Lawrence County Memorial Hospital

Lawrenceville, Illinois

Community Health Needs Assessment
and Implementation Strategy

Adopted by Board Resolution November 1, 2016[1]

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

Dear Community Member:

At Lawrence County Memorial Hospital (LCMH), we have spent more than 65 years providing high-quality compassionate healthcare to the greater Lawrenceville community. The "2016 Community Health Needs Assessment" identifies local health and medical needs and provides a plan of how LCMH will respond to such needs. This document suggests areas where other local organizations and agencies might work with us to achieve desired improvements and 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 now 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.

LCMH 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.

The 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 together. Together, we can make our community healthier for every one of us.

Thank You,

Doug Florkowski
Lawrence County Memorial Hospital

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EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

Lawrence County Memorial Hospital ("LCMH" 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 Lawrence County are:

1. Mental Health/Suicide/Substance Abuse
2. Coronary Heart Disease
3. Cancer
4. Obesity/Overweight
5. Stroke

The Hospital has developed implementation strategies for four of the five needs (Mental Health/Suicide/Substance Abuse, Coronary Heart Disease, Cancer, and Stroke) including activities to continue/pursue, community partners to work alongside, and leading and lagging indicators to track.

APPROACH

Approach

Lawrence County Memorial Hospital 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 assures LCMH identifies and responds 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

LCMH 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 to the less fortunate 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 is required to conduct a CHNA at least once every three taxable years and to adopt an implementation strategy to meet the community needs identified through such 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

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[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 QHR 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 Lawrence compared to all State counties	May 17, 2016	2012
www.cdc.gov/communityhealth	Assessment of health needs of Lawrence compared to its national set of "peer counties"	May 17, 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	May 17, 2016	2016
www.capc.org and www.getpalliativecare.org	To identify the availability of Palliative Care programs and services in the area	May 17, 2016	2015
www.caringinfo.org and iweb.nhpco.org	To identify the availability of hospice programs in the county	May 17, 2016	2015
www.healthmetricsandevaluation.org	To examine the prevalence of diabetic conditions and change in life expectancy	May 17, 2016	2010
www.cdc.gov	To examine area trends for heart disease and stroke	May 17, 2016	2010

[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

Website or Data Source	Data Element	Date Accessed	Data Date
http://svi.cdc.gov	To identify the Social Vulnerability Index value	May 17, 2016	2010
www.CHNA.org	To identify potential needs from a variety of resources and health need metrics	May 17, 2016	2015
www.datawarehouse.hrsa.gov	To identify applicable manpower shortage designations	May 17, 2016	2015
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	May 17, 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 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 19 Local Expert Advisors. Survey responses started March 23, 2016 and ended with the last response on April 1, 2016. All written comments are presented verbatim in the Appendix to this report.
- Information analysis augmented by local opinions showed how Lawrence 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
  - Local population is majority low-income and lacks access to preventative care
  - Transportation is needed for residents of rural areas
  - Mental health, substance abuse, and suicide are major issues in the community

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 13 Local Experts occurred again via an internet-based survey (explained below) beginning May 31, 2016 and ending June 8, 2016.

[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

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]

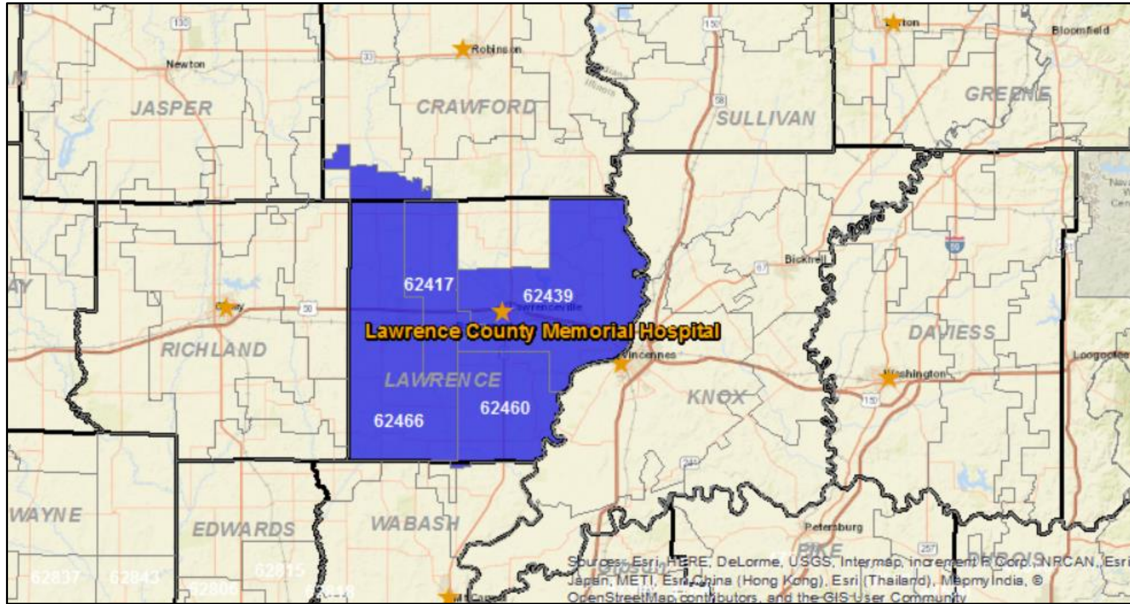
In the LCMH process, each Local Expert had the opportunity to introduce needs previously unidentified and to challenge conclusions developed from the data analysis. While there were a few opinions of the data conclusions not being completely accurate, the vast majority of comments agreed with our findings. 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 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 LCMH executive team where a reasonable break point in rank order occurred.[16]

[15] Response to Schedule h (Form 990) Part V B 5
[16] Response to Schedule h (Form 990) Part V B 3 g

COMMUNITY CHARACTERISTICS

Definition of Area Served by the Hospital[17]



LCMH, in conjunction with Quorum, defines its service area as Lawrence County in Illinois, which includes the following ZIP codes:[18]

62417 – Bridgeport 62439 – Lawrenceville

62460 – Saint Francisville 62466 – Sumner

In 2014, the Hospital received 88.4% of its patients from this area.[19]

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[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

Demographic of the Community[20] [21]

	County	State	U.S.
2016 Population[22]	**15,914**	**12,885,829**	**322,431,073**
% Increase/Decline	**-1.9%**	**0.4%**	**3.7%**
Estimated Population in 2021	**15,606**	**12,941,338**	**334,341,965**
% White, non-Hispanic	**84.3%**	**61.8%**	**61.3%**
% Black, non-Hispanic	**10.1%**	**14.0%**	**12.3%**
Median Age	**40.6**	**37.8**	**38.0**
Median Household Income	**$42,495**	**$59,102**	**$55,072**
Unemployment Rate	**9.0%**	**5.0%**	**4.9%**
% Population >65	**16.9%**	**14.5%**	**15.1%**
% Women of Childbearing Age	**14.5%**	**20.0%**	**19.6%**

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

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA
2010 Total Population	16,348	308,745,538
2016 Total Population	15,914	322,431,073
2021 Total Population	15,606	334,341,965
% Change 2016 - 2021	-1.9%	3.7%
Average Household Income	$56,924	$77,135

	2016	2021	% Change
Total Male Population	9,017	8,867	-1.7%
Total Female Population	6,897	6,739	-2.3%
Females, Child Bearing Age (15-44)	2,310	2,243	-2.9%

POPULATION DISTRIBUTION

	Age Distribution				
Age Group	2016	% of Total	2021	% of Total	USA 2016 % of Total
0-14	2,472	15.5%	2,337	15.0%	19.0%
15-17	543	3.4%	552	3.5%	4.0%
18-24	1,596	10.0%	1,635	10.5%	9.8%
25-34	2,337	14.7%	2,274	14.6%	13.3%
35-54	4,311	27.1%	3,999	25.6%	26.0%
55-64	1,972	12.4%	1,883	12.1%	12.8%
65+	2,683	16.9%	2,926	18.7%	15.1%
Total	**15,914**	**100.0%**	**15,606**	**100.0%**	**100.0%**

HOUSEHOLD INCOME DISTRIBUTION

	Income Distribution		
2016 Household Income	HH Count	% of Total	USA % of Total
<$15K	701	12.3%	12.3%
$15-25K	800	14.0%	10.4%
$25-50K	1,818	31.8%	23.4%
$50-75K	1,051	18.4%	17.6%
$75-100K	630	11.0%	12.0%
Over $100K	710	12.4%	24.3%
Total	**5,710**	**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	630	5.6%	5.8%
Some High School	2,017	17.8%	7.8%
High School Degree	3,852	34.1%	27.9%
Some College/Assoc. Degree	3,846	34.0%	29.2%
Bachelor's Degree or Greater	958	8.5%	29.4%
Total	**11,303**	**100.0%**	**100.0%**

RACE/ETHNICITY

	Race/Ethnicity Distribution		
Race/Ethnicity	2016 Pop	% of Total	USA % of Total
White Non-Hispanic	13,421	84.3%	61.3%
Black Non-Hispanic	1,609	10.1%	12.3%
Hispanic	630	4.0%	17.8%
Asian & Pacific Is. Non-Hispanic	55	0.3%	5.4%
All Others	199	1.3%	3.1%
Total	**15,914**	**100.0%**	**100.0%**

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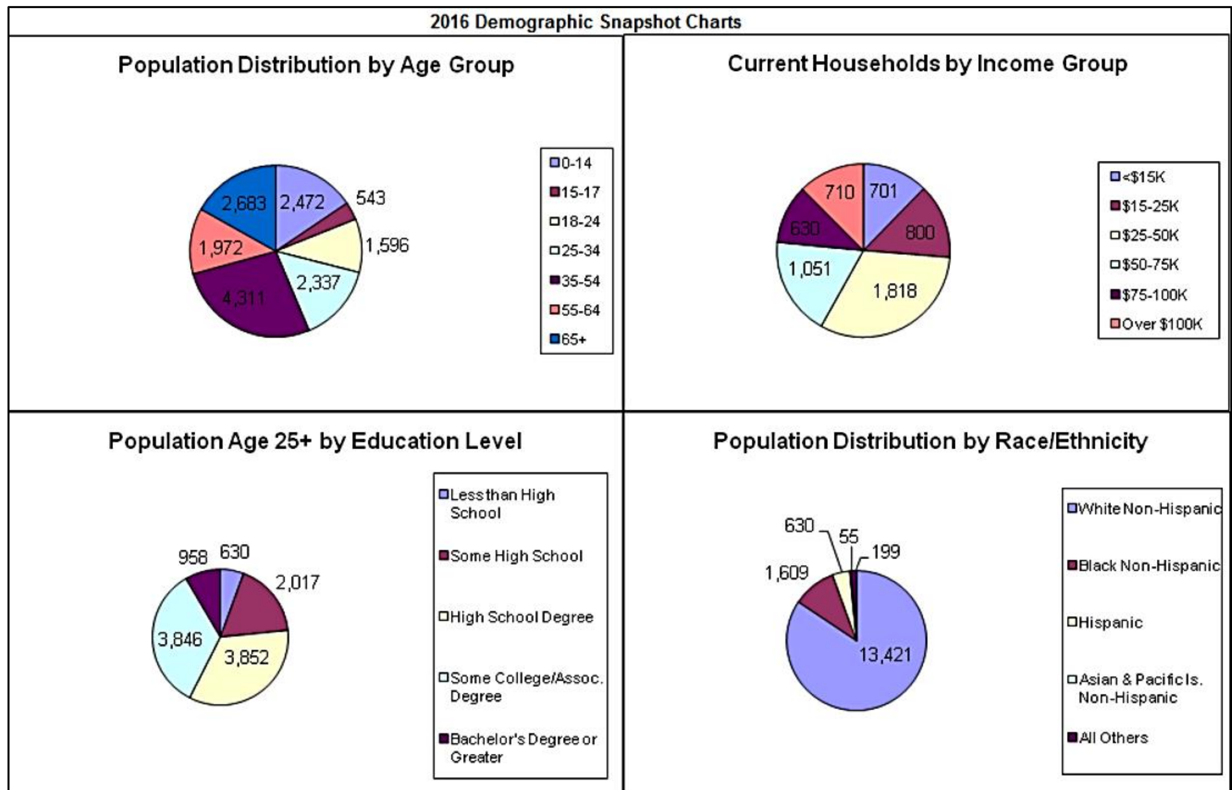
[20] Responds to IRS Schedule h (Form 990) Part V B 3 b
[21] The tables below were created by Truven Market Planner, a national marketing company
[22] All population information, unless otherwise cited, sourced from Truven (formally Thomson) Market Planner



2016 Benchmarks
Area: Lawrence County
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
Illinois	0.4%	37.8	14.5%	14.8%	20.0%	-1.6%	$59,102	$64,019	$186,693
Selected Area	-1.9%	40.6	16.9%	9.1%	14.5%	-2.9%	$42,495	$57,542	$67,525

Demographics Expert 2.7
DEMO0003.SQP
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Customer Segmentation

The population was also examined according to characteristics presented in the Claritas Prizm customer segmentation data. This system segments the population into 66 demographically and behaviorally distinct groups. Each group, based on annual survey data, is documented as exhibiting specific health behaviors. The top three segments in Lawrence County are:

Claritas Prizm Segments	Characteristics
Segment #1 (29%)	America was once a land of small middle-class towns, which can still be found today among Segment #1. This widespread segment consists of older couples with white-collar jobs living in sturdy, unpretentious homes. In these communities of small families and empty-nesting couples, residents pursue a rustic lifestyle where hunting and fishing remain prime leisure activities along with cooking, sewing, camping, and boating.
Segment #2 (17%)	With a population of white-collar couples and families, Segment #2 is a classic rural lifestyle. Residents are high school-educated, with lower incomes and modest housing; one-fifth live in mobile homes. And there's an air of self-reliance in these households as residents help put food on the table through fishing, gardening, and hunting.
Segment #3 (14%)	Segment #3 is mostly a retirement lifestyle, dominated by singles and couples over 65 years old. Found in small bucolic towns around the country, these high school-educated seniors live in small apartments on less than $35,000 a year; more than one in five reside in a nursing home. For these elderly residents, daily life is often a succession of sedentary activities such as reading, watching TV, playing bingo, and doing craft projects.

The makeup of the service area, according to the mix of Prizm segments and its characteristics, is contrasted to the national population averages to determine probable lifestyle and medical conditions present in the population. The national average, or norm, is represented as 100%. Where Lawrence County varies more than 5% above or below that norm (that is, less than 95% or greater than 105%), it is considered significant.

Items in the table below with red text are viewed as statistically important adverse potential findings—in other words, these are health areas that need improvement in the Lawrence County area. Items with blue text are viewed as statistically important, potentially beneficial findings—in other words, these are areas in which Lawrence County is doing better than other parts of the country. Items with black text are viewed as either not statistically different from the national norm or neither a favorable nor unfavorable finding—in other words more or less on par with national trends.

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	106.6%	31.8%	Mammography in Past Yr	98.2%	44.7%
Vigorous Exercise	96.1%	54.1%	Cancer Screen: Colorectal 2 yr	96.6%	24.6%
Chronic Diabetes	128.2%	15.5%	Cancer Screen: Pap/Cerv Test 2 yr	85.9%	51.6%
Healthy Eating Habits	90.2%	26.7%	Routine Screen: Prostate 2 yr	93.0%	29.8%
Ate Breakfast Yesterday	107.6%	64.6%	**Orthopedic**		
Slept Less Than 6 Hours	103.1%	17.7%	Chronic Lower Back Pain	125.6%	29.4%
Consumed Alcohol in the Past 30 Days	81.9%	45.0%	Chronic Osteoporosis	127.5%	12.5%
Consumed 3+ Drinks Per Session	114.3%	30.7%	**Routine Services**		
Behavior			FP/GP: 1+ Visit	103.0%	90.9%
I Will Travel to Obtain Medical Care	94.9%	22.7%	Used Midlevel in last 6 Months	108.6%	45.0%
I am Responsible for My Health	91.3%	59.7%	OB/Gyn 1+ Visit	84.1%	38.9%
I Follow Treatment Recommendations	95.2%	49.5%	Medication: Received Prescription	102.0%	54.8%
Pulmonary			**Internet Usage**		
Chronic COPD	123.5%	4.9%	Use Internet to Talk to MD	66.3%	8.4%
Tobacco Use: Cigarettes	116.3%	29.7%	Facebook Opinions	74.3%	7.6%
Heart			Looked for Provider Rating	84.8%	12.1%
Chronic High Cholesterol	114.7%	25.2%	**Emergency Service**		
Routine Cholesterol Screening	90.8%	46.2%	Emergency Room Use	106.2%	36.0%
Chronic Heart Failure	150.4%	6.9%	Urgent Care Use	95.4%	22.3%

Leading Causes of Death

Cause of Death			Rank among all counties in IL (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation (Compared to U.S. average)
Lawrence Rank	IL Rank	Condition		IL	Lawrence	
1	1	Heart Disease	57 of 102	169.7	210.8	As expected
2	2	Cancer	62 of 102	168.9	188.5	As expected
3	4	Stroke	9 of 102	37.4	66.3	Higher than expected
4	5	Accidents	7 of 102	34.4	58.6	Higher than expected
5	3	Lung	20 of 102	39.3	56.7	Higher than expected
6	6	Alzheimer's	3 of 102	21.9	47.4	Higher than expected
7	9	Flu - Pneumonia	20 of 102	16.8	26.0	Higher than expected
8	8	Kidney	23 of 102	17.2	21.7	Higher than expected
9	7	Diabetes	12 of 102	28.7	18.7	As expected
10	10	Blood Poisoning	25 of 102	12.4	14.5	Higher than expected
11	11	Suicide	38 of 102	10.5	12.0	As expected
12	14	Hypertension	9 of 102	7.0	11.0	Higher than expected
13	13	Parkinson's	35 of 102	7.9	7.4	Higher than expected
14	12	Liver	60 of 102	9.2	7.4	Lower than expected
15	15	Homicide	93 of 102	6.3	0.8	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 above 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]

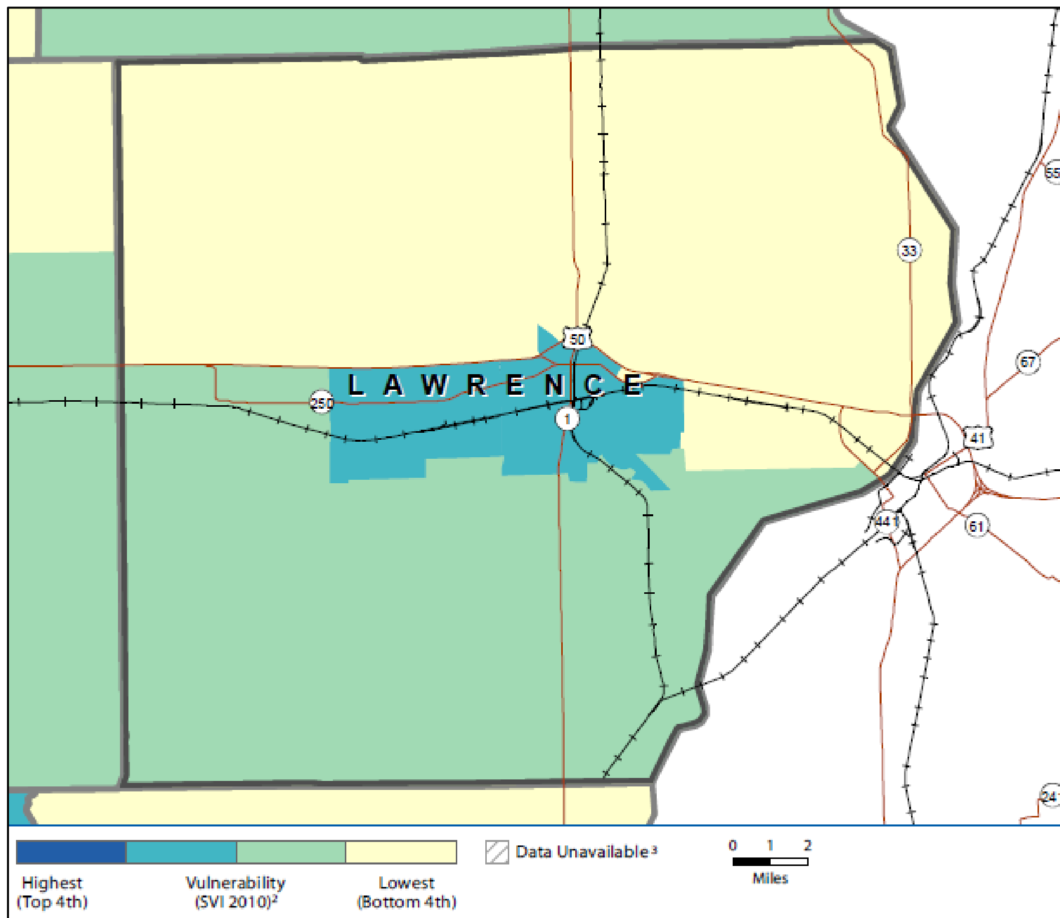
- Local population is majority low-income and lacks access to preventative care
- Transportation is needed for residents of rural areas
- Mental health, substance abuse, and suicide are major issues in the community

[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.

Lawrence County zip codes primarily fall into the lowest two quartiles of social vulnerability. However, the central portion falls into the second highest quartile.



Consideration of Written Comments from Prior CHNA

A group of 19 individuals provided written comment in regard to the 2013 CHNA. Our summary of this commentary produced the following points, which were introduced in subsequent considerations of this CHNA.

Commenter characteristics:

Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	3	14	17
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	8	9	17
3) Priority Populations	8	10	18
4) Representative/Member of Chronic Disease Group or Organization	1	16	17
5) Represents the Broad Interest of the Community	15	3	18
Other			
Answered Question			19
Skipped Question			0

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

- Obesity/Overweight
- Cancer
- Mental Health/Suicide/Substance Abuse
- Coronary Heart Disease
- Smoking/Tobacco Use
- Affordability
- Stroke
- Compliance Behavior/Predisposing Conditions
- Dental
- Chronic COPD/Lung Disease/Pulmonary
- Diabetes

LCMH received the following *verbatim* responses to the question: **"Comments or observations about this set of needs as being the most appropriate for the Hospital to take on in seeking improvements?"**

- **Should the Hospital continue to consider each need identified as most important in the 2013 CHNA report as the most important set of health needs currently confronting residents in the county?**

	Yes	No	No Opinion
Obesity/Overweight	14	2	0
Cancer	16	0	0
Mental Health/Suicide/Substance Abuse	14	2	0
Coronary Heart Disease	15	1	0
Smoking/Tobacco Use	8	8	0
Affordability	13	3	0
Stroke	14	2	0
Compliance Behavior/Predisposing Conditions	13	2	1
Dental	11	4	1
Chronic COPD/Lung Disease/Pulmonary	14	2	0
Diabetes	15	1	0

- **Specific comments or observations about <u>Obesity/Overweight</u> as being among the most significant needs for the Hospital to work on to seek improvements?**
  - *Lack of low cost physical fitness facilities. Lack of access to low cost fruits, vegetables, and other healthy foods. Lack of dietitians that can inform students at the school about how to prevent being overweight.*
  - *No comment.*
  - *INFORMATION*
  - *Obesity remains a major concern and should continue to be addressed. Maybe hospital personnel could help with schools to educate students the importance of a healthy diet and exercise.*
  - *Although it is a nationwide problem that does cause other health issues, and I agree that it should be a priority. I think a shift is in order maybe leaning more towards Mental Health, Cancer, Heart disease.*
  - *If a persons overall weight is in line then this will eliminate some overall risk and cost for all.*
- **Specific comments or observations about <u>Cancer</u> as being among the most significant needs for the Hospital to work on to seek improvements?**
  - *High rate of cancer in our area. No specialized doctors in the community that focus on cancer patients. Lack of preventative screenings.*
  - *YES*
  - *Cancer remains high -*
  - *As the scope and ongoing research continues to broaden ion this deadly disease, it is the role of the Hospital to be a voice for knowledge, treatment, and continuing information about ongoing advancements in the treatment of this disease. Letting the general public be aware that it is not necessarily a death sentence.*

  - *For this area we are all touched by cancer in our families*
- **Specific comments or observations about <u>Mental Health/Suicide/Substance Abuse</u> as being among the most significant needs for the Hospital to work on to seek improvements?**
  - *Limited physicians that focus on mental health needs. Limited mental health resources from the hospital.*
  - *This may be an issue in our community, but I see the health dept. as more responsible to address these issues. the hospital no longer has a mental health department.*
  - *With state cutbacks effecting almost every Mental Health facility, Mental Health is becoming a serious problem. Lack of trained professionals to deal with Mental Health, as well as facilities that provide counseling and continued support for the individual.This issue will only get worse with a potential of serious consequences.*
  - *Substance abuse is a major problem in this area. Families are being destroyed and children's lives are being adversely effected by their parents substance abuse. This is creating a pattern of substance abuse that continues for generations.*
- **Specific comments or observations about <u>Coronary Heart Disease</u> as being among the most significant needs for the Hospital to work on to seek improvements?**
  - *No local physicians that focus on heart disease or education on how to prevent heart disease.*
  - *YESYES*
  - *Heart disease is #1 cause of death in our community but more resources and attention is made to cancer.*
  - *As one of the leading causes of death in the Midwest, Heart Disease must have a multi faceted prevention approach. Education about causes, leading the way on technology , and be a leader in the community on awareness, and heart healthy choices.*
- **Specific comments or observations about <u>Smoking/Tobacco Use</u> as being among the most significant needs for the Hospital to work on to seek improvements?**
  - *High prevalence of asthma that may be due to second hand smoke.*
  - *I don't think this needs to be as high priority as other things on the list. There has been much media coverage of this for years, and now that most places are smoke-free, the message is not easily overlooked.*
  - *NONE*
  - *Smoking is high but do not see where hospital would take an active role in reducing the number of smokers*
  - *Even with the implementation of no smoking policies in almost every venue, this has truly not slowed down tobacco use. I feel that a more aggressive approach starting at the schools and continuing with hard hitting facts on just what the long term hazards are of tobacco use*

- **Specific comments or observations about <u>Affordability</u> as being among the most significant needs for the Hospital to work on to seek improvements?**
  - *Lack of job opportunities in the area, we are a high poverty area.*
  - *Af*
  - *NONE*
  - *prices in all hospitals are extremely high which makes it difficult for the poor to access care*
  - *With the implementation of our nationwide health insurance program (Obamacare) people are now more confused than ever in regards to their health coverage. More people are putting off medical needs because they cannot afford to have them done. A short stay in the hospital can cost a person hundreds maybe thousands of dollars depending on what the issue was. Hospitals are caught between the patient, drug, and insurance companies. This along with the rising cost of medical equipment needed to operate their facilities it is a major problem*
  - *Annual cost for check-up and older patients would be best to keep to a minimal cost to find issues sooner better than later*
- **Specific comments or observations about <u>Stroke</u> as being among the most significant needs for the Hospital to work on to seek improvements?**
  - *Limited education on how to prevent strokes.*
  - *I think this item, as well as coronary heart disease, should be high priority.*
  - *NONE*
  - *stroke remains a concern*
  - *Strokes are becoming more and more common today. I feel it is a combination of stress and trying to make ends meet along with high blood pressure are major factors. It is a fast pace world for those trying to succeed, not eating right, excessive drinking, smoking, sleep deprivation, all play roles in causing strokes. This is a society driven issue that I am not sure has a solution*
- **Specific comments or observations about <u>Compliance Behavior/Predisposing Conditions</u> as being among the most significant needs for the Hospital to work on to seek improvements?**
  - *School related issues - Low compliance with Vision and Hearing. Abuse of community members over using the Emergency Room.*
  - *Although this is important because other items on the list are directly related to this, this is a difficult area in which to show improvement, given the level of education of area residents, and a general unwillingness to change risky life styles.*
  - *NONE*
  - *compliance is a challenge among our population of poor uneducated people*
  - *With HIPPA and all the other agencies that oversee general healthcare hospitals must be the leader in identifying issues, correcting them, and plans for continued improvement. As issues arise they need to be*

dealt with in a timely manner and staff training be a key component in the correction program.

- **Specific comments or observations about <u>Dental</u> as being among the most significant needs for the Hospital to work on to seek improvements?**
  - *None of the local dentists accept public aide.*
  - *I don't consider this as critical as others on the list.*
  - *NONE*
  - *being in a poor community people are unable to access dental care. dentist is very expensive*
  - *Dental care is probably one of the most neglected thing people do today. Not realizing how the mouth affects your overall health does not seem to be a concern. However it comes back to low income area, dentists not taking medi cards and other factors. With increased forms of drug addiction dental becomes a major factor to the person*
  - *One visit a year would help greatly, and keeping this in front of the community as a priority*
- **Specific comments or observations about <u>Chronic COPD/Lung Disease/Pulmonary</u> as being among the most significant needs for the Hospital to work on to seek improvements?**
  - *NONE*
  - *COPD goes along with high smoking rates*
  - *COPD, linked to smoking is another rapidly growing issue. It is hard for small hospitals to provide the necessay needs for someone with COPD. Again educating at an early age the causes of COPD, programs in place to try and deter are possibles*
- **Specific comments or observations about <u>Diabetes</u> as being among the most significant needs for the Hospital to work on to seek improvements?**
  - *Increase amount of Type I and Type II diabetes.*
  - *NONE*
  - *Diabetes is connected to high obesity rates*
  - *Eating right, staying on a regimented plan, identifying factors at the on set are key in the fight against diabetes. Diabetes can lead to more serious health issue, loss of sight, amputations, and more. Doing educational strong fact based education again at an early age might offset early diabetes*
  - *Diet awareness and overall affects of sugar is needed*

Conclusions from Public Input

Our group of 19 Local Expert Advisors participated in an online survey to offer opinions about their perceptions of community health needs and the potential needs of unique populations. Complete *verbatim* written comments appear in the Appendix to this report.

LCMH received the following responses to the question: **"Should the Hospital continue to consider each need identified as most important in the 2013 CHNA report as the most important set of health needs currently confronting residents in the county? Please add any additional information you would like us to understand."**

- *Perhaps the local medical community/hospital could sponsor more educational programs aimed at encouraging citizens to engage in healthier life styles and prevention of some of the above illnesses.*
- *heart disease is #1 cause of death. If we could improve obesity rate alone this would improve heart disease and diabetes rates. and reduce # of smokers would help heart disease, COPD, stroke, cancer. Probably need to add substance abuse to this years list. Heroin and Meth are heavy*

Summary of Observations: Comparison to Other Counties

Health Outcomes

In a health status classification termed "Health Outcomes," Lawrence ranks 59 among the 102 ranked Illinois counties (best being #1). Premature Death (deaths prior to age 75) presents worse values (shorter survivability) than the average for the US and Illinois.

Health Factors

In another health status classification "Health Factors," Lawrence ranks number 92 among the 102 ranked Illinois counties. The following indicators compared to IL average and to national top 10% performance present such poor values it warrants investigating how to improve:

- Adult Obesity – Lawrence 32% of residents compared to IL 27% and US best of 25%
- Physical Inactivity – Lawrence 26% of residents compared to IL 22% and US best of 20%
- Teen Births – Lawrence 43 births per 1,000 (age 15-19) compared to IL 33 and US best of 19
- Access to Exercise Opportunities – Lawrence 44% compared to IL 89% and US best of 91%

Clinical Care

In the "Clinical Care" classification, Lawrence County ranks 99 among the 102 ranked Illinois counties. The following indicators compared to IL average and to national top 10% performance present such poor values it warrants investigating how to improve:

- Preventable Hospital Stays – Lawrence 93 compared to IL 59 and US best of 38
- Diabetic Monitoring – Lawrence 64% compared to IL 86% and US best of 90%
- Mammography Screening – Lawrence 59% compared to IL 65% and US best of 71%
- Population to Primary Care Physician – Lawrence 4,140:1 compared to IL 1,240:1 and US best of 1,040:1
- Population to Dentist – Lawrence 8,260:1 compared to IL 1,410:1 and US best of 1,340:1

Social and Economic Factors

In the "Social and Economic Factors" classification, Lawrence ranks number 91 among the 102 ranked Illinois counties. The following indicators compared to IL average and to national top 10% performance present such poor values it warrants investigating how to improve:

- Children in Poverty – Lawrence 24% of children compared to IL 20% and US best of 13%
- Unemployment – Lawrence 7.6% compared to IL 7.1% and US best of 3.5%
- Children in Single-Parent Households – Lawrence 35% of children compared to IL 32% and US best of 21%
- Injury Deaths – Lawrence 80 deaths per 100,000 compared to IL 50 and US best of 51
- High School Graduation – Lawrence 76% compared to IL 83% and US best of 93%
- Some College – Lawrence 43% compared to IL 67% and US best of 72%

Summary of Observations: Peer Comparisons

The Federal Government administers a process to allocate all counties into "Peer" groups. County "Peer" groups have similar social, economic, and demographic characteristics. Health and wellness observations when Lawrence County is compared to its national set of Peer Counties and compared to national rates result in the following:

Mortality

- *Better*
  - Motor Vehicle Deaths
- *Worse*
  - Female Life Expectancy - 78.6 years; 9th worst among 37 peer counties; US avg. 79.8
  - Chronic Lower Respiratory Disease Deaths (CLRD) - 67.6 deaths per 100,000; worst among 37 peer counties; US avg. 49.6
  - Diabetes Deaths - 33.8 deaths per 100,000; 5th worst among 28 peer counties; US avg. 24.7
  - Male Life Expectancy - 73.4 years; 9th worst among 37 peer counties; US avg. 75.0
  - Alzheimer's Disease Deaths - 54.4 deaths per 100,000; worst among 28 peer counties; US avg. 27.3

Morbidity

- *Better*
  - Adult Diabetes; Cancer; Older Adult Asthma
- *Worse*
  - Syphilis - 11.9 rate per 100,000; 2nd worst among 37 peer counties; US avg. 0.0
  - Gonorrhea - 41.8 rate per 100,000; 7th worst among 37 peer counties; US avg. 30.5
  - Preterm Births - 15.9% of births; 2nd worst among 37 peer counties; US avg. 12.1%

Healthcare Access and Quality

- *Better*
  - Uninsured
- *Worse*
  - Older Adult Preventable Hospitalizations - 135.4 per 100,000; 4th worst among 37 peer counties US avg. 71.3

Health Behaviors

- *Better*
  - Nothing
- *Worse*
  - Nothing

Social Factors

- *Better*
  - Nothing
- *Worse*
  - Children in Single-Parent Households - 34.3% of children; 7th worst among 37 peer counties; US avg. 30.8%
  - On Time High School Graduation - 80.4% of 9th grade cohort; 4th worst among 33 peer counties; US avg. 83.8%

Conclusions from Demographic Analysis Compared to National Averages

According to 2016 Truven Health Analytics data, the current population for Lawrence County is estimated to be 15,914 and expected to decrease at a rate of -1.9% through 2021. This is lower than Illinois' 0.4% growth rate and the national average of 3.7%. In 2021, Lawrence County anticipates a population of 15,606.

Population estimates indicate the 2016 median age for the county is 40.6 years, older than the Illinois average (37.8 years) and the national median age of 38.0. The 2016 Median Household Income for the area is $42,495, lower than the Illinois median income of $59,102 and the national median income of $55,072. Median Household Wealth value is lower than the Illinois value, but higher than the national average. Median Home Value ($67,525) for Lawrence is significantly lower than the Illinois median of $186,693 and the national median of $192,364. Lawrence's unemployment rate as of March 2016 is 9.0%, which is higher than the 5.0% statewide and the 4.9% national civilian unemployment rate.

The portion of the population in the county over 65 is 16.9%, compared to Illinois (14.5%) and the national average (15.1%). The portion of the population of women of childbearing age is 14.5%, lower than the Illinois average of 20.0% and the national rate of 19.6%. 84.3% of the population is White non-Hispanic. The largest minority is the Black non-Hispanic population which comprises 10.1% of the total.

The following areas were identified from a comparison of the county to national averages. Metrics impacting more than 30% of the population and statistically significantly different from the national average include the following. All are considered adverse:

- **BMI: Morbid/Obese** is 6.6% above average, impacting 31.8% of the population
- **Consumed 3+ Drinks per Session** is 14.3% above average, impacting 30.7% of the population
- **I Am Responsible for My Health** is 8.7% below average, impacting 59.7% of the population
- **Routine Cholesterol Screening** is 9.2% below average, impacting 46.2% of the population
- **Cervical Cancer Screening** in past two years is 14.1% below average, impacting 51.6% of the population
- **OB/GYN Visit** is 15.9% below average, impacting 38.9% of the population
- **Emergency Room Use** is 6.2% above average, impacting 36.0% of the population

Metrics impacting more than 30% of the population and statistically significantly different from the national average include the following. All are considered beneficial:

- **Ate Breakfast Yesterday** is 7.6% above average, impacting 64.6% of the population
- **Consumed Alcohol in the Past 30 Days** is 18.1% below average, impacting 45.0% of the population
- **Used Midlevel Services in the Last 6 Months** is 8.8% above average, impacting 45.0% of the population

Conclusions from Other Statistical Data

Among the Top 15 Causes of Death in the U.S., 4 of the 15 occurred at expected rates in Lawrence County. **Stroke, Accidents, Lung Disease, Alzheimer's, Flu/Pneumonia, Kidney Disease, Blood Poisoning, Parkinson's** and **Hypertension** occurred at higher rates than expected. **Liver Disease** and **Homicide** occurred at lower rates than expected. The Top 10 Causes of Death in Lawrence County are:

1. **Heart Disease** with Lawrence ranking #57 among 102 IL counties (where #1 is worst in state)
2. **Cancer** ranking #62 in IL
3. **Stroke** ranking #9 in IL
4. **Accidents** ranking #7 in IL
5. **Lung Disease** ranking #20 in IL
6. **Alzheimer's** ranking #3 in IL
7. **Flu/Pneumonia** ranking #20 in IL
8. **Kidney Disease** ranking #23 in IL
9. **Diabetes** ranking #12 in IL
10. **Blood Poisoning** ranking #25 in IL

The Institute for Health Metrics and Evaluation at the University of Washington analyzed all 3,143 US counties or equivalents applying small area estimation techniques to the most recent county information.

Unfavorable Lawrence County measures which are *worse than* the US average *and* had an *unfavorable change*:

- **Female Life Expectancy** – As of 2013, female life expectancy is at 77.5 years; value decreased 1.5 years since 1985
- **Male Smoking** – As of 2012, male smoking is at 32.2%; value increased 1.0 percentage point since 1996
- **Female Obesity** – As of 2011, 39.6% of females are obese; value increased 8.6 percentage points since 2001
- **Male Obesity** – As of 2011, 42.7% of males are obese; value increased 13.0 percentage points since 2001
- **Male Physical Activity** – As of 2011, physical activity for males is at 48.7%; value decreased 3.7 percentage points since 2001

Unfavorable Lawrence County measures which are *worse than* the US average *but* had a *favorable change*:

- **Male Life Expectancy** – As of 2013, male life expectancy is at 73.1 years; value increased 1.8 years since 1985

- **Female Smoking** – As of 2012, female smoking is at 24.1%; value decreased 2.4 percentage points since 1996
- **Female Physical Activity** – As of 2011, physical activity for females is at 45.6%; value increased 2.8 percentage points since 2001

Desirable Lawrence County measures *better than* the US average *but* had an *unfavorable change*:

- **Female Heavy Drinking** – As of 2012, 4.1% of females are heavy drinkers; value increased 1.0 percentage point since 2005
- **Female Binge Drinking** – As of 2012, 9.9% of females are binge drinkers; value increased 0.6 percentage points since 2002

Desirable Lawrence County measures *better than* the US average *and* had a *favorable change*:

- **Male Heavy Drinking** – As of 2012, 7.1% of males are heavy drinkers; value decreased 0.2 percentage points since 2005
- **Male Binge Drinking** – As of 2012, 21.2% of males are binge drinkers; value decreased 2.2 percentage points since 2002

Conclusions from Prior CHNA Implementation Activities

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:

- Net Community Benefit Expense = $1,133,664 (Financial Assistance and Means-Tested Government Programs)

Existing Healthcare Facilities, Resources, & 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 LCMH.[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 LCMH current efforts responding to the need including any written comments received regarding prior LCMH implementation actions
- Establishes the Implementation Strategy programs and resources LCMH will devote to attempt to achieve improvements
- Documents the Leading Indicators LCMH will use to measure progress
- Presents the Lagging Indicators LCMH 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, Lawrence County Memorial Hospital is the major hospital in the service area. LCMH is a 25-bed, critical access hospital located in Lawrenceville, Illinois. The next closest facilities are outside the service area and include:

- Good Samaritan Hospital in Vincennes, Indiana, 10 miles (16 minutes)
- Richland Memorial Hospital in Olney, Illinois, 21 miles (26 minutes)
- Wabash General Hospital in Mount Carmel, Illinois, 23 miles (29 minutes)
- Crawford Memorial Hospital in Robinson, Illinois, 24 miles (30 minutes)

The data that was analyzed to determine the significant needs are “Lagging Indicators,” or measures that present results after a period of time, showing historical performance. Lagging Indicators tell you nothing about how the outcomes were achieved. In contrast, the LCMH 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 Quorum 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. **MENTAL HEALTH/SUICIDE/SUBSTANCE ABUSE** – 2013 Significant Need; Local Expert concern; 'Consumed 3+ Drinks per Session' is 14.3% above average

Public comments received on previously adopted implementation strategy:

- *I don't think the hospital should be the only entity working on this problem. There should be cooperation among law enforcement agencies, schools, medical community and others to bring about public awareness of the problem.*
- *YES*
- *the hospital's key role would be to coordinate services with the health dept. by timely referrals and good communications between agencies. hospital typically see these patients in ED and then either transfer to another hospital or have health dept. follow as outpt.*
- *As a health care leader in the community, the hospital needs to be proactive in assisting other agencies and work side by side with them to get the needed programs started and make sure they continue.*

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

- Provide front-line staffing needs (primary care services/emergency department services) for initial treatment, identification, and referral to the appropriate mental health/substance abuse service
- Facility space provided bi-weekly to local substance abuse support groups
- Financial support provided to local law enforcement agencies (drug awareness programs) for the local school district
- Dine With a Doc education seminar on depression prevention/diagnosis/treatment for senior citizens

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

- Continue above actions
- Initiating steps to develop local substance abuse coalition (local schools/hospital/law enforcement/EMS/public health)
- Bringing in national substance abuse expert (awareness/treatment/education)
- Looking into developing detox beds
- Developing telepsych services
- Promote education/prevention opportunities through local media channels

[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

Anticipated results from LCMH 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 LCMH intended actions is to monitor change in the following Leading Indicator:

- Number of attendees at substance abuse awareness seminar (Currently = 0)

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

- Number of drug overdose deaths = 14.1 – 16.0 per 100,000 residents

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

Organization	Contact Name	Contact Information
Lawrence County Health Department	Sarah Fehrenbacher	(618) 943-3302; www.lchealth.com
Lawrenceville Unit 20 School District	Doug Daugherty	(618) 943-2326; sites.google.com/a/cusd20.net/cusd20
Red Hill Unit 10 School District	Jakee Walker	(618) 643-2328; www.unit10.com
Lawrence County Sherriff Department	Russell Adams	(618) 943-5766; www.usacops.com/il/s62439
Lawrence County Ambulance Service		(618) 943-3600
A Man in Recovery Foundation	Tim Ryan	www.amirf.org
Lawrence County AA		www.aasoutheasternillinois.org

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

Organization	Contact Name	Contact Information
Maple Street Clinic	Dr. Linda Hungerford	(618) 839-4618
Southeastern Illinois Counseling Center		www.seicc.org
Lawrence County Behavioral Health Center		(618) 943-3754
Harsha Behavioral Center		(812) 298-8888
Richland Memorial Hospital Psychiatric Unit		(618) 392-3302; www.richlandmemorial.com/ services/psychiatric.aspx
Good Samaritan Hospital Samaritan Center		(408) 559-2011 www.gshvin.org

[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. CORONARY HEART DISEASE – 2013 Significant Need; #1 leading cause of death

Public comments received on previously adopted implementation strategy:

- *Continue to emphasize healthy life styles, prevention, treatment etc. with public awareness campaigns.*
- *YES*
- *Education of public is only way hospital could help that I know of*
- *In this area with lower incomes, higher unemployment, taking care of people who are in these categories becomes hard. They will only come to the hospital when needed. Taking a strong stance on how to prevent heart disease, and working on less trips to emergency rooms for treatments are high goals to set. However unless information and programs are in place the problem will only increase.Even with the implementation of no smoking policies in almio*

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

- Visiting cardiology clinic in Lawrence Medical Center
- LCMH Primary Care Clinic Services
- LCMH Diagnostic Imaging
- LCMH Laboratory Services
- Stress Test Services
- Holter/Event Monitors
- LCMH Cardiac Rehab Program
- Promote Go Red For Women (national movement to end heart disease/stroke among women)
- Promote Heart Health Month
- Provide free cholesterol screenings at community events and health fairs
- Refer patients to health department smoking cessation program
- Dine With a Doc education seminar on heart disease prevention/diagnosis/treatment for senior citizens

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

- Continue above actions
- Increase cardiology coverage

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

- Hired a care coordinator who monitors high-risk patients and provides follow up-calls on discharge/education

Anticipated results from LCMH 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 LCMH intended actions is to monitor change in the following Leading Indicator:

- Number of Cardiac Rehab Department visits = 299 (2015)

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

- Coronary Heart Disease Deaths = 210.8/100,000 residents (IL = 169.7/100,000)

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

Organization	Contact Name	Contact Information
Good Samaritan Hospital Cardiology	Dr. Philip Bacidore	(812) 885-8020
Local Physician Clinics		

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

Organization	Contact Name	Contact Information
Other Local Physician Clinics		
American Heart Association		www.heart.org/HEARTORG
Lawrence County Health Department		(618) 943-3302; www.lchealth.com

3. CANCER – 2013 Significant Need; #2 leading cause of death; mammography screening below IL and US average; cervical cancer screening is 14.1% below average

Public comments received on previously adopted implementation strategy:

- *We have a local group that fundraises in order to help community members that have been diagnosed with cancer.*
- *YESYES*
- *Hospital has screenings for cancer. free mammograms are available. staff take part in local events such as cancer walks/runs etc.*
- *I feel the Hospital does a fine job in cancer awareness, and does their best to deal with patients in a manner they see to be the best outcome for them.*

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

- LCMH Diagnostic Imaging
- LCMH Laboratory Services
- LCMH screening colonoscopy
- Weekly visiting OB/GYN at clinic providing cervical cancer screenings
- LCMH Primary Care Services and surgical clinic providers address this need by education and medical services
- LCMH screening programs at various community events
- Participate in Relay for Life; promote breast cancer awareness month
- Utilize mobile mammography unit to provide on-site screening to local industries
- Provide educational materials regarding prevention/diagnosis/treatment
- Dine With a Doc education seminar on cancer prevention/diagnosis/treatment for senior citizens

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

- Continue above actions
- Researching stereotactic mobile services
- Continue to explore opportunities to deliver on-site clinical oncology services

Anticipated results from LCMH 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 LCMH intended actions is to monitor change in the following Leading Indicator:

- Number of total mammography screenings provided = 508 (2015)

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

- Cancer Death Rate = 188.5/100,000 residents (IL = 168.9/100,000)

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

Organization	Contact Name	Contact Information
Local Physicians		
Lawrence County Cancer Resource Center	Susan Gher	(618) 943-3302
American Cancer Society		www.cancer.org

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

Organization	Contact Name	Contact Information
Lawrenceville Veterans of Foreign War	Maurice Theriac	(618) 943-2244

4. **OBESITY/OVERWEIGHT** – 2013 Significant Need; adult obesity above IL and US average; BMI: Morbid/Obese is 6.6% above average; male and female obesity worse than US average

Public comments received on previously adopted implementation strategy:

- *No comment*
- *Perhaps hospital could partner with local restaurants, school cafeterias, etc. to provide education in nutrition and its impact on health.*
- *NONE*
- *In house the hospital has encouraged and supported its own employees to exercise by offering financial assistance with local fitness center. Hospital dietician educates patients about obesity.*
- *Continued information from the hospital about how important weight is in our everyday lives. How it affects the overall health of the community. Businesses have to look at potential employees as a risk, as well as repeated hospital visits for not following a regiment set out by doctors for them.Wellness clinics, health fairs, in school eat healthy plans are great ways to try and curb this issue*
- *Use a reasonable goal for weight and exercise*

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

- We are choosing not to respond to 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	
3. A relatively low priority assigned to the need	
4. A lack of identified effective interventions to address the need	**X**
5. Need is addressed by other facilities or organizations in the community	**X**
6. Other	

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

Organization	Contact Name	Contact Information
New Leaf Fitness Center		(618) 707-2400; newleaffitnessandspa.com

Organization	Contact Name	Contact Information
Ryan’s Total Fitness		(618) 943-4606
Vincennes YMCA		(812) 895-9622; www.vincennesymca.com
Anytime Fitness		(812) 882-6348
Local Public School Running Tracks		

5. STROKE – 2013 Significant Need; #3 leading cause of death

Public comments received on previously adopted implementation strategy:

- *Make use of opportunities to promote prevention and availability of medical care.*
- *NONE*
- *education is probably the only means of assistance -*
- *Education, health clinics specifically for Stroke prevention are starting points. Again possibly bringing in well known authorities to discus Stroke prevention. Rehab clinics for victims of Strokes that are affordable and accesible*

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

- Expanded rehabilitation services to treat stroke patients
- Dine With a Doc education seminar on stroke prevention/diagnosis/treatment for senior citizens
- Provide educational materials (prevention/identification)
- Board-certified neuro-radiologist reading CT Scans and implementing stat reads for stroke patients

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

- Continue above actions
- Expand telemedicine opportunities to monitor blood pressure/vital signs

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

- Designated as a Stroke Ready Hospital in 2014
- Added occupational therapy services in 2015
- Implemented 'Get with the Guidelines' stroke readiness protocol in Emergency Department
- Hired a care coordinator who monitors high-risk patients and provides follow-up calls on discharges/education

Anticipated results from LCMH 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

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
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 LCMH intended actions is to monitor change in the following Leading Indicator:

- Percentage of patients who came to ED with stroke symptoms who received CT results within 45 minutes of arrival = 5 (2015)

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

- Number of stroke deaths = 66.3/100,000 residents (IL = 34.4/100,000)

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

Organization	Contact Name	Contact Information
American Heart Association		www.heart.org/HEARTORG
Local Physician offices		
Clinical Radiologists	Dr. Charles Neal	(217) 788-3245

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

Organization	Contact Name	Contact Information
Deaconnes Health System		(812) 450-5000; www.deaconess.com

Other Needs Identified During CHNA Process

6. **COMPLIANCE BEHAVIOR/PREDISPOSING CONDITIONS** – 2013 Significant Need
7. **DIABETES** – 2013 Significant Need
8. **PHYSICAL INACTIVITY**
9. **AFFORDABILITY** – 2013 Significant Need
10. **SMOKING/TOBACCO USE** – 2013 Significant Need
11. **PHYSICIAN**
12. **FLU/PNEUMONIA**
13. **CHRONIC COPD/LUNG DISEASE/PULMONARY** – 2013 Significant Need
14. **KIDNEY DISEASE**
15. **ALZHEIMER'S**
16. **MATERNAL MEASURES**
17. **ACCIDENTS**
18. **LIFE EXPECTANCY**
19. **CHOLESTEROL**
20. **DENTAL** – 2013 Significant Need
21. **SEXUALLY TRANSMITTED INFECTION**
22. **BLOOD POISONING**
23. **EDUCATION/PREVENTION**

Overall Community Need Statement and Priority Ranking Score

Significant needs where hospital has implementation responsibility[28]

1. Mental Health/Suicide/Substance Abuse
2. Coronary Heart Disease
3. Cancer
5. Stroke

Significant needs where hospital did not develop implementation strategy[29]

4. Obesity/Overweight

Other needs where hospital developed implementation strategy

None

Other needs where hospital did not develop implementation strategy

6. Compliance Behavior/Predisposing Conditions
7. Diabetes
8. Physical Inactivity
9. Affordability
10. Smoking/Tobacco Use
11. Physician
12. Flu/Pneumonia
13. Chronic COPD/Lung Disease/Pulmonary
14. Kidney Disease
15. Alzheimer's
16. Maternal Measures
17. Accidents
18. Life Expectancy
19. Cholesterol

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[28] Responds to Schedule h (Form 990) Part V B 8
[29] Responds to Schedule h (Form 990) Part V Section B 8

20. Dental
21. Sexually Transmitted Infection
22. Blood Poisoning
23. Education/Prevention

APPENDIX

Appendix A – Written Commentary on Prior CHNA

Hospital solicited written comments about its 2013 CHNA.[30] 19 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.

1. **Please indicate which (if any) of the following characteristics apply to you. If none of the following choices apply to you, skip the indication and please continue to the next question.**

Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	3	14	17
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	8	9	17
3) Priority Populations	8	10	18
4) Representative/Member of Chronic Disease Group or Organization	1	16	17
5) Represents the Broad Interest of the Community	15	3	18
Other			
Answered Question			19
Skipped Question			0

- **Within the county, do you perceive the local Priority Populations to have any unique needs, as well as potential unique health issues needing attention? If you believe any situation as described exists, please also indicate who you think needs to do what.**
  - *Cancer, Mental Health/Suicide/Substance Abuse, Compliance Behavior/Predisposing Conditions, Diabetes*
  - *Preventive care for lower income families.*
  - *Mental Health/Suicide/Substance Abuse*
  - *Being a resident of a rural area is a significant factor that affects all local priority populations. The lack of a public transportation system and lack of a safe sidewalk infrastructure makes it difficult for Lawrence County residents to access the few resources that are available here. I don't think a county wide public transportation is feasible, but it would certainly be nice.*
  - *I am unaware of any local Priority Populations needs that are not being met. However, as a senior citizen, I think a worthy goal for our local health care system would be to provide a geriatric specialist.*
  - *low income area*
  - *Low income groups and psychosocial issues*
  - *Local population is majority low income. Preventive care would be an area for that population.*
  - *OLDER ADULTS AND MENTALLY ILL NEED CLOSER SUPERVISION*

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

- *Low income is probably our biggest problem. Only solution would be to have more jobs - IDC, Chamber of Commerce and County Gov't try but have not been very successful in gaining jobs for the area.*
- *It is becoming imperative that hospitals, health departments, mental health facilities try and assist in the epidemic of mental health issues, drug addiction, and abuse. All of these organizations need to work side by side and find ways to fund, and staff facilities to address these serious issues.*
- *No*
- *In this area we see more aging community that live in rural areas as well.*
- *No*

2. In the last process, several data sets were examined and a group of local people were involved in advising the Hospital. While multiple needs emerged, the Hospital had to determine what issues were of high priority and where it would be a valuable resource to assist in obtaining improvements.

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

- Obesity/Overweight
- Cancer
- Mental Health/Suicide/Substance Abuse
- Coronary Heart Disease
- Smoking/Tobacco Use
- Affordability
- Stroke
- Compliance Behavior/Predisposing Conditions
- Dental
- Chronic COPD/Lung Disease/Pulmonary
- Diabetes

Comments or observations about this set of needs being the most appropriate for the Hospital to take on in seeking improvements?

- Should the Hospital continue to consider each need identified as most important in the 2013 CHNA report as the most important set of health needs currently confronted residents in the county?

	Yes	No	No Opinion
Obesity/Overweight	14	2	0
Cancer	16	0	0
Mental Health/Suicide/Substance Abuse	14	2	0
Coronary Heart Disease	15	1	0
Smoking/Tobacco Use	8	8	0

	Yes	No	No Opinion
Affordability	13	3	0
Stroke	14	2	0
Compliance Behavior/Predisposing Conditions	13	2	1
Dental	11	4	1
Chronic COPD/Lung Disease/Pulmonary	14	2	0
Diabetes	15	1	0

- **Specific comments or observations about Obesity/Overweight as being among the most significant needs for the Hospital to work on to seek improvements?**
    - *Lack of low cost physical fitness facilities. Lack of access to low cost fruits, vegetables, and other healthy foods. Lack of dietitians that can inform students at the school about how to prevent being overweight.*
    - *No comment.*
    - *INFORMATION*
    - *Obesity remains a major concern and should continue to be addressed. Maybe hospital personnel could help with schools to educate students the importance of a healthy diet and exercise.*
    - *Although it is a nationwide problem that does cause other health issues, and I agree that it should be a priority. I think a shift is in order maybe leaning more towards Mental Health, Cancer, Heart disease.*
    - *If a persons overall weight is in line then this will eliminate some overall risk and cost for all.*
- **Specific comments or observations about Cancer as being among the most significant needs for the Hospital to work on to seek improvements?**
    - *High rate of cancer in our area. No specialized doctors in the community that focus on cancer patients. Lack of preventative screenings.*
    - *YES*
    - *Cancer remains high -*
    - *As the scope and ongoing research continues to broaden ion this deadly disease, it is the role of the Hospital to be a voice for knowledge, treatment, and continuing information about ongoing advancements in the treatment of this disease. Letting the general public be aware that it is not necessarily a death sentence.*
    - *For this area we are all touched by cancer in our families*
- **Specific comments or observations about Mental Health/Suicide/Substance Abuse as being among the most significant needs for the Hospital to work on to seek improvements?**
    - *Limited physicians that focus on mental health needs. Limited mental health resources from the hospital.*
    - *This may be an issue in our community, but I see the health dept. as more responsible to address these issues. the hospital no longer has a mental health department.*
    - *With state cutbacks effecting almost every Mental Health facility, Mental Health is becoming a serious problem. Lack of trained professionals to deal with Mental Health, as well as facilities that provide*

counseling and continued support for the individual.This issue will only get worse with a potential of serious consequences.

  - *Substance abuse is a major problem in this area. Families are being destroyed and children's lives are being adversely effected by their parents substance abuse. This is creating a pattern of substance abuse that continues for generations.*

- **Specific comments or observations about <u>Coronary Heart Disease</u> as being among the most significant needs for the Hospital to work on to seek improvements?**
  - *No local physicians that focus on heart disease or education on how to prevent heart disease.*
  - *YESYES*
  - *Heart disease is #1 cause of death in our community but more resources and attention is made to cancer.*
  - *As one of the leading causes of death in the Midwest, Heart Disease must have a multi faceted prevention approach. Education about causes, leading the way on technology , and be a leader in the community on awareness, and heart healthy choices.*
- **Specific comments or observations about <u>Smoking/Tobacco Use</u> as being among the most significant needs for the Hospital to work on to seek improvements?**
  - *High prevalence of asthma that may be due to second hand smoke.*
  - *I don't think this needs to be as high priority as other things on the list. There has been much media coverage of this for years, and now that most places are smoke-free, the message is not easily overlooked.*
  - *NONE*
  - *Smoking is high but do not see where hospital would take an active role in reducing the number of smokers*
  - *Even with the implementation of no smoking policies in almost every venue, this has truly not slowed down tobacco use. I feel that a more aggressive approach starting at the schools and continuing with hard hitting facts on just what the long term hazards are of tobacco use*
- **Specific comments or observations about <u>Affordability</u> as being among the most significant needs for the Hospital to work on to seek improvements?**
  - *Lack of job opportunities in the area, we are a high poverty area.*
  - *Af*
  - *NONE*
  - *prices in all hospitals are extremely high which makes it difficult for the poor to access care*
  - *With the implementation of our nationwide health insurance program (Obamacare) people are now more confused than ever in regards to their health coverage. More people are putting off medical needs because they cannot afford to have them done. A short stay in the hospital can cost a person hundreds maybe thousands of dollars depending on what the issue was. Hospitals are caught between the patient,*

drug, and insurance companies. This along with the rising cost of medical equipment needed to operate their facilities it is a major problem

  - *Annual cost for check-up and older patients would be best to keep to a minimal cost to find issues sooner better than later*

- **Specific comments or observations about <u>Stroke</u> as being among the most significant needs for the Hospital to work on to seek improvements?**
  - *Limited education on how to prevent strokes.*
  - *I think this item, as well as coronary heart disease, should be high priority.*
  - *NONE*
  - *stroke remains a concern*
  - *Strokes are becoming more and more common today. I feel it is a combination of stress and trying to make ends meet along with high blood pressure are major factors. It is a fast pace world for those trying to succeed, not eating right, excessive drinking, smoking, sleep deprivation, all play roles in causing strokes. This is a society driven issue that I am not sure has a solution*
- **Specific comments or observations about <u>Compliance Behavior/Predisposing Conditions</u> as being among the most significant needs for the Hospital to work on to seek improvements?**
  - *School related issues - Low compliance with Vision and Hearing. Abuse of community members over using the Emergency Room.*
  - *Although this is important because other items on the list are directly related to this, this is a difficult area in which to show improvement, given the level of education of area residents, and a general unwillingness to change risky life styles.*
  - *NONE*
  - *compliance is a challenge among our population of poor uneducated people*
  - *With HIPPA and all the other agencies that oversee general healthcare hospitals must be the leader in identifying issues, correcting them, and plans for continued improvement. As issues arise they need to be dealt with in a timely manner and staff training be a key component in the correction program.*
- **Specific comments or observations about <u>Dental</u> as being among the most significant needs for the Hospital to work on to seek improvements?**
  - *None of the local dentists accept public aide.*
  - *I don't consider this as critical as others on the list.*
  - *NONE*
  - *being in a poor community people are unable to access dental care. dentist is very expensive*
  - *Dental care is probably one of the most neglected thing people do today. Not realizing how the mouth affects your overall health does not seem to be a concern. However it comes back to low income area, dentists not taking medi cards and other factors. With increased forms of drug addiction dental becomes*

a major factor to the person

- *One visit a year would help greatly, and keeping this in front of the community as a priority*

- **Specific comments or observations about <u>Chronic COPD/Lung Disease/Pulmonary</u> as being among the most significant needs for the Hospital to work on to seek improvements?**
  - *NONE*
  - *COPD goes along with high smoking rates*
  - *COPD, linked to smoking is another rapidly growing issue. It is hard for small hospitals to provide the necessay needs for someone with COPD. Again educating at an early age the causes of COPD, programs in place to try and deter are possibles*

- **Specific comments or observations about <u>Diabetes</u> as being among the most significant needs for the Hospital to work on to seek improvements?**
  - *Increase amount of Type I and Type II diabetes.*
  - *NONE*
  - *Diabetes is connected to high obesity rates*
  - *Eating right, staying on a regimented plan, identifying factors at the on set are key in the fight against diabetes. Diabetes can lead to more serious health issue, loss of sight, amputations, and more. Doing educational strong fact based education again at an early age might offset early diabetes*
  - *Diet awareness and overall affects of sugar is needed*

3. **Comments and observations about the implementation actions of the Hospital to seek health status improvement?**

- Should the Hospital continue to allocate resources to assist improving the needs?

	Yes	No	No Opinion
Obesity/Overweight	13	3	0
Cancer	16	0	0
Mental Health/Suicide/Substance Abuse	15	1	0
Coronary Heart Disease	16	0	0
Smoking/Tobacco Use	8	6	2
Affordability	15	0	1
Stroke	16	0	0
Compliance Behavior/Predisposing Conditions	13	2	1
Dental	12	3	1
Chronic COPD/Lung Disease/Pulmonary	14	2	0
Diabetes	14	1	1

- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in <u>Obesity/Overweight</u>?**
  - *No comment*

- *Perhaps hospital could partner with local restaurants, school cafeterias, etc. to provide education in nutrition and its impact on health.*
- *NONE*
- *In house the hospital has encouraged and supported its own employees to exercise by offering financial assistance with local fitness center. Hospital dietician educates patients about obesity.*
- *Continued information from the hospital about how important weight is in our everyday lives. How it affects the overall health of the community. Businesses have to look at potential employees as a risk, as well as repeated hospital visits for not following a regiment set out by doctors for them.Wellness clinics, health fairs, in school eat healthy plans are great ways to try and curb this issue*
- *Use a reasonable goal for weight and exercise*

- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in <u>Cancer</u>?**
  - *We have a local group that fundraises in order to help community members that have been diagnosed with cancer.*
  - *YESYES*
  - *Hospital has screenings for cancer. free mammograms are available. staff take part in local events such as cancer walks/runs etc.*
  - *I feel the Hospital does a fine job in cancer awareness, and does their best to deal with patients in a manner they see to be the best outcome for them.*
- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in <u>Mental Health/Suicide/Substance Abuse</u>?**
  - *I don't think the hospital should be the only entity working on this problem. There should be cooperation among law enforcement agencies, schools, medical community and others to bring about public awareness of the problem.*
  - *YES*
  - *the hospital's key role would be to coordinate services with the health dept. by timely referrals and good communications between agencies. hospital typically see these patients in ED and then either transfer to another hospital or have health dept. follow as outpt.*
  - *As a health care leader in the community, the hospital needs to be proactive in assisting other agencies and work side by side with them to get the needed programs started and make sure they continue.*
- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in <u>Coronary Heart Disease</u>?**
  - *Continue to emphasize healthy life styles, prevention, treatment etc. with public awareness campaigns.*
  - *YES*
  - *Education of public is only way hospital could help that I know of*

- *In this area with lower incomes, higher unemployment, taking care of people who are in these categories becomes hard. They will only come to the hospital when needed. Taking a strong stance on how to prevent heart disease, and working on less trips to emergency rooms for treatments are high goals to set. However unless information and programs are in place the problem will only increase.Even with the implementation of no smoking policies in almio*

- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in Smoking/Tobacco Use?**
  - *As with other concerns on the list, hospital should use public awareness campaigns, to continue to remind area residents of the dangers of a risky life style.*
  - *NONE*
  - *the health dept has an active education program regarding smoking cessation*
  - *I know it is an addiction just like any other harmful substance. Possibly looking at following other substance abuse programs and see if anything can be gleaned from what they are doing to roll into a tobacco cessation 12 step program. E-cigarettes are now playing into this as I feel their will be health issues in the near future on the use of these as well. Staying current on all information form American Lung Assoc., and any other organization directly dealing with tobacco issues nationwide. Bringing in nationally known speakers to address this important problem*
- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in Affordability?**
  - *REASONABLE*
  - *hospital has a charity program and assists clients that have trouble paying their bill. hospital has also opened an after hours clinic to reduce the number of patients going to the emergency department for more expensive care*
  - *I feel that hospitals are going to have to take the lead in being he broker between insurance and drug companies. Explaining the burden it puts on them to provide necessary services to their patients. Along with slow Medicaid payments, some kind of system needs to be in place for assistance to meet the gap of what the hospital charges and out of pocket expense to the patient. Long term fund raising is always brought up but in cash strapped communities this becomes difficult. Identifying the big hitters in the area to set-up assistance programs might be an option to explore. Also encouraging doctors when they can to do more pro- bono work for the financially burdened patient*
- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in Stroke?**
  - *Make use of opportunities to promote prevention and availability of medical care.*
  - *NONE*
  - *education is probably the only means of assistance -*
  - *Education, health clinics specifically for Stroke prevention are starting points. Again possibly bringing in well known authorities to discus Stroke prevention. Rehab clinics for victims of Strokes that are*

affordable and accesible

- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in <u>Compliance Behavior/Predisposing Conditions</u>?**
    - *Hospital opened an acute care clinic, which helps with the abuse of the emergency room.*
    - *Perhaps implementing some health-related programs in the schools would start a healthier life cycle that would carry over into adulthood.*
    - *NONE*
    - *hospital is staff is patient and kind to their patients - continue to work closely with patients and provide proper follow-up to reduce readmissions*
    - *Continually being under the microscope by several governing agencies, hospitals must make it a priority to always stay ahead of the curve in regards to compliance. Continually looking at available resources to stay on top of changes, and prctices*
- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in <u>Dental</u>?**
    - *I would hope that area dentists would help educate residents, and recruit potential dentists.*
    - *NONE*
    - *do not see dental issues as being a priority for hospital to work on*
    - *Possibly bring in an on sight dental team to work in conjunction with the hospital for dental care. Discussing the prospect of a periodically hosting free dental care check-ups. Person would have to go through a pre- screen to qualify.*
- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in <u>Chronic COPD/Lung Disease/Pulmonary</u>?**
    - *NONE*
    - *education, treatment, follow-up will help the COPD clients*
    - *Looking at getting an on sight or clinic with a specialist in the treatment of COPD and lung disorders.*
- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in <u>Diabetes</u>?**
    - *Again, use public awareness campaigns to educate area residents about healthy choices.*
    - *NONE*
    - *education treatment and follow-up - proper referrals etc would be hospital role*
    - *As areas of concern are brought to the forefront the hospital should be extremely pro-active in implementing procedures. They are the torch carriers for the community in health care, and timely implementations on procedures should be priority one*
- **Do you have opinions about new or additional implementation efforts or community needs the Hospital**

should pursue?

  - *Not at this time.*
  - *None*
  - *Armed Security, better trained mental health social workers.*
  - *I think the hospital should attempt to partner with other organizations or agencies to educate and/or serve those with special needs. That might help ease the burden of allocating resources .*
  - *NO*
  - *Partnering with local agencies to look at Mental Health Counseling Centers.*

- **Finally, after thinking about our questions and the information we seek, is there anything else you think important as we review and revise our thinking about significant health needs within the county?**
  - *The LCMH Acute Care Clinic has been a resounding success. The need for the service is being met however there should be a reevaluation to study whether the service should be expanded. Also, we believe LCMH should study the need for more primary care physicians as their current staff ages. Also of use would be a study into the need of further specialty surgical providers (ie: ENT, general surgeon, etc.).*
  - *Not at this time. I believe the Hospital does a good job of meeting the needs of the community.*
  - *Armed Security*
  - *I think all of the above-listed concerns are worthy of attention, but some more than others. I think the hospital is addressing most of those needs quite well. I would reiterate my suggestions that bringing these concerns into public awareness is critical to bringing about improvement in many of these areas. Programs such as "Dine With a Doc" are good ways to do this.*
  - *no*
  - *NO*
  - *Our hospital remains treatment based as opposed to prevention. I think it needs to take a more active role in preventing disease. Education and screening could be a means of prevention*
  - *It is my feeling that we need to strongly be addressing Mental Health and drug addiction. Counseling, patient care on getting off addictive medications, and continued support after their initial care is done. These issues I feel are going to become major issues in the days ahead*

Appendix B – Identification & Prioritization of Community Needs

Need Topic	Total Votes	Number of Local Experts Voting for Needs	Percent of Votes	Cumulative Votes	Need Determination
Mental Health/Suicide/Substance Abuse - 2013 Significant Need	205	11	17.08%	17.08%	Significant Needs
Coronary Heart Disease - 2013 Significant Need	183	12	15.25%	32.33%	
Cancer - 2013 Significant Need	115	10	9.58%	41.92%	
Obesity/Overweight - 2013 Significant Need	90	8	7.50%	49.42%	
Stroke - 2013 Significant Need	86	8	7.17%	56.58%	
Compliance Behavior/Predisposing Conditions - 2013 Significant Need	65	8	5.42%	62.00%	Other Identified Needs
Diabetes - 2013 Significant Need	55	8	4.58%	66.58%	
Physical Inactivity	54	7	4.50%	71.08%	
Affordability - 2013 Significant Need	52	8	4.33%	75.42%	
Smoking/Tobacco Use - 2013 Significant Need	42	8	3.50%	78.92%	
Physician	42	6	3.50%	82.42%	
Flu/Pneumonia	37	5	3.08%	85.50%	
Chronic COPD/Lung Disease/Pulmonary - 2013 Significant Need	36	7	3.00%	88.50%	
Kidney Disease	31	5	2.58%	91.08%	
Alzheimer's	28	6	2.33%	93.42%	
Maternal Measures	25	5	2.08%	95.50%	
Accidents	12	5	1.00%	96.50%	
Life Expectancy	12	4	1.00%	97.50%	
Cholesterol	11	4	0.92%	98.42%	
Dental - 2013 Significant Need	6	4	0.50%	98.92%	
Sexually Transmitted Infection	6	5	0.50%	99.42%	
Blood Poisoning	5	5	0.42%	99.83%	
Education/Prevention	2	1	0.17%	100.00%	
Total	1200		100.00%		

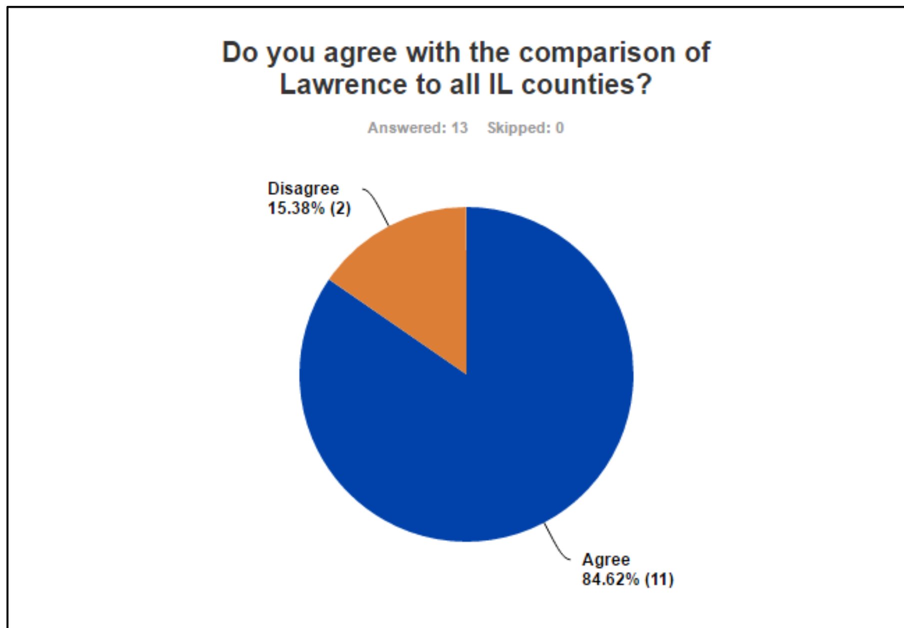
Individuals Participating as Local Expert Advisors[31]

Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	5	4	9
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	4	6	10
3) Priority Populations	5	4	9
4) Representative/Member of Chronic Disease Group or Organization	1	8	9
5) Represents the Broad Interest of the Community	11	1	12
Other			
Answered Question			13
Skipped Question			0

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

Advice Received from Local Expert Advisors

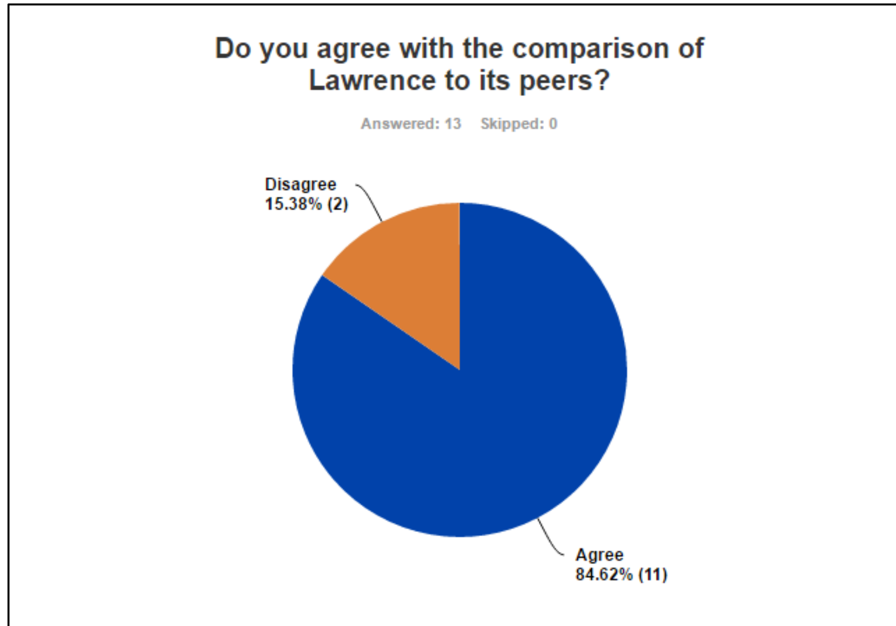
Question: Do you agree with the observations formed about the comparison of Lawrence County to all other Illinois counties?



Comments:

- *I think there are quite a few exercise opportunities in Lawrence County if residents are motivated to take advantage of them. I also believe diabetic monitoring and mammography screening are fairly readily available.*
- *Limited opportunity for a person to better themselves. Economic, and products of their environment play a large role in these statistics*

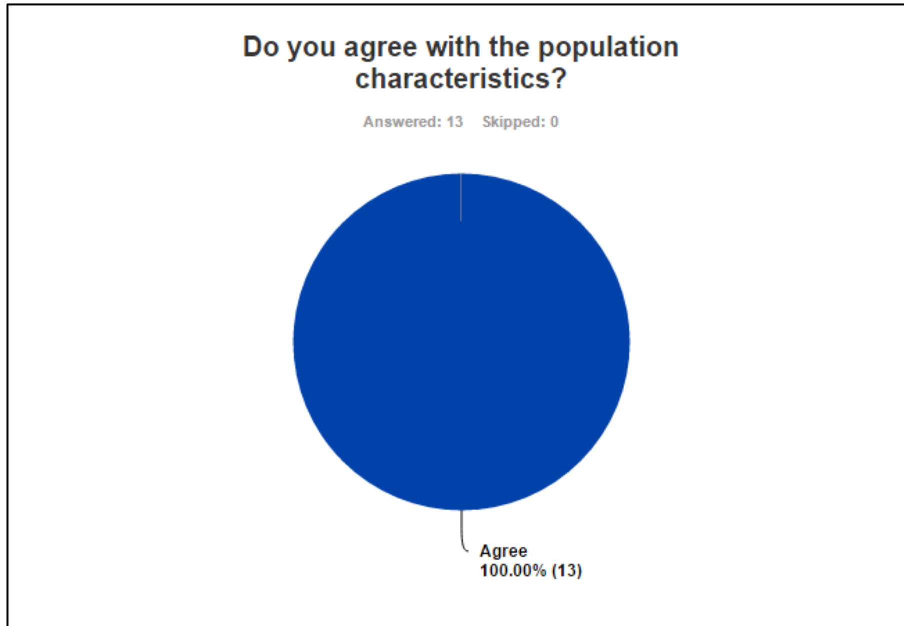
Question: Do you agree with the observations formed about the comparison of Lawrence County to its peer counties?



Comments:

- *I do not have access to data from some of the above categories so I can't credibly agree or disagree, but I think Lawrence County's close proximity to, and therefore access to, several large Indiana hospitals and health care systems might affect the above statistics in some way.*
- *High unemployment, no good paying jobs available to dive economy. This creates a lack of motivation, social skills, and results in poor health care management.Also the fact that most individuals cannot afford healthcare*

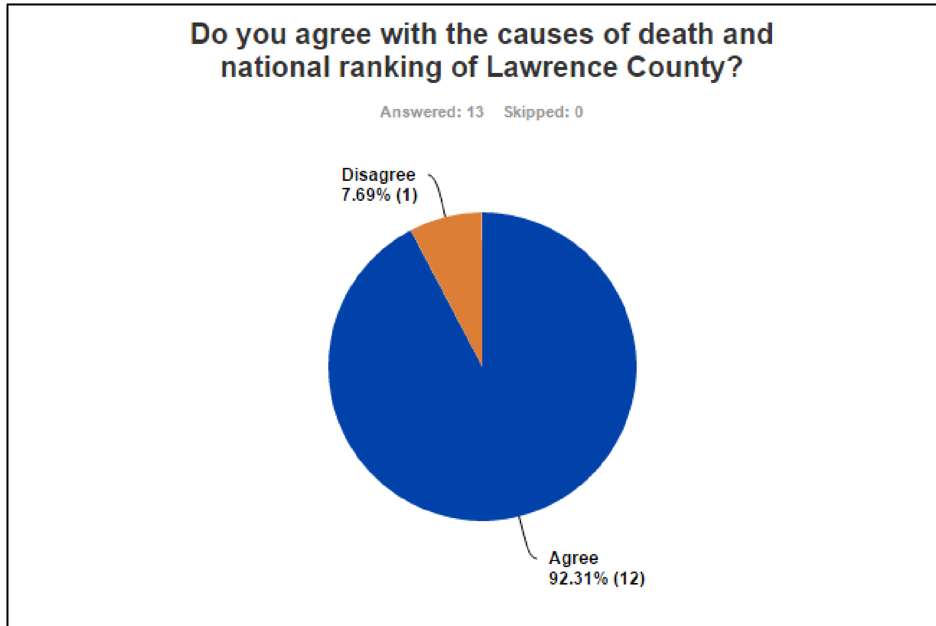
Question: Do you agree with the observations formed about the population characteristics of Lawrence County?



Comments:

- *Again these factors are all driven by no jobs, no room for economic growth, and the tendency for people not to take care of themselves. If you cannot afford insurance you are not going to get regular necessary health care.*

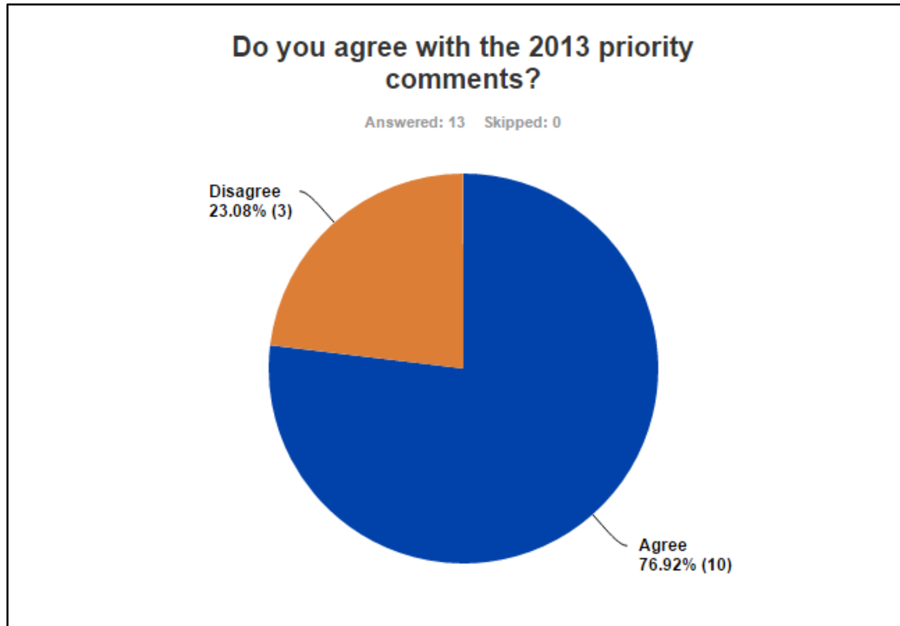
Question: Do you agree with the observations formed from the national ranking and leading causes of death?



Comments:

- *I am not sure if e-cigarettes were part of the survey, but they should be as I believe along with alcohol abuse this is going to become a health factor in the near future. Hard to start but programs with some kind of funding to address these areas is needed. It would work better in already established brick and mortar settings. Finding the funds and paying the people is always the issue.*

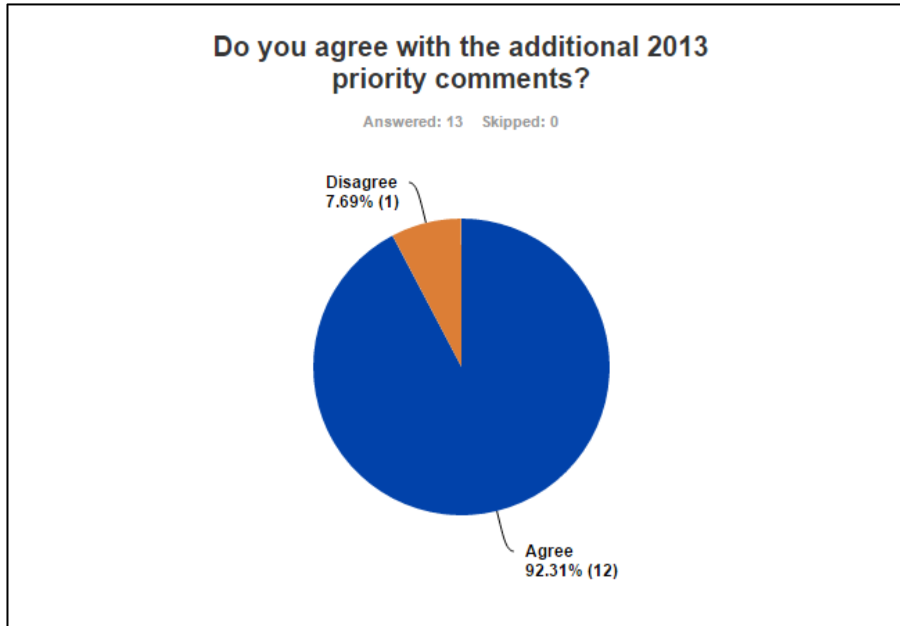
Question: Do you agree with the written comments received on the 2013 CHNA?



Comments:

- *I agree with those comments that recommend action; I disagree with those comments that state that nothing is needed. The hospital, and other agencies, should continually strive to meet the health needs of the community.*
- *I especially agree with partnering with Mental Health professionals as a source to address many of the counties needs. We need counselors, clinics, outpatient centers, and more. But how do you fund it???*

Question: Do you agree with the additional written comments received on the 2013 CHNA?



Comments:

- *Smoking cessation should be of higher importance.*
- *I do not see how hospital can impact dental needs of our community*
- *I think the numbers speak for themselves, people are always quick to blame if they do not have it their way, but as your survey numbers show everybody wants a hospital in Lawrence County. And it proves that Lawrence County Hospital has gained the trust of the public to use their facility.*
- *I think these are all important!*

Appendix C – National Healthcare Quality and Disparities Reports

The National Healthcare Quality and Disparities Reports (QDR) 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 reports are based on more than 250 measures of quality and disparities covering a broad array of healthcare services and settings. Data is 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,[32] consistent with these trends.

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.[33]

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.[34]

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

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[32] Levy J. In U.S., Uninsured Rate Sinks to 12.9%. http://www.gallup.com/poll/180425/uninsured-rate-sinks. aspx.
[33] In this report, racial groups such as Blacks and Whites are non-Hispanic, and Hispanics include all races.
[34] 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

- In 2012, people in poor households had worse access to care than people in high-income households on all access measures (green).
- 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 is 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.[35]
- 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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[35] 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.[36]
- 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:

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[36] 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)[37]

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 36 and footnote 27 on page38

   d. **How data was obtained**

      See footnote 11 on page 8

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

      See footnote 25 on page 35

   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 31 on page 61

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

      See footnotes 8 and 9 on page 7

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[37] 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__**

2013

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 10 and footnote 30 on page 51

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.lcmhosp.org/

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 efforts

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 28 and 29 on page 48

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

2013

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

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

https://www.lcmhosp.org/

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 27 on page 38

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