Rhea Medical Center

Dayton, TN

Community Health Needs Assessment
and Implementation Strategy

Adopted by Board Resolution June 17, 2019[1]

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

Dear Community Member:

At Rhea Medical Center, we have spent more than 60 years providing high-quality compassionate healthcare to the greater Rhea County community. The 2019 Community Health Needs Assessment identifies local health and medical needs and provides a plan of how Rhea Medical Center (RMC) will respond to such needs. This document illustrates one way we are meeting our obligations to efficiently deliver medical services.

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

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

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

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

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

Thank You,

David Bixler
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.

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

The 2019 Significant Health Needs identified for Rhea County are:

1. Affordability/Access to Care – 2016 Significant Need
2. Smoking/Tobacco Use
3. Drug/Substance Abuse
4. Obesity/Overweight – 2016 Significant Need
5. Cancer – 2016 Significant Need
6. Women's Health
7. Mental Health/Suicide

The Hospital will develop implementation strategies for five of the seven needs (Affordability/Access to Care, Smoking/Tobacco Use, Drug/Substance Abuse, Obesity/Overweight, and Cancer) including activities to continue/pursue, community partners to work alongside, and measures to track progress.

APPROACH

APPROACH

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

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

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

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

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

Project Objectives

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

- Complete a CHNA report, compliant with Internal Revenue Service (IRS) guidelines
- Provide the Hospital with information required to complete the IRS – Schedule H (Form 990)
- Produce the information necessary for the Hospital to issue an assessment of community health needs and document its intended response

Overview of Community Health Needs Assessment

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

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

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

[3] As of the date of this report all tax questions and suggested answers relate to 2017 Draft Federal 990 Schedule H instructions i990sh—dft(2) and tax form

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

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

Specifically, the IRS requires:

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

Community Health Needs Assessment Subsequent to Initial Assessment

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

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

[5] Section 6652

(1) At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of the community;

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

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

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

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

To complete a CHNA:

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

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

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

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

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

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

… final regulations provide that a CHNA report will be considered to describe the process and methods used to conduct the CHNA if the CHNA report describes the data and other information used in the

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

assessment, as well as the methods of collecting and analyzing this data and information, and identifies any parties with whom the hospital facility collaborated, or with whom it contracted for assistance, in conducting the CHNA."[7]

Additionally, all CHNAs developed after the very first CHNA must consider written commentary on the prior Assessment and Implementation Strategy efforts. The Hospital followed the Federal requirements in the solicitation of written comments by securing characteristics of individuals providing written comment but did not maintain identification data.

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

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

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

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

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

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

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

Other (please specify)

The methodology also takes a comprehensive approach to assess community health needs: Perform several independent data analyses based on secondary source data, augment this with Local Expert Advisor[9] opinions, and resolve any data inconsistencies or discrepancies by reviewing the combined opinions formed from local experts. The Hospital relies on secondary source data, and most secondary sources use the county as the smallest unit of analysis. Local expert area residents were asked to note if they perceived the problems or needs identified by secondary sources

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

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

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

existed in their portion of the county.[10]

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

Data sources include:[11]

Website or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Rhea County compared to all Tennessee counties	April 1, 2019	2012-2014
IBM Watson Health (formerly known as Truven Health Analytics)	Assess characteristics of the hospital's primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according to the proportion of each group in the entire area; and, to access population size, trends and socio-economic characteristics	April 1, 2019	2019
http://svi.cdc.gov	To identify the Social Vulnerability Index value	April 1, 2019	2012-2016
http://www.healthdata.org/us-county-profiles	To look at trends of key health metrics over time	April 1, 2019	2014
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	April 1, 2019	2016

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

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

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

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

needs of priority populations. Local Expert Advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and the Hospital's desire to represent the region's geographically and ethnically diverse population. Community input from 21 Local Expert Advisors was received. Survey responses started April 26th, 2019 and ended on May 10th, 2019.

- 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.[12] [13]
- Local opinions of the needs of Priority Populations, while presented in its entirety in the Appendix, was abstracted in the following "take-away" bulleted comments
  - The top three Priority Populations identified were low-income groups, residents of rural areas and older adults
  - Common themes: Access to care/health education and preventative health were identified as pressing needs

Having taken steps to identify potential community needs, the Local Experts then participated in a structured communication technique called a "Wisdom of Crowds" method. The premise of this approach relies on a panel of experts with the assumption that the collective wisdom of participants is superior to the opinion of any one individual, regardless of their professional credentials.[14]

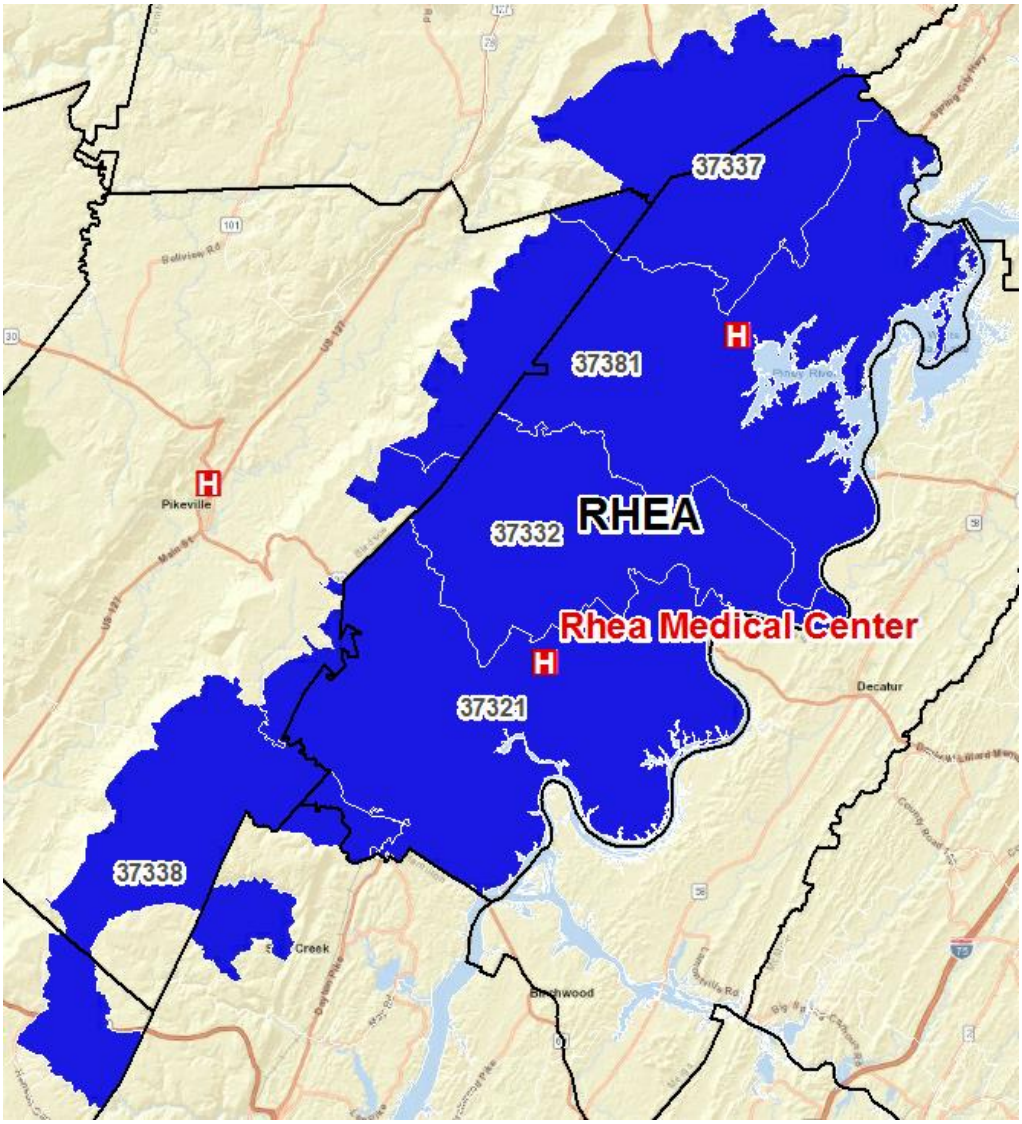
In the RMC process, each Local Expert had the opportunity to introduce needs previously unidentified and to challenge conclusions developed from the data analysis. While there were a few opinions of the data conclusions not being completely accurate, most of the comments agreed with the findings. A list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

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

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

COMMUNITY CHARACTERISTICS

Definition of Area Served by the Hospital[16]



For the purposes of this study, Rhea Medical Center defines its service area as Rhea County in Tennessee, which includes the following ZIP codes:[17]

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

(Zip code 37395 is included in the zip codes listed above.)

During 2017, the Hospital received 83.3% of its Medicare inpatients from this area.[18]

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

Demographics of the Community[19] [20]

Variable	Rhea County			Tennessee			United States		
	2019	2024	%Change	2019	2024	%Change	2019	2024	%Change
DEMOGRAPHIC CHARACTERISTICS									
Total Population	36,621	37,891	3.5%	6,794,664	7,074,906	4.1%	329,236,175	340,950,067	3.6%
Total Male Population	18,183	18,794	3.4%	3,313,720	3,453,446	4.2%	162,097,263	167,921,866	3.6%
Total Female Population	18,438	19,097	3.6%	3,480,944	3,621,460	4.0%	167,138,912	173,028,201	3.5%
Females, Child Bearing Age (15-44)	6,380	6,604	3.5%	1,315,884	1,340,336	1.9%	64,251,309	65,231,610	1.5%
Average Household Income	$62,351			$74,258			$89,646		
POPULATION DISTRIBUTION									
Age Distribution									
0-14	6,568	6,555	-0.2%	1,251,506	1,266,280	1.2%	61,258,096	61,645,382	0.6%
15-17	1,459	1,499	2.7%	259,735	273,841	5.4%	12,813,020	13,319,388	4.0%
18-24	3,322	3,635	9.4%	629,398	645,954	2.6%	31,474,821	32,296,411	2.6%
25-34	4,083	4,135	1.3%	902,240	909,366	0.8%	44,370,805	43,645,423	-1.6%
35-54	8,943	8,570	-4.2%	1,716,722	1,719,387	0.2%	83,304,733	84,255,193	1.1%
55-64	5,004	5,086	1.6%	890,181	910,453	2.3%	42,525,512	43,333,585	1.9%
65+	7,242	8,411	16.1%	1,144,882	1,349,625	17.9%	53,489,188	62,454,685	16.8%
HOUSEHOLD INCOME DISTRIBUTION									
Total Households	14,127	14,595	3.3%	2,673,135	2,784,905	4.2%	125,018,838	129,683,911	3.7%
2018 Household Income									
<$15K	2,133			327,277			13,139,420		
$15-25K	1,761			289,564			11,333,086		
$25-50K	3,857			664,977			26,888,001		
$50-75K	2,451			476,301			21,157,116		
$75-100K	1,405			317,722			15,409,735		
Over $100K	2,520			597,294			37,091,480		
EDUCATION LEVEL									
Pop Age 25+	25,272			4,654,025			223,690,238		
2018 Adult Education Level Distribution									
Less than High School	2,364			231,331			12,173,720		
Some High School	3,442			391,848			16,245,471		
High School Degree	9,473			1,520,412			61,068,735		
Some College/Assoc. Degree	6,700			1,303,992			64,945,355		
Bachelor's Degree or Greater	3,293			1,206,442			69,256,957		
RACE/ETHNICITY									
2018 Race/Ethnicity Distribution									
White Non-Hispanic	33,149			4,996,486			197,594,684		
Black Non-Hispanic	732			1,137,457			40,877,627		
Hispanic	1,793			379,742			60,675,779		
Asian & Pacific Is. Non-Hispanic	202			129,238			19,327,168		
All Others	745			151,741			10,760,917		

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

Consumer Health Service Behavior[21]

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

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

Health Service Topic	Demand as % of National	% of Population Affected
Weight / Lifestyle		
BMI: Morbid/Obese	116.4%	35.5%
Vigorous Exercise	92.0%	52.5%
Chronic Diabetes	117.8%	18.5%
Healthy Eating Habits	98.4%	22.9%
Ate Breakfast Yesterday	95.3%	75.4%
Slept Less Than 6 Hours	126.4%	17.2%
Consumed Alcohol in the Past 30 Days	77.4%	41.6%
Consumed 3+ Drinks Per Session	120.3%	33.9%
Behavior		
Search for Pricing Info	80.0%	21.5%
I am Responsible for My Health	99.4%	89.8%
I Follow Treatment Recommendations	101.0%	77.8%
Pulmonary		
Chronic COPD	135.0%	7.3%
Chronic Asthma	107.4%	12.7%
Heart		
Chronic High Cholesterol	113.2%	27.6%
Routine Cholesterol Screening	91.3%	40.5%
Chronic Heart Failure	153.5%	6.2%

Health Service Topic	Demand as % of National	% of Population Affected
Cancer		
Cancer Screen: Skin 2 yr	73.4%	7.9%
Cancer Screen: Colorectal 2 yr	85.9%	17.6%
Cancer Screen: Pap/Cerv Test 2 yr	79.9%	38.5%
Routine Screen: Prostate 2 yr	79.4%	22.5%
Orthopedic		
Chronic Lower Back Pain	112.0%	34.6%
Chronic Osteoporosis	131.6%	13.3%
Routine Services		
FP/GP: 1+ Visit	101.6%	82.7%
NP/PA Last 6 Months	103.7%	43.0%
OB/Gyn 1+ Visit	88.5%	34.0%
Medication: Received Prescription	102.8%	62.3%
Internet Usage		
Use Internet to Look for Provider Info	76.8%	30.7%
Facebook Opinions	82.7%	8.3%
Looked for Provider Rating	73.9%	17.3%
Emergency Services		
Emergency Room Use	105.3%	37.7%
Urgent Care Use	92.5%	30.5%

[21] Claritas (accessed through IBM Watson Health)

Conclusions from Demographic Analysis Compared to National Averages

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

- 16.4% more likely to have a **BMI of Morbid/Obese**, affecting 35.5%
- 8.0% less likely to **Vigorously Exercise**, affecting 52.5%
- 20.3% more likely to **Consume 3+ Drinks per Session**, affecting 33.9%
- 8.7% less likely to receive **Routine Cholesterol Screenings**, affecting 40.5%
- 20.1% less likely to receive **Cervical Cancer Screening every 2 years**, affecting 38.5%
- 12.0% more likely have **Chronic Lower Back Pain**, affecting 34.6%
- 11.5% less likely to receive **Routine OB/Gyn Visit**, affecting 34.0%
- 5.3% more likely to **Visit the Emergency Room (for non-emergent issues)**, affecting 37.7%

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

- 22.6% less likely to have **Consumed Alcohol in the Past 30 Days**, affecting 41.6%

Leading Causes of Death[22]

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

Cause of Death			Rank among all counties in TN (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation (Rhea County Compared to U.S.)
TN Rank	Rhea Rank	Condition		TN	Rhea	
1	1	Heart Disease	55 of 95	202.1	249.7	Higher than Expected
2	2	Cancer	36 of 95	173.4	209.0	Higher than Expected
3	3	Lung Disease	51 of 95	57.4	68.4	Higher than Expected
4	4	Accidents	18 of 95	62.9	68.1	Higher than Expected
6	5	Stroke	24 of 95	45.0	54.1	Higher than Expected
7	6	Diabetes	16 of 95	24.0	36.2	Higher than Expected
5	7	Alzheimer's	36 of 95	46.6	33.4	As Expected
8	8	Flu - Pneumonia	47 of 95	21.2	28.5	Higher than Expected
9	9	Suicide	57 of 95	16.7	15.8	As Expected
10	10	Kidney	23 of 95	14.4	15.6	As Expected
11	11	Liver Disease	19 of 95	12.7	12.8	As Expected
13	12	Hypertension	24 of 95	9.2	10.6	As Expected
12	13	Blood Poisoning	54 of 95	12.5	9.9	As Expected
14	14	Parkinson's	36 of 95	9.3	6.5	As Expected
15	15	Homicide	76 of 95	8.7	3.8	As Expected

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

Priority Populations[23]

Earlier in the document, a description was provided for Priority Populations, which is a collection of groups whose needs are to be considered during the CHNA process. It can be difficult to obtain information about Priority Populations in a hospital's community. The objective is to understand the general trends of issues impacting Priority Populations and to interact with the Local Experts to discern if local conditions exhibit any similar or contrary trends. The following discussion examines findings about Priority Populations from a national perspective.

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

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

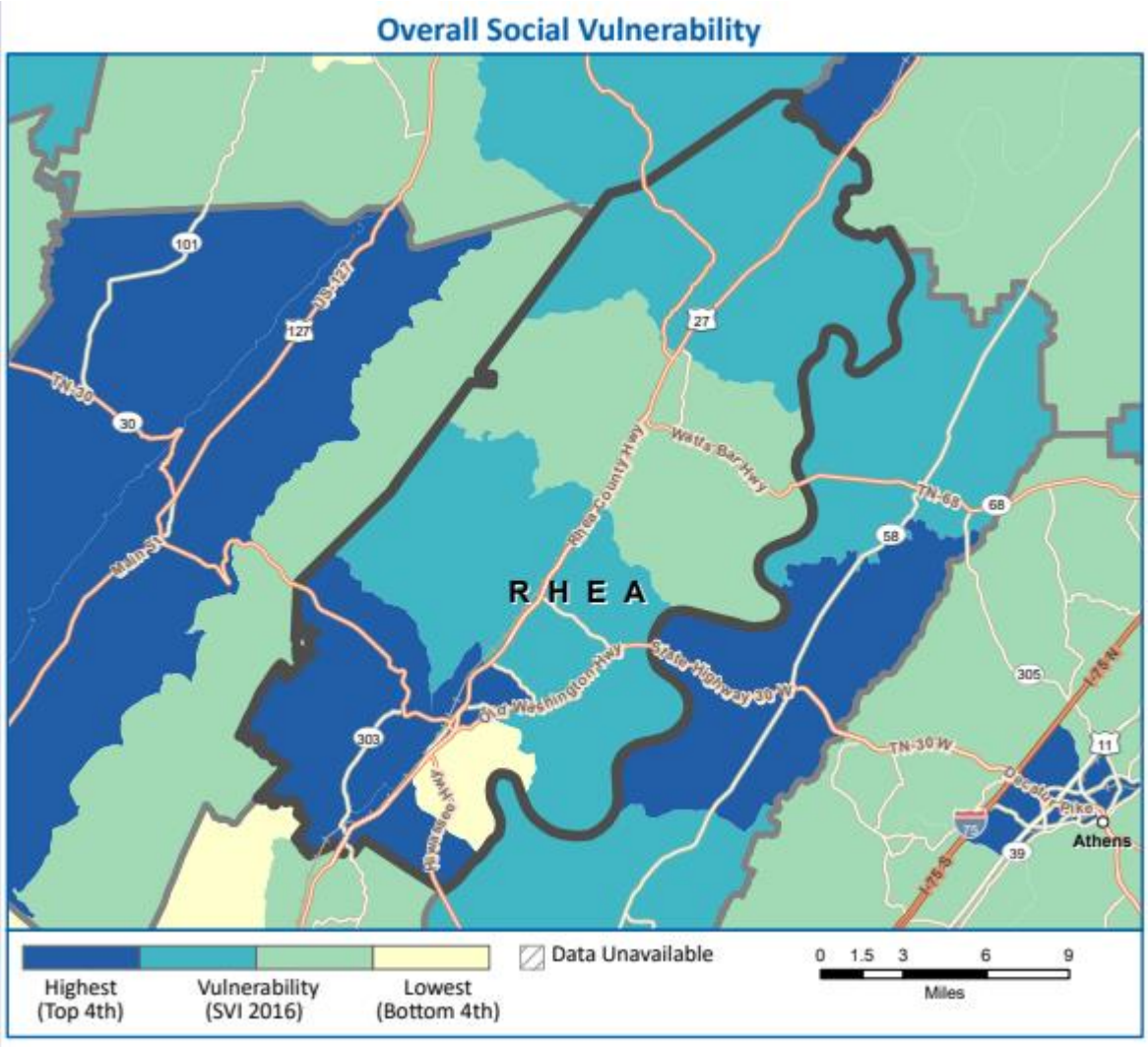
- The top three Priority Populations identified were low-income groups, residents of rural areas and older adults
- Common themes: Access to care/health education and preventative health were identified as pressing needs

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

Social Vulnerability[25]

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

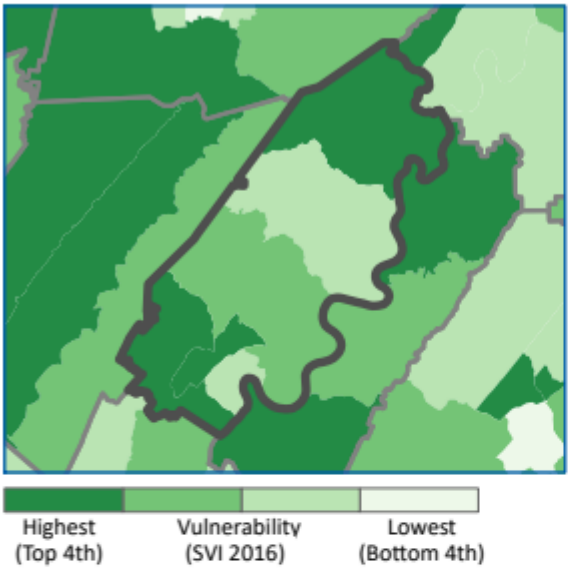
Rhea County falls into all four quartiles of social vulnerability; the areas of the county that are dark and light blue are considered more vulnerable:



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

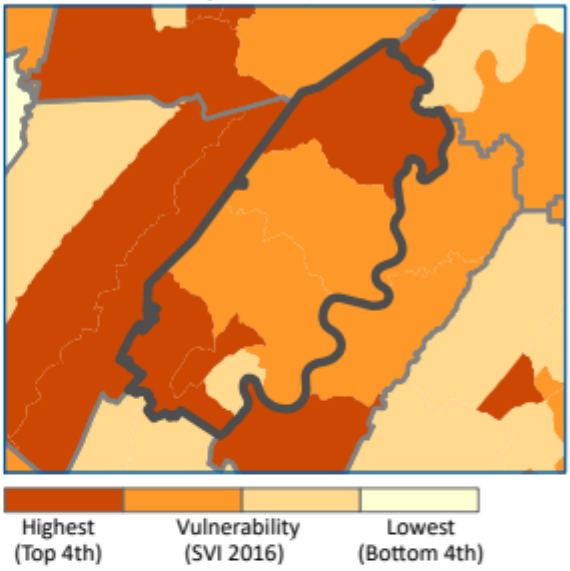
SVI Themes

Socioeconomic Status



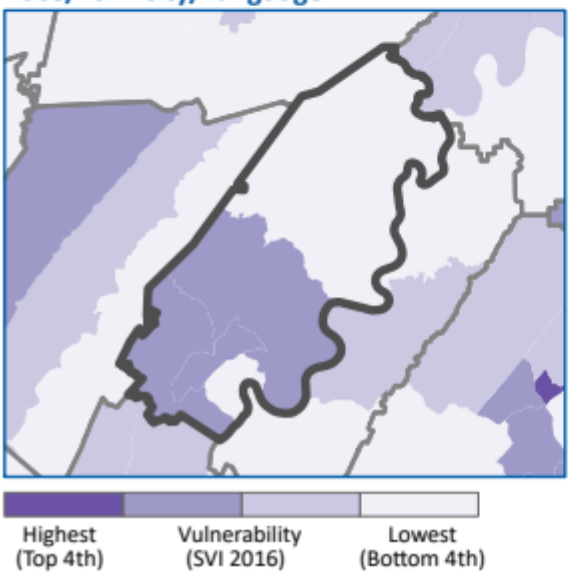
Highest (Top 4th) | Vulnerability (SVI 2016) | Lowest (Bottom 4th)

Household Composition/Disability



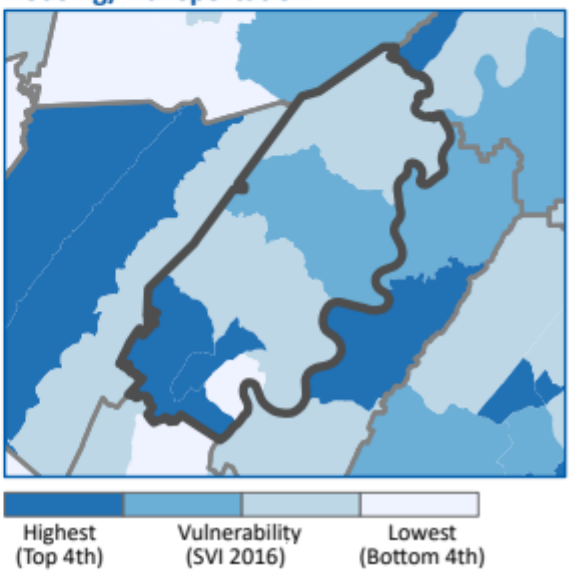
Highest (Top 4th) | Vulnerability (SVI 2016) | Lowest (Bottom 4th)

Race/Ethnicity/Language



Highest (Top 4th) | Vulnerability (SVI 2016) | Lowest (Bottom 4th)

Housing/Transportation



Highest (Top 4th) | Vulnerability (SVI 2016) | Lowest (Bottom 4th)

Comparison to Other State Counties[26]

To better understand the community, Rhea County has been compared to all 95 counties in the state of Tennessee across five areas: Length of Life (overall morbidity and mortality), Quality of Life (physical, mental, emotional, and social functioning), Health Behaviors (choices and lifestyles that affect personal health), Clinical Care (access to and availability of healthcare services), Social and Economic Factors (external forces that affect health) and Physical Environment (external conditions that affect health)

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

	Rhea	Tennessee	U.S. Median
Length of Life			
Overall Rank *(best being #1)*	73/95		
- Premature Death*	11,200	9,100	8,100
Quality of Life			
Overall Rank *(best being #1)*	68/95		
- Poor or Fair Health	22%	19%	17%
- Poor Mental Health Days	4.9	4.5	3.9
Health Behaviors			
Overall Rank *(best being #1)*	67/95		
- Adult Smoking	24%	22%	17%
- Adult Obesity	32%	33%	32%
- Physical Inactivity	33%	27%	26%
- Excessive Drinking	14%	14%	17%
- Alcohol-Impaired Driving Deaths	25%	26%	28%
Clinical Care			
Overall Rank *(best being #1)*	66/95		
- Uninsured	12%	11%	10%
- Population to Primary Care Provider Ratio	2,950:1	1,390:1	2,050:1
- Population to Dentist Ratio	4,090:1	1,880:1	2,450:1
- Population to Mental Health Provider Ratio	2,510:1	700:1	970:1
- Preventable Hospital Stays	6,191	5,305	4,648
- Mammography Screening	43%	40%	40%
- Flu vaccinations	45%	48%	42%
Social & Economic Factors			
Overall Rank *(best being #1)*	89/95		
- Unemployment	6.4%	3.7%	4.4%
- Children in Poverty	24%	21%	21%
- Children in Single-Parent Households	38%	35%	32%
- Violent Crime*	280	621	205
- Injury Deaths*	92	86	82
Physical Environment			
Overall Rank *(best being #1)*	4/95		
- Severe Housing Problems	12%	15%	14%

Per 100,000 Population

[26] www.countyhealthrankings.org

Conclusions from Other Statistical Data[27]

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

Rhea County	Current Statistic (2014)	Percent Change (1980-2014)
UNFAVORABLE Rhea county measures that are **WORSE** than the U.S. average and had an **UNFAVORABLE** change		
- Female Life Expectancy	77.5	-0.1%
- Female Trachel, Bronchus, and Lung Cancer*	62.7	98.1%
- Male Skin Cancer*	6.3	52.2%
- Female Diabetes, Urogenital, Blood, and Endocrine Disease Deaths*	75.9	83.2%
- Male Diabetes, Urogenital, Blood, and Endocrine Disease Deaths*	95.5	81.0%
- Female Self-Harm and Interpersonal Violence Related Deaths*	13.6	38.3%
- Female Mental and Substance Use Related Deaths*	17.7	879.9%
- Male Mental and Substance Use Related Deaths*	23.0	445.4%
- Female Liver Disease Related Deaths*	19.1	66.7%
- Male Liver Disease Related Deaths*	28.5	59.5%
UNFAVORABLE Rhea county measures that are **WORSE** than the U.S. average and had a **FAVORABLE** change		
- Male Life Expectancy	72.9	6.7%
- Female Heart Disease*	170.3	-36.8%
- Male Heart Disease*	248.1	-56.7%
- Female Stroke*	63.0	-19.8%
- Male Stroke*	61.0	-43.3%
- Male Tracheal, Bronchus, and Lung Cancer*	122.2	-11.6%
- Female Breast Cancer*	27.5	-11.5%
- Female Skin Cancer*	2.2	-4.8%
- Male Self-Harm and Interpersonal Violence Related Deaths*	35.1	-7.7%
- Female Transport Injuries Related Deaths*	17.1	-19.7%
- Male Transport Injuries Related Deaths*	38.8	-32.0%
DESIRABLE Rhea county measures that are **BETTER** than the US average and had an **UNFAVORABLE** change		
N/A		
DESIRABLE Rhea county measures that are **BETTER** than the US average and had a **FAVORABLE** change		
N/A		
AVERAGE Rhea county measures that are **EQUAL** to the US average and had a **FAVORABLE** change		
- Male Breast Cancer*	0.3	-8.0%

*rate per 100,000 population, age-standardized

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

Community Benefit

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

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

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

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

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

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

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

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

- $

IMPLEMENTATION STRATEGY

Significant Health Needs

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

- Identifies the rank order of each identified Significant Need
- Presents the factors considered in developing the ranking
- Establishes a Problem Statement to specify the problem indicated by use of the Significant Need term
- Identifies 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 a primary hospital in the service area. RMC is a 25-bed, acute care medical facility located in Dayton, Tennessee. The next closest facilities are outside the service area and include:

- Erlanger Bledsoe Hospital, Pikeville, TN; 22.0 miles (33 minutes)
- Starr Regional Medical Center, Athens, TN; 25.0 miles (38 minutes)
- Sweetwater Hospital Association, Sweetwater, TN; 37.0 miles (46 minutes)
- Tennova Healthcare – Cleveland, Cleveland, TN; 30.0 miles (49 minutes)
- CHI Memorial Hospital Hixson, Hixson, TN; 34.3 miles (52 minutes)

All statistics analyzed to determine significant needs are “Lagging Indicators,” measures presenting results after a period of time, characterizing historical performance. Lagging Indicators tell you nothing about how the outcomes were achieved. In contrast, the 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.

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

1. **AFFORDABILITY/ACCESS TO CARE – 2016 Significant Need; Rhea County's Population to Primary Care Provider, Dentist, and Mental Health Provider are worse than the state and national averages; Rhea County's unemployment rate is worse than the state and national averages; Rhea County's uninsured rate is worse than the state and national averages**

Public comments received on previously adopted implementation strategy:

- *See Appendix A for full list of comments*

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

- 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, and VRI for hearing impaired
- Provided Lunch 'n' Learn on Medicare Advantage
- Research providing free/low-cost physicals to student athletes
- Look at Physician Needs Assessment for other potential specialists
- RMC employees provide assistance to patients applying for charity care
    - Partnership with Hamilton County that helps set up appointment to get registered for TennCare

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

- Continue above actions
- Provide Tele stroke
- Potentially adding vascular surgery
- Explore adding the following services:
    - Oncology
        - Chemotherapy through infusion center
    - Urology
    - OB/Gyn (surgery)

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

- Behavioral health services for seniors

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

- Added a physician clinic
- Added the following services:
  - Ophthalmology services, including surgery
  - Allergy
  - Orthopedics
  - Cardiology
  - Pain management
  - Infusion services – onsite
- Increased the discount
  - Local physicians that don't take Tenn Care

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 patients approved for or qualifying for RMC charity care in 2018 (Hospital Measure)

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

- Hospital Medicaid Payer Mix – Example provided by QHR

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:[30]

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

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

2. **SMOKING/TOBACCO USE – Local expert concern; Rhea County's smoking rate is worse than the state and national averages; Cancer is the #2 Leading Cause of Death and Lung Disease is the #3 Leading Cause of Death in Rhea County**

Public comments received on previously adopted implementation strategy:

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

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

- Lung screenings offered to patients with a high risk of lung cancer
- Clinics, Med floor, and emergency department screens for tobacco use
    - Patients that are tobacco users are given education
- Investigate if the state offers smoking cessation – financial incentive
    - Tennessee tobacco quit line – physicians work with them
    - Look at how many are referred
- RMC is a smoke free campus
- RMC distribute flyers and brochures about the risk of smoking
    - Featured in the RMC newsletter
- Pulmonologist employed by RMC
- Rhea fit – under of umbrella of healthier ten- $10K state grant (Not sure this is associated with the hospital)

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

- Continue above actions
- Foundation to look into adding a smoking cessation class in the evening
    - Pulmonologist and Respiratory Therapist to come speak
- Look into adding premium reductions for employees who meet certain goals regarding tobacco use
- Look into partnership with new parenting class (not sure the name)
    - Individuals that fail out of the program get referred to RMC

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 participants in smoking cessation classes (Hospital measure)

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

- Rhea County's adults smoking rate = 24% (2016)[31]

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

Organization	Contact Name	Contact Information

[31] www.countyhealthrankings.org

Other local resources identified during the CHNA process that are believed available to respond to this need:[32]

Organization	Contact Name	Contact Information

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

3. **DRUG/SUBSTANCE ABUSE – Local expert concern; Rhea County's Mental and Substance Use Related Deaths is higher than the national average and increased from 1980-2014**

Public comments received on previously adopted implementation strategy:

- *This was not a 2016 Significant Need, so no comments were solicited.*

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

- Provide pain management services at RMC

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

- Continue above action
- Investigate collaboration with CADAS for drug and substance abuse/addiction treatment
- Begin working with school/groups out of Chattanooga on drug/substance abuse related issues
- Explore collaborating with the local law enforcement on adding a medication drop box at RMC
- Investigate state provided social worker that specifies around substance abuse

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 non-opioid patients visits to pain management clinic (Hospital Measure)

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

- Number of overdose patients in the emergency department (Hospital Measure)

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

Organization	Contact Name	Contact Information

Other local resources identified during the CHNA process that are believed available to respond to this need:[33]

Organization	Contact Name	Contact Information

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

4. **OBESITY/OVERWEIGHT – 2016 Significant Health Need; Rhea County's Adult Obesity rate is average compared to the state and national averages; Rhea County's Physical Inactivity rate is worse than both the state and national averages; 16.4% of Rhea County residents are likely to have a BMI of Morbid/Obese; Diabetes is the #6 Leading Cause of Death in Rhea County and is worse than the state and national averages**

Public comments received on previously adopted implementation strategy:

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

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 – added a heart healthy
- 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
- Sponsorship of Funky Monkey and Strawberry Chase (local running races) benefitting Rhea County Community Center (RC3)
- Started providing water at Farm/City Day as an alternative to sugary drinks; provided water at local races

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

- Continue above actions
- Foundation to investigate adding a walking challenge and water drinking challenges
- Explore adding obesity program through RMC's athletic trainer
- Look into partnering with United Way on annual "Give-A-Kid-A-Chance" event

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

- Implemented a local health fair through the Rhea Medical Center Physician Group
- Rhea Medical Center Physician Group implemented "Walk With a Doc" program
- Began Host Heart Healthy at local banks in the month of February (blood pressure screening and education)
- Hired an athletic trainer to work with student athletes at local schools
- Dietician provides heart healthy and diabetic classes monthly
- Monthly blood pressure checks are offered to the senior population
- Provide blood pressure screening at county fair

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 2018 (Hospital Measure)

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

- Rhea County adult obesity rate = 32% (2015)[34]

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		

[34] www.countyhealthrankings.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

5. **CANCER – 2016 Significant Health Need; Rhea County's Adult Smoking rate is worse than the state and national averages; Residents of Rhea County are less likely to receive Cervical Cancer Screenings Every 2 Years compared to the national average; Cancer is the #2 Leading Cause of Death in Rhea County; Rhea County's Female Tracheal, Bronchus, and Lung Cancer rate increased from 1980-2014; Rhea County's Male Skin Cancer rate increased from 1980-2014**

Public comments received on previously adopted implementation strategy:

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

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 (quarterly)
- Hospital is a sponsor for local Relay for Life
- Increased community outreach for mammography services
- Collaboration with Health Department to use available grants for breast and cervical cancer screenings

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

- Continue above actions
- Begin offering tomosynthesis mammography screenings
- Investigate adding oncologist services
- Explore Primary Care Physicians to begin offering lung screenings for patient that meet the criteria
- Explore options for hosting a cancer survivors' event in the community
- Research adding a cancer patient navigator

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

- Implemented CT Lung screening
- Published article on skin cancer in the most recent skin cancer awareness article

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 mammography screenings performed in 2018 (Hospital Measure)

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 = 43% (2016)[35]

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		

[35] www.countyhealthrankings.org

Organization	Contact Name	Contact Information

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

6. WOMEN'S HEALTH – Local expert concern

Public comments received on previously adopted implementation strategy:

- *This was not a 2016 Significant Need, so no comments were solicited.*

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

Due to the relatively low priority assigned to Women's Health, RMC chose not to respond to this need at this time. RMC feels they will have a greater impact by putting attention and resources towards other significant needs for which RMC is better qualified to serve.

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

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

Organization	Contact Name	Contact Information

7. **MENTAL HEALTH/SUICIDE – Local expert concern; Rhea County's Poor Mental Health Days is worse than the state and national averages; Suicide is the #9 Leading Cause of Death in Rhea County; Rhea County's Mental and Substance Use Related Deaths is higher than the national average and increased from 1980-2014**

Public comments received on previously adopted implementation strategy:

- *This was not a 2016 Significant Need, so no comments were solicited.*

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

Due to the relatively low priority assigned to Mental Health/Suicide, RMC chose not to respond to this need at this time. RMC feels they will have a greater impact by putting attention and resources towards other significant needs for which RMC is better qualified to serve.

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

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

Organization	Contact Name	Contact Information

Other Needs Identified During CHNA Process

8. **Diabetes**
9. **Coronary Heart Disease – 2016 Significant Need**
10. **Education/Prevention**
11. **Physical Inactivity**
12. **Alcohol Use**
13. **Chronic Pain Management**
14. **Hypertension**
15. **Stroke**
16. **Dental**
17. **Accidents**
18. **Alzheimer's**
19. **Lung Disease**
20. **Flu/Pneumonia**
21. **Kidney Disease**
22. **Respiratory Infections**
23. **Liver Disease**

Overall Community Need Statement and Priority Ranking Score

Significant needs where hospital has implementation responsibility[36]

1. Affordability/Access to Care – 2016 Significant Need
2. Smoking/Tobacco Use
3. Drug/Substance Abuse
4. Obesity/Overweight – 2016 Significant Need
5. Cancer – 2016 Significant Need

Significant needs where hospital did not develop implementation strategy[37]

1. Women's Health
2. Mental Health/Suicide

Other needs where hospital developed implementation strategy

1. N/A

Other needs where hospital did not develop implementation strategy

1. N/A

[36] Responds to Schedule h (Form 990) Part V B 8
[37] Responds to Schedule h (Form 990) Part V Section B 8

APPENDIX

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

Hospital solicited written comments about its 2016 CHNA.[38] 21 individuals responded to the request for comments. The following presents the information received in response to the solicitation efforts by the hospital. No unsolicited comments have been received.

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

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	7	10	17
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	7	12	19
3) **Priority Populations**	10	8	18
4) Representative/Member of **Chronic Disease Group** or Organization	3	13	16
5) Represents the **Broad Interest of the Community**	17	1	18
Other			0
Answered Question			21
Skipped Question			0

Congress defines "Priority Populations" to include:

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

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

- *More access to local healthcare*
- *Terrible internet access and below average healthcare literacy*
- *Older adults: someone to explain their benefits, the tests and procedures and their rights as a patient. Low-*

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

income: it seems there is little understanding in the community of how life choices (food, drink, physical activity, etc.) play a very large role in their health.

- *Obesity, tobacco use, lack of broadband internet, opioid abuse*
- *Obesity – Inactivity - Preventative steps to assure prolonged health*
- *Rhea County residents need education for health care literacy: insurance benefits, medication formulary, community resources (such as AAAD), and patient advocacy.*
- *We have on staff a full time Spanish Interpreter due to our high population of Spanish speaking clients.*

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

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

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

	Yes	No	Response Count
Obesity/Overweight	20	0	20
Affordability/Access to Care	20	1	21
Cancer	19	2	21
Diabetes	21	0	21
Coronary Heart Disease	20	1	21

Comments:

- *These are ALL most important areas of concern in our County.*
- *All of the above are need but priority wise please include affordable health care and access/diabetes and obesity.*
- *It may already be a component of the efforts to resolve the issues shown above, but I think smoking cessation programs and resources would be very helpful in our community.*
- *Too many areas - Focus on 2-3"*
- *If the problem of obesity were eliminated there would most definitely be less need for care due to diabetes, heart disease etc. With that being said education and help with this problem should be the highest priority.*
- *There is no improvement in outcomes. Heart disease still kills most Rhea County residents. Tobacco use is rampant. Access to affordable healthy food is limited. We have 4 public parks in the County that very few people use.*

6. Please share comments or observations about the actions RMC has taken to address <u>OVERWEIGHT/OBESITY</u>.

- *They have had lunch and learns on this topic and have a monthly "Walk with the Doc"*

- *I have observed community involvement.*
- *It seems like all that can be done for each of these areas is being done. I feel like the only thing I can add is MORE. MORE, MORE advertising of what is available. I did not see it on the list, but Rhea County has 2 health councils. Rhea Medical must attend these meetings if they are not already doing so.*
- *don't just count calorie counting, include fat and carbs. to get to the local public I would like to see the healthy screenings be done at local event opportunities... maybe strawberry parades, spring city 4 July day, or the Christmas parades. Another option is with downtown events. and don't forget Graysville. Maybe in front of a $ General we have several in all the towns.*
- *Provide more free health screening at major events in the county. The quarterly magazine is great and especially the healthy recipes provided within.*
- *Recent large data showed industrial health programs don't lower health cost or improve. It was a blurb I'd have to find; Health Fairs are good advertising and ways to connect people. They're not designed to be educational for most people; Free health screenings should list all local physicians to follow up issues; Invest in sponsorship for funky monkey etc; DM class and do cooking classes; Try a YouTube video of how to buy a week groceries and plan all meals for 4 people for $100.00"*
- *Supports local events promoting good health.*
- *Efforts in this area have been good*
- *Impressive list! Add? Partner with Rc3 for specific weight loss/healthy eating challenges.*
- *definitely continue occupational health providing wellness assessments at local industries*
- *We have no CDE at Rhea Medical Center. I do not know if nutrition classes are still offered. Community has not participated in Walk With A Doc program offered by my office.*
- *The only other suggestion I might have would be to set up a health screening when the Food Bank comes to town. You might reach the middle age or older age population that you wouldn't see at any of the other events mentioned.*
- *Offering of information to those patients while patients at the hospital. Would like to partner with RMC*

7. Please share comments or observations about the actions RMC has taken to address <u>AFFORDABILITY/ACCESS TO CARE</u>.

- *Rhea Medical bought the building in Spring City that was owned by Dr. Panda for future expansion.*
- *Ditto 5*
- *They participated in the RAM Clinic this year offering follow-ups. and they did have a health fair in January in the north end of the county. I would like to see a health fair in south end for the county for Graysville and Housing Authority residents.*
- *Started 340B program for medication for patients. Try to get more doctors involved in helping in the underserved areas for easy access.*

- *"New FM guidelines don't recommend sports physicals for all kids. They don't effectively prevent sudden death. It's so rare no healthcare provider affectively screens for idiopathic aperture of a cardiomyopathy because we don't have the tools necessary to do that. We spend $1000's of dollars lost school time to fill out those forms for now real prevention. PCP's don't accept TennCare secondary to reimbursement below cost of delivering care. I recommend RMC Board of Directors ask medical staff how to advocate for them on a state level. RMC is paid handsomely for TennCare admissions. If that's not accurate it needs to be clarified to local doctors*
- *Works to provide care regardless of ability to pay*
- *Efforts to bring in specialty physicians have been good*
- *Impressive list.*
- **It would be awesome if RMC could provide free/low cost physicals to student athletes *Self-paying patients discounts - two thumbs up*
- *My office routinely offers application for patient assistance program. ED patients are not provided applications. Patients do not use patient assistance programs for free medications from drug companies. We need a designated social worker to encourage patients to use the programs.*
- *It would be wonderful if Rhea County had an after-hours clinic so that residents didn't feel the need to go to emergency room for aches and pains that cause unnecessary high costs they can't afford to pay. I've thought to myself before this migraine may kill me tonight but I refuse to pay $100.00 copay. If I'm still alive in the morning I'll go to my PCP.*
- *Good services provided by the hospital, beneficial assistance.*

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

- *Rhea Medical is reviewing opportunities to bring in oncologists on site.*
- *I would to see continued support for screening of all cancers including mammograms and colonoscopies to encourage early detection. I would also like to see continued support the Relay for Life event.*
- *Ditto 5*
- *no knowledge*
- *Always a first that should be worked on*
- *Started an infusion lab so hopefully in the future cancer patients can receive their chemo treatments locally and not have to drive to a big city, stay home.*
- *Set up cancer survivors support group*
- *Established several new programs to work with cancer patients. Allow patients to be treated locally. Help in the uncertainty of cancer care. Navigator program.*
- *Continue efforts to bring oncology services to Rhea County*
- *Impressive list. Add? Partner with Rc3 to provide a LiveStrong program for cancer survivors.*

- *There are no cancer survivor support groups in Rhea County. The hospital cancer navigator program will help.*
- *The Hospital and the TN Breast and Cervical Program (Health Department) need to put their heads together and come up with an event that will draw ladies out that won't go to their doctors to be checked. The Health Department has had 2 events in the last 4 or 5 years but they weren't very successful. We need to partner together and plan a fun theme that will draw women to come.*
- *have retained a physician, conducting services locally for the community*

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

- *Ditto 5*
- *bring in a one day a week cardiologist and hope to increase days as it grows*
- *Great to have an Education heart doctor on staff. It would be good to add other services provided by them so people would be able to have all their medical needs taken care of locally*
- *This is directly related to tobacco and BP. See if Board would support smoke free town of Dayton? We could be the first smoke-free town in America*
- *Beginning Tele Stroke services*
- *No comments to share*
- *Impressive list. Would suggest stroke-specific goals like specific strike warning signs lunch and learns, post-stroke rehab/therapies improvement, stroke support groups*
- *Most of the time, patients are transferred to regional hospital if stoke symptoms are present. We need tobacco cessation program, which my office can perform.*
- *My only idea would be the same as in number 5 above.*
- *As a health care provider I have been educated on the programs RMC has available to work with preventing and treating stoke patients*

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

- *I would like to see continued support to provide cardiologist appointments at RMC*
- *Ditto 5*
- *not really aware of anything other than working with RC3 for exercising.*
- *Always a first that should be worked on*
- *Education provided is good put more would be better. Help patients to be comfortable with RMC so they don't think they need to go to the bid city*
- *Support USA expanding coverage to Dayton for vascular health care*
- *Educational seminars for the public to bring heart disease prevention and care to the forefront.*

- *Continue efforts outlined above*
- *Continue to develop program with Rc3*
- *It does not require 2 days to complete a stress test. Patients should be able to have a cardiac stress test during admission for chest pain. We also need Holter monitors.*
- *Again, I think everything the hospital is doing is great and they should continue it. My idea in number could be incorporated here as well.*
- *Would like to see additional training carried to extender providers*

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

Need Topic	Total Votes	Number of Local Experts Voting for Needs	Percent of Votes	Cumulative Votes	Need Determination
Affordability/Access to Care*	174	16	9.16%	9.2%	Significant Needs
Smoking/Tobacco Use	171	16	9.00%	18.2%	
Drug/Substance Abuse	169	10	8.89%	27.1%	
Obesity/Overweight*	163	16	8.58%	35.6%	
Cancer*	151	10	7.95%	43.6%	
Women's Health	147	12	7.74%	51.3%	
Mental Health/Suicide	123	13	6.47%	57.8%	
Diabetes*	115	12	6.05%	63.8%	Other Identified Needs
Coronary Heart Disease*	110	12	5.79%	69.6%	
Education/Prevention	100	12	5.26%	74.9%	
Physical Inactivity	87	11	4.58%	79.5%	
Alcohol Use	68	9	3.58%	83.1%	
Chronic Pain Management	67	9	3.53%	86.6%	
Hypertension	61	9	3.21%	89.8%	
Stroke	49	9	2.58%	92.4%	
Dental	45	6	2.37%	94.7%	
Accidents	37	6	1.95%	96.7%	
Alzheimer's	30	6	1.58%	98.3%	
Lung Disease	14	4	0.74%	99.0%	
Flu/Pneumonia	5	3	0.26%	99.3%	
Kidney Disease	5	3	0.26%	99.5%	
Respiratory Infections	5	3	0.26%	99.8%	
Liver Disease	4	3	0.21%	100.0%	
Points reserved for NEW health needs not listed above	0	1	0.00%	100.0%	
Total	1900		100.00%		

**= 2016 Significant Health Needs*

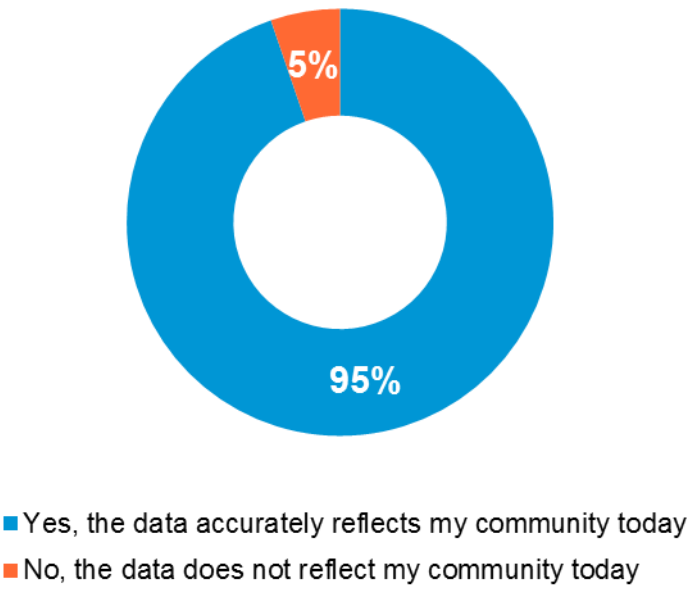
Individuals Participating as Local Expert Advisors[39]

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	7	10	17
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	7	12	19
3) **Priority Populations**	10	8	18
4) Representative/Member of **Chronic Disease Group** or Organization	3	13	16
5) Represents the **Broad Interest of the Community**	17	1	18
Other			0
Answered Question			21
Skipped Question			0

Advice Received from Local Expert Advisors

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

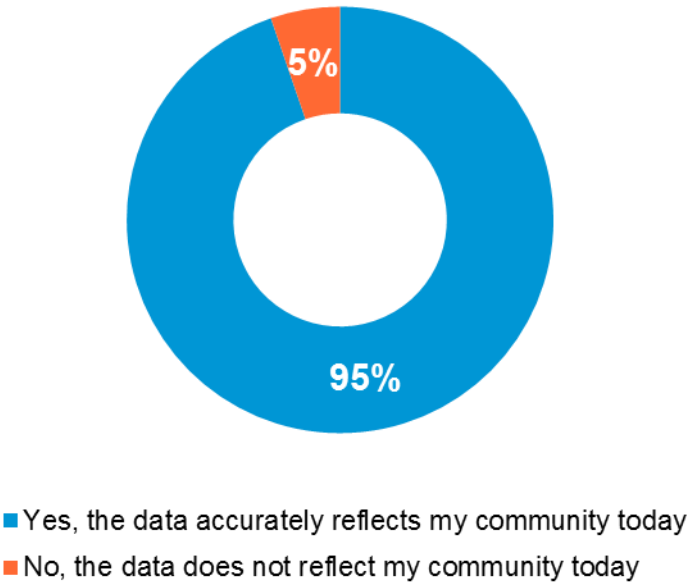
Question: Do you agree with the comparison of Rhea County to all other Tennessee counties?



Comments:

- *As far as my knowledge, looks pretty accurate.*
- *I believe adult obesity and physical inactivity should be a higher % for Rhea. Breast Screenings should be whats easiest for the client no a competition of what resources are used to obtain one. I believe our children in poverty rate should be higher based on the influx of food pantry requests. I also question the deaths by injuries unless this includes drugs/ suicide and auto accidents. and we defiantly have a severe housing problem with affordable availability. We have a large population that share single family homes, increase in homeless reports and then those that move as the rent is due based on utility or rent requests we receive.*
- *The shortfalls in dental and mental health care need improvement*
- *I am surprised at the ratios of population to health care providers.*

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



Comments:

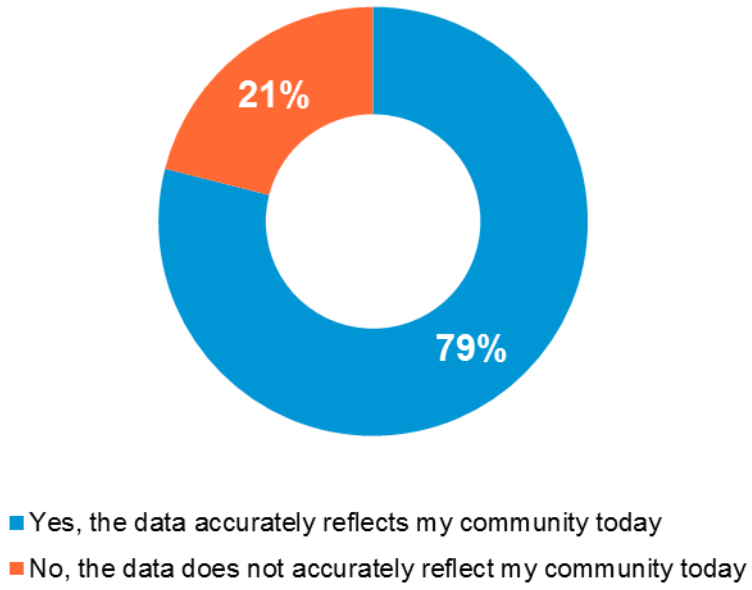
- *I believe our Hispanic population is higher, just not all accounted for. and the median household income is much lower.*

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

Comments:

- *I think it could be about right.*
- *These maps were somewhat difficult to see and interpret*

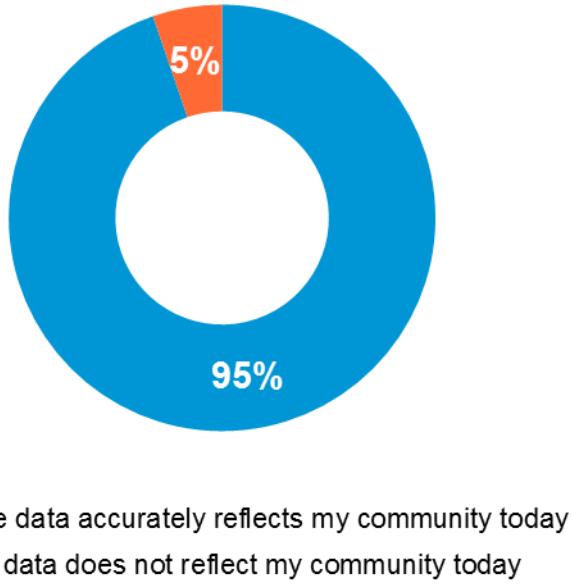
Question: Do you agree with the national rankings and leading causes of death?



Comments:

- *I would think accidents would be more, suicide and homicide less.*
- *I cannot honestly agree or disagree with these numbers.*
- *Drugs*
- *I think in my community, northern Rhea county, the observance of cancer seems to be more prevalent, especially those who worked at the nuclear plant*
- *Tobacco use (smoking) has been the number one cause of death in the United States for the past several decades. It is not even listed in your categories.*

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



Comments:

- *Again I don't know the numbers to agree with the favorable changes but I am not surprised by the higher unfavorable changes.*
- *Substance abuse is really a problem and needs immediate addressing*

Appendix C – National Healthcare Quality and Disparities Report[40]

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

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

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

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

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

Key Findings

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

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

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

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

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

Trends

- Trends show that about 55% percent of quality measures are improving overall for Blacks.[41] However, most recent data in 2014-2015 show that about 40% of quality measures were worse for Blacks compared with Whites.
- Trends show that about 60% of quality measures are improving overall for Asians. However, most recent data in 2014-2015 show that 20% of quality measures were worse for Asians compared with Whites.
- Trends show that almost 35% of quality measures are improving overall for American Indians/Alaska Natives (AI/ANs). However, most recent data in 2014-2015 show that about 30% of quality measures were worse for AI/ANs compared with Whites.
- Trends show that approximately 25% of quality measures are improving overall for Native Hawaiians/Pacific Islanders (NHPIs). However, most recent data in 2014-2015 show that nearly 33% of quality measures were worse for NHPIs compared with Whites.
- Trends show that about 60% of quality measures are improving overall for Hispanics, but in 2014-2015, nearly 33% of quality measures were worse for Hispanics compared with non-Hispanic Whites.
- Variation in care persisted across the urban-rural continuum in 2014-2016, especially in access to care and care coordination.

Looking Forward

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

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

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

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

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

Link to the full report:

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

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

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

Community Health Need Assessment Illustrative Answers

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

   No

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

   No

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

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

      See footnote 16 and 18 on page 12

   b. **Demographics of the community**

      See footnote 19 on page 13

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

      See footnote 30 on page 28

   d. **How data was obtained**

      See footnote 11 on page 9

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

      See footnote 29 on page 26

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

      See footnote 12 on page 10

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

      See footnote 15 on page 10

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

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

See footnotes 8 and 9 on page 8

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

See footnote 10 on page 9, footnotes 13 and 14 on page 10, and footnote 23 on page 17

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

N/A

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

2016

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

Yes, see footnote 14 on page 10 and footnote 38 on page 45

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

No

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

See footnote 4 on page 4 and footnote 7 on page 8

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

Yes

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

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

https://rheamedical.org/

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

No other website

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

Yes

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

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

Yes

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

2016

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

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

https://rheamedical.org/about-rmc/community-health-needs-assessments/

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

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

See footnote 30 on page 28

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

None incurred

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

Nothing to report

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

Nothing to report