Jennie Stuart Medical Center

Hopkinsville, Kentucky

Community Health Needs Assessment
and Implementation Strategy

Approved by Board on December 7, 2016[1]

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

Dear Community Member:

At Jennie Stuart Medical Center (JSMC), we have spent more than 100 years providing high-quality compassionate healthcare to the greater Hopkinsville community. The “2016 Community Health Needs Assessment” identifies local health and medical needs and provides a plan of how JSMC 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.

JSMC 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,

Eric Lee
Chief Executive Officer
Jennie Stuart Medical Center

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EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

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

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

The Significant Health Needs for Christian County are:

1. Alcohol/Substance Abuse
2. Obesity/Overweight
3. Cancer
4. Prevention/Wellness
5. Mental Health
6. Affordability/Accessibility
7. Coronary Heart Disease

The Hospital has developed implementation strategies for five of the seven needs (Alcohol/Substance Abuse, Obesity/Overweight, Cancer, Affordability/Accessibility, and Coronary Heart Disease) including activities to continue/pursue, community partners to work alongside, and leading and lagging indicators to track.

APPROACH

APPROACH

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

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

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

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

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

Project Objectives

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

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

Overview of Community Health Needs Assessment

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

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

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

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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 2014 Draft Federal 990 schedule h instructions i990sh—dft(2) and tax form

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

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

Specifically, the IRS requires:

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

Community Health Needs Assessment Subsequent to Initial Assessment

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

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

[5] Section 6652

the health needs of the community;

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

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

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

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

To complete a CHNA:

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

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

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

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

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

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

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

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

conducting the CHNA."[7]

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

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

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

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

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

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

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

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

Other (please specify)

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

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

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

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

county.[10]

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

Data sources include:[11]

Website or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Christian County compared to all State counties	September 2, 2016	2012
www.cdc.gov/communityhealth	Assessment of health needs of Christian County compared to its national set of "peer counties"	September 2, 2016	2011
Truven (formerly known as Thompson) Market Planner	Assess characteristics of the hospital's primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according to the proportion of each group in the entire area; and, to access population size, trends and socio-economic characteristics	September 2, 2016	2016
www.capc.org and www.getpalliativecare.org	To identify the availability of Palliative Care programs and services in the area	September 2, 2016	2015
www.caringinfo.org and iweb.nhpco.org	To identify the availability of hospice programs in the county	September 2, 2016	2015
www.healthmetricsandevaluation.org	To examine the prevalence of diabetic conditions and change in life expectancy	September 2, 2016	2010
www.cdc.gov	To examine area trends for heart disease and stroke	September 2, 2016	2010

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

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

http://svi.cdc.gov	To identify the Social Vulnerability Index value	September 2, 2016	2010
www.CHNA.org	To identify potential needs from a variety of resources and health need metrics	September 2, 2016	2015
www.datawarehouse.hrsa.gov	To identify applicable manpower shortage designations	September 2, 2016	2015
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	September 2, 2016	2015

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

- We deployed a CHNA "Round 1" survey to our Local Expert Advisors to gain input on local health needs and the needs of priority populations. Local Expert Advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and the Hospital's desire to represent the region's geographically and ethnically diverse population. We received community input from 25 Local Expert Advisors. Survey responses started August 9, 2016 and ended with the last response on August 27, 2016.
- Information analysis augmented by local opinions showed how Christian County relates to its peers in terms of primary and chronic needs and other issues of uninsured persons, low-income persons, and minority groups. Respondents commented on whether they believe certain population groups ("Priority Populations") need help to improve their condition, and if so, who needs to do what to improve the conditions of these groups.[12]
- Local opinions of the needs of Priority Populations, while presented in its entirety in the Appendix, was abstracted in the following "take-away" bulleted comments
    - Racial and ethnic minority groups exist within Christian County
    - Accessibility and transportation are issues given the rural nature of the area
    - There is a lack of ability to obtain mental health services in the community

When the analysis was complete, we put the information and summary conclusions before our Local Expert Advisors[13] who were asked to agree or disagree with the summary conclusions. They were free to augment potential conclusions with additional comments of need, and new needs did emerge from this exchange.[14] Consultation with 19 Local Experts occurred again via an internet-based survey (explained below) beginning September 7, 2016 and ending September 26, 2016.

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

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

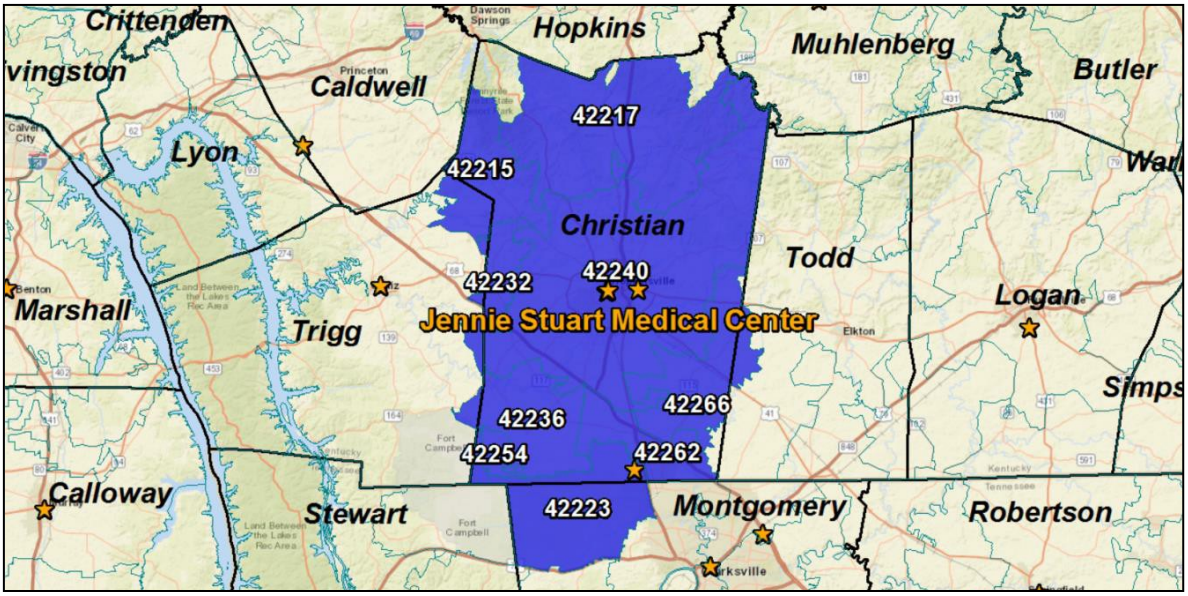
In the JSMC process, each Local Expert had the opportunity to introduce needs previously unidentified and to challenge conclusions developed from the data analysis. While there were a few opinions of the data conclusions not being completely accurate, the vast majority of comments agreed with our findings.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

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

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

COMMUNITY CHARACTERISTICS

Definition of Area Served by the Hospital[17]



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

42215 – Cerulean	42217 – Crofton	42223 – Fort Campbell	42232 – Gracey
42236 – Herndon	42240 – Hopkinsville	42254 – La Fayette	42262 – Oak Grove
42266 – Pembroke			

In 2014, the Hospital received 71.4% of its patients from this area.[19]

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

Demographics of the Community[20] [21]

	Christian County	Kentucky	U.S.
2016 Population[22]	**82,342**	**4,444,362**	**322,431,073**
% Increase/Decline	**1.4%**	**2.0%**	**3.7%**
Estimated Population in 2021	**83,516**	**4,533,548**	**334,341,965**
% White, non-Hispanic	**65.7%**	**84.8%**	**61.3%**
% Black, non-Hispanic	**19.8%**	**8.1%**	**12.3%**
Median Age	**31.2**	**38.9**	**38.0**
Median Household Income	**$45,328**	**$45,239**	**$55,072**
Unemployment Rate	**6.5%**	**4.9%**	**4.9%**
% Population >65	**10.3%**	**15.5%**	**15.1%**
% Women of Childbearing Age	**20.3%**	**19.1%**	**19.6%**

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

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA
2010 Total Population	80,717	308,745,538
2016 Total Population	82,342	322,431,073
2021 Total Population	83,516	334,341,965
% Change 2016 - 2021	1.4%	3.7%
Average Household Income	$62,297	$77,135

	2016	2021	% Change
Total Male Population	43,046	43,706	1.5%
Total Female Population	39,296	39,810	1.3%
Females, Child Bearing Age (15-44)	16,687	16,767	0.5%

POPULATION DISTRIBUTION

Age Distribution

Age Group	2016	% of Total	2021	% of Total	USA 2016 % of Total
0-14	20,637	25.1%	20,618	24.7%	19.0%
15-17	3,146	3.8%	3,527	4.2%	4.0%
18-24	11,664	14.2%	11,158	13.4%	9.8%
25-34	14,148	17.2%	13,340	16.0%	13.3%
35-54	17,446	21.2%	18,898	22.6%	26.0%
55-64	6,822	8.3%	6,764	8.1%	12.8%
65+	8,479	10.3%	9,211	11.0%	15.1%
Total	82,342	100.0%	83,516	100.0%	100.0%

HOUSEHOLD INCOME DISTRIBUTION

Income Distribution

2016 Household Income	HH Count	% of Total	USA % of Total
<$15K	4,357	15.4%	12.3%
$15-25K	3,220	11.4%	10.4%
$25-50K	7,960	28.1%	23.4%
$50-75K	5,710	20.2%	17.6%
$75-100K	2,713	9.6%	12.0%
Over $100K	4,370	15.4%	24.3%
Total	28,330	100.0%	100.0%

EDUCATION LEVEL

Education Level Distribution

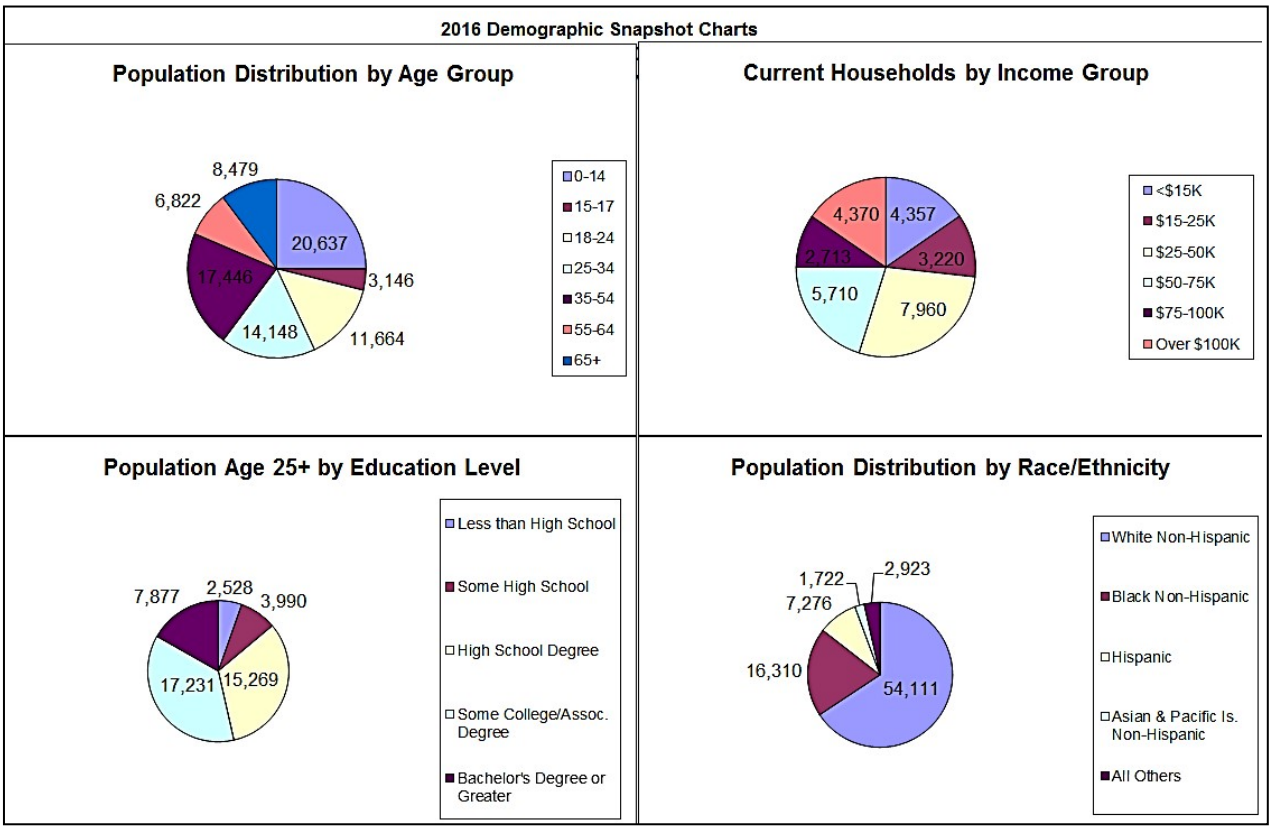
2016 Adult Education Level	Pop Age 25+	% of Total	USA % of Total
Less than High School	2,528	5.4%	5.8%
Some High School	3,990	8.5%	7.8%
High School Degree	15,269	32.6%	27.9%
Some College/Assoc. Degree	17,231	36.7%	29.2%
Bachelor's Degree or Greater	7,877	16.8%	29.4%
Total	46,895	100.0%	100.0%

RACE/ETHNICITY

Race/Ethnicity Distribution

Race/Ethnicity	2016 Pop	% of Total	USA % of Total
White Non-Hispanic	54,111	65.7%	61.3%
Black Non-Hispanic	16,310	19.8%	12.3%
Hispanic	7,276	8.8%	17.8%
Asian & Pacific Is. Non-Hispanic	1,722	2.1%	5.4%
All Others	2,923	3.5%	3.1%
Total	82,342	100.0%	100.0%

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



2016 Benchmarks
Area: Christian County
Level of Geography: ZIP Code

Area	2016-2021 % Population Change	Median Age	Population 65+ % of Total Population	Population 65+ % Change 2016-2021	Females 15-44 % of Total Population	Females 15-44 % Change 2016-2021	Median Household Income	Median Household Wealth	Median Home Value
USA	3.7%	38.0	15.1%	17.6%	19.6%	1.5%	$55,072	$54,224	$192,364
Kentucky	2.0%	38.9	15.5%	16.8%	19.1%	0.0%	$45,239	$48,691	$129,800
Selected Area	1.4%	31.2	10.3%	8.6%	20.3%	0.5%	$45,328	$34,501	$125,124

Demographics Expert 2.7
DEMO0003.SQP

Customer Segmentation

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

Claritas Prizm Segments	Characteristics	
Segment #1 (15%)	• Urbanicity: Town/Rural • Income: Upper Mid • Age Ranges: Age 45-64 • Presence of Kids: HH w/o Kids	• Homeownership: Mostly Owners • Employment Levels: Mix • Education Levels: College Graduate • Ethnic Diversity: White
Segment #2 (10%)	• Urbanicity: Town/Rural • Income: Low Income • Age Ranges: Age 25-44 • Presence of Kids: HH w/ Kids	• Homeownership: Mostly Renters • Employment Levels: Service Mix • Education Levels: High School • Ethnic Diversity: White, Black, Hispanic, Mix
Segment #3 (9%)	• Urbanicity: Second City • Income: Lower Mid • Age Ranges: Age 25-44 • Presence of Kids: HH w/ Kids	• Homeownership: Mostly Renters • Employment Levels: Service Mix • Education Levels: High School • Ethnic Diversity: White, Black, Asian, Hispanic, Mix
Segment #4 (9%)	• Urbanicity: Second City • Income: Low Income • Age Ranges: Age 35-54 • Presence of Kids: HH w/o Kids	• Homeownership: Mostly Renters • Employment Levels: Service Mix • Education Levels: High School • Ethnic Diversity: White, Black, Asian, Hispanic, Mix
Segment #5 (7%)	• Urbanicity: Rural • Income: Lower Mid • Age Ranges: Age 45-64 • Presence of Kids: HH w/o Kids	• Homeownership: Homeowners • Employment Levels: Blue Collar Mix • Education Levels: High School • Ethnic Diversity: White

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

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

Health Service Topic	Demand as % of National	% of Population Affected	Health Service Topic	Demand as % of National	% of Population Affected
Weight / Lifestyle			**Cancer**		
BMI: Morbid/Obese	115.7%	35.6%	Mammography in Past Yr	93.9%	42.8%
Vigorous Exercise	100.6%	57.7%	Cancer Screen: Colorectal 2 yr	93.8%	24.0%
Chronic Diabetes	122.6%	15.3%	Cancer Screen: Pap/Cerv Test 2 yr	93.3%	55.9%
Healthy Eating Habits	89.0%	26.4%	Routine Screen: Prostate 2 yr	89.7%	28.8%
Ate Breakfast Yesterday	95.9%	76.1%	**Orthopedic**		
Slept Less Than 6 Hours	118.1%	16.2%	Chronic Lower Back Pain	127.2%	30.0%
Consumed Alcohol in the Past 30 Days	90.7%	48.9%	Chronic Osteoporosis	99.8%	9.8%
Consumed 3+ Drinks Per Session	103.1%	29.2%	**Routine Services**		
Behavior			FP/GP: 1+ Visit	101.9%	89.9%
I Will Travel to Obtain Medical Care	96.7%	22.0%	Used Midlevel in last 6 Months	101.5%	42.0%
I am Responsible for My Health	94.6%	61.8%	OB/Gyn 1+ Visit	94.2%	43.5%
I Follow Treatment Recommendations	92.5%	48.0%	Medication: Received Prescription	97.6%	58.9%
Pulmonary			**Internet Usage**		
Chronic COPD	108.6%	4.3%	Use Internet to Talk to MD	76.0%	9.2%
Tobacco Use: Cigarettes	114.5%	29.1%	Facebook Opinions	95.4%	9.8%
Heart			Looked for Provider Rating	88.6%	12.5%
Chronic High Cholesterol	114.1%	25.0%	**Emergency Services**		
Routine Cholesterol Screening	94.0%	47.7%	Emergency Room Use	106.2%	35.9%
Chronic Heart Failure	107.6%	4.2%	Urgent Care Use	101.5%	23.6%

Leading Causes of Death

Cause of Death			Rank among all counties in KY (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		
Christian Rank	KY Rank	Condition		KY	Christian	Observation (Compared to U.S.)
1	2	Heart Disease	55 of 120	200.5	265.4	Higher than expected
2	1	Cancer	102 of 120	198.8	196.7	As expected
3	3	Lung	36 of 120	63.9	69.2	Higher than expected
4	5	Stroke	63 of 120	41.8	55.2	As expected
5	4	Accidents	107 of 120	58.3	44.1	As expected
6	8	Flu - Pneumonia	27 of 120	20.8	31.7	Higher than expected
7	7	Diabetes	38 of 120	23.4	30.8	Higher than expected
8	9	Kidney	49 of 120	19.5	22.7	Higher than expected
9	10	Blood Poisoning	26 of 120	16.1	18.3	Higher than expected
10	6	Alzheimer's	108 of 120	32.1	16.2	Lower than expected
11	11	Suicide	51 of 120	16.0	15.6	Higher than expected
12	13	Hypertension	7 of 120	7.2	10.2	Higher than expected
13	12	Liver	43 of 120	11.5	9.7	As expected
14	15	Homicide	17 of 120	4.7	7.1	Higher than expected
15	14	Parkinson's	80 of 120	7.1	4.7	As expected

Priority Populations[23]

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

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

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

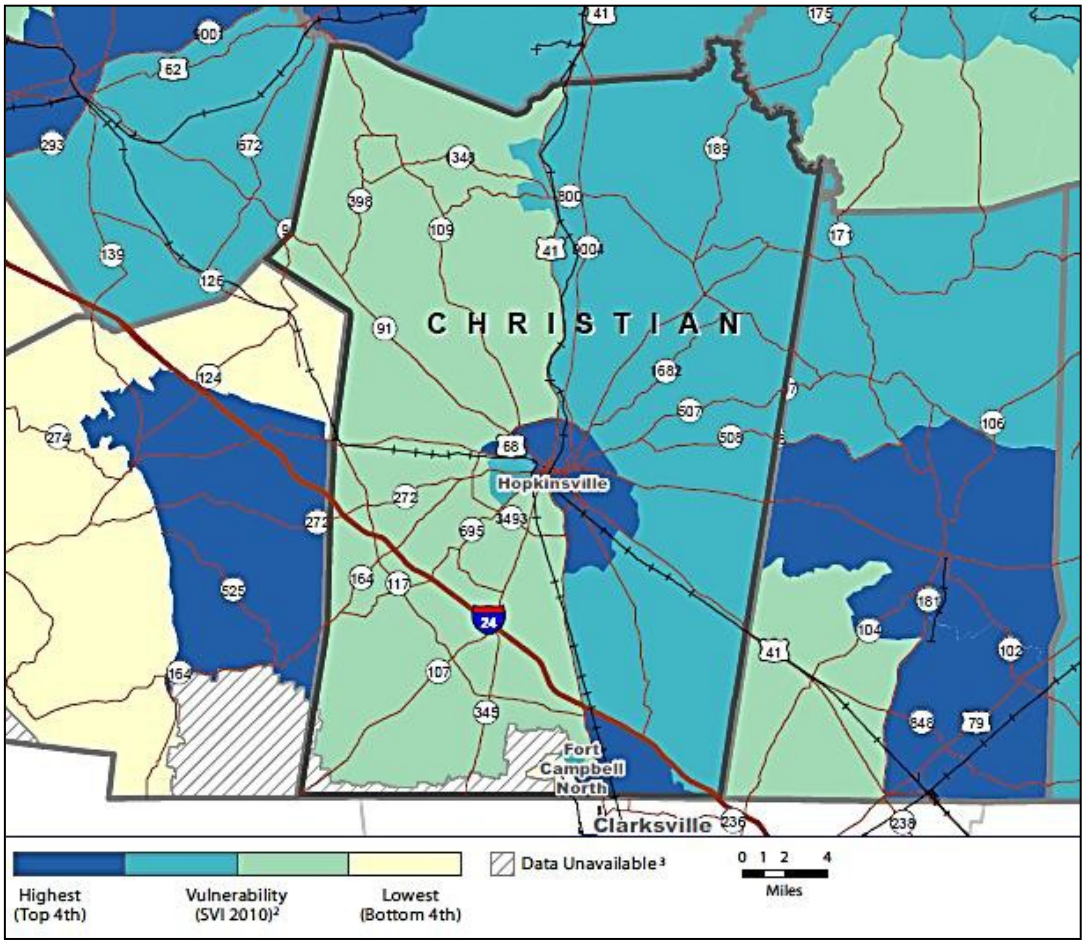
- Racial and ethnic minority groups exist within Christian County
- Accessibility and transportation are issues given the rural nature of the area
- There is a lack of ability to obtain mental health services in the community

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

Social Vulnerability

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

- The eastern half of Christian County falls primarily in the *second highest quartile*
- The western half of Christian County falls primarily in the *second lowest quartile*
- Central Christian County, around Hopkinsville, and a small piece in southern Christian County, are in the *highest quartile*



Summary of Survey Results on Prior CHNA

In the Round 1 survey, a group of 25 individuals provided feedback on the 2013 CHNA. Complete results, including *verbatim* written comments, can be found in Appendix A.

Commenter characteristics:

Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	2	15	17
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	4	14	18
3) Priority Populations	7	10	17
4) Representative/Member of Chronic Disease Group or Organization	3	15	18
5) Represents the Broad Interest of the Community	21	2	23
Other			
Answered Question			25
Skipped Question			0

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

- Substance Abuse
- Coronary Heart Disease
- Smoking/Tobacco Use
- Cancer
- Affordability/Accessibility
- Obesity/Overweight
- Prevention/Wellness
- Diabetes
- High Blood Pressure

JSMC received the following responses to the question: **"Should the hospital continue to consider the needs identified as most important in the 2016 CHNA as the most important set of health needs currently confronting residents in the county?**

	Yes	No	No Opinion
Substance Abuse	21	2	0
Coronary Heart Disease	23	0	0
Smoking/Tobacco Use	20	3	0
Cancer	22	1	0
Affordability/Accessibility	21	1	1
Obesity/Overweight	21	2	0
Prevention/Wellness	21	2	0
Diabetes	23	0	0
High Blood Pressure	22	1	0

JSMC received the following responses to the question: **"Should the Hospital continue to allocate resources to help improve the needs identified in the 2016 CHNA?"**

	Yes	No	No Opinion
Substance Abuse	20	1	2
Coronary Heart Disease	22	1	0
Smoking/Tobacco Use	18	3	2
Cancer	22	1	0
Affordability/Accessibility	20	2	1
Obesity/Overweight	19	2	2
Prevention/Wellness	19	3	1
Diabetes	23	0	0
High Blood Pressure	22	1	0

Comparison to Other State Counties

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

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

	Christian County	Kentucky	U.S. Best
Health Outcomes			
Overall Rank *(best being #1)*	69/120		
Premature Death (deaths prior to age 75)*	9,800	8,800	5,200
Health Behaviors			
Overall Rank *(best being #1)*	112/120		
Adult Smoking	27%	26%	14%
Adult Obesity	37%	32%	25%
Physical Inactivity	31%	29%	20%
Access to Exercise Opportunities	62%	70%	91%
Sexually Transmitted Infections*	617.8	391.2	134.1
Teen Births (per 1,000)	74	47	19
Clinical Care			
Overall Rank *(best being #1)*	30/120		
Uninsured	18%	17%	11%
Population to Primary Care Physician	1,950:1	1,500:1	1,040:1
Preventable Hospital Stays (per 1,000)	89	85	38
Diabetic Monitoring	85%	86%	90%
Social & Economic Factors			
Overall Rank *(best being #1)*	74/120		
High School Graduation	81%	88%	93%
Unemployment	7.6%	6.5%	3.5%

Children in Poverty	30%	26%	13%
Violent Crime*	254	235	59
Physical Environment			
Overall Rank *(best being #1)*	105/120		

**Per 100,000*

Comparison to Peer Counties

The Federal Government administers a process to allocate all 3,143 U.S. counties into "Peer" groups. County "Peer" groups have similar social, economic, and demographic characteristics. The counties are ranked across six health and wellness categories and divided into quartiles: Better (top quartile), Moderate (middle two quartiles), and Worse (bottom quartile). In the below chart, Christian County is compared to its peer counties and the U.S. average, but only areas where the county is Better or Worse are listed. (The list and number of peer counties used in each ranking may differ.)

	Christian County	Peer Ranking	U.S. Average
Mortality			
Better			
Alzheimer's Disease Deaths*	19.3	3/52	27.3
Worse			
Chronic Kidney Disease Deaths*	26.0	48/52	17.5
Chronic Lower Respiratory Disease Deaths*	66.9	50/53	49.6
Female Life Expectancy	77.7	41/53	79.8
Male Life Expectancy	72.2	46/53	75.0
Morbidity			
Better			
Older Adult Depression	10.8%	5/53	12.4%
Worse			
Adult Diabetes	12.8%	51/53	8.1%
Adult Obesity	33.5%	44/53	30.4%
Adult Overall Health Status	23.1%	51/53	16.5%
Gonorrhea*	278.6	49/53	30.5
Healthcare Access & Quality			
Better			
Uninsured	17.0%	13/53	17.7%
Worse			
Older Adult Preventable Hospitalizations (per 1,000)	103.0	52/53	71.3
Primary Care Provider Access*	50.3	48/53	48.0
Health Behaviors			

	Christian County	Peer Ranking	U.S. Average
Better			
Adult Female Routine Pap Tests	81.1%	11/52	77.3%
Worse			
Adult Physical Inactivity	32.7%	48/53	25.9%
Adult Smoking	25.7%	42/52	21.7%
Teen Births (per 1,000)	79.1	53/53	42.1
Social Factors			
Better			
Children in Single-Parent Households	33.3%	9/53	30.8%
Violent Crime*	254.3	9/53	199.2
Worse			
High Housing Costs	32.3%	42/53	27.3%
Poverty	22.0%	47/53	16.3%
Unemployment	10.9%	53/53	7.1%
Physical Environment			
Better			
Nothing	--	--	--
Worse			
Air Quality (annual average PM2.5 concentration)	12.3	44/53	10.7
Housing Stress	31.9%	42/53	28.1%

**Per 100,000*

Conclusions from Demographic Analysis Compared to National Averages

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

- BMI: Morbid/Obese = 15.7% above average, 35.6%
- I Am Responsible for My Health = 5.4% below average, 61.8%
- I Follow Treatment Recommendations = 7.5% below average, 48.0%
- Routine Cholesterol Screening = 6% below average, 47.7%
- Mammography in Past Year = 6.1% below average, 42.8%
- Cervical Cancer Screening in Past Two Years = 6.7% below average, 55.9%
- Chronic Lower Back Pain = 27.2% above average, 30.0%
- OB/Gyn Visit = 5.8% below average, 43.5%
- Emergency Room Use = 6.2% above average, 35.9%

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

- Consumed Alcohol in the Past 30 Days = 9.3% below average, 48.9%

Conclusions from Other Statistical Data

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

	Current Date of Data	Statistic	Percent Change	Last Date of Data
UNFAVORABLE COUNTY measures that are **WORSE** than the U.S. average and had an **UNFAVORABLE** change				
Female Life Expectancy	2013	76.8 years	-0.7 years	1985
Female Smoking	2012	27.7%	1.8% pts	1996
Female Obesity	2011	41.0%	8.2% pts	2001
Male Obesity	2011	40.1%	9.7% pts	2001
UNFAVORABLE COUNTY measures that are **WORSE** than the U.S. average and had an **FAVORABLE** change				
Male Life Expectancy	2013	72.0 years	2.3 years	1985
Male Smoking	2012	30.4%	-6.0% pts	1996
Female Physical Activity	2011	44.0%	12.0% pts	2001
Male Physical Activity	2011	50.9%	4.6% pts	2001
DESIRABLE COUNTY measures that are **BETTER** than the US average and had an **UNFAVORABLE** change				
Female Heavy Drinking	2012	3.9%	0.8% pts	2005
Male Heavy Drinking	2012	7.4%	1.6% pts	2005
Female Binge Drinking	2012	6.2%	2.9% pts	2002
Male Binge Drinking	2012	19.0%	4.6% pts	2002
DESIRABLE COUNTY measures that are **BETTER** than the US average and had an **FAVORABLE** change				
Nothing	--	--	--	--

Community Benefit

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

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

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

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

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

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

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

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

- $362,438 (2015)

IMPLEMENTATION STRATEGY

Significant Health Needs

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

- Identifies the rank order of each identified Significant Need
- Presents the factors considered in developing the ranking
- Establishes a Problem Statement to specify the problem indicated by use of the Significant Need term
- Identifies JSMC current efforts responding to the need including any written comments received regarding prior JSMC implementation actions
- Establishes the Implementation Strategy programs and resources JSMC will devote to attempt to achieve improvements
- Documents the Leading Indicators JSMC will use to measure progress
- Presents the Lagging Indicators JSMC 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, Jennie Stuart Medical Center is the major hospital in the service area. JSMC is a 194-bed, acute care medical facility located in Hopkinsville, Kentucky. The next closest facilities are outside the service area and include:

- Trigg County Hospital in Cadiz, KY, 19 miles (25 minutes)
- Tennova Healthcare – Clarksville in Clarksville, TN, 30 miles (34 minutes)
- Baptist Health – Madisonville in Madisonville, KY, 37 miles (39 minutes)
- Caldwell Medical Center in Princeton, KY, 31 miles (43 minutes)
- Logan Memorial Hospital in Russellville, KY, 38 miles (43 minutes)
- Owensboro Health Muhlenberg Community Hospital in Greenville, KY, 33 miles (43 minutes)

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

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

1. **ALCOHOL/SUBSTANCE ABUSE** – 2013 Significant Need

Public comments received on previously adopted implementation strategy:

- *Awareness and discussions as a community have taken place.*
- *None*
- *I am unaware of the efforts being made to address alcohol/substance abuse.*
- *Can't comment*
- *As for my observations the Hospital has addressed Alcohol/Substance Abuse by sponsoring various seminars which make this information available to the community*
- *TAKE PROGRAMS TO THE SCHOOLS WORKSHOPS FOR PARENTS*
- *unknown*
- *Don't know*
- *I am not aware of many of the actions that have been taken by the hospital regarding this need.*
- *Not aware of any implementation actions.*

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

- Partner with HPD and Anheuser-Busch to put on annual event around prom that shows high school students the effects of alcohol/drunk driving
- Major sponsor of Project Graduation, an all-night lock-in on graduation night to keep students safe and entertained
- Partnering with HPD to communicate incidents of synthetic drug use and educate community on dangers
- Sponsor of local fundraiser put on by Trilogy Center for Women
- Pennyroyal Mental Health performs mental health and substance abuse assessments/evaluations on site
- Providers check KASPER before prescribing narcotics to limit over-prescribing and "shopping"
- Standardized testing for pregnant mothers who present; if test is positive, provide follow-up care and assessments for the infants; specialists and neonatologists on site

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

- Add web links to addiction resources to the JSMC website
- Look into adding a CME for providers on alcohol/substance abuse

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

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

- Number of attendees at Project Graduation = 550

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

- Alcohol-impaired driving deaths = 19%[27] (KY = 29%, U.S. Best = 14%)

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

Organization	Contact Name	Contact Information
City of Hopkinsville Police Department	Paul Ray, Public Information Officer Dawn Pierce, Secretary	101 N Main St, Hopkinsville, KY 42240 (270) 890-1500 http://www.hoptown.org/departments/police/index.php
Trilogy Center for Women	Angie Jones, RN	100 Trilogy Ave, Hopkinsville, KY 42240 (270) 885-2902

[27] County Health Rankings. Percentage of motor vehicle crash deaths with alcohol involvement. 2010-2014.

Organization	Contact Name	Contact Information
Anheuser-Busch		http://anheuser-busch.com/index.php/our-responsibility/alcohol-responsibility-our-families-our-roads/underage-drinking-prevention/
Pennyroyal Center	Buffy Gaddis or Donna Wyatt	http://pennyroyalcenter.org/
Christian County public and private schools	Heather Lancaster, Director of Communications	
Western State Hospital	Roger Westfall, Facility Administrator	2400 Russellville Rd, Hopkinsville, KY 42240 (270) 889-6025 http://westernstatehospital.ky.gov/
Cumberland Hall Hospital	Kelly Higgins, Director of Human Resources	270 Walton Way, Hopkinsville, KY 42240 (270) 886-1919 www.cumberlandhallhospital.com

Other local resources identified during the CHNA process that are believed available to respond to this need:[28]

Organization	Contact Name	Contact Information
Genesis		2400 Russellville Rd, Hopkinsville, KY, 42240
Community Counseling Center		509 W 9th St, Hopkinsville, KY 42240 (270) 886-1515 http://communitycouns.org/
AA chapters		https://www.sober.com/meetings/aa?city=hopkinsville&state=kentucky
NA chapters		https://www.sober.com/meetings/na?city=hopkinsville&state=kentucky
Local faith-based ministries		

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

2. **OBESITY/OVERWEIGHT** – 2013 Significant Need; adult obesity above KY and US average; adult obesity 44th among 53 peer counties; BMI: Morbid/Obese 15.7% above average; male and female obesity worse than US average

Public comments received on previously adopted implementation strategy:

- *The hospital has sponsored awareness events.*
- *I would like the hospital to consider implementation actions that serve the root of the problem with obesity and take more of a lead role in fighting obesity throughout the community.*
- *Not sure on specifics of this one.*
- *There again Education*
- *NOT AWARE OF HOSPITAL ADDRESSING THIS ISSUE*
- *Career fairs - nutrition education*
- *Don't know*
- *n/a*

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

- Comprehensive bariatric service line that also includes Medicaid patients
  - Includes mandatory seminar (also available online) that covers the procedure as well as healthy living and lifestyle changes
  - Patients are required to undergo psychiatric evaluation prior to surgery
  - Dedicated nurse program coordinator and dedicated registered dietician who work with patients including mandated nutritional education classes prior to surgery and support group post-surgery
- Registered dietician on staff provides nutrition education and classes
- Sponsor of local events that promote physical activity including 5Ks, run/walks, golf scrambles, Senior Olympics
- Major sponsor of city's Rails to Trails walking trails
- Discounted gym memberships for hospital employees and families
- Provide certified master-level Athletic Trainer at all varsity level sporting events in Christian, Trigg, and Todd counties
- Breastfeeding and lactation consultant on staff
- Sponsor and host of Western Kentucky Women's Show that provides nutrition education (one-on-one nutrition counseling) and free screenings for blood sugar, cholesterol, BMI, blood pressure; bariatric program staff are also on site
- Participate in multiple community health fairs and provide free screenings for blood sugar, blood pressure, BMI
- Major sponsor of American Heart Association's local Heart Walk
- Inpatient and outpatient diabetes education classes provided by a certified diabetes educator
- Social media used to promote healthy lifestyles through nutrition, healthy eating, exercise, reducing stress, etc.

- Major contributor to local United Way to provide support and resources to community organizations like Boys and Girls Club, St. Luke Free Clinic, Rescue Team, Sanctuary, Pennyroyal Hospice, Salvation Army, Meals on Wheels, Aaron McNeal House, etc.

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

- Working on sponsoring and building a specific exercise-therapy pool at YMCA

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

- Major sponsor of local YMCA building project
- Hospital team participates in annual Walk to End Obesity

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

- Number of patients participating in bariatric program information seminars = 259 (2015)
- Number of patients receiving bariatric surgery = ~130 surgeries (10-12/mo)

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

- Adult obesity rate = 37%[29] (KY = 32%, U.S. Best = 25%)

[29] County Health Rankings. Percentage of adults that report a BMI of 30 or more. 2012.

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

Organization	Contact Name	Contact Information
Hopkinsville YMCA		7805 Eagle Way, Hopkinsville, KY 42240 (270) 887-5382 www.hopkinsvilleymca.org
American Heart Association (Western Kentucky)	Suzanne Riley	240 Whittington Pkwy, Louisville, KY 40222
American Diabetes Association		PO Box 21903, Lexington, KY, 40522 (859) 268-9129
Hopkinsville Parks and Recreation Department	Tab Brockman, Superintendent Pam Rudd, Coordinator	
Christian County private and public schools	Heather Lancaster, Director of Communications	
Christian County Health Department	Mark Pyle, Public Health Director Joshua Mosby, Human Resources Manager	1700 Canton St, Hopkinsville, KY 42240 (270) 887-4160 www.christiancountyhd.com

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

Organization	Contact Name	Contact Information
Other local fitness centers		

3. **CANCER** – 2013 Significant Need; #2 leading cause of death; mammography in past year 6.1% below average; cervical cancer screening 6.7% below average

Public comments received on previously adopted implementation strategy:

- *Healthy lifestyles campaign.*
- *Continue to have exceptional access to cancer through the E. C. Green Center.*
- *I see the hospital's involvement in community fairs and the Women's Show promoting screenings for cancer. I also hear the advertisements for screenings and for the EC Green Cancer Center. On a personal note, I have known many people who have traveled to Nashville for cancer care and were told that they could receive top quality treatments right here in Hopkinsville.*
- *Value the hospital cancer center*
- *The hospital has great impact on this issue.*
- *Preventive Care by offering various test, i.e, pap smears, mammograms, prostate, etc. to individuals in the community*
- *NOT AWARE OF ANY PROGRAMS PROVIDED BY HOSPITAL*
- *Mammogram screenings*
- *Don't know*
- *Cancer support groups and education are keys to combating the issue.*
- *The EC Cancer Center is a tremendous asset to the community. Provide prevention and treatment options close to home.*

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

- Full-spectrum E.C. Green Cancer Center that:
  - Provides medical oncology, radiation oncology, and surgical treatment options
  - Stays up to date on latest pharmaceutical treatments and technologies (digital mammography)
  - Provides treatment to all patients, regardless of insurance
- Pulmonologists performing screenings on at-risk patients to identify lung cancer at the early stages
- Sponsor and host of Western Kentucky Women's Show that (in partnership with Christian County Health department) provides free mammograms, pap smears, self-breast exams, colon cancer screenings, and skin cancer screenings
- Sponsor of local American Cancer Society's Relay for Life in several counties
- In partnership with local newspaper, JSMC matches funds raised for local Pink Ribbon Network
- Regular cancer support group meetings with participation from medical staff
- Partnership with Vanderbilt and other facilities for clinic trial treatment options

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

- Adding latest Varian TrueBeam linear accelerator for radiation oncology treatment
- Opening two new state-of-the-art digital X-ray machines providing faster, clearer scans utilizing less radiation

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

- Through affiliation with Vanderbilt, implementing best practices in cancer care navigation, providing patient access to research protocols, and facilitating transfer for higher levels of care
- Designated American College of Radiology Lung Cancer Screening Center
- Added cancer nurse navigator, but role is currently unfilled

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

- Number of patients seen through Cancer Center
  - Radiation Oncology = 260
  - Medical Oncology = 265,200

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

- Cancer Death Rate = 189.7 per 100,000[30]

[30] CHSI. Age-adjusted cancer death rate (ICD-10 codes C00-C97). 2005-2011.

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

Organization	Contact Name	Contact Information
American Cancer Society	Terri Lawson Joan Lang	http://main.acsevents.org/site/TR/RelayForLife/RFLCY17MS?pg=entry&fr_id=81963
Vanderbilt Medical Center		1211 Medical Center Dr, Nashville, TN 37232 www.mc.vanderbilt.edu
Kentucky New Era	Taylor Hayes, CEO	1618 East Ninth Street, Hopkinsville, KY 42240 (270) 886-4444 www.kentuckynewera.com

4. **PREVENTION/WELLNESS** – 2013 Significant Need; Local Expert concern; adult overall health status 51st among 53 peer counties

Public comments received on previously adopted implementation strategy:

- *Local media [radio & local newspaper] are used to promote wellness.*
- *Points, gifts, coupons, etc. should be used to induce people to observe and take note about their preventative and wellness activity.*
- *I am aware of screenings/education that have taken place at the Women's show and other various locations.*
- *Not sure*
- *As mentioned in #13 by making prevention/wellness care available to the community, i.e., Women's Health Seminar at Convention Center and other preventive Health Care Seminars*
- *NOT AWARE HOSPITAL IS ADDRESSING THIS ISSUE*
- *Completing sports physicals for athletes*
- *Don't know*
- *n/a*

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

Because most of the activities that address Prevention/Wellness fall within other significant health needs, we are choosing not to develop a separate implementation strategy for this need at this time.

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

5. MENTAL HEALTH – Local Expert concern

Public comments received on previously adopted implementation strategy:

This was not a Significant Need identified in 2013 so no written public comments about this need were solicited

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

- Pennyroyal Mental Health comes in for mental health and substance abuse assessments/evaluations
- Every emergency department patient screened for suicide/depression

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

- Applying for certificate of need to develop distinct geriatric psych care unit to treat senior adults with behavioral health issues who are also experiencing acute medical issues

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

Because there are several other strong organizations in the community that address this need, we are choosing not to develop an implementation strategy for this need at this time. We feel we can have a greater impact by putting attention and resources toward other significant needs for which we are better qualified to serve.

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

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

Organization	Contact Name	Contact Information
Pennyroyal Center	Buffy Gaddis or Donna Wyatt	http://pennyroyalcenter.org/
Cumberland Hall Hospital	Kelly Higgins, Director of Human Resources	270 Walton Way, Hopkinsville, KY 42240 (270) 886-1919 www.cumberlandhallhospital.com

Organization	Contact Name	Contact Information
Western State Hospital	Roger Westfall, Facility Administrator	2400 Russellville Rd, Hopkinsville, KY 42240 (270) 889-6025 http://westernstatehospital.ky.gov/
Community Counseling Center		509 W 9th St, Hopkinsville, KY 42240 (270) 886-1515 http://communitycouns.org/

6. **AFFORDABILITY/ACCESSIBILITY** – 2013 Significant Need; Local Expert concern; uninsured rate above KY and US average; primary care provider access 48th among 53 peer counties

Public comments received on previously adopted implementation strategy:

- *Fair & accessible.*
- *I believe that this is key, to provide care to priority populations where they reside or closer to where they reside, at the shopping facilities and community agencies with high traffic.*
- *I am aware of the nurse practitioner staffed clinic that the hospital has opened... I am not sure what the usage has been, but I think this could go a long way to discourage folks from using the emergency department as primary care.*
- *I believe the hospital does what it can and has to in order not to turn anyone away in need.*
- *Unknown*
- *NOT AWARE OF ANY PROGRAMS*
- *unknown*
- *Don't know*
- *Sharing ways that the hospital can assist individuals with education and information.*

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

- Financial Assistance Policy available with sliding fee scale and self-pay discounts
- Financial counselors on staff to help people understand their bills, work out payment plans, sign up for Medicare/Medicaid, and find other resources for financial assistance
- Free sports physicals for local student athletes provided at special clinics
- Specialties available on site include: family practice, internal medicine, cardiology, pulmonology, oncology, dermatology, gastroenterology, general surgery, orthopedic surgery, ENT, anesthesiology, urology, neurology, neuro surgery, pediatrics, OB/GYN, ophthalmology, nephrology, podiatry, radiology, oral surgery, dietician, rehabilitation and sports medicine (physical therapy), occupational health, speech therapy, sleep study, wound healing, home health, and inpatient dialysis
- Comprehensive bariatric service line that also includes Medicaid patients
    - Includes mandatory seminar (also available online) that covers the procedure as well as healthy living and lifestyle changes
    - Patients are required to undergo psychiatric evaluation prior to surgery
    - Dedicated nurse program coordinator and dedicated registered dietician who work with patients including mandated nutritional education classes prior to surgery and support group post-surgery
- Registered dietician on staff provides nutrition education and classes
- Discounted gym memberships for hospital employees and families
- Provide certified master-level Athletic Trainer at all varsity level sporting events in Christian, Trigg, and Todd

counties

- Breastfeeding and lactation consultant on staff
- Sponsor and host of Western Kentucky Women's Show that provides:
  - Nutrition education (one-on-one nutrition counseling)
  - Free screenings for blood sugar, cholesterol, BMI, blood pressure
  - Bariatric program staff on site
  - Mammograms, pap smears, colon cancer screenings, bone density screenings, self-breast exam education, HIV testing, anemia testing, and hearing screenings (in partnership with Christian County Health department)
- Participate in multiple community health fairs and provide free screenings for blood sugar, blood pressure, BMI
- Inpatient and outpatient diabetes education classes provided by a certified diabetes educator
- Full-spectrum E.C. Green Cancer Center that:
  - Provides medical oncology, radiation oncology, and surgical treatment options
  - Stays up to date on latest pharmaceutical treatments and technologies (digital mammography)
  - Provides treatment to all patients, regardless of insurance
- Regular cancer support group meetings with participation from medical staff
- JSMC Convenient Care Clinic open seven days a week with extended hours
- Sponsor/supporter of St. Luke Free Clinic, which provides services for the uninsured working poor
- Occupational Health mobile unit that goes to local employers to perform health screenings and hearing tests
- Full service lab on site; performs pre-employment drug screens for local employers
- Agreement with Christian County and Todd County Health Departments to provide discounted lab and radiology services
- Major contributor to local United Way to provide support and resources to community organizations like Boys and Girls Club, St. Luke Free Clinic, Rescue Team, Sanctuary, Pennyroyal Hospice, Salvation Army, Meals on Wheels, Aaron McNeal House, etc.
- Social media used to promote healthy lifestyles through nutrition, healthy eating, exercise, reducing stress, etc.

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

- Exploring telehealth options
- Implementing comprehensive pain management clinic
- Recruiting for ENT, other providers

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

- Affiliation with Vanderbilt to facilitate services and exploring urgent-care option

- Recruited and added five primary care providers and five advanced practice professionals in clinics around the county, including Trenton, which is a federally designated underserved area

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

- Number of free screenings provided = 2
- Number of people assisted in obtaining financial assistance through Medicaid or commercial insurance = 2,848 (12/2014 – 12/2015)

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

- Preventable Hospital Stays = 89[31] (KY = 85, U.S. Best = 38)

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

Organization	Contact Name	Contact Information
Vanderbilt Medical Center		1211 Medical Center Dr, Nashville, TN 37232 www.mc.vanderbilt.edu
St Luke Free Clinic		408 W 17th St, Hopkinsville, KY 42240 (270) 889-9340 www.stlukefreeclinic.com

[31] County Health Rankings. Number of hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees. 2013.

Organization	Contact Name	Contact Information
Christian County Health Department	Mark Pyle, Public Health Director Joshua Mosby, Human Resources Manager	1700 Canton St, Hopkinsville, KY 42240 (270) 887-4160 www.christiancountyhd.com
Todd County Health Department		205 Public Square, Elkton, KY 42220 (270) 265-2362 www.mytchd.com
LifeLinc Pain Centers		www.lifelincpain.com

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

Organization	Contact Name	Contact Information
Other local healthcare providers		
Baptist Health		www.baptisthealth.com
Community Medical Clinic (Pennyroyal Primary Care) (FQHC)	Martha Pool (270) 365-0227	739 North Dr, Hopkinsville, KY 42240 (270) 887-6152 x414
Oak Grove Health Clinic (FQHC)	Ronda Taylor, Support Services Supervisor	230 Dover Rd, Clarksville, TN 37042 (931) 920-5000 www.mwchc.org

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

Public comments received on previously adopted implementation strategy:

- *Sponsored events...awareness....healthy foods.....healthy lifestyles including exercise.*
- *I believe that implementation of teaching the community about heart disease should heavily involve workforce and radio.*
- *Know that they have an outreach program and a walk within the communtiy.*
- *Again, Making Health Fairs, etc., available to individuals in the community*
- *NOT SEEN ANY EVIDENCE OF ACTIONS*
- *unknown*
- *Don't know*
- *Prevention and awareness should be communicated regularly to individuals within our community.*

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

- Cardiac rehab program available on site with education classes led by registered nurses
- Partner with Christian County Health Department on smoking cessation program
- CPR, ACLS, and PALS training for EMTs and community members
- Stress testing, Holter Monitor, Echo Cardiography available on site
- Comprehensive bariatric service line that also includes Medicaid patients
    - Includes mandatory seminar (also available online) that covers the procedure as well as healthy living and lifestyle changes
    - Patients are required to undergo psychiatric evaluation prior to surgery
    - Dedicated nurse program coordinator and dedicated registered dietician who work with patients including mandated nutritional education classes prior to surgery and support group post-surgery
- Registered dietician on staff provides nutrition education and classes
- Sponsor of local events that promote physical activity including 5Ks, run/walks, golf scrambles, Senior Olympics
- Major sponsor of city's Rails to Trails walking trails
- Discounted gym memberships for hospital employees and families
- Sponsor and host of Western Kentucky Women's Show that provides nutrition education (one-on-one nutrition counseling) and free screenings for blood sugar, cholesterol, BMI, blood pressure; bariatric program staff also on site
- Participate in multiple community health fairs and provide free screenings for blood sugar, blood pressure, BMI
- Major sponsor of American Heart Association's local Heart Walk
- Social media used to promote healthy lifestyles through nutrition, healthy eating, exercise, reducing stress, etc.

- Inpatient and outpatient diabetes education classes provided by a certified diabetes educator

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

- Working on sponsoring and building a specific exercise-therapy pool at YMCA
- Working with Vanderbilt to increase resources including access to cardiologists

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

- Major sponsor of local YMCA building project
- Hospital team participates in annual Walk to End Obesity

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

- Number of blood pressure screenings provided = 2
- Number of cholesterol screenings provided = 1

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

- Coronary Heart Disease Deaths = 156.8 per 100,000[32] (U.S. median = 126.7)

[32] CHSI. Age adjusted coronary heart disease death rate (ICD-10 codes 120-125). 2005-2011.

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

Organization	Contact Name	Contact Information
Vanderbilt Medical Center		1211 Medical Center Dr, Nashville, TN 37232 www.mc.vanderbilt.edu
American Heart Association (Western Kentucky)	Suzanne Riley	240 Whittington Pkwy, Louisville, KY 40222
Christian County Health Department	Mark Pyle, Public Health Director Joshua Mosby, Human Resources Manager	1700 Canton St, Hopkinsville, KY 42240 (270) 887-4160 www.christiancountyhd.com
Hopkinsville YMCA		7805 Eagle Way, Hopkinsville, KY 42240 (270) 887-5382 www.hopkinsvilleymca.org
Christian County Parks and Recreation	Tab Brockman, Superintendent Pam Rudd, Coordinator	

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

Organization	Contact Name	Contact Information
Baptist Health		www.baptisthealth.com

Other Needs Identified During CHNA Process

8. **SMOKING/TOBACCO USE – 2013 Significant Need**
9. **HIGH BLOOD PRESSURE – 2013 Significant Need**
10. **DIABETES – 2013 Significant Need**
11. **PHYSICAL INACTIVITY**
12. **ALZHEIMER'S**
13. **PHYSICIAN**
14. **CHRONIC LOWER RESPIRATORY DISEASE**
15. **COMPLIANCE BEHAVIOR**
16. **SEXUALLY TRANSMITTED INFECTIONS**
17. **KIDNEY DISEASE**
18. **MATERNAL/INFANT MEASURES**
19. **STROKE**
20. **LUNG DISEASE**
21. **PHYSICAL ENVIRONMENT**
22. **SOCIAL FACTORS**
23. **CHRONIC LOWER BACK PAIN**
24. **FLU/PNEUMONIA**
25. **ACCIDENTS**
26. **BLOOD POISONING**
27. **SICK CELL DISEASE**
28. **LIFE EXPECTANCY**

Overall Community Need Statement and Priority Ranking Score

Significant needs where hospital has implementation responsibility[33]

1. Alcohol/Substance Abuse
2. Obesity/Overweight
3. Cancer
6. Affordability/Accessibility
7. Coronary Heart Disease

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

4. Prevention/Wellness
5. Mental Health

Other needs where hospital developed implementation strategy

None

Other needs where hospital did not develop implementation strategy

8. Smoking/Tobacco Use
9. High Blood Pressure
10. Diabetes
11. Physical Inactivity
12. Alzheimer's
13. Physician
14. Chronic Lower Respiratory Disease
15. Compliance Behavior
16. Sexually Transmitted Infections
17. Kidney Disease
18. Maternal/Infant Measures

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

19. Stroke
20. Lung Disease
21. Physical Environment
22. Social Factors
23. Chronic Lower Back Pain
24. Flu/Pneumonia
25. Accidents
26. Blood Poisoning
27. Sick Cell Disease
28. Life Expectancy

APPENDIX

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

Hospital solicited written comments about its 2013 CHNA.[35] 25 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.**

Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	2	15	17
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	4	14	18
3) Priority Populations	7	10	17
4) Representative/Member of Chronic Disease Group or Organization	3	15	18
5) Represents the Broad Interest of the Community	21	2	23
Other			
Answered Question			25
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?**

- *Yes*
- *Yes. Mental Health issues.*

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

- *Yes*
- *All of these exist within our population. Primary lack of ability to obtain mental health service due lack of access to psychiatric providers related to low reimbursement rates and nationwide shortage. Oral care remains a shortage. Lack of transportation for rural areas resulting in lack of access.*
- *Each exist within my community and carry unique needs and interest that should be addressed. The unique needs and interest that exist help to ensure that each priority population is served appropriately, such as diversity/economic inclusion in employment and contracting for racial and ethnic minority groups, payment options and "decentralized" service provisions for low-income groups, high amount of physicians that serve women and older adults.*
- *Yes, all of these exist in our community.*
- *We have all of these populations in our community, by varying degrees of course.*
- *Yes Low income Rural High use of dtugs*
- *All exist in my community and yes they do have some unique needs. Both medical and mental.*
- *Yes, all of the above. Food, Housing and economics*
- *These populations exist in our community and there needs additional assistance with medications that may not be covered through regular insurance.*
- *1. DIABETES 2. OBESITY 3. NUTRITION*
- *Yes; No*
- *Yes*
- *Yes, we have several of these populations in Hopkinsville and Christian County. Several of these groups do have needs that should be addressed especially in communicating with the groups. Finding ways to reach the groups with specific messages regarding assistance or services seems to be an issue within our community.*
- *Yes, several exist in the community. I believe there are several needs that really need to be addressed, especially the needs of the youth and the older adults.*
- *Yes the do exist in our community. I am unaware of specific needs.*
- *Yes We do have our share of the above though not sure about the last two. Of course they have unique needs Odd question, I think.*
- *Uneducated , low socio economic and little to no insurance.*
- *Yes*
- *All the above*

In the 2013 CHNA, there were 9 health needs identified as "significant" or most important:

1. **Substance Abuse**
2. **Coronary Heart Disease**
3. **Smoking/Tobacco Use**
4. **Cancer**
5. **Affordability/Accessibility**
6. **Obesity/Overweight**
7. **Prevention/Wellness**
8. **Diabetes**
9. **High Blood Pressure**

3. **Should the hospital continue to consider the needs identified as most important in the 2013 CHNA as the most important set of health needs currently confronting residents in the county?**

	Yes	No	No Opinion
Substance Abuse	21	2	0
Coronary Heart Disease	23	0	0
Smoking/Tobacco Use	20	3	0
Cancer	22	1	0
Affordability/Accessibility	21	1	1
Obesity/Overweight	21	2	0
Prevention/Wellness	21	2	0
Diabetes	23	0	0
High Blood Pressure	22	1	0

4. **Should the Hospital continue to allocate resources to help improve the needs identified in the 2013 CHNA?**

	Yes	No	No Opinion
Substance Abuse	20	1	2
Coronary Heart Disease	22	1	0
Smoking/Tobacco Use	18	3	2
Cancer	22	1	0
Affordability/Accessibility	20	2	1
Obesity/Overweight	19	2	2
Prevention/Wellness	19	3	1
Diabetes	23	0	0
High Blood Pressure	22	1	0

5. **Are there any new or additional health needs the Hospital should address? Are there any new or additional implementation efforts the Hospital should take? Please describe.**

- *Mental Health tied to substance abuse.*
- *Aging is a new/additional health need, the impact of synthetic drugs and physical therapy after surgery that pertain to mobility...new implementation efforts should include "decentralized care," electronic/virtual care provision*
- *Mental Health is of great concern in the populations I serve. Mental illness is a greatly underdiagnosed chronic condition for many, and those with mental illness tend not to be diligent with their overall health. Therefore, many of the other priority health concerns co-exist with mental illness, compounding the problem. Our community mental health providers are too few and limited.*
- *Probably, but the above list is the highest priority*
- *Our mental health is in a state of crises across the nation.*
- *Cannot think of any additional health needs at this time*
- *SICKLE CELL*
- *Don't know*
- *This community has a high degree of people who have free medical benefits yet they continue to make poor decisions regarding lifestyle changes. I conclude that this is becaause the care they receive is free. There is no motivation to change when care is free and readily available.*
- *I believe the ones that you have listed are having a major effect in the lives of so many people.*
- *N/A*
- *Help provide community benefit through the development of health and wellness infrastructure such as the expansion of the Hopkinsville Greenway System.*

6. **Please share comments or observations about keeping <u>Substance Abuse</u> among the most significant needs for the Hospital to address.**

- *I believe alcohol and other drugs continue to be an issue in our community.*
- *I feel certain that substance abuse has risen locally as it has in other parts of the State.*
- *Kentucky continues to have a significant lack of detox beds. Although there are some programs available for treatment detox requires medical oversight and therefore not undertaken by private industry except those that can afford the private insurance or private pay.*
- *I am somewhat unsure about the hospital allocating resources to provide care for "choice" related health issues. Also, I believe that this health issue is served equally by law enforcement and legislation.*
- *We know that substance dependency compounds other health concerns. Addiction also impacts workforce, family stability and personal healthcare.*

- *Still growing every day*
- *Yes, this is an addiction that needs to be addressed and treated. Not sure it's the most significant, but you would know better than I.*
- *Continue to Educate the community*
- *This is an issue that can become greater throughout the years. With new drugs constantly on the rise people need to be aware of these new issues and how they can try and overcome them.*
- *SUBSTANCE ABUSE - METH, HEROIN*
- *Yes - this is a high priority need.*
- *Keep a priority*
- *Drug and Alcohol abuse is a major factor in our workforce. Finding employees who can pass a drug test to become employed is a rarity. Finding ways to address it within the community would be helpful to all sectors of the workforce and would gain support from other industries other than healthcare.*
- *Prevention, awareness and treatment*
- *There is a definite need. However, JSMC does not have to be the provider of all services. The Pennyroyal Center can and should provide these services.*

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

- *Awareness and discussions as a community have taken place.*
- *None*
- *I am unaware of the efforts being made to address alcohol/substance abuse.*
- *Can't comment*
- *As for my observations the Hospital has addressed Alcohol/Substance Abuse by sponsoring various seminars which make this information available to the community*
- *TAKE PROGRAMS TO THE SCHOOLS WORKSHOPS FOR PARENTS*
- *unknown*
- *Don't know*
- *I am not aware of many of the actions that have been taken by the hospital regarding this need.*
- *Not aware of any implementation actions.*

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

- *Continue to be a serious problem.*
- *I personally know a number of people that have past away or whose families struggle to provide care for individuals, mostly women with COPD...*
- *With all that we know today about heart disease and prevention, this education can be critical to quality, as well as longevity, of life.*
- *Although great strides have been made in this area, we still need to keep this on our list.*
- *Yes!*
- *Continue to Educate*
- *KEEP CORONARY HEART DISEASE IN THE LIST BUT NOT HIGH ON THE LIST*
- *Yes - this is a high priority need.*
- *Keep a priority*
- *Heart disease is a major factor not only in Christian county, but the nation.*
- *Investment in new equipment, staffing and training.*

9. **Please share comments or observations about the implementation actions the Hospital has taken to address <u>Coronary Heart Disease</u>.**
    - *Sponsored events...awareness....healthy foods.....healthy lifestyles including exercise.*
    - *I believe that implementation of teaching the community about heart disease should heavily involve workforce and radio.*
    - *Know that they have an outreach program and a walk within the communtiy.*
    - *Again, Making Health Fairs, etc., available to individuals in the community*
    - *NOT SEEN ANY EVIDENCE OF ACTIONS*
    - *unknown*
    - *Don't know*
    - *Prevention and awareness should be communicated regularly to individuals within our community.*

10. **Please share comments or observations about keeping <u>Smoking/Tobacco Use</u> among the most significant needs for the Hospital to address.**
    - *Continues to be a problem.*
    - *The younger population seem to still fall into this category*
    - *I see this differently because I'm more passionate about Mental Health in this category.*

- *Continue to Educate*
- *SMOKING - PROVIDE PROGRAMS IN SCHOOLS - ELEMENTARY AGE CHILDREN*
- *Yes - this is a high priority need.*
- *Keep a priority*
- *Tobacco use is still very high in Christian County and education efforts should continue at all levels across the community. Young adults in Christian County seem to be using tobacco more frequently and this is of concern.*
- *The Christian County Health Department should provide this service.*

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

- *"Stop smoking" campaign.....Political pressure.....No smoking in public restaurants/businesses [especially helpful for those who were exposed to second-hand smoke].*
- *Have offered smoking cessation classes that have eesultes in increased awareness and successful cessation by many.*
- *I hear advertisements on smoking cessation classes offered through the hospital. I also applaud the ban of tobacco products on the hospital campus that occurred a few years ago. I think it sends a strong message.*
- *Again, I feel mental health should take this place in ranking.*
- *Smoking Sensation Classes*
- *NOT AWARE OF ANY PROGRAMS*
- *Speaking to expectant parents regarding tobacco use (how to have a health pregnancy).*
- *Don't know*
- *Smoking cessation should be taught more and encouraged more.*
- *Collaboration with the Health Dept.*
- *Do not duplicate resources.*

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

- *Continues to be an issue.*
- *High on the list. We have not clearly identified the direct cause for such a high percentage of people with cancer*
- *Yes....it's huge.*

- *Continue to Educate*
- *KEEP THIS ON LIST - IN TOP 10*
- *Yes - this is a high priority need.*
- *Keep a priority*
- *Cancer is a nationwide problem and linking the tobacco usage to cancer in our area is important.*
- *E.C . Green Cancer Center*

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

- *Healthy lifestyles campaign.*
- *Continue to have exceptional access to cancer through the E. C. Green Center.*
- *I see the hospital's involvement in community fairs and the Women's Show promoting screenings for cancer. I also hear the advertisements for screenings and for the EC Green Cancer Center. On a personal note, I have known many people who have traveled to Nashville for cancer care and were told that they could receive top quality treatments right here in Hopkinsville.*
- *Value the hospital cancer center*
- *The hospital has great impact on this issue.*
- *Preventive Care by offering various test, i.e, pap smears, mammograms, prostate, etc. to individuals in the community*
- *NOT AWARE OF ANY PROGRAMS PROVIDED BY HOSPITAL*
- *Mammogram screenings*
- *Don't know*
- *Cancer support groups and education are keys to combating the issue.*
- *The EC Cancer Center is a tremendous asset to the community. Provide prevention and treatment options close to home.*

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

- *Extremely important.*
- *I have not seen any significant change/impact in the hospital increasing accessibility.*
- *Even though insurance is in theory more accessible these days, we still have many in our community who are ill-informed as to the importance of having a primary care provider and being proactive in their own healthcare. Additionally, even the more "affordable" healthcare plans are still too much for the person who is*

barely getting by. I know we have had a shortage of primary care providers in the recent past and am not sure of this status now, but I do know there are still a great number of individuals in our midst who are not pursuing a primary care provider for a variety of reasons.

- *Always..*
- *Affordable Health Care for everyone*
- *THIS SHOULD BE HIGH ON LIST*
- *Yes - this is a high priority need.*
- *Keep a priority*
- *Affordable care is always an issue within the community. Our community's high poverty rate and under-educated individuals makes it very difficult for them to afford healthcare services or to be aware of ways to prevent illness.*
- *The should be JSMC primary service to the community.*

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

- *Fair & accessible.*
- *I believe that this is key, to provide care to priority populations where they reside or closer to where they reside, at the shopping facilities and community agencies with high traffic.*
- *I am aware of the nurse practitioner staffed clinic that the hospital has opened... I am not sure what the usage has been, but I think this could go a long way to discourage folks from using the emergency department as primary care.*
- *I believe the hospital does what it can and has to in order not to turn anyone away in need.*
- *Unknown*
- *NOT AWARE OF ANY PROGRAMS*
- *unknown*
- *Don't know*
- *Sharing ways that the hospital can assist individuals with education and information.*

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

- *Continues to be a problem in our city.*
- *We only have to look around our community to know that obesity is a problem among adults and children.*
- *Probably the toughest, broadest area to address. May help bring the other issues to the surface*

(drugs,smoking, etc.).

- *Yes, we are in crises as a nation with this category.*
- *Very Important. We have too may obese/overweight Adults and Children in the community*
- *OBESITY/OVERWEIGHT HIGH ON LIST*
- *Yes - this is a high priority need.*
- *Keep a priority*
- *Obesity is becoming the norm and unfortunately the high percentage of community members living at or below the poverty line contributes to this. They eat food that is relatively inexpensive but not healthy and they can not afford memberships to health facilities such as the YMCA. Under-educate parents do not teach children to make healthy choices when selecting food. Additionally, the higher cost of healthy food at the grocery store makes it difficult on struggling families.*
- *Other organizations such as the Christian County Health Department, YMCA and other organizations can partner to provide these services.*

17. Please share comments or observations about the implementation actions the Hospital has taken to address <u>Obesity/Overweight</u>.

- *The hospital has sponsored awareness events.*
- *I would like the hospital to consider implementation actions that serve the root of the problem with obesity and take more of a lead role in fighting obesity throughout the community.*
- *Not sure on specifics of this one.*
- *There again Education*
- *NOT AWARE OF HOSPITAL ADDRESSING THIS ISSUE*
- *Career fairs - nutrition education*
- *Don't know*
- *n/a*

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

- *Local area schools need kids in school. Wellness supports attendance in school.*
- *Helps all of us have a better life. A slow process, but this with health education is our best way to reach some of the early problems early on.*
- *We provide lots of information on prevention, how do we really get people to buy in? This is across all genre's of ages, race and social economics.*

- *Very important. The hospital should continue to keep prevention/wellness among the most significant needs to address*
- *THIS AREA SHOULD BE HIGH ON LIST*
- *Yes - this is a high priority need.*
- *Keep a priority*
- *Finding low or no cost wellness options and sharing and encouraging citizens to be more active.*
- *Again, try not to duplicate services and be all things to all people.*

19. Please share comments or observations about the implementation actions the Hospital has taken to address <u>Prevention/Wellness</u>.

- *Local media [radio & local newspaper] are used to promote wellness.*
- *Points, gifts, coupons, etc. should be used to induce people to observe and take note about their preventative and wellness activity.*
- *I am aware of screenings/education that have taken place at the Women's show and other various locations.*
- *Not sure*
- *As mentioned in #13 by making prevention/wellness care available to the community, i.e., Women's Health Seminar at Convention Center and other preventive Health Care Seminars*
- *NOT AWARE HOSPITAL IS ADDRESSING THIS ISSUE*
- *Completing sports physicals for athletes*
- *Don't know*
- *n/a*

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

- *Continues to be an issue.*
- *Yes*
- *Diabetes should be kept among the most significant needs for the Hospital to address*
- *DIABETES VERY IMPORTANT FOR HOSPITAL TO ADDRESS*
- *Yes - this is a high priority need.*
- *Keep a priority*
- *Diabetes, whether Type 1 or Type 2 is on the rise and is a going to be a national health issue. Type 1 and Type 2 are still confused within the general population and most individuals are still not properly educated on the*

two significantly different types.

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

- *Public service information is shared with the community.*
- *I am aware of screenings/education that have taken place at the Women's show and other various locations.*
- *I believe the hospital has done a great job in this are although I could not quote specifics.*
- *Making Diabetes Classes/Education available to individuals in need of knowing how to control their Diabetes*
- *NOT AWARE OF THIS BEING ADDRESS BY HOSPITAL*
- *unknown*
- *Don't know*
- *More information regarding support and treatment for Type 1 along with more education to schools regarding Type 1. As a parent, it is very frustrating to know that the people who are with my child at school are not educated about this disease and how it is a life-threatening disease. Type 2 can be reversed and managed and the education needs to be shared across the board.*

22. Please share comments or observations about keeping <u>High Blood Pressure</u> among the most significant needs for the Hospital to address.

- *Continues to be an issue.*
- *A big issue for many people, tied to other major health concerns*
- *Yes, again ...a huge issue in our society!*
- *High Blood Pressure, the silent killer should be kept among the most significant needs for the hospital to address*
- *SHOULD BE HIGH ON LIST*
- *Yes - this is a high priority need.*
- *Keep a priority*
- *Diet, exercise and lifestyle contribute to this disease. Not enough citizens are aware of how they can manage and control it.*

23. Please share comments or observations about the implementation actions the Hospital has taken to address <u>High Blood Pressure</u>.

- *Tied to overall wellness campaign.*

- *I am aware of screenings/education that have taken place at the Women's show and other various locations.*
- *Can't comment.*
- *There again through seminars and Health Fairs*
- *NOT AWARE OF HOSPITAL ADDRESSING THIS.*
- *unknown*
- *Don't know*
- *More information and ways to prevent should be shared.*

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

- *No*
- *Obviously education about wellness and preventative measures are worth investing in, but are not easy to evaluate their success.*
- *I would like the hospital to conduct weekly health and wellness topic talks on the radio and possibly send out a newsletter to residents, not via the local newspaper, but independently.*
- *I am not sure how the hospital could help address the high rate of mental illness in our community, but I think this is beginning to rise to crisis level among our more impoverished community members, leading to many other compounded health and community issues.*
- *Yes, we must address our Mental Health as a community and nation!*
- *I cannot think of any thing at this time. Just continue educating individuals in the community on those heath care needs that have been addressed in this survey*
- *N/A*
- *NOT AT THIS TIME*
- *Communication to the community agencies about available services.*
- *Not that I know of.*
- *Knowing how to reach the specific populations with the messages are key to helping educate them. The millennials very rarely read the newspaper or listen to the local radio stations. They get their information from FB, twitter, and other social media outlets. Finding ways to reach all the groups with the key information on health is important to our community for growth and quality of life.*
- *None*
- *The coming of age of the "baby boomer" generation and the increased healths needs of this large group of people.*

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

Need Topic	Total Votes	Number of Local Experts Voting for Needs	Percent of Votes	Cumulative Votes	Need Determination
Alcohol/Substance Abuse - 2013 Significant Need	132	14	9.46%	9.46%	Significant Needs
Obesity/Overweight - 2013 Significant Need	132	14	9.46%	18.92%	
Cancer - 2013 Significant Need	115	12	8.24%	27.17%	
Prevention/Wellness - 2013 Significant Need	112	12	8.03%	35.20%	
Mental Health	92	11	6.59%	41.79%	
Affordability/Accessibility - 2013 Significant Need	84	10	6.02%	47.81%	
Coronary Heart Disease - 2013 Significant Need	81	10	5.81%	53.62%	
Smoking/Tobacco Use - 2013 Significant Need	74	12	5.30%	58.92%	Other Identified Needs
High Blood Pressure - 2013 Significant Need	73	11	5.23%	64.16%	
Diabetes - 2013 Significant Need	72	11	5.16%	69.32%	
Physical Inactivity	46	9	3.30%	72.62%	
Alzheimer's	44	9	3.15%	75.77%	
Physician	41	6	2.94%	78.71%	
Chronic Lower Respiratory Disease	38	8	2.72%	81.43%	
Compliance Behavior	29	9	2.08%	83.51%	
Sexually Transmitted Infections	29	8	2.08%	85.59%	
Kidney Disease	28	8	2.01%	87.60%	
Maternal/Infant Measures	27	7	1.94%	89.53%	
Stroke	25	7	1.79%	91.33%	
Lung Disease	24	8	1.72%	93.05%	
Physical Environment	18	7	1.29%	94.34%	
Social Factors	17	6	1.22%	95.56%	
Chronic Lower Back Pain	16	7	1.15%	96.70%	
Flu/Pneumonia	14	6	1.00%	97.71%	
Accidents	10	7	0.72%	98.42%	
Blood Poisoning	9	6	0.65%	99.07%	
Sickle Cell Disease	8	5	0.57%	99.64%	
Life Expectancy	5	6	0.36%	100.00%	
Total	1395		100.00%		

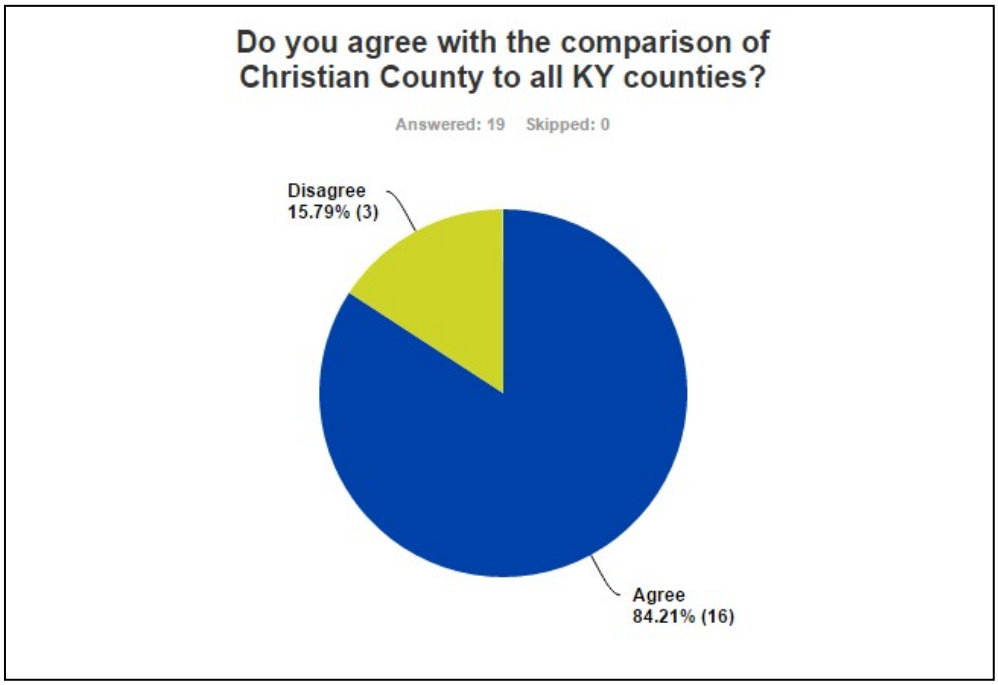
Individuals Participating as Local Expert Advisors[36]

Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	1	10	11
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	3	9	12
3) Priority Populations	7	6	13
4) Representative/Member of Chronic Disease Group or Organization	2	10	12
5) Represents the Broad Interest of the Community	15	2	17
Other			
Answered Question			19
Skipped Question			0

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

Advice Received from Local Expert Advisors

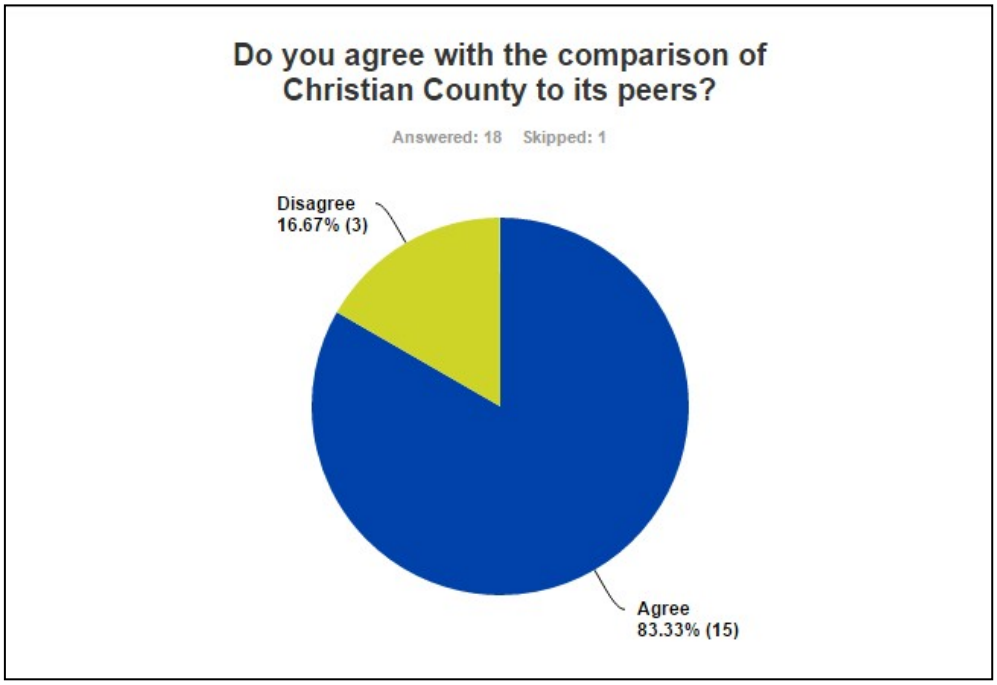
Question: Do you agree with the observations formed about the comparison of Christian County to all other Kentucky counties?



Comments:

- *I would agree with the above data being aware of the community today. The reason that I have to clarify my opinion is because the issue are generational, chronic and require a number of exceptional solutions to be implemented simultaneously for success.*
- *Since 2013 our graduation rates are higher than KY averages.*

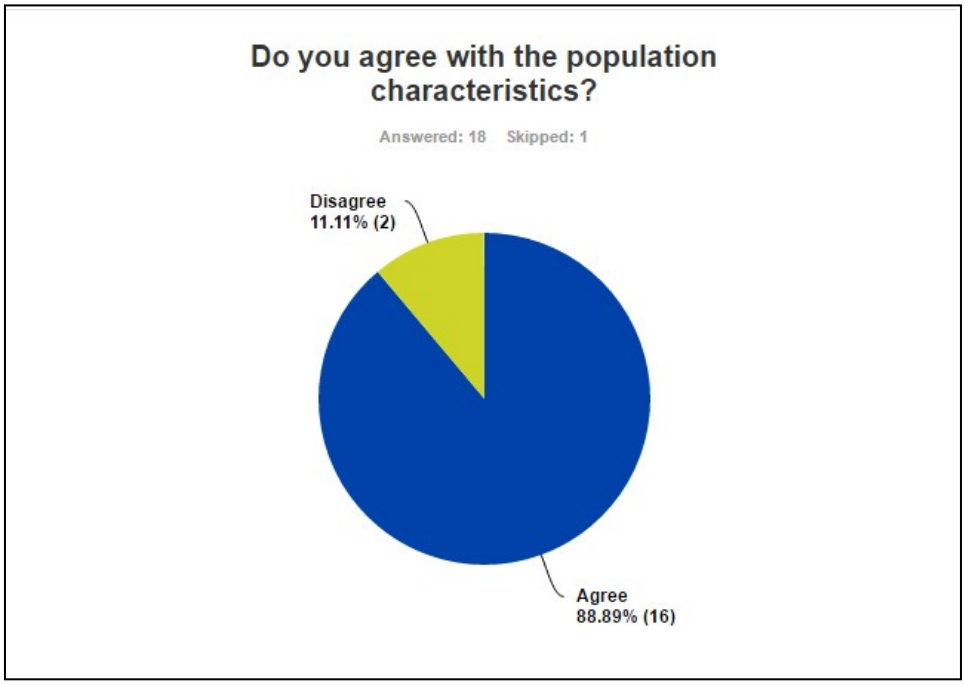
Question: Do you agree with the observations formed about the comparison of Christian County to its peer counties?



Comments:

- *CCHD has different county health data than above. The University of Kentucky College of Public Health published county health data with sources of data in 2016. if you would like a copy please let me know.*
- *I would question the facts on Alzheimer's*

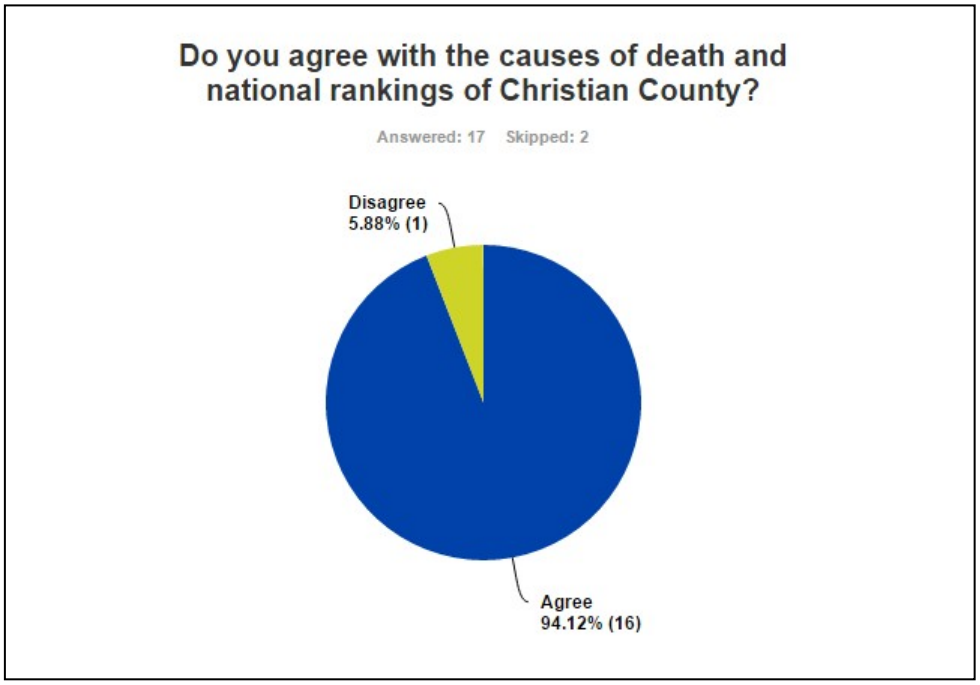
Question: Do you agree with the observations formed about the population characteristics of Christian County?



Comments:

- *The Christian County population and median household income seem to be inflated. We have population in 2014 as 74,250 and median household income in 2014 as $36,736.*
- *the previous page listed the unemployment rate as 10.9% while this chart shows 6.5%. Difference is 2013 figures in the previous page and the chart is a 2016 %?*

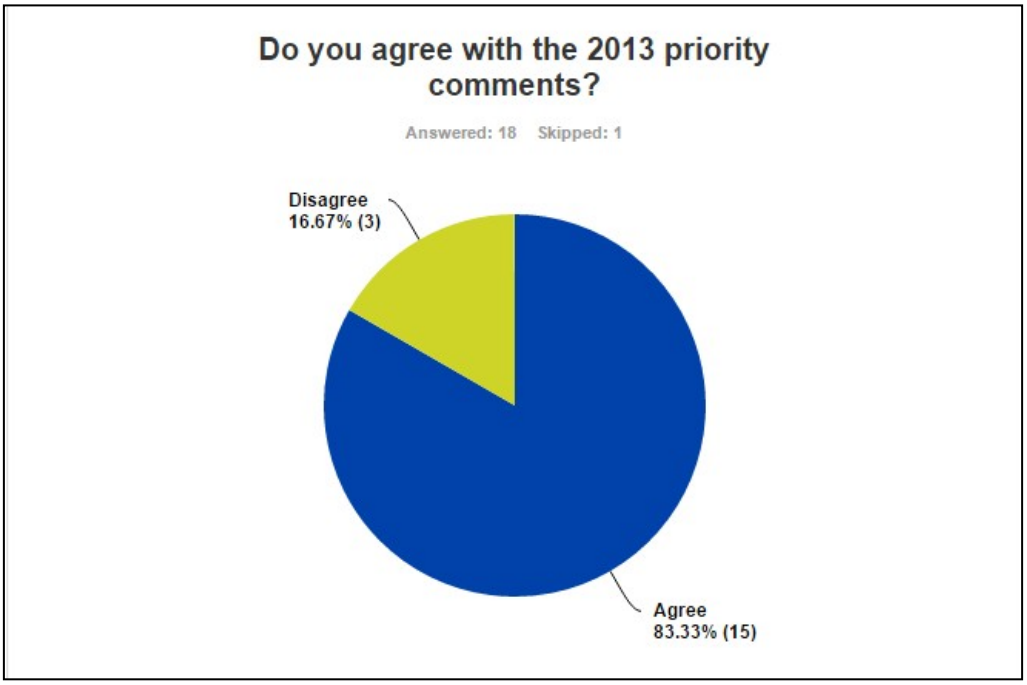
Question: Do you agree with the observations formed from the national rankings and leading causes of death?



Comments:

- *The us of KY data is insignificant without comparative US national data. KY ranks low in many health factors. I like the comparison to peer counties in the US, but the peer counties need to be defined.*
- *I have no way of knowing these statistics.*

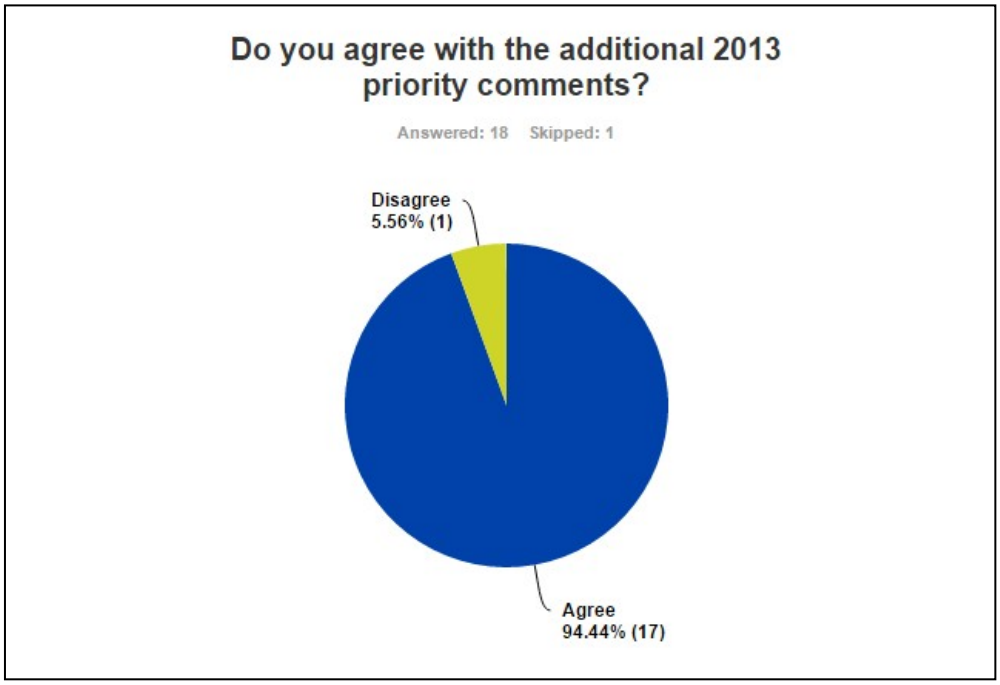
Question: Do you agree with the written comments received on the 2013 CHNA?



Comments:

- *The data would suggest that the community has either an education or a lack of care for their health. An increase in education and impressing upon people the importance of preventative health care would not only affect these unfavorable statistics, but it might also reduce the severity of problems down the road.*
- *Other than community benefit, aging, and surgery post op, none of the observations above seem to be he responsibility of JSMC. JSMC should remain focused on its core services.*
- *I think mental health should have it's own category*

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



Comments:

- *JSMC should partner with other organizations to deliver preventive services. JSMC cannot be all things to all people.*
- *Not necessarily in this exact order though.*

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 250 measures of quality and disparities covering a broad array of healthcare services and settings. Data are generally available through 2012, although rates of un-insurance have been tracked through the first half of 2014. The reports are produced with the help of an Interagency Work Group led by the Agency for Healthcare Research and Quality (AHRQ) and submitted on behalf of the Secretary of Health and Human Services (HHS).

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

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

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

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

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

Trends

- From 2000 to 2010, the percentage of adults ages 18-64 who reported they were without health insurance coverage at the time of interview increased from 18.7% to 22.3%.
- From 2010 to 2013, the percentage without health insurance decreased from 22.3% to 20.4%.
- During the first half of 2014, the percentage without health insurance decreased to 15.6%.
- Data from the Gallup-Healthways Well-Being Index indicate that the percentage of adults without health insurance continued to decrease through the end of 2014,[38] consistent with these trends.

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

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

Trends

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

Disparities

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

Trends

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

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

Trends

- Historically, Blacks and Hispanics have had higher rates of un-insurance than Whites.[39]

Disparities

- During the first half of 2014, the percentage of adults ages 18-64 without health insurance decreased more quickly among Blacks and Hispanics than Whites, but differences in un-insurance rates between groups remained.
- Data from the Urban Institute's Health Reform Monitoring System indicate that between September 2013 and September 2014, the percentage of Hispanic and non-White non-Hispanic adults ages 18-64 without health insurance decreased to a larger degree in states that expanded Medicaid under the Affordable Care Act than in states that did not expand Medicaid.[40]

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

Disparities

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

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

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

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

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

Disparity Trends

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

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

Trends

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

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

Trends

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

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

Achieved Success

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

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

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

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

Improving Quickly

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

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

time of surgery

Worsening

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

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

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

Disparities

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

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

Disparity Trends

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

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

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

Disparities Trends

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

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

Geographic Disparities

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

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

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

Trends

- From 2010 to 2013, the overall rate of hospital-acquired conditions declined from 145 to 121 per 1,000 hospital discharges.
- This decline is estimated to correspond to 1.3 million fewer hospital-acquired conditions, 50,000 fewer inpatient deaths, and $12 billion savings in health care costs.[41]
- Large declines were observed in rates of adverse drug events, healthcare-associated infections, and pressure ulcers.
- About half of all Patient Safety measures tracked in the QDR improved.
- One measure, admissions with central line-associated bloodstream infections, improved quickly, at an average annual rate of change above 10% per year.
- One measure, postoperative physiologic and metabolic derangements during elective-surgery admissions, got worse over time.

Disparities Trends

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

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

Trends

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

Disparities

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

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

Disparities Trends

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

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

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

Trends

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

Disparities

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

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

Trends

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

Disparities

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

Disparities Trends

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

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

Trends

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

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

Disparities

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

Disparities Trends

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

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

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

Trends

- From 2002 to 2010, the overall percentage of people unable to get or delayed in getting needed medical care, dental care, or prescription medicines and who indicated a financial or insurance reason rose from 61.2% to 71.4%.
- From 2002 to 2010, the rate worsened among people with any private insurance and among people from high- and middle-income families; changes were not statistically significant among other groups.
- After 2010, the rate leveled off, overall and for most insurance and income groups.
- Data from the Commonwealth Fund Biennial Health Insurance Survey indicate that cost-related problems getting needed care fell from 2012 to 2014 among adults.[42]
- Another Care Affordability measure, people without a usual source of care who indicate a financial or insurance reason for not having a source of care, also worsened from 2002 to 2010 and then leveled off.
- There are few measures to assess trends in Care Affordability.

Disparities

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

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

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

CONCLUSION

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

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

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

Illustrative IRS Schedule h Part V Section B (Form 990)[43]

Community Health Need Assessment Illustrative Answers

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

   No

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

   No

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

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

      See footnotes 17 and 19 on page 12

   b. **Demographics of the community**

      See footnote 20 on page 13

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

      See footnote 26 on page 32 and footnote 27 on page 33

   d. **How data was obtained**

      See footnote 11 on page 8

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

      See footnote 25 on page 31

   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 68

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

      See footnotes 8 and 9 on page 7

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

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

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

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

N/A

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

2013

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

Yes; see footnote 15 on page 10 and footnote 35 on page 55

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)**

http://www.jsmc.org/About-Us/Community-Health-Needs-Assessment/

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

No other website

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

Yes

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

No other effort

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

See footnotes 33 and 34 on page 52

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

2013

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

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

    http://www.jsmc.org/About-Us/Community-Health-Needs-Assessment/

    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 28 on page 34

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