

Caldwell Memorial Hospital

Lenoir, North Carolina

Community Health Needs Assessment
and Implementation Strategy

Adopted by Board Resolution October 10, 2017¹



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



Dear Community Member:

At Caldwell Memorial Hospital, we have spent more than 66 years providing high-quality compassionate healthcare to the greater Lenoir community. The “2017 Community Health Needs Assessment” identifies local health and medical needs and provides a plan of how Caldwell Memorial Hospital (CMH) 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.

CMH 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,

Laura Easton
President and Chief Executive Officer
Caldwell Memorial Hospital



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EXECUTIVE SUMMARY



EXECUTIVE SUMMARY

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

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

The Significant Health Needs for Caldwell County are:

1. Mental Health & Substance Abuse
2. Chronic Disease
3. Obesity
4. Cancer
5. Heart Disease

The Hospital has developed implementation strategies for three of the five needs (Mental Health & Substance Abuse, Chronic Disease, and Cancer; Obesity and Heart Disease are addressed within Chronic Disease) including activities to continue/pursue, community partners to work alongside, and leading and lagging indicators to track.



APPROACH



APPROACH

Caldwell Memorial 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 990 h filings made by the hospital.

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

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

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

Project Objectives

Caldwell Memorial Hospital partnered with Quorum Health Resources (Quorum) to:⁴

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

Overview of Community Health Needs Assessment

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

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

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

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

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



- 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. We followed the Federal requirements in the solicitation of written comments by securing characteristics of individuals providing written comment but did not maintain identification data.

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

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

- (1) Public Health** – Persons with special knowledge of or expertise in public health
 - (2) Departments and Agencies** – Federal, tribal, regional, State, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility
 - (3) Priority Populations** – Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs in the community served by the hospital facility. Also, in other federal regulations the term Priority Populations, which include rural residents and LGBT interests, is employed and for consistency is included in this definition
 - (4) Chronic Disease Groups** – Representative of or member of Chronic Disease Group or Organization, including mental and oral health
 - (5) Broad Interest of the Community** – Individuals, volunteers, civic leaders, medical personnel, and others to fulfill the spirit of broad input required by the federal regulations
- Other** (please specify)

Quorum also takes a comprehensive approach to assess community health needs. We perform several independent data analyses based on secondary source data, augment this with Local Expert Advisor⁹ opinions, and resolve any data inconsistency or discrepancies by reviewing the combined opinions formed from local experts. We rely on secondary source data, and most secondary sources use the county as the smallest unit of analysis. We asked our local expert area residents to note if they perceived the problems or needs identified by secondary sources existed in their portion of the

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

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

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



county.¹⁰

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

Data sources include:¹¹

Website or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Caldwell County compared to all North Carolina counties	June 9, 2017	2012
https://wwwn.cdc.gov/communityhealth	Assessment of health needs of Caldwell County compared to its national set of “peer counties”	June 14, 2017	2011
Truven (formerly known as Thompson) Market Planner	Assess characteristics of the hospital’s primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according to the proportion of each group in the entire area; and, to access population size, trends and socio-economic characteristics	June 5, 2017	2016
http://svi.cdc.gov	To identify the Social Vulnerability Index value	June 9, 2017	2010
http://www.healthdata.org/us-county-profiles	To look at trends of key health metrics over time	June 9, 2017	2014
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	June 16, 2017	2015

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



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

- We deployed a CHNA “Round 1” survey to our Local Expert Advisors to gain input on local health needs and the needs of priority populations. Local Expert Advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and the Hospital’s desire to represent the region’s geographically and ethnically diverse population. We received community input from 19 Local Expert Advisors. Survey responses started June 2, 2017, and ended with the last response on June 12, 2017.
- Information analysis augmented by local opinions showed how Caldwell County relates to its peers in terms of primary and chronic needs and other issues of uninsured persons, low-income persons, and minority groups. Respondents commented on whether they believe certain population groups (“Priority Populations”) need help to improve their condition, and if so, who needs to do what to improve the conditions of these groups.¹²
- Local opinions of the needs of Priority Populations, while presented in its entirety in the Appendix, was abstracted in the following “take-away” bulleted comments
 - Low income residents and older adults are the most prevalent priority groups
 - Substance use among these populations is also common
 - These groups need care for many chronic health issues

When the analysis was complete, we put the information and summary conclusions before our Local Expert Advisors¹³ who were asked to agree or disagree with the summary conclusions. They were free to augment potential conclusions with additional comments of need.¹⁴ Consultation with 16 Local Experts occurred again via an internet-based survey (explained below) beginning June 22, 2017, and ending June 30, 2017.

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

In the Caldwell Memorial Hospital 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 our findings. We developed a list of all needs identified by any of the analyzed data. 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.

We divided the ranked needs 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 our definition, a Significant Need had to include all rank ordered needs until at least fifty percent (50%) of all points were included and to the extent possible, represented points allocated by a

¹² Response to Schedule h (Form 990) Part V B 3 f

¹³ Response to Schedule h (Form 990) Part V B 3 h

¹⁴ Response to Schedule h (Form 990) Part V B 3 h

¹⁵ Response to Schedule h (Form 990) Part V B 5



majority of voting local experts. The determination of the break point — “Significant” as opposed to “Other” — was a qualitative interpretation by Quorum and the Caldwell Memorial Hospital executive team where a reasonable break point in rank order occurred.¹⁶

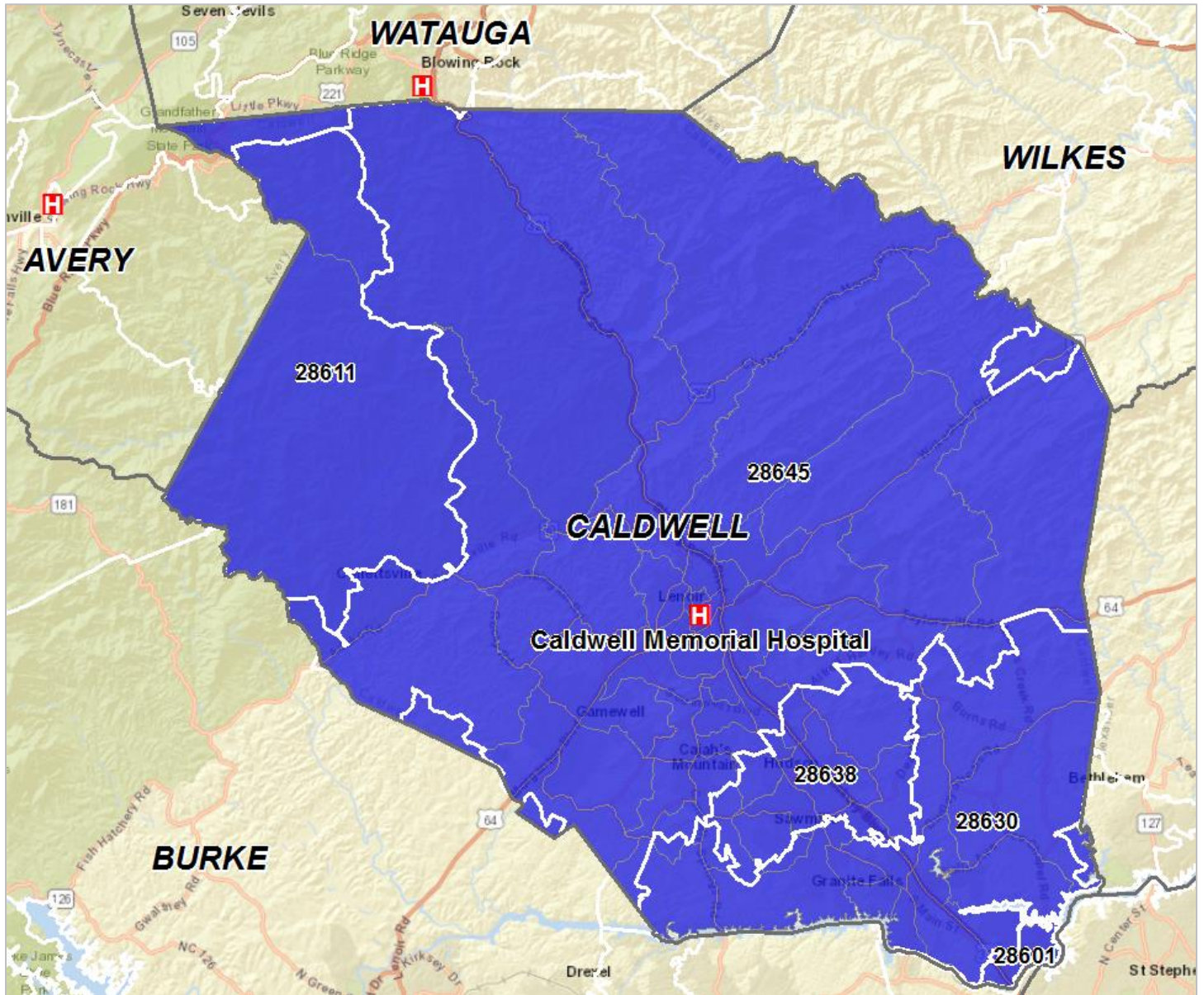
¹⁶ Response to Schedule h (Form 990) Part V B 3 g



COMMUNITY CHARACTERISTICS



Definition of Area Served by the Hospital¹⁷



For the purposes of this study, Caldwell Memorial Hospital defines its service area as Caldwell County in North Carolina, which includes the following ZIP codes:¹⁸

28611 – Collettsville 28630 – Granite Falls 28638 – Hudson 28645 – Lenoir

(28620 included in 28611, 28633 and 28661 included in 28645, and 28667 included in 28630)

During 10/1/2015 – 9/30/2016, the Hospital received 90.6% of its patients from this area.¹⁹

¹⁷ Responds to IRS Schedule h (Form 990) Part V B 3 a

¹⁸ The map above amalgamates zip code areas and does not necessarily display all county zip codes represented below

¹⁹ Truven Health Analytics patient origin data for the hospital; Responds to IRS Schedule h (Form 990) Part V B 3 a



Demographics of the Community^{20 21}

	Caldwell County	North Carolina	U.S.
2017 Population ²²	81,405	10,192,607	325,139,271
% Increase/Decline	0.7%	5.0%	3.8%
Estimated Population in 2022	81,995	10,702,054	337,393,057
Median Age	43.9	38.7	38.2
Median Household Income	\$39,528	\$49,039	\$56,873
Median Home Value	\$123,336	\$168,564	\$198,020
% Population over age 65	19.2%	15.7%	15.5%
% Women of Childbearing Age	17.1%	19.6%	19.6%
% White, non-Hispanic	87.4%	63.2%	60.8%
% Hispanic	5.3%	9.4%	18.0%
Unemployment Rate (April 2017)	4.0%	4.3%	4.4%

2017 Benchmarks									
Area: UNC Caldwell - Caldwell County 6.5.2017									
Level of Geography: Block Group									
Area	2017-2022 % Population Change	Median Age	Population 65+ % of Total Population	% Change 2017-2022	Females 15-44 % of Total Population	% Change 2017-2022	Median Household Income	Median Household Wealth	Median Home Value
USA	3.8%	38.2	15.5%	17.5%	19.6%	1.6%	\$56,873	\$61,832	\$198,020
North Carolina	5.0%	38.7	15.7%	19.0%	19.6%	2.3%	\$49,039	\$55,466	\$168,564
Selected Area	0.7%	43.9	19.2%	14.4%	17.1%	-0.6%	\$39,528	\$56,765	\$123,336
Demographics Expert 2.7									
DEMO0004.SQP									
© 2017 The Claritas Company, © 2017 Truven Health Analytics LLC									

²⁰ Responds to IRS Schedule h (Form 990) Part V B 3 b

²¹ Tables created by Truven Health Analytics

²² All population information, unless otherwise cited, sourced from Truven Health Analytics



Demographics Expert 2.7										
2017 Demographic Snapshot										
Area: UNC Caldwell - Caldwell County 6.5.2017										
Level of Geography: Block Group Code										
DEMOGRAPHIC CHARACTERISTICS										
			Selected Area	USA				2017	2022	% Change
2010 Total Population			83,029	308,745,538		Total Male Population		40,204	40,501	0.7%
2017 Total Population			81,405	325,139,271		Total Female Population		41,201	41,494	0.7%
2022 Total Population			81,995	337,393,057		Females, Child Bearing Age (15-44)		13,913	13,828	-0.6%
% Change 2017 - 2022			0.7%	3.8%						
Average Household Income			\$51,560	\$80,853						
POPULATION DISTRIBUTION						HOUSEHOLD INCOME DISTRIBUTION				
Age Distribution						Income Distribution				
Age Group	2017	% of Total	2022	% of Total	USA 2017 % of Total	2017 Household Income	HH Count	% of Total	USA % of Total	
0-14	13,347	16.4%	12,549	15.3%	18.8%	<\$15K	6,225	18.9%	11.8%	
15-17	3,150	3.9%	3,073	3.7%	3.9%	\$15-25K	4,624	14.1%	10.1%	
18-24	6,853	8.4%	6,962	8.5%	9.8%	\$25-50K	9,316	28.4%	22.9%	
25-34	8,812	10.8%	9,599	11.7%	13.4%	\$50-75K	6,123	18.6%	17.4%	
35-54	21,748	26.7%	19,633	23.9%	25.7%	\$75-100K	3,034	9.2%	12.1%	
55-64	11,882	14.6%	12,320	15.0%	12.9%	Over \$100K	3,529	10.7%	25.7%	
65+	15,613	19.2%	17,859	21.8%	15.5%					
Total	81,405	100.0%	81,995	100.0%	100.0%	Total	32,851	100.0%	100.0%	
EDUCATION LEVEL						RACE/ETHNICITY				
Education Level Distribution						Race/Ethnicity Distribution				
2017 Adult Education Level			Pop Age 25+	% of Total	USA % of Total	Race/Ethnicity	2017 Pop	% of Total	USA % of Total	
Less than High School			4,220	7.3%	5.8%	White Non-Hispanic	71,175	87.4%	60.8%	
Some High School			9,342	16.1%	7.7%	Black Non-Hispanic	3,947	4.8%	12.4%	
High School Degree			17,813	30.7%	27.8%	Hispanic	4,293	5.3%	18.0%	
Some College/Assoc. Degree			18,046	31.1%	29.1%	Asian & Pacific Is. Non-Hispanic	569	0.7%	5.7%	
Bachelor's Degree or Greater			8,634	14.9%	29.6%	All Others	1,421	1.7%	3.2%	
Total			58,055	100.0%	100.0%	Total	81,405	100.0%	100.0%	
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Customer Segmentation²³

Claritas Prizm uses Census data, sources of demographic and consumer information, and 30 years of annual consumer surveys to classify all U.S. households into 68 demographically and behaviorally distinct groups. These segments represent clusters of at least 250 households that have comparable characteristics and exhibit similar behaviors. The top segments in Caldwell County are:

Claritas Prizm Segments	Characteristics	
Segment #1 (44%)	<ul style="list-style-type: none"> • Urbanicity: Town/Rural • Income: Downscale • Income Producing Assets: Low • Age Ranges: Age 65+ • Presence of Kids: w/o Kids 	<ul style="list-style-type: none"> • Homeownership: Mostly Owners • Employment Levels: Mostly Retired • Education Levels: High School • Ethnic Diversity: White
Segment #2 (13%)	<ul style="list-style-type: none"> • Urbanicity: Town • Income: Lower Mid(Scale) • Income Producing Assets: Below Avg • Age Ranges: Age 25-44 • Presence of Kids: w/ Kids 	<ul style="list-style-type: none"> • Homeownership: Mix • Employment Levels: Service Mix • Education Levels: High School • Ethnic Diversity: White, Black, Hispanic, Mix
Segment #3 (12%)	<ul style="list-style-type: none"> • Urbanicity: Rural • Income: Downscale • Income Producing Assets: Low • Age Ranges: Age 55+ • Presence of Kids: Mostly w/o Kids 	<ul style="list-style-type: none"> • Homeownership: Mostly Owners • Employment Levels: Mostly Retired • Education Levels: High School • Ethnic Diversity: White
Segment #4 (10%)	<ul style="list-style-type: none"> • Urbanicity: Town/Rural • Income: Lower Mid(Scale) • Income Producing Assets: Low • Age Ranges: Age <55 • Presence of Kids: w/o Kids 	<ul style="list-style-type: none"> • Homeownership: Renters • Employment Levels: Service Mix • Education Levels: High School • Ethnic Diversity: White, Black, Hispanic, Mix
Segment #5 (7%)	<ul style="list-style-type: none"> • Urbanicity: Town/Rural • Income: Low Income • Income Producing Assets: Low • Age Ranges: Age 25-44 • Presence of Kids: w/ Kids 	<ul style="list-style-type: none"> • Homeownership: Mostly Renters • Employment Levels: Service Mix • Education Levels: High School • Ethnic Diversity: White, Black, Hispanic, Mix
Segment #6 (7%)	<ul style="list-style-type: none"> • Urbanicity: Rural • Income: Lower Mid(Scale) • Income Producing Assets: Below Avg • Age Ranges: Age 25-44 • Presence of Kids: w/ Kids 	<ul style="list-style-type: none"> • Homeownership: Mix • Employment Levels: Blue Collar Mix • Education Levels: High School • Ethnic Diversity: White, Black, Hispanic, Mix

²³ Truven Health Analytics Household Targeter



Each of the 66 Claritas Prizm segments exhibits prevalence toward specific health behaviors. In the second column of the chart below, 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 Caldwell County varies more than 5% above or below the national average (that is, less than 95% or greater than 105%), it is considered significant. Items in the table with **red text** are viewed as statistically significant **adverse** findings. Items with **blue text** are viewed as statistically significant **beneficial** findings. Items with black text are neither a favorable nor unfavorable finding.

Health Service Topic	Demand as % of National	% of Population Affected	Health Service Topic	Demand as % of National	% of Population Affected
Weight / Lifestyle			Cancer		
BMI: Morbid/Obese	108.3%	33.3%	Mammography in Past Yr	99.5%	45.4%
Vigorous Exercise	97.7%	56.0%	Cancer Screen: Colorectal 2 yr	98.3%	25.1%
Chronic Diabetes	132.3%	16.6%	Cancer Screen: Pap/Cerv Test 2 yr	84.8%	50.8%
Healthy Eating Habits	94.4%	28.0%	Routine Screen: Prostate 2 yr	102.2%	32.8%
Ate Breakfast Yesterday	98.2%	78.0%	Orthopedic		
Slept Less Than 6 Hours	117.8%	16.1%	Chronic Lower Back Pain	109.5%	25.8%
Consumed Alcohol in the Past 30 Days	82.6%	44.6%	Chronic Osteoporosis	126.0%	12.4%
Consumed 3+ Drinks Per Session	114.7%	32.5%	Routine Services		
Behavior			FP/GP: 1+ Visit	103.2%	91.1%
I Will Travel to Obtain Medical Care	97.4%	22.2%	Used Midlevel in last 6 Months	104.3%	43.1%
I am Responsible for My Health	92.9%	60.7%	OB/Gyn 1+ Visit	80.5%	37.1%
I Follow Treatment Recommendations	87.9%	45.6%	Medication: Received Prescription	103.7%	62.6%
Pulmonary			Internet Usage		
Chronic COPD	136.8%	5.4%	Use Internet to Talk to MD	65.6%	8.0%
Tobacco Use: Cigarettes	111.8%	28.4%	Facebook Opinions	91.4%	9.4%
Heart			Looked for Provider Rating	78.7%	11.1%
Chronic High Cholesterol	118.2%	25.9%	Emergency Services		
Routine Cholesterol Screening	93.4%	47.4%	Emergency Room Use	108.0%	36.5%
Chronic Heart Failure	164.5%	6.4%	Urgent Care Use	94.4%	22.0%



Leading Causes of Death²⁴

Cause of Death			Rank among all counties in NC (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Rate of Death Compared to U.S.
NC Rank	Caldwell Rank	Condition		NC	Caldwell	
2	1	Heart Disease	43 of 100	158.7	215.9	As expected
1	2	Cancer	24 of 100	169.3	201.7	Higher than expected
3	3	Lung	3 of 100	45.1	66.8	Higher than expected
4	4	Stroke	23 of 100	43.0	63.2	Higher than expected
5	5	Accidents	60 of 100	44.4	49.9	As expected
6	6	Alzheimer's	5 of 100	30.5	37.7	Higher than expected
7	7	Diabetes	43 of 100	23.7	26.5	As expected
8	8	Flu - Pneumonia	27 of 100	17.2	24.0	Higher than expected
9	9	Kidney	31 of 100	16.3	19.8	Higher than expected
11	10	Suicide	20 of 100	13.0	15.9	Higher than expected
10	11	Blood Poisoning	64 of 100	12.4	12.9	As expected
12	12	Liver	32 of 100	10.3	11.1	As expected
14	13	Parkinson's	35 of 100	7.1	6.3	As expected
13	14	Hypertension	72 of 100	7.9	6.2	As expected
15	15	Homicide	56 of 100	5.6	5.6	As expected

²⁴ www.worldlifeexpectancy.com/usa-health-rankings



Priority Populations²⁵

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

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

We asked a specific question to our Local Expert Advisors about unique needs of Priority Populations. We reviewed their responses to identify if any of the report trends were obvious in the service area. Accordingly, we place great reliance on the commentary received from our Local Expert Advisors to identify unique population needs to which we should respond. Specific opinions from the Local Expert Advisors are summarized below:²⁶

- Low income residents and older adults are the most prevalent priority groups
- Substance use among these populations is common
- These groups need care for many chronic health issues

²⁵ <http://www.ahrq.gov/research/findings/nhqdr/nhqdr14/index.html> Responds to IRS Schedule h (Form 990) Part V B 3 i

²⁶ All comments and the analytical framework behind developing this summary appear in Appendix A

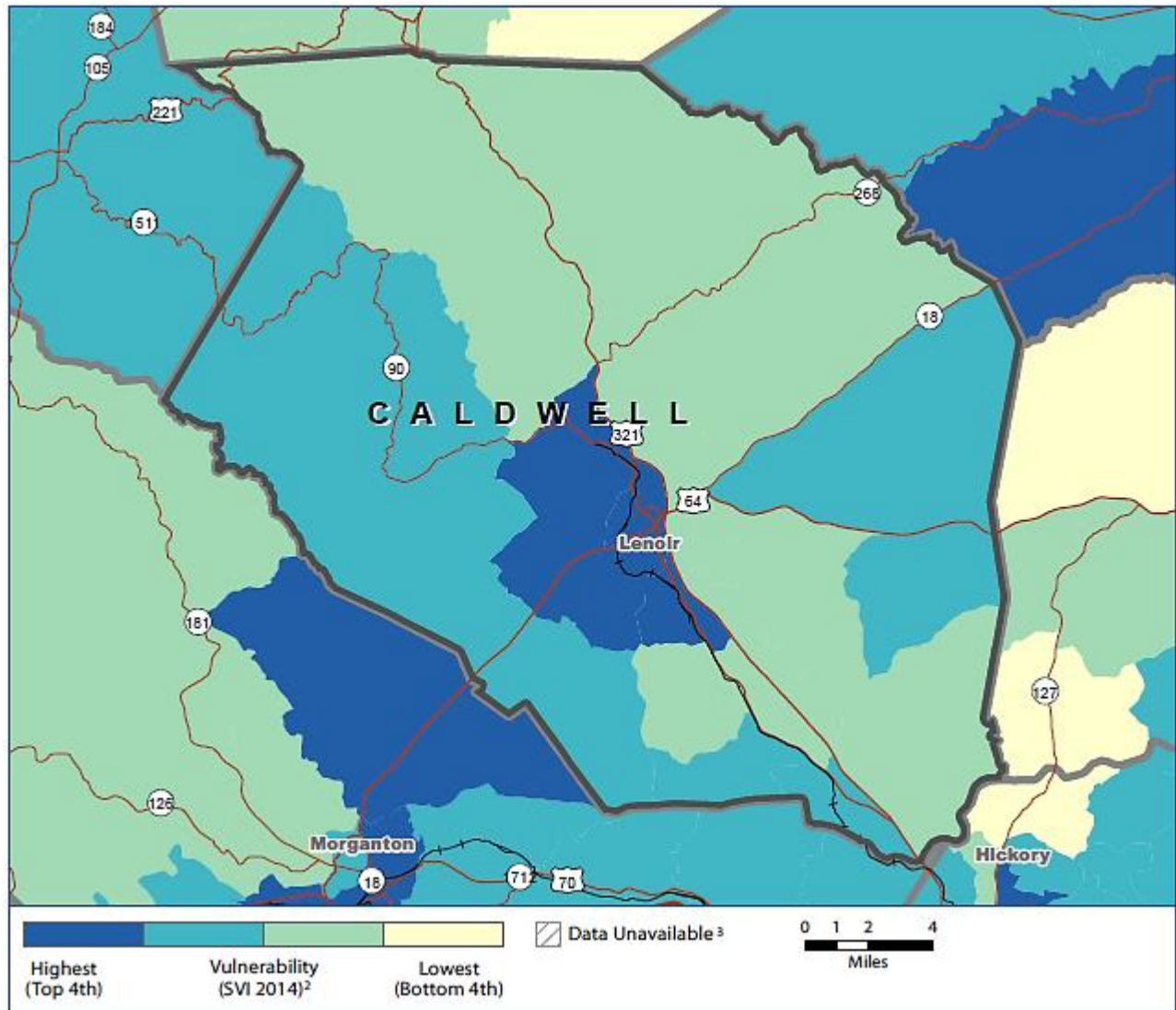


Social Vulnerability²⁷

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.

Caldwell County falls into three quartiles:

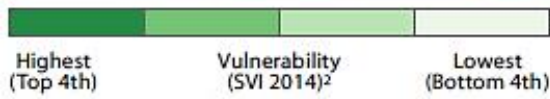
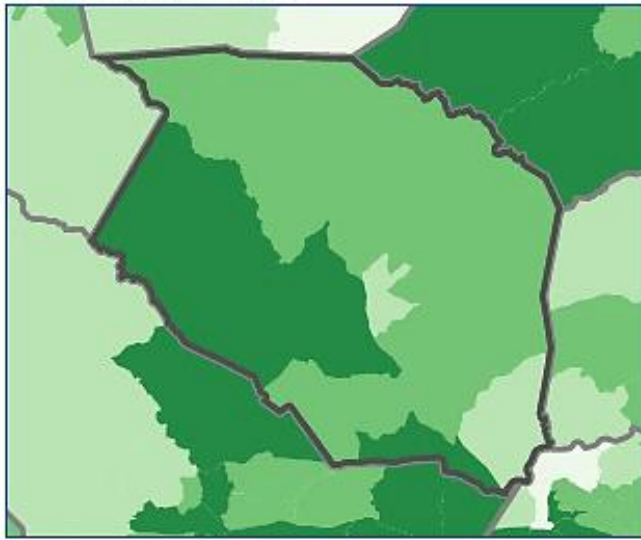
- The center of the county, around Lenoir, is in the highest quartile of vulnerability
- The western side of the county and a small section of the eastern edge are in the second highest quartile
- The rest of the county is in the second lowest quartile



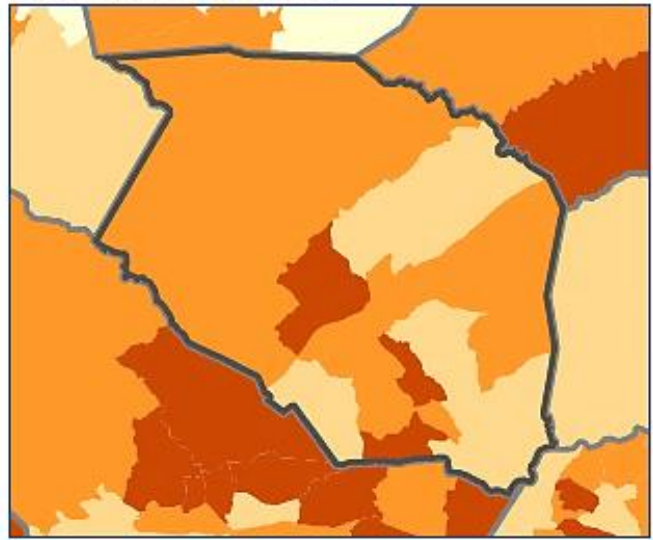
²⁷ <http://svi.cdc.gov>



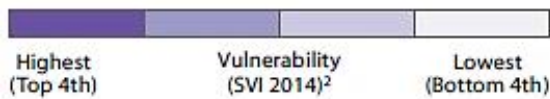
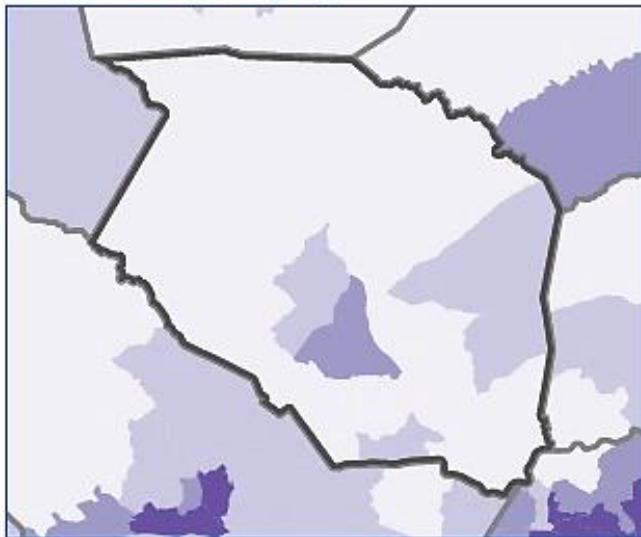
Socioeconomic Status⁵



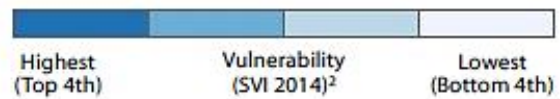
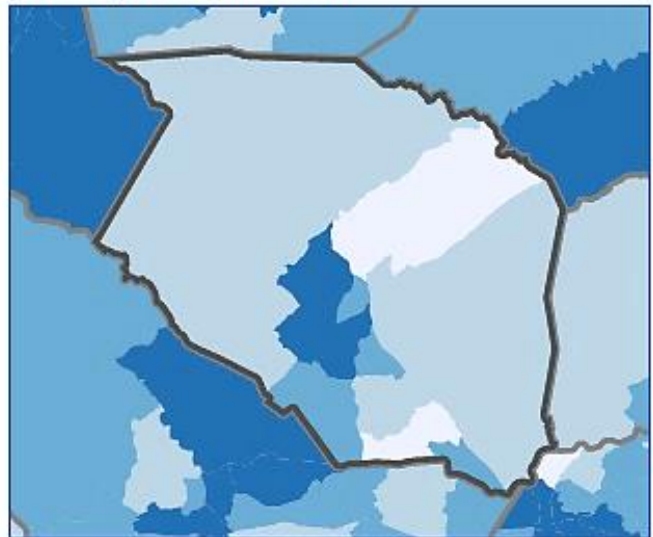
Household Composition⁶



Race/Ethnicity/Language⁷



Housing/Transportation⁸





Summary of Survey Results on Prior CHNA

In the Round 1 survey, a group of 19 individuals provided feedback on the 2014 CHNA. Complete results, including *verbatim* written comments, can be found in Appendix A.

Commenter characteristics:

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	2	8	10
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	6	9	15
3) Priority Populations	5	9	14
4) Representative/Member of Chronic Disease Group or Organization	1	10	11
5) Represents the Broad Interest of the Community	11	4	15
Other			1
Answered Question			19
Skipped Question			0

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

- Chronic Disease
- Teen Health
- Mental Health & Substance Abuse

CMH received the following responses to the question: **“Should the hospital continue to consider the 2014 Significant Health Needs as the most important health needs currently confronting residents in the county?”**

	Yes	No	No Opinion
Chronic Disease	18	0	18
Teen Health	12	5	17
Mental Health & Substance Abuse	18	0	18

CMH received the following responses to the question: **“Should the Hospital continue to allocate resources to help improve the needs identified in the 2014 CHNA?”**

	Yes	No	No Opinion
Chronic Disease	18	0	18
Teen Health	13	4	17
Mental Health & Substance Abuse	18	0	18



Comparison to Other State Counties²⁸

To better understand the community, Caldwell County has been compared to all 100 counties in the state of North Carolina across five areas: Health Outcomes, Health Behaviors, Clinical Care, Social & Economic Factors, and Physical Environment. The last four areas are all Health Factors that ultimately affect the Health Outcomes of Length (Mortality) and Quality of Life (Morbidity).

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

	Caldwell County	North Carolina	U.S. Best
Health Outcomes			
Overall Rank (<i>best being #1</i>)	67/100		
Premature Death (deaths prior to age 75)*	9,000	7,200	5,200
Health Behaviors			
Overall Rank (<i>best being #1</i>)	70/100		
Adult Smoking	20%	19%	14%
Adult Obesity	33%	30%	26%
Physical Inactivity	27%	24%	19%
Access to Exercise Opportunities	66%	75%	91%
Alcohol-impaired Driving Deaths	41%	32%	13%
Teen Births (<i>per 1,000 females age 15-19</i>)	46	36	17
Clinical Care			
Overall Rank (<i>best being #1</i>)	73/100		
Uninsured Rate	17%	15%	8%
Preventable Hospital Stays (<i>per 1,000 Medicare enrollees</i>)	62	49	36
Mammography Screening	66%	68%	71%
Population to Primary Care Physician	2,140:1	1,410:1	1,040:1
Population to Dentist	3,390:1	1,890:1	1,320:1
Population to Mental Health Provider	1,890:1	490:1	360:1
Social & Economic Factors			

²⁸ www.countyhealthrankings.org



Overall Rank (<i>best being #1</i>)	39/100		
Some College Attendance	53%	65%	72%
Unemployment	6.3%	5.7%	3.3%
Children in Poverty	24%	23%	12%
Injury Deaths*	86	65	53
Physical Environment			
Overall Rank (<i>best being #1</i>)	46/100		
Air Pollution (PM2.5 concentration)	9.5 µg/m ³	9.1 µg/m ³	6.7 µg/m ³
Driving Alone to Work	86%	81%	72%

***Per 100,000**



Comparison to Peer Counties²⁹

The Federal Government administers a process to allocate all 3,143 U.S. counties into "Peer" groups. County "Peer" groups have similar social, economic, and demographic characteristics. The counties are ranked across six health and wellness categories and divided into quartiles: Better (top quartile), Moderate (middle two quartiles), and Worse (bottom quartile).

In the below chart, Caldwell County is compared to its peer counties and the U.S. average, but only areas where the county is Better or Worse are listed. (The list and number of peer counties used in each ranking may differ.)

	Caldwell County	Peer Ranking	U.S. Median
Mortality			
Better			
Motor Vehicle Deaths*	17.8	9/44	19.2
Unintentional Injury*	54.2	11/46	50.8
Worse			
Chronic Lower Respiratory Disease (CLRD) Deaths*	70.3	42/46	49.6
Morbidity			
Better			
Alzheimer's Diseases/Deaths	9.8%	10/46	10.3%
Preterm Births	11.9%	10/46	12.1%
Syphilis*	0.0	21/46	0.0
Worse			
None	--	--	--
Healthcare Access & Quality			
Better			
Primary Care Provider Access*	49.8	11/46	48.0
Worse			
None	--	--	--
Health Behaviors			
Better			
Adult Binge Drinking	8.0%	4/29	16.3%
Worse			

²⁹ www.cdc.gov/communityhealth



	Caldwell County	Peer Ranking	U.S. Median
None	--	--	--
Social Factors			
Better			
Violent Crime*	154.6	8/43	199.2
Worse			
Unemployment	9.1%	43/46	7.1%
Physical Environment			
Better			
None	--	--	--
Worse			
Limited Access to Healthy Foods	15.7%	43/46	6.2%
Living Near Highways	2.5%	41/46	1.5%

***Per 100,000**



Conclusions from Demographic Analysis Compared to National Averages

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

- 8.3% more likely to have a **BMI of Morbid/Obese**, affecting 33.3%
- 14.7% more likely to **Consume 3+ Drinks per Session**, affecting 44.6%
- 7.1% less likely to agree "**I am Responsible for my Health**", affecting 60.7%
- 12.1% less likely to agree "**I Follow Treatment Recommendations**", affecting 45.6%
- 6.6% less likely to receive **Routine Cholesterol Screenings**, affecting 47.4%
- 15.2% less likely to receive **Cervical Cancer Screening every 2 years**, affecting 50.8%
- 8% more likely to use the **Emergency Room** (for non-emergent issues), affecting 36.5%

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

- 17.4% less likely to have **Consumed Alcohol in the Past 30 Days**, affecting 44.6%



Conclusions from Other Statistical Data³⁰

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 Caldwell County statistics to the U.S. average, and lists the change since the last date of measurement.

	Current Date of Data	Statistic	Change	Last Date of Data
Caldwell County measures that are WORSE than the U.S. average and got worse				
Female Obesity	2011	37.6%	25.6%	2001
Male Obesity	2011	37.8%	30.9%	2001
Male Physical Activity	2011	51.9%	-1.4%	2001
Caldwell County measures that are WORSE than the U.S. average but improved				
Female Life Expectancy	2014	78.4 years	0 years	1980
Male Life Expectancy	2014	73.5 years	5.3 years	1980
Female Smoking	2012	25.3%	-6.4%	1996
Male Smoking	2012	29.8%	-13.8%	1996
Female Physical Activity	2011	46.9%	27.4%	2001
Caldwell County measures that are BETTER than the U.S. average but got worse				
Female Heavy Drinking	2012	3.8%	38.8%	2005
Male Heavy Drinking	2012	7.8%	33.5%	2005
Female Binge Drinking	2012	7.2%	51.4%	2002
Male Binge Drinking	2012	18.2%	21.6%	2002
Caldwell County measures that are BETTER than the US average and improved				
None	--	--	--	--

³⁰ <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 included:

- \$17,684,455



IMPLEMENTATION STRATEGY



Significant Health Needs

We used the priority ranking of area health needs by the Local Expert Advisors to organize the search for locally available resources as well as the response to the needs by Caldwell Memorial Hospital.³¹ 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 CMH current efforts responding to the need including any written comments received regarding prior CMH implementation actions
- Establishes the Implementation Strategy programs and resources CMH will devote to attempt to achieve improvements
- Documents the Leading Indicators CMH will use to measure progress
- Presents the Lagging Indicators CMH 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, CMH is the major hospital in the service area. CMH is a 110-bed, acute care medical facility located in Lenoir, North Carolina. The next closest facilities are outside the service area and include:

- Blue Ridge Healthcare Valdese, Connelly Springs, NC; 13 miles (23 minutes)
- Blue Ridge Healthcare, Morganton, NC; 17.7 miles (28 minutes)
- Frye Regional Medical Center, Hickory, NC; 18 miles (29 minutes)
- Catawba Valley Medical Center, Hickory, NC; 24.8 miles (36 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 CMH 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.

³¹ Response to IRS Schedule h (Form 990) Part V B 3 e



1. MENTAL HEALTH & SUBSTANCE ABUSE – 2014 Significant Need; Suicide is #10 leading cause of death and higher than expected compared to US; Population to Mental Health Provider ratio worse than NC and US

Public comments received on previously adopted implementation strategy:

- *New mental health unit going in close to DSS. This office is not run by the hospital (I could be mistaken). This is the only area that I am aware of that is dealing with mental health issues.*
- *I have not been involved with activities or observed actions taken by the hospital to address these issues.*
- *again, based on my recent and personal interaction in the hospital, I cannot believe this has been a documented priority. not demonstrated or obvious in the hospital*
- *Caldwell has requested State Appropriations for Inpatient Psychiatric Beds at this location.*
- *Mental health is not a state priority and comes then at a much higher price for the community, however, no less critical or urgent. The two are often intertwined. We need to do more to reduce the incidents. The support for mental health services has been increased but the hospital only sees the patients at their most critical moment. Unfortunately that is often in the ER. Identifying these issues when they can be helped--prior to crisis--is paramount--for both mental health and drug addiction.*
- *Don't know*

CMH services, programs, and resources available to respond to this need include:³²

- Employee Assistance Program available to employees and family members that covers five counseling sessions
- Outpatient depression screenings provided at all clinics, including PHQ2 performed by medical assistants and PHQ9 performed as needed based on initial screening
- Collaborative relationship with state- and Medicaid-funded local management entity (LME), Vaya Health, providing mental health screenings in the emergency department
- Mental health meeting held quarterly at the hospital that includes the local department of social services, health department, local police department, and Vaya Health
- Resource guide made available in all clinics to help patients access healthcare services, but specifically mental health services
- Safe room/holding area specifically designed in the emergency department for patients presenting in mental distress
- Mental health counselor recruited to assist with placement of patients presenting with mental health issues in the emergency department
- Partnering with Project Lazarus, a regional collaboration, to help address issues of prescription drug abuse

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



- Physicians consistently check pharmaceutical database to confirm recent prescriptions for controlled substances and also utilize pain contracts to help manage prescription drug use
- Hospital promotes ‘black boxes’ available to the community to dispose of medications and controlled substances
- Hospital provides CMEs to medical staff to educate on substance abuse and consistency of policies

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

- In the process of adding an in-house psychiatric unit
 - Recruiting psychiatrists, counselors, social workers, mental health technicians, etc., to manage the services and improve access to mental health care
 - Unit will also include an outpatient psychiatric clinic
 - Collaborating within the UNC Health System to learn from other facilities and implement the best program possible
- Piloting a program with one primary care physician to offer telemedicine psychiatric services in partnership with UNC; if the pilot is successful, CMH will consider expanding the program to other providers
- Discussing options for telepsychiatry in the emergency department
- Developing system-wide protocol for the use of Narcan in emergency department

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

- Measuring progress from implementation of depression screenings and developing action plans based on results
- Evaluating impact of C3 unit
- Tracking hours that patients are held in emergency department

Anticipated results from CMH Implementation Strategy

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



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

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

- Number of depression screenings performed = 7,696 (2017)

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

- Suicide death rate = 15.9/100,000³³

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

Organization	Contact Name	Contact Information
Caldwell C3 Comprehensive Care Center	Donna Stevens	2415 Morganton Blvd., SW, Lenoir, NC 28645 (828) 394-5563 http://www.cityoflenoir.com/index.asp?SEC=002442AD-F21F-4C02-9FA7-CFF2481A9C2F&DE=7987C90B-5B6B-4DC0-8FDA-1E6035C6DAEA&Type=B_BASIC
Caldwell County Project Lazarus	Anna Martin	https://www.facebook.com/CaldwellCountyProjectLazarus/
Vaya Health	Kathlene Edgerton	825 Wilkesboro Blvd, Lenoir, NC (800) 849-6127 http://vayahealth.com/venue/smoky-mountain-mco-lenoir/

³³ Leading Causes of Death. <http://www.worldlifeexpectancy.com/usa/north-carolina-suicide>; 2015



Organization	Contact Name	Contact Information
UNC Healthcare System	Will Arey	101 Manning Dr, Chapel Hill, NC 27514 (984) 974-1000 www.unchealthcare.org
Lenoir Police Department	Captain Brett Phelps	1035 West Ave NW, Lenoir, NC 28645 (828) 757-2100 http://www.cityoflenoir.com/index.asp?Type=B_BASIC&SEC=%7B18D4E395-DE08-44A1-AE84-E898F7968A93%7D
Caldwell County Sheriff's Department	Major Marc Jarden	2351 Morganton Blvd SW, Lenoir, NC 28645 (828) 754-1518 www.caldwellcountync.org/sheriff
Caldwell County Emergency Management	Ed Anderson	www.caldwellcountync.org/emergency-management

Other local resources identified during the CHNA process that are believed available to respond to this need:³⁴

Organization	Contact Name	Contact Information
Caldwell County Social Services	Will Wakefield	2345 Morganton Blvd SW, Lenoir, NC 28645 (828) 426-8200 www.caldwellcountync.org/social-services

³⁴ 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



Organization	Contact Name	Contact Information
West Caldwell Health Council (FQHC)	Tom McCrary	Happy Valley Medical Center 1345 NC Highway 268, Lenoir, NC, 28645 (828) 754-6850 Collettsville Medical Center 4330 Collettsville Rd, Collettsville, NC 28611 (828) 754-2409 www.westcaldwellhc.org
Caldwell County Health Department	Joshua Swift	2345 Morganton Blvd SW, Lenoir, NC 28645 (828) 426-8400 www.caldwellcountync.org/health-department
RHA Behavioral Health	Derrick Jordan	2415 Morganton Blvd SW, Lenoir, NC 28645 (828) 394-5563 rhahealthservices.org



2. CHRONIC DISEASE – 2014 Significant Need; Premature Death is higher than NC avg and US best; 7 leading causes of death occur at higher than expected rates compared to US

Public comments received on previously adopted implementation strategy:

- *Not aware of any proactive actions the hospital is currently taking to address these issues.*
- *Embedded case managers in the physician practices help with the management of chronic disease. Nutrition services have been added in several physician practices. Implementation of Patient Centered Medical Homes will address chronic disease management.*
- *Supporting Helping Hands Clinic*
- *no knowledge*
- *The cancer center has been a blessing in our community.*
- *Excellent followup on patients to assure the minimum standards are being met for each chronic illness detected.*
- *In years past the hospital has been a community champion of healthy living choices, exercise and community education. It would also be helpful if total hospital culture evidenced the same high priority. I am overweight myself, however, I am not the person passing along doctor's dietary and exercise instruction to patients whose lives depend on it. Priority needs to be stepped up--me included.*
- *I don't know, aside from keeping Qwest operational and offering such great programs*

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

- Perform numerous screenings and track metrics in clinics to measure and address when stats are above certain levels
 - Placed retinal cameras in primary care practices to assist in early detection of diabetic retinopathy
 - Management of hypertension
 - Breast cancer screenings, colorectal cancer screenings, and cervical cancer screenings
 - Depression screenings
 - BMI screenings and follow-up
 - Tobacco screening and cessation assistance
 - Fall risk assessments
 - Post-discharge medication reconciliation
 - Track and encourage flu shots, Pneumovax
- Three provider practices that are patient-centered medical home-certified
- Tracking metrics to improve operations and patient care:



- Tracking emergency department utilization for patients and launched work group to manage and address
- Tracking SNF readmissions
- Tracking all-cause readmissions and per beneficiary cost per month for ACO patients
- Measuring and monitoring patient satisfaction and provision of patient education
- CHAMP (Caldwell Health and Mobility Partnership) program, in partnership with Caldwell County Community and Technical Institute, evaluates patients for fall risk and refers to clinics or primary care providers
- Provide smoking cessation assessment and counseling for inpatients and refer to outpatient counseling at Quest 4 Life (wellness clinic)
- At the Employee First Clinic (hospital-owned clinic for employees and family members), providers track chronic illnesses and insurance premium incentives are offered for managing chronic illnesses
- Recruited new radiation oncologist, nurse practitioner, nurse navigator, and primary care providers
- Added Sleep Medicine as a specialty due to the connections to many chronic illnesses
- Wellness program for employees includes free membership at Quest 4 Life
- Outpatient nutrition and diabetes services through Quest 4 Life and primary care practices include education sessions and cooking classes
- Health services provided to local employers to help employees manage overall wellness and chronic health needs
 - Quest 4 Life provides industry health fairs to local employers
 - Health Works program places advanced practice nurses on site at local employers (25+) to help with urgent care issues and encourage preventive care and screenings
 - Provide pre-employment screenings and ergonomic studies
 - Facilitate access to urgent care and primary care services through local clinic
 - Quest 4 Life worked with Appalachian State University on a research project to study the effects of ‘an apple a day’ with local employer population
- Urgent care providers facilitate referrals to primary care physicians and find locations/hours that work best for patients
- McCreary Cancer Center sponsors annual cancer screening day (September 29)
- Implemented group visits with pediatric practices that address childhood obesity; collaborating with Brenner FIT (Families in Training) program at Wake Forest Children’s Hospital for follow-up consultations
- Implemented CT screening for lung cancer
- Provided free annual high school athletic EKG screenings
- Provide reduced cost mammography and chest X-ray interpretations for the health department
- All employees are required to receive a flu vaccination



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

- Working to have all practices certified as patient-centered medical homes
- Bringing in intensivist care manager
- Adding outpatient nutrition and diabetes services to additional primary care practices
- Enhancing mammography services by adding 3D mammography

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

- Added MOB, RiverCrest, in southern part of county to improve access (added one physician and new expanded location)

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

- Number of employees (210) and family members using Quest 4 Life (71)
- Number of tobacco counseling sessions provided to inpatients = average 550 per year



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

- Adult Obesity Rate = 33%³⁵
- Adult Smoking = 20%³⁶

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

Organization	Contact Name	Contact Information
Caldwell Community College and Technical Institute	Edward Terry	2855 Hickory Blvd, Hudson, NC 28638 (828) 726-2200 www.cccti.edu
Caldwell County Health Department	Joshua Swift	2345 Morganton Blvd SW, Lenoir, NC 28645 (828) 426-8400 www.caldwellcountync.org/health-department
UNC Healthcare System	Will Arey	101 Manning Dr, Chapel Hill, NC 27514 (984) 974-1000 www.unchealthcare.org
Local Employers		
Helping Hands Clinic	John Francis	810 Harper Ave NW, Lenoir, NC 28645 (828) 754-8565 www.helpinghandsclinic.org
Caldwell Physicians Network	Rocky Brooks	caldwellmemorial.org/physicians
West Caldwell Health Council (FQHC)	Tom McCrary	Happy Valley Medical Center 1345 NC Highway 268, Lenoir, NC, 28645 (828) 754-6850 Collettsville Medical Center 4330 Collettsville Rd, Collettsville, NC 28611 (828) 754-2409 www.westcaldwellhc.org

³⁵ Percentage of adults (age 20 and older) that report a BMI of 30 or greater. www.countyhealthrankings.org. 2013.

³⁶ Adult Smoking is the percentage of the adult population that currently smokes every day or most days and has smoked at least 100 cigarettes in their lifetime. www.countyhealthrankings.org. 2015.



Organization	Contact Name	Contact Information
Caldwell County School District	Libby Brown	1914 Hickory Blvd., SW, Lenoir, NC 28645 (828) 728-8407 www.caldwellschools.com
Dr. Dy (Cross River Cardiology)	Paula Brisco	639 Pennton Ave SW, Lenoir, NC 28645 (828) 572-0778 www.crossrivercardiology.com
Caldwell County Emergency Management	Ed Anderson	www.caldwellcountync.org/emergency-management
McCreary Cancer Center	Tim Rote	212 Mulberry St SW, Lenoir, NC 28645 (828) 759-4960 https://unclineberger.org/patientcare/caldwell



3. **OBESITY – Adult Obesity and Physical Inactivity rates higher than NC averages and US best; Access to Exercise Opportunities below NC average and US best; Female and Male Obesity rates worse than US average and have gotten worse; Female and Male Physical Activity rates worse than US averages**

Public comments received on previously adopted implementation strategy:

This was not a 2014 Significant Need, so no comments were solicited.

CMH does not intend to develop a separate implementation strategy for this Significant Need

Because Obesity is also a Chronic Disease, we are choosing not to develop a separate implementation strategy for this need at this time.

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



4. CANCER – #2 Leading Cause of Death and higher than expected compared to US

Public comments received on previously adopted implementation strategy:

This was not a 2014 Significant Need, so no comments were solicited.

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

- Perform numerous screenings and track metrics in clinics to measure and address when stats are above certain levels, specifically breast cancer screenings, colorectal cancer screenings, cervical cancer screenings, and tobacco screening and cessation assistance
- Implemented CT screening for lung cancer
- Provide reduced-cost mammography and chest X-ray interpretations for the health department
- McCreary Cancer Center sponsors annual cancer screening day (September 29)
- Recruited new radiation oncologist, nurse practitioner, and nurse navigator in McCreary Cancer Center
- Provide smoking cessation assessments and counseling for inpatients and refer to outpatient counseling at Quest 4 Life (wellness clinic)
- Medical and radiation oncology, surgical services, and infusion therapy services offered locally
- Nutrition counseling, restorative yoga, and lymphedema therapy (outpatient OT) available to cancer patients
- Interdisciplinary Cancer Board performs a twice monthly review of every cancer diagnosis to help coordinate care
- McCreary Cancer Center meets criteria for American College of Surgeons designation
- Partner with Wig Bank for support groups and services provided to patients
- PET scans and MRI available on site (MRI enhanced this year to add breast cancer screenings)
- Participate in American Cancer Society programs

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

- Enhancing mammography services by adding 3D mammography



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

- Cancer screenings (FY2017)
 - Breast = 2,378
 - Cervical Cancer = 1,613
 - Colorectal Cancer = 4,591

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

- Cancer death rate = 201.7/100,000³⁷

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

Organization	Contact Name	Contact Information
The Wig Bank of Caldwell County	Angie Rash	226 Mulberry St. SW, Lenoir, NC 28645 (828) 726-9111 wigbank.org

³⁷ Leading Causes of Death. <http://www.worldlifeexpectancy.com/usa/north-carolina-cancer>. 2015.



Organization	Contact Name	Contact Information
UNC Healthcare System	Will Arey	101 Manning Dr, Chapel Hill, NC 27514 (984) 974-1000 www.unchealthcare.org
Caldwell Hospice and Palliative Care	Lisa Caviness	902 Kirkwood St NW, Lenoir, NC 28645 (828) 754-0101 www.caldwellhospice.org
Caldwell County Health Department	Joshua Swift	2345 Morganton Blvd SW, Lenoir, NC 28645 (828) 426-8400 www.caldwellcountync.org/health-department
Helping Hands Clinic	John Francis	810 Harper Ave NW, Lenoir, NC 28645 (828) 754-8565 www.helpinghandsclinic.org
Susan G Komen Foundation	Brittany Garrett	komennorthwestnc.org
Relay for Life	Lee Bogle	http://www.relayforlife.org/caldwellnc https://www.facebook.com/pg/caldwellrelay/about/?ref=page_internal
American Cancer Society	Amelia Sloan	https://www.cancer.org/about-us/local/north-carolina.html



5. HEART DISEASE – #1 Leading Cause of Death

Public comments received on previously adopted implementation strategy:

This was not a 2014 Significant Need, so no comments were solicited.

CMH does not intend to develop a separate implementation strategy for this Significant Need

Because Heart Disease is also a Chronic Disease, we are choosing not to develop a separate implementation strategy for this need at this time.

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



Other Needs Identified During CHNA Process

6. ALZHEIMER'S
7. ACCESSIBILITY/AFFORDABILITY
8. DIABETES
9. ALCOHOL USE
10. SUICIDE
11. TOBACCO USE
12. LUNG DISEASE
13. TEEN HEALTH – 2014 SIGNIFICANT NEED
14. NEED WRITTEN IN – DENTAL FOR UNINSURED
15. FLU/PNEUMONIA
16. KIDNEY DISEASE
17. FEMALE/MATERNAL HEALTH
18. ACCIDENTS
19. STROKE



Overall Community Need Statement and Priority Ranking Score

Significant needs where hospital has implementation responsibility³⁸

1. Mental Health & Substance Abuse
2. Chronic Disease
4. Cancer

Significant needs where hospital did not develop a separate implementation strategy³⁹

3. Obesity
5. Heart Disease

Other needs where hospital developed implementation strategy

None

Other needs where hospital did not develop implementation strategy

6. Alzheimer's
7. Accessibility/Affordability
8. Diabetes
9. Alcohol Use
10. Suicide
11. Tobacco Use
12. Lung Disease
13. Teen Health – 2014 Significant Need
14. Need Written In – Dental For Uninsured
15. Flu/Pneumonia
16. Kidney Disease
17. Female/Maternal Health
18. Accidents
19. Stroke

³⁸ Responds to Schedule h (Form 990) Part V B 8

³⁹ Responds to Schedule h (Form 990) Part V Section B 8



APPENDIX



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

Hospital solicited written comments about its 2014 CHNA.⁴⁰ 19 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	2	8	10
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	6	9	15
3) Priority Populations	5	9	14
4) Representative/Member of Chronic Disease Group or Organization	1	10	11
5) Represents the Broad Interest of the Community	11	4	15
Other			1
Answered Question			19
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?

- *Low-income*
Older adults
- *people with major comorbidity and complications*
- *low-income group: access to affordable health care*
Older adults

⁴⁰ Responds to IRS Schedule h (Form 990) Part V B 5



Rural area

- *Large low income population with poor dietary habits, which often leads to obesity, increased risk of heart disease, high blood pressure, and diabetes.*
- *Women, Older adults, Low-income, Rural, Racial, Disabled.*
- *Low income, uninsured Women Seniors Rural residents Special needs - homeless*
- - *Racial and ethnic minority groups*
 - *Low-income groups*
 - *Women*
 - *Older adults*
 - *Residents of rural areas*
 - *Individuals with with disabilities*
 - *Lesbian Gay Bisexual Transsexual (LGBT)*
- *Older Adults, Low Income groups*
- *Low income groups, residents of rural areas, older adults*
- *Low income/ Older adults*
- *Individuals with a need for long term psychiatric care.*
- *Low-Income groups, Children, Older Adults- have pressing needs*
- *Low-income groups, Children, Older adults, LGBT*
- *Low income groups and chronic care is common in our community. It is very difficult for this group to receive the medication and or treatment they need.*
- *Low income groups as a result of generational poverty or situational poverty have poor health, poor habits and do not seek health care unless it is an emergent situation. Drug use is significant. Children born to families with drug issues seems to be producing a larger percentage of young school age children with special needs. The aging of our population has produced increasing numbers of adults with poor health and comorbidity issues and complications.*
- *Low income/minority/older adults*
- *Low-income groups; Older adults; Individuals with special needs including those with disabilities, in need of chronic care, or in need of end-of-life care; people with major comorbidity and complications*



In the 2014 CHNA, there were three health needs identified as “significant” or most important:

1. Chronic Disease
2. Teen Health
3. Mental Health & Substance Abuse

3. Should the hospital continue to consider the 2014 Significant Health Needs the most important health needs currently confronting residents in the county?

	Yes	No	No Opinion
Chronic Disease	18	0	18
Teen Health	12	5	17
Mental Health & Substance Abuse	18	0	18

Comments:

- *Addiction is a mental health issue. This needs to be addressed with the current growth in opioid addiction. Overall health of our community needs to improve. Healthy lifestyles, diet, etc."*
- *Mental Health is definitely an area we need extra resources*
- *The emergent mental health and substance abuse issues are increasingly affecting families, schools and communities. That priority should be elevated. Progress has been made in teen pregnancy however sexual abuse with younger children and teens has seemed to increase.*
- *It seems the drug situation in particular has dramatically worsened.*

4. Should the Hospital continue to allocate resources to help improve the needs identified in the 2014 CHNA?

	Yes	No	No Opinion
Chronic Disease	18	0	18
Teen Health	13	4	17
Mental Health & Substance Abuse	18	0	18

Comments:

- *If the hospital has been allocating resources to help improve the mental health and substance abuse issues in Caldwell County, they have done so very quietly because I am not aware of them.*
- *prioritize funding according to the current needs. More resources should be applied to 1 and 3.*

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

- *Better services and patient care in ER*
- *geriatric physicians*
- *Prescription pain killers are too easily prescribed by physicians both in terms of length of use as well as*



medication strength. Regardless of income and age, but with particular carelessness for youth and young adults, prescription meds in today's world should be more conservatively used.

- As mentioned above the drug situation has worsened. Not sure how to fix but it needs more attention.

6. Please share comments or observations about keeping CHRONIC DISEASE among the most significant needs for the Hospital to address.

- Healthy lifestyles are more expensive and make it difficult for much of the working class. Local statics show that we have high diabetes, high blood pressure, and obesity rates. Need to be more proactive in addressing these types of issues in the long-term. This is a cultural issue that will take time (decades) to address.
- I serve on the Chronic Disease task force started during the 2014 survey. Efforts were made to provide free Chronic Disease Self Management courses to the community. The need to continue efforts is still very much needed, individuals trying to manage one or more chronic disease need to be empowered with the education on how to successfully control their disease(s). As a diabetes educator, I have seen first hand how providing someone with knowledge can make a tremendous difference in how they manage their disease. Identifying individuals with chronic disease and/or at risk of developing chronic disease through community health screenings, health fairs, and in physician practices, can reduce health care costs and improve the health of our community.
- I would think that chronic diseases eat up more of the health care dollar than anything else, as this population is certainly a very at risk group who will need more and more services if they are not under someone's care.
- All are significant health needs.
- no knowledge
- Chronic disease is very prevelant in older adults yet we do not have a geriatric phsycian in our system. The statistics in our county reflect a growing aging population and we must be prepared to treat the needs of this population.
- Health fairs including Blood work and followup .
- This continues to be a problem in our County. Great strides have been made, but more PREVENTION efforts are needed. More prevention efforts in the schools are needed.
- Increasing funding for preventative health will decrease cost of lengthy hopsital stays.
- It is apparent by the case loads that CMH sees more chronic disease patients than they should. Lifestyle issues are the culprit.
- Chronic-yes. In looking around I don't see how this has improved with the increase of obesity that leads to so many other issues listed as chronic.If we could impact obesity we'd impact many of the others. Teen health- pregnancy rates have decreased but I think this is a constant. Mental health and substance abuse- biggest problem is drugs. It's affecting everything..courts, DSS, ability to find adequate employees because of felony convictions, etc. This is such a big problem and everyone is going to have to work together.



7. Please share comments or observations about the implementation actions the Hospital has taken to address CHRONIC DISEASE.

- *Not aware of any proactive actions the hospital is currently taking to address these issues.*
- *Embedded case managers in the physician practices help with the management of chronic disease. Nutrition services have been added in several physician practices. Implementation of Patient Centered Medical Homes will address chronic disease management.*
- *Supporting Helping Hands Clinic*
- *no knowledge*
- *The cancer center has been a blessing in our community.*
- *Excellent followup on patients to assure the minimum standards are being met for each chronic illness detected.*
- *In years past the hospital has been a community champion of healthy living choices, exercise and community education. It would also be helpful if total hospital culture evidenced the same high priority. I am overweight myself, however, I am not the person passing along doctor's dietary and exercise instruction to patients whose lives depend on it. Priority needs to be stepped up--me included.*
- *I don't know, aside from keeping Qwest operational and offering such great programs*

8. Please share comments or observations about keeping TEEN HEALTH among the most significant needs for the Hospital to address.

- *Diet, exercise, etc. Again, the hospital needs to be proactive in helping get the message out about this.*
- *Education about safe activities and bullying will help protect our teens. Healthy teens are more likely to grow into healthy adults which will help improve the overall health of our community.*
- *Cheaper to focus on efforts that may prevent future healthcare crises than intervene once they occur.*
- *Teen pregnancy is a huge problem for health and the community.*
- *no knowledge*
- *Teen health will continue to be a need .*
- *I have no involvement or observations to report.*
- *Teen Health and Mental Health and Substance Abuse needs to be emphasized more in the GENERAL POPULATION. Adults need more education as to why this is a problem.*
- *Perhaps this is an area I am not as informed as I once was, but this priority is reduced for me.*
- *I just think if we're not working with teens we could quickly see an increase in pregnancies, etc*



9. Please share comments or observations about the implementation actions the Hospital has taken to address TEEN HEALTH.

- *Unaware of any current actions taken by hospital to deal with this issue.*
- *I have not been involved with activities or observed actions taken by the hospital to address teen health.*
- *Don't know of any.*
- *no knowledge*
- *Don't know*

10. Please share comments or observations about keeping MENTAL HEALTH & SUBSTANCE ABUSE among the most significant needs for the Hospital to address.

- *Very important to address the mental health of this community. Statistics show an increase in opioid addiction in the area.*
- *Huge concern in our community. The health and safety of our community is tremendously effected by mental health issues, access to care, and substance abuse.*
- *This is a major problem in Caldwell County and I do not know of efforts the hospital has made to be part of the solution. It seems they could work harder to reign in those physicians who are prescribing opiods and other pain meds so liberally, or require that those who are on these meds for a certain maount of time be referred to education or counseling programs. Very few of the physicians refer their patients to mental health services.*
- *Mental Health and Substance Abuse remains a significant need.*
- *these services are horrible, I am a working professional serving this population and had no idea this has been a priority. services in ER fail to demonstrate this*
- *Mental Health and Substance Abuse continue to be a growing problem in all age groups in our community. It is imperative that we continue to have physicians in Caldwell county who can diagnose and treat these issues.*
- *Using mental health questions part of every patients regiment.*
- *Mental Health and Substance Abuse is becoming a MUCH bigger problem. Early intervention in the elementary schools is needed.*
- *This has become more of crisis need to be met in this community. Expand the priority, please.*
- *I've stated repeatedly that this is a major problem.*

11. Please share comments or observations about the implementation actions the Hospital has taken to address MENTAL HEALTH & SUBSTANCE ABUSE.

- *New mental health unit going in close to DSS. This office is not run by the hospital (I could be mistaken). This is the only area that I am aware of that is dealing with mental health issues.*
- *I have not been involved with activities or observed actions taken by the hospital to address these issues.*



- *again, based on my recent and personal interaction in the hospital, I cannot believe this has been a documented priority. not demonstrated or obvious in the hospital*
- *Caldwell has requested State Appropriations for Inpatient Psychiatric Beds at this location.*
- *Mental health is not a state priority and comes then at a much higher price for the community, however, no less critical or urgent. The two are often intertwined. We need to do more to reduce the incidents. The support for mental health services has been increased but the hospital only sees the patients at their most critical moment. Unfortunately that is often in the ER. Identifying these issues when they can be helped--prior to crisis--is paramount--for both mental health and drug addiction.*
- *Don't know*

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

- *I am proud to be from this community and want to see it thrive. These questions made me realize that our hospital needs to do more to address these issues. If they are addressing this issues, I do not know it. To me, that is a problem that needs to be solved quickly and effectively.*
- *Low socioeconomic and education levels are important factors in all areas of community health. If we cannot educate our community or if they do not have access to affordable health care, our efforts to improve the health of our community will be hindered.*
- *I firmly believe that Caldwell County is an aging community and it is imperative that we be prepared to care for them.*
- *Again their needs to be an emphasis placed on mental health and how to deal with placement of these individuals*
- *The enormous need for Inpatient Psychiatric Care in Caldwell County. I can speak from personal experience about the total lack (or non existent) psychiatric care for patients in need. For families dealing with issues like Bi-Polar disorder there are limited facilities in the surrounding areas and long waits (up to 6 months) to receive psychiatric care. In may cases the burden rest completely on the family to seek care anywhere they can which is often the ER. True and lasting results can only be achieved by allowing a patient to become acclimated to the various prescribed medications that help manage the disorder. This takes time and in my experience weeks before the meds can help stabilize the individual. I can think of no greater need in our area than utilizing the available facilities and resources at Caldwell UNC Healthcare.*
- *Caldwell County desperately needs a mental health/substance abuse center much like Frye South.*
- *Collaboration with the free clinic, public health and FQHC and with Mental Health services is extremely important*
- *The economic crisis from 2002 to 2012 left a serious hole in the fabric of Caldwell County. How individuals and families handled it has in some cases done permanent damage. The greatest challenge has been re-establishing positive and healthy norms. The reviving local economy has been a good thing, but not equally for all. Many acquired drug and financial and legal problems that are not easily repaired. This isn't a hospital issue, however, the side effects and results are often finally seen in the hospital at the critical point.*



- *No*
- *I think there should be a bigger emphasis on prevention*



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

Need Topic	Total Votes	Number of Local Experts Voting for Needs	Percent of Votes	Cumulative Votes	Need Determination
Mental Health & Substance Abuse – 2014 Significant Need	298	13	23.01%	23.01%	Significant Needs
Chronic Disease – 2014 Significant Need	153	13	11.81%	34.83%	
Obesity	139	13	10.73%	45.56%	
Cancer	96	11	7.41%	52.97%	
Heart Disease	83	10	6.41%	59.38%	
Alzheimer's	83	9	6.41%	65.79%	Other Identified Needs
Accessibility/Affordability	78	7	6.02%	71.81%	
Diabetes	66	10	5.10%	76.91%	
Alcohol Use	52	6	4.02%	80.93%	
Suicide	47	7	3.63%	84.56%	
Tobacco Use	39	7	3.01%	87.57%	
Lung Disease	34	8	2.63%	90.19%	
Teen Health – 2014 Significant Need	28	7	2.16%	92.36%	
Need Written In - Dental for uninsured	20	1	1.54%	93.90%	
Flu/Pneumonia	19	5	1.47%	95.37%	
Kidney Disease	18	6	1.39%	96.76%	
Female/Maternal Health	15	5	1.16%	97.92%	
Accidents	14	5	1.08%	99.00%	
Stroke	13	5	1.00%	100.00%	
Total	1,295		100.00%		

Individuals Participating as Local Expert Advisors⁴¹

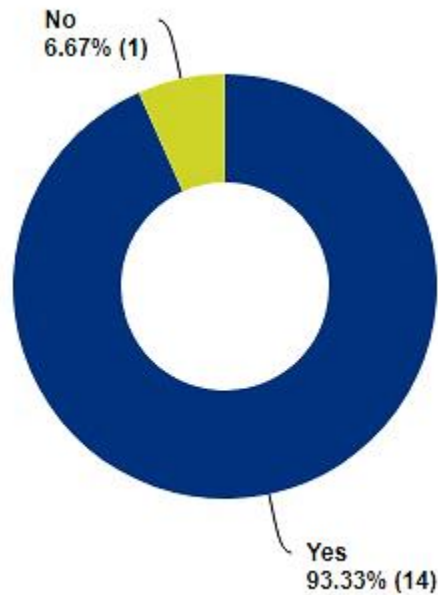
	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	4	6	10
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	5	7	12
3) Priority Populations	6	6	12
4) Representative/Member of Chronic Disease Group or Organization	4	7	11
5) Represents the Broad Interest of the Community	15	0	15
Other			1
Answered Question			16
Skipped Question			0

⁴¹ 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 Caldwell County to all other North Carolina counties?

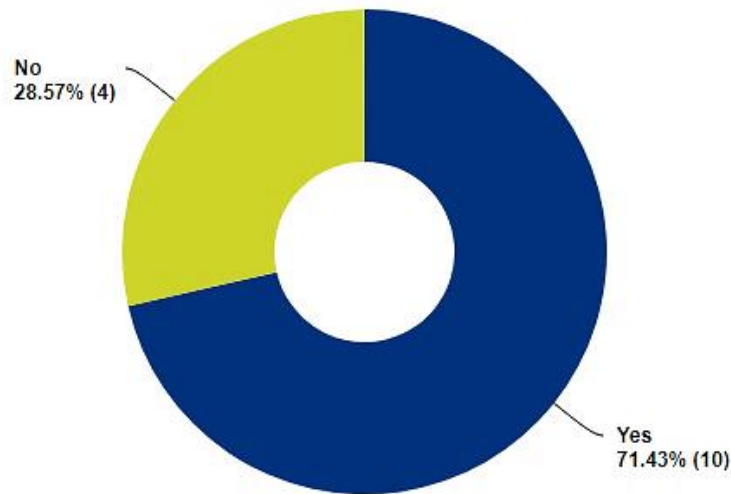


Comments:

- *I question how the statistics are calculated. As an employer of over 1000 people in the Caldwell and Catawba County area our organization provides free access to a full time Nurse Practitioner and Nurse. Free on site mammograms, yearly health screenings, flue shots, incentives to quit smoking, maintain a BMI under 30 and Spouse care.*
- *General observation and normal interaction with the population confirms the above data on an anecdotal basis.*
- *Experience in public health dentistry and statistical knowledge of county and state access and availability rankings.*



Question: Do you agree with the comparison of Caldwell County to its peer counties?



Comments:

- *Unemployment is less than 5% and is one of the lowest rates in NC. Again one must question the validity of the data.*
- *Unemployment today is 4% in Caldwell County and we are ranked 26th of the 100 counties. Your information is from 2013, 4 very long years ago. We now have a new grocer selling health foods, Farm to Family.*
- *I agree with most of this, but thought that the unemployment rate had now dropped to well below 7%.*
- *I believe Caldwell County should score worse against Peer Counties in Health Behaviors.*
- *Unemployment rate is 4% Binge drinking statistic seems to be an outlier. I didn't realize that syphilis was that big of an issue here. Why is this the first time I am learning this?*



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

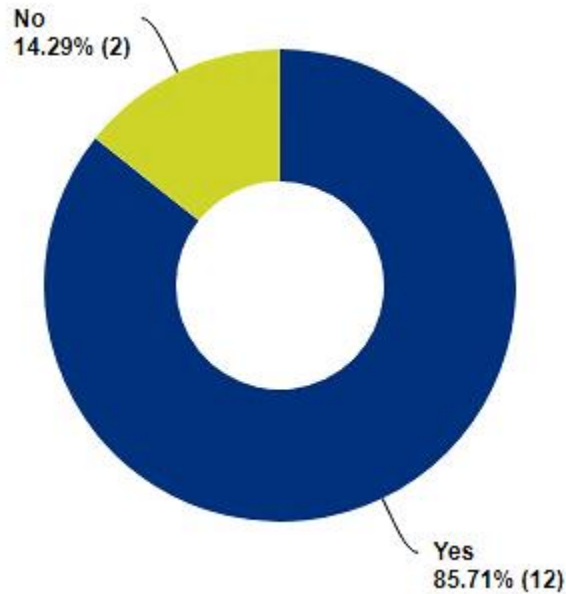


Comments:

- *I would think the unemployment rate is higher than stated*
- *Five years of experience as a public health dentist in Caldwell county.*



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

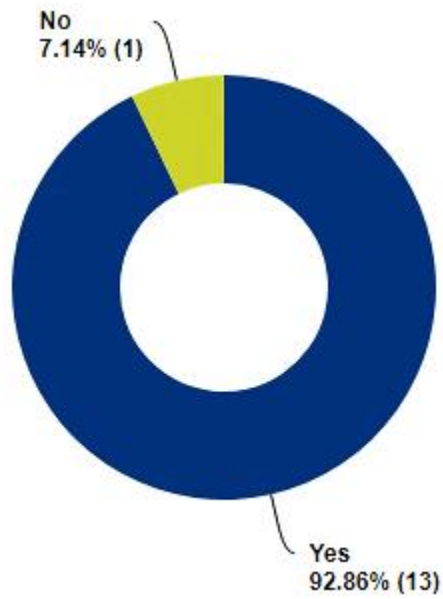


Comments:

- *I would think the Sawmills area would be the highest quartile of vulnerability Much greater concentration of poverty.*
- *The center of the County around Lenoir should actually have more resources to respond to disasters than areas farther away from Lenoir.*
- *Experience and use of Caldwell county demographics.*



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

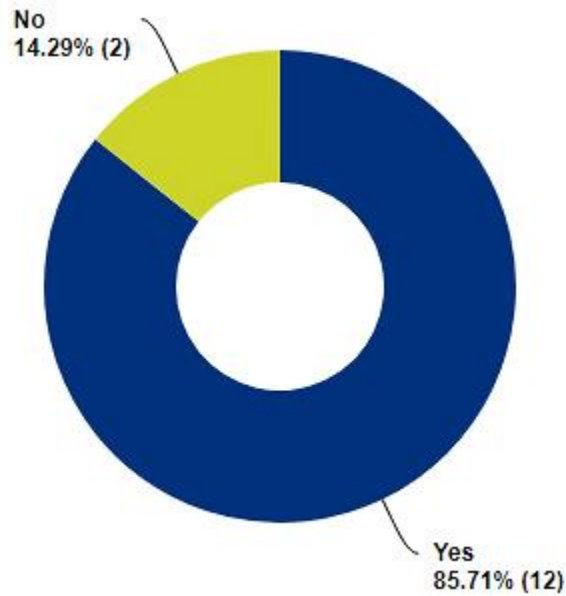


Comments:

- *I have no data, but I am surprised that with such a high obesity rate that diabetes does not rank higher on the scale.*
- *Lung disease concerns me. Because of smoking or environmental factors???*
- *Historic industries and employment professions in the county.*



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

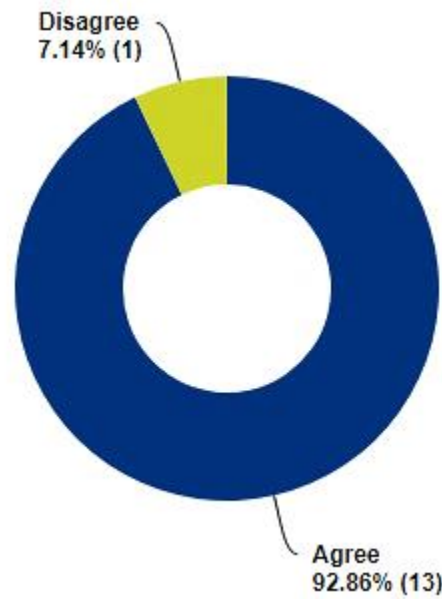


Comments:

- *I question how and where the binge drinking statistics are calculated.*
- *Binge drinking data - how was this taken?*



Question: Do you agree with the written comments received on the 2014 CHNA?

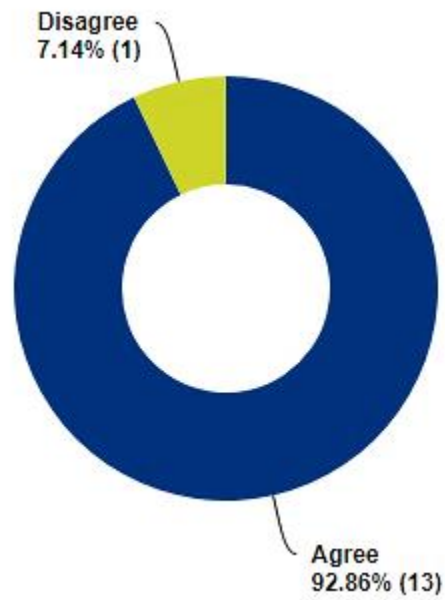


Comments:

- *I do not think these comments reflect the top priorities in Healthcare for Caldwell County*
- *The drug situation with opioids, meth and heroin in the area is continuing to get worse.*
- *In addition, obesity should be recognized as a root cause of many types or chronic illness.*
- *Prescription drug issue is a big deal. I am glad to see that on the list.*



Question: Do you agree with the additional written comments received on the 2014 CHNA?



Comments:

- *Mental health and abuse needs to be a priority.*



Appendix C – National Healthcare Quality and Disparities Report⁴²

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

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

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

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

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

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

Trends

- From 2000 to 2010, the percentage of adults ages 18-64 who reported they were without health insurance coverage at the time of interview increased from 18.7% to 22.3%.
- From 2010 to 2013, the percentage without health insurance decreased from 22.3% to 20.4%.
- During the first half of 2014, the percentage without health insurance decreased to 15.6%.
- Data from the Gallup-Healthways Well-Being Index indicate that the percentage of adults without health insurance continued to decrease through the end of 2014,⁴³ consistent with these trends.

⁴² <http://www.ahrq.gov/research/findings/nhqdr/nhqdr14/index.html> Responds to IRS Schedule h (Form 990) Part V B 3 i

⁴³ Levy J. In U.S., Uninsured Rate Sinks to 12.9%. <http://www.gallup.com/poll/180425/uninsured-rate-sinks.aspx>.



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

Trends

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

Disparities

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

Trends

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

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

Trends

- Historically, Blacks and Hispanics have had higher rates of un-insurance than Whites.⁴⁴

Disparities

- During the first half of 2014, the percentage of adults ages 18-64 without health insurance decreased more quickly among Blacks and Hispanics than Whites, but differences in un-insurance rates between groups remained.
- Data from the Urban Institute's Health Reform Monitoring System indicate that between September 2013 and September 2014, the percentage of Hispanic and non-White non-Hispanic adults ages 18-64 without health insurance decreased to a larger degree in states that expanded Medicaid under the Affordable Care Act than in states that did not expand Medicaid.⁴⁵

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

Disparities

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

⁴⁴ In this report, racial groups such as Blacks and Whites are non-Hispanic, and Hispanics include all races.

⁴⁵ Long SK, Karpman M, Shartz A, et al. Taking Stock: Health Insurance Coverage under the ACA as of September 2014. <http://hrms.urban.org/briefs/Health-Insurance-Coverage-under-the-ACA-as-of-September-2014.html>



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

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

Disparity Trends

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

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

Trends

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

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

Trends

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

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

Achieved Success

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



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

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

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

Improving Quickly

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

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



time of surgery

Worsening

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

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

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

Disparities

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

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

Disparity Trends

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



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

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

Disparities Trends

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

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

Geographic Disparities

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

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

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



Trends

- From 2010 to 2013, the overall rate of hospital-acquired conditions declined from 145 to 121 per 1,000 hospital discharges.
- This decline is estimated to correspond to 1.3 million fewer hospital-acquired conditions, 50,000 fewer inpatient deaths, and \$12 billion savings in health care costs.⁴⁶
- Large declines were observed in rates of adverse drug events, healthcare-associated infections, and pressure ulcers.
- About half of all Patient Safety measures tracked in the QDR improved.
- One measure, admissions with central line-associated bloodstream infections, improved quickly, at an average annual rate of change above 10% per year.
- One measure, postoperative physiologic and metabolic derangements during elective-surgery admissions, got worse over time.

Disparities Trends

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

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

Trends

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

Disparities

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

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

Disparities Trends

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

⁴⁶ Agency for Healthcare Research and Quality. Interim Update on 2013 Annual Hospital-Acquired Condition Rate and Estimates of Cost Savings and Deaths Averted From 2010 to 2013. <http://www.ahrq.gov/professionals/quality-patient-safety/pfp/interimhacrate2013.html>



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

Trends

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

Disparities

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

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

Trends

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

Disparities

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

Disparities Trends

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

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

Trends

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



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

Disparities

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

Disparities Trends

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

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

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

Trends

- From 2002 to 2010, the overall percentage of people unable to get or delayed in getting needed medical care, dental care, or prescription medicines and who indicated a financial or insurance reason rose from 61.2% to 71.4%.
- From 2002 to 2010, the rate worsened among people with any private insurance and among people from high- and middle-income families; changes were not statistically significant among other groups.
- After 2010, the rate leveled off, overall and for most insurance and income groups.
- Data from the Commonwealth Fund Biennial Health Insurance Survey indicate that cost-related problems getting needed care fell from 2012 to 2014 among adults.⁴⁷
- Another Care Affordability measure, people without a usual source of care who indicate a financial or insurance reason for not having a source of care, also worsened from 2002 to 2010 and then leveled off.
- There are few measures to assess trends in Care Affordability.

Disparities

- In all years, the percentage of people unable to get or delayed in getting needed medical care, dental care, or

⁴⁷ Collins SR, Rasmussen PW, Doty MM, et al. The Rise in Health Care Coverage and Affordability Since Health Reform Took Effect: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2014. http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/jan/1800_collins_biennial_survey_brief.pdf?la=en



prescription medicines who indicated a financial or insurance reason for the problem was:

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

CONCLUSION

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

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



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

Illustrative IRS Schedule h Part V Section B (Form 990)⁴⁸

Community Health Need Assessment Illustrative Answers

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

No

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

No

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

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

See footnotes 17 and 19 on page 12

- b. **Demographics of the community**

See footnote 20 on page 13

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

See footnote 32 on page 32 and footnote 34 on page 35

- d. **How data was obtained**

See footnote 11 on page 8

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

See footnote 31 on page 31

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

See footnote 12 on page 9

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

See footnote 41 on page 58

⁴⁸ Questions are drawn from 2014 Federal 990 schedule h.pdf and may change when the hospital is to make its 990 h filing



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

See footnotes 8 and 9 on page 7

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

See footnote 10 on page 8, footnotes 13 and 14 on page 9, and footnote 25 on page 18

j. Other (describe in Section C)

N/A

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

2014

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

Yes; see footnote 15 on page 9 and footnote 40 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

No

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

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

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

Yes

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

a. Hospital facility's website (list URL)

<http://caldwellmemorial.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)

No other effort



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

Yes

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

2014

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

a. If “Yes,” (list url):

<http://caldwellmemorial.org/>

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 32 on page 32

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 Form 4720 for all of its hospital facilities?

Nothing to report