Phelps Memorial Health Center

Holdrege, Nebraska

Community Health Needs Assessment
and Implementation Strategy

Adopted by Board Resolution December 12, 2016[1]

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

Dear Community Member:

At Phelps Memorial Health Center (PMHC), we have spent 48 years providing high-quality compassionate healthcare to the greater Holdrege community. The “2016 Community Health Needs Assessment” identifies local health and medical needs and provides a plan of how PMHC 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.

PMHC 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,

Mark Harrel
Chief Executive Officer
Phelps Memorial Health Center

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EXECUTIVE SUMMARY

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

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

The Significant Health Needs for Phelps County are:

1. Cancer
2. Diabetes
3. Obesity/Overweight
4. Physical Activity
5. Mental Health
6. Accessibility/Affordability
7. Heart Disease
8. Stroke

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

APPROACH

APPROACH

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

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

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

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

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

Project Objectives

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

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

Overview of Community Health Needs Assessment

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

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

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

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

[3] As of the date of this report all tax questions and suggested answers relate to 2014 Draft Federal 990 schedule h instructions i990sh—dft(2) and tax form

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

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

Specifically, the IRS requires:

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

Community Health Needs Assessment Subsequent to Initial Assessment

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

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

[5] Section 6652

the health needs of the community;

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

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

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

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

To complete a CHNA:

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

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

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

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

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

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

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

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

conducting the CHNA."[7]

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

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

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

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

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

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

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

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

Other (please specify)

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

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

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

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

county.[10]

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

Data sources include:[11]

Website or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Phelps County compared to all State counties	September 6, 2016	2012
www.cdc.gov/communityhealth	Assessment of health needs of Phelps County compared to its national set of "peer counties"	September 6, 2016	2011
Truven (formerly known as Thompson) Market Planner	Assess characteristics of the hospital's primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according to the proportion of each group in the entire area; and, to access population size, trends and socio-economic characteristics	September 6, 2016	2016
www.capc.org and www.getpalliativecare.org	To identify the availability of Palliative Care programs and services in the area	September 6, 2016	2015
www.caringinfo.org and iweb.nhpco.org	To identify the availability of hospice programs in the county	September 6, 2016	2015
www.healthmetricsandevaluation.org	To examine the prevalence of diabetic conditions and change in life expectancy	September 6, 2016	2010
www.cdc.gov	To examine area trends for heart disease and stroke	September 6, 2016	2010

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

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

http://svi.cdc.gov	To identify the Social Vulnerability Index value	September 6, 2016	2010
www.CHNA.org	To identify potential needs from a variety of resources and health need metrics	September 6, 2016	2015
www.datawarehouse.hrsa.gov	To identify applicable manpower shortage designations	September 6, 2016	2015
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	September 6, 2016	2015

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

- We deployed a CHNA "Round 1" survey to our Local Expert Advisors to gain input on local health needs and the needs of priority populations. Local Expert Advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and the Hospital's desire to represent the region's geographically and ethnically diverse population. We received community input from 15 Local Expert Advisors. Survey responses started August 15, 2016 and ended with the last response on August 22, 2016.
- Information analysis augmented by local opinions showed how Phelps County relates to its peers in terms of primary and chronic needs and other issues of uninsured persons, low-income persons, and minority groups. Respondents commented on whether they believe certain population groups ("Priority Populations") need help to improve their condition, and if so, who needs to do what to improve the conditions of these groups.[12]
- Local opinions of the needs of Priority Populations, while presented in its entirety in the Appendix, was abstracted in the following "take-away" bulleted comments
    - Low-income groups are prevalent in the community
    - There are a variety of issues for children including obesity and learning disabilities
    - Phelps County has a growing number of older adults with comorbidities

When the analysis was complete, we put the information and summary conclusions before our Local Expert Advisors[13] who were asked to agree or disagree with the summary conclusions. They were free to augment potential conclusions with additional comments of need, and new needs did emerge from this exchange.[14] Consultation with 16 Local Experts occurred again via an internet-based survey (explained below) beginning September 7, 2016 and ending September 22, 2016.

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

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

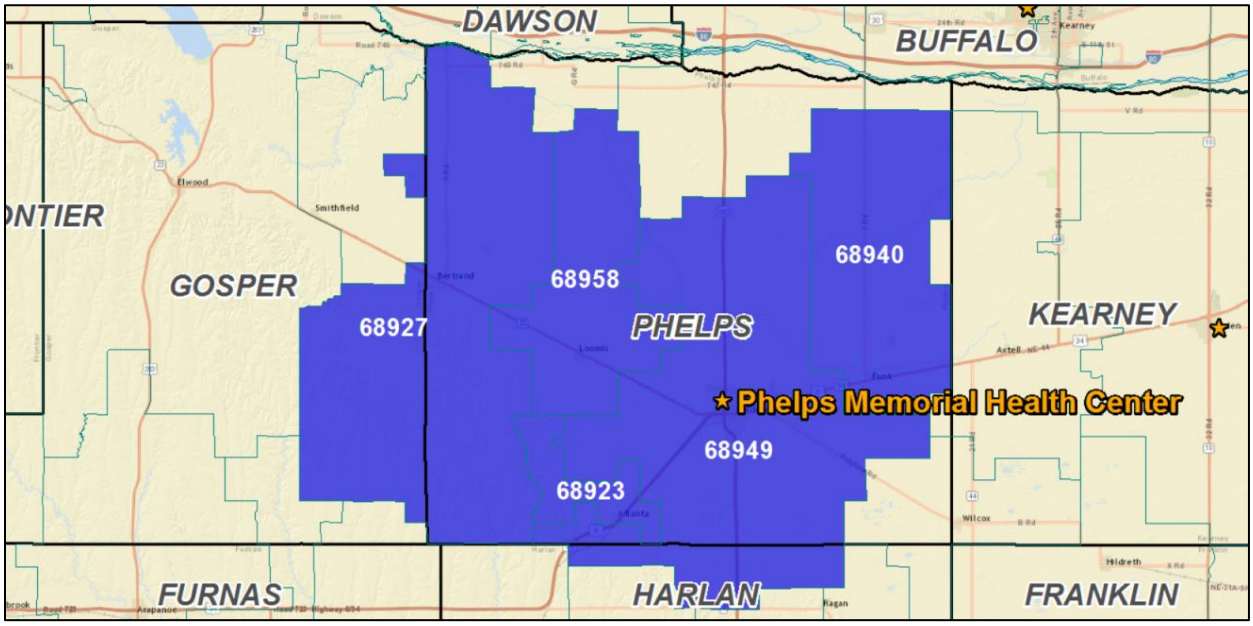
In the PMHC process, each Local Expert had the opportunity to introduce needs previously unidentified and to challenge conclusions developed from the data analysis. While there were a few opinions of the data conclusions not being completely accurate, the vast majority of comments agreed with our findings.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

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

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

COMMUNITY CHARACTERISTICS

Definition of Area Served by the Hospital[17]



PMHC, in conjunction with Quorum, defines its service area as Phelps County in Nebraska, which includes the following ZIP codes:[18]

68923 – Atlanta 68927 – Bertrand 68940 – Funk 68949 – Holdrege 68958 – Loomis

In 2014, the Hospital received 58.4% of its patients from this area.[19]

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

Demographics of the Community[20] [21]

	Phelps County	Nebraska	U.S.
2016 Population[22]	**8,887**	**1,900,948**	**322,431,073**
% Increase/Decline	**1.2%**	**3.6%**	**3.7%**
Estimated Population in 2021	**8,991**	**1,968,584**	**334,341,965**
% White, non-Hispanic	**91.7%**	**79.8%**	**61.3%**
% Hispanic	**5.9%**	**10.6%**	**17.8%**
Median Age	**41.9**	**36.6**	**38.0**
Median Household Income	**$53,335**	**$54,762**	**$55,072**
Unemployment Rate (July 2016)	**2.9%**	**3.5%**	**5.1%**
% Population >65	**20.5%**	**15.0%**	**15.1%**
% Women of Childbearing Age	**15.9%**	**19.3%**	**19.6%**

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

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA
2010 Total Population	8,877	308,745,538
2016 Total Population	8,887	322,431,073
2021 Total Population	8,991	334,341,965
% Change 2016 - 2021	1.2%	3.7%
Average Household Income	$70,845	$77,135

	2016	2021	% Change
Total Male Population	4,390	4,449	1.3%
Total Female Population	4,497	4,542	1.0%
Females, Child Bearing Age (15-44)	1,417	1,451	2.4%

POPULATION DISTRIBUTION

	Age Distribution				
Age Group	2016	% of Total	2021	% of Total	USA 2016 % of Total
0-14	1,804	20.3%	1,852	20.6%	19.0%
15-17	362	4.1%	359	4.0%	4.0%
18-24	718	8.1%	805	9.0%	9.8%
25-34	930	10.5%	931	10.4%	13.3%
35-54	2,055	23.1%	1,887	21.0%	26.0%
55-64	1,194	13.4%	1,177	13.1%	12.8%
65+	1,824	20.5%	1,980	22.0%	15.1%
Total	8,887	100.0%	8,991	100.0%	100.0%

HOUSEHOLD INCOME DISTRIBUTION

	Income Distribution		
2016 Household Income	HH Count	% of Total	USA % of Total
<$15K	287	7.7%	12.3%
$15-25K	405	10.8%	10.4%
$25-50K	1,081	28.9%	23.4%
$50-75K	685	18.3%	17.6%
$75-100K	488	13.0%	12.0%
Over $100K	794	21.2%	24.3%
Total	3,740	100.0%	100.0%

EDUCATION LEVEL

	Education Level Distribution		
2016 Adult Education Level	Pop Age 25+	% of Total	USA % of Total
Less than High School	112	1.9%	5.8%
Some High School	223	3.7%	7.8%
High School Degree	1,816	30.3%	27.9%
Some College/Assoc. Degree	2,567	42.8%	29.2%
Bachelor's Degree or Greater	1,285	21.4%	29.4%
Total	6,003	100.0%	100.0%

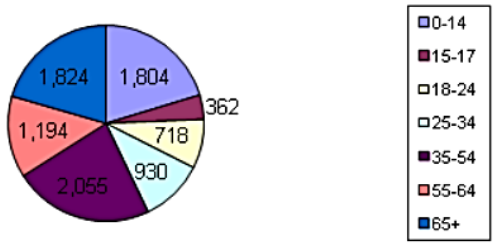
RACE/ETHNICITY

	Race/Ethnicity Distribution		
Race/Ethnicity	2016 Pop	% of Total	USA % of Total
White Non-Hispanic	8,153	91.7%	61.3%
Black Non-Hispanic	65	0.7%	12.3%
Hispanic	528	5.9%	17.8%
Asian & Pacific Is. Non-Hispanic	23	0.3%	5.4%
All Others	118	1.3%	3.1%
Total	8,887	100.0%	100.0%

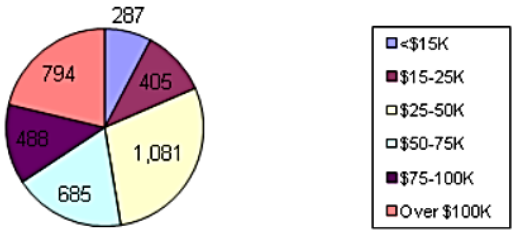
[20] Responds to IRS Schedule h (Form 990) Part V B 3 b
[21] The tables below were created by Truven Market Planner, a national marketing company
[22] All population information, unless otherwise cited, sourced from Truven (formally Thomson) Market Planner

2016 Demographic Snapshot Charts

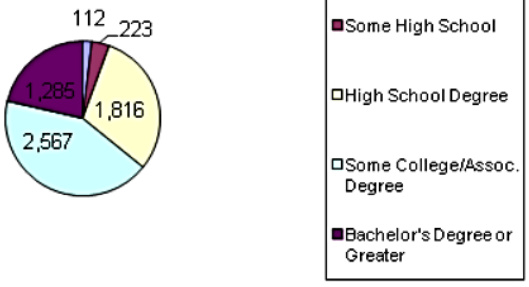
Population Distribution by Age Group



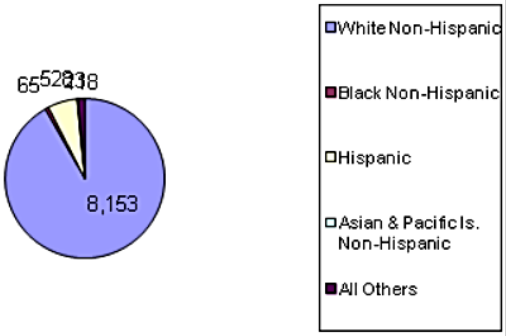
Current Households by Income Group



Population Age 25+ by Education Level



Population Distribution by Race/Ethnicity



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

Area	2016-2021 % Population Change	Median Age	Population 65+ % of Total Population	Population 65+ % Change 2016-2021	Females 15-44 % of Total Population	Females 15-44 % Change 2016-2021	Median Household Income	Median Household Wealth	Median Home Value
USA	3.7%	38.0	15.1%	17.6%	19.6%	1.5%	$55,072	$54,224	$192,364
Nebraska	3.6%	36.6	15.0%	16.0%	19.3%	3.0%	$54,762	$59,391	$144,926
Selected Area	1.2%	41.9	20.5%	8.6%	15.9%	2.4%	$53,335	$75,414	$117,973

Demographics Expert 2.7
DEMO0003.SQP

Customer Segmentation

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

Claritas Prizm Segments	Characteristics
Segment #1 (30%)	Among lifestyles, Segment #1 is the standout for midscale residents who live in remote towns and farmsteads. Here, men like to hunt and fish, women enjoy sewing and crafts, and everyone looks forward to going out to a country music concert.
Segment #2 (20%)	Segment #2 is the kind of lifestyle where small-town couples nearing retirement are beginning to enjoy their first empty-nest years. Typically in their fifties and older, these upper-middle-class Americans pursue a kind of granola-and-grits lifestyle. On their coffee tables are magazines with titles like Country Living and Country Home. But they're big travelers, especially in recreational vehicles and campers.
Segment #3 (13%)	There's a laid-back atmosphere in Segment #3, a collection of older, upscale households that have started to empty-nest. Many households boast two earners who have well-paying management jobs or own small businesses. Today, these Baby-Boom couples have the disposable income to enjoy traveling, owning timeshares, and going out to eat.

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

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

Health Service Topic	Demand as % of National	% of Population Affected	Health Service Topic	Demand as % of National	% of Population Affected
Weight / Lifestyle			**Cancer**		
BMI: Morbid/Obese	101.1%	30.5%	Mammography in Past Yr	101.3%	46.2%
Vigorous Exercise	102.0%	57.9%	Cancer Screen: Colorectal 2 yr	103.6%	26.4%
Chronic Diabetes	116.4%	14.3%	Cancer Screen: Pap/Cerv Test 2 yr	91.4%	54.8%
Healthy Eating Habits	95.8%	28.4%	Routine Screen: Prostate 2 yr	96.3%	30.9%
Ate Breakfast Yesterday	102.4%	70.0%	**Orthopedic**		
Slept Less Than 6 Hours	100.7%	15.7%	Chronic Lower Back Pain	111.5%	26.2%
Consumed Alcohol in the Past 30 Days	86.5%	47.1%	Chronic Osteoporosis	118.9%	11.7%
Consumed 3+ Drinks Per Session	106.4%	29.2%	**Routine Services**		
Behavior			FP/GP: 1+ Visit	103.1%	91.0%
I Will Travel to Obtain Medical Care	96.0%	22.4%	Used Midlevel in last 6 Months	110.4%	45.7%
I am Responsible for My Health	96.1%	62.8%	OB/Gyn 1+ Visit	89.3%	41.3%
I Follow Treatment Recommendations	99.2%	51.5%	Medication: Received Prescription	102.8%	58.3%
Pulmonary			**Internet Usage**		
Chronic COPD	128.4%	5.1%	Use Internet to Talk to MD	70.5%	8.7%
Tobacco Use: Cigarettes	104.4%	26.6%	Facebook Opinions	75.3%	7.7%
Heart			Looked for Provider Rating	87.7%	12.5%
Chronic High Cholesterol	119.3%	26.2%	**Emergency Services**		
Routine Cholesterol Screening	95.1%	48.3%	Emergency Room Use	97.6%	33.1%
Chronic Heart Failure	133.3%	5.8%	Urgent Care Use	95.1%	22.2%

Leading Causes of Death

Cause of Death			Rank among all counties in NE* (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation (Compared to U.S.)
Phelps Rank	NE Rank	Condition		NE	Phelps	
1	2	Heart Disease	57 of 82	143.0	171.4	Lower than expected
2	1	Cancer	60 of 82	159.6	159.4	Lower than expected
3	3	Lung	34 of 82	50.6	48.4	As expected
4	4	Stroke	53 of 82	37.7	42.3	Lower than expected
5	5	Accidents	62 of 82	38.6	38.5	Lower than expected
6	6	Alzheimer's	18 of 82	21.9	28.5	Higher than expected
7	7	Diabetes	14 of 82	21.5	27.2	As expected
8	8	Flu – Pneumonia	9 of 82	15.2	22.4	As expected
9	9	Kidney	33 of 82	11.6	12.9	As expected
10	11	Suicide	59 of 82	13.4	9.2	As expected
11	10	Hypertension	29 of 82	10.9	8.4	Higher than expected
12	13	Liver	20 of 82	8.0	8.1	As expected
13	14	Blood Poisoning	37 of 82	5.9	5.6	Lower than expected
14	12	Parkinson's	61 of 82	8.9	5.3	As expected
15	15	Homicide	0 of 82	3.4	0.0	Lower than expected

**Some counties in Nebraska do not have enough to data to be reported accurately, so the number of counties listed for this source may not match the total number of counties in Nebraska or the number used in other data sources.*

Priority Populations[23]

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

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

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

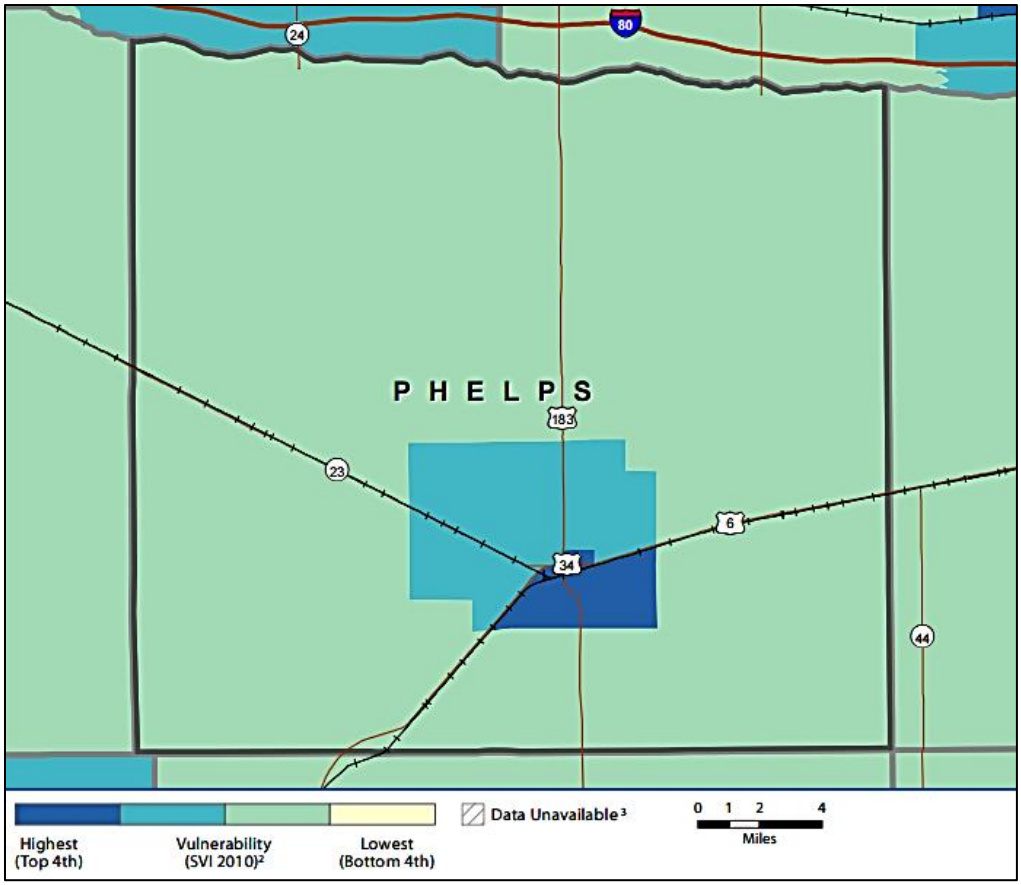
- Low-income groups are prevalent in the community
- There are a variety of issues for children including obesity and learning disabilities
- Phelps County has a growing number of older adults with comorbidities

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

Social Vulnerability

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

- Phelps County primarily falls into the second lowest quartile of social vulnerability
- Central Phelps County is in the first and second highest quartiles of vulnerability



Summary of Survey Results on Prior CHNA

In the Round 1 survey, 15 individuals provided feedback on the 2013 CHNA. Complete results, including *verbatim* written comments, can be found in Appendix A.

Commenter characteristics:

Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	3	8	11
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	6	6	12
3) Priority Populations	5	7	12
4) Representative/Member of Chronic Disease Group or Organization	2	9	11
5) Represents the Broad Interest of the Community	12	3	15
Other			
Answered Question			15
Skipped Question			0

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

- Maternal/Infant Measures
- Cancer
- Diabetes
- Obesity/Overweight
- Mental Health
- Accessibility/Affordability
- Substance Abuse
- Physical Activity

PMHC received the following responses to the question: **"Should the hospital continue to consider the needs identified as most important in the 2013 CHNA as the most important set of health needs currently confronting residents in the county?**

	Yes	No	No Opinion
Maternal/Infant Measures	12	1	1
Cancer	13	1	0
Diabetes	13	1	0
Obesity/Overweight	13	1	0
Mental Health	13	1	0
Accessibility/Affordability	14	0	0
Substance Abuse	10	3	1
Physical Activity	12	2	0

PMHC received the following responses to the question: **"Should the Hospital continue to allocate resources to help improve the needs identified in the 2013 CHNA?"**

	Yes	No	No Opinion
Maternal/Infant Measures	13	1	0
Cancer	14	0	0
Diabetes	13	1	0
Obesity/Overweight	12	2	0
Mental Health	12	2	0
Accessibility/Affordability	14	0	0
Substance Abuse	10	4	0
Physical Activity	12	2	0

Comparison to Other State Counties

To better understand the community, Phelps County has been compared to 78* counties in the state of Nebraska across five areas: Health Outcomes, Health Behaviors, Clinical Care, Social & Economic Factors, and Physical Environment. The last four areas are all Health Factors that ultimately affect the Health Outcomes of Length (Mortality) and Quality of Life (Morbidity).

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

	Phelps County	Nebraska	U.S. Best
Health Outcomes			
Overall Rank *(best being #1)*	57/78		
Premature Death (deaths prior to age 75)*	7,900	5,800	5,200
Health Behaviors			
Overall Rank *(best being #1)*	38/78		
Adult Obesity	35%	30%	25%
Physical Inactivity	27%	24%	20%
Alcohol-Impaired Driving Deaths	50%	35%	14%
Access to Exercise Opportunities	58%	80%	91%
Clinical Care			
Overall Rank *(best being #1)*	24/78		
Preventable Hospital Stays (per 1,000)	61	51	38
Mammography Screening	56%	62%	71%
Population to Dentist	1,840:1	1,420:1	1,340:1
Population to Mental Health Provider	660:1	410:1	370:1
Social & Economic Factors			
Overall Rank *(best being #1)*	5/78		
Injury Deaths*	61	54	51
Physical Environment			
Overall Rank *(best being #1)*	11/78		

**Some counties in Nebraska do not have enough to data to be reported accurately, so the number of counties listed for this source may not match the total number of counties in Nebraska or the number used in other data sources.*

Comparison to Peer Counties

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

	Phelps County	Peer Ranking	U.S. Average
Mortality			
Better			
Coronary Heart Disease Deaths*	78.6	3/67	126.7
Stroke Deaths*	33.1	14/65	46.0
Worse			
Chronic Lower Respiratory Disease Deaths*	49.4	47/62	49.6
Female Life Expectancy	80.7	53/67	79.8
Morbidity			
Better			
Cancer*	393.5	5/44	457.6
Gonorrhea*	0.0	17/67	30.5
Older Adult Depression	9.8%	15/67	12.4%
Syphilis*	0.0	48/67	0.0
Worse			
Alzheimer's Diseases/Dementia	10.6%	57/67	10.3%
Healthcare Access & Quality			
Better			
Primary Care Provider Access*	98.0	4/67	48.0
Uninsured	10.7%	17/67	17.7%
Worse			
Nothing	--	--	--
Health Behaviors			
Better			
Adult Smoking	13.8%	9/50	21.7%

	Phelps County	Peer Ranking	U.S. Average
Worse			
Nothing	--	--	--
Social Factors			
Better			
Children in Single-Parent Households	17.6%	11/67	30.8%
Unemployment	2.9%	4/67	7.1%
Worse			
Nothing	--	--	--
Physical Environment			
Better			
Air Quality	8.2	13/67	10.7
Worse			
Living Near Highways	2.9%	61/67	1.5%

Conclusions from Demographic Analysis Compared to National Averages

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

- Cervical Cancer Screening in Past Two Years = 8.6% below average; 54.8%
- OB/Gyn Visit = 10.7% below average; 41.3%

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

- Consumed Alcohol in the Past 30 Days = 13.5% below average; 47.1%
- Used Midlevel in Last 6 Months = 10.4% above average; 45.7%

Conclusions from Other Statistical Data

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

	Current Date of Data	Statistic	Percent Change	Last Date of Data
UNFAVORABLE COUNTY measures that are **WORSE** than the U.S. average and had an **UNFAVORABLE** change				
Male Heavy Drinking	2012	10.9%	3.2% pts	2005
Female Binge Drinking	2012	13.0%	2.5% pts	2002
Male Binge Drinking	2012	27.4%	1.4% pts	2002
Male Obesity	2011	35.9%	6.9% pts	2001
UNFAVORABLE COUNTY measures that are **WORSE** than the U.S. average and had an **FAVORABLE** change				
Female Smoking	2012	20.1%	-2.4% pts	1996
Male Smoking	2012	23.0%	-4.4% pts	1996
DESIRABLE COUNTY measures that are **BETTER** than the US average and had an **UNFAVORABLE** change				
Female Heavy Drinking	2012	5.6%	2.1% pts	2005
Female Obesity	2011	33.9%	6.5% pts	2001
DESIRABLE COUNTY measures that are **BETTER** than the US average and had an **FAVORABLE** change				
Female Life Expectancy	2013	81.7 years	2.6 years	1985
Male Life Expectancy	2013	77.0 years	3.5 years	1985
Female Physical Activity	2011	57.3%	%	2001
Male Physical Activity	2011	59.0%	%	2001

Community Benefit

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

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

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

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

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

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

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

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

- Financial Assistance at Cost = $310,623
- Medicaid = $2,052,237
- Health Professions Education = $46,768
- Community Health Improvement Services and Community Benefit Operations = $14,124

IMPLEMENTATION STRATEGY

Significant Health Needs

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

- Identifies the rank order of each identified Significant Need
- Presents the factors considered in developing the ranking
- Establishes a Problem Statement to specify the problem indicated by use of the Significant Need term
- Identifies PMHC current efforts responding to the need including any written comments received regarding prior PMHC implementation actions
- Establishes the Implementation Strategy programs and resources PMHC will devote to attempt to achieve improvements
- Documents the Leading Indicators PMHC will use to measure progress
- Presents the Lagging Indicators PMHC 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, Phelps Memorial Health Center is the major hospital in the service area. PMHC is a 25-bed, Critical Access Hospital located in Holdrege, Nebraska. The next closest facilities are outside the service area and include:

- Harlan County Health System in Alma, NE, 24 miles (27 minutes)
- Kearney County Health Services in Minden, NE, 25 miles (31 minutes)
- Kearney Regional Medical Center in Kearney, NE, 36 miles (37 minutes)
- CHI Health Good Samaritan in Kearney, NE, 36 miles (39 minutes)

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

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

1. **CANCER** – 2013 Significant Need; #2 leading cause of death; mammography screening below NE and US average; cervical cancer screening 8.6% below average

Public comments received on previously adopted implementation strategy:

- *unknown*
- *I know PMHC has had workshops on cancer topics. Need to continue such. I don'e know what your attendance is for a lot of your workshops. I know a lot of us don't educate ourselves enough until the problem is on the doorstep. Continue to work with Cancer related prevention issues. Continue to give prevention ideas on the radio every week. I know someone from PMHC is always on KUVR giving tips and information about the hospital. They could continue to give tips in all these areas. cancer, diabetes, obesity, alcohol, drugs, child care, etc.*
- *I believe Holdrege has a great Cancer treatment program.*
- *Screenings and early detection are key.*
- *Improvement is needed by the hospital & staff & doctors to more accurately diagnose cancers and ensure that they are locating the primary site of the cancer to best treat & avoid spreading.*
- *Don't know. Education!!!!! and Physical Annual Follow-up awareness*
- *n/a*

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

- Oncology and hematology outreach clinic provides chemotherapy, infusion therapy, and follow-up appointments
- PMHC contracts with mobile unit that comes on site to provide stereotactic services
- Digital mammography, PET/CT (lung screenings) available on site
- General surgery available for biopsies with full lab services
- Free annual colon cancer screenings
- Endoscopy, colonoscopy procedures available on site
- PMHC promotes Breast Cancer Awareness Month, and provides education on testing and prevention for other types of cancer
- Materials, collateral, and public service announcements with education on cancer awareness and preventive screenings
- Annual sponsor of Relay for Life with a participating hospital team

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

- Through the change to a new EMR, look into adding annual reminders for preventive screenings and appointments
- Actively recruiting for oncologist and planning to train advanced practitioner to provide oncology services

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

- Investigate options to increase availability of oncology services and/or capacity

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

- Number of cancer screenings (2015):
  - Mammograms = 1,671
  - PET/CT = 2,234
  - Colonoscopies = 527
  - Pap smears (all) = 137

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

- Cancer death rate = 170.6 per 100,000[27]

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

Organization	Contact Name	Contact Information
Advanced Medical Imaging (radiology)	Alison Jensen jensen@amimaging.com	7601 Pioneers Blvd, Lincoln, NE 68506 (402) 484-6677 amimaging.com

[27] CHSI. The age adjusted cancer death rate. 2005-2011.

Organization	Contact Name	Contact Information
Family Medical Specialties	Kim Kirwin kkirwin@ruralmed.net	516 W 14th Ave, Holdrege, NE 68949 (308) 995-4431 www.fammedspec.com
Mary Lanning Healthcare (oncology services)		715 N St Joseph Ave, Hastings, NE 68901 (402) 463-4521 www.marylanning.org
CHI Health Good Samaritan	Cliff Robertson, CEO	10 E 31st St, Kearney, NE 68847 (308) 865-7100 chihealthgoodsamaritan.org
American Cancer Society		3808 28th Ave E, Kearney, NE 68845 (308) 237-7481 http://main.acsevents.org/site/TR/RelayForLife/RFLCY17PL?pg=entry&fr_id=82571
Kearney Clinic, PC	Peggy Dobish, Administrator	211 W 33rd St, Kearney, NE 68845 (308) 865-2141 www.kearneyclinic.com

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

Organization	Contact Name	Contact Information
Two Rivers Public Health Department	Jeremy Eschliman, Director	701 4th Ave #1, Holdrege, NE 68949 (308) 995-4778 www.trphd.org

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

2. DIABETES – 2013 Significant Need; #7 leading cause of death

Public comments received on previously adopted implementation strategy:

- *There seems to be good diabetes education happening.*
- *They have had workshops on diabetes. Perhaps have local people on radio spots that others may know and relate to. This may generate a person to talk to and or educated themselves or come to program you have. When people hear someone they know has cancer, etc. it often times makes them examine their life and perhaps get a physical, colonoscopy, breast xray, etc since it hits close to home.*
- *I have not worked with the hospital on this issue*
- *N/A*
- *See question # 10 [Dabetes is on the rise with he population and much is to be attributed to our over weight society member. The hospital should increase efforts to communicate best ways to reduce this without just prescribing medication. Offer exercise classes, managed weight loss programs, along with all natural treatment classes and education to eliminate dibetes.]*
- *Affordability Act is a essential to continue and help those in need of any specifics.*
- *n/a*

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

- Certified diabetes educator on staff who works with inpatients and outpatients through one-on-one consultations; speaks on local radio segment "Health Talk"; presents at local schools; provides free glucometers to some patients
- Registered dietician on staff who works with inpatients and outpatients; speaks on local radio segment "Health Talk"
- Sponsor of the weight room at Loomis Public Schools
- Sponsor of the annual Silver Run (local fun run) to help support local YMCA; overall corporate sponsor of YMCA
- Three-part community education series focused on diabetes offered on-site
- Provide space to local diabetes support group
- Sponsor multiple local events promoting physical activity and health & wellness
- Materials, collateral, and public service announcements with education on diabetes
- Wound care outreach clinic available

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

- Working with Rural Med to develop Ideal Protein weight loss program
- Explore additional classes/education to target pre-diabetes and overall health and wellness

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

- Number of individuals participating in PMHC Diabetic Education Program = 108 (2015)

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

- Adult Diabetes Rate = 6.0%[29]

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

Organization	Contact Name	Contact Information
Family Medical Specialties	Kim Kirwin kkirwin@ruralmed.net	516 W 14th Ave, Holdrege, NE 68949 (308) 995-4431 www.fammedspec.com
Rural Med Management Resources	Bethanne Kunz, COO	www.ruralmed.net
YMCA of the Prairie	Ginger Cowne, CEO	415 Broadway St, Holdrege, NE 68949 (308) 995-4050 www.ymcaoftheprairie.org

[29] CHSI. The percent of adults living with diagnosed diabetes. 2005-2011.

Organization	Contact Name	Contact Information
American Diabetes Association		14216 Dayton Circle, Ste 6, Omaha, NE, 68137 (402) 571-1101 http://www.diabetes.org/in-my-community/local-offices/omaha-nebraska/?referrer=https://www.google.com/
Bryan Health		1600 S. 48th St., Lincoln, NE 68506 (402) 481-1111 www.bryanhealth.com
Two Rivers Public Health Department	Jeremy Eschliman, Director	701 4th Ave #1, Holdrege, NE 68949 (308) 995-4778 www.trphd.org

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

Organization	Contact Name	Contact Information
Local schools		

3. **OBESITY/OVERWEIGHT** – 2013 Significant Need; worse than NE and US average; male obesity worse than US average
4. **PHYSICAL ACTIVITY** – 2013 Significant Need; worse than NE and US average; access to exercise opportunities below NE and US average

Due to the similar services, programs, and resources available to respond to these needs, they have been combined into one Implementation Strategy.

Public comments received on previously adopted implementation strategy for OBESITY/OVERWEIGHT:

An implementation strategy was not developed for this Significant Need in 2013, so no written public comments were solicited.

Public comments received on previously adopted implementation strategy for PHYSICAL ACTIVITY:

- *unknown*
- *Work with the YMCA to implement activities/programs at the YMCA, YMCA preschool, Head Start and other area preschools. I don't know if there is a way to incorporate physical activity through social media????*
- *As I said they are very supportive and sponsor many activities.*
- *Offer hands on training of physical activity with exercise equipment with trainers and physical therapists and tie it in to an event like a health fair with a different 7 catchy name. People learn best when someone shows or demonstrates it to them. Work with the YMCA to offer more affordable pricing for all individuals to benefit from the exercise equipment.*
- *n/a*

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

- Registered dietician on staff who works with inpatients and outpatients; speaks on local radio segment "Health Talk"
- Sponsor of the weight room at Loomis Public Schools
- Sponsor of the annual Silver Run (local fun run) to help support local YMCA; overall corporate sponsor of YMCA
- Sponsor of multiple local events promoting physical activity and health & wellness
- Materials, collateral, and public service announcements with education on health and wellness
- Sponsor of Loomis baseball and softball teams

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

- Working with Rural Med to develop Ideal Protein weight loss program
- Look into providing free screenings (e.g., blood pressure, BMI) in local clinic or through other organizations

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

- Number of participants in sponsored local events/activities (2015)
  - Relay For Life = 300
  - Swedish Days Run = 300
  - Make A Wish = 1 Family per year
  - Relay For Life Survivors Dinner – 50
  - Teammates - 150
  - Kidney Disease Education - 40
  - Diabetes Education – 108
  - Rotary – 45
  - Foot Clinic – 50
  - CPR Training – 250
  - Senior Send Off Event – 200
  - YMCA Health Kids Day – 130
  - Junior Career Day – 60
  - Heart Health/Stroke – 57
  - Oncology Education – 50
  - Car Seat Community Event – 40

- Smoking Cessation – 12
- Crime Stoppers Self Defense Class – 20
- Feed My Starving Children – Hundreds of people served
- Immunization Clinic – 100
- Holdrege Annual Child Care Conference – 200+
- OB/BABE/Lactation Classes – 65
- Safe Communities – 250+

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

- Obesity Rate = 35%[30]

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

Organization	Contact Name	Contact Information
YMCA of the Prairie	Ginger Cowne, CEO	415 Broadway St, Holdrege, NE 68949 (308) 995-4050 www.ymcaoftheprairie.org
Rural Med Management Resources	Bethanne Kunz, COO	www.ruralmed.net
Local schools		
Community sports organizations		
Family Medical Specialties	Kim Kirwin kkirwin@ruralmed.net	516 W 14th Ave, Holdrege, NE 68949 (308) 995-4431 www.fammedspec.com

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

Organization	Contact Name	Contact Information
Two Rivers Public Health Department	Jeremy Eschliman, Director	701 4th Ave #1, Holdrege, NE 68949 (308) 995-4778 www.trphd.org

[30] County Health Rankings. Percentage of adults age 20+ that report a BMI of 30 or more. 2012.

5. **MENTAL HEALTH** – 2013 Significant Need; suicide #10 leading cause of death; population to mental health provider worse than NE and US

Public comments received on previously adopted implementation strategy:

An implementation strategy was not developed for this Significant Need in 2013, so no written public comments were solicited.

Due to resource constraints, PMHC is not developing an implementation strategy for this need at this time. We feel we can have a greater impact by putting attention and resources toward other significant needs for which we are better qualified to serve.

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

PMHC will continue taking the following steps to address this need:

- Safe room available on site to provide protective space for patients with identified behavioral health issues until the patient can be transferred
- Continue recruiting for psychiatrist/psychologist
- Social worker provides services to inpatients, outpatients, and employees, and helps provides access to resources and other contacts
- Continue search for telehealth services
- Employee Assistance Program available to hospital employees and families that covers sessions for counseling and provides educational materials, resources, and referrals
- Hospital employee attends Region 3 Behavioral Health Services meetings to help coordinate community efforts

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

Organization	Contact Name	Contact Information
Mary Lanning Healthcare		715 N St Joseph Ave, Hastings, NE 68901 (402) 463-4521 www.marylanning.org
Richard Young Hospital		1755 Prairie View Pl, Kearney, NE 68845 (308) 865-2000 chihealthgoodsamaritan.org
Nebraska Department of Health & Human Services	Brenda Bender, Supervisor, Kearney	301 Centennial Mall S, Lincoln, NE 68508 (402) 471-3121 dhhs.ne.gov
South Central Nebraska Area Agency on Aging	Rod Horsley, Executive Director	620 E 25th St #12, Kearney, NE 68847 (308) 234-1851 www.agingkearney.org
Two Rivers Public Health Department	Jeremy Eschliman, Director	701 4th Ave #1, Holdrege, NE 68949 (308) 995-4778 www.trphd.org
Local ministerial associations		
Local counseling agencies		

6. ACCESSIBILITY/AFFORDABILITY – 2013 Significant Need; preventable hospital stays above NE and US average

Public comments received on previously adopted implementation strategy:

- *unknown*
- *I don't know about affordability. I know PMHC does what it can to bring in doctors, and education programs for the public. I don't know if it is feasible for PMHC to run a shuttle for those who can't make it to the hospital or doctor appointments. I know there is a handi-bus and maybe there is not a problem for people getting to a medical facility to see a doctor.*
- *Budgets and fees need to be restructured as many community members can not afford the necessary health care and even with insurance they can't always be seen when they are ill. Great improvement is needed in this area that will benefit the entire community.*
- *Living in an low-income rural area; there is a need for accessibility and affordability for all..*
- *n/a*

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

- PMHC offers a financial assistance policy with a sliding fee scale and self-pay discounts
- PMHC has financial counselors on staff to help patients understand and pay their bills, and organize payment plans
- Social worker on staff helps patients sign up for Medicaid and provides information on health insurance exchange
- Specialty services available on site include: cardiology, nephrology, pulmonology, obstetrics/gynecology, general surgery, ENT, ophthalmology, orthopedics, oncology, hematology, spine, pain management, wound/ostomy care, sleep study, podiatry, urology, interventional radiology, PT/OT/ST, and cardiac/pulmonary rehab
- Oncology and hematology outreach clinic provides chemotherapy, infusion therapy, and follow-up appointments
- PMHC contracts with mobile unit that comes on site to provide stereotactic services
- Digital mammography, PET/CT (lung screenings) available on site
- General surgery available for biopsies with full lab services
- Free annual colon cancer screenings
- Endoscopy, colonoscopy procedures available on site

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

- Look into support or sponsorship for transportation services
- Actively recruiting for neurology, oncology, psychiatry, internal medicine, family practice/primary care, OB/GYN, general surgery
- Expanding hours of operation for various services

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

- Opened Phelps Medical Group clinic (formerly High Plains Medicine) increasing access to women's health, primary care; in the process of converting to a Rural Health Clinic
- Increased availability of spine, orthopedics, interventional radiology, general surgery

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

- Number of patients who receive Financial Assistance = 188 (2015)
- Number of specialty clinic visits (2015)
  - Cardiology = 1,843
  - ENT = 472
  - OB/GYN = 576
  - Oncology = 931
  - General Surgery = 1,337
  - Urology = 303
  - Pulmonary = 325
  - Nephrology = 192
  - Ortho = 1,558
  - Spine = 818
  - Psych = 117

- Pain = 187

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

- Cost Barrier to Care = 8.5%[31]

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

Organization	Contact Name	Contact Information
Advanced Medical Imaging	Alison Jensen jensen@amimaging.com	7601 Pioneers Blvd, Lincoln, NE 68506 (402) 484-6677 amimaging.com
Specialty groups that provide services on site		
CHI Health Good Samaritan	Cliff Robertson, CEO	10 E 31st St, Kearney, NE 68847 (308) 865-7100 chihealthgoodsamaritan.org
Family Medical Specialties	Kim Kirwin kkirwin@ruralmed.net	516 W 14th Ave, Holdrege, NE 68949 (308) 995-4431 www.fammedspec.com
Nebraska Department of Health & Human Services	Brenda Bender, Supervisor, Kearney	301 Centennial Mall S, Lincoln, NE 68508 (402) 471-3121 dhhs.ne.gov
Local ministerial associations		

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

Organization	Contact Name	Contact Information
Salvation Army	Cassandra Burkett	715 5th Ave, Ste 20, Holdrege, NE 68949 (308) 995-5692
Phelps County Community Foundation/Christian Charity Fund	Delores Schneider	504 4th Ave, Holdrege, NE 68949 (308) 995-6847 www.phelpsfoundation.org

[31] CHSI. The percent of adults 18+ ho did not see a doctor due to cost. 2006-2012.

7. **HEART DISEASE** – #1 leading cause of death
8. **STROKE** – #4 leading cause of death

Due to the similar services, programs, and resources available to respond to these needs, they have been combined into one Implementation Strategy.

Public comments received on previously adopted implementation strategy for HEART DISEASE:

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

Public comments received on previously adopted implementation strategy for STROKE:

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

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

- Cardiac Rehab services available
- Cardiology outreach clinics are available on site, and cardiologists perform outreach and education in the community
- PMHC provides sponsorships to local organizations and agencies to purchase defibrillators
- Hosted training event for local first responders/EMTs on STEMI protocol
- Provide community education, marketing, and fundraising for Go Red for Women in February
- Registered dietician on staff who works with inpatients and outpatients; speaks on local radio segment "Health Talk"
- Sponsor of the annual Silver Run (local fun run) to help support local YMCA; overall corporate sponsor of YMCA
- Sponsor of multiple local events promoting physical activity and health & wellness
- Materials, collateral, and public service announcements with education on health and wellness
- Sent general surgeon for pace maker insertion training
- Two community education sessions identifying signs of a stroke presented by Dr. Gardner
- Provide stroke rehabilitation services

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

- Working on implementing new state stroke protocols and ensuring emergency treatment meets best practice

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

- Number of visits to Cardiology Outreach Clinics = 1,843 (2015)

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

- Coronary Heart Disease Deaths = 78.6 per 100,000[32]

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

Organization	Contact Name	Contact Information
Bryan Heart		1600 S 48th St, Lincoln, NE 68506 (402) 483-3333 www.bryanhealth.com/locations/physician-offices/bryan-heart
Nebraska Heart		3219 Central Ave., Ste. 201, Kearney, NE 68847 (308) 865-7271 www.neheart.com
Platte Valley Medical Group	Tom McCleod	816 22nd Ave, Kearney, NE 68845 (308) 865-2263 plattevalleymed.com

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

Organization	Contact Name	Contact Information
American Heart Association	Jamie Schneider	9900 Nicholas Street Suite 200, Omaha, NE 68114 (402) 810-6870 http://www.heart.org/HEARTORG/Affiliate/Omaha/Nebraska/Home_UCM_MWA026_AffiliatePage.jsp
Kearney Regional Medical Center	Larry Speicher, CEO	804 22nd Ave, Kearney, NE 68845 (308) 455-3600 www.kearneyregional.com
CHI Health Good Samaritan	Cliff Robertson, CEO	10 E 31st St, Kearney, NE 68847 (308) 865-7100 chihealthgoodsamaritan.org
YMCA of the Prairie	Ginger Cowne, CEO	415 Broadway St, Holdrege, NE 68949 (308) 995-4050 www.ymcaoftheprairie.org
Family Medical Specialties	Kim Kirwin kkirwin@ruralmed.net	516 W 14th Ave, Holdrege, NE 68949 (308) 995-4431 www.fammedspec.com

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

Organization	Contact Name	Contact Information
Two Rivers Public Health Department	Jeremy Eschliman, Director	701 4th Ave #1, Holdrege, NE 68949 (308) 995-4778 www.trphd.org

Other Needs Identified During CHNA Process

9. **EDUCATION/PREVENTION**
10. **MATERNAL/INFANT MEASURES –** 2013 Significant Need
11. **ALZHEIMER'S**
12. **LUNG DISEASE**
13. **KIDNEY DISEASE**
14. **SUBSTANCE ABUSE** – 2013 Significant Need
15. **CHRONIC LOWER RESPIRATORY DISEASE**
16. **SMOKING**
17. **DENTAL**
18. **FLU/PNEUMONIA**
19. **ACCIDENTS**
20. **LIFE EXPECTANCY**

Overall Community Need Statement and Priority Ranking Score

Significant needs where hospital has implementation responsibility[33]

1. Cancer
2. Diabetes
3. Obesity/Overweight
4. Physical Activity
6. Accessibility/Affordability
7. Heart Disease
8. Stroke

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

5. Mental Health

Other needs where hospital developed implementation strategy

None

Other needs where hospital did not develop implementation strategy

9. Education/Prevention
10. Maternal/Infant Measures
11. Alzheimer's
12. Lung Disease
13. Kidney Disease
14. Substance Abuse
15. Chronic Lower Respiratory Disease
16. Smoking
17. Dental
18. Flu/Pneumonia
19. Accidents
20. Life Expectancy

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

APPENDIX

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

Hospital solicited written comments about its 2013 CHNA.[35] 15 individuals responded to the request for comments. The following presents the information received in response to the solicitation efforts by the hospital. No unsolicited comments have been received.

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

Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	3	8	11
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	6	6	12
3) Priority Populations	5	7	12
4) Representative/Member of Chronic Disease Group or Organization	2	9	11
5) Represents the Broad Interest of the Community	12	3	15
Other			
Answered Question			15
Skipped Question			0

Congress defines "Priority Populations" to include:

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

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

   - *All of these populations exist in our community and have the unique needs that these populations have in other areas of the state/nation.*
   - *All of the above exist in our community. All would have some unique needs that are different than the others.*

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

- *Low income groups, Children and Racial and ethnic groups*
- *I work in the school setting and there are a variety of issues for children. Obesity, disabilities, learning problems, as well as medical problems.*
- *Older adults: Weekend transportation*
- *Yes*
- *In general, our racial/ethnic minority groups often get overlooked in the Holdrege area. I don't know if it's individuals don't receive information, don't take advantage of opportunities, or don't feel welcomed, but my impression is they don't often participate in programs/services available in the community. Older adults seem well-represented and for the most part, participate in programs/services. The LGBT community is still ostracized - my conversations with individuals from that population is for the most part, they don't feel welcomed or safe.*
- *Racial & ethnic minority groups, low income groups, women, children, older adults, residents of rural areas, individuals with special needs.*
- *I do not see any Spanish materials in Phelps Memorial, and we do have a hispanci population here*
- *While Holdrege, like all communities, has some representation in all of the "Priority Populations" the most important would be a combination of Older, Rural residents; many with special and/or chronic illnesses typical of the "senior years". Obviously, Alzheimer's and Dementia would be a major health concern for that age group. Early diagnosis and proper treatment are vitally important as well as continued support for the patient and their family. I also believe Holdrege has a growing population of LMI families with children that need to be identified and cared for.*
- *Yes, they do exist.*
- *Consider developing local access to a visiting neurologist would be one recommendation and it would apply to more than one of the priority groups listed above..*
- *Yes! Homeless Children as well as target veteran disability (mental/Physical)*
- *Yes. Rural populations that include more than one of the priority sectors that may be geographically distant from services; higher incidences of older adults.*
- *Yes*

In the 2013 CHNA, there were 8 health needs identified as "significant" or most important:

1. **Maternal/Infant Measures**
2. **Cancer**
3. **Diabetes**
4. **Obesity/Overweight**
5. **Mental Health**
6. **Accessibility/Affordability**
7. **Alcohol Abuse**
8. **Physical Inactivity**

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

	Yes	No	No Opinion
Maternal/Infant Measures	12	1	1
Cancer	13	1	0
Diabetes	13	1	0
Obesity/Overweight	13	1	0
Mental Health	13	1	0
Accessibility/Affordability	14	0	0
Substance Abuse	10	3	1
Physical Activity	12	2	0

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

	Yes	No	No Opinion
Maternal/Infant Measures	13	1	0
Cancer	14	0	0
Diabetes	13	1	0
Obesity/Overweight	12	2	0
Mental Health	12	2	0
Accessibility/Affordability	14	0	0
Substance Abuse	10	4	0
Physical Activity	12	2	0

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

   - *n/a*
   - *The hospital could partner with local resources such as the health department to include evidence based practice to create change in the community and improve upon needs identified.*
   - *None that I can think of at the moment.*
   - *Clearer communication about screenings and what age they need done. For example colonoscopy at age 50. Many people are not hearing these messages even from their doctor and thus are not getting tested and ending up with colon cancer that could have been prevented with earlier screenings. This clearer communication needs to come from the hospital & also from the doctors. With health care costs rising, many people only go to the doctor when they are very sick and thus are not hearing this vital information. The hospital could play a major role in communicating this messaging to the public.*
   - *With aging population we can expect to see a rise in dementia/Alzheimers related symptoms.*
   - *Partnering more with local public health to develop plans to address these issues.*

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

   - *Our population, especially the child-bearing aged population continues to grow and this is extremely important to keep these kinds of services in the community.*
   - *I'm not too knowledgeable in this area. I think you do talk to new mothers about infant issues before leaving the hospital such as naps and having them sleep on their backs, use of car seats, regular check ups pre and post birth.*
   - *When children are born early there are an array of problems that come along with being early so education and prevention of preterm deliveries would benefit the families, the kids and the schools.*
   - *Maternal/Infant health is very important and from the 2013 CHNA it appears that premature births are above average. The mortality rate is around average but could also be improved.*
   - *Premature births and mico preemie births are on the rise and thus the hospital needs to improve their efforts to address this even tho most of these babies will be sent on to Omaha to a larger hospital. The hospital needs to reevaluate their NIC unit and make sure they are equipped to handle premature babies before they are sent to Omaha and afterwards as they transition to home. Possible invest in new, more update, life-saving equipment for premature babies.*
   - *I would suggest that keeping this as a priority is one of the important areas that would be considered by new professionals and companies who are considering moving into this area. Key areas of good care for marternity/infants, cancer, diabetes and accessibility/affordability are priorities in this area.*
   - *Plan Parenthood. I'm all for it. Education young women is a must to know their options and staying healthy.*

- *establishes young families' relationship to the local medical community*

7. **Please share comments or observations about the implementation actions the Hospital has taken to address <u>Maternal/Infant Measures</u>.**

    - *unknown*
    - *Continue with radio spots and newspaper ads as well as education programs at the hospital regarding health care and work with YMCA to educated new parents.*
    - *N/A*
    - *see comments above on question # 6*
    - *No comment*
    - *not informed about past practices*

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

    - *unknown*
    - *Cancer is a concern for everyone and there seems to be higher rates of some cancers in our area. It is important to have resources here and or be able to be directed to other facilities to assist.*
    - *Cancer has continued to be a problem but with many advances in treatment*
    - *This problem is so huge and I am not sure where you can make a difference other than local treatment opportunities.*
    - *Cancer appears to still be a leading cause of death, cancer may not be preventable but screenings and early detection can help.*
    - *Cancer is sweeping across our population and thus the hospital needs to be up-to-date with equipment and doctor staffing to improve on diagnosing and treatment of the various cancers.*
    - *I would suggest that keeping this as a priority is one of the important areas that would be considered by new professionals and companies who are considering moving into this area. Key areas of good care for marternity/infants, cancer, diabetes and accessibility/affordability are priorities in this area.*
    - *No comment.*
    - *incidence of cancer is likely to increase - should PMHC concentrate its resources on areas of highest incidence?*

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

- *unknown*
- *I know PMHC has had workshops on cancer topics. Need to continue such. I don'e know what your attendance is for a lot of your workshops. I know a lot of us don't educate ourselves enough until the problem is on the doorstep. Continue to work with Cancer related prevention issues. Continue to give prevention ideas on the radio every week. I know someone from PMHC is always on KUVR giving tips and information about the hospital. They could continue to give tips in all these areas. cancer, diabetes, obesity, alcohol, drugs, child care, etc.*
- *I believe Holdrege has a great Cancer treatment program.*
- *Screenings and early detection are key.*
- *Improvement is needed by the hospital & staff & doctors to more accurately diagnose cancers and ensure that they are locating the primary site of the cancer to best treat & avoid spreading.*
- *Don't know. Education!!!!! and Physical Annual Follow-up awareness*
- *n/a*

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

- *unknown*
- *Diabetes seems to continue to grow among our population and goes hand in hand with obesity.*
- *I have dealt with many children with diabetes and they have special needs so extra education & support is needed.*
- *I feel one of the significant factors in the increase of Type 2 diabetes is obesity and poor nutrition.*
- *Diabetes is the 4th leading cause of death and type 2 diabetes is preventable with a healthy lifestyle. There are many programs now available to help with the management of diabetes such as the National Diabetes Referral Network.*
- *Dabetes is on the rise with he population and much is to be attributed to our over weight society member. The hospital should increase efforts to communicate best ways to reduce this without just prescribing medication. Offer exercise classes, managed weight loss programs, along with all natural treatment classes and education to eliminate dibetes.*
- *I would suggest that keeping this as a priority is one of the important areas that would be considered by new professionals and companies who are considering moving into this area. Key areas of good care for marternity/infants, cancer, diabetes and accessibility/affordability are priorities in this area.*
- *I am diabetic. education is a must..*
- *tied to obesity for many - on the rise.*

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

- *There seems to be good diabetes education happening.*
- *They have had workshops on diabetes. Perhaps have local people on radio spots that others may know and relate to. This may generate a person to talk to and or educated themselves or come to program you have. When people hear someone they know has cancer, etc. it often times makes them examine their life and perhaps get a physical, colonoscopy, breast xray, etc since it hits close to home.*
- *I have not worked with the hospital on this issue*
- *N/A*
- *See question # 10*
- *Affordability Act is a essential to continue and help those in need of any specifics.*
- *n/a*

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

- *unknown*
- *Work with the YMCA and schools to emphasize exercise and proper eating habits.*
- *I continue to see rising BMIs and have done teaching but this really needs to be reinforced*
- *Eating healthy and living a healthy lifestyle is so very important. Many health issues are directly related to obesity.*
- *Healthy eating is below the state average and there is a significant amount of fast food restaurants in the community.*
- *See question # 10*
- *No comment*
- *the hospital could lead by example*

13. **Please share comments or observations about keeping <u>Mental Health</u> among the most significant needs for the Hospital to address.**

- *unknown*
- *Mental Health issues seem to continue to grow in our area and appears to be difficult for low income people to obtain funds for assistance, to travel to other communities for counseling and perhaps the lack of trained personnel for Mental Health issues.*
- *I deal with this minimally so don't know a lot about this but I have seen some teens struggle with depression*

and feel it needs to be addressed and watched closely.

- *Mental health is a major concern and there is continuously a lack of mental health provides and resources.*
- *All ages need improved communication and education on sucicide prevention and recognizing signs and steps to follow.*
- *does Phelps support any mental health providers in their clinics? I haven't heard of any advertised.*
- *For Veterans coming home. There is a need for accessibility to help those in need with mental illness. And as well as for everyone in need.*
- *one of the most difficult medical services to deliver - and most expensive. does PMHC offer acute in-patient or only out-patient services?*

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

- *unknown*
- *I know PMHC has had workshops on Alzheimer's which is great. Perhaps needs additional topics on mental health issues (bipolar and others)*
- *These programs are needed by many. As a school nurse I do have access to some reduced cost items for vision*
- *Accessibility and affordability will continuously be a concern and cannot be solved in a short period of time.*
- *Making sure doctors are not prescribing certain types of medication to a depressed person that can lead to suicide. Having staff it down with family members and educating them on signs to watch for, daily routines that can help, what to do in a crisis, and general suicide prevention steps.*
- *Phelps is way to expensive. I go to Kearney*
- *I would suggest that keeping this as a priority is one of the important areas that would be considered by new professionals and companies who are considering moving into this area. Key areas of good care for marternity/infants, cancer, diabetes and accessibility/affordability are priorities in this area.*
- *Sustaining accessibility and affordability is good. We need to find ways of improving the both.*
- *most cost drivers are outside PMHC control. regulatory-reporting burden is a major contributor to expense. important to have transparency with patients regarding the entire process. up-front knowledge helps.*

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

- *unknown*
- *I don't know about affordability. I know PMHC does what it can to bring in doctors, and education programs for the public. I don't know if it is feasible for PMHC to run a shuttle for those who can't make it to the*

hospital or doctor appointments. I know there is a handi-bus and maybe there is not a problem for people getting to a medical facility to see a doctor.

- *Budgets and fees need to be restructured as many community members can not afford the necessary health care and even with insurance they can't always be seen when they are ill. Great improvement is needed in this area that will benefit the entire community.*
- *Living in an low-income rural area; there is a need for accessibility and affordability for all..*
- *n/a*

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

- *unknown*
- *Alcohol abuse is a problem all across our country as well as Phelps County. I know the Phelps County Safety Coalition has addressed alcohol and other safety issues in the county and has brought in speakers and programs for students. It is important for parents to get into the loop and become educated on alcohol and drug issues rather than wait for it to hit their family.*
- *I feel alcohol & drug abuse will always be a problem and education is key to help with this.*
- *I am not aware that the hospital plays a part in alcohol/drug awareness and abuse.*
- *Our schools are helping communicate messaging about alcohol & substance abuse to kids at young ages which is helping them make informed choices and this need to continue. Our courts need much stricter penalties for underage drinking and driving & DWI & DUI to help ensure the safety of community members. Often they barely get a hand spank and are out there drinking & driving again and endangering innocent lives.*
- *Promoting more rehabilitation*
- *alcohol and substance abuse is often treated only after an unscheduled interaction with law enforcement. it would be nice to see something that engaged people in a less intensive environment on a proactive basis.*

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

- *unknown*
- *I personally believe physical activity has gone down among youth and some adults due to TV, Social networking, computer games, cell phones, etc.*
- *The hospital is very supportive of all physical activities that are available in Holdrege. We need to keep these going and need to maybe move these programs into more schools.*
- *Physical Activity is lower than average and physical activity is linked to overweight/obesity and a healthy lifestyle.*

- *See answer to # 10*
- *Well fitness centers*
- *can produce more positive results than many other initiatives IF it can be launched as an ongoing program(s) that are FUN. Exercise leads to good results but people avoid the drudgery of routine - needs to be presented as a menu of entertaining activities.*

18. Please share comments or observations about the implementation actions the Hospital has taken to address <u>Physical Activity</u>.

- *unknown*
- *Work with the YMCA to implement activities/programs at the YMCA, YMCA preschool, Head Start and other area preschools. I don't know if there is a way to incorporate physical activity through social media????*
- *As I said they are very supportive and sponsor many activities.*
- *Offer hands on training of physical activity with exercise equipment with trainers and physical therapists and tie it in to an event like a health fair with a different 7 catchy name. People learn best when someone shows or demonstrates it to them. Work with the YMCA to offer more affordable pricing for all individuals to benefit from the exercise equipment.*
- *n/a*

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

- *I think PMHC does a fantastic job in bringing in specialists. I hope they can continue to find the specialists willing to come to Holdrege to meet the needs listed in this survey.*
- *No*
- *no*
- *Perhaps record video of trainers or physical therapists addressing use of exercise equipment and post it on your website. Offer free night of exercise once a week or once a month to help combat obesity and diabetes. Bring in keynotes who specialize in these fields and offer some food with it & invite the public to come get informed. Reevaluate existing medical equipment and invest in new improved equipment where needed including exercise equipment that the public can utilize.*
- *Phelps Memorial has a great customer base because of the the number of doctors who practice in Holdrege. Also, the number of visiting physicians is a great plus. Replacing physicians who retire is a community concern.*
- *PMHC could be the catalyst for healthy living - a rural think tank devoted to engaging its service area in creative activities that enrich our lives.*

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

Need Topic	Total Votes	Number of Local Experts Voting for Needs	Percent of Votes	Cumulative Votes	Need Determination
Cancer - 2013 Significant Need	250	8	9.72%	9.72%	Significant Needs
Diabetes - 2013 Significant Need	171	8	6.65%	16.37%	
Obesity/Overweight - 2013 Significant Need	161	7	6.26%	22.63%	
Physical Inactivity - 2013 Significant Need	155	7	6.03%	28.65%	
Mental Health - 2013 Significant Need	154	8	5.99%	34.64%	
Accessibility/Affordability - 2013 Significant Need	145	7	5.64%	40.28%	
Heart Disease	137	7	5.33%	45.61%	
Stroke	135	7	5.25%	50.86%	
Education/Prevention	131	6	5.09%	55.95%	Other Identified Needs
Maternal/Infant Measures - 2013 Significant Need	129	7	5.02%	60.96%	
Alzheimer's	124	5	4.82%	65.79%	
Lung Disease	124	6	4.82%	70.61%	
Kidney Disease	117	6	4.55%	75.16%	
Substance Abuse - 2013 Significant Need	114	8	4.43%	79.59%	
Chronic Lower Respiratory Disease	114	4	4.43%	84.02%	
Smoking	103	7	4.00%	88.02%	
Dental	93	4	3.62%	91.64%	
Flu/Pneumonia	93	4	3.62%	95.26%	
Accidents	69	6	2.68%	97.94%	
Life Expectancy	53	5	2.06%	100.00%	
Total	2572		100.00%		

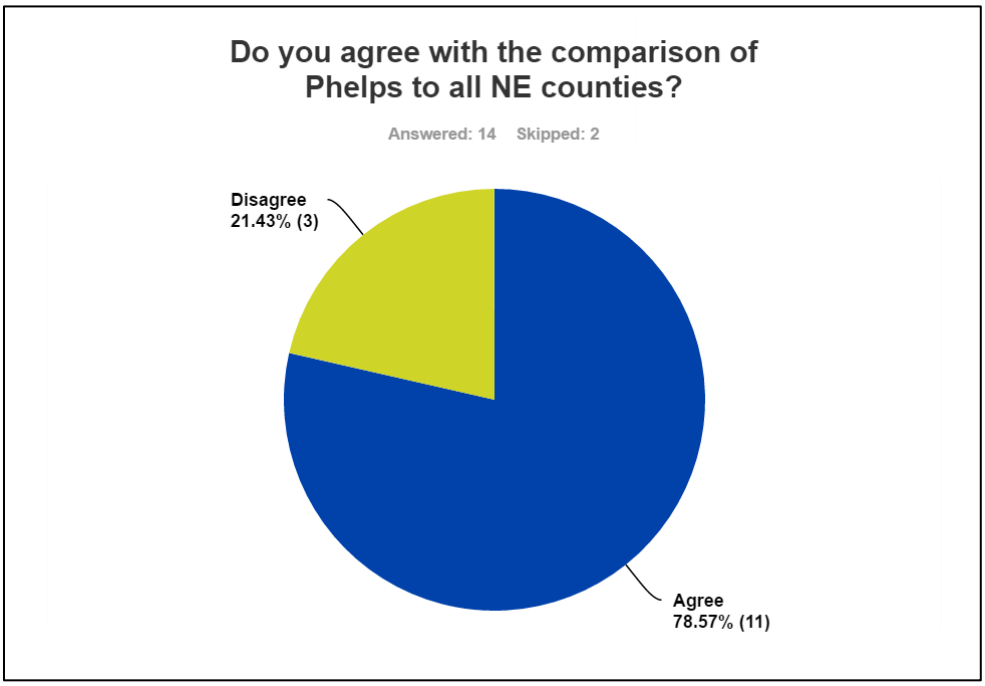
Individuals Participating as Local Expert Advisors[36]

Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	1	12	13
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	1	12	13
3) Priority Populations	5	9	14
4) Representative/Member of Chronic Disease Group or Organization	1	12	13
5) Represents the Broad Interest of the Community	15	0	15
Other			
Answered Question			16
Skipped Question			0

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

Advice Received from Local Expert Advisors

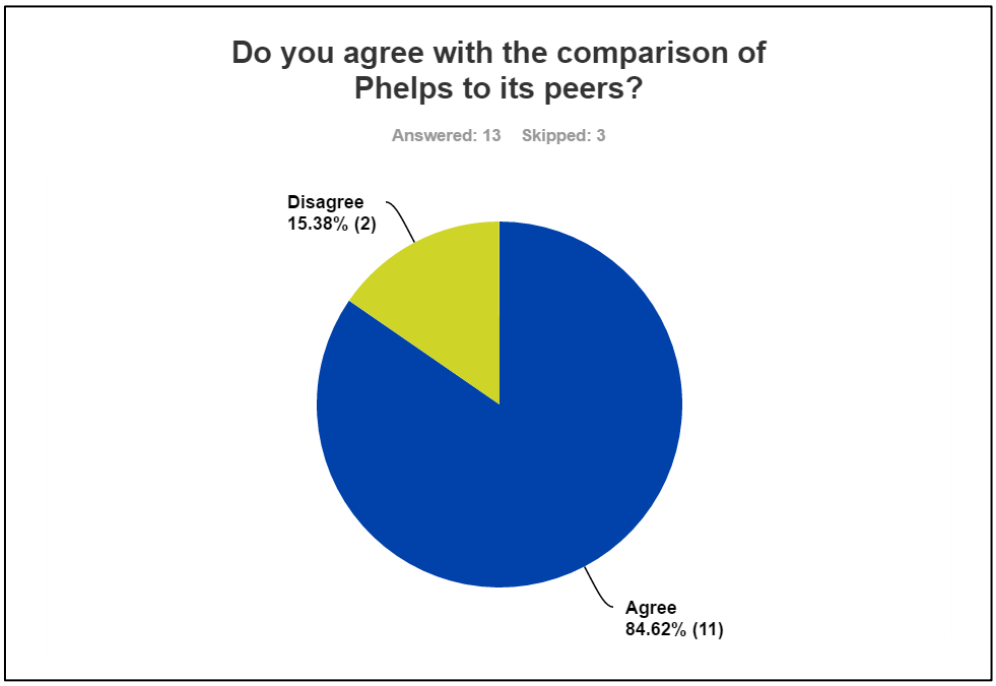
Question: Do you agree with the observations formed about the comparison of Phelps County to all other Nebraska counties?



Comments:

- *I agree but only because I have no knowledge of this data.*
- *I have no basis to disagree with the statistical*
- *I would think exercise opportunities are above the NE and US average.*
- *I'm not sure about all of these data items, but it seems to me that with the YMCA we have good access to exercise opportunities and I've always thought we have plenty of dentists. It seems like PMHC does a good job with education classes on some of these issues. Better access to mental health providers would be good.*

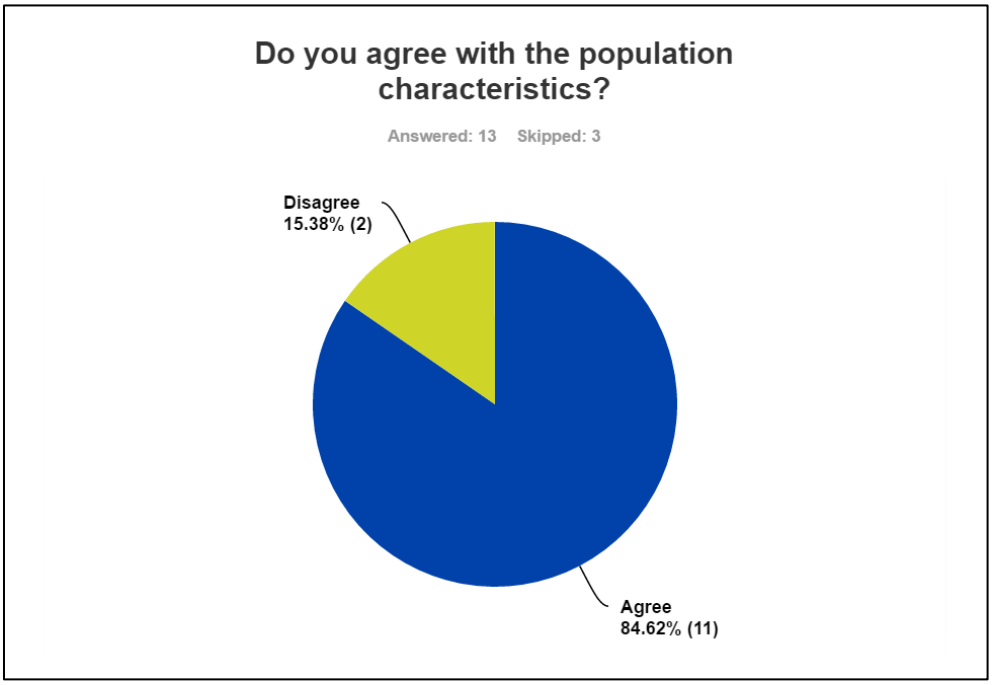
Question: Do you agree with the observations formed about the comparison of Phelps County to its peer counties?



Comments:

- *Seems that the data on CLRD and Alzheimer's are statistically indistinguishable from the average. Ranking in this situation is almost pointless.*
- *I think we have an exceptionally large elderly population due to 3 large nursing homes. Sometimes our health numbers could be 'out of wack' because of that.*

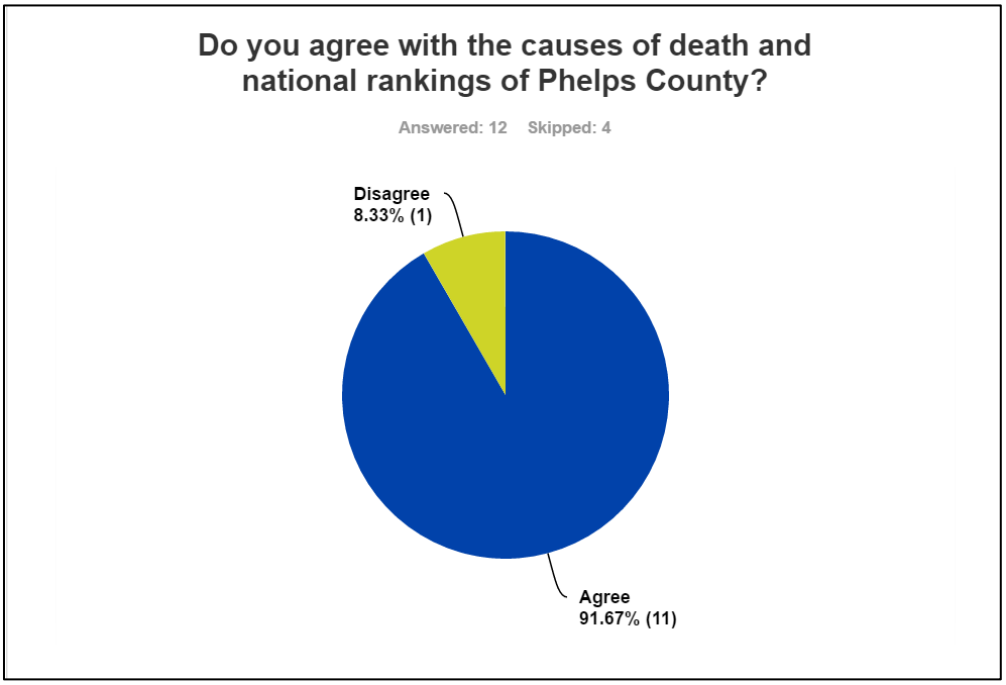
Question: Do you agree with the observations formed about the population characteristics of Phelps County?



Comments:

- *Disagree on the census population for Phelps County as well as disagree on the medium home value.*

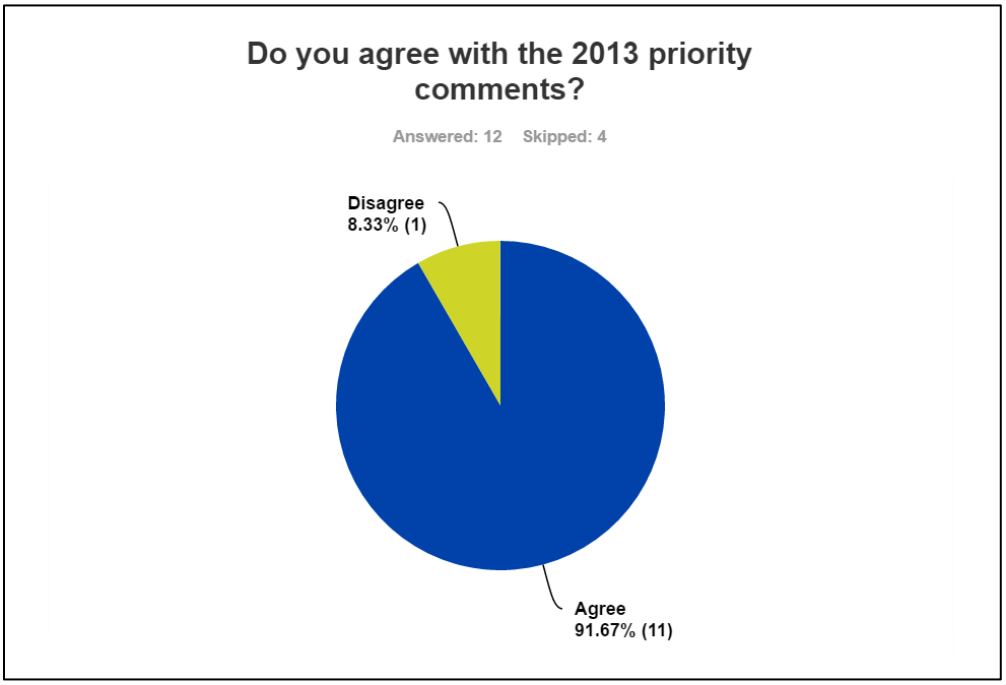
Question: Do you agree with the observations formed from the national rankings and leading causes of death?



Comments:

- *Fundamentally, youth and young adult culture in this community is strongly connected to alcohol.*
- *I am amazed at the number of people who smoke knowing the health risk. Obesity is also rampant...and disturbing among children.*

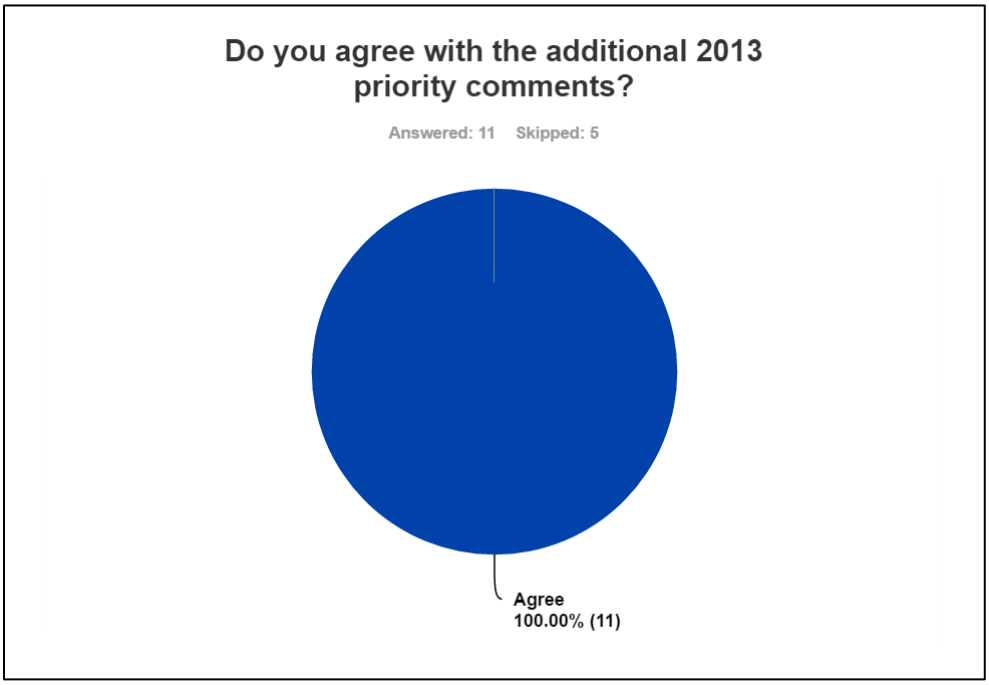
Question: Do you agree with the written comments received on the 2013 CHNA?



Comments:

- *The combination of Obesity, alcohol, and physical inactivity is a triad of self-defeating problems that needs to be addressed in a holistic way.*
- *Demographics suggest that Alzheimer's will grow, perhaps rapidly, within our service territory. We need to be prepared to not only treat but train physicians to recognize and diagnose dementia in a way that the whole family can become prepared. This is a very difficult condition for care givers to accept and deal with.*

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



Comments:

- *When everyone thinks everything is important, nothing is important.*

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

The National Healthcare Quality and Disparities Reports (QDR) (annual reports to Congress mandated in the Healthcare Research and Quality Act of 1999 (P.L. 106-129)) are based on more than 250 measures of quality and disparities covering a broad array of healthcare services and settings. Data are generally available through 2012, although rates of un-insurance have been tracked through the first half of 2014. The reports are produced with the help of an Interagency Work Group led by the Agency for Healthcare Research and Quality (AHRQ) and submitted on behalf of the Secretary of Health and Human Services (HHS).

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

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

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

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

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

Trends

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

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

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

Trends

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

Disparities

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

Trends

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

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

Trends

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

Disparities

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

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

Disparities

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

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[39] In this report, racial groups such as Blacks and Whites are non-Hispanic, and Hispanics include all races.
[40] Long SK, Karpman M, Shartzer A, et al. Taking Stock: Health Insurance Coverage under the ACA as of September 2014. http://hrms.urban.org/briefs/Health-Insurance-Coverage-under-the-ACA-as-of- September-2014.html

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

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

Disparity Trends

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

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

Trends

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

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

Trends

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

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

Achieved Success

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

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

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

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

Improving Quickly

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

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

time of surgery

Worsening

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

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

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

Disparities

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

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

Disparity Trends

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

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

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

Disparities Trends

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

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

Geographic Disparities

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

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

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

Trends

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

Disparities Trends

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

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

Trends

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

Disparities

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

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

Disparities Trends

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

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

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

Trends

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

Disparities

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

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

Trends

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

Disparities

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

Disparities Trends

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

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

Trends

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

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

Disparities

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

Disparities Trends

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

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

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

Trends

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

Disparities

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

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

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

CONCLUSION

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

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

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

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

Community Health Need Assessment Illustrative Answers

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

   No

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

   No

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

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

      See footnotes 17 and 19 on page 12

   b. **Demographics of the community**

      See footnote 20 on page 13

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

      See footnote 26 on page 31 and footnote 28 on page 33

   d. **How data was obtained**

      See footnote 11 on page 8

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

      See footnote 25 on page 30

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

      See footnote 12 on page 9

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

      See footnote 36 on page 61

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

      See footnotes 8 and 9 on page 7

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

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

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

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

N/A

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

2013

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

Yes; see footnote 15 on page 10 and footnote 35 on page 51

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

No

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

Yes; see footnote 4 on page 4 and footnote 7 on page 7

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

Yes

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

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

https://www.phelpsmemorial.com/Information/CommunityHealthNeedsAssessment.aspx

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

No other website

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

Yes

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

No other effort

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

See footnotes 33 and 34 on page 49

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

   2013

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

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

       https://www.phelpsmemorial.com/Information/CommunityHealthNeedsAssessment.aspx

    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 26 on page 31

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