Rhea Medical Center

Dayton, Tennessee

Community Health Needs Assessment
and Implementation Strategy

Adopted by Board Action June 28, 2016

Dear Community Member:

At Rhea Medical Center (RMC), we have spent almost 60 years providing high-quality compassionate healthcare to the Rhea County community. The "2016 Community Health Needs Assessment" identifies local health and medical needs and provides a plan of how RMC will respond to such needs. This document suggests areas where other local organizations and agencies might work with us to achieve desired improvements and illustrates one way we, RMC, are meeting our obligations to efficiently deliver medical services.

RMC will conduct this effort at least once every three years, and we welcome your review of this document. The report produced three years ago is also available for 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.

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

Thank You,

Ken Croom
Chief Executive Officer
Rhea Medical Center

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EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

Rhea Medical Center ("RMC" 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 Rhea County are:

1. Obesity/Overweight

2. Affordability/Access to Care

3. Cancer

4. Diabetes

5. Coronary Heart Disease

6. Dental

7. Smoking/Tobacco Use

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

APPROACH

APPROACH

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. *While Rhea Medical Center is not a not-for-profit entity,* this study is designed to comply with the same standards and

Project Objectives

RMC partnered with Quorum Health Resources (Quorum) to:[2]

- Complete a CHNA report

- Produce the information necessary for the Hospital to issue an assessment of community health needs and document its intended response

Overview of Community Health Needs Assessment

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

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

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

- Surplus funds used to improve patient care, expand facilities, train, etc.

- A board controlled by independent civic leaders

- All available and qualified physicians granted hospital privileges

Specifically, the IRS requires:

- Effective on tax years beginning after March 23, 2012, each 501(c)(3) hospital facility is required to conduct a CHNA at least once every three taxable years and to adopt an implementation strategy to meet the community needs identified through such assessment.

- The assessment may be based on current information collected by a public health agency or non-profit organization and may be conducted together with one or more other organizations, including related organizations.

- The assessment process must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge or expertise of public health issues.

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[2] Part 3 Treasury/IRS – 2011 – 52 Section 3.03 (2) third party disclosure notice

- 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.[3]

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 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.[4]*
>
> *…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."*

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[3] Section 6652
[4] 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

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 conducting the CHNA."[5]*

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."[6]*

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:

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[5] Federal Register Op. cit. P 78966 As previously noted the Hospital collaborated and obtained assistance in conducting this CHNA from Quorum Health Resources (Quorum)
[6] Federal Register Op. cit. P 78967

(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) **Represents the 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[7] 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 county.

Most data used in the analysis is available from public Internet sources and QHR 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:[8]

Website or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Rhea County compared to all state counties	March 14, 2016	2010 to 2012
www.communityhealth.hhs.gov	Assessment of health needs of Rhea County compared to its national set of "peer counties"	March 14, 2016	2005 to 2011
Truven (formerly known as Thomson)	Assess characteristics of the hospital's primary service area, at a zip code level,	May 18, 2016	2012 to 2016

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[7] "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 QHR/Hospital CHNA process.
[8] 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

Market Planner	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.		
www.capc.org and www.getpalliativecare.org	To identify the availability of palliative care programs and services in the area	March 14, 2016	2015
www.caringinfo.org and iweb.nhpco.org	To identify the availability of hospice programs in the country	March 14, 2016	2015
www.healthmetricsandevaluation.org	To examine the prevalence of diabetic conditions and change in life expectancy	March 14, 2016	2000 to 2010
www.cdc.gov	To examine area trends for heart disease and stroke	March 14, 2016	2008 to 2010
http://svi.cdc.gov	To identify the Social Vulnerability Index value	March 14, 2016	2010
www.CHNA.org	To identify potential needs from a variety of resource and health need metrics	March 14, 2016	2003 to 2015
www.datawarehouse.hrsa.gov	To identify applicable manpower shortage designations	March 14, 2016	2015
www.worldlifeexpectancy.com	To determine relative importance among 15 top causes of death	March 14, 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 12 Local Expert Advisors. Survey responses started January 18, 2016 and ended with the last response on February 29, 2016.

- Information analysis augmented by local opinions showed how Rhea 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.

- 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

  - Residents of rural areas face barriers including transportation and lack of resources close to them

  - Lack of mental health and/or substance abuse services in the community

  - Many low income residents cannot afford health insurance or medications to improve health

When the analysis was complete, we put the information and summary conclusions before our Local Expert Advisors 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. Consultation with 16 Local Experts occurred again via an internet-based survey (explained below) beginning March 30, 2016 and ending April 22, 2016.

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.

In the RMC 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 QHR and the RMC executive team where a reasonable break point in rank order occurred.

COMMUNITY CHARACTERISTICS

FINDINGS

Definition of Area Served by the Hospital
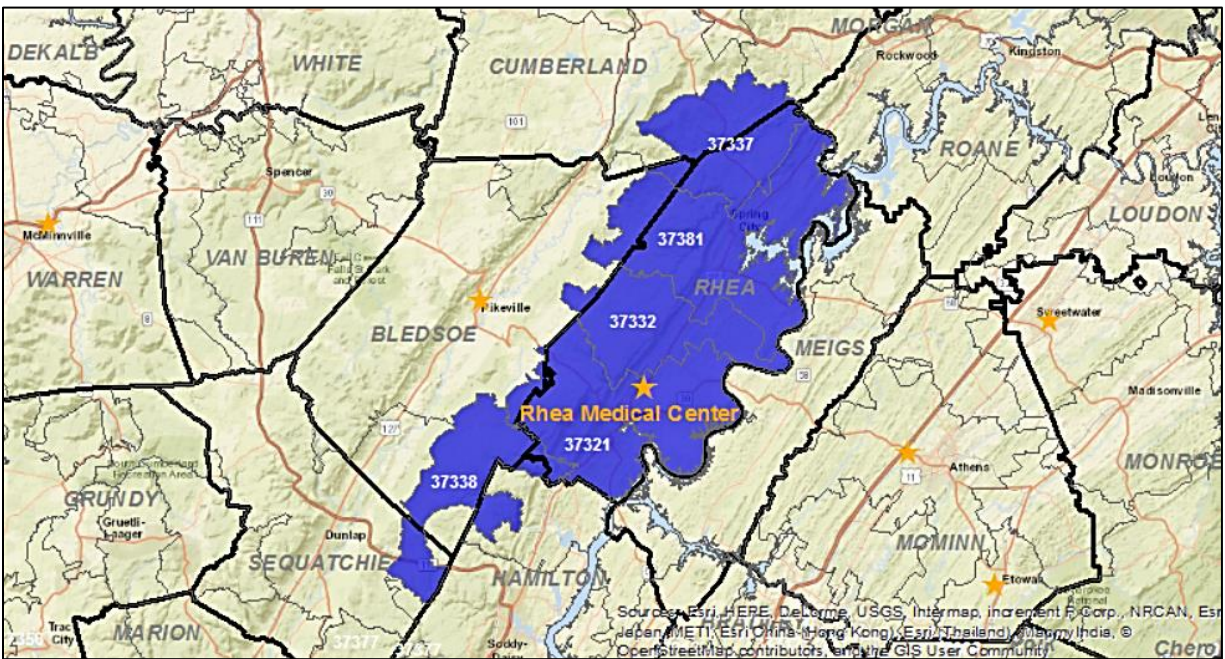
RMC, in conjunction with Quorum, defines its service area as Rhea County in Tennessee, which includes the following ZIP codes:[9]

37321 – Dayton	37332 – Evensville	37337 – Grandview
37338 – Graysville	37381 – Spring City	

In 2014, the Hospital received 85.7% of its patients from this area.[10]

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[9] The map above amalgamates zip code areas and does not necessarily display all county zip codes represented below
[10] Truven MEDPAR patient origin data for the hospital

Demographic of the Community[11]

	County	State	U.S.
2016 Population[12]	36,432	6,615,802	322,431,073
% Increase/Decline	3.7%	3.8%	3.7%
Estimated Population in 2021	37,810	6,867,962	334,341,965
% White, non-Hispanic	91.1%	74.2%	61.3%
% Hispanic	4.4%	5.3%	12.3%
Median Age	41.5	38.9	38.0
Median Household Income	$40,886	$46,484	$55,072
Unemployment Rate	7.8%	5.6%	5.0%
% Population >65	18.6%	15.7%	15.1%
% Women of Childbearing Age	17.8%	19.5%	19.6%

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

DEMOGRAPHIC CHARACTERISTICS

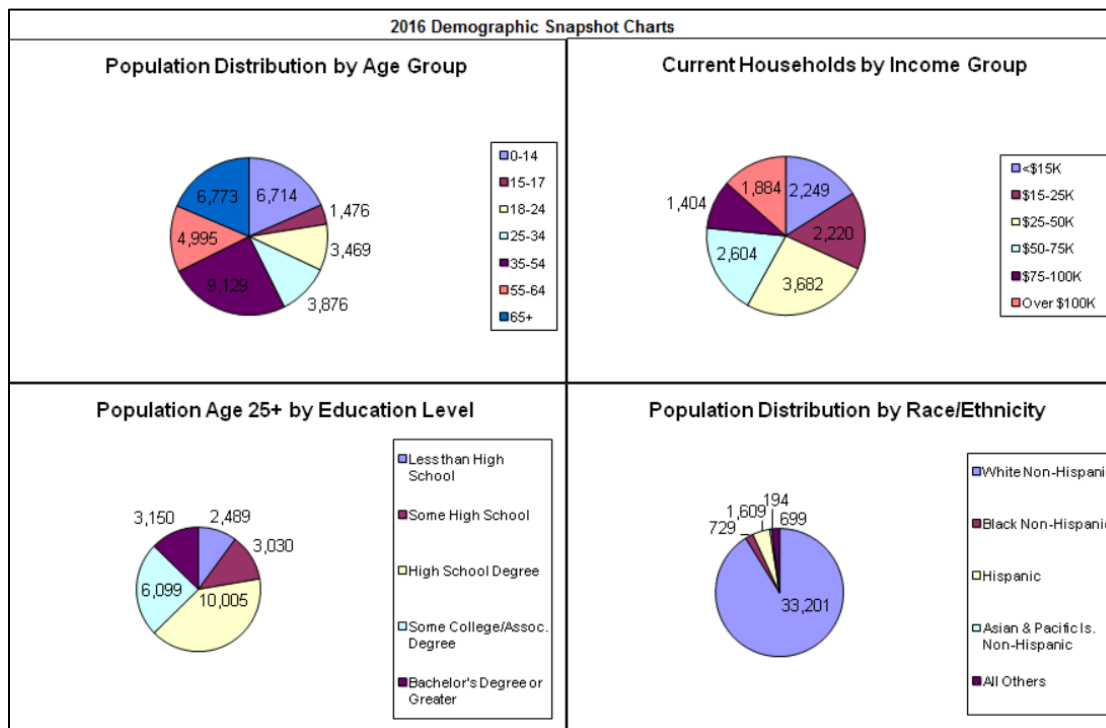|	Selected Area	USA				2016	2021	% Change
2010 Total Population	35,141	308,745,538		Total Male Population		17,958	18,613	3.6%
2016 Total Population	36,432	322,431,073		Total Female Population		18,474	19,197	3.9%
2021 Total Population	37,810	334,341,965		Females, Child Bearing Age (15-44)		6,491	6,755	4.1%
% Change 2016 - 2021	3.8%	3.7%						
Average Household Income	$55,493	$77,135						

POPULATION DISTRIBUTION

Age Distribution

Age Group	2016	% of Total	2021	% of Total	USA 2016 % of Total
0-14	6,714	18.4%	6,482	17.1%	19.0%
15-17	1,476	4.1%	1,612	4.3%	4.0%
18-24	3,469	9.5%	3,842	10.2%	9.8%
25-34	3,876	10.6%	4,133	10.9%	13.3%
35-54	9,129	25.1%	8,680	23.0%	26.0%
55-64	4,995	13.7%	5,073	13.4%	12.8%
65+	6,773	18.6%	7,988	21.1%	15.1%
Total	36,432	100.0%	37,810	100.0%	100.0%

HOUSEHOLD INCOME DISTRIBUTION

Income Distribution

2016 Household Income	HH Count	% of Total	USA % of Total
<$15K	2,249	16.0%	12.3%
$15-25K	2,220	15.8%	10.4%
$25-50K	3,682	26.2%	23.4%
$50-75K	2,604	18.5%	17.6%
$75-100K	1,404	10.0%	12.0%
Over $100K	1,884	13.4%	24.3%
Total	14,043	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	2,489	10.0%	5.8%
Some High School	3,030	12.2%	7.8%
High School Degree	10,005	40.4%	27.9%
Some College/Assoc. Degree	6,099	24.6%	29.2%
Bachelor's Degree or Greater	3,150	12.7%	29.4%
Total	24,773	100.0%	100.0%

RACE/ETHNICITY

Race/Ethnicity Distribution

Race/Ethnicity	2016 Pop	% of Total	USA % of Total
White Non-Hispanic	33,201	91.1%	61.3%
Black Non-Hispanic	729	2.0%	12.3%
Hispanic	1,609	4.4%	17.8%
Asian & Pacific Is. Non-Hispanic	194	0.5%	5.4%
All Others	699	1.9%	3.1%
Total	36,432	100.0%	100.0%

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[11] The tables below were created by Truven Market Planner, a national marketing company
[12] All population information, unless otherwise cited, sourced from Truven (formally Thomson) Market Planner

2016 Demographic Snapshot Charts

Population Distribution by Age Group

- 0-14
- 15-17
- 18-24
- 25-34
- 35-54
- 55-64
- 65+

6,773 | 6,714 | 1,476 | 3,469 | 3,876 | 9,129 | 4,995

Current Households by Income Group

- <$15K
- $15-25K
- $25-50K
- $50-75K
- $75-100K
- Over $100K

1,884 | 2,249 | 2,220 | 3,682 | 2,604 | 1,404

Population Age 25+ by Education Level

- Less than High School
- Some High School
- High School Degree
- Some College/Assoc. Degree
- Bachelor's Degree or Greater

3,150 | 2,489 | 3,030 | 10,005 | 6,099

Population Distribution by Race/Ethnicity

- White Non-Hispanic
- Black Non-Hispanic
- Hispanic
- Asian & Pacific Is. Non-Hispanic
- All Others

1,609 | 194 | 699 | 729 | 33,201

2016 Benchmarks
Area: Rhea 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
Tennessee	3.8%	38.9	15.7%	18.6%	19.5%	1.4%	$46,484	$50,733	$152,956
Selected Area	3.8%	41.5	18.6%	17.9%	17.8%	4.1%	$40,886	$52,899	$120,002

Demographics Expert 2.7
DEMO0003.SQP
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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 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 Rhea 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 Rhea County area. Items with blue text are viewed as statistically important potential beneficial findings—in other words, these are areas in which Rhea 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	**111.0%**	**32.5%**	**Mammography in Past Yr**	**94.0%**	**42.8%**
Vigorous Exercise	**94.5%**	**52.5%**	**Cancer Screen: Colorectal 2 yr**	**92.6%**	**23.6%**
Chronic Diabetes	**141.6%**	**16.9%**	**Cancer Screen: Pap/Cerv Test 2 yr**	**84.0%**	**50.5%**
Healthy Eating Habits	**86.8%**	**25.7%**	**Routine Screen: Prostate 2 yr**	**92.2%**	**29.5%**
Ate Breakfast Yesterday	**112.3%**	**56.0%**	**Orthopedic**		
Slept Less Than 6 Hours	**111.5%**	**20.9%**	**Chronic Lower Back Pain**	**130.1%**	**30.3%**
Consumed Alcohol in the Past 30 Days	**77.5%**	**43.1%**	**Chronic Osteoporosis**	**133.4%**	**13.1%**
Consumed 3+ Drinks Per Session	**112.4%**	**29.2%**	**Routine Services**		
Behavior			FP/GP: 1+ Visit	103.4%	91.3%
I Will Travel to Obtain Medical Care	94.3%	23.2%	**Used Midlevel in last 6 Months**	**107.9%**	**44.7%**
I am Responsible for My Health	90.8%	59.3%	**OB/Gyn 1+ Visit**	**85.2%**	**39.5%**
I Follow Treatment Recommendations	94.3%	49.0%	Medication: Received Prescription	98.6%	48.7%
Pulmonary			**Internet Usage**		
Chronic COPD	**135.0%**	**5.3%**	Use Internet to Talk to MD	67.8%	8.8%
Tobacco Use: Cigarettes	**120.6%**	**30.8%**	Facebook Opinions	76.8%	7.9%
Heart			Looked for Provider Rating	86.1%	12.4%
Chronic High Cholesterol	**125.7%**	**27.7%**	**Emergency Service**		
Routine Cholesterol Screening	**88.2%**	**44.8%**	**Emergency Room Use**	**107.7%**	**36.5%**
Chronic Heart Failure	**149.1%**	**7.5%**	**Urgent Care Use**	**92.8%**	**21.7%**

Leading Causes of Death

Cause of Death			Rank among all counties in TN (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation (County compared to U.S.)
TN Rank	Rhea Rank	Condition		TN	Rhea	
1	1	Heart Disease	63 of 95	204.1	243.9	As expected
2	2	Cancer	51 of 95	185.5	207.2	Higher than expected
4	3	Accidents	38 of 95	52.7	67.7	Higher than expected
3	4	Lung	18 of 95	53.2	66.7	Higher than expected
5	5	Stroke	57 of 95	44.4	55.9	As expected
7	6	Diabetes	19 of 95	24.8	34.8	Higher than expected
8	7	Flu - Pneumonia	30 of 95	22.1	30.0	Higher than expected
6	8	Alzheimer's	54 of 95	36.9	28.4	Higher than expected
10	9	Suicide	64 of 95	15.4	14.2	Higher than expected
9	10	Kidney	37 of 95	14.8	14.0	As expected
11	11	Liver	17 of 95	11.6	12.5	Higher than expected
13	12	Hypertension	18 of 95	9.6	10.2	Higher than expected
12	13	Blood Poisoning	50 of 95	11.5	9.5	As expected
14	14	Parkinson's	45 of 95	7.0	5.6	As expected
15	15	Homicide	54 of 95	6.4	4.7	As expected

National Healthcare Disparities Report – Priority Populations[13]

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

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

We asked a specific question to our Local Expert Advisors about unique needs of Priority Populations. We reviewed their responses to identify if any of the above trends were obvious in the service area. Accordingly, we place great reliance on the commentary received from our Local Expert Advisors to identify unique population needs to which we should respond. Specific opinions from the Local Expert Advisors are summarized below:[14]

- Residents of rural areas face barriers including transportation and lack of resources close to them

- Lack of mental health and/or substance abuse services in the community

- Many low income residents cannot afford health insurance or medications to improve health

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[13] http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/index.html
[14] 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.

Rhea County zip codes primarily fall into the second and third highest quartiles of social vulnerability. However, the southwestern portion is noted as being in the highest quartile of vulnerability.
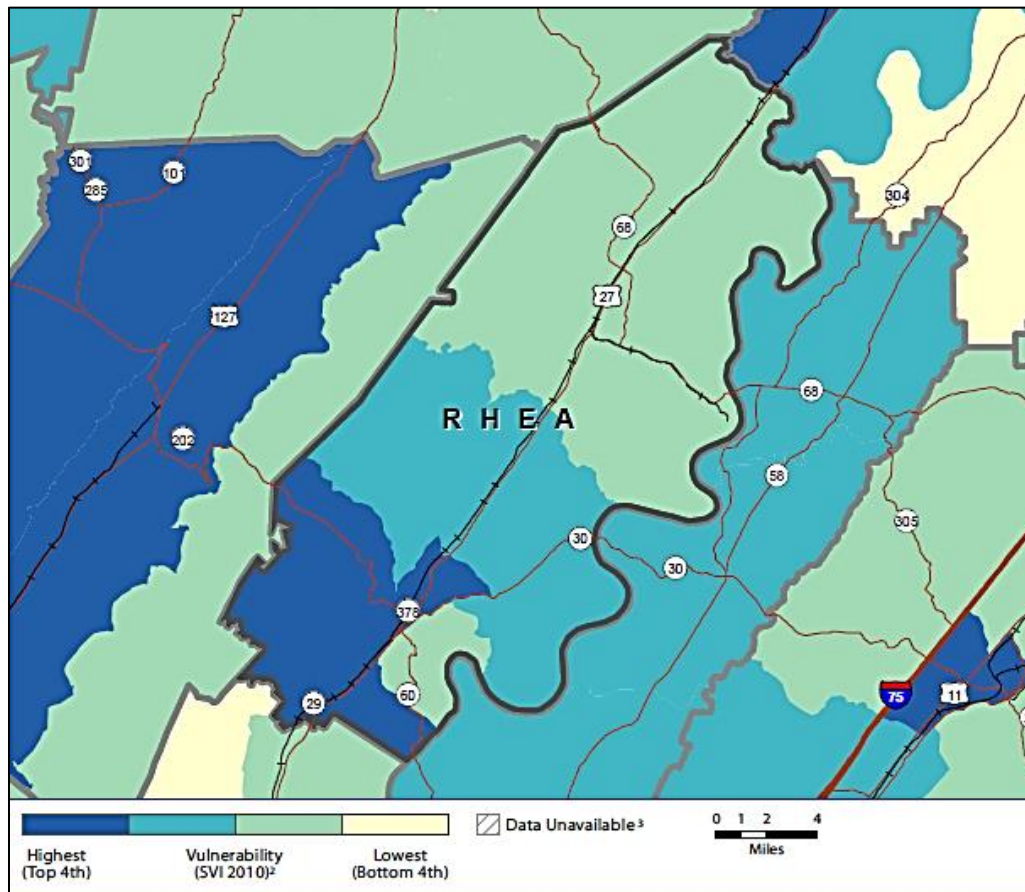
Consideration of Written Comments from Prior CHNA

A group of 12 individuals provided written comment in regard to the 2013 CHNA. Our summary of this commentary produced the following points, which were introduced in subsequent considerations of this CHNA.

Commenter characteristics:

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

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

- Affordability/Access to Care

- Obesity/Overweight

- Coronary Heart Disease

- Cancer

- Alcohol/Substance Abuse

- Smoking/Tobacco Use

- Maternal/Infant Measures

- Compliance Behavior

- Diabetes

- Physicians

- Alzheimer's

- Dental

- Mental Health/Suicide

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

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

	Yes	No	No Opinion
Affordability/Access to Care	9	2	0
Obesity/Overweight	11	0	0
Coronary Heart Disease	10	1	0
Cancer	10	1	0
Alcohol/Substance Abuse	11	0	0
Smoking/Tobacco Use	11	0	0
Maternal/Infant Measures	10	1	0
Compliance Behavior	9	1	1
Diabetes	9	1	1
Physicians	7	2	2
Alzheimer's	8	1	2
Dental	6	3	2
Mental Health/Suicide	10	0	1

- **Specific comments or observations about Affordability/Access to Care as being among the most significant needs for the Hospital to work on to seek improvements?**

    - *This is a poor county, not enough jobs, patients say they do not qualify for insurance because they " do not make enough money " The FQHC is the only center to accept sliding fee patients, the large Medicaid population have very few options.*

    - *We need to continue to educate our uninsured community about the resources available to them for Healthcare and Health Insurance.*

    - *affordable subtance rehab and metal health needs lest available in this county*

    - *More people now have access to care so I do not see it as an issue like it was*

    - *Currently I still have families without insurance, mostly parents, my specific focus is on the parent child relationship so not a great deal of our visits are devoted to finding coverage. Roughly 7 out of 18 families served were without insurance over the past year. Is there a local service that helps to enroll families? Since, DHS no longer provides this service, I have often referred families to the website healthcare.gov or allowed them to use my work phone to access enrollment services.*

    - *Access to care continues to be a priority for local residents due to cost. Providing case managers to each patient and follow up may prove to show improvements.*

- **Specific comments or observations about Obesity/Overweight as being among the most significant needs for the Hospital to work on to seek improvements?**

    - *We know that BMI data for students is improving in Rhea County, but the overweight/obesity numbers*

are still above state-level norms. These concerns begin with lifestyles at home. We also know, according to the Youth Risk Behavior Survey conducted by the CDC (with weighted data), that a large number of TN students do not participate in regular physical activity outside of school and outside of middle school, they do not necessarily get it daily during school. Students do not regularly receive healthy weight loss information.

- *Find ways to educate and motivate the community to want to improve their overall health by reducing the Obesity/Overweight rate in Rhea County.*

- *Obesity is a burden for the people of Rhea Co. Education is needed for diet choices and exercising.*

- *Several people are unable to afford healthy foods that I work with so they tend to purchase unhealthy items that are reasonably priced for the quantity*

- *Tennessee is the 4 th leading state in the nation for obesity. Before a patient leaves the hospital hand outs either pictures or written with a specific information for that patient to follow for life style change with diet and exercise as tolerated.*

- **Specific comments or observations about <u>Coronary Heart Disease</u> as being among the most significant needs for the Hospital to work on to seek improvements?**

  - *CAD and its complications are daily issues with the patient at the clinic*

  - *Coronary Heart Disease remains one of the most significant health problems within the community. It is an asset to the community to be able to have certain testing completed locally and periodically seen by a cardiologist without traveling out of the county.*

  - *as above with life style change with diet and exercise as tolerated with hand outs with follow up with health clinics/sessions provided by the hospital free of charge.*

- **Specific comments or observations about <u>Cancer</u> as being among the most significant needs for the Hospital to work on to seek improvements?**

  - *very little cancer diagnosis and treatment available here*

  - *there is no cancer treatment in Rhea county*

  - *when a patient goes through the ER or hospital information for screening appropriate for age is addressed with follow up to local provider*

- **Specific comments or observations about <u>Alcohol/Substance Abuse</u> as being among the most significant needs for the Hospital to work on to seek improvements?**

  - *This is a important need for this county*

  - *Lack of affordable inpatient treatment in this area, easy access to prescription medication that is easily abused. Physicians write prescriptions for Schedule II drugs for pain relief rather than Schedule III which was done many years ago. It was almost impossible to get Schedule II drugs unless you were being treated in a hospital for a serious condition.*

  - *Alcohol/Substance Abuse is an epidemic and while in the hospital or ER case managers should be provided.*

- **Specific comments or observations about <u>Smoking/Tobacco Use</u> as being among the most significant needs for the Hospital to work on to seek improvements?**

  - *Smoking and Tobacco continues to be a significant concern within the comunity and all efforts to aid in awareness and educating the community even further.*

  - *Tobacco use is very high in Rhea County which begins at a early age associated with family, social and "every body does it". Any form of tobacco use has health issues with low birth weight, all forms of cancer along with pulmonary and heart issues.*

- **Specific comments or observations about <u>Maternal/Infant Measures</u> as being among the most significant needs for the Hospital to work on to seek improvements?**

  - *I understand the many issues/concerns with adding prenatal care and delivery services at RMC; however, I would love to see more breastfeeding support for new moms. Having worked for the Health Department in the past and nursed my own children for 15+ months each I have seen/experienced a great need for breastfeeding support. So many women either do not know about the support offered at the health department or are unsure about their ability to access It if they are not WIC clients. Given so many misconceptions about breastfeeding partnered with its growing acceptance/popularity, I would love to see the hospital step-up for those who fall in the cracks since it is oftentimes very difficult to get to Women's East for classes, especially if there are other small children in tow.*

  - *Having OB/GYN doctors coming to the community is helping*

  - *to refer to local peds/GYN*

- **Specific comments or observations about <u>Compliance Behavior</u> as being among the most significant needs for the Hospital to work on to seek improvements?**

  - *Compliance Behavior is a difficulty area in the hospital and local providers for the limited time spent with each patient.*

- **Specific comments or observations about <u>Diabetes</u> as being among the most significant needs for the Hospital to work on to seek improvements?**

  - *Diabetes can go untreated for years without the person knowing they have the disease.*

  - *The community needs educations in all areas of this disease from avoidance and treatment*

  - *Diabetes education and outreach are still extremely important but diabetes is so linked with Coronary Artery Disease and Obesity it's becoming difficult to separate the issues.*

  - *Diabetes is at epidemic levels and could be controlled with education with life style change with diet and exercise which would be difficulty for the hospital to implement. When a patient is in the hospital have a diabetic educator visit the patient with follow up with the educator.*

- **Specific comments or observations about <u>Physicians</u> as being among the most significant needs for the Hospital to work on to seek improvements?**

  - *Has there ever been a time when this community has ever 'not' needed to recruit and show appreciation to medical providers?*

- *Physicians to make themselves available to questions and concerns of the patient and family. When patients are in house so much is going on and they do not really understand the immediate issues.*

- **Specific comments or observations about <u>Alzheimer's</u> as being among the most significant needs for the Hospital to work on to seek improvements?**

  - *Alzheimer's is a disease that affects not just the patient but the caregiver and the entire family. No one seems to understand this disease or how to manage it.*

  - *The needs of the caretakers needs to address as well as the treatment and diagnosis of Alzheimer's*

  - *Have educators on staff who understand the processes of Alzheimer's and stage.*

- **Specific comments or observations about <u>Dental</u> as being among the most significant needs for the Hospital to work on to seek improvements?**

  - *The uninsured population suffers with the lack of dental services available to them. Dental services are costly and not covered by TENNCARE for adults.*

  - *The county needs more Dentists willing to do more for less.*

  - *Dental is a significant need if not implemented results in diseases processes. Patient's in the hospital may be given a list of local dentist as they leave the hospital.*

- **Specific comments or observations about <u>Mental Health/Suicide</u> as being among the most significant needs for the Hospital to work on to seek improvements?**

  - *There is often a stigma for individuals seeking mental health treatment. Health providers need to feel comfortable referring individuals for mental health treatment.*

  - *People with Mental Health/Suicide needs are often hard to treat and can be stressful for the family who are trying to help them.*

  - *There are not enough quality mental health centers in the Rhea county area for adults. Children with private insurance lack services in this area. Most of the counseling agencies that serve children only accept TennCare.*

  - *Mental health is overlooked in the community. When a patient is in the hospital with mental health/suicide provider should be called in to evaluate the patient.*

Conclusions from Public Input

Our group of 12 Local Expert Advisors participated in an online survey to offer opinions about their perceptions of community health needs and the potential needs of unique populations. Complete verbatim written comments appear in the Appendix to this report.

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

- *Most of the boxes I mark requires a patient to go to cities our side of Rhea County to received long term care.*

Summary of Observations: Comparison to Other Counties

Health Outcomes

In a health status classification termed "Health Outcomes," Rhea ranks number 62 among the 95 ranked Tennessee counties (best being #1). Premature Death (deaths prior to age 75) presents worse values (shorter survivability) than on average for the US and Tennessee.

Health Factors

In another health status classification "Health Factors," Rhea County ranks number 58 among the 95 ranked Tennessee counties. The following indicators compared to TN average and to national top 10% performance present such poor values it warrants investigating how to improve:

- Adult Obesity – Rhea 37% of residents compared to TN 32% and US best of 25%

- Physical Inactivity – Rhea 36% compared to TN 30% and US best of 20%

- Access to Exercise Opportunities – Rhea 59% which is below the TN avg. of 70% and US best of 92%

- Teen Births - Rhea 65 births/1,000 females age 15 to 19 compared to TN 47 and US best of 20 births

Clinical Care

In the "Clinical Care" classification, Rhea County ranks number 40 among the 95 ranked Tennessee counties. The following indicators compared to TN average and to national top 10% performance present such poor values it warrants investigating how to improve:

- Population to Primary Care Physician – Rhea 2,687:1 which is more than the TN 1,388:1 and US best of 1,045:1

- Population to Dentist – Rhea 4,645:1 which is more than double the TN 1,996:1 and 3 times worse than the US best of 1,377:1

- Population to Mental Health Provider – Rhea 3,613:1 which is more than 4 times the TN 786:1 and over 9 times worse than the US best of 386:1

- Preventable Hospital Stays (a measure of potential shortage shortage) – Rhea 79 admissions per 1,000 compared to TN 73 and US best of 41 admissions

- Diabetic Monitoring – Rhea 84% compared to TN 86% and US best of 90%

Social & Economic Factors

In the "Social and Economic Factors" classification, Rhea County ranks number 79 among the 95 ranked Tennessee counties. The following indicators compared to TN average and to national top 10% performance present such poor values it warrants investigating how to improve:

- High School Graduation – Rhea 82% which is below the TN avg. of 87%

- Some College – Rhea 39.5% which is considerably below the TN avg. of 57.7% and US best of 71.0%

- Unemployment – Rhea 11.3% compared to TN 8.2% and US best of 4.0%

- Children in Poverty – Rhea 28% which is above the TN avg. of 27% and US best of 13%

- Injury Deaths – Rhea 96 per 100,000 residents compared to TN 78 and US best of 50

Summary of Observations: Peer Comparisons

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

Mortality

- *Better*

  - Chronic Kidney Disease Deaths

- *Worse*

  - Chronic Lower Respiratory Disease Deaths – 72.5 deaths per 100,000; 8th worst among 77 peer counties; US avg. 49.6

  - Diabetes Deaths – 36.1 deaths per 100,000; 9th worst among 75 peer counties; US avg. 24.7

  - Female Life Expectancy – 77.3 years; 13th worst among 77 peer counties; US avg. 79.8

  - Male Life Expectancy – 70.9 years; 6th worst among 77 peer counties; US avg. 75.0

  - Unintentional Injury (including motor vehicle) – 78.7 deaths per 100,000; 9th worst among 77 peer counties; US avg. 50.8

Morbidity

- *Better*

  - Syphilis

- *Worse*

  - Adult Obesity – 40.3% of adults; 12th worst among 75 peer counties; US avg. 30.4%

  - Adult Overall Health Status – 24.6% of adults reporting fair or poor health status; 15th worst among 74 peer counties; US avg. 16.5%

  - Cancer – 583.2 cases per 100,000; worst among 69 peer counties; US avg. 457.6

  - Preterm Births – 14.4% of births; 12th worst among 77 peer counties; US avg. 12.1%

Healthcare Access & Quality

- *Better*

  - Nothing

- *Worse*

  - Cost Barrier to Care – 23.9% of adults who did not see a doctor due to cost; 11th worst among 69 peer counties; US avg. 15.6%

Health Behaviors

- *Better*

- Adult Smoking

- *Worse*

  - Adult Female Routine Pap Tests – 69.8% of adult women; 14th worst among 65 peer counties; US avg. 77.3%

  - Adult Physical Inactivity – 37.0% of adults who report no leisure time physical activity; 10th worst among 75 peer counties; US avg. 25.9%

  - Teen Births – 65.5 births per 1,000 teens; 9th worst among 77 peer counties; US avg. 42.1

Social Factors

- *Better*

  - Nothing

- *Worse*

  - High Housing Costs – 30.3% of individuals; 14th worst among 77 peer counties; US avg. 27.3%

  - Unemployment – 11.3%; 8th worst among 77 peer counties; US avg. 7.1%

Physical Environment

- *Better*

  - Living Near Highways

- *Worse*

  - Access to Parks – 1.0% of individuals living within a half mile of a park; 12th worst among 77 peer counties; US avg. 14.0%

Conclusions from Demographic Analysis Compared to National Averages

The 2016 population for Rhea County is estimated to be 36,432 and expected to increase at a rate of 3.8% through 2021. This is higher than the 3.7% national rate of growth, while Tennessee's population is also expected to increase by 3.8%. In 2021, Rhea County anticipates a population of 37,810.

Population estimates indicate the 2016 median age for the county is 41.5 years, older than the Tennessee median age (38.9 years) and the national median age of 38.0 years. The 2016 Median Household Income for the area is $40,886, lower than the Tennessee median income of $46,484 and the national median income of $55,072. Median Household Wealth value ($52,899) is higher than the Tennessee value ($50,733), but lower than the national value of $54,224. Median Home values for Rhea ($120,002) are lower than both the national median of $192,364 and Tennessee median of $152,956. Rhea's unemployment rate as of December 2015 was 7.8%, which is higher than the 5.6% statewide and the 5.0% national civilian unemployment rate.

The portion of the population in county over 65 is 18.6%, compared to Tennessee (15.7%) and the national average (15.1%). The portion of the population of women of childbearing age is 17.8%, lower than the Tennessee average of 19.5% and the national rate of 19.6%. 91.1% of the population is White non-Hispanic. The largest minority is the Hispanic population which comprises 4.4% of the total.

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

- BMI: Morbid/Obese is 11.0% above average impacting 32.5% of the population

- Vigorous Exercise is 5.5% below average impacting 52.5% of the population

- I am Responsible for My Health is 9.2% below average impacting 59.3% of the population

- I Follow Treatment Recommendations is 5.7% below average impacting 49.0% of the population

- Tobacco Use (Cigarettes) is 20.6% above average impacting 30.8% of the population

- Routine Cholesterol Screening is 11.8% below average impacting 44.8% of the population

- Had a Mammogram is 6.0% below average impacting 42.8% of the population

- Cervical Cancer Screening is 16.0% below average impacting 50.5% of the population

- Chronic Lower Back Pain is 30.1% above average impacting 30.3% of the population

- Had an OB/GYN Visit is 14.8% below average impacting 39.5% of the population

- Emergency Room Use is 7.7% above average impacting 36.5% of the population

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

- Ate Breakfast Yesterday is 12.3% above average impacting 56.0% of the population

- Consumed Alcohol in the past 30 days is 22.5% below average impacting 43.1% of the population

- Used a Midlevel in last 6 months is 7.9% above average impacting 44.7% of the population

Conclusions from Other Statistical Data

Among the Top 15 Causes of Death in the U.S., 6 of the 15 occurred at expected rates in Rhea County. However, **Cancer, Accidents, Lung Disease, Diabetes, Flu/Pneumonia, Alzheimer's, Suicide, Liver Disease,** and **Hypertension** occurred at higher rates than expected. The Top 10 Causes of Death in Rhea County are:

1. **Heart Disease** with Rhea ranking #63 among 95 TN Counties (where #1 is worst in state)

2. **Cancer** ranking #51 in TN

3. **Accidents** ranking #38 in TN

4. **Lung Disease** ranking #18 in TN

5. **Stroke** ranking #57 in TN

6. **Diabetes** ranking #19 in TN

7. **Flu/Pneumonia** ranking #30 in TN

8. **Alzheimer's** ranking #54 in TN

9. **Suicide** ranking #64 in TN

10. **Kidney Disease** ranking #37 in TN

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

Unfavorable Rhea County measures which are *worse than* the US avg. *and* had an *unfavorable change*:

- **Female Life Expectancy** – As of 2013, female life expectancy is at 77.8 years; value decreased 0.6 years since 1985

- **Male Obesity** - As of 2011, 40.0% of males are obese; value increased 6.7 percentage points since 2001

- **Female Obesity** – As of 2011, 41.9% of females are obese; value increased 8.1 percentage points since 2001

Unfavorable Rhea County measures which are *worse than* the US avg. *but* had a *favorable change*:

- **Male Life Expectancy** - As of 2013, male life expectancy is at 73.0 years; value increased 3.9 years since 1985

- **Male Smoking** - As of 2012, male smoking is at 29.4%; value decreased 5.5 percentage points since 1996

- **Female Smoking** - As of 2012, female smoking is at 28.6%; value decreased 0.2 percentage points since 1996

- **Male Physical Activity** – As of 2011, recommended physical activity for males is at 43.9%; value has not changed since 2001

- **Female Physical Activity** - As of 2011, recommended physical activity for females is at 36.4%; value increased 3.4 percentage points since 2001

Desirable Rhea County measures *better than or the same as* the US avg. *but* had an *unfavorable change*:

- **Male Heavy Drinking** – As of 2012, 5.8% of males are heavy drinkers; value increased 1.0 percentage points since 2005

- **Female Heavy Drinking** - As of 2012, 2.3% of females are heavy drinkers; value increased 0.2 percentage points since 2005

- **Male Binge Drinking** – As of 2012, 14.9% of males are binge drinkers; value increased 3.9 percentage points since 2002

- **Female Binge Drinking** – As of 2012, 5.8% of female are binge drinkers; value increased 2.5 percentage points since 2002

Desirable Rhea County measures *better than or the same as* the US avg. *and* had a *favorable change*:

- **Nothing**

Conclusions from Prior CHNA Implementation Activities

"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:

- Rhea Medical Center claimed $5,536,728 Community Benefit in the 2015 fiscal year.

EXISTING HEALTHCARE FACILITIES, RESOURCES, & IMPLEMENTATION STRATEGY

SIGNIFICANT HEALTH NEEDS

We used the priority ranking of area health needs by the Local Expert Advisors to organize the search for locally available resources as well as the response to the needs by RMC. 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 RMC current efforts responding to the need including any written comments received regarding prior RMC implementation actions

- Establishes the Implementation Strategy programs and resources RMC will devote to attempt to achieve improvements

- Documents the Leading Indicators RMC will use to measure progress

- Presents the Lagging Indicators RMC 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, RMC is the major hospital in the service area. Rhea Medical Center is a 25-bed, general medical and surgical hospital located in Dayton, Tennessee. The next closest facilities are outside the service area and include:

- Cumberland Medical Center in Crossville, TN, 37 miles (45 minutes)

- Memorial North Park, Hixson, TN, 34 miles (43 minutes)

- Erlanger Medical Center, Chattanooga, TN, 42 miles (49 minutes)

- Memorial Health System, Chattanooga, TN, 44 miles (55 minutes)

- Roane Medical Center, Harriman, TN, 38 miles (44 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 RMC 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.

Significant Needs

1. **OBESITY/OVERWEIGHT** – 2013 Significant Need; adult obesity above TN average and US best rate; 12th worst among peer counties; 11.0% above average; male and female obesity worse than US average

Public comments received on previously adopted implementation strategy:

- *Provide community classes on healthy eating and educate those that are overweight/obesity on how to lose weight and be healthy.*

- *This is my fault for not knowing what the community programs in the area are ongoing or offered*

- *I commend the efforts of the Hospital offering luncheons and classes as well as other Community Programs geared toward Healthy Eating. We should continue trying different avenues to reach the rural community with such classes and or programs.*

- *as above making patients accountable for their own health* [*Tennessee is the 4 th leading state in the nation for obesity. Before a patient leaves the hospital hand outs either pictures or written with a specific information for that patient to follow for life style change with diet and exercise as tolerated*.]

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

- Quarterly newsletter distributed to households across the county and adjoining areas that includes healthy recipes and articles on healthy living (exercise, fitness, etc.)

- Calorie counts for menu items displayed in cafeteria

- Occupational health providing wellness assessments at local industries

- Local education sessions (Healthy Kids Day, Farm/City Day, heart-healthy eating classes, diabetes management classes) focusing on nutrition and exercise

- Free health screenings at local fishing tournament

- Sponsorship of Funky Monkey and Strawberry Chase (local running races) benefitting Rhea County Community Center (RC3)

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

- Research implementing a local health fair

- Continue above activities

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

- Started providing water at Farm/City Day as an alternative to sugary drinks; provided water at local races

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

- Number of occupational health wellness screenings provided to local industries in 2015 = 344

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

- Adult Obesity – 40.3% of adults; 12th worst among 75 peer counties; US avg. 30.4%

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

Organization	Contact Name	Contact Information
Rhea County Community Center (RC3)		http://www.rheacountycommunitycenter.org/ (423) 775-0821
Rhea County Health Council		https://www.facebook.com/RheaCountyHealthCouncil (423) 775-5633
Local Industries		

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

Organization	Contact Name	Contact Information
Rhea County Health Department		334 Eagle Ln, Evensville, TN 37332 (423) 775-7819

2. AFFORDABILITY/ACCESS TO CARE – 2013 Significant Need; 11th worst among peer counties for cost barrier to care

Public comments received on previously adopted implementation strategy:

- *They have a program for some indigent care work that is easy to access, but the volume of this care is not known to me, but several patients have been able to use these programs*

- *It would be beneficial for the community to have access to two or three different Providers for Cardiology and Mental Health.*

- *as above [Access to care continues to be a priority for local residents due to cost. Providing case managers to each patient and follow up may prove to show improvements.]*

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

- Financial Assistance Policy available including sliding-fee scale based on percentage of poverty level

- Discount for self-pay patients

- Primary Care Clinic that adopts the same financial assistance policies as the Hospital

- Hospital and Primary Care Clinic accept TennCare

- Hospital provides specialties including Cardiology, Orthopedics, Pulmonology, and OB/GYN for which residents would otherwise have to travel almost an hour to receive these services/treatments

- Hospital provides tele-health for behavioral health, telestroke, and VRI for hearing impaired

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

- Research providing free/low-cost physicals to student athletes

- Look at Physician Needs Assessment for other potential specialists

- Continue above activities

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

- Provided Lunch 'n' Learn on Medicare Advantage

Anticipated results from RMC 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

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

- Number of patients approved for or qualifying for RMC charity care in 2015 = 240

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

- Cost Barrier to Care – 23.9% of adults who did not see a doctor due to cost; 11th worst among 69 peer counties; US avg. 15.6%

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

Organization	Contact Name	Contact Information
Children's Advocacy Center		http://www.cachc.org/ 419 N. Market St, Chattanooga, TN 37405 (423) 266-6918

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

Organization	Contact Name	Contact Information
Rhea County Primary Care (FQHC)		8850 Rhea County Hwy, Dayton, TN 37321 (423) 775-1160
Rhea County Health Department		334 Eagle Ln, Evensville, TN 37332 (423) 775-7819
Women's Care Center		http://www.rheaofhope.org/ 423.775.0019
Johnson Mental Health Center		https://www.vbhcs.org/locations/chattanooga/ (423) 634-8884

3. **CANCER** – 2013 Significant Need; #2 leading cause of death; worst among peer counties; mammography screening 6.0% below average; cervical cancer screening 16.0% below average

Public comments received on previously adopted implementation strategy:

- *as above* [*when a patient goes through the ER or hospital information for screening appropriate for age is addressed with follow up to local provider*]

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

- Hospital offers digital mammography and stereotactic breast biopsies, lumpectomies, mastectomies
- Nuclear Medicine scans
- PET Scanner
- Local outpatient laboratory for follow-up tests
- OB/GYN and PCPs available for regular screenings
- Promote Breast Cancer Awareness Month through newsletter, free t-shirts, pink décor
- PSA screening performed as part of local industry wellness screenings
- Screenings provided for colonoscopies and endoscopies
- Cancer awareness articles in newsletter
- Hospital is a sponsor for local Relay for Life

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

- Continue above activities
- Investigate adding a visiting oncologist
- Research cancer survivors' event

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

- Increased community outreach for mammography services
- Collaboration with Health Department to use available grants for breast and cervical cancer screenings

Anticipated results from RMC 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

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

- Number of mammography screenings performed in 2015 = 1,715

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

- Percentage of female Medicare enrollees age 67-69 that receive mammography screenings = 65% in Rhea County (62% in TN, 71% in U.S.)

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

Organization	Contact Name	Contact Information
Relay for Life/American Cancer Society		http://main.acsevents.org/site/TR/RelayForLife/RFLCY17MS?pg=entry&fr_id=74362

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

Organization	Contact Name	Contact Information
Rhea County Health Department		334 Eagle Ln, Evensville, TN 37332 (423) 775-7819

4. **DIABETES** – 2013 Significant Need; #6 leading cause of death; 9th worst among peer counties; diabetic monitoring below the TN average and US best rate

Public comments received on previously adopted implementation strategy:

- *Provide more diabetes prevention in the community and focus on way to educate and help those with prediabetes to change their diets and life styles to keep their prediabete from becoming diabetes.*

- *There are programs to discuss the issues here, more public awareness is needed*

- *Continue efforts to educate and encourage individuals to seek evaluation, make lifestyle changes, and follow treatment plans.*

- *as above [Diabetes is at epidemic levels and could be controlled with education with life style change with diet and exercise which would be difficulty for the hospital to implement. When a patient is in the hospital have a diabetic educator visit the patient with follow up with the educator.]*

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

- Quarterly newsletter distributed to households across the county and adjoining areas that includes healthy recipes and articles on healthy living (exercise, fitness, etc.)

- Calorie counts for menu items displayed in cafeteria

- Occupational health and dietary professional providing wellness assessments at local industries

- Local education sessions (Healthy Kids Day, Farm/City Day, heart-healthy eating classes, diabetes management classes) focusing on nutrition and exercise

- Sponsorship of Funky Monkey and Strawberry Chase (local running races) benefitting Rhea County Community Center (RC3)

- Senior Day – perform blood pressure and glucose checks; provide medication cards, booklets, fruit, and water

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

- Continue above activities

Anticipated results from RMC Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations	X	
4. Enhances public health activities	X	
5. Improves ability to withstand public health emergency		X

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
6. Otherwise would become responsibility of government or another tax-exempt organization	X	
7. Increases knowledge; then benefits the public	X	

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

- Senior Day – number of glucose screenings provided at event in 2015 = 18

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

- Adult diabetes rate in 2015 = 10.4%

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

Organization	Contact Name	Contact Information
UT Agricultural Extension Services (Senior Day, Rhea County Fair)		https://extension.tennessee.edu/rhea/Pages/default.aspx (423) 775-7807

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

Organization	Contact Name	Contact Information
Rhea County Health Council		https://www.facebook.com/RheaCountyHealthCouncil (423) 775-5633
American Diabetes Association		http://www.diabetes.org/

5. CORONARY HEART DISEASE – 2013 Significant Need; Local Expert concern; #1 leading cause of death

Public comments received on previously adopted implementation strategy:

- *Since Coronary Heart Disease is the #1 cause of death in Rhea County, need to find ways to movitate community to stop smoking and have healthier lifestyles.*

- *The hospital is seeking to improve the heart care in the county and the care available locally*

- *The most common comments heard within the community is the lack of choices regarding Cardiac Care. It is the desire of county residents to have other Cardiologists available locally so out of county travel could be limited even further.*

- *as above [as above with life style change with diet and exercise as tolerated with hand outs with follow up with health clinics/sessions provided by the hospital free of charge.]*

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

- Quarterly newsletter distributed to households across the county and adjoining areas that includes healthy recipes and articles on healthy living (exercise, fitness, etc.)

- Calorie counts for menu items displayed in cafeteria

- Occupational health and dietary professional providing wellness assessments at local industries

- Local education sessions (Healthy Kids Day, Farm/City Day, heart-healthy eating classes, diabetes management classes) focusing on nutrition and exercise

- Sponsorship of Funky Monkey and Strawberry Chase (local running races) benefitting Rhea County Community Center (RC3)

- Senior Day – perform blood pressure and glucose checks; provide medication cards, booklets, fruit and water

- Three visiting cardiologists available for local appointments

- Stress tests and nuclear medicine available

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

- Investigate providing reduced-cost memberships to RC3 for hospital employees and families

- Lunch 'n' Learn session for cardiology education during 2016

- Continue above activities

Anticipated results from RMC Implementation Strategy

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

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

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

- Number of blood pressure checks provided at Senior Day in 2015 = 24

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

- Rate of coronary heart disease deaths in Rhea County = 153.4 per 100,000 adjusted

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

Organization	Contact Name	Contact Information
UT Agricultural Extension Service		https://extension.tennessee.edu/rhea/Pages/default.aspx (423) 775-7807
Rhea County Community Center (RC3)		http://www.rheacountycommunitycenter.org/

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

Organization	Contact Name	Contact Information
Rhea County Health Department		334 Eagle Ln, Evensville, TN 37332 (423) 775-7819
Rhea County Health Council		https://www.facebook.com/RheaCountyHealthCouncil (423) 775-5633

6. DENTAL – 2013 Significant Need; worse ratio than US and TN for population to dentist

Public comments received on previously adopted implementation strategy:

- *If there is anything the Hospital can do to assist the Health Department with recruiting a Dentist for our clinic it would be greatly appreciated. There is a tremendous need for emergent Dental care for our uninsured community. Our Dentist recently retired and there is no Dentist to fill this position at this time.*

- *If possible, the hospital would have a dental awareness at the hospital free to the public with speakers and handouts with local area dental clinics and transportation provided.*

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

- We are choosing not to respond to this need at this time. We feel we can have a greater impact by putting attention and resources toward other significant needs for which we are better qualified to serve.

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

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

Organization	Contact Name	Contact Information
Dr. Dennis J. Van Meter, DMD		225 Main Ave #400, Dayton, TN 37321 (423) 775-1444
Mike Allport, DDS		124 Timber Dr, Dayton, TN 37321 (423) 775-9971
Dr. Larry M. Smith, DDS		180 Walnut Grove Rd, Dayton, TN 37321 (423) 775-1464
Theresa B. Browder, DDS		155 Main Ave, Dayton, TN 37321 (423) 775-8280

Organization	Contact Name	Contact Information
Standifer Orthodontics		225 Main Ave #400, Dayton, TN 37321 (423) 775-9302

7. **SMOKING/TOBACCO USE – 2013 Significant Need; male and female smoking worse than US average; tobacco use (cigarettes) 20.6% above average**

Public comments received on previously adopted implementation strategy:

- *I am not aware of any programs*

- *To implement action is difficulty for tobacco abuse is addictive which includes the whole family unit.*

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

- We are choosing not to respond to this need at this time. We feel we can have a greater impact by putting attention and resources toward other significant needs for which we are better qualified to serve.

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

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

Organization	Contact Name	Contact Information
American Cancer Society		www.cancer.org
State of Tennessee Tobacco Quit Line		http://www.tnquitline.org/ 1-800-784-8669
American Lung Association		http://www.lung.org/about-us/local-associations/tennessee.html 1-800-LUNGUSA

Other Needs Identified During CHNA Process

8. **EDUCATION/PREVENTION**

9. **MATERNAL/INFANT MEASURES** – 2013 Significant Need

10. **ACCIDENTS**

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

12. **COMPLIANCE BEHAVIOR** – 2013 Significant Need

13. **PHYSICIANS** – 2013 Significant Need

14. **MENTAL HEALTH/SUICIDE** – 2013 Significant Need

15. **ALZHEIMER'S** – 2013 Significant Need

16. **STROKE**

17. **PHYSICAL INACTIVITY**

18. **KIDNEY DISEASE**

19. **CHOLESTEROL**

20. **FLU/PNEUMONIA**

21. **CHRONIC LOWER RESPIRATORY DISEASE**

22. **LIFE EXPECTANCY**

23. **LUNG DISEASE**

24. **CHRONIC LOWER BACK PAIN**

25. **PRIORITY POPULATIONS**

26. **SOCIAL VULNERABILITY**

Overall Community Need Statement and Priority Ranking Score

Significant needs where hospital has implementation responsibility

1. Obesity/Overweight
2. Affordability/Access To Care
3. Cancer
4. Diabetes
5. Coronary Heart Disease

Significant needs where hospital did not develop implementation strategy

6. Dental
7. Smoking/Tobacco Use

Other needs where hospital developed implementation strategy

None

Other needs where hospital did not develop implementation strategy

8. EDUCATION/PREVENTION
9. MATERNAL/INFANT MEASURES – 2013 Significant Need
10. ACCIDENTS
11. ALCOHOL/SUBSTANCE ABUSE – 2013 Significant Need
12. COMPLIANCE BEHAVIOR – 2013 Significant Need
13. PHYSICIANS – 2013 Significant Need
14. MENTAL HEALTH/SUICIDE – 2013 Significant Need
15. ALZHEIMER'S – 2013 Significant Need
16. STROKE
17. PHYSICAL INACTIVITY
18. KIDNEY DISEASE
19. CHOLESTEROL
20. FLU/PNEUMONIA

21. CHRONIC LOWER RESPIRATORY DISEASE

22. LIFE EXPECTANCY

23. LUNG DISEASE

24. CHRONIC LOWER BACK PAIN

25. PRIORITY POPULATIONS

26. SOCIAL VULNERABILITY

APPENDIX

Hospital solicited written comments about its 2013 CHNA. 12 individuals responded to the request for comments. The following presents the information received in response to the solicitation efforts by the hospital. No unsolicited comments have been received.

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

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

- **Within the county, do you perceive the local Priority Populations to have any unique needs, as well as potential unique health issues needing attention? If you believe any situation as described exists, please also indicate who you think needs to do what.**

    - *Residents of rural areas face barriers including transportation and lack of resources close to them.*

    - *I have concerns that there is not enough mental health help in the community. This is starting to grow and is better than a few years ago, but this could improve.*

    - *Increase access to health insurance, those without insurance have few options to improve their health*

    - *Low income groups have the potential of chronic health issues such as diabetes, heart disease and obesity due to the lack of income to purchase healthy foods or have exposure what healthy foods consist of and/or the dangers of a unhealthy diet, ie; fast food, etc.*

    - *We have no residential alcohol/drug facility in Rhea County for men or women. We have no emergency shelter for bad weather or foods supplies.*

    - *medication costs and inability to afford it due to being on fixed incomes*

    - *The greatest needs I encounter on a day to day basis while serving families include assistance with transportation beyond that provided through SETHRA, for example I have encountered families that could maintain work hours had they reliable access to public transportation, they could also perhaps ensure participation in recovery programs, and support groups therefore alleviating suffering related to mental health issues. Well informed nutritional support services, and more access to practical ways to live and eat affordably would be beneficial. Also more access, to early child care, affordable, safe, and convenient for lower income families. Beyond that I consistently see families on a month to month basis that could benefit from access to money management services, bill pay services, and emergency utility assistance. Regarding the parent child interaction, ideally if our community could partner more to normalize the need for evidence based parenting information I think we could see decreased trends of*

neglect and abuse, and perhaps more community involvement. Essentially I feel that if we could normalize, expand, and utilize more parenting support services through the Health Dept., Prevent Child Abuse TN, and any other preventive evidence based service we can possibly create a healthier community for our future generations. My specific interest, would be to have a breastfeeding support group or more access to these supports, I have offered in the past to partner with the Health Dept. however, we've had little success due in part to timing and resources. As a certified lactation counselor, it is my personal and professional interest to increase the trend of breastfeeding support in our community, I believe this could be done with more community partnerships and accessible space.

- *Most important need which may not be unique to the local county includes transportation, cost, medications, local teaching clinics for life style change with diet and exercise as tolerated. The local hospital and clinics should work together to achieve these goals.*

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

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

   - Affordability/Access to Care

   - Obesity/Overweight

   - Coronary Heart Disease

   - Cancer

   - Alcohol/Substance Abuse

   - Smoking/Tobacco Use

   - Maternal/Infant Measures

   - Compliance Behavior

   - Diabetes

   - Physicians

   - Alzheimer's

   - Dental

   - Mental Health/Suicide

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

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

	Yes	No	No Opinion
Affordability/Access to Care	9	2	0
Obesity/Overweight	11	0	0
Coronary Heart Disease	10	1	0
Cancer	10	1	0
Alcohol/Substance Abuse	11	0	0
Smoking/Tobacco Use	11	0	0
Maternal/Infant Measures	10	1	0
Compliance Behavior	9	1	1
Diabetes	9	1	1
Physicians	7	2	2
Alzheimer's	8	1	2
Dental	6	3	2
Mental Health/Suicide	10	0	1

- **Specific comments or observations about <u>Affordability/Access to Care</u> as being among the most significant needs for the Hospital to work on to seek improvements?**

  - *This is a poor county, not enough jobs, patients say they do not qualify for insurance because they " do not make enough money " The FQHC is the only center to accept sliding fee patients, the large Medicaid population have very few options.*

  - *We need to continue to educate our uninsured community about the resources available to them for Healthcare and Health Insurance.*

  - *affordable subtance rehab and metal health needs lest available in this county*

  - *More people now have access to care so I do not see it as an issue like it was*

  - *Currently I still have families without insurance, mostly parents, my specific focus is on the parent child relationship so not a great deal of our visits are devoted to finding coverage. Roughly 7 out of 18 families served were without insurance over the past year. Is there a local service that helps to enroll families? Since, DHS no longer provides this service, I have often referred families to the website healthcare.gov or allowed them to use my work phone to access enrollment services.*

  - *Access to care continues to be a priority for local residents due to cost. Providing case managers to each patient and follow up may prove to show improvements.*

- **Specific comments or observations about <u>Obesity/Overweight</u> as being among the most significant needs for the Hospital to work on to seek improvements?**

  - *We know that BMI data for students is improving in Rhea County, but the overweight/obesity numbers*

are still above state-level norms. These concerns begin with lifestyles at home. We also know, according to the Youth Risk Behavior Survey conducted by the CDC (with weighted data), that a large number of TN students do not participate in regular physical activity outside of school and outside of middle school, they do not necessarily get it daily during school. Students do not regularly receive healthy weight loss information.

- *Find ways to educate and motivate the community to want to improve their overall health by reducing the Obesity/Overweight rate in Rhea County.*

- *Obesity is a burden for the people of Rhea Co. Education is needed for diet choices and exercising.*

- *Several people are unable to afford healthy foods that I work with so they tend to purchase unhealthy items that are reasonably priced for the quantity*

- *Tennessee is the 4 th leading state in the nation for obesity. Before a patient leaves the hospital hand outs either pictures or written with a specific information for that patient to follow for life style change with diet and exercise as tolerated.*

- **Specific comments or observations about <u>Coronary Heart Disease</u> as being among the most significant needs for the Hospital to work on to seek improvements?**

  - *CAD and its complications are daily issues with the patient at the clinic*

  - *Coronary Heart Disease remains one of the most significant health problems within the community. It is an asset to the community to be able to have certain testing completed locally and periodically seen by a cardiologist without traveling out of the county.*

  - *as above with life style change with diet and exercise as tolerated with hand outs with follow up with health clinics/sessions provided by the hospital free of charge.*

- **Specific comments or observations about <u>Cancer</u> as being among the most significant needs for the Hospital to work on to seek improvements?**

  - *very little cancer diagnosis and treatment available here*

  - *there is no cancer treatment in Rhea county*

  - *when a patient goes through the ER or hospital information for screening appropriate for age is addressed with follow up to local provider*

- **Specific comments or observations about <u>Alcohol/Substance Abuse</u> as being among the most significant needs for the Hospital to work on to seek improvements?**

  - *This is a important need for this county*

  - *Lack of affordable inpatient treatment in this area, easy access to prescription medication that is easily abused. Physicians write prescriptions for Schedule II drugs for pain relief rather than Schedule III which was done many years ago. It was almost impossible to get Schedule II drugs unless you were being treated in a hospital for a serious condition.*

  - *Alcohol/Substance Abuse is an epidemic and while in the hospital or ER case managers should be provided.*

- **Specific comments or observations about <u>Smoking/Tobacco Use</u> as being among the most significant needs for the Hospital to work on to seek improvements?**

  - *Smoking and Tobacco continues to be a significant concern within the comunity and all efforts to aid in awareness and educating the community even further.*

  - *Tobacco use is very high in Rhea County which begins at a early age associated with family, social and "every body does it". Any form of tobacco use has health issues with low birth weight, all forms of cancer along with pulmonary and heart issues.*

- **Specific comments or observations about <u>Maternal/Infant Measures</u> as being among the most significant needs for the Hospital to work on to seek improvements?**

  - *I understand the many issues/concerns with adding prenatal care and delivery services at RMC; however, I would love to see more breastfeeding support for new moms. Having worked for the Health Department in the past and nursed my own children for 15+ months each I have seen/experienced a great need for breastfeeding support. So many women either do not know about the support offered at the health department or are unsure about their ability to access It if they are not WIC clients. Given so many misconceptions about breastfeeding partnered with its growing acceptance/popularity, I would love to see the hospital step-up for those who fall in the cracks since it is oftentimes very difficult to get to Women's East for classes, especially if there are other small children in tow.*

  - *Having OB/GYN doctors coming to the community is helping*

  - *to refer to local peds/GYN*

- **Specific comments or observations about <u>Compliance Behavior</u> as being among the most significant needs for the Hospital to work on to seek improvements?**

  - *Compliance Behavior is a difficulty area in the hospital and local providers for the limited time spent with each patient.*

- **Specific comments or observations about <u>Diabetes</u> as being among the most significant needs for the Hospital to work on to seek improvements?**

  - *Diabetes can go untreated for years without the person knowing they have the disease.*

  - *The community needs educations in all areas of this disease from avoidance and treatment*

  - *Diabetes education and outreach are still extremely important but diabetes is so linked with Coronary Artery Disease and Obesity it's becoming difficult to separate the issues.*

  - *Diabetes is at epidemic levels and could be controlled with education with life style change with diet and exercise which would be difficulty for the hospital to implement. When a patient is in the hospital have a diabetic educator visit the patient with follow up with the educator.*

- **Specific comments or observations about <u>Physicians</u> as being among the most significant needs for the Hospital to work on to seek improvements?**

  - *Has there ever been a time when this community has ever 'not' needed to recruit and show appreciation to medical providers?*

- *Physicians to make themselves available to questions and concerns of the patient and family. When patients are in house so much is going on and they do not really understand the immediate issues.*

- **Specific comments or observations about <u>Alzheimer's</u> as being among the most significant needs for the Hospital to work on to seek improvements?**

    - *Alzheimer's is a disease that affects not just the patient but the caregiver and the entire family. No one seems to understand this disease or how to manage it.*

    - *The needs of the caretakers needs to address as well as the treatment and diagnosis of Alzheimer's*

    - *Have educators on staff who understand the processes of Alzheimer's and stage.*

- **Specific comments or observations about <u>Dental</u> as being among the most significant needs for the Hospital to work on to seek improvements?**

    - *The uninsured population suffers with the lack of dental services available to them. Dental services are costly and not covered by TENNCARE for adults.*

    - *The county needs more Dentists willing to do more for less.*

    - *Dental is a significant need if not implemented results in diseases processes. Patient's in the hospital may be given a list of local dentist as they leave the hospital.*

- **Specific comments or observations about <u>Mental Health/Suicide</u> as being among the most significant needs for the Hospital to work on to seek improvements?**

    - *There is often a stigma for individuals seeking mental health treatment. Health providers need to feel comfortable referring individuals for mental health treatment.*

    - *People with Mental Health/Suicide needs are often hard to treat and can be stressful for the family who are trying to help them.*

    - *There are not enough quality mental health centers in the Rhea county area for adults. Children with private insurance lack services in this area. Most of the counseling agencies that serve children only accept TennCare.*

    - *Mental health is overlooked in the community. When a patient is in the hospital with mental health/suicide provider should be called in to evaluate the patient.*

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

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

	Yes	No	No Opinion
Affordability/Access to Care	9	2	0
Obesity/Overweight	10	0	1
Coronary Heart Disease	9	1	1
Cancer	9	1	1
Alcohol/Substance Abuse	10	1	0

	Yes	No	No Opinion
Smoking/Tobacco Use	9	2	0
Maternal/Infant Measures	9	1	1
Compliance Behavior	7	2	2
Diabetes	9	1	1
Physicians	7	2	2
Alzheimer's	6	2	3
Dental	5	3	3
Mental Health/Suicide	9	1	1

- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in <u>Affordability/Access to Care</u>?**

  - *They have a program for some indigent care work that is easy to access, but the volume of this care is not known to me, but several patients have been able to use these programs*

  - *It would be beneficial for the community to have access to two or three different Providers for Cardiology and Mental Health.*

  - *as above*

- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in <u>Obesity/Overweight</u>?**

  - *Provide community classes on healthy eating and educate those that are overweight/obesity on how to lose weight and be healthy.*

  - *This is my fault for not knowing what the community programs in the area are ongoing or offered*

  - *I commend the efforts of the Hospital offering luncheons and classes as well as other Community Programs geared toward Healthy Eating. We should continue trying different avenues to reach the rural community with such classes and or programs.*

  - *as above making patients accountable for their own health*

- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in <u>Coronary Heart Disease</u>?**

  - *Since Coronary Heart Disease is the #1 cause of death in Rhea County, need to find ways to movitate community to stop smoking and have healthier lifestyles.*

  - *The hospital is seeking to improve the heart care in the county and the care available locally*

  - *The most common comments heard within the community is the lack of choices regarding Cardiac Care. It is the desire of county residents to have other Cardiologists available locally so out of county travel could be limited even further.*

  - *as above*

- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in <u>Cancer</u>?**

- ▪ *as above*

- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in <u>Alcohol/Substance Abuse</u>?**

  - ▪ *I am unaware of programs offered*

  - ▪ *An affordable residential program is needy badly in our county.*

  - ▪ *as above implementation action is a high priority with information and handouts and contact numbers providing before a patient leaves the hospital.*

- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in <u>Smoking/Tobacco Use</u>?**

  - ▪ *I am not aware of any programs*

  - ▪ *To implement action is difficulty for tobacco abuse is addictive which includes the whole family unit.*

- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in <u>Maternal/Infant Measures</u>?**

  - ▪ *Offer a monthly class/support group for new moms moderated by a certified lactation consultant. Advertise with local OB/GYN groups who come to Rhea County and in neighboring counties.*

  - ▪ *I am not aware of any programs , but the hospital is helping to get the OB doctors to see patients locally*

  - ▪ *The Rhea County Health Department and the Women's Care Center are working with a Program called Baby and Me that is helping to decrease low birth weight and premature babies significantly. Maybe there is a way the Hospital can participate in this program as well.*

  - ▪ *as above*

- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in <u>Compliance Behavior</u>?**

  - ▪ *To implement action of Compliance Behavior would involve time which is limited in the hospital setting but handouts to local facility for follow up would be a choice with feed back.*

- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in <u>Diabetes</u>?**

  - ▪ *Provide more diabetes prevention in the community and focus on way to educate and help those with prediabetes to change their diets and life styles to keep their prediabete from becoming diabetes.*

  - ▪ *There are programs to discuss the issues here, more public awareness is needed*

  - ▪ *Continue efforts to educate and encourage individuals to seek evaluation, make lifestyle changes, and follow treatment plans.*

  - ▪ *as above*

- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in <u>Physicians</u>?**

- *the hospital is very involved in recruiting and keeping Physicians here.*

- *With insurance reimbursements being at an all time low and physicians feeling frustrated and burnt out because they're seeing more and more patients for less return maybe there's something the community can do to help our local physicians and providers feel more appreciated and valued.*

- *as above*

- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in <u>Alzheimer's</u>?**

  - *Provide more educational information. Have Support Groups led by experts in the field to guide caregivers and patients on what to expect and how to deal with this horrible disease.*

  - *Not aware of any programs*

  - *To refer to appropriate provider along with support groups for the family*

- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in <u>Dental</u>?**

  - *If there is anything the Hospital can do to assist the Health Department with recruiting a Dentist for our clinic it would be greatly appreciated. There is a tremendous need for emergent Dental care for our uninsured community. Our Dentist recently retired and there is no Dentist to fill this position at this time.*

  - *If possible, the hospital would have a dental awareness at the hospital free to the public with speakers and handouts with local area dental clinics and transportation provided.*

- **Specific comments and observations about the implementation actions of the Hospital seeking improvement in <u>Mental Health/Suicide</u>?**

  - *Provide a regular screening of all patients presenting to the ER for mental health needs.*

  - *More resources needed.*

  - *The hospital does help with these issues but does not have emergency placement in house at this time or the staff to deal with this issue*

  - *Any education/outreach would be beneficial to increase the community's knowledge regarding the risk of suicide - especially among our teen population.*

  - *Affordable mental health care is very limited.*

  - *Make appropriate referral*

- **Do you have opinions about new or additional implementation efforts or community needs the Hospital should pursue?**

  - *Need more intense heart care locally, There needs to be more public awareness of the programs offered by the hospital.*

  - *Implementation efforts could be focused on the new Rhea County Community Center in the form of funding and/or education regarding the areas of greatest needs in Rhea County. Such as physical activity, nutritional habits, chronic disease prevention, etc.*

- *realizing the finances are limited and it not possible to do well with all these areas I see the biggest need in substance abuse and mental health have the least available services.*

- *I understand that we do not have a birthing hospital and do respect that reality. However, I feel it would be beneficial to increase access to breastfeeding support, as our community is still on the lower end of those trends, as well as breastfeeding being a proven preventive way to alleviate diabetes in mother and child, we could create a continuum of services perhaps by partnering with regional birthing hospitals to create support groups for mothers and families, perhaps have a child birth education class or breastfeeding class provided through the hospital. Possibly by creating deeper partnerships with existing local service providers such as OB GYN's and pediatricians we can further send the message to families, especially at those most vulnerable, that reaching out for support, information, and well informed care is normal and accessible. I think it's more cost effective for our community to have these resources on the front end. Free breastfeeding classes, child birth classes, newborn care classes. While we do have some of these resources available, the need is still great, and transportation to these resources would more than likely be the determining factor of whether they were used or not, by families that could benefit from the information most. Thank you for the opportunity to share and to advocate for the growth of quality services for our families.*

- *To ensure that each patient upon discharge understands his health regime before leaving the hospital with follow up with local provider to ensure continuation of reaching stability with any acute or chronic condition and is made accountable.*

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

  - *I think I need a little more information about all the community help the hospital offers*

  - *One final thought, education and information is key but how do you ensure attendance for any and all implementation of programs, etc?*

  - *I think the top community health needs are listed here. The only other topic that comes to mind is Infant Sleep Education. We have had several infant sleep related deaths in our county in the last couple of years. We need to increase efforts to educate mothers of the critical need for infants to sleep alone, on their back, in their crib.*

  - *Thank you for the efforts to identify needs of our community. Prevent Child Abuse TN appreciates the opportunity to partner in ways that will promote the health of families and prevent the abuse and neglect of children.*

  - *The most important issue is patient/population to be accountable for their actions. The hospital serves as a immediate health supplier but limited. Continue with implementing teaching, handouts/pictures for those whose reading is limited and most of all let them know " concern for their well being as an individual who is special".*

Appendix B – Identification & Prioritization of Community Needs

| Need Topic	Total Votes	Number of Local Experts Voting for Needs	Percent of Votes	Cumulative Votes	Need Determination
Obesity/Overweight - 2013 Significant Need	101	7	14.43%	14.43%	Significant Needs
Affordability/Access to Care - 2013 Significant Need	81	7	11.57%	26.00%	
Cancer - 2013 Significant Need	63	7	9.00%	35.00%	
Diabetes - 2013 Significant Need	50	5	7.14%	42.14%	
Coronary Heart Disease - 2013 Significant Need	46	5	6.57%	48.71%	
Dental - 2013 Significant Need	43	5	6.14%	54.86%	
Smoking/Tobacco Use - 2013 Significant Need	40	5	5.71%	60.57%	
Education/Prevention	32	4	4.57%	65.14%	Other Identified Needs
Maternal/Infant Measures - 2013 Significant Need	29	4	4.14%	69.29%	
Accidents	26	4	3.71%	73.00%	
Alcohol/Substance Abuse - 2013 Significant Need	25	4	3.57%	76.57%	
Compliance Behavior - 2013 Significant Need	25	4	3.57%	80.14%	
Physicians - 2013 Significant Need	24	4	3.43%	83.57%	
Mental Health/Suicide - 2013 Significant Need	19	4	2.71%	86.29%	
Alzheimer's - 2013 Significant Need	18	3	2.57%	88.86%	
Stroke	18	3	2.57%	91.43%	
Physical Inactivity	17	3	2.43%	93.86%	
Kidney Disease	14	3	2.00%	95.86%	
Cholesterol	6	2	0.86%	96.71%	
Flu/Pneumonia	5	2	0.71%	97.43%	
Chronic Lower Respiratory Disease	4	2	0.57%	98.00%	
Life Expectancy	4	2	0.57%	98.57%	
Lung Disease	4	2	0.57%	99.14%	
Chronic Lower Back Pain	3	2	0.43%	99.57%	
Priority Populations	2	2	0.29%	99.86%	
Social Vulnerability	1	2	0.14%	100.00%	
Total	700		100.00%		

Individuals Participating as Local Expert Advisors

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	10	3	13
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	10	4	14
3) Priority Populations	7	6	13
4) Representative/Member of Chronic Disease Group or Organization	5	7	12
5) Represents the Broad Interest of the Community	11	3	14
Other			
Answered Question			16
Skipped Question			0

Advice Received from Local Expert Advisors

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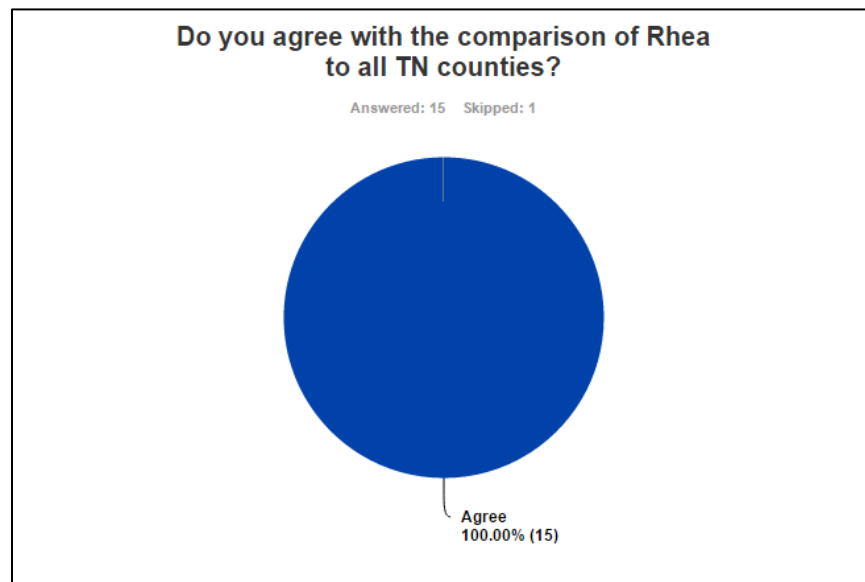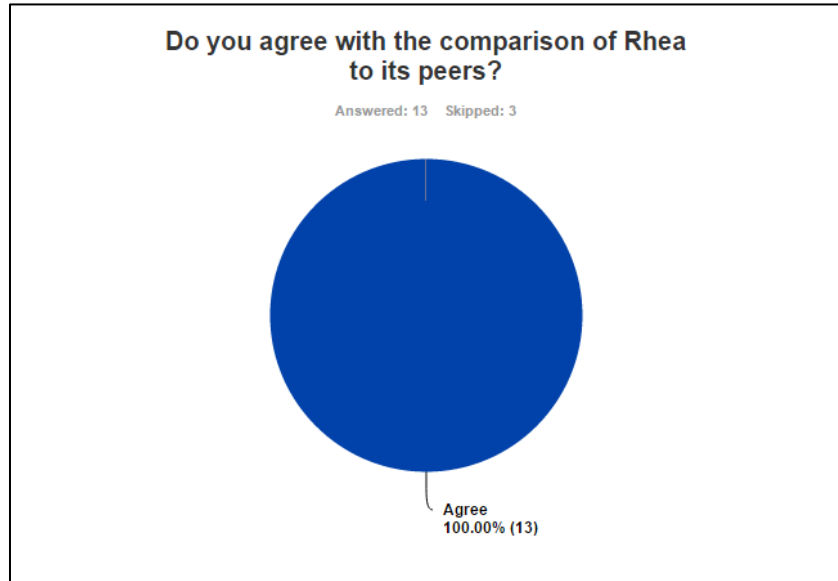

Comments:

- *I am not sure about some of the observations regarding health issues. While I am not sure of the actual statistics I do agree with the Social and Economic Factors classification. Regarding health factors, I think that these generally would be from personal health choices.*

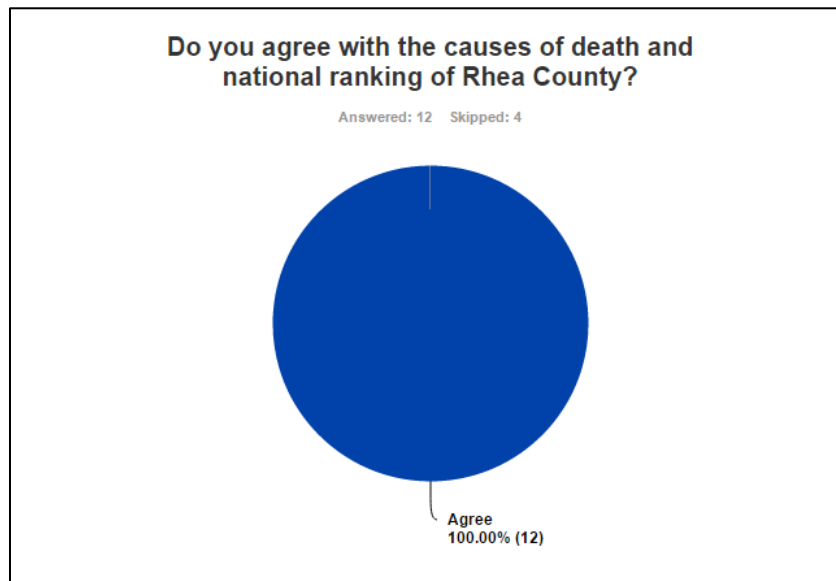**Question: Do you agree with the observations formed about the comparison of Rhea County to its peer counties?**

Do you agree with the comparison of Rhea to its peers?

Answered: 13   Skipped: 3

Agree
100.00% (13)

Comments:

- *I am not in a position to know*

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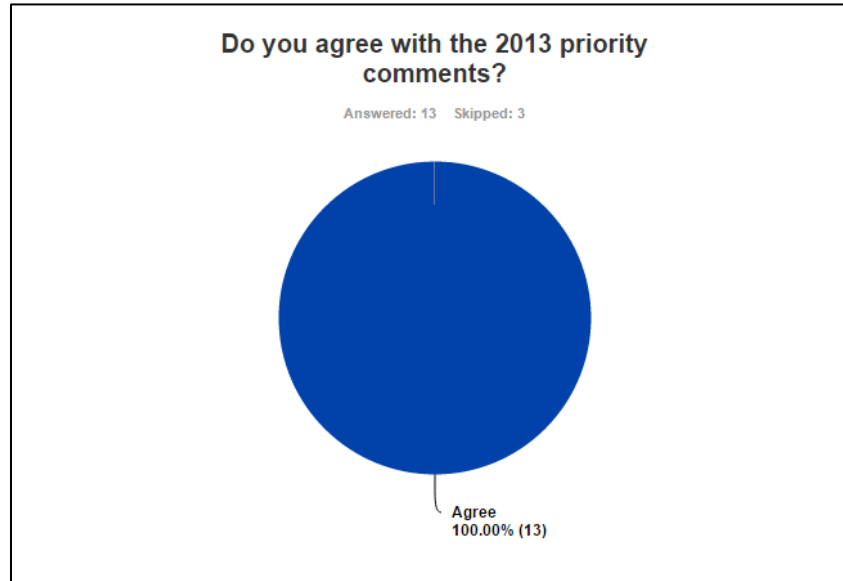
Do you agree with the population characteristics?

Answered: 12   Skipped: 4
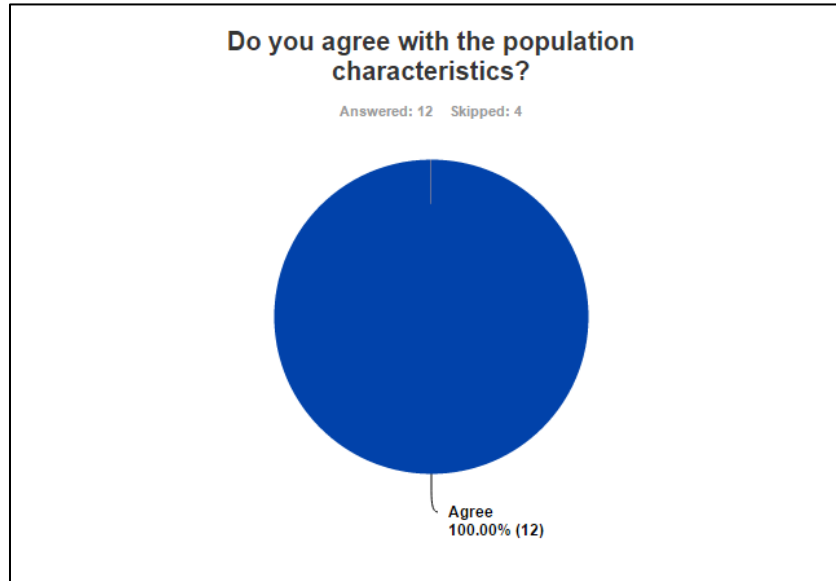
Agree
100.00% (12)

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

Do you agree with the causes of death and national ranking of Rhea County?

Answered: 12   Skipped: 4

Agree
100.00% (12)

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

Do you agree with the 2013 priority comments?

Answered: 13   Skipped: 3

Agree
100.00% (13)

Comments:

- *Agree with most however, mentally ill pts are increasingly costly to the hospitals due to ER visits and chronic behaviors that impact overall physical wellness. Should be more attention to this area.*

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

Do you agree with the additional 2013 priority comments?

Answered: 13   Skipped: 3

Agree
100.00% (13)
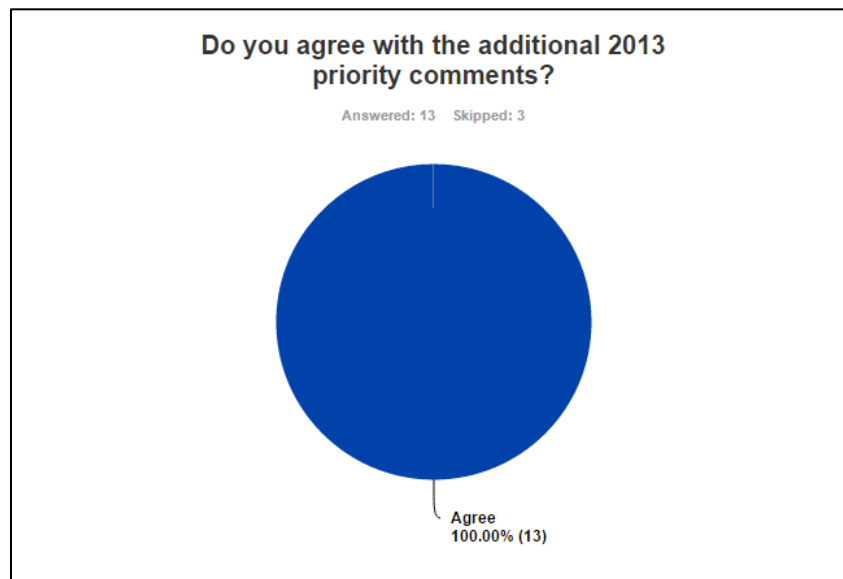
Appendix C – National Healthcare Quality and Disparities Reports

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

The reports are based on more than 250 measures of quality and disparities covering a broad array of healthcare services and settings. Data 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,[15] consistent with these trends.

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

Trends

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

Disparities

- Children with only Medicaid or CHIP coverage were less likely to get care as soon as wanted compared with children with any private insurance in almost all years.

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

Trends

- Through 2012, most access measures improved for children. The median change was 5% per year.

- Few access measures improved substantially among adults. The median change was zero.

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

Trends

- Historically, Blacks and Hispanics have had higher rates of un-insurance than Whites.[16]

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.[17]

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

Disparities

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[15] Levy J. In U.S., Uninsured Rate Sinks to 12.9%. http://www.gallup.com/poll/180425/uninsured-rate-sinks. aspx.
[16] In this report, racial groups such as Blacks and Whites are non-Hispanic, and Hispanics include all races.
[17] Long SK, Karpman M, Shartzer A, et al. Taking Stock: Health Insurance Coverage under the ACA as of September 2014. http://hrms.urban.org/briefs/Health-Insurance-Coverage-under-the-ACA-as-of- September-2014.html

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

- Blacks had worse access to care than Whites for about half of access measures.

- Hispanics had worse access to care than Whites for two-thirds of access measures.

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

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

Disparity Trends

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

- I n four of the five comparisons shown above, the number of disparities that were improving (black) exceeded the number of disparities that were getting worse (green).

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

Trends

- Through 2012, across a broad spectrum of measures of health care quality, 60% showed improvement (black).

- Almost all measures of Person-Centered Care improved.

- About half of measures of Effective Treatment, Healthy Living, and Patient Safety improved.

- There are insufficient numbers of reliable measures of Care Coordination and Care Affordability to summarize in this way.

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

Trends

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

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

Achieved Success

Eleven quality measures achieved an overall performance level of 95% or better this year. At this level, additional improvement is limited, so these measures are no longer reported in the QDR. Of measures that achieved an overall performance level of 95% or better this year, seven were publicly reported by CMS on the Hospital Compare website (italic).

- *Hospital patients with heart attack given percutaneous coronary intervention within 90 minutes*

- Adults with HIV and CD4 cell count of 350 or less who received highly active antiretroviral therapy during the year

- *Hospital patients with pneumonia who had blood cultures before antibiotics were administered*

- *Hospital patients age 65+ with pneumonia who received pneumococcal screening or vaccination*

- *Hospital patients age 50+ with pneumonia who received influenza screening or vaccination*

- *Hospital patients with heart failure and left ventricular systolic dysfunction who were prescribed angiotensin-converting enzyme or angiotensin receptor blocker at discharge*

- *Hospital patients with pneumonia who received the initial antibiotic dose consistent with current recommendations*

- *Hospital patients with pneumonia who received the initial antibiotic dose within 6 hours of arrival*

- Adults with HIV and CD4 cell counts of 200 or less who received Pneumocystis pneumonia prophylaxis during the year

- People with a usual source of care for whom health care providers explained and provided all treatment options

- Hospice patients who received the right amount of medicine for pain management

Last year, 14 of 16 quality measures that achieved an overall performance level of 95% or better were publicly reported by CMS. Measures that reach 95% and are no longer reported in the QDR continue to be monitored when data 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.[18]

- 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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[18] 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.[19]
- Another Care Affordability measure, people without a usual source of care who indicate a financial or insurance reason for not having a source of care, also worsened from 2002 to 2010 and then leveled off.
- There are few measures to assess trends in Care Affordability.

Disparities

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

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[19] 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.