Three Rivers Health

Three Rivers, Michigan

Community Health Needs Assessment
and Implementation Strategy

Adopted by Board Resolution December 19th, 2019[1]

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

Dear Community Member:

At Three Rivers Health (TRH), we have spent more than 60 years providing high-quality compassionate healthcare to the greater Three Rivers community. The “2019 Community Health Needs Assessment” identifies local health and medical needs and provides a plan of how Three Rivers Health (TRH) 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.

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

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

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

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

Thank You,

David Shannon
Chief Executive Officer
Three Rivers Health

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EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

Three Rivers Health ("TRH" or the "Hospital") has performed a Community Health Needs Assessment to determine the health needs of the local community.

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

The 2019 Significant Health Needs identified for St. Joseph County are:

1. Mental Health – 2016 Significant Need
2. Affordability
3. Accessibility
4. Drug/Substance Abuse – 2016 Significant Need
5. Suicide – 2016 Significant Need
6. Obesity – Significant Need
7. Education/Prevention – 2016 Significant Need

The Hospital has developed implementation strategies for these seven needs including activities to continue/pursue, community partners to work alongside, and measures to track progress.

APPROACH

APPROACH

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

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

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

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

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

Project Objectives

TRH 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 – Schedule H (Form 990)
- Produce the information necessary for the Hospital to issue an assessment of community health needs and document its intended response

Overview of Community Health Needs Assessment

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

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

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

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

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

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

Specifically, the IRS requires:

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

Community Health Needs Assessment Subsequent to Initial Assessment

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

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

[5] Section 6652

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

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

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

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

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

To complete a CHNA:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Other (please specify)

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

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

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

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

existed in their portion of the county.[10]

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

Data sources include:[11]

Website or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of St. Joseph County compared to all Michigan counties	July 16, 2019	2012-2018
IBM Watson Health (formerly known as Truven Health Analytics)	Assess characteristics of the hospital's primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according to the proportion of each group in the entire area; and, to access population size, trends and socio-economic characteristics	July 16, 2019	2019
http://svi.cdc.gov	To identify the Social Vulnerability Index value	July 17, 2019	2012-2016
http://www.healthdata.org/us-county-profiles	To look at trends of key health metrics over time	July 17, 2019	2014
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	July 17, 2019	2017

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

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

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

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

needs of priority populations. Local Expert Advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and the Hospital's desire to represent the region's geographically and ethnically diverse population. Community input from 27 Local Expert Advisors was received. Survey responses started September 10th, 2019 and ended on October 8th, 2019.

- Information analysis augmented by local opinions showed how St. Joseph County relates to its peers in terms of primary and chronic needs and other issues of uninsured persons, low-income persons, and minority groups. Respondents commented on whether they believe certain population groups ("Priority Populations") need help to improve their condition, and if so, who needs to do what to improve the conditions of these groups.[12] [13]
- Local opinions of the needs of Priority Populations, while presented in its entirety in the Appendix, was abstracted in the following "take-away" bulleted comments
  - Top three priority populations in the area are low-income groups, children, and residents of rural areas
  - There should be a focus on providing affordable and accessible care to the community

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

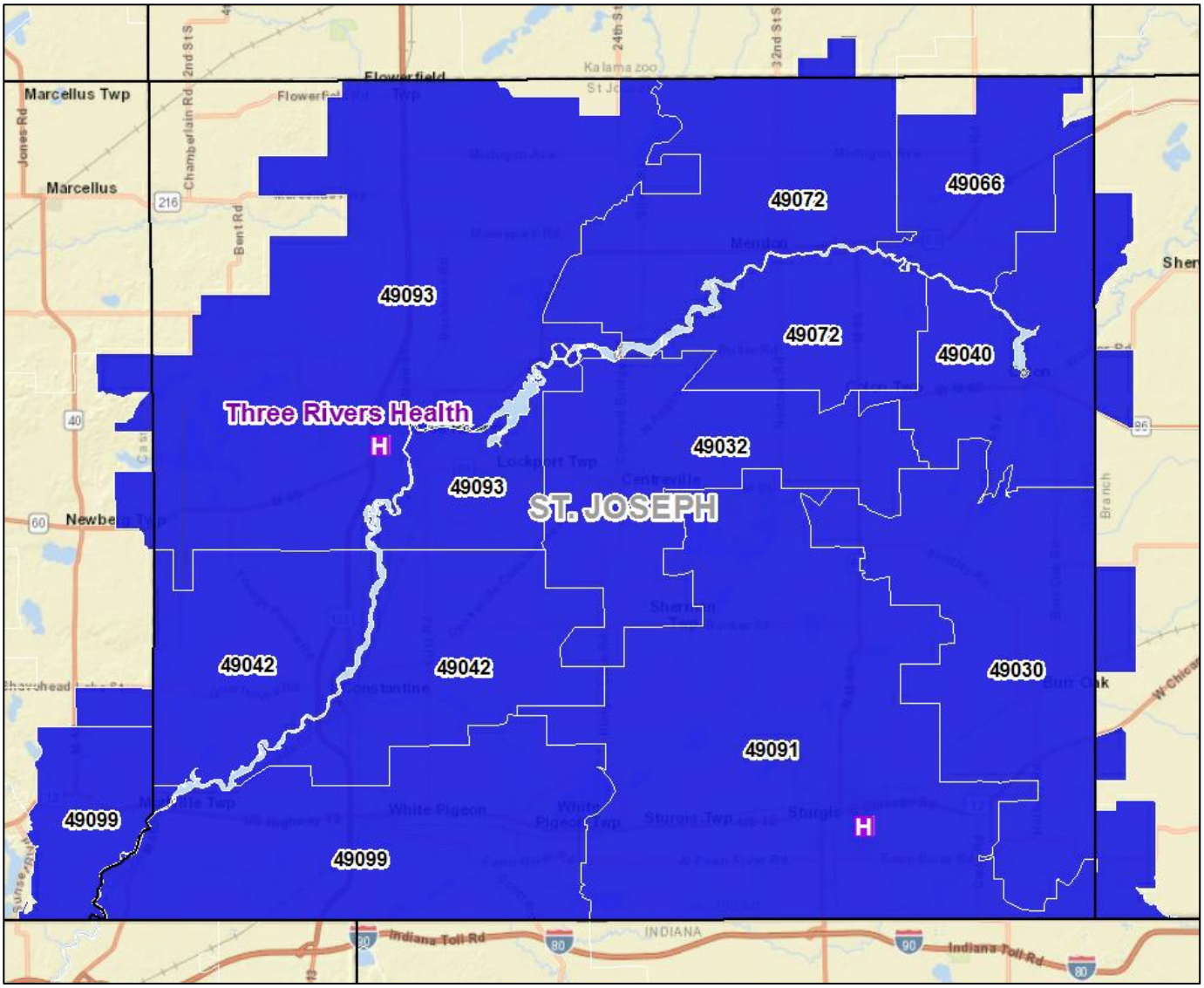
In the TRH process, each Local Expert had the opportunity to introduce needs previously unidentified and to challenge conclusions developed from the data analysis. While there were a few opinions of the data conclusions not being completely accurate, most of the comments agreed with the findings. A list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

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

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

COMMUNITY CHARACTERISTICS

Definition of Area Served by the Hospital[16]



For the purposes of this study, Three Rivers Health defines its service area as St. Joseph County in Michigan, which includes the following ZIP codes:[17]

49030 – Burr Oak	49032 – Centreville	49040 – Colon	49042 – Constantine	49066 – Leonidas
49072 – Mendon	49091 – Sturgis	49093 – Three Rivers	49099 – White Pigeon	

During 2017, the Hospital received 81.2% of its Medicare inpatients from this area.[18]

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

Demographics of the Community[19] [20]

Variable	St. Joseph County 2019	St. Joseph County 2024	St. Joseph County %Change	Michigan 2019	Michigan 2024	Michigan %Change	United States 2019	United States 2024	United States %Change
DEMOGRAPHIC CHARACTERISTICS									
Total Population	61,516	61,692	0.3%	9,988,842	10,074,380	0.9%	329,236,175	340,950,067	3.6%
Total Male Population	30,673	30,770	0.3%	4,915,481	4,961,189	0.9%	162,097,263	167,921,866	3.6%
Total Female Population	30,843	30,922	0.3%	5,073,361	5,113,191	0.8%	167,138,912	173,028,201	3.5%
Females, Child Bearing Age (15-44)	10,750	10,909	1.5%	1,881,405	1,879,399	-0.1%	64,251,309	65,231,610	1.5%
Average Household Income	$65,695			$80,341			$89,646		
POPULATION DISTRIBUTION									
Age Distribution									
0-14	12,386	12,177	-1.7%	1,768,017	1,730,249	-2.1%	61,258,096	61,645,382	0.6%
15-17	2,581	2,590	0.3%	392,436	383,296	-2.3%	12,813,020	13,319,388	4.0%
18-24	5,368	5,675	5.7%	990,674	979,286	-1.1%	31,474,821	32,296,411	2.6%
25-34	7,085	7,166	1.1%	1,262,883	1,265,922	0.2%	44,370,805	43,645,423	-1.6%
35-54	14,268	13,534	-5.1%	2,436,937	2,356,706	-3.3%	83,304,733	84,255,193	1.1%
55-64	8,591	7,963	-7.3%	1,402,195	1,377,528	-1.8%	42,525,512	43,333,585	1.9%
65+	11,237	12,587	12.0%	1,735,700	1,981,393	14.2%	53,489,188	62,454,685	16.8%
HOUSEHOLD INCOME DISTRIBUTION									
Total Households	23,496	23,619	0.5%	3,968,532	4,021,850	1.3%	125,018,838	129,683,911	3.7%
2019 Household Income									
<$15K	2,463			436,858			13,139,420		
$15-25K	2,419			384,833			11,333,086		
$25-50K	6,559			921,284			26,888,001		
$50-75K	4,837			705,512			21,157,116		
$75-100K	3,012			490,025			15,409,735		
Over $100K	4,206			1,030,020			37,091,480		
EDUCATION LEVEL									
Pop Age 25+	41,181			6,837,715			223,690,238		
2019 Adult Education Level Distribution									
Less than High School	2,274			207,557			12,173,720		
Some High School	3,507			456,928			16,245,471		
High School Degree	16,020			2,007,210			61,068,735		
Some College/Assoc. Degree	13,108			2,249,721			64,945,355		
Bachelor's Degree or Greater	6,272			1,916,299			69,256,957		
RACE/ETHNICITY									
2019 Race/Ethnicity Distribution									
White Non-Hispanic	52,882			7,458,452			197,594,684		
Black Non-Hispanic	1,549			1,374,654			40,877,627		
Hispanic	5,037			526,836			60,675,779		
Asian & Pacific Is. Non-Hispanic	415			327,101			19,327,168		
All Others	1,633			301,799			10,760,917		

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

Consumer Health Service Behavior[21]

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

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

Health Service Topic	Demand as % of National	% of Population Affected
Weight / Lifestyle		
BMI: Morbid/Obese	115.8%	35.4%
Vigorous Exercise	100.1%	57.2%
Chronic Diabetes	101.5%	15.9%
Healthy Eating Habits	91.0%	21.2%
Ate Breakfast Yesterday	97.2%	76.9%
Slept Less Than 6 Hours	110.8%	15.1%
Consumed Alcohol in the Past 30 Days	83.1%	44.6%
Consumed 3+ Drinks Per Session	107.4%	30.2%
Behavior		
Search for Pricing Info	86.5%	23.3%
I am Responsible for My Health	101.4%	91.8%
I Follow Treatment Recommendations	101.5%	78.2%
Pulmonary		
Chronic COPD	126.6%	6.8%
Chronic Asthma	108.6%	12.8%
Heart		
Chronic High Cholesterol	101.0%	24.7%
Routine Cholesterol Screening	91.9%	40.8%
Chronic Heart Failure	159.3%	6.4%

Health Service Topic	Demand as % of National	% of Population Affected
Cancer		
Cancer Screen: Skin 2 yr	79.7%	8.6%
Cancer Screen: Colorectal 2 yr	91.3%	18.8%
Cancer Screen: Pap/Cerv Test 2 yr	88.5%	42.7%
Routine Screen: Prostate 2 yr	90.6%	25.7%
Orthopedic		
Chronic Lower Back Pain	112.1%	34.6%
Chronic Osteoporosis	103.0%	10.4%
Routine Services		
FP/GP: 1+ Visit	101.4%	82.4%
NP/PA Last 6 Months	104.3%	43.2%
OB/Gyn 1+ Visit	88.9%	34.1%
Medication: Received Prescription	105.2%	61.5%
Internet Usage		
Use Internet to Look for Provider Info	77.5%	30.9%
Facebook Opinions	76.3%	7.7%
Looked for Provider Rating	77.5%	18.2%
Emergency Services		
Emergency Room Use	106.4%	37.0%
Urgent Care Use	90.7%	29.9%

[21] Claritas (accessed through IBM Watson Health)

Conclusions from Demographic Analysis Compared to National Averages

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

- 15.8% more likely to have a **BMI of Morbid/Obese**, affecting 35.4%
- 7.4% more likely to **Consume 3+ Drinks per Session**, affecting 30.2%
- 8.1% less likely to receive **Routine Cholesterol Screenings**, affecting 40.8%
- 11.5% less likely to receive **Cervical Cancer Screening every 2 years**, affecting 42.7%
- 12.1% more likely have **Chronic Lower Back Pain**, affecting 34.6%
- 11.1% less likely to receive **Routine OB/Gyn Visit**, affecting 34.1%
- 6.5% more likely to visit the **Emergency Room (for non-emergent issues)**, affecting 37.0%

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

- 16.9% less likely to have **Consumed Alcohol in the Past 30 Days**, affecting 44.6%

Leading Causes of Death[22]

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

Cause of Death			Rank among all counties in MI (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation (St. Joseph County Compared to U.S.)
MI Rank	St. Joseph Rank	Condition		MI	St. Joseph	
1	1	Heart Disease	12 of 83	196.0	251.1	Higher than expected
2	2	Cancer	19 of 83	161.3	192.8	Higher than expected
3	3	Lung	30 of 83	44.3	52.6	Higher than expected
4	4	Accidents	21 of 83	52.9	47.8	As expected
5	5	Stroke	39 of 83	39.2	46.6	Higher than expected
7	6	Diabetes	5 of 83	22.1	36.2	Higher than expected
6	7	Alzheimer's	63 of 83	34.4	21.4	Lower than expected
9	8	Flu - Pneumonia	42 of 83	14.1	16.6	As expected
8	9	Kidney	31 of 83	14.7	14.5	As expected
10	10	Suicide	47 of 83	14.1	13.8	As expected
11	11	Liver	63 of 83	10.9	8.7	As expected
12	12	Blood Poisoning	35 of 83	9.8	7.9	As expected
13	13	Parkinson's	48 of 83	8.5	7.0	As expected
14	14	Hypertension	52 of 83	7.3	5.4	As expected
15	15	Homicide	42 of 82	6.2	1.9	As expected

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

Priority Populations[23]

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

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

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

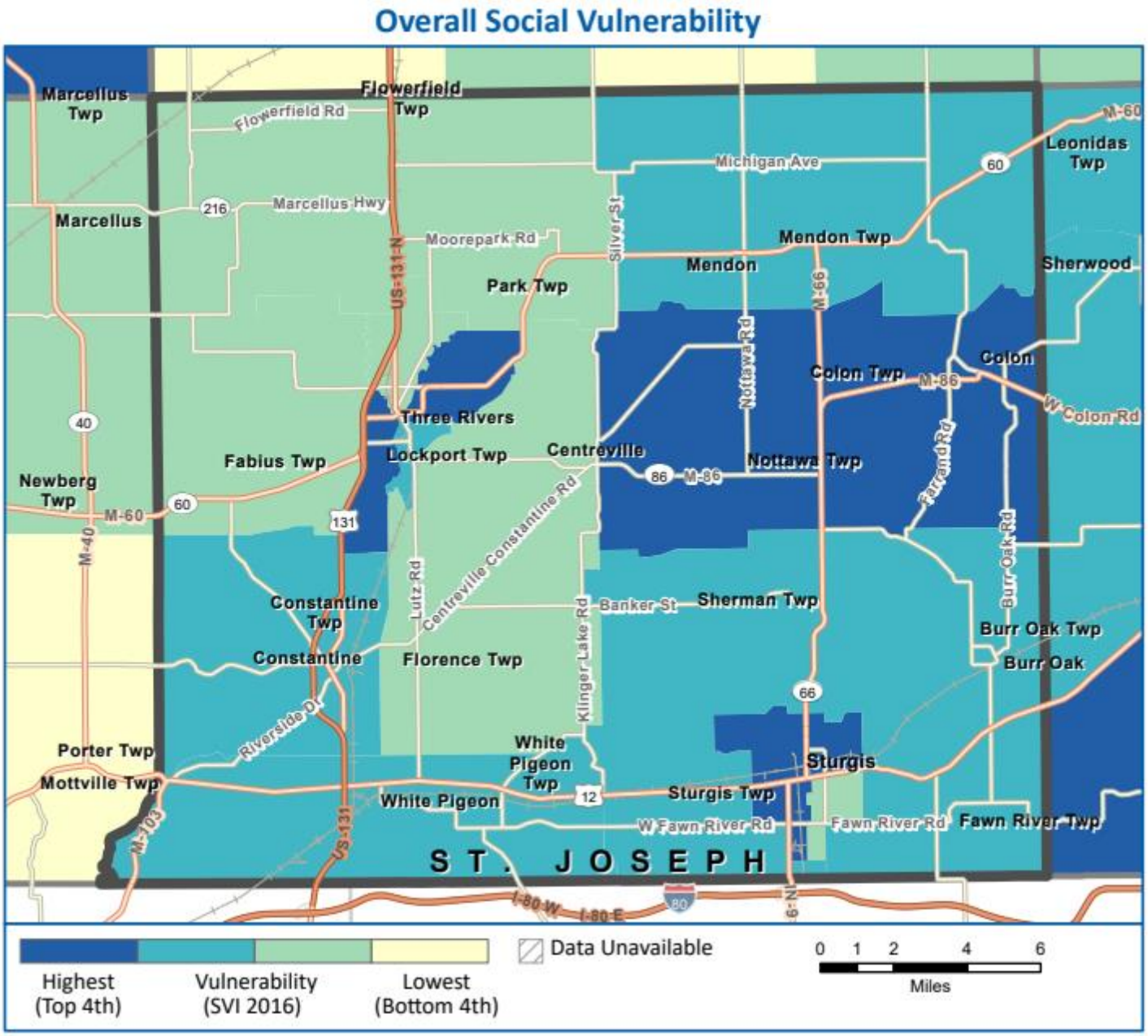
- Top three priority populations in the area are low-income groups, children, and residents of rural areas
- There should be a focus on providing affordable and accessible care to the

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

Social Vulnerability[25]

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

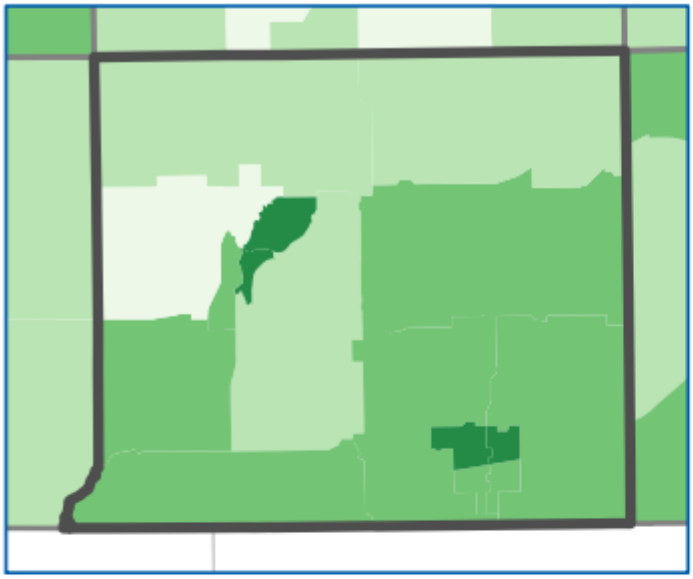
Overall, St. Joseph County falls into three of the four quartiles of social vulnerability. The regions in the light green (2nd quartile) have the lower social vulnerability in the county. The regions in dark blue (4th quartile) have the highest social vulnerability. The lower the vulnerability the better.



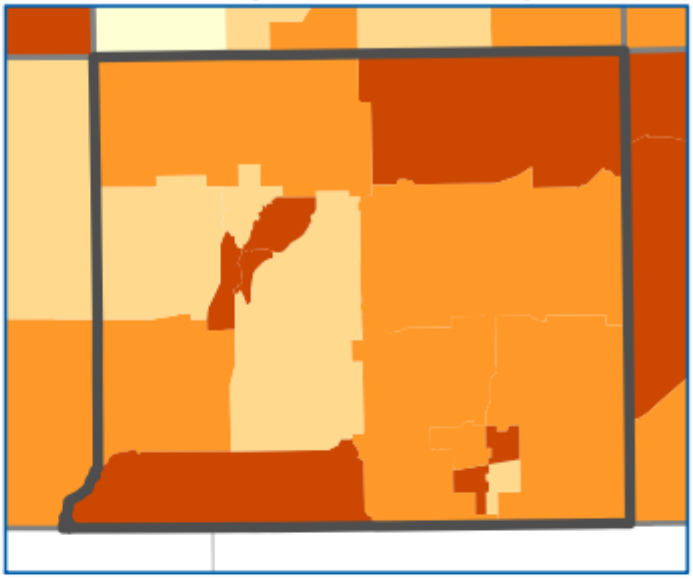
[25] http://svi.cdc.gov

SVI Themes

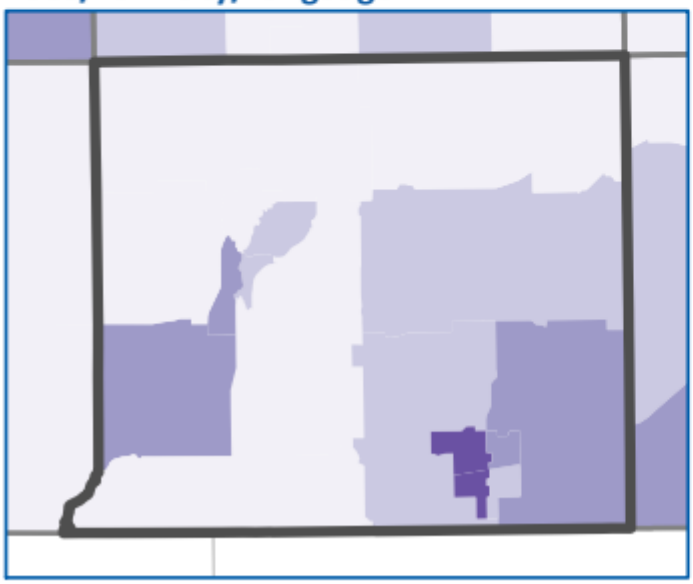
Socioeconomic Status



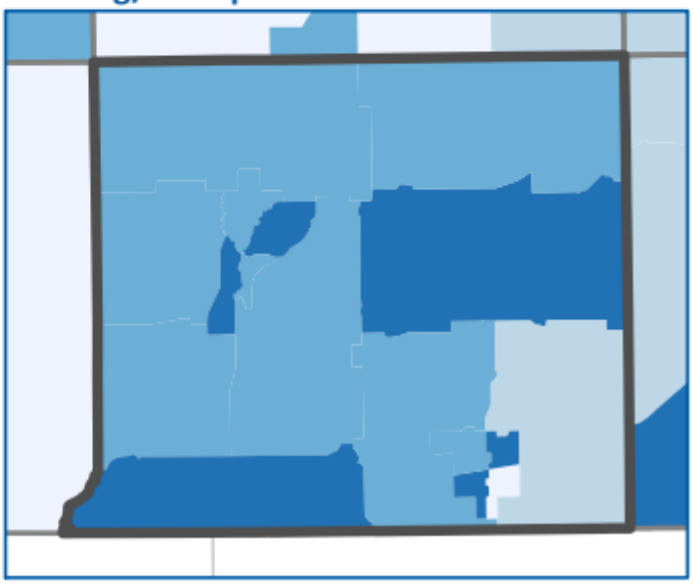
Household Composition/Disability



Race/Ethnicity/Language



Housing/Transportation



Comparison to Other State Counties[26]

To better understand the community, St. Joseph County has been compared to all 83 counties in the state of Michigan across six areas: Length of Life, Quality of Life, Health Behaviors, Clinical Care, Social & Economic Factors, and Physical Environment.

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

	St. Joseph	Michigan	U.S. Median
Length of Life			
Overall Rank *(best being #1)*	**51/83**		
- Premature Death*	7,700	7,600	8,100
Quality of Life			
Overall Rank *(best being #1)*	**58/83**		
- Poor or Fair Health	17%	17%	17%
- Poor Physical Health Days	4.1	4.3	3.9
- Poor Mental Health Days	4.1	4.4	3.9
- Low Birthweight	8%	8%	8%
Health Behaviors			
Overall Rank *(best being #1)*	**61/83**		
- Adult Smoking	20%	20%	17%
- Adult Obesity	31%	32%	32%
- Physical Inactivity	30%	22%	26%
- Access to Exercise Opportunities	54%	85%	66%
- Excessive Drinking	20%	21%	17%
- Alcohol-Impaired Driving Deaths	35%	29%	28%
- Sexually Transmitted Infections*	322.9	462.9	321.7
- Teen Births *(per 1,000 female population ages 15-19)*	37	22	31
Clinical Care			
Overall Rank *(best being #1)*	**69/83**		
- Uninsured	8%	6%	10%
- Population to Primary Care Provider Ratio	3,380:1	1,260:1	2,050:1
- Population to Dentist Ratio	2,770:1	1,360:1	2,450:1
- Population to Mental Health Provider Ratio	580:1	400:1	970:1
- Preventable Hospital Stays	4,781	5,188	4,648
- Mammography Screening	43%	43%	40%
- Flu vaccinations	42%	45%	42%
Social & Economic Factors			
Overall Rank *(best being #1)*	**25/83**		
- Unemployment	4.3%	4.6%	4.4%
- Children in Poverty	19%	20%	21%
- Children in Single-Parent Households	32%	34%	32%
- Violent Crime*	301	443	205
- Injury Deaths*	73	72	82
Physical Environment			
Overall Rank *(best being #1)*	**47/83**		
- Air Pollution - Particulate Matter	12.6 $\mu g/m^3$	8.4 $\mu g/m^3$	9.2 $\mu g/m^3$
- Severe Housing Problems	14%	16%	14%

Per 100,000 Population

[26] www.countyhealthrankings.org

Conclusions from Other Statistical Data[27]

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

St. Joseph County	Current Statistic (2014)	Percent Change (1980-2014)
UNFAVORABLE St. Joseph County measures that are **WORSE** than the U.S. average and had an **UNFAVORABLE** change		
- Female Tracheal, Bronchus, and Lung Cancer*	57.8	79.3%
- Female Diabetes, Urogenital, Blood, and Endocrine Disease Deaths*	65.4	43.3%
- Male Diabetes, Urogenital, Blood, and Endocrine Disease Deaths*	80.1	35.0%
UNFAVORABLE St. Joseph County measures that are **WORSE** than the U.S. average and had a **FAVORABLE** change		
- Female Life Expectancy	79.4	2.4%
- Male Life Expectancy	75.0	6.5%
- Female Heart Disease*	203.7	-24.2%
- Male Heart Disease*	271.3	-48.6%
- Male Tracheal, Bronchus, and Lung Cancer*	84.2	-21.1%
- Female Transport Injuries Related Deaths*	12.5	-36.5%
- Male Transport Injuries Related Deaths*	31.4	-33.6%
DESIRABLE St. Joseph County measures that are **BETTER** than the US average and had an **UNFAVORABLE** change		
N/A		
DESIRABLE St. Joseph County measures that are **BETTER** than the US average and had a **FAVORABLE** change		
- Male Stroke*	46.5	-47.3%
AVERAGE St. Joseph County measures that are **EQUAL** to the US average and had an **UNFAVORABLE** change		
- Female Skin Cancer*	2.2	21.1%
- Male Skin Cancer*	5.4	59.4%
- Female Self-Harm and Interpersonal Violence Related Deaths*	8.5	0.1%
- Male Self-Harm and Interpersonal Violence Related Deaths*	29.2	5.9%
- Female Mental and Substance Use Related Deaths*	8.9	614.9%
- Male Mental and Substance Use Related Deaths*	18.4	424.4%
- Female Liver Disease Related Deaths*	11.7	10.1%
- Male Liver Disease Related Deaths*	21.4	10.2%
AVERAGE St. Joseph County measures that are **EQUAL** to the US average and had a **FAVORABLE** change		
- Female Stroke*	46.2	-45.0%
- Female Breast Cancer*	26.3	-27.9%
- Male Breast Cancer*	0.4	-2.9%

*rate per 100,000 population, age-standardized

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

Community Benefit

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

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

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

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

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

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

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

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

- $44,237

IMPLEMENTATION STRATEGY

Significant Health Needs

The methodology 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 TRH.[28] 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 TRH current efforts responding to the need including any written comments received regarding prior TRH implementation actions
- Establishes the Implementation Strategy programs and resources TRH will devote to attempt to achieve improvements
- Documents the Leading Indicators TRH will use to measure progress
- Presents the Lagging Indicators TRH 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, TRH is the major hospital in the service area. TRH is a 48-bed, acute care medical facility located in Three Rivers, MI. The next closest facilities are outside the service area and include:

- Sturgis Hospital in Sturgis, MI; 22 miles (33 minutes)
- Ascension Borgess-Lee Hospital in Dowagiac, MI; 29 miles (38 minutes)
- Bronson LakeView Hospital in Paw Paw, MI; 37 miles (43 minutes)
- ProMedica Coldwater Regional Hospital in Coldwater, MI; 37 miles (52 minutes)

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

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

1. **MENTAL HEALTH – 2016 Significant Need; St. Joseph County's poor mental health days is slightly worse than the U.S. median; St. Joseph County's population to mental health provider ratio is worse than the state average; Suicide is the #10 leading cause of death in St. Joseph County; St. Joseph County's female and male self-harm and interpersonal violence related deaths increased from 1980-2014 (Female death rate increased 0.1%; Male death rate increased 5.9%); Female and male mental and substance abuse related deaths increased from 1980-2014 (Female death rate increased 614.9%; Male death rate increased 424.4%)**

4. **DRUG/SUBSTANCE ABUSE – 2016 Significant Need; St. Joseph County's drug overdose death rate is worse than the state average; St. Joseph County's female and male mental and substance abuse related deaths increased from 1980-2014 (Female death rate increased 614.9%; Male death rate increased 424.4%)**

5. **SUICIDE – 2016 Significant Need; St. Joseph County's poor mental health days is slightly worse than the U.S. median; St. Joseph County's population to mental health provider ratio is worse than the state average; Suicide is the #10 leading cause of death in St. Joseph County; St. Joseph County's female and male self-harm and interpersonal violence related deaths increased from 1980-2014 (Female death rate increased 0.1%; Male death rate increased 5.9%); Female and male mental and substance abuse related deaths increased from 1980-2014 (Female death rate increased 614.9%; Male death rate increased 424.4%)**

Due to the similar actions required to address these needs, a single implementation strategy has been developed.

Public comments received on previously adopted implementation strategy:

- *See Appendix A for full list of comments*

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

- Three Rivers PAWS Clinic – provide mental health services and counseling to youth (18 or under); also provides substance abuse counseling
- Social workers available – assists with aligning services for all patients (Medicaid, etc.)
- Refer to Community Mental Health (CMH) for Medicaid patients
- Collaborate with CMH to assess patients presenting at ER with mental health issues
- Work with CMH to link women with substance abuse issues to primary care providers
- Collaborating with CMH and other partners to provide trauma-informed services
- Added PHQ9 (depression screening) to electronic health records systems
- Promotes local "Drug Take-Back Day"
- Through school-linked program, mental health counseling provided to children at no charge
    - Drug screenings provided to pregnant women; if positive results; referred to CMH or primary provider

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

for counseling

- HelpNet is provided free to employees of THR to address mental health needs
- Suicide precautions have been revised to improve personalization to better identify patient needs
- Depression counseling is completed prenatally, prior to hospital discharge post-partum, and at post-delivery appointment

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

- Continue above activities
- Explore Mental Health First Aid training for staff
- Expand de-escalation training to community members though collaboration with CMH
- Explore implementing a short stay detox program for self-referring patients
    - Working with the state to get 60 day license
- Provide community education and awareness on vivitrol and where it is available in the community; Currently available at CBH
- Implementing tele psych in the emergency department

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

- TRH and CMH provide social workers to the local schools where they offer crisis stabilization and de-escalation
- Implemented a Community Integrated Network with other Michigan hospitals to provide a proactive approach to population Health Risk Management
- Conduct meetings on how people can use Narcan to treat narcotic overdoses in emergency situations
- Established a community wide suicide task force

Anticipated results from TRH Implementation Strategy

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

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

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

- Number of patients presenting in emergency department with mental health crisis = 349
- Number of Narcan cans distributed in St. Joseph County = 40 administered by EMS in 2018

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

- Average number of poor mental health days = 4.1[30] (St. Joseph County)
- Suicide deaths = 13.8 per 100,000 population[31]
- Drug overdose deaths = less than 10 per year

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

Organization	Contact Name	Contact Information
Community Mental Health (CMH)		(269) 467-1000
Three Rivers Public Schools		(269) 279-1100
Human Services Commission		(269) 625-1820
Substance Abuse Task Force		(269) 244-0008
Covered Bridge Healthcare (CBH)		(269) 467-3228

[30] Countyhealthrankings.com. Average number of mentally unhealthy days reported in past 30 days. Age-adjusted. 2016.
[31] Worldlifeexpectany.com. 2017.

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

Organization	Contact Name	Contact Information
Local AA Chapters	Southwest Central Intergroup	(606) 467-1107
Riverside Church (Celebrate Recovery)		http://www.riverside-church.com/cr/ 207 E Michigan Ave, Three Rivers, MI 49093 (269) 273-8723
Firm Foundations Ministries		http://www.ffmcentreville.org/
St. Joseph County Sherriff's Department		(269) 467-9045

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

2. **AFFORDABILITY – Local expert concern; St. Joseph County's uninsured rate is worse than the state average; Regions of St. Joseph County have a higher vulnerability relating to socioeconomic status**

Public comments received on previously adopted implementation strategy:

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

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

- TRH and Covered Bridge Health (CBH) implemented programs to assist uninsured patients with potential programs
- TRH employee assists patients with Medicaid application and enrollment; CMH has a kiosk in the lobby that patients can use for Medicaid assistance
- TRH accept walk-in appointments at clinics
- Work with VCAT (Veterans Community Action Team) on identifying solutions for gaps in veteran healthcare services
- CMH offers vaccines to patient with no insurance; Children are covered through vaccine program
- CBH offers a sliding scale fee
- CMH has public dental services with a sliding scale fee
- TRH provides chargemaster for hospitals and average charges pe Diagnostic Related Group (DRG)
- TRH offers a wide array of specialty services; patients don't have to go long distances for specialty services
- Local health department offers free birthing and breast feeding classes
- Social workers are available to assist with aligning services for all patients (Medicaid, etc.)
- Through school-linked program, mental health counseling provided to children at no charge
- Provide the St. Joseph County Resource Guide (created by the St. Joseph County Human Services Commission) on the website; provides information on health and human services available through non-profits and governmental bodies in St. Joseph County, Michigan
- Community health screenings to include healthy eating habits/activity, risk assessments, BMI screenings, glucose/cholesterol (free or reduced costs)

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

- Continue above activities
- Implement a program that educates the community on what services and resources are available in the community
- Look into interagency collaboration as a core principle in systems of care, focusing on bringing together and

engaging stakeholders to increase coverage and affordability while increasing community awareness

- Primary Care Physicians connecting patients with appropriate services at visits

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

- Number of patients that apply for financial assistance = 566
- Number of people with no insurance that are converted to some type of program = 402

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

- Three Rivers Health Bad debt expense = $5,083,000
- Three Rivers Health Charity care contribution = $212,660

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

Organization	Contact Name	Contact Information
Covered Bridge Health (CBH)		(269) 467-3228
Community Mental Health (CMH)		(269) 467-1000

Organization	Contact Name	Contact Information
Veterans Community Action Team		(517) 284-5295

3. **ACCESSIBILITY – Local expert concern; St. Joseph County's population to primary care provider and dentist ratio are worse than the state average and U.S. median; population to mental health provider ratio is worse than the state average**

Public comments received on previously adopted implementation strategy:

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

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

- TRH accept walk-in appointments at clinics
- TRH offers a wide array of specialty services; patients don't have to go long distances for specialty services
- CMH offer after hours appointments
- Public transportation available to the community that TRH refers patients to
- Three Rivers PAWS Clinic – provide mental health services and counseling to youth (18 or under); also provides substance abuse counseling
- Social workers available to assist with aligning services for all patients (Medicaid, etc.)
- Collaborate with CMH to assess patients presenting at ER with mental health issues
- Work with CMH to link women with substance abuse issues to primary care providers
- Collaborating with CMH and other partners to provide trauma-informed services
- Work with St. Joseph County Commission to offer Commission on Aging, providing services, support, activities and information to individuals age 60 or older
- Provide the St. Joseph County Resource Guide (created by the St. Joseph County Human Services Commission) on the website; provides information on health and human services available through non-profits and governmental bodies in St. Joseph County, Michigan

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

- Continue above activities
- Implement a program that educates the community on what services and resources are available in the community
- Look into interagency collaboration as a core principle in systems of care, focusing on bringing together and engaging stakeholders to increase coverage and affordability while increasing community awareness
- Primary Care Physicians connecting patients with appropriate services at visits
- Evaluate opportunity for telemedicine visits in a primary care setting
- Look into launching a patient survey on accessibility

- TRH Implementing tele-psych in the emergency department

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

- Track scheduled appointments vs actually kept appointment

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

- TRH to identify measure to track going forward

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

Organization	Contact Name	Contact Information
Community Mental Health (CMH)		(269) 467-1000

6. **OBESITY – 2016 Significant Need; St. Joseph County's physical inactivity rate and access to exercise opportunities are worse than the state average and U.S. median; Residents of St. Joseph County are more likely to have a BMI of morbid/obese compared to the national average; Diabetes is the #6 leading cause of death in St. Joseph County; St. Joseph County's diabetes, urogenital, blood, and endocrine disease deaths is worse than the U.S. average and increased from 1980-2014 (Female death rate increased 43.3%; Male death rate increased 35.0%)**

Public comments received on previously adopted implementation strategy:

- *See Appendix A for full list of comments*

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

- Offer nutrition and diabetes education programs with registered dietician
- School-linked program
- Collaboration with Step Up St. Joseph and United Way
- Hospital wellness committee
- Community health screenings to include healthy eating habits/activity, risk assessments, BMI screenings, glucose/cholesterol (free or reduced costs)
- Sponsor of community-wide, annual "biggest loser" contest through local fitness center (HealthTrac)
- Fitness center open to community (Hospital-owned)
- Sponsor of annual Color Run
- Sponsor of Three Rivers Health Fair
- St. Joseph County Grange Fair – provide nutritional education, sponsor booth, promote wellness
- Sponsor of Relay For Life
- Occupational Health and Wellness Program
- HealthTrac senior fitness programming in collaboration with the Commission on Aging; alternative fee schedule
- School-related programming for low income youth
- Community programs to address dietary considerations to promote health
- Hospitalized morbidly obese and underweight patients are seen by a dietician prior to discharge
- Regular social media postings with a focus on nutrition
- Work with St. Joseph County Commission to offer Commission on Aging, providing services, support, activities and information to individuals age 60 or older
- Provide the St. Joseph County Resource Guide (created by the St. Joseph County Human Services Commission) on the website; provides information on health and human services available through non-profits and governmental bodies in St. Joseph County, Michigan

- Offer Mindset 365 program at the HealthTrac

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

- Continue above activities
- Work with city on walking trail connecting from 131 to the hospital
- Increase utilization for nutritional outpatient services covered by insurance
- Additional nutrition education and outreach services

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

- Hired certified instructors to teach pre-diabetes program
- TRH and CBH started senior annual wellness visits at primary care clinic
- Partnered with Step Up St. Joseph to promote and organize walking activities (Walking program)
- Sponsored Corey Lake triathlon
- Implemented a Community Integrated Network with other Michigan hospitals to provide a proactive approach to population Health Risk Management
- Expanded community-wide dietary education for children, adults, and seniors with a focus on health and wellness

Anticipated results from TRH 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	

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
7. Increases knowledge; then benefits the public	X	

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

- Number of senior wellness visits completed = 107
- Number of participants in the community health & wellness program = 535

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

- Adult obesity rate = 31%[33] (St. Joseph County)
- Percentage of students who are overweight (at or above 85th percentile for BMI and below the 95th percentile for BMI by age and sex) = 36.6% (St. Joseph County)[34]

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

Organization	Contact Name	Contact Information
HealthTrac		(269) 278-8722
BHSJCHA (health department)		(517) 279-9561
Three Rivers Public School		(269) 279-1100
Step Up St. Joseph		(269) 659-4385
Relay for Life		(269) 659-2504
City of Three Rivers		(269) 273-1075, ext. 106
Chamber of Commerce		(269) 278-8193
Human Services Commission		(269) 625-1820
St. Joseph County Commission on Aging		(269) 279-8083

[33] Countyhealthrankings.org. Percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2. 2015.
[34] Michigan Department of Education. The Michigan Profile for Healthy Youth (MiPHY) was completed by 7, 9 and 11 grade students in Michigan. 2017-2018.

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

Organization	Contact Name	Contact Information
Michigan State University Extension		(269) 467-5522
Glen Oaks Community College		(269) 294-4247

7. **EDUCATION/PREVENTION – 2016 Significant Need; St. Joseph County's preventable hospital stays is worse than the state average and U.S. median; Mammography screening rate is worse than the U.S. median; Flu vaccination rate is worse than the state average; Residents in St. Joseph County are less likely to receive routine cholesterol screenings and routine pap/cervical cancer screenings compared to the U.S. average**

Public comments received on previously adopted implementation strategy:

- *See Appendix A for full list of comments*

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

- Nutrition education program with registered dietician
- School-linked program
- Community health screenings to include healthy eating habits/activity, risk assessments, BMI screenings, glucose/cholesterol (free or reduced costs)
- St. Joseph County Grange Fair – provide nutritional education, sponsor booth, promote wellness
- School-related programming for low income youth
- Community programs to address dietary considerations to promote health
- Regular social media postings with a focus on nutrition
- Skin, mammography, and prostate cancer screenings
- Quarterly newsletter with health and wellness information
- Host health fair which promotes wellness/safety/community screenings/school physicals
- Provide health education materials in front lobby of Hospital
- Specialty fairs focusing on Cardiac, Stroke, Diabetes
- Provide health tips and education through social media platforms
- Implemented a Stroke Education program
- Free birthing and breast feeding classes are available at TRH through the local health department
- CBH offers education and wellness outreach to at risk populations
    - Home visits available
- Vaccine program available through local health department
- Hearing and vision screenings offered to the local schools through local health department
- Substance abuse education is provided to the local schools and jail through CMH's prevention department
- Offer smoking cessation classes to staff
- Promote Michigan Tobacco Quitline services to patients in need of coaching to help them towards a tobacco-

free life

- Promotes local “Drug Take-Back Day”

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

- Continue above activities
- COA commission on aging a lot of education offerings open to the public
- Provide community education and awareness on vivitrol and where it is available in the community; Currently available at CBH

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

- Advanced social media presence
- Increased community education (health/wellness) through presentations with various organizations
- Increased collaboration with schools through the PAWS clinic
- Provided education hospital staff on malnutrition

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

- Number of annual wellness visits provided = 961
- Number of attendees at free birthing classes = 9

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

- Adult overall health status = 17%[35] (St. Joseph County)

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

Organization	Contact Name	Contact Information
Project Connect (collaboration)		(269) 625-1820
Human Services Commission		(269) 625-1820
BHSJCHA (health department)		(517) 279-9561
HealthTrac		(269) 278-8722
Three Rivers Public Schools		(269) 279-1100
Step Up St. Joseph		(269) 659-4385
Relay for Life		(269) 659-2504
City of Three Rivers		(269) 273-1075, ext. 106
Chamber of Commerce		(269) 278-8193
Community Mental Health (CMH)		(269) 467-1000

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

Organization	Contact Name	Contact Information
Michigan State University Extension		
Covered Bridge Healthcare		(269) 467-3228

[35] Countyhealthrankings.org. Percentage of adults reporting fair or poor health. Age=adjusted. 2016.

Other Needs Identified During CHNA Process

8. **Diabetes – 2016 Significant Need**
9. **Physical Inactivity – 2016 Significant Need**
10. **Cancer**
11. **Smoking/Tobacco Use**
12. **Physician Services – 2016 Significant Need**
13. **Heart Disease**
14. **Lung Disease**
15. **Women's Health**
16. **Alcohol Abuse**
17. **Hypertension**
18. **Chronic Pain Management**
19. **Respiratory Infections**
20. **Accidents**
21. **Liver Disease**
22. **Kidney Disease**
23. **Stroke**
24. **Alzheimer's**
25. **Dental**
26. **Flu/Pneumonia**

Overall Community Need Statement and Priority Ranking Score

Significant needs where hospital has implementation responsibility[36]

1. Mental Health – 2016 Significant Need
2. Affordability
3. Accessibility
4. Drug/Substance Abuse – 2016 Significant Need
5. Suicide – 2016 Significant Need
6. Obesity – Significant Need
7. Education/Prevention – 2016 Significant Need

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

1. N/A

Other needs where hospital developed implementation strategy

1. N/A

Other needs where hospital did not develop implementation strategy

1. N/A

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

APPENDIX

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

Hospital solicited written comments about its 2016 CHNA.[38] 27 individuals responded to the request for comments. The following presents the information received in response to the solicitation efforts by the hospital. No unsolicited comments have been received.

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

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	14	10	24
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	15	10	25
3) **Priority Populations**	8	14	22
4) Representative/Member of **Chronic Disease Group** or Organization	4	18	22
5) Represents the **Broad Interest of the Community**	19	4	23
Other			1
Answered Question			27
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?

- *Outdated water supplies for some homes and outdated septic systems.*
- *Food, housing*
- *Access to care, Cost of care, Support to seek care in cases where the individual is unable to navigate the system*

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

independently.

- *Poor health habits; low income, limited transportation to health care providers*
- *Access to affordable healthcare, specifically affordable co-pay, deductible, max out of pocket.*
- *Mostly the low-income groups and the children, and mixing in the rural folks we have a lot of residents that don't have affordable, reliable transportation for basic doctor appointments. Offering a "pop up" clinic at the local schools once per week to do the yearly physicals of the kids would be ideal. Parents that work and don't have the luxury of taking a 1/2 day off to take the children to a well-child appointment just end up not taking them at all. Also, the mental health needs of our children are not being met. A child with anxiety, depression, or learning disorders (dyslexia, ADD, ADHD) has EXTREMELY limited options for diagnosis and treatment. The providers we have are overbooked and CMH won't take anyone with private insurance. TR Health should hire a specialist in children's mental health and the court system alone would keep that person employed full-time with referrals for child psych evals and treatment. We DESPERATELY need children's mental health workers. Currently all psych evals are sent to doctor in Battle Creek, or Pine Rest in Grand Rapids. It is IMPOSSIBLE to get kids screened and seen timely. (Recall the 9-10 year old that shot and killed his mother this past year in Sturgis. A review of her Facebook showed weeks of calling CMH and not getting anywhere with scheduling an appt, only to find out they don't take private insurance. She then called a private provider, and had the child scheduled for a few days after she died. This is not acceptable.)*

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

1. **Obesity/Physical Inactivity**
2. **Mental Health/Suicide/Substance Abuse**
3. **Physician Services**
4. **Education/Prevention**
5. **Diabetes**

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

	Yes	No	Response Count
Obesity/Physical Inactivity	24	1	25
Mental Health/Suicide/Substance Abuse	25	1	26
Physician Services	24	2	26
Education/Prevention	27	0	27
Diabetes	24	1	25

Comments:

- *If anything, the needs are more pronounced. Not sure the hospital has the resource available. The larger issue is reasonable payment for services delivered. Hospitals can't be expected to carry the primary financial burden of providing healthcare to all.*
- *Childhood obesity is where it starts. Implementing a healthy eating initiative can help combat the issue. So many parents now don't know how to cook a healthy but tasty meal, and turn to cheap, prepackaged food. Having a*

"family cooking class" could help the situation. Each school has an area that could be used, like the cafeteria, or home ec room. It shocks me to see the number of high school kids with literally NO basic cooking skills. No idea how to use a stovetop or oven, how to make basic meals.

4. **Please share comments or observations about the actions TRH has taken to address <u>OBESITY/PHYSICAL INACTIVITY.</u>**

- *indoor track at health track however the membership prices are extremely high and some of these people are low income and are struggling already. better lighting at the trails but could use a few more benches for people that need to take more frequent breaks due to health.*
- *HealthTRAC continues to offer programs to the community (fee paying members), Authorized use of TRH land for construction of a walking trail.*
- *Sturgis hospital financial challenges limits SJCHealth Network and cooperation; CIN has been slow to start; HealthTrak remains excellent fitness facility and programs*
- *Step up St. Jo initiative*
- *Many of the listed action steps have been initiated by TRH*
- *Great list but no direct knowledge of what has actually been done or the effectiveness. Sponsoring triathlon lasted a year.*
- *-While TRH no longer sponsors the Corey Lake Triathlon and that event is no longer running I think if we did an event (5K, bike-a-thon at HealthTRAC, 1 mile walk, etc.) where the funds made were allocated for steps to reduce obesity and sedentary lifestyles in St. Joseph County. I would love to see an event where the funds were allocated towards a scholarship fund for individuals who would like to become a HealthTRAC member but cannot afford the $52 a month annual rate or $75 monthly rate. I think more dietary education in schools would be good too, not just in Three Rivers Schools but in all St. Joseph County Schools. Maybe afterschool or once a month programs for students AND parents that cover different dietary topics; healthy eating on a budget, healthy eating on the go, recipe modification, etc.*
- *TRH has acknowledged the obesity/physical inactivity in the community. It's providers and dietitians and staff throughout the hospital are recommending and promoting healthy lifestyle alternatives.*
- *The ideas look great—but more outreach is needed. Maybe partner with the schools and youth sports programs to get more kids participating. We started Magi Youth Sports, Inc in Colon to increase the number of youth sporting options available to the kids, as well as have a financially accountable management team. Having TR Health send representatives to talk to the kids about healthy eating choices might be an extra outreach option.*
- *Health Trac is a great asset to provide*
- *I am fairly new to the Colon Community and have not had much interaction with TRH or it's services.*

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

- *there has been an increase in mental health physicians however not all accept Medicaid and we are needing to outsource to other communities and churches for help.*
- *I would like to see Recovery Coaches returned to the hospitals. I would also like increased collaboration with CMH.*
- *Unaware of actions*
- *Initiatives for TelePsych are encouraging; recruiting locally based practitioners remains problematic.*
- *There are still a great many needs that need to be address in this area.*
- *Great list but no direct knowledge of what has actually been done or the effectiveness. Partnering with Sturgis on anything is unlikely today.*
- *TRH has acknowledged and monitored Mental health, suicide, substance abuse in our community. TRH has partnered with our local FQHC and CMH to provide needed services and needs by this population. TRH also assists the community in providing placement for cases that are beyond its ability to help. TRH is aware of the need for more accessible services related to mental health care.*
- *I would LOVE to see not only an adult psychiatric facility, but also a youth one. We have extensive needs in our county for that. TR Health should partner and support CTAG (Child Trauma Assessment Group) that Judge started to identify and treat these traumatized children and facilitate learning and reunification between the parents that caused or allowed the trauma and the child if it can be safely accomplished.*
- *Interaction with CMH and area resources*
- *I am fairly new to the Colon Community and have not had much interaction with TRH or it's services. This area of need cannot be helped fast enough!*

6. Please share comments or observations about the actions TRH has taken to address <u>PHYSICIAN SERVICES</u>.

- *We need more physicians in the area we are very excited for the new clinic that will be opening.*
- *Brochures*
- *Added several new primary care physicians and specialty providers.*
- *Three additional primary care physicians recruited and on board*
- *Many of the listed action steps have been initiated by TRH.*
- *To my knowledge we are in pretty good shape on recruiting. Retention is the bigger issue.*
- *TRH has and continues to provide quality physician services to the community. TRH provides several specialty clinics on its campus which gives much needed service to this community.*
- *Need more quality doctors. Period.*
- *Great improvements & physician specialists*
- *I am fairly new to the Colon Community and have not had much interaction with TRH or it's services.*

7. **Please share comments or observations about the actions TRH has taken to address <u>EDUCATION/PREVENTION</u>.**

- *Our community is expanding in cultural differences including language barriers we have had many clients wanting to learn the English language but our community doesn't offer any adult classes therefore we are sending them to other communities for services.*
- *PAWS clinic active in partnership with the schools.*
- *Significant marketing program to educate community on surprisingly broad and competent services available close to home. Market share remains low indicating high potential for improvement.*
- *Many of the listed action steps have been initiated by TRH.*
- *Great list but no direct knowledge of what has actually been done or the effectiveness.*
- *-Continue social media presence on Facebook, Instagram, website. specifically, patient or HealthTRAC member testimonials from people that live in our community -I would like to see HealthTRAC collaborate more with the PAWS clinic. Students receive a three month membership to HealthTRAC when they are in the PAWS program but typically a parent has to bring them to the gym, and that doesn't always happen. Maybe onsite exercise classes for PAWs participants brought by HealthTRAC? Free?*
- *TRH provides health screening through the community.*
- *As stated throughout, there is more that can be done in the schools.*
- *Awareness and Training*
- *I am fairly new to the Colon Community and have not had much interaction with TRH or it's services. I will gladly welcome partners in this work at Colon Community Schools.*

8. **Please share comments or observations about the actions TRH has taken to address <u>DIABETES</u>.**

- *Need more info and places to turn for new diabetic patients.*
- *A diabetic specialist in our area is very much needed. Clients are having to go to Kalamazoo mi or Indiana to see specialist. Our specialty clinic needs to expand and bring in more physicians.*
- *Nutrition classes*
- *Unaware of actions*
- *Nutritional education programs well received; obesity, poor diet and low physical activity remain worse locally than statewide or nationally*
- *Many of the listed action steps have been initiated by TRH.*
- *Great list but no direct knowledge of what has actually been done or the effectiveness.*
- *-I don't believe we are currently doing monthly lunch and learns for employees. I think it is hard for most of the staff to get to the lunch and learns so what if we do monthly webinars? Email to TRH all or put on homepage?*

- *Diabetes is at epidemic proportions in this community and TRH is addressing the needs of the community on this level with education, monitoring and follow-up.*
- *See above. Healthy eating habits start with the kids.*
- *Center by the hospital for Dialysis, Nutritionists*
- *I am fairly new to the Colon Community and have not had much interaction with TRH or it's services.*

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

Need Topic	Total Votes	Number of Local Experts Voting for Needs	Percent of Votes	Cumulative Votes	Need Determination
Mental Health*	196	13	10.9%	10.9%	Significant Needs
Affordability	191	13	10.6%	21.5%	
Accessibility	170	12	9.4%	30.9%	
Drug/Substance Abuse*	132	11	7.3%	38.3%	
Suicide*	122	12	6.8%	45.1%	
Obesity*	119	11	6.6%	51.7%	
Education/Prevention*	116	9	6.4%	58.1%	
Diabetes*	112	12	6.2%	64.3%	Other Identified Needs
Physical Inactivity*	103	11	5.7%	70.1%	
Cancer	97	9	5.4%	75.4%	
Smoking/Tobacco Use	97	8	5.4%	80.8%	
Physician Services*	41	7	2.3%	83.1%	
Heart Disease	40	7	2.2%	85.3%	
Lung Disease	38	6	2.1%	87.4%	
Women's Health	28	6	1.6%	89.0%	
Alcohol Abuse	26	6	1.4%	90.4%	
Hypertension	25	6	1.4%	91.8%	
Chronic Pain Management	24	6	1.3%	93.2%	
Respiratory Infections	22	5	1.2%	94.4%	
Accidents	18	4	1.0%	95.4%	
Liver Disease	18	5	1.0%	96.4%	
Kidney Disease	17	5	0.9%	97.3%	
Stroke	14	4	0.8%	98.1%	
Alzheimer's	13	4	0.7%	98.8%	
Dental	11	4	0.6%	99.4%	
Flu/Pneumonia	10	4	0.6%	100.0%	

**= 2016 Significant Needs*

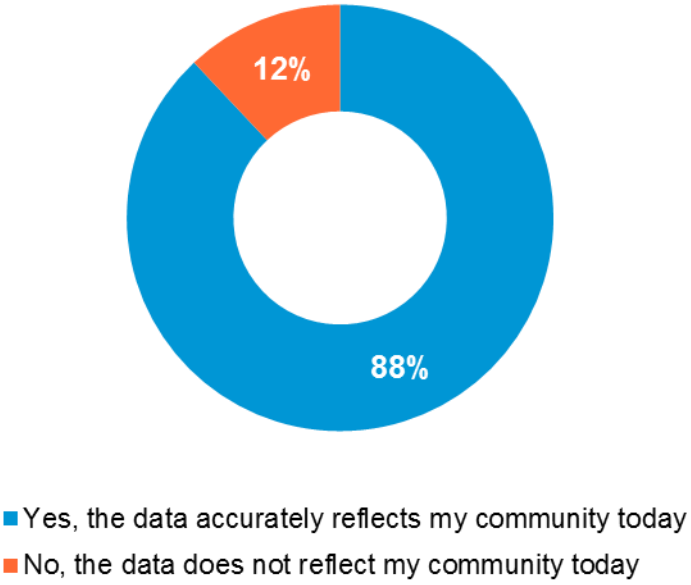
Individuals Participating as Local Expert Advisors[39]

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	14	10	24
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	15	10	25
3) **Priority Populations**	8	14	22
4) Representative/Member of **Chronic Disease Group** or Organization	4	18	22
5) Represents the **Broad Interest of the Community**	19	4	23
Other			1
Answered Question			27
Skipped Question			0

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

Advice Received from Local Expert Advisors

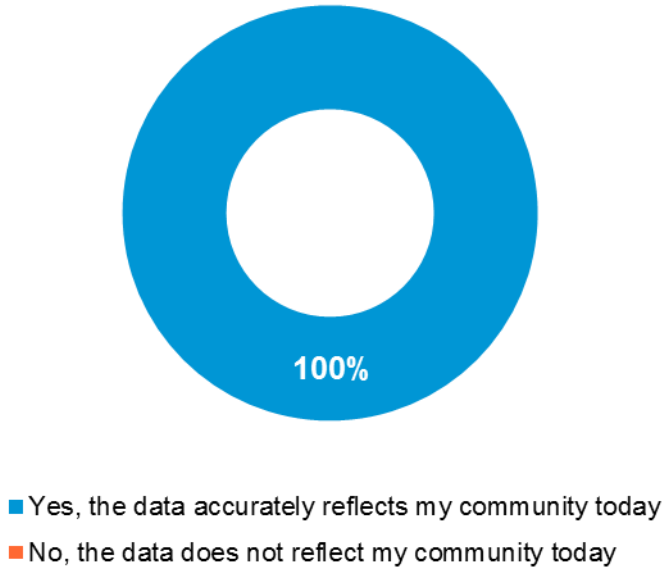
Question: Do you agree with the comparison of St. Joseph County to all other Michigan counties?



Comments:

- *Unemployment is lower; table does not include drug impairment; SJC is the highest meth incidence in MI*
- *Statistics are what they are, but it is hard to believe that Access to Exercise is so low. Using it is another matter. Assume all the "Population to" stats are more a function of population density. Society today is extremely mobile and thinks nothing of jumping in a car and driving 30 minutes. Larger issue might be access to public transportation. Teen births and Air Pollution both seem questionable.*
- *We have a large number of teen pregnancies. We need more access to exercise. Since TR Health has bargaining power for rehab/exercise equipment, maybe you can partner with the local schools or gyms to lease out equipment, or donate aging but functional equipment. Kim Stuck runs Studio on State in Colon, a small workout facility for group exercise. She has wanted to do spin classes, but doesn't have the capital to put into purchasing the bikes. Places like that are where TR health could find a great community outreach.*
- *My greatest concerns are primary care provider ratio and teen births.*

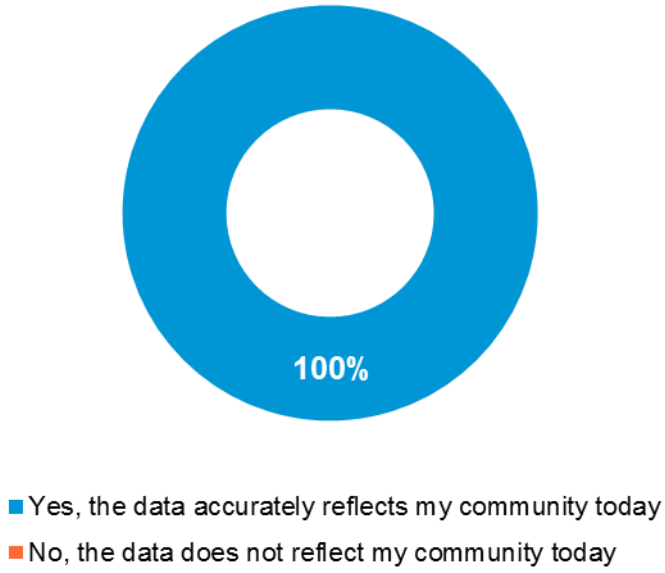
Question: Do you agree with the demographics and common health behaviors of St. Joseph County?



Comments:

- *There are significant differences within the county; Sturgis higher income; TR area multi-mode with some townships more affluent and likely healthier than the city*
- *-I thought the median household income was lower for SJC*
- *People use the ER for their family doc since the hours of family docs aren't conducive to their blue collar work schedules. We need later hours for the clinics or move to concierge healthcare.*

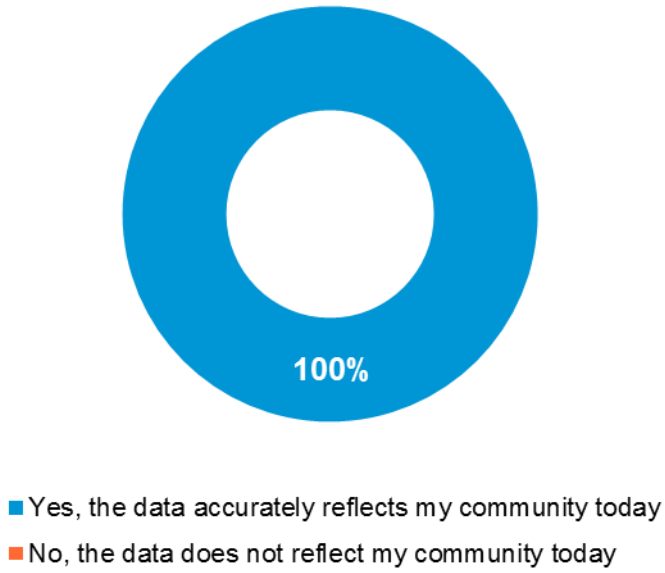
Question: Do you agree with the overall social vulnerability index for St. Joseph County?



Comments:

- *I am new to the community, so I don't feel confident in my answer.*
- *But that is really an assumption.*
- *Colon/Burr Oak are high needs. However, Colon especially has a core group of people in the community working to equalize that.*

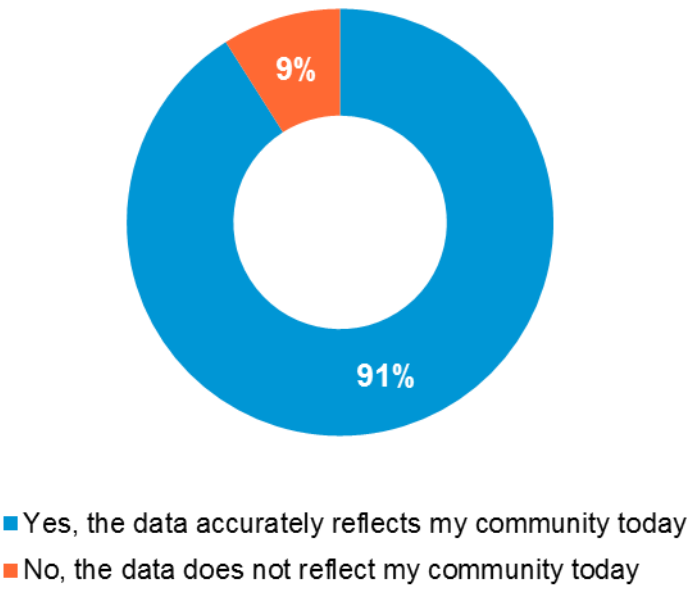
Question: Do you agree with the national rankings and leading causes of death?



Comments:

- *Lots of cancer in Mendon area on Nottawa Rd.*
- *These data could be broken out by socioeconomic factors; especially age; income; controllable health care habits including obesity, physical activity and diet*
- *I have no basis for challenging the data.*
- *Too many teen suicides. Kelly Hostetler at United Way is working on a program. TRH should contact her.*

Question: Do you agree with the health trends in St. Joseph County?



Comments:

- *Higher in 2019 now cancer, diabetes*
- *Data are 5 years old. May be statistically "significant" but not socially so*
- *Sorry, but can only assume that the data is accurate.*

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

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

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

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

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

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

Key Findings

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

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

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

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

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

Trends

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

Looking Forward

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

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

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

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

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

Link to the full report:

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

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

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

Community Health Need Assessment Illustrative Answers

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

   No

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

   No

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

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

      See footnote 16 on page 11

   b. **Demographics of the community**

      See footnote 19 on page 12

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

      See footnote 29 on page 25 and footnote 32 on page 28

   d. **How data was obtained**

      See footnote 11 on page 8

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

      See footnote 28 on page 24

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

      See footnote 12 on page 9

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

      See footnote 15 on page 9

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

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

See footnotes 13 on page 9

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

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

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

N/A

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

2016

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

Yes, see footnote 14 on page 9 and footnote 38 on page 50

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**

Answer

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

See footnote 4 on page 4 and footnote 7 on page 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.threerivershealth.org/

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

No other website

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

Yes

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

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

Yes

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

2016

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

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

https://www.threeriversshealth.org/wp-content/uploads/2016-CHNA-1-1.pdf

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

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

See footnote 29 on page 25

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

None incurred

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

Nothing to report

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

Nothing to report