2015

Community Health Needs Assessment and Implementation Strategy





Knox Community SM
HOSPITAL

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Adopted by Board December 30, 2015

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

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Dear Community Member:

In compliance with the Affordable Care Act, all not-for-profit hospitals are now required to develop a report on the medical and health needs of the communities they serve. At Knox Community Hospital (KCH), we have spent more than 75 years providing high-quality compassionate health care to the greater Mount Vernon community. 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.

The "2015 Community Health Needs Assessment" identifies local health and medical needs and provides a plan of how KCH will respond to such needs. This document suggests areas where other local organizations and agencies might work with us to achieve desired improvements and illustrates one way we, KCH, are meeting our obligations to efficiently deliver medical services.

KCH 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.

The 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 together. Together, we can make our community healthier for every one of us.

Thank You,

Chief Executive Officer
Knox Community Hospital

EXECUTIVE SUMMARY

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Knox Community Hospital ("Hospital" or the "KCH") 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 assures KCH identifies and responds 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

KCH partnered with Quorum Health Resources ("QHR") 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 to the less fortunate who did not have means to pay. With the introduction of Medicare, the government met the burden of providing compensation for such care.

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

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

[3] As of the date of this report all tax questions and suggested answers relate to 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 is required to conduct a CHNA at least once every three taxable years and to adopt an implementation strategy to meet the community needs identified through such assessment.
- The assessment may be based on current information collected by a public health agency or non-profit organization and may be conducted together with one or more other organizations, including related organizations.
- The assessment process must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge or expertise of public health issues.
- 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.

[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

APPROACH

APPROACH

To complete a CHNA:

> *"… the final regulations provide that a Hospital facility must document its CHNA in a CHNA report that is adopted by an authorized body of the Hospital facility and includes:*
>
> *(1) A definition of the community served by the hospital facility and a description of how the community was determined;*
>
> *(2) a description of the process and methods used to conduct the CHNA;*
>
> *(3) a description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves;*
>
> *(4) a prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs; and*
>
> *(5) a description of resources potentially available to address the significant health needs identified through the CHNA.*
>
> *… final regulations provide that a CHNA report will be considered to describe the process and methods used to conduct the CHNA if the CHNA report describes the data and other information used in the assessment, as well as the methods of collecting and analyzing this data and information, and identifies any parties with whom the hospital facility collaborated, or with whom it contracted for assistance, in conducting the CHNA."*[7]

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

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

QHR 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

[7] Federal Register Op. cit. P 78966 As previously noted the KCH collaborated and obtained assistance in conducting this CHNA from Quorum Health Resources (QHR). & 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

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

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

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

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

Other (please specify)

QHR also takes a comprehensive approach to assess community health needs. We perform several independent data analyses based on secondary source data, augment this with Local Expert Advisor[9] opinions, and resolve any data inconsistency or discrepancies by reviewing the combined opinions formed from local experts. We rely on secondary source data, and most secondary sources use the county as the smallest unit of analysis. We asked our local expert area residents to note if they perceived the problems or needs identified by secondary sources existed in their portion of the county.[10]

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

Data sources include:[11]

Website or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Knox County compared to all State counties	September 24, 2014	2005 to 2013
www.communityhealth.hhs.gov	Assessment of health needs of Knox County compared to its national set of "peer counties"	September 24, 2014	1996 to 2009
Truven (formerly known as Thomson) Market Planner	Assess characteristics of the hospital's primary service area, at a zip code level, based on classifying the population into various socio-	September 24, 2014	2012 to 2014

[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 QHR written comment solicitation classifications, with whom the hospital solicited to participate in the QHR/KCH CHNA process. Response to Schedule h (Form 990) V B 3 h

[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

	economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according to the proportion of each group in the entire area; and, to access population size, trends and socio-economic characteristics		
www.capc.org and www.getpalliativecare.org	To identify the availability of Palliative Care programs and services in the area	September 24, 2014	2014
www.caringinfo.org and iweb.nhpco.org	To identify the availability of hospice programs in the county	September 24, 2014	2014
www.healthmetricsandevaluation.org	To examine the prevalence of diabetic conditions and change in life expectancy	September 24, 2014	2000 to 2010
www.dataplace.org	To determine availability of specific health resources	September 24, 2014	2006
www.cdc.gov	To examine area trends for heart disease and stroke	September 24, 2014	2008 to 2010
www.CHNA.org	To identify potential needs from a variety of resource and health need metrics	September 24, 2014	2003 to 2014
www.datawarehouse.hrsa.gov	To identify applicable manpower shortage designations	September 24, 2014	2014
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	September 24, 2014	1999-2011 published 7/23/14

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

- We solicited comments about the existing CHNA report from a group of individuals selected to represent each of the unique population groups as delineated in the regulations. This resulted in sixteen written comments that were taken into consideration during this process. Comments were obtained beginning Friday, November 7, 2014 at 1:01 PM and ended on Wednesday, November 12, 2014 at 7:09 PM. All written comments are presented verbatim in the Appendix to this report.[12] No unsolicited written comments have been received by the hospital.
- 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

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

from 18 Local Expert Advisors. Survey responses started Friday, December 5, 2014 at 3:26 PM and ended with the last response on Friday, January 6, 2015 at 7:57 PM.

- Information analysis augmented by local opinions showed how Knox 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.[13]
- Local opinions of the needs of Priority Populations, while presented in its entirety in the Appendix, was abstracted in the following "take-away" bulleted comments:
  - More information and communication is beneficial
  - A poverty culture is prevalent
  - Opportunities, education, transportation, and remove the barriers
  - There is a lack of critical mass of such populations
  - The hospital meets the needs of these groups
  - They tend to smoke more and eat more starch and sugar
  - Hey have an inability to travel

When the analysis was complete, we put the information and summary conclusions before our Local Expert Advisors[14] who were asked to agree or disagree with the summary conclusions. They were free to augment potential conclusions with additional comments of need, and new needs did emerge from this exchange.[15] Consultation with 25 Local Experts occurred again via an internet-based survey (explained below) beginning Monday, February 2, 2015 at 2:03 PM and ending Thursday, February 19, 2015 at 7:48 PM.

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.[16]

In the 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, the vast majority of comments agreed with our findings. We developed a summary of all needs identified by any of the analyzed data sets. The Local Experts then allocated 100 points among the potential significant need candidates, including the opportunity to again present additional needs that were not identified from the data. A rank order of priorities emerged, with some needs receiving none or virtually no support, and other needs receiving identical point allocations.

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

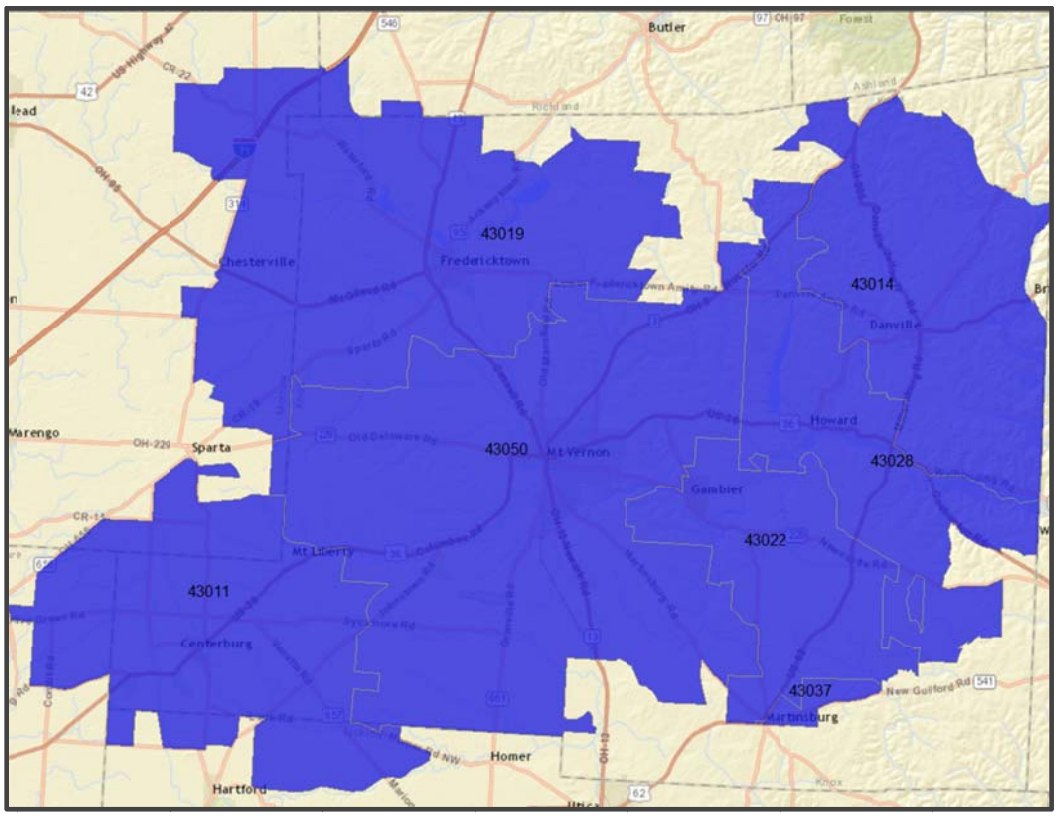
We dichotomized the rank order of prioritized needs into two groups: “Significant” and “Other Identified Needs.” Our criteria for identifying and prioritizing Significant Needs was based on a descending frequency rank order of the needs based on total points cast by the Local Experts, further ranked by a descending frequency count of the number of local experts casting any points for the need. By our definition, a Significant Need had to include all rank ordered needs until at least fifty percent (50%) of all points were included and to the extent possible, represented points allocated by a majority of voting local experts. The determination of the break point — “Significant” as opposed to “Other” — was a qualitative interpretation by QHR and the KCH executive team where a reasonable break point in rank order occurred.[17]

[17] Response to Schedule h (Form 990) Part V B 3 g

FINDINGS

FINDINGS

Definition of Area Served by the Hospital[18]



KCH, in conjunction with QHR, defines its service area as Knox County in Ohio, which includes the following ZIP codes:[19]

43011 – Centerburg	43028 – Howard
43014 – Danville	43037 – Martinsburg
43019 – Fredericktown	43050 – Mount Vernon
43022 – Gambier	

In 2013, the hospital received 82.9% of its patients from this area.[20]

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

Demographic of the Community[21]

The 2014 population for Knox County is estimated to be 60,166[22] and expected to decrease at a rate of 1.6%. The State of Ohio disputes this data with the 2013 estimate to be 60,810 and developed population projections stipulating the expectation of Knox County growing to 64,960[23] . This is in contrast to the 3.5% national rate of growth, while Ohio's population is expected to remain unchanged. Knox County in 2019 anticipates a population of 59,213.

According to the population estimates utilized by Truven, provided by The Nielsen Company, the 2014 median age for the county is 38.9 years (39 by State of Ohio), younger than the Ohio median age (39.3 years) and older than the national median age of 37.7 years. The 2014 Median Household Income for the area is $55,328, higher than the Ohio median income of $46,381($49,323 by State of Ohio) and the national median income of $51,423. Median Household Wealth value is significantly higher than the National and the Ohio value. Median Home Values for Knox ($137,362) is between the comparison values, above the Ohio median of $133,531 and below the national median of $179,326. Knox's unemployment rate as of July, 2014 was 5.5%[24], which is better than the 5.7% statewide and the 6.2% national civilian unemployment rate.

The portion of the population in the county over 65 is 16% (14.8% by State of Ohio), compared to Ohio (15.3%) and the national average (14.2%). The portion of the population of women of childbearing age is 19.2%, relatively in line with the Ohio average of 19.1% and the national rate of 19.8%. 94.8% (98.6% by the State of Ohio) of the population is White non-Hispanic, the largest minority. The Hispanic population comprises 1.6% (1.2% by the State of Ohio) of the total.[25]

[21] Responds to IRS Schedule h (Form 990) Part V B 3 b
[22] All population information, unless otherwise cited, sourced from Truven (formally Thomson) Market Planner
[23] State of Ohio, Office of Policy, Research and Strategic Planning, Ohio County Profiles, Knox County
[24] http://research.stlouisfed.org/fred2/series/IDLATA7URN; http://research.stlouisfed.org/fred2/series/IDUR
[25] The tables below were created by Truven Market Planner, a national marketing company.

2014 DEMOGRAPHIC SNAPSHOT

DEMOGRAPHIC CHARACTERISTICS

	Knox County	USA
2010 Total Population	60,883	308,745,538
2014 Total Population	60,166	317,199,353
2019 Total Population	59,213	328,309,464
% Change 2014 - 2019	-1.6%	3.5%
Average Household Income	$67,668	$71,320

	2014	2019	% Change
Total Male Population	29,422	28,967	-1.5%
Total Female Population	30,744	30,246	-1.6%
Females, Child Bearing Age (15-44)	11,564	11,465	-0.9%

POPULATION DISTRIBUTION

	Age Distribution				
Age Group	2014	% of Total	2019	% of Total	USA 2014 % of Total
0-14	11,384	18.9%	10,737	18.1%	19.3%
15-17	2,569	4.3%	2,530	4.3%	4.1%
18-24	7,374	12.3%	7,685	13.0%	10.0%
25-34	6,319	10.5%	6,332	10.7%	13.2%
35-54	14,765	24.5%	13,154	22.2%	26.6%
55-64	8,133	13.5%	8,000	13.5%	12.6%
65+	9,622	16.0%	10,775	18.2%	14.2%
Total	60,166	100.0%	59,213	100.0%	100.0%

HOUSEHOLD INCOME DISTRIBUTION

	Income Distribution		
2014 Household Income	HH Count	% of Total	USA % of Total
<$15K	2,569	11.5%	13.3%
$15-25K	2,089	9.3%	11.2%
$25-50K	5,469	24.4%	24.4%
$50-75K	4,794	21.4%	17.9%
$75-100K	3,076	13.7%	11.9%
Over $100K	4,412	19.7%	21.3%
Total	22,409	100.0%	100.0%

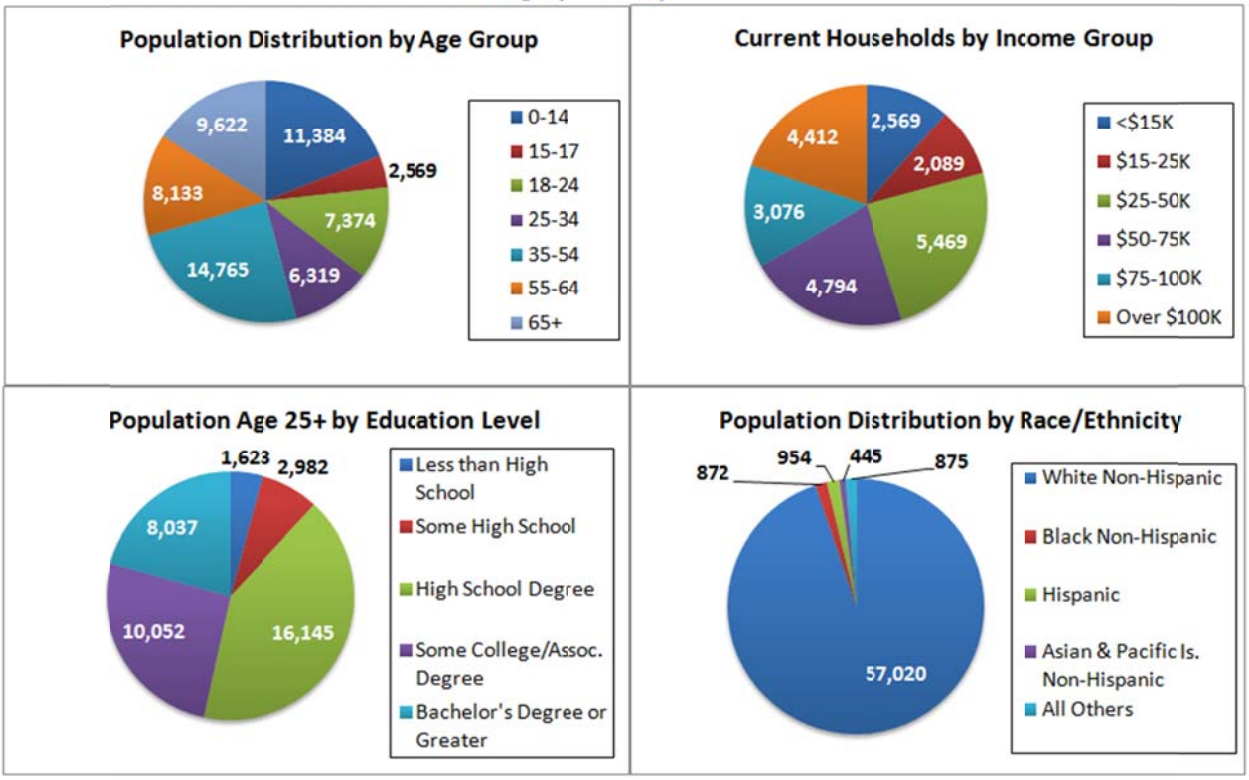
EDUCATION LEVEL

	Education Level Distribution		
2014 Adult Education Level	Pop Age 25+	% of Total	USA % of Total
Less than High School	1,623	4.2%	6.0%
Some High School	2,982	7.7%	8.2%
High School Degree	16,145	41.6%	28.4%
Some College/Assoc. Degree	10,052	25.9%	29.0%
Bachelor's Degree or Greater	8,037	20.7%	28.4%
Total	38,839	100.0%	100.0%

RACE/ETHNICITY

	Race/Ethnicity Distribution		
Race/Ethnicity	2014 Pop	% of Total	USA % of Total
White Non-Hispanic	57,020	94.8%	62.1%
Black Non-Hispanic	872	1.4%	12.3%
Hispanic	954	1.6%	17.6%
Asian & Pacific Is. Non-Hispanic	445	0.7%	5.1%
All Others	875	1.5%	3.0%
Total	60,166	100.0%	100.0%

2014 Demographic Snapshot Charts



2014 Benchmarks									
Area	2014-2019 % Population Change	Median Age	Population 65+ % of Total Population	Population 65+ % Change 2014-2019	Females 15-44 % of Total Population	Females 15-44 % Change 2014-2019	Median Household Income	Median Household Wealth	Median Home Value
USA	3.5%	37.7	14.2%	18.0%	19.8%	1.0%	$51,423	$53,606	$179,326
Ohio	0.0%	39.3	15.3%	14.3%	19.1%	-1.4%	$46,381	$55,248	$133,531
Knox County	-1.6%	38.9	16.0%	12.0%	19.2%	-0.9%	$55,328	$79,884	$137,362

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

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

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

Health Service Topic	Demand as % of National	% of Population Effected	Health Service Topic	Demand as % of National	% of Population Effected
Weight / Lifestyle			**Cancer**		
BMI: Morbid/Obese	108.6%	33.2%	Mammography in Past Yr	98.4%	44.8%
Vigorous Exercise	103.3%	59.2%	Cancer Screen: Colorectal 2 yr	99.6%	25.4%
Chronic Diabetes	101.7%	12.6%	Cancer Screen: Pap/Cerv Test 2 yr	94.6%	56.7%
Healthy Eating Habits	94.3%	28.0%	Routine Screen: Prostate 2 yr	97.9%	31.4%
Ate Breakfast Yesterday	100.2%	76.7%	**Orthopedic**		
Slept Less Than 6 Hours	108.8%	15.4%	Chronic Lower Back Pain	106.5%	25.1%
Consumed Alcohol in the Past 30 Days	91.1%	49.2%	Chronic Osteoporosis	99.7%	9.8%
Consumed 3+ Drinks Per Session	104.5%	29.4%	**Routine Services**		
Behavior			FP/GP: 1+ Visit	103.2%	91.1%
I Will Travel to Obtain Medical Care	96.4%	22.1%	Used Midlevel in last 6 Months	106.4%	44.0%
I am Responsible for My Health	97.9%	64.0%	OB/Gyn 1+ Visit	93.3%	43.1%
I Follow Treatment Recommendations	99.7%	51.7%	Medication: Received Prescription	102.6%	61.0%
Pulmonary			**Internet Usage**		
Chronic COPD	104.4%	4.1%	Use Internet to Talk to MD	80.2%	9.8%
Tobacco Use: Cigarettes	96.4%	24.5%	Facebook Opinions	88.3%	9.1%
Heart			Looked for Provider Rating	92.2%	13.0%
Chronic High Cholesterol	103.8%	22.7%	**Emergency Service**		
Routine Cholesterol Screening	96.8%	49.2%	Emergency Room Use	98.3%	33.3%
Chronic Heart Failure	114.7%	4.7%	Urgent Care Use	102.2%	23.8%

Leading Causes of Death

Cause of Death			Rank among all counties in OH (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation
OH Rank	Knox County Rank	Condition		OH	Knox County	
1	1	Heart Disease	31 of 88	204.4	238.9	As expected
2	2	Cancer	43 of 88	197.7	200.5	Higher than expected
4	3	Stroke	13 of 88	45.2	57.0	Higher than expected
3	4	Lung	62 of 88	50.6	47.3	As expected
5	5	Accidents	38 of 88	41.1	44.0	As expected
6	6	Diabetes	25 of 88	29.1	36.5	Higher than expected
7	7	Alzheimer's	54 of 88	27.4	23.2	As expected
9	8	Flu - Pneumonia	46 of 88	13.3	17.7	Lower than expected
8	9	Kidney	64 of 88	13.5	12.7	As expected
12	10	Hypertension	75 of 88	9.2	11.7	Lower than expected
10	11	Suicide	80 of 88	11.0	7.9	Lower than expected
11	12	Blood Poisoning	76 of 88	9.5	7.0	Lower than expected
13	13	Liver	13 of 88	9.0	5.2	Higher than expected
14	14	Parkinson's	67 of 88	6.8	4.9	As expected
15	15	Homicide	46 of 88	5.7	2.2	Lower than expected

National Healthcare Disparities Report – Priority Populations[26]

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.

> *To examine the issue of disparities in health care, Congress directed the Agency for Healthcare Research and Quality (AHRQ) to produce an annual report to track disparities related to "racial factors and socioeconomic factors in priority populations." Although the emphasis is on disparities related to race, ethnicity, and socioeconomic status, this directive includes a charge to examine disparities in "priority populations," which are groups with unique health care needs or issues that require special attention…*
>
> *Integrated throughout the Highlights in both the National Healthcare Disparities Report (NHDR) and the National Healthcare Quality Report (NHQR) and Chapters 2 through 10 of this report are racial, ethnic, socioeconomic, sex, geographic location, and age differences in quality of and access to healthcare in the general U.S. population. Subpopulation data for Asians and Hispanics are also integrated into these chapters where data is available.*
>
> *Priority Populations, specified by Congress in the Healthcare Research and Quality Act of 1999 (Public Law 106-129), are:*
>
> - *Racial and ethnic minority groups*
> - *Low-income groups*
> - *Women*
> - *Children (under age 18)*
> - *Older adults (age 65 and over)*
> - *Residents of rural areas*
> - *Individuals with special healthcare needs including individuals with disabilities and individuals who need chronic care or end-of-life care.*
>
> *Although not mandated, other populations, such as LGBT and people with MCC, are also included.*
>
> ***Blacks or African Americans***
>
> *… Previous NHDRs showed that Blacks had poorer quality of care and worse access to care than Whites for many measures tracked in the reports. Among all measures of healthcare quality and access that are tracked in the reports and support trends over time, Blacks had worse care than Whites in the most recent year for 78 measures.*

[26] http://www.ahrq.gov/research/findings/nhqrdr/nhdr13/chap11.html Responds to IRS Schedule h (Form 990) Part V B 3 i

Most of these measures showed no significant change in disparities over time. These include preventive care measures for cancer, children's dental care, and flu vaccinations for adults over age 65; hospital admissions for diabetes complications; hospital admissions for asthma; hospital care for pneumonia; hospital care for heart attack; hospital infection deaths; infant mortality; patient safety events; patient-centered care; and access to care.

For 13 measures, the gap between Blacks and Whites grew smaller, indicating improvement:

- *Prostate cancer deaths per 100,000 male population per year*
- *Cancer deaths per 100,000 population per year*
- *Hospital admissions for congestive heart failure per 100,000 population*
- *Incidence of end-stage renal disease (ESRD) due to diabetes per million population*
- *Hospital admissions for uncontrolled diabetes per 100,000 population age 18 and over*
- *New AIDS cases per 100,000 population age 13 and over*
- *HIV infection deaths per 100,000 population*
- *Hospital patients age 65 and over with pneumonia who received pneumococcal screening or vaccination*
- *Long-stay nursing home residents who were assessed for pneumococcal vaccination*
- *Short-stay nursing home residents who were assessed for pneumococcal vaccination*
- *Short-stay nursing home residents with pressure sores*
- *Adults age 65 and over with any private insurance*
- *Deaths per 1,000 elective surgery admissions having developed specified complications of care during hospitalization, ages 18-89 or obstetric admissions*

For 3 measures, the gap grew larger, indicating worsening disparities:

- *Breast cancer diagnosed at advanced stage (regional, distant stage, or local stage with tumor greater than 2 cm) per 100,000 women age 40 and over*
- *Maternal deaths per 100,000 live births*
- *Adults age 40 and over with diagnosed diabetes who received at least two hemoglobin A1c measurements in the calendar year*

Asians

… Previous NHDRs showed that Asians had similar or better quality of care than Whites, but worse access to care than Whites for many measures that the report tracks. Among all measures of healthcare quality and access that are tracked in the reports and support trends over time, Asians or Asians and Pacific Islanders in aggregate had worse care than Whites in the most recent year for 38 measures.

Most of these measures showed no significant change in disparities over time. These include measures on preventive care for breast cancer, cervical cancer, and colorectal cancer; obstetric trauma; hospice care; timeliness of care; patient-centered care; and access to care.

For 2 measures, the gap between Asians and Whites grew smaller, indicating improvement:

- *Adults with limited English proficiency and a usual source of care that had language assistance*
- *Hospital patients age 65 and over with pneumonia who received pneumococcal screening or vaccination*

For 2 measures, the gap grew larger, indicating worsening disparities:

- *Adults ages 18-64 at high risk (e.g., chronic obstructive pulmonary disease) who ever received pneumococcal vaccination*
- *Children 0-40 lb. for whom a health provider gave advice within the past 2 years about using child safety seats when riding in a car*

American Indians and Alaska Natives

… Previous NHDRs showed that American Indians (AI) and Alaska Natives (ANs) had poorer quality of care and worse access to care than Whites for many measures tracked in the reports. Among all measures of healthcare quality and access that are tracked in the reports and support trends over time, AI/ANs had worse care than Whites in the most recent year for 40 measures.

Most of these measures showed no significant change in disparities over time. Such measures include measures for HIV/AIDS, preventive care for children, care for residents in nursing homes, home healthcare, hospice care, and access to care.

For one measure, the gap between AI/ANs and Whites grew smaller, indicating improvement:

- *Incidence of ESRD due to diabetes per million population*

For 2 measures, the gap grew larger, indicating worsening disparities:

- *Adults age 50 and over who ever received a colonoscopy, sigmoidoscopy, or proctoscopy*
- *People with difficulty contacting their usual source of care over the telephone*

Hispanics or Latinos

… Previous NHDRs showed that Hispanics had poorer quality of care and worse access to care than non-Hispanic Whites for many measures that the reports track. Among all measures of healthcare quality and access that are tracked in the reports and support trends over time, Hispanics had worse care than non-Hispanic Whites in the most recent year for 72 measures.

Most of these measures showed no significant change in disparities over time. Such measures include measures on preventive care for cervical cancer and colorectal cancer; diabetes care; HIV/AIDS; hospital admissions for asthma; quality of care for residents of nursing homes; home healthcare; timeliness of care; patient-centered care; and access to care.

For 7 measures, the gap between Hispanics and non-Hispanic Whites grew smaller, indicating improvement:

- *Hospital admissions for uncontrolled diabetes per 100,000 population age 18 and over*
- *Children ages 2-17 who had a dental visit in the calendar year*
- *Hospital patients age 65 and over with pneumonia who received pneumococcal screening or vaccination*
- *Short-stay nursing home residents who were assessed for pneumococcal vaccination*
- *Hospital admissions for congestive heart failure per 100,000 population*
- *Hospital admissions for long-term complications of diabetes per 100,000 adults*
- *Adults age 65 and over with any private health insurance*

For 3 measures, the gap between Hispanics and non-Hispanic Whites grew larger, indicating worsening disparities:

- *Adult home healthcare patients whose ability to walk or move around improved*
- *Adult home healthcare patients whose shortness of breath decreased*
- *Adult home healthcare patients whose management of oral medications improved*

Low-Income Groups

In this report, poor populations are defined as people living in families whose household income falls below specific poverty thresholds. These thresholds vary by family size and composition and are updated annually by the U.S. Bureau of the Census. … Previous chapters of this report describe healthcare differences by income. Among all measures of healthcare quality and access that are tracked in the reports and support trends over time, poor individuals had worse care than high-income individuals in the most recent year for 77 measures. Most of these measures showed no significant change in disparities over time. These measures include measures for preventive care for children, diabetes care, asthma care, obesity prevention, patient safety, and access to care.

For 5 measures, the gap between poor and high-income individuals grew smaller, indicating improvement:

- *Hospital admissions for congestive heart failure per 100,000 population*
- *Children ages 2-17 who had a dental visit in the calendar year*
- *Hospital admissions for asthma per 100,000 population, ages 2-17*
- *People under age 65 whose family's health insurance premium and out-of-pocket medical expenditures were more than 10% of total family income*
- *People under age 65 with private insurance whose family's health insurance premium and out-of-pocket medical expenditures were more than 10% of total family income*

For 4 measures, the gap grew larger indicating worsening disparities:

- *Adults age 50 and over who ever received a colonoscopy, sigmoidoscopy, or proctoscopy*
- *Hospital admissions for short-term complications of diabetes per 100,000 population, adults*
- *Adolescents ages 16-17 who received 1 or more doses of tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap) since the age of 10 years*
- *People without a usual source of care who indicated a financial or insurance reason for not having a source of care*

Residents of Rural Areas

According to 2010 U.S. Census data, 19.3 % of the U.S. population lives in a rural area. Compared with their urban counterparts, rural residents are more likely to be older, be poor, be in fair or poor health, and have chronic conditions. Rural residents are less likely than their urban counterparts to receive recommended preventive services and are more likely to report having deferred care due to cost.

Although about 19% of Americans live in rural areas, only 11% of physicians in America practice in those settings. Other important providers of health care in those settings include nurse practitioners, nurse midwives, and physician assistants. A variety of programs deliver needed services in rural areas, such as the National Health Service Corps Scholarship Program, Indian Health Service, State offices of rural health, rural health clinics, and community health centers.

Many rural residents depend on small rural hospitals for their care. There are approximately 2,000 rural hospitals throughout the country. Most of these hospitals are critical access hospitals that have 25 or fewer beds. Rural hospitals face unique challenges due to their size and case mix. During the 1980s, many were forced to close due to financial losses. More recently, finances of small rural hospitals have improved and few closures have occurred since 2003.

Language barriers are often greater in rural areas. … Each Critical Access Hospital (CAH) established a comprehensive language access program.

Similarly, transportation needs are pronounced among rural residents, who must travel longer distances to reach healthcare delivery sites. Of the nearly 1,000 "frontier counties" in the nation, most have limited healthcare services and many do not have any…

Among all measures of healthcare quality and access that are tracked in the reports and support trends over time, residents of noncore areas had worse care than residents of large fringe metropolitan areas in the most recent year for 32 measures. Most of these measures showed no significant change in disparities over time. These include measures for cancer mortality, obesity prevention, patient-centered care, and access to care.

For 2 measures, the gap grew larger, indicating worsening disparities:

- *Cancer deaths per 100,000 population per year*
- *Deaths per 1,000 adult hospital admissions with pneumonia*

Individuals with Disabilities or Special Healthcare Needs

… For the purpose of the NHDR, adults with disabilities are those with physical, sensory, and/or mental health conditions that can be associated with a decrease in functioning in such day-to-day activities as bathing, walking, doing everyday chores, and engaging in work or social activities.

Among all measures of healthcare quality and access that are tracked in the reports and support trends over time, individuals with basic activity limitations had worse care than individuals with neither basic nor complex activity limitations in the most recent year for 21 measures. Most of these measures showed no significant change in disparities over time. Such measures included measures for patient-centered care and access to care…

For 2 measures, the gap between individuals with basic activity limitations and individuals with neither basic nor complex activity limitations narrowed, indicating improvement:

- *People under age 65 with any private health insurance*
- *People under age 65 whose family's health insurance premium and out-of-pocket medical expenditures were more than 10% of total family income*

For 1 measure, the gap grew larger, indicating worsening disparities:

- *People under age 65 with health insurance*

Individuals with complex activity limitations had worse care than individuals with neither basic nor complex activity limitations in the most recent year for 21 measures. Most of these measures showed no significant change in disparities over time. Such measures included measures for patient-centered care and access to care.

For 1 measure, the gap between individuals with complex activity limitations and individuals with neither basic nor complex activity limitations narrowed, indicating improvement:

- *People under age 65 whose family's health insurance premium and out-of-pocket medical expenditures were more than 10% of total family income…*

We asked a specific question to our Local Expert Advisors about unique needs of Priority Populations. We reviewed their responses to identify if any of the above trends were obvious in the service area. Accordingly, we place great reliance on the commentary received from our Local Expert Advisors to identify unique population needs to which we should respond. Specific opinions from the Local Expert Advisors are summarized below:[27]

- More information and communication is beneficial
- A poverty culture is prevalent.
- Opportunities, education, transportation, and remove the barriers
- There is a lack of a critical mass of such populations

[27] All comments and the analytical framework behind developing this summary appear in Appendix A

- The hospital meets the needs of these groups
- They tend to smoke more and eat more starch and sugar
- They have an inability to travel

Statistical information about special populations:

Vulnerable Populations: Knox County, OH

Vulnerable populations may face unique health risks and barriers to care, requiring enhanced services and targeted strategies for outreach and case management.

Vulnerable Populations Include People Who[1]	
Have no high school diploma (among adults age 25 and older)	7,033
Are unemployed	1,923
Are severely work disabled	1,141
Have major depression	3,568
Are recent drug users (within past month)	4,089

nda No data available.

[1] The most current estimates of prevalence, obtained from various sources (see the Data Sources, Definitions, and Notes for details), were applied to 2008 mid-year county population figures.

Access to Care: Knox County, OH

In addition to use of services, access to care may be characterized by medical care coverage and service availability

Uninsured individuals (age under 65)[1]	5,789
Medicare beneficiaries[2]	
Elderly (Age 65+)	8,188
Disabled	1,550
Medicaid beneficiaries[2]	9,694
Primary care physicians per 100,000 pop[2]	62.4
Dentists per 100,000 pop[2]	47.2
Community/Migrant Health Centers[3]	No
Health Professional Shortage Area[3]	No

nda No data available.

[1] The Census Bureau. Small Area Health Insurance Estimates Program, 2006.
[2] HRSA. Area Resource File, 2008.
[3] HRSA. Geospatial Data Warehouse, 2009.

Findings

Upon completion of the CHNA, QHR identified several issues within the community:

Consideration of Written Comments from Prior CHNA

A group of 16 individuals provided written comment in regard to the 2012 CHNA. Our summary of this commentary produced the following points, which were introduced in subsequent considerations of this CHNA.

Commenter characteristics:

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
Represents the Broad Interest of the Community	12	3	15
Representative of Groups of People	10	4	14
Has Special Public Health Expertise	3	9	12
Member of or representative of underserved, low-income, minority population	1	10	11
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	4	8	12
Representative of or member of chronic disease group or organization	2	11	13
Other (please specify)			
Hospital Foundation Board Member	2		2
Board Member of the National Kidney Foundation			
(Representing Ohio, Kentucky and Middle TN)			
answered question			16
skipped question			0

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

- Need #1. Cancer (cancer screening, cancer deaths, breast cancer, lung cancer, colon cancer) with the intent to lower cancer deaths
- Need #4. Cardiovascular Health (coronary heart disease, stroke, chronic high blood pressure) with the intent to lower the cardiovascular death rate
- Need #5. Maternal and Infant Care (births to unmarried women, teen birth rate, infant mortality, low birth weight, no care in the first trimester, premature births, neonatal infant mortality, post-neonatal infant mortality, very low birth weight, white non-Hispanic infant mortality and births to women age 40 to 54) with the intent to improve utilization of available resources (i.e. care during first trimester)
- Priority #7 Diabetes (Diabetic screening and diabetes rate) with the intent to better manage the disease and its process

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

- The needs appear to be appropriate for the hospital to take on, although a thorough study of the entire document could shine a light on those not included. It would seem that the hospital could integrate an improvement in the prevalence of obesity within its community while addressing needs #4 and #7, for example.

- All items appear within KCH's collective abilities and expertise, as well as physical and financial resources
- Considering the population it serves, I believe these are correct
- High importance to be efficient and up-to-date in these services - screening, screening, screening and FYI workshops
- I believe this set still represents the plurality of events seen at the Hospital; therefore, the list retains its relevancy
- Improved cancer clinics and treatment
- Expanded heart cath lab
- Expanded 24/7 heart care
- Improved birthing center for mother and others
- Do diabetic screening and continue diabetic education
- I agree with these being priorities
- While there are other pressing needs in our community, I would agree this is a valid set of priorities affecting broad segments of the population
- Fully agree with the stated objective above

Conclusions from Public Input

Our group of 17 Local Expert Advisors participated in an online survey to offer opinions about their perceptions of community health needs and the potential needs of unique populations. Complete verbatim written comments appear in the Appendix to this report.

KCH received the following responses to the question: "*What advice do you give us about written comments on maintaining the prior identified priority needs?*"

- I disagree that the priorities should change due to the proximity of OSU
- It is clear the priorities still deserve the resources allocated to them
- I agree these are all valid areas of emphasis. To the list, I would add mental health services, though I am aware of the difficulty of such implementation
- I know cancer patients appreciate having treatment in our community, as opposed to traveling to Columbus
- Cancer can occur anywhere in the body. There is no way that KCH can have expert cancer care for all local residents. Are there couples that have standard protocols that could be emphasized and dealt with locally?
- Drug addiction has become a huge problem. I agree with the comment that OSU/James Hospital provides superior care. I understand many cannot travel to Columbus, so chemo should continue to be offered here, but further emphasis on cancer care could be shifted to substance abuse
- Interesting that there were no negative votes on any of the needs. It makes me question the knowledge/understanding the respondents had on each subject/priority need area
- Yes
- The hospital should continue to allocate resources. Should also take a look at obesity and kidney disease treatment
- I think it is obvious that the community wants to see these top needs continue to be addressed. I believe these four should be the focus of the county's community health improvement plan where specific goals are set for each with long-term measurement indicators and collaborative best practices are identified and implemented in a comprehensive system with KCH as a leader in most cases, but with support from other partners infused in the approach as well

Summary of Observations: Comparison to Other Counties

In general, Knox County residents are in average health compared to the healthiest in Ohio.

In a health status classification termed "Health Outcomes", Knox ranks number 26 among the 88 Ohio ranked counties (best being #1). Premature Death (deaths prior to age 75) for ten years has deteriorated, presenting poorer values (shorter survivability) than on average for the US, and slightly better than OH.

In another health status classification, "Health Factors", Knox County ranks number 34 among the 88 ranked Ohio counties, with adult obesity and alcohol-impaired driving deaths being above the OH average and the US average. Smoking and Excessive Drinking were also adverse findings in 2012. The teen birth rate is below the OH average, but above the national goal.

In the “Clinical Care” classification, Knox County ranks number 46 among the 88 ranked OH counties. Uninsured rate is above the OH average, however, below the US average. The important outlier indicator is the population to physician ratio is twice the State average.

Summary of Observations: Peer Comparisons

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

UNFAVORABLE observations occurring at rates worse than national AND worse than Peers:

- Births to Women Age 40 to 54
- No Care in First Trimester
- Breast Cancer (female)
- Colon Cancer
- Coronary Heart Disease
- Motor Vehicle Injury
- Stroke

SOMEWHAT A CONCERN observations because occurrence is EITHER above national average or above Peer group average:

- Very low Birth Weight (less than 1,500g)
- Post-Neonatal Infant Mortality
- Lung Cancer
- Unintentional Injury

BETTER PERFORMANCE than Peers and national rates:

- Low Birth Weight (less than 2,500g)

- Premature Births (less than 37 weeks)
- Births to Women Under 18
- Births to Unmarried Women
- Infant Mortality
- White Non-Hispanic Infant Mortality
- Neonatal Infant Mortality
- Suicide

Conclusions from Demographic Analysis Compared to National Averages

We solicited opinions based on QHR Truven database of population characteristics, as we were unaware of Ohio statistics indicating a projected small population growth rather than anticipating a slight decline. The population commentary for which we obtained local opinions was as follows:

Knox County in 2014 comprises 60,166 residents. Since 2010, it has experienced a slight population decrease, and anticipates a continued decline through the next five years to 59,213 residents. The population is 94.8% non-Hispanic White. Asian and Pacific Island non-Hispanics constitute 0.7% of the population. Hispanics comprise the largest minority population at 1.6% of the population. Black non-Hispanics are at 1.4%. 16.0% of the population is age 65 or older. This is a slightly larger population segment than the elderly comprise elsewhere in Ohio, on average, or in comparison to the national average. 19.2% of the women are in the childbirth population segment. This segment is relatively in line with elsewhere, on average, in Ohio or in comparison to the national average. The median income and median household wealth are above their respective Ohio averages. Median home values are higher than the Ohio average, but lower than the US average.

The following areas (*not in dispute by the State of Ohio population data)* were identified from a comparison of the county to national averages. Metrics impacting more than 25% of the population and statistically significantly different from the national average include the following. All are considered adverse findings unless otherwise noted:

- Obtained a Pap/Cervix test in last 2 years 5% below average impacting 57% of the population
- Had OB/Gyn in last year is 7% below average impacting 43% of the population
- BMI: Morbid/Obese is 9% above average impacting 33% of the population
- Health eating habits 6% below average impacting 28% of the population
- Chronic lower back pain 7% above average impacting 25% of the population

Situations and Conditions statistically significantly different from the national average, but impacting less than 25% of the population, include the following - all are considered adverse findings, unless otherwise noted:

- Slept less than 6 hours is 8,8% above average impacting 15% of the population
- Chronic heart failure is 15% above average impacting 5% of the population

Conclusions from Other Statistical Data

Additional observations of Knox County found:

- Palliative Care (programs focused not on curative actions but designed to relieve disease symptoms, pain, and stress arising from serious illness) do exist in the County. A Hospice program, Hospice of Knox County, is in the County.

Among the leading causes of death, Knox County has a significantly lower death rate in 4 of the 15 leading causes of death, and a significantly higher death rate in 4 of the 15 leading causes of death.

Ranking the causes of death in Knox County finds the leading causes to be the following (in descending order of occurrence):

1. **Heart Disease** – Knox County ranks 31 of 88 NM counties (being ranked as #1 means you are the worst county in the state) with a death rate of 238.9/100,000, and this rate is as expected
2. **Cancer** – Knox County ranks 43 of 88 with a death rate of 200.5/100,000, and this rate is higher than expected
3. **Stroke** – Knox County ranks 13 of 88 with a death rate of 57/100,000, and this rate is higher than expected
4. **Lung** – Knox County ranks 62 of 88 with a death rate of 47.3/100,000, and this is as expected
5. **Accidents** – Knox County ranks 38 of 88 with a death rate of 44/100,000, and this is as expected
6. **Diabetes** – Knox County ranks 25 of 88 with a death rate of 36.5/100,000, and this is higher than expected
7. **Alzheimer's** – Knox County ranks 7 of 88 with a death rate of 23.2/100,000, and this is as expected
8. **Flu-Pneumonia** – Knox County ranks 46 of 88 with a death rate of 17.7/100,000, and this is lower than expected
9. **Kidney** – Knox County ranks 64 of 88 with a death rate of 12.7/100,000, and this is as expected
10. **Hypertension** – Knox County ranks 75 of 88 with a death rate of 11.7/100,000, and this is lower than expected

Conclusions from Prior CHNA Implementation Activities

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 relieving 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:

- 2013 KCH Expended $777,204 after netting out offsets to benefit 144,270 individuals

EXISTING HEALTHCARE FACILITIES, RESOURCES, & IMPLEMENTATION STRATEGY

EXISTING HEALTHCARE FACILITIES, RESOURCES, & IMPLEMENTATION STRATEGY

Significant Health Needs

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

- Identifies the rank order of each identified Significant Need
- Presents the factors considered in developing the ranking
- Establishes a Problem Statement to specify the problem indicated by use of the Significant Need term
- Identifies KCH current efforts responding to the need including any written comments received regarding prior KCH implementation actions
- Establishes the Implementation Strategy programs and resources KCH will devote to attempt to achieve improvements
- Documents the Leading Indicators KCH will use to measure progress
- Presents the Lagging Indicators KCH 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, KCH is the major hospital in the service area. KCH is a 115-bed, acute care medical facility located in Mount Vernon, Ohio. The next closest facilities are outside the service area and include:

- Morrow County Hospital – 25-bed critical access hospital in Gilead, OH; 26.7 miles from Mount Vernon (36 minutes)
- Licking Memorial Hospital – 227-bed hospital in Newark, OH; 27 miles from Mount Vernon (41 minutes)
- MedCentral Health System Mansfield Hospital – 286-bed hospital in Mansfield, OH; 30.2 miles from Mount Vernon (40 minutes)

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

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

Ohio Community Benefit Requirements

Ohio requires hospitals that participate in the Hospital Care Assurance Program to provide community benefits.

Although Ohio law does not otherwise expressly require nonprofit hospitals to provide community benefits, a hospital that elects to participate in Ohio's disproportionate share hospital program (called the Hospital Care Assurance Program) must provide "basic, medically necessary hospital level services" to Ohio residents whose income is below the federal poverty level and who are not eligible for Medicaid. Ohio Administrative Code 5160-2-07.17.[29]

Significant Needs

1. CARDIOVASCULAR HEALTH 2012 Significant Need; 2015 Unfavorable compared to Peers, higher mortality than average, #1 cause of death, heart failure 15% above average

   Problem Statement: Incidents of heart disease and stroke need to decline while an increasing portion of the population needs to achieve/maintain blood pressure control

Public comments received on previously adopted implementation strategy:

- The Hospital has improved its Cath Lab and provided additional resources in this area. It provides free screening events for blood sugar levels, and support groups for Cancer survivors and people impacted by diabetes. The Hospital has recently hired additional OB/GYNs and is in the process of providing additional funds focusing on the improvement of care
- "Implemented cardiology 24/7 coverage. Implemented more surgeons and urology services"
- I would agree that KCH has been very focused on implementing improvements in the areas of cancer treatment and cardiac interventions. I am less aware of measures that have been initiated in the other two areas (which is not to say measures have not been taken)
- Anecdotal evidence, at the least, exists to suggest cancer treatment and cardiac care are two areas of excellence in our hospital
- I think the hospital could try to become a community leader in providing opportunities for education by class and also example in improving one's diet, especially focusing on refined sugar. This could lessen the impact of the diabetes tsunami, as well as the cardiovascular health. Targeting the Medicaid population of young women might also improve infant outcomes. In addition, providing information and a more useful exercise area could also positively impact the cardiovascular area. The present exercise area is only available to non-rehab folk a few hours in early morning and a few hours in late afternoon

KCH services, programs, and resources available to respond to this need include:[30]

KCH currently offers a number of services, programs and resources to address this need, including:

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[29] http://www.hilltopinstitute.org/hcbpDocs/HCBP_CBL_OH.pdf

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

- Two, state-of-the-art Heart catheterization laboratories, cardiovascular Invasive and Non-invasive testing, outpatient cardiologist and vascular surgeon offices, and a cardiac rehab program
- Free, monthly, community screenings, including blood pressure and cholesterol checks, annual 20-minute heart checks, and vascular screenings
- Community education programs such as annual 'lunch and learn' events, diabetes education, and an annual heart health radio program
- KCH offers to the community a Pathway to Change program (to decrease modifiable risk factors), and offers employees monthly health screenings, a weight loss program, and smoking cessation and stress management programs

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

Since the 2012 CHNA, KCH opened a second cath lab (in 2012) and submitted an application for Chest Pain Accreditation. These efforts toward Chest Pain Accreditation have delivered the following results:

- Improved door to biomarker result to 80 minutes or less, with a consistent collect to result time of 45 minutes or less;
- Improved EKG transmission from field for chest pain, respiratory distress, and syncope to 90%;
- Improved door to EKG to less than 10 minutes;
- Improve EKG to Doctor read to 10 minutes or less;
- Improved registration for patients bypassing the Emergency Department to be registered by Patient Access 100% of the time.

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

- We are choosing not to respond to Cardiovascular Health at this time, essentially because it is a core element of our overall organizational business and strategic planning. We're not anticipating any new projects or initiatives in either area, and we believe we already provide outstanding healthcare services in the area. We feel we can have a greater impact by putting new attention and dollars toward the other needs.

Federal Classification of Reasons a Hospital May Cite for Not Developing an Implementation Strategy for a Defined Significant Need	
1. Resource Constraints	Partial explanation for decision to respond more forcefully to other Significant Needs
2. Relative lack of expertise or competency to effectively address the need	
3. A relatively low priority assigned to the need	Partial explanation for decision to respond more forcefully to other Significant Needs

4. A lack of identified effective interventions to address the need	
5. Need is addressed by other facilities or organizations in the community	Partial explanation for decision to respond more forcefully to other Significant Needs
6. Other	

Other local resources identified during the CHNA process that are believed available to respond to this need:[31]

Organization	Contact Name	Contact Information
Knox County Health Department	http://www.knoxhealth.com	740.392.2200
Ohio Department of Health	https://www.odh.ohio.gov	614.466.3543
American Heart Association	http://www.heart.org	800.242.8721
Knox County Emergency Management	http://www.co.knox.oh.us/offices/em/	740.393.6772

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

2. CANCER 2012 – SIGNIFICANT NEED; 2015 #2 CAUSE OF DEATH AND HIGHER THAN EXPECTED, PAP/CERVIX TEST BELOW AVERAGE, BREAST AND COLON RATES UNFAVORABLE COMPARED TO PEERS AND LUNG SOMEWHAT A CONCERN

Problem Statement: Disease rates should not exceed national incident rates while screening and detection services should increase

Public comments received on previously adopted implementation strategy:

- The Hospital has improved its cath lab and provided additional resources in this area. It provides free screening events for blood sugar levels, and support groups for cancer survivors and people impacted by diabetes. The Hospital has recently hired additional OB/GYNs and is in the process of providing additional funds focusing on the improvement of care
- I would agree that KCH has been very focused on implementing improvements in the areas of cancer treatment and cardiac interventions. I am less aware of measures that have been initiated in the other two areas (which is not to say measures have not been taken)
- Anecdotal evidence, at the least, exists to suggest cancer treatment and cardiac care are two areas of excellence in our hospital
- Since it has become a smoke-free facility, it is more pleasant to visit people there. One can observe events where a person is still living who would have died without the hospital's intervention, but I believe that since many of these issues involve lifestyle changes in the population, it will take a longer period of time than two years to see marked improvement
- With OSU nearby, I don't believe we need to continue to develop cancer treatment
- Within cancer, distorted attention should be placed toward lung cancer. In addition, additional attention should be placed on kidney disease

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

- Medical Oncologist (board certified) with cancer treatment services
- Radiation Oncologists (board certified) with radiation treatment services: IMRT
- Radiologist (board certified) and diagnostic imaging services for diagnosis
- Pathologist (board certified)
- Board certified general surgeons, ENTs, Urologists
- Patient Navigation Program; Breast Navigation Program
- Commission on Cancer Accredited Program 2009-present
- Cancer patients are provided access to cancer-related clinical trials
- Certified Oncology Registered Nurses
- Cancer conferences (tumor board) - multi-disciplinary

- Genetic testing/Counseling
- Cancer support groups, including breast cancer and young breast cancer survivors
- Breast & Cervical Cancer Project
- Palliative Care and Symptom Management Programs
- On-site Licensed Social Workers resource
- Annual Report provided via hospital website
- Cancer committee – multi-disciplinary: meets quarterly
- American Cancer Society Programs
- Reach to Recovery
- Wigs
- Personal health managers (books)
- Road to Recovery
- Hope Lodge
- Look Good, Feel Better

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

- Pulmonologist (board certified) added to medical staff: Dr. Costello
- Head and neck cancer screenings - 2013 and 2014
- Susan G Komen Grant - 2013/2014 and 2014/2015 - provided screening and diagnostic mammograms
- Colorectal screening kits provided free to community – 2013 and 2014
- See Community Outreach Grid/Annual Report
- DI breast specialty physician added: Dr. Konstan
- OB/GYN added: Dr. Prior - 2014
- Smoking Cessation Program referral to Knox County Health Department
- Amish Clinic created and implemented - included lab, annual exam, and mammography
- Breast health and general wellness education developed and provided to Hispanic community members - 2012, 2013, and 2014
- Annual cancer survivor celebration and education
- Annual breast cancer survivor awareness event - 2012, 2013, and 2014

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

- We are choosing not to respond to cancer at this time, essentially because it is a core element of our

overall organizational business and strategic planning. We're not anticipating any new projects or initiatives in either area, and we believe we already provide outstanding healthcare services in the area. We feel we can have a greater impact by putting new attention and dollars toward the other needs.

Federal Classification of Reasons a Hospital May Cite for Not Developing an Implementation Strategy for a Defined Significant Need	
1. Resource Constraints	Partial explanation for decision to respond more forcefully to other Significant Needs
2. Relative lack of expertise or competency to effectively address the need	
3. A relatively low priority assigned to the need	Partial explanation for decision to respond more forcefully to other Significant Needs
4. A lack of identified effective interventions to address the need	
5. Need is addressed by other facilities or organizations in the community	Partial explanation for decision to respond more forcefully to other Significant Needs
6. Other	

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

Organization	Contact Name	Contact Information
Knox County Health Department	http://www.knoxhealth.com	740.392.2200
American Cancer Society	http://www.cancer.org	800.227.2345
Susan G. Komen for The Cure	http://ww5.komen.org/	614.297.8155

3. DIABETES 2012 – SIGNIFICANT NEED; 2015 #6 CAUSE OF DEATH AND HIGHER THAN EXPECTED

Problem Statement: Enhance diabetic awareness, problem identification and controls such that Knox County no longer resides in the bottom 10% of Ohio Counties, as well as achieving diabetes as being a less frequent contributor to stroke comorbidities.

Public comments received on previously adopted implementation strategy:

- The Hospital has improved its cath lab and provided additional resources in this area. It provides free screening events for blood sugar levels, and support groups for cancer survivors and people impacted by diabetes. The Hospital has recently hired additional OB/GYNs and is in the process of providing additional funds focusing on the improvement of care

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

- Diabetes Education Program accredited by the American Association of Diabetic Educators, which includes:
    - Living with Diabetes classes (4 x year)
    - "Take Your Diabetic Diet Out To Eat" event at area restaurants (2 x year)
    - Diabetic Grocery Tour at Kroger's (3 x year)
    - Diabetes Hike For Health (1 x year)
    - Once a year overall Diabetes Education Event-Pre-Diabetes Dinner (planned for April 16, 2015)
- Outpatient nutrition appointments are ordered for diabetic patients by physicians/providers. These patients are seen privately by the Registered Dietitian Nutritionist/Diabetes Coordinator
- Community access to the Center for Rehabilitation and Wellness
- Free monthly screenings at KCH Urgent Care facility and screening, and risk assessments done at Interchurch Social Services Food Pantry in Mount Vernon, Centerburg, and Fredericktown
- Pathway to Change (weight management program)
- Wellness Center exercise programs
- Pre-employment monthly screening

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

- KCH will explore offering a Patient-Centered Medical Home meeting to persons with diabetes who miss their scheduled Medical Nutrition or Living with Diabetes appointments. This Patient-Centered Medical Home meeting could be offered quarterly to patients who don't show up or don't reschedule their private Medical Nutrition or Diabetes Education appointments
- Involvement of community health coaches in chronic disease management
- Dr. Jaime Goodman, Endocrinologist - hired March 2015

  - Will coordinate introduction of best practices
  - Will assist in developing standard order sets
- RN diabetes educator to become certified
- Increase free screening events
- Provide free education through public school health classes about diabetes risk and prevention
- Provide diabetes education and risk assessments at Knox County Hot Meals Program
- Increase attendance at Living with Diabetes - diabetes self-management education classes
- Provide community education and information via local radio outlets through public service announcements and monthly radio programs

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

- The KCH Living with Diabetes classes show an average Hemoglobin A1c dropping from 8.3% to 7.5% and an average weight loss of 10% (24 pounds) for patients who attended classes in 2013 -2014
- Developed an inpatient protocol that allows inpatients to be seen by the RN diabetes educator and RD and for follow-up as an outpatient
- Annual Status and Performance Measurement Report for Diabetes Education and Accreditation Program was filed and accepted in October 2014
- In June 2014, completed patient market research to gather information leading to a redesign of KCH diabetic program, so it better aligns with patient education needs
- Provided free education to residents in assisted living facilities in Knox County

Anticipated results from KCH Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	Yes	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	Yes	
3. Addresses disparities in health status among different populations		No
4. Enhances public health activities		No
5. Improves ability to withstand public health emergency		No

6. Otherwise would become responsibility of government or another tax-exempt organization		No
7. Increases knowledge; then benefits the public	Yes	

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

- The percentage of KCH patients with HbA1c labs at levels greater than 7 from 2014 to 2017. In 2014, there were 2061 patients with levels greater than 7 out of a total of 6474, resulting in a percentage of 31.83%.

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

- Number of admitted patients with Diagnosis Related Group (DRG) codes 637-Diabetes W MCC, 638-Diabetes W CC, or 639- Diabetes W/O CC/MCC, from 2014 to 2017. The total number of admitted patients with these codes in 2014 is 28.

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

Organization	Contact Name	Contact Information
WQIO Radio	http://www.wqioradio.com/	740.397.1000
WMVO Radio	http://www.wmvo.com/	740.397.1000
Mount Vernon City Schools	http://www.mt-vernon.k12.oh.us/	740.397.7422
East Knox Local School District	http://www.eastknox.k12.oh.us/site/default.aspx?PageID=1	740.599.7493, Ext. 1002
Fredericktown Local Schools	http://www.fredericktownschools.com/	740.694.2956
Centerburg Local Schools	http://www.centerburgschools.org/	740-625-6346
North Fork Local School District	http://www.northfork.k12.oh.us/	740.892.3666
Danville Local Schools	http://www.danvilleschools.org/	740.599.6116
Mount Vernon News	http://mountvernonnews.com/	740.397.5333

Knox County Health Department	http://knoxhealth.com/	740.392.2200
Interchurch	http://www.interchurchknox.org/	740.397.4825
Mount Vernon Hot Meals Program	http://www.mvucc.org/missions/hot-meals/	740.393.1736

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

Organization	Contact Name	Contact Information
Knox County Health Department	http://www.knoxhealth.com	740.392.2200
Ohio Department of Health	https://www.odh.ohio.gov	614.466.3543
American Diabetes Association	http://www.diabetes.org/	800.342.2383
Central Ohio Diabetes Association	http://www.diabetesohio.org/	615.884.4400

4. OBESITY – **DEATHS ABOVE OH AND US AVG.; MORBID/OBESE 9% ABOVE AVG. IMPACTS 33% OF POP.; HEALTHY EATING HABITS 6% BELOW AVG. IMPACTS 28% OF POP.**

Problem Statement: The portion of the population meeting clinical obesity standards needs to decline

Public comments received on previously adopted implementation strategy:

- BMI data and healthy eating habits need are more accurately reflected with peer counties in our state

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

- Pathway to Change Weight Management Program
- Dietician sees outpatients for medical nutrition appointments for obesity
- YMCA partnership with dietitians for nutrition presentations
- Articles written by KCH dietitians for KnoxWise newsletter
- Radio programs addressing good nutrition/healthy lifestyle
- Dietitian presentations to community businesses and schools addressing nutrition and weight management
- Grocery store tours led by dietitians
- KCH employee insurance premium reduction with weigh loss to/maintenance of ideal BMI
- KCH Center for Rehab and Wellness offers a fitness center available to the community
- KCH offers fitness centers available to the community in Centerburg and Fredericktown
- Nurse practitioner on-site at Ariel Corporation Health Clinic

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

- Dieticians are working with KCH food service director to provide healthy options in the cafeteria
- Increase the enrollment in Pathway to Change program
- Will explore printing caloric values on hospital cafeteria items
- Provide community education and information related to nutrition and healthy diets through local radio, newspaper, and school systems

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

Obesity was not a Significant Need identified in the 2012 CHNA. However, initiatives were pursued with KCH employees and clients as target audiences, and we obtained the following results:

- Pathway to Change has measurable drop in client BMI and body fat percentage
- Total employee weight loss in 2014 at KCH of 3,015 pounds

- Positive feedback from the community concerning articles, recipes, and radio programs conducted by the KCH dietitians
- Increased # of fitness visits/memberships by more than 5000 between 2012 and 2014

Anticipated results from KCH Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	Yes	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	Yes	
3. Addresses disparities in health status among different populations		No
4. Enhances public health activities		No
5. Improves ability to withstand public health emergency		No
6. Otherwise would become responsibility of government or another tax-exempt organization		No
7. Increases knowledge; then benefits the public	Yes	

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

- Percentages of KCH Primary Care patients with BMI between 30-34.9 (Obese I), 35-39.9 (Obese II), and greater than 40 (Obese III) from 2014 to 2017. 2014 data reflects the following:
    - Obese 1—20.7%
    - Obese 2—10%
    - Obese 3—8.2%

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

- Number of admitted patients with Diagnosis Related Group (DRG) codes 637-Diabetes W MCC, 638-Diabetes W CC, or 639- Diabetes W/O CC/MCC, from 2014 to 2017. The total number of admitted patients with these codes in 2014 is 28.

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

Organization	Contact Name	Contact Information
YMCA of Mount Vernon	http://mtvymca.org/	740.392.9622
WQIO Radio	http://www.wqioradio.com/	740.397.1000
WMVO Radio	http://www.wmvo.com/	740.397.1000
Mount Vernon City Schools	http://www.mt-vernon.k12.oh.us/	740.397.7422
East Knox Local School District	http://www.eastknox.k12.oh.us/site/default.aspx?PageID=1	740.599.7493, Ext.1002
Fredericktown Local Schools	http://www.fredericktownschools.com/	740.694.2956
Centerburg Local Schools	http://www.centerburgschools.org/	740-625-6346
North Fork Local School District	http://www.northfork.k12.oh.us/	740.892.3666
Danville Local Schools	http://www.danvilleschools.org/	740.599.6116
Mount Vernon News	http://mountvernonnews.com/	740.397.5333
Knox County Health Department	http://knoxhealth.com/	740.392.2200

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

Organization	Contact Name	Contact Information
Get Healthy Knox	http://www.gethealthyknox.org/	740.399.8002
Ohio Department of Education	http://education.ohio.gov/	877.644.6338

5. MATERNAL AND INFANT CARE 2012 – **SIGNIFICANT NEED; 2015 BIRTHS TO OLDER WOMEN AND NO CARE IN FIRST TRIMESTER UNFAVORABLE COMPARED TO PEERS, VERY LOW BIRTH WEIGHT SOMEWHAT A CONCERN, OTHER METRICS FAVORABLE, VISITING OB/GYN 7% BELOW AVERAGE**

Problem Statement: Enhance prenatal care and seek improvement in other underlying conditions resulting in very low weight babies and infant mortality

Public comments received on previously adopted implementation strategy:

- I think the hospital could try to become a community leader in providing opportunities for education by class and also example in improving one's diet, especially focusing on refined sugar. This could lessen the impact of the diabetes tsunami, as well as the cardiovascular health. Targeting the Medicaid population of young women might also improve infant outcomes. In addition, providing information and a more useful exercise area could also positively impact the cardiovascular area. The present exercise area is only available to non-rehab folk a few hours in early morning and a few hours in late afternoon
- The adult smoking rate reported as average is unacceptable, and 28-29% of pregnant mothers in Knox Co. report smoking during pregnancy. Heavy alcohol consumption may be average; however, alcohol-impaired driving deaths in Knox Co. are 12% higher than the Ohio average
- I don't believe that KCH has proven much success in improving the maternal and infant care priority. I believe that other organizations need to be even better connected to KCH's work; however, I believe that KCH management (not just CEO) should be better connected to the organizations supporting the health of the community. Prevention is not for the hospital to own, but to do in partnership

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

- Within 24 months, complete recruitment of additional obstetricians into the community to augment the patient care resources of the two, currently available obstetricians
- Childbirth education classes
- Prenatal lactation education classes (free of charge)
- Prenatal grandparent classes (free of charge)
- Prenatal sibling classes (free of charge)
- New Mother Guide education booklet
- Prenatal vitamins supplied to underprivileged mothers (free of charge)
- Participated in the ODH Safe Sleep Campaign

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

- Work with the newly-formed collaborative partnership of other community organizations to stratify the population to identify specific needs of targeted populations
- Increase lactation counselor availability
- Increase number of KCH Birthing Center RNs certified in External Fetal Monitoring
- Implement a tracking system in the OB/GYN offices to ensure patient compliance with all recommended prenatal visits

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

- Continue Maternal Child Health Meetings at KCH
- Board Certified OB/GYNs
- Partner with Knox County Health Department (KHD) for smoking cessation education
- Added an OB/GYN in 2014
- 54 childbirth education classes annually
- 12 lactation classes annually
- 12 sibling classes annually
- 12 grandparenting classes annually
- Recipient of the Knox County Youth Philanthropy Grant
- Moved to swaddlers in the Nursery
- Initiated skin to skin at delivery
- Applied for the Aladdin Shriners Hospital Association for Children Grant
- Offered classes taught by Clinical Nurse Educators from Ohio State University Hospital for all KCH RNs to improve nursing care during obstetrical emergencies
- Offered fetal monitoring classes for all KCH Birthing Center RNs
- Formed collaborative partnership with community organizations (KHD, Knox County Children's Services, Help Me Grow, Starting Point, Women's Infants and Children's, Knox County Head Start)

Anticipated results from KCH Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	Yes	

2. Reduces barriers to access services (or, if ceased, would result in access problems)	Yes	
3. Addresses disparities in health status among different populations	Yes	
4. Enhances public health activities		No
5. Improves ability to withstand public health emergency		No
6. Otherwise would become responsibility of government or another tax-exempt organization		No
7. Increases knowledge; then benefits the public	Yes	

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

- Number of patients delivering at KCH with obstetrical care received during their first trimester from 2014 to 2017.

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

- Percentage of babies delivered at KCH with low birth weight, 2014 to 2017.

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

Organization	Contact Name	Contact Information
Knox County Health Department	http://knoxhealth.com/	740.392.2200
Knox County Children and Family Services	http://www.co.knox.oh.us/offices/jobfam/childfam.asp	740.397.7177, Ext. 3043
Ohio Department of Health Help Me Grow	http://www.helpmegrow.ohio.gov/	614.644.8389
Knox County Starting Point	http://www.carenetcommunity.org/	740.393.0370
Knox County WIC	http://www.womaninfantchildrenoffice.com/knox-county-wic-clinic-wc1773	740.392.2200
Knox County Head Start	http://www.knoxheadstart.org/	740.397.1344

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

Organization	Contact Name	Contact Information
La Leche League of Ohio	http://www.lllohio.org/	
Hospice of Knox County	http://www.hospiceofknox.org/	740.397.5188
Healthy Mom & Baby	http://www.health4mom.org/	877.377.5326
OhioHealth Riverside Methodist Hospital Nursing Education	https://www.ohiohealth.com/riverside/	614.566.5000
The Ohio State University Wexner Medical Center Nursing Education	http://wexnermedical.osu.edu/	614.293.8000
Voices For Ohio's Children	http://www.raiseyourvoiceforkids.org/	877.881.7860
Ohio Department of Health	http://www.odh.ohio.gov/	614.466.3543

Other Needs Identified During CHNA Process

5. COMMUNICATION AND PREVENTION increase identified by written comments as underlying factor to solve problems
7. SMOKING deaths above OH and US avg., adverse findings also in 2012
8. ALZHEIMER'S #7 cause of death, at expected rate
9. POPULATION TO PHYSICIAN RATIO twice OH avg. (a doctor shortage); Knox qualifies for Medically Underserved Area federal designation
10. MENTAL AND SUBSTANCE ABUSE SERVICES need identified by Local Experts
11. HYPERTENSION #10 cause of death, at rate lower than expected
12. ALCOHOL IMPAIRED DRIVING deaths above OH and US avg.; Excessive Drinking adverse finding in 2012, heavy alcohol consumption below OH avg
13. POVERTY impacts 13.2% of pop., 24.2% of Knox children
14. KIDNEY #9 cause of death, at expected rate
15. UNINSURED rate above OH avg. below US avg.
16. LUNG #4 cause of death, rate as expected
17. STROKE rates worse than US and Peer Co. avg.: #3 cause of death, significantly higher than expected
18. ACCIDENTS #5 cause of death, at expected rate
19. MOTOR VEHICLE INJURY rates worse than US and Peer Co. avg.
20. SLEEP less than 6 hours 8.8% above avg. impacts 15% of pop.
21. FLU/PNEUMONIA #8 cause of death, at lower than expected rate
22. CHRONIC LOWER BACK PAIN 7% above avg. impacts 25% of pop.
23. LIFE EXPECTANCY/PREMATURE DEATH (deaths prior to age 75) deteriorated over 10 years; Male Life expectancy 4 years behind best rates
24. LIVER #13 cause of death, significantly higher than expected
25. UNIDENTIFIED (Points allocated by a Local Expert for an undefined need)

Overall Community Need Statement and Priority Ranking Score

Significant needs where KCH has implementation responsibility[32]

3. DIABETES
4. OBESITY
5. MATERNAL AND INFANT CARE

Significant needs where KCH did not develop implementation strategy[33]

1. CARDIOVASCULAR DISEASE
2. CANCER

Other needs where KCH developed implementation strategy

None

Other needs where KCH did not develop implementation strategy

6. COMMUNICATION AND PREVENTION
7. SMOKING
8. ALZHEIMER'S
9. POPULATION TO PHYSICIAN RATIO
10. MENTAL AND SUBSTANCE ABUSE SERVICES
11. HYPERTENSION
12. ALCOHOL IMPAIRED DRIVING
13. POVERTY
14. KIDNEY
15. UNINSURED
16. LUNG
17. STROKE
18. ACCIDENTS
19. MOTOR VEHICLE INJURY
20. SLEEP
21. FLU/PNEUMONIA
22. CHRONIC LOWER BACK PAIN

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

23. LIFE EXPECTANCY/PREMATURE DEATH
24. LIVER
25. UNIDENTIFIED

APPENDIX

Appendix A – Written Commentary on Prior CHNA

KCH solicited written comments about its 2013 CHNA.[34] 16 individuals responded to the request for comments. The following presents the information received in response to the solicitation efforts by the hospital. No unsolicited comments have been received.

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

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
Represents the Broad Interest of the Community	12	3	15
Representative of Groups of People	10	4	14
Has Special Public Health Expertise	3	9	12
Member of or representative of underserved, low-income, minority population	1	10	11
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	4	8	12
Representative of or member of chronic disease group or organization	2	11	13
Other (please specify) Hospital Foundation Board Member Board Member of the National Kidney Foundation (Representing Ohio, Kentucky and Middle TN)	2		2
answered question			16
skipped question			0

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

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

   - Need #1. Cancer (cancer screening, cancer deaths, breast cancer, lung cancer, colon cancer) with the intent to lower cancer deaths
   - Need #4. Cardiovascular Health (coronary heart disease, stroke, chronic high blood pressure) with the intent to lower the cardiovascular death rate
   - Need #5. Maternal and Infant Care (births to unmarried women, teen birth rate, infant mortality, low birth weight, no care in the first trimester, premature births, neonatal infant mortality, post-neonatal infant mortality, very low birth weight, white non-Hispanic infant mortality and births to women age 40 to 54) with the intent to improve utilization of available resources (i.e. care during first trimester)
   - Priority #7 Diabetes (Diabetic screening and diabetes rate) with the intent to better manage the disease and its process.

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

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

- The needs appear to be appropriate for the hospital to take on, although a thorough study of the entire document could shine a light on those not included. It would seem that the hospital could integrate an improvement in the prevalence of obesity within its community while addressing needs #4 and #7, for example.
- All items appear within KCH's collective abilities and expertise, as well as physical and financial resources
- Considering the population it serves, I believe these are correct
- High importance to be efficient and up-to-date in these services - screening, screening, screening and FYI workshops
- I believe this set still represents the plurality of events seen at the Hospital; therefore, the list retains its relevancy
- Improved cancer clinics and treatment
- Expanded heart cath lab
- Expanded 24/7 heart care
- Improved birthing center for mother and others
- Do diabetic screening and continue diabetic education
- I agree with these being priorities
- While there are other pressing needs in our community, I would agree this is a valid set of priorities affecting broad segments of the population
- Fully agree with the stated objective above

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

- I would not agree that the above information defines implementation actions of the hospital. Attempting to read the current Needs Assessment, I would comment that it is not easy to determine what the actions of the hospital are, other than the committing of services and some grant monies for education
- It appears that KCH conducted appropriate and measured responses
- The results are above average for a hospital of our size. We just need to have more people recognize this fact
- High importance
- The Hospital has improved its cath lab and provided additional resources in this area. It provides free screening events for blood sugar levels, and support groups for cancer survivors and people impacted

by diabetes. The Hospital has recently hired additional OB/GYNs and is in the process of providing additional funds focusing on the improvement of care

- Emergency room
- Implemented cardiology 24/7 coverage
- Implemented more surgeons and urology services
- The hospital takes great care in determining how to allocate its capital spend. It appears that a good portion of this spend is directed at health status improvement
- I would agree that KCH has been very focused on implementing improvements in the areas of cancer treatment and cardiac interventions. I am less aware of measures that have been initiated in the other two areas (which is not to say measures have not been taken)
- Hospital working toward objectives as outlined

5. **Do you perceive the efforts by the hospital made any improvement in the identified priority needs?**
   - I have no material from which to make that determination
   - Don't know
   - Yes
   - Cannot fairly evaluate
   - Since it has become a smoke-free facility, it is more pleasant to visit people there. One can observe events where a person is still living who would have died without the hospital's intervention, but I believe that since many of these issues involve lifestyle changes in the population, it will take a longer period of time than two years to see marked improvement
   - Improvements in ER flow
   - Improvements in clinics that address the above need areas
   - Yes
   - Anecdotal evidence, at the least, exists to suggest cancer treatment and cardiac care are two areas of excellence in our hospital
   - Yes, the hospital has ongoing special education and awareness building projects that are very visible within the community
6. **Should the hospital continue to allocate resources to assist improving the needs last identified?**
   - I feel that obesity is a serious underlying problem in our community. Wellness incentives, where appropriate, should be considered
   - With OSU nearby, I don't believe we need to continue to develop cancer treatment
   - None

- Within cancer, distorted attention should be placed toward lung cancer. In addition, additional attention should be placed on kidney disease

7. **Do you have opinions about new implementation efforts or community needs the hospital should pursue?**
   - It would be interesting to see what services/resources that the hospital offers and are still appropriate are being under-used. Is more outreach needed to make sure that services reach those who need it? It would appear that the hospital has a wide network of doctors to determine services needed for their patients. Are citizens simply not seeking health care? Does it continue to be an insurance-related issue?
   - Participation in FQHC assessment
   - None at this time
   - I think the hospital could try to become a community leader in providing opportunities for education by class and also example in improving one's diet, especially focusing on refined sugar. This could lessen the impact of the diabetes tsunami, as well as the cardiovascular health. Targeting the Medicaid population of young women might also improve infant outcomes. In addition, providing information and a more useful exercise area could also positively impact the cardiovascular area. The present exercise area is only available to non-rehab folk a few hours in early morning and a few hours in late afternoon
   - I believe the hospital is currently on the right track
   - Acute mental health services (difficult to support, I know); dermatology; gastroenterology
   - See above

Appendix B – Local Expert Advisor Opinions on Significant Needs

18 Local Expert Advisors[35] participated in the first round of an online survey offering opinions about their perceptions of community health needs.

Area of Expertise (i.e. a general brief statement such as: Public health, representative of a specific population, long term area resident etc.)
1. Physician
2. Government and education
3. Lifetime resident
4. Long term area resident
5. Interact with those seeking social services.
6. Adult Education
7. Adult Education
8. Community planning and collaboration
9. Finance/long term resident
10. Public Health/Nursing
11. Long term area resident.
12. Long term area resident
13. Long-term care, Mount Vernon native
14. Long term area resident
15. CITY GOVERNMENT
16. CITY GOVERNMENT
17. Former Hospital Board Member; Current KCH Founbdation Board Member
18. Long Term Area Resident

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

Question 1: *"What do you believe to be the most important health or medical issue confronting the residents of your County?"*

Answers were placed in a "Word Cloud" format for analysis and generated the following image:

Word Clouds are analytical tools that give greater visual prominence to words appearing more frequently in the source text. This information visualization establishes a portrait of the aggregate responses, presenting the more frequently used terms with greater text size and distinction in the visual depiction. Common article words (e.g., "a,", "the"), non-contextual verbs (e.g., "is", "are"), and similar words used when writing sentences are suppressed by this application.

Specific verbatim comments received were:

- I believe the hospital has made improvements in the areas identified, but they remain priorities for the community. I agree with the first comment that integrating efforts to combat obesity would be useful
- It appears the set of needs are appropriate for the area but it appears there may be other needs not represented. As it is difficult to meet all needs, tackling the ones that are financially feasible as well as partnering with other organizations/agencies within the county my assist in meeting these needs in a timely manner
- Certainly with respect to cardiac and cancer care the hospital is dialed in to these priorities. The suggested emphases on maternal care and diabetes, though I believe to be in place at KCH clinically, might benefit from a higher public profile to make the availability of these services better known
- Each of the identified needs are appropriate and important for the community and mental health is another improvement area to consider
- These priorities hit the target for our community
- I also agree that the stated priorities are appropriate

- These needs probably address the largest segments of our local population and as such would have the largest impact on overall health
- This list was appropriate for this county. I'm curious what #2, 3, and 6 were
- Good responses.....on target for our community needs
- Apparently there was collective support for the identified priorities, as I reflect on them I do not see the recommendation that the hospital address the priorities in partnership with their community. Consideration of addressing the priorities with community stakeholders, partners and residents should also be a priority
- While I agree with the priorities, I believe we need to provide more education as to prevention including addictions
- With some variation, the responses appear to be generally consistent with respect to the appropriateness for the hospital seeking improvements on the stated needs
- Prevention is key in all of the priorities in order to create community-level change. Collaborative groups exist in the community to look at different ways of addressing and preventing these issues, with KCH being a key element in doing that work. Other organizations need to be even better connected to KCH's work to both provide input and planning for addressing specific needs of certain populations, as well as a means for better connecting residents to appropriate services and especially community education. We are starting to see some new collaborative approaches for wellness screenings at hot meal sites, delivering community education where consumers of financial/emergency serves are already accustom to frequenting, etc. I think these connections and open lines of communication are important in order to address these issues
- These comments seem to all indicate that the need priority list is comprehensive and appropriate for this community

Question 2: ***"What advice do you give us about the implementation written comments?"***

The responses generated the following image:

Specific verbatim comments received were:

- I agree the hospital has been responsive to the identified needs
- Possibly more information marketing is needed to make public aware of the improvements although there has been good communication regarding the improvements in cardiac as well as securing more doctors in the area
- Nothing of substance to add to this list of comments
- Community leaders recently had the opportunity to do a virtual tour of the entire hospital. It was an impressive presentation and showed the forward thinking of KCH and its response to the needs of our community
- Privacy is a factor in local people choosing KCH, especially in diagnostic areas. The above comments seem to acknowledge actions taken which are all appropriate, and address some needs. Did they go far enough? Lab - everyone in the waiting chairs hears why you are there. X-RAY is not private at all and they usually require some level of disrobing
- I would recommend that the hospital consider how they communicate their outcomes measurement to the public. I know that they have implemented some of the improvements (moved strategies forward) but how have you proven outcomes or assisted in improving health status?
- I believe the hospital is working toward objectives as outlined but needs to incorporate more outreach projects

- It appears that the respondents agree that implementation actions are appropriate. The hospital should continue these implementation actions
- I think the work around ACA has been incredible...congrats and thank you. We need to aggressively find more people who need coverage and connect them, and then through their relationships with other service providers model/mentor good behaviors in prevention and wellness, as well as addressing chronic health issues
- It appears that participants know that improvements/expansions have been implemented, however, is the same information reaching an underserved population

Question 3: *"What advice do you give us about the perceived improvement written comments?"*

The responses generated the following image:

Specific verbatim comments received were:

- I do believe the hospital has made improvements. The community may only become aware of the efforts when they are personally impacted. Communication efforts are helpful, but sometimes not retained unless of personal importance
- It appears there is improvement but the measurement of the improvement is not readily available or well known. It makes sense to include these metrics in future marketing to make the public not only aware there are improvements but the actual impact of the improvements
- With respect to cardiac intervention, the number of procedures performed would indicate KCH has been very responsive to the stated need for heart care. I presume the volume of services provided in the cancer center would likewise indicate a high lively responsiveness
- I don't have any suggestions here
- The above responses would indicate the respondents did not know whether or not the improvements had an impact on the need identified. Either KCH needs to consider some benchmark reporting or identify standards that can be measured going forward and share specific outcomes, numbers or changes that might speak to this
- I am not aware of measured improvement; however, I've heard some positive things
- I am unsure whether respondents understood the question or were not aware of what the hospital has accomplished. Again, communication of strategies and outcomes to the community may be of benefit and utilizing stakeholders and partners as your informed advocates
- Yes

- It appears that it is not clear that the hospital has made any improvement in the identified priority needs. Improvements should be publicized in a more effective manner
- I perceive that there are improvements, but I still think better connectedness to find people where they are in what they view as a comfortable environment would be even more helpful in building relationships with them, providing education, and connecting them to services
- Mostly evident to participants that improvements have been made

Question 4: ***"What advice do you give us about written comments on maintaining the prior identified priority needs?"***

The responses generated the following image:

Specific verbatim comments received were:

- I disagree that the priorities should change due to the proximity of OSU
- It is clear the priorities still deserve the resources allocated to them
- I agree these are all valid areas of emphasis. To the list I would add mental health services, though I am aware of the difficulty of such implementation
- I know cancer patients appreciate having treatment in our community as opposed to traveling to Columbus
- Cancer can occur anywhere in the body. There is no way that KCH can have expert cancer care for all local residents. Is there a couple that have standard protocols that could be emphasized and dealt with locally?
- Drug addiction has become a huge problem. I agree with the comment that OSU/James Hospital provides superior care. I understand many cannot travel to Columbus so chemo should be continue to be offered here, but further emphasis on cancer care could be shifted to substance abuse
- Interesting that there were no negative votes on any of the needs. It makes me question the knowledge/understanding the respondents had on each subject/priority need area

- Yes
- The hospital should continue to allocate resources. Should also take a look at obesity and kidney disease treatment
- I think it is obvious that the community wants to see these top needs continue to be addressed. I believe these four should be the focus of the county's community health improvement plan where specific goals are set for each with long-term measurement indicators and collaborative best practices are identified and implemented in a comprehensive system with KCH as a leader in most cases, but with support from other partners infused in the approach as well

Question 5: "What advice do you give us about the written comments suggesting new needs or implementation efforts?"

The responses generated the following image:

Specific verbatim comments received were:

- Educational outreach is always important, but may only be well-received when it currently impacts community members
- The comments all seem appropriate. Education partners could assist with the need for healthcare information, healthy living, etc.
- The general area of nutrition (linked with the problems of obesity) and mental health would be welcomed. Also, as our community ages, an emphasis on geriatric services might be considered
- Again I was impressed with what I saw on the virtual tour of KCH to community leaders
- I certainly agree with the comment on gastroenterology, dermatology and mental health as being services we lack locally. I have no way to know how many are driving out for those services, but I know of at least 15 personally that drive to Columbus for this. I also think privacy should be addressed. I hear it mentioned a lot. Don't put me in a paper gown and sit me in a hallway with other patients awaiting service
- Substance abuse and mental health
- Question: What does the hospital want to be in regards to health care in the community? Do they want to be the "place to go for all aspects of health care" and "reign supreme"? Or do you want to be known as the best, rural, community hospital in Ohio offering inpatient services for illness care with superb diagnosticians, diagnostic tools, and professionals and work in partnership with the community to improve our community's health?
- Again, more outreach and educational programs

- These responses are quite mixed and collectively offer no common theme
- Participation in the creation of a federally qualified health center/community health center to increase local collaboration, to create a system for all aspects of care and wellbeing can be addressed (mental/dental/behavioral/physical), along with case management to work with households as needed longer term to improve household stability and wellness, would go far in addressing these priority community health related issues, as well as others
- While we have ready list of community needs, but very few new ideas about how to reach community members - especially our underserved population. Perhaps negotiating with KAT to provide transportation to informational sessions/classes would give people a better opportunity to attend. Perhaps these classes/sessions could be held off-site in each county community to allow better access for those unable to get to the hospital

Question 6: ***"In your own words ...What do you believe to be the most important health or medical issue confronting the residents of your County? Health needs can be physical health, public health, mental health, dental health, environmental issues and / or any other situation or condition you believe important. Your description could reference service availability (or lack thereof) concerns about payment, insurance, government or industry programs or anything else you believe important. There is no right or wrong answer; we just want your opinion."***

The responses generated the following image:

Specific verbatim comments received were:

- Understanding general, overall health needs and the availability of quality services right here in our community. Too often people don't use the services available locally, believing they can only find quality in a bigger city, or perhaps not even taking the time to discover that the services and specialties are available here
- "1. Health insurance access is a major concern. With all the changes, information, cost, and understanding the system make it very difficult for people to be served in this area
- 2. Drug abuse and the effects on society caused by drug abuse are extreme concerns. The more we try to assist our residents, the more we attract those who want to take advantage of a system to help those who need it
- 3. Mental health issues need more attention. There are not enough service providers or immediate access to providers
- At this particular time, I would agree we need to get a handle on prescription and illegal drug abuse, as our negligence (and ignorance?) in this area will eventually have severe negative social and economic impacts on our community

- The lack of available physicians. When my position retired I had a long wait to see his replacement who then left and I had to see a second replacement. Fortunately we have the urgent care center to meet immediate needs in the interim
- Obesity with smoking being a close second. These two factors contribute to many health conditions that progress into very serious outcomes and expensive consequences to treat
- Currently, drug abuse
- Access to integrated healthcare on a continuum - from "twinkle to wrinkle" - where providers communicate and wellness and whole health are a priority
- I believe care is provided to the extent we can financially support it. Grants for education and public awareness/education would be helpful
- Heart and cancer issues are the most important
- Wellness efforts and understanding of their importance in addressing and preventing obesity, stress relief, sleep, along with less reliance on medication for every issue. This is a tough question. Dental care has to be there, as does mental health. And to me, the real issue is the need for a community health center holistic approach
- I feel some of the most important health/medical issues within Knox County include substance abuse, mental health and simply being proactive about health issues. I'm worried that more and more individuals are opting not to continue routine wellness visits, dental, vision appointments - these don't seem to be a priority (especially to the underserved population)

Question 7: ***"Do you perceive there are any needs, as well as potential health issues, impacting racial and ethnic minority groups, low-income groups, women, children, older adults, residents of rural areas, individuals with special health needs including those with disabilities or in need of chronic care or in need of end-of-life care, including populations such as LGBT and people with Major Co-morbidity and Complications? If you believe any situation as described exists, please also indicate who you think needs to do what?"***

The responses generated the following image:

Specific verbatim comments received were:

- Our community is most impacted by the needs of low-income groups who don't seek out the available resources. We have a number of social and health organizations that work to communicate the available resources to this population, but more information and communication is always beneficial
- The poverty culture is prevalent in some areas of the county. Therefore, the issues associated with poverty need addressed if the culture is to change in the county. Opportunities, education, transportation, and removing the barriers that exist for residents to live a healthy life are important areas of concentration that existing or new groups can address
- The lack of a critical mass of such populations in our community makes it difficult for me to make any valid observations

- I believe the hospital meet the needs of these groups; however, it is at a cost to hospital to pay for the services that are not reimbursed by the patients. That certainly has an impact on the finances of the hospital
- Low income groups tend to smoke more and eat more starch and sugar as they stretch their food dollar. They are also the least able to pay for programs that might educate and support improvements such as gym memberships, nutrition programs, etc.
- The health of children who have parents addicted to drugs
- Mount Vernon may be central in the county however we have many residents who cannot access care due to the inability to travel to the city. Discussion needs to continue/take place on the opportunity to take integrated care to those individuals or bring them to the care. One example is pediatric care (not enough providers) and pediatric specialty care
- A seamless program for elder care and rehabilitation would be helpful. That care is a bit dis-jointed today
- None perceived
- I believe low-income and even low to moderate income groups are in significant need of care (dental, physical, behavioral). We need to better understand the gaps of ACA coverage in order to understand if the low-income or moderate-income groups have more trouble finding/obtaining care. I think there are community experts available who could and would have very productive conversations about the needs of special populations which would be very beneficial
- I think that some individuals in low-income groups do not regard health/wellness as a high priority. Their access to healthcare can be limited by economics and geography. Taking resources to outlying communities could be an option for increased access

Appendix C – Identification & Prioritization of Community Needs

Significant Need Candidate	Total Votes for Need	Percent of Votes	Cummulative Vote	Number of Experts Voting for Need	Significant Need Determination
1. CARDIOVASCULAR HEALTH	323	16.15%	16.15%	20	Significant
2. CANCER	297	14.85%	31.00%	20	
3. DIABETES	263	13.15%	44.15%	18	
4. OBESITY	237	11.85%	56.00%	15	
5. MATERNAL and INFANT CARE	225	11.25%	67.25%	15	
6. COMMUNICATION AND PREVENTION	108	5.40%	72.65%	8	Other Identified Needs
7. SMOKING	82	4.10%	76.75%	7	
8. ALZHEIMER'S	55	2.75%	79.50%	8	
9. POPULATION TO PHYSICIAN RATIO	55	2.75%	82.25%	8	
10. Mental and Substance Abuse Services	45	2.25%	84.50%	4	
11. HYPERTENSION	44	2.20%	86.70%	7	
12. ALCOHOL-IMPAIRED DRIVING	42	2.10%	88.80%	7	
13. POVERTY	40	2.00%	90.80%	6	
14. KIDNEY	32	1.60%	92.40%	6	
15. UNINSURED	28	1.40%	93.80%	6	
16. LUNG	24	1.20%	95.00%	5	
17. STROKE	19	0.95%	95.95%	5	
18. ACCIDENTS	14	0.70%	96.65%	4	
19. MOTOR VEHICLE INJURY	13	0.65%	97.30%	4	
20. SLEEP	13	0.65%	97.95%	4	
21. FLU / PNEUMONIA	12	0.60%	98.55%	4	
22. CHRONIC LOWER BACK PAIN	9	0.45%	99.00%	4	
23. LIFE EXPECTANCY / PREMATURE DEA	8	0.40%	99.40%	4	
24. LIVER	8	0.40%	99.80%	4	
25. Undefined	4	0.20%	100.00%	1	
Total	2000				

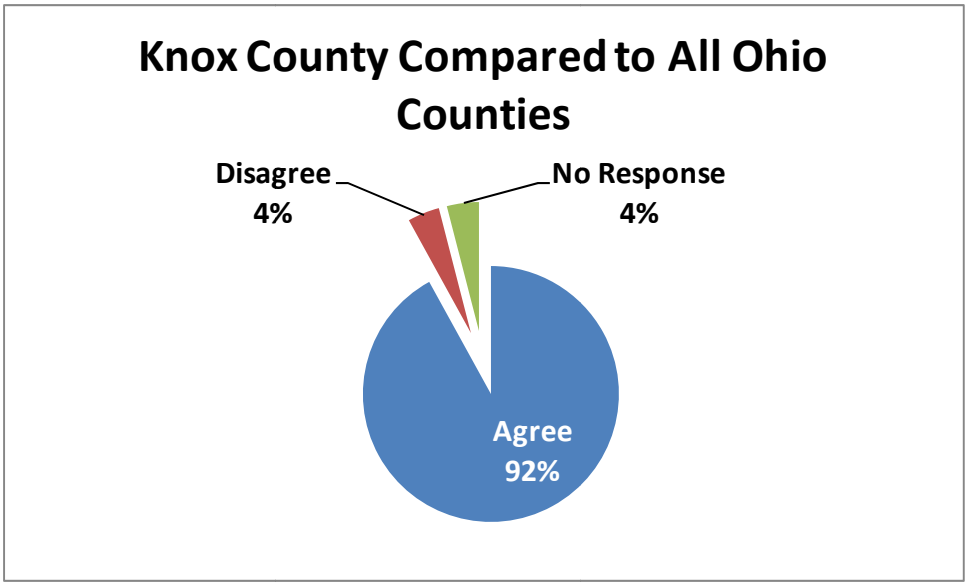
Individuals Participating as Local Expert Advisors[36]

Characteristics of Local Experts	APPLIES to me	DOES NOT Apply to me	Response Count
(1) **Public Health** - Persons with special knowledge of or expertise in public health	4	21	25
(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	5	20	25
(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	3	22	25
(4) **Chronic Disease Groups** - Representative of or member of Chronic Disease Group or Organization, including mental and oral health	1	24	25
(5) **Represents the Broad Interest of the Community** - Individuals, volunteers, civic leaders, medical personnel and others to fulfill the spirit of broad input required by the federal regulations.	21	4	25
		Answered Question	25
		Skipped Question	0

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

Advice Received from Local Expert Advisors

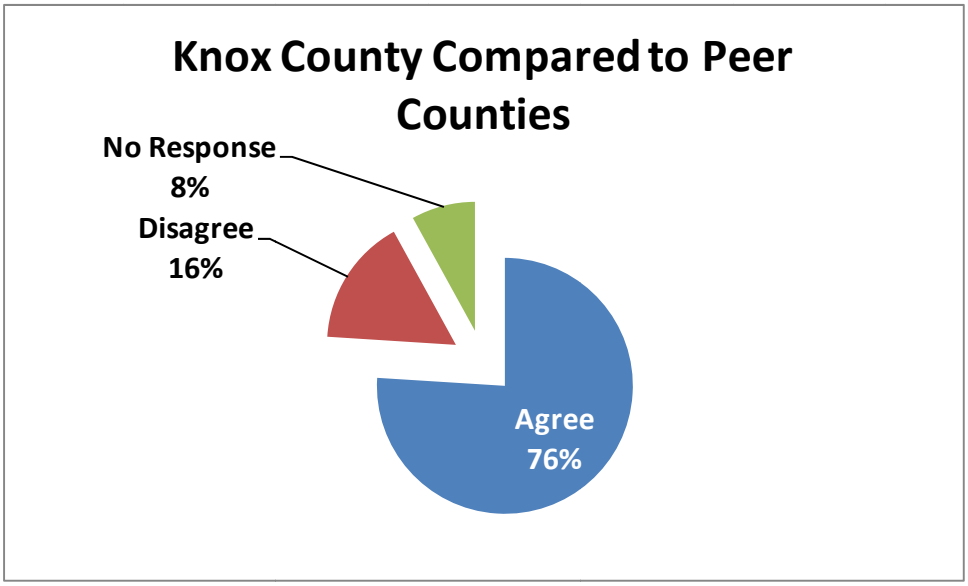
Question: *Do you agree with the observations formed about the comparison of Knox to all other Ohio counties?*



Comments:

- No knowledge base from which to argue. Seems reasonable
- I am aware of the majority of these studies/data sets and concur with the information/rationale displayed here
- I'm uncertain about the last observation about population to physician ratio. There seems to be a need for more primary care practitioners because many are not accepting new patients

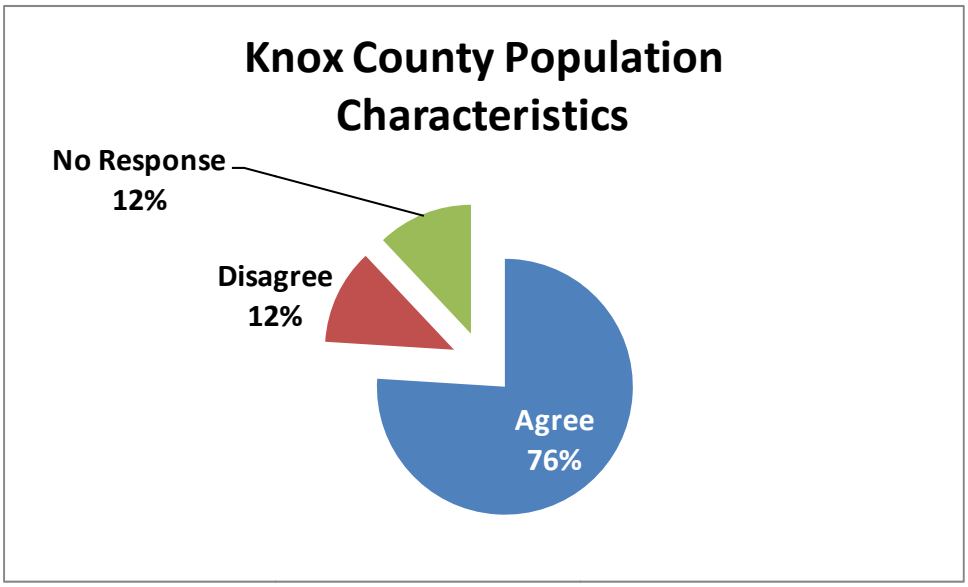
Question: *Do you agree with the observations formed about the comparison of Knox to its peer counties?*



Comments:

- A few of these ratings are contrary to my perceptions

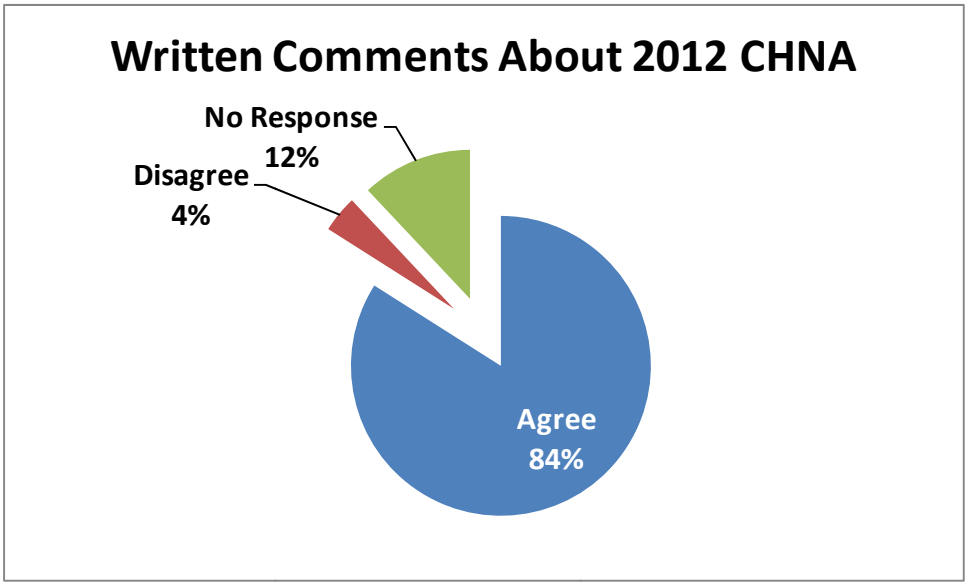
Question: *Do you agree with the observations formed about the population characteristics of Knox?*



Comments:

- BMI data and healthy eating habits need are more accurately reflected with peer counties in our state
- I don't expect the population of Knox County to decrease

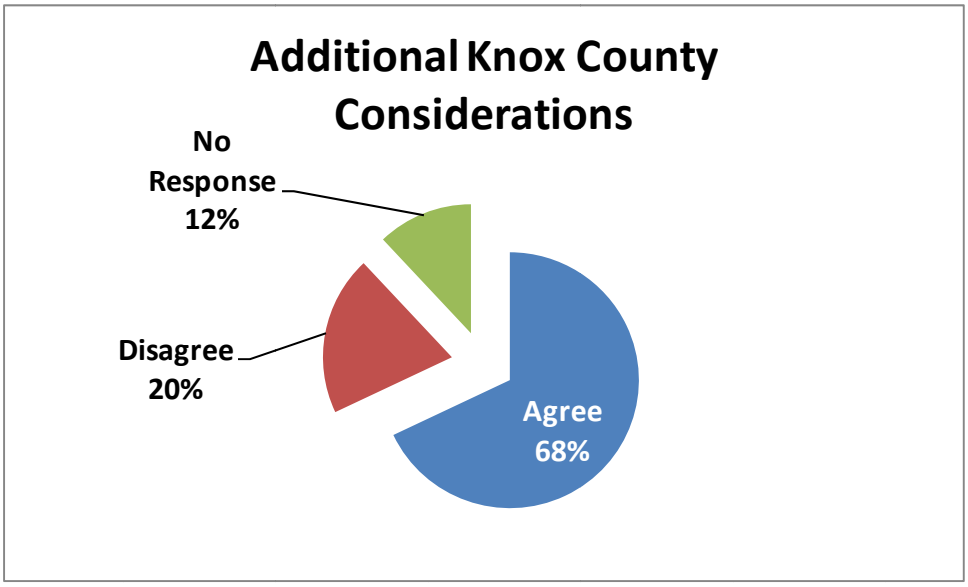
Question: *Do you agree with the observations formed about the opinions from local residents?*



Comments:

- I don't believe that KCH has proven much success in improving the maternal and infant care priority. I believe that "other organizations need to be even better connected to KCH's work however, I believe that KCH management (not just CEO) should be better connected to the organizations supporting the health of the community. Prevention is not for the hospital to own but to do in partnership

Question: *Do you agree with the observations formed about the additional data analyzed about Knox County?*



Comments:

- I thought Knox Co. was a HPSA for dentists. Julie Miller, health commissioner, would be able to confirm that. In addition, our community most recently received a MUA designation.....once again Julie would be best to confirm the exact designation and details
- Knox County is designated as a dental health professional shortage area. The adult smoking rate reported as average is unacceptable and 28-29% of pregnant mothers in Knox Co. report smoking during pregnancy. Heavy alcohol consumption may be average, however alcohol-impaired driving deaths in Knox Co. are 12% higher than the Ohio average
- It seems Knox County would qualify as a HPSA due to the need for mental health care. Also, more than one organization is providing hospice care- Heartland, etc.

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

Illustrative IRS Schedule h Part V Section B (Form 990)[37]

Community Health Need Assessment Illustrative Answers

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

   No

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

   No

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

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

      See footnote #18 page 14 and #20 page 14

   b. **Demographics of the community**

      See footnote #21 page 15

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

      See footnote #30 page 35 and #31 page 38

   d. **How data was obtained**

      See footnote #11 page 9

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

      See footnote #28 page 35

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

      See footnote #13 page 11

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

      See footnote #17 page 12 and #36 page 77

[37] Questions are drawn from 2014 Federal 990 schedule h 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 footnote #8 page 8; #9 page 9; #12 page 10; #14 page 11; #15 page 11 and #35 page 61

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

See footnote #10 page 9 and #26 page 19

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

No additional information as last report was in 2012

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

See footnote #1 front cover page

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**

See footnote #16 page 11 and #34 page 57

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 page 4 and #7 page 8

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

Yes

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

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

https://www.kch.org/resources/health-needs-assessment#qt-resources_additional-ui-tabs1

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

none

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

Yes

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

No additional actions were taken

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

   See footnote #32 page 54 and #33 page 54

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

   2012

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

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

       https://www.kch.org/resources/health-needs-assessment#qt-resources_additional-ui-tabs1

    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 #31 page 38

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?

    None incurred so Form 4720 not filed

    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?

    None incurred so no Form 4720 files so no amount reported