Lawrence County Memorial Hospital

Lawrenceville, IL

Community Health Needs Assessment
and Implementation Strategy

Adopted by Board Resolution July 2, 2019[1]

LAWRENCE COUNTY MEMORIAL HOSPITAL

[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 60 years providing high-quality compassionate healthcare to the greater Lawrence County community. The “2019 Community Health Needs Assessment” identifies local health and medical needs and provides a plan of how LCMH will respond to such needs. This document illustrates one way we are meeting our obligations to efficiently deliver medical services.

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

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.

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

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

Thank You,

Don Robbins
Chief Executive Officer
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.

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. Additionally, the group reviewed the data gathered from the secondary sources and determined the Significant Health Needs for the community.

The 2019 Significant Health Needs identified for Lawrence County are:

1. Mental Health/Suicide/Substance Abuse – 2016 Significant Need
2. Stroke – 2016 Significant Need
3. Coronary Heart Disease – 2016 Significant Need
4. Cancer – 2016 Significant Need
5. Affordability
6. Alcohol Abuse
7. Education/Prevention

The Hospital will develop implementation strategies for the seven needs including activities to continue/pursue, community partners to work alongside, and measures to track progress.

APPROACH

APPROACH

LCMH Regional Medical Center ("LCMH" or the "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 helps the hospital identify and respond to the primary health needs of its residents.

This study is designed to comply with standards required of a not-for-profit hospital.[2] Tax reporting citations in this report are superseded by the most recent Schedule H (Form 990) 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 IRS Guidelines
- Provide the Hospital with information required to complete the IRS – Schedule H (Form 990)
- Produce the information necessary for the Hospital to issue an assessment of community health needs and document its intended response

Overview of Community Health Needs Assessment

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

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

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[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 2017 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

- An Emergency Room open to all, regardless of ability to pay
- Surplus funds used to improve patient care, expand facilities, train, etc.
- A board controlled by independent civic leaders
- All available and qualified physicians granted hospital privileges

Specifically, the IRS requires:

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

Community Health Needs Assessment Subsequent to Initial Assessment

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

> *"The 2013 proposed regulations provided that, in assessing the health needs of its community, a hospital facility must take into account input received from, at a minimum, the following three sources:*

[5] Section 6652

(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 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

[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

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 conducting the CHNA."[7]

Additionally, all CHNAs developed after the very first CHNA must consider written commentary on the prior Assessment and Implementation Strategy efforts. The Hospital 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]

The methodology takes a comprehensive approach to the solicitation of written comments. As previously cited, input was obtained from the required three minimum sources and expanded input to include other representative groups. The Hospital 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)

The methodology also takes a comprehensive approach to assess community health needs. 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. The Hospital relies on secondary source data, and most secondary sources use the county as the smallest unit of analysis. Local expert area residents were asked to note if they perceived the problems or needs identified by secondary sources

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

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

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

existed in their portion of the county.[10]

Most data used in the analysis is available from public Internet sources and proprietary data. Any critical data needed to address specific regulations or developed by the Local Expert Advisor individuals cooperating 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 County compared to all Illinois counties	February 19, 2019	2012-2014
IBM Watson Health (formerly known as Truven Health Analytics)	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	February 19, 2019	2019
http://svi.cdc.gov	To identify the Social Vulnerability Index value	February 20, 2019	2012-2016
http://www.healthdata.org/us-county-profiles	To look at trends of key health metrics over time	February 20, 2019	2014
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	February 20, 2019	2016

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

- A CHNA survey was deployed to the Hospital's Local Expert Advisors to gain input on local health needs and the

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

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

needs of priority populations. Local Expert Advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and the Hospital's desire to represent the region's geographically and ethnically diverse population. Community input from 15 Local Expert Advisors was received. Survey responses started March 10, 2019 and ended on May 10, 2019.

- 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] [13]
- 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
    - The top three priority populations in the area are low-income groups, residents of rural areas, and older adults
    - There should be a focus on affordable healthcare and accessibility

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.[14]

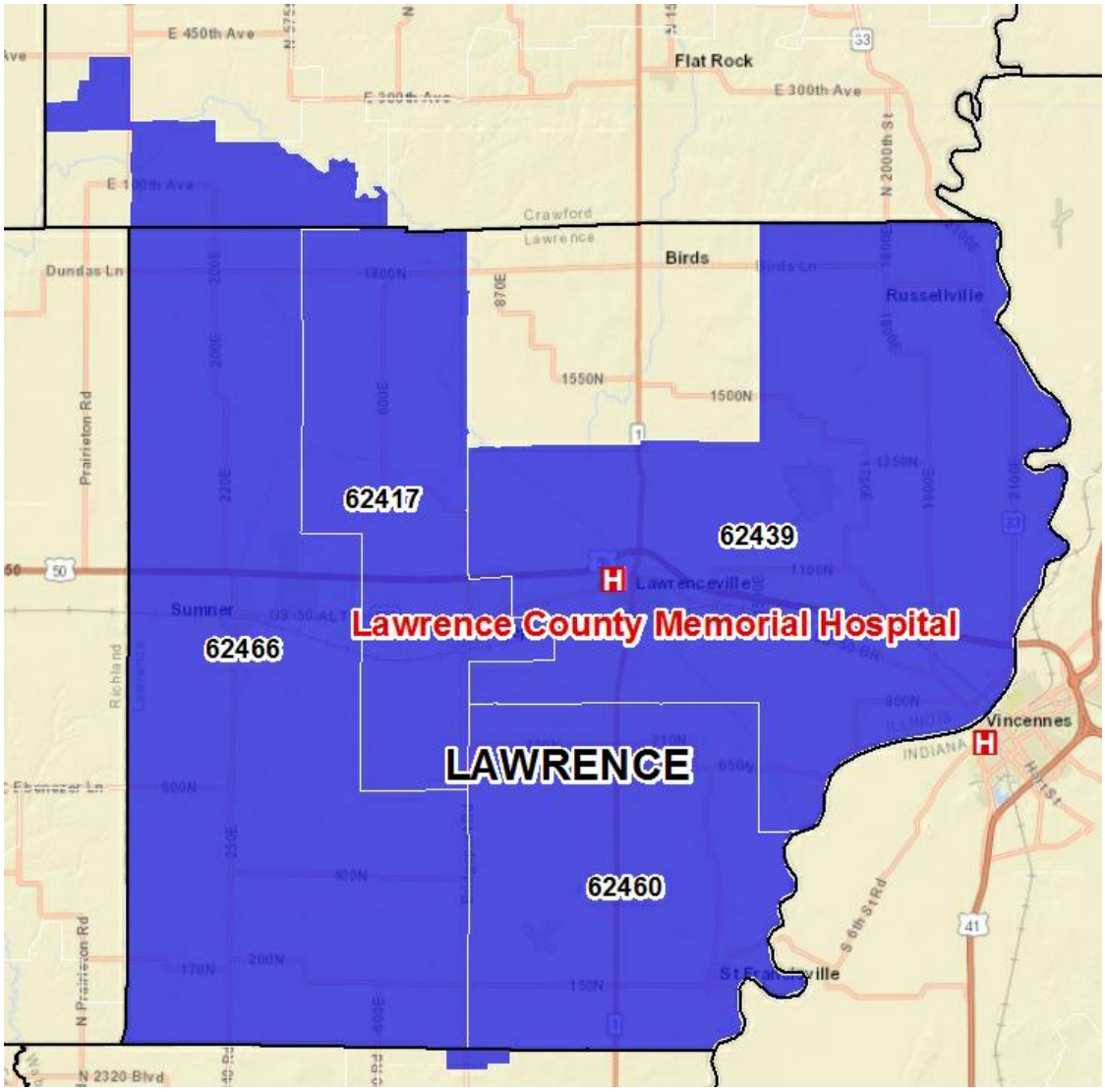
In the LCMH process, each Local Expert had the opportunity to introduce needs previously unidentified and to challenge conclusions developed from the data analysis. While there were a few opinions of the data conclusions not being completely accurate, most of the comments agreed with the findings. A list of all needs identified by any of the analyzed data was developed. The Local Experts then allocated 100 points among the list of health needs, including the opportunity to list additional needs that were not identified from the data.

The ranked needs were divided into two groups: "Significant" and "Other Identified Needs." The Significant Needs were prioritized based on total points cast by the Local Experts in descending order, further ranked by the number of local experts casting any points for the need. By definition, a Significant Need had to include all rank ordered needs until at least fifty percent (60%) 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 where a reasonable break point in rank order occurred.[15]

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

COMMUNITY CHARACTERISTICS

Definition of Area Served by the Hospital[16]



For the purposes of this study, Lawrence County Memorial Hospital defines its service area as Lawrence County in Illinois, which includes the following ZIP codes:[17]

62417 – Bridgeport 62439 – Lawrenceville 62460 – Saint Francisville 62466 - Sumner

(Zip code 62453 is included in the above zip codes.)

During 2017, the Hospital received 88.0% of its Medicare inpatients from this area.[18]

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

Demographics of the Community[19] [20]

Variable	Lawrence, IL 2019	Lawrence, IL 2024	Lawrence, IL %Change	Illinois 2019	Illinois 2024	Illinois %Change	United States 2019	United States 2024	United States %Change
DEMOGRAPHIC CHARACTERISTICS									
Total Population	15,779	15,500	-1.8%	12,768,392	12,745,737	-0.2%	326,533,070	337,947,912	3.5%
Total Male Population	9,013	8,898	-1.3%	6,273,893	6,268,625	-0.1%	160,763,625	166,448,475	3.5%
Total Female Population	6,766	6,602	-2.4%	6,494,499	6,477,112	-0.3%	165,769,445	171,499,437	3.5%
Females, Child Bearing Age (15-44)	2,219	2,148	-3.2%	2,532,890	2,475,046	-2.3%	63,920,735	64,819,726	1.4%
Average Household Income	$55,475			$90,881			$86,278		
POPULATION DISTRIBUTION									
Age Distribution									
0-14	2,472	2,353	-4.8%	2,374,838	2,282,469	-3.9%	61,041,209	61,251,924	0.3%
15-17	511	538	5.3%	508,198	505,600	-0.5%	12,768,680	13,285,276	4.0%
18-24	1,563	1,622	3.8%	1,233,930	1,227,762	-0.5%	31,582,678	32,239,015	2.1%
25-34	2,334	2,234	-4.3%	1,714,528	1,633,150	-4.7%	43,889,724	43,505,348	-0.9%
35-54	4,183	3,941	-5.8%	3,328,912	3,233,372	-2.9%	83,269,718	83,715,341	0.5%
55-64	1,959	1,826	-6.8%	1,660,051	1,641,197	-1.1%	42,204,839	43,372,785	2.8%
65+	2,757	2,986	8.3%	1,947,935	2,222,187	14.1%	51,776,222	60,578,223	17.0%
HOUSEHOLD INCOME DISTRIBUTION									
Total Households	5,634	5,510	-2.2%	4,859,258	4,868,032	0.2%	123,942,877	128,512,554	3.7%
2018 Household Income									
<$15K	680			505,222			13,504,093		
$15-25K	829			431,606			11,746,600		
$25-50K	1,740			1,012,165			27,363,648		
$50-75K	1,032			807,912			21,179,900		
$75-100K	673			609,580			15,192,390		
Over $100K	680			1,492,773			34,956,246		
EDUCATION LEVEL									
Pop Age 25+	11,233			8,651,426			221,140,503		
2018 Adult Education Level Distribution									
Less than High School	591			458,530			12,391,997		
Some High School	1,944			547,505			16,363,756		
High School Degree	3,857			2,315,377			61,028,690		
Some College/Assoc. Degree	3,805			2,494,107			64,253,906		
Bachelor's Degree or Greater	1,036			2,835,907			67,102,154		
RACE/ETHNICITY									
2018 Race/Ethnicity Distribution									
White Non-Hispanic	13,133			7,772,620			197,066,325		
Black Non-Hispanic	1,679			1,782,712			40,402,616		
Hispanic	685			2,234,086			59,581,510		
Asian & Pacific Is. Non-Hispanic	67			724,170			18,958,063		
All Others	215			254,804			10,524,556		

[19] Responds to IRS Schedule H (Form 990) Part V B 3 b
[20] Claritas (accessed through IBM Watson Health)

Consumer Health Service Behavior[21]

Key health services topics for the service area population are presented in the table below. In the second column of the chart, the national average is 100%, so the 'Demand as % of National' shows a community's likelihood of exhibiting a certain health behavior more or less than the national average. The next column shows the percentage of the population that is likely to exhibit those behaviors.

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

Health Service Topic	Demand as % of National	% of Population Affected
Weight / Lifestyle		
BMI: Morbid/Obese	115.2%	35.2%
Vigorous Exercise	92.2%	52.6%
Chronic Diabetes	98.2%	15.4%
Healthy Eating Habits	100.3%	23.4%
Ate Breakfast Yesterday	96.2%	76.1%
Slept Less Than 6 Hours	108.3%	14.8%
Consumed Alcohol in the Past 30 Days	80.4%	43.2%
Consumed 3+ Drinks Per Session	105.1%	29.6%
Behavior		
Search for Pricing Info	87.0%	23.4%
I am Responsible for My Health	100.2%	90.7%
I Follow Treatment Recommendations	103.7%	79.8%
Pulmonary		
Chronic COPD	159.0%	8.6%
Chronic Asthma	101.3%	12.0%
Heart		
Chronic High Cholesterol	102.6%	25.1%
Routine Cholesterol Screening	90.7%	40.2%
Chronic Heart Failure	163.0%	6.6%

Health Service Topic	Demand as % of National	% of Population Affected
Cancer		
Cancer Screen: Skin 2 yr	78.0%	8.4%
Cancer Screen: Colorectal 2 yr	96.0%	19.7%
Cancer Screen: Pap/Cerv Test 2 yr	78.9%	38.0%
Routine Screen: Prostate 2 yr	96.3%	27.4%
Orthopedic		
Chronic Lower Back Pain	113.5%	35.0%
Chronic Osteoporosis	122.2%	12.4%
Routine Services		
FP/GP: 1+ Visit	101.5%	82.8%
NP/PA Last 6 Months	104.2%	43.2%
OB/Gyn 1+ Visit	79.7%	30.5%
Medication: Received Prescription	105.2%	63.8%
Internet Usage		
Use Internet to Look for Provider Info	80.6%	32.2%
Facebook Opinions	74.7%	7.5%
Looked for Provider Rating	81.4%	19.1%
Emergency Services		
Emergency Room Use	105.3%	36.8%
Urgent Care Use	88.9%	29.3%

[21] Claritas (accessed through IBM Watson Health)

Conclusions from Demographic Analysis Compared to National Averages

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

- 15.2% more likely to have a **BMI of Morbid/Obese**, affecting 35.2%
- 7.8% less likely to **Vigorously Exercise**, affecting 52.6%
- 5.1% more likely to **Consume 3+ Drinks per Session**, affecting 29.6%
- 9.7% less likely to receive **Routine Cholesterol Screenings**, affecting 40.2%
- 21.1% less likely to receive **Cervical Cancer Screening every 2 years**, affecting 38.0%
- 13.5% more likely have **Chronic Lower Back Pain**, affecting 35.0%
- 20.3% less likely to receive **Routine OB/Gyn Visit**, affecting 30.5%
- 5.3% more likely to **Visit the Emergency Room (for non-emergent issues)**, affecting 36.8%

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

- 19.6% less likely to have **Consumed Alcohol in the Past 30 Days**, affecting 43.2%

Leading Causes of Death[22]

The Leading Causes of Death are determined by official Centers for Disease Control and Prevention (CDC) final death total. Illinois's Top 15 Leading Causes of Death are listed in the table below in Lawrence county's rank order. Lawrence county was compared to all other Illinois counties, Illinois state average and whether the death rate was higher, lower or as expected compared to the U.S. average.

Cause of Death			Rank among all counties in IL (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation (Lawrence County Compared to U.S.)
IL Rank	Lawrence Rank	Condition		IL	Lawrence	
1	1	Heart Disease	52 of 102	165.7	211.9	Higher than expected
2	2	Cancer	52 of 102	163.4	190.6	Higher than expected
3	3	Stroke	9 of 102	37.8	62.9	Higher than expected
4	4	Lung	19 of 102	38.0	56.5	Higher than expected
5	5	Accidents	11 of 102	41.0	56.3	Higher than expected
6	6	Alzheimer's	2 of 102	25.4	49.2	Higher than expected
7	7	Diabetes	9 of 102	18.6	30.1	Higher than expected
9	8	Flu - Pneumonia	19 of 102	14.4	25.5	Higher than expected
8	9	Kidney	25 of 102	16.9	21.2	Higher than expected
10	10	Blood Poisoning	30 of 102	11.4	14.2	As expected
11	11	Suicide	43 of 102	10.7	12.3	As expected
15	12	Hypertension	9 of 102	7.5	11.3	As expected
13	13	Parkinson's	24 of 102	8.6	8.0	As expected
12	14	Liver	63 of 102	9.4	7.2	As expected
14	15	Homicide	93 of 98	9.2	0.6	Lower than expected

[22] www.worldlifeexpectancy.com/usa-health-rankings

Priority Populations[23]

Earlier in the document, a description was provided for Priority Populations, which is one of the groups whose needs are to be considered during the CHNA process. It can be difficult to obtain information about Priority Populations in a hospital's community. The objective is to understand the general trends of issues impacting Priority Populations and to interact with the 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.

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 the Hospital's 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.

A specific question was asked to the Hospital's Local Expert Advisors about unique needs of Priority Populations, and their responses were reviewed to identify if there were any report trends in the service area. Accordingly, the Hospital places a great reliance on the commentary received from the Hospital's Local Expert Advisors to identify unique population needs to which the Hospital should respond. Specific opinions from the Local Expert Advisors are summarized below:[24]

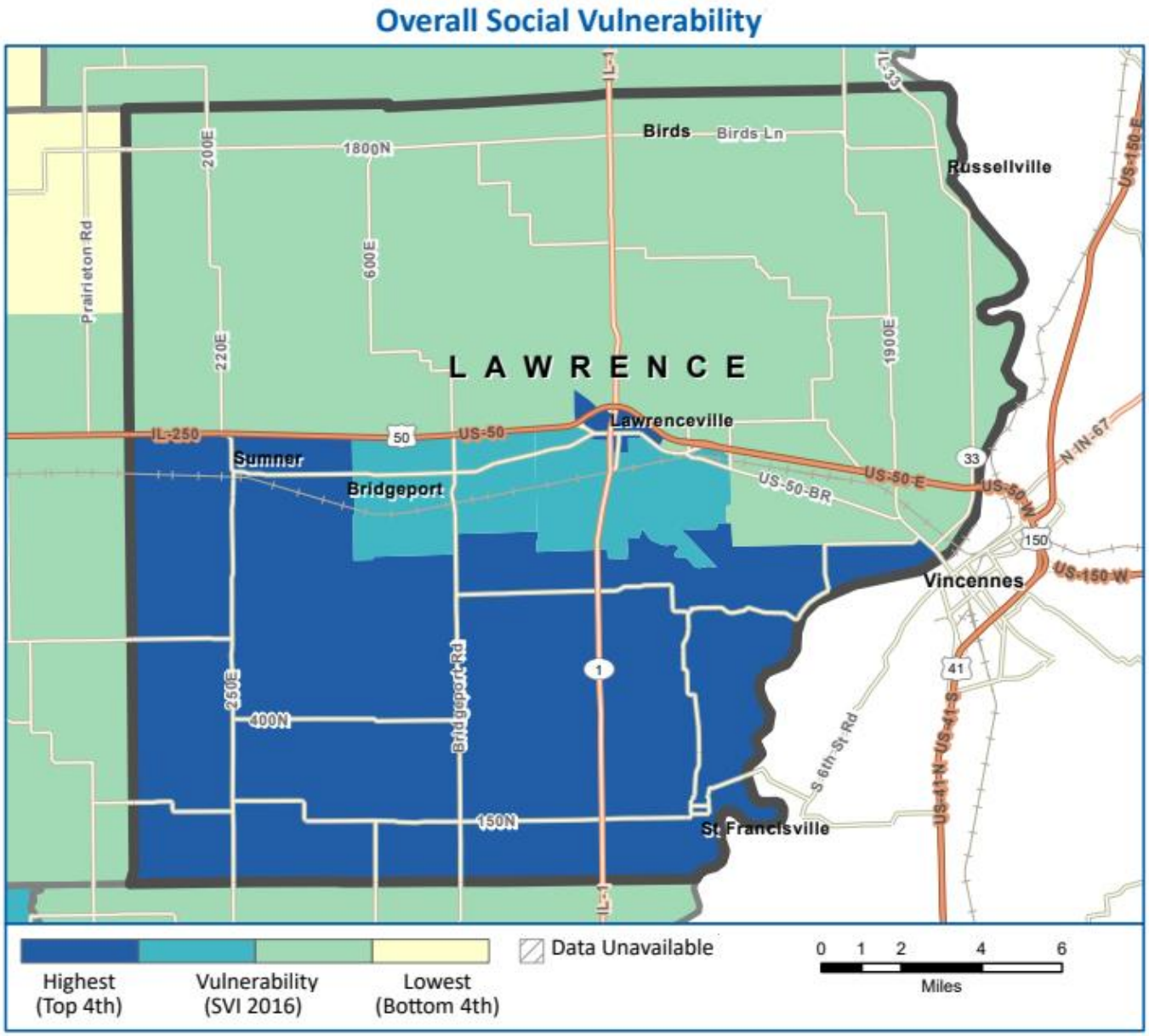
- The top three priority populations in the area are low-income groups, residents of rural areas, and older adults
- There should be a focus on affordable healthcare and accessibility

[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[25]

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

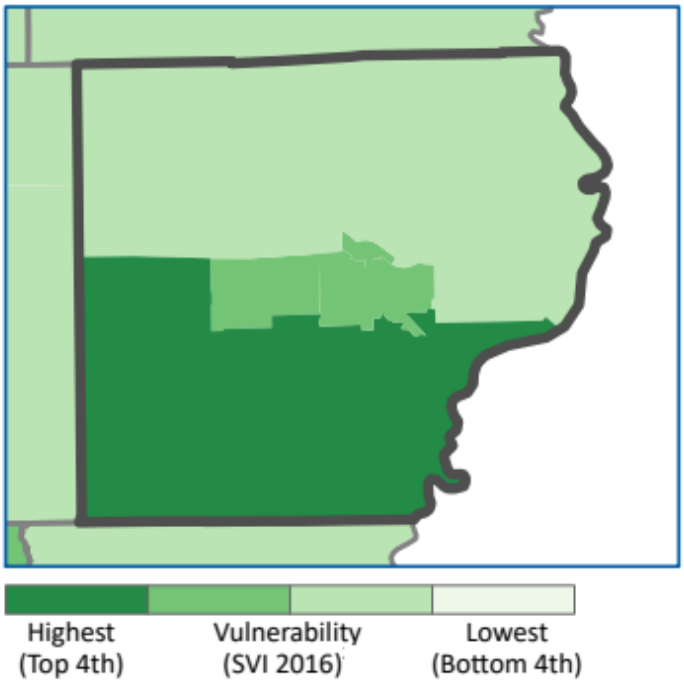
Lawrence County falls into three of the four quartiles of social vulnerability. The upper half of the county makes up the second quartile, meaning that region of the county has lower social vulnerability than the rest of the county. The lower half region of the county fall into both the dark blue (fourth quartile) and light blue (third quartile), making those regions higher in social vulnerability, with the dark blue having the highest:



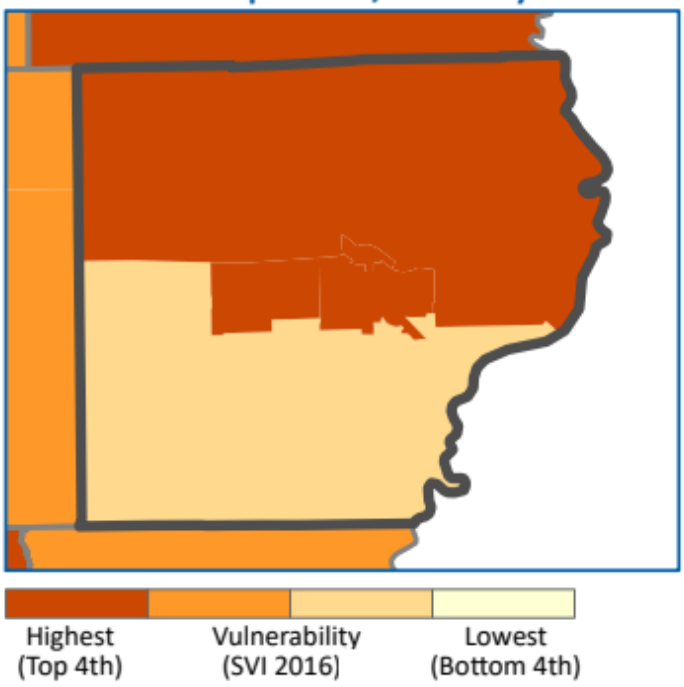
[25] http://svi.cdc.gov

SVI Themes

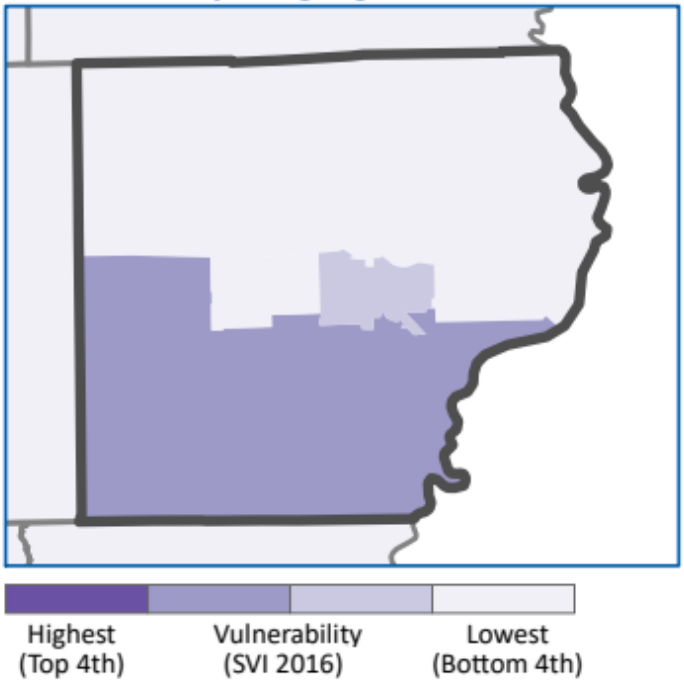
Socioeconomic Status



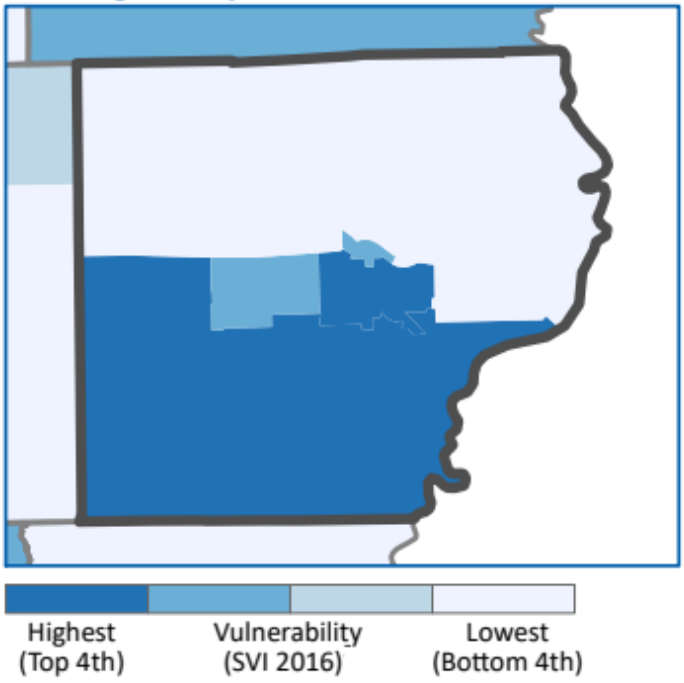
Household Composition/Disability



Race/Ethnicity/Language



Housing/Transportation



Comparison to Other State Counties[26]

To better understand the community, Lawrence County has been compared to all 102 counties in the state of Illinois across six areas: Length of Life, Quality of Life, Health Behaviors, Clinical Care, Social & Economic Factors, and Physical Environment.

In the chart below, the county's rank compared to all counties is listed along with measures in each area compared to the state average and U.S. Median.

	Lawrence	Illinois	U.S. Median
Length of Life			
Overall Rank *(best being #1)*	69/102		
- Premature Death*	7,700	6,300	7,800
Quality of Life			
Overall Rank *(best being #1)*	79/102		
- Poor or Fair Health	18%	17%	17%
- Poor Mental Health Days	3.8	3.5	3.9
Health Behaviors			
Overall Rank *(best being #1)*	91/102		
- Adult Smoking	19%	16%	17%
- Adult Obesity	28%	28%	32%
- Physical Inactivity	22%	22%	27%
- Excessive Drinking	21%	21%	17%
- Alcohol-Impaired Driving Deaths	53%	33%	29%
Clinical Care			
Overall Rank *(best being #1)*	100/102		
- Uninsured	6%	8%	11%
- Population to Primary Care Provider Ratio	4,120:1	1,240:1	2,040:1
- Population to Dentist Ratio	16,380:1	1,330:1	2,520:1
- Population to Mental Health Provider Ratio	470:1	530:1	1,050:1
- Preventable Hospital Stays	97	55	56
- Diabetes Monitoring	63%	86%	86%
- Mammography Screening	54%	64%	61%
Social & Economic Factors			
Overall Rank *(best being #1)*	95/102		
- Unemployment	7.5%	5.9%	5.0%
- Children in Poverty	25%	18%	21%
- Children in Single-Parent Households	34%	32%	32%
- Violent Crime*	111	388	198
- Injury Deaths*	76	56	79
Physical Environment			
Overall Rank *(best being #1)*	13/102		
- Severe Housing Problems	9%	18%	14%

Per 100,000 Population

[26] www.countyhealthrankings.org

Conclusions from Other Statistical Data[27]

The Institute for Health Metrics and Evaluation at the University of Washington analyzed all 3,143 U.S. counties or equivalents applying small area estimation techniques to the most recent county information. The below chart compares Lawrence County statistics to the U.S. average, as well as the trend in each measure over a 34-year span.

Lawrence County	Current Statistic (2014)	Percent Change (1980-2014)
UNFAVORABLE Lawrence county measures that are **WORSE** than the U.S. average and had an **UNFAVORABLE** change		
- Female Tracheal, Bronchus, and Lung Cancer*	51.9	66.1%
- Female Diabetes, Urogenital, Blood, and Endocrine Disease Deaths*	70.8	59.1%
- Male Diabetes, Urogenital, Blood, and Endocrine Disease Deaths*	98.2	90.6%
- Female Mental and Substance Use Related Deaths*	10.9	623.7%
- Female Liver Disease Related Deaths*	13.1	25.2%
UNFAVORABLE Lawrence county measures that are **WORSE** than the U.S. average and had a **FAVORABLE** change		
- Female Life Expectancy	79.1	2.4%
- Male Life Expectancy	73.6	5.3%
- Male Tracheal, Bronchus, and Lung Cancer*	95.0	-17.1%
- Female Breast Cancer*	26.7	-22.7%
- Female Stroke*	67.3	-35.4%
- Male Stroke*	73.0	-47.5%
- Female Transport Injuries Related Deaths*	16.0	-11.0%
- Male Transport Injuries Related Deaths*	34.5	-21.1%
- Male Heart Disease*	228.4	-55.3%
DESIRABLE Lawrence county measures that are **BETTER** than the US average and had an **UNFAVORABLE** change		
N/A		
DESIRABLE Lawrence county measures that are **BETTER** than the US average and had a **FAVORABLE** change		
- Female Heart Disease*	106.6	-59.9%
AVERAGE Lawrence county measures that are **EQUAL** to the US average and had an **UNFAVORABLE** change		
- Male Breast Cancer*	0.4	1.6%
- Female Skin Cancer*	2.1	0.8%
- Male Skin Cancer*	4.7	35.4%
- Female Self-Harm and Interpersonal Violence Related Deaths*	9.2	20.6%
- Male Self-Harm and Interpersonal Violence Related Deaths*	30.7	26.0%
- Male Mental and Substance Use Related Deaths*	18.8	401.0%
- Male Liver Disease Related Deaths*	21.3	11.2%

*rate per 100,000 population, age-standardized

[27] http://www.healthdata.org/us-county-profiles

Community Benefit

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

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

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

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

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

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

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

Activities reported by the Hospital in its implementation efforts and/or its prior year tax reporting (FY2018) included:

- Held a drug take back day (January 2018).
- Judge Shaner presented 7 reasons to leave a party for both Lawrenceville and Red Hill Jr. High Students with support from the Lawrence County Drug Coalition (February 2018).
- Held a Naloxone training session for Lawrence County Schools and the communities (March 2018).
- Held a "Spring Into Health Event" at LCMH to educate patients on breast cancer awareness (April 2018).
- LCMH employees involved with the drug coalition handed out questionnaires to all junior high students in Lawrence County to gain data about drugs, alcohol, bullying and safety (March 2018).
- Participated in Red Ribbon week with local school systems (March 2018).
- LCMH Practice Manager spoke on forming a drug coalition at the Illinois Opioid Conference (June 2018).
- LCMH worked with the Lawrence County Drug Coalition (LCDC) to present the "Hidden in Plain Sight" Drug Room at both local high schools, at LCMH for staff to review and at the Lawrence County Health Department during it's "Kids Back to Health" Day activity (August 2018).
- Judge Shaner presented 7 reasons to leave a party and Josh Decausey, of the LCDC, spoke to the students (September 2018).
- LCMH participated, along with the Drug Coalition, in Anti-Bullying Week where students form each school recorded an Anti-Bullying message on our local radio station, WAKO and ran ads on the topic (November 2018).
- Lawrence County Senior Citizen Center hosted "Dine with a Doc" up to 6 times in 2018 where LCMH asked local providers to speak to the senior citizens on various topics ranging from diabetes to general wellness and fitness activities (2018).
- LCMH developed a Tele-Psych Program in conjunction with SIU for our local patients where they can receive care by a licensed professional without having to drive an extended distance to receive this care (May/June 2018).
- LCMH worked with local newspapers to provide stories related to various health issues and conditions in order to educate the public as well as multiple ads related to health issues and conditions such as breast cancer awareness, kidney disease, heart disease, etc. (2018).
- Net Community Benefit Expenses = $1,256,522 (Financial Assistance and Means - Tested Government Programs)

IMPLEMENTATION STRATEGY

Significant Health Needs

LCMH used the priority ranking of area health needs by Local Expert Advisors to organize the search for locally available resources as well as the response to the needs by LCMH.[28] The Implementation Strategy includes the following:

- 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, LCMH is the major hospital in the service area. LCMH is a 25-bed, acute care medical facility located in Lawrenceville, Illinois. The next closest facilities are outside the service area and include:

- Good Samaritan Hospital, Vincennes, IN; 10.3 miles (17 minutes)
- Carle Richland Memorial Hospital, Olney, IL; 21.3 miles (26 minutes)
- Crawford Memorial Hospital, Robinson, IL; 25.1 miles (32 minutes)
- Wabash General Hospital, Mount Carmel, IL; 23.2 miles (30 minutes)
- Daviess Community Hospital, Washington, IN; 32.0 miles (39 minutes)
- Sullivan County Community Hospital, Sullivan, IN; 44.0 miles (46 minutes)

All statistics analyzed to determine significant needs are “Lagging Indicators,” measures presenting results after a period of time, characterizing historical performance. Lagging Indicators tell you nothing about how the outcomes were achieved. In contrast, the 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 QHR application, Leading Indicators also must be within the ability of the hospital to influence and measure.

[28] Response to IRS Schedule H (Form 990) Part V B 3 e

1. **MENTAL HEALTH/SUICIDE/SUBSTANCE ABUSE – 2016 Significant Need; Lawrence County's Poor Mental Health Days rate is worse than the state average; Suicide is the #11 Leading Cause of Death in Lawrence County; Lawrence County's Mental and Substance Use Related Deaths and Self-Harm and Interpersonal Violence Related Deaths rates increased from 1980-2014**

Public comments received on previously adopted implementation strategy:

- *See Appendix A for full list of comments*

6. **ALCOHOL ABUSE – Local Expert Concern; Lawrence County's Alcohol-Impaired Driving Deaths is worse than the state and national averages; Residents of Lawrence County are 5% more likely to Consume 3+ Drinks per Session compared to the national average; Lawrence County's Liver Disease Related Deaths rate increased from 1980-2014**

This was not a significant health need in 2016, so no comments were solicited.

Due to the similar nature of these, one implementation plan has been created to address both needs.

LCMH services, programs, and resources available to respond to this need include:[29]

- 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
- Member of the Lawrence County Drug Coalition (See activities outlined below)
- Collaborated with the Lawrence County Sheriff's Department in Prescription Drug Take-Back activities, which allows community members the opportunity to turn in unused or expired medication for safe disposal
- Brought in national substance abuse expert (awareness/treatment/education)

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

- Continue above actions
- Working on developing a Community Health & Wellness Group Consortium
- Explore hiring a licensed clinical social worker to supplement psych coverage

[29] 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

- Explore adding geriatric outpatient psych services at LCMH
- Develop ad campaign to address mental health/behavioral health/suicide/substance abuse including alcohol abuse
    - Combination of traditional advertising campaign via radio, newsprint and mailers identifying speaking engagements and contacts for professionals to help with these conditions
    - Add social media via Facebook advertising for events focused on these topics
- Quarterly news stories developed in-house to educate the public on mental health and the options for patients as presented by local healthcare providers in Lawrence County

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

- Added tele-psych services through the SIU School of Medicine Rural Health and Social Services
    - LCMH's emergency department has seen a decrease in psych patients as a result
- LCMH published articles in the local newspaper and on social media about mental health and substance abuse
- LCMH created a community drug coalition in November 2017, bringing county, law enforcement, and hospital leaders to improve education and reduce drug use in the community. The actions taken by this coalition are as follows:
    - Conducted a survey on drug use with junior high students in local schools
    - Spoke at the IL State Opioid Conference about coalition forming in rural communities
    - Donated money to the annual Drug Court benefit
    - Sponsored Drug Take-Back Activities
    - Participation in Red Ribbon Week and Anti-Bullying activities in local schools
        - Students from the high school earned the opportunity to create a radio message against bullying on the WAKO radio station.
    - Conducted a survey for students in local junior high schools to assess the ease of accessing drugs/alcohol
    - Presented to local schools on drug abuse and alcohol abuse
        - "7 Reasons to Leave a Party"
    - Participation with the Health Department on Hidden in Plain Sight Room, held for LCMH employees and local schools during registration
    - Created the Lawrence County Community Resource Guide that provides information on the resources available to the community
    - Work with Lizz Cooley at the Egyptian Health Department to provide local businesses and school nurses training on naloxone and provide naloxone kit following training
- LCMH brought in nationally renowned clinical psychologist and stand-up comedian, Dr. Matt Belis to speak to our schools and community on his message that we need to support young people in both words and actions if

we want them to make healthy choices. The event focused on topics including: Resilience, Substance Abuse Prevention, Vaping, Social Media Issues among Kids, Stress Reduction and Adolescent Brain Development. LCMH was able to utilize a grant provided by the Illinois Critical Access Hospital Association (ICAHN) to bring Dr. Belis to Lawrenceville, IL.

- Provide depression screenings at the rural health clinic
    - LCMH's emergency department has seen a decrease in psychiatrist patients
- 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:

- Accountable Care Organization (ACO) Tracking and Ranking of the following Quality Metrics include:
    - Medicare Well Visits = 121% (FY2018)
    - Post Discharge Follow-up = 82.5% (FY2018)
    - Transitional Care Monitoring Follow-up = 79% (FY2018)
    - Transfers = 67% (4th Qtr. 2018)
    - Care Coordination = 159 patients (4th Qtr. 2018)
    - Emergency Room PCP Alignment = 52% (FY2018)
    - Emergency Room Telephone Follow-up Calls = 60% (FY2018)

        - Note: Only one RN making and collecting all data during start op of ACO. Process changed to improve number of follow-up calls made as of mid-year 2018.
    - Referral Closure = 61% (FY2018)
- Number of tele-psych consults = 212 patients (FY2018)
- Amount of drugs gathered in Take-Back Activities = 8 total bins, size- 3'tall x 12"x 12" containers, collected during FY2018

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

- Number of drug overdose deaths per 100,000 = 0/100,000 (FY2018)

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	Terry Lawrence	(618) 943-3600
A Man in Recovery Foundation	Tim Ryan	www.amirf.org
Lawrence County AA	Dr. Gary Vanwinkle	www.aasoutheasternillinois.org
Maple Street Clinic	Dr. Linda Hungerford	(618) 839-4618
Lawrence County Behavioral Health Center	Amy Marley, Lawrence County Health Department Interim Administrator	(618) 943-3754 www.lchealth.com
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

Organization	Contact Name	Contact Information
Deaconess Illinois	Jared Florence	(812) 450-5000; www.deaconess.com

2. STROKE – 2016 Significant Health Need; Stroke is the #3 Leading Cause of Death in Lawrence County; Lawrence County's Stroke rate is worse than the national average

Public comments received on previously adopted implementation strategy:

- *See Appendix A for a full list of comments*

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
- Expand telemedicine opportunities to monitor blood pressure/vital signs
- 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

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

- Continue above actions
- Increase stroke education/prevention
- Explore adding stroke as an educational speaking engagement topic put on by LCMH surgeon

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

- Through ACO maintain contact with patients post treatment
- Conduct blood pressure clinics in the community that follow the new hypertension guidelines
- Hired a care coordinator who monitors high-risk patients and provides follow up-calls on discharge/education
- Developed stroke alert process that notifies the appropriate team of providers when a patient is presenting symptoms of a stroke. In this process, a stoke alert code is sent to team members to initiate the following services:
    - CT Scan prepared and ready
    - Clotting agent mixed in pharmacy
    - Stroke care team ready for patient arrival
    - Partner facilities notified of potential transfer

- All nurses receive NIH Stroke training and certificate
- Partnership with Deaconess
    - Partnership began May 2019
- Local newspaper interviewed LCMH employee for an article about stroke symptoms and awareness
- Added increase access to speech therapy through swing bed and stroke program

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:

- Percentage of patients who came to ED with stroke symptoms who received CT results within 45 minutes of arrival = 89% (8 out of 9 acute stroke patients received their CT results in 45 minutes)
    - Note: The 9th candidate received their CT results in 51 minutes
- Stroke symptomology times and results (FY2018)
    - Door to CT scan within 15 minutes = 6/9 pts. (67%)
    - Door to available CT results within 45 minutes = 8/9pts. (89%)
    - Door to available lab results within 45 minutes = 6/9 pts. (67%)
    - Door to needle (anti-thrombolytic) within 60 minutes = 1/5pts. (20%)
    - Door to transfer from ER within 2 hours = 3/8pts. (38%)

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

- Number of stroke deaths = 62.9/100,000 residents (IL = 37.8/100,000)

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	Gene Allen, Practice Manager LCMH Primary Care Clinic	(618) 943-7273
Clinical Radiologists	Dr. Charles Neal	(217) 788-3245
Deaconess Illinois	Jared Florence	(812) 450-5000; www.deaconess.com

3. **CORONARY HEART DISEASE – 2016 Significant Need; Residents of Lawrence County are 9% less likely to receive Routine Cholesterol Screenings compared to the national average; Heart Disease is the #1 Leading Cause of Death in Lawrence County**

Public comments received on previously adopted implementation strategy:

- *See Appendix A for a full list of comments*

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
    - Tracked by LCMH
- "Dine With a Doc" education seminar on heart disease prevention/diagnosis/treatment for senior citizens
- Hired a care coordinator who monitors high-risk patients and provides follow up-calls on discharge/education

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

- Continue above actions
- Increase of cardiology coverage to see patients on a regular basis in specialty clinic through recent partnership with Deaconess

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

- Hired care coordinator through the ACO to collect data and track high-risk patients
- Conduct blood pressure clinics in the community that follow the new hypertension guidelines
- All patients that come to the emergency department receive a discharge call to ensure they have a follow-up appointment scheduled 7-14 days following their emergency room visit

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 = 421 (FY2018)

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

- Coronary Heart Disease Deaths = 211.9/100,000 residents (IL = 165.7/100,000)

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 Physicians Clinics	Gene Allen, Practice Manager LCMH Primary Care Clinic	(618) 943-7273
Deaconess Illinois	Jared Florence	(812) 450-5000; www.deaconess.com

Other local resources identified during the CHNA process that are believed available to respond to this need:[30]

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

[30] 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

4. **CANCER – 2016 Significant Need; Lawrence County's Mammography Screening rate is worse than the state and national averages; Residents of Lawrence County are 21% less likely to receive Cervical Cancer Screenings Every 2 Years compared to the national average; Cancer is the #2 Leading Cause of Death in Lawrence County; Lawrence County's Tracheal, Bronchus, and Lung Cancer rate is worse than the national average; Lawrence County's Skin Cancer rate increased from 1980-2014**

Public comments received on previously adopted implementation strategy:

- *See Appendix A for a full list of comments*

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 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
- Donate meeting space for local Cancer Board meetings
- Through community donations/benefit events to the Cancer Board of Directors, LCMH offers cancer patients free transportation, wigs, hats, etc.
- Provide periodic community education seminars on cancer
    - Colon rectal cancer, skin cancer, prostate cancer and breast cancer

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

- Continue above actions
- Research implementing stereotactic mobile services for breast core biopsies
- Continue to explore opportunities to deliver on-site oncology clinical services through recent partnership with Deaconess
- Explore hosting a 'Spring into Health' wellness fair during spring timeframe
- Cancer Education Campaign: LCMH will develop an educational seminar series presented by local physicians to the community designed to educate the community on cancer awareness and how to protect yourself
    - A focus on skin cancer, breast cancer and testicular cancer will be our initial focus with other forms of

cancer addressed

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

- Started providing tele-dermatology services in 2018
- Increased cancer screenings through wellness visits
    - Cologuard screening device offered for patients
        - Recognized by CMS now as a proof test
        - Reimbursable
        - Low cost screening
- Increased mobile mammogram availability to an additional Saturday each month
    - Also visits local businesses and nursing homes
- Upgraded mammography equipment to support 3-0 Imaging services
- Upgraded the MRI magnet to enhance image quality

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 total mammography screenings provided = 682 (FY2018)

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

- Cancer Death Rate = 190.6/100,000 residents (IL = 163.4/100,000)

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

Organization	Contact Name	Contact Information
Local Physicians	Gene Allen, Practice Manager LCMH Primary Care Clinic	(618) 943-7273
Lawrence County Cancer Resource Center	Susan Gher	(618) 943-3302
American Cancer Society		www.cancer.org
Deaconess Illinois	Jared Florence	(812) 450-5000; www.deaconess.com

Other local resources identified during the CHNA process that are believed available to respond to this need:[31]

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

[31] 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

5. **AFFORDABILITY – Local Expert Concern; Lawrence County's Unemployment rate is worse than the state and national averages**

Public comments received on previously adopted implementation strategy:

- *See Appendix A for a full list of comments*

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

- Radiology Director works with Prairie State Women's Health through the Illinois Breast and Cervical Cancer Program, a state funded program for underinsured women
- LCMH employee assists patients with state funding registration
- LCMH Financial Assistance Policy
- Lawrence County Community Resource Guide that provides information on the resources available to the community
- Rural health clinic provides free sports physicals to local students
- LCMH Providers conducted free health screenings at the local health department on Health Day
- Price list available on website
- LCMH charity care program provides over $1M annually to cover costs of care
- Participation in Medicaid and Medicaid Managed Care Organizations
- Opened acute care clinic in 2017 with "after-hours" access
- Offered CLIA-waived influenza A/B, RSV & Strep A testing
- Regular communication with health department
    - Bi-monthly meeting to discuss tactics to address community needs in the community

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

- Continue above actions
- Research implementing an additional rural health clinic
- Enhance hospital behavioral health services with geriatric psych services
- Explore expanding affordable services through recent partnership with Deaconess
- Explore opportunity to make price transparency information more relatable
- Conduct regular chargemaster reviews to ensure pricing transparency
- Radiology Director is working with the Illinois Critical Access Hospital Association to research possible grant funding for some services related to mammography

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:

- Shift in after-hours visits to the acute clinic visits vs LCMH Emergency Department
- Net Community Benefit Expenses Reported in 2018 = $1,256,522 (Financial Assistance and Means - Tested Government Programs)
- Annual Charity Care Contribution (Reported on Form 990) = $628,789

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

- Number of Lawrence County residents enrolled in Medicaid program in 2017 = 3,542[32]
- Hospital Medicaid Payer Mix (% of Hospital Volumes with Medicaid as the primary payer) = 28%

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

Organization	Contact Name	Contact Information
Department of Health and Human Services	Amy Marley, Interim Administrator	(818) 943-3302; RR1 P.O. Box 418, Lawrenceville, IL
Deaconess Illinois	Jared Florence	(812) 450-5000; www.deaconess.com

[32] https://www.illinois.gov/hfs/info/factsfigures/Program%20Enrollment/Pages/lawrence.aspx

Organization	Contact Name	Contact Information
Prairie State Women's Health		https://montgomeryco.com/health/BCCP/IBCCP.html

7. **EDUCATION/PREVENTION – Local Expert Concern; Lawrence County's Preventable Hospital Stays is worse than the state and national averages; Residents of Lawrence County are 9% less likely to receive Routine Cholesterol Screening compared to the national average; Residents of Lawrence County are 21% less likely to receive Cervical Cancer Screenings Every 2 Years compared to the national average**

Public comments received on previously adopted implementation strategy:

- *See Appendix A for a full list of comments*

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

- 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
- Member of the Lawrence County Drug Coalition (see activities outlined below)
- Collaborated with the Lawrence County Sherriff's Department in Prescription Drug Take-Back activities, which allows community members the opportunity to turn in unused of expired medication for safe disposal
- Expanded rehabilitation services to treat stroke patients
- Expand telemedicine opportunities to monitor blood pressure/vital signs
- Hired a care coordinator who monitors high-risk patients and provides follow-up calls on discharges/education
- Implemented 'Get with the Guidelines' stroke readiness protocol in Emergency Department
- Lawrence County Community Resource Guide that provides information on the resources available to the community
- Rural health clinic provides free sports physicals to local students
- LCMH Providers conducted free health screenings at the local health department on Health Day
- Offered CLIA-waived influenza A/B, RSV & Strep A testing
- LCMH Diagnostic Imaging
- LCMH Laboratory Services
- LCMH screening colonoscopy
- Weekly visiting OB/GYN at clinic providing cervical cancer screenings
- 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
- Research implementing stereotactic mobile services for breast core biopsies

- Explore hosting a 'Spring into Health' wellness fair during spring timeframe
- 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
- Conduct blood pressure clinics in the community that follow the new hypertension guidelines
- All patients that come to the emergency department receive a discharge call to ensure they have a follow-up appointment scheduled 7-14 days following their emergency room visit
- Financial support provided to local law enforcement agencies (drug awareness programs) for the local school district

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

- Continue above actions
- Develop ad campaign to address mental health/behavioral health/suicide/substance abuse including alcohol abuse
    - Combination of traditional advertising campaign via radio, newsprint and mailers identifying speaking engagements and contacts for professionals to help with these conditions
    - Add social media via Facebook advertising for events focused on these topics
- Quarterly news stories developed in-house to educate the public on mental health and the options for patients as presented by local healthcare providers in Lawrence County
- Develop a Community Health & Wellness Consortium made up of healthcare professionals, health related businesses, local schools and community stakeholders to address overall community health and wellness
- Cancer Education Campaign: LCMH will develop an educational seminar series presented by local physicians to the community designed to educate the community on cancer awareness and how to protect yourself
    - A focus on skin cancer, breast cancer and testicular cancer will be our initial focus with other forms of cancer addressed
- Radiology Director is working with the Illinois Critical Access Hospital Association to research possible grant funding for some services related to mammography
- Increase stroke education/prevention
- Explore adding stroke as an educational speaking engagement topic put on by LCMH surgeon

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 community education seminars
- Number of total mammography screenings provided = 682 (FY2018)

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

- Preventable Hospital Stays in Lawrence County

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

Organization	Contact Name	Contact Information
Department of Health and Human Services	Amy Marley, Interim Administrator	(818) 943-3302; RR1 P.O. Box 418, Lawrenceville, IL
Deaconess Illinois	Jared Florence	(812) 450-5000; www.deaconess.com
Prairie State Women's Health		https://montgomeryco.com/health/BCCP/IBCCP.html
Local Physicians	Gene Allen, Practice Manager LCMH Primary Care Clinic	(618) 943-7273

Organization	Contact Name	Contact Information
Lawrence County Cancer Resource Center	Susan Gher	(618) 943-3302
American Cancer Society		www.cancer.org
American Heart Association		www.heart.org/HEARTORG
Lawrence County Sherriff Department	Russell Adams	(618) 943-5766; www.usacops.com/il/s62439

Other Needs Identified During CHNA Process

8. **Chronic Pain Management**
9. **Obesity**
10. **Alzheimer's**
11. **Accessibility**
12. **Diabetes**
13. **Flu-Pneumonia**
14. **Dental**
15. **Hypertension**
16. **Women's Health**
17. **Lung Disease**
18. **Physical Inactivity**
19. **Accidents**
20. **Kidney Disease**
21. **Liver Disease**
22. **Stroke Education**

Overall Community Need Statement and Priority Ranking Score

Significant needs where hospital has implementation responsibility[33]

1. Mental Health/Suicide/Substance Abuse – 2016 Significant Need
2. Stroke – 2016 Significant Need
3. Coronary Heart Disease – 2016 Significant Need
4. Cancer – 2016 Significant Need
5. Affordability
6. Alcohol Abuse
7. Education/Prevention

Significant needs where hospital did not develop implementation strategy[34]

1. None

Other needs where hospital developed implementation strategy

1. None

Other needs where hospital did not develop implementation strategy

1. None

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

APPENDIX

Appendix A – Written Commentary on Prior CHNA (Local Expert Survey)

Hospital solicited written comments about its 2016 CHNA.[35] NUMBER 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, please give a description of your role in the community.

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	8	7	15
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	7	7	14
3) **Priority Populations**	5	9	14
4) Representative/Member of **Chronic Disease Group** or Organization	1	13	14
5) Represents the **Broad Interest of the Community**	13	2	15
Other			2
Answered Question			15
Skipped Question			0

Congress defines "Priority Populations" to include:

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

2. Do any of these populations exist in your community, and if so, do they have any unique needs that should be addressed?

- *Lack of reliable transportation. Low threshold of what would be considered as affordable healthcare. Education on wellness & prevention.*

[35] Responds to IRS Schedule H (Form 990) Part V B 5

- *Mental health diagnosis*
- *Decreased availability of medical professional in the community to treat the lower income.*
- *Availability of convenient, affordable healthcare.*
- *We have a high incidence of obesity, smoking, and drug use. Deaths by heart disease remains largest cause*
- *Affordable housing, affordable medications, home health visits to assess health status of older adults on a periodic basis*
- *Racial and ethnic minority groups was selected though this is a seasonal influx not year round*

In the 2016 CHNA, there were seven health needs identified as "significant" or most important:

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

3. Should the hospital continue to consider and allocate resources to help improve the needs identified in the 2016 CHNA?

	Yes	No	Response Count
Mental Health/Suicide/Substance Abuse	13	1	14
Coronary Heart Disease	12	1	13
Cancer	12	0	12
Stroke	12	1	13

Comments:

- *I think chronic illness especially diabetes also need some consideration*
- *I feel our local health department does a good job treating mental health and cancer care is mostly covered by specialty clinics outside the area.*
- *Morbid obesity is also an issue in this community.*
- *While all of the above mentioned are important to focus on, I would suggest a heavier focus on the mental health/suicide/substance abuse needs. To sustain a healthy, thriving community we need mentally healthy community members. Education in a more deliberate manner might help. Re imagining mental health (depression/anxiety, etc.) needs major attention. There is a negative connotation with the act of asking for help.*

6. Please share comments or observations about the actions LCMH has taken to address <u>MENTAL HEALTH/SUICIDE/SUBSTANCE ABUSE</u>.

- *I am not qualified to answer this question.*
- *Continued services currently available.*
- *Known Actions taken: Drug coalition established and active. Tele psych services available through clinic. Continued needs: Detox beds at hospital. Psych floor at hospital to treat those in MH crisis (huge shortage in this*

area). Additional education for PCP's/NP's prescribing psych medications (to kids specifically) to ensure high quality of care and competence. Active engagement with local agency providing behavior/mental health services to clients.

- *Continue services / promote education*
- *I think these are still appropriate*
- *Did start tele psych services and our ED has implemented strict discipline in prescribing narcotics*
- *Tele psych Services have been initiated.*

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

- *I am not qualified to answer this question.*
- *Good use of therapy in recovery from heart attacks*
- *Continued services currently available*
- *Unfamiliar with these programs*
- *Continue services / LCMH lacks in coronary heart specialist / need to increase availability*
- *Still appropriate*
- *Unsure if any action taken*
- *Not aware*

8. Please share comments or observations about the actions LCMH has taken to address <u>CANCER</u>.

- *I am not qualified to answer this question.*
- *Continued services currently available*
- *Unfamiliar with these programs*
- *Need to increase oncology department / limited offerings*
- *Mostly appropriate, due to low demand and cost of stereotactic breast biopsy, LCMH works with GSH to provide this service to the community*
- *Active Mammogram screening promotion*
- *Not aware*

9. Please share comments or observations about the actions LCMH has taken to address <u>STROKE</u>.

- *I am not qualified to answer this question.*
- *Instituted 24 hours stroke coverage.*

- *Unfamiliar with these programs*
- *Continue services*
- *Still appropriate*
- *Unsure of any action taken*
- *Not aware*

Appendix B – Identification & Prioritization of Community Needs (Local Expert Survey Results)

Need Topic	Total Votes	Number of Local Experts Voting for Needs	Percent of Votes	Cumulative Votes	Need Determination
Mental Health/Suicide/Substance Abuse – 2016 Significant Need	138	11	11.5%	11.5%	Significant Needs
Stroke – 2016 Significant Need	120	10	10.0%	21.5%	
Coronary Heart Disease – 2016 Significant Need	118	11	9.8%	31.3%	
Cancer – 2016 Significant Need	116	10	9.7%	41.0%	
Affordability	77	10	6.4%	47.4%	
Alcohol Abuse	72	11	6.0%	53.4%	
Education/Prevention	68	11	5.7%	59.1%	
Chronic Pain Management	63	10	5.3%	64.3%	Other Identified Needs
Obesity	54	9	4.5%	68.8%	
Suicide	50	8	4.2%	73.0%	
Alzheimer's	39	10	3.3%	76.3%	
Accessibility	36	9	3.0%	79.3%	
Diabetes	36	8	3.0%	82.3%	
Flu/Pneumonia	35	9	2.9%	85.2%	
Dental	34	9	2.8%	88.0%	
Hypertension	30	8	2.5%	90.5%	
Women's Health	27	7	2.3%	92.8%	
Lung Disease	26	7	2.2%	94.9%	
Physical Inactivity	17	7	1.4%	96.3%	
Accidents	16	8	1.3%	97.7%	
Kidney Disease	13	7	1.1%	98.8%	
Liver Disease	13	7	1.1%	99.8%	
Points reserved for NEW health needs listed above	2	5	0.2%	100.0%	
Total	1200		100.00%		

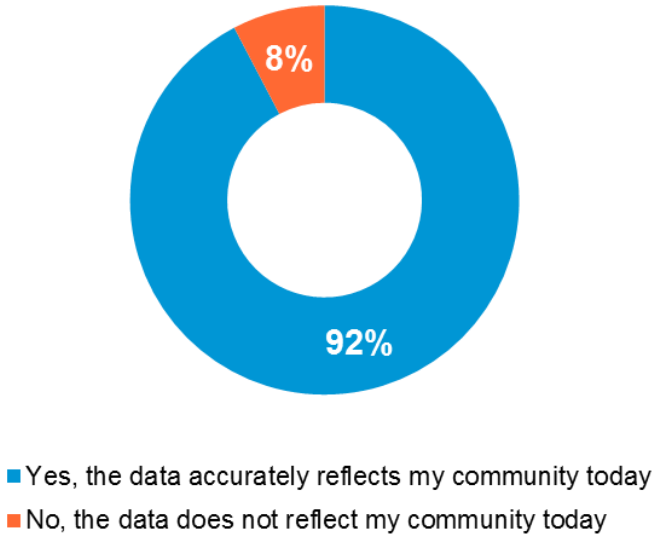
Individuals Participating as Local Expert Advisors[36]

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	8	7	15
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	7	7	14
3) **Priority Populations**	5	9	14
4) Representative/Member of **Chronic Disease Group** or Organization	1	13	14
5) Represents the **Broad Interest of the Community**	13	2	15
Other			2
Answered Question			15
Skipped Question			0

Advice Received from Local Expert Advisors

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

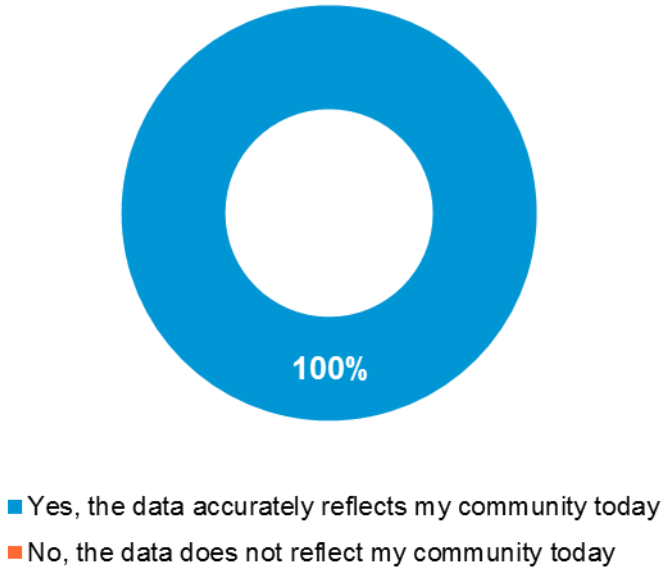
[36] Responds to IRS Schedule H (Form 990) Part V B 3 g



Comments:

- *Being a border county to Indiana, with care less than 20 miles away is not reflected. Lawrence County residents have become used to driving for services outside of the county.*
- *I wonder if the children in poverty could be larger - it sure seems to be more than 25%. Perhaps schools would have an accurate picture. I know we have a high poverty rate and many children need to take advantage of free or reduced rate meals at school and also a weekend meal program distributed by a volunteer group called Fishes and Loaves*
- *Quality of life and health behaviors may have worsened over the past three years.*
- *Though, I might add that seeing these numbers it appears we need another dentist and perhaps one that accepts Medicaid since we are in a rural low income area. I do think that while our numbers do not show a promising light especially in the Clinical Care area, the quality of the clinical care Lawrence County offers is very good in my opinion.*

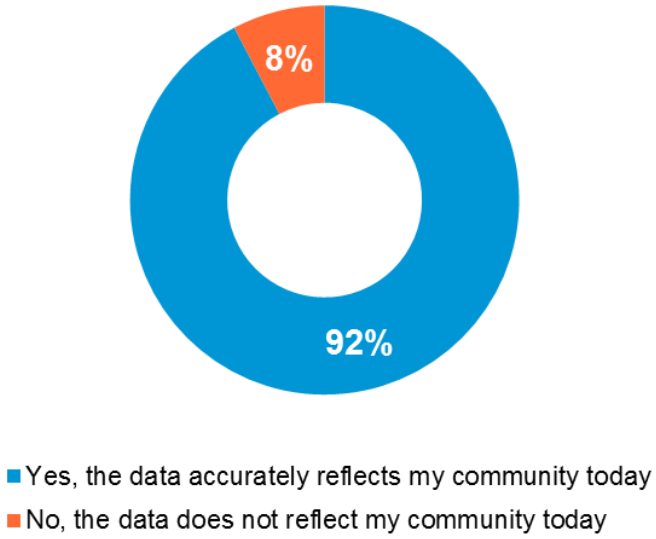
Question: Do you agree with the demographics and common health behaviors of Lawrence County?



Comments:

- *A higher percentage is less likely to exercise at this time.*

Question: Do you agree with the overall social vulnerability index for Lawrence County?



Comments:

- *We do not see much difference between the top and lower halves of the county. We wonder if low population density can somehow skew the data.*
- *I'm really not sure*

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

Comments:

- *Substance abuse deaths may now be on this list.*

Question: Do you agree with the health trends in Lawrence County?

Comments:

- *I'm sorry but cannot agree or disagree with the above data*
- *Male substance abuse deaths may now be higher.*

Appendix C – National Healthcare Quality and Disparities Report[37]

The National Healthcare Quality and Disparities Reports (QDR; annual reports to Congress mandated in the Healthcare Research and Quality Act of 1999 (P.L. 106-129)) are based on more than 300 healthcare process, outcome, and access measures, covering a wide variety of conditions and settings. Data years vary across measures; most trend analyses include data points from 2000-2002 to 2012-2015. An exception is rates of uninsured, which we are able to track through 2017. The reports are produced with the support of an HHS Interagency Work Group (IWG) and guided by input from AHRQ's National Advisory Council and the Institute of Medicine (IOM), now known as the Health and Medicine Division of the National Academies of Sciences, Medicine, and Engineering.

For the 15th year in a row, the Agency for Healthcare Research and Quality (AHRQ) has reported on progress and opportunities for improving healthcare quality and reducing healthcare disparities. As mandated by the U.S. Congress, the report focuses on "national trends in the quality of health care provided to the American people" (42 U.S.C. 299b-2(b)(2)) and "prevailing disparities in health care delivery as it relates to racial factors and socioeconomic factors in priority populations" (42 U.S.C. 299a-1(a)(6)).

The 2017 report and chartbooks are organized around the concepts of access to care, quality of care, disparities in care, and six priority areas—including patient safety, person-centered care, care coordination, effective treatment, healthy living, and care affordability. Summaries of the status of access, quality, and disparities can be found in the report.

The report presents information on trends, disparities, and changes in disparities over time, as well as federal initiatives to improve quality and reduce disparities. It includes the following:

- **Overview of Quality and Access in the U.S. Healthcare System** that describes the healthcare systems, encounters, and workers; disease burden; and healthcare costs.
- **Variation in Health Care Quality and Disparities** that presents state differences in quality and disparities.
- **Access and Disparities in Access to Healthcare** that tracks progress on making healthcare available to all Americans.
- **Trends in Quality of Healthcare** that tracks progress on ensuring that all Americans receive appropriate services.
- **Trends in Disparities** that tracks progress in closing the gap between minority racial and ethnic groups and Whites, as well as income and geographic location gaps (e.g., rural/suburban disparities).
- **Looking Forward** that summarizes future directions for healthcare quality initiatives.

Key Findings

Access: An estimated 43% of access measures showed improvement (2000-2016), 43% did not show improvement, and 14% showed worsening. For example, from 2000 to 2017, there were significant gains in the percentage of people who reported having health insurance.

[37] http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/index.html Responds to IRS Schedule H (Form 990) Part V B 3 i

Quality: Quality of healthcare improved overall from 2000 through 2014-2015, but the pace of improvement varied by priority area:

- Person-Centered Care: Almost 70% of person-centered care measures were improving overall.
- Patient Safety: More than two-thirds of patient safety measures were improving overall.
- Healthy Living: More than half of healthy living measures were improving overall.
- Effective Treatment: More than half of effective treatment measures were improving overall.
- Care Coordination: Half of care coordination measures were improving overall.
- Care Affordability: Eighty percent of care affordability measures *did not* change overall.

Disparities: Overall, some disparities were getting smaller from 2000 through 2014-2015; but disparities persist, especially for poor and uninsured populations in all priority areas.

Trends

- Trends show that about 55% percent of quality measures are improving overall for Blacks.[38] However, most recent data in 2014-2015 show that about 40% of quality measures were worse for Blacks compared with Whites.
- Trends show that about 60% of quality measures are improving overall for Asians. However, most recent data in 2014-2015 show that 20% of quality measures were worse for Asians compared with Whites.
- Trends show that almost 35% of quality measures are improving overall for American Indians/Alaska Natives (AI/ANs). However, most recent data in 2014-2015 show that about 30% of quality measures were worse for AI/ANs compared with Whites.
- Trends show that approximately 25% of quality measures are improving overall for Native Hawaiians/Pacific Islanders (NHPIs). However, most recent data in 2014-2015 show that nearly 33% of quality measures were worse for NHPIs compared with Whites.
- Trends show that about 60% of quality measures are improving overall for Hispanics, but in 2014-2015, nearly 33% of quality measures were worse for Hispanics compared with non-Hispanic Whites.
- Variation in care persisted across the urban-rural continuum in 2014-2016, especially in access to care and care coordination.

Looking Forward

The National Healthcare Quality and Disparities Report (QDR) continues to track the nation's performance on healthcare access, quality, and disparities. The QDR data demonstrate significant progress in some areas and identify other areas that merit more attention where wide variations persist. The number of measures in each priority area varies, and some measures carry more significance than others as they affect more people or have more significant consequences. The summary charts are a way to quantify and illustrate progress toward achieving accessible, high-quality, and affordable

[38] Throughout this report and its appendixes, "Blacks" refers to Blacks or African Americans, and "Hispanics" refers to Hispanics or Latinos. More information is available in the Reporting Conventions section of the Introduction and Methods.

care at the national level using available nationally representative data. The summary charts are accessible via the link below.

This report shows that while performance for most access measures did not change significantly over time (2000-2014), insurance coverage rates did improve (2000-2016). Quality of healthcare improved in most areas but some disparities persist, especially for poor and low-income households and those without health insurance.

U.S. Department of Health and Human Services (HHS) agencies are working on research and conducting programs in many of the priority areas—most notably opioid misuse, patient safety, effective treatment, and health disparities.

Link to the full report:

https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/2017qdr.pdf

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

Illustrative IRS Schedule h Part V Section B (Form 990)[39]

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 footnote 16 on page 11

   b. **Demographics of the community**

      See footnote 19 and 20 on page 12

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

      See footnote 29 on page 25

   d. **How data was obtained**

      See footnote 11 on page 8

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

      See footnote 28 on page 24

   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 36 on page 49

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

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

See footnotes 8 and 9 on page 7

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

See footnote 10 on page 8, footnotes 14 on page 9, and footnote 23 on page 16

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

N/A

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

2016

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 14 on page 9 and footnote 35 on page 45

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://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)**

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**

Yes

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

   2016

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

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

       https://lcmhosp.org/wp-content/uploads/2018/02/Assessment_2016.pdf

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

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

    See footnote 29 on page 25

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