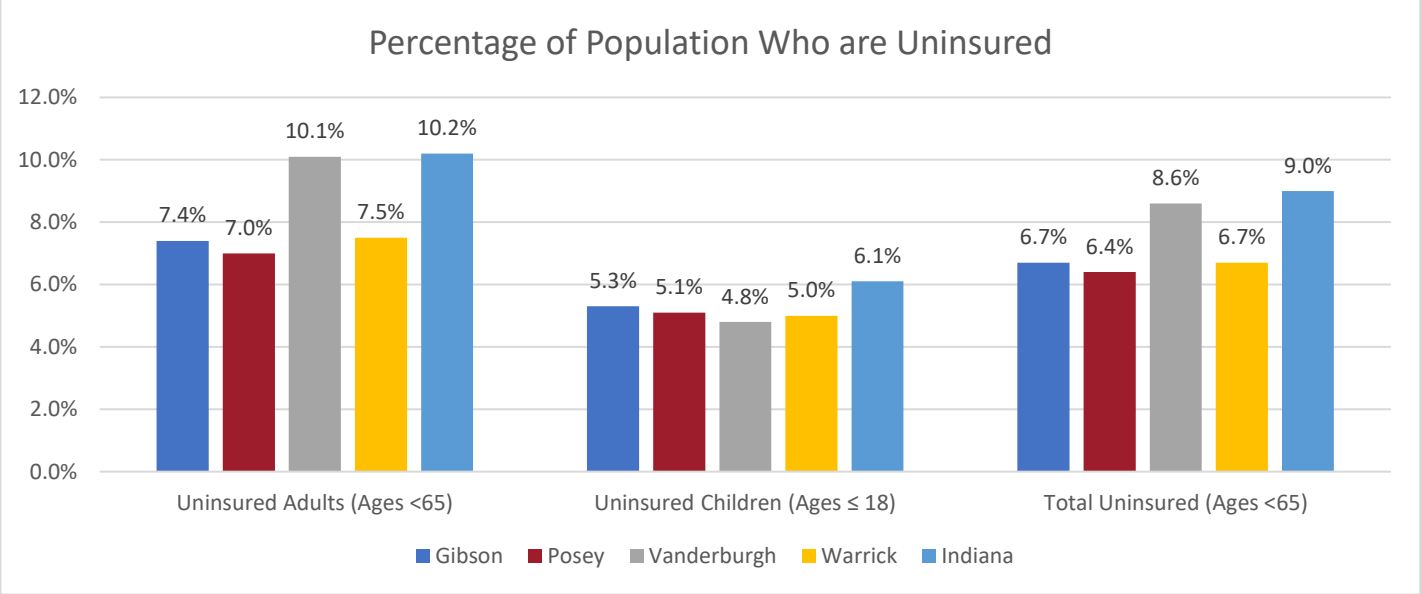
Source: National Institute on Minority Health and Health Disparities: HD Pulse Data Portal. Age-Adjusted to the 2000 US Standard Population Death Rate, deaths per 100,000, 2016-2020.

Access to Healthcare Providers	Vanderburgh	Warrick	Gibson	Posey	Indiana
Primary Care Physicians Ratio[1]	1200:1	633:1	3075:1	3159:1	1500:1
Other Primary Care Providers Ratio[2]	474:1	603:1	1135:1	5023:1	830:1
Dentist Ratio[3]	1385:1	2481:1	1733:1	4186:1	1701:1

Sources: [1]Area Health Resources File/American Medical Association, 2020; [2]Area Health Resource File/National Provider Identifier, 2021; [3]CMS, National Provider Identification, 2022.

Our region is not only designated as a HRSA behavioral health workforce shortage area, there is shortage of general medical providers also. This shortage increases the likelihood a client presenting for behavioral health services has not seen a primary care physician in the past 12 months. Health screenings help identify underlying and possibly exacerbating health issues.

Percentage of Population Who are Uninsured



	Gibson	Posey	Vanderburgh	Warrick	Indiana
Uninsured Adults (<65 Years Old)[1]	7.4%	7.0%	10.1%	7.5%	10.2%
Uninsured Children (18 and Under)[1]	5.3%	5.1%	4.8%	5.0%	6.1%
Total Uninsured (<65 Years Old)[1]	6.7%	6.4%	8.6%	6.7%	9.0%

Source: [1]Small Area Health Insurance Estimates, 2020.

Uninsured and underinsured adult and child rates are consistently at or below state average. Providing insurance navigation and utilizing presumptive eligibility connects individuals with needed access to care. Over 90% of Southwestern clients are insured through Medicaid, earning 200% or less of the U.S. poverty standard.

SUMMARY OF FINDINGS: MENTAL HEALTH AND SUBSTANCE USE SERVICES NEEDS

The community need for behavioral health services identifies the need to improve access to care in a medical and behavioral workforce shortage area. The number of regional workers available for hire is limited, which restricts the access individuals have to dentists, primary care specialists, mental health therapists, psychiatrists, and other medical specialists. To effectively serve the most residents of the region, Southwestern utilizes available resources through coordination and collaboration with diverse community partnerships across the region.

Several barriers to care were identified including a lack of coordination among health service providers, long wait times, a shortage of providers, inadequate crisis, and long-term treatment options. Community members in focus groups specifically mentioned the stigma surrounding seeking mental health and substance use treatment as a barrier, along with the cost of care, associated medications, and insurance coverage.

The region faces significant challenges with high rates of depression, anxiety, and substance use disorders. Generalized Anxiety Disorder (GAD) and Post-Traumatic Stress Disorder (PTSD) are the most common diagnoses, with GAD affecting 34.7% of clients. There are serious concerns about adolescent mental health and the long-term impact of Adverse Childhood Experiences. Suicide rates range from 14.4 to 20 per 100,000 people. The region also has a high opioid overdose mortality rate, particularly among younger populations.

Physical health integration is crucial as many individuals experience co-occurring conditions. Those with co-occurring mental health issues often have poor physical health outcomes. The CCBHC model emphasizes care coordination, and the community identifies the need to recognize and treat co-occurring disorders concurrently.

Suggestions for improvement include recruiting more providers and increasing access to services for families and individuals. Strengthening partnerships with local organizations to improve outreach and care coordination is also recommended.

Economic and Social Drivers of Health in the Region

Social Drivers of Health (SDOH) are mitigatable risk factors, common to lack of socioeconomic status (SES), and can lead to illness and health issues that have a known impact upon mental health outcomes. Some factors include stability of income, ability to be housed securely, having access to a high-quality education, ability to access employment opportunities and maintain access to the job once secured, freedom from abuse and neglect, having access to strong social supports, and access to acceptable living condition and neighborhood stability. These factors have a strong impact on chronic physical and behavioral health conditions and regularly influence longevity and quality of life lived. SDOH and the inability to mitigate difficulties stemming from them are so powerful that they often impact subsequent generations' health, longevity, and wellbeing. Establishing positive outcomes among those seeking services requires considering the impact of SDOH and addressing difficulties in equity among individuals within our service population.[xlvii] Given the importance of SDOH factors in the successful implementation of treatment it is important to understand the factors impacting individuals who seek services in our region.

ECONOMIC AND SOCIAL DRIVERS OF HEALTH IN OUR SERVICE AREA

The resources needed to overcome poverty is not always easily accessed, and assistance is often needed in navigation of the various programs that supply relief. Southwestern, as CCBHC, has a duty to address health disparities and assist individuals in accessing a full and engaged life. CCBHC principals encourage approaches and services that improve the overall health status of individuals within the community. These approaches focus on the wellness of the individual and their overall health. This approach can have the added benefit of enhancing economic productivity and reducing healthcare costs. As a CCBHC, Southwestern is in a unique position to impact the health and wellbeing of our region.

Regional poverty status statistics mirror those of the state at 10.1%. In Vanderburgh County, over 1 in 5 children are living in poverty (20.3%). The rural Posey and Gibson Counites ranges are near 11%, or 1 in 11 children. In Warrick County, a rural and suburban hybrid, nearly 7% of children are living below the national poverty line.

Educational Attainment (% of Total Population 25+)

Location	High School Graduate or Higher	Bachelor's Degree or Higher	Total Population 25+
Vanderburgh	91.2% (n=112,656)	27.1% (n=33,416)	123,502
Warrick	94.9% (n=42,012)	34.5% (n=15,264)	44,259
Gibson	90.6% (n=20,313)	18.0% (n=4,027)	22,417
Posey	93.7% (n=16,805)	25.5% (n=4,568)	17,929
Area Total	92.2% (n=191,786)	27.5% (n=57,275)	208,107
Indiana	90.0% (n=4,078,837)	28.2% (n=1,279,648)	4,532,091

Source: 2022 ACS 5-Year Estimate: Table S1501

The majority (92.2%) of our region has a high school diploma or equivalent. Warrick County has the highest percentage of residents with a bachelor's degree or higher (34.5%). The regional average is 27.5%. or a little more than 1 in 4 residents. Gibson County education attainment percentages are lower for high school equivalency (90.6%) and college degree (18%).

Income and Unemployment Measures					
	Vanderburgh	Warrick	Gibson	Posey	Indiana
Median Household Income[1]	$58,839	$91,105	$64,153	$75,594	$67,173
Unemployment Rate[2]	3.0%	2.6%	2.2%	2.4%	3.0%

Sources: [1]2022 ACS 5-Year Estimate: Table S1901; [2]Bureau of Labor Statistics Local Area Unemployment Statistics Annual Unemployment Rate, 2022.

The average household income in Indiana is $67,173. Income across our 4-county region ranges from a high of $91,105 in Warrick County to $58,839 in Vanderburgh County.

Poverty Status (% of Total Population for Who Poverty Status is Determined)		
Location	Below Federal Poverty Line	Total Population With Poverty Status Determined
Vanderburgh	14.3% (n=24,763)	173,666
Warrick	6.1% (n=3,815)	62,952
Gibson	10.0% (n=3,210)	32,198
Posey	10.0% (n=2,490)	24,873
Area Total	11.7% (n=34,278)	293,689
Indiana	12.3% (n=810,702)	6,589,135

Source: 2022 ACS 5-Year Estimate: Table S1701

Vanderburgh County has the most residents living below the poverty line (14.3%) and Warrick County the least (6.1%). One in ten residents of Gibson and Posey Counties live below the Federal poverty line.

Child Poverty Status (% of Total Population Under 18 for Who Poverty Status is Determined)		
Location	Below Federal Poverty Line	Total Population Under 18 With Poverty Status Determined
Vanderburgh	20.3% (n=7,733)	38,116
Warrick	6.7% (n=982)	14,646
Gibson	10.8% (n=846)	7,816
Posey	11.6% (n=626)	5,412
Area Total	15.4% (n=10,187)	65,990
Indiana	16.1% (n=249,085)	1,544,580

Source: 2022 ACS 5-Year Estimate: Table S1701

The poverty status of children in the region also varies. Over 1 in 5 children in Vanderburgh County live below the poverty line, almost 5% higher than state averages. The remaining counties are well below the state average.

Poverty Status by Race (% of Total Race Population for Who Poverty Status is Determined)					
Location	**White**	**Black or African American**	**Asian**	**Some Other Race**	**Two or More Races**
Vanderburgh	12.0% (n=17,299)	28.5% (n=4,850)	6.8% (n=158)	25.7% (n=707)	25.1% (n=1,749)
Warrick	6.0% (n=3,433)	0.6% (n=7)	0.3% (n=4)	49.5% (n=365)	0.3% (n=6)
Gibson	10.0% (n=2,952)	12.8% (n=70)	--	3.2% (n=27)	13.5% (n=161)
Posey	9.3% (n=2,197)	50.7% (n=147)	--	42.0% (n=132)	3.2% (n=14)
Area Total	10.1% (n=25,881)	26.6% (n=5,074)	3.9% (n=162)	26.4% (n=1,231)	18.5% (n=1,930)
Indiana	10.1% (n=535,650)	25.1% (n=153,913)	14.8% (n=23,795)	19.6% (n=39,081)	17.3% (n=58,263)

Black or African Americans in Vanderburgh County experience the highest rate of poverty status in the region. The percentage of white residents meeting poverty status is 15% less.

Focus Group Feedback on Economic Factors and Drivers of Health[1]	
Focus Group	**Summary of Relevant Feedback**
Community-At-Large	• Treatment for specific services (e.g., alcohol treatment programs) seems unaffordable, even when provided on a sliding scale. • Transportation limitations may keep individuals from pursuing needed care, especially among aging adults and other populations experiencing mobility issues. • The community struggles to navigate supplemental insurance programs. While selected organizations (e.g., SWIRCA, Carver) help navigate the system, more support is needed for individuals and providers. • Some neighborhood revitalization efforts negatively impact the sense of community among long-time residents.
Community Leaders	• Homelessness is associated with mental health and substance use issues. Organizations working with people experiencing homelessness should be equipped to recognize, address, and/or refer these concerns to other providers.

Focus Group Feedback Around Economic and Social Drivers of Health	
Focus Group	**Summary of Relevant Feedback**
Parents of Youth Clients	• For individuals making too much money to qualify for certain assistance programs, medications and other treatment options may still be unaffordable. • Even when private insurance may be in place, coverage can be limited due to specific prior diagnoses.
SUD Clients	• Participants described concerns around navigating insurance issues (i.e., lack of coverage all together and/or difficulty navigating the system of coverage). • Recommendations were offered to incorporate assistance with finances and job placement after treatment. As described elsewhere, clients desired better preparation to return to their lives after treatment. • Additionally, participants described the desire for support in obtaining public assistance (e.g., SNAP, housing assistance).

SUMMARY ON SOCIAL DRIVERS OF HEALTH

As mitigatable risk factors, addressing social drivers of health (SDOH) for individuals with lower socioeconomic status (SES) can significantly impact mental health outcomes and reduce health disparities. Key factors such as income stability, secure housing, quality education, employment access, social support, and neighborhood conditions play a crucial role in influencing chronic health conditions and overall quality of life.

High school graduation rates are high across the region, with varying rates of higher education attainment. Median household incomes and unemployment rates vary across counties, with Warrick County having the highest median income and lowest unemployment rate. The regional poverty rate mirrors the state average at 10.1%. Child poverty is concerning, with Vanderburgh at 20.3%, and Posey and Gibson counties around 11%; all higher than the state average.

Identified needs and priorities consist of addressing:

- Child Poverty: A consistent need across all counties in the region.
- Homelessness: Linked to mental health and substance use.
- Insurance Navigation: Assistance required for navigating insurance.
- Treatment Costs: Financial burden of treatment.
- Post-Treatment Financial Needs: Specifically, job placement post-treatment.

Addressing these will enhance overall health and reduce healthcare costs.

Culture and Language in the Region

The term LEP refers to individuals who face potential barriers in accessing and understanding health and human services due to their limited proficiency in English. SAMHSA defines Limited English Proficiency (LEP)as a status applied individuals that have limited ability to read, write, speak, or understand English; often these individuals do not speak English as their primary language. These individuals may require an interpreter and translated documents to have meaningful access to services. The goal is to ensure that every individual, regardless of their primary language or reading ability can access important health and human services. This is in line with Title VI of the Civil Rights Act of 1964, which requires recipients of Federal financial assistance to take reasonable steps to make their programs, services, and activities accessible by eligible persons with LEP. [xlviii]

Some Limited English Proficiency (LEP) needs are not easily identified via Census demographic data alone. An example of this is when needed LEP resources were initially identified by Southwestern's administrative support staff, when addressing members of our community who speak Haitian Creole and Marshallese. This need was not adequately captured in the Electronic Health Record (EHR) or within the 2020 Census data. While English is spoken by 96+% of the population in our region there is still a significant need for cultural and language informed services.

CULTURE AND LANGUAGE IN OUR SERVICE AREA

The following tables help to capture the potential need for LEP services. As can be seen a supermajority of the population speaks English and the remaining non-English speaking population have varying language needs with Spanish being the most well represented of these.

English and Non-English Speaking (% of Total Population Ages 5+)

Location	Speak Only English	Speak a Language Other than English	Total Population ages 5+
Vanderburgh	96.1% (n=162,747)	3.9% (n=6,683)	169,430
Warrick	96.2% (n=58,086)	3.8% (n=2,311)	60,397
Gibson	97.6% (n=30,249)	2.4% (n=753)	31,002
Posey	98.5% (n=23,564)	1.5% (n=356)	23,920
Area Total	96.5% (274,646)	3.5% (n=10,103)	284,749
Indiana	90.8% (n=5,786,596)	9.2% (n=588,234)	6,374,830

Source: 2022 ACS 5-Year Estimate: Table S1601

The most common language spoken at home in our region is English (96%). Census data indicates that in 1.5% of households in the region, Spanish is the language spoken at home. Languages other than English and Spanish are spoken at home in 2% of reporting households.

Language Spoken at Home (% of Total Population Ages 5+)						
Location	English	Spanish	Other Indo-European Languages	Asian and Pacific Island Languages	Other Languages	Total Population Ages 5+
Vanderburgh	96.1% (n=162,747)	1.7% (n=2,921)	0.8% (n=1,345)	1.1% (n=1,781)	0.4% (n=636)	169,430
Warrick	96.2% (n=58,086)	1.3% (n=763)	1.2% (n=744)	1.3% (n=769)	0.1% (n=35)	60,397
Gibson	97.6% (n=30,249)	1.7% (n=518)	0.5% (n=146)	0.3% (n=86)	<0.1% (n=3)	31,002
Posey	98.5% (n=23,564)	0.8% (n=197)	0.2% (n=41)	0.5% (n=118)	0.0% (n=0)	23,920
Area Total	96.5% (274,646)	1.5% (n=4,399)	0.8% (n=2,276)	1.0% (n=2,754)	0.2% (n=674)	284,749
Indiana	90.8% (n=5,786,596)	4.8% (n=305,104)	2.3% (n=149,800)	1.5% (n=96,148)	0.6% (n=37,182)	6,374,830

Source: 2022 ACS 5-Year Estimate: Table S1601

Focus Group Feedback on Culture and Language	
Focus Group	Summary of Relevant Feedback
Community Leaders	• The African American community is reluctant to seek help for mental health issues. Groups are breaking down this barrier through community education offered through sororities, churches, etc., but the barrier remains. • Similarly, mental health care does not really exist in Haiti, so the Haitian community is not accustomed to these services being available. • Further, all immigrant populations may experience a language barrier when seeking and receiving services.

SUMMARY ON LIMITED ENGLISH PROFIVCIENCY

To ensure meaningful access to services for all individuals, regardless of their primary language, in compliance with Title VI of the Civil Rights Act of 1964, healthcare providers must make accommodation for individuals who do not speak English as their primary language and have limited ability to read, write, speak, or understand English. Within our region the population largely speaks English, however despite this, there is a notable population with limited English proficiency (LEP).

Of those who are LEP, Spanish is the most common non-English language spoken, followed by other Indo-European, Asian, and Pacific Island languages.

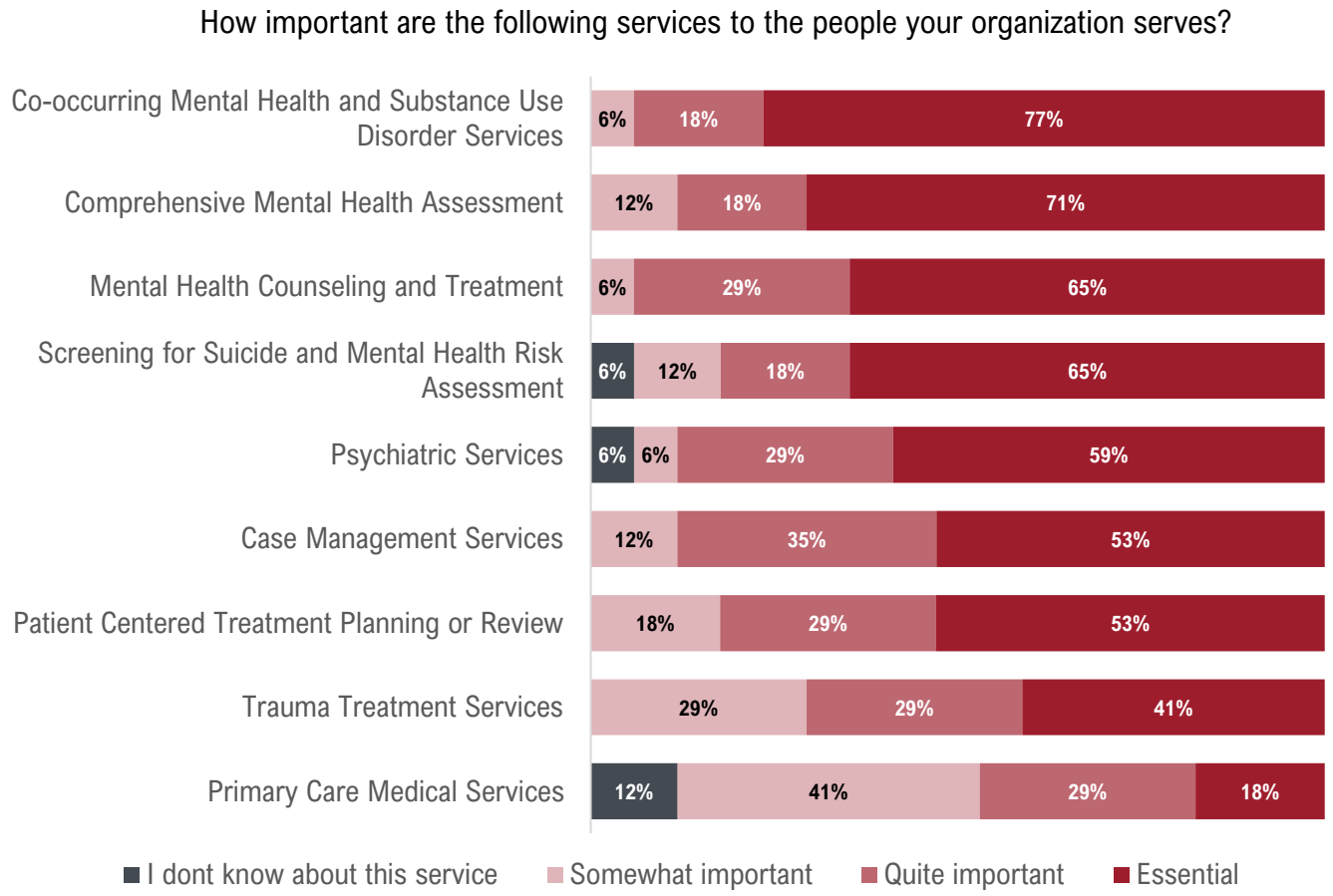
- Vanderburgh: 96.1% speak only English; 3.9% speak other languages.
- Warrick: 96.2% speak only English; 3.8% speak other languages.
- Gibson: 97.6% speak only English; 2.4% speak other languages.
- Posey: 98.5% speak only English; 1.5% speak other languages.
- Indiana State: 90.8% speak only English; 9.2% speak other languages

Of note was the community feedback that indicated African American, and Haitian communities face cultural barriers to accessing mental health services in addition to LEP issues. The community also made it clear that immigrant populations often encounter language barriers when seeking services. Complications to providing LEP adaptive services include a reluctance within certain communities to seek mental health services. Outreach and education were identified as ways to break down these barriers.

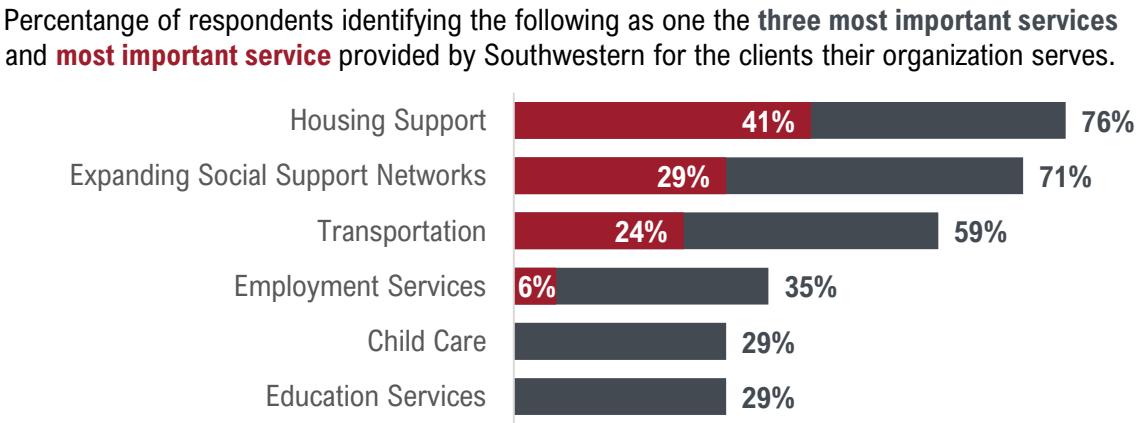
Strengths and Challenges

A. Strengths

Southwestern partners ranked the core services Southwestern provides in terms of importance to the populations served by the partner organizations:



Further, partners identified the most important support services provided by Southwestern:



Focus Group Feedback on Strengths of Community-Responsive Staffing and Services	
Focus Group	**Summary of Relevant Feedback**
Community-At-Large	• It should be noted that many participants in this group expressed a lack of awareness about services available through Southwestern. • Assertive Community Treatment (ACT) was, however, elevated as an important service available to the community.
Community Leaders	• Crisis response emerged as a critical service Southwestern provides. As one participant shared, "It is much better to have a crisis intervention team than police as the first responders to a situation." The 24-7 crisis services line addresses a major need in the community. • Residential care at Stepping Stone was lifted up as a necessary resource provided by Southwestern. • The coordination of care between Southwestern primary care and other primary care providers in the community was commended. According to Community Leaders, additional efforts—particularly around coordinating gender affirming care—will be important moving forward.
Parents of Youth Clients	• The continuum of youth classes (e.g., ability to transition from anger management supports to social skills development) hold clients accountable while providing parenting skills and other supports for parents. • Comprehensive wrap around services (WRAP) effectively coordinates resources for the whole family and information with therapists. • Southwestern staff (e.g., social skills teachers) are transparent and create a safe environment for discussion. It is helpful for clients to be able to share with others who have similar experiences—it creates a support system. • The front desk at the Moran Center makes participants feel welcome and "not like just another client."
SUD Clients	• The matrix program, individual support from case workers, cognitive strategies, and one to one therapy were elevated as among the most important services Southwestern provides. • Participants appreciated the promptness of Southwestern's services after a legal incident, as well as the organization's "willingness to meet [clients] where they are." • The primary medical care services available through Southwestern were commended. Participants felt the medical staff really listens to what is going on and does not assume clients are "just blowing off steam."

Southwestern leaders (i.e., any team members in supervisory positions or higher) were invited to reflect on things the organization is doing well. A summary of the most common themes is included directly below, followed by a quantitative breakdown of all response themes:

TOP STRENGTHS (Identified by Southwestern Leaders)

Work Environment

"Developing a teamwork environment within departments"

"My department has great teamwork and fosters an environment of trust allows for mistakes and growth"

Access to care/services

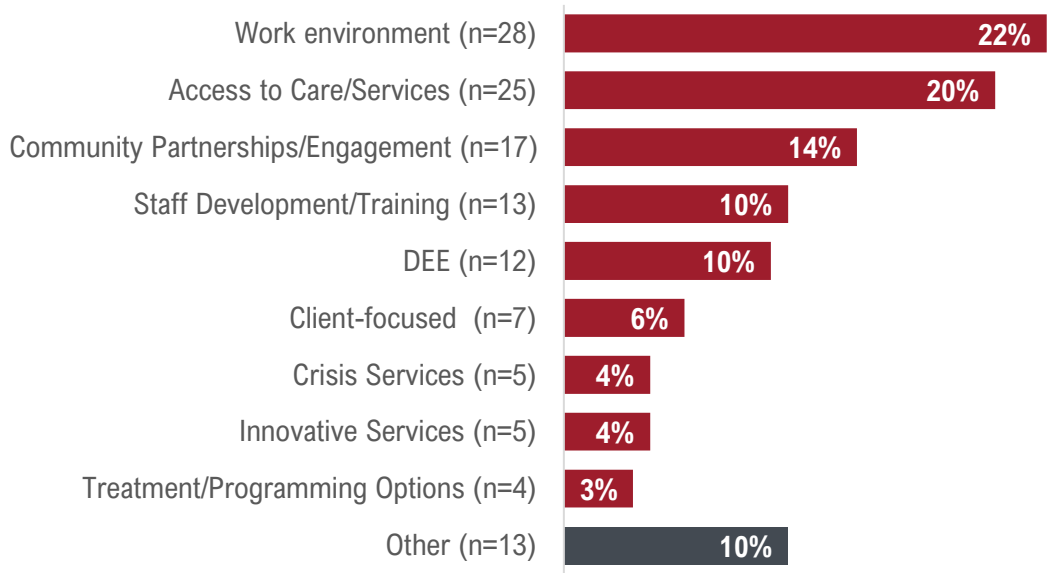
"Increased access to treatment in a timely manner"

"Adapting and making changes when needed to provide the best services to our ever changing client population"

Community Partnerships/Engagement

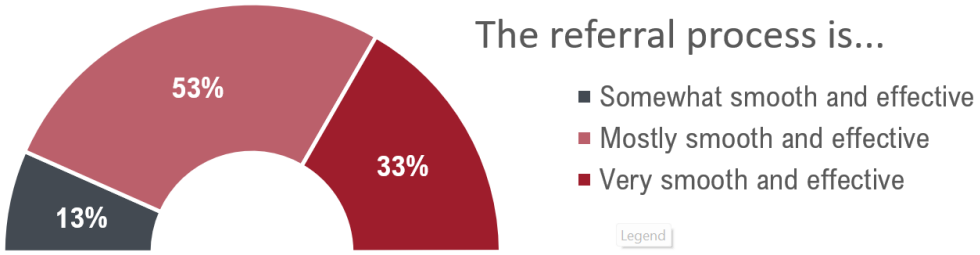
"Building community partnerships to reduce or eliminate barriers to access of treatment"

"I'm seeing improved coordination and engagement with community partners"



Focus Group Feedback on Strengths of Partnerships and Care Coordination	
Focus Group	**Summary of Relevant Feedback**
Community Leaders	• Community leaders described recommendations for partnerships with other service providers as well as with organizations who can spread awareness about available services. These recommendations are included in the discussion of gaps below, though it is understood that some of these partnerships already exist at some level.
Parents of Youth Clients	• The Neurodevelopmental Clinic partnership with Easterseals was commended as addressing a common need in the community. • Participants felt Southwestern is already receiving and making referrals to other providers. Other service providers mentioned include Circle City, Hope Bridge, Adapt for Life, Evansville Children's Psychiatric Center, Deaconess Crosspoint, Bloomington Meadows, Hillcrest Youth Home, Youth First, and private practices.
SUD Clients	• Clients sited additional service providers with which Southwestern could collaborate. These included Now Counseling, Always Hope Counseling, Brentwood Meadows, and Fresh Start. • The willingness of Southwestern staff to come to county jails for service provision was lifted up as a partnership strength.

Nearly all (94%) partners responding to the Southwestern Partner Survey reported their organization had referred individuals to Southwestern in the past. Importantly, nearly 9 out of 10 reported that the referral process was at least "mostly smooth and effective."



B. Challenges and Gaps

Southwestern partners identified the following services as lacking in the community, and specific community groups who may be unserved or underserved by available services.

Mental health or substance use services that are lacking in the community

Transitional Services

Long-term Treatment Facilities

Spanish Speaking Providers

Care Coordination

Community groups not being served or are underserved by Southwestern

LGBTQ+

Spanish Speaking Population

Haitian Community

BIPOC

Focus Group Feedback on Community-Responsive Staffing and Services Gaps	
Focus Group	**Summary of Relevant Feedback**
Community-At-Large	• It should be noted that many participants in this group expressed a lack of awareness about services available through Southwestern. This points to an opportunity for increased and/or continued promotion of available services through a community awareness campaign.
Community Leaders	• As noted elsewhere, participants described underserved populations such as African Americans, immigrant populations (Haitian, Marshallese, Spanish), gender diverse populations, youth, individuals experiencing homelessness, and individuals with co-occurring mental health and developmental needs. In some cases, this is due to actual services available (e.g., resources in the needed languages, capacity of the neurodevelopmental clinic). In other cases, however, selected populations may be underserved due to limited awareness of services that *are* available and/or cultural obstacles.
Parents of Youth Clients	• Suggestions involved more promotion of available services (e.g., building greater awareness of residential care options) and continuing to address the negative stigma around mental health services. • It is important for providers such as Southwestern to "walk with clients rather than just handing them brochures" about available services. • In a perfect world, participants described shorter wait lists for services that are available in the community. • Additional community education opportunities—specifically around medication education—would address a community need.
SUD Clients	• Clients described several ways in which services could improve. In many cases, these reflections involved issues clients described as interfering with their treatment: o Some medications are not allowed or available if staff see a potential for abuse (ADHD medication, anxiety meds). o There is too little downtime between classes (6:00am to 10:00pm) with no time to go to dorms, make phone calls, etc. o Children must be aged 14 or older to visit, which leads to separation from younger children. One participant recently gave birth and has not seen her baby, another has not seen children since New Year's Eve. o Onsite medical requires a request slip to be seen, which can take days. This leads to having to visit the hospital, then a long wait (3 hours) to be transported back to Stepping Stone. o Clients have needs to contact our clergy, sponsors, etc. and yet phone calls are limited and observed. o Clients should be treated with dignity, not like children with regulations around snacks, smoking, phone calls, going outside, and going to dorms. At a minimum, rules and regulations should be aligned with other providers (e.g., Brentwood Meadows). o Some classes are less productive due to occurring too late in the day, including outdated content (videos or handouts), or being redundant with other classes. o The library includes only pre-approved books, all of which involve religion or recovery.

Southwestern leaders (i.e., any team members in supervisory positions or higher) were invited to reflect on opportunities for the organization to improve. A summary of the most common themes is included directly below, followed by a quantitative breakdown of all response themes.

TOP OPPORTUNITIES FOR IMPROVEMENT (Identified by Southwestern Leaders)

Staffing (Compensation, Retention, Diversity)

"Better pay especially for entry level staff we are competing for staff that are qualified and trained with places that pay more and require less qualifications"

"Intentional recruitment of staff who are not represented in current staffing"

Collaboration

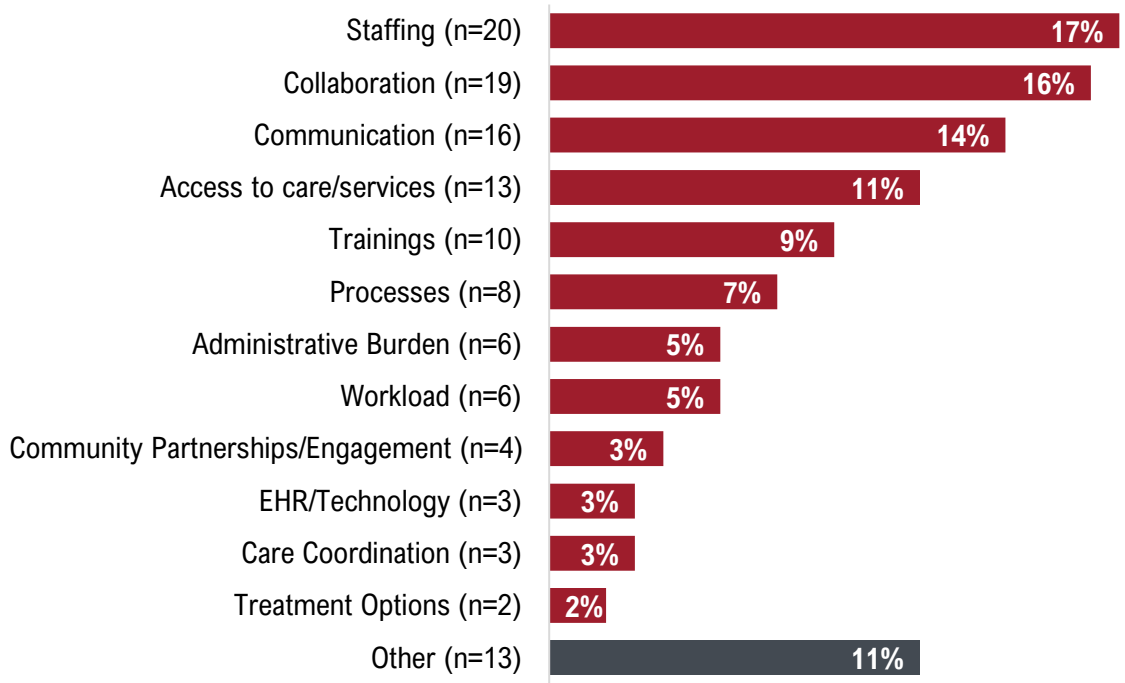
"Collaboration among departments to meet client needs"

"Communication and developing plans with other departments"

Communication

"Communication regarding process changes all offices doing the same process"

"Continued work on communication"



Focus Group Feedback on Partnerships and Care Coordination Gaps	
Focus Group	**Summary of Relevant Feedback**
Community Leaders	• Existing and potential partners may lack awareness of the full scope of services Southwestern offers. Potential referral sources (e.g., schools, Youth First, Inc., primary care providers, psychiatric care at ECHO, etc.) may benefit from additional outreach around how Southwestern can address needs of the populations they serve. • Southwestern's primary care services should be coordinated with primary care providers in the community. Participants noted the need to bridge the communication gap between providers of gender affirming care. • In an attempt to spread awareness of available service options to underserved populations (e.g., African American, immigrant populations), participants recommended partnering with local cultural organizations such as NAACP and churches for events and promotional opportunities. • Additional opportunities for new and/or expanded partnerships involved discussion of Acacia, Anchored by Hope, Youth First, Inc., local schools, YWCA, Albion, MCDC, and Festival of Nations.
SUD Clients	• Clients noted that many providers associate Southwestern with mental health but not necessarily substance-related needs. Additional promotion of available services to local providers is needed to support partnership and collaboration.

Southwestern partners described obstacles they have experienced when making referrals to Southwestern as well as suggestions for making Southwestern's services more accessible. A summary of the most common themes is included below.

Obstacles for respondents' organizations when referring people to Southwestern for services

Waiting/Response Time

"Length of time waiting for appointments."

"I believe there have been some long waits for appointments in the past."

Access to Providers

"Many of our obstacles involve the capacity of our clients including transportation, etc."

"Turnover of providers, get kicked out after missing appointments"

Ways Southwestern could make services more accessible and convenient

Service Expansion/More Providers

"Expand mobile crisis team beyond Vanderburgh County."

"Having more professionals that are culturally competent and/or have language assistance for existing team members."

More Outreach/Marketing

"Many people in the community do not know what services Southwestern offers."

Further, Southwestern partners offered suggestions for ways in which Southwestern could improve partnerships with partner organizations. A summary of the most common themes is included below.

Ways that Southwestern could better partner with respondents' organizations to better serve the people in the community

Cultural Awareness and Support

"We will love to coordinate some cultural awareness sessions and promote any openings for Bilingual Professionals. It will be amazing if Southwestern could probably provide a scholarship for Latino Bilingual Students who would like to prepare professionally in this matter to serve this community."

"Work on offering services for these [underserved] populations."

Expand Partnership

"Talk to our home visiting group, our education outreach group, our CD group."

"Our partnership is good. A focused effort by both, our organization and Southwestern, in strengthening the partnership would go a long way to help unhoused individuals and families."

Ways that Southwestern and respondents' organizations may be able to partner more often, or more deeply

Regularly Scheduled Meetings

"I believe that collaborated once a month meetings to ensure a continuum of care for certain individuals could better serve the homeless community."

"I would like to see a community meeting 1 a month or quarter to discuss initiatives in these specific areas and for he marginalized groups."

Increased Collaboration

"Working more in tandem with SWBH Case Management services/staff on shared patients/clients."

"Greater channels of communication and case conferencing."

C. Summary of Findings: Current Southwestern Strengths and Challenges

Focus groups identified a significant need for coordination and navigation of services for individuals and families with complex needs, extending beyond traditional behavioral health services to include IDD, social safety net, crisis, and long-term treatment services. Participants stressed the importance of assistance in navigating initial mental health treatment and social safety net services—addressing basic needs would enable better focus on behavioral health treatment.

The need for continued and expanded crisis services was highlighted, as well as addressing cultural reluctance to seek treatment and increasing awareness of available services. Underserved populations, including African Americans, immigrants, and those facing gender or sexuality-based discrimination, require added support and population-specific interventions. There is a need for youth-targeted services, homelessness support, and services for individuals with co-occurring mental health and developmental needs.

Medication access and affordability were major concerns, along with the need for increased support at the end of treatment. Expanding access to Substance Use Disorder (SUD) services and reevaluating treatment criteria were also priorities, with an emphasis on meeting clients where they are. Transitional services, long-term treatment facilities, and Spanish-speaking providers were also noted as vital.

Direct communication and networking with community leaders were seen as essential for effective outreach, ensuring a safe and transparent environment for discussion and growth. Limited awareness of Southwestern's services was a recurrently identified barrier among those in our community. Participants strongly encouraged expanding programs to benefit the community. They emphasized the need for culturally sensitive services and collaboration with community organizations. Suggestions included establishing and growing partnerships with external agencies like Now Counseling and Always Hope Counseling. Additionally, ensuring full access to mental health services for individuals involved with the judicial system was highlighted as a potential priority.

Southwestern partners ranked services such as co-occurring mental health and substance use disorder services, comprehensive mental health assessments, and psychiatric services as essential. Support services like housing support and expanding social support networks were also deemed crucial. Focus group feedback revealed strengths in community-responsive staffing and services, with praise for crisis response, residential care, and youth programs. Opportunities for improvement were identified, including increased access to care, improved collaboration and communication, and making efforts to increase staffing retention with recruitment for diversity in staffing as a consideration.

Challenges included a lack of transitional services, long-term treatment facilities, and Spanish-speaking providers. It was also identified that attention needed to be directed to improving access for underserved groups such as the LGBTQ+ and BIPOC (Black and Indigenous People of Color) communities. Additional suggestions for approaches to improving Southwestern included increasing awareness of services, bridging communication gaps, and engaging with cultural organizations.

Overall, the importance of enhancing service delivery and community partnerships were the two most notable ways that were identified to better serve individuals in the community. Obstacles like wait times and provider turnover were noted, with suggestions for expanding mobile crisis teams and improving outreach. Southwestern partners ranked services such as co-occurring mental health and substance use disorder services, comprehensive mental health assessments, and psychiatric services as essential. Support services like housing support and expanding social support networks were also deemed crucial.

Focus group feedback revealed strengths in community-responsive staffing and services, with praise for crisis response, residential care, and youth programs. However, opportunities for improvement were identified, including increased access to care, improved collaboration and communication, and making efforts to increase staffing retention and to recruit for diversity in staffing.

Action Plan to Address Findings

Strategic Plan to Address CNA

THE STRATEGIC PLANNING PROCESS

Utilizing preliminary CNA regional demographic information, client demographic information, survey and focus group results, two separate Southwestern strategic planning meetings took place. The first meeting included key stakeholders such as members of the Southwestern Behavioral Healthcare Board of Directors, members of the agency's leadership, members of Southwestern Healthcare, and community members. During this meeting, the group discussed their individual takeaways from the CNA and identified primary needs and barriers. They determined several priorities to be developed into an action plan. Notes were taken throughout the process to create a document describing the priorities this group determined needed further development.

Between the first and second planning meetings, general areas of discussion were prepared for the leadership team of Southwestern Behavioral Healthcare. The notes from the first meeting and the CNA were used to inform this second meeting. At the meeting, the leadership team (a group consisting of all members of middle and upper management) divided into four small groups and discussed four topics derived from the first meetings notes and the CNA. Each of these groups were asked to consider reasonable and actionable goals that could be used to meet the needs found by the CNA and the initial strategic planning session notes. Notes were taken and important takeaways were condensed from the discussions.

The planning and discussion sessions were then discussed among the directors and the CEO. A priority strategic map was the result of this discussion. The priority map was then used to rank the various actionable suggestions and to inform the implementation plan. The outcome of this process identified three overarching priorities Improve access to care for individuals seeking services, care coordination capacity building, and seamless communication between Southwestern teams, departments, and outside entities. A secondary priority was also identified, overseeing the renovation of Mulberry Plaza, to accommodate service expansion.

SOUTHWESTERN'S PRIMARY PRIORITIES FOR IMPLEMENTATION

1. **Improve access to care for individuals seeking services:** Over the last fiscal year, Southwestern has reduced the wait time for initial assessment from 21 to 12 days; the CCBHC standard is 10 days. Return time to reschedule a follow up appointment is currently in data analytics logic modeling and EHR reporting build. The triage from crisis services into ongoing treatment and open access initiatives have been successful in early implementation. This priority will be tracked and evaluated through SMART GOAL 1: The Time Between Initial Request for Services and 1st Appointment Will be 10 Days or Less, SMART GOAL 2: Follow-up Appointments for Southwestern Clients Will be Available Within 14 Days of the Previous Service Received and SMART GOAL 5: Improve Staff Retention Rates.

2. **Care Coordination Capacity Building**: Care coordination is the building block of the CCBHC model of care. With a goal of addressing Social Drivers of Health issues including barriers to transportation, housing, food, employment and education, care coordinators are needed. To provide more clinical services, our therapists, social workers, and psychiatrists must be allowed to focus only on service provision. Care coordination will reduce the clinical administrative workload to meet that standard. This means that care coordination must be a position as well as an activity. This priority will be monitored through SMART GOAL 6: Establish Data-driven Decision-making Capacity for Care Coordination Expansion and SMART GOAL 4: Improve Client Access to Health Screening.

3. **Seamless communication between Southwestern Teams, Departments, and outside entities**: As Southwestern implements full state CCBHC certification, the need to improve both communication within the agency and with our community partners is vital. Expanding internal and community knowledge and engagement was a key component of launching a successful Crisis System. From 2021 to 2023, Crisis Services actively engaged in building partnerships with local law enforcement, jails, hospitals, agencies, and internal and external programs. This was done with the understanding that, "If you have a crisis service, and no one knows, you do not have a crisis service." In 2024 this outreach and communication of priorities has enabled crisis services to expand into Warrick and Posey Counties. As we move forward and address the concerns uncovered in this CNA we have identified that communication and outreach are a key component to involving the community and growing the awareness and success of our CCBHC.
    - **Southwestern Marketing and Outreach Campaign to Underserved Communities:** Focus groups conducted with BIPOC and LGBTQ+ community leaders identified a lack of knowledge of Southwestern and the services we offer. We have identified a need to target outreach to these communities. These populations of interest (Veterans, people over the age of 65, and children) were not alone; all populations of interest would benefit from outreach and engagement and is why we are instituting SMART GOAL 7: Expand Community Awareness of Southwestern CCBHC Services and SMART GOAL 8: Increase Involvement with Local Social Service Associations, Coalitions and Boards.
    - **Crisis Expansion through Community Awareness and Education:** Crisis services has launched into Warrick and Posey Counties; awareness, educational outreach engagements and community marketing will assure the expansion of crisis and other mental health, and substance use services are successful. This goal will be monitored through SMART GOAL 3: Expand Crisis Services to Three Additional Rural Counties.

SECONDARY PRIORITIES

1. **Implement a transitional mental health program by December 31, 2026**: As Southwestern examines the community service gaps, the operational barrier we face is a lack of transitional care for those stepping down from inpatient hospitalization, state psychiatric hospital discharge, or stepping up for longer crisis intervention that does not require hospitalization. A transitional living program is planned for both men and women (20 beds total) to address this gap in service provision using the peer respite model. Southwestern is funded for capital renovation (through City of Evansville ARPA funding) that will be required to address the ability to meet the staffing and service needs of this program. This priority will be tracked and monitored through SMART GOAL 9: Establish a Transitional Program.

Staffing Plan

The results of the needs assessment are being integrated into our staffing plan. Staffing has often been reactive to sudden growth in newly launched programs, such as Crisis Services and the Neurodevelopmental Center. Southwestern is in the process of building a data-driven staffing model based on service utilization and staffing ratios to project anticipated growth and identify unanticipated program growth early. This will provide the data-driven capacity to answer some difficult questions. If there is a new program; what are its staffing needs? Where do we need staff the most? What is the program client/staff ratios? Has a program grown more rapidly than we have staffed for? We are establishing baseline reporting numbers to answer these questions.

Southwestern experienced an approximate 15% increase in services provided between FY22 and FY24, providing a baseline for us to measure future growth.

There are 372 full-time employees and 52 vacant staff openings. Our 13% vacancy rate is lower than the 16.8% statewide average for CMHCs. Added CNA related staff positions will raise that vacancy rate to 17%. In FY24 our staff turnover rate was 35.2% compared to the state average of 34.3%.

Southwestern has 52 full-time employees who are in supervisory leadership positions; 6 are department directors. 12 supervisory positions were created as part of CCBHC programmatic development, since the inception of the 2021 SAMHSA CCBHC-E grant award. Southwestern has a full-time Chief Executive Officer. Our Chief Medical Officer is an actively licensed psychiatrist in Indiana. Both are actively engaged in all CCBHC program development, implementation and oversight.

Described as the lynchpin of CCBHC, care coordination implementation resulted in a systems redesign from limited-access case management to agency-wide service. Care coordination has been presented as a work function that can be integrated into existing positions such as case management, skills coaching, and nursing. Care Coordinator can also be a standalone job position. Southwestern is currently operationalizing this hybrid model. Workflows, policies, processes, training plans, and EHR documents have built the foundation of care coordination.

As CCBHC has moved from grant to Medicaid Demonstration state status, staffing needs across the clinical and administrative systems have increased. Our need for more licensed clinical therapists has been an ongoing issue since before the pandemic. Our current staffing plan has 10 vacant LCSW or LSW positions. Care coordination positions by name or function (Care Coordinator, Case Manager) will be increased by 8 full-time staff (FTE); the barrier is that we have 12 existing vacancies in these job categories. There are 7 open positions for Peer Support Specialists, a number recently revised upwards with the launch of mobile crisis services to surrounding counties and expansion of the Crisis Receiving and Stabilization Services (CRSS).

Expansion of High-Fidelity Wrap Around Services indicates expansion of facilitators by 4 FTEs to provide intensive in-home services including care coordination. The remaining 11 positions include an additional data analytics reports writer, an LPN to assist with medical monitoring within the crisis team, and support positions in medical records, IT, and facilities staff.

Our staffing plan does not reflect staff added across the agency during the prior 6 months. There was a 250% increase in crisis services over the past fiscal year. Southwestern pivoted to a hybrid living room model to double CRSS capacity. Therapists, mobile crisis responders, an insurance navigator and peers were hired to staff the expansion of mobile crisis response from 1 to 4 counties. Certification of bi-lingual staff began in June 2024. Crisis Services is now the Department of Crisis and Outreach; the newly established director began work in August 2024.

We are altering our staffing model as indicated to respond to community need and requests for services in real-time.

The primary barrier to CCBHC program staffing remains: all 4 counties in our service region are HRSA designated behavioral healthcare workforce shortage areas. We are actively recruiting therapists, care coordinators and peer support specialists. We are utilizing MSW and BSW interns, who often remain with Southwestern post-graduation. Our psychiatric staff supervise psychiatric residents. We are offering HRSA student loan forgiveness and partial student loan payment reimbursement. We recruit at every outreach event in the community. Our staff with lived experience have successfully recruited many newly certified Peer Support Specialists through word-of mouth and social media posts. CCBHC certification may improve retention as wages become more competitive with similar private employment. CCBHC grant status and pilot site status have allowed us to make market adjustments to staff salaries that have helped retention.

Primary Implementation Plan FY25 - FY27

A. Community Needs and Barriers to Care

The implementation plan to address the Community Needs Assessment findings focus on access to care, expanding crisis services, increasing healthcare screenings and care coordination, improving staff retention and expanding awareness across the general community with an emphasis on communities the needs assessment identified as unserved or underserved. The following SMART goals are integrated into the FY25 Southwestern CQI plan. Additional internal CQI plans are in operation within the Southwestern CLAS Steering Committee, and CCBHC Implementation Committee. All SMART goals identified are accompanied by Plan-Do-Study Act plans (PDSAs) designed to move projects towards successful implementation.

ACCESS TO SERVICES FOR NEW and EXISTING CLIENTS

SMART GOAL 1: The Time Between Initial Request for Services and 1st Appointment Will be 10 Days or Less	
Specific	Access to routine initial evaluation appointments will be an average of 10 days or less for 3 consecutive months by the end of FY25; access to initial evaluation an average of 5 days or less for at least 3 consecutive months by FY26: and by FY27 appointments will be available through same day access. The Innovative Practices Team (IPT) will collect, analyze and report this data to DMHA and SAMHSA; the CQI Committee will monitor outcomes monthly and refine workflows and processes to improve access.
Measurable	All EHR data linked to the I-Serve technical specifications is accessible in the IPT data warehouse (August 2024). Internal Southwestern logic models are fully operationalized for DMHA and SAMSHA reporting. Southwestern is currently monitoring this measure as part of our FY25 CQI plan. By FY26, Power Bi reporting dashboards will be completed to automate this reporting process. (CQI Goal #1)
Attainable	CQI efforts since FY23 resulted in reduced wait times for initial services from 22 to 12 days. Expansion of our open access model should further reduce time between inquiry and service to meet the 10-day goal in FY25. I-Serve reportable data is being collected, extracted, analyzed and reported as part of a broader strategy to operationalize all Clinic-Collected measures by January 2, 2025, establishing a data baseline for CY26-27 modeling.
Relevant	Per the Southwestern CNA, access to services with minimal wait time is a community priority. Operationalizing the I-Serve measure is also a requirement for IN CCBHC Certification and the SAMHSA-IA grant.
Time bound	Monitoring = monthly by CQI Committee Reporting: June 30, 2025, June 30, 2026, and June 30, 2027 (IN DMHA Fiscal Year)

SMART GOAL 2: Follow-up Appointments for Southwestern Clients Will be Available Within 14 Days of the Previous Service Received.	
Specific	Access to appointments will be an average of 14 days or less for active clients over a period of at least 3 consecutive months within FY24. By the conclusion of FY26 average access to appointments will be 14 days or less for active clients for at least 6 consecutive months. Access will remain at 14 days for all 12 months. The Innovative Practices Team (IPT)will provide data analytics and CQI development oversight, working with the CQI Committee on process and workflow design and efficiency. EHR Department will populate and maintain the IPT data warehouse.
Measurable	The data foundation is built for reporting this information and it is part of the FY25 Southwestern CQI plan. Analytics capacity in place for granular comparison of Southwestern program and departments to identify agency best practices. (CQI goal #6)
Attainable	CQI PDSA plans will establish system capacity baseline in FY25. In FY26 staffing capacity (vacancy rate) will be cross tabulated to determine the impact of HRSA workforce shortage area designation, as PPS rates are implemented. FY27 goal will be monitoring progress for both staffing and access to follow-up appointments within 14 days.
Relevant	Often focusing on rapid access to an initial appointment has the unintended cost of lengthening the wait time for established client follow-up visits. Attestation criterion 2.b.3 specifies the 14-day access to follow-up parameter for availability to next appointment date. Consistency of access to care will be monitored in FY25 to establish a CQI baseline.
Time bound	Monitoring = monthly by CQI Committee Reporting: June 30, 2025, June 30, 2026, and June 30, 2027 (IN DMHA Fiscal Year)

B. Community Responsive Staffing and Services Care

EXPAND CRISIS SERVICES

SMART GOAL 3: Expand Crisis Services to Three Additional Rural Counties	
Specific	Expand crisis services to surrounding rural counties (Posey, Gibson, and Warrick). Collect baseline of total encounters by county in FY25, 20% growth over FY26, and 10% over FY27. IPT, Crisis Services, and the EHR departments are tasked with operationalizing the IPT data warehouse, stratified reporting, documentation, and workflow processes.
Measurable	A crisis services reporting dashboard has been created by the data analytics team which provides an ongoing mechanism to document crisis services delivery in a granular format for DMHA Crisis Services contract reporting. County level data can actively be stratified and reported via this dashboard.
Attainable	Crisis Services EHR notes have been internally designed, tested, and implemented to facilitate reporting and clinical process documentation. Data extraction plans and logic modelling are completed. Vanderburgh County crisis services utilization will continue to be monitored while individual county services baselines for Warrick, Gibson, and Posey Counties will be established in FY25.
Relevant	In January 2024, crisis services expanded to include 3 additional rural counties in the Southwestern service area. CCBHC required services and was initiated by Southwestern in 2021. From FY23 to FY24, crisis services delivery increased by 250%.
Time bound	Monitoring = Monthly in CCBHC CQI Team Meeting. Reporting and revising = June 30, 2025, June 30, 2026, and June 30, 2027. Refinement of goals will be based on lessons learned across FY25-FY27 of this project, as well as state and federal guidance.

EXPAND PRIMARY HEALTH SCREENINGS

SMART GOAL 4: Improve Client Access to Health Screening	
Specific	Collection of health screening data will be done on 80% of active clients for 3 consecutive months in FY25, Collection will rise to 85% in FY26, and 95+% by FY26.
Measurable	Utilizing the internally designed Healthcare Measures Flow Sheet, health screenings can now be tracked across the agency (August 2024). FY25 baseline data indicates 73% of current Southwestern clients have completed a health screening in the past 12 months. Healthcare screening measure results can be stratified by demographic group, or diagnosis, program, or location. Power Bi automation of this measure will be complete by January 1, 2025 (CQI goal #2)
Attainable	Full EHR data transfer protocols have been established to populate data tables in the IPT data warehouse to facilitate full data reporting and analysis on this measure (August 2024). All workflow processes and staff training are complete.
Relevant	Behavioral Health Primary Care screening is one of the 9 core services required of a CCBHC. It is one of the newest service lines at Southwestern and is being implemented in alignment with an expanded PIPBHC model and DMHA oversight. Our goal is expansion of health screenings and care coordination of the referrals between Southwestern and external providers.
Time bound	Monitoring = Monthly in CQI Reporting and revising: June 30, 2025, June 30, 2026, and June 30, 2027

IMPROVE STAFF RETENTION

SMART GOAL 5: Improve Staff Retention Rates	
Specific	FY24 baseline Southwestern staff turnover rate is 35.2% (compared to the Indiana average of 3.3%). Reduce staff turnover rate by 2.5% from FY25 to FY 26 and FY26 to FY27.
Measurable	Staffing levels will be maintained and tracked through data provided by HR. Retention Rate = (Remaining headcount during set period/ Starting headcount during set period) x 100**,** Rate will be calculated quarterly and annually to determine short-term and long-term stability of staff retention and Turnover Rate= (Average the number of employees at the beginning and end of the time period) x 100**,** Rate will be calculated monthly and yearly to determine short-term and long-term stability of staff turnover.
Attainable	This may or may not be an aspirational goal. There are realities of operating in a HRSA designated behavioral health shortage area. As we have an established baseline of staff turnover rates, it can be effectively tracked. Recruitment and retention strategies are in place.
Relevant	To provide clinical services to our community we require clinical service providers to be available at both intake and throughout an individual's episode of care.
Time bound	Monitoring: Biannual review of staffing plan will be conducted collaboratively with IPT, the CEO, the CFO, and the Chief HR Officer. Reporting and updated PPS rate staffing plan submission: June 30, 2025, June 30, 2026, June 30, 2027,

C. Effective Partnerships and Care Coordination

EXPAND CARE COORDINATION

SMART GOAL 6: Establish Data-driven Decision-making Capacity for Care Coordination Expansion	
Specific	Establish baseline reporting capacity for care coordination FY25 Identify staffing needs based on stratified program/location/department utilization; identify gaps and forecast FY26 and FY27 care coordination staffing needs. Care Coordination process development assigned to IPT CQI Manager; DFA note and reporting table implementation responsibility of EHR Department; utilization reporting and dashboard development assigned to IPT Data Analyst.
Measurable	Southwestern has internally designed and launched Care Coordination documents in our EHR for the express purpose of documenting care coordination, ROI completion, and external medical records exchange (August 2024). The resulting data from these notes populate the IPT data warehouse and can be extracted and reported by the data analyst. These notes facilitate forecasting, reporting and tracking by our data analyst in FY26 and FY27.
Attainable	With the launch of the Care Coordination notes in the EHR and IPT Data Warehouse, Southwestern can launch collection of baseline data in FY25, stratified according to department, location, and program. Southwestern is reengineering a very limited CMHC case management model into a 'care coordination is the lynchpin of CCBHC' model. Utilizing SAMHSA attestation criteria, DMHA certification criteria, and the National Council CCBHC Care Coordination Toolkit, our care coordination model is the focus of multiple PDSA workgroups. A CQI PDSA set is established to accomplish this goal.
Relevant	Care coordination is key to impacting health disparities. The CCBHC model is grounded in real-time intervention with SDOH issues, coordination during transition from higher to lower levels of care, and networking with local agencies and service providers. There are multiple attestation criteria outlining the importance and function of this role.
Time bound	Stratified baseline reporting and staffing needs projection by June 30, 2025. Staffing needs reevaluated and realigned by June 30, 2026; June 30, 2027

EXPAND AWARENESS OF CCBHC SERVICES AT SOUTHWESTERN THROUGH EXPANDING PARTNERSHIPS

SMART GOAL 7: Expand General Community and Targeted Outreach to Increase Awareness of CCBHC Service	
Specific	Ongoing community marketing and targeted outreach will be conducted with a minimum of 15 quarterly contacts by the Southwestern Crisis and Community Outreach Department, Southwestern DEE Committee, Marketing Department, Southwestern Department Directors, and their leadership teams- with new community partners and referral sources. Additionally, the Outreach Team or authorized members of the Southwestern staff will conduct at minimum 1 outreach conference, community training, or presentation to a community partner or coalition once per quarter to raise awareness of Southwestern CCBHC services. A minimum of 15% of outreach activities will be targeted towards underserved or underrepresented communities including: Veteran, Haitian, Spanish-speaking, BIPOC, LGBTQ+ and older adults.

	These activities will be submitted to and tracked by the Marketing Department, then compiled and reported on by IPT, during monthly CCBHC CQI meetings.
Measurable	Southwestern will utilize the SAMHSA IPP specifications for PC2: the number of organizations collaborating, coordinating, or sharing resources with other organizations (as a result of the grant). We will merge existing tracking mechanisms used across departments to expand, capture and report on community outreach and engagement efforts. We will collect information on BOTH formal and not-necessarily-formal relationships that actively participate in collaboration/coordination/resource sharing or agreement in a quarter. In the spreadsheet, kept in Microsoft Teams, the name of the organization and type of partnership should be noted and a description of the collaboration/sharing/coordinating and activities that were done within that quarter will be documented.
Attainable	Two separate outreach and community awareness activity trackers are currently in place by Marketing and IPT. These two tracking processes will be merged into one standardized reporting process.
Relevant	If no one knows you have a program, you do not have a program. Per the CNA focus groups, knowledge of Southwestern services is lacking in both the general community, and in minority communities specifically. This outreach and engagement model was used successfully in launching our new crisis services in 2022 and will be used as a guide.
Time bound	Monthly reports will be monitored in the monthly CCBHC CQI meeting during FY25 and quarterly in FY26 andFY27 by IPT and Marketing.

Secondary Implementation Plan FY25 - FY27

A. Establish Transitional Mental Health Services

ESTABLISH TRANSITIONAL PEER RESPITE PROGRAM

SMART GOAL 8: Establish a Transitional Peer Respite Program	
Specific	Establish PDSA plans to operationalize proposed transitional unit by December 31, 2026. The CEO is the lead of the transitional recovery program project. Crisis and Outreach and Community Support Services will take lead on operationalizing processes. IPT and EHR will collaborate on EHR document builds and data models for tracking and reporting.
Measurable	Currently PDSA plans are designed to build foundational programmatic design needs such as architectural renovation plan, programming plan, staffing plan, sustainability plan, and operational plan. This project is not yet at a stage for quantifiable utilization or outcome tracking. Documentation providing clinical documentation and data reporting needs will be built in-house as an EHR document. Crisis and Outreach Services, the EHR Department and IPT will collaborate on the full build.
Attainable	Southwestern has demonstrated the capacity to launch new service lines including crisis services, care coordination, PIPBHC, and healthcare integration. Best practices from these projects will be used for the transitional program launch. A detailed set of PDSAs have been established to accomplish launch of this service line.
Relevant	Per our CNA, services addressing the transition from higher level of care into community is a missing and needed recovery option in our community. Transitioning from an inpatient unit, state psychiatric hospital, or jail into the community requires a level of services that is client centered, and emphasizes peer support, recovery focus, care coordination, and plans to address SDOH disparities.
Time bound	Launch is projected to be December 31, 2026.

The Needs Assessment Cycle and Updates

A. Plan to Update Needs Assessment

The CNA will be updated at least every three years per the expectation of both the Indiana DMHA and SAMHSA.

B. Southwestern Communications Plan

The results of our community needs assessment will be marketed on multiple levels and in multiple formats. The purpose of variations in presentation will aid in ensuring transparency and engagement with stakeholders when communicating results and actionable insights from the CNA.

External Stakeholders and members of the focus groups will have the completed CNA shared with them and will be able to observe that their input was heard, valued, and used to inform the project. The CNA will be made available through the Southwestern website so that it will be easily accessible for the community. Community events for partners and the public, such as a press conference, will be hosted so that the CNA and its derivative work within the agency can be discussed. A focus on the transformation of CMHC through the CCBHC initiative will be presented; services will also be a highlight of this discussion. Social media posts with infographics and excerpts from the CNA will be used to spread awareness, reach a wider audience, and raise awareness within the overall community.

The CNA will be provided to community agencies and private medical practices as an opening to discussions about community need and strengthening a broader community network. Smaller agencies are encouraged to use the results of the needs assessment in their own grant writing efforts.

Internal stakeholders, including the Southwestern Behavioral Board of Directors and staff, will have copies of the full report available to them. The CNA will be reviewed, discussed, debriefed, and implementation plans refined during monthly agency leadership team meetings. The Board of Directors will be asked to review the action plan to address the findings and will be invited to affirm the final draft. Upon approval by the board, a thorough review of the CNA will be conducted during departmental and programmatic meetings to ensure all internal stakeholders are informed and engaged.

By communicating the CNA results on multiple levels and in various formats, we can ensure that all stakeholders are well-informed, engaged, and prepared to act based on the findings.

C. Integration of Needs Assessment Action Plan with CQI Process

The FY25 Southwestern CQI Plan is driven by Southwestern's efforts to achieve the Indiana CCBHC certification status and is based on the Comprehensive Needs Assessment (CNA). Operationalizing the SAMHSA Clinic-Collected Measures is paramount, with key goals including:

- Access to services time
- Depression remission after six months of services
- Completion of suicide risk assessments
- Screening for problematic alcohol use
- Identifying social drivers of health reporting capacity

These measures are essential as Southwestern is required by DMHA to report them as a foundational element of being a CCBHC pilot site.

At the beginning of each fiscal year, committee leadership reviews and identifies key processes and measures to be tracked and improved over the following 12 months. The selection of these measures and processes is influenced by their impact on individual populations identified within the CNA. The following is a description of the current FY25 CQI goals. As CQI processes are dynamic, the current plan will be reviewed periodically, and the identified goals will be revised as needed based on progress. FY25 CQI plan holds 6 measures.

FY25 CQI Goal 1: Develop and Implement Reports for Five Mandated Clinic Collected Measures

This CQI process details the current state of our system's ability to report and collect information in relation to the required clinic collected quality metrics.

Goal:	Develop and implement BI-driven reports for the five mandated clinic-collected measures from SAMHSA.											
RIE Purpose:	1) Document current status of each measure as it goes through development. 2) Identify choke-points											
Plan-Do-Study-Act Link												
Process Status	Tech Specs	Preliminary Date Sourced	Initial Logic Model	Supplimental Data Sourced	Detailed Logic Model	Data Being Collected	Power Query Development	Power Query Testing	Power BI Development	Power BI Testing	CPT Coding	Reportable to DMHA
I-SERV	**Completed**	**Completed**	**Completed**	**NA**	**Completed**	**Completed**	**Technical Consultation**					
Dep Rem-6	**Completed**	**Completed**	**Completed**	**NA**	**Completed**	**Completed**	**Started 4/26/2024**					
ASC	**Completed**	**Completed**	**Clinical Consultation**	**Started 8/7/2024**								
CDF - AD / CH	**Completed**	**Completed**	**Completed**	**NA**	**Completed**	**Completed**						
SDOH	**Completed**	**Clinical Consultation**	**Started 6/26/2024**	**Started 8/7/2024**	**Completed**							
Required by: SAMHSA, CCBHC		POC: Lisa Withrow & Shawn Edwards						**Collaborators: SAMHSA**				

FY25 CQI Goal 2: Health Measure Screening

This CQI process reports and follows the current state of our system ability to conduct Primary Health Screenings, along with Southwestern's internal progress on conducting primary care health screening, tracked by primary program.

SMART Goal 4: Increase the collection of health screening data to 80% of active clients for 3 consecutive months in FY25, 85% in FY26, and 95% by FY27.

FY25 CQI #2 Primary Care Health Measure Screening												
Measure:	The tracking of clients who have received primary care health screening against the whole SBH In Treatment Population between Assessment and ReAssessment. While the window between Assessment and ReAssessment is 6 months, the measure looks over a 12 month period.											
Goal:												
Plan-Do-Study-Act Link	CQI Teams											
	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	FY25 Av
In Treatment Population	**4407**											**4407**
Total In Treatment Population that Received a Tracked Primary Care Health Measure	**2508**											**2508**
Percentage of In Treatment Population that has Received a Tracked Primary Care Health Measure	**56.91%**											**56.91%**
Diastolic	**56.75%**											**56.75%**
Pain	**3.13%**											**3.13%**
Pain Level	**18.24%**											**18.24%**
Pulse	**42.73%**											**42.73%**
Respiratory	**5.90%**											**5.90%**
Systolic	**56.77%**											**56.77%**
Temperature	**11.57%**											**11.57%**
HIV / Hep Testing Referral	**0.16%**											**0.16%**
Required by: DMHA, CCBHC		**Data Source: SBH Data Tables**						Collaborators: EHR, Primary Care Staff, IPT Team				

FY25 CQI Goal 3: Inpatient Psychiatric Discharges, Follow-Up Services, and Readmissions

This CQI process involves tracking and reporting on the current state of our system's ability to track and follow up on inpatient stays for clients who are released from inpatient services. It is a drill down of data starting with inpatient discharges and their follow-up services, into any inpatient readmissions and their related follow-ups. Data tracking goes into not only internal program follow-up tracking, but also the patient's length of stay.

FY25 CQI #3 Focus on Inpatient Psychiatric Discharges, Follow-Up Services, and Readmissions														
Measure:	Compare and contrast inpatient psychiatric discharges and the rate of follow-up services for these clients against inpatient psychiatric clients that were readmitted within 30 days and their rate of follow-up services. Readmit measures will be delayed 30 days to allow of complete 30 day data collection.													
Goal:														
Plan-Do-Study-Act Link	CQI Teams													
	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	FY25 Av	FY24 Av
IP Discharges	**52**	**34**											**43**	
IP Discharges that Received Follow-Ups within 7 Days	**36**	**21**											**28.5**	
IP Discharge Follow-Up Percentage	**69.2%**	**61.8%**											**66.3%**	
IP Discharges that were Readmitted within 30 Days	**9**												**9**	
IP Readmit Percentage	**17.3%**												**17.3%**	
IP Readmits that Received Follow-Ups within 7 Days	**8**												**8**	
IP Readmit Follow-Up Percentage	**88.9%**												**88.9%**	
Required by: DMHA, CCBHC	**Data Source: SBH Data Tables**							Collaborators: EHR, Hospital Liaisons, IPT Team						

FY25 CQI Goal 4: Client Access to Treatment

This CQI process involves tracking and reporting on the current state of our system's ability to provide initial assessments. This internal measure is a breakdown of the clinic collected measure I-SERV, whereas instead of tracking Inquiry to Start of Treatment, we further stratify the data to look at Inquiry to Assessment and then Assessment to Start of Treatment.

SMART Goal 1: Reduce the time between the initial request for services and the first appointment to an average of 10 days or less by the end of FY25, 5 days or less by FY26, and achieve same-day access by FY27.

FY25 CPI #4 Client Access to Treatment														
Goal	The average wait days from inquiry to assessment appointment should be **10 days or less**. Number of scheduled													
Target	**10 days maximum wait time for Routine, 1 day for Urgent, and 0 (Same) Day for Emergent Assessments**													
CCBHC Relevance:	Criteria 2.b.3 Timing of Services Current data reflects average wait for treatment. *Note: data reflects the month 60 days prior in order for inquiries to resolve													
	Jul-24	**Aug-24**	**Sep-24**	**Oct-24**	**Nov-24**	**Dec-24**	**Jan-25**	**Feb-25**	**Mar-25**	**Apr-25**	**May-25**	**Jun-25**	**FY25 Av**	**FY24 Av**
Number of Completed Assessments	**360**												**360**	**326**
Average Days Wait from Inquiry to Assessment	**9**												**9**	**12**
Average Days Wait from Assessment to 1st Treatment	**13**												**13**	**12**
Required by: CCBHC	**Source--> SBH_ClientEpisodes Data Table**						Collaborators: IPT, Spear Outpatient, Stepping Stone							

FY25 CQI Goal 5: Completion of Client Demographic Profiles

This CQI process tracks our collection of client demographic information in order to stratify other measures by demographic categories. This is a continuation of an FY24 goal focused on updating complete demographics on all Southwestern clients.

SMART Goal 6: Establish baseline reporting capacity for care coordination in FY25 and identify staffing needs for FY26 and FY27.

FY25 CQI #5 Inventory Existing Southwestern clients' demographic profiles on SAMHSA required stratifications													
Process Measure:	Inventory the demographic profiles of existing In Treatment SBH clients for the specific demographic datapoints required for SAMHSA clinic collected measures (Age, Race and Ethnicity), along with the protected class of Veteran Status. Will measure standalone Intake data from SmartCare versus data collected via the Indiana NOMS suplimented with Intake data from SmartCare for the Ethncity and Veteran Status datapoints.												
Goal:	*Standard 11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery												
	Jul-24	**Aug-24**	**Sep-24**	**Oct-24**	**Nov-24**	**Dec-24**	**Jan-25**	**Feb-25**	**Mar-25**	**Apr-25**	**May-25**	**Jun-25**	**FY25 Total**
In Treatmeant Client Count	4382												4382
# Profiles Missing Race Data	1												1
% Profiles Missing Race Data	0.02%												0.02%
# Profiles Missing Age Data	2												2
% Profiles Missing Age Data	0.05%												0.05%
# Profiles Missing Intake Ethnicity Data	83												83
% Profiles Missing Intake Ethnicity Data	1.89%												1.89%
# Profiles Missing IN NOMS / Intake Ethnicity Data	69												69
% Profiles Missing IN NOMS / Intake Ethncity Data	1.57%												1.57%
# Profiles Missing Intake Veteran Status Data	1224												1224
% Profiles Missing Intake Veteran Status Data	27.93%												27.93%
# Profiles Missing IN NOMS / Intake Veteran Status Data	363												363
% Profiles Missing IN NOMS / Intake Veteran Status Data	8.28%												8.28%

FY25 CQI Goal 6: Existing Clients' Access to Services

This CQI process tracks our ability to provide follow-up appointments in a timely manner as requested by clients.

SMART Goal 2: Ensure follow-up appointments are available within 14 days of the previous service for active clients, maintaining this average for at least 3 consecutive months by FY24, 6 consecutive months by FY26, and consistently for all 12 months by FY27.

FY25 CQI #6 Existing Clients' Access to Services														
Measure:	People who are already receiving services from the CCBHC who are seeking routine OP clinical services must be provided with an appointment within 10 business days of the request, unless the person receiving services chooses otherwise.													
Goal:	An average of 10 business days from the most recent OP clinical service to the next scheduled OP clinical service.													
CCBHC Relevance:	CCBHC Standard 2.b.3 Timing of Services													
FY 2024 Tracking	**Jul-24**	**Aug-24**	**Oct-24**	**Nov-24**	**Dec-24**	**Jan-25**	**Jan-25**	**Mar-25**	**Apr-25**	**May-25**	**Jun-25**	**Jun-24**	**FY25 Av**	**FY24 Av**
Average Days Between Recent OP Service and Next Scheduled OP Service	15												15	15
% of Clients That Meet 10 Business Day Standard	32%												32%	29%
% of Clients That Meet 10 Business Day Standard and Have a Service Scheduled	35%												35%	32%
Required by: CCBHC	**Data Source: SBH Data Tables**							Collaborators: EHR, IPT Team						

Summary

This 2024 Community Needs Assessment has provided a demographic and geographic overview of Vanderburgh, Warrick, Gibson, and Posey Counties along with behavioral health issues. The CNA identified Southwestern Behavioral Healthcare service sites and programs, examined underserved communities and populations, and presented both quantitative and qualitative outcomes of surveys and focus groups conducted with individuals and families receiving services, members of the community at large, and community leaders of underserved communities in our area. This was followed by an action plan and continuous quality improvement plan for Southwestern over the next three years.

Southwestern has completed our SAMHSA CCBHC attestation statement, DMHA CCBHC certification, and Community Needs Assessment simultaneously. We are both a SAMHSA CCBHC-IA grantee and an Indiana DMHA CCBHC pilot-site. Concurrent work to meet CCBHC certification criteria, developing our fiscal year CQI plan, CCBHC budget, and the CNA have provided us the opportunity to integrate the findings and requirements of these documents. Southwestern strategic plan development has involved all departmental leaders across the agency. The CNA identified gaps, and leadership has designed goals accompanied by a granular list of objectives (PDSAs) to meet them. Continuous Quality Improvement workgroups are actively working to meet our presented goals.

Over the next three years, Southwestern will continue expansion of CCBHC services, while continuing to refine care coordination, Veteran's services, and healthcare integration across the agency. Outreach to underserved populations and communities will be targeted towards developing community-based partnerships. Our new Crisis Services and Outreach Department will collaborate with the Marketing Department to expand awareness of the crisis service continuum and all Southwestern services across the region.

Several of Southwestern's providers are certified Star Behavioral Health Providers (SBHP). Southwestern connects military service members and their families with licensed behavioral health professionals who have specialized training in military culture and treatments shown to be effective with military families. Southwestern is also a member of the VA Community Care Network which pays for Veterans health care outside VA, in their local communities, when needed. The relationship between Southwestern and the VA continues to be refined. We have a dedicated Veterans therapist who provides clinical services and care coordination, who is herself a Veteran. Our goal is to increase Veteran utilization of crisis services, care coordination links to VA care, and direct services based on client choice.

In addition to the CQI Committee, the Diversity, Equity and Engagement Committee and CLAS Steering Committee will continue to work on outreach to diverse communities, continue work to recruit a diverse and engaged staff, ensure access to interpreters and translated documents, provide community and staff training on diversity, and conduct staff and community trainings. General and targeted community outreach will take place and be centrally tracked. Best practices in marketing our crisis services will be replicated to improve community awareness and establish needed partnerships for success. Expanding services to underserved communities and establishing a trauma-informed environment of care for all to receive services is an overarching goal.

Stepping Stone has successfully implemented same day access to assessment and treatment. Capacity to provide treatment for co-occurring disorders requires clinical providers who are trained and licensed LCSWs and LCACs. Southwestern is in partnership with the University of Southern Indiana (USI) Department of Social Work and Community Health Network, participating in the Behavioral Health Academy; this partnership offers all coursework and practicum opportunities needed to meet the qualifications for dual licensure. EBP training and certification in

Motivational Interviewing, Acceptance and Commitment Therapy, and Cognitive Therapy is built into this innovative model to prepare future therapists.

The presence of strong mutual self-help groups is a regional strength. Between the 12-step groups of Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Al-Anon, Adult Children of Alcoholics, Celebrate Recovery, and SMART Recovery throughout the region, there are over 200 combined meetings per week, available any given day. The strength of Stepping Stone alumni in our region cannot be understated in providing peer support specialists, therapists, nurses, and other essential staff to Southwestern with lived recovery experience.

As Southwestern implements the CCBHC model, the lack of space to expand is an ongoing barrier to full implementation. Southwestern is utilizing ARPA funding through the City of Evansville on a $10 million renovation project across multiple facilities. Renovation completion is scheduled for December 2026. This includes a 20 bed transitional program as well as a comprehensive multidisciplinary clinic for children and families.

Evansville has strong interagency coalitions that collaborate to provide services to individuals experiencing homelessness. Crisis Services and the Evansville Police Department (EPD) are actively engaged in this coalition. Sequential Intercept Mapping has provided connections and guidelines for forensic diversion; EPD has a full-time Mental Health Liaison Officer and a full-time Homeless Outreach Liaison Officer. Both were instrumental partners in launching crisis services in Evansville and surrounding counties. Continued interagency collaboration between Southwestern Crisis Services, hospitals, jails, first responders, and members of the community will continue.

As Southwestern moves forward building CCBHC infrastructure with the results of the 2024 Community Needs Assessment, we recognize the multitude of practices, agencies, faith-based communities, and programs that work together to provide behavioral healthcare in our region. To our existing and future partners, thank you. We look forward to continuing work to establish coordinated care networks across our region.

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