Monroe County Medical Center

Tompkinsville, Kentucky

Community Health Needs Assessment
and Implementation Strategy

Adopted by Board Resolution February 20, 2017[1]

[1]Response to Schedule h (Form 990) Part V B 4 & Schedule h (Form 990) Part V B 9

Dear Community Member:

At Monroe County Medical Center, we have spent more than 37 years providing high-quality compassionate healthcare to the greater Tompkinsville community. The “2017 Community Health Needs Assessment” identifies local health and medical needs and provides a plan of how Monroe County Medical Center will respond to these needs. This document illustrates one way we are meeting our obligations to efficiently deliver medical services.

In compliance with the Affordable Care Act, all not-for-profit hospitals are required to develop a report on the medical and health needs of the communities they serve. We welcome you to review this document not just as part of our compliance with federal law, but of our continuing efforts to meet your health and medical needs.

Monroe County Medical Center will conduct this effort at least once every three years. The report produced three years ago is also available for your review and comment. As you review this plan, please see if, in your opinion, we have identified the primary needs of the community and if you think our intended response will lead to needed improvements.

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

Because this report is a response to a federal requirement of not-for-profit hospitals to identify the community benefit they provide in responding to documented community need, footnotes are provided to answer specific tax form questions; for most purposes, they may be ignored. Most importantly, this report is intended to guide our actions and the efforts of others to make needed health and medical improvements in our area.

I invite your response to this report. As you read, please think about how to help us improve health and medical services in our area. We all live in, work in, and enjoy this wonderful community, and together, we can make our community healthier for every one of us.

Thank You,

Vicky McFall
Chief Executive Officer
Monroe County Medical Center

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EXECUTIVE SUMMARY

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Monroe County Medical Center ("MCMC" or the "Hospital") has performed a Community Health Needs Assessment to determine the health needs of the local community, develop an implementation plan to outline and organize how to meet those needs, and fulfill federal requirements.

Data was gathered from multiple well-respected secondary sources to build an accurate picture of the current community and its health needs. A survey of a select group of Local Experts was performed to review the prior CHNA and provide feedback, and to ascertain whether the previously identified needs are still a priority. A second survey was distributed to the same group that reviewed the data gathered from the secondary sources and determined the Significant Health Needs for the community.

The Significant Health Needs for Monroe County are:

1. Substance Abuse
2. Heart Disease
3. Diabetes
4. Cancer
5. Obesity

The Hospital has developed implementation strategies for four of the five needs (Heart Disease, Diabetes, Cancer, and Obesity) including activities to continue/pursue, community partners to work alongside, and leading and lagging indicators to track.

APPROACH

APPROACH

Monroe County Medical Center (MCMC) is organized as a not-for-profit hospital. A Community Health Needs Assessment (CHNA) is part of the required hospital documentation of "Community Benefit" under the Affordable Care Act (ACA), required of all not-for-profit hospitals as a condition of retaining tax-exempt status. A CHNA helps the hospital identify and respond to the primary health needs of its residents.

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

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

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

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

Project Objectives

MCMC partnered with Quorum Health Resources (Quorum) to:[4]

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

Overview of Community Health Needs Assessment

Typically, non-profit hospitals qualify for tax-exempt status as a Charitable Organization, described in Section 501(c)(3) of the Internal Revenue Code; however, the term 'Charitable Organization' is undefined. Prior to the passage of Medicare, charity was generally recognized as care provided those who did not have means to pay. With the introduction of Medicare, the government met the burden of providing compensation for such care.

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

- An Emergency Room open to all, regardless of ability to pay

[2] Federal Register Vol. 79 No. 250, Wednesday December 31, 2014. Part II Department of the Treasury Internal Revenue Service 26 CFR Parts 1, 53, and 602

[3] As of the date of this report all tax questions and suggested answers relate to 2014 Draft Federal 990 schedule h instructions i990sh—dft(2) and tax form

[4] Part 3 Treasury/IRS – 2011 – 52 Section 3.03 (2) third party disclosure notice & Schedule h (Form 990) V B 6 b

- Surplus funds used to improve patient care, expand facilities, train, etc.
- A board controlled by independent civic leaders
- All available and qualified physicians granted hospital privileges

Specifically, the IRS requires:

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

Community Health Needs Assessment Subsequent to Initial Assessment

The Final Regulations establish a required step for a CHNA developed after the initial report. This requirement calls for considering written comments received on the prior CHNA and Implementation Strategy as a component of the development of the next CHNA and Implementation Strategy. The specific requirement is:

> *"The 2013 proposed regulations provided that, in assessing the health needs of its community, a hospital facility must take into account input received from, at a minimum, the following three sources:*
>
> *(1) At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to*

[5] Section 6652

the health needs of the community;

(2) members of medically underserved, low-income, and minority populations in the community, or individuals or organizations serving or representing the interests of such populations; and

(3) written comments received on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy.[6]

…the final regulations retain the three categories of persons representing the broad interests of the community specified in the 2013 proposed regulations but clarify that a hospital facility must ''solicit'' input from these categories and take into account the input ''received.'' The Treasury Department and the IRS expect, however, that a hospital facility claiming that it solicited, but could not obtain, input from one of the required categories of persons will be able to document that it made reasonable efforts to obtain such input, and the final regulations require the CHNA report to describe any such efforts."

Representatives of the various diverse constituencies outlined by regulation to be active participants in this process were actively solicited to obtain their written opinion. Opinions obtained formed the introductory step in this Assessment.

To complete a CHNA:

"… the final regulations provide that a hospital facility must document its CHNA in a CHNA report that is adopted by an authorized body of the hospital facility and includes:

(1) A definition of the community served by the hospital facility and a description of how the community was determined;

(2) a description of the process and methods used to conduct the CHNA;

(3) a description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves;

(4) a prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs; and

(5) a description of resources potentially available to address the significant health needs identified through the CHNA.

… final regulations provide that a CHNA report will be considered to describe the process and methods used to conduct the CHNA if the CHNA report describes the data and other information used in the assessment, as well as the methods of collecting and analyzing this data and information, and identifies any parties with whom the hospital facility collaborated, or with whom it contracted for assistance, in

[6] Federal Register Vol. 79 No. 250, Wednesday December 31, 2014. Part II Department of the Treasury Internal Revenue Service 26 CFR Parts 1, 53, and 602 P. 78963 and 78964

conducting the CHNA."[7]

Additionally, a CHNA developed subsequent to the initial Assessment must consider written commentary received regarding the prior Assessment and Implementation Strategy efforts. We followed the Federal requirements in the solicitation of written comments by securing characteristics of individuals providing written comment but did not maintain identification data.

> *"…the final regulations provide that a CHNA report does not need to name or otherwise identify any specific individual providing input on the CHNA, which would include input provided by individuals in the form of written comments."*[8]

Quorum takes a comprehensive approach to the solicitation of written comments. As previously cited, we obtained input from the required three minimum sources and expanded input to include other representative groups. We asked all participating in the written comment solicitation process to self-identify themselves into any of the following representative classifications, which is detailed in an Appendix to this report. Written comment participants self-identified into the following classifications:

(1) Public Health – Persons with special knowledge of or expertise in public health

(2) Departments and Agencies – Federal, tribal, regional, State, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility

(3) Priority Populations – Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs in the community served by the hospital facility. Also, in other federal regulations the term Priority Populations, which include rural residents and LGBT interests, is employed and for consistency is included in this definition

(4) Chronic Disease Groups – Representative of or member of Chronic Disease Group or Organization, including mental and oral health

(5) Broad Interest of the Community – Individuals, volunteers, civic leaders, medical personnel, and others to fulfill the spirit of broad input required by the federal regulations

Other (please specify)

Quorum also takes a comprehensive approach to assess community health needs. We perform several independent data analyses based on secondary source data, augment this with Local Expert Advisor[9] opinions, and resolve any data inconsistency or discrepancies by reviewing the combined opinions formed from local experts. We rely on secondary source data, and most secondary sources use the county as the smallest unit of analysis. We asked our local expert area residents to note if they perceived the problems or needs identified by secondary sources existed in their portion of the

[7] Federal Register Op. cit. P 78966 As previously noted the Hospital collaborated and obtained assistance in conducting this CHNA from Quorum Health Resources. Response to Schedule h (Form 990) B 6 b

[8] Federal Register Op. cit. P 78967 & Response to Schedule h (Form 990) B 3 h

[9] "Local Expert" is an advisory group of at least 15 local residents, inclusive of at least one member self-identifying with each of the five Quorum written comment solicitation classifications, with whom the Hospital solicited to participate in the Quorum/Hospital CHNA process. Response to Schedule h (Form 990) V B 3 h

county.[10]

Most data used in the analysis is available from public Internet sources and Quorum proprietary data from Truven. Any critical data needed to address specific regulations or developed by the Local Expert Advisor individuals cooperating with us in this study are displayed in the CHNA report appendix.

Data sources include:[11]

Website or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Monroe County compared to all Kentucky counties	November 7, 2016	2012
www.cdc.gov/communityhealth	Assessment of health needs of Monroe County compared to its national set of "peer counties"	November 7, 2016	2011
Truven (formerly known as Thompson) Market Planner	Assess characteristics of the hospital's primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according to the proportion of each group in the entire area; and, to access population size, trends and socio-economic characteristics	November 7, 2016	2016
http://svi.cdc.gov	To identify the Social Vulnerability Index value	November 7, 2016	2010
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	November 7, 2016	2015

Federal regulations surrounding CHNA require local input from representatives of particular demographic sectors. For this reason, Quorum developed a standard process of gathering community input. In addition to gathering data from the above sources:

- We deployed a CHNA "Round 1" survey to our Local Expert Advisors to gain input on local health needs and the

[10] Response to Schedule h (Form 990) Part V B 3 i

[11] The final regulations clarify that a hospital facility may rely on (and the CHNA report may describe) data collected or created by others in conducting its CHNA and, in such cases, may simply cite the data sources rather than describe the ''methods of collecting'' the data. Federal Register Op. cit. P 78967 & Response to Schedule h (Form 990) Part V B 3 d

needs of priority populations. Local Expert Advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and the Hospital's desire to represent the region's geographically and ethnically diverse population. We received community input from 26 Local Expert Advisors. Survey responses started October 9, 2016, and ended with the last response on October 19, 2016.

- Information analysis augmented by local opinions showed how Monroe County relates to its peers in terms of primary and chronic needs and other issues of uninsured persons, low-income persons, and minority groups. Respondents commented on whether they believe certain population groups ("Priority Populations") need help to improve their condition, and if so, who needs to do what to improve the conditions of these groups.[12]
- Local opinions of the needs of Priority Populations, while presented in its entirety in the Appendix, was abstracted in the following "take-away" bulleted comments
  - ALL of these populations exist in the community
  - Education and preventive care are top needs for these populations
  - Senior adults need help with transportation and affording medication
  - Low income populations and women and children need specific assistance

When the analysis was complete, we put the information and summary conclusions before our Local Expert Advisors[13] who were asked to agree or disagree with the summary conclusions. They were free to augment potential conclusions with additional comments of need, and new needs did emerge from this exchange.[14] Consultation with 17 Local Experts occurred again via an internet-based survey (explained below) beginning December 12, 2016, and ending January 10, 2017.

Having taken steps to identify potential community needs, the Local Experts then participated in a structured communication technique called a "Wisdom of Crowds" method. The premise of this approach relies on a panel of experts with the assumption that the collective wisdom of participants is superior to the opinion of any one individual, regardless of their professional credentials.[15]

In the MCMC process, each Local Expert had the opportunity to introduce needs previously unidentified and to challenge conclusions developed from the data analysis. While there were a few opinions of the data conclusions not being completely accurate, the vast majority of comments agreed with our findings. We developed a summary of all needs identified by any of the analyzed data sets. The Local Experts then allocated 100 points among the potential significant need candidates, including the opportunity to again present additional needs that were not identified from the data. A rank order of priorities emerged, with some needs receiving none or virtually no support, and other needs receiving identical point allocations.

We dichotomized the rank order of prioritized needs into two groups: "Significant" and "Other Identified Needs." Our criteria for identifying and prioritizing Significant Needs was based on a descending frequency rank order of the needs

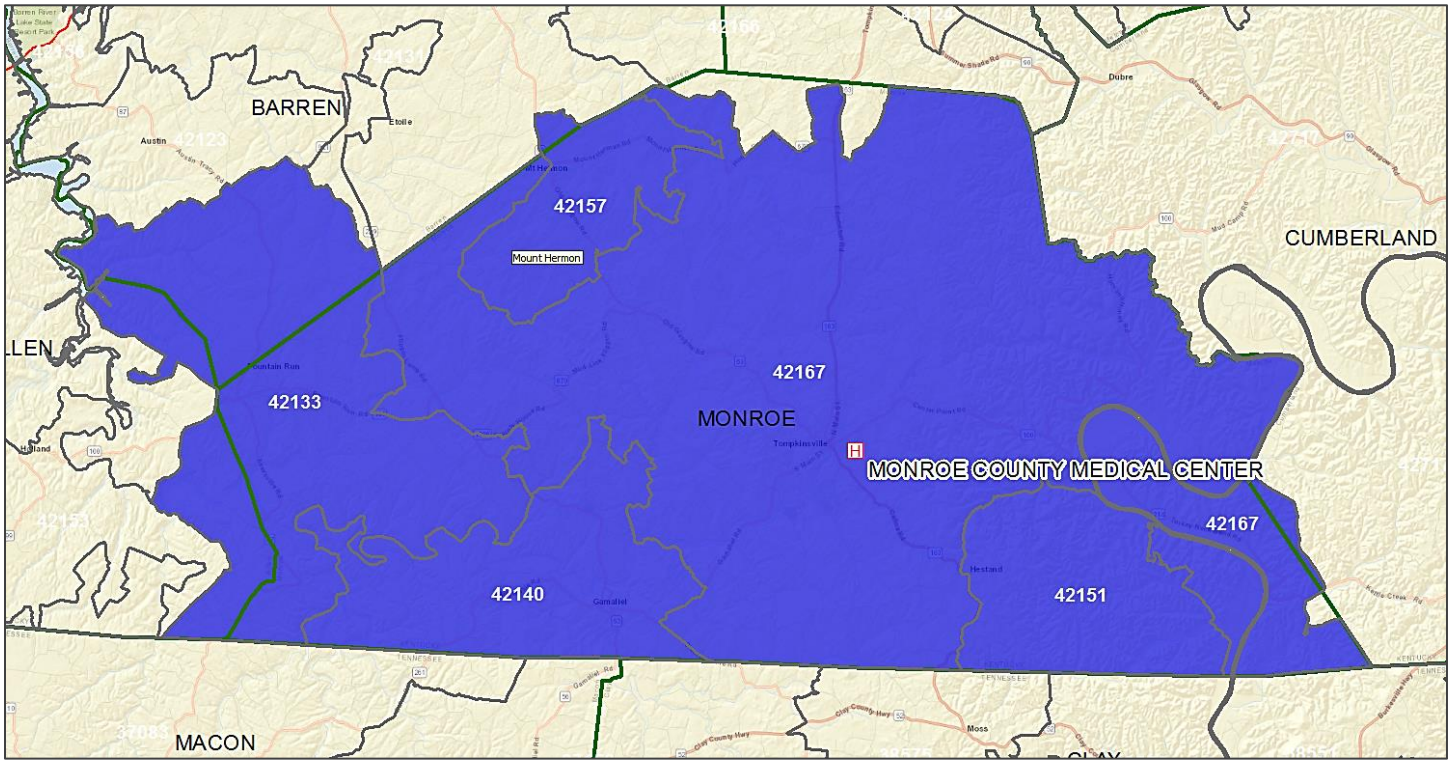
[12] Response to Schedule h (Form 990) Part V B 3 f
[13] Response to Schedule h (Form 990) Part V B 3 h
[14] Response to Schedule h (Form 990) Part V B 3 h
[15] Response to Schedule h (Form 990) Part V B 5

based on total points cast by the Local Experts, further ranked by a descending frequency count of the number of local experts casting any points for the need. By our definition, a Significant Need had to include all rank ordered needs until at least fifty percent (50%) of all points were included and to the extent possible, represented points allocated by a majority of voting local experts. The determination of the break point — "Significant" as opposed to "Other" — was a qualitative interpretation by Quorum and the MCMC executive team where a reasonable break point in rank order occurred.[16]

[16] Response to Schedule h (Form 990) Part V B 3 g

COMMUNITY CHARACTERISTICS

Definition of Area Served by the Hospital[17]



MCMC, in conjunction with Quorum, defines its service area as Monroe in Kentucky, which includes the following ZIP codes:[18]

42133 – Fountain Run 42140 – Gamaliel 42151 – Hestand 42157 – Mount Hermon
42167 – Tompkinsville

Zip code 42132 is included in 42140, and zip code 42158 is included in 42167.

In 2015, the Hospital received 75% of its patients from this area.[19]

[17] Responds to IRS Schedule h (Form 990) Part V B 3 a
[18] The map above amalgamates zip code areas and does not necessarily display all county zip codes represented below
[19] Truven MEDPAR patient origin data for the hospital; Responds to IRS Schedule h (Form 990) Part V B 3 a

Demographics of the Community[20] [21]

	Monroe County	Kentucky	U.S.
2016 Population[22]	**11,085**	**4,444,362**	**322,431,073**
% Increase/Decline	**-1.2%**	**2.0%**	**3.7%**
Estimated Population in 2021	**10,950**	**4,533,548**	**334,341,965**
% White, non-Hispanic	**93.0%**	**84.8%**	**61.3%**
% Hispanic	**3.2%**	**3.6%**	**17.8%**
Median Age	**43.2**	**38.9**	**38.0**
Median Household Income	**$32,581**	**$45,239**	**$55,072**
Unemployment Rate (Sept 2016)	**4.0%**	**4.8%**	**4.9%**
% Population >65	**19.5%**	**15.5%**	**15.1%**
% Women of Childbearing Age	**16.7%**	**19.1%**	**19.6%**

2016 Benchmarks
Area: Monroe County KY
Level of Geography: ZIP Code

Area	2016-2021 % Population Change	Median Age	Population 65+ % of Total Population	Population 65+ % Change 2016-2021	Females 15-44 % of Total Population	Females 15-44 % Change 2016-2021	Median Household Income	Median Household Wealth	Median Home Value
USA	3.7%	38.0	15.1%	17.6%	19.6%	1.5%	$55,072	$54,224	$192,364
Kentucky	2.0%	38.9	15.5%	16.8%	19.1%	0.0%	$45,239	$48,691	$129,800
Selected Area	-1.2%	43.2	19.5%	12.2%	16.7%	-1.9%	$32,581	$39,099	$74,367

Demographics Expert 2.7
DEMO0003.SQP

[20] Responds to IRS Schedule h (Form 990) Part V B 3 b
[21] The tables below were created by Truven Market Planner, a national marketing company
[22] All population information, unless otherwise cited, sourced from Truven (formally Thomson) Market Planner

Demographics Expert 2.7
2016 Demographic Snapshot
Area: Monroe County KY
Level of Geography: ZIP Code

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA
2010 Total Population	11,427	308,745,538
2016 Total Population	11,085	322,431,073
2021 Total Population	10,950	334,341,965
% Change 2016 - 2021	-1.2%	3.7%
Average Household Income	$44,481	$77,135

	2016	2021	% Change
Total Male Population	5,517	5,460	-1.0%
Total Female Population	5,568	5,490	-1.4%
Females, Child Bearing Age (15-44)	1,850	1,815	-1.9%

POPULATION DISTRIBUTION

	Age Distribution				
Age Group	2016	% of Total	2021	% of Total	USA 2016 % of Total
0-14	1,967	17.7%	1,855	16.9%	19.0%
15-17	438	4.0%	429	3.9%	4.0%
18-24	929	8.4%	949	8.7%	9.8%
25-34	1,167	10.5%	1,217	11.1%	13.3%
35-54	2,802	25.3%	2,491	22.7%	26.0%
55-64	1,619	14.6%	1,583	14.5%	12.8%
65+	2,163	19.5%	2,426	22.2%	15.1%
Total	11,085	100.0%	10,950	100.0%	100.0%

HOUSEHOLD INCOME DISTRIBUTION

	Income Distribution		
2016 Household Income	HH Count	% of Total	USA % of Total
<$15K	1,188	25.9%	12.3%
$15-25K	715	15.6%	10.4%
$25-50K	1,179	25.7%	23.4%
$50-75K	761	16.6%	17.6%
$75-100K	342	7.5%	12.0%
Over $100K	404	8.8%	24.3%
Total	4,589	100.0%	100.0%

EDUCATION LEVEL

	Education Level Distribution		
2016 Adult Education Level	Pop Age 25+	% of Total	USA % of Total
Less than High School	1,196	15.4%	5.8%
Some High School	843	10.9%	7.8%
High School Degree	3,317	42.8%	27.9%
Some College/Assoc. Degree	1,470	19.0%	29.2%
Bachelor's Degree or Greater	925	11.9%	29.4%
Total	7,751	100.0%	100.0%

RACE/ETHNICITY

	Race/Ethnicity Distribution		
Race/Ethnicity	2016 Pop	% of Total	USA % of Total
White Non-Hispanic	10,312	93.0%	61.3%
Black Non-Hispanic	262	2.4%	12.3%
Hispanic	357	3.2%	17.8%
Asian & Pacific Is. Non-Hispanic	13	0.1%	5.4%
All Others	141	1.3%	3.1%
Total	11,085	100.0%	100.0%

Customer Segmentation

Claritas Prizm uses Census data, sources of demographic and consumer information, and 30 years of annual consumer surveys to classify all U.S. households into 66 demographically and behaviorally distinct groups. These segments represent clusters of at least 250 households that have comparable characteristics and exhibit similar behaviors. The top segments in Monroe County are:

Claritas Prizm Segments	Characteristics	
Segment #1 (62%)	• Urbanicity: Rural • Income: Downscale • Income Producing Assets: Low • Age Ranges: Age 55+ • Presence of Kids: Mostly w/o Kids	• Homeownership: Mostly Owners • Employment Levels: Mostly Retired • Education Levels: High School • Ethnic Diversity: White
Segment #2 (38%)	• Urbanicity: Town/Rural • Income: Low Income • Income Producing Assets: Low • Age Ranges: Age 45-64 • Presence of Kids: HH w/o Kids	• Homeownership: Homeowners • Employment Levels: Mix • Education Levels: High School • Ethnic Diversity: White, Black, Mix

Each of the 66 Claritas Prizm segments exhibits prevalence toward specific health behaviors. In the second column of the chart below, the national average is 100%, so the 'Demand as % of National' shows a community's likelihood of exhibiting a certain health behavior more or less than the national average. The next column shows the percentage of the population that is likely to exhibit those behaviors.

Where Monroe County varies more than 5% above or below the national average (that is, less than 95% or greater than 105%), it is considered significant. Items in the table with **red text** are viewed as statistically significant **adverse** findings. Items with **blue text** are viewed as statistically significant **beneficial** findings. Items with black text are neither a favorable nor unfavorable finding.

Health Service Topic	Demand as % of National	% of Population Affected	Health Service Topic	Demand as % of National	% of Population Affected
Weight / Lifestyle			**Cancer**		
BMI: Morbid/Obese	114.2%	32.9%	Mammography in Past Yr	97.1%	44.2%
Vigorous Exercise	91.5%	50.1%	Cancer Screen: Colorectal 2 yr	96.3%	24.5%
Chronic Diabetes	136.2%	15.9%	Cancer Screen: Pap/Cerv Test 2 yr	82.1%	49.4%
Healthy Eating Habits	87.8%	26.0%	Routine Screen: Prostate 2 yr	89.3%	28.6%
Ate Breakfast Yesterday	120.7%	49.5%	**Orthopedic**		
Slept Less Than 6 Hours	103.1%	22.0%	Chronic Lower Back Pain	141.1%	32.7%
Consumed Alcohol in the Past 30 Days	65.8%	37.3%	Chronic Osteoporosis	150.4%	14.7%
Consumed 3+ Drinks Per Session	113.4%	28.4%	**Routine Services**		
Behavior			FP/GP: 1+ Visit	104.4%	92.3%
I Will Travel to Obtain Medical Care	92.4%	23.4%	Used Midlevel in last 6 Months	108.3%	45.0%
I am Responsible for My Health	93.0%	60.8%	OB/Gyn 1+ Visit	84.0%	39.1%
I Follow Treatment Recommendations	102.1%	53.0%	Medication: Received Prescription	96.8%	43.3%
Pulmonary			**Internet Usage**		
Chronic COPD	160.3%	6.3%	Use Internet to Talk to MD	64.2%	8.5%
Tobacco Use: Cigarettes	137.6%	35.2%	Facebook Opinions	76.1%	7.8%
Heart			Looked for Provider Rating	83.9%	12.2%
Chronic High Cholesterol	120.9%	26.7%	**Emergency Service**		
Routine Cholesterol Screening	87.6%	44.6%	Emergency Room Use	110.6%	37.5%
Chronic Heart Failure	170.8%	9.0%	Urgent Care Use	91.6%	21.4%

Leading Causes of Death

Cause of Death			Rank among all counties in KY (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation (Compared to U.S.)
KY Rank	Monroe Rank	Condition		KY	Monroe	
2	**1**	Heart Disease	10 of 120	200.5	344.8	Higher than expected
1	**2**	Cancer	65 of 120	198.8	214.9	Higher than expected
4	**3**	Accidents	16 of 120	58.3	85.7	Higher than expected
5	**4**	Stroke	3 of 120	41.8	76.3	Higher than expected
3	**5**	Lung	101 of 120	63.9	50.1	As expected
8	**6**	Flu - Pneumonia	2 of 120	20.8	46.2	Higher than expected
9	**7**	Kidney	21 of 120	19.5	26.8	Higher than expected
7	**8**	Diabetes	92 of 120	23.4	21.8	As expected
6	**9**	Alzheimer's	102 of 120	32.1	19.3	As expected
11	**10**	Suicide	42 of 120	16.0	16.1	Higher than expected
10	**11**	Blood Poisoning	44 of 120	16.1	15.9	Higher than expected
12	**12**	Liver	36 of 120	11.5	10.1	As expected
15	**13**	Homicide	16 of 120	4.7	7.6	Higher than expected
13	**14**	Hypertension	93 of 120	7.2	4.6	Lower than expected
14	**15**	Parkinson's	103 of 120	7.1	3.5	Lower than expected

Priority Populations[23]

Information about Priority Populations in the service area of the Hospital is difficult to encounter if it exists. Our approach is to understand the general trends of issues impacting Priority Populations and to interact with our Local Experts to discern if local conditions exhibit any similar or contrary trends. The following discussion examines findings about Priority Populations from a national perspective.

We begin by analyzing the National Healthcare Quality and Disparities Reports (QDR), which are annual reports to Congress mandated in the Healthcare Research and Quality Act of 1999 (P.L. 106-129). These reports provide a comprehensive overview of the quality of healthcare received by the general U.S. population and disparities in care experienced by different racial, ethnic, and socioeconomic groups. The purpose of the reports is to assess the performance of our health system and to identify areas of strengths and weaknesses in the healthcare system along three main axes: **access to healthcare**, **quality of healthcare**, and **priorities of the National Quality Strategy** (NQS). The complete report is provided in Appendix C.

We asked a specific question to our Local Expert Advisors about unique needs of Priority Populations. We reviewed their responses to identify if any of the report trends were obvious in the service area. Accordingly, we place great reliance on the commentary received from our Local Expert Advisors to identify unique population needs to which we should respond. Specific opinions from the Local Expert Advisors are summarized below:[24]

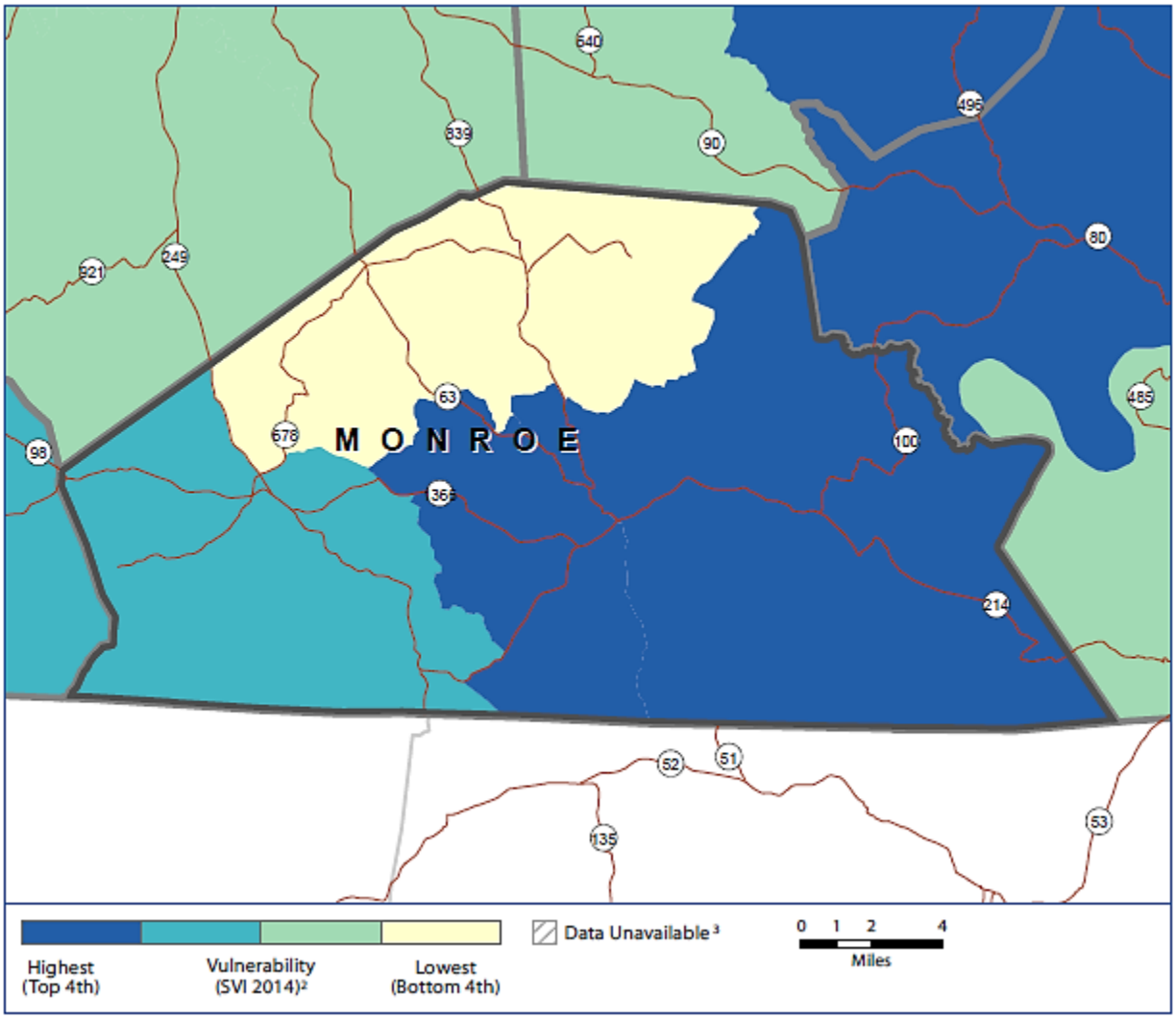
- ALL of these populations exist in the community
- Education and preventive care are top needs for these populations
- Senior adults need help with transportation and affording medication
- Low income populations and women and children need specific assistance

[23] http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/index.html Responds to IRS Schedule h (Form 990) Part V B 3 i
[24] All comments and the analytical framework behind developing this summary appear in Appendix A

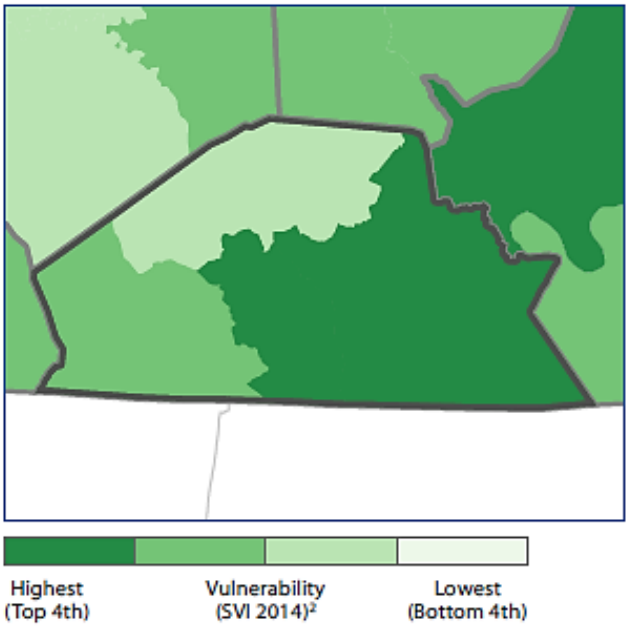
Social Vulnerability

Social vulnerability refers to the resilience of communities when confronted by external stresses on human health, stresses such as natural or human-caused disasters, or disease outbreaks.

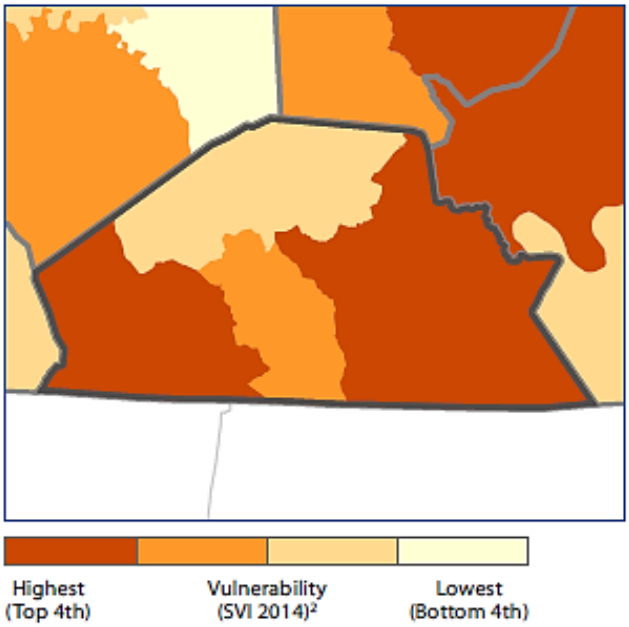
Monroe County falls into three sections. The southeast corner of Monroe County is in the *highest quartile*, the southwest corner is in the *second highest quartile*, and the northwestern corner is in the *lowest quartile*.



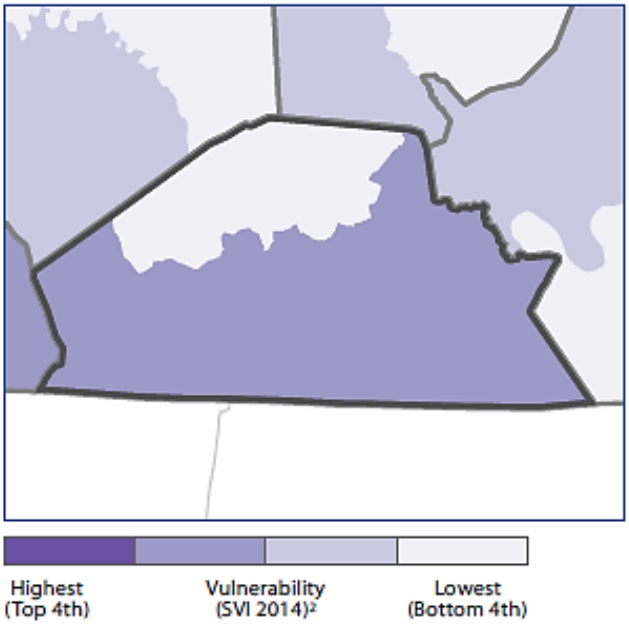
Socioeconomic Status[5]



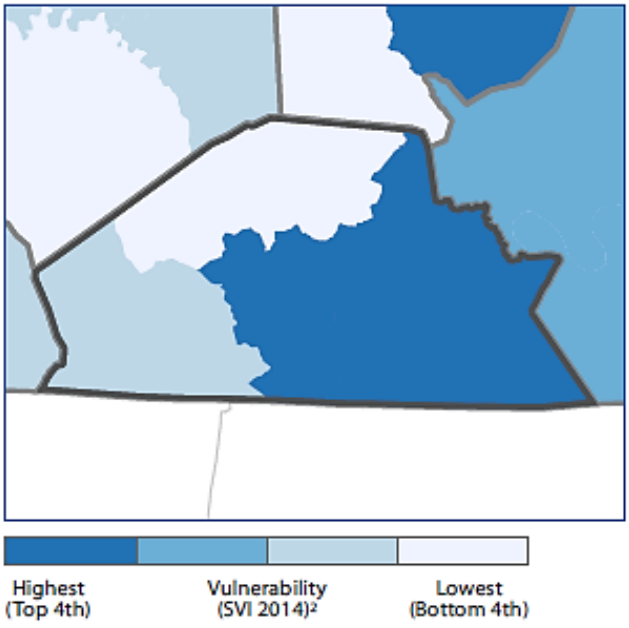
Household Composition[6]



Race/Ethnicity/Language[7]



Housing/Transportation[8]



Summary of Survey Results on Prior CHNA

In the Round 1 survey, a group of 26 individuals provided feedback on the 2014 CHNA. Complete results, including *verbatim* written comments, can be found in Appendix A.

Commenter characteristics:

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	10	9	19
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	13	7	20
3) Priority Populations	13	6	19
4) Representative/Member of Chronic Disease Group or Organization	7	12	19
5) Represents the Broad Interest of the Community	17	5	22
Other			3
Answered Question			25
Skipped Question			1

Priorities from the last assessment where the Hospital intended to seek improvement:

- Heart Disease
- Diabetes
- Obesity
- Lung Cancer
- Substance Abuse

MCMC received the following responses to the question: **"Should the hospital continue to consider the needs identified as most important in the 2014 CHNA as the most important set of health needs currently confronting residents in the county?**

	Yes	No	No Opinion
Heart Disease	24	0	1
Diabetes	24	0	1
Obesity	24	0	1
Lung Cancer	21	2	2
Substance Abuse	24	1	0

MCMC received the following responses to the question: **"Should the Hospital continue to allocate resources to help improve the needs identified in the 2014 CHNA?"**

	Yes	No	No Opinion
Heart Disease	23	1	1
Diabetes	24	0	1
Obesity	23	1	1
Lung Cancer	21	2	2
Substance Abuse	24	1	0

Comparison to Other State Counties

To better understand the community, Monroe County has been compared to all 120 counties in the state of Kentucky across five areas: Health Outcomes, Health Behaviors, Clinical Care, Social & Economic Factors, and Physical Environment. The last four areas are all Health Factors that ultimately affect the Health Outcomes of Length (Mortality) and Quality of Life (Morbidity).

In the chart below, the county's rank compared to all counties is listed along with any measures in each area that are ***worse than*** the state average and U.S. Best (90th percentile).

	Monroe County	Kentucky	U.S. Best
Health Outcomes			
Overall Rank *(best being #1)*	89/120		
Premature Death (deaths prior to age 75)*	11,100	8,800	5,200
Health Behaviors			
Overall Rank *(best being #1)*	52/120		
Alcohol-impaired Driving Deaths	38%	29%	14%
Teen Births *(per 1,000 females age 15-19)*	50	47	19
Access to Exercise Opportunities	53%	70%	91%
Clinical Care			
Overall Rank *(best being #1)*	120/120		
Uninsured Rate	22%	17%	11%
Preventable Hospital Stays *(per 1,000 Medicare enrollees)*	196	85	38
Mammography Screening	44%	58%	71%
Diabetic Monitoring	65%	86%	90%
Population to Primary Care Physician	1,780:1	1,500:1	1,040:1
Population to Dentist	1,780:1	1,610:1	1,340:1
Population to Mental Health Provider	1,340:1	560:1	370:1
Social & Economic Factors			
Overall Rank *(best being #1)*	65/120		
Children in Poverty	39%	26%	13%
Children in Single-parent Households	36%	34%	21%

Injury Deaths*	131	82	51
Some College Attendance	45%	59%	72%
Physical Environment			
Overall Rank *(best being #1)*	53/120		
Air Pollution – particulate matter	13.8 µg/m^3	13.5 µg/m^3	9.5 µg/m^3
Severe Housing Problems	16%	14%	9%
Long Commute – Driving Alone	30%	28%	15%

**Per 100,000*

Comparison to Peer Counties

The Federal Government administers a process to allocate all 3,143 U.S. counties into "Peer" groups. County "Peer" groups have similar social, economic, and demographic characteristics. The counties are ranked across six health and wellness categories and divided into quartiles: Better (top quartile), Moderate (middle two quartiles), and Worse (bottom quartile).

In the below chart, Monroe County is compared to its peer counties and the U.S. average, but only areas where the county is Better or Worse are listed. (The list and number of peer counties used in each ranking may differ.)

	Monroe County	Peer Ranking	U.S. Median
Mortality			
Better			
Diabetes Deaths*	22.8	11/44	24.7
Worse			
Chronic Kidney Disease Deaths*	35.6	39/43	17.5
Coronary Heart Disease Deaths*	227.3	45/50	126.7
Stroke Deaths*	85.0	49/49	46.0
Morbidity			
Better			
Adult Diabetes	7.9%	3/45	8.1%
Adult Overall Health Status	19.7%	2/48	16.5%
Gonorrhea*	0.0	2/50	30.5
Preterm Births	12.3%	10/50	12.1%
Syphilis*	0.0	12/50	0.0
Worse			
HIV*	119.3	28/35	105.5
Healthcare Access & Quality			
Better			
None	--	--	--
Worse			
Older Adult Preventable Hospitalizations *(per 1,000 Medicare enrollees)*	246.7	49/50	71.3
Health Behaviors			
Better			

	Monroe County	Peer Ranking	U.S. Median
Adult Smoking	25.4%	11/47	21.7%
Teen Births *(per 1,000 females age 15-19)*	51.1	11/50	42.1
Worse			
Adult Female Routine Pap Tests	57.1%	40/40	77.3%
Social Factors			
Better			
Children in Single-parent Households	27.2%	9/50	30.8%
Unemployment	7.5%	8/50	7.1%
Violent Crime*	37.1	2/43	199.2
Worse			
High Housing Costs	28.3%	44/50	27.3%
Physical Environment			
Better			
Living Near Highways	0.0%	3/50	1.5%
Worse			
Air Quality (annual average PM2.5 concentration)	12.0 µg/m^3	47/50	10.7 µg/m^3

**Per 100,000*

Conclusions from Demographic Analysis Compared to National Averages

The following areas were identified from a comparison of the county to national averages. **Adverse** metrics impacting more than 30% of the population and statistically significantly different from the national average include:

- BMI: Morbid/Obese = 14.2% above average, impacting 32.9%
- Vigorous Exercise = 8.5% below average, impacting 50.1%
- I am Responsible for my Health = 7% below average, impacting 60.8%
- Tobacco Use: Cigarettes = 37.6% above average, impacting 35.2%
- Routine Cholesterol Screening = 12.4% below average, impacting 44.6%
- Cervical Cancer Screening in past 2 years = 17.9% below average, impacting 49.4%
- Chronic Lower Back Pain = 41.1% above average, impacting 32.7%
- Annual OB/GYN Visit = 16% below average, impacting 39.1%
- Emergency Room Use = 10.6% above average, impacting 37.5%

Beneficial metrics impacting more than 30% of the population and statistically significantly different from the national average include:

- Ate Breakfast Yesterday = 20.7% above average, impacting 49.5%
- Consumed Alcohol in the Past 30 Days = 34.2% below average, impacting 37.3%
- Used Midlevel in last 6 Months = 8.3% above average, impacting 45.0%

Conclusions from Other Statistical Data

The Institute for Health Metrics and Evaluation at the University of Washington analyzed all 3,143 U.S. counties or equivalents applying small area estimation techniques to the most recent county information. The below chart compares Monroe County statistics to the U.S. average, and lists the change since the last date of measurement.

	Current Date of Data	Statistic	Percent Change	Last Date of Data
UNFAVORABLE COUNTY measures that are **WORSE** than the U.S. average and had an **UNFAVORABLE** change				
Female Life Expectancy	2013	76 years	-1 year	1985
Female Obesity	2011	42.3%	5.8% pts	2001
Male Obesity	2011	37.9%	5.9% pts	2001
UNFAVORABLE COUNTY measures that are **WORSE** than the U.S. average and had an **FAVORABLE** change				
Male Life Expectancy	2013	70.8 years	2.2 years	1985
Female Smoking	2012	29.6%	-0.3% pts	1996
Male Smoking	2012	31.4%	-7.3% pts	1996
Female Physical Activity	2011	39.3%	12.3% pts	2001
Male Physical Activity	2011	43.3%	7.1% pts	2001
DESIRABLE COUNTY measures that are **BETTER** than the US average and had an **UNFAVORABLE** change				
Female Heavy Drinking	2012	1.2%	0.3% pts	2005
Male Heavy Drinking	2012	8.2%	3.1% pts	2005
Female Binge Drinking	2012	4.5%	2.5% pts	2002
Male Binge Drinking	2012	14.2%	4.7% pts	2002
DESIRABLE COUNTY measures that are **BETTER** than the US average and had an **FAVORABLE** change				
None	--	--	--	--

Community Benefit

Worksheet 4 of Form 990 h can be used to report the net cost of community health improvement services and community benefit operations.

> *"Community health improvement services" means activities or programs, subsidized by the health care organization, carried out or supported for the express purpose of improving community health. Such services do not generate inpatient or outpatient revenue, although there may be a nominal patient fee or sliding scale fee for these services.*
>
> *"Community benefit operations" means:*
>
> - *activities associated with community health needs assessments, administration, and*
> - *the organization's activities associated with fundraising or grant-writing for community benefit programs.*

Activities or programs cannot be reported if they are provided primarily for marketing purposes or if they are more beneficial to the organization than to the community. For example, the activity or program may not be reported if it is designed primarily to increase referrals of patients with third-party coverage, required for licensure or accreditation, or restricted to individuals affiliated with the organization (employees and physicians of the organization).

To be reported, community need for the activity or program must be established. Community need can be demonstrated through the following:

- A CHNA conducted or accessed by the organization.
- Documentation that demonstrated community need or a request from a public health agency or community group was the basis for initiating or continuing the activity or program.
- The involvement of unrelated, collaborative tax-exempt or government organizations as partners in the activity or program carried out for the express purpose of improving community health.

Community benefit activities or programs also seek to achieve a community benefit objective, including improving access to health services, enhancing public health, advancing increased general knowledge, and relief of a government burden to improve health. This includes activities or programs that do the following:

- Are available broadly to the public and serve low-income consumers.
- Reduce geographic, financial, or cultural barriers to accessing health services, and if they ceased would result in access problems (for example, longer wait times or increased travel distances).
- Address federal, state, or local public health priorities such as eliminating disparities in access to healthcare services or disparities in health status among different populations.
- Leverage or enhance public health department activities such as childhood immunization efforts.
- Otherwise would become the responsibility of government or another tax-exempt organization.
- Advance increased general knowledge through education or research that benefits the public.

Activities reported by the Hospital in its implementation efforts and/or its prior year tax reporting included:

- $22,991

IMPLEMENTATION STRATEGY

Significant Health Needs

We used the priority ranking of area health needs by the Local Expert Advisors to organize the search for locally available resources as well as the response to the needs by MCMC.[25] The following list:

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

In general, Monroe County Medical Center is the major hospital in the service area. MCMC is a 49-bed, acute care medical facility located in Tompkinsville, KY. The next closest facilities are outside the service area and include:

- Cumberland River Hospital, Celina, TN, 19.7 miles (29 minutes)
- Cumberland County Hospital, Burkesville, KY, 28.2 miles (39 minutes)
- Macon County General Hospital, Lafayette, TN, 29.5 miles (42 minutes)
- TJ Samson Community Hospital, Glasgow, KY, 31.3 miles (41 minutes)
- The Medical Center at Scottsville, Scottsville, KY, 35.5 miles (53 minutes)

All data items analyzed to determine significant needs are “Lagging Indicators,” measures presenting results after a period of time, characterizing historical performance. Lagging Indicators tell you nothing about how the outcomes were achieved. In contrast, the MCMC Implementation Strategy uses “Leading Indicators.” Leading Indicators anticipate change in the Lagging Indicator. Leading Indicators focus on short-term performance, and if accurately selected, anticipate the broader achievement of desired change in the Lagging Indicator. In the QHR application, Leading Indicators also must be within the ability of the hospital to influence and measure.

[25] Response to IRS Schedule h (Form 990) Part V B 3 e

1. **SUBSTANCE ABUSE –** 2014 Significant Need; Alcohol-impaired Driving Deaths above KY average and US best; Female and Male Heavy Drinking increased from 2005 to 2012; Female and Male Binge Drinking increased from 2002 to 2012

Public comments received on previously adopted implementation strategy:

- *See above [I receive the local paper and belong to several local groups. I have to say, I have seen very minimal interaction between MCMC and these sources of info.]*
- *Provide meeting space for CARES meetings. Would like to have a volunteer representing the hospital on the board.*
- *None!!!!!!*
- *Partnering in community town-hall events; Monroe Co CARES Coalition support.*
- *There are few resources for detox and rehabilitation in our community.*
- *participation in CARES group initiatives*
- *I know that the hospital has been working in partnership with other groups in this community to develop education and support group programs.*
- *MCMC is a member of the CARES coalition, and helps to combat the drug abuse problems.*
- *The hospital is also active with this support group.*
- *support group*
- *Supporting the CARES coalition is a great way to help take action, but I am unaware of other actions the hospital has taken to address the problem. Prescription pain killers are over prescribed and the doses that are prescribed are entirely too high. Patients also are given no information about the proper disposal of the remained of their pain killers after their issue is resolved, and medications left in the home are often stolen or abused when they should be placed in either of the two permanent disposal boxes.*

MCMC services, programs, and resources available to respond to this need include:[26]

- Provide location for CARES organization with volunteer representative from the hospital
- Provide meeting space for Narcotics Anonymous group
- Promote prescription take-back events and drug drop boxes in the community
- ER physicians only prescribe narcotics for acute injuries, but send chronic pain issues to PCPs
- Facilitated bringing in pain management clinic to help provide treatment and alternatives to prescription pain medicine

[26] This section in each need for which the hospital plans an implementation strategy responds to Schedule h (Form 990) Part V Section B 3 c

- Sponsoring Project 12, a local coalition to help educate on and address substance abuse in the community
- CME provided to medical staff on opioid addiction
- Provided sample contract to physician offices to use with patients to manage narcotics prescriptions

Additionally, MCMC plans to take the following steps to address this need:

- Find ways to provide more education to patients about substance abuse and treatment options
- Continue working with Project 12 to help bring substance abuse/detox services or treatment to the county
- Equip case managers, providers , and staff with lists of resources for substance abuse treatment/detox

MCMC does not intend to develop an implementation strategy for this Significant Need

Due to resource constraints and a lack of expertise or competency to address this need, we are choosing not to develop an implementation strategy for this need at this time. We feel we can have a greater impact by putting attention and resources toward other significant needs for which we are better qualified to serve.

Federal classification of reasons why a hospital may cite for not developing an Implementation Strategy for a defined Significant Need	
1. Resource Constraints	**X**
2. Relative lack of expertise or competency to effectively address the need	**X**
3. A relatively low priority assigned to the need	
4. A lack of identified effective interventions to address the need	
5. Need is addressed by other facilities or organizations in the community	

MCMC anticipates collaborating with the following other facilities and organizations to address this Significant Need:

Organization	Contact Name	Contact Information
Citizens Advocating Responsible EnvironmentS (CARES)	Amy Hutchinson, Project Coordinator	www.monroecountycares.com 401 W 4th St, Tompkinsville, KY (270) 487-1368
Project 12	Sonya Turner	www.project12joh.org

Organization	Contact Name	Contact Information
Monroe County Health Department	Jill Ford, Public Health Director	www.monroecohealth.com 452 E 4th St, Tompkinsville, KY 42167 (270) 487-6782
Local law enforcement	Dale Ford, Monroe County Sherriff Brian Coffelt, Chief of Police – Tompkinsville	
Al Anon	Tami Dodson	al-anon.org Meetings in Education Room #1 at MCMC, Thursdays at 6:00pm
Alcoholics Anonymous	Tim Proffitt	www.aa.org

Other local resources identified during the CHNA process that are believed available to respond to this need:[27]

Organization	Contact Name	Contact Information
Addiction Deliverance Outreach	John Jordan	

[27] This section in each need for which the hospital plans an implementation strategy responds to Schedule h (form 990) Part V Section B 3 c and Schedule h (Form 990) Part V Section B 11

2. **HEART DISEASE –** 2014 Significant Need; #1 Leading Cause of Death; Coronary Heart Disease Deaths 45th of 50 peer counties; Routine Cholesterol Screening is 12.4% below avg
3. **DIABETES –** 2014 Significant Need; #8 Leading Cause of Death; Diabetic Monitoring below KY average and US best
5. **OBESITY –** 2014 Significant Need; Access to Exercise Opportunities is below KY and US; BMI: Morbid/Obese is 14.2% above avg; Vigorous Exercise is 8.5% below avg; Female and Male Obesity increased from 2001 to 2011

Due to the similar services, programs, and resources available to respond to this need, only one implementation strategy has been developed.

Public comments received on previously adopted implementation strategy for HEART DISEASE:

- *I receive the local paper and belong to several local groups. I have to say, I have seen very minimal interaction between MCMC and these sources of info.*
- *Not aware of any*
- *We used to have seminars on heart related issues, but we never do any more*
- *Local clinics provided by cardiologists from Nashville, Louisville and Bowling Green are especially helpful for the community to access excellent care*
- *I am unaware that any sort of preventative programs for heart disease exist in Monroe County.*
- *Protocol for Chest Pain through ER and EMS*
- *I have not been back in the community very long but prior to my leaving, I seem to recall Heart Health classes and heart healthy meals being offered at the hospital and taught by the RD at the hospital .*
- *MCMC takes an active role in supporting collaborative agencies to help educate and encourage the public to change life patterns to combat/eliminate all of the above health concerns.*
- *Have 2 doctors coming to hold clinics for our community.*
- *blood work screening such as, mini prevention screening*

Public comments received on previously adopted implementation strategy for DIABETES:

- *See above [I receive the local paper and belong to several local groups. I have to say, I have seen very minimal interaction between MCMC and these sources of info.]*
- *Diabetes Support Group/Coalition; Health Fair*
- *Diabetic meeting used to occur every month at the hospital, but I do not think they do now. Why do we never have inservices for our hospital staff?? Would be great for our CEU'S and become more educated on all these unrivaled subjects*
- *Support group is good.*
- *The hospital has a Certified Diabetes Educator on staff who is available to the community for referrals. This is a*

major benefit to the community. The local hospital also has a Diabetes Education and Support group that meets monthly.

- *The Diabetes support group. Diabetes health fair. Dietician on staff that is available to consult people.*
- *More needs to be done to improve the poor health literacy of our population.*
- *Diabetes Support Group, Dietician consults and Diabetes Health Fair participation*
- *Again, I have been gone for awhile but I recall the classes and educational material that was given to members of the community and the support groups.*
- *MCMC participates in a diabetes coalition established in the county.*
- *Regular Support Group Meetings, pamphlets, local doctor referrals*
- *doing a good job*

Public comments received on previously adopted implementation strategy for OBESITY:

- *See above [I receive the local paper and belong to several local groups. I have to say, I have seen very minimal interaction between MCMC and these sources of info.]*
- *Not aware of any*
- *None*
- *Encourage physical activity and stress need for physical activity in schools*
- *I am not sure. I know that the Heart Disease and the Diabetes programs can help with obesity but I don't recall anything specific offered for obesity.*
- *MCMC encourages patients and the public to eat healthier and lose weight.*
- *na*

MCMC services, programs, and resources available to respond to this need include:

- Dietician on staff that provides free counseling to anyone in the community for diabetes, heart healthy habits, etc.
- Diabetic support group sponsored by the hospital that meets monthly at the hospital
- Sponsor for annual diabetes health fair that provides free hemoglobin A1C screenings (November)
- Hospital participates weekly in radio talk show, Monroe Mondays, to cover key health topics including diabetes, heart disease, and healthy living
- Provide free screenings like lipids, cholesterol, etc., at local events and community organization meetings
- Retired Teachers exercise program and Diabetics exercise program led by physical therapy department
- Dietician speaks at schools on digestion and healthy eating and activity; speaks at senior center on supplements

and exercise

- Speed and Agility classes provided to school-age children to educate on physical activity and sports
- Sponsor of local 5Ks, run/walks
- Three cardiologists come in weekly to provide cardiac care to Monroe County residents
- ACO Care Coordinator works with patients to help afford medications and nutritional supplements through Kentucky Prescription Assistance Program; provides home visits and follows up with diabetic patients; working with extension office to promote Medicare Wellness Screenings (includes cholesterol, mammograms, colonoscopies, etc.)
- Hospital provides free CPR classes to the community (attendees pay for certification card)
- "Nurse-wise" 24-hour help line available to anyone enrolled in the ACO
- Offering telehealth CE program on obesity for medical staff

Additionally, MCMC plans to take the following steps to address this need:

- Look into providing more lunch 'n' learns or other speaking engagements on healthy eating and active living
- In discussions with Skyline Medical and working on grant funding to bring in robotics to help assist with evaluation of stroke patients
- Implementing new CT scanner that will perform calcium scoring
- Bringing in balance machine to test for peripheral neuropathy to help diabetic and stroke patients
- Investigate providing space for Weight Watchers or similar meetings and consider facilitating/coordinating
- Explore opportunities to work with Wellness Center
- Look into options for other health fairs or specific times to offer discounted blood draws
- Look into providing scales to help people monitor weight for congestive heart failure patients

MCMC evaluation of impact of actions taken since the immediately preceding CHNA:

- Worked with Barren River Health Department to bring in Community Health Worker (see last CHNA)
- Continues to follow Chest Pain protocols for patients presenting with chest pain
- Provided Lunch 'n' Learn on women's heart health, co-sponsored by extension office
- Worked with extension office to put on mini-clinics that helped educate on selecting ingredients and making healthy meals

Anticipated results from MCMC Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations	X	
4. Enhances public health activities	X	
5. Improves ability to withstand public health emergency		X
6. Otherwise would become responsibility of government or another tax-exempt organization	X	
7. Increases knowledge; then benefits the public	X	

The strategy to evaluate MCMC intended actions is to monitor change in the following Leading Indicator:

- Number of free A1C screenings provided = 41 (3/1/2015 – 2/29/2016)
  - Other screenings = 12 (lipid panels)
- Number of consultations provided by dietician = 191
- Number of participants in Retired Teachers and Diabetics exercise programs = 25 (Retired Teachers), 20 (Diabetics)

The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:

- Heart Disease Deaths = 344.8/100,000[28]
- Adult Diabetes = 7.9%[29]
- Adult Obesity = 31%[30]

[28] World Life Expectancy. Kentucky Heart Disease age adjusted death rate. CDC: 1999-2014 Final Data.
[29] CHSI. Percentage of adults living with diagnosed diabetes. 2005-2011.
[30] County Health Rankings. Percentage of adults that report a BMI of 30 or more. 2012.

MCMC anticipates collaborating with the following other facilities and organizations to address this Significant Need:

Organization	Contact Name	Contact Information
Monroe County Health Department	Jill Ford, Public Health Director	www.monroecohealth.com 452 E 4th St, Tompkinsville, KY 42167 (270) 487-6782
Monroe County Schools	Amy Thompson, Superintendent	www.monroe.kyschools.us 309 Emberton Street, Tompkinsville, KY 42167
Monroe County Cooperative Extension – University of Kentucky	Susan Turner	https://monroe.ca.uky.edu 1194 Columbia Ave, Tompkinsville, KY 42167 (270) 487-5504
TriStar Skyline Medical Center		tristarskyline.com 3441 Dickerson Pike, Nashville, TN 37207 (615) 769-2000
Monroe County Retired Teachers Association	Lewis Carter	https://www.facebook.com/Monroe-County-Retired-Teachers-Association-503040393178789
Monroe County Senior Center (Southern Kentucky Community Action Program)	Alicia Beasley	800 Capp Harlan Rd, Tompkinsville, KY 42167 (270) 487-5602 www.casoky.org 921 Beauty Ave, Bowling Green, KY 42101 (270) 782-3162
Barren River District Health Department	Janarae Conway	www.barrenriverhealth.org 1109 State St, Bowling Green, KY 42101 (270) 781-8039
Monroe County Family Wellness Center	John Petett	https://www.facebook.com/mcfwc 60 Old Mulkey Rd, Tompkinsville, KY 42167 (270) 487-1184

Organization	Contact Name	Contact Information
Saint Thomas Health (cardiologist)	Dr. Graves	www.sthealth.com 2000 Church St, Nashville, TN 37236 (888) 655-2111
WTKY-FM (Monroe Mondays)	Randy Kerr	tunein.com/radio/WTKY-FM-921-s23177
American Heart Association	Angie Drexler	https://www.heart.org/HEARTORG/Affiliate/Lexington/Kentucky/Home_UCM_GRA012_AffiliatePage.jsp

4. **CANCER –** #2 Leading Cause of Death; Mammography screening below KY avg and US best; Adult Female Routine Pap Tests 40th of 40 peer counties; Cancer Screen – Pap/Cervical Test every 2 years is 17.9% below avg

Public comments received on previously adopted implementation strategy:

This was not a 2014 Significant Need, so no comments were solicited.

MCMC services, programs, and resources available to respond to this need include:

- Purchased and installed new 3D mammography machine and planning to offer 3D mammograms as requested
- ACO Care Coordinator working with patients to help afford medications through Kentucky Prescription Assistance Program; working with extension office to promote Medicare Wellness Screenings (includes cholesterol, mammograms, colonoscopies, etc.)
- Provide storage space for local American Cancer Society representatives to distribute wigs and head coverings to cancer patients/survivors
- Surgeon available to perform colonoscopies
- Sponsor of Relay for Life
- Provide space and employee facilitator for Cancer Support Group that meets monthly
- Provide tobacco cessation education to every patient
- Provide location for CARES organization with volunteer representative from the hospital
- Visiting plastic surgeon who works with dermatology cases to test for or treat skin cancer
- Education program for medical staff on cancer screenings by Kentucky Cancer Program

Additionally, MCMC plans to take the following steps to address this need:

- New CT machine will provide low dose CT scans for early detection of lung cancer for smokers
- Explore adding additional cancer screenings like PSAs

Anticipated results from MCMC Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
3. Addresses disparities in health status among different populations		X
4. Enhances public health activities	X	
5. Improves ability to withstand public health emergency		X
6. Otherwise would become responsibility of government or another tax-exempt organization	X	
7. Increases knowledge; then benefits the public	X	

The strategy to evaluate MCMC intended actions is to monitor change in the following Leading Indicator:

- Number of CT colonoscopies provided = start tracking in 2017
- Number of low dose lung cancer screenings provided = start tracking in 2017
- Number of mammograms provided = 722 (9 at reduced cost)

The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:

- Cancer death rate = 214.88/110,000[31]

MCMC anticipates collaborating with the following other facilities and organizations to address this Significant Need:

Organization	Contact Name	Contact Information
Citizens Advocating Responsible EnvironmentS (CARES)	Amy Hutchinson, Project Coordinator	www.monroecountycares.com 401 W 4th St, Tompkinsville, KY (270) 487-1368
American Cancer Society	Susan Clarkson, Andrea McAlpin	https://www.cancer.org 952 Fairview Ave # 4, Bowling Green, KY 42101 (270) 782-3654

[31] World Life Expectancy. Kentucky cancer age adjusted death rate. CDC: 1999-2014 Final Data.

Organization	Contact Name	Contact Information
Kentucky Cancer Program	Elizabeth Westbrook (270) 842-0950	www.kcp.uky.edu 2365 Harrodsburg Road, Suite A230, Lexington, KY 40504-3381

Other Needs Identified During CHNA Process

6. **MENTAL HEALTH/SUICIDE**
7. **LUNG CANCER – 2014 SIGNIFICANT NEED**
8. **SOCIAL FACTORS**
9. **TOBACCO USE**
10. **STROKE**
11. **FEMALE/MATERNAL HEALTH**
12. **ALZHEIMER'S**
13. **AFFORDABILITY/ACCESSIBILITY**
14. **LIFE EXPECTANCY**
15. **FLU/PNEUMONIA**
16. **ACCIDENTS**
17. **KIDNEY DISEASE**
18. **NEED WRITTEN IN - COPD**
19. **SEXUALLY TRANSMITTED INFECTIONS**
20. **NEED WRITTEN IN - PREVENTIVE CARE**

Overall Community Need Statement and Priority Ranking Score

Significant needs where hospital has implementation responsibility[32]

2. Heart Disease
3. Diabetes
4. Cancer
5. Obesity

Significant needs where hospital did not develop implementation strategy[33]

1. Substance Abuse

Other needs where hospital developed implementation strategy

None

Other needs where hospital did not develop implementation strategy

6. Mental Health/Suicide
7. Lung Cancer – 2014 Significant Need
8. Social Factors
9. Tobacco Use
10. Stroke
11. Female/Maternal Health
12. Alzheimer's
13. Affordability/Accessibility
14. Life Expectancy
15. Flu/Pneumonia
16. Accidents
17. Kidney Disease
18. Need Written In - COPD
19. Sexually Transmitted Infections
20. Need Written In - Preventive Care

[32] Responds to Schedule h (Form 990) Part V B 8
[33] Responds to Schedule h (Form 990) Part V Section B 8

APPENDIX

Appendix A – Written Commentary on Prior CHNA (Round 1)

Hospital solicited written comments about its 2014 CHNA.[34] 26 individuals responded to the request for comments. The following presents the information received in response to the solicitation efforts by the hospital. No unsolicited comments have been received.

Please indicate which (if any) of the following characteristics apply to you. If none of the following choices apply to you, please give a description of your role in the community.

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	10	9	19
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	13	7	20
3) Priority Populations	13	6	19
4) Representative/Member of Chronic Disease Group or Organization	7	12	19
5) Represents the Broad Interest of the Community	17	5	22
Other			3
Answered Question			25
Skipped Question			1

Congress defines "Priority Populations" to include:

- **Racial and ethnic minority groups**
- **Low-income groups**
- **Women**
- **Children**
- **Older Adults**
- **Residents of rural areas**
- **Individuals with special needs including those with disabilities, in need of chronic care, or in need of end-of-life care**
- **Lesbian Gay Bisexual Transsexual (LGBT)**
- **People with major comorbidity and complications**

1. **Do any of these populations exist in your community, and if so, do they have any unique needs that should be addressed?**
   - *All exist and have, by the high level of poverty combined with the low level of education, unique/special needs.*
   - *ALL OF THE ABOVE*
   - *yes, yes*

[34] Responds to IRS Schedule h (Form 990) Part V B 5

- *Most of these populations exist in this community. Low-income groups have inadequate resources to provide even a minimal standard of living and therefore must often times choose between healthcare and food or between other necessary expenditures.*
- *All the above*
- *Elderly in rural areas have problems with transportation.*
- *yes*
- *Low income, children, women, large geriatric population, rural area, chronic lung disease, diabetes, chronic heart disease, obesity, smoking are all groups represented in this county. Public forums and education for many are needed to educate personal self sufficient life styles for proper health are constantly needed.*
- *Yes*
- *yes they exist. more funding for all types of preventive health measures.*
- *All these populations exist in my community. Their specific needs are being addressed to the best of my knowledge.*
- *Many older adults are in need of medication they cannot afford. They need assistance understanding mail from Medicare, and insurance companies. The geriatric needs of our community are overshadowed by mother and children's assistance needs.*
- *yes*
- *yes rural areas*
- *yes most all of this exist in our community and their unique needs need to be addressed*
- *They do exist and there are currently programs addressing those needs.*
- *Yes. I believe that all areas are being addressed.*
- *All the populations exist in my community, and all populations have been represented in this homeless facility. There are many that come in that still are not covered by a health insurance plan.*
- *not that I can think of because the hospital offer classes and support group already!!!!!*
- *We have all of the above. They need to get quality health care closer to home.*
- *Many of the above listed populations exist in my community and all have their own set of unique needs*
- *most of these exist in our community*

In the 2014 CHNA, there were five health needs identified as "significant" or most important:

1. **Heart Disease**
2. **Diabetes**
3. **Obesity**
4. **Lung Cancer**
5. **Substance Abuse**

3. Should the hospital continue to consider the needs identified as most important in the 2014 CHNA as the most important set of health needs currently confronting residents in the county?

	Yes	No	No Opinion
Heart Disease	24	0	1
Diabetes	24	0	1
Obesity	24	0	1
Lung Cancer	21	2	2
Substance Abuse	24	1	0

- *These conditions are endemic in our county.*
- *Needs of the disabled*
- *Access to professional psychologists and psychiatric care are needed locally. Group counseling is difficult in a small community. Personal mental health issues and rehabilitation from psychiatric or addiction are extremely needed local services.*
- *All cancer should be considered.*
- *most of these issues have been addressed, but continue to be a problem.*
- *n/a*
- *I think COPD should possibly included.*

4. Should the Hospital continue to allocate resources to help improve the needs identified in the 2014 CHNA?

	Yes	No	No Opinion
Heart Disease	23	1	1
Diabetes	24	0	1
Obesity	23	1	1
Lung Cancer	21	2	2
Substance Abuse	24	1	0

- *Concentrate resources on increased education, especially in schools, and community outreach.*
- *Needs of the disabled*
- *We need to evaluate those we send to the schools more closely. Those with known substance abuse issues who*

have not sought treatment should never be working with our children.

- *Emphasis on substance abuse is critical.*
- *n/a*
- *all cancer not just lung!! Breast cancer support group*

5. **Are there any new or additional health needs the Hospital should address? Are there any new or additional implementation efforts the Hospital should take? Please describe.**
   - *I would like to see involvement in the movement to decrease the use of prescription drugs of all kinds - not just controlled substances.*
   - *All types of cancer, not just lung cancer.*
   - *Needs of Disabled, more education for diabetes*
   - *Childhood obesity and nutrition. Our children learn poor eating and physical activity habits and they can just as easily learn good habits. Classes, partnerships, and programs for youth and adult nutrition education would be beneficial. Parents won't spend the money on "good" foods because they either don't think their children will eat it and/or they don't know how to prepare foods. Developing better nutritional habits would go a long way towards helping the other issues identified. Re-institute the importance of family meal time and allow the children to assist in meal preparation. Youth health fairs are needed as well.*
   - *Emphasis on future abilities and resources the hospital will have will newer more advanced imaging for diagnoses should be advertised and repeatedly. Breast cancer awareness remains high priority along with annual pap smears, routine prostate exams, psa, hemoglobin A1C. Community education on proper habits to improve quality of life are to front and center in goals for MCMC*
   - *All types of cancer seem to be rising in our area. We have a large number of breast cancer cases.*
   - *n/a*
   - *possibly place additional emphasis on heart disease (especially women), obesity, and lung cancer. Would be nice to see Health Fair again as we have had in the past*
   - *no*
   - *The hospital continues to recruit health providers to for specialty clinics for our community, however being in a rural setting most providers are not able to travel the distance.*

6. **Please share comments or observations about keeping <u>HEART DISEASE</u> among the most significant needs for the Hospital to address.**
   - *Education appropriate to the demographics of the county with public/vocal support by community groups and medical staff.*
   - *It is the number one killer of men and women*

- *I believe it's one of our main causes of death and also one that is largely preventable. That alone should make it a priority.*
- *Promoting smoking cessation and physical activity will enhance this need.*
- *Emphasis on annual check ups, blood work, cholesterol levels monitored , proper exercise are critical*
- *Heart disease continues to be a leading cause of death and disability in Monroe County.*
- *Yes*
- *Monthly Diabetes Support Group, participation in the annual Diabetes Health Fair both of these help keep DIabetes in the forefront.*
  Substance Abuse - providing space for CARES' meetings and participation in their activities help address this issue and we have seen progress.
  Heart Disease - hospital's affiliation with St. Thomas and their ER protocol for chest pain; quick and knowledgeable response by EMS both examples of addressing heart disease.
  Include Obesity and Lung Cancer in a unique way in a Health Fair - address prevention through smoking cessation, better eating habits, etc.
- *Heart Disease is a chronic disease in our area. Due to our diets and lack of activity and education, there appears to be more and more individuals having heart catheters, stints, etc. Sometimes, its not so easy to change the bad habits of adults but reaching the kids at earlier ages might have some long term benefits.*
- *There are so many other risk factors that contribute to this. Most of the homeless clients I see have at least one of the above health concerns.*
- *I can't imagine any hospital not listing Heart Disease as a priority in their community.*
- *along time agree workshop on eating healthy and cooking heart healthy food!!! that would be good again*

7. Please share comments or observations about the implementation actions the Hospital has taken to address <u>HEART DISEASE</u>.

- *I receive the local paper and belong to several local groups. I have to say, I have seen very minimal interaction between MCMC and these sources of info.*
- *Not aware of any*
- *We used to have seminars on heart related issues, but we never do any more*
- *Local clinics provided by cardiologists from Nashville, Louisville and Bowling Green are especially helpful for the community to access excellent care*
- *I am unaware that any sort of preventative programs for heart disease exist in Monroe County.*
- *Protocol for Chest Pain through ER and EMS*
- *I have not been back in the community very long but prior to my leaving, I seem to recall Heart Health classes and heart healthy meals being offered at the hospital and taught by the RD at the hospital .*

- *MCMC takes an active role in supporting collaborative agencies to help educate and encourage the public to change life patterns to combat/eliminate all of the above health concerns.*
- *Have 2 doctors coming to hold clinics for our community.*
- *blood work screening such as, mini prevention screening*

8. Please share comments or observations about keeping <u>DIABETES</u> among the most significant needs for the Hospital to address.

- *See above*
- *Another leading cause of death and loss of quality life.*
- *We need much much more education on diabetes*
- *Very important especially for our youth. Perfect example of the connection between nutrition and health.*
- *Diet planning, obesity treatment opportunities and proper care for diabetics might be improved by local clinic access to Endocrinologist clinic. Continued community lectures forums from staff are good ideas.*
- *More and more students with diabetes.*
- *Diabetes has a major impact on the community and the health care system as a whole. Uncontrolled diabetes specifically is linked to worsening other conditions, such as heart and kidney disease.*
- *Yes*
- *growing number of individuals with pre-diabetes or those that don't know they are diabetic - address signs/symptoms, treatment*
- *Diabetes/heart disease/obesity usually go hand in hand. Diabetes can increase the morbidity rate among any population and cause the residents of your community to develop kidney disease, wounds that won't heal and other organ issues. It can increase the overall health cost to an individual and community.*
- *KY has a high rate of diabetes, which causes other health problems.*
- *Hospital sponsors a Diabetic Support Group, I feel like this and Obesity could almost be one in the same.*
- *blood work screening and food training*

9. Please share comments or observations about the implementation actions the Hospital has taken to address <u>DIABETES</u>.

- *See above*
- *Diabetes Support Group/Coalition; Health Fair*
- *Diabetic meeting used to occur every month at the hospital, but I do not think they do now. Why do we never have inservices for our hospital staff?? Would be great for our CEU'S and become more educated on all these unrivaled subjects*

- *Support group is good.*
- *The hospital has a Certified Diabetes Educator on staff who is available to the community for referrals. This is a major benefit to the community. The local hospital also has a Diabetes Education and Support group that meets monthly.*
- *The Diabetes support group. Diabetes health fair. Dietician on staff that is available to consult people.*
- *More needs to be done to improve the poor health literacy of our population.*
- *Diabetes Support Group, Dietician consults and Diabetes Health Fair participation*
- *Again, I have been gone for awhile but I recall the classes and educational material that was given to members of the community and the support groups.*
- *MCMC participates in a diabetes coalition established in the county.*
- *Regular Support Group Meetings, pamphlets, local doctor referrals*
- *doing a good job*

10. Please share comments or observations about keeping <u>OBESITY</u> among the most significant needs for the Hospital to address.

- *See above*
- *Again, leads to other more dangerous diseases that can result in death.*
- *More Classes available for excercise and nutrition classes*
- *Community partners must continue to address this epidemic. Body image, nutrition, physical activity of the upmost importance.*
- *Continue to provide Medical Nutrition Therapy (performed by RD). Search for novel ways to partner and promote increased physical activity in youth.*
- *Yes*
- *Too much fast food available in the community, not enough incentive or will power to stay motivated and lose weight*
- *I myself am obese. I know the negative impact this has on my life. I am not diabetic and my blood work has been great so far with no heart disease complications but this is not true for everyone. My weight has negatively impacted my knees and I do foresee knee surgery in the future. Obesity again seems to go hand in hand with so many other co morbidity issues.*
- *Obesity is a major concern in this county. It also contributes to other health risks.*
- *Obesity is everywhere as well, our community has a Wellness Center that does work with the hospital, however needs to be better utilized by the community*
- *na*

- *I'm not certain of specific hospital activities that could be completed, but continuing to support and promote healthy nutrition options and opportunities for physical activity would be good as these are lacking in our community and they are very greatly needed.*

11. Please share comments or observations about the implementation actions the Hospital has taken to address <u>OBESITY</u>.

- *See above*
- *Not aware of any*
- *None*
- *Encourage physical activity and stress need for physical activity in schools*
- *I am not sure. I know that the Heart Disease and the Diabetes programs can help with obesity but I don't recall anything specific offered for obesity.*
- *MCMC encourages patients and the public to eat healthier and lose weight.*
- *na*

12. Please share comments or observations about keeping <u>LUNG CANCER</u> among the most significant needs for the Hospital to address.

- *See above*
- *Will continue to be an issue until we can decrease smoking rates in Kentucky.*
- *Education is the key!!*
- *Promote smoke-free businesses and workplaces. Provide referrals to smoking cessation programs for employees and patients that smoke.*
- *Lung cancer is important. Need to look at all types of cancers*
- *Yes*
- *Seems to be an increase in number of individuals diagnosed with lung and other cancers, education regarding second and third-hand smoking, continue to support Relay for Life, as research is our hope for a cancer free future*
- *I have seen quite a few people affected by lung cancer including my mother. This community has been a strong tobacco grower in the past and the baby boomers grew up in an environment where smoking was considered socially acceptable and not a health danger. I believe that as time continues, we will find that even vaping will cause lung issues once enough data has been obtained.*
- *Monroe County has a very high rate of tobacco use, and needs to continue to encourage the public to not smoke.*

- *As with any cancer, our community has to travel for treatment and health providers, local clinics would help.*
- *na*
- *Smoking and tobacco use, which leads to lung cancer, continues to plague our community and must be addressed.*

13. Please share comments or observations about the implementation actions the Hospital has taken to address <u>LUNG CANCER</u>.

- *See above*
- *Not aware of any*
- *None*
- *Smoke-free campus*
- *Continuation of the Cancer Support Group, participation in Relay for Life*
- *I know that the hospital has offered smoking cessation classes and educational materials and group support.*
- *MCMC is also a member of the CARES coalition, who continues to work on a smoke free community, and strongly encourage the public to quit.*
- *na*
- *Making the hospital campus tobacco free was a great start, but from my experiences this policy is not enforced. On multiple occasions as I entered the emergency room, patients with IV poles have been standing at the front doors smoking with no regard to the policy.*

14. Please share comments or observations about keeping <u>SUBSTANCE ABUSE</u> among the most significant needs for the Hospital to address.

- *See above*
- *I think this one should be higher up on the list. The myriad of repercussions that result from this disease go far beyond the individual and affect families and the community at large.*
- *Selling drugs on the streets is a major problem. It even becomes a greater problem when your law enforcement does nothing to the guilty party!!*
- *This is one of the most dire needs that is on the rise for our community. It will be important for us as a community to explore increased avenues for drug abuse treatment. Also, it will be important for community partners to work together to assess IV drug use, as well as communicable disease rates and eventually move forward with/explore a needle exchange program for the community.*
- *We are lacking on this front. A more coordinated referral system with a detailed policy of options for treatment is needed.*

- *Substance abuse is evident throughout our county and should remain a top priority for all.*
- *Substance abuse is a continuing problem in my community, possibly contributing to the largest loss of patient years.*
- *Yes, may be at the top of the list*
- *drug abuse in Kentucky increasing, Meth production in news*
- *This area is a low socio economic area and people are using substances to help them forget their problems, looking for highs and don't care what it does to them long term. So many of our youth are turned on to drugs at an early age by peers. Sometimes the youth or adult can just be depressed and come from a higher income bracket but are looking for ways to self medicate and feel better. Addiction can happen for many reasons and this area seems to have a large number of people who are addicted/produce/abuse drugs especially meth. Plus the meth production can cause illness among the children who live in that environment and transfer powder, etc to others at school creating a vicious cycle.*
- *Prescription drug abuse has become a huge problem for this county.*
- *Our community has Substance Abuse support that is quite active. They work very well with our doctors in obtaining information, pamphlets, re-hab assistance, etc.*
- *support group*
- *Substance abuse among our citizens, both young and old, continues to be an issue. With impending wet/dry votes and the possibility of "medical" marijuana being legalized in the next legislative session, these issues are only going to worsen.*

15. Please share comments or observations about the implementation actions the Hospital has taken to address <u>SUBSTANCE ABUSE</u>.

- *See above*
- *Provide meeting space for CARES meetings. Would like to have a volunteer representing the hospital on the board.*
- *None!!!!!!*
- *Partnering in community town-hall events; Monroe Co CARES Coalition support.*
- *There are few resources for detox and rehabilitation in our community.*
- *participation in CARES group initiatives*
- *I know that the hospital has been working in partnership with other groups in this community to develop education and support group programs.*
- *MCMC is a member of the CARES coalition, and helps to combat the drug abuse problems.*
- *The hospital is also active with this support group.*
- *support group*

- *Supporting the CARES coalition is a great way to help take action, but I am unaware of other actions the hospital has taken to address the problem. Prescription pain killers are over prescribed and the doses that are prescribed are entirely too high. Patients also are given no information about the proper disposal of the remainder of their pain killers after their issue is resolved, and medications left in the home are often stolen or abused when they should be placed in either of the two permanent disposal boxes.*

16. **Finally, after thinking about our questions and the information we seek, is there anything else you think is important as we review and revise our thinking about significant health needs in the county?**

- *MCMC is what people in Monroe County think when they are ill, hurt or seeking help for a loved one. Use and build on this trust. Become THE source for information as well as care.*
- *I think community outreach could be improved.*
- *We need to have more things available for physically handicap individuals. We also need services for mentally handicap people. The law enforcement needs to be educated on Mental Illness and. Services out there for these patients!!*
- *Psychiatric care, substance abuse counsel, protocol for referral to treat abuse and know whom to call for specific questions and guidance on immediate care when overdose occurs and rehab is needed would be great.*
- *We still have children that do not get the health care that they need as evidenced by the lack of routine screenings need for school being incomplete and difficult to obtain.*
- *Continue to participate in community efforts and lead the way in prevention efforts*
- *Not at this time.*
- *Keep legislators WELL informed about how resources (funds) have been cut and reduced in small rural areas that rely on those resources to fund these issues for our aging community.*
- *support group is great!!!!*

Appendix B – Identification & Prioritization of Community Needs (Round 2)

Need Topic	Total Votes	Number of Local Experts Voting for Needs	Percent of Votes	Cumulative Votes	Need Determination
Substance Abuse – 2014 Significant Need	333	15	22.11%	22.11%	Significant Needs
Heart Disease – 2014 Significant Need	182	13	12.08%	34.20%	
Diabetes – 2014 Significant Need	161	13	10.69%	44.89%	
Cancer	135	10	8.96%	53.85%	
Obesity – 2014 Significant Need	115	12	7.64%	61.49%	
Mental Health/Suicide	107	11	7.10%	68.59%	Other Identified Needs
Lung Cancer – 2014 Significant Need	100	10	6.64%	75.23%	
Social Factors	61	8	4.05%	79.28%	
Tobacco Use	50	7	3.32%	82.60%	
Stroke	48	6	3.19%	85.79%	
Female/Maternal Health	36	7	2.39%	88.18%	
Alzheimer's	33	6	2.19%	90.37%	
Affordability/Accessibility	30	6	1.99%	92.36%	
Life Expectancy	26	5	1.73%	94.09%	
Flu/Pneumonia	21	5	1.39%	95.48%	
Accidents	16	6	1.06%	96.55%	
Kidney Disease	16	5	1.06%	97.61%	
Need Written In - COPD	15	1	1.00%	98.61%	
Sexually Transmitted Infections	11	6	0.73%	99.34%	
Need Written In - Preventive Care	10	1	0.66%	100.00%	
Total	1506		100.00%		

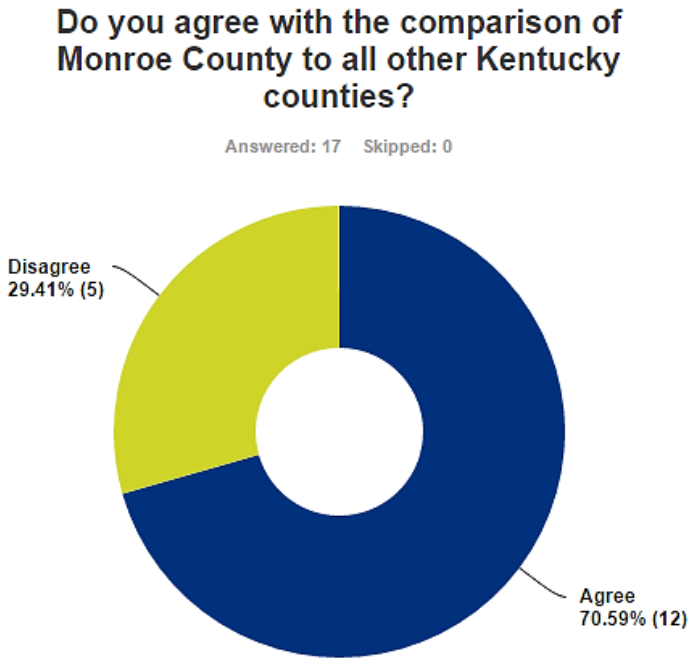
Individuals Participating as Local Expert Advisors[35]

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	6	4	10
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	9	4	13
3) Priority Populations	8	3	11
4) Representative/Member of Chronic Disease Group or Organization	3	6	9
5) Represents the Broad Interest of the Community	11	2	13
Other			0
Answered Question			17
Skipped Question			0

[35] Responds to IRS Schedule h (Form 990) Part V B 3 g

Advice Received from Local Expert Advisors

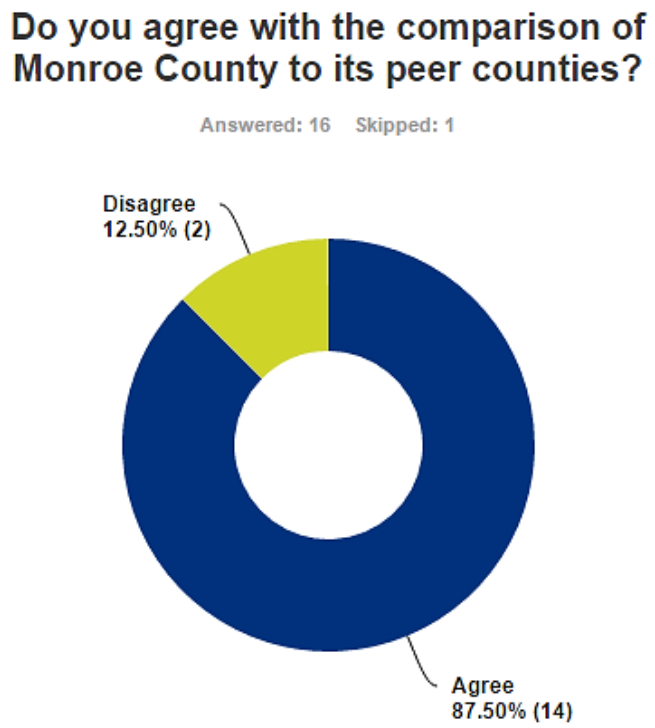
Question: Do you agree with the comparison of Monroe County to all other Kentucky counties?



Comments:

- *I feel the population to physician and dentist ratio is wrong.*
- *Monroe County is a rural county that does not have access to better, specialized care without traveling a long distance. I believe the social/economic factors contributes mostly to the other factors listed.*
- *I feel our community has access to Primary Care Physicians; community has access to Mammography Screening and Diabetic Monitoring but do not take advantage of it. Am not aware of the Premature Death being so bad in our community. Surprised that Children in Poverty, Children in Single-Parent households is not worse.*
- *Exercise opportunities, are available. The variety may be limited.*
- *Health Behaviors - Access to exercise opportunities, Monroe County has a Wellness Center where the public can utilize for exercise and equipment to work-out on.*

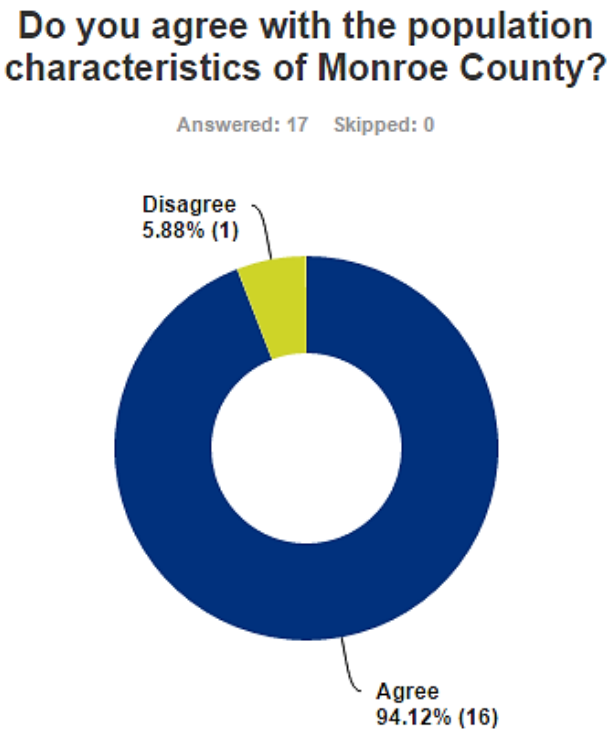
Question: Do you agree with the comparison of Monroe County to its peer counties?



Comments:

- *Again, social/economic factors are in my opinion, the greatest influence.*
- *Living Near Highways??? HIV morbidity - not aware we had issue*
- *I think air quality is better than represented.*

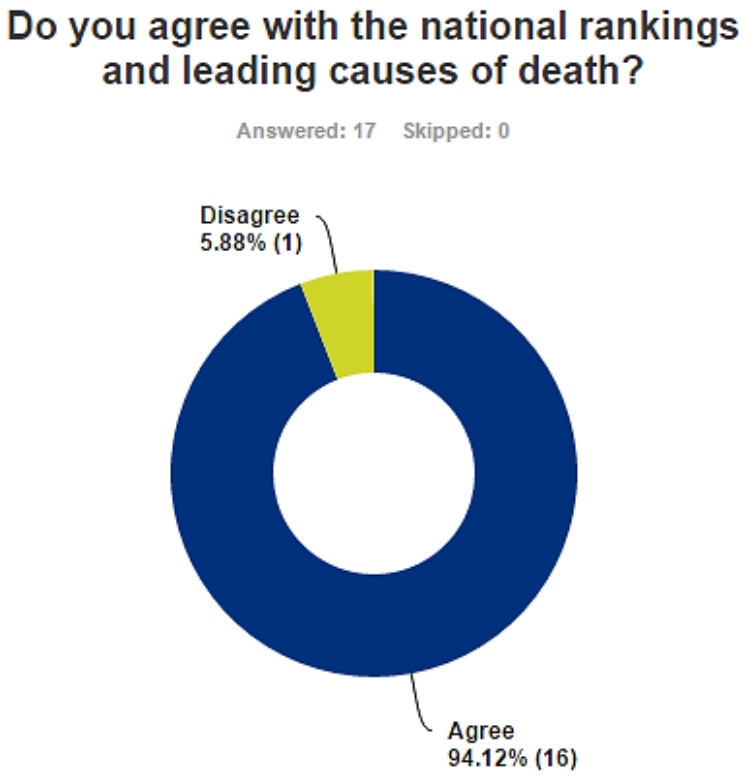
Question: Do you agree with the population characteristics of Monroe County?



Comments:

- *With few jobs to attract our college students, Monroe County has become a county for the older population, and those with some type of medical issues. The unemployment rate does not reflect those who are still looking for work, yet, are no longer eligible for benefits. I see a lot of people using the emergency room, as Monroe County does not have any urgent care medical facilities.*
- *Monroe County is in poor risk for health, I think due to a lot of barriers in our county, one being the water*

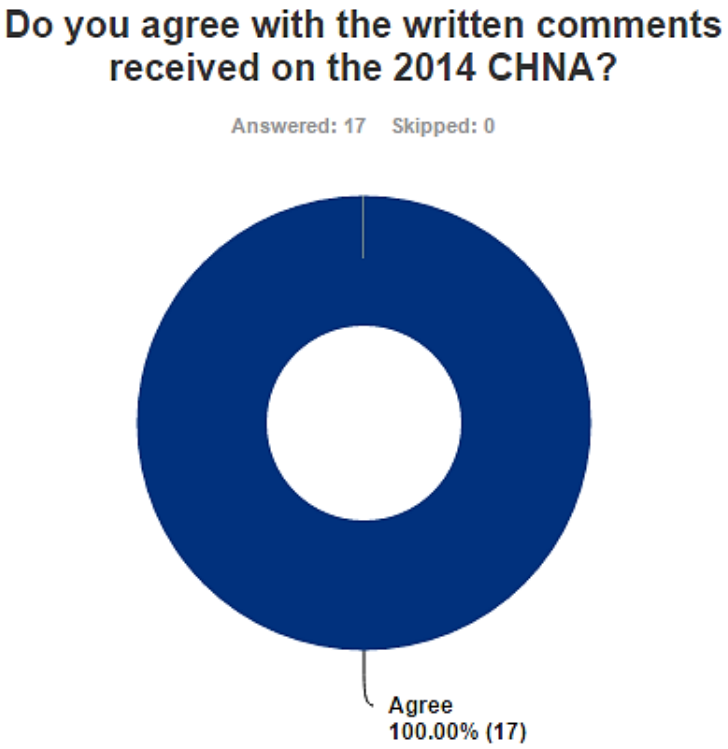
Question: Do you agree with the national rankings and leading causes of death?



Comments:

- *I thought Diabetes death rates would be higher.*
- *I figured Cancer and Stroke would have been higher %*

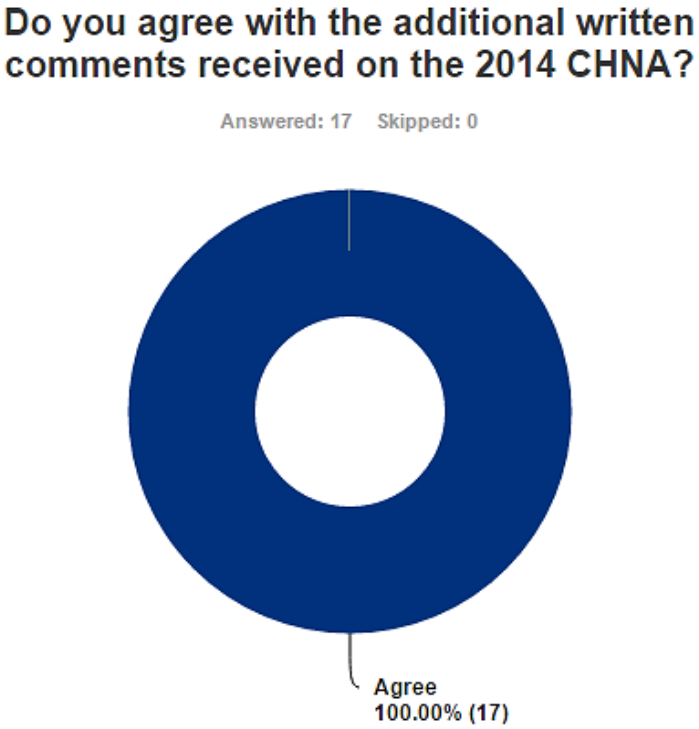
Question: Do you agree with the written comments received on the 2014 CHNA?



Comments:

- *Hospital needs more education and resources to educate and treat individuals with drug addiction and alcoholism. ALL hospital employees need to be educated on addiction. The hospital administration should be the LARGEST advocate in Monroe County in addressing the current drug epidemic our county has been and continues to face. Our hospital has not taken the action needed to be part of a solution in helping our community.*

Question: Do you agree with the additional written comments received on the 2014 CHNA?



Comments:

- *I find it very sad that the table above has 0 for no opinion on substance abuse. I agree with comment on "Personal mental health issues and rehabilitation from psychiatric or addiction are extremely needed" in our community. We NEED a specialist in addiction, we NEED a specialist in mental health. We NEED to educate our community on drug addiction.*
- *Agree that all cancer should be considered and addressed.*
- *I agree that COPD should be considered.*

Appendix C – National Healthcare Quality and Disparities Report[36]

The National Healthcare Quality and Disparities Reports (QDR) (annual reports to Congress mandated in the Healthcare Research and Quality Act of 1999 (P.L. 106-129)) are based on more than 250 measures of quality and disparities covering a broad array of healthcare services and settings. Data are generally available through 2012, although rates of un-insurance have been tracked through the first half of 2014. The reports are produced with the help of an Interagency Work Group led by the Agency for Healthcare Research and Quality (AHRQ) and submitted on behalf of the Secretary of Health and Human Services (HHS).

Beginning with this 2014 report, findings on healthcare quality and healthcare disparities are integrated into a single document. This new National Healthcare Quality and Disparities Report (QDR) highlights the importance of examining quality and disparities together to gain a complete picture of healthcare. This document is also shorter and focuses on summarizing information over the many measures that are tracked; information on individual measures will still be available through chartbooks posted on the Web (www.ahrq.gov/research/findings/nhqrdr/2014chartbooks/).

The key findings of the 2014 QDR are organized around three axes: **access to healthcare**, **quality of healthcare**, and **NQS priorities**.

To obtain high-quality care, Americans must first gain entry into the healthcare system. Measures of access to care tracked in the QDR include having health insurance, having a usual source of care, encountering difficulties when seeking care, and receiving care as soon as wanted. Historically, Americans have experienced variable access to care based on race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, and residence location.

ACCESS: After years without improvement, the rate of un-insurance among adults ages 18-64 decreased substantially during the first half of 2014.

The Affordable Care Act is the most far-reaching effort to improve access to care since the enactment of Medicare and Medicaid in 1965. Provisions to increase health insurance options for young adults, early retirees, and Americans with pre-existing conditions were implemented in 2010. Open enrollment in health insurance marketplaces began in October 2013 and coverage began in January 2014. Expanded access to Medicaid in many states began in January 2014, although a few had opted to expand Medicaid earlier.

Trends

- From 2000 to 2010, the percentage of adults ages 18-64 who reported they were without health insurance coverage at the time of interview increased from 18.7% to 22.3%.
- From 2010 to 2013, the percentage without health insurance decreased from 22.3% to 20.4%.
- During the first half of 2014, the percentage without health insurance decreased to 15.6%.
- Data from the Gallup-Healthways Well-Being Index indicate that the percentage of adults without health insurance continued to decrease through the end of 2014,[37] consistent with these trends.

[36] http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/index.html Responds to IRS Schedule h (Form 990) Part V B 3 i
[37] Levy J. In U.S., Uninsured Rate Sinks to 12.9%. http://www.gallup.com/poll/180425/uninsured-rate-sinks. aspx.

ACCESS: Between 2002 and 2012, access to health care improved for children but was unchanged or significantly worse for adults.

Trends

- From 2002 to 2012, the percentage of people who were able to get care and appointments as soon as wanted improved for children but did not improve for adults ages 18-64.

Disparities

- Children with only Medicaid or CHIP coverage were less likely to get care as soon as wanted compared with children with any private insurance in almost all years.
- Adults ages 18-64 who were uninsured or had only Medicaid coverage were less likely to get care as soon as wanted compared with adults with any private insurance in all years.

Trends

- Through 2012, most access measures improved for children. The median change was 5% per year.
- Few access measures improved substantially among adults. The median change was zero.

ACCESS DISPARITIES: During the first half of 2014, declines in rates of un-insurance were larger among Black and Hispanic adults ages 18-64 than among Whites, but racial differences in rates remained.

Trends

- Historically, Blacks and Hispanics have had higher rates of un-insurance than Whites.[38]

Disparities

- During the first half of 2014, the percentage of adults ages 18-64 without health insurance decreased more quickly among Blacks and Hispanics than Whites, but differences in un-insurance rates between groups remained.
- Data from the Urban Institute's Health Reform Monitoring System indicate that between September 2013 and September 2014, the percentage of Hispanic and non-White non-Hispanic adults ages 18-64 without health insurance decreased to a larger degree in states that expanded Medicaid under the Affordable Care Act than in states that did not expand Medicaid.[39]

ACCESS DISPARITIES: In 2012, disparities were observed across a broad spectrum of access measures. People in poor households experienced the largest number of disparities, followed by Hispanics and Blacks.

Disparities

- In 2012, people in poor households had worse access to care than people in high-income households on all access measures (green).

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[38] In this report, racial groups such as Blacks and Whites are non-Hispanic, and Hispanics include all races.

[39] Long SK, Karpman M, Shartzer A, et al. Taking Stock: Health Insurance Coverage under the ACA as of September 2014. http://hrms.urban.org/briefs/Health-Insurance-Coverage-under-the-ACA-as-of- September-2014.html

- Blacks had worse access to care than Whites for about half of access measures.
- Hispanics had worse access to care than Whites for two-thirds of access measures.
- Asians and American Indians and Alaska Natives had worse access to care than Whites for about one-third of access measures.

ACCESS DISPARITIES: Through 2012, across a broad spectrum of access measures, some disparities were reduced but most did not improve.

Disparity Trends

- Through 2012, most disparities in access to care related to race, ethnicity, or income showed no significant change (blue), neither getting smaller nor larger.
- I n four of the five comparisons shown above, the number of disparities that were improving (black) exceeded the number of disparities that were getting worse (green).

QUALITY: Quality of health care improved generally through 2012, but the pace of improvement varied by measure.

Trends

- Through 2012, across a broad spectrum of measures of health care quality, 60% showed improvement (black).
- Almost all measures of Person-Centered Care improved.
- About half of measures of Effective Treatment, Healthy Living, and Patient Safety improved.
- There are insufficient numbers of reliable measures of Care Coordination and Care Affordability to summarize in this way.

QUALITY: Through 2012, the pace of improvement varied across NQS priorities.

Trends

- Through 2012, quality of health care improved steadily but the median pace of change varied across NQS priorities:
  - Median change in quality was 3.6% per year among measures of Patient Safety.
  - Median improvement in quality was 2.9% per year among measures of Person-Centered Care.
  - Median improvement in quality was 1.7% per year among measures of Effective Treatment.
  - Median improvement in quality was 1.1% per year among measures of Healthy Living.
  - There were insufficient data to assess Care Coordination and Care Affordability.

QUALITY: Publicly reported CMS measures were much more likely than measures reported by other sources to achieve high levels of performance.

Achieved Success

Eleven quality measures achieved an overall performance level of 95% or better this year. At this level, additional improvement is limited, so these measures are no longer reported in the QDR. Of measures that achieved an overall

performance level of 95% or better this year, seven were publicly reported by CMS on the Hospital Compare website (italic).

- *Hospital patients with heart attack given percutaneous coronary intervention within 90 minutes*
- Adults with HIV and CD4 cell count of 350 or less who received highly active antiretroviral therapy during the year
- *Hospital patients with pneumonia who had blood cultures before antibiotics were administered*
- *Hospital patients age 65+ with pneumonia who received pneumococcal screening or vaccination*
- *Hospital patients age 50+ with pneumonia who received influenza screening or vaccination*
- *Hospital patients with heart failure and left ventricular systolic dysfunction who were prescribed angiotensin-converting enzyme or angiotensin receptor blocker at discharge*
- *Hospital patients with pneumonia who received the initial antibiotic dose consistent with current recommendations*
- *Hospital patients with pneumonia who received the initial antibiotic dose within 6 hours of arrival*
- Adults with HIV and CD4 cell counts of 200 or less who received Pneumocystis pneumonia prophylaxis during the year
- People with a usual source of care for whom health care providers explained and provided all treatment options
- Hospice patients who received the right amount of medicine for pain management

Last year, 14 of 16 quality measures that achieved an overall performance level of 95% or better were publicly reported by CMS. Measures that reach 95% and are no longer reported in the QDR continue to be monitored when data are available to ensure that they do not fall below 95%.

Improving Quickly

Through 2012, a number of measures showed rapid improvement, defined as an average annual rate of change greater than 10% per year. Of these measures that improved quickly, four are adolescent vaccination measures (italic).

- *Adolescents ages 16-17 years who received 1 or more doses of tetanus-diphtheria-acellular pertussis vaccine*
- *Adolescents ages 13-15 years who received 1 or more doses of tetanus-diphtheria-acellular pertussis vaccine*
- Hospital patients with heart failure who were given complete written discharge instructions
- *Adolescents ages 16-17 years who received 1 or more doses of meningococcal conjugate vaccine*
- *Adolescents ages 13-15 years who received 1 or more doses of meningococcal conjugate vaccine*
- Patients with colon cancer who received surgical resection that included 12+ lymph nodes pathologically examined
- Central line-associated bloodstream infection per 1,000 medical and surgical discharges, age 18+ or obstetric admissions
- Women with Stage I-IIb breast cancer who received axillary node dissection or sentinel lymph node biopsy at

time of surgery

Worsening

Through 2012, a number of measures showed worsening quality. Of these measures that showed declines in quality, three track chronic diseases (italic). Note that these declines occurred prior to implementation of most of the health insurance expansions included in the Affordable Care Act.

- Maternal deaths per 100,000 live births
- Children ages 19-35 months who received 3 or more doses of Haemophilus influenzae type b vaccine
- People who indicate a financial or insurance reason for not having a usual source of care
- Suicide deaths per 100,000 population
- Women ages 21-65 who received a Pap smear in the last 3 years
- *Admissions with diabetes with short-term complications per 100,000 population, age 18+*
- *Adults age 40+ with diagnosed diabetes who had their feet checked for sores or irritation in the calendar year*
- Women ages 50-74 who received a mammogram in the last 2 years
- Postoperative physiologic and metabolic derangements per 1,000 elective-surgery admissions, age 18+
- *People with current asthma who are now taking preventive medicine daily or almost daily*
- People unable to get or delayed in getting needed medical care, dental care, or prescription medicines due to financial or insurance reasons

QUALITY DISPARITIES: Disparities remained prevalent across a broad spectrum of quality measures. People in poor households experienced the largest number of disparities, followed by Blacks and Hispanics.

Disparities

- People in poor households received worse care than people in high-income households on more than half of quality measures (green).
- Blacks received worse care than Whites for about one-third of quality measures.
- Hispanics, American Indians and Alaska Natives, and Asians received worse care than Whites for some quality measures and better care for some measures.
- For each group, disparities in quality of care are similar to disparities in access to care, although access problems are more common than quality problems.

QUALITY DISPARITIES: Through 2012, some disparities were getting smaller but most were not improving across a broad spectrum of quality measures.

Disparity Trends

- Through 2012, most disparities in quality of care related to race, ethnicity, or income showed no significant change (blue), neither getting smaller nor larger.

- When changes in disparities occurred, measures of disparities were more likely to show improvement (black) than decline (green). However, for people in poor households, more measures showed worsening disparities than improvement.

QUALITY DISPARITIES: Through 2012, few disparities in quality of care were eliminated while a small number became larger.

Disparities Trends

- Through 2012, several disparities were eliminated.
  - One disparity in vaccination rates was eliminated for Blacks (measles-mumps-rubella), Asians (influenza), American Indians and Alaska Natives (hepatitis B), and people in poor households (human papillomavirus).
  - Four disparities related to hospital adverse events were eliminated for Blacks.
  - Three disparities related to chronic diseases and two disparities related to communication with providers were eliminated for Asians.
  - On the other hand, a few disparities grew larger because improvements in quality for Whites did not extend uniformly to other groups.
  - At least one disparity related to hospice care grew larger for Blacks, American Indians and Alaska Natives, and Hispanics.
  - People in poor households experienced worsening disparities related to chronic diseases.

QUALITY DISPARITIES: Overall quality and racial/ethnic disparities varied widely across states and often not in the same direction.

Geographic Disparities

- There was significant variation in quality among states. There was also significant variation in disparities.
- States in the New England, Middle Atlantic, West North Central, and Mountain census divisions tended to have higher overall quality while states in the South census region tended to have lower quality.
- States in the South Atlantic, West South Central, and Mountain census divisions tended to have fewer racial/ethnic disparities while states in the Middle Atlantic, West North Central, and Pacific census divisions tended to have more disparities.
- The variation in state performance on quality and disparities may point to differential strategies for improvement.

National Quality Strategy: Measures of Patient Safety improved, led by a 17% reduction in hospital-acquired conditions.

Hospital-acquired conditions have been targeted for improvement by the CMS Partnership for Patients initiative, a major public-private partnership working to improve the quality, safety, and affordability of health care for all Americans. As a result of this and other federal efforts, such as Medicare's Quality Improvement Organizations and the HHS National Action Plan to Prevent Health Care-Associated Infections, as well as the dedication of practitioners, the general trend in patient safety is one of improvement.

Trends

- From 2010 to 2013, the overall rate of hospital-acquired conditions declined from 145 to 121 per 1,000 hospital discharges.
- This decline is estimated to correspond to 1.3 million fewer hospital-acquired conditions, 50,000 fewer inpatient deaths, and $12 billion savings in health care costs.[40]
- Large declines were observed in rates of adverse drug events, healthcare-associated infections, and pressure ulcers.
- About half of all Patient Safety measures tracked in the QDR improved.
- One measure, admissions with central line-associated bloodstream infections, improved quickly, at an average annual rate of change above 10% per year.
- One measure, postoperative physiologic and metabolic derangements during elective-surgery admissions, got worse over time.

Disparities Trends

- Black-White differences in four Patient Safety measures were eliminated.
- Asian-White differences in admissions with iatrogenic pneumothorax grew larger.

National Quality Strategy: Measures of Person-Centered Care improved steadily, especially for children.

Trends

- From 2002 to 2012, the percentage of children whose parents reported poor communication significantly decreased overall and among all racial/ethnic and income groups.
- Almost all Person-Centered Care measures tracked in the QDR improved; no measure got worse.

Disparities

In almost all years, the percentage of children whose parents reported poor communication with their health providers was:

- Higher for Hispanics and Blacks compared with Whites.
- Higher for poor, low-income, and middle-income families compared with high-income families.

Disparities Trends

- Asian-White differences in two measures related to communication were eliminated.
- Four Person-Centered Care disparities related to hospice care grew larger.

National Quality Strategy: Measures of Care Coordination improved as providers enhanced discharge processes and adopted health information technologies.

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[40] Agency for Healthcare Research and Quality. Interim Update on 2013 Annual Hospital-Acquired Condition Rate and Estimates of Cost Savings and Deaths Averted From 2010 to 2013. http://www.ahrq.gov/professionals/quality-patient-safety/pfp/interimhacrate2013.html

Trends

- From 2005 to 2012, the percentage of hospital patients with heart failure who were given complete written discharge instructions increased overall, for both sexes, and for all racial/ethnic groups.
- There are few measures to assess trends in Care Coordination.

Disparities

- In all years, the percentage of hospital patients with heart failure who were given complete written discharge instructions was lower among American Indians and Alaska Natives compared with Whites.

National Quality Strategy: Many measures of Effective Treatment achieved high levels of performance, led by measures publicly reported by CMS on Hospital Compare.

Trends

- From 2005 to 2012, the percentage of hospital patients with heart attack given percutaneous coronary intervention within 90 minutes of arrival increased overall, for both sexes, and for all racial/ethnic groups.
- In 2012, the overall rate exceeded 95%; the measure will no longer be reported in the QDR.
- Eight other Effective Treatment measures achieved overall performance levels of 95% or better this year, including five measures of pneumonia care and two measures of HIV care.
- About half of all Effective Treatment measures tracked in the QDR improved.
- Two measures, both related to cancer treatment, improved quickly, at an average annual rate of change above 10% per year.
- Three measures related to management of chronic diseases got worse over time.

Disparities

- As rates topped out, absolute differences between groups became smaller. Hence, disparities often disappeared as measures achieved high levels of performance.

Disparities Trends

- Asian-White differences in three chronic disease management measures were eliminated but income-related disparities in two measures related to diabetes and joint symptoms grew larger.

National Quality Strategy: Healthy Living improved in about half of the measures followed, led by selected adolescent vaccines from 2008 to 2012.

Trends

- From 2008 to 2012, the percentage of adolescents ages 16-17 years who received 1 or more doses of meningococcal conjugate vaccine increased overall, for residents of both metropolitan and nonmetropolitan areas, and for all income groups.
- About half of all Healthy Living measures tracked in the QDR improved.

- Four measures, all related to adolescent immunizations, improved quickly, at an average annual rate of change above 10% per year (meningococcal vaccine ages 13-15 and ages 16-17; tetanusdiphteria-acellular pertussis vaccine ages 13-15 and ages 16-17).
- Two measures related to cancer screening got worse over time.

Disparities

- Adolescents ages 16-17 in nonmetropolitan areas were less likely to receive meningococcal conjugate vaccine than adolescents in metropolitan areas in all years.
- Adolescents in poor, low-income, and middle-income households were less likely to receive meningococcal conjugate vaccine than adolescents in high-income households in almost all years.

Disparities Trends

- Four disparities related to child and adult immunizations were eliminated.
- Black-White differences in two Healthy Living measures grew larger.

National Quality Strategy: Measures of Care Affordability worsened from 2002 to 2010 and then leveled off.

From 2002 to 2010, prior to the Affordable Care Act, care affordability was worsening. Since 2010, the Affordable Care Act has made health insurance accessible to many Americans with limited financial resources.

Trends

- From 2002 to 2010, the overall percentage of people unable to get or delayed in getting needed medical care, dental care, or prescription medicines and who indicated a financial or insurance reason rose from 61.2% to 71.4%.
- From 2002 to 2010, the rate worsened among people with any private insurance and among people from high- and middle-income families; changes were not statistically significant among other groups.
- After 2010, the rate leveled off, overall and for most insurance and income groups.
- Data from the Commonwealth Fund Biennial Health Insurance Survey indicate that cost-related problems getting needed care fell from 2012 to 2014 among adults.[41]
- Another Care Affordability measure, people without a usual source of care who indicate a financial or insurance reason for not having a source of care, also worsened from 2002 to 2010 and then leveled off.
- There are few measures to assess trends in Care Affordability.

Disparities

- In all years, the percentage of people unable to get or delayed in getting needed medical care, dental care, or prescription medicines who indicated a financial or insurance reason for the problem was:

[41] Collins SR, Rasmussen PW, Doty MM, et al. The Rise in Health Care Coverage and Affordability Since Health Reform Took Effect: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2014. http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/jan/1800_collins_biennial_survey_brief.pdf?la=en

- Higher among uninsured people and people with public insurance compared with people with any private insurance.
- Higher among poor, low-income, and middle-income families compared with high-income families.

CONCLUSION

The 2014 Quality and Disparities Reports demonstrate that access to care improved. After years of stagnation, rates of un-insurance among adults decreased in the first half of 2014 as a result of Affordable Care Act insurance expansion. However, disparities in access to care, while diminishing, remained.

Quality of healthcare continued to improve, although wide variation across populations and parts of the country remained. Among the NQS priorities, measures of Person-Centered Care improved broadly. Most measures of Patient Safety, Effective Treatment, and Healthy Living also improved, but some measures of chronic disease management and cancer screening lagged behind and may benefit from additional attention. Data to assess Care Coordination and Affordable Care were limited and measurement of these priorities should be expanded.

Appendix D – Illustrative Schedule h (Form 990) Part V B Potential Response

Illustrative IRS Schedule h Part V Section B (Form 990)[42]

Community Health Need Assessment Illustrative Answers

1. **Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year?**

   No

2. **Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C**

   No

3. **During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12. If "Yes," indicate what the CHNA report describes (check all that apply)**

   a. **A definition of the community served by the hospital facility**

      See footnotes 17 and 19 on page 12

   b. **Demographics of the community**

      See footnote 20 on page 13

   c. **Existing health care facilities and resources within the community that are available to respond to the health needs of the community**

      See footnote 26 on page 33 and footnote 27 on page 35

   d. **How data was obtained**

      See footnote 11 on page 8

   e. **The significant health needs of the community**

      See footnote 25 on page 32

   f. **Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups**

      See footnote 12 on page 9

   g. **The process for identifying and prioritizing community health needs and services to meet the community health needs**

      See footnote 35 on page 59

   h. **The process for consulting with persons representing the community's interests**

      See footnotes 8 and 9 on page 7

[42] Questions are drawn from 2014 Federal 990 schedule h.pdf and may change when the hospital is to make its 990 h filing

i. **Information gaps that limit the hospital facility's ability to assess the community's health needs**

See footnote 10 on page 8, footnotes 13 and 14 on page 9, and footnote 23 on page 18

j. **Other (describe in Section C)**

N/A

4. **Indicate the tax year the hospital facility last conducted a CHNA: 20__**

2014

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

Yes; see footnote 15 on page 9 and footnote 34 on page 48

6. **a. Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C**

No

b. Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C

Yes; see footnote 4 on page 4 and footnote 7 on page 7

7. **Did the hospital facility make its CHNA report widely available to the public?**

Yes

If "Yes," indicate how the CHNA report was made widely available (check all that apply):

a. **Hospital facility's website (list URL)**

https://www.mcmccares.com/

http://www.mcmccares.com/docs/2014_MCMC_CHNP.pdf

b. **Other website (list URL)**

No other website

c. **Made a paper copy available for public inspection without charge at the hospital facility**

Yes

d. **Other (describe in Section C)**

No other effort

8. **Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11**

See footnotes 32 and 33 on page 46

9. **Indicate the tax year the hospital facility last adopted an implementation strategy: 20__**

   2014

10. **Is the hospital facility's most recently adopted implementation strategy posted on a website?**

    a. **If "Yes," (list url):**

       Yes; http://www.mcmccares.com/docs/2014_community_health_plan.pdf

    b. **If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?**

11. **Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed**

    See footnote 26 on page 33

12. **a. Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r) (3)?**

    None incurred

    b. If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?

    Nothing to report

    c. If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form4720 for all of its hospital facilities?

    Nothing to report